Mental Health, Mental Retardation and Substance Abuse Services in Southwest Georgia

Issues and Challenges facing Regions 10 and 11

Report and Recommendations to the Georgia Division of Mental Health, Mental Retardation and Substance Abuse

April 30, 2002

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DRAFT

Executive Summary

The southwestern part of Georgia faces many challenges but possesses many strengths in providing behavioral health services to its residents. The system has gone through numerous financial and structural upheavals, and now faces serious workforce shortages, low staff morale, and continued funding constraints. In the past year alone, the MHMRSA system has had to adapt to rapid and difficult changes. The switch to the rehab option, implementation of revenue maximization and accompanying new billing systems, and changes in leadership at DHR and the Division have all required fast reaction at the state, regional and provider level.

At the same time, both Division and provider staff in the Region remain committed to providing high quality services to consumers, to working collaboratively with each other, and to create a more efficient—and effective—behavioral health delivery system. The recent passage of House Bill 498 allows the Division to make changes to the administrative structure of the MHMRSA system, and the appointment of a permanent Division Director will only increase confidence and stability in the system.

Summary of Findings

Public Works spent several months studying the issues and challenges facing the Regions 10 and 11 and the Division. Based on our visits, conversations, review of material, and ongoing analysis, **Public Works** can make the following observations of the fundamental challenges facing Regions 10 and 11. These findings enabled **Public**

Works to focus our recommendations on those issues most pressing to Regions 10 and 11.

- **In an effort to maximize service to consumers, individual providers are trying to provide too many behavioral health services to too many people at too many locations, thereby stretching available resources.** The array of mental health, mental retardation and substance abuse services available to MHMRSA consumers is comprehensive and requires staff, expertise, program development and infrastructure to provide. Community Service Boards (CSBs) have historically provided all Medicaid behavioral health services at all available service locations (determined by the historical existence of a service center in each county, rather than by consumer demand). Medicaid requires that all services are available to all consumers; however, it does not demand that each provider provide each service. While the commitment of providers to provide a full complement of services is laudable, the attempt to provide "all services to all people" is putting the both the system and individual CSBs under significant programmatic and fiscal strain.

- **The unresolved legal and financial structure of the Community Service Boards, their relationship to Regional Boards, and overall implementation of House Bill 100 hinders effective service delivery.** The MHMRSA system underwent significant structural change with the implementation of House Bill 100 and the shift in status of CSB staff from state to non-state employees (with the subsequent change in benefit and retirement structure). The status of the CSBs and their relationship to the regional boards and the Division continue to be unresolved both within Regions 10 and 11 and statewide, and often hamper effective collaboration and service delivery. While the legal status of the CSBs may or may not have a direct impact on service delivery, the ambiguity of their status has put the system in a degree of "limbo" which hinders effective planning and service delivery. Resolution of these issues is more likely with the passage of House Bill 498, though questions will likely still remain as HB 498 is implemented.

- **Workforce shortages, illustrated by difficulties in recruitment and retention of staff are a critical problem facing Regions 10 and 11 at all levels.** National health manpower shortages make it difficult for Regions 10 and 11 to recruit, retain and deploy qualified, competent behavioral staff. These shortages are particularly acute in licensed professionals and physicians, and are exacerbated by the rural location of Region 10 and 11 providers. Pension and benefit policies across governmental and quasi-government agencies create a non-level playing field and limit the CSBs' abilities to attract experienced staff. State agencies within and outside of DHR compete with each other for funding and staff to serve many of the same individuals. Variations in salary levels between CSBs and between MHMRSA and other state agencies, as well as consistently low levels of compensation, place the MHMRSA system at a clear disadvantage in recruitment and retention.

- **Transportation to and from community-based and hospital services currently operate in an inefficient and costly manner.** The original intent of the Unified

Transportation System (also known as Consolidated and Coordinated Transportation System) was to expand access to transportation services by combining consumers within the behavioral health system and those within other state-sponsored programs under one system. Under the Unified Transportation System, local service providers are required to provide funding to maintain administrative and operating costs, while operating responsibilities are centralized under one state agency. However, recent budgetary cutbacks have hindered local service providers' ability to expend the necessary funding to maintain current transportation demands. These tight economic conditions have greatly diminished the system's service capacity, leaving the Regional Boards and CSBs to question whether or not the cost of operating this system in its present design is cost effective.

- **Budgetary constraints, as well as conservative billing practices based on past HCFA audits and billing concerns, have rendered some of the CSBs, and the system as a whole, fiscally unstable.** Providers are still dealing with recent and rapid changes in funding and billing systems and are not drawing down all available Medicaid funds to maintain the system of services. CSBs are not billing as efficiently as necessary to fully fund reimbursable services, thereby putting the stability of the system, as well as individual agencies, in danger.

- **State billing policies or lack of clarity thereof at times contradict the goals of the Region and further exacerbate the existing challenges.** State policies and procedures regarding billing practices are often difficult to understand, while written protocols are often hard to obtain due to the multi-level communication chain. Some policies appear to contradict themselves, while others are often not available in advance of their implementation. This exacerbates the difficulties the regions are having in aggressively billing for Medicaid services.

- **The process to assess need and set program priorities is uneven and does not fully involve all parties at critical intervals.** The current schedule and structure of planning, priority setting and funding does not allow for effective input, feedback and a locally driven assessment of need. The timeline for completion of the Division's annual plan does not always allow for sufficient information to be drawn from local planning. As a result, staffing and services are not necessarily designed and funded based on actual local need.

Despite these significant challenges, the Division, CSBs and Regional Boards have demonstrated a strong commitment to the community they serve. Division staff has expressed significant concern over the challenges facing the Region and expressed strong commitment to addressing local issues, while operating within their own budget constraints. CSB and Regional Board commitment to the community is also clear and there is a strong willingness to partner and collaborate and make the system stronger. Changes necessitated by the passage of House Bill 498, as well as permanent leadership at the Department and Division level will all impact positively on the Region.

Summary of Recommendations

Based on the findings above, Public Works has developed numerous recommendations to address the problems facing Region 10 and 11. These recommendations are described briefly in this executive summary and detailed in future sections. In addition, the attached tables list each recommendation with corresponding timeframes (short, medium or long-term), as well as which entity should take the leadership role in implementing the recommendation (state, region, or provider). Most important to implementing these recommendations is to recognize that:

- The Division must provide the leadership, coordination, and support necessary to truly address the system constraints in southwest Georgia. Regions 10 and 11 cannot be left on their own to address the challenges they face.

- At the same time, regional staff, SWSH, CSBs, and other providers must act as full partners with the Division and take responsibility for implementing those recommendations that are best addressed at the regional level.

Other issues to consider in reviewing recommendations include:

- Some recommendations are not new to Regions 10 and 11 or the Division. Some recommendations are already in the process of implementation, though often at an individual provider level and not by the entire system of care in the two regions.

- Some recommendations provide short-term strategies to address regional problems and should be fairly quick to implement. Other recommendations are more complex, involve the collaboration and cooperation of multiple entities, and require considerable time and additional study to implement. **Public Works** recognizes the need for short-term solutions to many of the challenges facing Region 10 and 11. At the same time, implementation of longer-term recommendations is necessary in order to effectively change in the system.

Regional System Structure and Organization

While the commitment to comprehensive service delivery is impressive, the current funding, workforce and transportation constraints make it programmatically and fiscally impractical for each provider to continue to provide the level and complement of services now being offered. Continuing down this path will likely result in a sudden and potentially haphazard reduction of services due to the inability of some CSBs to stay solvent and fully staffed, or the continued reduction in available services by individual providers because of workforce and funding constraints. By engaging in proactive, planned service realignment, the Division and Regions 10 and 11 have the opportunity not only to improve service delivery and fiscal stability in Regions 10 and 11, but also to

set a model of planning and service delivery for the rest of the MHMRSA system. The proposed restructuring process is detailed in Section 2; the basic elements include:

1. Realignment and restructuring of the clinical and administrative functions of Region 10 and 11 through a collaborative state/regional partnership. This would result in one unified region with a new administrative, planning and service delivery structure, beyond the administrative restructuring required by House Bill 498.

2. Engaging the community and private sector in the system redesign and the provision of services through increased outreach to private hospitals and providers who are not currently engaged in the MHMRSA service system.

3. Revising the current system for planning, funding and service delivery by becoming more inclusive of providers, and setting timelines that enable local planning to inform Division planning and funding decisions. Local planning data should be scheduled to arrive at the Division in time to fully inform statewide planning.

Workforce Recruitment, Retention and Reengineering

The behavioral health profession is constantly facing a need for qualified professionals. This is certainly the case in Georgia and is made even more difficult by the rural nature of Southwest Georgia. The combination of a national health care shortage and the preexisting difficulties of workforce recruitment in rural areas have put Southwest Georgia at a distinct disadvantage. As with other rural areas in the country, Southwest Georgia is constrained in its ability to recruit and retain behavioral health professionals due to economic, geographic and social disadvantages.

Public Works recommends several overarching strategies to address workforce issues in Southwest Georgia. However, the workforce shortages facing the region are significant and not subject to any "quick fixes." These recommendations are detailed fully in Section 3.

1. Workforce issues must be addressed through a comprehensive, statewide approach that addresses the workforce shortage statewide. Regions 10 and 11 cannot continue to solve their workforce problems on their own. The Division must lead this statewide strategy but include systems beyond MHMRSA and focus on both short and long-term strategies.

2. While the Division should provide leadership in addressing the regional workforce shortages, Region 10 and 11 must also reinvent their local approach to recruitment, retention and effective staffing of mental health, mental retardation and substance abuse services.

