North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

Michael Moseley, Director

April 27, 2007

MEMORANDUM

To:
- Legislative Oversight Committee Members
- Commission for MH/DD/SAS
- Consumer/Family Advisory Committee Chairs
- State Consumer Family Advisory Committee Chairs
- Advocacy Organizations and Groups
- North Carolina Association of County Commissioners
- County Managers
- County Board Chairs
- North Carolina Council of Community Programs
- NC Association of Directors of DSS
- State Facility Directors
- Area Program Directors
- Area Program Board Chairs
- DHHS Division Directors
- Provider Organizations
- MH/DD/SAS Professional Organizations and Groups
- MH/DD/SAS Stakeholder Organizations and Groups
- Other MH/DD/SAS Stakeholders

From: Mike Moseley

Re: **Communication Bulletin #072**
Draft State Strategic Plan 2007-2010

State Plan Communication Bulletin

Attached is a draft of the State Strategic Plan for 2007-2010 for public review and comment. As directed by the General Assembly through HB 2077, the Division has undertaken the development of a three-year strategic plan specifying how State and local resources shall be organized and used to provide mental health, developmental disabilities and substance abuse services.

This plan is considerably different from previous state plans. The focus of this plan is on five strategic objectives and associated action steps to be accomplished during the next three years. The plan identifies milestones for each action step for determining progress made and measures to determine the effects on consumer outcomes and system performance. Through discussions with consumers and families, providers, advocates, and leaders of Local Management Entities, the Division has identified these objectives as being the most critical for meeting the needs of consumers and families and furthering the transformation of the public system of mental health, developmental disabilities and substance abuse services.

During the next 30 days the Division will continue to fine-tune the plan and make adjustments based upon public comments. We seek and welcome your thoughtful input and guidance. The Division encourages you to send in your responses in a timely way to facilitate our consideration. Please submit your comments and questions regarding this communication no later than Friday, May 25, 2007 to Rebecca Carina, Planning Team Leader, by e-mail at Rebecca.Carina@ncmail.net or by mail at 3003 Mail Service Center, Raleigh, North Carolina 27699-3003.

Thank you for your continued participation in transformation of North Carolina's system.

cc: Secretary Carmen Hooker Odom
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Transformation of North Carolina's System of Services for Mental Health, Developmental Disabilities And Substance Abuse

The State Strategic Plan: 2007-2010

Draft for Public Comment

April 27, 2007

North Carolina
Department of Health and Human Services

Division of Mental Health, Developmental Disabilities
And Substance Abuse Services

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Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Vision

- Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.
- Services for persons with mental illness, developmental disabilities and substance abuse problems will be cost effective, will optimize available resources – including natural and community supports – and will be adequately funded by private and public payers.
- System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.
- All organizations and individuals that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.

Guiding Principles

- Participant-driven
- Community based
- Prevention focused
- Recovery outcome oriented
- Reflect best treatment/support practices
- Cost effective

Chapter 1. A Journey of Transformation

Introduction

Six years ago North Carolina charted a course to reform the services it provides for people who experience mental illness, developmental disabilities and substance abuse. The journey began in 2001 when the North Carolina General Assembly set the initial expectations for reform of the publicly funded system.[1] The legislature mandated transformation of the way services were managed and delivered in the state. The required changes affect virtually every individual involved in the system – consumers and family members, management and staff of state operated facilities and community service providers, and State and local government. As a result, there have been and continue to be many ideas about the new system of services, as well as the natural resistance to such a major change.

In response to the mandate, the North Carolina Department of Health and Human Services and its Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) embarked on the journey by publishing ***State Plan 2001: A Blueprint for Change***. Since that time, the Division has published an annual plan on July 1 of each State fiscal year through 2005. In response to Session Law 2006-142, the Division reviewed all previous plans and produced a single document of the still applicable provisions. That analysis was published October 2006.

Progress of Reform: 2001 through 2006

Over the years, the Division and system stakeholders have been involved in numerous efforts to reach consensus to substantially transform the types of services offered, as well as the manner in which the system operates. Ongoing dialogue has produced areas of both agreement and disagreement on what our system could become and highlighted shortfalls in the present service delivery system. As on any journey, ongoing agreement about the destination is essential.

A number of recommendations for next steps in the process are provided in the Long-Range Plan and a Funding Allocation Report produced for the Division through competitively bid contracts awarded to Heart of the Matter, Inc. and Pareto Solutions, LLC, and presented to the Legislative Oversight Committee in January of 2007.[2] The final reports suggest policy changes designed to address service gaps. The Department of Health and Human Services is already moving forward on pursuing some of the suggestions that can be implemented within existing statutory authority. In addition, the Division has given thoughtful consideration to the recommendations in the process of developing this strategic plan. A matrix showing the recommendations and the current response is shown in chapter 3.

[1] See North Carolina Session Law 2001-437, House Bill 381, Section 1.5.

[2] See North Carolina Session Law 2006-276, Senate Bill 622, Section 10.24.

North Carolina has made significant progress during the past six years in meeting the challenges of implementing the requirements of transformation. The 25 accomplishments shown in table 1 were selected from many to demonstrate the enormity of this state-wide undertaking. These and many other accomplishments provide the baseline and foundation for moving forward.

Table 1. Twenty-five accomplishments in community services, facilities and system organization and operation	
1.	Expanded access and provided services to more consumers.
2.	Designed and implemented state-wide a new array of best practices and evidence-based mental health and substance abuse services.
3.	Implemented a redesigned Medicaid waiver for individuals with developmental disabilities (CAP-MR/developmental disabilities) that provides more flexibility and lays the foundation to move to self-directed services. The CAP-MR/developmental disabilities Waiver added over 3,050 Medicaid-eligible individuals in 2006.
4.	Allocated more than $50 million in Mental Health Trust Funds to address system transformation and capacity building needs.
5.	Implemented new rules for Child Residential Treatment providers designed to improve the health and safety of children served in those facilities through increased staffing and increased staff qualifications.
6.	Allocated funding to support dedicated System of Care liaisons in each local management entity (LME) to better coordinate services for children following the System of Care best practice model.
7.	Created the North Carolina Practice Improvement Collaborative (PIC), a group of clinical leaders, research leaders and consumers and advocates, to evaluate new and promising services to ensure that North Carolina offers the best possible array of services for individuals with mental illness, developmental disabilities and substance use disorders.
8.	Funded six new halfway houses for adults recovering from substance use disorders, bringing the total number in North Carolina to 106, providing homes for nearly 800 people.
9.	Developed and implemented, in partnership with the North Carolina Housing Finance Agency, a program of rental subsidies to assist individuals with disabilities in obtaining safe, decent and affordable housing. Expanded the program with support from the General Assembly in 2006 to build and provide rental assistance for an additional 400 housing units.
10.	Through a contract with consultants, the Division developed a long range plan report and a cost model to determine the cost of providing needed services in the community. Concurrent with this long range plan and cost model, developed the finance and allocation model to assist in determining how services might be funded and how to reduce funding variability among local management entities (LMEs) to ensure an equitable distribution of resources.

Table 1. Twenty-five accomplishments in community services, facilities and system organization and operation	
11.	Permanently closed 539 state psychiatric hospital beds and transferred over $15.4 million in annual recurring savings from the hospitals' budgets to the community to pay for community services.
12.	Permanently closed 82 beds in the state developmental centers and transferred $4.1 million in Medicaid from centers' budgets to the CAP-MR/developmental disabilities program to pay for community services.
13.	Created a redesigned evidence-based treatment model for the alcohol and drug abuse treatment centers (ADATCs). Established 15 additional acute beds at the R. J. Blackley Alcohol and Drug Abuse Treatment Center and opened 10 new acute beds at Julian F. Keith Alcohol and Drug Abuse Treatment Center.
14.	Assessed all consumers served in state psychiatric hospitals and state developmental centers to determine their interest in and need for community services.
15.	Converted Black Mountain Center from an Intermediate Care Facilities for the Mentally Retarded to a Skilled Nursing Facility, providing a new model of care for people with developmental disabilities who are aging and have health care needs.
16.	Began construction of a new state psychiatric hospital in Butner to replace aging facilities at Dorothea Dix and John Umstead Hospitals.
17.	Established the Specialized Treatment for Adolescents in a Residential Setting Program (STARS) by realigning 18 Whitaker School beds to Murdoch Center.
18.	Created the State Consumer and Family Advisory Committee (SCFAC) for consumers and family members to provide advice and input to the Department of Health and Human Services and the Division. Required and facilitated the creation of local consumer and family advisory committees for each local management entity.
19.	Facilitated transformation of area authorities and county programs from the role of service provision to local management entities (LMEs). Mergers have reduced the number of local management entities from 40 to 30, more closely in alignment with the original mandate of the General Assembly. Most local management entities have successfully recruited providers and divested service provision in accordance with legislative requirements that they focus on management functions.
20.	Reorganized the Division of Mental Health, Developmental Disabilities and Substance Abuse Services along functional lines to correspond to the requirement of reform including establishing an Advocacy and Customer Service Section within the Division.
21.	Implemented a provider endorsement process to ensure that providers enrolling in the Medicaid program to serve individuals with mental health, developmental disabilities and substance abuse services needs meet minimum quality requirements.
22.	Implemented new information technology systems to track system performance and guide

Table 1. Twenty-five accomplishments in community services, facilities and system organization and operation	
	policy decisions based upon quantifiable data through: a) the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS), an on-line system that tracks outcomes for all consumers with mental illness and substance use disorders and measures providers' performance in achieving positive outcomes, and b) the Integrated Payment and Reporting System (IPRS) for data on state-funded services and supports to consumers.
23.	Created a Cultural and Linguistic Competency Advisory Committee to recommend strategies to ensure that services meet the needs of varied populations within North Carolina. Adopted and published a Cultural and Linguistic Competency Action Plan.
24.	Created and implemented various committees, communications series, trainings and interactive events to improve communication with all participants and interested individuals: a) the External Advisory Team comprised of advocates, consumers, provider trade associations, the North Carolina Council of Community Programs, and other stakeholders to provide advice and guidance on policy decisions; b) the Provider Action Agenda Committee deals with the needs of providers in the new, privatized service delivery environment; c) hosted 16 Town Meetings across the state; d) created communication bulletins and implementation updates to inform the system; and e) created the Division's web site as a means to facilitate communication and reference for policy and events.
25.	Jointly conducted with the Division of Facility Services licensure reviews in 1,054 child/adolescent residential facilities. These reviews found that 305 facilities were vacant and that 83 of the vacant facilities had never served any clients, 458 facilities had standard deficiencies, 71 had administrative sanctions and 105 surrendered their license to operate. As of December 2006, there were 635 licensed facilities.

