

- 
- MENTAL HEALTH
 - DEVELOPMENTAL DISABILITIES &
 - SUBSTANCE ABUSE

NORTH CAROLINA COUNCIL OF COMMUNITY PROGRAMS

Status of Council Action:

Developed by Clinical Services & Support Wrkgroup

1/11/08: Endorsed by Area Directors Forum

1/31/08: Adopted by Council Board of Directors

Clinical Functions of the Local Management Entity

As Local Management Entities (LMEs) have transitioned from their previous roles as a primary provider of clinical services into their present roles as a Local Management Entity responsible for overseeing the provision of clinical services provided by the private provider community, their core functions have significantly changed. DMH has broadened the role of the LME as its agent, and requires that licensed clinicians fulfill many of these functions. Given the emphasis on the business functions performed by the LMEs, it is imperative to be mindful of the clinical activities and functions embedded in this management. It is important to recognize that these functions serve as the first line in ensuring consumer protection and safety, fiscal responsibility within the system, and effective, available provider and service arrays at the community level. Moreover, the Local Management Entity is accountable for ensuring that the needs of its community's most involved mental health, developmentally disabled, and substance-involved consumers are addressed thru true partnership and advocacy. The clinical aspects of LME work are embedded in many of the core functions described in the local business plan; they must be recognized and valued in order for the system to be successful.

The North Carolina Council of Community Programs' Clinical Services and Support Workgroup conducted a detailed review of the eight core functions of the LME: governance and administration, business management and human resources, provider relations and development, consumer services/consumer affairs, service management, quality management, claims adjudication, and access, screening and triage. The goal of the review was to determine which, if any, of the functions require a demonstrated

clinical knowledge base to complete the work. The results of this review indicated the following:

- That clinical activities are embedded in a number of the core functions
- That clinical skills and expertise are implicit in the performance of many of these functions
- That the clinical aspects of core functions should be considered when determining local vs. regional/other accessibility.

Careful consideration should be given not only to the fiscal impact but equally importantly to the clinical impact upon consumers before a function is moved from the local to a regional or statewide provider.

Clinical Oversight

The primary clinical function in the area of management is the role of Clinical Director. The Clinical Director provides significant clinical impact through consultation with other health care professionals, review of utilization decisions and critical incidents that occur within our consumer community. Additionally, this position is a critical liaison with primary care physicians and instrumental in our coordination of integration models that will move us into an era where primary and behavioral health care is fully integrated. Management is also involved in the clinical aspects of community disaster planning which contains a clinical component.

Provider Relations and Development

There are a number of clinical functions that are performed by the Provider Relations unit of the LME. These are as follows:

1. Provider Endorsement and Monitoring Activities
 - Processing applications for endorsement; conducting post-endorsement reviews; subsequent monitoring to assess for clinical capacity; and ensuring that clinical integrity is the paramount of our provider network. Monitoring first responder capabilities, assuring that providers are using Evidence-Based Practice thereby ensuring that high quality clinical services and supports are delivered to those we serve.
2. Technical Assistance for the Provider Community
 - Providing technical assistance to improve service delivery, including assurances that crisis plans are developed for consumers by the provider community.
3. Community Development Planning to Address Gaps in Services
 - Analysis of gaps in services and the ability of providers to ensure that we have adequate emergency response capability, expanding evidence based practices within our provider network in developing outcomes and performance measures to assess our provider network. Assessing implementation of culturally and linguistic competency efforts within our network.
4. Provider Contracting
 - Ensure that we are active participants in consumer services and community awareness endeavors such as public forums, educational opportunities and

communication. Acting as a primary liaison to providers and other LME units for initiatives that impact systematic change.

5. Arbitration and Resolution of Provider Complaints and Grievances
 - Ensure arbitration and resolution of provider complaints and grievances that always uses a foundation of determining the clinical impact of a decision made.

