

- MENTAL HEALTH
- DEVELOPMENTAL
DISABILITIES &
- SUBSTANCE
ABUSE

NORTH CAROLINA COUNCIL OF COMMUNITY PROGRAMS

Status of Council Action:

Developed by Management Systems Workgroup

11/09/07: Endorsed by Area Directors Forum

11/16/07: Approved by Council Board of Directors

12/12/07: Adopted by Council Membership

EFFICIENCIES IN LME SYSTEMS MANAGEMENT POSITION PAPER

Background/Basis for Position

In 1955, the United States Congress authorized the Mental Health Study Act which called for an objective and thorough analysis and evaluation of mental health conditions and resources. The information collected as a result of the Act was entitled "Action for Mental Health" and was presented to Congress in 1961. In 1963 President Kennedy proposed and signed legislation that created the Community Mental Health Act. The act provided funding to establish community mental health centers nationwide with the intent of reducing institutionalization. An amendment of the Act in 1965 extended funding for construction of facilities to those serving alcohol and substance abuse disorders. In 1975 the Act was again amended to provide for a more comprehensive set of core services available in the community.

In 1971 North Carolina passed its own legislation establishing an Area Authority system to deliver and manage mental health, developmental disability and substance abuse services of a defined geographic area. From 1971 to 2001 the public mental health system in North Carolina operated under this system, service provided by public entities and managed by public entities (in a clinic setting). In 2001 the North Carolina General Assembly passed legislation that changed the system of care to one where direct service provision would be

provided by private or other government entities. Area Authorities, also known as Local Management Entities (LMEs), were tasked with the responsibility of managing the system and performing a set of functions that were both clinically and business oriented. As noted recently in a consultant report, LMEs lost some of their focus on the clinical system of care. This loss of focus is a direct result of the rapid and tumultuous transformation process and the attempt by LMEs to comply with statutory requirements and policies that included the development of specific business functions. The time and effort required to make this transition related to business functions detracted from the LMEs ability to maintain an appropriate level of focus on clinical systems.

Overall Position

The NC Council of Community Programs contends that any effort to improve the system of care and the quality of services to citizens of the State must begin with a review of LME functions. The existing functions are clearly needed however not all need to be delivered at the local level. There are business functions that can be provided on a larger scale leaving each of the current LMEs the time and resources to focus on the clinical aspects of the system and to create a system that can be managed successfully at the local level. The clinical functions cannot and should not be performed at either a state or on a large regional basis. The local presence is needed in order to manage individual care and to be the face of the public system. Without the local presence, citizen care will continue to deteriorate. We must act now to refocus our attention on the clinical care and clinical systems needed in each local area in order to fulfill our obligations to legislation passed in 1963.

LMEs also have an obligation to fulfill their statutory requirement, pursuant to GS 122C-115.4, in an efficient manner. The NC Council of Community Programs encourages LMEs to pursue operational and fiscal efficiencies in an effort to increase standardization, maximize the State dollar, and streamline the system for easier navigation by consumers and providers alike. Structural and financial efficiencies can be achieved by a number of approaches ranging from mergers of organizations to the sharing of functional resources.

It must be reiterated that there are specific elements of LME functions that are suitable for centralization or sharing and there are specific elements of LME functions that must be conducted at the local level due to the community collaboration component necessary for the successful execution of such activities.

Recommendations

- Recommend that the DHHS share its short-term and long-term goals for the system and if goals have not been developed the Council recommends that the DHHS work with LMEs as public partners on the development of a shared vision.
- Significant progress and efficiencies have been achieved by voluntary LME mergers that resulted in a decrease in LMEs from 41 to 25. The Council recommends that LMEs continue to explore and exhaust opportunities for merger, consolidation of functions, sharing of resources or conversion to public providers.
- Recommend that the DHHS identify LMEs that should be considered potential merger candidates based on the financial inefficiency of the program due to size and/or the inability of the LME to fulfill its contractual obligations with the DHHS
- Recommend that the DHHS create financial incentives for merger, consolidation of functions, and the sharing of resources to counteract the current incentive that provides a higher Per Member Per Month (PMPM) rate to LMEs with smaller populations.
- The DHHS has made significant progress in the area of standardization. The Council recommends the continued development of standardized business “processes” for all business functions that impact providers and consumers. Consumer’s clinical and demographic information (HIPAA and 42 CFR compliant) must be readily available for use by S/T/R, crisis and care coordination staff for prompt and appropriate linkages to care.
- Recommend that the DHHS mandate the use of interface mechanisms to achieve the results of a seamless IT system(s) that provides a single portal for Provider data entry in which data would segregate to the appropriate LME’s database. The DHHS should finance any future programming modifications based on the DHHS’ and or other State or Federal requirements.
- Recommend that any savings achieved by consolidation and efficiency efforts be shared in an agreed upon manner and directed toward services.
- Recommend that the DHHS share the results of the independent Evaluation of LME Performance with LMEs so LMEs can make appropriate structural and business modifications in a timely manner.