Values and Principles

An essential part of clarifying the destination is coming to an agreement on the values and principles that guide decision-making. For system reform to be comprehensive and enduring, it must be based on values and principles that reflect the consensus of stakeholders in the system, as well as national perspectives and scientific findings.

Many federal reports have stated the need for transformation of the country's mental health system. In 1999, the U.S .Surgeon General released a report on mental health services that recognized the importance of recovery in adult mental health. The 2003 final report of the President's New Freedom Commission on Mental Health called for "recovery to be the common recognized outcome of mental health services." The report described the mental health system throughout the country as fragmented, complex and filled with gaps, unmet needs and barriers that mandated a complete system transformation and not just a reform of the existing system to fully reflect the implications for policy, funding and practice as well as attitude and belief shifts.

In a transformed mental health system, people understand that "mental health is essential to overall health; mental health care is consumer and family driven and recovery oriented; disparities in mental

health services are eliminated; early mental health screening, assessment, and referral to services are common practice; excellent mental health care is delivered and research is accelerated; and technology is used to access mental health care and information." (President's New Freedom Commission).

In a transformed developmental disabilities system, people are supported to make choices about where they live, work and play; resources are allocated based on individual needs and preferences; people are supported to be members of their communities and to build lasting relationship; families receive the information, resources, and support that they need; direct support staff are trained and competent; and individual health and well being is assured.

A transformed system of community-based substance abuse services incorporates proven psychosocial interventions such as cognitive behavioral therapy, contingency management and motivational enhancement therapy. Additional best practices include the use of medications for specific diagnoses; screening and brief intervention in primary care settings; expanded post treatment care; and provision of case management, wrap-around and supportive services. In North Carolina, as in most other states, there is also a need to extend substance abuse treatments to a larger proportion of the priority consumers that need such services. Nationally, only about 10% of people with substance abuse receive treatment, and of those that do receive treatment, less than 50% receive evidence base care.[3]

The Guiding Principles

The Division adopted six "Guiding Principles" that encompass expectations, desired outcomes, and elimination of barriers. These principles drive the ongoing progress. They provide a solid basis for comprehensive reform of the current system and are consistent with areas of concern that have achieved consensus among stakeholders. The Division's guiding principles describe a system that is:

- Participant-driven.
- Community based.
- Prevention focused.
- Recovery outcome oriented.
- Reflect best treatment/support practices.
- Cost effective.

Implementation of the guiding principles envisions a sustainable system in which consumers and family members are involved in the planning and management of system services. Additionally, adherance to the guiding principles create conditions under which all people experience a system that protects consumer's rights, provides detailed descriptions of core services and service standards, has a uniform portal of entry and exit, targets services to specific populations and promotes intersystem collaboration.

During the development of this strategic plan, the Division, with the assistance of consultants from Technical Assistance Collaborative, Inc. and Human Services Research Institute, Inc. (HSRI), identified key concerns and issues that cut across all activities for the next three years. The table

[3] This information is summarized from the Robert Wood Johnson Foundation ***Advancing Recovery***" program.

below provides more detailed aspects of the Guiding Principles that will assist the Division with assuring that current concerns and ongoing values reinforce mental health reform as envisioned by the North Carolina legislature. They include:

Consumer and Family Principles

- Consumers and families involvement in planning and management of system services*
- Protection of consumer rights*
- Recovery and self-determination
- Choice and self-direction of services

System Principles

- Continuity of care
- Description of core services* and service standards for the mental health/developmental disabilities/substance abuse system.*
- Implementation of uniform portal.*
- Targeted populations and criteria for identifying them.*
- Integration and best use of state facilities with community systems of care
- Attention to and involvement of providers in the system
- Intersystem collaboration*
- Workforce development
- Cultural competence and cultural relevance
- Data-driven planning, management and performance evaluation.
- Compliance with federal mandates in establishing service priorities*

* Required by Senate Bill 2077.

Chapter 2. Overview of the Strategic Plan

The Division accepts the challenge to act boldly and decisively and in collaboration with its partners and stakeholders to develop and implement a three-year strategic plan. While it is expected that change will be ongoing as the system continues to evolve and adjust to circumstances, the strategic plan provides a clear vision of the future. The plan establishes a policy framework for action at all levels of the system and performance objectives and benchmarks for accountability.

The strategic plan renews the promise that every consumer will have an opportunity for growth, recovery and self-determination. Improving mental health, developmental disabilities and substance abuse services and meeting the complex needs of the State's residents is a long standing goal in North Carolina. A state strategic plan that is jointly developed by stakeholders and agency staff revisits the vision and the purpose of transformation.

As the necessary strategies are implemented over the next three years, it is the Division's desire that the system will evolve to become more responsive to feedback and accountability measures will be expanded and continually refined. This vision can only be realized through the collaborative efforts of all stakeholders.

Purpose of the State Strategic Plan for 2007-2010

In 2006, the North Carolina General Assembly specified changes to the implementation of mental health reform in House Bill 2077, Session Law 2006-142. These changes include provision of a clear and concise plan for service provision and the prudent use of local and state resources. The Division has identified specific goals for the next three years, including benchmarks of progress toward the goals. This document presents North Carolina's strategic objectives for further transformation of the system.

The State Strategic Plan advances the planning blueprint for the transformed system and establishes measurable outcomes. The strategic plan outlines priorities and details strategies that will be accomplished over the next three years with the current staffing and funding levels. All levels of the system are addressed in the strategies through performance objectives and benchmarks.

This Plan describes the achievable actions that support progress in the system's transformation and marks out steps with timeframes to achieve the objectives in specific areas. The Division will monitor, evaluate and report progress on the strategic plan's objectives.

Process of Development

Immediately after the legislation was passed in July 2006, the Division prepared a request for proposals (RFP) to hire a consultant to assist the Division with the three-year strategic planning process. This process during the fall of 2006 resulted in a contract with Technical Assistance Collaborative, Inc. (TAC) to provide technical assistance beginning January 2007. The team of TAC consultants included a number of individuals with expertise in planning, research and

evaluation of mental health, substance abuse and developmental disabilities services. Especially important is TAC's extensive prior consulting experience in North Carolina.

- Early in January 2007, the Division's Executive Leadership Team began the strategic planning process with an initial list of issues and goals for the upcoming three years. The Division's Management Leadership Team, the State Consumer and Family Advisory Committee, directors of local management entities (LMEs), and the External Advisory Team provided input to the Executive Leadership Team resulting in a revised list.

- During mid to late January, the consultants provided four events on strategic planning for the Executive Leadership Team; the Division planning, quality management and LME liaison staff; the Management Leadership Team; and local management entity (LME) directors and planning staff. As a result of this process, the Executive Leadership Team selected five objectives as the most essential for moving system transformation forward.

- Next, Division leadership and management, the consultants and the External Advisory Team identified needed action steps for each objective. Selection criteria specified that action steps must:

    - Be activities for which the Division can and will hold itself accountable.
    - Result in improved outcomes for consumers and families.
    - Be concrete critical actions that result in obvious successes for the overall system.
    - Produce concrete progress by the end of three years.
    - Create an agenda for the Division and its partners at the State and local levels.
    - Address concerns raised in the Long-Range Plan and Funding Allocation Report.

- The Executive Leadership Team finalized the objectives, action steps and milestones presented in chapter 3. It is important to consider the availability of current resources and the need for additional resources to accomplish these tasks. In addition, consideration has been given to the potential use of the Mental Health Trust Fund to support these efforts.

- The draft State Strategic Plan 2007-2010 was prepared for distribution for the 30-day public comment. During this 30-day period, the Division continues to examine the best measures for each objective of the potential effects on consumer outcomes and system performance.

- Following the receipt of comments from stakeholders, the Executive Leadership Team with the assistance of consultants, the State Consumer and Family Advisory Committee and the External Advisory Team will review the public comments submitted and revise the strategic plan as needed. The final state strategic plan will be published by June 30, 2007.

Chapter 3. Strategic Objectives and Action Steps

The strategic plan is organized into five objectives. The objectives define the work that the Division is committed to undertake between July 1, 2007 and June 30, 2010. The strategic objectives are:

- ❖ Establish and support a stable and high quality provider system with an appropriate number and choice of providers of desired services.
- ❖ Continue development of comprehensive crisis services.
- ❖ Achieve more integrated and standardized processes and procedures in the mental health/developmental disabilities/substance abuse services system.
- ❖ Improve consumer outcomes related to housing.
- ❖ Improve consumer outcomes related to education and employment.

The five objectives are equally important; they are not placed in a particular order. These five objectives and strategies for their accomplishment are described in this chapter. Two or more action steps are identified as important for accomplishing each objective. Two or more milestones are defined to clarify what activities and deliverables must be accomplished for each action step and by when. Therefore, the structure used in the following sections looks like:

Objective

Action Step 1

- **Milestone**

The Five Objectives Work Together

Successful implementation of the crisis system is dependent on a highly qualified provider system. A highly qualified provider system is dependent on adequate training as well as standard protocols and expectations for utilization management and claims payment. Improved outcomes for consumers related to housing is dependent on consumers taking responsibility for their own person-centered planning as well as the design of a high quality protocols for to assure person centered planning and continuity of care.

Therefore, accomplishment of some of the action steps under one objective may be dependent on the completion of other action steps in the same objective or in another objective. The dates for milestones have been chosen to correspond to a necessary sequencing of related milestones, plus recognition of limited resources for implementation at any one time. In addition, time has been allowed for engaging partners at the State level, such as the Division of Medical Assistance and the Division of Vocational Rehabilitation, and at local levels with local management entities, local governments as well as providers of mental health/developmental disabilities/substance abuse services and other community agencies.

The Plan Requires Accountability

Progress will be measured in terms of the timely completion of the deliverables and activities as defined in the action steps and milestones. In addition, the overall effectiveness of these endeavors will be measured in terms of outcomes for consumers and changes in system performance over time. These will be described in chapter 4.

Each objective is described in the following sections of this chapter. Each section describes why the specific strategic objective was selected and what it means for consumers and the system. It identifies current issues and barriers, what problems must be overcome and what impedes progress. Such an environmental scan becomes the basis for the action steps.

It is important to recognize that a plan is a dynamic process and neither the Division nor any part of the mental health/developmental disabilities/substance abuse services system can control the many variables - including financial limitations – that affect the outcomes. What is written in statute and rule outlines the specific authority of the Division, local management entities, local governments, consumer and family advisory committees and providers. Beyond that, it is the Division's responsibility to provide policy guidance and tools for managing the system through performance and process expectations at State and local levels.

Ultimately, successes and failures rest with all stakeholders, including the Division. With everyone's participation and commitment, the definition and accomplishment of the objectives should produce concrete, visible progress and changes for consumers and families within three years. The Division is motivated and accepts the challenges presented by the plan.

