# Mississippi Board of Mental Health and Mississippi Department of Mental Health

# STRATEGIC PLAN FY 2013 - 2017

## STAYING THE COURSE

July 1, 2012

# Message from the Chair

Determining the best ways to make our Vision a reality is an ongoing effort. There are always going to be challenges, but as the Board of Mental Health's Strategic Planning Subcommittee presents the fourth Strategic Plan, the need for a Strategic Plan to guide our transformation to a community-based system is more important than ever. Looking ahead to the accomplishments we want to witness in the next five years helps keep our focus on change.

Each year's review of the Strategic Plan allows us to see the changes that are occurring. Progress has been made in each goal. While not all activities are complete, we are moving towards completion of objectives that will help fully develop a community-based system.

Furthermore, for the last several years, DMH has requested additional funds from the Legislature to address numerous activities listed in the Strategic Plan goals. While the State's budget has been such that no additional funds have been available, DMH will continue to request funds to help make the changes needed to provide more community supports.

Progress could not happen without the continuing commitment and efforts of all the Goal Leaders, Goal Team members, consumers, advocates and our community partners. The Strategic Planning Subcommittee sincerely appreciates everyone's contributions. We look forward to your continuing involvement as we stay the course on striving to reach our Vision.

*Margaret Cassada, M.D., Chair*
Board Strategic Planning Subcommittee

## STRATEGIC PLANNING SUBCOMMITTEE

Dr. Margaret Cassada, Board of Mental Health
Mr. George Harrison, Board of Mental Health
Mr. Johnny Perkins, Board of Mental Health
Mrs. Rose Roberts, LCSW, Board of Mental Health
Ms. Lisa Romine, Bureau of Interdisciplinary Programs
Dr. Lydia Weisser, Mississippi State Hospital
Ms. Lynda Stewart, Division of Children and Youth

# Foreword

When the Mississippi Board of Mental Health and the Department of Mental Health set out to develop a Strategic Plan four years ago, our main goal was to create a living, breathing document. We envisioned a road map, developed with the help of partners across the state, to guide the future of the agency.

We wanted to ensure that strategic planning was an open process with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies.

We wanted to make strides toward developing a community-based service system which focuses on evidence-based practices and improves access to care.

We wanted to use available resources effectively and efficiently to meet our goals and improve our current service system.

By reviewing the quarterly and annual reports from the last three years, it is easy to see that we are steadily making progress in meeting our goals.

With the assistance of our dedicated staff and partners, we have been able to achieve much even during difficult budget times. The economic climate has changed since the first Strategic Plan was crafted. During such a serious budget crisis, it continues to be a difficult task to transform the public mental health system to a more community-based, recovery-driven system. But, we will continue to move forward to the best of our ability.

Now is the time to push forward to help the thousands of Mississippians in need of our services. It is important not only to have a Strategic Plan, but to stay the course and continue the Plan's actions. The five goals within this Plan reflect the future course of DMH and the public mental health system. My hope is that you will continue to work with us in supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual or developmental disabilities one person at a time.

Edwin C. LeGrand III
DMH Executive Director

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# Executive Summary

The purpose of the Strategic Plan is to drive the transformation of the mental health system into one that is outcomes-oriented and community-based. The Board's 2012 Strategic Planning Subcommittee consisted of Board members Dr. Margaret Cassada, Mr. George Harrison, Mr. Johnny Perkins, and Ms. Rose Roberts; Central Office staff liaison, Ms. Lisa Romine; Clinical Services Director, Dr. Lydia Weisser, MSH; and Ms. Lynda Stewart, DMH Division of Children and Youth.

The Board's Strategic Planning Subcommittee is charged to review annually and revise as necessary the Strategic Plan, which serves as a map for guiding the continuing transformation of the DMH service system. The Board of Mental Health intends for the Strategic Plan to be a flexible, living document which meets the needs of the people we support and enables us to face the challenges of an ever-changing environment. The Strategic Plan is an essential tool for system transformation.