3. Maximize existing recruitment resources such as the National Health Service Corps, reimbursement for graduate medical education (GME), partnerships with local colleges and universities, and residency education on-site in rural Georgia.

4. Invest human and financial resources on retention of existing staff such as employee recognition and professional development.

5. Reengineer the workplace to maximize the efficiency of existing staff, including use of staff appropriate for their level of education, training and licensure.

6. Invest in long-term strategies to build the workforce pool, such as further development of relationships with academic institutions, increasing the number of graduates who choose to work in the Region.

7. Use consumers to provide peer and other necessary services, recognizing the challenges of certification and training.

8. Develop an aggressive outreach program to reduce the number of “no-shows” at provider sites and to reduce the resulting non-productive clinician hours.

9. Investigate combining processes for accreditation and meeting quality standards to reduce the workload and stress on providers. This includes identifying areas of overlap and eliminating duplication of effort.

10. Expand uses of technology such as telehealth, distance supervision and learning, and video-conferencing to extend the range of staff availability and qualifications.

11. Investigate expansion of scope of practice for nurses and other clinicians both to attract them to Georgia and to enhance their scope of work.

Transportation

The development of a fully staffed, high-quality service system is only one component of delivering services. Transporting consumers to services or services to consumers can pose yet another set of funding and structural barriers to any behavioral health system. Transportation to services is a particularly daunting issue in rural areas. While urban areas have the benefit of a transportation infrastructure, rural areas, including Southwest Georgia, often rely on a patchwork of systems, funding sources, and creativity to get services to consumers and consumers to services.

The current transportation system does not effectively serve the consumers of Southwest Georgia, and is costly and inefficient. Section 3 details the following recommendations:

1. Allow the regions to "opt-out" of the unified system and return to their own operations or, better yet, develop and implement a new transportation system.

2. Examine the "Med Zip" transportation model, which focuses on geographic scheduling of consumers, for implementation in Southwest Georgia.

If a full system redesign is not possible:

3. Continue funding levels to maintain consistency of service.

4. Develop a region-specific scheduling system that standardizes resources throughout the region.

5. Designate vehicles for specialized service usage so that vehicles are used either for the same purpose or same population during specified time periods.

Funding

Funding levels for MHMRSA services have remained relatively stable in the past decade, despite a growing population in need. In addition, federal and state requirements for Medicaid reimbursement have become more difficult to meet, and actual dollar reimbursement has not increased at a level commensurate with providing services. Section 4 details the following recommendations to address funding issues in Region 10 and 11:

1. Bill more efficiently for Medicaid-reimbursed services.

2. Maximize Medicaid and CHIP enrollment.

3. Increase efforts to compete for private funding and non-Medicaid federal funding.

4. Review cost and reimbursement policies related to Crisis Stabilization Unit and restructure the service and reimbursement mechanisms as appropriate.

Introduction

The mental health, mental retardation and substance abuse system in Georgia has faced many challenges in recent years. Changes have been made in the organization of regional planning and method of service delivery, funding and billing practices, and MHMRSA and DHR leadership. These changes, combined with level or reduced funding despite a growing population, have all put the service delivery system under significant stress. Georgia's two southwestern regions – Region 10 and Region 11– face the additional challenges of providing mental health, mental retardation and substance abuse services in predominantly poor, rural communities that are geographically and culturally distant from the hub of state activity.

In July of 2001, the Georgia Division of Mental Health, Mental Retardation and Substance Abuse (the Division) contracted with **Public Works**, a public policy consulting firm, to assist Regions 10 and 11 in assessing some of their new and longstanding challenges and to make both short and long-term recommendations to meet these challenges. **Public Works** was also directed to make recommendations that address state level policy and structure of Georgia's behavioral health system that directly impact the functions of Region 10 and Region 11. This draft report was prepared by **Public Works**' consultants, and does not necessarily represent the views and opinions of the Department of Human Resources, Division of Mental Health, Mental Retardation and Substance Abuse, or staff of the Regional Boards and Community Service Boards in Region 10 and Region 11.

Scope and Methodology

As determined by the initial proposal, then revised in subsequent meetings and memoranda[1], the scope of work for this project included the following:

- **Identification of the system constraints and challenges facing Region 10 and Region 11.** These constraints and challenges were identified through initial meetings with Division officials, site visits with both Region 10 and 11 Community Service Boards (CSBs) and Regional Boards, follow-up with the Regional Executive Directors and CSB directors of each region and extensive review of state and regional planning and service related documents.

[1] Meeting on August 2, 2001 and January 22, 2002; memo of October 3, 2001; e-mail correspondence August-October, 2001.

- **Identification of key challenges to service delivery facing Region 10 and Region 11.** Staff of the regional boards and CSBs, as well as independent review and analysis by **Public Works**' consultants identified system structure and planning, transportation, workforce, and funding as the most pressing issues facing the Region.

- **Recommendations to strengthen and maximize the service delivery system offered by the CSBs and private providers.** Given the challenges and constraints identified above, these recommendations include actions to be taken by the regions themselves, actions that require Division leadership and those that require a state/regional collaboration and partnership.

Public Works gathered data and conducted its analysis using several approaches. These activities included:

- Extensive review of Southwest Georgia documents, including Regional plans, Department of Human Resources and Division plans, and CSB technical assistance reports.

- Onsite interviews conducted by Jennifer Kolker and Christie Gross (September 10-11, 2001) in Thomasville and Adel, and Molly Raphael (January 29, 2002) in Albany, Georgia.

- Telephone interviews conducted by Jennifer Kolker (August-October, 2001) and Molly Raphael (January-March, 2002).

- Ongoing communication throughout the consulting period via e-mail and telephone with Ken Brandon and Cathy McCrae.

- Telephone and in-person interviews with Karl Schwarzkopf and Annette Bowling.

- Meetings with advocates during the Georgia Needs Assessment/Planning Project, October 2001.

- Interviews with providers, administrators, and planners in mental health, mental retardation and substance abuse service delivery from other states.

- Research on "best practice" models from multiple states.

Report Format

Each area defined in the scope of work is addressed in the following sections, with detailed recommendations contained in each chapter. Section 1 discusses System Structure and Organization; Section 2 discusses Workforce Recruitment, Reengineering and Redesign; Section 3 discusses Transportation to Services; and Section 4 discusses

Maximization of Funding Resources. Each section discusses both regional and state-level issues and recommendations.

Charts, tables, additional best practice information and additional resources are contained in the appendices. Because the topics discussed are different in their scope, depth and content, each chapter varies somewhat in its scope and format.

Section 1: System Structure and Organization

Background and Problem Identification

The MHMRSA system in Regions 10 and 11 is built upon a premise of community-based, high availability of a full complement of services. Division staff, Regional Board staff, and Community Service Board staff are clearly committed to providing high quality behavioral health care to all residents in need.

Currently, all providers within Regions 10 and 11 are grappling with providing all services to all consumers in multiple locations, and doing so under budget constraints and severe workforce shortages. A comprehensive change to the current system is needed in order to prevent an already-stressed system from worsening. Funding availability is not likely to improve markedly over the next several years. Requirements for Medicaid reimbursement are likely to become stricter with reimbursement levels lower, and state funding is not predicted to increase. Workforce shortages are projected to worsen nationally and in Southwest Georgia, severely affecting Regions 10 and 11 and further limiting the availability of qualified behavioral health staff to provide required services. Regional transportation systems have the potential for redesign to solve some current problems, but doing so within the current framework of two separate regions with different structures and resource levels is impractical. While short-term, individual actions can address many of these issues, the success of the system of behavioral health care requires change at the system and structural level.

Most parties have recognized that some type of merging of administrative and clinical functions is necessary to address some of the underlying system problems and re-stabilize the system of care. The “umbrella concept” that has been proposed by the Regional Boards and State Hospital builds upon and maximizes the regional willingness to collaborate and partner. However, simply combining administrative and organizational entities alone will not address the fundamental system problems nor meet the existing challenges. As long as each provider within the “umbrella” continues to try to provide its current level of service with the existing funding, conduct their own workforce recruitment within a national shortage, and deal with transportation issues with varying levels of available funding, the proposed change in structure will not alleviate the system constraints.

By centralizing the two regions’ administrative and clinical functions it can increase clinical effectiveness and operational efficiency. The newly created region would be stronger because it would be able to spread the total resources over the Region while eliminating redundant functions, particularly in management and administration, and carefully plan for and deliver services to meet consumer needs.

Although administrative change will not cure the ailments facing the system, a realignment of the structure of Regions 10 and 11 will encourage resources to be used more efficiently, and thereby help to sustain the current system and individual provider’s

capability to offer high quality services to consumers in the region. By creating one unified region, the CSBs, State Hospital and Division staff can better overcome the challenges facing Southwest Georgia.

By creating a unified region, the following improvements can be made:

- Realizing of economies of scale by reducing the administrative structure. By reducing administrative burden on each provider, the new Region's administrative structure will have more time to pursue regional partnerships and innovative practices that they currently do not have time to pursue.

- Reduction of some staff needs by sharing staff resources across CSBs and the state hospital, particularly for authorization of services.

- Improved recruitment and retention by approaching the workforce as one Region and not as individual providers.

- Better assessment of need for services through a unified planning process.

- Increased participation of private providers, hospitals and academic institutions as the Region 10 and 11 are realigned and a role for public/private partnerships is better defined and encouraged.

Recommendations

1. Realign and restructure the clinical and administrative functions of Region 10 and 11 through a collaborative state/regional partnership. This would result in one unified region with a new administrative, planning and service delivery structure.