Consumer Services/Consumer Affairs

1. Consumer Services and Rights
 - Assess consumer's services and assist and guide them in addressing issues that may impact their rights.
2. System Navigation
 - Assist consumers and providers in addressing barriers to care that may occur because of communication issues. Ensuring that services are offered to consumers in a manner that takes into account an individual's unique ethnicity and race. Assist with identification of qualified interrupters who have knowledge and skills in the area behavioral health
3. Appeals and Grievances
 - Because a significant number of appeals and grievances initiated by consumers involve their primary clinical providers it is essential that LME staff with clinical expertise be involved to engage in arbitration and mediation with consumers and their providers.
4. Consumer Satisfaction
 - Conducting and analyzing consumer satisfaction surveys to mold policy and procedural changes that are developed.
5. Support to Committees
 - Providing support to our CFAC committees; legislatively mandated to participate in Fatality Review Committees, Juvenile Crime Prevention Councils, Smart Start Boards, continuity of care meetings with our institution and community collaborative meetings, etc.

Service Management

1. Care Coordination
 - Ensure continuity of care for all consumers discharged from institutions and emergency services. Monitor hospital discharge planning and service provision for individuals placed on involuntary outpatient commitments. A point of contact in dealing with local crisis and Inpatient units, jails, and emergency rooms. Participation in Child and Family team meetings. Provide case coordination for all consumers who are not yet engaged with a primary clinical provider.
2. Utilization Review/Utilization Management of State Dollars
 - Conducting utilization review and management for services provided to consumers within our catchment area; this entails review of the PCP's containing non-Medicaid funded services as well as post payment review for clinical services. This department is charged with authorization of utilization

of state psychiatric and substance abuse treatment center beds. Assists with the determination of waivers for recipients under our CAP/MR waiver.

3. Community Collaboration
 - Utilizing System of Care values and core principals in collaborating with local community partners in the establishment and development of a community response that ensures that both children and adults have local emergency and ongoing crisis response systems to address their needs
4. Concurrent Review of Medicaid Covered Person Centered Plans (PCP's)
 - Review all PCP's from Medicaid funded high risk high cost consumers to assure the appropriateness of clinical services.
5. Benefit Design
 - The annual development of state and local benefit design (determination of services to be offered plus the amount of each to be available) is based both on the assessment of clinical need and upon fiscal realities.

Quality Management

1. Quality Assurance
 - Conduct audits of service providers, incident reviews and complaint investigations. Providing technical assistance to remediate any areas of change identified.
2. Quality Improvement
 - Development of surveys and studies including Evidence Based Practice and Promising Practices and review community provider network Quality Improvement studies. Analysis of the prevalence and penetration data and develop strategies to realize service intensity. Responsible for assuring the level of quality provided by both internal and external programs and services.
3. Data Analysis/Reports
 - Conduct Consumer Satisfaction surveys and analysis of the outcomes. Review utilization patterns that will be used in the development of benefit plans. Compile and analyze trends with consumer complaints, client rights, performance indicator outcomes including Evidence Based Practice and the satisfaction of internal and external partners.

Access, Screening, Triage and Referral

1. Screening, Triage and Referral
 - Provide both face to face and telephonic brief clinical screenings for any individual. Make referrals to an indicated provider depending on the level of need, urgent, emergent or routine.
2. Crisis Plans/First Responder
 - Maintain and monitor crisis plans on all consumers.

The clinical functions noted above are critical in protecting the safety and welfare of consumers, their families and the community in ensuring the appropriate utilization of resources at the community level.

- MENTAL HEALTH
- DEVELOPMENTAL DISABILITIES &
- SUBSTANCE ABUSE

NORTH CAROLINA COUNCIL OF COMMUNITY PROGRAMS

Status of Council Action:

*Developed by Clinical Services & Support
Workgroup*

9/12/08: Endorsed by Area Directors Forum

10/17/08: Adopted by Council Board of Directors

The Clinical Role of the LME in the Community: A Critical Local Presence

The North Carolina Council of Community Programs' Clinical Services and Support Workgroup developed this position paper for two purposes: 1) to highlight the current clinical roles of Local Management Entities (LMEs) based upon an analysis of clinical activities currently embedded within the core functions of the LME and 2) to articulate the importance of the community-based LME in maintaining and enhancing a local clinical infrastructure reflective of and responsive to the unique needs of their respective communities.

