

SECTION IV.

SERVICE MANAGEMENT

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.ccmmentalhealth.org
Submission Date	April 1, 2003

Item: IV. Service Management

Goal: 1. The Local Business Plan provides for adequate management of core service functions in accordance with the State Plan. (W)

Effective Date: April 1, 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a) A management plan for oversight and operation of core service functions is attached and addresses multiple elements as defined below.</p> <ol style="list-style-type: none"> 1. Screenings and assessments are currently available in multiple locations by MHC staff. 2. MHC staff are located in other community agencies and are available for assessment and screenings on site. 3. Trainings have occurred with other agencies to facilitate identifying when a more comprehensive mh/dd/sa screenings and/or assessment is indicated. 	<ol style="list-style-type: none"> 1. The interface between a local 1-800 number for access to the system and a DHHS-developed information and assistance program will be developed as transition into an LME occurs. <p>Training and technical assistance will occur with other community groups as well as providers to further develop the screening and assessment process.</p>	<p>The State has not developed the DHHS information and assistance program.</p> <p>Many providers are not well versed in level of care criteria and target population determination. Further, many do not have structured screening instruments that are utilized in determining appropriateness for services. To further develop this process, a standardized screening and assessment tool is needed from the State.</p>

<ol style="list-style-type: none"> 4. The MHC is consolidating assessments for children and adults to allow cross disability assessments to occur by the same staff. This will streamline access to appropriate services based on target population determination. 5. The MHC contracts with CONTACT for after hours screening and referral services. MHC staff are also accessible to CONTACT as are MHC on-call physicians. 6. Discussions are occurring with providers re: provision of screening and assessment services in the communities. 7. The MHC has multiple partnerships with others in the community. These are utilized in referring individuals for community supports and services. 8. The community has a large number of providers but not many who are serving or are willing to serve target population clients. 9. Providers are seeing consumers with other third party payors at times (Champus, private insurance). 10. Many resources to be utilized for non-target populations have been developed. They need to be further defined and a resource book completed. 11. Community initiatives, (Neighborhood Guardian Program, Youth Leadership Initiative, Families Helping Families, and Cumberland Interfaith Hospitality Network) are further promoting partnering to develop natural and faith-based supports as appropriate. 12. Draft on policy for service coordination has been completed. 	<p>Other referral networks will be identified and developed based on community data and CFAC recommendations.</p> <p>The Qualified Provider Network Plan will address strategies to enhance provider willingness to serve target and non-target populations. This will include information from community needs assessments on areas that have scare resources and those that may not be very accessible to consumers in the area.</p> <p>Resource guide will be completed and updated on a regular basis.</p> <p>Obtain Area Board Approval for policy.</p>	<p>CONTACT has limited capacity at this time and, although there are trained professional support workers available, the staff answering the calls are volunteers and not clinical staff.</p>
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<p>13. Service Monitoring, Evaluation Committee and CFAC are addressing monitoring roles for various individuals.</p> <p>14. There are strong recommendations to have a “citizen monitoring” component to the overall monitoring and evaluation plan for the LME.</p> <p>15. The community has strong advocates that lobbied for SB 163. These advocates and family members are highly motivated to ensure that quality services are provided that promote healthy outcomes for consumers, families, the community and the system of services.</p> <p>16. CFAC members and others identified difficulties with the current access to care system that led to agency changes.</p> <p>17. CFAC and others will be highly involved in the overall monitoring and management plan that evolve for the LME, both from a policy formulation and implementation perspective to an actual evaluation of effectiveness and efficiency of the delivery of core services.</p> <p>18. The MHC and other agencies have longstanding partnerships that have enabled the community to develop resources and supports even when finances have been limited.</p> <p>19. The MHC have staff on multiple boards and participating in community initiatives/activities focusing on developing stronger communities, blending resources and keeping a focus on what the citizens, families and communities say they need and works-</p>	<p>Evaluation Plan for the community that will include the LME and providers, will include monitoring roles and responsibilities as defined by consumers and family members.</p> <p>Citizen monitoring model will be presented by consumers and advocates to LBP committees. This will be studied and included based on models presented that match community needs.</p>	