Objective: Establish and support a stable and high quality provider system with adequate number and choice of providers of desired services

A system of providers of mental health, developmental disabilities and substance abuse services that is stable and high quality is absolutely necessary to meet the varying needs of consumers and also family members. Desired services are based on strengths and are either evidence-based or the best practices known at any given time. A stable and highly qualified provider system includes community services and best practices offered at state operated facilities. Such services are constantly evolving.

A stable provider system means providers that exercise efficient and effective business management practices. Stable may also mean consistency in staffing with low turnover rates. Such practices ensure the longevity of the provider and its staff. Consumers must be able to count on the provider agency and its staff to be reliable, compassionate and responsive.

High quality means each provider consistently meets and exceeds performance standards in the services offered to consumers. The standards are those required by service definition, by endorsement, by Medicaid enrollment, by professional organizations, by national accrediting bodies and by DHHS and local management entities. A qualified provider offers safe and effective services and employs trained staff that meets all clinical requirements. The services offered are evidence-based or best practices. Consumers can count on providers to offer their best in helping them toward self-determination and recovery.

Currently, providers have been conditionally endorsed by local management entities to provide specific services. Before they achieve full endorsement, many providers will need additional training and staffing stability. Provider audits reveal that appropriate staffing and training is needed; turnover rates among staff are high; and person-centered planning is not applied as intended. Some services are being provided in greater quantities than envisioned in lieu of referring consumers to other services which might be more appropriate to meet the person's needs.

Choice means that there are a sufficient number of quality providers offering a service or array of services in a given geographic area. Given that the system has moved away from a franchise system to a competitive market system, any provider organization has the opportunity to participate in the system as long as they follow the endorsement and enrollment requirements and other standards. In many areas, this market system is still evolving. Choice also means there are a sufficient number of providers and consumers are informed about choices available.

Another issue is a clear definition of the fundamental menu of services that are ideally available to consumers for each age and disability group. Such benefit designs spell out what the State wants to purchase from a provider system. This array of services is about consumers' access to appropriate services. Even when funding is limited, there must at least be a minimum of basic types and amounts of services available for consumers. Benefit designs specify expectations for those essential services and recommendations for the order in which additional services are offered as funding becomes available.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns of establishing and supporting a provider system.

Objective: Stable and High Quality Provider System **Action Steps and Milestones**
<u>Action Step 1</u>: Develop strategies to inform and empower consumers and families to fulfill their responsibility in the person-centered planning process and by accessing services, exercising choice and rights, and expecting best practices and service quality.
• By 6/30/08, analyze complaints and concerns filed with the Division to identify trends and issues regarding providers to inform Division policy guidance and a communication plan.
• By 6/30/08, develop a communication plan in conjunction with the State and local consumer and family advisory committees that includes strategies and materials to inform all stakeholders about how to access the system, participate in person-centered planning, exercise choice, exercise rights, and expect best practices and quality.
• By 6/30/09, work with local management entities' (LMEs') customer service and consumer affairs offices to publicize information about providers through a variety of media including the NC Care Link web site.
• By 6/30/09, provide technical assistance to local management entities' (LMEs') customer service and consumer affairs offices and to State and local consumer and family advisory committees in the implementation of strategies to inform and empower consumers including their active participation in the development of person-centered plans and assess strategies of the communication plan on an ongoing basis.
• By 6/30/10, assess the results and refine the strategies of the communication plan to make them more effective in empowering consumers and also families.
<u>Action Step 2</u>: Establish and communicate a benefit design and provider sufficiency standards that reflect best and preferred practices for each age/disability group.
• By 6/30/08, identify variables that impact a benefit design.
• By 6/30/08, establish and communicate the fundamental benefit design and provider sufficiency standards for mental health, developmental disabilities and substance abuse target populations.
• By 6/30/09, implement the benefit designs and provider sufficiency standards statewide.
• By 6/30/10, develop procedures for reviewing the benefit designs on an ongoing basis and complete the first annual evaluation.

Objective: Stable and High Quality Provider System
Action Steps and Milestones

<u>Action Step 3</u>: Define statewide provider performance standards (including national accreditation, service definitions, federal and state requirements) and clarify local management entities' (LMEs') responsibility for holding providers accountable for those standards and reporting about performance to the public.

- By 6/30/08, work with the Division of Medical Assistance (DMA) and other applicable entities at the state level to clarify and develop provider quality and performance expectations, measures and indicators of fidelity, quality and performance, and tracking processes.
- By 6/30/08, provide guidance to local management entities (LMEs) on their responsibility for holding providers accountable and reporting performance of all providers.
- By 6/30/09, train staff of local management entities (LMEs) in reporting and using data to monitor and improve quality of providers.
- By 6/30/10, review and refine provider quality and performance expectations, measures and indicators and the methods for analyzing consumer outcomes as needed.

<u>Action Step 4</u>: Establish strategies for providers to enhance quality and effectiveness (through training, technical assistance, workforce development, quality improvement, national accreditation and other activities).

- By 12/31/07, assess the progress of providers in preparing for national accreditation.
- By 12/31/07, establish strategies for workforce development.
- By 6/30/08, provide technical assistance to local management entities (LMEs) as they assist providers with regard to enhancing quality and effectiveness and accreditation.
- By 6/30/09, implement a training process that allows providers to build internal training capacity to meet requirements of specific services and to adhere to best practice models.
- By 6/30/10, examine financial incentives to move the system to best practices to support quality and effectiveness.

<u>Action Step 5</u>: Continue to implement best practices in state operated facilities to complement community services.

- By 12/30/07, define and implement standard protocols for admission, medical clearance, discharge and information sharing among the state hospitals and alcohol and drug abuse treatment centers (ADATCs) and the local management entities (LMEs).
- By 6/30/08, develop ICF-MR bed transfers as a vehicle for downsizing of developmental centers.

Objective: Stable and High Quality Provider System Action Steps and Milestones
• By 6/30/08, increase utilization of acute and sub-acute services in alcohol and drug abuse treatment centers (ADATCs).
• By 6/30/08, establish three neuro-medical treatment centers in the state.
• By 6/30/09, establish consistent policies and procedures for clinical practices and corporate business practices for all state operated facilities as appropriate to the lines of business.
• By 6/30/09, develop and implement policies and protocols that ensure continuity of care between community and State operated facilities.
• By 6/30/09, identify appropriate fidelity measures for evidence based practices and administer these measures semi-annually for alcohol and drug abuse treatment centers (ADATCs).
• By 6/30/09, complete planning and design for facilities to replace Cherry hospital.
• By 6/30/10, complete planning and design for facilities to replace Broughton hospital.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning, access to services, promotion of best practices, quality management, system efficiency and effectiveness and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes

- Increased percent of consumers receiving timely and adequate care.
- Increased percent of consumers given a choice of providers.
- Increased percent of consumers participating in the development of their person-centered plans.

System Performance

- Increased public access to provider performance reports.
- Increased proportion of public resources spent on evidence based and best practices.
- Increased percent of providers that are nationally accredited for each disability group.
- Increased number of providers who meet statewide provider performance standards.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Development of consumer-friendly materials and training that will include, but is not limited to: the use of a variety of media, consumer and family education on empowerment and responsibility regarding best practices, provider choice, and person-centered planning.
- Contracting with specialized independent entities to provide technical assistance to providers to help ensure their success. Technical assistance may include activities related to information technology; development of business plans to support sound business and management operations; financing strategies to maximize resources such as Medicaid, private insurance and fees; quality improvement and management; and data/information management.
- Development of training curricula and media regarding system-wide accountability for provider quality, access and performance.
- Request for proposals or applications that invite providers through local management entities (LMEs) to apply for funding to:
    - Support the development of evidence based practices;
    - Transitional support for providers to enhance their business and information technology functions to help ensure an array of stable and viable community-based service providers;
    - Transitional support, such as start-up funding, technical assistance, etc., for developing providers as local management entities (LMEs) continue to divest direct service provision.
    - Transitional support for both the development of additional service providers and the enhancement of existing providers to increase service availability to facilitate the downsizing of State operated facilities through reduced utilization.

Objective: Continue development of comprehensive crisis services

A comprehensive crisis service system is critical to stabilize the system across all disabilities state-wide. Such a comprehensive system must be prepared to meet the needs of any individual who experiences a crisis related to a mental health or substance abuse problems or a developmental disability. Such a comprehensive system must be prepared to provide appropriate services that are evidence-based or best practices. At the community level, a comprehensive crisis service system must be totally integrated with the existing community medical and public safety emergency response system.

While state facilities clearly have an important role in a comprehensive crisis service system, admission to a state psychiatric hospital should be the choice of last resort. All too often, individuals who experience such a crisis are quickly transported by police to hospital emergency rooms or to state operated psychiatric hospitals. Improved access to commitment evaluations and community resources serving as alternatives to state hospital admission are important in providing a comprehensive crisis system and in decreasing inappropriate state hospital admissions. Use of the state psychiatric hospitals or the alcohol and drug abuse treatment centers is quite appropriate when community options are exhausted and a thorough crisis evaluation has ruled out all less restrictive community alternatives.

When existing consumers of the system have a fully developed person-centered plan including a crisis prevention/intervention plan, the consumers, family members and first responders know what actions are needed to prevent escalation of the crisis and intervene in a way that is appropriate for the person. Crisis prevention begins with a good risk assessment and a plan that anticipates the supports needed for the person in the eventuality that a crisis occurs. Often, the crisis can be resolved in a timely manner in the person's home community given a comprehensive array of crisis services. Training of first responders regarding crisis planning and management is also critical. Currently, individualized planning as person-centered plans, including crisis plans and transition plans, is not fully exercised state-wide as intended.

Currently, each local management entity (LME) has submitted a plan for developing comprehensive crisis services in its geographic area. As mandated by the North Carolina General Assembly, each plan must provide community crisis services for any person experiencing crisis due to a mental health or substance abuse problem or developmental disability. Further, the General Assembly appropriated funding for development of these services and for their ongoing operation. The Division contracted with consultants from Technical Assistance Collaborative, Inc. to assist with review of plans and provision of technical assistance to local management entities in their implementation through June 2008.

The Division is also very aware of the possibility of wide-scale disasters (such as natural disasters and medical epidemics) and that communities and state operated facilities must be prepared for such events. The Division, each state operated facility and each local management entity has developed

disaster plans for behavioral health response and recovery. Consumers must be cared for by responding to their individual needs, including health support medications, and safety.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns for continuing the development of comprehensive crisis services.

