Overview of Strategic Plan 2016-2017

The strategic plan of Focus Behavioral Health Services, LLC is centered on the care and support of the client and is recovery oriented. The plan provides a framework for action and a basis for measuring outcomes. Objectives include benchmarks for accountability and evidence of progress. Improving communication by giving those served and other stakeholders' opportunities for input and response is a priority. The plan will be reviewed at annually by all Directors responsible for facilitating change and will be updated a minimum of every two years as goals are achieved and new goals needed.

Purpose of the Plan

The organization's strategic plan is designed to identify the needs of the person served, needs of all stakeholders involved and to provide the framework for action and define the achievable goals for services in the years ahead. The plan outlines and details strategies which will be used to achieve objectives and evaluate results. Attention is given to the input of those served and other stakeholders. The views and observations obtained from stakeholders through surveys, suggestion boxes, interviews and other methods will be given top priority in planning and management decisions.

Strategic Objectives

To maintain programs founded on the principles of best practice and focused on the individuals served, their families, employees, and other stakeholders within the community. This plan outlines opportunities for improvement and recovery while maintaining efficiency and financial viability. The plan is developed in order to establish additional clinical best practice models and programs within the state and to achieve excellence in clinical integrity and outcomes.

Agency Mission, Core Values and Clinical Philosophy

Mission Statement

The overall mission of Focus Behavioral Health Services, LLC is to provide appropriate prevention, treatment, and support for individuals and families impacted by mental health disorders, substance abuse and/or developmental disabilities, while working in collaboration with the community, empowering clients to experience personal satisfaction and to live with dignity in their own communities.

Core Values

- To assure continuous quality improvement
- To promote creativity, adaptability and challenges
- To utilize community partnerships and natural supports
- To empower and involve consumers and families served
- To promote healthy relationships through honesty, openness, respectfulness and fairness
- To exercise personal, programmatic and fiscal responsibility
- To promote awareness of cultural diversity

Clinical Philosophy

- To place consumers and family at the center of all we do and recognize the treatment of the individual is most effective when we include the family/support network
- To base services in the community, available in non-traditional sites, least restrictive and at convenient locations and times
- To be visible in the community and form partnerships, which promote the achievement of service delivery
- To promote the cross-training of staff in order to provide services across an array of age, disability and culturally diverse categories
- To insure services are delivered in an integrated manner that does not dwell on disability categories or cultural differences but on individual client and family needs and strengths
- To promote freedom of choice for clients and families
- To serve individuals who have the fewest available resources and the greatest need
- To utilize "best clinical practices" in the delivery of services
- To promote utilization of natural supports in the community.

Customers

From January 1st to December 31st 2016 Focus Behavioral Health Services, LLC served approximately 606 clients and their families. Ages ranged from age 3 to 19. The census in services representative of this number is as follows:

Census and Ages Served by Service Area

Service	Age Range	Clients Served 2013	Clients Served 2014	Clients Served 2015	Clients Served 2016
Residential Level III	12 to 18	31	31	29	24
Residential Level II	12 to 19	N/A	N/A	N/A	11
Child/Adolescent DTX	5 to 18	136	131	126	125
Intensive In-Home	5 to 19	68	66	66	47
Medication Management	3 to 19	279	293	302	236
Outpatient	3 to 19	365	497	473	510
Foster Care	8 to 18	8	10	18	6
Total Census		**618**	**627**	**578**	**606**

Race and Ethnicity of Clients Served

Race	Census 2015	% of Total Population	Census 2016	% of Total Population
Caucasian	458	79%	485	79%
African American	71	12%	65	11%
Hispanic	28	5%	47	8%
Asian	1	> 1%	4	> 1%
Other	19	3%	15	2%

Race and Ethnicity of Work Force

Race	Census 2015	% of Total Population	Census 2016	% of Total Population
Caucasian	102	78%	89	74%
African American	27	21%	28	23%
Hispanic	2	1%	2	2%
Asian	0	0	0	0
Other	-	-	1	1%

The ethnicity percentages of clients served commensurate with the United States Census Bureau, 2015 Estimate for surrounding counties. The agency strives to serve all clients and be sensitive to various cultural values and beliefs. Our workforce is also comparable with the surrounding counties ethnic populations as well as the client populations served.

