

HPR-5 PARTNERSHIP  
STRATEGIC PLAN  
AND  
RECOMMENDATIONS FOR STATE-  
LEVEL ACTIONS

May 2005

## TABLE OF CONTENTS

<b>Executive Summary</b>	<b>3</b>
<b>Introduction</b>	<b>5</b>
<b>HPR-5 Regional Partnership Mission, Values and Strategic Direction</b>	<b>6</b>
<b>Overview of HPR-5 Partnership Strategic Plan</b>	<b>8</b>
<b>Summary of HRP-5 Strategic Assessment</b>	<b>10</b>
<b>Constituent and Consumer Expectations</b>	<b>10</b>
<b>SWOT Analyses</b>	<b>18</b>
<b>Strategic Issues, Goals, Action Steps</b>	<b>22</b>
<b>HRP-5 Partnership Recommendations for State-level Actions</b>	<b>27</b>
<b>Region’s Assessment for Readiness for and Viability of Restructuring State Facilities and Community Services</b>	<b>31</b>
<b>Conclusion</b>	<b>32</b>
<b>Appendix</b>	<b>33</b>
<b>Oversight Committee Organizational Chart</b>	
<b>Data Sources</b>	
<b>Survey Instrument</b>	
<b>Questionnaire Responses</b>	
<b>Aggregate SWOT Data</b>	

## **HPR-5 STRATEGIC PLAN AND RECOMMENDATIONS FOR STATE-LEVEL ACTIONS**

### **EXECUTIVE SUMMARY**

The HPR-5 Partnership is comprised of nine Community Service Boards and two State facilities, which provide mental health, mental retardation and substance abuse services throughout the region. The Partnership represents the cities of Chesapeake, Franklin, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, Virginia Beach and Williamsburg and the counties of Accomack, Essex, Gloucester, Isle of Wight, James City, King and Queen, King William, Lancaster, Matthews, Middlesex, Northampton, Northumberland, Poquoson, Richmond, Southampton, Westmoreland and York. In July 2004, the Partnership undertook a strategic planning effort to address major issues facing the region and to develop recommendations for state-level actions. The project included data collection from questionnaires sent to consumers, advocates, Community Services Board (CSB) and facilities staff, and providers. Data was also collected from consumers, families, advocates and providers through focus groups, site visits and individual interviews.

A Coordinators Group was appointed with representatives from all HPR-5 Partnership CSBs to form a planning committee. The group conducted SWOT analyses, assessing internal strengths and identifying environmental conditions. As a result of these exercises, the group identified six strategic issues:

- Community Based Services
- Collaboration
- Funding
- Quality of Care
- Human Resources
- Rural Issues

The goals that the group developed in support of these issues were reviewed, modified and adopted by the CSB Executive Directors.

The Executive Directors and other members of the Partnership participated in a number of facilitated discussions to identify issues requiring state-level action on the part of the Department of Mental Health, Mental Retardation and Substance Abuse Services. Five themes emerged from these discussions:

- Administrative Requirements
- Department's Structure and Role as Partner
- Resource Development
- Leadership
- Communication

The Executive Directors then developed specific recommendations in response to these issues.

Finally, the members of the HPR-5 Partnership discussed the region's readiness for and potential viability of significant restructuring of state facility and community services within the region. While the Partnership fully supports the policy and practice redirection to community based services, it noted a number of concerns that have yet to be fully addressed. These include the need to continue to build community based capacity, the continued investment and reinvestment of funding to support community based programming, the necessity of inclusive decision-making, and the clear definition of the Department's roles and responsibilities.

The HPR-5 strategic plan reflects the Partnership's belief in self-determination, empowerment and resiliency. The plan provides a tool for the region to continue to serve consumers and their families through a model based on the principles of recovery, while ensuring access, quality and accountability.

## INTRODUCTION

The HPR-5 Partnership is comprised of the nine Community Services Boards (CSB) in eastern Virginia – Chesapeake, Colonial, Eastern Shore, Hampton-Newport News, Middle Peninsula-Northern Neck, Norfolk, Portsmouth, Western Tidewater and Virginia Beach – and the leadership of Eastern State Hospital and the Southeastern Virginia Training Center. The region represents a diversity of demographics, in addition to being geographically dispersed. Service delivery in the HPR-5 catchment area is challenged by a number of unique factors: the relative isolation of the Eastern Shore, separated from resources by distance and a bridge-tunnel with an expensive toll; the lack of Medicaid inpatient psychiatric facilities; the rapid growth of suburban areas and the fiscal stress of core cities.

In 2004, the HPR-5 Partnership undertook a strategic planning process to begin to examine the issues, challenges and direction of the region. While many localities had completed Board-specific strategic plans, this effort was an opportunity to assess the region's response to a shift – in policy and practice – from the reliance on State facilities to the development and utilization of community based services. The regional strategic planning process began to measure the region's progress in adapting further to a philosophy grounded in recovery and empowerment, and in implementing a service delivery model based on those principles.

### **Acknowledgments:**

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## HPR-5 REGIONAL PARTNERSHIP MISSION, VALUES AND STRATEGIC DIRECTION

The HPR-5 Partnership adopted a number of **principles** as it entered the reinvestment project:

- The behavioral health system is consumer centered and focused on the needs of consumers and their families.
- Services will be tailored to consumers' needs with a view towards improved quality of life.
- Consumer and family choice and access to services will be enhanced.
- Clinical services will be integrated and coordinated so that consumers will move easily from one part of the system to the other.
- Services will be evidence based and grounded in best practice.
- Implementation of reinvestment initiatives and services will proceed deliberately and thoughtfully to ensure performance outcomes are being achieved, to allow for modifications in design at every phase of implementation.
- The system will be committed to the retention, redeployment, training and development of services system staff who are affected by the Reinvestment Initiative.
- There will be continued investments/reinvestments in quality mental health services to support community tenure and increase the overall capacity of the system.

**Goals** for reinvestment were developed to provide direction to the Partnership as reinvestment initiatives were implemented. These affirm that core mental health services and supports:

- are provided within a comprehensive continuum of services designed to meet consumer and family needs and based on best practices;
- are well integrated with the broader continuum of care provided by health and social services;
- are organized and coordinated based on a "levels of need" structure to ensure that consumers have access to services that best meet their needs;
- are appropriately linked to other services and supports within the geographic area;
- facilitate a shared service approach to meeting the needs of consumers with serious mental illness who have co-occurring disorders and multiple service needs;
- achieve a clear system/service responsibility through the development of standardized operational goals and performance indicators; and,
- are simplified and readily accessible, according to the needs of consumers and their families.

Because the Partnership recognized the potential impact of the Reinvestment Initiative on acute care service delivery, it developed and adopted the following specific **guiding principles for acute care**:

- The intended population served will be Seriously Mental Ill (SMI) adults with acute inpatient needs.
- There will be development of a community based system of care that promotes family involvement, consumer choice and recovery.
- There will be provision of quality acute care that is integrated with a comprehensive array of community based services that support community tenure.

## OVERVIEW OF HPR-5 PARTNERSHIP STRATEGIC PLAN

### HPR-5 (Reinvestment) Accomplishments

The HPR-5 Executive Directors meet twice each month to stay apprised of the reinvestment project, analyze critical success factors and review other issues with regional impact. The reinvestment project hired a director in December 2003 and instituted an Oversight Committee for project operational oversight. From July 2004 through February 2005, the number of admissions to psychiatric hospitals decreased from an average of 20.4 per month to 14.5 per month, while the average Length of Stay (LOS) has remained relatively constant at 5.82 days. Utilization management training was conducted with hospital doctors, nursing directors, case managers, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Utilization Management Director, the DMHMRSAS Medical Director and DMHMRSAS Pharmacist to improve communication and discharge planning. Other utilization management tools, such as a regional report card and concurrent record reviews, were adopted to focus attention on reinvestment progress. The Oversight Committee has recently restructured itself to assume more responsibility and to continue to nurture the success of the continuum. (See Organizational Chart in Appendix.) Individual local Boards are implementing programs, with regional access, to provide alternatives to inpatient care. For example, the Middle Peninsula-Northern Neck CSB is developing a Recovery House for crisis intervention and stability services, Hampton-Newport News is implementing a 23-hour "urgent care" program and Virginia Beach is pursuing a detox center to replace temporary detention orders (TDOs) when appropriate for some consumers. In summary, the key accomplishments have been the reduction of dependence upon Eastern State Hospital and a more seamless approach to service delivery throughout the region as a result of closer coordination among local Boards and their Executive Directors.

## **The HPR-5 Partnership Strategic Planning Process**

In the summer of 2004, the Partnership began the process of data collection by surveying consumers, families, Community Services Board staff, facilities staff, advocates and providers in the region. (See Appendix.) The surveying was augmented by site visits, focus groups and interviews with consumers, families and other stakeholders. Additional surveys were distributed to consumers at clubhouses and special events. The data was compiled, analyzed and presented to the HPR-5 Partnership. The Executive Directors of the region's CSBs then appointed a coordinator from each Board to serve on a planning group to conduct an internal assessment and environmental scan, and to develop strategic goals from the information that emerged from the data. The Executive Directors and State facility Directors conducted their own SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis in validation of the assessments and draft goals from the coordinators. The goals were distributed through the local CSBs for review and comment, modified and approved by the Partnership. The Executive Directors, with the leaders of the region's State facilities, developed recommendations for State-level action to complete the strategic planning process. The final draft of the plan was published through local Board websites to solicit public comment. Input was reviewed, the plan was modified as appropriate, and approved for adoption by the Partnership.

## **SUMMARY OF HPR-5's STRATEGIC ASSESSMENT**

### **Constituent and Consumer Expectations**

Information from consumers and families was gathered through surveys, focus groups, site visits and individual interviews. Consumers and families were asked:

1. What works well in the current system?
2. What is not working well?
3. What do you need that is not available?
4. What do you think people in the system will need five years from now?

