FORSYTH COUNTY
BOARD OF COMMISSIONERS

MEETING DATE: OCTOBER 14, 2013 **AGENDA ITEM NUMBER:** 6

SUBJECT: **RESOLUTION APPROVING THE LOCAL BUSINESS PLAN OF CENTERPOINT HUMAN SERVICES, THE MANAGED CARE ORGANIZATION FOR FORSYTH, DAVIE, STOKES, AND ROCKINGHAM COUNTIES, FOR SUBMISSION TO THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

COUNTY MANAGER'S RECOMMENDATION OR COMMENTS: Recommend Approval

SUMMARY OF INFORMATION:

See attached

ATTACHMENTS: [X] YES [ ] NO

SIGNATURE: J. Dudley Watts Jr. /dh
COUNTY MANAGER

DATE: October 9, 2013

RESOLUTION APPROVING THE LOCAL BUSINESS PLAN OF CENTERPOINT HUMAN SERVICES, THE MANAGED CARE ORGANIZATION FOR FORSYTH, DAVIE, STOKES, AND ROCKINGHAM COUNTIES, FOR SUBMISSION TO THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

WHEREAS, CenterPoint Human Services, the managed care organization for the Counties of Forsyth, Davie, Stokes, and Rockingham has developed and submitted for approval by the board of county commissioners of each participating county the business plan required under the provisions of N.C.G.S. 122C-115.2; and

WHEREAS, CenterPoint Human Services, as the managed care organization, is required to submit an approved business plan to the Secretary of the Department of Health and Human Services for its approval and certification; and

WHEREAS, the Forsyth County Board of Commissioners has reviewed the business plan as developed and submitted by CenterPoint Human Services entitled, "Local Business Plan FY 2014-2016" for assuring that accessible, quality and accountable care is available for those with mental health, intellectual and developmental disabilities and substance abuse challenges; and

WHEREAS, the said business plan includes the detailed information on how the managed care organization will meet State standards, laws, and rules for ensuring quality mental health, developmental disabilities, and substance abuse services, including outcome measures for evaluating program effectiveness as required by applicable law.

NOW, THEREFORE, BE IT RESOLVED that the Forsyth County Board of Commissioners, pursuant to the provisions of N.C.G.S. 122C-115.2, hereby approves the above-described Local Business Plan FY 2014-2016, which is incorporated herein by reference, as prepared by CenterPoint Human Services (the managed care organization, area authority and local management entity for Forsyth, Davie, Stokes, and Rockingham Counties) and approved by its Board of Directors on April 25, 2013, for submission to the Secretary of the Department of Health and Human Services for approval and certification as provided by law.

Adopted this 14th day of October 2013.

CenterPoint Human Services

URAC ACCREDITED

Quality Improvement Organization (QIO)-Like Entity certified by the Centers for Medicare and Medicaid Services

LOCAL BUSINESS PLAN
FY 2014 – 2016

MISSION

CenterPoint Human Services is a managed care organization responsible for assuring that accessible, quality and accountable care is available for those with mental health, intellectual and developmental disabilities and substance abuse challenges.

*Goals apply to all clients regardless of funding source; however, state-funded services may be subject to funding constraints.

GOAL 1

To support the State's Initiative of *Transition to Community Living*

Develop the infrastructure within CenterPoint and the community to provide community-based housing alternatives.

A. Finalize housing placement for eligible individuals identified under the *Transition to Community Living* Initiative (Department of Justice [DOJ] Settlement), meeting State benchmark of providing housing for 3 individuals per month in each of the three fiscal years.

B. Care Coordination staff (including care coordinators, transition planners and certified peer support specialists) will work together to perform in-reach and/or transition functions to clients defined in the DOJ Settlement. Clinical and non-clinical staff will work together to assure that clients fully understand their options and the supports (e.g. treatment services) that will be available to assist them during transition and afterwards.

