

LOCAL BUSINESS PLAN

2008 • 2009 • 2010



CenterPoint
Human Services

People In Partnership Making A Difference

**CPHS HUMAN SERVICES
LME BUSINESS PLAN
FISCAL YEAR 2008 - 2010**

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NOTE: In all objective stakeholder grids, "CEO" also represents the CenterPoint Human Services Board of Directors.

Consumer & Family Advisory Committee	Motion of Support	02/19/07
Board of Directors	Approved	02/22/07
Davie County Board of Commissioners	Approved	03/05/07
Stokes County Board of Commissioners	Approved	03/12/07
Forsyth County Board of Commissioners	Approved	03/12/07

CPHS Human Services Local Business Plan Executive Summary

Pursuant to the North Carolina Legislature's statutory mandate, NCGS 122C-115, which requires all Local Management Entities (LME) to create a Local Business Plan (LBP), CenterPoint Human Services (CPHS), began its process of adhering to the mandate in October 2006. Fifteen months prior, the CPHS Leadership Team initiated a strategic planning process to move forward as a fully divested LME which incorporated input from the Consumer and Family Advisory Committee, CPHS Board, various advisory committees, and community focus groups. During an initial Leadership Team meeting addressing the LBP, department personnel agreed to incorporate the Strategic Plan into the LBP, and to create individual departmental mission statements. It is from the Strategic Plan and mission statements that the LBP began to take a tangible shape.

After formulating initial objectives and strategies to reach those objectives, CPHS sought input from its Provider Council. After responding to the council's suggestions, CPHS conducted Community Input Focus Groups in Forsyth, Stokes and Davie Counties in December of 2006. CPHS submitted its LBP Pre-Plan to the Division of Mental Health December 29, 2006.

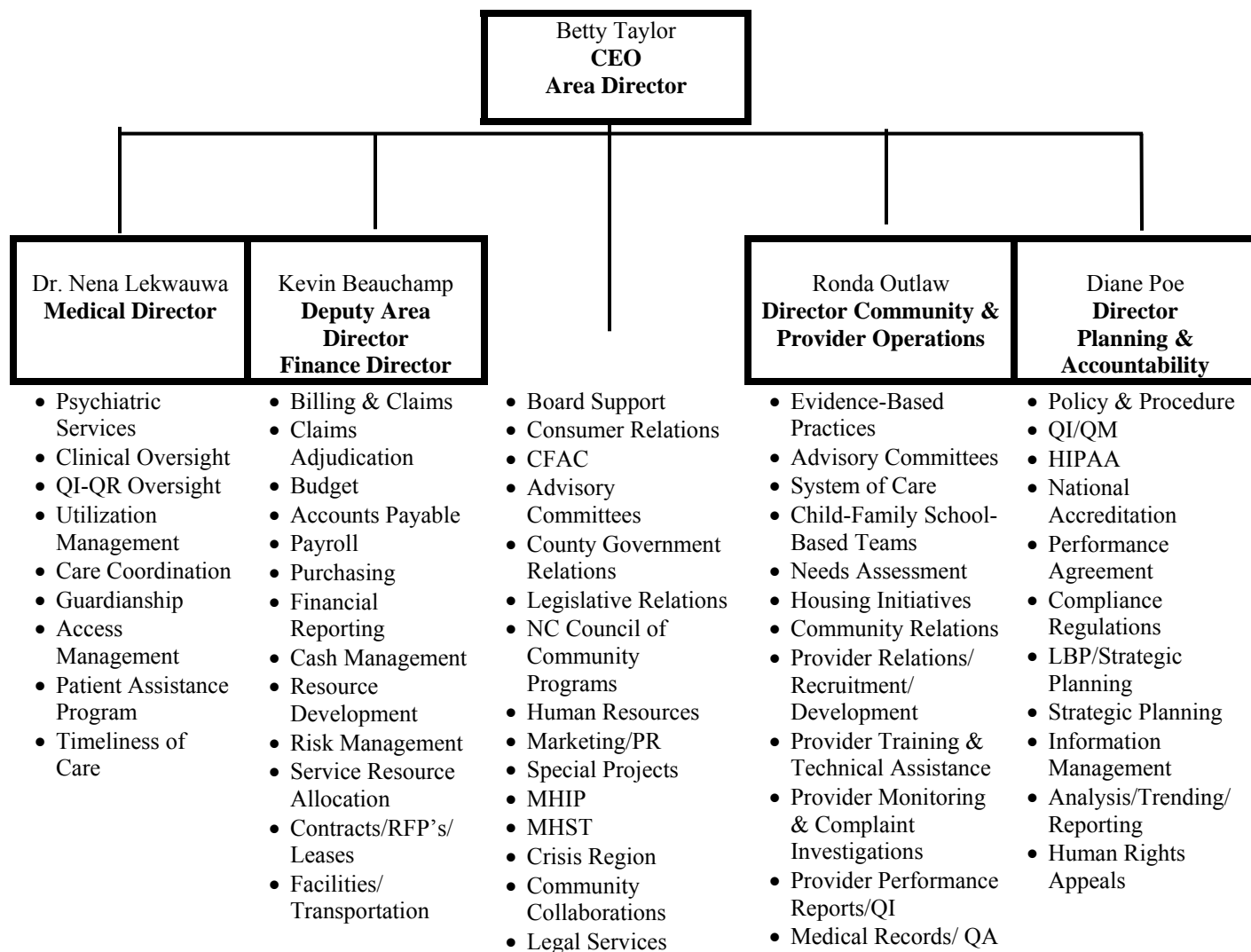
Seeking external input once again, CPHS presented a drafted LBP to the Consumer and Family Advisory Committee in early February, 2007. After responding to the committee's suggestions, CPHS then presented the finalized draft to its own board for approval later that same month. The LBP as it currently stands is to be submitted for approval in March, 2007 to CPHS's local county boards of commissioners. Following the boards of commissioners' approval, the LBP will officially be submitted to the North Carolina Division of Mental Health by March 31, 2007.

Resulting from the months of work and external input, CPHS's finalized LBP draft consists of close to 50 pages highlighting each department in individualized chapters. The six chapters include mission statements, current operations, resource allocation, business rules that both enhance and inhibit department efficiency, and most importantly objectives and strategies. From the six departments, 42 objectives have been submitted to improve and maintain CPHS's overall function as an LME. Stemming from those objectives are 129 strategies to achieve them.

It is CPHS's full intention to adhere to all objectives and strategies to better serve all persons within the community and provider networks. Thanks to those same people, CPHS's LBP has been created to follow the organization's vision to, "Aspire to make a positive difference in the quality of people's lives through dynamic partnerships with community stakeholders," and organizational mission to, "Lead the development and provision of quality behavioral health services that provide accessibility and choice to all eligible persons within our community."

CPHS Human Services

FUNCTIONAL ORGANIZATIONAL CHART



**CPHS HUMAN SERVICES
LME BUSINESS PLAN
FISCAL YEAR 2008 - 2010**

Chapter 1 GOVERNANCE AND ADMINISTRATION LME FUNCTIONS

1. MISSION:

To govern and manage the LME effectively with results that demonstrate added value in the following ways:

- Policies that support CPHS Human Services' (CPHS) Vision, Mission and Values and advance Evidence Based Practices (EBP).
- Strategic planning which defines the ends/outcomes to be achieved.
- Community linkages that enhance collaborations, communication and community services.
- Professional and knowledgeable governance and management that build community trust and respect.

2. CURRENT OPERATIONS:

The following describes how governance and Cost Model management and administration functions are implemented. A Functional Organization Chart is attached to the LBP for clarity.

Governance & Appointment to the Board

CPHS limits its Board size to 19 (Forsyth 13, Davie 3, Stokes 3) and will comply through attrition with statutory composition requirements. Board composition is currently at 68% regarding the 50% cap on specified categories of members.

The application for appointment to the Board is continuously posted on CPHS's website as well as on the relevant county's website when a vacancy occurs in its representation. Applications submitted to CPHS are reviewed for completeness and statutory requirements prior to their being sent to the three Commissioners serving on the Board. The Commissioners confer, decide on an appointment and the Commissioner of the county of residence of the appointee notifies both the appointee and CPHS.

Consumer & Family Advisory Committee (CFAC)

CFAC meets twice monthly and provides reports at every Board meeting. CFAC's membership predominantly represents Forsyth County, and recruitment efforts in Stokes and Davie Counties are underway. The Chair and Vice Chair meet with the CEO and CFAC staff support at least monthly. A Relational Agreement is in final draft.

Board Committees

Board Committees include Human Rights (HR), Quality Improvement (QI), Finance and Executive. HR, QI, and Finance consist of both Board members and non-members.

Advisory Committees

Advisory Committees that predate the creation of CFAC represent Adult Mental Health (AMH), Developmental Disability (DD), Substance Abuse (SA), and Child & Family (C&F) with consumer, family, provider and community representation. Directors serve as Board Liaisons to every advisory committee and CFAC. In 2006, the Provider Council was established and now meets with CPHS leadership monthly, co-sponsors Provider Forums for education/information in conjunction with membership meetings, and collaborates on generation of items such as the Benefit Design.

Development of policies to support LME's role in defining quality/good EBPs for provider, consumers and other stakeholders

As a key duty of governance, the Board Bylaws mandate the review of Board policies at least annually. The actual generation of Board policies falls under Planning & Accountability while the identification of the need for policy revision, deletion or addition is the responsibility of each member of the Leadership Team (CEO/Area Director, Deputy Area/Finance Director, Medical Director, Director of Community & Provider Operations, and Director of Planning & Accountability). Through the Leadership Team (LT) policy issues are raised based on input from staff, Board Committees, CFAC, and Advisory Committees. Supporting participation in educational opportunities, professional associations, and community/state organizations creates an arena for exposure and heightened awareness of policy issues and development.

Implementation of an EBP focus requires relevant operational policies and processes. Accountability and tracking are essential at the organizational, departmental and individual levels. The LT sets Organizational Goals for each fiscal year based on the LBP. In support of achieving the Organizational Goals, department and individual goals are set in the Performance Evaluation Plan. "Success" depends on focused individual effort producing the results needed to achieve department goals that in turn enable CPHS to achieve its strategic goals. Quarterly reviews of staff and department progress set the stage for course corrections and adaptation to new directions.

Strategic planning promoting EBPs across all functions of the LME; LBP development and implementation

CPHS's LBP is the result of strategic planning processes that began in the spring 2005 involving the Board, Advisory Committees, CFAC, and the communities served. Planning & Accountability is the lead department responsible for the overall production of the LBP, as well as the tracking/reporting of the implementation of the Strategic Objectives.