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<p>not just what an agency says, based on their perspective, is needed (sometimes because it is what is available).</p> <p>20. Outreach activities have been and will continue to be provided throughout the community.</p> <p>21. The MHC has a prevention unit that has been in operation for many years.</p> <p>22. Selective and universal prevention activities have been provided in the community. Many activities have focused around substance abuse and youth.</p> <p>23. System of Care principles have been used in child services for many years. These efforts are now expanding into the adult world.</p> <p>24. MHC staff have been co-located in other agencies which has enhanced collaboration, sharing of resources and more comprehensive service planning with consumers and families.</p> <p>25. Collaboration around shared populations occurs with DSS, Public Health, Community Corrections, Juvenile Justice, the school system, Child Advocacy Center, Rape Crisis, the hospital, Homeless Coalition, Detention Center, Headstart, Partnership for Children, Juvenile Assessment Center.</p> <p>26. Crisis and emergency services are offered by the MHC, through a contract with CONTACT for telephone crisis services, and with the hospital.</p> <p>27. Home based therapists and diversion specialists are available 24/7.</p> <p>28. Physicians are on site in the emergency room to better assess and triage</p>	<p>All stakeholders will analyze where more outreach services are needed and why certain individuals are not identified in a more proactive manner, prior to development of serious problems. Analysis will include barriers to identification, cultural sensitivity and competency as well as increased knowledge on what is needed by whom at what point.</p> <p>Community needs on prevention will be analyzed to determine areas in which adequate prevention activities are not provided due to limited resources or lack of knowledge on the need.</p> <p>Collaboration will occur with others to expand prevention activities and include consumers and family members more in the process for the community, as appropriate.</p> <p>A more comprehensive emergency services plan will be developed. Communication is ongoing with the hospital as they are revamping the psychiatric services offered through the emergency room.</p> <p>Public awareness campaign on the local community response system will be ongoing.</p>	
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<p>individuals into other services outside of inpatient care whenever possible.</p> <p>29. ACT Team has been approved for adult consumers and interviews are being conducted.</p> <p>b) CFAC has received service management section of the business plan. Preliminary report is submitted.</p> <p>c) Community has a well-developed disaster response plan.</p> <p><i>See Attachment IV. 1-a: Management Plan for Core Service Functions</i> <i>Draft Policy on Service Coordination and Consumer Support: Section 89</i> <i>Draft Policy on Emergency/Crisis Services: Section 40</i></p> <p><i>Attachment IV. 1-b: CFAC report</i> <i>Attachment IV.1-c: Disaster Response Plan</i></p>	<p>Obtain Area Board Approval</p> <p>Obtain Area Board Approval</p>	<p>Cost figures for core services, including emergency services, are needed in order to determine what the hospital can do in assisting in provision of emergency response services. Part of their involvement will depend on the resources available for service provision.</p>
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Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Cumberland County MH/DD/SAS
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Submission Date	April 1, 2003
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Item: IV. Service Management

<p>Goal 2: The Local Business Plan describes how the LME will conduct service authorization within state standards, including the following: method of service authorization for each service, including decision making criteria; methodology that ensure services are not delayed by the authorization process; how service authorization relates to claims management to assure that unauthorized services are not paid, and claims management does not reject authorized services; how the service authorization process addresses person-centered planning mechanisms; how service authorization consistently promotes models of best practice; mechanisms to ensure that consumers/families have the ability to resolve differences or disputes between person-centered planning outcomes and service authorization decisions.</p>

Effective Date: January 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<ol style="list-style-type: none"> 1) The Mental Health Center developed a comprehensive review process for all cases involving services to children under the 18 over 10 years ago and was expanded to Adult Services 5 years ago. 2) Child & Family and Adult Team meetings are held to review goals, outcomes and strategies from a person and family centered perspective. 3) Recommendations are made on the level of care or service that appears indicated. 4) Case managers present cases for review by a clinical management team that compares the request to the medical necessity guidelines provided by the State and DMA and the level of care guideline for services to adults and/or 	<p>The overall authorization process will continue to be developed by the agency with more input from all stakeholders on what is working and what needs to be improved.</p> <p>Additional training for providers on best practices, person-centered planning and authorization protocols will be needed.</p> <p>Appeals protocols will be enhanced as the process develops. There have been few appeals of decisions made by the authorization committee, in large part due to the intense involvement of consumers and family members throughout the treatment planning process.</p>	

children and adolescents. Parents and/or guardians participate in the child team reviews along with the case manager. When the consumer is old enough, he/she also participates in the review.

