

2012 Mental Hygiene Priority Outcomes Form
Erie County Dept. of Mental Health (70290)
Plan Year: 2012
Certified: William Fremgen (6/1/11)

Consult the LSP Guidelines for additional guidance on completing this exercise.

2012 Priority Outcomes

Priority Outcome 1 In Progress
To ensure that services in the Adult Mental Health System are focused on rehabilitation and recovery

The actions and strategies to be used in order to ensure that adults are being served in the behavioral health system with improved rehabilitation and recovery outcomes are described below.

The Erie County Department of Mental Health (ECDMH) continues active participation in the WNY Care Coordination project. ECDMH staff will continue to take leadership roles in this transformation effort and to support the value of employment as an essential component of recovery.

Erie County has implemented PROS programs, will continue implementing Clinic Restructuring, and is beginning to implement a Recovery Center. These programs reinforce person centered approaches to support recovery, and track recovery outcomes with a focus on employment. With OMH, we will continue to support evidence based approaches to help individuals get and keep jobs.

It is critical that as we implement these system changes, that OMH, the County and the Agencies attend to the following:

- Work force training/retraining
- Fidelity to practice
- Quality Improvement
- Disproportionate minority representation at the highest levels of care.
- Data reliability

Because it has been our experience that availability of real time data across programs and agencies supports improvement in outcomes and system accountability, Erie County has expanded the use of consistent program performance measures across similar programs. These performance measures include both system goals, such as reducing the use of inpatient and emergency rooms, and recovery goals, such as involvement in community activities and employment.

Erie County is continuing to work with contract agencies to align contract outcomes with recovery practices and outcomes. The County has also changed our traditional contract to better articulate performance accountability i.e. "Is Anyone Better Off" and making Quality Improvement Plans a requirement of the contract.

Agency: OMH;
Target Complete Year: 2011

Strategy 1.1 Accomplished

PROS Implementation

Objective 1 - Train Agencies - completed

Objective 2 - PARS submitted and approved - completed

Objective 3 - Program implementation - completed except for Horizon and RSI

Objective 4 - Program Evaluation

- Erie County is requesting access to CAIRS and NYISER data in order to evaluate the success of PROS against recovery indicators and to integrate services for individuals in the the Single Points of Entry for Care Coordination and Housing

2011 Progress: PROS has been implemented at the following agencies:

- Spectrum
- Lake Shore
- Mid-Erie
- Horizon

We still do not have direct access to performance reports on these programs. Upon request, we are being sent a capacity report and Medicaid data. We are unable to access system evaluation and program evaluation data such as race/ethnicity of individuals served, point in time capacity etc. 2012 progress We are moving forward with the implementation of a Recovery Center. Performance measures will be focused on the following service components:

- Non-traditional Work Support
- Credentialed Benefits Advisement
- Life Coaching
- Financial Literacy
- Parenting Support

Agency: OMH;
Target Complete Year: 2011

Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity);

Strategy 1.2 Accomplished

Improve Site Visit Process

This strategy is important to do now because reductions in state aid are resulting in our need to use resources more effectively. Site visits are an important tool to help us be more informed about programs in order to take any necessary actions such as working with agencies to improve programs or reallocating the resource to programs better supporting recovery for the target populations.

Site visits are time consuming for staff but the quality of these reports are inconsistent. Site visits in general had not been focused on critical issues and the length of time it takes to issue a report varied from a few weeks to several months. As a result, staff was spending time working and reworking site visit reports, changes in practice at the program level could not take place in a timely fashion, and the Department did not have sufficient information to make resource allocation decisions as part of the integrated quality improvement plan in support of optimizing recovery outcomes.

This strategy fits into the Department's vision regarding fidelity to practice and recovery outcomes for high need, high risk individuals. We will improve the quality of site visits as evidenced by an increase in critical issues addressed in the report and request for agency corrective actions, and by shortening the length of time between the visit and issuing of the report within the 3 month project time frame.

2011 Progress: Since the last Local Plan submission the process for site visits has been expanded to include many of Children's system of care services. While doing so the site review process has incorporated a review of outcomes and related practices not only found w/n the case record itself but also that which is supported via the Critical Data Dashboards in place for both the children's care coordination services as well as those services w/n the Juvenile Justice system. We have begun holding joint site reviews with Community Connections of New York which, along with the ECDMH takes the opportunity to review various data metrics as well as progress against established Quality Improvement Practices. Site visits are now part of the Agency/program evaluation process. Because of the work done prior to the site visit and the collaboration of the work team, draft site visit reports are usually given to the agency at the close

of the site visit. Final reports are sent within two weeks. As a result, we have increased the effectiveness of this process and our agency customers are pleased with this approach. This process was developed to focus on Adult programs and Housing programs. The process is being expanded to include programs serving Children.

Agency: OMH;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: Yes
Focus: Quality Management;

Priority Outcome 2 In Progress
Integrate Services for high need, high risk individuals through improved discharge planning, care coordination and system evaluation

The actions and strategies to be used in order to ensure that adults are being served in the behavioral health system with improved rehabilitation and recover outcomes are described below.

The ECDMH continues to integrate the Adult Single Point of Entry with Housing and Forensic services to provide a broader range of coordination and systems evaluation for our high-need, high-risk consumers. Our goal is to provide recovery-oriented services and to strengthen discharge planning services through training and enhanced staffing in order to better bridge the community mental health system and the forensic mental health population. Our next area of focus is to develop methods of identifying high need, high risk individuals prior to their "deep end" penetration into the service system, establish consistent level of care criteria, and to shorten lengths of stay in order to better use limited resources.

As part of the Western New York Care Coordination Program, the Erie County Department of Mental Health will continue to identify approaches to improve the integration of primary health care and behavioral health care.

Agencies: OASAS; OMH;
This outcome has been selected as a top two priority for OMH.
Target Complete Year: 2012

Strategy 2.1 In Progress

Successful community reintegration of parolees returning to Erie County:

Implementation of a Reentry System Level Task force having a subcommittee structure to explore community strengths, limitations, and barriers to the successful reintegration of parolees to the community.

As a result of the Reentry System Level Task Force procedures and/or resources will be identified so as to positively impact community integration with respect to housing, benefits, and employment or other measures of community integration deemed necessary and critical to reduce parolee recidivism by the community Reentry System Task Force.

Objective 1 Convene initial Reentry System Level Task Force of community stakeholders

Objective 2 Develop working Subcommittee structure each of which will identify and prioritize critical system level resource needs, related challenges and required solutions critical to facilitating effective Community Reintegration

Objective 3 Implement at least one system level solution

2011 Progress: Erie County has developed a Reentry Taskforce consisting of 42 federal, state, county, community-based and faith-based agencies. This group meets every other month at a central location in Erie County to discuss the system level progress in servicing former offenders in the community. The Taskforce has developed a case management model that works with the Erie Reentry Unit in Orleans Correctional Facility, Albion, NY, and the Buffalo Office of NYS Parole servicing approximately 400 former offenders per year. The Taskforce continues to work on additional goals of community awareness/education and identifying the system gaps and barriers in the reentry process. The Taskforce has developed a subcommittee structure that addresses barriers in the areas of housing, employment, education, public benefits, mentoring and case management. These groups meet regularly to develop and implement solutions for the system wide gaps. Current issues include increasing housing capacity, developing employment opportunities, organizing mentoring activities, expedite public benefits and the provision of a comprehensive case management model. This is an ongoing process that could continue beyond 2012. The community education component has developed and launched a reentry website in WNY. In collaboration with Niagara County and 211 WNY, the Taskforce hosts <http://www.wynnewstart.org>, which is designed to reach out to former offenders, family members, and service providers with reentry information that can assist in successful reintegration back in the community. This site speaks to the importance of the first 72 hours after release and easy access information of all service providers that work with reentry in Erie County.

Agencies: OASAS; OMH;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: Yes
Focus: Criminal Justice; Cross System Collaboration;

Strategy 2.2 In Progress

Improve housing data management in order to better serve high need, high risk individuals.

Our goal is to have a standard set of information on individuals in all levels of care that would allow us to perform the following Housing SPOE critical functions including:

- Review of referrals prior to admission in order to assure access by high need, high risk individuals
- Monitor wait lists
- Targeted administrative quality and UR reviews of individuals
- o Length of stay
- o Progress on system outcomes
- o Progress on recovery outcomes
- Capture outcomes across providers and levels of care, including state operated (BPC) residential services
- o Have those outcomes be transparent to users, consistent with the level of information that they need to develop report cards or dashboards based on these outcomes
- Be able to cross reference individuals in housing to those in other services
- Track individuals with state inpatient (BPC) long lengths of stay in order to improve system performance with this group of individuals.

2011 Progress: 2011 Progress: The Housing Providers have had agreed to use the same outcome reporting that is used by Care Coordination Programs participating in the New York Care Coordination program. In order to minimize the data entry burden on providers and the housing SPOE, we originally agreed to use CAIRS moving forward. However, because CAIRS is not available to the County, we will continue to develop an alternative electronic reporting system. Progress has been made towards this goal with the development of intensive collaboration between the Department and Community Connections of New York (CCNY). The architectural framework has been developed for a multiple task electronic management tool that is projected to be complete by July 2011. We are moving forward using a single, web based referral format for both Housing and Care Coordination. The goals are as follows:

- Improve our ability to triage and manage referrals
- Allow us to better manage wait lists for licensed housing
- Enable us to use Quality Improvement measures on SPOA activities
- Better integrate housing and care coordination for high need high risk individuals
- Start moving towards Utilization Management

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Agencies: OASAS; OMH;
Target Complete Year: 2011

Is this an innovative practice that you would like to share with others?: No
Focus: Housing; Service Access (Capacity);

Strategy 2.3 In Progress

Facilitate movement of BPC long stay individuals into housing in the community.

As a result of the implementation of a new supported housing program 30 individuals will transition from long stays in the Buffalo Psychiatric Center into community living.

Objective 1 - supported housing program will be implemented at a community based voluntary agency

Objective 2 - the Buffalo Psychiatric Center will begin offering intensive preparation for individuals identified to move to a supported housing apartment in the community

Objective 3 - the Voluntary agency and the Psychiatric Center will begin working with individuals to transition into the community

Objective 4 - the Voluntary agency will establish two leased apartments in the community for training and transition purposes

Objective 5 - Identified individuals will move into the community with a goal of 10 individuals/quarter until the target enrollment has been met

Objective 6 - the Erie County Housing SPOA, the Voluntary Agency and the Psychiatric Center will identify and address barriers to this process with a goal of establishing a replicable program.

2011 Progress: We started with a capacity of 30 beds and were awarded an additional 23 beds in 2009. In October of 2010, we were awarded an additional 10 beds for a total of 63 BPC long stay beds. As of April 2011, we have 42 individuals placed into permanent supported housing with 5 waiting placement for a total of 47. Continued progress is being made with regular interactions with the regional field office, the BPC, and Housing Options Made Easy to create the philosophical shift to facilitate greater independence at this level of community housing. We started with a capacity of 30 beds and were awarded an additional 23 beds. As of April 15, 2010, we have placed 34 long stay individuals in housing with 9 pending approval for a total of 43. All of these individuals were placed in independent apartments. 2012 update We still have

Agencies: OASAS; OMH;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Housing;

Strategy 2.4 In Progress

Strategy 2.4 Improve the functionality of the Single Points of Entry for Adults

In conjunction with the Western New York Care Coordination Project Management Demonstration Program and Beacon Strategies, accomplish the following, consistent with providing the right service to the right person at the right time:

- improve case finding capabilities
- enhance medical necessity criteria and introduce consistent application of criteria across the region
- calibrate provider services offered and enrollee services needed
- foster consistent provider capabilities for individuals with serious mental illnesses
- improve coordination between medical and behavioral health care
- better control costs

Phase I objectives include:

- Implement a process to identify the highest risk individuals, as defined by selection criteria related to items such as inpatient utilization, co-morbid conditions etc. for SPOE/A services
- Implement a process for non-binding utilization management to be utilized with long length of treatment or highest risk individuals
- Implement level of care criteria
- Implement on-line SPOA/E application and associated reporting

In Erie County, because of problems using CAIRS and the inadequacy of the CAIRS system in supporting SPOA functions for the Adult System of Care, we are in the process of developing an information system to do so.

2011 Progress: In collaboration with the Western New York Care Coordination Program, Beacon Health and Spectrum Human Services, Erie County is piloting a Complex Care Coordination program in order to provide Care Coordination Service to individuals. We are using Medicaid Adjudicated Claims to identify high risk high need individuals with serious co-morbid physical and behavioral disorders. We have broadened eligibility for this initiative to referrals coming into the SPOA who we can demonstrate will fit this criteria if we had more immediate access to their Medicaid claim history. Also in collaboration with the Western New York Care Coordination Program and Beacon Health, we are encouraging Adult Care Coordination and Treatment Agencies to participate in voluntary non-binding utilization management. The first phase of this effort has been to distribute the following sets of reports:

- the county benchmark report
- the provider contrast report
- client profile reports

Level of Care Criteria have been developed for several levels of care by the Western New York Care Coordination, Beacon Health and the providers. The on line SPOA application was piloted mid-2009 for both Care Coordination and Housing. The pilot application was used minimally for Care Coordination but was more difficult for the Housing providers. Extensive work was done with local providers, particularly Housing providers, to shape the next version of the SPOA application. In Erie County, we are no longer able to use CAIRS. While we had been using CAIRS to support the SPOA, it was inadequate to support SPOA functions for the Adult System of Care. As a result, we are in the process of developing an information system to do so. 2012 Update The following SPOA reform initiatives will be implemented:

- Target individuals high cost individuals for engagement in Care Coordination services
- Improve the functionality of the Adult Single Points of Entry using Utilization Management approaches
- Critical Time intervention

SPOA Reform - Targeting High Users. As part of the previously described SPOA reform, we targeted Erie County Adults who had used Mental Health services and who, in a three month period, had a Mental Health hospital admission and a previous Behavioral or Physical Health admission in the prior 90 days, excluding individuals with nursing home or prior OPWDD claims. The source of data was Erie County Fee for Service Medicaid. This data run resulted in 192 individuals who we are defining as high cost/high need. The total cost of these 192 individuals in 2010 was \$7,827,745.