Objective: Comprehensive Crisis Services **Action Steps and Milestones**
<u>Action Step 1</u>: Develop and implement strategies to ensure that consumers and also family members participate in crisis service planning at all levels (personal, local and state) so they understand how to access crisis services and their roles in advocacy for appropriate use of resources.
• By 6/30/08, provide training for State and local consumer and family advisory committees in their roles as advisory bodies regarding crisis service access, planning and implementation.
• By 6/30/08, encourage consumers and family members to understand and participate in consumer-centered approaches to crisis intervention, such as Crisis Intervention Teams (CIT) a law enforcement education program.
• By 6/30/08, assist consumers and family members in understanding their participation in crisis planning at all levels, particularly development and implementation of individualized crisis plans.
• By 6/30/09, provide guidance for consumers and local management entity (LME) customer service offices in the development of crisis information materials.
• By 6/30/09, work with local management entity (LME) customer service and consumer affairs offices to publicize crisis services providers through a variety of media including the NC Care Link web site, and to publicize how to report complaints about crisis services.
<u>Action Step 2</u>: Coordinate and implement comprehensive crisis services for each age/disability group that: ❖ **Incorporates the functions and responsibilities of state operated facilities, local management entities (LMEs) and community providers; and** ❖ **Ensures continuity of care and support across all components of the crisis system.**
• By 6/30/08, set expectations for multi-year development of comprehensive crisis system and designate functions, expertise and responsibility of state operated facilities, local management entities (LMEs) and community providers.
• By 6/30/08, provide technical assistance to local management entities (LMEs) in implementing approved regional and local management entities (LMEs) crisis service plans.
• By 6/30/08, provide guidance on the standardized person-centered plan including a risk assessment, a crisis prevention/intervention plan, and transition plan for

Objective: Comprehensive Crisis Services Action Steps and Milestones
individuals at risk of or discharged from inpatient or out of home care.
• By 6/30/08, increase the capacity for acute treatment at all alcohol and drug abuse treatment centers (ADATCs).
• By 6/30/08, establish guidance that ensures continuity of care and supports for consumers among local management entities (LMEs), local providers, and state operated facilities to ensure transition from emergency/crisis services to an ongoing provider.
• By 6/30/09, ensure local management entities (LMEs) fully implement their approved crisis services plan in coordination with assigned crisis region.
• By 6/30/10, assess remaining gaps in the development of all crisis service system components and services, including appropriate behavior supports for services for individuals with developmental disabilities, and provide Mental Health Trust Funds to address gaps and needs.
Action Step 3: Design and implement comprehensive training on crisis intervention and stabilization techniques for local management entities (LMEs) and providers.
• By 6/30/08, prepare a comprehensive training plan for crisis intervention and stabilization techniques that includes development, implementation and maintenance of ongoing training.
• By 6/30/08, secure contracts between the Division and education and training consultants to develop curricula and/or provide training as identified in the training plan, including first responder, person-centered planning, crisis planning, transition planning, crisis prevention/intervention techniques, skills training and treatment.
• By 6/30/09, initiate all applicable recommendations of the training plan.
• By 6/30/10, evaluate and revise training plan as needed.
Action Step 4: Establish cooperative relationships and protocols for continuity of care at state and local levels including general hospitals, primary care physicians, clinics and networks and other community agencies essential to effective crisis response systems.
• By 12/31/08, work with local management entities (LMEs) and provide guidance and examples of memoranda of agreement regarding the importance of developing local agreements about handling crisis situations with hospitals, local offices of Community Care of North Carolina (CCNC) and other representatives of the primary health care system.
• By 12/31/08, ensure collaboration with hospital emergency departments on crisis response and stabilization.
• By 12/31/08, work with local management entities (LMEs) to establish protocols for appropriate use of local law enforcement and courts in crisis situations.
• By 12/31/08, implement legislation passed pertaining to first level commitment evaluations.

Objective: Comprehensive Crisis Services Action Steps and Milestones
<u>Action Step 5</u>: Develop and implement methods to assure local management entities' (LMEs) authority and accountability and to explore performance incentives regarding admissions to and utilization of state psychiatric hospitals, alcohol and drug abuse treatment centers and developmental centers.
• By 2/28/08, analyze the statutory authority for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to define the roles and responsibility of local management entities (LMEs) with regard to admission to state operated facilities.
• By 6/30/08, establish and communicate targets for each local management entity (LME) and for each facility by exploring performance incentives for both admissions and discharges.
• By 6/30/08 Division of Mental Health/Developmental Disabilities/Substance Abuse Services will analyze and publish performance results for local management entities (LMEs) and facilities related to their admission and utilization targets.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and supports, access to services, promotion of best practices, quality management, system efficiency and effectiveness, early intervention and prevention, and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes

- Increased percent of consumers with crisis prevention/intervention plans.
- Reduced rate of re-hospitalization within 30 days of inpatient discharge.
- Decreased rate of preventable deaths of consumers including suicide, homicide and other violence.

System Performance

- Increased availability of local crisis services.
- Reduced percent of hospital admissions for short-term stays.
- Increased continuity of care for consumers between crisis services and appropriate ongoing services.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Request for proposals / applications that invite providers, through local management entities (LMEs) to apply for funding as a supplement to other crisis service funding that may be available to:
    - Support one-time start up costs for crisis services such as minor facility modifications and acquisition of equipment; or
    - Transitional support for crisis service providers to enhance their business and information technology functions to help ensure an array of stable and viable community-0based crisis service providers that link seamlessly to LMEs, State facilities and other community-based service providers; or
    - Short-term transitional support for crisis service operations until newly developed crisis services can become self-sufficient via Medicaid and State support fee-for-service billings.
- Development of consumer-friendly materials in a variety of media regarding individualized crisis prevention/intervention planning, the availability of local comprehensive crisis services, and 24/7/365 access to such services.
- Development of curricula and media regarding system-wide training in crisis intervention and stabilization techniques for staff of local management entities, service providers, law enforcement, school systems and other local agencies.

Objective: Achieve more integrated and standardized processes and procedures in the MH/DD/SA services system

The success of any system or business is directly related to its practices that integrate its parts and facilitate smooth operations, continuous quality improvement and constant communication and flow of information. Success does not mean rigidity and cookie cutter mandates, but encourages creativity, flexibility, evolution and growth. This objective is intended to promote three basic premises: (1) consumers must have consistent access to services across the state based on their level of need and with reasonable adjustment for urban and rural areas; (2) the public mental health/developmental disabilities/substance abuse service system will operate more effectively and efficiently if all local management entities (LMEs) and providers adopt standard processes and procedures, at a minimum, regarding particular areas of operation; and (3) there must be consequences for lack of accountability at every level.

The areas of operation that are of major concern are utilization management of state-funded services, provider management, clinical protocols, care coordination, information systems, and local management entity functions. Every level of the system (Division, state partners, LMEs, providers, local partners and consumers) is accountable for the success or failure of the system. Providers must be accountable to the people they serve and to local management entities. Local management entities must be accountable to consumers in its geographic area, to county governments and to the Division for the expenditure of public funds, and to the state for oversight of the providers it has endorsed as well as compliance with laws, rules and established standards and policies. The Division must be accountable for the expenditure of public funds and for the overall operation and success of system performance and outcomes for consumers. Consumers must be accountable for their individual needs and standing up for their rights.

The importance of systematic quality management systems and consistent expectations across the systems is also reinforced by the increased expectations expressed in the last few years by the Centers for Medicare and Medicaid Services regarding the administration of Home and Community Based Waivers. The federal Centers for Medicare and Medicaid (CMS) now requires states to describe their procedures for establishing provider capacity, monitoring individual plans of care, protecting individual health and safety and assuring that services outlined in plans of care are provided. The data generated from these discovery processes must in turn be shown to be used to remediate individual and provider related issues. Further the state must describe how findings from monitoring processes are used to support policy, practice, and other improvements in the service system.

Currently, with the provider system still under development, there is inconsistency in what services are available across the state and the quality of those services. There is inconsistency in accountability. There is inconsistency in the quality of providers. There is inconsistency in processing of claims and payments to providers. There is inconsistency in the availability and flow of information for monitoring system operations to assure clinical, programmatic and technical quality and to measure and report outcomes for consumers. These problems limit how well we can

manage funding and implement adequate care coordination for those consumers who are at highest risk and consequently are the highest cost to the system.

The Division must set expectations and measure the impact for the entire system. However, this objective confronts an inherent conflict within the North Carolina system as currently established. That is, the Division is given responsibility for designing, implementing and overseeing a system over which it has limited authority. Consequently, in addition to proposing rules based on statutory language, the Division can at best provide policy guidance based on its best clinical and professional judgment of what is best for the people the system serves. To be most successful that guidance must be based on conversations with all stakeholders of the system. Considerable time is needed to research the issues, hold the conversations, gain consensus, and formally communicate the guidance. However, if the policy guidance is not in rule, the Division cannot enforce its implementation. Unfortunately, some stakeholders do not comply and yet expect funding to continue.

Each local management entity (LME) has prepared a local business plan for 2007-2010 that outlines how it will carry out the functions that the State is contracting with it to provide for its geographic area. Once approved, local business plans become effective through a contract with the Department of Health and Human Services. The Division will use a model for equitable allocation of funding to local management entities (LMEs) to support the functions. As mandated by the North Carolina General Assembly, the Division must monitor how well each local management entity (LME) carries out the functions and in the event that an local management entity (LME) does not successfully carry out a function, the Division must provide technical assistance to improve the situation or remove the function from an local management entity's (LME's) responsibility and contract with another entity to fulfill that function. This is the most practical way for the Division to encourage a local management entity (LME) to utilize the Division's policy guidance.

It is important to note that the Division has contracted with consultants from Technical Assistance Collaborative, Inc. (TAC) to assist with the development and implementation of standard practices for utilization management of state funded services, provider management, and measurement and reporting of system performance and consumer outcome data through June 2008.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns.

Objective: Integrated and Standardized Processes and Procedures **Action Steps and Milestones**
<u>Action Step 1</u>: Develop strategies and materials to inform consumers and also family members of statewide standard processes and procedures, to support their legal rights and to support them in processing their complaints and concerns.
• By 6/30/08, provide training to local management entity's (LME's) customer service and consumer affairs offices regarding client rights protection and other functions of those offices.

Objective: Integrated and Standardized Processes and Procedures
Action Steps and Milestones

- By 6/30/08, provide guidance to local management entity's (LME's) customer service and consumer affairs offices on the development of consumer-friendly materials in a variety of formats regarding rights, filing complaints, and utilization of standard system processes such as appeal processes (Medicaid and non-Medicaid), availability and quality of providers, and other standard processes that impact consumers.
- By 6/30/09, assist State and local consumer and family advisory committees and client rights committees to review quarterly customer services data reports and data and to recommend appropriate responses to these reports.