VAYA Catchment Area – Rank Order of Underserved Populations by Disability

Ranking of Service Needs	Disability/Age	Estimated Number of Individuals Needing Services by Disability/Age	Estimated Percentage Underserved
1	**Child SA**	**2,061**	**83%**
2	**Adult MH**	**13,434**	**40%**
3	**Adult SA**	**6,022**	**38%**
4	**Child MH**	**2,831**	**17%**
5	**Child I/DD**	**265**	**14%**
6	**Adult I/DD**	**-**	**-**

VAYA and PBHM identified in the 2017 Gaps and Needs Assessment the most significant needs and gaps for Children with mental health conditions as the following:

- Services for children with Co-Occurring conditions (Health Providers);
- Natural Supports (Health Providers, Justice/Law Enforcement)
- Community Based Services (Health Providers); and
- Short-Term Crisis Stabilization (Health Providers, Justice/Law Enforcement).
- Children and youth services
- Language barriers for Spanish and Hmong speaking individuals
- Support for the LGBTQ community

Race, Economy, Education, Crime, and Other Significant Health Indicators

North Carolina Racial Make-up based on United States Census Bureau, 2015 estimate

Caucasian	Hispanic	Black	American Indian & Alaskan Native	Asian-Pacific Islander	Two or More Races
63.8 %	9.1 %	22.1 %	1.6 %	2.9 %	2.1%

Economy

FBHS Served 3 Counties in the VAYA catchment designated as "Tier One" (40 most economically distressed counties state wide)

- Caldwell
- Mitchell
- McDowell

The average unemployment rate for the catchment area is 5.1% and is slightly higher than the average rate for all 100 NC counties (4.9% being state average). Mitchell County, with an unemployment rate of 6.1%, exceeded the North Carolina average by greater than 1.0%. Individuals with low socioeconomic status are at increased risk of developing mental health and substance use disorders that require intervention and care.

Education

Drop-out rate by FBHS Service Area:
Alexander 2.93%, Caldwell 2.89%, McDowell 4.49%, Mitchell 2.45%, State Average 3.01 – McDowell County has the highest in the entire state. They are in dire need of more services and supports within the school system.

Crime and Violence

The State Board of Education has defined 16 criminal acts that are to be included in its annual report. Nine of the 16 are considered dangerous and violent. The acts of crime and violence include:

- Homicide
- Assault resulting in serious bodily injury
- Assault involving the use of a weapon
- Rape
- Sexual offense

- Sexual assault
- Kidnapping
- Robbery with a dangerous weapon
- Taking indecent liberties with a minor
- Assault on school personnel
- Bomb threat
- Burning of a school building
- Possession of Alcohol, controlled substance
- Possession of firearm or powerful explosive
- Possession of a weapon

None of the FBHS counties were listed in the states' highest reported crimes. There are many positive contributing factors around our service area such as proactive law enforcement, enhanced mental health services and our agency feels strongly that utilization of child/adolescent day treatment services has contributed in keeping these numbers low. We are serving very high risk consumers that have the potential to engage in the above listed crimes. Early intervention and system of care approaches have contributed to keeping these numbers low for our service areas.

Service Area Economy rates by county

Statistic	Burke	Caldwell	McDowell	Mitchell	State Average
Pop ages 0 – 17 in poverty	19.9%	27.7%	27.1%	28.5%	24.1%
Percent of Uninsured	12.1	17%	15%	16.0%	11.2
Unemployment Rate	11.6	5.2%	4.6%	6.1%	4.9%
Per Capita Income	$20,346	$19,601	$18,717	$21,429	$25,920

Demographics of clients served

- Low income/disabled individuals
- Children with mental illness and/or co-occurring diagnoses
- Incidents of interaction with law enforcement
- Dependent upon service system to meet many of their basic needs
- In need of basic needs such as clothing, shoes, toiletries, etc.
- Often in need of a stronger support system – i.e. families, extended families, foster families, etc.