Their responses are summarized as follows:

#### **What Works Well in the Current System?**

- Staff meets consumers' needs
- The clubhouse offers structure, socialization and a safe place to be
- Mental health programs
- Clinics, doctors and nurses
- Lunch and outings

#### **What is Not Working Well?**

- Non-compliant clubhouse members
- Everything works well
- Case managers not available/caseloads too large
- Housing
- Need more activities at clubhouses

#### **What Do You Need That is Not Available?**

- Nothing
- Jobs/employment services
- Housing
- Dental care
- Transportation

#### **What Do You Think People in the System Will Need Five Years from Now?**

- Housing/supportive living
- Jobs (without loss of benefits)/employment services
- More services/more help
- Help with SSI/more SSI benefits

- Education (GED) programs

A number of consumers and family members spoke to the difficulty of accessing acute care and of the criminalization of mentally ill individuals. As one family member said, “It’s easier to get my daughter into jail, than into a hospital.”

**CSB, Facilities, Provider and Advocate Input**

The representatives of regional Community Service Boards, facilities, providers and advocates were surveyed via survey instruments, focus groups and interviews. The respondents were asked to identify:

- five key issues
- service gaps in adult mental health services, child and adolescent services, mental retardation services, substance abuse services and in services to other populations
- entities with which coordination could be improved
- issues related to quality of care
- structural options
- recommendations concerning Eastern State Hospital and Southeastern Virginia State Training Center

The responses from Community Services Board staff, facilities staff, providers and advocates are summarized below:

**FIVE KEY ISSUES**

Community Service Board Staff	<ol style="list-style-type: none"> <li>1. Lack of affordable housing</li> <li>2. Funding</li> <li>3. Acute care and long-term bed shortage</li> <li>4. Lack of qualified staff/need for more staff</li> <li>5. (tie) Development of community based resources</li> </ol> <p>Lack of public transportation Need for more waiver slots</p>
Facility Staff	<ol style="list-style-type: none"> <li>1. Housing</li> <li>2. (tie) Quality of care in short term treatment facilities</li> </ol> <p>Assistance for homeless consumers Lack of transportation Difficulty in stabilizing patients Need for community based supports</p>
Providers/Advocates	<ol style="list-style-type: none"> <li>1. Funding</li> <li>2. Difficulty in coordinating services and referrals among providers</li> <li>3. Need for more staff (including daily support workers)</li> </ol>

	4. Need for more staff training and support 5. Lack of bed availability
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***It should be noted that, as the strategic planning process continued, another key issue emerged from CSB staff and leadership as a priority:***

***Duplicative paperwork requirements and other ineffectual administrative burdens***

Responses related to gaps in services, coordination issues and recommendations about structural options are summarized below:

**SERVICE GAPS**

	<b>Adult Mental Health Services</b>	<b>Child and Adolescent Services</b>	<b>Mental Retardation Services</b>	<b>Substance Abuse Services</b>	<b>Other Special Populations</b>
<b>CSB Staff</b>	<ul style="list-style-type: none"> <li>• Residential care facilities</li> <li>• Housing</li> <li>• Intensive community based resources</li> <li>• Geriatric psychiatric services</li> </ul>	<ul style="list-style-type: none"> <li>• Limited funding for C&amp;A services</li> <li>• Limited funding for non-Medicaid outpatient services</li> <li>• C&amp;A psychiatric services</li> <li>• More in-home intensive services</li> <li>• Parental education</li> <li>• Limited residential facilities</li> <li>• Inpatient beds</li> </ul>	<ul style="list-style-type: none"> <li>• More waiver slots</li> <li>• More housing and residential services</li> <li>• Better communication between C&amp;A and adult MR systems</li> </ul>	<ul style="list-style-type: none"> <li>• Housing and residential services</li> <li>• Increased funding</li> <li>• Increased Medicaid reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• Need for specialized interventions and treatment approaches for consumers with co-occurring disorders</li> <li>• Need for more services for the incarcerated population</li> <li>• Services for the HIV/Hepatitis C population</li> </ul>
<b>Facilities staff</b>	<ul style="list-style-type: none"> <li>• Services to indigent consumers</li> <li>• Dental care</li> <li>• Podiatry care</li> <li>• Vision care</li> <li>• Eyeglasses</li> </ul>	None identified	None identified	None identified	None identified

<b>Providers/ Advocates</b>	<ul style="list-style-type: none"> <li>• Access to services (funding and insurance)</li> <li>• Psychosocial services</li> <li>• Outpatient services</li> <li>• Residential placements</li> <li>• Job placement/ Vocational services</li> <li>• Housing</li> <li>• Bed availability</li> <li>• Family involvement</li> <li>• 24/7 support</li> </ul>	<ul style="list-style-type: none"> <li>• Access to treatment</li> <li>• Funding</li> <li>• In-home programs</li> <li>• Respite</li> <li>• Domestic violence intervention/ Counseling</li> <li>• Divorce/ Parental separation counseling</li> <li>• Family involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Vocational programs</li> <li>• Services to aging consumers</li> <li>• Housing</li> <li>• Funding</li> <li>• Need for more waiver slots</li> <li>• Children's services</li> <li>• More providers</li> <li>• Training re: the difference between MR and MH</li> <li>• 24/7 support</li> </ul>	<ul style="list-style-type: none"> <li>• Funding/ Medicaid reimbursement</li> <li>• Inpatient care in the community</li> <li>• Relapse prevention</li> <li>• Access to services</li> <li>• Inadequate detox funding</li> </ul>	<ul style="list-style-type: none"> <li>• Programming and staff to support dually diagnosed consumers</li> <li>• Programs for the physically handicapped</li> <li>• Day programs for the dually diagnosed</li> <li>• Housing for dually diagnosed</li> <li>• Crisis stabilization</li> <li>• Programming for pregnant teens</li> <li>• Programs for female offenders</li> <li>• Programs for non-English speaking offenders</li> <li>• Domestic violence</li> </ul>
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### OTHER ISSUES

	<b>Better Coordination with:</b>	<b>Quality of Care Improvements</b>	<b>Structural Options</b>
<b>CSB Staff</b>	<ul style="list-style-type: none"> <li>• Medical providers and institutions</li> <li>• Departments of Social Services</li> <li>• Public schools</li> <li>• Department of Rehabilitative Services</li> </ul>	<ul style="list-style-type: none"> <li>• Funding to develop services to currently unfounded consumers</li> <li>• Develop state-wide quality assurance and workload measures</li> <li>• Develop region-wide model to identify and address needs of consumers with co-occurring disorders</li> <li>• Increase access to mental health support services</li> </ul>	<ul style="list-style-type: none"> <li>• More public/private partnerships</li> <li>• Prevention programs in schools, courts, etc.</li> <li>• More collaboration between CSBs and state facilities</li> <li>• MH/MR unit at SEVTC</li> <li>• Create facility for non-violent TDOs</li> <li>• Establish intermediate care facilities</li> <li>• Develop regional PACT network</li> <li>• Alignment with DSS for case management</li> <li>• Alignment with DPH for physical health care</li> </ul>
<b>Facilities Staff</b>	<ul style="list-style-type: none"> <li>• Area agency on aging</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive and transitional employment</li> <li>• More family involvement</li> <li>• More activities at community level</li> </ul>	No recommendations
<b>Providers/ Advocates</b>	<ul style="list-style-type: none"> <li>• Public schools</li> <li>• Departments of Social Services (DSS)</li> <li>• Health facilities</li> <li>• CSBs</li> </ul>	<ul style="list-style-type: none"> <li>• Increase funding</li> <li>• More interagency cooperation</li> <li>• More staff</li> <li>• Paperwork reduction</li> <li>• Increase staff salaries</li> </ul>	<ul style="list-style-type: none"> <li>• Use videoconferencing to involve families</li> <li>• Increase vocational opportunities</li> <li>• More access to recreational activities</li> <li>• Build volunteer capacity</li> <li>• Additional training for judges, police, probation and parole officers</li> <li>• Eliminate jails as MH facilities</li> </ul>

Finally, respondents were asked for their recommendations about the future utilization of the two state facilities in the region – Eastern State Hospital and the Southeastern Virginia Training Center. Their input is summarized as follows:

**RECOMMENDATIONS – STATE FACILITIES**

	<b>Eastern State Hospital</b>	<b>Southeastern Virginia Training Center</b>
<b>CSB staff</b>	<ul style="list-style-type: none"> <li>• Build local capacity to manage all hospital placements</li> <li>• Assure bed capacity first</li> <li>• Invest to build community infrastructure</li> <li>• Provide training re: community reintegration</li> <li>• Use diverted funds to create PACTs</li> <li>• Develop hospital diversion programs – 23-hour programs, intermediate care resources, regional crisis stabilization program</li> <li>• Establish SA/MH inpatient unit at ESH</li> </ul>	<ul style="list-style-type: none"> <li>• Increase number of available beds</li> <li>• Provide dental and gynecological services for community based consumers</li> <li>• Serve MR/MH consumers in specialized cottage</li> <li>• Increase capacity for emergency admissions via 90 day crisis management unit</li> </ul>
<b>Facilities staff</b>	No recommendations	No recommendations
<b>Providers/Advocates</b>	<ul style="list-style-type: none"> <li>• Improve community based support to reduce length of stay</li> <li>• Use for geriatric placements for consumers unsuitable for nursing home care</li> <li>• Re-open closed ESH beds</li> <li>• Develop young adult placement home</li> <li>• Develop partial hospitalization program in community</li> <li>• Close ESH and</li> </ul>	<ul style="list-style-type: none"> <li>• Increase funding to serve more consumers</li> <li>• Refit facility for respite services and rehabilitation training</li> <li>• Use for day support</li> <li>• Vocational training facility</li> <li>• Communications center for technology advances for persons with disabilities</li> <li>• Close SEVTC and reinvest money into community services,</li> </ul>

	reinvest money into community based services, sponsored placements and waiver slots <ul style="list-style-type: none"> <li>• Fund an support transitional housing</li> <li>• Develop crisis stabilization program</li> </ul>	sponsored placements, waiver slots <ul style="list-style-type: none"> <li>• Establish a forensic unit</li> <li>• Provide services for closed head injury clients</li> <li>• Establish a “Center for Excellence” at SEVTC</li> </ul>
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### **Law Enforcement, Providers and Advocates Focus Group**

The HPR-5 Partnership recognized that the process of accessing acute care often presents significant challenges to law enforcement officials and providers. Therefore, an additional focus group was conducted with **law enforcement, provider and advocate representatives**. These participants were asked:

1. What are your biggest challenges working with the system today?
2. What is working well in the current system?
3. From your perspective, what would be the components of an ideal system?