To be clinically effective, to increase operational efficiency and to strengthen the Community Service Boards, **Public Works** proposes a total re-engineering involving all Region 10 and 11 staff and providers, under the leadership and support of the Division. Implementation of House Bill 498 will provide an overall framework for the administrative realignment of the Region. **Public Works** recommends that the unification of the Region go beyond the requirements of HB 498 and include a realignment of clinical functions.

Regions 10 and 11 share many of the same workforce, transportation and funding problems. These shared concerns provide an opportunity for more formal partnership, since a region-specific solution can be more easily constructed. By combining clinical and administrative needs, Regions 10 and 11 can come together, determine true consumer demand for specific services, and design a system that meets consumer needs while reducing the burden on each provider.

A combined approached to service delivery will require a reexamination of the need for all services to be provided at all locations and will operate on the premise that unless and until personnel and financial resources dramatically increase, services may need to be reduced and realigned throughout the "new Region." Realigning-services based on consumer needs and measuring demand and availability can improve the overall quality of services delivered. Providers can be relieved of the burden of providing all services and focus on providing the services that are needed and those in which they excel.

In order for this realignment to truly work, the Division needs to provide both leadership and support to the new Region during the planning and transition phases, ensuring that participation in this process will not further harm the CSBs. Necessary steps in this re-engineering process will require the Division and new Region to:

- Redefine the geographic boundaries of the new Region as well as the internal, county-based geographic distinctions, and create one administrative and management office for the new Region.

- Create a leadership team of the CSB directors, Regional Directors or appropriate state staff, and State Hospital leadership to recommend a management structure and process for service realignment within a mutually-agreed-upon time frame.

- Identify the design of the new regional leadership structure and those duties that are purely administrative and those that are clinical and separate these responsilbities when appropriate so that staff may perform their duties as effectively as possible. (For example, some staff now have caseloads as well as administrative duties for compliance and accreditation. While everyone in the organization is responsible for delivering high quality care, staff in leadership positions need to be able to focus on specific areas of responsibility and not be torn between two very different functions.)

- For planning purposes, condense the full complement of Medicaid defined services into more distinct service clusters, avoiding the traditional breakdowns of mental health, mental retardation and substance due to dual diagnoses and reimbursements and focus on more functional distinctions. By looking at functional distinctions, and consumer need and location, staffing and service needs can be more easily assessed. Service clusters may be based on population, type of service, or type of funding stream.

- Conduct a consumer-based needs assessment to determine the services that are in greatest demand based on identified consumers' need and which services can be reduced or realigned throughout a newly combined "single region."

- Identify current best practices within the new cluster of services in the new Region for replication. While all providers are currently providing a full array of services, it is likely that certain providers have become "experts" in particular

areas of service or in particular populations. Use the process of realignment to identify these areas of expertise and share with other providers.

- Once the service clusters have been defined, and best practices determined, designate a "lead provider" for each cluster of service. The "lead provider" will provide leadership to the new Region in the planning for and provision of the service, instituting best practices in service delivery, and assuring that the service is available to those who need it throughout the new Region. For example, one CSB may be determined to be the "expert" in the provision of services to children, and will then manage those services for the new Region and determine service locations as well as staffing needs. Another provider may lead the new Region in outpatient substance abuse services.

- Determine the staffing needs for each service cluster and determine the best location for staff and potential staff-sharing arrangements between CSBs and the state hospital. Once staffing needs are determined, develop a unified recruitment and retention plan that is regional and not provider-based, and uses both full-time and hourly paid staff where necessary.

- Examine geographic barriers, transportation hurdles, population density, caseload, political ramifications and other factors to determine where the new service configurations may be located, their hours of operation, the type of services and quality mechanisms. This will entail working closely with the Regional Boards as well as local advocacy and consumer groups.

- Once the configuration of services is determined, develop a one-year transition timeline to shift services to new providers while avoiding disruption to the existing service system. This will require support from the Division, including "bridge" dollars where necessary through the transition.

- Develop and implement an integrated technology system for the new Region.

- Prioritize service needs so that in instances when there simply are not enough qualified staff to perform services, there will be a planned strategy for service category elimination or reduction. Conversely, as resources improve and demand changes, additional services can be reinstated or expanded in accordance with needs and priorities.

- Strengthen and expand the Single Point of Entry (SPOE), including resolution of existing legal and structural issues. The SPOE system is a critical component of a unified approach to service delivery and an example of the ability to work well collaboratively. According to Regional Board staff, the SPOE is working reasonably well for hospital and crisis admissions, but is not fully utilized for general information and referral to services.

2. Engage the community and private sector in the system redesign and the provision of services.

The system cannot be successfully redesigned without the input and commitment of the community and private providers. The problems facing the CSBs and public behavioral health system belong to the community as well, and a shared approach may yield better solutions. Specifically:

- Identify private or other providers who are not currently part of the service system who, based on their competency and skills, would be willing to become part of the broader network of services. This would include the local hospitals, behavioral health providers not connected to the MHMRSA system, and public and private providers of physical health services (many of whom are serving MHMRSA clients and who could collaborate on service provision, co-location of services, outreach, and assessment of need). This would enhance the provider network and increase the availability of qualified staff to provide services.

- Develop a communication plan that involves all sectors of the community, including consumers, and solicits their input and support as the new service plan is implemented.

- Involve the community and private provider system to enhance and stretch the range and locations of services based on state compensation standards. Identify problems that can be mutually addressed, e.g., provide after-hours on-call capability, provide urgent assessment, assist with medication evaluation.

- Coordinate service planning with other state agencies within and outside of DHR who serve the same or similar populations, particularly Public Health, DFACS, and Corrections.

3. Revise the current system for planning, funding and service delivery.

Local planning must rationally and effectively inform state planning and funding allocations. Comprehensive and inclusive planning will maximize the workforce, insure better use of available funding and deliver the appropriate complement of services to those most in need. The recommended service realignment and state/local partnership will be greatly enhanced if the process for planning and funding is improved to increase local input. Specifically:

- Adjust state planning guidelines to foster timelier regional plan development and outcomes measurement. A rational planning and funding process across state agencies that interact with MHMRSA consumers need to be developed to better use scarce resources and involve all entities in planning for the delivery of services.

- Actively involve the CSBs in the overall planning process and design of the service models regardless of their statutory role. The CSBs are essential service providers or managers of service delivery. The Division should use the knowledge and information available from the CSBs because of the special place they occupy in the provision of government funded behavioral health services.

- Assure that regional and local data are included in the development of the biennial state plan. This requires an adjustment of the timelines currently established for receipt of information from the new Region. Furthermore, the state may find it helpful to seek input from the new Region (including CSBs) before the service priorities and targets are established.

- Develop better mechanisms for access to and integration of research for evidence-based programs and services.

Section 2: Workforce: Recruitment, Retention and Reengineering

Background and Problem Identification

From the outset of this project, staff at all levels have stated the difficulties of recruiting and retaining staff.

There is a well-documented national shortage of health care workers and behavioral health is no exception. It is especially difficult to attract qualified staff to rural areas. Often these areas cannot offer salaries, benefits and other lifestyle amenities comparable to more cosmopolitan areas. In addition, the public delivery system generally cannot use costly techniques such as finder's fees and hiring bonuses to recruit staff. These disadvantages continually inhibit the capacity of Regions 10 and 11 to compete for health professionals, and thereby challenge their ability to supply quality health care services to its consumers. While recruitment of licensed staff and physicians is the most serious problem, regional staff also identified difficulties in hiring even nonprofessional staff such as clerks and administrative staff that are reliable and not prone to rapid turnover.

Workforce shortage is a critical issue that has been discussed and explored by several agencies within the state of Georgia. Workforce shortages not only exist in Southwest Georgia, but have also been documented throughout the state. For example, according to a report issued in December 2000 by the Georgia Health Profile of the Health Resources and Services Administration:

- With 8.5 psychiatrists per 100,000 population in 1998, Georgia ranked lower than the national ratio of 11.1 and Georgia ranked 26th among states in psychiatrist per capita.

- Georgia had 19.0 psychologists per 100,000 population in 1998, well below the national average of 31.2 and ranking 40th among states in psychologists per capita.

- In 1998, Georgia ranked 40th in psychologists and 33rd in social workers. Georgia also lacks an adequate nursing supply, ranking 40th for nurses, 34th for nurse practitioners and 17th for LPNs.[2]

(Details on demographics and workforce projections are found in Appendix 1.)

While the CSBs and SWSH have varying levels of workforce problems, all recognize the urgency of addressing this issue. Unfortunately, due to market conditions and other factors, the situation has not improved despite this significant effort. As a result, there is often an overall feeling of failure among providers and the sense that "nothing will work." A new strategy, with its accompanying energy and enthusiasm, needs to be infused into the Division and the new Region to begin to correct the skilled workforce shortage. This strategy needs to involve regional and state leaders.

Recommendations

While the shortage of licensed professionals is severe and national experts do not see marked relief for several years, there are steps that can be taken to minimize the effects in the Regions 10 and 11. **Public Works** recommends several strategies to assist the in recruiting and retaining behavioral health professionals and staff.

1. Workforce issues must be addressed through a comprehensive, state-led approach that address the workforce shortage statewide and does not leave Regions 10 and 11 to solve their workforce problems on their own. This strategy should include leadership from MHRSA, DHR and other related agencies and focus on both short-term and long-term strategies.