Focus Population Payer Source

Payer Sources	% of Billing 2011	% of Billing 2012	% of Billing 2013	% of Billing 2014	% of Billing 2015	% of Billing 2016
Medicaid	93%	87%	70%	73%	78%	84%
Health Choice	4%	5%	11%	9%	7%	6%
Private Insurance	0	3%	17%	18%	15%	10%
State Dollars	3%	6%	> 1%	0	0	0
Private Pay/Self Pay	0	2%	1%	> 1%	> 1%	> 1%

2015/2016 SWOT ANALYSIS (Strengths, Weaknesses, Opportunities, Threats)

2016 Agency Strengths

- Staff flexibility and dedication around needed changes with State and Federal regulation and around agency needs in order to remain a viable company
- Professional, ethical and therapeutically trained and "minded" staff
- Personnel processes that screen all potential employees (fingerprinting, sex offender registry, Health Care Registry, criminal background, drivers license, infection control, drug testing)
- High standards of practice both in clinical and administrative work
- Strong Corporate Compliance oversight

- Health and Safety conscious program staff and facilities
- Structurally sound, clean community based facilities
- Facilities located in the community
- Partnerships with the public school systems to serve clients in day treatments and in public school – with safety of the child and the public in mind
- Opened level II facility in 2016
- Strong referral base for Burke and Caldwell counties
- Strong reputation in the community for helping Children/Adolescents with mental health and sexualized behaviors
- Progressive agency with vision of future growth and development.
- Working with Duke University collaborative for Trauma Focused Cognitive Behavioral Therapy (TFCBT)
- Community Partnerships with other public entities, MCO's, DSS, DJJ
- Authorization processes mainstreamed with constant and thorough monitoring to decrease loss of potential revenues.
- Quality control of person centered plans for Intensive In-Home, Day Treatment, and Residential Services leading to: more individualized plans that focus on strength based interventions, empower clients and their families to increase self-advocacy, ensure involvement of clients in creation of plans, and promote inclusion of all stakeholders involved with client.
- Quality Control of documentation across the agency and monthly paperwork audits to ensure compliance
- Dedicated Management across all programming and services
- CARF accredited through February 2018

2016 - Agency Weaknesses

- Staff longevity – decreased to 2.4 years
- Higher turnover rate for management positions
- Cost of ongoing training and support to increase staff clinical knowledge
- Some facilities are still outdated and need cosmetic repairs to improve our appearance in the community
- Keeping up with technology - Computer equipment gets very outdated
- Outdated equipment (rental copiers) and vehicles
- More marketing of program and clinical strengths
- LME's putting all Residential Level III into the same category when we serve a very specialized population (sexually reactive and sexually offending youth) and cost is more extensive
- Residential Level III Federal MCD rates do not support the staff to client ratios and other expenses – received rate cuts 2 additional times since 2008
- Constant change with State and Federal regulation
- Medicaid and Health Choice rates not keeping up with the cost of treatment
- Effective communication among all enhanced services and all aspects of the agency.
- Higher acuity level in clients we serve

2015/2016 - External Opportunities

- Due to constantly having a waiting list – there is a huge potential for growth of the agency in serving our specific populations.
- Teaching and raising community awareness pertaining to the treatment and rehabilitation of sexually reactive and offense specific youth.
- Community Collaborative to teach on Trauma Focused CBT, and agency tools and programs
- Potential for Focus Behavioral Health Services, LLC to develop further services that will provide a fuller continuum of care such as SAIOP
- Need to take advantage of other funding through the LME's – such as RFP's and Title 1 Funding through DPI.
- Decreasing the adolescent drop-out rate within the public schools through day treatment services
- Submitting the Focus Behavioral Health Services, LLC - Cognitive/Behavioral model as a possible Best Practice model
- Helping the community develop more acceptance/tolerance with populations served by providing them with comprehensive education
- Marketing our current services more in the community

- Healthy competition and collaboration with other providers that provide comprehensive and strengths based programs to children/youth and families
- Electronic Personnel Records and using technology to support efficient and effective operations in order to better serve all populations.
- Agency Restructuring due to elimination of CABHA requirement