	2010 Cost
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Substance abuse	\$ 414,334
Mental Health	\$ 4,546,455
OPWDD	\$ 59
Physical health	\$ 2,203,908
Pharmacy	\$ 662,989
Total	\$ 7,827,745
Average Cost per person	\$ 40,770
Standard deviation	\$ 33,995
Mean Cost per person	\$ 31,390
Highest Cost person	\$ 195,135

The SPOA reviewed the highest cost individuals from this group to triage outreach and engagement by Care Coordination Agencies, and are including the most recent contact information that we available. With the Agencies, we have developed a process for referral from the SPOA and created a tool to track engagement activities /timeframes. We are currently evaluating practices used by Care Coordination Agencies in the engagement process in order develop timing and practice standards. Adult SPOA reform will be moving towards · Shifting from "individual meets admission criteria" towards assessment and triage to ensure right person, right service, right time and right length of time. Utilization management throughout the SPOA/Care Coordination process i.e. front and back door management of services · Timely access · Consistent practice across Agencies/Programs · Data driven decision making · Predictive modeling for high cost individuals. These interventions not only need to pay for themselves, they will need to result in cost savings Critical Time Intervention (CTI) is a nine-month case management intervention designed to enhance continuity of support for persons with severe mental illness during periods of transition. Such periods may include the months following discharge from hospitals, jails and other institutions, the transition from homelessness to housing, or the transition between different levels of treatment and support. CTI operates in two ways: by strengthening the individual's long-term ties to services, family, and friends; and by providing emotional and practical support during the critical time of transition. An important aspect of CTI is that post-discharge services are delivered by a worker who has established a relationship with the client before discharge. CTI shares with long-term assertive community treatment models a focus on promoting in vivo development of independent living skills and building effective support networks in the community. The emphasis, however, is on maintaining continuity of care during the critical period of transition while primary responsibility gradually passes to existing community supports that will remain in place after the intervention ends. Such an approach, we believe, increases the likelihood that the impact of a time-limited intervention will persist beyond its actual endpoint, which is the primary goal of CTI. CTI is delivered in three phases, each of which lasts approximately three months (see table). Phase one--transition to the community--focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers. Ideally, the CTI worker will have already begun to engage the client in a working relationship before he or she leaves the institutional setting. This is important because the worker will build on this relationship to effectively support the client following discharge from the institution. The CTI worker generally makes detailed arrangements in only the handful of areas seen as most critical for community survival of that individual. Phase two--try out-- is devoted to testing and adjusting the systems of support that were developed during phase one. By now, community providers will have assumed primary responsibility for delivering support and services, and the CTI worker can focus on assessing the degree to which this support system is functioning as planned. In this phase, the worker will intervene only when modification in the system is needed or when a crisis occurs. Phase three--transfer of care-- focuses on completing the transfer of responsibility to community resources that will provide long-term support. One way in which CTI differs from services typically available during transitional periods is that the transfer of care process is not abrupt; instead, it represents the culmination of work occurring over the full nine months. CTI is an evidence-based model that has been tested in several rigorously designed trials. It is listed in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). Further information is available at www.criticaltime.org

Phase	Transition	Try-Out	Transfer of Care
Timing	Months 1-3	Months 4-6	Months 7-9
Purpose	Provide specialized support & implement transition plan	Facilitate and test client's problem-solving skills	Terminate CTI services with support network safely in place
Activities	<ul style="list-style-type: none"> · CTI worker makes home visits · Accompanies clients to community providers · Meets with caregivers · Supplements the role of caregivers when necessary · Gives support and advice to client and caregivers · Mediates conflicts between client and caregivers 	<ul style="list-style-type: none"> · CTI worker observes operation of support network · Helps to modify network as necessary · Intervenes when a crisis arises 	<ul style="list-style-type: none"> · CTI worker reaffirms ongoing roles of support network members · Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification). · Holds party/meetings to symbolize transfer of care

Agencies: OASAS; OMH;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity); Quality Management;

Strategy 2.5 In Progress

Complex Case Management

The Department will work with Beacon as part of the Western New York Care Coordination Program to implement SPOE/A best practices, and Complex Case Management.

The complex case management component of the WNYCCP managed care initiative will focus initially on 200 individuals across the project counties. These individuals will be drawn from the top 10% in total Medicaid paid health care costs out of the total cohort of users of mental health services. The cost and diagnostic profile for these individuals indicates that a complex case management approach that is focused on improved access to and coordination with community based services and supports, and a wellness/illness self-management strategies could lead to significant cost savings.

Note that complex case management will be an added resource for individuals with serious behavioral health issues and co-occurring physical health problems, and will complement current care coordination.

2011 Progress: Across the WNYCCP counties, 488 individuals were identified as eligible based on Medicaid adjudicated claims. 113 were put on hold because of Health Insurance status, and outreach was begun on 369. Of these 369, 80 had already been enrolled in Care Coordination, and 89 were ineligible for a variety of other reasons such as moved out of county, in jail, in nursing homes etc. Access to accurate current addresses has been a perceived barrier to finding and enrolling individuals. We have found that relationships with service providers are a good resource to find individuals. However, we need to improve our ability to identify and engage high need, high risk individuals with complex needs. We have begun to accept some "live" referrals i.e. individuals who meet the risk and need criteria for this program prior to their showing up on Medicaid adjudicated claim. Our planned next steps are:

- Operationalizing the new Data Exchange Agreement so that we are using more current data
- Analysis of barriers to finding individuals based on experience to date, with recommended action steps
- Development of an MOU with the Center for Transportation Excellence.
- Spectrum will develop internal procedures and criteria for outreach
- We will ask the WNYCCP Steering Committee to address the impact of decreasing numbers of individuals with Fee For Service Medicaid as a result of mandated enrollment in Medicaid Managed Care for individuals on SSI.

Agencies: OASAS; OMH;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Service Engagement;

Priority Outcome 3 In Progress
Continued Implementation and Expansion of the Children's system of Care Reform Initiative for Children to decrease out of home placement and ensure community integration.

The Department has forged highly successful collaborations with the Erie County Departments of Social Services, Probation and Health to identify opportunities within a matrix of organizational structures to redefine reporting relationships and reform service practice in support of service coordination, integration, and accountability in each of the following areas:

- o Adoption, Foster Care and Preventive Services;
- o PINS and JD Diversion & Supervision Services;

Each of these transitional initiatives will be data driven, define change opportunities in response to identified problems and criteria for success and will utilize a process that includes broad based input of the diverse stakeholders, the empowerment of a leadership team, and team building activities that support a learning community culture. To the extent possible, each initiative will include technical supports to enhance communication, implement quality improvement, and increase accountability.

- Initiatives will be evaluated using a set of common elements including:
 - Capacity – utilization of assigned slots
 - Engagement – first face to face visit w/specified number of days depending on program type
 - Functional improvement – consistent with service plans
 - Out of home placement – reduction in RTC, stabilization in community
 - System penetration – diversion from higher levels of care

2010 - Erie County is positioned to sustain the System of Care:

- The Erie County System of Care has developed a sustainability plan that ensures the continuation of services past the completion of the grant. A variety of local DSS and OMH monies have been blended to sustain and improve a variety of community services
- Presently capacity and flexibility of community services are meeting the needs of youth and families in our community. Most community services are designed to meet the needs of high risk/high need youth and their families. Outcomes are showing more youth are successfully remaining in their community and homes
- The growing quality improvement and management oversight infrastructure and practice ensuring the achievement of valued outcomes through the efficacy of practice to outcomes paradigm.
- The impact will be improved access and integration of services to support high risk high need families/youth. The 'right service to the right child/family at the right time'. In 2009, Model Family Court project concluded. This implementation was successful both to the multi-department and multi-system collaboration established through the primary Family Court Judge. This initiative will continue to be worked on through a quality improvement approach.
- The C.A.R.E.S. program began in July 2009 with the primary goals of supporting families in resolving crisis situations in their own home or community and to help them prevent future crisis from occurring. From July 2009 thru March 2010 the service received 1190 initial calls (one call only), with 465 visit requests and completed 386 initial visits. Of these initial visits, 333 resulted in in-home stabilization and 40 led to transportation for a psychiatric evaluation. During this same time frame the service made and received a total of 7823 calls, had a total of 644 visit requests, and completed a total of 599 visits. Of these visits, a total of 507 resulted in in-home stabilization while 69 resulted in transport for a psychiatric evaluation. It is also noted that the service was designed to serve the children's system of care (CSOC) and data through this month reflect referrals from a broad range of service providers and other community stakeholders throughout the CSOC.

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Agencies: OASAS; OMH;
This outcome has been selected as a top two priority for OMH.
Target Complete Year: 2011

Strategy 3.1 In Progress

3.1 Reduce the number of out of home placements.

Objective 1 - Shortening the normative length of stay in Residential Treatment Centers

Objective 2 - Implement a Quality Improvement Initiative focused on changing practice in residential treatment centers for children/youth enrolled in the shortened length of stay component of Family Voices Network.

Objective 3 - Evaluate experience against established milestones as specified in the quality improvement plan

Objective 4 - Establish practice standards for both the RTC and Care Coordination Program that result in shortened lengths of stay and are replicable for other RTCs and Care Coordination Programs

2011 Progress: In 2011, after implementing the Juvenile Justice Dashboard, the Department continued its work and refined the critical data dashboard to more accurately reflect critical data metrics reflective of preventing further juvenile justice penetration, enhancing the percentage of youth who remain in the community, and successful discharge to name a few. The learning community spoken of has been implemented and is supported by the work of Community Connections of NY (CCNY) in collaboration with the Department. The work group utilizes data analysis at the system, provider, and individual worker level to develop quality improvement practices in the practice to outcome model. 2011 Progress:

Majority of Residential Treatment Center placement orders have been reduced to 6 month orders with the understanding when the family has the necessary supports in place the youth can potentially be returned home in a variable length of stay. The normative length of stay is in the range of 4-6 months with minimal recidivism rates to out of home care. The Quality Improvement initiative has continued to evolve and improve. There is a working relationship between the department and a few local residential Treatment agencies to challenge historical residential services delivery and evolve into a more intergraded model with the focus of timely, successful reintegration of the youth back into their home community in order to sustain this movement. The county is in the process of identifying ways to shape contracts with residential providers to reinforce the practice and measure its outcomes. We have also expanded the scope of the initiative. Families who already enrolled in the Family Voices Network remain with their agency/team to reduce disruption for the family. Placement is evolving as part of the system of care not an end point due to failed community interventions. Quality Improvement plans have become integral to contract agencies and the county. Through identification of benchmark of the agencies dashboard, quality improvement plans have been developed to improve practice. Learning communities have been function in the agencies and program to help each other to improve the delivered practice for the improvement of families' impairments resulting in youth remaining in their homes. There has been an intentional movement toward ensuring youth are placement as close to home as possible to sustain family contact and ensure timely successful reintegration back to home. A data driven practice model has been introduced to support service delivery and improvement strategies with the focus of sustain youth in the community and when necessary to be placed in out of home care it is done in a focused, timely, successful manner. The Department continues to support regular learning community meetings with its provider network to support and identify promising practices, and create greater accountability to the primary goals of reducing system penetration and increasing community based care. These efforts are supported by the Quality improvement planning processes each of these providers have implemented through consultation with CCNY and the technical assistance that they and the Department provide.

Agencies: OASAS; OMH;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity); Service Engagement;

Strategy 3.2

In Progress

3.2 - Improve community standards of practice for service to high need/high risk youth.

Objective 1 - Implement and sustain a Family Voices Network Quality Improvement Process with necessary data support and infrastructure

Objective 2 - Implement and sustain a plan for vendor service development that improves the efficacy of services, vendor responsibility to deliver services in the context of the achievement of planned objectives and the achievement of cultural competence

Objective 3- Ensure that Care Coordination is being carried out consistently with local standards of care including cultural and linguistic competence

Objective 4- Implement and sustain a business plan for fiscal oversight and centralized management of and payment for Wraparound purchases in a manner that assures fidelity of practice.