Work on the annual review began with the goals' objectives and action plans. The five Goal Leaders were asked to solicit the help of their goal team members and others to make recommendations on which objectives/action plans to include, keeping in mind the need to show observable and measurable outcomes and taking into account current activities and the changing environment. These Goal Leaders were Kelly Breland and Trisha Hinson, Goal 1; Jake Hutchins and Sandra Parks, Goal 2; Ashley Lacoste and Thaddeus Williams, Goal 3; Dr. Mardi Allen, Goal 4; and James Dunaway, Goal 5. DMH Bureau Directors, Lisa Romine, Kris Jones, Matt Armstrong, Diana Mikula, and Jerri Avery, also provided input into the revision as did Wendy Bailey, DMH Central Office. During the review of each goal, objectives/action plans were removed from the Plan if these measures had been completed, were duplicated in another goal, or are now part of ongoing DMH activities. Timelines and performance indicators were also reviewed and revised as necessary. In response to emerging issues, new objectives and action plans were added as well.

The Goal Leaders for FY 2012 then presented their proposed revisions to the Board's Strategic Planning Subcommittee. The Subcommittee discussed each goal and made suggestions for revisions. A draft Strategic Plan was then reviewed by the Subcommittee and Board prior to approval. A summary of the finalized goals follows.

***Goal 1*** calls for DMH to continue to execute cost reduction measures and enhance its accountability and management practices to ensure the most efficient use of its resources. The goal also emphasizes the need to maximize funding through grants and available Medicaid waiver programs and services. Transforming to a community-based system will necessitate an increase in community capacity and require funding – both new funds and the reallocation of existing funds.

***Goal 2*** sets forth DMH's vision of individuals receiving services having a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Goal 2 also highlights the transformation to a community-based service system. This transformation is woven throughout the

entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long-term community supports and other specialized services along with services to help individuals transition from institutions to the community. Goal 2 provides a foundation on which DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

**Goal 3** addresses the methods by which DMH intends to increase individuals' access to care and services statewide. Goal 3 seeks to promote shared responsibility among communities, state and local governments, and service providers to build and strengthen the community-based system of care for individuals served by DMH. DMH recognizes that formal partnerships with traditional and nontraditional partners are critical to the overall success of the system of care.

***Goal 4*** establishes the use of evidence-based or best practice models and service outcomes. DMH embraces the importance of identifying and implementing the most cost-effective EBP models available within the system of care. By incorporating state-of-the-art research, clinical and administrative practices will consistently produce specific, intended results and meet scientific and stakeholder criteria for effectiveness.

***Goal 5*** focuses on using data and available technology in decision making. DMH will enhance its ability to communicate effectively and share data and information across the agency. DMH will fully implement and utilize its Central Data Repository project and continue activities to establish Electronic Health Records and a Health Information Exchange. With better data and analysis, decision making will be enhanced.

Changes in the mental health system are occurring even though the environment in which the mental health system operates continues to offer challenges. It is the obtainment of our vision of a community-based service system that keeps DMH's dedicated staff and engaged stakeholders staying the course.

# Mission, Vision, and Core Values

## DMH Mission

Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities, one person at a time.

## Vision

We envision a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports.

### *A better tomorrow exists when…*

- All Mississippians have equal access to quality mental health care, services and supports in their communities.
- People actively participate in designing services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance abuse and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services, and supports.

## Core Values & Guiding Principles

***People*** We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice and provision of services to meet their unique needs.

***Community*** We believe that community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

***Commitment*** We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

***Excellence*** We believe services and supports must be provided in an ethical manner, meet established outcome measures, and be based on clinical research and best practices. We also emphasize the continued education and development of our workforce to provide the best care possible.

***Accountability*** We believe it is our responsibility to be good stewards in the efficient and effective use of all human, fiscal, and material resources. We are dedicated to the continuous evaluation and improvement of the public mental health system.

***Collaboration*** We believe that services and supports are the shared responsibility of state and local governments, communities, family members, and service providers. Through open communication, we continuously build relationships and partnerships with the people and families we serve, communities, governmental/nongovernmental entities and other service providers to meet the needs of people and their families.