Promoting EBPs requires that staff understand and value EBPs so transformational goals can be articulated and achieved. Finance must encourage provider implementation; provider operations must define and track outcomes and report to the LME; contracts must capture requirements for providers clearly and with sufficient specificity; utilization management must assess PCPs and convey information to provider operations; consumer input must be captured by both the LME and providers and then used to make a difference; MIS must provide enhanced data tracking with trend analysis and reports. Communication must flow freely. Education must be provided to the community, consumers, families and decision makers. Demand will drive the market.

To further the transformation of the LME, a new position addressing consumer relations and LME special projects reports to the CEO. Consumer Relations is detailed in Chapter 4 while current special projects are discussed below. CPHS will continue to examine its organizational structure at least annually to facilitate promotion of EBPs and cultural competency.

- **Crisis Region** designation and community need requires that CPHS find a collaborative way to meet the demand for 23 hour and in-patient beds. Great strides have been made in implementing other pieces of the comprehensive Crisis Response Network as reflected on the schematic, page six (6). The vision will be expanded to include additional areas when identified.
- **Mental Health System Transformation (MHST)** project has successfully gathered consumer, provider, and CPHS staff input towards the best approach available to incorporating Supported Employment for severe mentally ill consumers in the CPHS service area. This project is on scheduled to deliver the required LME project infrastructure manual to the NC Division of MH/DD/SAS by June 2007.
- **Mental Health Integration Project (MHIP)** while in its last year as a pilot, will continue its work through the commitment of the participants in Forsyth County. The feasibility of a reverse co-location model making medical services available at the Behavioral Health Plaza (houses our two main mental health providers, as well as the Department of Public Health pharmacy with CPHS's \$2.0 million per year PAP program) will be explored.
- **Geriatric Specialty Team Geriatric Specialty Team** project is just starting for CPHS. An agency has been contracted to provide comprehensive Geriatric training for all Adult Care and Family Care Homes' staff towards reducing hospitalization and staff turnover.
- **Crisis Intervention Team** held its first training class during the week of February 19-23, 2007 in Forsyth County. Future CIT trainings are being developed for both Davie and Stokes Counties.

Marketing & Public Relations (MPR)

Being that the MPR position is new to CPHS, the MPR staff is responsible for positioning CPHS in all appropriate marketing avenues. By achieving this new objective, all persons within the catchment area will have a better opportunity to hear about and understand exactly what CPHS does for them and their communities. When executed properly, marketing strategies will provide persons who are both unfamiliar and familiar with CPHS with understandable and informative knowledge that will equip them with reasons to support our overall functions.

Human Resources (HR)

CPHS is a fully divested LME going from more than 350 FTEs in 2004 to less than 70 in 2007. HR shrank from a Manager with three specialists to a Manager being responsible for all HR functions. RIFs were implemented. All job descriptions were revised for post-divestiture duties. Mandatory e-learning with tracking was re-examined. Through a staff workgroup, a new performance evaluation tool focuses on individual/department/organizational goals to enhance accountability. Through competitive bidding, HR working with Finance continues to pay the full cost of medical benefits for staff.

Compliance with state and federal regulations;**Compliance with DHHS/LME Contract**

Planning & Accountability is responsible for tracking compliance and reporting the results to the LT and the Board and QI Committee. Each member of the LT is responsible for knowledge of and compliance with the requirements applicable to the department supervised. Both the CEO and the Manager of Contracts are licensed attorneys.

County Government Relations

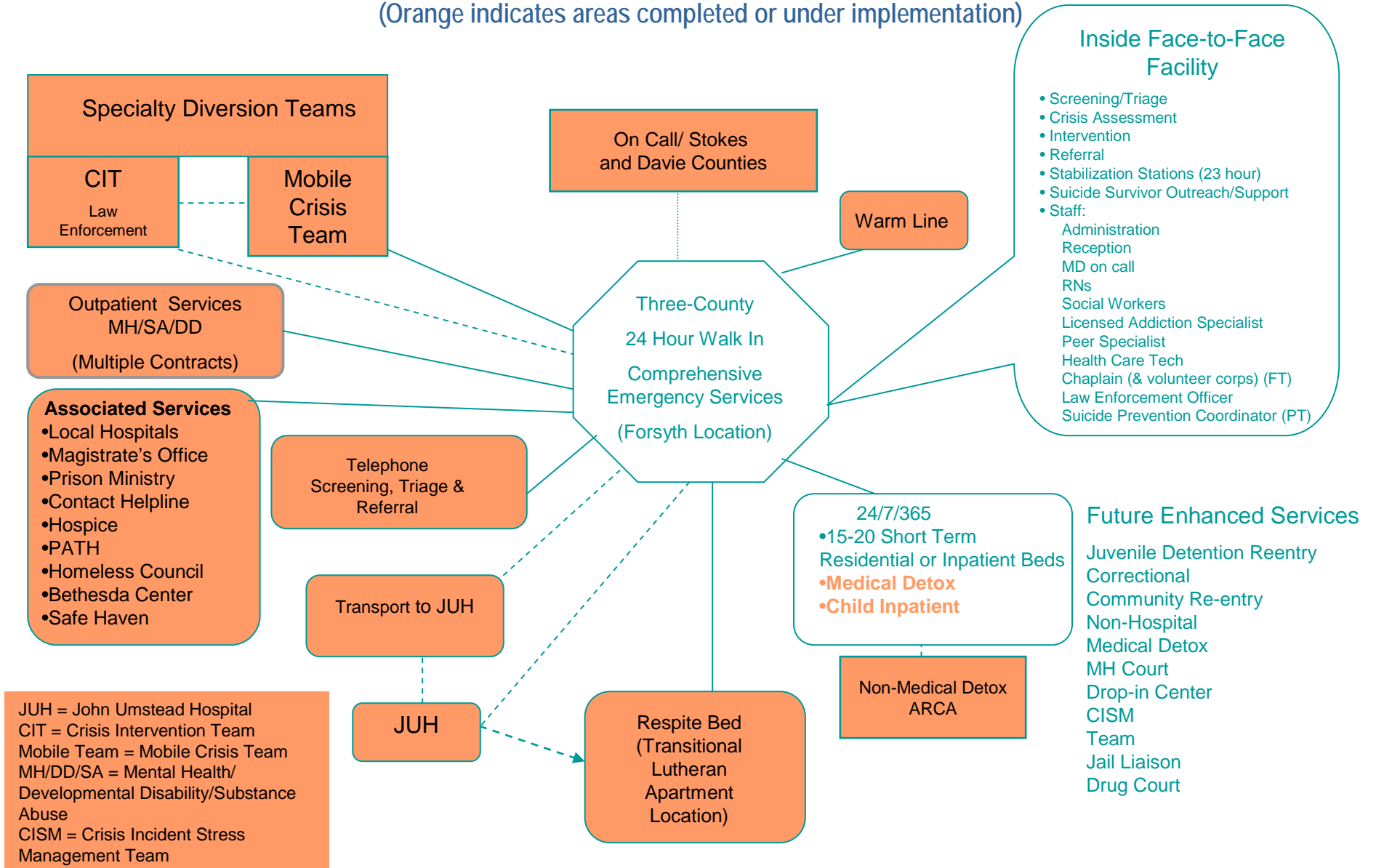
The CEO and the Deputy Area/Finance Director manage County government relations. Staff supports these efforts both on an *ad hoc* basis and through representation/leadership in a variety of community organizations and agencies. Currently, approximately twenty-one (21) staff represents CPHS in excess of fifty (50) entities.

Medical Director Clinical Oversight

Through active participation on the LT and direct management of Screening/Triage/Referral, Utilization Management, Guardianship, Care Coordination, and Medical Services the Medical Director provides pervasive clinical oversight and serves as medical consultant to the CEO. *The operations under the Medical Director are discussed in Chapter 5, Service Management.*

Proposed Crisis Response Network

(Orange indicates areas completed or under implementation)



3. STRAGETIC OBJECTIVE

Objective	Strategies	Responsible Party	Target Date	Stakeholder Input
1. Enhance the capability of the Board to govern with professionalism.	<ol style="list-style-type: none"> 1. Recommend a Code of Ethics for adoption by the Board. 2. Facilitate consideration by the Board expectations for decorum and for debate in open meetings. 3. Propose to the Board orientation/mentor program for new Directors. 4. Design & facilitate implementation of Board recruitment plan. 5. Support Board & Board Officer succession planning. 	<p>CEO, Planning & Accountability (P&A)</p> <p>Leadership Team (LT)</p> <p>CEO</p>	<p>01/01/08</p> <p>01/01/08</p> <p>03/01/08</p> <p>07/01/08</p> <p>07/01/08</p>	Board, CEO, P&A
2. Provide the Board with educational opportunities to strengthen its ability to govern with knowledge.	<ol style="list-style-type: none"> 1. Provide training on: <ul style="list-style-type: none"> • Parliamentary procedure, • Open Meetings Act, • Mental Health Reform legislation & philosophy, • CPHS Bylaws & Board Policies, • LBP. 2. Propose annual Board training curriculum including EBPs, management best practices, LME initiatives. 3. Propose leadership development experiences including trainings, conference attendance. 4. Present annual facilitated Board retreat. 	<p>LT</p> <p>CEO</p> <p>CEO, LT</p>	<p>12/31/07,08,09</p> <p>9/1/07, 08, 09</p> <p>9/1/07,08,09</p> <p>01/01/08,08,09</p>	Board, CEO, LT
3. Operate in compliance with legal and regulatory requirements.	<ol style="list-style-type: none"> 1. Develop management reports including strategies, benchmarks, tracking and analysis for all functional LME areas. 2. Design comprehensive reporting overview of all measures tracked including legal, regulatory and performance. 	Deputy Area Director (DAD), P&A	03/01/08	CFAC, Advisory Communities., QI Committee, LT, CPHS Board
4. Clearly delineate the limits of authority of the Board Executive Committee and the CEO/Area Director.	<ol style="list-style-type: none"> 1. Recommend to the Board a Chart of Authority outlining the Board's delegation of authority to its Executive Committee. 2. Recommend to the Board a Chart of Authority outlining the authority of the CEO. 	CEO, P&A	<p>09/30/08</p> <p>09/30/09</p>	CEO, CPHS Board