2011 Progress: 3.2. Objectives 1 and 3 – The quality improvement processes implemented during 2010 have not only been sustained but also enhanced through the expansion of various tools, reports and specialized initiatives. • CCNY continues to provide monthly EQUIPS reports (Evaluation and Quality Improvement Program Support) to all agencies providing services both within Family Voices Network and the Children’s System of Care as a whole. • The EQUIP report provides the necessary data to monitor, track and trend both fidelity to wraparound practice as well as locally identified standards of practice. • The EQUIP report was modified to provide analysis of pertinent variables by race and ethnicity in order to identify and act on disparities among racial and ethnic groups. • The report allows for analysis of disparities in objectives met or not at case close, levels of improvement in youths functional impairment, and living situation/placement rates by system, program and individual worker. • CCNY meets regularly with all provider organizations within the system of care to provide support, monitoring and quality improvement technical assistance. • Additional evaluation and quality improvement initiatives focused on measuring and monitoring fidelity of practice within Care Coordination include a Child and Family Team Analysis, development of a transition tool with subsequent monitoring and QI, a document review measure and an annual family voice and choice survey. • A hybrid training curriculum (mixed on-line and in-person delivery) is being developed in conjunction with the department of mental health to provide sustainable quality improvement training to providers within the system of care. • A CLC and disparities scorecard on-line application was developed by CCNY and is being piloted by a local agency with an anticipated larger launch of 2nd quarter 2011. This application allows an organization to assess its cultural and linguistic competence in conjunction with disparities in client outcomes, incidents, and organizational infrastructure and includes a “traffic light” guidance system with quality improvement plan development built in when data analysis by the program may be indicative of a problem area (yellow or red light in the “traffic light” system). Erie County Department of Mental Health and CCNY are facilitating a community learning forum and associated workgroup focused on developing local capacity to address disparities through data and quality improvement. • Training on core CLC competencies continues to be provided via both on-line and in-person training opportunities. • New trainings being offered this year to the vendor network and care coordinators include: ○ Conflict resolution ○ Transition ○ Cultural Strengths and Discovery

Objective 2 – Implement and sustain a plan for vendor service development that improves the efficacy of services, vendor responsibility to deliver services in the context of the achievement of planned objectives and the achievement of cultural competence. CCNY continues to provide on-going development and quality improvement oversight and assistance to the vendor network to improve efficiency and effectiveness of services, achievement of cultural competence and achievement of planned objectives. These include:

- On-going analysis of utilization of and service provision within various vendor service codes ○ This process includes analysis of utilization trends, re-definition of codes as necessary, re-training of service providers as necessary as well as gaps analysis • CCNY has instituted an annual contract compliance and organizational infrastructure assessment process for all agencies within the vendor network. This allows CCNY to assess compliance with contract requirements as well as fidelity to practice. The assessments result in development of targeted quality improvement plans based on the identified barriers. • A CLC and disparities scorecard on-line application was developed by CCNY and is being piloted by a local agency with an anticipated larger launch of 2nd quarter 2011. This application allows an organization to assess its cultural and linguistic competence in conjunction with disparities in client outcomes, incidents, and organizational infrastructure and includes a “traffic light” guidance system with quality improvement plan development built in when data analysis by the program may be indicative of a problem area (yellow or red light in the “traffic light” system). Training on core CLC competencies continues to be provided via both on-line and in-person training opportunities. • New trainings being offered this year to the vendor network and care coordinators include: ○ Conflict resolution ○ Transition ○ Cultural Strengths and Discovery

Objective 4- Implement and sustain a business plan for fiscal oversight and centralized management of and payment for Wraparound purchases in a manner that assures fidelity of practice. CCNY continues to implement fiscal oversight of wraparound vendor purchases through a centralized management process including but not limited to:

- Timely reimbursement to vendor agencies of accepted progress notes (progress notes indicate accepted service provision which then triggers the billing) • Trending and monitoring of critical data relative to spending patterns and vendor utilization (supports prospective management of funds) • Trending and monitoring of key financial practices and planning as they relate to critical standards of practice • Development of necessary reports to support both vendor and Care Coordination supervisors in fiscal oversight of their programs • Monthly EQUIPS includes real-time data detailing vendor expenditures by program, care coordinator and case level detail (every month) ○ Progress note Overlap report has been created to assist vendor and care coordination supervisors in monitoring service and billing detail to detect and correct errors in record keeping and billing

Timeliness of planned actions for service ○ Timeliness of progress notes documenting services

3.2. Objectives 1 and 3 – The quality improvement processes implemented during 2010 have not only been sustained but also enhanced through the expansion of various tools, reports and specialized initiatives. • CCNY continues to provide monthly EQUIPS reports (Evaluation and Quality Improvement Program Support) to all agencies providing services both within Family Voices Network and the Children’s System of Care as a whole. • The EQUIP report provides the necessary data to monitor, track and trend both fidelity to wraparound practice as well as locally identified standards of practice. • The EQUIP report was modified to provide analysis of pertinent variables by race and ethnicity in order to identify and act on disparities among racial and ethnic groups. • The report allows for analysis of disparities in objectives met or not at case close, levels of improvement in youths functional impairment, and living situation/placement rates by system, program and individual worker. • CCNY meets regularly with all provider organizations within the system of care to provide support, monitoring and quality improvement technical assistance. • Additional evaluation and quality improvement initiatives focused on measuring and monitoring fidelity of practice within Care Coordination include a Child and Family Team Analysis, development of a transition tool with subsequent monitoring and QI, a document review measure and an annual family voice and choice survey. • A hybrid training curriculum (mixed on-line and in-person delivery) is being developed in conjunction with the department of mental health to provide sustainable quality improvement training to providers within the system of care. • A CLC and disparities scorecard on-line application was developed by CCNY and is being piloted by a local agency with an anticipated larger launch of 2nd quarter 2011. This application allows an organization to assess its cultural and linguistic competence in conjunction with disparities in client outcomes, incidents, and organizational infrastructure and includes a “traffic light” guidance system with quality improvement plan development built in when data analysis by the program may be indicative of a problem area (yellow or red light in the “traffic light” system). Erie County Department of Mental Health and CCNY are facilitating a community learning forum and associated workgroup focused on developing local capacity to address disparities through data and quality improvement. • Training on core CLC competencies continues to be provided via both on-line and in-person training opportunities. • New trainings being offered this year to the vendor network and care coordinators include: ○ Conflict resolution ○ Transition ○ Cultural Strengths and Discovery

Objective 2 – Implement and sustain a plan for vendor service development that improves the efficacy of services, vendor responsibility to deliver services in the context of the achievement of planned objectives

and the achievement of cultural competence. CCNY continues to provide on-going development and quality improvement oversight and assistance to the vendor network to improve efficiency and effectiveness of services, achievement of cultural competence and achievement of planned objectives. These include:

- On-going analysis of utilization of and service provision within various vendor service codes
- This process includes analysis of utilization trends, re-definition of codes as necessary, re-training of service providers as necessary as well as gaps analysis
- CCNY has instituted an annual contract compliance and organizational infrastructure assessment process for all agencies within the vendor network. This allows CCNY to assess compliance with contract requirements as well as fidelity to practice. The assessments result in development of targeted quality improvement plans based on the identified barriers.
- A CLC and disparities scorecard on-line application was developed by CCNY and is being piloted by a local agency with an anticipated larger launch of 2nd quarter 2011. This application allows an organization to assess its cultural and linguistic competence in conjunction with disparities in client outcomes, incidents, and organizational infrastructure and includes a "traffic light" guidance system with quality improvement plan development built in when data analysis by the program may be indicative of a problem area (yellow or red light in the "traffic light" system)
- Training on core CLC competencies continues to be provided via both on-line and in-person training opportunities
- New trainings being offered this year to the vendor network and care coordinators include:
 - o Conflict resolution
 - o Transition
 - o Cultural Strengths and Discovery
- Objective 4- Implement and sustain a business plan for fiscal oversight and payment for Wraparound purchases in a manner that assures fidelity of practice. CCNY continues to implement fiscal oversight of wraparound vendor purchases through a centralized management process including but not limited to:
 - Timely reimbursement to vendor agencies of accepted progress notes (progress notes indicate accepted service provision which then triggers the billing)
 - Trending and monitoring of critical data relative to spending patterns and vendor utilization (supports prospective management of funds)
 - Trending and monitoring of key financial practices and planning as they relate to critical standards of practice
 - Development of necessary reports to support both vendor and Care Coordination supervisors in fiscal oversight of their programs
- Monthly EQUIPS includes real-time data detailing vendor expenditures by program, care coordinator and case level detail (every month)
- Progress note Overlap report has been created to assist vendor and care coordination supervisors in monitoring service and billing detail to detect and correct errors in record keeping and billing
- Timeliness of planned actions for service
- Timeliness of progress notes documenting services

3.2. Objectives 1 and 3 – The quality improvement processes implemented during 2010 have not only been sustained but also enhanced through the expansion of various tools, reports and specialized initiatives.

- CCNY continues to provide monthly EQUIPS reports (Evaluation and Quality Improvement Program Support) to all agencies providing services both within Family Voices Network and the Children's System of Care as a whole
- The EQUIP report provides the necessary data to monitor, track and trend both fidelity to wraparound practice as well as locally identified standards of practice
- The EQUIP report was modified to provide analysis of pertinent variables by race and ethnicity in order to identify and act on disparities among racial and ethnic groups
- The report allows for analysis of disparities in objectives met or not at case close, levels of improvement in youths functional impairment, and living situation/placement rates by system, program and individual worker
- CCNY meets regularly with all provider organizations within the system of care to provide support, monitoring and quality improvement technical assistance
- Additional evaluation and quality improvement initiatives focused on measuring and monitoring fidelity of practice within Care Coordination include a Child and Family Team Analysis, development of a transition tool with subsequent monitoring and QI, a document review measure and an annual family voice and choice survey
- A hybrid training curriculum (mixed on-line and in-person delivery) is being developed in conjunction with the department of mental health to provide sustainable quality improvement training to providers within the system of care
- A CLC and disparities scorecard on-line application was developed by CCNY and is being piloted by a local agency with an anticipated larger launch of 2nd quarter 2011. This application allows an organization to assess its cultural and linguistic competence in conjunction with disparities in client outcomes, incidents, and organizational infrastructure and includes a "traffic light" guidance system with quality improvement plan development built in when data analysis by the program may be indicative of a problem area (yellow or red light in the "traffic light" system)
- Erie County Department of Mental Health and CCNY are facilitating a community learning forum and associated workgroup focused on developing local capacity to address disparities through data and quality improvement
- Training on core CLC competencies continues to be provided via both on-line and in-person training opportunities
- New trainings being offered this year to the vendor network and care coordinators include:
 - o Conflict resolution
 - o Transition
 - o Cultural Strengths and Discovery
- Objective 2 – Implement and sustain a plan for vendor service development that improves the efficacy of services, vendor responsibility to deliver services in the context of the achievement of planned objectives and the achievement of cultural competence
- CCNY continues to provide on-going development and quality improvement oversight and assistance to the vendor network to improve efficiency and effectiveness of services, achievement of cultural competence and achievement of planned objectives. These include:
 - On-going analysis of utilization of and service provision within various vendor service codes
 - This process includes analysis of utilization trends, re-definition of codes as necessary, re-training of service providers as necessary as well as gaps analysis
 - CCNY has instituted an annual contract compliance and organizational infrastructure assessment process for all agencies within the vendor network. This allows CCNY to assess compliance with contract requirements as well as fidelity to practice. The assessments result in development of targeted quality improvement plans based on the identified barriers.
 - A CLC and disparities scorecard on-line application was developed by CCNY and is being piloted by a local agency with an anticipated larger launch of 2nd quarter 2011. This application allows an organization to assess its cultural and linguistic competence in conjunction with disparities in client outcomes, incidents, and organizational infrastructure and includes a "traffic light" guidance system with quality improvement plan development built in when data analysis by the program may be indicative of a problem area (yellow or red light in the "traffic light" system)
 - Training on core CLC competencies continues to be provided via both on-line and in-person training opportunities
 - New trainings being offered this year to the vendor network and care coordinators include:
 - o Conflict resolution
 - o Transition
 - o Cultural Strengths and Discovery
 - Objective 4- Implement and sustain a business plan for fiscal oversight and payment for Wraparound purchases in a manner that assures fidelity of practice. CCNY continues to implement fiscal oversight of wraparound vendor purchases through a centralized management process including but not limited to:
 - Timely reimbursement to vendor agencies of accepted progress notes (progress notes indicate accepted service provision which then triggers the billing)
 - Trending and monitoring of critical data relative to spending patterns and vendor utilization (supports prospective management of funds)
 - Trending and monitoring of key financial practices and planning as they relate to critical standards of practice
 - Development of necessary reports to support both vendor and Care Coordination supervisors in fiscal oversight of their programs
 - Monthly EQUIPS includes real-time data detailing vendor expenditures by program, care coordinator and case level detail (every month)
 - Progress note Overlap report has been created to assist vendor and care coordination supervisors in monitoring service and billing detail to detect and correct errors in record keeping and billing
 - Timeliness of planned actions for service
 - Timeliness of progress notes documenting services
- Objective 1 - Implement and sustain a Family Voices Network Quality Improvement Process with necessary data support and infrastructure
- 2010 Progress: CCNY continues to meet quarterly with all Care Coordination agencies and every other month with all vendor agencies (via the All Vendor Meeting) to review Quality Improvement initiatives and data. Each Care Coordination agency, and select vendor agencies (those with identified quality issues to be addressed), have documented quality improvement plans in place that are monitored and reviewed regularly with our Director of QI, Vendor Development and Evaluation teams. The CCNY EQUIPS tool (both Care Coordination and Vendor versions) are distributed monthly to all program supervisors. The tools clearly document the critical data elements that indicate effective standards of practice.
- Objective 2 - Implement and sustain a plan for vendor service development that improves the efficacy of services, vendor responsibility to deliver services in the context of the achievement of planned objectives and the achievement of cultural competence
- 2010 Progress: CCNY has initiated several QI projects to improve service provision and quality of services. This includes the following:
 - o re-defining of certain in-home therapy and para-professional codes to include more specific guidelines around effective and best practice treatment modalities
 - o Developing new targeted trainings for vendor on skill development, including but

not limited to: (to launch quarter 2 2010) § Mentoring § Gang Awareness § Transitions o Implementation of an on-line training system that includes not only system process and core requirements but the opportunity for professional development in various clinical and specialized skill areas. New trainings in development during 2009 and to be launched in 2010 include Motivational Interviewing and Trauma-Informed Solution Focused Therapy