- 5) Decision making process includes review of the diagnosis, level of functioning, treatment/placement history and response, review of service plan, goals to be achieved by the requested intervention, step-up and step down plan, exit plan, levels of intervention and client rights concerns, and best practices.
- 6) Based on the review and documented appropriateness for the service as outlined above, an authorization is provided to the case manager that includes a recommended duration for the initial authorization. The case is scheduled for the next review, which will occur within 30 days for children and within 90 days for adults. Disposition form is signed by all involved in the decision making process and copies are circulated to relevant parties, with the original filed in the chart.
- 7) Parents/guardians are provided with a list of possible providers for services and based on their choice, contacts are made to secure services.
- 8) The case manager acts as a liaison between the provider and the consumer/family.
- 9) The case manager completes necessary paperwork for submission to Value Options and EDS for Medicaid funded

services. For state funded services, the authorization is noted in the medical record and MIS staff enter the authorization into Unicare.

- 10) For outpatient treatment referrals on consumers under the age of 21, a request is received from the provider and/or parent/guardian for an authorization for Medicaid recipients to receive outpatient treatment from a direct enrolled provider. If the provider is not in the network, an application packet is mailed with a request that the person complete and return as soon as possible. Once received, the application is reviewed within 24 hours and the provider is notified whether their application has been approved. If information is missing, the provider is requested to provide this as soon as possible.
- 11) Once a provider is in the network, he/she is able to accept referrals for outpatient services. The provider faxes or mails the initial assessment to the area program. An authorization letter is then given to the provider along with the authorization number. The provider is responsible for ongoing re-authorizations.
- 12) To assure that services are not delayed, providers agree to participate in ongoing clinical reviews. For Residential Level II and CBS services, the provider is responsible for ensuring adequate information is submitted to complete a clinical review. If additional information is needed prior to the management review, the provider is notified and

given a deadline for submission of needed information.

- 13) The agency is using components of the Managed Care module of Unicare to track services and authorizations. Services will not be reimbursed if there is not a current authorization in Unicare.
- 14) Throughout the process, attention is focused on the involvement of the consumer and family in the service planning and decision making process. Documentation must be provided for all management reviews for services, that the consumer and family are provided opportunities to participate in all phases of treatment.
- 15) The case manager is responsible for ensuring that the consumer/parent-guardian is able to attend team meetings, including coordinating reviews in the community and providing transportation if this is needed.
- 16) Decisions will include review of information provided to show the development and use of social and community supports whenever possible. Consumers and family members will be linked with advocacy persons and groups in the community to assist in the process.
- 17) The comprehensive plan should include other aspects in an array of services and supports outside of the public behavioral health arena as appropriate.
- 18) Models of best practice will be promoted throughout the process and will include a focus on person-centered planning, self-determination principles,

recovery model philosophy, system of care philosophy and evidence based substance abuse treatment.

- 19) Appeals and grievance processes regarding authorization denials or authorization decisions regarding suspension, reduction, or termination of services are outlined for Medicaid and non-Medicaid eligible consumers. This information is reviewed during team meetings and consumer/parents-guardians are given letters outlining the process if there are differences.
- 20) Consumers are made aware that they can appeal to the Division of MH/DD/SAS or the Office of Administrative Hearings (OAH) or their case can be reviewed through an administrative committee of the area program.
- 21) All appeals are initially reviewed by the Managed Care Director and the Consumer Relations officer in conjunction with program and management staff.
- 22) Local reviews are completed by a panel of clinical/management staff. The review includes all information that was used by the authorizing committee to determine denial, termination, suspension or reduction of services. The panel does not include program staff involved in the initial decision.
- 23) Guidelines approved by the Division and DMA are followed for all reviews, including informing consumers of their legal rights to continue services until an appeal has been resolved.

