

**CenterPoint Strategic Plan**  
**World Café – January 22, 2010**  
**Raw Notes**

**What Has Happened in the last 3 Years That Has Worried or Concerned You?**

- Beyond academics / continued funding
- Community support going away – how to influence state budget people
- Cuts in S.A. funding
- Competitive LMEs
- Instability of the systems
- High expectations – low financial support
- Redundant audits
- Lack of vision, sharing
- CABHA
- Continuing to reinvent the broken pipe (MH reform, 7 years ago)
- Targeted CM reduction hours / 3 hours per month
- Community support – MH children
- S.A. budget cuts
- Competition with LME's
- CABHAs
- #5 being served
- DD \$ cuts
- Targeted care management to 3 hrs. / mo.
- Very concerned about children in MH Services
- Having support for 2+ years now, then level of care will end in the next few weeks. With
- Virtually no opportunity to support severely mentally young youngsters, who will need
- Hospitalization which has been avoided with the community support services.
- Recovery / Resiliency
- Follow-up support and supervision
- Transitional Housing
- Halfway House
- Self-help Therapeutic
- Economic Crisis = Decreased in Funding
- Level 3-4 Youth Group Homes
- Cut community support for most needy
- Push back from State to serve on local level but no help at local level.
- Homeless w / sever mental illness are not allowed in the shelters-need a facility and help with their meds.
- Housing – shortage, expensive, and no availability for some population
- Employment for DD consumers
- State changes constant – no stability

- Changing definitions
- Perceptions of LME not being a partner with community
- Developmentally Disabled
- Community support for children being removed
- Jocelyn knows 3-4 children who will undoubtedly be hospitalized (some will be OK, but many not)
- Cuts in substance abuse funds
- Cuts diminishing options – people (DD, MH, SAS )
- Not getting what they need in order to become happy, well productive citizens.
- LME's being rather competitive –having to figure out survival
- Lack of vision, sharing, partnership. Coalitions = a voice
- Instability of the system
- Lack of uniformity of control LME's across the state
- Redundant audits
- High expectations, low support \$\$
- Need for standardization
- Budget cuts – elderly, therapy and Medicare
- Changes MH –policies
- Org. structure LME
- Access to information
- Board membership
- Lack of stability
- Effortless
- Coordination
- Voice to those in need of services
- Direct funding
- Expand housing
- Incentives for Psychiatrists to stay
- Expand SA Treatment
- Communication
- Person centered
- Integrated Care
- Hispanic population
- Access
- Language = Major Barrier
- Family services
- Need to look at whole picture, needs and individual
- Make community more aware
- Recovery and resiliency services
- Early screening (5th grade)
- EBP funded more
- Comprehensive clinical home – Hopefully will encourage use of EBP's
- Integrated behavior and primary care / physical health care
- Lack of ability to utilize peer support

- Cost models
- State changes provide instability
- Community support issues
- Lack of knowledge – officials who are making or supporting changes
- Accessing services and knowing how
- Lack of EBP – funding, support
- CAP waiting list grew
- Lack of Public School Inclusion
- Medicaid reductions
- Federal and local redefinition of habilitative priorities
- Case Management hourly reductions
- Transportation barriers to access – system-wide
- Day services lacking especially DD
- LME consolidation of services statewide
- Housing options
- Lack of continuing of services for DD pop. Over person’s lifetime
- National, State and local economy
- Lack of funding
- Long wait for MH hospital beds
- Lack of transportation to appointments. No bus passes anymore. CFAC survey indicates this is a major consumer concern.
- Better communications when bids for services are announced. Sometimes existing providers don’t know it is time to rebid and miss the opportunity.
- No drop-in center 24 / 7 Run by consumers would serve as much needed wellness support
- No DDT services, which are greatly needed, evidence – based
- Not approved billing category at this point
- Closer supervision of group homes
- Programs not user friendly to get services for special needs kids
- Not enough programs in NC for kids that fall into a middle category (not autistic, not LD )
- No decent programs in school
- Medical Director committing to more than one provider. How does a provider guarantee that they wont be stuck at the end thinking they have a M.D. and the State comes in and says “no”
- Need for more transparency
- Too large percentage spent on oversight – management ( not enough for providers)
- Board appears too insulated (not enough outside influence)
- Lack of stability
- NC Mental Health is not a very healthy system
- Problem for consumer to access MH/AOD services because of little information / guidance available
- State system confusing