***Integrity*** We believe the public mental health system should act in an ethical, trustworthy, and transparent manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

***Awareness*** We believe awareness, education, and other prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

***Innovation*** We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

***Respect*** We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the public mental health system.

# Philosophy

The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention, service, and support options for adults and children with mental illness or emotional disturbance, alcohol/drug problems, and/or intellectual or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The Department supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

# Core Competencies

The Department of Mental Health established Core Competencies to serve as indicators of success in realizing its mission and vision. The core competencies are:

**Allocating resources based on established priorities and agency vision**

**Demonstrating a strong commitment to excellence in services/supports delivery to promote positive outcomes for people**

**Practicing good stewardship with all resources**

**Exhibiting commitment to continual evaluation and a shift in focus to a community-based service system**

**Involving individuals, families, and self advocates in service planning, design, and delivery**

**Valuing and supporting the workforce by providing opportunities for continued education, training, and advancement**

**Possessing the cultural competencies necessary to work effectively with diverse people, families, communities, and workforces**

**Embodying an organizational culture of innovation, creativity, resourcefulness, self-evaluation, and continuous quality improvement**

**Collecting, interpreting, and applying information from a variety of sources when making decisions, preparing budget requests, and planning for and designing mental health policies, services, and supports**

**Establishing partnerships with others to achieve common goals and outcomes**

**Communicating effectively to promote awareness and prevention as well as to dispel the stigma of mental illness, intellectual/developmental disabilities, substance abuse, and dementia**

# Organizational Overview

The Mississippi Department of Mental Health's organizational structure consists of three separate but interrelated components: the Board of Mental Health, the DMH Central Office, and DMH-Operated Facilities and Community Services Programs.

## Board of Mental Health

The Board of Mental Health, the Department's governing body, is comprised of nine members appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the nine-member board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' terms are staggered to ensure continuity of quality care and professional oversight of services.

As specified in MISS CODE ANN Section 41-4-7 (1972), the Board of Mental Health is statutorily responsible for such primary duties as:

- Appointing an agency director,
- Establishing rules and regulations to carry out the agency's duties,
- Setting up state plans for major service areas,
- Certifying, coordinating and establishing minimum standards for programs and providers,
- Establishing minimum standards for operation of facilities,
- Assisting community programs through grants,
- Serving as the single state agency in receiving and administering funds for service, delivery, training, research and education,
- Certifying/licensing mental health professionals,
- Establishing and maintaining a toll-free grievance system,
- Establishing a peer review/quality assurance evaluation system, and other statutorily-prescribed duties.

## DMH Central Office

As specified in MISS CODE ANN Section 41-4-1 (1972), the purpose of the Department of Mental Health is:

> to coordinate, develop, improve, plan for, and provide all services for persons of this state with mental illness, emotional disturbance, alcoholism, drug dependence, and an intellectual disability; to promote, safeguard and protect human dignity, social well-being and general welfare of these persons under the cohesive control of one (1) coordinating and responsible agency so that mental health and intellectual disability services and facilities may be uniformly provided more efficiently and economically to any resident of the state of Mississippi; and further to seek means for the prevention of these disabilities.

Furthermore, MISS CODE ANN Section 41-4-5 (1972) provides for the establishment of divisions within the Department of Mental Health.

The overall statewide administrative functions are the responsibility of DMH Central Office. The Central Office is headed by an Executive Director and consists of seven bureaus and the executive division:

- **Bureau of Administration**
- **Bureau of Mental Health**
- **Bureau of Alcohol and Drug Services**
- **Bureau of Intellectual and Developmental Disabilities**
- **Bureau of Community Services**
- **Bureau of Workforce Development and Training**
- **Bureau of Quality Management, Operations and Standards**

*DMH Central Office also has a Legal Division and a Clinical Services Liaison*

## DMH-Operated Facilities and Community Services Programs

DMH directly operates five psychiatric facilities, one mental health residential center, five regional facilities for persons with intellectual and developmental disabilities, and one specialized facility that serves adolescents with intellectual and developmental disabilities. The facilities serve designated counties or service areas and offer residential and/or community services for people with mental illness, substance abuse issues, intellectual and developmental disabilities, Alzheimer's disease and other dementia.

# Services/Supports Overview

The Mississippi Department of Mental Health (DMH) provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance abuse problems, and Alzheimer's disease and/or other dementia. It is our goal to improve the lives of Mississippians by supporting a better tomorrow…today.

The success of the current service delivery system is due to the strong, sustained advocacy of the Governor, State Legislature, Board of Mental Health, the Department's employees, consumers and their family members, and other supportive individuals. Their collective concerns have been invaluable in promoting appropriate residential and community service options.

## Service Delivery System

The mental health service delivery system is comprised of three major components: state-operated facilities and community services programs, regional community mental health centers, and other nonprofit/profit service agencies/organizations.