LMEs are responsible for ensuring that appropriate and effective mental health, developmental disability and substance abuse services are available for all residents who qualify for publicly-funded mental health services under the *State Plan*. Their role is integral to Mental Health Reform, which was intended to:

- ◆ Increase consumer choice by divesting service delivery from Area Programs to private providers
- ◆ Increase the range and quality of community-based services and decrease inappropriate utilization of institutional care
- ◆ Increase funds for community service development as a result of savings from decreased institutional utilization and costs
- ◆ Establish an organized service system with the uniqueness of each community being the key factor in determining the system configuration (*MGT Report, 2003*)

As Local Management Entities (LMEs) have transitioned from their previous role as primary provider of clinical services into overseer and manager of clinical services now delivered by the private provider community, their core functions have significantly changed. While LMEs

continue to fulfill a vital clinical role in their communities, this role has been overshadowed by the emphasis on LME business infrastructure, which has taken center stage for the past several years. This circumstance, along with a growing trend to centralize formerly community-based mental health functions, prompted the *North Carolina Council of Community Programs' Clinical Services and Support Workgroup* to undertake a detailed review of the eight core functions of the LME¹. The goal of the review was to determine which, if any, of the functions require a local clinical knowledge base to successfully and competently complete the work. The results of this review indicate that clinical activities are embedded in a number of the core functions and that clinical skills and expertise grounded in knowledge and partnership within the local community are essential to successfully perform these functions.

The clinical skills and expertise situated within each LME assure local consumer protection and safety, fiscal responsibility within the system, and effective, available provider and service arrays at the community level. Moreover, they are essential to ensuring that the needs of its community's most involved mental health, developmentally-disabled and substance-involved consumers are addressed through true partnership and advocacy. These clinical elements must be recognized and valued in order for the system to be successful and should weigh heavily in State policy decisions, especially those related to local vs. centralized (regional or statewide) control of community service management.

LMEs are best equipped to unify and make greatest use of local public/private resources to carry out these clinical functions. Local relationships, knowledge of the community and familiarity with consumers place LMEs in the best possible position to successfully implement the goals of MH Reform. They are also best positioned to operate as the nexus for the communities' clinical infrastructure, mobilizing clinical expertise and first-hand knowledge of and relationships with consumers, community partners and local government. This role is consistent with the original goals of MH Reform and is essential to:

- ◆ Establish a local service array that broadens the range of best practice services
- ◆ Increase community service quality and outcomes accountability
- ◆ Establish an organized local service system that promotes choice, coordination and continuity of care
- ◆ Establish a community safety net responsive to the specific needs of each community.

Following are key elements necessary to achieve these goals and rationale as to why local clinical presence is necessary to accomplish them.

Clinical Oversight

The Clinical Director provides significant clinical influence through consultation with other health care professionals, review of utilization decisions and critical incidents that occur within our consumer communities. Additionally, this position is a critical liaison with primary care physicians and is instrumental in our coordination of integration models that will move us into an era where primary and behavioral health care is fully integrated. LMEs also play a leadership role in local disaster planning, including critical clinical components to help ensure the well-being of consumers and their communities.

¹ Core LME functions are governance and administration, business management and human resources, provider relations and development, consumer services/consumer affairs, service management, quality management, claims adjudication, and access, screening and triage.

Provider Relations and Development

- ◆ **Technical Assistance and Consultation** activities are essential to promote quality service delivery, initiate new services and trouble shoot local challenges. This is particularly important given the newness of the majority of providers level of staff turnover in provider agencies. LME clinical expertise, coupled with knowledge of the community and the strengths and weaknesses of local providers ensures that technical assistance and consultation activities are relevant and effective within the context of consumer needs and local provider capacity.
- ◆ LMEs clinical perspective and knowledge of local providers, agency partners and the community at large ensures that **Training Development and Delivery** is targeted to local needs in terms of content and readiness. LMEs also have the advantage of local relationships that help promote cross-agency training opportunities, as well as collaborative planning, which increases buy-in and relevancy.
- ◆ LMEs are best positioned to perform **Community Development Planning to Address Gaps in Services** in their communities. They know the high cost/high need consumers, the overall consumer utilization patterns, and movement within the local service array. They garner ongoing information regarding service gaps through routine contact with local public agencies, faith-based and non-profit organizations, and their Consumer and Family Advocacy Committees (CFAC). They have the clinical expertise necessary to compile and analyze these multiple data points within the context most representative of the needs of their consumers and community.
- ◆ **Service System Development Based on Best-Practices** requires a broad clinical knowledge base regarding local provider capacity to implement best practices. LMEs are best equipped to design service development contracts that balance these capacity needs with implementation goals, and to ensure fidelity to best practices. LME relationships with their providers and community partners (through their leadership role in the Community Collaborative, with CFAC, etc.) allow them to mobilize community-wide support and share resources to develop best practice services, to help ensure the cultural and linguistic competence of those services, and to maximize their coordination within the context of the local human service system.