<u>Action Step 2</u>: Develop and implement uniform practices, clinical protocols and performance expectations for utilization review and utilization management for state funded services.

- By 12/30/07, complete information collection and analysis of current local management entities (LMEs) utilization management and utilization review practices, clinical criteria and protocols for state funded services, and compare to the practices of the Division of Medical Assistance and ValueOptions and criteria for Medicaid services for each service and target population
- By 6/30/08 develop utilization management/utilization review system design, standards, performance indicators and quality assurance processes for utilization management/utilization review functions for state funded services within the standard benefit designs for each age/disability group
- By 6/30/09 complete local management entity (LME) training and implementation of standard utilization management/utilization review functions and practices for state funded services

<u>Action Step 3</u>: Work with local management entities (LMEs) and other stakeholders to develop and implement uniform practices and performance expectations for provider management, including provider endorsement, provider monitoring and claims payment.

- By 12/31/07, develop and implement standard processes and procedures for provider endorsement including conditional and full endorsement, and withdrawal of endorsement.
- By 12/31/07, develop standardized provider monitoring tools and manual.
- By 6/30/08, develop and implement standard procedures for service authorizations and processing claims related to State funded services.
- By 6/30/08, develop and implement standard processes for provider monitoring.
- By 6/30/09, integrate provider level consumer outcomes and performance measures into the provider quality and performance monitoring system

<u>Action Step 4</u>: Work with local management entities (LMEs), providers and other stakeholders to design and implement uniform high quality clinical systems and protocols to assure care coordination and protocols for monitoring and continuity of care for consumers.

Objective: Integrated and Standardized Processes and Procedures
Action Steps and Milestones

- By 6/30/08, develop and implement processes and procedures for referral and continuity of care of consumers of mental health/developmental disabilities/substance abuse services across a variety of service types and providers.
- By 6/30/08, develop and implement processes and procedures for care coordination between state operated facilities and local management entities (LMEs) community services.
- By 6/30/08 work with DMA to develop continuity of care standards for Medicaid providers and protocols for consumers receiving care from Medicaid providers.
- By 6/30/08, share with DMA and ValueOptions protocols for evidence based practices and audit reviews.
- By 6/30/09, develop standardized quality management tools for monitoring individual care.

<u>Action Step 5</u>: Work with local management entities (LMEs) and the Division of Medical Assistance (DMA) to develop a consistent framework based on person-centered planning and best practice for care coordination of high risk and/or high cost consumers.

- By 6/30/08, submit a draft rule to the mental health Commission that defines criteria for identifying high risk and high cost consumers.
- By 6/30/09, develop and implement standard procedures for planning and implementing services for high cost and/or high risk consumers of mental health/developmental disabilities/substance abuse services.
- By 6/30/09, collaborate with DMA and ORDHRD to develop processes and procedures for participation in Community Care of NC (CCNC) and coordination of generic health issues, hospital utilization, etc. for consumers of mental health/developmental disabilities/substance abuse services.

<u>Action Step 6</u>: Implement system-wide outcome and performance measures, and conduct quarterly and annual analyses of outcome and performance data for use by managers and staff at all levels of the system to assure the quality, effectiveness and accountability of the mental health/developmental disabilities/substance abuse services system.

- By 12/31/07, refine current measures and reporting mechanisms.
- By 6/30/08, define how system-wide outcome and performance measures will be used at the State level for planning and system improvement.

<u>Action Step 7</u>: Replace or upgrade existing information systems to respond to a changing business environment and federal reporting requirements.

- By 12/31/07, clarify the procedures and legalities for sharing data on mental health, developmental disabilities and substance abuse consumers between the Division of Medical Assistance (DMA), ValueOptions, DMH/DD/SAS, local management entities (LMEs) and providers to facilitate responsibilities and accountability at every level of the system.

Objective: Integrated and Standardized Processes and Procedures **Action Steps and Milestones**
• By 12/31/07, implement a state-wide notice of privacy and consent form to cover sharing of all consumer information for the Division's client data warehouse (CDW), consumer outcomes, claims data, incident data, and system performance measures.
• By 6/30/10, implement an electronic health record (E.H.R.) and standardized clinical information system for all consumers in the Central Regional Hospital with long-range plans for implementation at all state psychiatric hospitals.
• By 6/30/10, explore a long-term plan to provide incentives for local management entities (LMEs) and providers to utilize a standardized electronic health record capable of sharing and transmitting consumer information and treatment data in real time.
• By 6/30/10, explore an effective interface of consumer information between state facilities and local management entities (LMEs) within the constraints of federal and state regulations.
<u>Action Step 8</u>: Develop standardized processes and procedures for monitoring local management entity (LME) functions.
• By 6/30/08, develop and provide guidance and implement strategies to streamline and standardize local management entity (LME) managerial and administrative processes and procedures.
• B7 6/30/08, specify the elements of a public report on local management entity (LME) management, budget and administration that local management entity (LME) boards must review on a monthly basis.
• By 6/30/08 develop for State and local levels standard quality management expectations to employ outcome and performance data to assure continuous improvement of best practices and to encourage clinical excellence and protection of consumer rights and dignity.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and support, access to services, promotion of best practices, quality management, system efficiency and effectiveness and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes

- Increased rate of care coordination for high cost/high risk consumers.

System Performance

- Increased percent of consumer data received by local management entities (LMEs) and the Division according to established time frames.
- Increased timeliness of claims processing for non-Medicaid funded services.
- Increased percent of annual non-Medicaid and federal service funds spent proportionately throughout the year by age/disability group and overall.
- Reduced rates of over-utilization and under-utilization of state funded services.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Development of curricula and media regarding system-wide training related to utilization management of State funded services; management, contracting, claims adjudication and monitoring of providers; person-centered planning; service access; and care coordination.
- Provision of financial assistance to local management entities (LMEs) and providers to implement electronic clinical / health record systems capable of sharing and transmitting data about all persons served in real time.
- Implementation of system-wide outcome and performance reporting and quality management system.
- Development of an effective interface of consumer information between State operated facilities, local management entities (LMEs) and providers.
- Standardized surveys of local management entity (LME) boards, providers, consumer and family advisory committees and partner agencies associated with overall mental health, developmental disabilities and substance abuse system performance.
- Ongoing analysis, implementation and modification of processes and procedures that, to the extent practical, help ensure an effective and efficient public system through integration and standardization of such processes and procedures.

Objective: Improve consumer outcomes related to housing

Housing is a basic need and every individual that the system serve needs the opportunity for increased access to safe, decent, affordable housing with the supports and services based on individual needs and choices. Every provider must realize the importance of housing for the people they serve, including keeping children in their home communities. Therefore, housing must be addressed in every consumer's person-centered plan.

Yet, for many who experience mental health or substance abuse problems or developmental disabilities, housing can be difficult to obtain or maintain. The difficulties may be associated with costs, need for services or supervision, licensing, and just the difficulty of navigating the complex and complicated housing system. Individuals who are discharged from state operated facilities may end up homeless due to these difficulties.

Permanent supportive housing integrates permanent, affordable housing with the supportive services needed to help people with disabilities access and maintain stable housing in the community. Permanent supportive housing is a nationally recognized model being replicated throughout the country as a proven, cost-effective solution to preventing and ending homelessness among low-income people with disabilities. Permanent supportive housing is typically targeted to people with serious and long-term disabilities including mental illnesses, developmental disabilities, substance use disorders, physical disabilities and chronic health conditions such as HIV/AIDS. In addition to challenges in accessing housing, these populations often have co-occurring disabilities, resulting in complex service needs that require flexible services and supports to establish and maintain long-term housing stability. Key components of permanent supportive housing that facilitate successful housing tenure include:

- Individually tailored and flexible supportive services that are voluntary, can be accessed 24 hours a day/7 days a week, and are not a condition of ongoing tenancy;
- Leases that are held by the tenants without limits on length of stay; and
- Ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

Studies on the housing preferences of people with disabilities have consistently shown a desire to live in independent housing that is integrated in the community, and greater satisfaction and perceived choice with the permanent supportive housing model. Creating integrated housing options in the community for people with disabilities is also aligned with the Supreme Court's *Olmstead* decision which requires a choice of housing options for people in institutions who would prefer to live in integrated housing in the community. In addition to promoting greater choice, self-sufficiency, and community integration, research has demonstrated positive impacts in terms of cost-effectiveness, and improved quality of life, housing stability, and health and behavioral outcomes for those it serves.

The Division recognizes housing as a significant issue for the people we serve and currently has one staff person that oversees and supports a housing specialist in each of about 20 local management entities. In addition, the Division participates in the Governor's task force on housing and in the Department of Health and Human Services' housing effort.

While the housing specialists in local management entities (LMEs) are currently devoted to housing programs for consumers of the system, what is needed is broad housing competence at the State and local level. Housing competence means having the knowledge about state laws pertaining to housing, the federal fair housing law and programs, having the skills of how to get and keep housing, how to get access to subsidies and lease accommodations, how to utilize various payment methods, how to negotiate with landlords, and how to resolve housing problems. Given that housing is a highly complicated and evolving area of programs and funding for which the system does not have major responsibility, providers responsible for person-centered planning need to be able to recognize when a consumer needs assistance with getting or maintain housing, what housing programs are available and who to contact to access the programs. The local management entity (LME) housing specialist could provide ongoing training and information to providers.

The Division is participating in a three-year pilot project to develop housing assistance teams that will teach ACT Teams how to access housing for their consumers.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns.

Objective: Housing **Action Steps and Milestones**
<u>Action Step 1</u>: Involve consumers in promoting the aspects of the communication plan (developed in the objective on the provider system) that emphasizes the role that stable housing plays in treatment and recovery.
• By 6/30/08, analyze complaints and concerns filed with the Division to identify trends and issues regarding housing to inform Division policy guidance.
• By 6/30/08, ensure that Division staff providing customer service is aware of appropriate contacts and resources regarding housing.
• By 6/30/08, provide guidance and materials for local management entity (LME) customer service staff to communicate housing options available for consumers.
• By 6/30/10, convene training, presentations or workshops for consumers as well as family members to increase awareness about housing.
<u>Action Step 2</u>: Develop strategies for implementing the Division's long-term integrated housing plan and build upon the mental health/developmental disabilities/substance abuse Commission's housing recommendations with revisions as needed.
• By 6/30/08, identify unmet housing needs for specialized population groups (such as consumers who are homeless or at high risk of loss of housing, living in supported care facilities, physically disabled, discharged from jail, and children moving back into home communities).