5. Perform annual needs assessments to receive community input, to identify service gaps, and to update priorities.	<ol style="list-style-type: none"> Analyze initial Needs Assessment by HSRI. Present initial Needs Assessment to community collaborative partners in 3 counties, CFAC, Advisory Committees, Board and Boards of Commissioners. 	LT	09/01/07 01/01/09	
6. Expand connections in Stokes, Davie, and Forsyth Counties to collaboratively identify and address areas of need and opportunity.	<ol style="list-style-type: none"> Map existing connections, collaborations, representation on Boards. Identify gaps and develop strategies to address. Establish communication plan for sharing community-wide initiatives/developments internally and externally. 	P&A, LT LT CEO	10/01/07 02/01/08 09/01/07	
7. Enhance community, consumer and provider understanding and support of CPHS operations.	<ol style="list-style-type: none"> Develop marketing public relations plan. 	CEO	01/01/08	CEO, LT, CFAC, Providers, Consumers
8. Sustain and enhance the efforts of the Mental Health Integration Project (MHIP) in linking the medical and behavioral health community to enhance provision of both medical and psychiatric services.	<ol style="list-style-type: none"> Develop next steps with MHIP partners. Develop MHIP strategic plan with benchmarks that supports development of further initiatives. With Wake Forest University Baptist Medical Center participates in the collaborative selection and utilization of psychiatrists in the community public sector. Establish funding and protocol for medical lab tests for indigent. 	CEO, MD CEO, MD, Finance Director (FD) MD, FD	7-1-08	
9. Continue implementation of Mental Health System Transformation (MHST) to empower the successful development of the LME to meet community needs and challenges.	<ol style="list-style-type: none"> Define annual departmental outcomes to be measured to assess progress on MHST, implementation of EBPs, SOC, and consumer/family involvement. Annually review organizational chart to facilitate promotion of EBPs and cultural competency. 	CEO/LT	07/01/08	
10. Promote consumer and family involvement in planning through support of Advisory Committees.	<ol style="list-style-type: none"> Specify Advisory Committees functions and determine how they may interface with CFAC to contribute meaningfully planning. 	CEO, LT	07/01/08	Advisory Committees, CFAC

<p>11. Continue implementation of the Crisis Response Network.</p>	<p>1. Suicide Prevention:</p> <ul style="list-style-type: none"> • Development of 3 County Education Taskforces. <p>2. CIT training in all counties:</p> <ul style="list-style-type: none"> • Reduction in Officer Contact Time, • Training of 55 Law Enforcement Personnel. <p>3. First Opinion Waiver in Forsyth County:</p> <ul style="list-style-type: none"> • Expansion of trained professionals, • Hospitalization & Jail Diversion Reduction. <p>4. Transportation.</p> <p>5. Identify/connect justice system initiatives.</p> <p>6. Increased utilization of mobile crisis team:</p> <ul style="list-style-type: none"> • Expand contact capabilities via collaboration with Jail Diversion initiatives and Grassroots Re-entry programs. 	<p>Community & Provider Operations (CPO), Special Projects (SP) SP, CEO SP, CEO, MD SP, CEO SP, CEO SP, CEO</p>	<p>01/01/09 01/01/09 01/01/08 07/01/08 07/01/08 01/01/08</p>	<p>CFAC, Advisory Comm., Stakeholders Law Enforcement, Advisory Comm. CFAC MD, Daymark, Local Hospitals Law Enforcement, CFAC Law Enforcement, CPHS, Grassroot Org., CFAC, Advisory Comm., Judicial, MHA Daymark, Grassroot Org., Judicial, MHA</p>
<p>12. Define workforce recruitment needs and orientation process.</p>	<p>1. Analyze existent staffing and generate succession planning, recruitment and training.</p> <p>2. Design written materials and process for new staff orientation including MIS training.</p> <p>3. Accreditation Compliance Planning.</p>	<p>Human Resources (HR), DAD, CEO HR/MPR HR/CEO</p>	<p>03/01/08 07/01/08 07/01/09</p>	
<p>13. Increase staff accountability, recognition and reward.</p>	<p>1. Analyze individual/department goals and create baselines of achievement.</p> <p>2. Utilize department to department evaluations of customer service.</p> <p>3. Provide incentives to staff for securing advanced degrees, licensures and certifications.</p> <p>4. Identify educational needs/design ways to meet including implementation of EBP and continuing the LME transformation.</p> <p>5. Implement employee milestone recognitions.</p>	<p>HR/CEO/LT HR/LT HR/DAD HR/CEO/LT HR/DAD</p>	<p>10/01/07 10/01/08 10/01/07 10/01/07 09/01/07</p>	
<p>14. Increase efficiency through electronic processes.</p>	<p>1. Make all job descriptions available electronically.</p> <p>2. Implement electronic timesheets.</p>	<p>HR HR/DAD/P&A</p>	<p>08/01/07 07/01/09</p>	

15. To evaluate employee work life.	<ol style="list-style-type: none"> 1. Measure employee satisfaction. 2. Evaluate workloads and productivity. 3. Analyze performance evaluations results. 4. Review compensation package to remain competitive. 5. Cultural competency assessments included in staff performance evaluations. 6. Develop and implement a strategy to educate staff, on cultural competency and recruit within limitations of staff pool that exists. 	HR	<p>09/01/07</p> <p>12/01/07</p> <p>09/01/07</p> <p>06/30/08</p> <p>7/1/08</p> <p>07/01/09</p>	
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4. RESOURCE ALLOCATION:

Comparison of Actual Staffing Costs to Cost Model

General Administration and Governance

Salary & Benefits

Cost Model	\$322,415
Actual	<u>\$413,361</u>
Variance	\$90,946
Variance %	28

5. BUSINESS RULES:

The business rules, which enhance the efficiency and effectiveness of Governance and Administration are listed below.

- 1) County Commissioners serve as directors, collectively evaluating Board composition and making appointments to the Board.
- 2) Provide Board trainings on targeted topics on LME functions such as contracts, financials and Board responsibilities and exposures.
- 3) Introduced public session and consent agenda in Board meetings.

The business rules, which inhibit the efficiency and effectiveness of Governance and Administration, are listed below.

- 1) The size of the Board presents challenges for education, communication, maintaining focus on the core mission and building consensus.
- 2) The predominately pre-divestiture “services” Board finds it a challenge to transition to being an LME “management oversight” Board.
- 3) An environment of constant change and unpredictability intensifies resistance to change.

Chapter 2 BUSINESS MANAGEMENT AND INFORMATION MANAGEMENT

1. MISSION:

To preserve, enhance, and provide accountability for the LME's financial resources for the purpose of maintaining a viable entity that can fund the needs of the LME and the catchment area it serves.

2. CURRENT OPERATIONS:

Budget

In accordance with NCGS 159 *The Local Government Budget and Fiscal Control Act*, CPHS operates under an annual balanced budget ordinance. Staff prepares a budget that is presented to management, CFAC, the Finance Committee and Board Executive Committee for review and comment. After the review process, a final budget draft is presented to the full board and public for review, a budget hearing is held, and a final budget is adopted by the CPHS Board of Directors.

Tracking of County, State UCR and Non-UCR Funds

During the fiscal year, finances are managed within the balanced budget and available financial resources. A component of the financial management is to track and report the use of county funds, State UCR and State Non-UCR funds. These funds are included as revenues with corresponding expenditures in CPHS's annual budget. These funds are allocated to providers and agencies through contracts and encumbered. The allocations are made in accordance with criteria adopted by the Board to be used as a guide for allocating county and State funds. At any point, Finance can report how these funds have been allocated, how much has been expended, and how much funding remains.

Financial Reporting

On a monthly basis, financial reports are prepared and presented to management, the Finance Committee, and the Board of Directors that describe CPHS's financial condition on a month-to-date and year-to-date basis. In addition, on a monthly basis, Finance prepares and submits the *Monthly Report of LME Expenditures* to the DHHS Budget Office and the DHHS Office of the Controller. On a quarterly basis, financial reports are prepared for Forsyth, Stokes and Davie counties that describe CPHS's financial condition on a year-to-date basis. In addition, on a quarterly basis, Finance prepares and submits the *Fiscal Monitoring Report* to the DHHS Office of the Controller. At various times during the year, additional reports are prepared and submitted to divisions within DHHS as required.

Risk Management

CPHS has developed a Board approved policy for risk management that establishes a coordinated and on-going process to identify, analyze, and control/prevent the risks to which CPHS may become exposed. The Finance Director is charged with the oversight of the Risk Management Program, which addresses exposure identification, risk evaluation, and risk control.

To assist the Finance Director with the discharge of his Risk Management responsibilities, with the assistance of the Forsyth County Risk Manager, a Risk Management Committee is being established which will include CPHS personnel and external personnel affiliated with the field of Risk Management.

Cash Management

Cash Management is responsible for monitoring deposits and disbursements that occur in CPHS's operating, payroll and investment accounts. This monitoring is carried out through cash analysis, managing payables, wiring monetary funds, and verifying all deposits and written checks. In addition, Cash Management is responsible for all government cash reports as required by the State Treasurer's Office, unclaimed property reports, sales tax and usage reports, and other special financial reports.

Purchasing

Finance is responsible for the administration of the purchasing function for CPHS. All purchases must be approved by division managers prior to the purchase and all invoices submitted for payment must be approved by the division manager. Any purchases costing \$750 require a purchase order and must be ordered by the accounting technician in Finance responsible for purchasing at which time funds are encumbered. All purchase orders are reviewed and approved by the Finance Director.

In accordance with G.S. 143-129 *Procedure for Letting of Public Contracts* and G.S. 143-131 *When Counties, Cities, Towns and Other Subdivisions May Let Contracts on Informal Bids*, Finance requires formal bids for construction or repair contracts costing \$300,000 and above, and the purchase of apparatus, supplies, materials, and equipment costing \$90,000 and above. Informal bids are required for construction or repair contracts costing \$5,000 to the formal limit, and the purchase of apparatus, supplies, materials, and equipment costing \$5,000 to the formal limit.

Contract Administration

Finance is responsible for the negotiation of administrative contracts which include equipment and space leases, maintenance, audit and provider contracts. In accordance with G.S. 159 *The Local Government Budget and Fiscal Control Act*, all contracts contain a pre-audit statement which state the instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act and is signed by the Finance Director. For contract approval, the following dollar limits have been established:

- Contracts up to \$25,000 require the approval and signature of the CEO.
- Contracts from \$25,000 and up to \$50,000 require the approval and signature of the CEO and Board Chairperson.
- Contracts \$50,000 and above must be presented to the Board of Directors for review and approval by vote. These contracts are signed by the CEO and Board Chairperson.

All contracts are encumbered to ensure funds are available and disbursed only against the appropriate contract.