The results are as follows:

#### **Biggest Challenges:**

1. Funding
  - Adequacy
  - Access
  - Structure
2. Bed Availability
  - Children/Geriatric/Consumers with mental retardation
  - Communication issues
  - Premature discharges
3. Diversion/community crisis stabilization
4. Liability
5. Lack of tracking system/inadequate data across region and state
6. Law enforcement resources encumbered by transporting TDO's/EDO's
7. Medical Clearance
  - No consistent definition
  - No consistent protocol

8. Aftercare needs in all disability areas
  - Transportation
  - Housing
  - Crisis stabilization
  - Community support
9. Co-occurring disorders
  - Difficult to access treatment
  - Lack of integrated treatment
10. Need for use of different strategies to impact policymakers
  - Education
  - Advocacy
  - New priorities
11. No pre- or post-arrest diversion programs
12. Need for training related to cultural awareness
13. Staffing crises
  - MR providers/nursing homes
  - HR shortages throughout system

**What's Working Well:**

1. Dedicated staff in a “bad system”
2. Compassionate law enforcement staff using “helpful” approach
  - Better training
  - Focus on community policing
  - Leadership expectations
3. Communication among agencies and consumers is better than in the past
4. CSB's have better understanding of the elderly population
5. Better inclusion of advocates
6. Effective use of mental health support staff/one-to-one staffing to support discharged consumers
7. New philosophy of empowerment, choice self-determination

**Components of an Ideal System:**

- Fully funded

- Comprehensive systemic approach
- Diversion
  - Sub-acute units
  - Critical Incident Teams
- Crisis placement instead of jail
  - Family participation
  - Thorough assessment
- Psychiatric Emergency Room
- Available transportation in diversion and aftercare services
- Prevention efforts
  - Early intervention
  - Early screening
  - Early treatment
  - Substance abuse education in schools
  - Mental health screening in schools
  - Increased role for the private sector
- “Treatment on demand”
  - Immediate access to substance abuse treatment
  - Access to outpatient counseling
- Case management
  - Re-examine eligibility requirements
  - Expand past Medicaid
  - Use for Substance abuse services
  - Use in diversion and aftercare services
- State funding tied to national standards
  - Caseload size
  - Evidence based programming/treatment
- Examine access to medication (re-investment issue)
- Develop opportunities for real and meaningful work for MR and MH consumers
- Develop integrated MIS system
  - Track consumer information
  - Resource for best practice information
- Change Medicaid eligibility rules

## HPR-5 SWOT Analyses

SWOT (**S**trengths, **W**eaknesses, **O**pportunities, **T**hreats) analyses were conducted by three groups – the CSB Executive Directors and State facility Directors, the Peninsula coordinators, and the Southside coordinators.

### Executive Directors SWOT

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Cooperation and collaboration               <ul style="list-style-type: none"> <li>○ Other CSBs</li> <li>○ State agencies</li> <li>○ Local government; local government agencies</li> <li>○ Private providers</li> </ul> </li> <li>• Staff               <ul style="list-style-type: none"> <li>○ Experienced</li> <li>○ Dedicated</li> <li>○ Committed</li> </ul> </li> <li>• Quality of care               <ul style="list-style-type: none"> <li>○ Comprehensive array of services</li> <li>○ Comprehensive system of coordination of care</li> <li>○ Comprehensive oversight from outside entities</li> <li>○ Reputation for providing good services</li> <li>○ Able to meet unique local needs</li> <li>○ Consumers indicate high level of satisfaction with services</li> </ul> </li> <li>• Community Based Services               <ul style="list-style-type: none"> <li>○ System has worked to reduce or eliminate acute services in state facilities</li> <li>○ Consumers have ready access to voice issues</li> <li>○ Serving more consumers than ever</li> <li>○ Locally based service delivery system</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Funding               <ul style="list-style-type: none"> <li>○ Insufficient to meet needs</li> <li>○ Inadequate local funding</li> <li>○ Unfunded mandates</li> <li>○ Dependence upon Medicaid</li> <li>○ Disjointed funding</li> <li>○ Inadequate reimbursement rates</li> </ul> </li> <li>• Insufficient community capacity               <ul style="list-style-type: none"> <li>○ Insufficient capacity for non-Medicaid population</li> <li>○ No medication programs for indigent except via aftercare</li> <li>○ Inadequate safe and affordable housing</li> <li>○ Inadequate public transportation</li> <li>○ Local response to bed shortage</li> </ul> </li> <li>• Service gaps               <ul style="list-style-type: none"> <li>○ Inadequate services for children and adolescents</li> <li>○ Few, if any, specialized programs for multiply involved individuals</li> <li>○ No employment focus for MI or SA consumers</li> <li>○ Support for, or alternatives to, aging caregivers</li> <li>○ Crisis intervention/stabilization</li> <li>○ Little or no outcome data</li> </ul> </li> <li>• Human resources               <ul style="list-style-type: none"> <li>○ Staff shortages</li> <li>○ Staff burnout</li> </ul> </li> <li>• Paperwork requirements               <ul style="list-style-type: none"> <li>○ Over-regulated system</li> <li>○ Excessive documentation</li> <li>○ Non-service requirements diminish direct service delivery</li> </ul> </li> <li>• Leadership               <ul style="list-style-type: none"> <li>○ Lack of proactive leadership at state</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>level</li> <li>○ Lack of support for regional initiatives</li> <li>○ Lack of communication/coordination among state agencies</li> </ul>
<b>Opportunities</b>	<b>Threats</b>
<ul style="list-style-type: none"> <li>● Reinvestment <ul style="list-style-type: none"> <li>○ Supports efforts to build community capacity</li> <li>○ Increased community based funding through closing of state facilities</li> <li>○ Encourages continued collaboration of CSBs within the region</li> </ul> </li> <li>● Potential system improvements <ul style="list-style-type: none"> <li>○ Integrated system of care efforts at local level</li> <li>○ Development of outcome based system</li> <li>○ Opportunities for public-private partnerships Increased education and advocacy</li> <li>○ Better regional planning</li> <li>○ Maximize technology advancements</li> <li>○ Better integration among health and human service systems</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Inadequate funding <ul style="list-style-type: none"> <li>○ Non-reimbursable expenses</li> <li>○ Creation of resource competition between urban/suburban areas and rural localities</li> <li>○ Medicaid cap and overdependence upon Medicaid</li> <li>○ Budget cuts and block granting</li> </ul> </li> <li>● Too many regulations/paperwork <ul style="list-style-type: none"> <li>○ Distracts and detracts from service delivery</li> <li>○ Negative impact on staff/morale</li> <li>○ Unenforceable regulations</li> </ul> </li> <li>● Takeover of system by private sector <ul style="list-style-type: none"> <li>○ Leadership void at state level increases vulnerability</li> <li>○ Over-regulation decreases public sector's competitiveness</li> </ul> </li> <li>● Service trends <ul style="list-style-type: none"> <li>○ Aging consumers and aging caregivers</li> <li>○ Consumers who are non-compliant, violent, suicidal</li> <li>○ Need for indigent medications program</li> </ul> </li> </ul>

### Peninsula Coordinators SWOT

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>● Strong collaboration among CSBs</li> <li>● Collaboration among other state and city/county agencies</li> <li>● Good relationships in the community</li> <li>● Educated, experienced, dedicated and skilled staff</li> <li>● Staff development and training services are excellent/on-line training offered</li> <li>● Strong family interest in prevention and early intervention</li> <li>● Use of strengths-based recovery model</li> </ul>	<ul style="list-style-type: none"> <li>● Funding has not kept pace with needs</li> <li>● Different information systems for data collection case records in different cities/counties</li> <li>● Lack of adequate housing</li> <li>● Need for more children's services</li> <li>● Salary inadequacies/inequities</li> <li>● Growing workforce capacity crisis due to Medicaid and licensure credentialing requirements</li> <li>● Lack of reimbursement for psychiatric services</li> </ul>

	<ul style="list-style-type: none"> <li>• Rural areas face greater impact of funding cuts (Ex. – Medicaid no longer covers transportation)</li> <li>• Community services have not yet developed to support emergency services</li> </ul>
<b>Opportunities</b>	<b>Threats</b>
<ul style="list-style-type: none"> <li>• Restructure services to maximize Medicaid funding (care coordination, med management)</li> <li>• Pursue private payment for services</li> <li>• Improve information sharing throughout the region re: best practices (MIS, QA, clinical)</li> <li>• Increase mental health support services/increase funding and service delivery</li> <li>• Expand public information about prevention and early intervention</li> <li>• Develop better identification methods for early intervention</li> <li>• Increase linkages within CSBs for prevention and early intervention efforts</li> <li>• Improve treatment for co-occurring disorders</li> <li>• Decrease paperwork while maintaining accountability and meeting requirements</li> <li>• Continue to strengthen housing programs</li> <li>• Improve relationships with state legislature, businesses, military family services, PCPs, courts, schools and churches</li> </ul>	<ul style="list-style-type: none"> <li>• Dependence on Medicaid funding</li> <li>• Antiquated State allocation formula</li> <li>• Flat funding from localities</li> <li>• Funding cuts in Part C</li> <li>• Hospitalization has become a placement issue vs. meeting a treatment need</li> <li>• Increased requirements for credentialing are not supported with resources</li> <li>• Culture of over-reactivity and fear of litigation that stifles new and creative approaches</li> <li>• Population needing services is increasing</li> <li>• Unmet needs of the elderly population</li> <li>• Competition for staff from the private sector</li> </ul>