- CCNY continues to support culturally competent vendor organizations in the system of care.
- 3 new minority run community-based organizations joined the network of providers in 2008. These 3 new organizations are located and serve specific targeted zip code areas of the city of Buffalo (targeted zip codes were identified by FVN needs).
- CCNY continues to support these organizations via targeted professional development, marketing assistance and informal supervision
- CCNY continues to use data to track certain process objectives that are indicators of good vendor practice and has developed targeted QI Plans to address and discrepancies across both system and individual agency levels
- The on-line training system also has a training module on cultural competency for individual vendor providers to participate.
- 2 Vendor organizations participate on the DSD committee (formerly named CLC) and regularly share the information with the other vendor agencies at the all vendor meeting every other month

Objective 3- Ensure that Care Coordination is being carried out consistently with local standards of care including cultural and linguistic competence 2010 Progress Disrupting Systemic Disparities Committee (aka CLC) Progress YTD: 4/2010 · Identify committee membership · Develop purpose/goals/framework: · Identify and analyze data to determine needs of system · Develop best practice guidelines based on needs of system identified through data (on-going) · Agreed to use PDSA model to examine potential best/promising practices to disseminate as formal guidelines to SOC · Dissemination and training developed and implemented for year · QI Tech Assistance for agencies on incorporating CLC elements into QI plans (on-going) · Reading List: ongoing *The Forming – Storming – Norming – Performing is a model of group development. Since its inception in October 2009, the CLC committee (now known as the “Disrupting Systemic Disparities Committee”) recognizes that these group phases are all necessary and inevitable in order for the DSD committee to grow, to face up to challenges, to tackle problems, to find solutions, to plan work, and to deliver results. This model has become the basis for our development moving forward. Objective 4- Implement and sustain a business plan for fiscal oversight and centralized management of and payment for Wraparound purchases in a manner that assures fidelity of practice. 2010 Progress CCNY continues to implement fiscal oversight of wraparound vendor purchases through a centralized management process including but not limited to: · Timely reimbursement to vendor agencies of accepted progress notes (progress notes indicate accepted service provision which then triggers the billing) · Trending and monitoring of critical data relative to spending patterns and vendor utilization (supports prospective management of funds) · Trending and monitoring of key financial practices and planning as they relate to critical standards of practice · Development of necessary reports to support both vendor and Care Coordination supervisors in fiscal oversight of their programs o EQUIPS-CC has been modified to include real-time data detailing vendor expenditures by program, care coordinator and case level detail (every month) o Progress note Overlap report has been created to assist vendor supervisors in monitoring service and billing detail by their per diem workers CCNY list of accomplishments and tasks for 2009 are as follows: Vendor Network Development and Management: § Facilitated timely and accurate payment of all vendor agencies within the Family Voices Network § On-line group supervision forum was initiated as an optional support for those members of the per-diem vendor workforce that may not have access to regular clinical supervision (clinical supervision provided by Denise Krause from SUNY Buffalo, School of Social Work) § Training o Converted traditional method of training per diem vendor workers from live 3-day training to a hybrid model (mix of on-line and in-person training) o In process of developing 2 new on-line clinical trainings (motivational Interviewing (Fe. 2010) and trauma-informed solution focused therapy (June 2010) o All participants in system of care have access to the new on-line trainings in addition to a library of 300 other research papers and trainings (through the hosted training website) o Hosted a local training for all care coordinators and other system of care participants on Motivational Interviewing (facilitate by Dr. Jonathan Fader) § Follow up training was also provided to monitor implementation of the skills learned and provide a booster/refresher as well as skills for supervisors § Developed standards of practice and reports/guidelines for vendor agencies regarding utilization of data in program management · Technical Assistance to existing minority owned and operated vendor agencies to increase utilization within the vendor network o Hispanics United of Buffalo o Native American Community Services · 4 new Vendor Agencies incorporated into the network within the past year o Edison Street Baptist Church § Faith based, minority owned and operated § Provides transportation, mentoring and skill building services o Upgrade Academics § Provides tutoring, interpretation, translation, teacher aide and educational advocacy services o Samaritan Pastoral Counseling § Faith-based, minority operated § Provides mental health therapy, intensive in-home services, skill building o HEART Foundation § Grass roots, minority owned and operated § Provides mentoring, skill building, intensive in-home services, Strengthening Families groups, Community Supervision and monitoring Quality Improvement Efforts: § Development of monthly EQUIPS tool for Care Coordination (Evaluation and Quality Improvement Program Supports) that supports Care Coordination supervisors in monitoring data detailing fidelity to quality practices that impact outcomes § o Tool outlines program level outcomes as well as worker level and case level outcomes § Development of on-line asset map for families and other stakeholder to utilize to identify natural supports, services and positive recreation and cultural opportunities within their home community o LINKS (local information neighborhood knowledge supports) Program – to go live Dec 2009§ Reinforced the wraparound philosophy of family voice and choice through the development and implementation of FAMILY FIRST software program o The program allows families to search the database of per diem vendor workers for a worker that matches their service needs as well as specific characteristics of what the family prefers (searchable by age, gender, interests and skills) o The program will rank order the families top 5 selections of workers and then email the vendor supervisor (in rank order) in order to secure the worker based on families preferences§ Analysis of fidelity of the implementation of certain “services” (mentoring, skill building, respite, life coach, intensive in-home, and in-home and community behavior services) o Data analysis determined “blending” of multiple services is occurring within the system (low fidelity to the operational definition of what is each service is supposed to provide) o System level QI Plan developed and in beginning process of implementation § Completed multiple Quality Improvement Efforts related to process issues within Family Voices Network o Timeliness of progress note entry and approval o Timeliness of planned actions for service o Utilization of services (individualized service plans vs. cookie cutter approach for all families) o Assistance to youth development coordinator in completion of program logic model o CAFAS (rater reliability and use as a clinical tool) 2010 Progress; Six Sigma Project- Decrease Length of Stay >14months: The prior Utilization Review (UR) Committee process was changed to actively manage length of stay (LOS) (normative best practice 11-14months) and Change in Status and has identified best practice standards to be utilized during case conference review. In 2008 the LOS > 14 months was an average 34 cases/mo (8.8%): a high in March of 42 cases (11%) and a low in December of 28 cases (7%). In 2009 the name of the committee was changed to Utilization Management, this signified a change to active case management to ensure youth and family success, with the right services, within the expected length of time. A Case Conference Tool was created that highlighted best practice standards and led to a succinct case review. A report was created to show current CAFAS scores and cases with a low CAFAS score (showing low level of impairment), those with a LOS at 8 months, and cases referred by the care coordination supervisor are reviewed monthly. A decrease number of cases with a low CAFAS score was noted between May of 2009 (9%) and January of 2010 (3%). The average LOS > 14 mos from Jan-June of 2009 was 9% of all cases, this decreased to 7% for July-Dec. 2009, and is now 4% Jan-April 2010. There has been a steady decline in LOS >14 months for 11 consecutive months. The last 6 months (red data points) are 3 standard deviations below the mean which signifies a change in practice and not a random event. See attachment in Priority Activities: SPOA Assignmentw/10days

2010 Progress: Family Voices Network Care Coordination services continue to show improvement surpassing even the gains reported in last years Local Plan update. From 2007 to February 2010 improvements continue to be achieved in such areas as Length of Stay, timeliness to case assignment and first visit, the Child and Adolescent Functional Assessment Scale (CAFAS):at critical 6 month, 12 month and discharge intervals, and increase number of youth maintained in the community. These and other improvements in outcomes and practice are the result of several factors some of which are include but are not necessarily limited to the following:

- Implementing Quality Improvement plans as part of the 2010 contracting process;
- TA provided by CCNY (QI Organization) and the Department;
- Ongoing refinement of vendor practices;
- Improved cross-system collaboration; and
- Substantial gains in provider competency that has led to the incorporation of improved supervisory and clinical practices for which training and support were provided in prior years

As a result of having achieved a historical data base of outcome and practice measures in 2010 the Department established community

benchmarks against which individual provider and overall system performance is evaluated and minimum standards have been set against which Quality Improvement plans are, in part, designed. From 2007 to February of 2010, the Critical Data Dashboard trends continue to improve. The key metrics are listed below:

2007 - Feb 2010 Key Metrics Improvement		
Green=Significant Improvement 07-10		
(↓) = lower # desired	YTD Feb 2010	2007 Avg.
Metric	%	%
Assignment w/in 10 days	90.4	41.7
Slot Utilization	86.0	78
Staffing	99.2	92
LOS >14 months (↓)	4.2	13.1
Engagement % assigned and discharged < 90days (↓)	1.5	4.2
First Face-2-Face in 9 days	91.3	53.2
Avg. days until first Face-2-Face (↓)	5.3 days	11.3 days
CAFAS % enrolled w/ ≥10 pt. change at 6 months	65.5	66.4
CAFAS % enrolled w/ ≥ 20 pt. change at 12 months	93.3	71
CAFAS % discharged w/ ≥ 20 pt. change from episode open to discharge	78.1	UNK
Successful Discharge	68	51
Community Based Care	83	79

2010 Six Sigma Projects Update: A. Assessment of Case Assignments from Family Voices Network SPOA to Care Coordination in < 10 days: This project was completed in May 2009 with a goal of increasing the percent of cases assigned in <10 days to at least 85%. The six sigma intervention demonstrated a statistically significant difference as the percentage of cases assigned in less than <10 days from went from 48.3% of cases prior to the six sigma intervention to 93.3% of cases after the six sigma intervention. In addition, the median number of days to assignment dropped from 10.7 to 3.1 days. Continued monitoring occurred throughout 2009 and this has indicated that the above gains have been maintained. As of 12/31/09, the % of cases assigned in <10 days was 93.46% and the mean number of days to assignment is 3.65. Through the first quarter of 2010, 91.3% of cases have been assigned in <10 days.

See Attachment in Priority Activities: FVN Critical Care Dashboard 2008-2009-2010 Comparison

Agencies: OASAS; OMH;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity); Quality Management;

Strategy 3.3 In Progress

Strategy 3.3 To better address the behavioral health needs of students in the Buffalo Public School District. The City of Buffalo is one of the poorest cities in the nation. The ECDMH and BPS have recognized that there are unmet behavioral health needs in the schools and that a high level of child/family support is needed to better impact academic success of students.

Objective 1- Continue to work in collaboration with the Buffalo Public School (BPS) System to serve high risk high need students in the community.

Objective 2 - In 2010, CFCP providers will look at providing a greater number of early childhood screenings.

2011 Progress: Objective 1- Continue to work in collaboration with the Buffalo Public School (BPS) System to serve high risk high need students in the community 2011 Progress

Key Points: Promise Zone Initiative

- Effort moving in 4 targeted schools in South Buffalo. PBIS is actively working in the elementary schools and that effort is linked well with Promise Zone (PZ).
 - Hillary Park #27 – Pre-K – 8.
 - Lorraine Elementary #72 – Pre-K – 8
 - Southside Elementary #93 – Pre-K – 8
 - South Park High School #205 – 9 – 12
 - Total Enrollment: 2,876
- PZ Leadership Team membership includes: EC Dept of Mental Health (Phil Endress), Buffalo Public Schools (Diane Cozzo), Erie 1 BOCES (Jane Ogilvie), and United Way of Buffalo & Erie County (Jill Robbins-Jabine).
- PZ Leadership Team MOU has been drafted.
- PZ Coordinator job description has been finalized and position is posted. Leadership Team to interview final candidates and make selection. This position will be funded under DCJS grant.
- Initiative's Evaluation:
 - BPS hiring Hedy Chang to do an attendance study that will address suspensions, excused and unexcused absences to address data that average daily attendance by itself does not provide. Attendance study revealed significant number of students who are chronically absent. Follow-up survey with Parents, students, and others will identify needs and strategies.
 - Consultant Karen Finn worked with Leadership Team members, providing an overview on Results Based Accountability (RBA) that provides framework for achieving outcomes, data and follow-through. Members of PZ Leadership Team have been trained in RBA (train the trainer).
 - There was discussion on the intended outcomes. It was clarified that the specific outcomes are to be determined by each site as long as they focus on improving key indicators of student engagement. Those being addressed by Buffalo, school attendance and drop-outs, are appropriate. Process steps are necessary, but the results are achieved by getting all partners on board with the identified indicators (e.g., attendance and drop-outs).
 - It is expected that each site will identify for the State Leadership group, policies, funding mechanisms, rules, regulations, etc. that they need help with to more effectively achieve their common goals. The State group will work to address these areas.
- Student Support Team. Goal continues to be a full-time SST in schools with a consistent protocol for building bridges between school and community services. United Way of Buffalo & Erie County convenes and facilitates Afterschool Network of WNY and can assist PZ schools with access to provider

network. Closing the Gap is a critical and well integrated partner. Next steps:

- Continued SST training (see attached list). Includes training on behalf of PZ Leadership Team to support implementation efforts.
- Explore linkages with afterschool providers to assist District in achieving improved attendance.
- PZ Leadership Team to revisit Advisory Committee members to insure alignment with revised goals.
- On-going efforts and next steps:
 - Roles and responsibilities documentation (SST Manual) is in development and will also include policies and procedures.
 - Included with policies and procedures will be development of universal MOU (between partner providers) and universal consent (for parents).
 - BPS SST/PBIS Tier 2 & 3 leadership team established and meeting monthly.
 - Universal screening at PZ School #27 implemented with integrity
 - Six day universal training accomplished in elementary schools.
 - Spectrum Services has worked with Clinic Plus to provide mental health screenings in all PZ schools
 - Development, oversight and implementation of all training efforts
 - PZ Leadership Team to hold PZ Principal breakfast (after Spring break)
 - Review plans and goals
 - Outline plans for resource mapping and gap analysis
 - Continued exploration of linkages with Afterschool Network of Western NY providers to assist District in achieving improved attendance.
 - Still awaiting information from State identifying regional/local staff (e.g., OASAS) to act as contact person and participant.