Workforce problems have largely been left to individual providers to solve. There is an obvious need for an aggressive, statewide approach to workforce development. Coordination, leadership and support will need to come from the Division in order to make certain that high-quality services are delivered to Southwest Georgia consumers. The Division needs to tackle workforce development as a statewide initiative, pulling together all stakeholders to develop a statewide strategy. (For additional information on efforts in other states, see Appendix 2) The Division should undertake the following initiatives:

- Coordinate with other state agencies both within and outside of DHR that are facing workforce shortages to coordinate state approaches to recruitment and retention and put workforce development on the statewide agenda.

[2] (Ibid) * Reflects data from 1996

- Equalize the salary and benefit structure throughout DHR divisions and other state agencies. Currently, staff move from MHMRSA to other state agencies because of better pay, resulting in competition within DHR agencies as well as other agencies in the state; an equitable salary structure would increase MHMRSA retention and recruitment. In addition, unequal salaries across CSBs within the state and Regions 10 and 11 undermine staff retention and add to the instability of the system. This overhaul of the salary structure will require DHR leadership at a minimum and higher-level leadership for full implementation.

- Implement previous statewide efforts at addressing workforce challenges. There have been several workgroups and committees charged with examining workforce problems in Georgia that should be implemented. This includes the recommendations listed in the Health Care Workforce Technical Advisory Committee, "Code Blue: Workforce in Crisis" report and develop appropriate action plans. The report investigates contributing factors leading to health services' deficits and outlines suggested strategies that government administrators and providers throughout the state can use to prevent further deficiencies. [3] Other reports and recommendations exist as well that should be examined for potential implementation.

- Offer clear guidelines as to state and federal staffing requirements and opportunities for waivers or exceptions to help the new Region meet their staffing requirements for reimbursed services. This includes clear communication between the Division and APS regarding allowable staffing for reimbursement.

- Coordinate workforce information sharing by developing a statewide structured formal process in which information on staff mobility is shared across regions whenever staff resign positions or relocate to other areas within the state. The Division should coordinate this with connection to other DHR agencies.

2. While MHMRSA should provide leadership in addressing the regional workforce shortages, Regions 10 and 11 must also reinvent their local approach to recruitment, retention and effective staffing of mental health, mental retardation and substance abuse services.

The crux of the workforce problem for Regions 10 and 11 is twofold: First, a national workforce shortage resulting in a lack of qualified professional staff necessary to provide services and, second, a lack of funding to recruit staff aggressively in an environment of high demand.

[3] Physicians' Assistants, Medical Assistants, Home Health Aides and Medical Records Technicians are among the nine health care occupations, defined as the state's "fastest growing." "Code Blue: Workforce in Crisis." Health Care Workforce Technical Advisory Committee. May 2001. (Table 3: Health Resources and Services Administration, State Health Workforce Profiles, November, 2000)

The increasing demand for community-based behavioral health services and decreasing supply of qualified staff have not only hurt service delivery in Regions 10 and 11 but also decreased staff morale and left recruitment staff feeling helpless. Each provider has been left on its own to recruit staff. Outreach and marketing efforts have often been reduced to traditional approaches like newspaper advertisements and web postings that have limited effects, particularly during a workforce shortage. As part of a partnership with the Division and a statewide approach to workforce development, the new Region will need to reinvent and rejuvenate its own approach to staffing. The Region must take the following steps:

- Approach workforce development as a Regional—not provider—issue.

- Examine previous and current recruitment approaches for potential revision and implementation. This should be done in light of the newly structured service system and be regionally based.

    - Develop "entrance" surveys that ask new hires how they learned about the position and what factors led them to take the position. Use the completed surveys and staff input to re-examine previous and current recruitment approaches.

    - Identify previous recruitment practices that have been successful at filling positions, even if not at the level desired.

- Expand community outreach. Too often, a long-standing entity like a CSB is taken for granted as an employer (particularly for non-professional positions). An aggressive community outreach effort can enhance provider visibility and "remind" the community of the CSB as a professional entity. This includes partnering with area hospitals, nursing homes, senior centers, academic institutions or other community organizations to increase visibility, strengthen the image of behavioral health providers, and build stronger relationships with the general public.

- Collaborate with local hospitals and community groups to identify nurses and other professionals who leave the hospital setting. Many nurses are leaving hospital-based jobs because of the disadvantages of the hospital setting (long hours, high caseloads, short-staffing, mandatory overtime, irregular schedules, etc.) By developing a network to identify nurses leaving the hospital setting, the CSBs can act quickly to contact these staff and describe the more attractive working conditions of CSBs.

- Use staff to reach out to friends and colleagues who may already be thinking about leaving their current employment. Provide "reach out" or "recruitment cards" similar to those recently developed by the Department of Corrections. These small business cards contain information on the positive reasons for

working in the Prison Health Services and supply contact information for those interested in employment.

- Work with community groups to identify retired individuals who may want to rejoin the workforce on a limited basis. The high level of persons over the age of 65 living in Southwest Georgia suggests a current regional strength, and illustrates a potential recruitment option as part-time employees for either administrative or other clerical positions. The Area Councils on Aging and Green Thumb project are resources to recruit this population.

3. Maximize existing recruitment resources.

Employee Benefits and Salaries

While there are many issues that affect workforce availability, salary is a key focal point in workforce recruitment and retention. Salary levels might deter potential employees from accepting a position, especially during a documented shortage period, while impacting turnover rates or employee retention.

Appendix 4 illustrates a range of behavioral health and support position salaries to evaluate Southwest Georgia's Merit Pay System in relation to other states,[4] as well as a comparison of salary rates from the Albany and Georgia Pines CSBs in order to capture local provider differences. The findings from this comparison show that the Region is at a competitive *disadvantage* for certain professional categories but at a competitive *advantage* for others:

- In the master's level mental health professional category, Georgia could lose potential candidates to nearby Florida.

- Similarly, pharmacists could cross the state line to work in Alabama in order to receive more benefits.

- At the same time, salary differentials indicate that the Region could expand recruitment efforts for master's level mental health professionals to Alabama and other states.

As important as the differentials in salary between states are the salary differences between Region 10 and Region 11 CSBs. For instance, Georgia Pines CSB has been able to increase its starting salaries for licensed service providers to reflect mid-range salary rates. Albany CSB, due to budgetary limitations, has little to no flexibility in raising starting salaries at this time. This extreme variation increases competition between regional partners, which will ultimately pose a barrier to effective collaboration and true partnership. Finally, since the salary structure of the merit

[4]States selected were Florida and Alabama (for geographic proximity), Vermont (a northern state), and Idaho (a western state). All states have significant rural population.

system only allows a large increase in salary if a staff member leaves and then returns, there is inherent instability in the system as staff change employment to maximize their compensation.

The CSBs have limited resources that can be allocated to salaries and benefits and as a result have difficulty competing with the private sector or even non-MHMRSA state agencies. Absent changes in the current funding situation, and recognizing the financial difficulties that many of the CSBs are facing, there are some strategies to increase benefit and salary levels that may be utilized:

- Develop a commitment to raise revenue that will be dedicated to staff needs. Demonstrate this commitment by inviting all staff to help identify potential lost revenues and opportunities for increasing revenue that relate to the CSBs mission and purpose. Examples might include steps such as aggressively pursuing Medicaid enrollment for eligible but unenrolled consumers, increasing outreach to decrease consumer no-shows, and improving staff understanding of the billing system so that all billable units are recorded. Helping staff to see the relationship between such activities and salary levels may help generate enthusiasm for raising revenue.

- Approach philanthropic and other organizations to fund special-purpose projects such as staff development workshops that can be funded outside of the wage and salary schedules.

National and State Recruitment Resources

There are recruitment resources in Georgia that can be more strongly utilized by the new Region, with adequate support and coordination statewide. Some of these resources are not well publicized at the regional level and therefore not integrated into regional recruitment strategies. Two of these programs--the National Health Service Corps (NHSC) and state sponsored financial aid programs available to supplement the cost of medical college--offer potential examples. It is important to note that 96 of Georgia's 159 counties have been designated health professional shortage areas by the federal government, well positioning the state for grant and other funding for workforce development.

The NHSC is the single most direct federal program addressing health personnel distribution. A reported 60 percent of clinician placement occurs in rural areas. The NHSC supports doctors, nurses, dentists, behavioral health professionals, and other clinicians who serve in rural and inner-city areas lacking adequate access to quality health care. In return for a commitment to practice in an underserved area, the Corps offers scholarship and loan repayment assistance to students and clinicians. A significant percentage of Corps clinicians remain in the area after fulfilling their commitments.

The proposed federal 2003 budget includes $191.5 million to strengthen the NHSC. This represents a $44 million increase over current spending levels. Also included is $15 million to expand the Nursing Education Loan Repayment program specifically to address the professional nurse shortage.[5] **Public Works** recommends the following to expand use of these programs:

- Aggressively investigate and maximize its use of the NHSC. Currently the NHSC program is used sporadically, without a central place for providers to go for assistance. The state should establish a centralized resource either by the development of a NHSC state website or direct link from a state agency website, like DHR, to ensure that all federal and state-sponsored programs and opportunities are identified.

- Capitalize on the attractiveness of the new Region as a place to work. The new Region needs to appeal to potential NHSC participants. In addition to providing the necessary support funds for providers, a sound, redesigned and collaborative behavioral health network will provide an incentive to health professionals to relocate to Southwest Georgia.