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Reviewers Comments:

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Submission Date	April 1, 2003

Item: IV. Service Management

Goal: 3. The Local Business Plan demonstrates responsibility for oversight of the local delivery of services to target populations. (NW)

Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a) Local business plan committees have been addressing eligibility status of consumers currently being served by providers in the community. Education is continuing with providers and others in the community on target populations and the array of services.</p> <p>b) The area program is the primary provider of case management services in the community at this time. A few providers have expressed interest in learning more about provision of case management services. This will be pursued. Two CAP consumers have requested outside case management. Contract has been written and budget revision has been approved by Program Services Finance Committee with The ARC of North Carolina to provide this to consumers.</p> <p>c) A list of service agreements, MOA and contracts with other agencies and systems is attached to ensure that client care is coordinated.</p> <p>d) Draft policy on Service Coordination and Consumer Supports has been developed.</p> <p>e) There are currently review protocols to</p>	<p>Training and technical assistance will continue as a comprehensive plan for individual care management is developed during the next year.</p> <p>A table outlining the availability of case management services, including number and identification of case management providers will be revised based on changes in providers.</p> <p>List will continue to be reviewed and modified as other agreements and contracts are developed.</p> <p>Contract to be approved with The ARC of N.C. in April and implemented immediately.</p> <p>Obtain area board approval for policy.</p> <p>Protocols will continue to develop to ensure that</p>	

<p>assess all services needed by consumers. All consumers are provided access to the same services and supports, whether Medicaid eligible or not. Their financial status and benefits are noted by finance staff and administrative access staff who enter appropriate documentation into the data base. When staff are made aware that services are not covered by Medicaid or that there has been a change in a consumer's Medicaid status, attempts are made to secure other funding and supports for the services. MIS and Finance staff review Medicaid eligibility on an ongoing basis and advise case management and clinical staff when changes occur. An example of coordination to provide non-covered services to Medicaid consumers includes CMSED children attending a specialized summer day activity program that is supported by a grant from the Community Foundation. Charge to family members or guardians is \$1.00 per day, contingent on ability to pay.</p> <p>f) Area Program has a policy governing consumer right to grievance and appeals that includes a description of the process for review and corrective action.</p> <p>g) Draft policy on protocols for coordinated and consumer friendly transitions between services: See draft policy on Continuity of Care</p> <p>h) Draft policy on Continuity of Care addresses continued provision of services when provider is no longer available, accessing LME funds on a specific time limited basis to ensure</p>	<p>services are not interrupted due to changes in Medicaid eligibility.</p> <p>Continue education of stakeholders on grievance and appeals process.</p> <p>Guidelines on contractual language (hold back provisions) with providers that discourages disruptions to the provision of care will be developed as part of the business plan process.</p>	
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<p>continuation of care</p> <p>i) Continuity of Care policy address active and collaborative discharge planning to facility continuity of care for individuals discharged from state hospitals and residential schools.</p> <p><i>Attachments:</i> <i>Table of case management providers</i> <i>Contracts and MOAs with other agencies and supports; contract listing for 2001-2002</i> <i>Service Coordination and Consumer Support Policy- Section 89</i> <i>Area Board Policy: Client Grievance/Reporting</i> <i>Client Rights Violation-Section 14.4</i> <i>Draft Policy on Continuity of Care- Section 53</i></p>		
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Submission Date	April 1, 2003

Item: IV. Service Management

Goal: 4. The Local Business Plan complies with essential elements of the models of best practice as determined by the State. (W)

Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a) The Area Program adopts best practices approaches as identified by the State and will further refine these as additional information is provided. Best practices shall be consistent with but not limited to the following:</p> <ul style="list-style-type: none"> ✓ Person-centered planning practice ✓ Self determination principles as applied to practice ✓ Recovery model philosophy as applied to practice ✓ System of care/supports philosophy as applied to practice ✓ Evidence based prevention practice ✓ Evidenced bases substance abuse prevention/treatment <p>b) A subcommittee of the Qualified Provider Network Committee has been identifying training and technical assistance needs for the providers in the community. A multitude of topics have been identified, some of which should be part of a general competency curriculum for providers, with others clearly focusing on implementing best practices principles.</p>	<p>As information is received from the State on further delineating Best Practices models, this will be included in development of the service delivery system for the community. Providers will be required to adhere to best practices in order to be part of the Qualified Provider Network for the LME.</p> <p>Best practices will apply to target populations, as defined by the Division and will be supported through individual outcome based goals.</p> <p>Comprehensive training and technical assistance plan will be developed with involvement from all stakeholders. Plan will include information on best practices.</p> <p>Annual training plan for all LME staff, consumers and families will be developed and will incorporate best practice models.</p>	

c) Consumers, family member and advocates are also identifying training and technical assistance concerns for providers that will be addressed by the LME. Area program staff are doing an inventory of training protocols to identify strengths and weaknesses as it related to conversion to an LME and implementation of a comprehensive service delivery system that embraces best practices models.

Reviewers Comments:

Management Plan for Core Service Functions

Cumberland County Mental Health Center is developing a management plan for the oversight and operation of core service functions. This is being done in collaboration with the Local Business Planning process that includes the other stakeholders in the community affected by mental health reform. This process will evolve over the next year as the agency transitions from a primary provider of services to a Local Management Entity with continuation of service provision as permitted by the Secretary of Health and Human Services.

The following outlines our initial management plan.

- **Interface with DHHS developed information and assistance program**

Cumberland County MHC will develop an interface between a local 1-800 number for access to the system and the DHHS developed information and assistance program.

- **Accessibility and availability of screenings and assessment services:**

The Mental Health Center offers screenings both telephonically and face-to-face for individuals in the catchment area. Currently individuals can call or walk in and receive an initial screening for services during standard operating hours. Screenings are conducted at the Child Center for individuals under the age of 18 and in the Adult Center for individuals 18 and older. Staff are trained to determine the individual's preliminary needs across all disability areas. Individuals can contact the Mental Health line of CONTACT after hours and be connected to a Mental Health Center staff or physician. Emergencies are immediately routed to a physician. Other calls are routed to a clinician the next day for follow up. We are developing a 24/7 access to care line that will allow telephone screenings to be done at all times. The telephone screening will serve as triage and clinical screening, using a structured interview to gather needed information. The Mental Health Center will refine this system over the next year.

Assessments are currently offered in multiple locations by Mental Health Center staff. As the Qualified Provider Network is developed, plans will include providers conducting assessments as well. At this time a provider, who has been seeing a consumer, can present information to the Multi-disciplinary Clinical Team of the Mental Health Center in order to obtain an authorization for services reimbursed by Medicaid. If sufficient information is available to determine medical necessity, level of care and target population eligibility, the authorization is provided. The Mental Health Center would open a record to provide case management and care coordination services on behalf of the consumer. If there is not enough information, the Mental Health Center staff will further assess the consumer and collaborate with the provider and family member around appropriate services. The majority of providers are not using standardized instruments for assessments and are not well versed in level of care criteria approved by the State or target population definitions. Education and technical assistance will be provided on current assessment and screening tools utilized. In the future this will expand to include training on instruments identified by the State for use in screening and assessment services.

- **Capacity for referral and development of community referral networks**

There are many providers of services within the catchment area, some under contract and others who receive an authorization from the Area Program and are then able to direct bill Medicaid for services. There are also many providers serving consumers through use of other third party sources, such as Champus, Medicare and private insurance. The plan will be to increase the number of providers willing to serve those individuals traditionally served by the area program with public funds. It has already been noted that some providers do not see an incentive to working with those individuals who meet target population criteria. The Qualified Provider Network Plan will address strategies to enhance the willingness of providers to serve those most in need. The Needs Assessment will further refine areas in the community that are resource rich and those that have scarce resources. This data will be correlated with demographics on consumers with the goal being to identify more resources in those areas with a

high concentration of service need demonstrated. There are already many partnerships in the community that are allowing resources to go further in meeting the needs of consumers and their families. These will be further nurtured and expanded to develop more and better community referral networks.