Service Funds Management

Finance is responsible for the management and reconciliation of the State UCR and State Non-UCR funds. These funds are allocated to service providers and agencies in accordance with criteria adopted by the Board of Directors. These funds are allocated through contracts and encumbered. All service dollars are paid out in monthly 1/12th arrangements except for CTSP and MR/MI funds which are paid out on a fee for service basis. The use of these funds must be authorized by the CPHS UM staff using authorization guidelines and the IPRS benefit design. The benefit design is established to ensure critical needs are met. To ensure funding is available for critical needs, the benefit design is constantly reviewed in conjunction with available funding and changes are made to benefit levels as required. At any point, Finance can report how these funds have been allocated, how much has been expended, and how much funding remains.

Accounts Payable

Finance is responsible for managing payments to vendors and providers. All vendor invoices must be approved by the appropriate division director before payment will be made. Accounts Payable works closely with cash management to ensure the adequate availability funds when payables are processed.

Payroll

Finance is responsible for the processing of the bi-weekly payroll for CPHS employees. The processing of payroll includes processing employee timesheets, preparing the various deposits required for direct deposit, retirement, insurance, 401k, etc. Payroll is responsible for preparing various monthly, quarterly, and annual reports.

Billing and Claims

Billing and Claims is responsible for assuring billing system and edits are correct; verifying that all events are billed to the correct funding source; ensuring that applicable events are re-billed when new funding sources are added; make certain that billing denials are followed up and processed; assure completion of all on-line IPRS enrollments; ensures that services have been appropriately authorized prior to payment of claims; ensure that all claims submitted by providers are processed in compliance with State Prompt Pay Provisions; provides technical assistance to providers regarding the submission and payment of claims.

3. STRATEGIC OBJECTIVE:

Objective	Strategies	Responsible Party	Target Date	Stakeholder Input
1. Implement and oversee an effective LME financial strategy.	1. Link Utilization Review (UR) & Finance. 2. Generate average cost per consumer type.	Finance Director (FD)	01/01/08 01/01/08	CFAC
2. Develop financial directives that position CPHS to maximize the use of funding to address service needs.	1. Move from prospective 1/12 th reimbursement strategy to fee for service and ultimately to capitation. 2. Move from State-designated categories for IPRS funds to single-stream funding utilizing 15% allowable in compliance with State guidelines, process and approval. 3. Develop criteria and monitor the use of the allocation of discretionary funds. 4. Collaboratively, develop process by which other stakeholders (CFAC, Advisory Committees, etc.) are involved in awarding a Request for Proposal (RFP) or contract.	FD	07/01/08 07/01/09 07/01/08 09/01/07	Community Forums CFAC, Advisory Committees
3. Manage organizational hazards through a comprehensive risk management plan.	1. Develop plan to identify risks in the areas of: <ul style="list-style-type: none"> • Clinical, • Financial, • Legal, • Providers. 2. Based on analysis of risk assessment determine steps to mitigate identified risk(s).	FD	07/01/08 07/01/08	
4. Support provider network through timely and effective Claims Adjudication.	1. Produce remittance advice/EOB for providers of state funded services.	FD	01/01/08	
5. Create a comprehensive resource development plan.	1. Create Resource Development Position. 2. Recruit staff. 3. Generate core components of Resource Development Plan.	FD	01/01/08 07/01/08 01/01/09	

5. RESOURCE ALLOCATION:

Comparison of Actual Staffing Costs to Cost Model

Business Management - Finance, Claims, Human Resources, and Information Technology

Salary & Benefits

Cost Model	\$1,036,975
Actual	<u>\$1,305,630</u>
Variance	\$268,655
Variance %	26

6. BUSINESS RULES:

The business rules, which enhance the efficiency and effectiveness of Business Management, are listed below.

- 1) For fee-for-service billings, CPHS does not pay its providers until the agency receives reimbursement.
- 2) For IPRS dollars, CPHS pays providers one-twelfth of the annual allocation in July. After that, provider's monthly payment is based on the lesser of the submitted claims or the amount of the one-twelfth allocation.
- 3) Best business practices of going to market for competitive price quotes for vendors, such as landlords and insurance, are used.

The business rules, which inhibit the efficiency and effectiveness of Business Management, are listed below.

- 1) CPHS uses the provider's submitted claims rather than paid claims to determine monthly allocation for IPRS dollars.
- 2) There is a negative impact on CPHS's LME management funds because of the dependency on State's cash flow.
- 3) Forsyth County's charge outs and in-kind support create a false perception of "service" dollars.

Chapter 3 PROVIDER RELATIONS AND DEVELOPMENT LME FUNCTIONS

1. MISSION:

To improve quality of life for consumers through development and maintenance of a comprehensive service system, driven by community/stakeholder collaboration and delivering evidence-based best practices, resulting in the highest level of clinically and culturally competent care.

2. CURRENT OPERATIONS:

Provider Relations & Development functions are conducted primarily by the Community & Provider Operations Department at CPHS. This department is also responsible for various community and service-based collaborations with providers and other stakeholders, including Disability Advisory Committees, System of Care, Child/Family School-Based Teams, housing initiatives and community outreach/education.

The following describes provider relations and development functions, as well as community and service-based collaborations, as currently implemented at CPHS.

Needs Assessment & Provider Network Development

Provider recruitment, based on needs assessment, as well as activities to maintain the provider network, is conducted to ensure availability of an adequate service array. A contract has been established for an extensive needs assessment to be initiated in 3rd Quarter FY 2006-07. Support and collaboration with providers focuses on initial provider orientation; completion of outcome measures (consumer satisfaction, NC-TOPPS, DD-COI); and provider relations activities, including response to provider questions and concerns.

Provider Endorsement

Provider Relations staff verify provider readiness and appropriate implementation of Enhanced Benefit services through the processes of conditional and full endorsement. CPHS successfully completed endorsement for CAP MR/DD and Child Residential services within state-mandated timeframes, resulting in all persons served being able to continue to receive services from their current provider. By January 2007, endorsement had been completed for 194 providers within the catchment area, with Memoranda of Agreement completed for 282 providers statewide. Estimated provider capacity to deliver the new Enhanced Benefit services was at 95% (20 of 21 new services met or exceeded anticipated consumer need – only Facility Based Crisis was not yet available).

Provider Monitoring

Monitoring is conducted routinely, as well as in response to complaints and incidents, to assess quality of services delivered and provider compliance with applicable requirements. Annual monitoring occurs for providers within the three-county catchment area and for providers outside the area who serve CPHS consumers. When corrective action is required, staff follow up with the provider until issues are resolved and/or report to oversight or regulatory bodies.

The number of monitoring events conducted by CPHS is frequently at or above the number conducted by other LME's in the state. Provider satisfaction with the monitoring process, as measured by post-review surveys, is at approximately 92%.

Provider Training / Technical Assistance / Collaboration

Training & technical assistance, offered to providers via site visits and Provider Forums, addresses compliance with required standards and quality of care. CPHS is working internally and externally to increase knowledge, capacity and skill in delivery of evidence-based practices, implementing and expanding System of Care, cultural competency and other quality initiatives that will lead to improved outcomes for consumers. For calendar year 2006, a total of 49 hours of provider training was offered through Provider Forums. Also in 2006, a Provider Council was established and now meets monthly with leadership for information-sharing and problem-solving; co-sponsors Provider Forums; and collaborates with the LME on issues of mutual concern.

Advisory Committees

Age/disability-specific Advisory Committees are composed of consumers, family members, advocates and a CPHS Board of Directors representative. These Committees serve the unique interests of each group by assisting LME management to identify and address specific issues. Additional information regarding Advisory Committees is located in Chapter 1 – Governance/Administrative Functions.

System of Care

In August 2006, CPHS hired one full-time staff devoted to implementation of System of Care principles and processes in the three counties. Initial efforts have begun. A major consultation is in process with UNC-G professionals knowledgeable about SOC. A Care Review Committee is being established to review child admissions to specialized intensive services (Whitaker School, Wright School, out-of-county residential placements). Community Collaboratives are being established in each county. A Quality Improvement initiative has been developed to track and reduce the number of children placed in out-of-area residential placements. Extensive training in System of Care philosophies is needed for all stakeholders, including LME staff and providers.

Child/Family School-Based Teams

Due to the availability of special funding in late 2006, CPHS hired one full-time staff devoted to LME linkage with the newly developed school-based teams (7 teams, led by a school social worker or nurse, are now in the Winston Salem/Forsyth County School System). Expectations for this position dovetail with SOC efforts. Flex Funds managed by the LME are available to meet child or family needs not otherwise funded.

Housing

CPHS has a strong collaborative relationship with community agencies dedicated to reduction/elimination of homelessness, including participation on the Mayor's 10-Year Committee to End Homelessness. CPHS's highly productive housing program currently oversees a total of 135 units. These include management of four housing grants (Tenant-Based Shelter Plus Care, Sponsor-Based Shelter Plus Care, HUD 811, Supportive Housing Program) with a total of 68 housing units. CPHS is the lead agency for referrals to tax credit developments, with a total of 40 units designated for disabled individuals and/or families. CPHS contracts with several providers who operate apartment programs, with a total of 35 apartments. In addition, CPHS is currently applying for grant funds, the "400 Initiative" pilot project, to provide housing for an additional 8 families with mental health needs.

Community Collaboration / Outreach / Education

Community and stakeholder collaboration is conducted via staff participation on various community-based committees and initiatives; development of training opportunities featuring local and national speakers; special events planning; collaboration with AHEC and other LME's. Recent examples during FY 2006-07 include collaborating with AHEC to bring Dr. Russell Barkley to speak on ADHD, hosting the Annual Statewide Self-Advocacy Convention, partnering with WSTA to sponsor Annual Accessible Festival, assisting with "Get Out the Vote", etc. Efforts going forward will include promoting a broader representation of age/disability areas for these type activities. Additional information regarding community collaboration is located in Chapter 1 – Governance/Administrative Functions.