***State-operated facilities***: DMH administers and operates five state psychiatric facilities, one mental health residential center, five regional facilities for persons with intellectual/developmental disabilities, and one facility that serves adolescents with intellectual and developmental disabilities These facilities serve specified populations in designated counties/service areas of the state.

The psychiatric facilities provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance abuse. These facilities include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Specialized Treatment Facility. Nursing facility services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, the psychiatric hospitals also provide transitional, community-based care. The Specialized Treatment Facility is a Psychiatric Residential Treatment Facility for adolescents with mental illness and a secondary need of substance abuse prevention/treatment. Central Mississippi Residential Center is a residential center for persons with mental illness.

The facilities for persons with intellectual/developmental disabilities provide residential services. These facilities include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center. The facilities are also a primary vehicle for delivering community services throughout Mississippi. Mississippi Adolescent Center is a specialized facility for adolescents with intellectual/developmental disabilities.

***Regional community mental health centers (CMHCs):*** CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 15 CMHCs make available a range of community-based mental health, substance abuse, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. DMH is responsible for certifying, monitoring, and assisting CMHCs. CMHCs are the primary service providers with whom DMH contracts to provide community-based mental health and substance abuse services.

***Other Nonprofit/Profit Service Agencies/Organizations:*** These agencies and organizations make up a smaller part of the service system. These programs are certified by DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol/drug abuse services, community services for persons with intellectual/ developmental disabilities, and community services for children with mental illness or emotional problems.

## Available Services and Supports

Both facility and community-based services and supports are available through DMH. The type of services provided depends on the location and provider.

### *Facility Services*

The types of services offered through the regional psychiatric facilities vary according to location but statewide include:

Acute Psychiatric Care
Intermediate Psychiatric Care
Continued Treatment Services
Adolescent Services
Nursing Home Services
Medical/Surgical Hospital Services
Forensic Services
Alcohol and Drug Services

The types of services offered through the facilities for individuals with intellectual/developmental disabilities vary according to location but statewide include:

ICF/MR Residential Services
Psychological Services
Social Services
Medical/Nursing Services
Diagnostic and Evaluation Services
Community Services Programs
Special Education
Recreation
Speech/Occupational/Physical Therapies
Vocational Training
Employment Services

### *Community Services*

A variety of community services and supports is available. Services are provided to adults with mental illness, children and youth with serious emotional disturbance, children and adults with intellectual/ developmental disabilities, persons with substance abuse problems, and persons with Alzheimer's disease or dementia.

## Services for Adults with Mental Illness

Crisis Stabilization Programs
Psychosocial Rehabilitation
Consultation and Education Services
Emergency Services
Pre-Evaluation Screening/Civil Commitment Exams
Outpatient Therapy
Case Management Services
Halfway House Services
Group Home Services
Acute Partial Hospitalization
Elderly Psychosocial Rehabilitation
Peer Support Services
Community Support Services
Assertive Community Treatment
Medication Management
Crisis Services
Supervised Housing
Physician/Psychiatric Services
SMI Homeless Services
Drop-In Centers
Day Support
Individual and Family Education and Support

## Services for Children and Youth with Serious Emotional Disturbance

Therapeutic Group Home
Treatment Foster Care
Prevention/Early Intervention
Crisis Services
Crisis Residential
Targeted Case Management
Peer Support (Family & Youth)
Community Support Services
Day Treatment
Outpatient Therapy
Physician/Psychiatric Services
MAP (Making A Plan) Teams
Family Education and Support
Wraparound Facilitation
Intensive Outpatient Psychiatric Services
Respite Services

## Services for People with Alzheimer's Disease and Other Dementia

Adult Day Centers
Caregiver Training

## Services for People with Intellectual/Developmental Disabilities

Early Intervention
Community Living Programs
Work Activity Services
Supported Employment Services
Day Support
Diagnostic and Evaluation Services
Community Support Services
ID/DD Waiver Home and Community Supports
ID/DD Waiver Community Respite
ID/DD Waiver Behavioral Support/Intervention
ID/DD Waiver In-Home Nursing Respite
ID/DD Waiver ICF/MR Respite
ID/DD Waiver Day Services - Adult
ID/DD Waiver Prevocational Services
ID/DD Waiver Support Coordination
ID/DD Waiver Occupational, Physical, and Speech/Language Therapies

**Alcohol and Drug Services**

Detoxification Services
Chemical Dependency Units
Outpatient Services
DUI Diagnostic Assessment Services
Prevention Services
Primary Residential Services
Transitional Residential
Outreach/Aftercare

## Additional Information

Additional information concerning the location of the facilities, services, and supports and descriptions of the specific services can be found on the DMH website: *www.dmh.ms.gov* or through DMH's Toll-Free Help Line Number: 1-877-210-8513.