- **Availability of services and supports for non-target populations.**

The Mental Health Center has been working with the Chamber of Commerce, DSS and other agencies in identifying community based resources for individuals. A subcommittee of the Planning and Collaboration Committee conducted outreach activities in the community with local churches, non-profit organizations, providers, consumers, family members and other counseling services in an attempt to identify resources for non-target populations. It was seen that at times an individual will present to the Mental Health Center or the hospital with a stated psychiatric emergency when in reality the emergency may be one of meeting basic needs at that moment. Over 100 resources have been identified so far with outreach efforts continuing. A resource guide is being compiled that will group resources together, i.e. housing, transportation, food and clothing, counseling and supports, energy assistance, etc. This guide will be made available to the community in hard copy as well as on the web. Collaboration will occur with the Partnership for Children that publishes a Family Focus Guide noting resources for families with children under the age of five, and the library, that publishes The Answer Book, a compilation of general community resources. The groups will continue identifying community needs and resources and offer training and technical assistance to those groups indicating an interest in offering more services (to those non-target population individuals) if they had access to additional training or awareness.

Formal Memoranda of Agreement will be developed between and among community agencies and organizations in order to enhance the availability of services and supports to non-target populations as needed. Currently there are several MOAs between the area authority and community groups, some being formal written agreements and others that are understood. These include agreements with the Juvenile Assessment Center, Falcon Children's Home and the school system.

- **Service Coordination and Management**

Service coordination begins with the first contact a consumer and/or family has with the Mental Health Center, whether this contact is by telephone, face to face or through a consultation with another provider or agency. The process of identifying whether the individual will meet the criteria for a target population begins with the first contact. If additional screening and information gathering is needed to make the decision, this is offered to the consumer. If it appears that the person will not meet the eligibility criteria, staff work diligently to determine what services and supports might be helpful and then refer and network on behalf of the consumer/family in accessing those resources. Staff will follow up to determine if the resources were beneficial and if there are additional areas that may still need further assessment.

Service coordination activities will include care coordination and community collaboration. The care coordination aspects will focus on coordinating care for individuals who may be admitted to an inpatient facility for services but whose overall clinical assessment does not qualify them for inclusion in a target population. These individual coordination activities will also be available to those individuals in a target population but for whom case management services have not been authorized. Typically these individuals may be receiving outpatient treatment services but a psychiatric emergency necessitates additional intensive services for a brief period of time.

The community collaboration aspects of service coordination will include ongoing community needs assessments, developing a network of supports and services, increasing community awareness, enhancing existing natural supports, and analyzing the system capacity for services for all consumers. These duties will be shared among all stakeholders, with the LME assuming a leadership role to ensure the data is analyzed, gaps are addressed and community awareness continues to grow.

- **Role of consumers, families and stakeholders**

Consumers, family members, advocates, other community partners and providers have all expressed a desire to be involved in the monitoring of services within our catchment area. This includes provision of core services as well as intensive treatment services to target population consumers. Providers who have become actively involved in the business plan process, express the need to ensure that all individuals serving consumers be truly “qualified and culturally competent.” They report that the provider network of services and supports is only as strong as the weakest link. Consumers and family members know best what works and does not work for them and their input will be critical in helping the community system of supports be as user friendly and accessible as possible. The group developing the comprehensive evaluation plan for the LME will include a section on monitoring that focuses on consumer monitoring. CFAC members with information on these concepts are sharing this with others. Other human services agencies want to be a part of the process to determine how changes in delivery of mental health services will impact on what they do and their capacity to meet needs of existing and future consumers. A comprehensive monitoring plan will be developed over the next year.