Consumer Services/Consumer Affairs

- ◆ LMEs provide essential **Support to Community-Based Groups and Committees**, ensuring that clinical perspectives inform their work and building/maintaining local relationships that are vital to the successful delivery of MH/DD/SA services. This work includes providing support to their CFACs and their Community Collaboratives, and fulfilling legislative mandates to participate in Fatality Review Committees, Juvenile Crime Prevention Councils, Smart Start Boards, continuity of care meetings with our institution, etc.
- ◆ **System Navigation** still requires clinical expertise and specific knowledge of local resources in order to assist consumers who encounter barriers to care. This is particularly important when provider agencies discontinue or downsize service, when new providers initiate services, and when consumers need services from multiple local agencies.
- ◆ **Consumer Services and Rights** are best addressed in the community by staff who have clinical expertise and knowledge regarding consumer protection and advocacy parameters,

coupled with a familiarity with consumers and their community. Consumers are far more likely to seek and apply guidance regarding their rights from the LME, which are staffed by persons who know their community and are readily accessible by phone and face-to-face conversations.

Service Management and Utilization Review and Management

- ◆ **Care Coordination** – LME clinical expertise and knowledge of local providers and local services/resources is essential to the effective coordination and integration of the full range of services and supports that local consumers need. This is especially important for consumers/families with complex needs that require multiple services and supports such as social services, housing, education and vocation, as well as those who are involved with the justice system. A central point of care coordination occurs through Child and Family Teams, where LMEs offer a broad knowledge of the entire range of services and resources in the community and help ensure coordination and connectivity for continuity of care. Care coordination is also central to help ensure that local consumers not yet engaged with a primary clinical provider remain engaged and do not “fall through the cracks.” LMEs further ensure continuity of care by monitoring hospital and residential treatment discharge planning as well as service delivery for individuals placed on involuntary outpatient commitments. Finally, they maintain a reliable and familiar central point of contact and coordination for local crisis and inpatient units, jails and emergency departments.
- ◆ **Utilization Review and Management** – LMEs provide Utilization Management and Utilization Review of Person-Centered Plans funded by State funds. Currently, the LME role in relationship to Medicaid funded services is limited to concurrent review of Person-Centered Plans. In order for LMEs to fully ensure that all consumers have access to and receive the right services locally, all Utilization Review and Management functions should be provided locally, regardless of the funding source. These activities are essential to ensure that local consumers get the right services at the right time, that local services and supports are coordinated, and that crisis plans are fully in place. These functions require considerable clinical expertise, familiarity with the needs of local consumers, and an overarching knowledge of community services and resources. Some communities have established “Care Reviews” that engage a range of local service partners to promote best practices, maximize use of all local resources, and avoid overly-restrictive placements in institutions.
- ◆ **Community Collaboration and System of Care** – System of Care is inherently based in the local community and requires collaboration among public and private human service professionals, along with consumers, families and the larger community. LMEs are essential to the development and implementation of local Systems of Care, having taken a leadership role in their local Community Collaboratives and in comprehensive service delivery through Child and Family Teams. Their clinical knowledge, local agency relationships and familiarity with the community is irreplaceable in forming the partnerships necessary to develop a networked local service system to provide seamless care for consumers. These collaborative activities promote opportunities to integrate existing resources, create new services and help ensure full local participation in Person-Centered Planning activities.
- ◆ **Planning and Oversight** – LMEs frequently meet with consumers, providers and other agency partners. The relationships and knowledge resulting from these interactions, along with utilization analysis, capacity analysis, data retrieval/analysis, evaluation of ongoing programs, prevalence analysis, quality analysis, county comparison data and surveys put LMEs in the best position to ensure that the oversight of local services and development of new resources reflect the specific needs of local consumers and their community.