- Develop relationships with psychiatric residency programs. To attract resident physicians to the Region for ambulatory and community learning, the Division and Region must develop relationships with senior physicians, deans and the directors of residencies education programs. For example, the Louisiana State University Health Sciences Center has a rural residency program that they started in 1992. Licensed physicians go to rural areas to do parts of their residency education requirements. Thirty-six percent of the school's physicians now choose to practice in designated rural areas. The program is managed by the Department of Family Medicine and Comprehensive Care and supported by the Louisiana Academy of Family Physicians.

Another approach to encouraging the provision of care in geographic and specialty shortage areas is by compensating prospective physicians' graduate medical education (GME) costs that are incurred by accredited training programs. The Georgia State Education Medical Board (SEMB) manages two financial aid programs for the state with the goals of (1) providing an adequate supply of physicians, resident psychiatrists, nurses and other healthcare workers in the rural areas of Georgia; and (2) providing a program of aid to promising medical students who do not have the financial means to attend medical college.[6] These goals are accomplished through the County

[5] Providers can discover additional criteria needed to qualify for physician assistance by reviewing the NHSC website: http://www.bphc.hrsa.gov/pinspals/. The site also provides a Recruitment and Retention Assistance Application that can be easily downloaded.

[6] Source: http://www.communityhealth.state.ga.us/, specific information: For further information on the Georgia Medical Fair contact the State Medical Education Board of Georgia at 404/656-2226 (voice) or 404/651-5788 (fax). To receive a complete application package, complete the *Request for Medical Fair Application Form*.

Doctor Scholarship Program and the Loan Repayment Program. Particular strategies to The Region can undertake several strategies to enhance use of GME reimbursement:

- Increase financial incentives available to students in GME programs, which support training and placement of physicians in underserved areas through a state investment.

- Expand recruitment efforts by including information about Georgia's GME financial aid programs and residency education programs in a newsletter or brochure that is circulated to medical colleges throughout the country. Increase the awareness of these financial programs by providing a direct link from regional boards and CSBs' websites to the SEMB's website in order to ensure that prospective students can obtain access to information resources.

- Develop a mechanism for the Board to share information and develop collaborative recruitment strategies. Persistent communications and interactions with this Board are critical to maintaining, and in some areas expanding, recruitment efforts. The new Region should aggressively work with the Board to inform them of other professional shortages beyond physicians, specifically licensed professionals. While the Board's original intent is to recruit physicians, the Board could either work with the new Region in defining helpful region-specific recruitment strategies, like Medical Career Fairs, or develop a Board-sponsored program used exclusively to recruit behavioral health professionals.[7]

In addition to formal reimbursement mechanisms, the CSBs can take the following steps to formalize and structure the current relationships they have with professional schools and colleges for nursing, social work, physician's assistants, and mental health counselors.

- Create an inventory of schools in the area and schools that have educational programs in the manpower issues in question.

- Identify those schools with which there is already an existing relationship, e.g. Albany State, Darton and Southwest Georgia. Talk to the leadership in these schools to attempt to devise an agreement that would give a priority to placing qualified students in the CSB network in the new Region.

- Assign top clinical staff to mentor and supervise the students and encourage them to remain in Southwest Georgia when they complete their training. If students do not wish to stay in the Region after completion of their program, mentors can try to maintain contact with them so that they will keep the CSB in mind should their circumstances change and they seek to return at some time in

[7] Information about these opportunities can be found on the SEMB website: www.communityhealth.state.ga.us/. In addition to providing graduate education funding opportunities, the SEMB produces an annual listing of scholarship recipients that are in training. The physician listing is available to all rural areas that qualify for service repayment.

the future. This approach may help with recruitment as well as current service delivery.

- Maintain frequent contract with school leadership, attend career fairs, conduct open houses, and participate in on-site school programs.

4. Invest Human and Financial Resources in Retention of Existing Staff.

As the staff shortage continues to worsen, many health care employers are studying their ability to keep the staff they have. The high cost of turnover, difficulties in recruiting new staff, decreased morale among other workers when experienced staff leave or positions go unfilled, and the detrimental impact vacancies have on maintaining the delivery of quality care make retention of existing staff critical. Studies of workforce retention in the health care industry typically focus on employee benefits and salaries, employee recognition, and worksite modification.

Employee Recognition Programs

Good employers know that employees respond positively when they believe that their employer values their services and contributions. Clearly the public behavioral health care system cannot compete with the private sectors on a salary and benefits basis. Taxpayer dollars cannot be spent on color televisions, new cars, and other gimmicks that are given to reward workers who stay on the job. However, steps can be taken to communicate to current employees that they are valued, wanted, respected and vital to the success of the CSB and SWSH, particularly at a time of low staff morale due to rapid system change and staff shortages. Providers can initiative or enhance the following activities.

- Develop formal mechanisms to acknowledge exemplary staff such as public recognition (e.g., “employee of the month” or acknowledgement on the local radio station), small financial rewards, and investment in professional development.

- Identify best practices in a specific area and ask staff to share their techniques with others through formal staff training, newsletters, web sites, and professional development seminars.

- Conduct formal annual recognition programs that focus on length of time on the job, professional accomplishments, attainment of degrees, and cost saving or quality enhancement ideas.

- Work with “problem” and marginal workers to help them improve their skills and performance, through the use of mentoring and peer review and assistance.

- Maintain a responsive communication program so that employees can initiate discussion about concerns and problems without fear of retribution. Create a

mechanism for staff groups to meet to share ideas and to develop a sense of connectedness to the overall agency.

Employee Development

Ongoing skill development and professional growth are important to professional staff. Access to stimulating courses and educational experiences is often more difficult in remote rural areas. Yet, within its boundaries Georgia has many fine academic institutions and teaching facilities. Suggestions include:

- Develop a core staff development plan for all staff. Stipulate that participation is dependent on available funds and staff coverage. Using the newly combined and realigned regional system to coordinate coverage so that staff may participate and not be disappointed.

- Provide workshops and training opportunities in topics that will improve job skills and performance. Solicit staff input for the topics that they believe will best strengthen their skills.

- Expand telehealth and video-conferencing to provide opportunities for staff to interface with clinical experts and use video-conferencing to conduct peer discussions.

- Develop formal arrangements with universities and technical programs to allow staff to participate in distance learning for graduate credits, to finish an uncompleted degree, to earn continuing education credits, and to advance from lower levels positions (such as technicians) to higher ones (such as vocational nurses). Work with staff to design flexible hours that enable participants to complete the courses. This can also be used as a recruitment resource if potential hires want to join the CSB while still working on their required degree or credential.

- Invite representatives from other programs in the state to provide on-site conferences on their best practices. If funding permits, enable staff to travel to see “best practice” programs in their natural settings.

- Seek funding from philanthropic or civic groups to support focused workshops that impart new information needed by a large number of staff and that helps address a care problem that exists in the community. Examples may include child abuse, domestic violence, and teen alcohol use, among others.

Worksite and Position Modification

Although employers need to impose structure and uniformity throughout the organization there are times when flexibility is warranted. The current competitive

environment requires an innovative approach that often looks to employees for input and problem solving:

- Enable the use of "flex time." Child care and dependent care may interfere with full-time employment or cause a good employee to leave. Often allowing employees to work a flexible schedule is enough to keep them on the job. "Flex time" takes many forms including fewer days worked per week, longer hours worked on fewer days, nontraditional starting and ending times and split shifts.

- Facilitate job sharing. Job sharing involves allowing two or more employees to share one position, agreeing to make certain all job functions are carried out. The employees do the basic scheduling and arranging within a fixed amount of hours.

- Standardize and implement exit interviews. Since retention efforts do not always succeed, every effort should be made to ascertain the real reasons why staff leaves. While salary is often the first reason given, there are often additional, and equally important reasons that can be addressed.

5. Reengineer and Redesign the Workplace to Maximize the Efficiency of Existing Staff.

During times of severe manpower shortages the Division needs to revisit policies and procedures that limit the provision of services to a given area. Furthermore, where restrictive policies originate in other agencies outside of MHMRSA, it may be timely to talk with others about policy changes that ultimately may improve quality of services as well as promote more efficient use of taxpayer dollars.

In the absence of improved numbers of available staff, providers can change the workplace and delivery of behavioral health services to maximize the use of existing staff. The proposed restructuring and redesign of the system in Section One is a comprehensive step in that direction, as are the following recommendations:

- Standardize training, documentation, and authorization procedures across all provider sites so staff can easily move throughout the new Region and provide services at any site.

- Inventory all licensed staff able to authorize services, and restructure workloads so they are maximizing their ability to authorize care and maximize reimbursement.

- Create a short-term work group with representation from the Division and CSBs to examine all job descriptions for professional staff. The work group should identify all job functions and tasks that can be performed by non-licensed personnel that will maximize efficient use of the clinicians' skills and minimize time spent doing lower level tasks.

- Re-examine current job descriptions to determine if requirements and qualifications are unrealistically high given the length of experience of potential applicants and other credentialing criteria.

- Examine the current state policies that require that only graduates of four-year nursing programs (e.g., those with a BS degree) be allowed to perform certain nursing functions. Since, apparently, graduates of associate degree programs are allowed to perform a wider range of functions in the private sector and bill for Medicaid, state restrictions should be examined to determine if state policy could more easily be more flexible, or if an exceptions process could be used if a total policy change is undesirable.

- Explore the credentialing of professional staff using standards beyond education, such as equivalent experience in a psychiatric setting or requiring targeted supervision for a specified period of time.

- Determine what is acceptable under the scope of practice regulations for behavioral health providers (graduates of baccalaureate and associate degree nursing programs, licensed marriage and family therapists, licensed mental health counselors) and make sure they are effectively billing for services they are able to perform.