GOAL 2

To support the State's Initiative for *Assertive Community Treatment Team/Supported Employment*
Develop and/or enhance community-based wrap-around supports including
Assertive Community Treatment Teams and Supported Employment with fidelity to evidence-based models.

A. Following the State's onsite analysis beginning July 2013 of Assertive Community Treatment Team (ACTT) provider fidelity to the Tool for Measurement of Assertive Community Treatment (TMACT) standards, analyze the capacity of qualified ACTT providers to serve individuals in or at risk of adult care home placement; identify and contract only with ACTT providers operating with fidelity to TMACT standards.

B. Following State training on Supported Employment/Long-Term Vocational Support (SE) models and establishment of service definition, identify and establish contract(s) with provider(s) to deliver SE in all four counties; analyze network adequacy and capacity of qualified SE providers to serve individuals in or at risk of adult care home placement; add additional provider(s) based on identified capacity needs and available funding.

C. Care Coordination staff, as well as Utilization Management (UM) staff in their role as Care Manager, will work with clients and providers to assure that clients identified as part of the DOJ settlement are connected to the most appropriate wrap-around supports to build a successful plan for transition into more integrated housing. UM staff will also complete focused post-payment reviews on randomly selected cases to assure services are being provided appropriately, e.g. according to evidence-based models, and that level of support is meeting the client's needs.

GOAL 3

To support the State's Initiative for addressing *Crisis Services/Emergency Department Wait Times*
Align programs to emphasize importance of recovery, self-determination and least restrictive level of care.

A. With support of community stakeholders, plan a Facility-Based Crisis Center with 24 hour assessment capability.

B. Customer Services staff will be trained in and will implement an evidence-based triage tool to assess lethality and/or potential harm to self on all calls to the Customer Services line from individuals requesting services/assistance. This tool will better prepare the staff to detect subtle cues that indicate possible lethality or potential harm to self, leading to more appropriate interventions/referrals.

C. Care Coordination staff will improve integration of behavioral and physical health care through tracking increases in primary care data for individuals identified as having "high cost/high risk" needs and "special health care needs" to support efforts to reduce inappropriate use of crisis services.

D. Improve client engagement in the treatment process, thereby improving appointment compliance (initial, follow-up and post-hospitalization) and decreasing the use of crisis services as well as decreasing readmission rates to hospitals and other treatment facilities. In addition to benefitting clients, process also benefits providers by preventing lost revenue due to no-shows and decreasing inappropriate use/overuse of crisis services.

GOAL 4
To support the State's Initiative *Closer to Home*
Through encouraging the appropriate use of residential treatment services for children.

A. Implement a comprehensive "system of care" that includes a thorough comprehensive clinical assessment, reviews by Child & Family Teams, Person-Centered Plan development, involvement with Care Coordination staff and rigorous review of authorization requests by Utilization Management so that only medically necessary placements occur, with a strong preference for local options.

B. Enhance local options for diversion from Psychiatric Residential Treatment Facilities (PRTF) and step-down from more intensive services.

C. Admission and continued stay decisions on children/adolescents in PRTF consistently based on medical necessity criteria resulting, by end of year 3, in a 5% reduction in PRTF admissions and 20% reduction in out-of-state PRTF placements, as well as a 5% reduction in average length of stay (baselines to be set based on usage during calendar years 2011 and 2012).

GOAL 5
To support the State's Initiative *Intellectual/Development Disabilities (I/DD) Waitlist*
Supporting the needs of individuals waiting for Innovations services.

A. CenterPoint will increase the number of individuals with intellectual/developmental disabilities (I/DD) served by enrolling currently unserved or under-served individuals in B3 services, state-funded services and Innovations services.

GOAL 6
For the Local Initiative *Planning for the Future*
Strengthen CenterPoint's viability in the evolving health care system to assure that publicly managed, accessible, quality and accountable care continues to be available.