Quality Management

- ◆ LMEs provide clinically informed **Quality Assurance and Improvement** activities that are essential for the delivery of best practice services. They routinely collect data and provide analysis that is specific and relevant to the local community. These activities position LMEs to communicate best practice standards, establish local accountability to quality and outcomes, and determine technical assistance needs.
- ◆ **Data Analysis and Reports** generated by LMEs ensure that there is local oversight and analysis of quality, including routine feedback to providers and the larger community regarding what is working well in MH/DD/SA services and where improvements are needed. A local presence is required to effectively identify and monitor adherence to quality benchmarks.

Financial

- ◆ LMEs are best positioned to **Manage and Oversee Local Funding** given their day-to-day and historical knowledge of MH/DD/SA funding streams. They are also uniquely qualified in this area due to their relationships and routine interactions with city and county officials and local human service agencies. These factors help ensure the most efficient and effective use of limited funds on behalf of local consumers.
- ◆ LMEs offer the advantage of being well-equipped to assess the relative benefits of and **Seeking Outside Funding** based on local needs. Their knowledge of and relationships within the community allow them to weigh risks and benefits of grant applications and awards, such as evaluation requirements, matching funds, service system capacity and appropriateness of fit within the local political environment. LMEs are also uniquely positioned in this area, since virtually all grant and foundation funding requires compelling evidence of local need and local collaboration, along with assurances that funded activities will be locally-maximized and sustained beyond the period of financial award.

Access, Screening, Triage and Referral

- ◆ The development and oversight of consumer **Crisis Plans and First Responder** activities require clinical expertise as well as knowledge of provider and community emergency service availability and capacity. LMEs have the skill and knowledge base best suited to developing and managing these activities, which are intrinsically linked to their expertise and experience in care coordination, quality improvement and PCP oversight.
- ◆ Local presence is essential to ensure effective **Screening, Triage and Referral (STR)** for local consumers. LMEs are best qualified to implement STR due to their clinical expertise, familiarity with local consumers and resources, and their knowledge of specialized local programs and protocols within the community that must be navigated and actively managed. Further, consumers, public and private human service providers, along with the broader community, rely on an accessible local clinical STR response, which also promotes a greater confidence in self, agency, and community referrals for MH/DD/SA care.

Public Safety Net

Ensuring a reliable and accessible public safety net requires local presence, local partnerships and core knowledge of the community. LMEs are the best-qualified entity to build and sustain the local public safety net for several reasons:

- ◆ They have current and historical experience and expertise in the provision of services to those most in need, including services to individuals who are uninsured and vulnerable and who require services that are not deemed profitable regardless of ability to pay.
- ◆ They have the knowledge of local resources and the local relationships necessary to mobilize comprehensive responses to consumers in crisis.
- ◆ They have the clinical expertise required to coordinate and make the greatest use of local psychiatric, primary care, and crisis/emergency services
- ◆ They operate within the context of the local community culture with a visibility that promotes accountability to consumers, peers, local government and citizens.

A one-size-fits-all approach to crisis prevention and management services has little hope of being effective, as each community's needs and resources are unique. The key to successfully restoring the public safety net is to support and fund the implementation of the comprehensive crisis plans recently submitted by each LME.

- MENTAL HEALTH
- DEVELOPMENTAL DISABILITIES &
- SUBSTANCE ABUSE

NORTH CAROLINA COUNCIL OF COMMUNITY PROGRAMS

Status of Council Action:

*Developed by Clinical Services & Support
Workgroup*

9/12/08: Endorsed by Area Directors Forum

10/17/08: Adopted by Council Board of Directors

The Clinical Role of the LME in the Community: Summary

The N.C. Council of Community Programs' Clinical Services and Support Workgroup (*Workgroup*) developed this position paper in order to: 1) highlight current clinical roles of Local Management Entities (LME), based upon analysis of clinical activities currently embedded within LME core functions; 2) articulate the importance of the community-based LME to maintain and enhance local infrastructure reflective of the unique needs of their respective communities.