Objective: Housing Action Steps and Milestones
• By 6/30/08, work with consumers to identify the range of safe, affordable housing options by age/disability groups that meet the needs of consumers.
• By 6/30/08, update the Division's housing plan to incorporate the Housing 400 Initiative and other initiatives supported by DHHS.
• By 6/30/09, examine housing options and develop strategies for ensuring accessible housing alternatives for specialized populations (such as safe, stable housing for the homeless; housing that promotes independence for those in supported care facilities).
• By 6/30/08, define the Division's role in working with DHHS, the North Carolina Housing Financing Agency and others in the state-level housing community.
• By 6/30/08, develop and provide guidance for local management entities (LMEs) about the full continuum of housing options, how to conduct an environmental scan and how to develop a local housing plan.
• By 6/30/08, publish the Division's revised long-term integrated housing plan.
• By 6/30/09, publish the first annual update of the Division's long-term housing plan.
• By 6/30/10, examine the results and make recommendations for the feasibility of expansion of the pilot Homeless Mental Health Housing Initiative use of housing support teams and include this in the annual updated housing plan if appropriate.
<u>Action Step 3</u>: Develop guidance and provide additional training and support to local management entities' (LMEs') housing specialists to increase knowledge and skills in all options regarding housing for consumers of mental health/developmental disabilities/substance abuse services.
• By 6/30/08, increase the knowledge and skills of housing specialists including fair housing practices, the requirements and procedures for accessing tax credit units for people with disabilities and the importance of linkages between housing and supportive services.
• By 6/30/09, provide support for housing specialists in training local management entities' (LMEs') staff, providers responsible for person-centered planning as well as advocacy groups regarding housing issues.
• By 6/30/10, develop and implement technical assistance, training and workforce development activities for local management entities (LMEs) and providers to improve capacity and effectiveness in assisting consumers to attain and sustain permanent housing.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and supports, access to services, promotion of best practices and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes

- Increased percent of consumers by disability that report having safe, stable housing.
- Increased percent of person-centered plans that have goals addressing consumers' housing preference.
- Increased numbers of homeless individuals with disabilities placed in housing.

System Performance

- Increased number of affordable and accessible housing units available.
- Increased number of collaborative relationships at the State level that inform and support housing specialists at the local level.
- Increased outreach to homeless individuals.

Use of Mental Health Trust Funds

- Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:
- Development of curricula and media regarding system-wide training in housing competence for housing specialists at the community level and for providers of mental health, developmental disabilities and substance abuse services.
- Pilot Homeless Mental Health Housing Initiative to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with ACTT and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the county.
- Continue housing initiative through a joint effort with DHHS, LMEs and the North Carolina Housing Finance Agency (NCHFA) to leverage funds and increase the availability of housing resources and options for individuals with mental illness, developmental disabilities and substance abuse problems.
- Provision of mental health, developmental disabilities and substance abuse services on a transitional basis, i.e., until sufficient ongoing revenues are available, to support individually tailored and flexible support services that will enhance successful housing opportunities for individuals with disabilities.
- Support for non-recurring cost necessary to support successful housing utilization such as rental deposits, utility deposits, and furnishings.

Objective: Improve consumer outcomes related to education and employment

Developing and using one's talents and skills are essential to experiencing a rich and fulfilling life. Regardless of the personal limitations or challenges that any individual experiences, each has gifts to be shared within a community. This is equally true for those who experience challenges related to mental health or substance abuse or developmental disabilities. Every individual served in the public system deserves the opportunity for education, employment or other meaningful daily life activities based on individual needs and choices. Every provider must discover the importance of education or employment for each person they serve. Therefore, every consumer's person-centered plan must include specified activities that relate to the development and use of individual skills in daily life, whether through education, or employment, or some other meaningful daily activity.

Part of the challenge of developing a community based services system is transforming the community itself to be inclusive and accept diversity. The vision calls for communities to work together to enable consumers to live successfully in their communities. This includes opportunities for education and employment. This is a long-term endeavor, but we must begin.

Best practices for children and adults with developmental disabilities increasingly revolve around the use of individualized educational and employment supports to maximize a successful job placement. In the past, people were relegated to segregated vocational settings that offered few opportunities for individual choice or career paths. As the system has evolved, efforts are directed at ensuring that adolescents receive job counseling and skills preparation before they graduate so that there is a more seamless transition into employment. For adults seeking jobs, there are a range of creative solutions including the use of job coaches and the identification of natural supports within the workplace.

"The great majority of people with severe mental illness desire competitive employment, and evidence-based supported employment is currently the most effective way to help them achieve their goal. Evidence-based supported employment emphasizes the following: competitive jobs that are based on a person's preferences for type and amount of work, integrated work settings, job-seeking when the unemployed person expresses interest, minimal pre-vocational preparation and assessment, and follow-along supports from mental health and vocational specialists to maintain the job or transition to another one. Supported employment has been endorsed by the President's New Freedom Commission on Mental Health (2003), the Surgeon General (1999), the National Alliance for the Mentally Ill (2001), the National Institute of Mental Health (1999), the Substance Abuse and Mental Health Services Association (www.mentalhealthservices.com), and many other federal organizations, state agencies, advocacy groups, and private foundations." [4]

The challenges are primarily two-fold. First, this requires effective linkages and collaboration partnering with and supporting the initiatives of agencies and organizations that provide education and employment expertise and services. At the State level, the Division's primary partners are the Department of Public Instruction, the North Carolina university and community college systems,

[4] Deborah R. Becker, M.Ed. and Robert E. Drake, M.D., Ph.D. *Supported Employment for People with Severe Mental Illness :*A guideline developed for the Behavioral Health Recovery Management Project; New Hampshire-Dartmouth Psychiatric Research

and the Division of Vocational Rehabilitation. Local partnerships to develop and support consumer's access to educational programs and jobs include the local school systems, community colleges and offices of vocational rehabilitation. Secondly, staff at local management entities (LMEs) and among providers who are responsible for person-centered planning must know about available programs and have the skills to assist the people they serve to find appropriate activities that reflect each individual's choice.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns.

Objective: Education and Employment **Action Steps and Milestones**
<u>Action Step 1</u>: Involve consumers and also family members in promoting the aspects of the communication plan (developed in the objective on the provider system) that emphasizes the role that education and employment plays in self-determination and recovery.
• By 6/30/08, analyze complaints and concerns filed with the Division to identify trends and issues regarding education and employment.
• By 6/30/08, involve consumers and also family members in developing and pilot testing of guidance on emphasizing education and employment across age/disability groups.
• By 6/30/08, provide guidance to local management entity (LME) customer service offices in the development of materials regarding the role education and employment play in self determination and recovery in a variety of media and languages.
• By 6/30/10, provide training workshops and/or presentations for consumers and also family members to increase awareness of education and employment.
<u>Action Step 2</u>: Develop and communicate guidance for local management entity (LME) staff and providers about the importance of addressing education and employment in all person-centered plans.
• By 6/30/08, research supported education programs and models (see models in Kansas and other states) and potential funding for these programs.
• By 6/30/08, provide training to local management entities about education and employment programs and importance of addressing education and employment in all person-centered plans.
• By 6/30/09, revise service definitions regarding supported employment for transition age youth and adults.
• By 6/30/09, work with consumers to define and strengthen peer directed and delivered services that can be included in person-centered plans.
• By 6/30/09, provide training and technical assistance to local management entities (LMEs) and providers on best practice supported employment approaches tailored to age/disability populations.

Objective: Education and Employment
Action Steps and Milestones

<u>Action Step 3</u>: Expand and enhance joint efforts with the Division of Vocational Rehabilitation to provide training for state and local staff and to provide employment opportunities for consumers of mental health, developmental disabilities and/or substance abuse services.

- By 6/30/08, conduct initial cross training for State and local staff as indicated in the memorandum of agreement with the Division of Vocational Rehabilitation and plan for this on an annual basis.
- By 6/30/08, exchange policy and programmatic information on an ongoing basis with the Division of Vocational Rehabilitation regarding supported employment and related services to better meet the needs of eligible individuals.

<u>Action Step 4</u>: Work at the state level to develop strategies and disseminate information for consumers related to maintenance of benefits (e.g., Medicaid, Supplemental Security Income, Social Security Disability Income) while engaging in employment.

- By 6/30/09, disseminate information through local management entities' (LMEs') customer service offices and advocacy groups to families and individuals regarding the benefits of employment and the ways in which benefits can be protected
- By 6/30/10, develop guidance, training, TA and other resources to improve the competence of local management entity (LME) staff regarding federal requirements and employment opportunities.

<u>Action Step 5</u>: Develop a plan and communicate guidance to local management entities for youth (up to age 21) consumers to move into jobs or vocational development or post secondary education.

- By 6/30/09, work with Division of Vocational Rehabilitation and the Department of Public Instruction to develop transitional work plans for youth.
- By 6/30/09, identify resources available for working with youth who dropout of school to support their obtaining their high school diploma or GED.
- By 6/30/09, provide guidance for community support workers and targeted case managers in schools to provide skill building to keep youth in school.

<u>Action Step 6</u>: Expand the availability of supported employment and job placement services and supports.

- By 6/30/09, assess costs to expand supported employment and job placement services.
- By 6/30/09, work with local management entities (LMEs) to identify and assist individuals who desire and could benefit from supported employment.
- By 6/30/09, monitor data regarding the numbers of people receiving supported employment to determine current availability.

Objective: Education and Employment Action Steps and Milestones
• By 6/30/10, review best and evidence-based practices in supported employment and available tool kits, literature, and publications and disseminate information to local management entities (LMEs), providers, consumers, and also families.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and support, access to services, promotion of best practices and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes

- Increased percent of consumers with stable employment.
- Increased percent of consumers participating in supported employment.
- Increased percent of consumers with developmental disabilities that like the jobs and/or other daily activities that they have.
- Reduced rates of dropout, suspension and expulsion from school among youth consumers (up to age 21).
- Increased percent of educational or job placements for youth consumers (up to age 21).

System Performance

- Increased percent of local management entities (LMEs) providing public information to consumers and families about education and employment opportunities and maintenance of entitlements and other benefits while employed.
- LME staff and case managers are knowledgeable about employment and the maintenance of entitlements.
- Increased number of employment opportunities for consumers.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Development of curricula and media regarding system-wide training in education/employment competence for local management entity (LME) staff and for providers of mental health, developmental disabilities and substance abuse services.
- Transitional funding of proposals / applications from providers, in conjunctions wit6h LMEs, that demonstrate effective and promising approaches to support positive consumer outcomes related to education and employment.