Action Step: CCF will identify regional/local state agency staff and provide to each PZ site.
site.

Objective 2 - In 2010, CFCP providers will look at providing a greater number of early childhood screenings. 2010-2011 Progress

- CFCP Monthly Meetings - CFCP providers continue to meet monthly with Buffalo Public Schools (BPS) and ECDMH. Procedures for completing screenings at the BPS's registration days has been operationalized.
- Buffalo Public Schools CFCP Quarterly Report - In 2010, each CFCP provided a quarterly report that is specific to the work with BPS. See report below for 2010. The number of screenings for 2010 remained the same from 2009.

Buffalo Public Schools - Child and Family Clinic Plus Report -						
Year 2010						
Agency 2010 Buffalo Public School Child and Family Clinic Plus Report	# of screens	Per screening # Indicated	Per screening # Non Indicated	Of those indicated # Already receiving services	Of those indicated # who Completed Intakes or referrals elsewhere	#of indicated that refused or didn't respond
CATS	2103	251	1852	41	100	182
CFS	584	40	475	17	0	10
Mid-Erie	709	76	628	7	22	61
Monsignor Carr	521	62	452	2	0	4
YTD Totals	3917	429	3407	67	122	257

- ECDMH and two CFCP providers participated in the CFCP restructuring meeting with NYS OMH on February 18, 2011. To date the restructuring plan has not been released.

Agency: OMH;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Employment / Education; Social Connectedness / Inclusion / Social Support;

Strategy 3.4 In Progress

3.4 Transition Aged Youth

Objective 1: Explore the development of a plan to service Transition Aged Youth. Recognizing that accessing needed services continues to be a challenge for this population. ECDMH will complete an inventory of existing services and evaluate to what extent the capacity is being utilized.

Objective 2: Understand the inventory collected and become cognizant of cultural competence issues associated with serving population.

Objective 3: Explore Evidence Based Practices to the population.

2011 Progress: *This issue continues to be challenging and progress has been limited.*

Agencies:
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Social Connectedness / Inclusion / Social Support; Service Access (Capacity);

Strategy 3.5 In Progress

3.5 In a culturally competent manner evaluate the permanency/well being for children in foster care who come from families whose parents have mental health/chemical dependency issues.

Objective 1: Develop strategies to partner with the local Department of Social Services to reduce the number and length of foster care placements of pre-K age children focusing on children of color.

2011 Progress: *Objective 1: Develop strategies to partner with the local Department of Social Services to reduce the number and length of foster care placements of pre-K age children focusing on children of color. 2011 Progress: Efforts cited in 2010 are continuing. In addition, the ECDMH has added a Disproportionate Minority Representation (DMR) goal to required Quality Improvement Plans. For those agencies providing services to the Children's System of Care this goal was specifically defined and a workgroup consisting of representatives from providers, the ECDMH and Community Connections of NY are currently working*

through baseline Data issues, reporting and QI implementation steps. This is being done to have a specific and uniform definition, measure and reporting methodology of DMR for this consumer population which will facilitate community wide Learning Community, QI efforts, and accountability.

Agencies:
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity); Service Engagement;

Priority Outcome 4 In Progress
Service System Restructuring

The ECDMH is in the process of aligning performance management, contract monitoring with our vision of support of recovery and resilience.

The Erie County Department of Mental Health will implement performance contracting in a way that aligns the interests of participating voluntary agencies and county/state government by creating financial incentives for agencies to improve and sustain positive recovery outcomes for individuals within priority target populations

The Erie County Department of Mental Health will support agencies in implementing Clinic Restructuring in a way that fosters the hope of recovery and builds on the strengths of the whole person to assist them in building a meaningful life in the community.

Agencies: OASAS; OMH;
Target Complete Year: 2012

Strategy 4.1 Dropped

Strategy 4.1 - Implement Performance Contract

The recent passage of the 41.35 waiver will allow the County to provide incentives for agencies to monitor and measure performance against clinical and system outcomes in exchanges for agency flexibility with greater accountability. The County implemented this new contract process with two adult and two children's agencies in 2009 and is considering the additional agencies for 2011.

Objective 1- Define operational definitions for additional target populations

Objective 2- Define operational definitions for the performance milestones reflecting:

- Service capacity and system accessibility
- Fidelity to practice
- Recovery and system outcomes

Objective 3 - New providers develop Quality Improvement plans focused on performance milestones using real time data and strategic interventions.

Objective 4- Agencies develop baseline data

Objective 5 - County revised performance contract

Objective 6 - County continues to work with OMH to develop and finalize procedures for budgeting and claiming that reinforce the goals of the performance contract, and are consistent with the 41.35 waiver

2011 Progress: This goal was continued in 2010 but effective January 1, 2011 this goal was discontinued. During 2009, the County completed Year 1 of the performance contract implementation with the first two adopting providers, Lake Shore Behavioral Health and Spectrum Human Services. The performance of both providers has been reviewed and is now under review by OMH for approval of the incentive payments. Agency performance indicated that: 1. Both providers met objectives in Level I providing 100% reimbursement against expense 2. Both providers also met objectives in Level II thereby receiving added funding flexibility and retained earnings of the predetermined incentive. 3. Each provider met at least 1 Level III objective and therefore earned 50% of the incentive premium. We have held quarterly discussions with OMH staff to continue procedural planning and keep everyone apprised of project progress. We have completed a procedure for annual plan submissions that will be approved by OMH during the Fall of each year for the subsequent calendar contract cycle. Closeout procedures are still in development however OMH has established some preliminary guidelines for 2010. Currently OMH is reviewing 2009 results and if approved the retained earnings and performance premiums earned by each provider will be incorporated into their contracts following issuance of a revised state aid letter. We continue to work with providers, OMH and our Monroe County partners in refining the procedures for performance contract processing. Additional objectives and procedures will be developed over the course of 2010 and more providers will be brought into the process. There is no change to the current objectives as we continue to detail contract closeout and monitoring procedures as well as consider expansion to additional provider groups.

Agencies: OASAS; OMH;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Quality Management;

Strategy 4.2 In Progress

Strategy 4.2 - Assist agencies in implementing clinic restructuring.

The Department program and fiscal staff will act as a support to children and adult agencies during this transition, providing technical assistance and advocacy to address system issues. These include:

- identification and assistance in resolving fiscal issues
- Identification of emerging underserved groups of high need/high risk individuals
- Coordination of multi-agency response
- Employee training/retraining
- Cultural competence and disproportionate minority representation at higher levels of care
- Utilization of Evidence Based Practices and Fidelity to Practice; focus on recovery
- Impact on Crisis Response
- Movement of individuals in and out of the behavioral health programs such as PROS
- Identify training needs for supervisors and clinicians
- Impact of licensing requirements on the availability of qualified staff

2011 Progress: The current proposed implementation date for Clinic Restructuring is 10/1/2010

Agency: OMH;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Quality Management;

Strategy 4.3 In Progress

Strategy 4.3: Improve the Contracting Process for all Programs to focus on QI & Improved Outcomes for Individuals

The Erie County Department of Mental Health's contracting approach beginning in 2010 for all agencies moves us beyond the Performance Based Contract. Instead, we shifted the contract emphasis away from retrospective penalties for performance deficits to supporting a focus on accountability for active management of agency and program Quality Improvement.

An approach focused on quality improvement and on understanding the relationship between practice and outcomes is essential to program growth and development, effective services and client outcomes. Consistent monitoring of data related to both process and outcomes, allows agency administrators and practitioners to assess the effectiveness of their programs in

supporting client outcomes as well as to develop targeted intervention and process improvements when data indicates potential issues affecting the achievement of both client and program outcomes.

The first step for this growth was incorporation of a 2010 contracted agency level Quality Improvement Plan and associated mechanisms. This will serve as the foundation for contract deliverables and, for the adoption of a pay-for-performance model of contracting after 2010. It will also be a core component of the Program/Budget Submission (P/BS) form.

Quality Improvement is more than the development of a plan. It is an active integration of data collection, monitoring and understanding the relationship between practice and outcomes. This is achieved through both the administration and management of a program as well as group and individual clinical supervision. It is through a combination of integrated management and clinical practices that improvement opportunities are identified and effective solutions are implemented.

The Department required that each Agency select one fiscal and one cultural competence outcome, plus two additional outcomes of the agency's choice. The agency, in collaboration with the Contract Manager (or at the Contract Manager's request) may add additional elements to the Quality Improvement Plan.

Beginning mid-2010, the Department will begin issuing a series of RFPs focused on improving performance accountability for particular service areas and/or target populations.

2011 Progress: The Erie County Department of Mental Health contracts for approximately \$55.6 million in services annually. After a review of its existing RFP procedures the County while recognizing unique challenges to expanding the utilization of RFP of behavioral health services, believes reforming the existing practice will increase the capacity for and implementation of data driven quality improvement practices in contracted services, ensure efficacy of service, and greater accountability. Objective 1: Implement three categories of RFP renewal:

- Carved out services with a 3-5 year contract renewal
- RFP and contract renewal in a 5 year cycle.
- RFP and contract renewal in a 3 year cycle

Objective 2: Implement a RFP planning and response cycles that provides for greater community input in the RFP planning/development cycle and enhanced communication, clarity and transparency to stakeholders in the distribution/announcement/response cycle. 2011 Progress On August 16, 2010 ECDMH put out the first RFP in the planning cycle to provide Older Adult Mental Health Services to individuals who are age 60 and over who have a serious mental illness (chronic or recently diagnosed with functional deficits). In addition, individuals served are at risk for nursing home or institutional placement as a result of any one of the following: mental health symptoms, co-morbid medical issues that complicate treatment/effect long term stability, co-occurring substance abuse, poverty presenting as a barrier to accessing needed and appropriate services, supports and/or resources (medical, social, environmental needs). The process began by meeting with providers of older adult services in Erie County through a project called the Second Act Initiative which is a partnership between Erie County Senior Services (ECDSS) and Mental Health (ECDMH), and United Way of Buffalo & Erie County. The purpose for the meeting was to launch an effort in working together to improve the performance of the senior service sector. We identified common community-level results and effective strategies, and gained consensus on standard performance measures facilitating common expectations among funders and service providers and, in the future, will enable us to evaluate our collective ability to meet the current and future needs of seniors. After the RFP was released, interested applicants were invited to attend an optional pre-proposal meeting to ask questions relative to the RFP application and submission. Following the meeting all questions and answers were posted on the ECDMH web site. The review process included ECDMH staff and stakeholders who provide older adult services in Erie County. Three area providers who were awarded funding to provide older adult services have worked with the ECDMH and ECDSS in the development of the Senior Services NY Connects Single Point of Entry (SPOE). Senior Services NY Connects is a Single Point of Entry for older adults in Erie County that assists the Local Governmental Unit to achieve effective community based mental health systems that are cohesive and well coordinated in order to meet the needs of those individuals at risk. The NY Connects process provides for the identification of individuals most in need and management of service access. A key feature of the SPOE is the use of a shared data system that allows ECDSS and older adult agencies to track the services being provide to individuals who are part of the senior service system of care. The system that is currently being used by the ECDSS is called PeerPlace. PeerPlace is 100% web based software designed to electronically manage workflow and information from the first point of client contact through every encounter. All types of services are tracked including basic information requests to full case management functions. PeerPlace offers various levels of information sharing (Paths), maintaining case record confidentiality. ECDMH is working with Erie County legal council to assure the use of the data system does not compromise client confidentiality. The collaborative partners have also developed DRAFT policy and procedures that include the following: I. Senior Services NY Connects Single Point of Entry (SPOE) Target Population II. Referral Process Peer Place Process Client Profile III. Documentation IV. Screening Tools Kessler 6 V. Quality of Life Assessment VI. ADL's/IADL's/Benefits Assessment VII. Initial Individual Action Plan Individualized Action Plan Review Discharge Summary Plan VIII. Performance Measures and Data Collection IX. Per the Standards of Practice- Supervision against standards Learning community Discharge criteria Case Review X. Memorandum of Understanding