As LMEs transitioned from clinical services provider to clinical services manager via private providers, their core functions significantly changed. LMEs continue to fulfill vital clinical roles in their communities, yet these have been overshadowed by emphasis on business infrastructure, which has taken center stage for the past several years. This, along with a growing trend to centralize formerly community-based mental health functions, prompted the *Workgroup* to review the eight core functions of the LME. Results of this review indicate that clinical activities are embedded in the core functions and that LME clinical skills, expertise, knowledge and partnerships within the local community are essential to perform these functions. The clinical skills and expertise situated within each LME assure local consumer protection and safety, fiscal responsibility, and effective service arrays in the community. Moreover, they are essential to ensure the needs of the community's most involved mh, dd, sa consumers are addressed through true partnership and advocacy. These clinical elements must be recognized and valued for the system to be successful and should weigh heavily in state policy decisions related to local vs. centralized (regional or statewide) control of community service management. LMEs are best positioned to operate as the nexus for the communities' clinical infrastructure, mobilizing their clinical expertise, their first hand knowledge of and relationships with consumers, community partners and local government, as described further below:

Clinical Oversight - The Clinical Director exerts significant clinical influence via consultation with other health care professionals, review of utilization decisions and critical incidents that occur within our consumer community. The Director plays a critical role as LME liaison with primary care physicians moving us toward integrated primary and behavioral health care. LMEs play a leadership role in local disaster planning, including critical clinical components to help ensure the well being of consumers and their community

Provider Relations & Development

- **Technical Assistance (TA) and Consultation** - Particularly important given the level of staff turnover in provider agencies, LME clinical expertise, knowledge of the community, and the strengths and weaknesses of local providers ensures that TA and consultation is relevant and effective.
- LMEs' clinical perspective and knowledge of local providers, agency partners and the community at large ensures that **Training Development and Delivery** addresses content and readiness. Local relationships help promote cross-agency training and collaborative planning, which increases buy-in and relevancy.
- **Community Development Planning to Address Gaps in Services** - LMEs know their high cost/high need consumers, their utilization patterns and movement within the local service array. They garner ongoing information regarding service gaps through routine contact with local public agencies, faith-based, non-profit organizations, and their Consumer and Family Advocacy Committee (CFAC). They have the clinical expertise necessary to analyze these data within the context most representative of the needs of their consumers and community.
- **Service System Development Based on Best-Practices** - LMEs are best equipped to design service development contracts balancing capacity needs with implementation goals; ensuring fidelity to best practices. Relationships with providers, agency, other community partners (through LME roles in the Community Collaborative, with CFAC, etc.) allow them to mobilize community-wide support and share resources to develop best practice services, help ensure cultural and linguistic competency, and maximize coordination within the context of the local human service system.

Quality Management

- LMEs provide clinically informed **Quality Assurance and Improvement** activities essential for delivery of best practices. They collect and analyze data specific and relevant to the local community. These activities help LMEs communicate best practice standards and establish local accountability to quality and outcomes.
- **Data Analysis and Reports** generated by LMEs ensure local oversight of quality, routine feedback to providers and the community regarding what is working well in mh, dd, sa service and where improvements are needed.

Financial

- LMEs are best positioned to **Manage and Oversee Local Funding** given their day to day and historical knowledge of mh, dd, sa funding streams, relationships and interactions with city, county officials and local human service agencies. These factors help ensure highest and best use of limited resources.
- LMEs can best assess the relative benefits of **Seeking outside Funding**. Knowledge of and relationships within the community allow them to weigh risks/benefits of grant applications and awards, (evaluation requirements, matching funds, capacity, goodness of fit within the local political environment). Virtually all grant/foundation funding requires evidence of local need and collaboration, assurances that funded activities will be locally sustained.