### Southside Coordinators SWOT

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Regional cooperation on projects</li> <li>• Regional initiatives affecting the area</li> <li>• Experienced staff</li> <li>• Region has advocacy groups which support improvements in our system (Ex. – Housing Coalition)</li> <li>• Good relationships with other agencies</li> </ul>	<ul style="list-style-type: none"> <li>• While the region cooperates together, the needs of the multi-jurisdictional and/or rural boards vs. urban boards are often different</li> <li>• Inadequate funding</li> <li>• Area is fractured politically</li> <li>• Lack of housing</li> <li>• Staff is experienced but stagnant in growth</li> </ul>

<ul style="list-style-type: none"> <li>• Good collaboration among CSBs allows exploration of shared efficiencies</li> <li>• General standards are met <ul style="list-style-type: none"> <li>○ Licensure</li> <li>○ CARF</li> <li>○ Medicaid</li> <li>○ Human Resources</li> </ul> </li> <li>• Good relationships with State leadership</li> <li>• Focus on science-based, evidence-based services</li> <li>• PAC teams and other community outreach efforts/community based services</li> <li>• Strengths-based approach to services</li> <li>• Focus on recovery model</li> <li>• Prevention/early intervention efforts</li> <li>• Mental health and drug courts</li> </ul>	<ul style="list-style-type: none"> <li>• Needs of the population are increasing <ul style="list-style-type: none"> <li>○ Waiting lists for services</li> <li>○ Caseloads are growing</li> </ul> </li> <li>• Need for more aftercare services</li> <li>• Need for more prevention and early intervention programs</li> <li>• Need more attention to funding children's services</li> <li>• Transportation needs (regional issue)</li> <li>• Employment/vocational services</li> </ul>
<p><b>Opportunities</b></p>	<p><b>Threats</b></p>
<ul style="list-style-type: none"> <li>• Current process allows for sweeping input to governor to set priorities</li> <li>• Chance to increase public education about TDO's and the commitment process before crises arise</li> <li>• Remove stigma surrounding mental illness</li> <li>• Opportunity to define how to measure accountability/streamline paperwork</li> <li>• Improve MIS to manage forms and training</li> <li>• Expansion of mental health and drug courts</li> <li>• Growth of consumer-driven and consumer-generated support services/support groups</li> <li>• Development of private sector linkages</li> <li>• Develop/expand guardianship and substitute decision maker programs</li> <li>• Planning/restructuring effort supports collaboration on meeting needs</li> <li>• Opportunity to adopt and reinforce value of strength-based approaches/ empowerment, recovery, self-determination/regional needs assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Region is fractured politically</li> <li>• Change in policy direction driven by anti-tax environment</li> <li>• Competition from private sector</li> <li>• Potential liability results in requirements for over-documentation</li> <li>• Housing <ul style="list-style-type: none"> <li>○ Lack of affordable housing</li> <li>○ Affordable housing is often substandard</li> <li>○ Affordable housing continues to decrease as cities re-develop</li> </ul> </li> <li>• Concentration on billable hours hinders program innovation</li> </ul>

## STRATEGIC ISSUES, GOALS, ACTION STEPS

### STRATEGIC ISSUE # 1: COMMUNITY-BASED SERVICES

#### *Goal 1:*

Implement a children's services demonstration project with a local, CSB-managed residential component, completely integrated with CBS services, to model a system of care approach

#### *Goal 2:*

Advocate re-focusing Medicaid away from a medical model toward support of a recovery model

#### *Goal 3:*

Partner with advocates to build a critical mass of support for mental illness prevention and mental health promotion

#### *Goal 4:*

Build programming around mental health and substance abusing consumers who enter the system through criminal justice

##### Action Steps:

- Increase education about mental illness and substance abuse for judges, attorneys and law enforcement officials
- Design interventions to precede incarceration
- Advocate/support additional drug and mental health courts

#### *Goal 5:*

Fund and implement a pilot "Recovery House" model as a crisis intervention and stabilization alternative to hospitalization (Components would include step down, diversion from acute care, peer support, support groups, community liaison)

#### *Goal 6:*

Explore supporting and expanding employment and vocational opportunities for consumers (without adversely impacting benefits)

#### *Goal 7:*

Establish a Center of Excellence at SEVTC, with an outreach component similar to a PACT for MR consumers

## **STRATEGIC ISSUE # 2: COLLABORATION**

### *Goal 1:*

Establish collaborative relationships with non-traditional partners

#### Action Steps:

- Seek out collaboration with the military, business community, faith community, educational institutions, private medical sector and foundations
- Foster collaborations to develop access to leadership talent

### *Goal 2:*

Build a focused regional advocacy initiative to involve and educate consumers, families, local and State elected officials and judges around mental health, substance abuse and mental retardation issues

#### Action Steps:

- Identify sub-regional issues
- Create and disseminate a consistent message
- Provide leadership and guidance to empower advocates

### *Goal 3:*

Explore cross-jurisdictional linkages

#### Action Steps:

- Identify geographic centers for shared services (Ex. – Churchland, Suffolk/Franklin)
- Research transportation options to improve effectiveness and efficiency of community-based service delivery

### *Goal 4:*

Adopt and promote a “no wrong door” philosophy within CSB disability areas and among other local agencies in support of a “whole person” approach to services

#### Action Steps:

- Streamline access to intake
- Expand cross training
- Articulate a commitment to customer service and train to support it
- Explore opportunities for more proactive transitions (from adolescent to adult services, from one jurisdiction to another)

### *Goal 5:*

Maintain and support HPR-5 partnership

### **STRATEGIC ISSUE # 3: FUNDING**

#### *Goal 1:*

Reduce dependence on Medicaid

##### Action Steps:

- Assess viability of future Medicaid funding
- Explore opportunities for public-private contracts with fee-splitting arrangements and management services
- Build in-house capacity for revenue generation

#### *Goal 2:*

Aggressively advocate for increased funding

##### Action Steps:

- Pursue strategic partnerships to support funding requests
- Build advocacy network to strengthen voice

#### *Goal 3:*

Consolidate administrative processes in smaller jurisdictions (Ex. – purchasing)

#### *Goal 4:*

Explore private sector alternatives to state pharmacy services

#### *Goal 5:*

Ensure support for current level of funding by using evidence-based practices, delivering on effective outcome measures and effectively utilizing funds for expanded services

### **STRATEGIC ISSUE # 4: QUALITY OF CARE**

#### *Goal 1:*

Conduct a cost-benefit analysis of current utilization of high-cost children's services, including assessment of Medicaid, CSA and local funding supports

#### *Goal 2:*

Adopt a commitment toward requiring evidence-based practice in all programming

*Goal 3:*

Support a cultural shift from quality assurance (retrospective) to quality improvement (prospective)

Action Steps:

- Explore and support relationships between chart reviews and the human factor
  - Consumer satisfaction surveys
  - Consumer involvement on quality improvement councils

*Goal 4:*

Establish system-wide accountability to reduce paperwork without sacrificing quality

Action Steps:

- Address inconsistent licensure interpretation and documentation requirements (State-level action)
- Identify and address inconsistencies between licensing and Medicaid regulations (State-level action)
- Create core forms for state-wide use
- Develop uniform data collection and data sharing protocols and systems

**STRATEGIC ISSUE # 5: HUMAN RESOURCES**

*Goal 1:*

Broaden regional training efforts

Action Steps:

- Develop region-wide opportunities to accrue contact hours and other continuing education
- Expand use of technology for training and competency development
- Partner with local educational institutions to develop “real world” curricula, improve meaningful internships and establish “MSW cohorts” within agencies

*Goal 2:*

Share recruitment innovations

*Goal 3:*

Establish a regional Human Services Leadership Academy to develop skills in leadership, management and supervision throughout CSB staff

## **STRATEGIC ISSUE # 6: RURAL ISSUES**

### *Goal 1:*

Advocate for reimbursement differential for rural areas to compensate for unique services delivery issues, such as travel costs

### *Goal 2:*

Explore technology to improve access to training for staff in rural agencies

### *Goal 3:*

Explore collaboration in benefits procurement and management

## **HPR-5 PARTNERSHIP RECOMMENDATIONS FOR STATE-LEVEL ACTIONS**

In developing recommendations for state-level action, the HPR-5 Partnership reviewed the work of the Coordinators' Planning Group, examined data captured from input of consumers, advocates, facilities and staff, conducted a SWOT analysis and engaged in facilitated discussion to identify trends and issues. The Partnership's recommendations revolve around five fundamental issues:

- Administrative requirements
- Department's structure and role as partner
- Resource development
- Leadership
- Communication

### **Administrative Requirements**

**The HPR-5 Partnership offers a number of recommendations related to the Department's role in addressing the ever increasing, and often ineffectual, administrative requirements. The Partnership's recommendations in this area should not be construed as reluctance for accountability, but rather as a call to action to address the reality of over-regulation, which is reflected in decreased personal contact with consumers and staff turnover. At the heart of this issue is the necessity for the Department to recognize and address the conceptual disconnect between a patriarchal medical model and the recovery model.**

- Review all administrative requirements that are in State Board policy, the performance contract, CCS, licensure regulations and human rights regulations with the goals of:
  - Negotiating annually with the local Boards to reduce paperwork requirements by an established percentage
  - Aligning regulations in support of the recovery model
  - Eliminating the layering of regulations and coordinating the alignment of regulations
- Review the performance contract for relevance and effectiveness, and to focus on the requirements of the primary payor
- Adopt same standards of accountability for public and private providers
- Exercise leadership to resolve conflicts between regulatory interpretations
- Accept accreditation and HIPAA standards in lieu of, rather than in addition to, departmental standards wherever applicable

### **Department's Structure and Role as Partner**

**The current structure emphasizes a “Community vs. Facility” focus rather than reflecting an organizational approach that supports addressing mental health, mental retardation and substance abuse systemic issues. The Department should demonstrate the same sense of ownership to the consumer of community-based services as it does to the state facilities.**

- Reorganize the Department around function versus disability area
- Eliminate separate Assistant Commissioners for facilities and communities; create one Assistant Commissioner to serve both
- Demonstrate commitment to the state-local partnership through re-organization, policy development and proactive, inclusive problem solving

### **Resource Development**

**The Department should be in the business of insuring that resources are available to provide services. A consumer should be able to expect some core level of services regardless of whether he or she is served in the community or in state facilities. The Department is in the best position to “grow” resources to account for the increasing cost of doing business.**