3. STRATEGIC OBJECTIVE:

Objective	Strategies	Responsible Party	Target Date	Stakeholder Input
<p>1. Improve quality of life for consumers through development and maintenance of a comprehensive service system delivering evidence-based and emerging best practices.</p>	<ol style="list-style-type: none"> 1. Complete moving conditionally endorsed providers to full endorsement within mandated time frame(s). 2. Monitoring of providers for: <ul style="list-style-type: none"> • Cultural/linguistic competency, • Adequacy of network to provide evidence - based practices. 3 Provider training/technical assistance: <ul style="list-style-type: none"> • Define training needs & LME Responsibility, • Develop training plan, including education on evidence-based practices, • Implement training & technical assistance for EBPs. 4. Strengthen collaborative relationship with providers via Provider Council: <ul style="list-style-type: none"> • Broaden provider representation & input (service and/or population served, size of agency), • Develop provider profile to assist consumer choice of provider including System of Care and Cultural Competency. 5. Proactively develop continuity of care plan for consumers receiving services to be discontinued, possibly Level III & IV Residential. 	<p>Community & Provider Operations (CPO)</p>	<p>07/01/09</p> <p>07/01/09</p> <p>07/01/08</p> <p>07/01/09</p> <p>01/01/08</p>	<p>Human Rights Committee, Quality Improvement, CFAC, Advisory Committees, Provider Council, System of Care Training Workgroup</p>
<p>2. Integrate “System of Care” philosophies and processes as best practice throughout the service system, including development of a functioning Community Collaborative in each of the three counties.</p>	<ol style="list-style-type: none"> 1. Establish clear definition of Community Collaborative. 2. Develop Community Collaboratives in Davie, Forsyth & Stokes Counties. 3. Collaboratives manage the Flex Funds. 4. Implement Organization Cultural Self- Assessment. 5. Develop indicators/outcomes for System of Care and Cultural Competency for LME and providers. 	<p>CPO</p>	<p>07/01/07</p> <p>01/01/08</p> <p>07/01/08</p> <p>01/01/09</p> <p>01/01/09</p>	<p>Child/Family Advisory Committee, CFAC, Provider Council</p>

<p>3. Improve care for school-aged children through increased person-centered service planning & collaboration that includes consumers and families, Child/Family School-Based Teams Initiative.</p>	<ol style="list-style-type: none"> 1. Work with local school systems to develop criteria for providers approved to deliver behavioral health services in school setting. 2. Strengthen existing linkages and information flow between Child/Family School-Based Teams Initiative and the School Health Alliance Board. 	<p>CEO, CPO</p>	<p>01/01/08 07/01/08</p>	
<p>4. Maximize high quality, affordable housing for consumers.</p>	<ol style="list-style-type: none"> 1. Submit grant application for “400 Initiative” to provide housing for families. 2. Participate with stakeholders on “Mayor’s 10-Year Plan to End Homelessness.” 3. Identify & submit additional grants applications or access other housing funding sources. 	<p>CPO</p>	<p>07/01/07 01/01/09 07/01/10</p>	<p>Housing Advisory Committee, Adult Mental Health Advisory Committee</p>
<p>5. Promote community collaboration / outreach / education in order to:</p> <ul style="list-style-type: none"> • Improve quality of life for individuals & communities through stakeholder collaborations that promote increased access and community participation for consumers, as well as widespread awareness, sensitivity, and knowledge. • Improve quality and quantity of services available to consumers through joint stakeholder efforts that leverage existing resources. 	<ol style="list-style-type: none"> 1. Promote increased representation of MH & SA consumer populations in all collaborative efforts (maintain DD inclusion) - Develop plan; implement; monitor. 2. Promote community, LME, stakeholder & service-based collaborations that leverage existing resources through: <ul style="list-style-type: none"> • Child/Family School-Based Teams, • Housing Initiatives, • Managing Flex Funds, • Staff participation on community-based committees & initiatives, • Special events planning/involvement. 3. Community education & outreach: <ul style="list-style-type: none"> • Determine availability of MH Systems Transformation (MHST) funds to bring trainers on evidence-based practices, • Collaboration with other entities (AHEC, other LME’s) re: training & educational needs, • Coordinate or participate in events that promote awareness, sensitivity & knowledge re: all age/disability areas. 	<p>CPO CPO CPO</p>	<p>07/01/08 07/01/10 07/01/08</p>	<p>CFAC, Advisory Committees, Provider Council</p>

<p>6. Increase consumer access to care and services by identifying gaps and barriers and responding via creation of a comprehensive continuum of care.</p>	<p>1. Project and respond to gaps identified through needs assessment data:</p> <ul style="list-style-type: none"> • Work with providers to improve penetration rate for child/adolescent mental health services, • Work with providers to improve penetration rate for adult mental health services. <p>2. Based on needs assessment, recruit, orient & support new providers.</p> <p>3. Develop plan for dual diagnosis services.</p>	<p>CEO, CPO</p> <p>CEO</p> <p>CEO, CPO</p> <p>CPO</p> <p>CEO, CPO</p>	<p>07/01/09</p> <p>07/01/08</p> <p>07/01/08</p> <p>07/01/08</p> <p>07/01/09</p>	<p>CFAC, Advisory Committees, Provider Council</p> <p>Provider Council</p>
<p>7. Foster quality of care and financial stability of providers by verifying that providers meet required standards of third party funding sources, including compliance with required Quality Improvement initiatives.</p>	<p>1. Provider Accreditation.</p> <p>2. Define LME plan/criteria for enforcement and for non-compliance.</p> <p>3. Work with providers to improve compliance on Initial NC TOPPS submissions.</p>	<p>Planning & Accountability (P&A)</p> <p>CEO, CPO</p> <p>CPO</p>	<p>07/01/10</p> <p>07/01/08</p> <p>07/01/08</p>	<p>Providers, Provider Council</p>
<p>8. Make decisions based on outcomes / data.</p>	<p>1. Specify required outcomes including consumer satisfaction in provider service contracts. On an aggregate level, consumer outcomes are defined by domains that are important to all individuals to enable control over one's life as follows:</p> <ul style="list-style-type: none"> • Safe stable housing, • Meaningful daily activities, • Justice, • Respectful inclusion in a community of choice, • Supportive relationships, • Emotional well-being, • Employment, • Freedom from addiction & disruptive symptoms. 	<p>DF, CPO</p>	<p>12/01/07</p>	<p>Provider Council, CFAC and Advisory Committees, SOC consult</p>

4. **RESOURCE ALLOCATION:**

Comparison of Actual Staffing Costs to Cost Model

Provider Relations

Salary & Benefits

Cost Model	551,365
Actual	<u>\$575,736</u>
Variance	\$24,371
Variance %	4

5. **BUSINESS RULES:**

The business rules, which enhance the efficiency and effectiveness of Provider Relations and Development, are listed below.

- 1) CPHS does not increase the regulatory burden for providers by adding additional requirements.
- 2) When performing endorsement and monitoring functions, CPHS offers providers full disclosure of all appeals processes and assists/supports provider movement through the process.
- 3) CPHS proactively identifies and responds to issues that threaten provider solvency or that creates other potentially negative impacts on service delivery.

The business rules, which inhibit the efficiency and effectiveness of Provider Relations and Development, are listed below.

- 1) Current environment of multiple, rapidly occurring mandated changes fails to provide an adequate timeline for implementation and weakens the provider community.
- 2) Mandated changes, although theoretically sound, may not be adequately linked to implementation, resulting in unintended, often negative, consequences for service delivery.
- 3) Responding to negativity based on inaccurate information creates obstacles to Provider Relations' receiving consumer and family input at an optimal level.

Chapter 4 CUSTOMER SERVICE / CONSUMER AFFAIRS LME FUNCTIONS

1. MISSION:

To deliver quality customer services through education, training, empowerment, and constructive solutions by enhancing effective relationships.

2. CURRENT OPERATIONS:

Community Collaboration

This function fosters and supports collaboration with community stakeholders including consumers, families, providers, schools, peer institutions (DSS, DPH, etc.), court system, county and city leaders.

Evidence Based Practices (EBP)

EBP analyzes current services, identifies and responds to gaps making recommendations based on evidence based or best practices.

Complaint, Concerns, Appeals

This function assures that consumers can voice compliments, concerns, or appeals regarding services throughout the provider system with timely solution-oriented resolutions.

Committees

Committees support the work of CFAC, the LME advisory committees, and ad hoc committees to encourage community involvement and to solicit unique consumer and family input.

Customer Service and Consumer Affairs (CSCA)

CSCA is discussed in Chapter 1 under Governance and Administration.

3. STRATEGIC OBJECTIVE:

Objective	Strategies	Responsible Party	Target Date	Stakeholder Input
1. Define the relationship between the Board, CFAC and advisory committees.	<ol style="list-style-type: none"> 1. Negotiate and approve Relational Agreement with CFAC. 2. Collaborate with CFAC to establish a CFAC /LME quick response process that will be used in responding to short deadlines or immediate needs. 3. Determine with CFAC the processes by which CPHS will support CFAC statutory responsibilities. 4. Define charge to Advisory Committees. 5. Facilitate development of strategic plan with outcomes and benchmarks for each Advisory Committee. 	<p>CEO</p> <p>CEO, Consumer Affairs (CA)</p> <p>CEO, Community & Provider Operations (CPO), CA</p>	<p>09/01/07</p> <p>09/01/07</p> <p>03/01/08</p> <p>07/01/08</p> <p>09/01/08</p>	<p>CFAC, Advisory Committees and Board</p>
2. Educate the community on mental health reform and other relevant topics	<ol style="list-style-type: none"> 1. Education/outreach re rights protection, complaint process, advocacy, EBP's, authorization guidelines, system navigation. 2. Consumer outreach for informational / educational purposes. 3. Staff support regarding consumer-run businesses, peer support initiatives. 	<p>CEO, CPO</p>	<p>07/01/08</p> <p>01/01/08</p> <p>07/01/10</p>	<p>Focus Groups w/Consumers</p>
3 Support to Committees.	<ol style="list-style-type: none"> 1. Support of CFAC: <ul style="list-style-type: none"> • Educate and communicate with CFAC re: EBP and clinical practice standards, • Develop Plan for Resource Room at BHP, • Work w/CFAC to develop plan to improve CFAC attendance/involvement. 	<p>CA</p>	<p>07/01/09</p> <p>07/01/08</p> <p>01/01/07</p>	<p>CFAC</p>

4. **RESOURCE ALLOCATION:**

Comparison of Actual Staffing Costs to Cost Model

Consumer Affairs

Salary & Benefits

Cost Model	\$226,171
Actual	<u>\$224,123</u>
Variance	\$(2,048)
Variance %	-1

5. **BUSINESS RULES:**

The business rules, which enhance the efficiency and effectiveness of Customer Service, are listed below.

- 1) Developed clear internal definition of complaints and the resolution and reporting process.
- 2) Innovative consumer empowerment initiatives such as Peer Specialist Association, WRAP trainings and forming of Peer Specialist certification process.
- 3) Facilitating of CFAC relational agreement.

The business rules, which inhibit the efficiency and effectiveness of Customer Service, are listed below.