- Budget cuts related to services for elderly, this population is only getting larger
- Liability issues
- Transit agencies
- Input from respect for differences collaboration
- Cuts to Medicaid and Medicare – all population
- Impacts of funding cuts on growing elderly population
- Limited community focus and services for SA
- Limited info from Center Point, hard to get answers
- How are funding decisions made, people “shut out”
- Need for stabilization for system / providers
- Changing rules, funding, consumer populations, systemic px
- State has poor planning and worse implementation
- Case management
- CABHA
- Competition between LME’s
- Standards change monthly
- Economy
- Inconsistency
- Complications of system
- Decrease funding for services – all areas
- Cut in services and support
- DD reduced hrs., management and most needy not getting what they need
- Reliance on community SYSC that are not there
- Homeless with medical illness that are not allowed in shelters and illness not managed
- Not enough housing for disabled
- Housing with supports
- Employment opportunities for disabled
- Roller coaster with constant changes and lack of stability
- Perception that LME does not partner with community
- Funding
- Raise benchmarks to meet to qualify for services-
- Eliminates consumer and creates gaps
- Excessive regulations
- Unfounded mandates
- Fractured services
- Clients lose
- Budget cuts
- Service cuts
- Lack of funding for uninsured
- Multiple changes
- Confusion of consumers
- Reduction of hours
- Lack of natural support

- Demand for MH Services
- Lack of Primary Care
- Adolescents more likely to homeless, courts falling through cracks
- Stress / burnout/ because of all the above
- Confusion about role of LME
- Communication breakdown
- Lack of information about resource
- Mental Health services and treatment is too fragmented for the consumer
- Politics play too much of a role in providing treatment and funding
- Length of time, patients wait in ER for initial evaluation
- Individuals in custody should not be committed
- Lack of services in rural counties
- Patients often lack transportation to Winston-Salem
- Lack of out patient services for uninsured patient
- Lack of involvement of legislators and county commissioners
- State funding cuts to providers
- State changes policy quickly prior to having set plans in place
- LME system has taken MH back 50 years
- Lack of research to implement what we have learned
- CHBHA
- Accreditation
- Quality of providers
- The many changes in last 3 years through state level- concern what is next
- The quality of care
- CABHA
- Access to care- quality
- More collaboration with other agencies and community resource
- How effective is the LME's to quality care
- Peer support opportunities in the future
- More peer support for DD population
- Rehabilitation versus Habilitation barriers
- System of care approach for MH/SA/DD
- Quality of providers
- Quality of work
- Provider choice for clients with CABHA
- Peer support effective supervision / better training for supervisors
- Primary care
- Integrated services for Medicaid and non-insurance
- Interest in access to universal health care
- Continuity of care in mental health system
- Public and private working together
- Disadvantaged have access and able to navigate services like to see more individual goals

- The consumer needs to assume levels of responsibility for positive outcome, no matter how minor those outcomes may be
- Instead of sending them through revolving door/counseling
- Teaching long term behavior accountabilities vs. short term fix
- Setting longer goals to encourage individual choices
- More of looking into the future to remedy, instead of short term fix
- Teach them to fish instead of giving them fish

### **What has Happened in the last 3 years That Has Inspired, Energized or Excited You?**

- CAP slots this time
- Respite services
- Beyond academics
- 8 LME's working together in a collaboration – fizzled out
- Good to share ideas with different agencies
- Need way to share and learn about each others area
- Mobile Crisis Unit
- Old Vineyard
- State awarded and \$ for rapid re-housing
- 3 ply contract with Center Point, Forsyth and State to set aside beds in local community
- Private provider now has transport services to State hospitals
- Peer support and its expansion
- HOT- homeless applies for treatment / partnership with WFU psychiatry
- Pharmacy program
- Patient Assistance Program with samples and lower cost meds
- New CAP services
- CIT Training for law enforcement
- Old Vineyard 24 hr. psychiatric drop off, so law enforcement doesn't have to stay
- LME has "survived" and is thriving Rockingham joining
- Center Point support of prov / program
- This process Center Point willingness and openness to listening
- Teachers in school system who are caring and competent
- Provider companies that are caring and competent
- Outcome – driven treatment, evidence based services
- Schools like Carter are amazing (although my child is too high functional to go
- Certain teachers are champions for our children
- Rockingham
- Training for area
- Transportation
- Beyond academics
- Systems of care
- Respite for DD kids ) but need Medicare to learn and grow