Progress report for 2012 LSP: On January 12, 2011, the Department issued an RFP, to provide non-regulated recovery oriented adult mental health services. Non-regulated Mental Health Services are those recovery oriented services that support mental illness recovery with a particular focus on community integration and reduced reliance on the mental health system of care. It is targeted to the highest need and highest risk adult mentally ill, regardless of whether currently in a treatment program. This RFP aimed to replace virtually all of such services currently provided to assure that the resultant new configuration of these services would be data driven, evidence-based and, outcome focused. The Erie County Department of Mental Health in collaboration with the Mental Hygiene Community Services Board and, with current ECDMH contract providers of various non-regulated recovery oriented adult mental health services identified principles/core values, community valued outcomes and, related performance areas for these services in Erie County. Based on these, the Department identified associated performance measures, the attainment of which will be the deliverables to be contracted under this RFP. It was the Department's overarching goal to re-engineer the use of these resources to achieve greater community integration of the priority populations through a narrower focus on developing the critical skills necessary. This RFP focused on adults, defined as individuals age eighteen (18) and over, who have a serious mental illness (chronic or recently diagnosed with functional deficits, with a particular focus on high need /high risk and emerging populations. This RFP invited applicants to submit proposals in one or more of the following five (5) Performance Components: Work Support · Financial Literacy · Life Coaching · Parenting Support · Benefits Advisement The RFP also invited proposals for "Recovery Centers," which were defined as an integration of all of the five (5) specified Performance Components. It was the Department's intent to fund at least one Recovery Center. Overarching the specified Performance Measures for each Performance Component, applicants were required to clearly specify the use of evidence-based and/or evidence-informed practices, valid performance measurement data systems and, Quality Improvement management practices. Proposals were received from six (6) applicants. The review team was comprised of three (3) Department of Mental Health staff and two (2) individuals from the community. Using a rigorous scoring tool the review process produced a high degree of alignment among reviewers. One Recovery Center proposal was approved and three other applicants received awards. Two applicants were not successful, resulting in closure of one small agency previously funded for this category of services and, termination of two programs in this category of service within a larger agency. Based on our experience with the recent RFP's the Department intends to continue utilizing an RFP process to reform our system of services toward meeting the highest priorities with an environment of shrinking resources and expectations for improving cost effectiveness accountability.

Agencies: OASAS; OMH;
Target Complete Year: 2012

Is this an innovative practice that you would like to share with others?: No
Focus: Quality Management; Cross System Collaboration;

Priority Outcome 5 In Progress

Increase access to housing:

Types of housing

- 24/7 including behavioral, medical, elderly and children, specialized housing
- < 24/7 certified and non-certified setting in all of the above areas for parents who themselves have Developmental Disabilities
- Built in clinical supports (non certified option)

Issues:

- Younger people in need specifically adolescence with autism
- Inclusion

- Lack of safety net for people who move out of 24/7; infrastructure needs to change (transition); look at people in certified settings moving to non certified; back fills may be inappropriate for people in need
- Look at children's residential treatment facilities (criteria) share AUTISM LEGISLATIVE TRANSCRIPT

Increase access to housing:

Agency: OPWDD;
This outcome has been selected as a top two priority for OPWDD.
Target Complete Year: 2014

Strategy 5.1 In Progress

Recommendations: Develop a research committee to research alternative housing programs/services models

- Identify and (re)allocate funding for
1. Supports available – when moving to a less restrictive environment
 2. Safety net if move doesn't work – should be planned and safe
 3. Redistribution of resources

Develop comprehensive care plans that are cost effective and inclusive of all identified needs

2011 Progress: A Resource Allocation Advisory Board (RAAB) was established and continues to meet. The RAAB is comprised of representatives from people with developmental disabilities/self advocates, family of people with developmental disabilities, OMRDD provider agencies and other affiliated entities as identified by the WNYDDSO. The Board is charged with assisting the WNYDDSO in establishing and implementing policies, procedures and practices related to the distribution of the Consolidated Residential/Supported Employment Allocation for FY 2009-10 through FY 2010-13. The committee reported that residential beds for younger adults are increasing

Western NY DDSO The DDAWNY web site is up and running and provides the following information regarding housing opportunities by township to individuals in need of services and provides agencies an opportunity to list vacancy information. **Certified Living Opportunities** Welcome to the our Certified Living Opportunities section. **If you are searching for a living opportunity please select a township from the list below to see what is available in your area. If you are an agency that has a room available and would like to post your residence in this section Information re people served through OMRDD programs in Erie County – April 1, 2010 through March 31, 2011**

People receiving CSS services in non-certified settings	3 (new)
People receiving ISS services in non-certified settings	10 (new)
Total new beds developed	19
Number of relocations that allowed backfill opportunities	251
Number of housing programs that were developed-were any for individuals with special needs/dual diagnosis	1-6bed home for young adults w/autism/challenging behaviors
Number of IRAs developed	1
Number of people on NYS-CARES Residential Registration list ("wait list")	1091
Current placements in IRAs	Supervised (2115), Supportive (40)
Current placements in ICF/DD	157
Number of individuals that are currently living in Developmental Center	0
Increase in the opportunities (including respite) for families with medically frail individuals or with individuals with behavioral challenges	1-6 bed home for young adults w/autism/challenging behaviors
Current capacity for respite	Provided 5054 days of respite to over 400 individuals

Agency: OPWDD;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Housing; Social Connectedness / Inclusion / Social Support;

Priority Outcome 6 In Progress
Increase Transportation Supports

The target population includes all individuals with developmental disabilities. Stakeholders report that there is inadequate transportation available for employment and recreational activities. This is in particular a concern related to employment and the increased state and local focus on community integration.

Issues:

- Erie County does not have modes of transportation that meet individuals' needs as in rural areas
- Transportation access is not available in the community that a person resides in
- Lack of agency reimbursement for transportation
- Limited transportation access limits community integration (employment, social, recreational)

Agency: OPWDD;
Target Complete Year: 2011

Strategy 6.1 In Progress

Transportation continues to be a concern for community stakeholders and the effects that the lack of transportation has on individuals served by impairing their ability to achieve community integration. Local efforts will continue to include advocacy, researching and developing rural community practices where possible, and collaborate with transportation providers to develop more efficient services.

2011 Progress: In an effort to address the issues outlined by stakeholder the Western New York Independent Living Center Getting there Transportation program has provided the following services in 2010:

- 1051 round trip van rides
- 304 round there reimbursement
- 1414 round trips used with a bus pass

Recommendations:

- Adopt rural community transportation practices; expand generic transportation options
- Increase efficient use for existing transportation options
- Develop relationships with existing resources (NFTA) to assist with transportation
- Increase reimbursement rates to agencies for transportation services

Agency: OPWDD;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No

Focus: Employment / Education; Transportation;

Priority Outcome 7 In Progress
Improve individuals and families knowledge about health care, increase access to needed services and improve integration/coordination of health care and other services

Include: Mental health, dental, physical, hospital, therapy (in-home, OT, PT), clinics to improve intergration with primary health and other services the individual may participate in.

Agencies: OMH; OPWDD;
 This outcome has been selected as a top two priority for OPWDD.
 Target Complete Year: 2012

Strategy 7.1 In Progress

Recommendations: Merge with 1115 Waiver development process which includes individuals receiving service, parents, providers as part of the stakeholder group

The People First waiver will demonstratet:

Better care coordination for developmentally disabled individuals with extremely complex medical/behavioral health needs can be achieved through specialized systems of care management/coordination

A transformed long-term care delivery system that places person-centered planning, individual responsibility and self-determination at the forefront can enhance care and individual satisfaction and lower Medicaid costs.

New reimbursement models for institutional and community-based care systems can encourage efficiency, improve accountability and reduce costs

The continued provision of essential mental hygiene services through the establishment of a safety net care pool will provide lower-cost services that meet individuals' needs and defer entry into higher costs Medicaid services.

Comprehensive primary and acute care services will be available for all enrollees under the People First Waiver and waiver enrollees will be able to access an array of long term care services currently available under the authority of the state plan or the 1915 (c) home and community based services waiver authority.

- Increase knowledge about existing developmental disabilities and mental health services across the two systems of care.
- Promote inter-agency and cross-system collaborations.
- Continue cross system collaboration through Safety Net for Youth Committee and Committee on Autism and Mental Health Advocacy.
- Continue legislative advocacy.
- Continue researching effective services/treatments that are used nationally and internationally.
- Preliminary Strategies and Action Steps:

Strategies:

1. Increase stakeholders, individuals and families knowledge/information about services available in the health care system.
2. Provide ongoing supports and training sessions, including guardianship, with medical professionals and parents to discuss the unique medical concerns with individuals with a developmental disability.
3. Increase collaborations with healthcare professionals specializing in care of individuals with developmental disabilities. Enhancing relationships with behaviorial and psychiatry providers.

Actions:

1. Develop a database identifying medical professionals, including psychiatry, that accept Medicaid.
2. Evaluate current availability of psychiatry and what services are needed.
3. Continue to update and educate professionals and families.

2011 Progress: A meeting was attended on March 22, 2011 in Albany to advocate for legislative support of the following bills To track NYS legislation online please use the following websites: www.assembly.state.ny.us or www.senate.state.ny.us The Safety Net for Youth Committee continues to meet on a monthly basis with stakeholders that include, state agencies, providers, law guardians and school districts. This collaborative meeting seeks to assist in working with individuals that have been unsuccessful with intervention thus far to coordinate other treatment and/or placement options. Stakeholders are working across the barriers that exist with individuals with a dual diagnosis.

Bill Number & Sponsor	Description
A.4380 – Schroeder Health Committee S.4110 – McDonald Mental Health & Developmental Disabilities Committee	Relates to establishing a universal child health passport; the holders of such passport universally consent to the transfer or release of pertinent records and/or information to certain groups without individual consent of the parent or guardian of such child.

A.4949-A – Schroeder Education Committee S.3416 – Parker Education	Requires all teachers to complete training in area of autism and directs the commissioner of education to assure that such training is included in all teacher certification programs.
A.3217 – Schroeder Health Committee S.3404 – Parker Health Committee	Directs the commissioner of health and commissioner for people with developmental disabilities to jointly promulgate rules and regulations requiring pediatric health care providers to screen children beginning at the age of 18 months for autism spectrum disorders during each wellness and preventative care examination.
A.4999 – Schroeder Health Committee S.4109 – McDonald Health Committee	Provides for behavioral wraparound demonstration projects combining services through the office for people with developmental disabilities, the office of mental health, and the department of health.
A.6403 – Schroeder Mental Health Committee S.4132 – McDonald Mental Health & Developmental Disabilities Committee	Directs the commissioner of the office for people with developmental disabilities, the commissioner of education, the commissioner of health and the commissioner of mental health to study and report the costs to the state for the early diagnosis of autism spectrum disorder and the long-term treatment for individuals with autism spectrum disorder.
A.5723 – Schroeder Insurance Committee	Expands required health insurance coverage for the treatment and diagnosis of autism spectrum disorders.

Agencies: OMH; OPWDD;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Service Engagement; Cross System Collaboration;

Priority Outcome 8 In Progress
Increase supports for individuals and families to stay in their own home for as long as they choose

The target population is families with an individual with a developmental disability living at home and in need of supports to maintain that individual in the family, at home. Many families need supports to assist them in maintaining their son or daughter at home while they await a residential placement opportunity. In this time of financial difficulties with limited ability to have residential placements, families may need additional supports.

Issues:

- Transportation
- Cost to purchase and modify vehicles
- Increase community habilitation
- In home clinic services: nursing
- Guardianship when appropriate
- Respite/timely intervention (temporary and flexible)
- Lack of qualified staff to provide family support in the home
- Behavioral intervention
- Recreational activities
- Crisis response
- Family reimbursement for funds used to maintain the individual in the home

Agency: OPWDD;
Target Complete Year: 2012

Strategy 8.1 In Progress

Recommendations:

- Expedite access to services
- Increase funding for services for individuals
- Federal regulations – access to clinical services
- Amend nurse practitioner act to allow medication administration in non certified settings
- Consumer directed as a model to expedite respite services

2011 Progress: In an announcement letter dated March 17, 2011 the Western New York DDSO released an RFP of \$609, 000 that stated the following: The Western New York Developmental Disabilities Services Office (DDSO) is accepting proposals for Family Support Services (FSS). These funds are available to develop new or expanded Family Support Services in Western New York counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara and Orleans. Most families caring for a family member with a developmental disability wish to raise their child or family member in a family setting. However, these families may experience exceptionally high financial outlays as well as physical and emotional challenges for the complex task of supporting the needs of their children/family member. These expenses and challenges often exceed the resources of families. The goal of family support services is to assist families to remain intact for as long as they desire and avoid unnecessary out of home placement. The primary emphasis is to empower families to design and obtain services which will meet their individual service needs. Up to \$609,000 (annualized amount) is available at this time. The RFP priority is to address underserved/unserved individuals including individuals with Autism and others with unmet needs. The local funding priorities are listed below: · Behavior Management · Recreation/Respite · Transportation Anticipated program start-up for successful applicants will be 9/1/2011. First year funding will be pro-rated based upon program start date. Awards will result in the development of a multi year contract for up to five years. Individual contract may be less than 5 years to coincide with the calendar year. Western New York DDSO reserves the option of funding certain programs as a Home and Community Based Hourly Waiver Respite service if the review team and provider agree that this would be appropriate. Therefore, funding may be used to revise an existing Hourly Respite Rate should one exist or develop a new rate if needed.