- Create a dedicated funding stream for CSBs
- Adopt and support the concept of funded plans of care in which funding is attached to the consumer as he or she moves through the system
- Ensure current levels of funding; advocate against decreases in Medicaid funding
- Aggressively pursue means by which to increase the total amount of available funding
  - Advocate for increased Medicaid reimbursement
  - Advocate for increased percentage of individuals eligible for Medicaid based on diagnosis
  - Sell downsized state facilities, build smaller complexes and re-direct savings to local CSBs
- Assure that CSBs will be the sole provider of case management services
- Create and implement a plan to articulate how the Department will respond to future funding changes, such as:
  - Medicaid changes at the federal level
  - State funding reductions
  - Inadequate and stagnant reimbursement levels

- Reductions in covered services
- Changes in other revenue sources or resources

## **Leadership**

**While the role of DMHMRSAS as a primary funder has diminished, there are a number of areas in which the Department could and should demonstrate leadership to support the recovery model and to sustain the system state-wide. How will the Department address the changing needs and types of populations served? How will the Department address the population growth?**

- Assist localities build capacity in all disability areas
  - Address residential capacity issues
    - Funding
    - Zoning
  - Help localities meet needs for the recovery model
    - Employment services
    - Transportation
    - Medical care
    - Medication for indigent consumers
    - Socialization
  - Develop consistent outcome measures
  - Set standards for caseload size
- Identify and address state-wide issues
  - Provide centralized bed management
  - Negotiate with DMAS to determine responsibility for indigent beds
  - Identify and articulate the State's position on TDOs and the admission criteria for TDO facilities
- Generate a workforce development plan at the State level
  - Initiate efforts with community colleges, colleges and universities to train staff
  - Develop initiatives with institutions of higher learning to attract graduates to the field
    - Establish scholarship opportunities
    - Eliminate disincentives, such as lack of reimbursement for psychiatric services
    - Review QMHP requirements

## **Communication**

**The communication between the Department and local Boards requires continued attention to ensure effectiveness, efficiency and mutual trust.**

- Establish regular channels of communication with leaders in the community
- Establish and adhere to policies and procedures to ensure timely response to local requests for information and policy interpretation
- Ensure consistent communication among internal divisions in the Department
- Respond to and act upon recommendations from CSB Executive Directors

## **REGION'S READINESS FOR AND VIABILITY OF RESTRUCTURING STATE FACILITIES AND COMMUNITY SERVICES**

While the HPR-5 Partnership acknowledges the improved relationship between DMHMRSAS and local Community Services Boards, there is still considerable skepticism surrounding the issue of restructuring. The Partnership perceives a historical tendency on the part of the Department to redefine its responsibility, shift funding and implement other significant changes without considering the impact upon localities, state facilities, consumers or families. There has often been a lack of understanding from the Department that there are regional, sub-regional and local needs that differ substantially and require unique responses.

The HPR-5 Partnership offers the following comments related to restructuring:

- Any restructuring decisions must take into consideration the choices and voices of consumers, families, localities and state facilities.
- No restructuring efforts should be undertaken without adequate community services. Capacity in state facilities should not be decreased without assurance that consumers can be served appropriately and effectively in the community.
- Funding remains a crucial issue. The HPR-5 Partnership agrees with its counterparts in the Southwest that the restructuring of the system is less about re-investment than it is about investment.
- HPR-5 is willing and able to continue to work successfully with its partners in the state facilities, the private provider network, advocates, families, consumers and local officials to craft regional, sub-regional and local solutions. However, these solutions cannot substitute local resources for those that should legitimately be the responsibility of state and federal entities, nor can these efforts replace the leadership and responsibility that appropriately resides at the state level.
- The responsibility of the state vis a vis community services must be clearly defined. There must be continued dialogue between the Department and localities to establish levels of responsibility – and accompanying liability – that support the recovery model and an effective and efficient system of care.

## **CONCLUSION**

This strategic plan represents a comprehensive ten-month effort on the part of the HPR-5 Partnership to examine the behavioral health system in the region. Through the process, the Partnership assessed the current state of the system, analyzed short-term and long-term needs and developed recommendations to address major issues facing the region. The planning process itself was dynamic and produced a number of immediate concrete responses during its development.

Key to the success of the strategic plan is continued dialogue with, and action from, the Department of Mental Health, Mental Retardation and Substance Abuse Services. The balance of state responsibility and local accountability, the clear understanding and articulation of roles, and the demonstration of appropriate state leadership and support are all critical elements in building a system grounded in the principles of recovery.

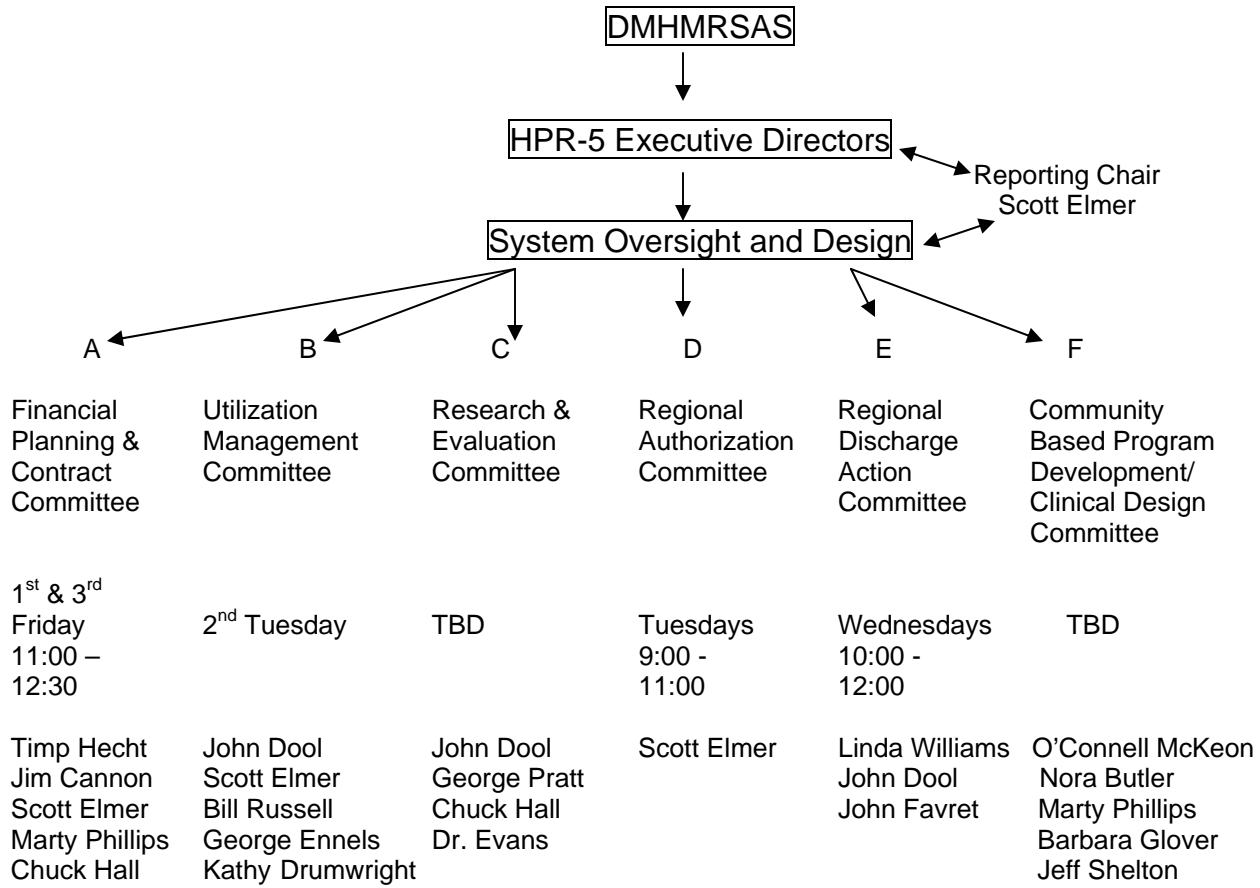
Our citizens – throughout the region and throughout the Commonwealth – deserve no less than a responsive and responsible state-local partnership that offers adequate levels of quality services and access to those services. The HPR-5 Partnership strategic plan reflects the region's commitment to understanding the needs of consumers, families, providers, advocates and staff, to communicating those needs to the Department and to developing creative, proactive responses to those needs.

## **APPENDIX**

Appendix A	Oversight Committee Organizational Chart
Appendix B	Survey Instrument
Appendix C	Data Sources
Appendix D	Questionnaire Responses
Appendix E	SWOT Data



**OVERSIGHT COMMITTEE ORGANIZATIONAL CHART**



Appendix B      **SURVEY INSTRUMENT**

**HPR V**  
**Regional Partnership Strategic Plan**

**Name of CSB/unit or division:**

\_\_\_\_\_

**Name of**

**Facility:** \_\_\_\_\_

**Name of Provider or**

**Advocate:** \_\_\_\_\_

Please complete and return by: \_\_\_\_\_ to:

On any of the items, use addition space if needed.

**Key Issues:** List the top five key issues facing the Region over the next five years.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**Consumer Services:** List the three top “gaps” in consumer services facing your CSB over the next five years for each disability area.

**Adult Mental Health:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Child/Adolescent Mental Health:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Mental Retardation:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Substance Abuse:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Other/Special Populations: *Please describe the population and what services they need*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Coordination:** *What other local or regional agencies or organizations which impact your consumers would you like to have a significantly improve relationships and coordination? Please name the agency or organization and note what you feel would improve the coordination*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Quality of Care:** List any “quality of care” improvements your CSB believes are critical in order to upgrade consumer care and family supports. Briefly describe.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Structural Options:** Are there any new structural arrangements among the region’s CSBs, Eastern State Hospital, and Southeastern Virginia Training Center or with a new entity that your CSB would consider being part of in order to improve operational efficiencies or to provide direct services?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Eastern State Hospital:** What do you believe are the next steps if any and time frame to consider restructuring Eastern State Hospital’s current services in order to reinvest dollars in community services?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Southeastern Virginia Training Center:** What do you believe are the next steps if any and time frame to consider restructuring Southeastern Virginia Training Center’s current services in order to reinvest dollars in community services?