- Peer support
- CIT
- Growth of Advocacy
- Pulling resources together
- SOC Statewide
- Continued optimism
- New programs- independent living / academics / partnership / collaboration
- Increased collaboration with law enforcement, schools, etc.
- Beyond Academics
- Increased wavier slots
- Respect Mobile Crisis Units for Mental Health
- Wait time for commitments in – patient beds was decreased some
- Dr. Lekwauwa
- Response to CIT training from LE community (WSPD fully supports)
- Community invests in CIT training
- Stokes grant to hire mental health provider to work in primary care providers office
- Clinically – great improvements in brain research
- Good ideas are coming from outside the “system”
- Rebuilt CFAC
- Beyond academics
- Attempts at collaboration ( needs and services )
- LME business plan re-do
- 2 tiers – CAP MR DD
- More ( slightly ) cap slots
- New MH hospital
- CIT TNG – mobile crisis team
- No limits and other social client opportunities
- CIT
- Hospitals remodeled ER’s to be nicer for folks waiting
- Mobile crisis teams
- Criminal Justice program for SA clients coming out of jail
- CPHS sponsoring Peer Support training- graduates actually getting jobs
- “unseen” co-op between CPHS and community (wrap training)
- CFAC 4 groups that meet together
- Pharmacy Assistance plans
- Old Vineyard expansion and possibility of 24 / 7 drop off for consumers accompanied by LEO’s

**What future opportunities do you see regarding innovative clinical care, such as person-centered care; recovery and resiliency services; comprehensive, care/physical health care?**

- CABHA – accountability – full continuum of care –how do we keep personalized care
- Finding clinicians

- Loss of small providers
- Integrated care
- Children's home – co –located at DHP
- NW Council for Community Care
- Stokes Co. grant for LMHP in PCP practice
- Peer supports Specialists
- Focus on Recovery oriented system of care
- Mobile crisis
- DDT
- Smoother transition from adolescent service to adult services
- Better tracking of “no shows”
- Outreach to Hispanic Community
- Educate providers about the nature of the major MI
- Develop drop-in center with recreational opp, fun activities, social interaction
- Opportunities for more collaborations hopeful CABHA's means more person centered
- Medical services behavioral services
- Co-locations in schools
- Wish more training of MD's at MH
- More education, teachers and parents
- Person centered perspective
- Recovery and resilience
- Comprehensive “clinical home” care
- Behavioral health/primary care integration
- More community based services ‘one stop shop’ for homeless, under funded individuals
- More family centered care – for support purposes
- Person centered care
- Clinical home care
- Integrated care
- Primary care
- MO's educated on MH issues
- Co-location efforts /SWK/therapist/ case manager
- Law enforcement training
- Laws about Medical coverage
- Sell – advocacy
- Peer support
- Quality day programs
- Child care while services are being provided
- Collaboration
- Fathering discussion about how to apply non tax approaches
- Applications of personal strength
- Person centeredness
- Recovery comprehensive provider
- Integrated health and primary health
- Interdisciplinary approach without health systems greater community

- Emergence of new degree in REHAB counseling
- Clarifying scope of authority and role of family
- Reproach of assessments tools medical model
- Educate the greater community
- DD advisory – CFAC discussing transportation opportunity to access services
- More understanding of Community Care Network
- Medicaid providers in the catchments area working together for primary care access =medical home provider which brings about more efficiencies and better targeted care
- Beyond academics- post- secondary school for young adults with dependent Medicaid
- Benefits are cut from inmates today. Most are indigent and Medicaid eligible but not allowed to have services
- CABHAs can be one-stop shop
- Reverse co-location mental health providers
- Housing for homeless
- Stop revolving door of people coming in and out of services
- Coordination environment person back after discharge
- Difficulty/cumbersome accessing services
- Web design to link service and help people navigate system
- Increase public awareness of services
- Primary preventions and recognition and skills for family to deal with issue
- Shortage of Board Certified Psych. For children
- Early intervention programs that are evidence based
- Self advocates
- Reduction in clinical homes
- Increase in LME monitoring
- Full continuum of care
- Interpreted care
- Increase in peer specialist
- Bed space
- Integrated care
- PMD's office is working well
- Grant \$25,000.00
- Get rid of automated telephone systems, too confusing
- Early intervention and education to providers and public about resources available
- Future opportunities
- Person centered care
- Recovery services
- Comprehensive, home oriented care
- NW Community Care Network thru violations
- New innovations
- The Dr. Is In program
- Sheriffs and police training
- Role of volunteers
- Consumers and families