- 1) Constant change triggers chronic anxiety for consumers and families.
- 2) Challenges in communicating the LME's current and evolving management role.
- 3) Redundancy of focus on historical and/or inaccurate information impedes CFAC's ability to meet its statutory responsibilities.

Chapter 5 SERVICE MANAGEMENT

1. MISSION:

To manage and facilitate an evidence based clinical service delivery system driven by outcomes in order to provide a safety net within available financial resources for CPHS consumers.

To provide telephonic screening, triage and referral services to CPHS consumers using evidence based approach and providing information and referral linkages to naturally occurring community resources.

2. CURRENT OPERATIONS:

The following describes how the various components of Service management are currently set up and operates.

The Clinical oversight role of the Medical Director

The goal of this function is to drive clinical policy that results in improved quality of services both internally –within the LME – and externally among the LME stakeholders. This function is carried out through the following activities.

Provision of clinical consultation

The Medical Director is currently performing this function by being a member of the Leadership Team, attending Leadership Team Meetings regularly, and offering necessary input.

Collaborative Activities

The Medical Director is a member the North Central LME Medical Directors' Forum where issues related to the system transformation are discussed, needed clinical information obtained that are used to improve Clinical operations of the LME and Providers. This function requires extensive involvement/collaboration with the Local Medical School/Hospitals and both Local and State/National Medical/Psychiatric associations.

Liaison Activities

In this role, the Medical Director is a member of the North Carolina Practice Improvement collaborative where current evidenced based practice and their application in the North Carolina Service delivery System are discussed and input given. This function requires extensive involvement/collaboration with community providers.

Designing Clinical Protocols

Examples are the CPHS Human Services IPRS Benefit plan, IPRS Appeals process, Auto-authorization Package, Criteria for Developmental Therapy Service Authorization, Community Support Services and Provider outcome is also a function of this role. A function of this role is providing Technical Assistance and Education to staff and providers, defining needs area, in addition to being consultant to the CEO and CPHS's leadership/Staff in clinical matters.

Administrative / Clinical Supervision of medical Services Unit

This function involves providing direct/administrative supervision to the STR/ACCESS, Utilization Management and Pharmacy Unit Managers.

Medical Services

The goal of this unit is to provide those physician oriented services that provide some safety net for the consumers of our catchment area during this transformation and currently consists of Physician, Pharmacy and Laboratory Services.

Physician Services

This function consists of about 40 hours a week of adult psychiatric services time contracted out to Daymark Recovery Services in Winston-Salem. This time is shared between two Psychiatrists. A contract was signed the week of February 11, 2007 with Quest Laboratories to provide these services to consumers in the CPHS Human Services catchment area using a sliding fee schedule. This service will be free to the truly indigent consumers. CPHS Human Services intends to hire a 0.5 FTE for this service who will also be cross trained to work with the pharmacy unit.

Pharmacy Services

This function currently employs one staff and a 0.5 FTE supervisor, but hopes to add a 1 full time employee (FTE) cross trained to work this and laboratory services. This unit works closely with the Forsyth County Department of Public Health Pharmacy in carrying out its various functions. This unit establishes the sliding fee schedules to be used to assess co-pay for county funded medications. It also assists the pharmacy staff and consumers in filling out forms for the various drug company pharmacy assistance program and collecting sample medications from pharmaceutical company representatives.

- CPHS, in collaboration with Forsyth, Stokes, and Davie Counties has designed a comprehensive Medication Assistance Program to assist consumers in its catchment area to access needed medications.
- CPHS works closely with the Forsyth County Public Health Pharmacy and has a contract with Stokes Reynolds Pharmacy in King and Danbury and Foster Drugs in Mocksville.
- Most of the activities of this program take place at the Behavioral Health Plaza in Winston Salem, where CPHS staff works closely with Forsyth County Pharmacy staff. Prescribing is limited to contract Physicians or those working for a contracted Provider.
- Several types of assistance are available to eligible consumers and these include: Sliding fee payment (this type of subsidy is not available for Atypical Antipsychotic Medications), Sample Medications and Pharmaceutical Company application for Indigent Medications.
- CPHS Patient Assistance Program benefit is only for consumers currently enrolled with contracted providers, of those who are in need of medication prescribed by a qualified Physician of these providers, and of those who are eligible based upon an assessment using CPHS's Sliding Fee Scale and with no other insurance and also consumers who are not eligible for Medicare or Medicaid (except for those newly discharged from a hospital).

- This unit establishes the sliding fee schedules to be used to assess copay for county funded medications. It also assists the Forsyth County pharmacy staff and consumers in filling out forms for the various drug company pharmacy assistance programs and collecting sample medications from pharmaceutical company representatives.
- CPHS has also signed a contract with the office of Rural Hall Health to be a part of the MARP (Medication Access and Review Program). The MARP will streamline paper work involved in accessing the various pharmaceutical companies' patient assistance programs.
- The Pharmacy Patient Assistance Program is supported solely by CPHS through county appropriations and the Pharmaceutical companies through Sample and Indigent medication programs and not by any state or federal funding.
- Co-pays collected are the sole funding of the Indigent laboratory program.

Utilization Management

The goal of this unit is to ensure that all authorized IPRS services meet medical necessity criteria and that there are financial resources available to pay for them. The concurrent review of Medicaid PCPs is also included here.

- This unit also works to improve consumer health and welfare within our community through providing authorizations that are timely, cost effective, clinically appropriate and based on consumer needs.
- The utilization management unit employs two Masters level Licensed Professional Counselors with extensive experience in both the private and public sectors who complete the clinical reviews and issue authorizations for services
- Authorization requests are received via ProviderLink (a web based system), by mail or by fax. The requests are reviewed by Billing/Claims staff for documentation of IPRS target population or any other funding source and for those requests that meet the auto authorization criteria. If warranted, that information is forwarded to Utilization Management for review. Once received by UM, the two staff clinicians review the authorization requests for clinical necessity, necessary documentation and appropriate dispositions. Should the incoming authorization request not have the necessary information that is needed to proceed with the authorization, the requesting company is given specific instructions on what is needed and is given five business days to submit the necessary information. If at the end of that time, the appropriate documentation has not been received, an Authorization Discard Response is sent to the company requesting the authorization.
- They are informed that they have an additional five business days to submit the needed information.
- If the information is not received, the request is discarded. The provider may resubmit a request for authorization, but requests will be honored on the day they are next submitted. CPHS does not backdate authorizations.
- Requests that come to the department and have all the necessary information to be authorized are authorized immediately and are returned to the provider the same day they are received.

- Authorizations are issued according to the benefit design plan that was developed by the medical director in conjunction with consumers, collaborating provider agencies and the clinical team at CPHS.
- Treatment Plans are currently being reviewed by the staff in Utilization Management for clinical appropriateness. At present, only plans for IPRS funded clients are reviewed. In the near future, staff will begin reviewing a portion of the plans for Medicaid consumers as well.
- Training and support will be provided to requesting agencies related to preparation of Person Centered plans and on ways to ensure authorization requests are appropriate, detailed and organized enough so authorizations can be processed in a timely manner.
- On-site chart reviews will be conducted routinely by Provider Services to ensure clinical appropriateness of interventions, documentation and services to meet the needs of each client.

Community collaboration

The goal of this function, is the involvement of stakeholders and the community at large in problem solving, education about behavioral health issues that is affecting or will affect the community, provision of technical assistance and care coordination. Various CPHS staff is assigned to represent it with various Community Stakeholders . CPHS currently has staff assigned to Forsyth Medical Center, The Local Psychiatric/Medical Societies. The Primary Care /Behavioral Health Integration project is an example of CPHS collaboration with a Community stakeholder to pilot this project.

Screening, Triage and Referral

The goal of this unit is to serve as the gateway for all mental health, substance abuse and developmentally disabled consumers to enter into services in the CPHS catchment area.

- Monday through Friday from 8AM to 5PM, calls are answered by 3 licensed clinicians and two additional qualified professionals. An additional licensed clinician is available to take calls during times of high volume and when other clinicians are absent. The STR manager also has the capability of taking calls when needed. After 5PM, on weekends, and on holidays, the calls are answered by the staff at The Guilford Center. Consumers call the same toll free number 24/7/365 to obtain services. One Spanish-speaking clinician works during daytime hours and additional language interpretation services are available 24/7/365.
- Generally, State benchmarks are met regarding answering calls within 5 rings/30 seconds. Also, staffing is usually sufficient to meet the benchmark regarding abandonment rate; we continue to work on scheduling to improve this situation but also realize there are times when large numbers of calls are received unexpectedly and it is not possible to answer all calls prior to abandonment. It is not felt that hiring additional clinicians would significantly improve the abandonment rate, as this is usually only a problem when an extremely large number of calls are received in a short amount of time, i.e. fifteen or more clinicians would be needed to take the calls.

- The large number of informational calls received may also contribute to the abandonment rate. We continue to seek out ways to divert these calls from the STR clinicians.
- The clinicians complete a brief screening using a standardized screening form. They determine the urgency of need and then schedule the consumer with a provider of their choice. In the event that the consumer does not know which provider they want to provide services, the screening system randomly generates the name of three providers who can provide the needed service. The consumer is then given a brief description of each provider and they then make a choice of provider. The clinicians consult the web based calendar and schedule the appointment with the chosen provider. Emergent calls are warm transferred to a provider so arrangements for immediate intervention can be made. Urgent calls are given a scheduled appointment with 48 hours; if no appointment is available the call is treated as emergent.
- An attempt is made to schedule routine callers within 7 days. For Medicaid consumers, this is not a problem.
- However, for consumers whose services are funded through IPRS funds, this has become increasingly difficult. To improve this situation, additional funds would need to be made available to those providers serving IPRS consumers so that they can increase their capacity.
- The majority of callers are referred to a provider, but there are a small number of callers who may be referred to community resources; currently there is no follow up on these cases. On all other referrals, the providers report to us whether or not the consumer kept the scheduled appointment and this data is reported to the division on a quarterly basis.
- Generally, the majority of consumers access services through STR. However, a few providers are submitting the STR interview and registration form and this data are entered into CPHS's database so that the information can be reported to CDW.

Guardianship

The goal of this function is to provide individuals who do not have the capacity to make and communicate important decisions about their personal affairs the assistance of a legally appointed surrogate decision maker to help them exercise their rights.