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*Thank you for your assistance in creating our regional plan.*

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## Appendix C      **Data Sources**

### **Surveys:**

#### **CSB Units/Divisions**

- Chesapeake Administration
- Chesapeake CSAP
- Chesapeake Mental Health and Substance Abuse
- Chesapeake Residential
- Colonial
- Eastern Shore
- Middle Peninsula Northern Neck Administration
- MPNN CSB Case Management
- MPNN Mental Health and Substance Abuse Services
- MPNN Mental Retardation
- MPNN Nursing Staff – GCC
- MPNN Wingrove's Unit
- Norfolk
- Portsmouth Dep't. of Behavioral Health Services
- Virginia Beach Mental Health and Substance Abuse Services
- Western Tidewater Mental Health and Substance Abuse
- Western Tidewater Mental Health, Mental Retardation, Consumer Affairs
- Western Tidewater Mental Retardation, Community Support
- Western Tidewater Mental Health, Mental Retardation, Case Coordination
- Western Tidewater Outpatient Services

#### **Facilities**

- Cary Avenue Adult Home
- PSR – Charter House
- Middlesex DSS (Service provider but completed facility survey?)

#### **Service Providers/Advocates**

- Chesapeake Community Corrections Program
- Chesapeake Fire Department
- Chesapeake CSB Mental Health Coastal Clubhouse
- Chesapeake Office of Intergovernmental Affairs
- Essex County Sheriff Dep't.
- MPNN Law Enforcement
- MPNN Support Network/Parent Groups of MPNN
- Parent to Parent of Virginia
- Rappahannock General Hospital
- Richmond County Sheriff Dep't.

- Riverside-Tappahannock Hospital
- SAARA of the Bay
- Three Rivers Health District Resource Mothers Program
- West Point Adult Care Residence

### **Consumers**

- Hampton-Newport News
- Norfolk
- Portsmouth

### **Strategic Plans**

- Hampton/Newport News CSB
- Norfolk CSB
- Portsmouth CSB
- Virginia Beach CSB

### **Quality Improvement Plans**

- Colonial CSB

### **Interviews/Focus Groups**

- Cary Avenue Adult Group Home
- Dr. MacPherson-Smith, SEVTC
- H-NN NAMI
- MPNN Charter House
- Regional law enforcement, provider and advocate representatives
- Western Tidewater Consumer Association

This appendix reports the raw data from questionnaire responses. On a number of issues, there were an equal number of responses. Those are noted as “tie.”

A summary of responses from the **Community Service Boards** follows:

**FIVE KEY ISSUES:**

1. Lack of affordable housing
2. Funding
3. Acute care and long-term bed shortage
4. Lack of qualified staff/need for more staff
5. Development of community based resources (tie)
  - Lack of public transportation
  - Need for more waiver slots

**SERVICE GAPS:****Adult Mental Health Services**

1. Lack of residential care facilities
2. Housing
3. Lack of intensive community based services (tie)
  - Geriatric psychiatric services

**Child and Adolescent Mental Health Services**

1. Limited funding for child and adolescent services
2. Limited funding for non-Medicaid outpatient services (tie)
  - Lack of child and adolescent psychiatric services
  - Need for more in-home intensive services
  - Parental education
3. Limited residential facilities (tie)
  - Lack of inpatient beds

**Mental Retardation Services**

1. Need for more waiver slots
2. Need for housing and residential services
3. Need for better coordination between the child and adolescent and adult MR systems

**Substance Abuse Services**

1. Need for housing and residential services
2. Need for increased funding/increased Medicaid reimbursement
3. Lack of medical and social detox at the local level

### **Other special populations**

1. Need for specialized interventions and treatment approaches for consumers with co-occurring disorders
2. Incarcerated population
3. HIV/Hepatitis C population

### **COORDINATION:**

1. Medical providers and institutions (tie)  
Departments of social services/human services
2. Public schools
3. Department of Rehabilitative Services

### **QUALITY OF CARE:**

1. Funding to provide services to currently unfunded consumers
2. Develop state-wide quality assurance and workload measures
3. Develop region-wide model to identify and address the needs of consumers with co-occurring disorders (tie)  
Increase access to mental health support services

### **STRUCTURAL OPTIONS:**

- Partnerships with housing authorities to enhance housing resources
- Public/private negotiated contracts for special services (Ex.; Pre-purchased case management)
- Prevention programs in schools, courts, homes
- CSB services on-site at hospitals to facilitate transition into community
- More collaborative involvement with ESH, SEVTC and CSBs, including sharing staff and resources
- Explore MH/MR unit at SEVTC
- Explore sharing doctors
- Alignment with DSS for case management
- Alignment with Health Dept. to improve medical services
- More regional collaboration for staff training, recruitment, programs and services
- One regional CSB to pool resources
- Establish facility for non-violent TDO's (like ARISE program in Lynchburg)
- Establish intermediate care facilities – temporary supervised residences for consumers receiving day treatment
- Establish a pool of PRN staff for crisis stabilization, in-home and mental health support
- Develop a regional PACT network
- Improve services in adult living facilities by providing training re: mental illness and mental retardation

## **RECOMMENDATIONS – EASTERN STATE HOSPITAL (ESH):**

- Explore local facility with capacity of ESH to manage all hospital resources locally
- Must resolve current acute bed capacity issue
- Assure bed capacity first
- Upgrade bed availability in HPR5
- Invest to build community services infrastructure
- Increase length of stay options
- Provide training re: community reintegration
- Manage PSR consumers as region is currently managing acute care services
- Manage funding for intermediate care as part of developing Phase 2 services
- Use diverted funds to establish PACT teams
- Establish regional programs, such as a specialized nursing home, to work with elderly mentally ill consumers
- Develop 23-hour bed capacity for hospital diversion
- Establish a regional crisis stabilization program
- Regionally manage all admissions and discharges to ESH
- Establish a SA/MH inpatient unit at ESH
- Establish a center modeled on the ARISE program on ESH grounds
- Make more extensive use of teleconferencing equipment

## **RECOMMENDATIONS – SOUTHEASTERN VIRGINIA TRAINING CENTER (SEVTC):**

- Individuals at SEVTC who meet criteria to reside in community, but LARs will not agree to discharge. (If discharged, more capacity for individuals who meet institutional criteria.)
- Increase number of available beds
- Provide dental and gyn services for community consumers
- Increase capacity for emergency admissions by utilizing 90 day crisis management unit
- Increase ICFs to mitigate lack of supervised housing options
- Serve MR/MH consumers in a specialized cottage

Responses from representatives of **facilities** are summarized as follows:

### **FIVE KEY ISSUES:**

1. Housing
2. Quality of care in short-term treatment facilities (tie)
  - Assistance for homeless consumers
  - Lack of transportation
  - Adequate spending money for residents
  - Difficulty in stabilizing residents

Need for support to maintain community based placements

**SERVICE GAPS:**

**Adult Mental Health Services**

1. Consumers without resources or benefits, but who need treatment (tie)  
Need for dental care
2. Need for podiatry care (tie)  
Need for vision care/eyeglasses

No service gaps identified for other disability areas

**COORDINATION:**

1. Area agency on aging

**QUALITY OF CARE:**

1. Supportive and transitional employment
2. More family involvement (tie)  
More activities at the community level  
Employment opportunities to provide clients with spending money without jeopardizing their benefits

No recommendations regarding structural options, Eastern State Hospital or the Southeastern Virginia Training Center.

**Providers and advocates** provided the following input:

**FIVE KEY ISSUES:**

1. Funding
2. Difficulty in coordinating services and referrals among providers
3. Need for more staff (including daily support workers)
4. Need for more staff training and support
5. Lack of bed availability

**SERVICE GAPS:**

**Adult Mental Health Services**

1. Access to services (including insurance and other funding)
2. Psychosocial services
3. Outpatient services (tie)  
Residential placements  
Job placement/vocational services  
Bed availability

Housing  
Family involvement  
24/7 support

### **Child and Adolescent Services**

1. Access to treatment
2. Funding
3. In-home programs (tie)
  - Respite
  - Domestic violence intervention/counseling
  - Divorce/parental separation counseling
  - Family involvement

### **Mental Retardation Services**

1. Vocational programs
2. Services to aging consumers with mental retardation
3. Housing (tie)
  - Funding
  - Lack of children's services
  - Need for more waiver slots
  - Training in differences between MH and MR
  - Need for more providers
  - 24/7 support

### **Substance Abuse Services**

1. Funding/Medicaid reimbursement
2. Inpatient care in the community
3. Relapse prevention (tie)
  - More accessible services
  - Inadequate detox funding

### **Other populations**

1. Programming and staffing to support dually diagnosed consumers (tie)
  - Programs for physically handicapped
2. Day programs for dually diagnosed (tie)
  - Housing programs for dually diagnosed
  - Crisis stabilization
  - Partial hospitalization
  - Programming for pregnant teens
  - Programs for female offenders
  - Non-English speaking offenders
  - Homelessness
  - Domestic violence
  - LTA public awareness, training for safety

### **COORDINATION:**

1. Public schools
2. Departments of social services/human services
3. Health facilities (tie)  
Community Service Boards

### **QUALITY OF CARE:**

1. Increase funding (tie)  
More interagency cooperation
2. More staff to meet increased demands (tie)  
Paperwork reduction  
Increase staff salaries

### **STRUCTURAL OPTIONS:**

- Use videoconferencing technology to involve families
- Increase vocational opportunities
- Develop more access to recreational activities
- Build volunteer capacity to assist during emergency events
- More training for judges, police and probation and parole officers about MH issues
- Eliminate use of jails as mental health facilities