- Peer support – get connected ASAP
- Link with under served population
- Trauma informed care
- Pay attention to clinical advancement
- Center for excellence - motivate
- Agencies to be more effective
- What clinical practices are working
- Spreading beyond academics throughout NC
- How to help non-profits give free programs/support systematically- better integrated
- CP reaches out/ consumer voice
- Generous community
- Family support network
- Service at MHA
- Family support network
- Primary care (except not well – versed in rare conditions)
- Build on transition
- Work at WFUBMC
- Spread out-support groups best health
- Parenting program for children
- Special health care needs
- MH specialist in schools more inclusion
- 1-800 for special needs
- Support groups (free)
- PED MH inventory

### **What are potential barriers and ways to overcome them?**

- Are we reducing the pool of appropriate staff by increasing credentials
- Is liking peer support to community a good idea
- Medical directors- when they don't commit to agencies
- We don't look systemically at why programs aren't working
- Funding
- Lack of support for EBPs
- Fluctuating state direction
- STIGMA
- Red tape can cause a set back
- Burden of excessive paperwork for IPRS
- Decision –making needs to be more transparent and more objective
- Have provider to supply services just to Hispanics. Contact Amy Barnhardt with Hispanic League
- Include consumers as teachers (CFAC? – NAMI?) Mental Health first aid?
- \$2 movie
- Bowling
- Cook-out

- Judy Johnson, Gloria Faulkner Volunteers
- Church groups
- Lack of public/private information
- Budgets and cuts challenge to continue to provide services at quality levels
- Parent of twin autistic children, did not realize services available for children who were 12 yrs. old, whose fault is that? The parents? The schools? Obviously there was a breakdown somewhere...
- Way to reach people like “Dear Abbey” designed for both consumer and provider
- Similar to AA sponsor
- Training required – 60 hrs. was 40
- Transition time service
- Develop peer programs
- Special training for police dept. to learn to identify crisis situations mobile crisis units- line up to go for services, 300 trained so far
- Forsyth –w/s police chief committed to train all police force
- New innovations
- The Dr. Is In program
- Sheriffs and police training
- Volunteers as pals
- Clubhouse concept
- Red tape = Barrier overwhelming to patient
- LME’s restricted by HIPA to talk with care providers
- Federal Health Care Reform
- Not enough providers (wait for appointment)
- Process is overwhelming and complicated
- Criteria for services is based on eligibility vs. person care
- Medicare cuts, definition
- UNC system afraid to offer resources to DD students who are a part of Beyond Academics
- Understanding the issue by legislators- Federal-State
- CABA causing private providers to go out of business of stringent criteria
- Evidence based practices but Medicaid is not paying for it appropriately so service is cut or abbreviated on an individual basis
- No incentive for LME to develop monitor evidence based training
- Medical schools not producing enough psychiatrists- other professionals who deal with behavior health
- MO’s that so not understand MH/SA
- Reduce stigma of MH in medical world
- Complicated system
- Transportation
- Not a billable category
- Few people trained to provide
- Lack of MI services or providers in some counties. Need local providers, not providers in LME area, but a distance away
- Time

- Lack of communication
- Not required to track
- Language
- Don't recognize illness, know about services, have transportation. Are illegal and don't want to come to attention of authorities
- No program that we know of
- Money
- Site
- Passionate leader
- Transportation
- Liability
- Family involvement, empowering the patient, best practice
- Lack of funding for support
- Confusion about role of LME vs. providers
- Adult providers not prepared
- Communication
- Barriers between MH systems and primary care
- Privacy care
- Privacy issues
- Laws
- Education of primary care providers
- Middle class people- financial barrier
- Transportation
- Cost