6. Invest in long-term strategies to build the workforce pool.

There are many career choices available today. Young people turn away from health care because of lack of status, long hours, and low salaries and because of an attitude that in general there are better work environments. The problem is particularly acute in rural Georgia communities, which have experienced difficulty keeping many of their young people from moving to more urban areas.

Building a workforce pool for the future can be a daunting task. Energy expended now will not be realized until much later and will not address the current pressing needs. However, short-term fixes will not stabilize the system and health care shortages are projected to get worse, not better. Investment in long-term strategies to build the pool of future employees is critical to future success.

The Region should take the following steps to improve the adequacy of their supply of workers in future years:

- Strengthen partnerships and relationships with colleges and professional graduate schools to maximize the numbers of graduate level students who choose providers in the new Region for internships or field experience. Develop a formal plan with the universities and professional schools to attract resident psychiatrists, advanced practice nurses and clinical social workers. Expand the

pool of universities and professional schools who offer relevant coursework and degrees in the behavioral health field.

- Develop opportunities with local colleges and universities to assist current staff to pursue completion of degrees, to move from lower to higher status levels within their profession while continuing their current employment.

- Develop relationships with local middle and secondary schools to create mentoring programs for students interested in health, create health clubs to stimulate interest and share information, conduct open-houses to inform students about careers in health and human services, and participate in career days as an "investment in the future."

- Implement the "Kids into Health Careers" program, a national education campaign to attract more children's interest to careers in nursing and the health professions. The "Kids into Health Careers" tool kit contains information on more than 270 health careers with information on the level of education preparation needed to pursue specific health careers, salary outlook and resources on obtaining financial assistance to pursue an education in the health professions.

- Work with other state agencies to develop a comprehensive strategy to work with the elected leadership to pursue loan forgiveness programs within the state for areas facing significant workforce shortages.

- Develop state and regional relationships with established health associations such as the Georgia Hospital Association and the Georgia Nurses Association to strategize to address long term recruitment problems such as pooled advertising, educational campaigns, tracking of staff who may relocate within the state.

7. Use consumers to provide peer and other necessary services.

The use of consumers to provide services is a nationally recognized strategy both to improve quality of service and address workforce availability and cost. Consumers as employees have been underutilized in Southwest Georgia, and development of this area has strong potential, despite the difficulties in certification and training of consumers. To increase the use of consumers as employees, providers should:

- Develop and strengthen the Peer Services approach that has recently received approval for federal reimbursement. Successful peer counselors from elsewhere in the state can be called upon to design and set up effective programs in the Region. Furthermore, these experienced peer counselors can mentor new peer providers from the Region via video-conferencing or other appropriate means.

While peer counselors are effective in their own right, they can also function as physician or nurse extenders with certain restrictions.

- Use consumers to fill administrative positions. Nationally, behavioral health providers have recognized the value of consumers as employees within behavioral health settings. Not only are workforce issues addressed, the employment is a positive component of treatment for the consumer and creates positive role modeling by seeing consumers in professional roles.

8. Develop an aggressive outreach program to reduce the number of "no-shows" at provider sites and to eliminate the resulting large number of non-productive clinician hours.

Getting consumers to keep scheduled appointments is a critical issue facing all behavioral health systems. When consumers miss appointments (which CSBs reported as a problem), transportation arrangements are upset, scarce clinician scheduled hours are wasted, and the consumer's care is put in jeopardy. Some proven practices to decrease no-shows include:

- Have counselors and checkout personnel remind patients of the importance of keeping their next appointment.

- Create and use an appointment letter. Give a copy of the letter to existing patients as they make future appointments and, when possible, mail the letter to new and existing patients well in advance of their appointments.

- Institute a telephone confirmation system that makes contact with patients two days before their appointment.

- Use community networks of family members, neighbors, churches, etc., to remind consumers of appointments.

- Develop a telephone confirmation script that reminds patients of the importance of keeping appointments.

In addition to the activities above, CSBs can devise a routine approach to identifying chronic no-shows and developing scheduling around them both to ensure their care and to cause the least disruption to clinician schedules. Some strategies include:

- Identify the reason for missing the appointment and target a consumer-specific intervention.

- Offer rewards, as in behavior therapy, for making appointments

- Double-book patients when one is a chronic "no-show."

- Have multiple therapy sessions instead of individual sessions so that sessions are held and revenue generated even if there are no-shows.

- Conduct home visits, particularly with peer counselors or other consumers.

- Place extra emphasis on avoiding no-shows for clients that suffer recidivism more frequently, i.e., develop a high priority list for the no-show population.

9. Review processes for accreditation and meeting quality standards.

Providers are currently required to achieve accreditation from one of several sources such as JCAHO and CARF, as well as meet MHMRSA standards and comply with additional performance requirements in their vendor contracts, such as APS. While a system requiring compliance with high quality standards should be put into effect and maintained, there is a staff and budgetary cost to rigorous compliance. Typically the same small group of staff is charged with compliance and then with preparing corrective action plans. When these staff also carry caseloads and have clinical assignments, they cannot adequately perform their clinical duties while also conducting their administrative requirements. To eliminate or reduce redundancy, **Public Works** recommends that all performance standards be compared and evaluated:

- Review and compare all national and state imposed performance and quality assurance standards.

- Identify duplicate standards and adjust the process so that providers do not have to duplicate their efforts.

- Identify conflicting interpretations of performance standards so that confusing corrective action plans do not result.

- Work with outside contractors and vendors to assure that uniform standards are put in place. These standards should not conflict with existing national and state requirements.

10. Expand uses of technology such as telehealth, distance supervision and learning, and video-conferencing to extend the range of staff availability and qualifications.

Telehealth, video-conferencing, and reducing the number of provider sites to which a physician must travel can assist in expanding consumer access to physicians. By utilizing this technology, the Region can enhance the availability of doctors, nurses and psychologists who are legally authorized to provide services, thus improving quality of care through increased access to appropriate treatment options.

While defining many of the solutions to today's problems needs to begin now, their implementation will not occur overnight. Such is the case with telehealth and its applications. Telehealth presents an important approach to extending access to care for many in rural or remote areas. Telehealth can decrease some of the problems of accessing services by using technology to bring the patient and the treating professional together. It can also be used for recruitment, education, and professional development.

While telehealth is gaining greater recognition in physical health, its use has been much slower in behavioral health. However, as the health manpower shortage continues to worsen and the cost of providing care continues to increase providers are looking for cost efficient and effective approaches to increase or maintain access to care and to assure quality.

Examples of successful behavioral health uses include physicians in West Virginia who are providing direct care and medicine monitoring both within their state and outside of its boundaries. They are equipping provider offices with sophisticated technology that offers real-time evaluation, consultation and supervision. Mountaineer Doctor Television based at West Virginia University has 21 teleconference sites in West Virginia, five in Pennsylvania and one each in Maryland and Ohio. The sites are used with psychiatric patients who report to find the approach to be attractive and comforting. Patients don't have to travel on bad roads for long distances, clinics save money because they don't have to hire expensive doctors even if doctors were available, and consumers avoid waiting long hours in office waiting rooms. Medicare has recently approved the use of telehealth for psychotherapy.

Currently, the use of telecommunications is very limited in rural Georgia. Some attempts were made several years ago to bring telemedicine to the Region but were only moderately successful (A collaboration between Phoebe Putney and the Department of Corrections did not succeed due to a lack of consultants, though Region 11 is using telemedicine through a collaboration with the Department of Health). The landscape has changed over the past few years, however, with more funding available and more examples of use for both clinical care and staff development. Expanding its use would greatly enhance supervision and staff education as well as improve the quality of clinical care. Since both public and private providers have difficulty attracting qualified psychiatrists who are board certified and meet credentialing standards, a public-private partnership could distribute the costs of developing telehealth capacity over a larger mass while improving the level of care for a much greater section of the community.

Public Works recommends that the Division consider expanding telehealth technology to its rural and remote areas. Much of this expansion will focus on development of relationships with those partners most appropriate to expand the access, as well as developing a long-term funding strategy to develop this as a sustainable program. The Department of Health and Human Services' Office of Rural Health Policy awards grants as part of its federal Rural Telemedicine Grants Program.

These funds can be used to offset the costs of consultations and to increase the infrastructure in communities that use telemedicine, some of which can be used for MHMRSA services. The MHMRSA office can establish collaborative arrangements with universities and training programs operating within the state. **Public Works** recommends that the private and public providers join together to:

- Identify shared clinical and quality of care concerns that can be addressed through telecommunications.

- Identify a mechanism to supervise clinical staff and to provide appropriate levels of clinical care. These mechanisms might include specialty practice groups or graduate medicine education programs located elsewhere in the state or perhaps beyond the state boundaries.

- Identify funding sources that would support the implementation and maintenance of the telecommunications structure. These funding sources include federal government rural health programs as well as philanthropic organizations that may be more accessible via the private sector.

- Explore the use of telehealth to conduct treatment sessions for selected patients who are not threatened by telecommunications and who are medication compliant. Begin the project on a demonstration basis and expand to wider areas as needed once the new approach's effectiveness is proven.

On a local or regional basis, audio-video conferencing equipment can be installed in the most remote offices so that travel time for physicians can be decreased and patient care hours can be increased. Psychiatrists would continue to travel to the provider sites to see patients on a face-to-face basis but the frequency of their visits would decrease. Nurses and counselors could communicate with the psychiatrists regularly to provide patient specific data on which some of the evaluations and care decisions would be based.