### **RECOMMENDATIONS – EASTERN STATE HOSPITAL (ESH):**

- Clients discharged too soon; longer lengths of stay needed
- Need better community based support
- Geriatric placements for persons who cannot be managed in nursing home setting
- Re-open ESH
- Fund and support halfway and transitional housing
- Increase bed space at ESH
- Close ESH and re-invest money into community based services, sponsored placements, waiver slots
- Develop young adult placement home
- Increase bed space in the community
- Develop partial hospitalization program in the community
- Develop crisis stabilization program

### **RECOMMENDATIONS – SOUTHEASTERN VIRGINIA TRAINING CENTER (SEVTC):**

- Clients discharged too soon

- Increase funding to serve more consumers
- Need better community based supports
- Close SEVTC and re-invest money in community based services, sponsored placements, waiver slots
- Refit facility for respite services and rehab training
- Use as a central communications center to connect local, state options and individuals
- Use for day support
- Vocational training facility
- Communications center for technology advances for persons with disabilities
- Establish a “Center of Excellence” at SEVTC
- Establish a forensic unit
- Provide services for closed head injury clients

**SWOT Analysis  
Peninsula Coordinators**

**October 2004**

**Strengths:**

- Strong collaboration among CSBs
- Collaboration among other state and city/county agencies
- Good relationships in the community
- Supportive Board
- Informed and supportive State legislators
- Flexibility/CSBs can operate to meet the unique needs of their communities
- 
- Hiring flexibility in some CSBs due to autonomous status
- Young, energetic mid-level managers
- Educated, experienced, dedicated and skilled staff
- Staff development and training services are excellent/on-line training offered
- Innovative leadership
- Informal information sharing among CSBs
- Take good advantage of grant funding
- Strong family interest in prevention and early intervention

**Weaknesses:**

- Different information systems for data collection case records in different cities/counties
- Intake process could be streamlined

- Focus on medical model vs. strengths-based, recovery model
- Vagueness in definition of “prevention”
- Children’s services get shortchanged
- Salary inadequacies
- Growing workforce capacity crisis due to Medicaid and licensure credentialing requirements
- Lack of reimbursement for psychiatric services
- Hours spent in EOC services are not reimbursable
- Rural areas take a bigger hit in funding cuts (Ex. – Medicaid no longer covers transportation)
- Community services have not yet developed to support emergency services
- Culture of over-reactivity and fear of litigation that stifles new and creative approaches

**Opportunities:**

- Restructure services to maximize Medicaid funding (care coordination, med management)
- Pursue private payment for services
- Improve information sharing throughout the region re: best practices (MIS, QA, clinical)
- Develop on-line training management system
- Continue to have staff trainings to assist with new treatment options
- Increase mental health support services/increase funding and service Delivery
- Develop an active patient advocacy program and “friends of the agency” program
- Expand public information about prevention and early intervention

- Develop better identification methods for early intervention
- Increase linkages within CSBs for prevention and early intervention efforts
- Improve treatment for co-occurring disorders
- Decrease paperwork while maintaining accountability and meeting requirements
- Dedicate staff to grant writing and other revenue generating activities
- Develop “Recovery House” model
- Continue to strengthen housing programs
- Improve relationships with state legislature, businesses, military family services, PCPs, courts, schools and churches

**Threats:**

- Dependence on Medicaid funding
- Antiquated State allocation formula
- Flat funding from localities
- Funding cuts in Part C
- Funding doesn’t support “natural environment” service delivery
- Hospitalization has become a placement issue vs. meeting a treatment need
- Increased requirements for credentialing are not supported with resources
- Ensuring compliance with regulatory and funding sources
- Population needing services is increasing
- Unmet needs of the elderly population
- Competition for staff from the private sector
- Lack of affordable and decent housing for consumers

**SWOT Analysis  
Southside Coordinators  
October 2004**

**Strengths:**

- Region is cooperating on several MH and SA projects effecting the area
- Region has management staff who have many years of experience in large project management
- Region has advocacy groups which support improvements in our system (Ex. – Housing Coalition)
- ESH diversion project has brought together a variety of stakeholders who have worked well together
- Experienced staff
- Lots of energy in new hires; robust hiring pool (NSU grads)
- Good relationships with other agencies
- Good collaboration among CSBs allows exploration of shared efficiencies
- Affiliate groups
- Sharing among children’s services coordinators
- General standards are met
  - Licensure
  - CARF
  - Medicaid
  - Human Resources
- Decentralized structure allows for flexible programming to meet specific needs of city or county residents
- Excellent leadership in support of substance abuse, prevention and children’s services at the State level
  - MHMRSAS
  - DMAS
  - Governor’s Office of Substance Abuse Prevention
- Focus on science-based, evidence-based services

- Current Commissioner
- PAC teams and other community outreach efforts
- Demographics of the region
  - Relatively low unemployment rate
  - Pockets of poverty, but region is generally better off financially than other large metropolitan areas
- Strengths-based approach to services

**Weaknesses:**

- While the region cooperates together, the needs of the multi-jurisdictional and/or rural boards vs. urban boards are often different
- Not enough resources are allocated at the state level to do the adequate services delivery in the community for disabled individuals
- Care for the disabled is not a high priority at the state level
- Area is fractured politically
- Housing is lacking for our disabled consumers
- Staff is a “dying breed” – no replacement staff at higher levels
- Top positions have little turnover
- Staff is experienced but stagnant in growth
- Impacts of inadequate funding:
  - Staff experiences feeling of being overwhelmed with paperwork requirements
  - Being asked to do more with less, but just “treading water”
  - Feeling of not serving the client as much as doing paperwork
  - Needs of the population are increasing
  - Percent of time spent with client is decreasing, while time spent in supportive services and paperwork is increasing
  - Concentration on programs with “billable hours” leads to elimination of innovative programs and creative services
  - Waiting lists for services
  - Hiring freezes

- Caseloads are growing
- Need for more aftercare services
- Need for more prevention and early intervention programs
- Need more attention to funding children's services
- Transportation needs (regional issue)
- Housing
  - Cumbersome administrative requirements for HUD funding
- Need for more parental involvement
- Consumers lack ability to make informed choices
  - Consumers are isolated; no family involvement
  - Legally Authorized Representative (LAR) system is flawed

**Opportunities:**

- Current process allows for sweeping input to governor to set priorities
- Chance to partner with advocacy groups for one voice
- This year SA Council (VACSB) is developing a grass roots program of advocacy which dovetails nicely with our efforts
- Chance to increase public education about TDO's and the commitment process before crises arise
- Remove stigma surrounding mental illness
- Opportunity to define how to measure accountability/streamline paperwork
- Improve MIS to manage forms and training
- Housing planning in cities (Ex. – increased Sec. 8 certificates in Chesapeake)
- Broader opportunities to link individuals in service to housing
- Expansion of mental health and drug courts
- Growth of consumer-driven and consumer-generated support services/support groups
- Chances to partner with advocates for one voice

- Develop/expand guardianship and substitute decision maker programs
- Planning/restructuring effort supports collaboration on meeting needs
- Opportunity to adopt and reinforce value of strength-based approaches/empowerment, recovery, self-determination/regional needs assessment

**Threats:**

- Last budget season was a problem for Commonwealth
- Lack of a driver to push folks into action
- No sharing of resources
- Region is fractured politically
- Change in policy direction driven by anti-tax environment
- Competition from private sector for staff
- Potential liability results in requirements for over-documentation
- Housing
  - Lack of affordable housing
  - Affordable housing is often substandard
  - Affordable housing continues to decrease as cities re-develop
- Lack of funding limits expansion of aftercare services/"revolving door"

**SWOT ANALYSIS  
EXECUTIVE DIRECTORS – HPR5**

**Strengths:**

- VACSB ability to agree on major issues, advocacy, information dissemination
- There are many committed and talented persons in the system who are working every day to improve services for persons with disabilities. Staff have experience working with the most chronically impaired consumers and can provide an expertise based upon this experience that can be critical to the quality of care of such consumers.
- CSBs provide a comprehensive system of coordination of care among diverse service providers for clients with multiple complex needs.

- Public provision of services removes conflict of interest for some services, such as the prescreening process for hospitalization that would be present with the private sector.
- Public funding supports intensive services for the most chronically impaired consumers beyond what a for-profit entity could provide.
- Comprehensive oversight from outside licensure/accreditation entities ensure safety/quality guidelines are met.
- Regional cooperation has improved during the last few years concurrent with budgetary and regulatory challenges.
- The system has worked diligently to reduce or eliminate acute services in public mental hospitals in favor of community-based services.
- The department has been given more ability to work collaboratively with CSBs in the last few years creating a more positive climate.
- The CSB Executive Directors get along quite well. We are supportive of one another, share information and share items so that one board does not have to redo work another CSB has done.
- Serving more consumers than ever
- Cooperation between Dept. and CSBs
- Comprehensive service array with few exceptions
- CSBs work cooperatively to share information and assist each other
- CBBs have a reputation for providing good services
- Locally operated services provided by Boards appointed by local governments are better able to meet the needs of local consumers than are state or privately run services.
- CSBs have over 30 year history of serving the most disabled mentally challenged and addicted people in the community.
- Because the services are operated by local providers in the public sector, consumers have a ready access to voice their issues.
- The current community based Boards have a long history of contracting with private providers and collaborating with other public agencies. Collaboration between agencies is more the norm than would be between private providers.
- Reinvestment has helped us move to a more collaborative and unified system of care. We are the experts in the delivery of MH, MR and SA services.
- Positive shift from facility based care to community care
- Development of more collaborative relationships with DMHMRSAS, DMAS, State Psychiatric Facilities, Private-Public Partnerships, DOC
- Development of solid advocacy and lobbyist groups. Legislators have a better understanding of the issues.
- Quality oversight of program management, i.e. – Office of Licensure, Office of Human Rights, internal and external auditing bodies, comprehensive supervision and oversight of cases
- CSB has a collaborative relationship with other related public/private entities that are internal and external to the locality to expand available resources, maximize revenue and ensure quality of services.
- Committed staff dedicated to accomplishing the mission