- **Services/supports to increase effectiveness and efficiency of community resources**

Cumberland County Mental Health Center has been a partner with other agencies and community groups for many years. The community has made great strides in adopting the philosophy that it does not matter what door a person enters, he/she is a part of our community. Agencies and others must work together to pool resources in order to meet the changing demands of the community. The Mental Health Center is actively involved in the Neighborhood Guardian Program, a child abuse prevention initiative that grew out of the Chamber of Commerce Metro Visions report. The program began by bringing together 40+ agencies to look at the red flags for our community that were identified in the Metro Visions report. Each agency/person analyzed what role they thought they could play in working to decrease child abuse and neglect in our community. The Chamber has been tracking certain key indicators for 11 years. Having this data available, along with data from other agencies and needs assessments, allowed us to create a program that consumers and family members say does make a difference. With very few additional funds, but enhanced partnerships among community stakeholders, services and supports are being offered to families in different ways.

The Agency has been actively involved in the Families Helping Families initiative with DSS, the Partnership for Children, Juvenile Assessment Center, Homeless Coalition, Child Advocacy Center, NAMI, Interagency Council, Criminal Justice Partnership, Juvenile Crime Prevention Council, Cumberland County CommuniCare, Rape Crisis, Child Care Solutions, just to name a few. Goals of each of these groups include how to braid and blend funds in order to better serve citizens in our community. The partnerships extend to the non-profits as well. There is a relationship with the Community Foundation to access funds for specialized summer activities for children. The Florence Rogers Trust has provided funds to Family Court for support groups for children whose parents are going through a divorce and other community/faith based groups have provided funds and enrichment activities for consumers and their families.

The community will continue to assess the services and supports available noting where gaps exist and barriers interfere with timely access. The Mental Health Center will continue its leadership in this area, promoting system of care principles for children and adults.

- **Outreach Efforts to Identify Those at Risk for Inclusion in a Target Population**

Cumberland County has multiple initiatives at this time that are allowing community partners to come together around a common goal of enriching the quality of life for citizens. As part of its role in these

activities, the Mental Health Center has provided training and technical assistance to others around risk factors that contribute to mental health problems and protective factors that can enhance the likelihood of an individual or family functioning at an optimal level. There has also been a focus on identifying key red flags that suggest the need for more in-depth analysis of mh/dd/sa issues. Ongoing efforts continue with those potentially most at risk (and the groups that come into contact with them), which includes those at risk of homelessness or those in transitional housing situations, families in which there are histories of substance abuse and mental health concerns, families with histories of physical, sexual and/or emotional abuse/neglect, communities in which there is little community or family connectedness, the migrant workers, many of whom are here as illegal aliens, and those displaced by the military. Analysis will occur with all stakeholders to identify and intervene early on when possible to prevent more serious problems developing.

- **Universal Prevention/Other Prevention Activities**

Cumberland County Mental Health Center and other groups, including CommuniCare, are involved in both universal and indicated prevention activities. Several prevention programs are focusing on children and adolescents and are related to the abuse of substances, including tobacco. These programs are offered through the Mental Health Center as well as non-profit providers in the community. Universal prevention efforts include partnering with Child Advocacy, the Community Protection Team, the hospital, DSS, and the Chamber to increase public awareness on coping with stress, effective parenting, healthy lifestyles and developmental challenges for children and adults. There are several T.V. shows on the community channel weekly geared toward enhancing community knowledge and awareness. An in-depth analysis of all prevention activities will be completed over the next year as the Mental Health Center transitions to an LME which will lead to development of more prevention activities.

- **Collaboration Around Shared Populations**

Several years ago Child & Family Services implemented many of the components of the System of Care. Resources were limited and the likelihood that they would increase substantially, even though needs were growing, was doubtful. Thus, the community recognized the need to work together to better serve all consumers. Through these efforts, the community was able to develop and continue a wide range of community based services to seriously disturbed children and adolescents, whether they met the criteria for Willie M. or not. These blending of resources have been strengthened as the State has mandated the System of Care Model for all of children's services. As training has occurred, consumers and family members have asked what was the "New Beginning" as the community was already implementing those practices.