2015/2016 - External Threats/Challenges

- Constant changes in state and federal regulation makes the agency often times reactive instead of proactive.
- Economical challenges relating to public funding both in County, State and Federal funding.
- More children and families in need and therefore needing more financial resources by agency, county, State and Federal funding.
- Residential Level III Federal MCD rates do not support the staff to client ratios and other expenses Medicaid has cut rates 2 additional times since 2008
- Consistency and standardization between MCO's relating to contract requirements, room and board, state funding/authorization
- Development of a not for profit agency in order to get grant funding
- Constant monitoring by numerous entities - much duplication of efforts – takes a great deal of staff time and resources
- 1915 b Waiver – Medicaid Changes consistently occurring – NCTRACKS, MCO's, NCHC, Rules/regulations, Compliance in Tracking, etc.
- residential authorizations – state not following their own guidelines for 90 day concurrent authorization when all paperwork is in place
- Lack of community awareness and teaching around adolescent/child mental health and/or sexually reactive or offense specific populations. The general community (neighborhoods, schools, legal systems, etc.) often times seem very intolerant to this population and very reactive if children are placed inside their communities.
- Community opinions and prejudices toward sexually reactive youth – forget their victimization issues
- Constant changes in technology create struggles for small organizations to keep up with LME's and other public entities that have the resources to continually upgrade their systems.
- Private Providers do not have all the infrastructure and fiscal support the LME's and other public entities have
- LME's recruit all the highly qualified staff. Private providers cannot compete with their benefits and wages – not always getting the most highly qualified staff.
- Lack of equality when small agencies are providing the services and lack of adequate funding from DHHS. LME's receive all the funding.
- Funding Options and Integrated Care Billing – State is pushing for this model – however, current regulations and rules and state billing software does not support this model. State needs to make appropriate changes before mandating Integrated Care to the private providers.
- Many providers that market the provision of offense specific treatment while their model does not reflect the appropriate course of treatment or client supervision – this makes it difficult for providers that do specialize in this type of treatment.

CRITICAL ISSUES TO THE SUCCESS OF OUR AGENCY

2015/2016 – Critical Personnel Issues:

- Continue to look at turnover rates – analyze with data from exit interviews and employee satisfaction surveys.
- Develop concentrated work groups for each specific service to look at all aspects of the program and develop goals for each service.
- Increase Employee Benefits
- Continue to build a culturally diverse workforce that is bilingual and sensitive to the needs of all populations served.
- More cross training of all staff throughout all programming and in administration (i.e. Residential staff can work in Day Treatment, Receptionist can cover for Reimbursement staff, etc.)
- Continue to develop supervisory training for all leaders within each program area. Develop modules on all aspects of supervision duties to include:
    - ✓ Clinical Supervision Requirements

- ✓ Begin a mandatory Supervisory Learning Forum a minimum of quarterly - topics to include:
    - What is it to be a new leader?
    - Leadership Essentials
    - Conflict Resolution
    - Setting Expectations for Employees
    - Communication
    - Coaching Staff to Improve
    - Working with Constant Change

2015/2016 – Critical Fiscal Issues:

- Constant rate cuts with Medicaid and Health Choice put programs at risk of not being fiscally viable – costs more to run some of the programs than the agency can afford – during 2009 to 2011 there has been an overall rate cut of approximately 6%;
- Constant changes in services definitions and implementation bulletins – making it very difficult for agencies to stay abreast of all the changes.
- DMA and DHHS establishing higher rates for Level III residential in order to pay for services rendered and to provide more intensive treatment and care. This is a tremendous issue for the viability of the company and residential programs. Rate does not cover the ratios and treatment being provided. Services need to be unbundled by the service definition changing.
- All referrals should come through outpatient for initial clinical assessment and basic therapy needs to be provided by outpatient. The need for enhanced services should be referred out to our continuum.
- Needing to purchase a company network to assist in consistency across the agency with forms, policies, procedures, e-mails, etc. and to aid in more effective communication
- Managers having ownership and control with a budget for their specific facility – learning the importance of staying within the confines of their individual budgets.
- Local input and management of budgets for cost finding and evidence of local fiscal responsibility
- Develop preventive maintenance schedule for buildings and vehicles – work on better communication and resources for maintenance personnel functions