- Consumers consistently indicate high level of satisfaction with CSB services on consumer satisfaction surveys
- CSB meets service needs of many indigent consumers with mental retardation and/or developmental delays, mental illness and/or substance abuse
- CSB enriches the lives of consumers and the community system of care and strengthens families.
- 90% of CSB funding (Portsmouth) comes from funds that are independent of the City.
- Resilient and dedicated management team who are adept at providing quality services according to our Mission and Vision in spite of frequent changes in City and CSB management
- Locally based system of service delivery
- Experienced management and staff in all of our communities
- Credibility with elected leadership, media and community at large
- Positive working relationships within the region
- Consumer and family support

**Weaknesses:**

- Lack of sufficient funding
- Lack of inpatient capacity
- Insufficient community capacity especially for non-Medicaid clientele
- Growing homeless and jail populations
- Lack of affordable housing and sufficient public transportation
- Locality provides only minimally mandated local funding necessary to receive State and federal funds. These funds are used to pay for administrative and support functions provided by the locality.
- Inadequate public transportation limits consumers' ability to access needed services and community resources.
- State funding does not meet service needs.
- Lack of adequate safe and affordable housing for consumers
- Underfunded system of care/unfounded mandates
- Financially dependent on Medicaid. Decreasing state funds. Unable to build adequate community capacity to serve consumers. Shifting of State's responsibility for funding the system of care to Medicaid.
- Inadequate services for children. No increase in funding either Medicaid or other for SA services
- Too many consumers not able to fully access services due to inability to meet Medicaid eligibility criteria.
- No specialized programs/services for multiple involved individuals, i.e. – MH/MR; MR/SA; MH/SA, etc.
- Little or no outcome data to demonstrate program effectiveness.
- During the last decade, CSBs have been besieged by threatened and actual budget cuts when more resources are required to address demands on the

system. Lack of adequate funding results in waiting lists and/or overburdened caseloads. In addition, the funding is disjointed with different requirements.

- State and federal regulations, and accompanying documentation requirements, have become excessive, which has demoralized line and administrative staff; unfunded mandates especially from the DMHMRSAS; paperwork in general
- The department appears to wait for leadership to emerge from CSBs, rather than provide proactive leadership. As a correlate, department staff, while more receptive to listening to CSBs, often appear to lack the authority to clear aside barriers to system change.
- No employment focus for MI or SA
- There is little attention at any level to the changing human services workforce. Few people 25 and under are being recruited into the system and many younger workers are not staying in the field due to comparatively low pay and the amount and burden of the work. Other staff are leaving the field or the public system due to burnout of too much to do and not enough folks to do it.
- Shortage of critical staff or services such as psychiatric staff, particularly with specialty in children and adolescents, TDO beds or alternatives, safe and affordable housing, transportation
- Aging caregivers of the chronically disabled MR and MH clients with no resources for future planning. Our system has traditionally been very dependent on family members providing key services. These family members are aging and the younger members of the family are not willing to take responsibility for a disabled family member.
- System is top heavy with paperwork; consumers are suffering the effects. Good employees are leaving the system. It's a major morale buster. Those who try don't ever seem to get it right according to the regulatory police. Those employees who don't, pass/aggress on the issue causing major data base corruption.
- Workforce is diminishing and in danger of critical shortages.
- Some service gaps identified years ago are still in existence with no improvement. Residential is the most prominent for all MH/MR/SA. Crisis intervention/stabilization is another large one. Little increases in local emergency response teams to address the shrinking bed capacity is a critical weakness. This is also a threat if not addressed immediately.
- Some services are available and needed but cannot be provided due to lack of adequate reimbursement rates/capacity building funds.
- So many regulations tax current staff to the point of expecting the impossible
- Inadequate resources for indigent medications. No indigent medication program in the state, only an Aftercare Pharmacy for those returning from a state facility
- Lack of specific leadership/guidance/hands on involvement by CO on issues that impact the region.
- Lack of support by individual CBSs to create legitimate regional programs with guaranteed access to all Boards in the region; aversion to creating regional entities

- The system of care is grossly underfunded.
- There is little or no collaboration between local providers and the many state agencies that support the CSBs. For example, DMAS and DMHMRSAS have not collaborated to resolve who is responsible for TDO beds.
- DMHMRSAS requires a significant amount of non-service, producing overhead and administration. 40% of the service worked time is spent in paperwork and administration.
- There is simply no leadership on statewide policy related to MH, MR or SA services other than they want something other than what we have now.
- Each year, more and more non-services requirements are placed on the public sector that is not in place on the private sector; therefore, we spend an excessive amount of resources on administration.

### **Opportunities:**

- Through reinvestment, continue effort to increase community care by building community capacity
- Continue to shift state facility dollars to the community
- More collaboration and partnership building among State facilities, DMHMRSAS, DMAS, CSBs, DOC, private providers
- Develop an outcome based system of care
- Maximize the current trend in the Recovery Movement by having consumers more actively engaged in their recovery process
- Potential sale of ESH may result in increased programming/funding opportunities to expand community based programs
- State DMHMRSAS is offering to expand crisis stabilization programs in respective regions – potentially two for HPR5
- Local efforts to improve and integrate human services system
- Local efforts to support service capacity through improved/new physical space and infrastructure
- Community outreach to pull together all the diverse, well-trained regional staff and management to increase community support for chronically impaired consumers
- Private-public partnerships could result in increased community services
- Development of system of care to involve initiatives from family members and consumers and increase interdependency within the community
- Increased education of the public regarding the mental health, mental retardation and substance abuse systems and its interface within their lives. This has reduced some of the stigma.
- The reinvestment projects are fostering significantly greater cooperation between involved CSBs and pressuring regions to utilize their resources in more effective and efficient ways.
- Virginia appears to be more competitive with other states in obtaining federal grants which are much needed to import innovative technologies for service delivery.

- There are more providers of some services providing more opportunities for us to partner with them.
- As new waiver slots/funding is approved, more people can be served.
- By re-organizing state resources, including facilities, to develop opportunities in the local communities to max local strength while at the same time developing regional programs with guaranteed access for those services that would not be available to all local CSBs because of economies of scale.
- Do more to entice future human service providers to the field. This is critical in rural areas that don't have a dynamic/broad based/highly populated labor pool to draw from.
- By better planning for and phasing in growth and new services when they become available, taking into consideration special needs of each Board/locality.
- Technology should bring better operation/communication opportunities, particularly to aid smaller CSBs to control admin/operational overhead.
- Develop a state-wide indigent pharmacy program that includes entire indigent chronic population, not just the aftercare population.
- If done correctly, the public sector, representing local government, can partner with the state and private sector to develop a provider model.
- There must be some integration of physical health with behavioral health care. Currently, the majority of physical health care is provided in the private sector and the majority of behavioral health care is in the public sector.
- Moving resources and consumers out of facilities where they can is the right model from a fiscal, human rights and efficiency standpoint.
- There must be more integration between the behavioral health care and criminal justice systems.

### **Threats:**

- Dwindling work force and paperwork overkill!!!
- Growth without taking into consideration CSB-specific and regional-specific planning for the benefit of all communities.
- Lack of funding for expenses not reimbursable through fee for service, specifically admin and technical costs like IT/automated data bases for all activities and services.
- Communication gaps between the Dept. and CSBs when changes occur. No guidance-specific actions from the CO on local and regional needs/development. Specifically, the current ECO/TDO bed crisis, the failure to maintain POS for psych beds for areas that could benefit directly in their respective communities utilizing psych bed services.
- Too many regulatory entities with no coordination to eliminate redundancy, creating contradictory requirements, a volume of regs that no one can effectively enforce and creating an environment that results in an inability to provide needed services.

- Shrinking resources gravitating toward the massive demands of the highly populated areas at the expense of the lesser populated rural areas.
- Lack of other local resources in the rural communities such as religious organizations, non-profit providers, public shelter programs, medications programs, etc. that provide ancillary support to urban/suburban CSB clients.
- Privatization that does not take into account the needs of the most difficult clients and service areas that are not profitable to serve, i.e. – low population density, isolated rural areas.
- Because of leadership void at the state-wide level, someone or some organized group will fill the void. While we are planning for some ideal system, it is being given away to the private sector.
- Because of government bureaucracy and inefficiency, the public sector can not be as cost effective as the private sector.
- Cap on Medicaid, and our system has already leveraged itself on Medicaid funding.
- Too few services in the community and we get blamed when something goes wrong. Accountability is a hammer.
- Growing number of clients that are treatment resistant, non-compliant, criminally involved, impulsive, suicidal, violent and use lots of resources
- Aging workforce; the retirement of baby boomers, coupled with the declining proportion of younger people entering and staying in the field, will create a vacuum.
- Aging caregivers and aging consumers with resulting increased case management needs
- Cutbacks of medication for indigent consumers from pharmaceutical companies. We get \$400,000+ a year in free medications from the pharmaceutical companies, which is great, but what happens when they have to pull the plug on this because of sagging profits.
- Increased need for local government to utilize DMHMRSAS agency staff and resources for other challenges, e.g. disaster relief for local citizens. Increased incidents of all levels of government to look to the CSB to solve the problem without additional resources
- Unless advocacy efforts become more widespread and effective, especially in SA, CSBs will generally become more unable to address the many needs of their service populations since resources will dwindle.
- The Reinvestment Projects are endangered in that they lack sufficient resources to implement community-based resources as they have accepted the responsibility for providing acute care.
- Proposed state budget cuts and use of block grant funding in FY-06 may impact the ability to provide service delivery and result in increased homelessness, crime, overloaded emergency rooms, youth risk factors and lack of ability of families to care for family members.
- Over-regulation results in increased paperwork burden with possible loss of revenue, less time for direct services, high degree of debate regarding service implementations.

- Sale of ESH may be the beginning of a privatization process of the community mental health system and/or HPR5 specifically.
- Take over of the service delivery system by HMO
- Medicaid caps and/or restriction on the use of Medicaid dollars
- SPO services, i.e. – case management, MH supports open to private providers. Since there are so little state and local dollars coming to the Board, we use Medicaid generated dollars to subsidize psychiatric services, outpatient services and services for individuals who are on a sliding scale. If Medicaid dollars are reduced, many services and consumers will be in jeopardy.
- Regionalism may have a consequence of splitting the CSB system.
- Liability to the Boards increases as inadequate funding and resources continue.