- CPHS offers such a service to individuals appointed to them by the NC Court system and works with the courts and the Department of Social Services to determine the correct and most effective guardian placement for each "ward."
- CPHS makes every attempt to be sensitive to the ward's needs, values and wishes to ensure that the decisions being made are individualized, consistent with the ward's value system and are in the ward's best interest.
- CPHS also seeks to include the ward's family members and other significant supports in the decision making process when possible.
- CPHS utilizes a guardian representative system where an experienced, qualified professional of at least the Bachelors level and experience with individual's diagnosed with mental illness, developmental disabilities and/or substance abuse issues represents the legal guardian in the ward's affairs.

The Guardian Representative has direct access to their supervisor, the medical director and the guardian as needed for those decisions needing additional consultation.

- Currently CPHS is responsible for 109 individuals who reside in 15 different counties across the state. Placement outside the CPHS catchment area is a common occurrence due to the nature of the “wards” appointed to CPHS and their individualized needs. While most of the wards have additional support via Community Support, Case Management or ACTT, at least 23 wards remain without that support for various reasons. This means that CPHS staff is responsible for that support. Additionally, with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services pending decision to stop guardians from providing CAP services to their own wards (their own children), CPHS has the possibility of rapidly doubling, or quadrupling their ward responsibilities overnight.
- To keep with NC Statute, CPHS needs to continue to work with the Department of Social Services in Forsyth, Stokes and Davie Counties to assure that the most appropriate guardian appointment is made to best meet the needs of the individual wards; continue to evaluate each ward to determine if restoration of competency is appropriate (since July 2006 three individuals have had their competency restored); meet with each ward quarterly; attend each ward’s person centered plan meeting and continue to review and sign all legal paperwork for each person.
- To be more effective in our desire to treat each ward as if they were our own beloved family member, CPHS will need to hire additional staff to comply with the state statute and provide a true safety net for all wards, not just the ones in crisis. Staff would benefit from additional trainings on guardianship and ethical decision making as well.

Care Coordination

The goal of this function is to facilitate the linking of consumers who are not already receiving services to appropriate services and providing consultation for providers for consumers who have complicated problems.

- Care Coordinators manage consumer care across the care continuum, throughout various care settings, and work in conjunction with the consumer, providers, and others to improve outcomes and make the best use of funds.
- CPHS currently employs three care coordinators with a number of years of experience in direct care and case management with a variety of populations. One care coordinator focuses on clients with developmental disabilities, another coordinates care for both adults and children with mental health and substance abuse problems. The third works with the school system and participates in Child and Family team meetings as a part of the Child System of Care.

- The MH/SA Care Coordinator primarily works with adults and children, linking consumers with needed services and troubleshooting funding and placement issues. This staff also serves as the liaison with public and private inpatient facilities and in that role provides clinical and treatment background information to clinicians at time of admission, assists them in discharge planning, and tracks all discharges to determine if aftercare appointments are kept. In the event of missed appointments, this staff makes attempts to contact the consumer and makes arrangements for follow up care. This staff visits John Umstead Hospital at least weekly to further assist hospital staff in discharge planning and address problems that might hinder timely, appropriate discharges. Attention is concentrated on high risk/high use consumers and attempts to ensure they receive the most appropriate services for their benefit as well as in an attempt to prevent overuse of State hospitals. In an ongoing effort to improve the quality of the SOC, Care Coordinator also participates in data collection and analysis pertaining to variables of bed Day Utilization and Hospital Admissions.
- The DD Care Coordinator focuses attention on the CAP-MR/DD and MR/MI populations and maintains a waiting list for services, acts as liaison between the Murdoch Center and provider agencies in determining CAP eligibility, coordinates DMA audits and oversees NCSNAP assessments. This staff also serves as a consultant to families and providers in identifying appropriate treatment options and locating resources (particularly in more complicated cases) and may be involved in the person centered planning process for high risk/high profile/high cost consumers to insure the plan promotes community integration and least restrictive care in balance with the consumer's health and safety needs.
- Assessments completed by TASC are reviewed to determine appropriateness of treatment recommendations.
- The LME employs staff with training and experience across all disability areas. The Care Coordinators have experience in providing services to developmentally disabled consumers, adult and child mental health consumers and those with co-occurring Substance Abuse diagnoses and the Medical Director is an ASAM certified Psychiatrist.

3. STRATEGIC OBJECTIVE:

Objective	Strategies	Responsible Party	Target Date	Stakeholder Input
1. Expand Care Coordination activities to adequately address the needs of consumers.	<ol style="list-style-type: none"> 1. Work with providers to improve timely follow-up after inpatient care. 2. Monitoring the continuity of care across service continuum for high cost/high risk/high service utilizing consumers. 3. Participate in Child & Family Team meetings re high cost/high risk. 	<p>Medical Director (MD)</p> <p>MD, Community & Provider Operations (CPO)</p> <p>MD, CPO</p>	<p>07/01/09</p> <p>07/01/08</p> <p>01/01/08</p>	<p>JUH/FMC/WFUBMC</p> <p>Advisory Committees, CFAC</p> <p>Collaboratives, School Health Alliance</p>
2. Develop a Utilization Management (UM) plan focused on outcomes and best practice.	<ol style="list-style-type: none"> 1. Evaluate strategies for reducing bed day allocation and utilization for state hospitals and link to Crisis Response Network. 2. Concurrent review of 10% PCP's for Medicaid when provided. 3. Selected reviews of IPRS treatment plans for achievement of appropriate outcomes. 	MD	<p>07/01/08</p> <p>01/01/08</p> <p>07/01/08</p>	Providers, State Hospitals
3. Manage the STR process to provide seamless, timely access to providers identified by consumer choice.	<ol style="list-style-type: none"> 1. Establish timeline for bringing 24/7 STR in-house. 2. Work with providers to secure consumer access to services within state defined benchmarks for Urgent, Emergent, Routine care. 	<p>MD</p> <p>MD, CPO</p>	<p>01/01/08</p> <p>01/01/08</p>	Provider Council
4. Registration Management.	<ol style="list-style-type: none"> 1. Explore ways to identify consumers new to the system for whom Initial NCTOPPS' assessment is required. 	CPO	07/01/08	Provider Council
5. Develop and operationalize the First Responder System using the crisis plan developed for each consumer as a part of the treatment plan.	<ol style="list-style-type: none"> 1. Maintain consumer crisis plans & "hot sheets" from treatment plan for use by STR staff. 2. Design a process which includes STR care coordinators, CPO, First Responders, Mobile Crisis Teams, when necessary, for quality crisis plan and effective responder interventions. 	<p>MD</p> <p>MD, CPO</p>	<p>07/01/08</p> <p>07/01/08</p>	Provider Council, Mobile Crisis Teams, First Responders

4. RESOURCE ALLOCATION:

Comparison of Actual Staffing Costs to Cost Model

Service Management: Service Management, STR, and UM

Salary & Benefits

Cost Model	\$2,070,089
Actual	<u>\$1,522,729</u>
Variance	\$(547,360)
Variance %	-26

5. BUSINESS RULES:

The business rules, which enhance the efficiency and effectiveness of Service Management, are listed below.

- 1) Care Coordination position is interactive and onsite with John Umstead hospital.
- 2) CPHS has improved the delivery of guardianship services by collaborating with DSS & DPH on criteria for most appropriately assigning guardianship & hiring 1 FTE who is able to provide more individualized, person-centered guardianship services.
- 3) A benefit design package was developed by the Medical Director, Finance Director and providers resulting in our ability to authorize medically necessary services within available financial resources.
- 4) Development of Patient Assistance Program for pharmacy services for indigent consumers.

The business rules, which inhibit the efficiency and effectiveness of Service Management, are listed below.

- 1) One third of all calls are information and referrals, thus negatively impacting abandonment rate and length of call outcomes.
- 2) Community Support providers who do not offer Evidence Based Practices (EBP) may be unmotivated or unwilling to refer consumers to other providers who do offer EBP's, due to the possibility of losing the consumer, with a result that consumers are less able to access EBP's.
- 3) CPHS does not have access to ValueOptions authorizations; therefore, unable to effectively coordinate care for these consumers.

Chapter 6 QUALITY MANAGEMENT

1. MISSION:

To improve the quality of life for CPHS consumers and families by developing a dynamic Quality Improvement (QI) process which defines outcomes and accountability to ensure the community system of care and support while simultaneously assessing and improving LME functions.

2. CURRENT OPERATIONS:

The functions under Quality Management report to the Planning and Accountability Department. The Planning and Accountability Department is responsible for oversight and implementation of comprehensive compliance procedures. This helps ensure agency compliance in the following areas.

- Health Insurance Portability and Accountability (HIPAA)
- National Accreditation
- State Performance Agreement
- Quality Management
- Development and monitoring of Strategic Plan and Local Business Plan
- Review and maintenance of policies

The Planning and Accountability Department (P&A) provides oversight to the Information Technology (IT) for the agency. This includes all mainframe computer, telephone and network hardware and software. The Quality Improvement (QI) Coordinator helps define, maintain and monitor CPHS's Quality Improvement activities. Oversight of data analysis and trending is provided in order to implement solutions for any identified trends and problems. The following functions are handled collaboratively between the Quality Improvement and Information Technology areas:

- Data analysis/reports & Trend analysis
 - Service utilization patterns: IPRS (Integrated Payment Reporting System), hospitals, crisis services
 - DMHDDSAS Compliance reports
 - Screening, Triage and Referral (STR)/Access
 - Mystery Shopper to STR/Access
 - Mobile Crisis
 - Housing
 - System of Care (child placement)
 - Consumer complaints/outcomes
 - State dollar management/state facility usage/bed day utilization

The P&A staff have been involved in various initiatives over the past year including implementation of STR/Access, review and revision of all Board policies, redefining the role of the Human Rights Committee, redefining/reemphasizing the role of the Quality Improvement functions and committees, strategic planning, customer satisfaction and developing a more data driven IT Department.

Planning

A CPHS team met with a team from The Guilford Center from November, 2005 through March, 2006 to develop a transition plan for moving the STR functions back to the community rather than outsourcing. In April, 2006, it was decided CPHS would provide STR services from 8am-5pm Monday through Friday, and The Guilford Center would provide all after hours and holiday STR services for CPHS's catchment area. The Information Technology Department developed a new interactive software program to capture the screenings on-line, randomly offer provider choice and access provider's schedules in order to schedule appointments for consumers. Symposium, a telephone software system was purchased to capture various data. A STR team continued to meet after the implementation date of July 1, 2006 in order to develop management reports on abandonment rate, calls answered after threshold, average talk time, number of emergent, urgent and routine calls. In August, 2006 a Mystery Shopper program was developed to monitor calls being answered, friendliness of staff, etc. Consumers and peer specialists were recruited to make these calls. The Leadership Team receives weekly trending reports on STR/Access.