2015/2016 - Critical IS issues:

- Continually refine Encryption and Firewall protection for continued confidentiality and HIPAA compliance.
- Need enhancements to our current electronic Medical Record or research other providers
- Purchase of new computers and software as needed
- Further refine job duties of the IT staff
- consistency across the agency with forms, policies, procedures, e-mails, etc. and to aid in more effective communication
- Website – enhancements
- Cellular Phone and Mobile Device Management Enhancements – texting, e-mail
- More control of Social Media
- Social Media Policy

2015/2016 - Critical Purchases:

- New car for Intensive In-Home
- Video Cameras installed in Day Treatment Programs – increases staff accountability
- Video and audio enhancements in the already existing Residential Program camera systems
- Computer systems (tablets vs. laptops) for specific programs

2015/2016 Critical need for training of personnel to implement the following:

- Training for personnel relating to agency changes with policy and procedures and Quality Improvement incentives across the agency
- Training to raise staff awareness of state and federal requirements in operations of residential and day treatment programs

- Consistency in the program models and tools used between all the different sites in both residential and day treatment
- Training clinicians on Trauma Focused Cognitive Behavioral Treatment strategies – to better align with the high risk populations served
- Becoming more strict on training and supervision requirements – stress importance of staff having mandatory trainings and/ or supervisions and not being allowed to continue working
- Training all direct care staff during 2017 on the FOCUS CBT Model and Tools system – Counselors Learning Journals
- Training to all supervisors during 2017 on the core Supervisor requirements
- Set up basic computer skills class for all identified staff

2015/2016 Critical Service Needs within the community served:

- Develop Substance Abuse Services for Children/Adolescent – to include Substance Abuse Intensive Outpatient, Substance Abuse Groups, Substance Abuse Level II and III facilities
- Further develop program models to keep up with evidence based practices
- Continually Train new (all) clinicians on Trauma Focused Cognitive Behavioral Therapies
- Staffing high risk clients with medical and clinical directors in CLF
- More capacity to serve more consumers within Residential and Day Treatment to meet community needs
- No waiting lists
- Build stronger referral network for services that our agency does not provide – i.e. adult MH/DD/SA services and child DD services.

Goals for Focus Behavioral Health Services, LLC 2015/2016

1. Achieve 3 year CARF National Accreditation during next review period 2017
2. Update website to include more modern content and technology – (parallax scrolling, updated media, photos and design, etc.). In addition, develop website to be more of a community resources for identifying Behavioral Health issues (depression questionnaires, ADHD questionnaires, psychotropic medication education, information on top MH diagnosis, SNAP IV, etc.)
3. Employee Appreciation / Merit Incentives/Improve Morale 2017
    - Reinstate Employee of the Month
    - Training on Program Model for Direct Care Staff
    - Team Building with management and direct care staff 2017
    - Merit/Bonus Increase 2017
4. Research viability of low performing programs (MDTX, TFC) Implement strategies to increase productivity, meet with outside agencies to promote communication and collaboration. If strategies continue to be ineffective concentrate resources on successful programming.
5. Update all materials during 2016 and 2017 to stay abreast of evidence based approaches.
6. Submit model to designated entity to have it listed as a Best Practice Model for NC and Nationally.
7. Selected Clinicians were entered into a Program for NC Child Treatment Program, Duke Endowment with Duke University Collaborative on Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
8. Research and add Substance Abuse Intensive Outpatient - 2018
9. Registration and Paneling in the Medicare system and other insurance entities.
10. Research Integrated HealthCare and begin process of planning and implementation.
11. Build Complete continuum of care for Children and Families to include:
    - Outpatient
    - Enhanced Outpatient – Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
    - Medication Management
    - Residential Treatment Staff Secure for Children or Adolescents – Level III (.1700)
    - Residential Treatment for Children/Adolescents - Level II (.1300)
    - Child/Adolescent Day Treatment (.1400)
    - Child/Adolescent Intensive In Home
    - Child/Adolescent Substance Abuse Intensive Outpatient **(New – Not Developed)**
12. Get all child therapists fully licensed and rostered in Trauma Focused CBT