Home based services are provided in conjunction with DSS for families in which there are high risk factors from abuse and neglect. Staff participate in Team Decision Making conferences at DSS daily when decisions are being made about children being removed or reunited with their families. DSS, Juvenile Justice, GAL and school staff, along with any other agency/person involved with a family, attend clinical team meetings to develop comprehensive plans of care with children and families.

Staff have been located with the Juvenile Court Counselors for 18 years, which has led to excellent working relationships with law enforcement, attorneys, judges and juvenile justice staff. Other staff partner with Head Start and the Partnership for Children to address issues for young children and their families. Substance abuse staff are located at DSS to assess and treat substance abuse issues as they are identified by DSS workers. Mental Health and Substance Abuse staff provide assessments, short term counseling and crisis services to any youth placed in the Juvenile Detention Center. The Community Corrections Center partners with the MHC with the TASC Program with clinical and case management staff being co-located with adult probation and parole and day reporting center staff. The Mental Health Center has a staff liaison to the hospital to facilitate appropriate discharge planning and transitions to alternate levels of community based treatment. There are also other liaisons with the Salvation Army

and Homeless Coalition, the Deaf Community, the Latino Center, Rape Crisis, The Child Advocacy Center and the schools. We will continue to nourish these relationships and develop others for the purpose of better care coordination for shared populations.

- **Emergency Services**

Any individual can be assessed for services during standard working hours by either calling or walking into one of the Mental Health Center locations. All individuals determined to be an emergency, based on the telephone screening, are asked to immediately come to the MHC or go to the Emergency Room. These individuals are seen as soon as they present for services. Based on the assessment, the individual may receive medication services, respite services, crisis stabilization in a group home or therapeutic home, additional community based services or is admitted into the hospital or Roxie Avenue. Care coordination and case management services are provided to all individuals in emergency situations.

The Mental Health Center contracts with CONTACT for 24/7 crisis telephone services. CONTACT can access a physician for any psychiatric emergency. The Department of Social Services has emergency duty/after hours social workers who also may contact appropriate MHC staff when it appears that assistance is needed because of mental health concerns. The Roxie Avenue Center provides facility based crisis services to adults with mental health and substance abuse issues as well as those who are multiply-diagnosed. Case management staff are on call to provide hospital diversion services for dually diagnosed individuals, primarily those with MR/MI.

Home based therapists are on call to families receiving these services, 24/7 and frequently respond to behavioral crises with children to prevent the child having to be placed out of the home. Clinical staff respond to all clients in therapeutic homes and residential settings, again to assess and prevent higher levels of care when possible. Case managers are accessible by pager and cell phone for those receiving intensive case management services. The Adult Services component is developing an ACT Team to better meet the needs of SPMI individuals. It is hoped that this will be operational within the next three months. Consideration is also being given to the need for a Child ACT Team.

Psychiatrists are located in the Emergency Room of the hospital until 11:00 p.m. After that time, they are available by pager and can be reached following an assessment by the psychiatric triage nurse at the hospital.

Cape Fear Valley Health Systems, which has a behavioral health component, is revamping their emergency services to better meet the needs of the community. Needs assessments have shown that persons may be admitted into the hospital overnight for further assessment or stabilization when this could have been avoided if there were more coordination and case management services available, particularly at night and on week-ends. The hospital is developing more 23 hour observation beds, enhancing assessments and medication protocols, and partnering with others in the community to develop/access other emergency services. Enhanced case management services will allow more timely access to respite and shelter services when these are indicated. Discussions are occurring with the hospital to determine what their capacity is relative to overall psychiatric emergency services and how to build on their resources as part of the core service delivery role for the LME. Clearly there needs to be more mobile crisis intervention services in the community, better public awareness on diversion resources and accessibility to more supports after hours. Providers are assessing their capacity and willingness to offer more emergency support services. All of these will be considered as a comprehensive emergency services component is developed for the community by the LME.

- **Disaster Response Services**

Cumberland County has a well developed disaster response plan that encompasses all health and human services agencies as well as other community partners. The Plan is a collaborative effort coordinated by County Management with the hospital and the Red Cross. (See Disaster Response Plan)