**When planning the next three years for the (MH/DD/SA) service system...  
What's most important for the Strategic Plan?**

- Accompany all the objectives
- Put a true meaning to their partnership, everyone needs to do their share.
- Don't give a certain type of perception
- Inclusion was mentioned for a second time
- Information sharing
- F% "Refresh"
- 4or 5 big things- largest overriding factors-how to address
- ID need- Candidates/limits
- Establish providers
- Address all counties
- Hybrid between 'pie in the sky' and state mandates limited \$
- Consider investments that will have long term returns
- Move away from deficit model (don't wait for failure to initiate services) access continuously for response to intervention
- Earlier access to psychiatry services-address shortage

- Create incentive to move people forward toward independence recovery
- Strengthen social skills education (parenting, schools)
- Keep children in schools
- Listen to diverse needs
- Crises care/emergency services
- State legislators on board-acknowledge mistakes
- Strengthen collaboration- especially large players
- Include school /primary care in systems of care/communications
- Education about resources
- Electronic system needs to facilitate communication
- Efficient, effective management of resources
- Collaboration, parenting
- Social value- respect, dignity, self determination, people first language for all.
- Consistent, dependable authority
- Constant “checking in” about adherence to mission of serving people
- Strategic view of long-range (not just 3 years)
- Consider provider involvement in utilization MGMT.
- How are we getting information to people/consumer and who should manage such information
- Consider a rating system of providers
- Continue to assess management of recourses and identify new recourses
- Collaboration involvement in -industry providers and non-industry partners
- Creative thinking
- Concept of what is a resources beyond exclusively financial resources (E.G.) human resources
- Preserving/defining scope of authority through duration of plan
- How to implement money follows person and self direction
- Blending concepts
- Identify more resources
- More collaboration across the board between providers, churches, other
- Thinking more creatively about how funds are used
- Communication on what’s available
- More info. To Board of Directors to make better decisions
- Monthly newsletter- schools, and radio
- Place in MD offices, TV’s, senior services, etc.
- Involve users in newsletter
- Need more legislators here to participate in process
- More community forums to determine needs on their perceived levels
- Must maximize the resources- look at it from community services not just Center Point
- Do it all, but be realistic ( about available resources)
- Need a strategy- not just about goals and implementation.
- Built in ability to evolve strategic plan/update flexibility accountability, and evaluation
- Integration of health care and behavior care
- What are the non-negotiable? - integrated care, effectiveness wont decrease, number of people served does not decrease, less complicated to navigate by the average person

- Communications of all services available (access to all the info. On one site)
- Seamless integration of services (better empowers individuals/consumers)
- Annual World Cafes to discuss success and evolve strategic plan
- Knowing who the clients are and what they need
- Making sure the clients have family/community support
- Integrated care
- Sense of diversity (child/adults)
- Involve more of Hispanic population
- Look at different access
- Overcome the language barrier
- Case management needed
- Educate people on what services are available
- Get the word out
- Are going to be 1 of 8 wavier participants
- Education
- Lack of psychiatrist-recruitment
- Funding /resources
- Commitment to work with the Community Care Network Program-NC has elected to handle its Medicaid program
- Business world changed- let's keep up!
- Collaborate others for efficient use of \$
- New diagnosis
- Parents most power
- Gaps- not enough service availability
- LME- 800#
- More transportation services for persons with MI
- National policy changes
- Early intervention of child mental health
- Rubber hits the road
- Opportunities for people who could not attend-e.g., evening hours, weekday
- Peer program training
- Training important
- Medical component -\$ - time-few doctors who have been on staff of MH facility available
- QAQI
- LME have more staff
- Return to more state system - ideal state
- More choices for client
- Requirements lacking/ experience component lacking
- Work load management absent
- Some good ones will close
- Some larger less experience will be able to pay doctors, servers, etc
- Too many doing same thing
- To much design at state level (medical) and guidelines have to be met locally
- Get training, but no monitoring---not really qualified