Agency: OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity); Service Engagement;

Priority Outcome 9 In Progress
Improve access to care and service coordination across systems of care for children and adults with a Developmental Disability and an emotional/psychiatric disorder as evidenced by successful linkage to care.

Issues:

- Gap in coordination and communication
- Barrier between systems; individuals served by one not both

Lack of knowledge about and between systems
Lack of crisis intervention/opportunities

1. Increase mobile crisis outreach
2. Crisis response/intervention is reactive not proactive
3. In home crisis response

Agencies: OMH; OPWDD;
Target Complete Year: 2011

Strategy 9.1 In Progress

Recommendations:

Educate crisis/police response teams
Clinical training for dual diagnosis
Increase collaboration between systems to serve individuals served through cross systems
Increase Psychiatric Services
Develop required cross systems trainings for direct care workers (MSC)

2011 Progress: Attendees at the Community Forum will develop committees to address each of the recommended areas. ECDMH is working with Community Services for the Developmentally Disabled, a current contract agency, and the WNY OMH field office to apply for a clinic license to provide psychiatric services to individuals who are dually diagnosed with SMI and DD.

Agencies: OMH; OPWDD;
Target Complete Year: 2012
Is this an innovative practice that you would like to share with others?: No
Focus: Health & Wellness;

Priority Outcome 10 In Progress
Increased community awareness, concern and, action for addressing chemical dependency in Erie County.

The anticipated long term goals for this (once finalized) for residents of Erie County are to:

- raise awareness of the extent to which alcohol/substance abuse exists in the county and what its impact is;
- increase the perception of harm;
- increase prevalence of the attitude disapproving illegal use and, abuse;
- stimulate development of new community action to pro-actively address community alcohol/substance prevention and treatment issues.

As part of the Prevention Plan being developed (see Prevention Needs Assessment in the Planning Activities Report) there will be a comprehensive Environmental Strategies / Community Education plan for the entire county. It will be evidence based, data driven and outcome focused. Contracted Prevention providers that do environmental prevention and/or community education will develop an agency plan for these services. This plan will be subordinate to the larger County plan. County approval will be required. All such contracted services delivered by an agency will be guided by and consistent with this agency plan.

The County will work also with its contracted CD treatment agencies to define a role they will play in contributing to this focused effort.

It is intended and expected that this will bring about a relative uniformity of intent, focus and message across the County. This intensity should result in greater efficacy for these services and, have a greater beneficial impact, increasing the level of achievement of this priority outcome.

Agency: OASAS;
This outcome has been selected as a top two priority for OASAS.
Target Complete Year: 2012

Strategy 10.1 In Progress

Prevention plan under development will include a specific environmental education / public education plan. Each contracted prevention program providing these types of services will be expected to develop an approved counter-part plan, subordinate to the county- wide plan for these services, to guide all funded services of this nature.

2011 Progress: This is partially achieved. Erie County's long term Comprehensive Prevention Plan was completed late in 2009. It dedicated a section to environmental prevention and community education, consistent with the long term goals articulated for this Priority Outcome. Also consistent with this outcome is that contracted prevention providers that include environmental strategies and community education as a component of the constellation of prevention strategies they provide each submitted approved agency level plans for these specific services. Each of these agency plans include elements specific to their particular target populations and communities, to their constituencies and stake holders and, to their organizational history and character. These agency plans also contain elements common to each of them addressing the goals of this Priority Outcome. One of the implementation mechanisms of the Department's Prevention Plan includes the formation of an environmental prevention/community education workgroup comprised of those OASAS funded providers that deliver these strategies; Membership also includes two OMH funded agencies for improving cross-system collaboration in this arena. The Department is a member of this active workgroup along with the leadership of the Center for Health and Social Research of Buffalo State College. The most significant work product of this workgroup has been its design and sponsorship of a well-attended half-day local conference focused on underage drinking. Entitled, "Underage Drinking - It's Everybody's Problem," this conference major speakers included OASAS Commissioner Karen Carpenter-Palumbo and, Erie County Sheriff Timothy Howard. Moreover, U.S Drug Czar Gil Kerlikowske delivered a personalized recorded video message to the conference's attendees and sponsors. A crowd of nearly 200 parents, school administrators, board of education members, law enforcement officers, and representatives from the substance abuse and mental health fields came to the WNED-TV studios on the morning of April 28th the conference. The event served to educate all in attendance on the local and national underage drinking phenomenon and why this issue is so important. In addition, attendees were exposed to innovative local strategies that have been employed by schools, agencies, and law enforcement organizations to address underage drinking. Incidental collaborations among these agencies has been another fruit of this workgroup. UPDATE: Anticipated Year of Completion changed to 2014, due to this being seen as an ongoing strategy at this time. May, 2011 Prevention update for 2012 LSP: Px20 is the coordinating council of prevention service providers (which includes all major prevention providers contracted by the Erie County Mental Health), the Department of Mental Health staff, and experts in assessment and applied. Px20 formed as part of implementing the "Comprehensive Prevention Plan: Erie County Department of Mental Health 2009-2012" to enhance coordinated, collaborative prevention activities in Erie County. In Erie County, the Px20 group is a direct outcome of a year-round process initiated by the Erie County Department of Mental Health, which oversees most chemical dependency and mental health funding in Erie County, to develop a multi-year comprehensive prevention plan that incorporates data-driven decision making and evidence-based practices into a local framework. Px20 is made up of ten different organizations, including substance abuse prevention and mental health service providers Preventionfocus, the Erie County Council for the Prevention of Alcohol and Substance Abuse (ECCPASA), Western New York United Against Drug & Alcohol Abuse, Every Person Influences Children (EPIC), Native American Community Services, West Side Community Services, the Erie County Mental Health Association, and the Erie County Sheriff's Office Prevention is Awareness Program. The Erie County Department of Mental Health, which manages the NYS OASAS, NYS OMH and Erie County funded contracts of all the different member organizations, convenes the group. The effort is cooperatively guided by the Center for Health and Social Research at Buffalo State College. Through monthly meetings and the web site www.Px20.org, all of the participating organizations share information on programs, target populations, and locations to erase duplication and address gaps in service. The group also maximizes their limited resources by working together on large endeavors like special events and media campaigns. This also brings about a coordinated singular message that stands a greater chance of making an impact than several smaller independent efforts. Px20 has primarily focused on environmental approaches to prevention and workforce development as the areas where their direct collaboration is most obvious. One of the keys to the success of Px20 has been the participation of law enforcement in all aspects of the group's work. Erie County Sheriff, Timothy B. Howard, has served as the visible champion and spokesperson for the group. The group has worked to increase knowledge of existing laws, the benefits of obeying those laws and the possible consequences of breaking those laws. The creation of campaign materials concurrent with community mobilization efforts has brought about larger visibility of these issues and an atmosphere of expectations of law enforcement and judges that the laws will be enforced and punishments carried out when convictions occur. Erie County District Attorney Frank Sedita has recently joined a Px20 underage drinking campaign as well. Underage drinking was identified as the initial issue of concentration for Px20 based on evidence of the magnitude of the problem and demonstrated linkages of underage drinking to current health, criminal justice, traffic safety, violence, other drug use, mental health, and alcohol use disorders, including current diagnoses as well as increased risk for addiction later in life. The effort of the last two years uses the tagline "It's Everybody's Problem!" to stress the relevance of underage drinking to all county residents. The ongoing "Underage Drinking: It's Everybody's Problem!" effort works to support policies directed at reducing underage drinking, increase enforcement of underage drinking laws (including adult party hosts, underage alcohol purchases, underage drinking at public events, and drinking and driving by persons under age 21), change social norms towards underage drinking, increase the average age of first alcohol use, and reduce underage binge/high volume drinking. The following lists many of the accomplishments of Px20 since roughly April, 2010: [Key Accomplishments of Px20 Collaborative 2010-2011](#). The main collaborative effort, Px2010 and Px2011: Underage Drinking It's Everybody's Problem, under which the following accomplishments fall. Px2010 conference held at WNED public television in April 2010 o Well attended and featured key presentations from the then OASAS Commissioner Karen Carpenter-Palumbo, Erie County Sheriff Timothy B. Howard, Lake Shore Central Schools Superintendent Jeff Rabe, and a scientific overview of the data to support why underage drinking is everybody's problem by Dr. Wieczorek o Additionally, U.S. Drug Czar Gil Kerlikowske provided a taped message to the audience o Legislative outreach/press event in December 2010. o Continued the underage drinking theme and added specific emphasis on alcohol/drug impaired driving. This event (as did all other press conferences) received notable publicity and was attended by State and County legislators and/or their staff members. Press Conference with

the Sheriff and DA unveiling new "Party with Kids, Pay the Price" Billboard o Great media coverage and collaborative involvement · Parent awareness forums o Presented to parents at schools as part of their children participating in extracurricular activities) o Conducted at numerous schools throughout Erie County · Px20 Website development and maintenance · Business First Profile · Significant Activities of Individual Agencies or Collaborations between Agencies o Alcohol Free Weekend o Red Ribbon Week o Sticker Shock o Underage Drinking Tip Line o Family Day o First Night o Increased enforcement and underage drinking targeting in ECSO patrol districts o Numerous environmental prevention billboards and cinema ads § Serve Kids Serve Time § Holiday Billboard § Party With Kids, Pay the Price · Currently under development: o Contribution to NYS Sheriff's Association Conference o Bee News Back to School Insert profiling Px20 o Business First ad for Px20

Agency: OASAS;
Target Complete Year: 2014
Is this an innovative practice that you would like to share with others?: No
Focus: Cross System Collaboration; Other - ;

Priority Outcome 11 In Progress
Reform of Local System of Crisis Services for Chemical Dependency

To improve the local system of Crisis Services for Chemical Dependency, in collaboration with local providers of this category of treatment services and, with other volunteer experts, the Department has previously submitted to OASAS a report on and recommendations for reforming the local system of crisis services. The overarching purpose is to assure that individuals receive the right service at the right time. It is additionally geared toward decreasing the total cost per individual, increasing access and, improving consumer outcomes. The entirety of this report has been attached to the Mental Hygiene Planning Activities Report component of this Local Services Plan. It has also been referenced in various other sections of this Plan. Implementation of the recommendations contained therein comprises priority outcome. The brief version of these recommendations are:

- Develop a coordinated network to provide appropriate crisis services.
- Identify appropriate medication assistance to be utilized at levels of care other than inpatient settings, such as the use of suboxone and of methadone in community-based medically supervised withdrawal programs.
- Make professional assessment of intoxication and the potential for withdrawal readily available in community settings. The results of such assessments would also include timely linkage and any necessary transportation to the level of treatment the patient requires.
- Retain medically monitored withdrawal services at its current level versus replacing it with medically supervised detoxification.
- Develop mechanisms of identifying and coordinating services for the chronic recidivist chemical dependency patient.
- Assure the financial and geographic availability of substance-free crisis housing.

There are 23 specific recommendations cited in the report. Two recommendations should yield savings, two would require re-investment of funds, and the rest are either cost-neutral or require some minimal cost that could be absorbed with some ease.

Agency: OASAS;
This outcome has been selected as a top two priority for OASAS.
Target Complete Year: 2012

Strategy 11.1 In Progress

Crisis Services Reform Workgroup will continue to meet with the express purpose of a planful implementation of the reform recommendations. The initial foci are:

- Identification, collection and compiling baseline data against which the impact of recommendations' implementation can be assessed.
- Reduce crisis service utilization by those individuals who have a history of multiple admissions to these service types and, by those who have a history of excessive multiple presentations with alcohol or substance abuse complaints to the Emergency Department at the Erie County Medical Center.
- Establish a common set of referral and admission criteria and procedures among all local providers of crisis services to improve patient access and linkage to most appropriate service.
- Development of a crisis housing capacity, since in many cases the availability of this resource could allow effective treatment without the necessity of inpatient treatment and/or, could insure more timely access to appropriate treatment.

