



Mental Health and Disability Services Redesign 2011

Regional Workgroup Report Summary

Source: Regional Workgroup / DHS

Date Created: November 9, 2011

Charge

The goals of the regionalization redesign effort was multi-faceted and included creating a regional system that improves and clarifies methods of entry and local points of access by which individuals and families can engage and utilize mental health and developmental disability services. In addition, the Regional Workgroup was charged with assuring equal and consistent access to services across the regions and throughout the state while assuring accountability, efficiency and proper stewardship of public resources throughout the system.

Criteria for Formations of Regions

- The target population for regions should be in the range of 200,000 to 700,000 total people.
- Per SF 525:
 - a. There must be the presence of or assured access to inpatient psychiatric bed capacity for the citizens of each region.
 - b. There must be a state-certified Community Mental Health Center (CMHC) or a Federally Qualified Health Center (FQHC) that provides behavioral health services within each region.
 - c. Regions must be comprised of contiguous counties.
- There must be no fewer than three counties per region.
- There is no upper limit on the number of counties that can be included in a region.
- There will be no specific criteria for minimum travel times or distances to administrative offices within a region.

Timeframe for Regional Formation & Implantation

- Regions voluntarily form January 2012 through June 30, 2013.
- DHS will work with counties and nascent regions to assist with regional formation January 2012 through the end of 2013.
- All regions must meet the “formation” criteria by July 1, 2013 and the “implementation” criteria by July 1, 2014.

Regional Governance

- Governing boards of counties would be comprised of one Supervisor (or their designees) from each of the counties included in a region.
- “One county-one vote” principle for the regional governing boards is to be adopted.
- Governing body for each region should have at least three consumer/family members on the board. The method of selection/appointment could be spelled out in each region’s 28E agreement.
- DHS nor or other representatives of the state shall have a seat on the governing boards.
- Providers should have an active role in advising Regions in service system planning, implementation and quality improvement, but providers should not be included in the governing boards.
- The 28E agreements governing Regions could either support creation of a new organizational entity or could cement a regional consortium of participating counties.
- Adopt the definition of residency used by the MHDD Commission.

Regional Financial Management

- Regions should utilize a “single” checking account into which county levy funds would be deposited and from which they would be spent.

Regional Functions

- Regional management and strategic planning
- Designation of access points
- Designation of targeted case management
- Designation of service management for non-Medicaid people/services
- Plan for core services
- Plan for systems of care
- Assure effective crisis prevention, response and resolution
- Provider network formation and management
- Provider reimbursement approaches for non fee-for-service modalities and for non-traditional systems of care providers
- Provider certification
- Grievances
- Appeals
- Quality management/quality improvement
- Assurance of payment of providers
- Funds accounting
- Financial forecasting
- Data collection and reporting
- Interagency and multi-systems collaboration and care coordination