- Effort to use paperwork appropriate/client friendly
- Quality and care
- Opportunities for certification-better ways to do it
- Should expand supportive housing for MH consumers with a continuous person to supervise and support the individuals as trust can be established
- Establish a plan for individuals, with that person, that would follow them thru recovery. Should be an outcome plan
- Reduce “paper work” for providers so there is more time for direct services
- Fully implemented
- Inclusive of all community stakeholders
- Focus on prevention and early intervention
- Access barriers for indigent population
- Peer advocate program
- Peer support specialist awareness –utilization
- Comprehensive wrap-around services including housing
- Every person has a medical home and adequate case mgmt
- Improved coordination between providers
- Electronic data systems (medical record, etc.)
- No wrong door- no barriers- no waiting
- Co location of MH services in schools
- Funding to best practices for prevention of early intervention
- Flexibility
- Accountability
- Collaboration
- Vision as the core
- Non negotiable – integrated care, quality care seamless access treatment
- Collaboration between agencies
- Identify financial resources
- Creativity
- Higher priority on the relationship [between the consumer and provider, who needs to use well trained and happy with their roles. Their needs to be more incentives for professionals
- Follow-up, needs to be a priority in system delivery model
- CABHA’s good idea to help coordinate svcs however concern on the down side of residential svcs for children/adolescents
- CABHA concern for smaller less rich resource areas in the state being able to be supported well
- Good that State has corrected the community support situation; ex: one on one in school \$ was wasted. But now what do we do that CSS is gone what svcs will be in its place?
- Maybe this is a better way to organize the delivery of svcs
- Good that CenterPoint LME is seeking grant; hopefully with those \$ will “beef up” care; particularly with more incorporation of families and changing/supporting environments
- PCP great idea but with some consumers particularly those with DD or TBI, it seems cumbersome and provider; since some of these consumers have “plateaued”
- Co-locating” developing our communities to help PCP and our behavior health agencies work together better communicate; be a source for each other. What about applying for a waiver as a

demonstration project to develop a model with willing participants to develop this concept. Maybe an example would be co-locating a BH EM RM in with a regular E.D. as a place to start

- That info and ideas actually get implemented
- Need advocates
- Feelings today are a smoke screen. Similar event in past and nothing done except 10 pages and no action taken.
- Should have every meeting repeat so providers, ER staff and others can come. Meeting in a.m. does limit great input from other groups
- Dialogue is important- so a survey wont substitute for this café
- Inpatient beds/units
- Each county needs its own services so people can be treated close to home
- Need a continuum of care esp. for children
- Need infrastructure to assure quality and continuum of care
- Early intervention services
- Transparency!! For Center Point leadership and board liability for clinical oversight if consulting by a provider company
- SA/dual dx-huge issue – how to train?

**If effortless, harmonious collaboration and absolute success were guaranteed..**

**What bold steps would you take right now?**

- Give a voice to the disenfranchised
- Direct funding to the people instead of getting caught in administration
- Expanding housing for the homeless
- Hospitals take a more active role with people with MH issues
- Incentives to get psychiatrists to stay
- Community involvement
- Communications – keep lines open along the way
- Listen to what people have to say
- Follow the person
- Provider involvement in decision making
- Require that providers marketing dollars go to reaching out to consumers (not just fancy web sites)
- Determine how to get out quality information to people
- Not to water down quality by unrealistic expectations of CPA staff
- Use CPA's to make it happen
- Consumer involvement
- Standards raised for eligibility
- New Bern drop ins. \$450,000
- Mobile crises unit in Rockingham
- Ongoing assessment needed to move to less restrictive
- More vocal in Raleigh
- Political involvement

- Look at the models that worked
- More pilot programs done
- Have more board meetings that people can speak
- More forums for parents of special needs children
- More programs in school for special needs
- Funding available for transportation
- Housing – community for special needs
- More transparency
- When board meetings, when can ride bus transportation
- Have clear directions and information to providers and training
- LME do community education of services offered
- No favoritism on providers
- Start from scratch with strategic plan
- Get the state to re-evaluate its plans for reorganization. Some don't like going away from local control.
- Include consumers in a meaningful way in planning process
- Develop more wellness, recovery services to keep people out of the hospital
- Install a new CPHS Board with knowledge of good business practices to help reorganize
- Hire 3<sup>rd</sup> party to evaluate business organization
- CPHS management and Board should address changes suggested by recent consultants report
- More MH/DD providers in public schools
- More time between announcement and meeting time. More mtgs. After regular working hours
- LME involved in CABA process
- Expansion early intervention Mental Health Services
- More money for uninsured folks who “fall thru the cracks”
- Transportation assistance/Improved access to care
- Mental Health coordinator in all counties – like Stokes
- LME help manage service for ex offenders into community
- Sharing of resources
- Jobs
- Housing
- Providers to services
- Peer support specialist
- Monitoring of providers to assure quality care
- Less open interpretation of laws or guidelines
- Community M.H. like CABHA
- Projects
- Assistance and transitions for the homeless
- Evidence based practice
- Implementation update
- Supported employment
- Local
- Mental health
- Entity