2011 Progress: In 2008, the Erie County Commissioner of Mental Health empanelled a work group to re-design how detoxification is conducted in Erie County. Membership is comprised of Erie County's providers of OASAS certified Crisis Services, the Department and, a few community volunteers with relevant expertise. The Crisis Services Reform Workgroup (the Workgroup) continues to meet monthly. The group issued a report; one major recommendation was to address the multiple recidivists in the CD population. The group recommended that care coordination be utilized to reduce the utilization of inpatient detoxification services. The goal is to engage these individuals as quickly as possible to interrupt their patterns of multiple admissions and to curb their high cost to taxpayers. The Spectrum Human Services MATS program provides such services to the CD population. In meeting with the MATS program staff, the work group noted that the current process to enroll clients is quite inefficient. One primary obstacle is the extended time it can take to have recent Medicaid claims adjudicated to affirm that the client meets the threshold for eligibility for enrollment in the MATS program. The threshold is \$15,000 of treatment costs (medical, psychiatric, CD, prescription) within a 12 month period over the last three years. The group is making several recommendations to maximize the impact of the MATS program, to be presented to the OASAS Field Office by the Department. The most important are as follows: 1. A client is admitted to inpatient detoxification and has had several treatment episodes at that same facility in the past 12 months. - The staff would obtain the information from their own billing department as to whether the \$15,000 threshold was met in the past 12 months. If so, the client would be referred to MATS without delay. 2. A client is admitted to inpatient detoxification and reports treatment episodes across several facilities in the past year. - The staff at the admitting site would secure pertinent release of information authorizations and contact the other treatment sites to confirm days of care provided. A list of average costs per days of care per treatment facility would be constructed and made available at each facility that provides withdrawal services. To minimize false positive referrals to MATS, such clients would need to meet a threshold of \$18,000 estimated costs before linkage with MATS. If that threshold is met, the client is linked with MATS immediately. 3. The current requirement for 12 consecutive months of treatment to establish eligibility should be revised to the \$15,000 threshold being met within the three years. Clients who have a lapse in Medicaid eligibility can otherwise not be eligible for the program. 4. Permit waivers to eligibility based on need as assessed by the MATS staff. A similar waiver process currently exists in the SPOE formulation. In rare instances, there are clients who request case management services because they feel at high risk for relapse. Alcohol and Drug Dependency Services (ADDS) and the Erie County Medical Center (ECMC) have established a referral relationship that helps individuals expeditiously access the appropriate care, regardless which agency from which services initially sought. This relationship has become characterized by open lines of communication among staff of the two agencies and, periodic review meetings to assure that cross-referrals work as smoothly and efficiently as possible. Both agencies report this is working very well for the benefit of those seeking care. ADDS and Sheehan Hospital have initiated a referral relationship based on the model being utilized by ADDS and ECMC. While this relationship is much newer and is not yet working as well as the ADDS/ECMC one, both agencies report gratifying progress. ECMC, Sheehan and, ADDS have each placed a focus on increasing utilization of medication assisted treatment, primarily Suboxone, to assist in the provision of treatment at lower levels of care for opiate dependent individuals who, without such treatment, would likely receive services at more expensive levels of care. Moreover, both ECMC and Sheehan have been using Suboxone assisted outpatient treatment to a limited extent, reporting good results. Anecdotal reports from ECMC indicate that these individuals do much better over a 4 to 5 month period than opiate dependent individuals who receive traditional, inpatient withdrawal services only or who are then referred to traditional outpatient. ECMC notes that the most significant barrier to greater utilization of this approach is that it is extremely physician intensive and, current reimbursements do not cover the cost of the requisite physician time. A related barrier is the apparently limited number of physicians providing suboxone in collaboration with outpatient programs. Resource limitations have curtailed establishing a good results data mechanism. The Department is abandoned last year's effort toward getting approval for a revised Communities of Solution proposal. It appears to the Department that this is not a viable avenue at this time.

Agency: OASAS;
Target Complete Year: 2013
Is this an innovative practice that you would like to share with others?: No
Focus: Service Access (Capacity); Service Engagement;

Priority Outcome 12 In Progress
To Support Behavioral Health Care Readiness for Health Care Reform

The Behavioral Health Care System should address the following issues in preparation for Health Care Reform, effective 2014

* Service Delivery

- o Improve Behavioral health provider capacity to provide measureable, high performing, treatment, prevention and wellness oriented services and supports;
- o Person centered health care homes as part of meeting the demand to integrate physical and behavioral health, using emerging best practice clinical and support models to link primary care and specialty behavioral health care;
- o Expansion of peer counselors and consumer operated services (supporting recovery) consistent with implementation of implementation of performance accountability and;

- o Faster dissemination of evidence based clinical guidelines to improve the integration of health and behavioral health in conjunction with the development of physical/behavioral health homes
- * System management
 - o Need to Improve in the quality and value of behavioral health services as Medicaid and Health insurance exchanges prepare for expansion and the implementation of parity;
 - o Use of behavioral health services to address absenteeism and to assist in the management of chronic diseases, including better management of health care expenditures and;
 - o Participation in the development of structures supporting health care reform such as Accountable Care Organizations.
- * Infrastructure
 - o Development of infrastructure to participate in Quality Improvement strategies that improve the delivery of behavioral health services, outcomes for individuals being served, improve wellness and control the increase in costs;
 - o Implementation of electronic medical records that support quality improvement, performance accountability and integration with physical health;
 - o Development of fiscal stability plans enabling the provision of specialty behavioral health services under evolving payment mechanisms as fee for service reimbursement decreases and;
 - o Work force development to provide services with fidelity to unfolding best practice and emerging need while remaining fiscally stable.

Agencies: OASAS; OMH;
Target Complete Year: 2013

Strategy 12.1 In Progress

The following examples illustrate components of the Erie County Department of Mental Health's strategy to build readiness for Health Care Reform:

- Implementing of contracts that focus on Performance Accountability and Quality Improvement
- Partnering with other funders to build capacity to demonstrate measurable improvements as a result of our services
- In collaboration with the Western New York Care Coordination Program, Implementing a Complex Care Management pilot, targeted to high need, high risk individuals with co-occurring chronic Physical Health conditions
- In collaboration with the Western New York Care Coordination program, encouraging agencies to participate in a non-binding Managed Care Utilization Management process
- Including the provision of Evidence Based Practices in our Requests for Proposals
- Working with Agencies to explore interoperable behavioural records
- Requiring Agencies to develop fiscal stability and corporate compliance plans

The Department will continue to pursue these and similar actions through the next year.

2011 Progress: Contracting Process Improvement The Erie County Department of Mental Health's contracting approach beginning in 2011 for all agencies moves us beyond the Performance Based Contract. Instead, we are shifting the contract emphasis away from retrospective penalties for performance deficits to supporting a focus on accountability for active management of agency and program Quality Improvement. An approach focused on quality improvement and on understanding the relationship between practice and outcomes is essential to program growth and development, effective services and client outcomes. Consistent monitoring of data related to both process and outcomes, allows agency administrators and practitioners to assess the effectiveness of their programs in supporting client outcomes as well as to develop targeted intervention and process improvements when data indicates potential issues affecting the achievement of both client and program outcomes. Quality Improvement is more than the development of a plan. It is an active integration of data collection, monitoring and understanding the relationship between practice and outcomes. This is achieved through both the administration and management of a program as well as group and individual clinical supervision. It is through a combination of integrated management and clinical practices that improvement opportunities are identified and effective solutions are implemented. The Department is requiring the following outcomes in Agency-wide Quality Improvement Plans:

- Fiscal
- Disproportionate Minority Share outcome, defined as achievement of valued outcomes across race/ethnicity
- For Agencies participating in the Children's System of Care "Effective Transition Planning", defined as early proactive planning and engagement in natural supports within the person's home community
- For Agencies participating in the Children's System of Care, one additional outcome and for all other Agencies, two additional outcomes selected from the following:

o Family Stability (children) o Recovery (community integration, work, rehabilitation, habilitation etc.) o Reduced System Penetration o Community Impact o Chemical Dependence or Problem Gambling Prevention Agencies are required to submit Corporate Compliance plans for review by the department and update these plans annually. Complex Care Management Working with Beacon Health Strategies, NYCCP has developed and field-tested a Complex Care Management program that includes many of the elements of a health home program. Through analysis of Medicaid claims data and collaboration with County Single Point of Access programs and participating providers, we identify high-risk individuals with serious mental illness and co-occurring medical disorders who might benefit from greater co-ordination of physical and behavioral health services. Participating behavioral health providers that operate targeted case management programs designate specially trained Complex Care Coordinators to work with consumers to develop person centered individual services plans, taking into consideration physical, behavioral health and social needs of individuals and individual interests. Beacon Case Managers are experienced clinicians who are trained in identification and treatment of co-occurring physical and behavioral health disorders. They provide consultative support to provider Care Coordinators to help behavioral health providers to identify the physical health needs of individuals with serious mental illness and work with Health Maintenance Organizations to develop a services plan and arrange for the delivery of physical health services. Beacon Case Managers have access to Beacon's software system, which includes a Case Management record system and supports operation of the program. Results to date for persons served by this Complex Care Management model show significantly shorter lengths of stay compared to typical targeted case management users. SPOA Reform Using 2008 Medicaid data, the most recent year available at the time of analysis, ICM/SCM/Blended Case Management programs potentially save \$4,116 in Medicaid for each individual served, and ACT potentially saves \$3,960 in Medicaid per person served. As the SPOA is moving towards serving high need high cost individuals earlier in their trajectory, savings will increase. We are planning to implement Critical Time Intervention as a key component of SPOA reform and have begun work with Dr. Dan Herman. Critical Time Intervention (CTI) is a nine-month case management intervention designed to enhance continuity of support for persons with severe mental illness during periods of transition. Such periods may include the months following discharge from hospitals, jails and other institutions, the transition from homelessness to housing, or the transition between different levels of treatment and support. CTI operates in two ways: by strengthening the individual's long-term ties to services, family, and friends; and by providing emotional and practical support during the critical time of transition. An important aspect of CTI is that post-discharge services are delivered by a worker who has established a relationship with the client before discharge. CTI shares with long-term assertive community treatment models a focus on promoting in vivo development of independent living skills and building effective support networks in the community. The emphasis, however, is on maintaining continuity of care during the critical period of transition while primary responsibility gradually passes to existing community supports that will remain in place after the intervention ends. Such an approach, we believe, increases the likelihood that the impact of a time-limited intervention will persist beyond its actual endpoint, which is the primary goal of CTI. CTI is delivered in three phases, each of which lasts approximately three months (see table). Phase one--transition to the community--focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers. Ideally, the CTI worker will have already begun to engage the client in a working relationship before he or she leaves the institutional setting. This is important because the worker will build on this relationship to effectively support the client following discharge from the institution. The CTI worker generally makes detailed arrangements in only the handful of areas seen as most critical for community survival of that individual. Phase two--try out--is devoted to testing and adjusting the systems of support that were developed during phase one. By now, community providers will have assumed primary responsibility for delivering support and services, and the CTI worker can focus on assessing the degree to which this support system is functioning as planned. In this phase, the worker will intervene only when modification in the system is needed or when a crisis occurs. Phase three--transfer of care-- focuses on completing the transfer of responsibility to community resources that will provide long-term support. One way in which CTI differs from services typically available during transitional periods is that the transfer of care process is not abrupt; instead, it represents the culmination of work occurring over the full nine months. CTI is an evidence-based model that has been tested in several rigorously designed trials. It is listed in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). Further information is available at www.criticaltime.org Reshaping Non-licensed Services We had been funding a wide range of non-licensed recovery oriented services, increasing funding through time on an incremental basis. Using the RFP process, we funded specific services with the following core components and accountability measures:

- Credentialed benefit advisement
- Support for work
- Parenting support
- Financial literacy
- Live coaching
- and Recovery Center, for all components

Medicaid savings should result from our increasing focus on serving high need/high risk and emerging populations, many of whom are high Medicaid users. Older Adult Reform We had been funding services for older adults based on what we had historically been funding. As part of our RFP process, we evaluated these services and then focused on a target population at risk of nursing home or institutional placement as a result of the following:

- mental health symptoms
- co-morbid medical issues that complicate treatment/effect long term stability
- co-occurring substance abuse
- poverty presenting a barrier to accessing needed and appropriate services, supports and/or resources

We are implementing these newly awarded services in strong partnership with our Department of Senior Services and are using their information system to track and improve performance. Medicaid savings should result occur as a result of diversion from nursing homes and other institutional placements.

Agencies: OASAS; OMH;
 Target Complete Year: 2013
 Is this an innovative practice that you would like to share with others?: No
 Focus: Service Engagement; Quality Management;

Priority Outcome 13 In Progress
Employment

Increase Opportunities for individuals with Developmental Disabilities to develop, obtain and maintain competitive employment/supported employment/out or out of home options.

At the Community Forum providers indicated the following as barriers to employment:
 Issues:

- Lack of intensive support time frames (unrealistic)
- Transportation services
- School transition
- Job exploration/shadowing to make informed decisions about work

Agency: OPWDD;
 Target Complete Year: 2012

Strategy 13.1 In Progress

Strategies and Action Steps:

Strategies:

1. Increase stakeholders, individuals and families knowledge/information about the services available.
2. Educate individuals and families about the benefits of competitive employment as currently there is some reluctance, especially if the individual has had a history of sheltered employment.

Action Steps:

1. Collaborate with the Western New York DDSO to hold stakeholder meetings to increase awareness about employment opportunities.
2. Hold informational sessions regarding employment and effects on benefits.

2011 Progress: The ECDMH is no longer providing deficit funding for sheltered workshops with three primary providers. The strategies outlined will remain the same for 2011 and moving forward. Stakeholders will be meeting to develop further action steps to address the issues noted below. Issues: Lack of intensive support time frames (unrealistic) Transportation School transition Job exploration/shadowing to make informed decisions about work The following represents employment placements for three EC providers:

Agency	OPWDD - Supported Employment Placements	ACCESS - VR	SSA	Enclave
Cantalician	7	13		
Heritage 2010 Breakdown	Combination of all categories is 393 which is the total number of individuals working and is inclusive of 2010 placements			195
	9	71	5	
Suburban Adult Services	48			

Agencies:
 Target Complete Year: 2012
 Is this an innovative practice that you would like to share with others?: No
 Focus: Employment / Education;