Consumer Services/
Consumer Affairs

- LMEs provide essential **Support to Community Based Groups and Committees**; ensuring that clinical perspectives inform their work and building/maintaining local relationships vital to the successful delivery of mh, dd, sa services. This includes providing support to CFAC committees, Community Collaborative(s), and fulfilling legislative mandates to participate in Fatality Review Committees, Juvenile Crime Prevention Councils, Smart Start Boards, continuity of care meetings with state institutions, etc.
- **System Navigation** requires clinical expertise and specific knowledge of local services to assist consumers who encounter barriers to care. This is particularly important when provider agencies discontinue or downsize services, when new providers initiate services, and when consumers need services from multiple local agencies.
- **Consumer Services and Rights** are best addressed in the community, by LME staff with clinical expertise and knowledge regarding consumer protection and advocacy, coupled with a familiarity with consumers and community. Consumers are far more likely to seek and apply guidance regarding their rights from persons who know their community and are readily accessible by phone and face to face conversations.

- **Care Coordination** – LME clinical expertise, knowledge of local providers and local services/resources is essential to coordinate and integrate the full range of services and supports that consumer’s need. This is especially important for those with complex needs that require multiple services, (social services, housing, education, vocation, the justice system). Central to care coordination are Child and Family Teams, where LMEs offer knowledge of the range of resources in the community. LMEs ensure continuity of care by monitoring hospital and residential treatment discharge planning, and service delivery for individuals placed on involuntary outpatient commitments. Finally, they maintain a reliable and familiar central point of contact and coordination for local crisis and inpatient units, jails, and emergency departments.
- **Utilization Review and Management** – LMEs provide UM and UR of PCPs funded by State dollars and Concurrent Review of those funded by Medicaid. In order for LMEs to fully ensure that all consumers have access to and receive the right services locally, all Utilization Review and Management functions should be provided locally, regardless of the funding source. These activities ensure that local consumers get the right services at the right time, that services are coordinated, and that crisis plans are fully in place. These functions require considerable clinical expertise, familiarity with local consumers’ needs, and knowledge of community services. Some communities have established cross-agency and consumer ‘Care Reviews’, engaging local partners to promote best practices, maximize use of all local resources, and avoid overly restrictive placements.
- **Community Collaboration and System of Care** – SOC is inherently based in the community and requires collaboration among public/private human service professionals, consumers, families, community. LMEs are essential to develop and implementation of local SOC, with leadership roles in local Community Collaboratives and through Child and Family Teams. Their clinical knowledge, agency relationships and familiarity with community is irreplaceable in the development of seamless networked service systems. These activities integrate resources, create new services, and help ensure participation in Person Center Planning activities.
- **Planning and Oversight** – LMEs routinely meet with consumers, providers, and other agency partners. Relationships and knowledge from these interactions, along with utilization analysis, capacity analysis, and data retrieval/analysis, evaluation of ongoing programs, prevalence analysis, quality analysis, county comparison data, and surveys put LMEs in the best position to ensure the oversight of local services and development of new resources that reflect the specific needs of local consumers and their community.

- Development and oversight of consumer **Crisis Plans and First Responder** activities requires clinical expertise, knowledge of provider and community emergency service patterns and capacity. LMEs have the skill and knowledge base best suited to develop and manage these activities given their expertise and experience in care coordination, quality improvement and PCP oversight.
- Local presence is essential to ensure effective **Screening, Triage and Referral (STR)** for local consumers. LMEs are best qualified to implement STR due to their clinical expertise, familiarity with local consumers and resources, knowledge of specialized local programs and protocols that must be navigated and managed. Consumers, public and private human service providers, and the community rely on an accessible local clinical STR presence, which also promotes a greater confidence in referrals for mh, dd, sa care.

A reliable and accessible public safety net requires local presence, local partnerships, and core knowledge of community. LMEs are best qualified to build/sustain the local public safety net because they have: 1) current and historical experience/expertise in service delivery to those most in need, (individuals who are uninsured, vulnerable and require services not deemed profitable), 2) knowledge of local resources and relationships necessary to mobilize comprehensive responses to consumers crises; 3) clinical expertise required to coordinate and make highest use of local psychiatric, primary care, and crisis/emergency services; 4) the ability to operate within the context of community culture with local visibility that promotes accountability to consumers, peers, local government and citizens. *A one-size-fits-all approach to crisis prevention and management services has little hope of being effective, as each community’s needs and resources are unique. The key to successfully restoring the public safety net is to support and fund the implementation of the comprehensive crisis plans recently submitted by each LME.*