- Access equality and diversity
- Person centered
- Children's approved residential adolescent substance abuse
- Care- bit of a joke
- 80% get full acceleration
- Community
- Alternatives
- Program
- Part of Medicaid
- Community supports
- Mental health
- Development disabled
- Substance abuse
- Consumer & family advisory committee
- Continued development of peer support
- Natural supports
- Wavier
- CIT development
- Development of EBP's
- Job development
- Increased primary doc MU training and support much like CIT in conjunction with MUA
- Increased use of volunteers in service functions
- Living room
- Housing supports
- Having materials already on hand to keep transitions more pliable and smoother. Windows of time are always or seem short
- Clients should have the loudest voice and their wishes being carried out without restrictions- then helping others understand these wishes
- Coming in as equal partners when providers/agencies must merge. Accreditations, endorsements-make it almost certain that endorsed/accredited agencies take over other agencies
- Move training by LME>comprehensive> to SVS providers instead of providers going all over the state. Expanding those training to stake holder agencies like DDS, Health dept, aging SVS providers
- Higher intensity; more comprehensive monitoring of input, output and residential providers in communities. (un-announced)
- What LME can control versus what they cant control
- Instituting a penalty when non-compliant with regularities/requirements
- Fewer high qualified providers
- More communications; care coordination
- SA input- got to have a better plan- recovery homes; coordination of MH SVS
- Transitional housing for mentally ill
- Authorize care based on need
- Mental health court-get mc!!!

- Single pay
- Make PCP changes really get people to come together as a team
- Health available to all
- Move from 100% fee for service to more grants
- Direct people from jail-fund med programs
- Bring state psych hospital \$ to LME's to manage
- TBI wavier- wavier all the way-all disabilities
- Stability
- Grow and expand natural supports
- Psych units in every county-enough hospital beds
- CABHAs as a few comprehensive service provides and fewer LME's
- CABHA in every county
- Accessible transportation
- Allow Medicaid to pay for independent psychiatric unit services like OV National policy changes
- Person centered comprehensive clinical
- Behavior health
- Medical care (integrated) for the indigent
- Housing creative thinking
- Prevention on reducing risk factors, building personal resiliency
- Drop in center ( cross-disability
- Better ability of the average person to access the system
- Better website that allows people to access other organizations
- Creation of a community plan that reaches above and beyond the CPHS plan
- Prevention
- Protective environment
- Early intervention
- Resources on front end
- Drop in 24/7
- Never lose sight of the vision and the passion. MLK said "I have a dream" he never said "I have a strategic plan"
- Integrated care
- Wait list – addressing it
- Accessible website
- If you could envision a whole new society-what world would you create, if you did not know what your place would be in it.
- Use forums like this to help identify and implement strategic plan. Training, esp. on evidence-based services for professionals.
- Need relationship with hospitals/input facilities
- Real working CABA one stop shop (many in the community)
- Join with medical community so that medical help would be available for indigent
- Build into system appropriate after care and support services
- Reduce risk factors- build protective environments for all children
- Share data – secure – private

- Drop in center that can deal with cross disabilities (like in New Bern) peer support. Managed by consumers
- Integration of health and physical
- Make it easy for LME to manage Medicaid dollars in form of a wavier