Once effectiveness is determined in remote offices, the Region can explore expansion of the audio-visual conferencing equipment in additional offices so that physician coverage can be extended and is available for emergencies and urgent walk-in patient needs. Non-psychiatrist staff can consult with the psychiatrist on-call, the psychiatrist can provide some direct assessment, medications and appropriate treatment can be quickly implemented and the patient can be diverted from unnecessary hospitalization because prompt treatment was conducted. While uses of telehealth would need to meet state and federal laws and regulations, the uses of technology offer promise to the new Region.

11. Investigate Expansion of Scope of Practice

Scope of practice laws and regulations can determine the availability of mental health, mental retardation and substance abuse services. By expanding the scope of practice for particular positions (particularly nurses and licensed mental health worker), the scope of service can be expanded and reimbursement levels increased. While expanding the scope of practice for one profession often serves to anger other professions, Georgia's current health manpower shortage warrants aggressive action, despite potential political barriers. The process to change professional practice regulations is time consuming often taking two years or longer, therefore activity needs to begin as soon as possible. For example:

- Expand the scope of practice for advanced practice nurses to allow for some prescriptive authority. Currently all states except for Georgia grant some type of prescriptive authority to qualified graduate level nurses. In Georgia, only physicians may order psychiatric medications. The mentally ill population of Georgia needs to continue to have easy access to qualified professionals who can prescribe the most effective drug for them. Granting prescriptive authority to qualified nurses is one approach that has worked in other states. Patients would have easier access to practitioners who could order drugs and monitor the effect of the medication and encourage improved client compliance. As a result, recidivism can be prevented, quality of life improved and expensive hospitalizations avoided. In addition, expanding the scope of practice may attract more nurses to settle in rural Georgia.

- Explore expansion of scope of practice for licensed mental health workers to ensure that their legal scope of practice is truly reflective of the roles and duties they are trained to perform.

- Reexamine scope of practice regulations that mandate functions that may legally be carried out by licensed psychologists. Specially qualified and educated nurses in many states are allowed to prescribe various medications and to monitor their effect. Psychologists, however, have not been given these privileges until quite recently. Georgia may want to consider the recent legislative action in New Mexico making that state the first in the nation to allow psychologists to prescribe psychotropic medications. The law requires psychologists to have at least 450 hours of pharmacotherapy training and demonstrate competency by passing a series of tests. In addition, they must undergo a two-year supervisory period under the guidance of a psychiatrist or a physician. These supervisors must sign off on all prescriptions during the supervisory period. This is a significant issue and change in the scope of practice for psychologists and should be examined in great depth.

Section 3: Transportation

Background and Problem Identification

Transporting consumers to services—or services to the consumers—poses its own set of funding and structural challenges to any behavioral health system. Transportation to services is a particularly daunting issue in rural areas. While urban areas have the benefit of a transportation infrastructure, rural areas, including Southwest Georgia, often rely on a patchwork of systems, funding sources, and creativity to get services to consumers and consumers to services.

The Georgia Department of Transportation (GDOT) is revamping its public transportation system in order to expand mental health, mental retardation and substance abuse services to maintain consistency with Georgia's recent population growth. Besides the GDOT transportation system, the Department of Human Resources (DHR) also provides transportation assistance to the Region through the DHR Unified Transportation System. Region 10 providers and Cook County providers in Region 11 are provided funding allocations to cover partial costs of supplying transportation to consumers. The remainder of Region 11 is presently not included in the Unified Transportation System. In addition to these systems, there are informal and emergency uses of transportation through the police and ambulance systems.

The Department of Human Resources (DHR) recently regionalized their transportation services to account for economies of scale, which are designed to promote more efficient service usage. Although the present unified system theoretically is designed to promote efficient use of services, the system is unable to functionally and practically support this concept in its current design. While Region 10 and 11 differ somewhat in their approaches to the transportation problems in Southwest Georgia, all stakeholders acknowledge that there is not enough transportation and that the current system is proving both costly and inefficient. Specifically:

- Due to overall budget constraints, many CSBs are unable to fund the level of transportation services required. Moreover, CSBs in Region 10 are required to provide vehicle maintenance, which is not entirely covered in their transportation allocation funds.

- As the attached GIS map shows, service providers are not necessarily located in densely populated counties and transportation routes are not necessarily directed towards provider locations.

- In addition to funding limitations and an irrational system for transportation, there is also a lack of standardization of resources and systems across Region 10 and 11 leaving a disproportionate burden on specific parts of the Region and certain providers.

- Existing measures to transport individuals to treatment are often ad hoc and therefore costly, less reliable, and not targeted to consumer needs. For example, the Southwestern State Hospital has relied on the law enforcement community for transportation support.

- The traditional transportation system is often incompatible with the needs of consumers residing in their counties. Work training opportunities often exist during weekends and evening hours when traditional transportation services are not available. Transportation and reimbursement policies limit consumer use of the transportation service, thus consumers are deprived of valuable learning and income –producing experiences. In addition, interested employers may feel rebuffed by this seemingly uncooperative approach and rigid procedures.

- Transportation difficulties contribute to consumer no-shows, increased recidivism rates and overall disruptions in consumers' care plans.

Recommendations

The Region has two basic options regarding transportation. It can move ahead in the development of a comprehensive, new approach to transportation and develop a new system. Or, it can make more modest changes to the existing system to improve efficiency and cost. **Public Works** recommends the following:

1. Allow the new Region to "opt-out" of the unified system and return to regionally based operations or, better yet, develop and implement a new transportation system.

While developing a new transportation program in the current environment is a challenging task, **Public Works** believes it poses the greatest likelihood of addressing the long-term transportation problems in the new Region. The critical issues facing such a step are the administration, structure and funding of a system, as well as providing mental health, mental retardation and substance abuse services in the interim. In determining whether to move ahead, the Division also needs to evaluate whether or not the new Region is able to plan and implement an alternative transportation system. This new system would most likely be separate from the GDOT and existing transportation systems. Ultimately, the Division would need to weigh the benefits and costs associated with such an alternative and determine whether or not any financial support could be provided to assist with operational costs. More importantly, the Division would likely need to work with the new Region in determining what agency would be responsible for administering a new transportation program.

Public Works conducted a best practice research analysis to determine whether or not successful innovative programs have been undertaken in other states that provide adequate transportation to consumers needing access to appropriate behavioral

or physical health care. A summary of these programs can be found as Appendix 5. Each program is discussed and program components described. In addition, **Public Works** has provided implementation ideas specific to Southwest Georgia.

2. Examine the "Med Zip" transportation model for implementation in Southwest Georgia.

Public Works recommends one model in particular – Project Access: The Med Zip Transportation Program, Tennessee Model.[8] Although this model is fairly new in its implementation process, its short-term success might provide the State of Georgia with a potential alternative to consider for future development, perhaps as a pilot program with plans for regional implementation.[9]

- The goal of the Med Zip program, also referred to as Project Access, is to establish a regional medical appointment scheduling system that results in patients from the same zip code being scheduled on the same days and times, thus benefiting from group travel discounts.

- Med Zip provides transportation to population segments, which are organized by zip codes through the use of taxis and other, subsidized or privately owned vehicles.

- Funding from the *Building Health Systems for People with Chronic Illness Program (BHS)*, a Robert Wood Johnson Foundation initiative coordinated by the Center for Health Care Strategies was used to fund the Tennessee Med Zip initiative. An additional $43,800 in passenger subsidies was provided through contracts with the Tennessee Department of Human Services and the Commission on Aging. In addition, the Metro Transit Authority increased its spending in a user side subsidy (coupon) program by $20,000 per year, much of which is used to support Med Zone trips for people with disabilities.

- Key implementation steps to be considered for Southwest Georgia include hiring of designated staff to manage the program, establishment of a transportation board and public/private partnership, and centralizing the scheduling process and route designation process through the state hospital. Appendix 6 illustrates the key implementation steps for the Region.

[8] Center for Health Care Strategies, Inc.: Project Access: The Med Zip Transportation Program. Jack Jacobik (Special Transportation Services, Inc.)

[9] In addition, a basic planning model also has been developed, and is located in the Appendix that clearly and simply illustrates basic implementation steps. Contact information for the program has also been given to Region 10 and 11 Executive Directors.

If the Division and Region determine that a large-scale change in the transportation system in Southwest Georgia is untimely, there are several mechanisms to improve upon the existing system without significant change to the system:

3. Continue funding levels to maintain consistency of service.

Consistent funding allocations need to be appropriated to the Region to ensure proper implementation of a region-specific transportation service. Funding reductions, as have been experienced in the Region by Albany Area CSB, Mitchell Baker Service Center and Thomas Grady Service Center are planned to receive an allocation reduction for Department of Human Resources (DHR) Unified Transportation in FY 2002[10], can affect access to care in rural areas. While short term effects might not be noticeable, long-term effects of a reduced ability to access care will negatively affect the new Region, resulting in higher costs for consumers who could have otherwise been treated through outpatient care, but due to the inaccessibility of transportation were forced to postpone treatment until their condition required more immediate and expensive inpatient care.

4. Develop a Region-specific scheduling system that standardizes resources throughout the Region.

In order to maximize resource capacity, it is essential that a Region specific scheduling system be developed, sharing all existing resources across the new Region. This will reduce both the over-or under-use of services, and establish a more efficient system.

5. Designate vehicles for specialized service usage.

Vehicle specialization that is linked to either a period of time or a specific population could assist providers in maximizing their use of resources while working within their resource limitations.

One example of service specialization might involve assigning specific vehicles to be used for the purposes of transporting children or adolescents; and another vehicle could be designated only for consumers receiving substance abuse treatment programs. If, for example, vehicle usage is restricted further, one vehicle could be used to complete two services at two separate times of day. For instance, the morning shift would be devoted to the sole purpose of weekly doctor's visits while the afternoon shift would provide transportation to consumers needing family or group therapy.