Relationship of the Strategic Objectives to Long-Range Plan

This strategic plan addresses many of the conclusions and recommendations of the Long-Range Plan prepared by Heart of the Matter, Inc. and Pareto Solutions, LLC, in December 2006. Table 2 provides a crosswalk of the major recommendations from that report to the strategic objectives by identifying relevant action steps as described above. To facilitate this process, table 2 shows the categories of chapter VI of the Long-Range Plan report for this table rather than the detailed discussion in each category.

Table 2. Response of State Strategic Plan to Recommendations of Long-Range Plan

Categories of Recommendations from the Long-Range Plan	Objective: High Quality Provider System	Objective: Comprehensive Crisis System	Objective: Standardized Processes & Procedures	Objective: Consumer Outcomes related to Housing	Objective: Consumer Outcomes related to Education & Employment
Foundations	Action step 1			Action step 1	Action step 1
Rules[5]	As needed	As needed	As needed	As needed	As needed
Information Systems		Action Step 4	Action Steps 4, 6, 7 & 8		
Service Inadequacy	Action Steps 2, 3 & 4	Action Step 2	Action Steps 3, 4 & 6	Action Step 2	Action Step 5
Population, Prevalence & Treated Prevalence			Action Steps 6 & 8	Action Step 2	
Per Capita Spending		Action Steps 2 & 4	Action Step 4		
Service Utilization	Action Steps 3 & 4	Action Steps 3 & 5	Action Steps 2, 3, 4 & 8	Action Step 2	Action Step 2 & 4
Projected Start-up & Total Funding Needed	Action Steps 4 & 5	Action Steps 2 & 5			
Monitoring & Oversight	Action Step 1	Action Step 5	Action Step 6		

[5] Note that the drafting of appropriate rules is a detailed task that will be included in the achievement of a milestone and action step as appropriate. The Division drafts and proposes rules for consideration by the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, which then provides them for public consideration and final disposition. The length of time required for enacting a rule depends on comments received.

Chapter 4. Measures of Results

As defined in the previous chapter and sections related to each objective, there are two ways in which the success of this strategic plan will be measured.

First, the Division will measure progress of implementation by monitoring the action steps taken to accomplish each objective. In other words,

- Was each milestone accomplished in a timely manner?
- Was each action step accomplished as intended?
- Were challenges or barriers successfully addressed?

Secondly, and more importantly, the Division anticipates changes for consumers and other stakeholders as a result of this strategic plan. Therefore, the overall effectiveness of the five strategic objectives will be measured in terms of outcomes for consumers and/or changes in system performance over time.

Data collected during 2006 and 2007 will be the baseline data against which the Division will measure overall progress and effectiveness. For example, 88% of discharges from state psychiatric hospitals during the first two quarters of SFY 06-07 were for consumers with lengths of stay for 30 days or less.[6] Over half of these were for consumers who were discharged within seven days of admission. When crisis services are fully implemented in communities, the Division expects both of these percentages to drop.

The successful effects of some of the objectives may be more readily apparent than others. For example, considerable effort and time beyond the three years of this plan may be necessary to fully develop employment opportunities in communities for consumers who desire to and can work. The three years will be used to lay the groundwork. Considerable visible change should be apparent throughout the State with regard to local crisis services within the three years.

In House Bill 2077, the General Assembly requires that the Division track and report performance in the following domains or areas:

- Individualized planning and supports.
- Access to services.
- Consumer focused outcomes.
- Promotion of best practices.
- Quality management system.
- System efficiency and effectiveness.
- Early intervention and prevention.

These domains are used in the previous chapter to guide the Division's selection or creation of measures of effectiveness. These domains were first reported in the Division's semi-annual report to the Legislative Oversight Committee.[7] The Division has contracted with consultants from

[6] See Semi-Annual Report to the Joint Oversight Committee on MH/DD/SAS, Statewide System Performance Report, SFY 2006-07, Spring Report.

[7] See http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm for copies of these semi-annual reports.

Technical Assistance Collaborative, Inc. and Human Services Research Institute to assist in the refinement of measures.

The Division will use measures from the semi-annual report on statewide performance to the Legislative Oversight Committee to track success as a result of the State Strategic Plan objectives. In addition, the Division will use measures from a number of reports on consumer outcomes, annual statistics, consumer adverse events and local management entity (LME) performance. The sharing of information among providers, local management entities (LMEs) and the Division is critical to having adequate data to measure the effects of the objectives and the success of this endeavor for the entire system.

Table 3 summarizes the consumer outcomes and system performance measures of the five objectives selected by the Division.

Table 3. Measures of Objectives

Objective	Consumer Outcomes	System Performance
Provider System	• Increased percent of consumers receiving timely and adequate care. • Increased percent of consumers making a choice of providers. • Increased percent of consumers participating in the development of their person-centered plans.	• Increased public access to provider performance reports. • Increased proportion of public resources spent on evidence based and best practices. • Increased percent of providers that are nationally accredited for each disability group. • Increased number of providers who meet statewide provider performance standards.
Crisis Services	• Increased percent of consumers with crisis prevention/intervention plans. • Reduced rate of re-hospitalizations within 30 days of inpatient discharge. • Decreased rate of preventable deaths among consumers including suicides, homicides and other violence.	• Increased availability of local crisis services. • Reduced percent of hospital admissions for short-term stays. • Increased continuity of care for consumers between crisis services and appropriate ongoing services.
Integrated Processes	• Increased rate of care coordination for high cost/high risk consumers.	• Increased percent of consumer data received by LMEs and the Division according to established time frames. • Increased timeliness of claims processing for non-Medicaid funded services. • Increased percent of annual non-Medicaid and federal service

Table 3. Measures of Objectives		
Objective	**Consumer Outcomes**	**System Performance**
		funds spent proportionately throughout the year by age/disability group and overall. • Reduced rates of over-utilization and under-utilization of state funded services.
Housing	• Increased percent of consumers by disability that report having safe, stable housing. • Increased percent of person-centered plans that have goals to address consumers' housing preference. • Increased numbers of homeless individuals with disabilities placed in housing.	• Increased number of affordable and accessible housing units available. • Increased number of collaborative relationships at the State level that inform and support housing specialists at the local level. • Increased outreach to homeless individuals.
Education/Employment	• Increased percent of consumers with stable employment. • Increased percent of consumers participating in supported employment. • Increased percent of consumers with developmental disabilities that like the jobs and/or other daily activities that they have. • Reduced rates of dropout, suspension and expulsion from school among youth consumers (up to age 21). • Increased percent of educational or job placements for youth consumers (up to age 21).	• Increased percent of local management entities (LMEs) providing public information to consumers and families about education and employment opportunities and maintenance of entitlements and other benefits while employed. • LME staff and case managers are knowledgeable about employment and the maintenance of entitlements. • Increased number of employment opportunities for consumers.

In addition to the strategic objectives and related measures set forth in this document, the Division will also focus business planning efforts to help ensure efficient and effective resource management with the public mental health, developmental disabilities and substance abuse system and increased accountability for Medicaid and non-Medicaid services. This shall be addressed through, but not limited to the following:

- Review of quarterly fiscal monitoring reports submitted by LMEs. Such reports encompass funding which flows through the LMEs and reflects quarterly updates on overall expenditures and revenues and the balance between the two, accounts payable and accounts receivable;
- Review of monthly LME Systems Management expenditure reports which reflect actual expenditures associated with LME management activities;
- In conjunction with the DHHS Office of the Controller, review and resolution of any audit findings contained in local LME annual audit reports and Management Letters.
- Periodic review of service payments processed for payment to the LMEs for State funded services through the Integrated Payment and Reporting System (IPRS) to ensure that funds are being earned on a timely basis;
- Increase the ability of the Division, through improved reporting, to track the provision of all services, whether provided and billed through IPRS and the Medicaid Management Information System (MMIS) on a fee-for-service basis, or provided through the use of county funds or State allocated resources which are outside of the IPRS billing and payment system, i.e., non-Unit Cost Reimbursement;
- Ongoing review of data related to (a) number of persons served, i.e., increases or decreases n penetration rates, (b) number and mix of service units provided – both Medicaid and State-only, (c) rate at which Division allocated resources are being utilized, and (d) average per person and per event cost;
- Ongoing coordination, assessment and review of all LME requests to move funding from Unit Cost Reimbursement (UCR) to non-UCR categories;
- Ongoing and targeted monitoring of providers of services to ensure that service delivery is documented and performed in the manner envisioned for each service;
- In conjunction with the Division of Medical Assistance and the LMEs, oversight of the provider endorsement process to help ensure that only qualified providers participate in the public mental health, developmental disabilities and substance abuse system; and
- Provision of guidance to LMEs regarding the authorization of State-only services and, in conjunction with the Division of Medical Assistance (DMA), to the DMA contractor engaged for authorization of Medicaid funded mental health and substance abuse services.

Chapter 5. Implementation Structure and Process

Conceptual Framework

Based on research, a persistent problem encountered throughout reviews of transforming systems is the lack of a common language and the lack of a common framework for thinking about implementation. This strategic plan intends to commit to setting priorities in these areas by defining objectives, action steps and milestones. Based on the review of continuous learning over the last several years, the Division has arrived at a conceptual framework for implementation of well defined practices and programs. This plan demonstrates the five essential components that are necessary to ensure implementation of the designated activities accounted for within this plan.

The five essential components that support implementation are:

1. **Source** - This component validates that learning has occurred within the system and that learning has been taken into account by developing specific milestones and actions to support additional system development.
2. **Destination** – The Division will consider adopting, supporting and funding the installation and ongoing use of innovations (such as evidence based practices and benefit designs).
3. **Communication Link** - This plan understands and assumes responsibility for communication in all relevant areas/topics.
4. **Feedback** - Mechanisms are outlined to provide a regular flow of reliable data/information about the performance of the Division and other organizations.
5. **Influence** - The plan recognizes the framework in which social, economic, political and historical factors impinge directly or indirectly on people, organizations, or system.

What is Implementation?

For the purposes of this plan, implementation is a specified set of activities designed to put into practice communication, policy or program(s) of known or intended positive outcomes for consumers and families. According to this definition, implementation processes are purposefully defined by the objectives, action steps and milestones within the State Strategic Plan. In addition, the activities or policies being implemented are described in sufficient detail so that the system and all members can detect its presence and strength. The State Strategic Plan incorporates two sets of activities 1) intervention-level activity and 2) implementation-level activity. These two activities provide accountability of outcomes to consumers, families and the system.

It is important to have an "implementation headset" while reading this plan. This type of perspective suggests that strategies of leadership, organizational frameworks and consumer input are valued as non-negotiable.

Degrees of Implementation

During the three years of this State Strategic Plan, various purposes and outcomes of implementation have been planned in different ways. The Strategic Plan categorizes implementation in three ways.