Quality Improvement

The Quality Improvement Board Committee met in January, 2006 to approve a revised QI policy. The QI Council, which is comprised of consumers, providers and LME staff, reviewed the revised QI Plan. The QI Council began reviewing Performance Agreement reports and identifying other reports to be reviewed by this committee. The QI Coordinator met with each point person for the current QI initiatives to get a better understanding of the current projects. The QI Initiatives developed for the year are Bed Day Utilization, Psychiatric Services, System of Care and STR/Access. The QI Coordinator worked with the complaints staff to ensure CPHS reports were focused on reporting and resolving complaints. Reports mistakenly included calls that were "Information" or "Referral" issues rather than complaints. The definition of a complaint had never been clearly defined by the Division or CPHS. In August, 2006, a data analyst began working with the QI Coordinator to graph and trend identified reports.

Policies

All Board policies were reviewed to determine if revisions were necessary or if the policy was relevant for the existing functions of the LME. Many of the policies still reflected the LME as a provider of services. The majority of the policies were approved prior to the January, 2007 Board meeting. A few Human Resources policies remain to be approved by the Board.

Strategic Planning

In 2005, the CPHS Leadership Team (the CEO/Area Director and departmental Directors) discussed the needs (1) for analysis of the current LBP following full divestiture of services; (2) for the Board and management to develop a sharper knowledge and understanding of their LME roles; and (3) for the generation of a rolling three-year strategic plan beginning in July, 2007.

In June, 2005, the Board and the Leadership Team met again for a weekend retreat facilitated by Christina Thompson, Heart of the Matter Consulting, Inc., to develop five critical success factors to focus and guide further strategic planning.

The critical success factors developed by the Board were:

1. Governance
2. Financial Stability
3. Service Delivery
4. Quality Improvement
5. Public Affairs

The Leadership Team, over a two-day retreat, developed the objectives and strategies under the critical success factors. The retreat resulted in the production of the first draft of CPHS's rolling three-year plan.

By August, 2006; the Leadership Team finished the development of a draft Strategic Plan, complete with target dates spanning the three-year period. This draft Strategic Plan (soon to become the new LBP) was distributed to CFAC in August, 2006 for thorough review prior to a planned discussion at CFAC's October, 2006 meeting. Due to a mix-up with their October agenda, the draft plan was not presented to CFAC until November. However, in the interim, it was necessary to continue with the plan for briefing the Board on the draft Strategic Plan on October 26, 2006. On November 6, 2006, the draft Strategic Plan was presented to CFAC and its concerns were addressed in Plan revisions.

Community Forums were held in early December, 2006 for community input. January-March, 2007 was used to finalize the plan with CFAC, seek approval from CPHS Board and the three Boards of County Commissioners.

Customer Satisfaction

CPHS posted a survey on its website during April-May, 2006 in order to measure customer satisfaction for the overall LME. Sixty-four people responded to the survey, which resulted in an average score of 7.35 out of 10. The development of additional surveys is planned for the future utilizing the survey tool, survey monkey.com.

Human Rights Committee

The Quality Improvement Coordinator acts as liaison and provides support to the Human Rights Committee, which is a Board appointed committee. The staff from the Division's Consumer Empowerment Section met with CPHS staff in October, 2006 to discuss the role of the Human Rights Committee.

Information Technology (IT)

A consultant was hired to help with CPHS's IT initiative. The goal of this initiative, is to explore and implement procedures, which would enable departments to operate within a data-driven system. This initiative will help Leadership staff make management decisions based on reliable and timely data.

3. STRATEGIC OBJECTIVE

Objective	Strategies	Responsible Party	Target Date	Stakeholder Input
1. In order to improve the quality of life for consumers, families, and communities develop and maintain a robust Quality Improvement system.	1. Identify and track quality indicators: <ul style="list-style-type: none"> • LME functions, • Provider network, • Consumer, families, communities (DSS, schools, Board of Commissioners). 2. Develop internal processes to monitor and evaluate the level of quality obtained by all programs and services. 3. Monitor minimum of three QI studies of LME operations and functions. 4. Right-size the Quality Improvement staff.	Planning & Accountability (P&A) P&A, Community & Provider Operations (CPO) P&A P&A P&A	07/01/08 01/01/09 07/01/09 01/01/08	Consumer, DSS, Dept of Public Health, QI, CFAC Provider Council
2. Provide LME feedback on its performance under all applicable standards.	1. Design and implement a process to monitor and evaluate progress and recommend adjustments under the Local Business Plan. 2. Track and report on compliance with Performance Agreement and Performance Indicators. 3. Approve Corporate Compliance Plan.	P&A P&A P&A	01/01/08 01/01/08 01/01/08	CFAC QI Council, Board QI Committee
3. Develop reports for trend analysis.	1. Trend analysis: <ul style="list-style-type: none"> • Consumer: complaints, human rights, outcomes, • Provider: audits, performance, satisfaction, • Evidence-Based/Promising Practices, • Internal LME Operations: Management of State dollars & State Facility usage, continuity of care from State operated facilities, LME Care Management effectiveness of high-risk consumers. 2. Other stakeholders: community agency complaints. 3. Compare population census disability prevalence data w/ LME consumer penetration data.	P&A	07/01/08 07/01/09 07/01/09 07/01/08 07/01/08 07/01/08	QI Council, HR Committee, CPHS Board, Counties

4. Information Technology-To develop a fully functioning data-driven system with future orientation.	1. IT functionality to meet all required electronic data gathering/exchange requirements.	P&A	01/01/09	QI Council, Board QI Committee & CPHS Board IT Consultant Provider Council, NC Council Workshop
	2. Monthly reporting on STR, hospital bed day usage, IBNR, claims payment, appeals & grievances, use of EBPs.	P&A	01/01/09	
	3. Receive data from DMA or DMH, process, analyze, and report on utilization of Medicaid services.	P&A	01/01/08	
	4. Work w/IT consultant to develop and implement systems to streamline data collection, storage and reporting.	P&A/LT	01/01/08	
	5. Identify major provider to help implement various initiatives.	LT	01/01/08	
	6. Identify efficiency tools such as paper reduction systems, i.e. electronic time sheet.	P&A & HR	01/01/09	
	7. Analyze progress towards a paperless system with appropriate redundancy.	P&A	07/01/09	
	8. Work towards standardization (forms, data, systems).	P&A	07/01/10	
5. To adhere to National Accreditation.	1. Identify new timeline.	P&A	01/01/08	CFAC
	2. Reevaluate accrediting body.	P&A/LT	07/01/08	
	3. Prioritize preparatory tasks.	P&A	01/01/09	
	4. Develop work plan.	P&A	01/01/09	
6. Measure Customer Satisfaction.	1. Administer surveys to assess consumer knowledge/satisfaction with the process and with the support they receive.	P&A	02/01/09	CFAC, Consumers
	2. Develop surveys and studies including EBP's and Promising practices.	P&A	01/01/09	

4. RESOURCE ALLOCATION:

Comparison of Actual Staffing Costs to Cost Model

Quality Improvement and Outcome Evaluation

	<u>Salary & Benefits</u>
Cost Model	\$198,419
Actual	<u>\$222,677</u>
Variance	\$24,258
Variance %	12

5. BUSINESS RULES:

The business rules, which enhance the efficiency and effectiveness of Quality Management are listed below.

- 1) Tracking, analyzing and refining STR incidents in order to ensure back up plan is effective.
- 2) Developed Mystery Shopper Program utilizing consumers to track and analyze customer satisfaction with STR.
- 3) Integration of data in policy decision-making.

The business rules, which inhibit the efficiency and effectiveness of Quality Management, are listed below.

- 1) Lack of access to Medicaid data due to ValueOptions authorizing Medicaid services.
- 2) Limited provider compliance with State mandated outcome measures such as NCTOPPS.
- 3) Limited interdepartmental data linkages.

Local Management Entity: CPHS Human Services

Crosswalk of Key Functions to LME's Organizational Structure

LME Function	Per Cost Model Organizational Structure	Per LME Organizational Structure	Page # of Local Business Plan
CEO	General Governance	CEO	5
Board support and expense	General Governance	CEO	5
Policy analysis	General Governance	CEO, Planning & Accountability	6, 40
Human Resources	Business Management	CEO	8
Accounting / Budgeting / Payroll	Business Management	Finance	15, 16, 17
Financial reporting	Business Management	Finance	15
Claims processing, billing, payment	Claims Processing	Finance	17
CDW and IPRS reporting	IT	Planning & Accountability	39
Provider endorsement and monitoring	Provider Relations	Community & Provider Ops	20
Provider recruiting and contracting	Provider Relations	Community & Provider Ops	20
Provider technical assistance	Provider Relations	Community & Provider Ops	21
Handling provider complaints	Provider Relations	Community & Provider Ops	21
24/7/365 Access, screening, triage and referral	STR	Service Management	33, 34
Consumer registration	STR	Service Management	33, 34, 37
Person Centered Plan reviews	Service Management	Service Management	32, 33
State funded service authorization	Service Management	Service Management	32, 33
Maintenance of waiting list for CAP-MR/DD Waiver	Service Management	Service Management	36
Care Coordination	Service Management	Service Management	35, 36
Community Collaboration	Service Management	CPO, Consumer Affairs, Serv Mgt	22, 30, 33
System of Care and other interagency coordination/collaboration	Service Management	(CPO) Community & Provider Operations	21
Education to general public and activities to address stigma	Service Management	Consumer Affairs Community & Provider Operations	24, 28
Consumer appeals and grievances	Customer Service	Consumer Affairs	27
CFAC staff and expenses	Customer Service	CEO, Consumer Affairs	5, 27, 28
Consumer education and outreach	Customer Service	CPO, Consumer Affairs	22, 24, 28
Internal data analysis and reporting	Quality Management	Planning & Accountability	42
Critical incident reporting	Quality Management	CPO, P&A	20, 42
Quality Improvement studies	Quality Management	Planning & Accountability	39, 40, 42
Develop and stabilize a highly qualified provider system**	Provider Relations	Community & Provider Operations	20, 21, 23, 25
Implement comprehensive crisis services**	Service Management	CEO	7, 9, 12
Assure a unified system and standardization**	Service Management/ Provider Relations	Planning & Accountability	43
Develop opportunities for consumer employment**	Service Management	Community & Provider Operations	25
Develop opportunities for consumer housing**	Service Management	Community & Provider Operations	22, 24

**State Strategic Goals