[10] Southwest Georgia Regional Board Mental Health, Mental Retardation and Substance Abuse, 2000 Annual Report and FY 2002 Plan for Services. January 2001

Section 4: Funding

Background and Problem Identification

Everyone, at all levels of the system, feels funding constraints. The reductions in Grant-in-aid funds, difficulties in billing for and capturing appropriate funds for Medicaid have created financial instability for the system as a whole. Since the fiscal picture for the state is not likely to improve anytime soon, other means of fiscal infusion are necessary. In the past decade, funding for behavioral health services has not kept pace with population growth, demand for services and increasing administrative requirements. In order to keep up with the need for services, the Division and Region need to increase the level of dollars coming into the Region to support service delivery.

Recommendations

1. Bill more efficiently for Medicaid reimbursed services.

As discussed throughout the report, CSBs and other providers need to be more aggressive in submitting claims for Medicaid funding. While there are understandable anxieties resulting from previous HCFA audits, the current system necessitates an aggressive funding approach. Staff needs to more thoroughly understand the types of service categories for which Medicaid can be billed in order to maximize revenue and avoid fraudulent practices. The Division, working with the Division of Medicaid Services, needs to be clear as to staffing waivers and reimbursement policies. APS can be used to accomplish many of the following recommendations.

- Share best practices across CSBs and across providers for aggressive and effective billing.

- Expand assistance and hands-on training by state officials and APS. Make sure that the Division and APS are conducting routine audits that will identify missed revenue producing activities and assist staff to improve their billing.

- Develop a more structured tutorial approach to changes in billing for services provided. Staff is weary of developing billing practices that eventually may be viewed as fraudulent and thus may precipitate another embarrassing audit. On-site hands-on guidance and instruction may result in improved more timely and more accurate claims submission.

- Conduct an aggressive and ongoing audit process to verify those providers and provider sites that do not meet billing and service targets. Provide education and remedial information for the under-performers.

- Audit staff to determine questions and misunderstanding of the billing and utilization protocols to identify areas that need explanation and clarification (e.g., the misunderstanding over six months versus 180 days from the vendors). Seek immediate resolution.

- Create an atmosphere that is not adversarial but one that questions the appropriateness of various billing categories so that mutual learning and problem-solving might occur.

2. Maximize Medicaid and CHIP enrollment.

Medicaid and CHIP Eligibility is currently assessed sporadically and often only when a consumers first enters service. Consumers are constantly cycling on and off Medicaid and need to be assessed regularly to enhance effective drawdown of federal Medicaid dollars when the consumer is eligible.

- Assign existing administrative staff to aggressively assess and reassess consumer's Medicaid eligibility.

- Pursue shared staff arrangements with other agencies to identify staff whose job responsibilities include Medicaid eligibility verification.

- Utilize community members—paid or volunteer—the elderly, TANF recipients, etc., to perform eligibility assessments and provide enrollment assistance.

- Conduct periodic audits to confirm that the aggressive verification process is effective and continual.

- Review current management information data to set goals to lower the current rates of adult consumers without Medicaid.

3. Increase efforts to compete for private funding and non-Medicaid federal funding.

Several private foundations have a made a strong commitment to funding new an innovative programs and system change in the MHMRSA arena. In particular, the Robert Wood Johnson foundation has funded millions of dollars in this area in the past several years. While these dollars are usually not for actual direct services, they can be used for pilot programs in transportation, unique service delivery mechanisms (e.g., telehealth), and changes in systems and infrastructure.

The federal government, through the Substance Abuse and Mental health Service Administrating (SAMHSA), supplies program funding for a variety of these activities as well. These grants are highly competitive and usually require the

collaboration of several entities—private, government and in some cases, academic. In addition, the federal Department of Health and Human Services recently announced grant awards to expand clinical services and strengthen community-based health care systems in America's rural areas. The Rural Health Outreach grants and Rural Health Network Development grants, funded by HHS' Health Resources and Services Administration (HRSA), support a wide range of programs and services vital to rural health care, including mental health treatment and strengthening regional and local service delivery systems in rural communities. Several Georgia communities were the recipients of these grants and might provide valuable information on further grant opportunities and lessons learned from these programs. These grants support improved mental health service delivery so the new Region may be able to enter into shared service agreements or consultative with the grantees depending on where they are located.[11]

Competing for funding can be a daunting task and small agencies, CSBs and regional offices historically do not have dedicated resources to identify funding and develop proposals. However, with a targeted and centralized effort, there is the potential for large reward.

- Designate someone at the Division to assist the new Region in grant identification through subscriptions to appropriate funding guides, regular foundation research and consistent identification of non-Medicaid federal funding streams.

- Provide MHMRSA leadership to facilitate necessary collaboration to compete for additional funding. This should include collaboration with providers of physical health services—including boards of health—to provide comprehensive physical and behavioral health services to consumers.

- Make technical assistance in grant writing available, and assist CSBs and others in the writing and submission of grants.

4. Review cost issues related to Crisis Stabilization Unit.

In the past, the CSBs have responded to client demands, service designations and funding requirements through a variety of means. The Albany Area CSB developed a sophisticated attractive Crisis Stabilization Unit designed to accommodate involuntary admissions who would stay overnight for a short time before being transferred to less intensive treatment settings. Often clients do not need to be admitted to the state hospital – a more expensive treatment alternative. While per diem costs in the Crises Stabilization Unit are far less than in the state hospital, most of the services are not reimbursable due to federal payment restrictions based on bed capacity of inpatient units. The open floor plan of the unit facilitates good patient observation and reduces

[11] Communities selected include: Center, Clyattville, Dublin and Lyons Boards of Health.

the need for additional staff that would be needed if the large 30-bed unit were subdivided into smaller clinical program areas.

Currently the CSB receives zero reimbursement for patients who stay overnight in the unit. Public Works suggests that discussions begin quickly with Phoebe Putney to determine if they have capacity to receive and admit clients in crises. If the private provider system will assist in admitting that group of clients, then the CSB should evaluate the feasibility of using the existing physical plant for substance abuse and other residential services that may be billable and for whom a waiting list exists. In addition, the nursing staff shortage in the unit might be abated by transferring responsibility to Phoebe Putney, the nursing shortage (which results in overtime accrual, burn-out and can compromise quality of care) might also abate.

Since the present arrangement limits the ability of the CSB to receive adequate reimbursement for services provided to most clients, **Public Works** recommends that an in-depth examination be conducted that would focus on the following.

- Conduct a cost/reimbursement analysis on the Region 10 Crisis Stabilization facility. The size of the facility exceeds the IMD limit of 16 beds, thus rendering the facility ineligible for government funding. Alternate or reduced uses of this physical plant may result in reimbursement for services currently considered unreimburseable. It is possible that operating with less government funded beds will reduce the total loss currently incurred when these beds are filled.

- If the results of the analysis indicate, enter into discussions with Phoebe Putney to determine if they have capacity to receive and admit clients in crises, and explore shared solutions and service agreements. This will be more feasible to both the CSB and the hospital now that the DACE approach will be eliminated. All possibilities should be explored including shared staff, management services contract, consulting opportunities as well as others. This public/private collaboration could serve as a model for similar partnerships that could financially benefit both parties. For example, the cost issues discussed above are not unique to the Crisis Stabilization Unit. Funding the detox unit in Region 11 is presenting similar reimbursement and staffing issues, and lessons learned from new arrangements for the Crisis Stabilization Unit might be applicable to detox as well. Potential arrangements might include:

    - The crisis stabilization unit can be staffed as a step down unit for clients not requiring state hospital care and not in need of acute inpatient care, and also receive commercial pay clients that would enhance revenue generation to the CSB.

    - If the private provider system will assist in admitting that group of clients, then the CSB should evaluate the feasibility of using the existing physical plant for substance abuse and other residential services that may be billable.

- The CSB could "split" the Unit into two 16-person beds with the CSB and Phoebe Putney each managing half, thereby drawing down full reimbursement.

- Depending on state regulations, it might be financially desirable for both parties for the "new inpatient or step-down beds" to fall under the Phoebe Putney license. This would need to be explored further against accreditation requirements.

- Seek legislative and industry support to change the federal Institute for Mental Disorders (IMD) 16 bed designation. Federal Medicaid policy places strict reimbursement restrictions of psychiatric units that house more than 16 inpatient beds. This archaic regulation has long been the target of advocacy and provider groups. Recently, CMS formed a Commission charged with reviewing and recommending changes to HCFA regulations that are overly burdensome to providers. Georgia's Commissioner of Community Health is a representative to that Commission and might be a valuable resource.

  Currently there are no exceptions to this rule and psychiatric facilities that exceed the 16-bed capacity may not bill Medical Assistance programs for the services provided. In the past national trade associations and advocacy groups have worked to change this old regulation but they have not succeeded in convincing enough individuals of the need for a change.

Conclusion

Southwest Georgia has faced numerous challenges in recent years. The rural nature of the Region, workforce shortages, lack of a sound transportation infrastructure, and funding constraints have all put the Region under great stress in recent years. In addition, changes and instability in leadership and legislation have made it difficult to meet these challenges.

Recent changes have given both the Division and the Region a wonderful opportunity to meet these challenges and make great improvements to the structure and quality of MHMRSA services. The permanent appointment of a Division Director, passage of House Bill 498, and the obvious willingness of Division staff, CSBs and providers to collaborate fully make the system well poised for positive change.