**Miscellaneous Comments (Didn't know to which question they were attached or they were additional comments)**

- What is the plan for Center Point when merging occurs?
- This mess is confusing! You need a handbook that breaks it all down and has education about all upcoming changes, big words and what they mean and names and phone numbers to contact
- How do we ensure quality-person centered service delivery inside of the CABHA
- Central Resource cleaning house- Resource officer
- Wavier?
- Less paperwork
- More accountability on local level
- SA-prevention-cost effective
- Local community support for runaway
- Early intervention
- Supported housing for chronically homeless
- Hot project at Samaritan Ministries
- "Revolving door" patient with severe MI, SA and other disabilities
- Access service
- Awareness of service
- Mental Health is too fragmented
- Educate more providers
- Baby boomer pop.
- Home centered care
- Dementia care by families at home
- More support staff from home health – respite care
- Mental health care for everyone (single payer- LME)
- Directory of local supports, natural supports so family member providers can access and secure needed services
- LFS – G-H –TB1 population Clemmons, Winston Salem
- Community plan resources outside of our fields
- Peer support
- Use the PCP template as tool to develop the 3yr. strategic plan
- DD population interest can not get lost
- Educating the community
- Challenge myths about an illness
- Too illness focused

- Remove the need for testing
- What does support look like?
- Supportive housing- for chronically homeless-mentally ill
- What is personal recovery?
- Some work must be done by individual, not just to them
- Improved access to disability income (soar model)
- Representative payees
- More support for evidence based clinical programs
- Improved discharged protocols from hospitals/jails/shelters
- Decrease barriers
- Improve website access
- Need to ensure consistency of care
- Clinical one-stop shop centered located
- Increase preventive care
- Increase access to family/support system
- Need more child psychiatrist
- Need more early intervention programs
- Community based services combing housing and services
- We will come to you services- not you come to us
- Need person centered services
- Support hot project
- Need more permanent supportive housing options
- Need more street based treatment access for homeless; indigent population
- Revolving door for consumers –Where is provider accountability?
- Historical fragmentation
- Evolution
- Changes in leadership, Census composition, and Scope of Accountability
- Communication is key
- Who monitors authority?
- Future opportunities
- Role of community members, LME, and providers (linking all) and supporting roles and representatives
- Person centered care
- Recovery and Resiliency service
- Comp “clinical home” oriented care
- Integrated behavior and primary care/physical care and health care
- Transportation issue
- Economy
- Improve assessment tools used to diagnose
- Early intervention is the key-diagnosis in hospital and at pediatrician
- Cleaning house
- Focus on getting people on line not automated system
- Transportation
- Medical coverage

- Peer support
- Means instead of ends
- Treatment vs. recovery
- No real control
- Good point of day to talk across from each other
- Bad- negative
- Loss of \$ to MH/DD/SA
- Loss of LME input
- Inadequate input of people
- New leadership in Raleigh
- General assembly wakeup
- Future opportunities related to innovative clinical care
- Enhanced coordination of services
- Cross-agency communication
- Personal decision made at higher levels that are based on personalities not issues
- Better use of natural supports
- Centers of excellence
- Better re-entry from prison and jails
- CM consolidation; what is that going to look like?
- Concern about it just being only 10 agencies
- How will these relations be formed and nurtured?
- Concern about agencies hanging on to clients when there may be a better SVS else where with other providers
- Specialized training for those professionals for this type of svcs
- Should we see how this works first with CABHA's
- How will this impact specialty providers who have a specific "niche?"
- Maybe take away some state power/oversight and let LME's develop their communities as needed?
- Medical Wavier- future impact
- Medical directors (psychiatrists) concern over signing off other professionals whether licensed or unlicensed service activities
- What happens to the consumer through this process? How much information are they getting, understanding and able to utilize
- Transportation! Where is it and how do you get it?
- Where's \$ for more rehabilitation?
- Where do you start as a new family in town? (For families needing services)
- Concerns about clients who will leave their services when providers close down because of CABHA's definition
- Housing for families with special needs? LME would have a bigger staff to monitor and train providers adequately
- Loss of good personnel
- Loss of dollars
- Lack of limited funding and services for non-medical eligible consumers
- Housing

- Loss of LME input into division decisions
- Inadequate input from people (addressed by World Café process today)
- Inadequate monitoring of contracts
- New governor with interest in MH services
- New DHHS secretary appointed by new governor
- Trained police/sheriff personnel
- Law enforcement- FC
- Great progress-2 MH caseworkers in jail-gender specific services
- Need more diversion, decrease re-arrest?