- **Paper implementation** will be acknowledged by implementing new policies and procedures promising incorporation of stakeholder feedback across all settings. Within this process is a sincere commitment to evaluate any and all redundancy of paper work and other meaningless activities the systems currently has in place. The system will continue to use communications bulletins, implementation updates and other various communications to provide leadership and direction as outlined in chapter 6.

- **Process implementation** is noted throughout the plan by creating and designing new ways to participate with different stakeholder groups, by providing leadership forums, by organizing trainings and by standardizing processes across systems, while developing strategies to create positive and effective work environments to ensure benefits to consumers and families.

- **Performance implementation** is reflected by means of putting procedures and processes in place in such a way that the identified functional components of change are used with good effect for consumers. The plan is written in such a way that it structures implementation to be accountable for actual benefits to consumers, organizations and systems. It requires more careful and thoughtful efforts as described by the actions in creating methods to acquire data concerning consumer and provider outcomes and to monitor system performance to ensure higher quality of services.

Once the State Strategic Plan is finalized and published July 1, 2007, the Division will develop an internal detailed implementation plan using technical monitoring tools to identify specific tasks for each milestone and accountability for each. Implementation may involve existing teams and newly created and time limited work groups. Implementation will also involve current contracts with consultants from Technical Assistance Collaborative, Inc., HSRI, and/or various grants including the North Carolina Adolescent Substance Abuse Treatment Project and the Strategic Prevention Framework State Incentive Grant from the federal Substance Abuse and Mental Health Services Administration. The Executive Leadership Team will monitor progress on an ongoing basis.

The involvement of representatives of consumers, family members, providers, local management entities (LMEs), advocacy groups, other state agencies and other stakeholders are essential to implementation of this large endeavor. Coordination with the Medicaid State Plan and North Carolina Health Choice are essential as the Division develops standardized processes and procedures to make the system more effective and efficient.

The extensiveness to which implementation of this strategic plan is achieved and timeliness are dependent on funding. With existing funds, Division staffing resources are limited and therefore, progress is slower as some tasks will have greater priority than others. With additional funds and staff resources, progress can achieved more quickly.

In State fiscal years 2006 and 2007, the Division, through contracts with independent consultants, continued the ongoing process of: identifying gaps in services at the local level – including

transition to best and promising service practices as well as improving penetration rates and continuity in service provision; quantifying the level of all resources (Medicaid, State funds, etc.) needed and available to close such service gaps; and, establishment of an allocation system which would help ensure funding equity, i.e., equal access to services throughout the State, among LMEs.

During the next three years, State fiscal years 2008, 2009 and 2010, the Department and Division will continue to work with the General Assembly, and all related committees, consumers, LMEs, providers and other stakeholders, to operationalize the appropriate findings and recommendations contained in the reports from the above-referenced independent consultants. The continuing challenges will be: (a) prioritization of service initiatives within available resources, (b) identification of resources, and (c) ability to allocate funding in a manner that moves the overall system towards equity in service access throughout the State.

Strategic Plan for Use of Mental Health Trust Funds

The availability of the Mental Health Trust Fund (MHTF) is key to the implementation of several of the strategic objectives of this plan. How the Division would use new funds is outlined under each objective and summarized in table 4 below. For example, the Division might publish a request for proposals or applications that invite providers in conjunction with LMEs to apply for funding to develop the provider system or that invites local management entities (LMEs) and providers to enhance the electronic data systems for use by all providers in their area. In terms of strategic planning, the potential uses of the Mental Health Trust Fund set forth within this document represent the major initiatives but not necessarily every potential use of Mental Health Trust Fund resources.

Table 4. Summary of recommended use of Mental Health Trust Funds

Objective: Stable & High Quality Provider System	• Development of consumer-friendly materials and training that will include, but is not limited to: the use of a variety of media, consumer and family education on empowerment and responsibility regarding best practices, provider choice, and person-centered planning. • Contracting with specialized independent entities to provide technical assistance to providers to help ensure their success. Technical assistance may include activities related to information technology; development of business plans to support sound business and management operations; financing strategies to maximize resources such as Medicaid, private insurance and fees; quality improvement and management; and data/information management. • Development of training curricula and media regarding system-wide accountability for provider quality, access and performance. • Request for proposals or applications that invite providers through local management entities (LMEs) to apply for funding to: o Support the development of evidence based practices; o Transitional support for providers to enhance their business and information technology functions to help ensure an array of stable and viable community-based service providers;

Table 4. Summary of recommended use of Mental Health Trust Funds	
	○ Transitional support, such as start-up funding, technical assistance, etc., for developing providers as local management entities (LMEs) continue to divest direct service provision. ○ Transitional support for both the development of additional service providers and the enhancement of existing providers to increase service availability to facilitate the downsizing of State operated facilities through reduced utilization.
Objective: Comprehensive Crisis Services	• Request for proposals / applications that invite providers, through local management entities (LMEs) to apply for funding as a supplement to other crisis service funding that may be available to: ○ Support one-time start up costs for crisis services such as minor facility modifications and acquisition of equipment; or ○ Transitional support for crisis service providers to enhance their business and information technology functions to help ensure an array of stable and viable community-0based crisis service providers that link seamlessly to LMEs, State facilities and other community-based service providers; or ○ Short-term transitional support for crisis service operations until newly developed crisis services can become self-sufficient via Medicaid and State support fee-for-service billings. • Development of consumer-friendly materials in a variety of media regarding individualized crisis prevention/intervention planning, the availability of local comprehensive crisis services, and 24/7/365 access to such services. • Development of curricula and media regarding system-wide training in crisis intervention and stabilization techniques for staff of local management entities, service providers, law enforcement, school systems and other local agencies.
Objective: Integrated and Standardized Processes & Procedures	• Development of curricula and media regarding system-wide training related to utilization management of State funded services; management, contracting, claims adjudication and monitoring of providers; person-centered planning; service access; and care coordination. • Provision of financial assistance to local management entities (LMEs) and providers to implement electronic clinical / health record systems capable of sharing and transmitting data about all persons served in real time. • Implementation of system-wide outcome and performance reporting and quality management system. • Development of an effective interface of consumer information between State operated facilities, local management entities (LMEs) and providers. • Standardized surveys of local management entity (LME) boards, providers, consumer and family advisory committees and partner agencies associated with overall mental health, developmental disabilities and substance abuse system performance.

Table 4. Summary of recommended use of Mental Health Trust Funds	
	• Ongoing analysis, implementation and modification of processes and procedures that, to the extent practical, help ensure an effective and efficient public system through integration and standardization of such processes and procedures.
Objective: Improved Housing Consumer Outcomes	• Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways: • Development of curricula and media regarding system-wide training in housing competence for housing specialists at the community level and for providers of mental health, developmental disabilities and substance abuse services. • Pilot Homeless Mental Health Housing Initiative to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with ACTT and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the county. • Continue housing initiative through a joint effort with DHHS, LMEs and the North Carolina Housing Finance Agency (NCHFA) to leverage funds and increase the availability of housing resources and options for individuals with mental illness, developmental disabilities and substance abuse problems. • Provision of mental health, developmental disabilities and substance abuse services on a transitional basis, i.e., until sufficient ongoing revenues are available, to support individually tailored and flexible support services that will enhance successful housing opportunities for individuals with disabilities. • Support for non-recurring cost necessary to support successful housing utilization such as rental deposits, utility deposits, and furnishings.
Objective: Improved Education/ Employment Consumer Outcomes	• Development of curricula and media regarding system-wide training in education/employment competence for local management entity (LME) staff and for providers of mental health, developmental disabilities and substance abuse services. • Transitional funding of proposals / applications from providers, in conjunctions wit6h LMEs, that demonstrate effective and promising approaches to support positive consumer outcomes related to education and employment.

Chapter 6. Communications Plan

The Division recognizes the significance in communicating progress made as this strategic plan is implemented. The Division will report progress on applicable measures, to include action steps delivered with timelines in addition to reporting on changes in outcomes for consumers and system performance.

Strong emphasis on collaborative efforts with other agencies, stakeholders, community members, consumers, and advocacy groups will be highlighted on the Division's website, as collaboration is vital to the success of the reform process. The Division plans to regularly update the public on progress with the Division's transformation efforts on a quarterly basis. In addition, annual progress reports about the strategic plan will be generated and distributed to the North Carolina General Assembly's Legislative Oversight Committee and to all other stakeholders.

In addition, the Division will continue its existing communications regarding rules, policy changes, plans, strategies related to reform, pertinent information to consumers, family members, service providers, advocacy groups, government entities, and stakeholders through email broadcasts, web postings and regular mail.

- Communication Bulletins - Various communications regarding policy changes and updates are distributed to stakeholders as a portable document format (.PDF) file letter and are housed on the Division's website. Communication Bulletins are numbered and labeled to assist the reader in locating the document with ease.

- Implementation Updates – The purpose of implementation updates is to communicate important joint policy decisions of the Division with the Division of Medical Assistance regarding transformation. These are similarly sent via "DMH Broadcast" to a list of applicable stakeholders, providers, departments, divisions, and advocacy groups within the state of North Carolina.

- Announcements and other publications - Other information is posted on the Division's website to include the current budget, the Division's annual report, quick facts on quality management, statistical data, Town Hall Meeting notices, reports, and archived reports. The list of groups in receipt of current communications includes, but is not limited to:
  - Local Oversight Committee
  - State Consumer and Family Advisory Committee
  - Local Consumer and Family Advisory Committee
  - Commission for Mental Health, Developmental Disabilities, Substance Abuse Services
  - Advocacy organizations and groups
  - North Carolina Association of County Commissioners
  - County Managers
  - County Board Chairs
  - North Carolina Council of Community Programs
  - North Carolina Association of Directors of Departments of Social Services
  - State Facility Directors
  - Local Management Entity Directors

- Local Management Entity Board Chairs
- Department of Health and Human Services Division Directors
- Provider organizations
- Mental Health, Developmental Disabilities and Substance Abuse Services Professional Organizations and Groups
- Mental Health, Developmental Disabilities and Substance Abuse Services Stakeholder Organizations and Groups
- Other Mental Health, Developmental Disabilities and Substance Abuse Services Stakeholders

Clinical and administrative trainings for providers across disabilities are posted on the website and emailed using "web trees" to providers of mental health, developmental disability, or substance abuse services in the state of North Carolina. This assists with ongoing professional development and skill-building among practitioners in the field.

Appendices or References

Index of all Communication Bulletins by subject

Index of all Implementation Updates

Target population descriptions
(web address)

Cultural and Linguistic Competency Plan,
http://www.ncdhhs.gov/mhddsas/announce/commbulletins/culturallinguisticcompetencyactionplan-10-23-06.pdf

Service Definitions
http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm#qanda

Note: Other references will be added in this section for the final document.