A. Prepare for a successful expansion capacity assessment, a pre-condition for assuming management of a non-certified Local Management Entity/Managed Care Organization (LME/MCO).

B. Enhance positive outcomes through quality services by actively participating in the statewide provider/MCO collaborative effort to implement a streamlined, sustainable system infrastructure.

C. Position CenterPoint to emerge as an industry leader of publicly managed behavioral health care through regional and/or state alliances following analysis and evaluation of all available business models.

GOAL 7
For the Local Initiative *Finance*
Assure financial stability of the LME/MCO.

A. Achieve defined financial indicators and benchmarks including, but not limited to, those specified in:
- The "Contract Between the NC Department of Health and Human Services Division of Medical Assistance and CenterPoint".
- The "Contract Between the NC Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services and CenterPoint".
- All relevant legislation, including Session Law 2013-85.

GOAL 8

For the Local Initiative *Performance-Based Contracts*

Ready the provider network for performance-based contracts with incentives based on client outcomes focused on quality and recovery.

A. Establish client outcomes for Intensive In-home and Day Treatment services that are focused on quality and recovery, e.g. length of stay in service, movement to another level of service, use of crisis services. Establish benchmarks for all providers of these services.

B. Establish client outcomes for ACTT and Community Support Team providers that are focused on quality and recovery, e.g. adult hospital readmission rates and the average length of stay in each specific service. Establish benchmarks for all providers of these services.

C. Support provider network focus on recovery and client outcomes through expansion of Peer Support capacity by increasing numbers of trained, certified Peer Support Specialists (PSS) in the catchment area; increasing numbers of employed PSS; training and supporting providers in employment and supervision of PSS.

D. Provide training and consultation via contracted vendor for enhanced sustainability and quality outcomes for LME/MCO and provider network.

GOAL 9

For the Local Initiative *User-Friendly Systems*

Maximize system-wide standardization and enhanced Management Information System capabilities.

A. Maintain the Management Information System (MIS) infrastructure, assuring the reliability and security of electronic resources.

B. Redesign the system testing process and link to user training to encourage the utilization of varied instructional strategies and assessment techniques which will address the needs of all learners.

C. Support the evolution of a standards based user-friendly system while maintaining simple user interface, secure and scalable technology solutions aligned with clinical workflows to support LMLE/MCO activity, with AlphaCM and North Carolina LME/MCOs.

GOAL 10
For the Local Initiative *Rural Service Enhancement*
Implement service enhancements designed to improve service quality, access and provider choice in rural communities.

A. Implement service enhancements in Rockingham County that improve mental health and substance abuse service access, quality and provider choice as specified in a county-specific work plan developed with extensive local input and including outcomes, tasks, responsible parties, and timelines.

GOAL 11
For the Local Initiative *Enhancing Lives*
Focus the I/DD service system on delivering meaningful day activities and least restrictive residential settings.

A. Transition at least 5% of total census of individuals with I/DD needs residing in Intermediate Care Facilities (ICF-I/DD) to community-based Innovations services over the next three years; in year one, implement transition plans for a minimum of 5 individuals living in ICF-I/DD facilities.

B. Honoring self-determination and choice, transition individuals currently served in sheltered workshops by end of Fiscal Year 16 to evidence-based Supported Employment (community-based or competitive employment) or other appropriate services. All clients transitioned by end of year 3.

C. By assuring timely medical care and by moving clients to the least restrictive residential setting, reduce overall service costs for I/DD clients who currently reside in an ICF-I/DD facility while maintaining clinically appropriate services.

GOAL 12
For the Local Initiative *Housing*
Develop infrastructure within CenterPoint and the community to provide community-based housing alternatives.

A. Using the expanded range of housing options ("Housing First", Housing Authority of Winston Salem Initiative), provide linkage and/or appropriate housing for 15 clients by 4/30/14. Goals for subsequent years are to be determined by April, 30, 2014.