# Goals and Objectives

Using the mission, vision, and values, the Board of Mental Health developed five-year goals to address the transformation of the DMH service system. These goals address the key issues of accountability/efficiency, a person-centered and person-driven system, access, community services/ supports, outcomes, partnerships, and information management.

The goals and objectives will guide DMH's actions in moving toward a community-based service system. Each goal's objectives include action plans, performance measures, timelines, and responsible parties. Furthermore, unless specified, these goals and objectives are inclusive of the populations DMH is charged to serve, and services developed and/or provided will take into account the cultural and linguistic needs of these diverse populations.

**The system-wide goals are as follows:**

**GOAL 1** *Maximize efficient and effective use of human, fiscal, and material resources*

**GOAL 2** *Continue transformation to a person-driven, community-based service system*

**GOAL 3** *Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers*

**GOAL 4** *Implement evidence-based or best practice models and service outcome measures*

**GOAL 5** *Utilize information/data management to enhance decision making and service delivery*

# Goal 1 Maximize efficient and effective use of human, fiscal, and material resources

## *Objective 1.1 Increase efficiency within DMH*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Continue to implement proven cost reduction measures across DMH programs/services | Amounts and relative percentages realized from expenditure reductions projects | 2013 | 2014 | 2015 | 2016 | 2017 | Bureau of Administration, assigned DMH staff |
| b) Implement at least one new Expenditure Reduction Project each year | By 2017, five projects developed and implemented with projected cost reductions reported | 2013 | 2014 | 2015 | 2016 | 2017 | Bureau of Administration, assigned DMH staff |
| c) Determine personnel needed to transform the service system | Increase in types and numbers of community-based support staff | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BWDT |
| d) Increase efficient use of human resources by developing innovative cost-reduction measures concerning personnel (i.e., job sharing, flex scheduling of staff, etc.) | Consolidated report with expenditure reductions and/or efficiencies in human resources | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BWDT |

## *Objective 1.2 Maximize funding opportunities*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Assist the Division of Medicaid with submission of a Medicaid State Plan Amendment to include services allowed under Section 1915i | Waiver request finalization and submission | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BQMOS |
| b) Apply for at least two new grants or additional funding in targeted areas: infrastructure and capacity building | Number of grants applied for and increase in the amount of grant dollars obtained | 2013 | 2014 | 2015 | 2016 | 2017 | Assigned DMH Staff |
| c) Collaborate with Division of Medicaid to amend the Medicaid State Plan initially for IDD services to provide a full array of person-centered services (respite services and MAP teams) | Medicaid State Plan amendments submitted | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD |

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| d) Maximize use of Elderly/Disabled Waiver to provide services/programs for individuals with Alzheimer's Disease | Increased number of individuals served in Garden Park using the Elderly/Disabled Waiver funds | 2013 2014 2015 2016 2017 | BCS |
| e) Expand use of Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) program services for children and youth | Increased number of children served by CMHCs receiving EPSDT services | 2013 2014 2015 2016 2017 | BCS, BIDD |
| f) Investigate the need for tiered service options | Needs assessment conducted to determine services that could be provided through tiered options | 2013 2014 2015 2016 2017 | BIDD, BCS |

## *Objective 1.3 Revise system-wide management and oversight practices to improve accountability and performance*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Maximize stakeholder input by streamlining the number of required task forces and steering committees | One representative committee for stakeholder input that meets requirements of applicable statutes or policies | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |
| b) Increase effectiveness of coordination of MAP teams | State Level Coordinator hired for C&Y and Adult MAP Teams | 2013 2014 2015 2016 2017 | BCS |
| c) Establish a DMH quality management council to assist DMH with identification of trends and patterns among all DMH certified providers | Quality management council established | 2013 2014 2015 2016 2017 | BCS, BQMOS, BIDD, BADS |
| d) Implement resource allocation strategy to support EBP/BPs and service outcome models | Funding amounts (dollars) reallocated, itemized by service, and number and type of EBP/BPs in use | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| e) Publish an annual report that benchmarks like programs with established performance indicators/ outcomes/national core indicators | Core indicator database completed and benchmarking begun | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS, BQMOS |
| f) Increase percentage of funding allocation to priority services (crisis services, housing, supported employment, and early intervention/prevention) | Funding amounts (dollars) allocated to top three priorities | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |

# Goal 2 Strengthen commitment to a person-driven, community-based service system

## *Objective 2.1 Expand meaningful interaction of self advocates and families in designing and planning at the system level*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Provide opportunities for individuals and family members to participate in program development, service planning and recovery training | Active participation of peers and family members on Advisory Councils | 2013 | 2014 | 2015 | 2016 | 2017 | DCS and all DMH |
| b) Provide statewide training to all service providers on the recovery model, person-centered planning, and System of Care principles/values | Increased knowledge of staff and increase in positive responses to the Council on Quality and Leadership's (CQL) 21 Personal Outcome Measures © | 2013 | 2014 | 2015 | 2016 | 2017 | DCS, BIDD, BQMOS, C&Y |
| c) Determine system's responsiveness to individual needs and desired outcomes | 100% of certified programs evaluated according to the CQL's 21 Personal Outcome Measures © | 2013 | 2014 | 2015 | 2016 | 2017 | BQMOS, DCS and CQL Review Team |
| d) Incorporate Peer Recovery Supports Services into core services in DMH Operational Standards | Peer Recovery Specialist employed by DMH certified providers | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BQMOS |
| e) Incorporate Peer Supports Services into core services in DMH Operational Standards | Certified Peer Support Specialist employed by DMH certified providers | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BQMOS |
| f) Evaluate effect of implementation of CQL's 21 Personal Outcome Measures © on the system's transformation to a recovery and resiliency model | Programs that were evaluated and trained met or exceeded national norms | 2013 | 2014 | 2015 | 2016 | 2017 | DCS , CQL Review Team, BCS, BIDD, BADS, BQMOS |
| g) Expand representation in the Office of Consumer Support to include at least one peer specialist or parent advocate for each population served by DMH | Representative for IDD included | 2013 | 2014 | 2015 | 2016 | 2017 | DCS , BIDD, BQMOS |

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| h) Identify barriers and make recommendations concerning the state's implementation of CQL's 21 Personal Outcome Measures © | CQL's 21 Personal Outcome Measures © re-evaluated to determine if the state met the threshold and the need to add or delete Personal Outcome Measures | 2013 | 2014 | 2015 | 2016 | 2017 | Bureau Directors, BQMOS |
| i) Implement an action plan for next steps based on the recommendations made regarding CQL's 21 Personal Outcome Measures | Action Plan for next steps developed and implementation begun | 2013 | 2014 | 2015 | 2016 | 2017 | Bureau Directors, BQMOS |

## *Objective 2.2 Develop a comprehensive crisis response system*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Provide Crisis Stabilization Unit (CSU) services through each CMHC region | By end of FY 2016, each CMHC region will have a CSU | 2013 | 2014 | 2015 | 2016 | 2017 | BCS |
| b) Evaluate CMHC-operated crisis stabilization units based on defined performance indicators for diversion, length of stay, and recidivism | Report of increase in diversion rate, length of stay, and recidivism rate | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BQMOS |
| c) Provide readily available community crisis services | 24/7 emergency/crisis services provided by all 15 CMHCs for all 82 counties | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS |
| d) Investigate the feasibility and impact of providing crisis detoxification services at CSUs | Report developed outlining the impact of providing crisis detoxification services at CSUs | 2013 | 2014 | 2015 | 2016 | 2017 | BADS, BCS |

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| e) Develop transition/step-down residential options for people leaving crisis stabilization units | Designation of at least two crisis apartment beds per CSU to assist individuals in transition back into the community | 2013 2014 2015 2016 2017 | BCS |
| f) Develop crisis support plans for individuals as a standard component of care and mitigation strategy | Crisis Support Plan developed for each person at risk of crisis, frequent user of inpatient services, or transitioning from inpatient/more restrictive placement or environment | 2013 2014 2015 2016 2017 | BIDD, BCS, BADS |
| g) Provide crisis and emergency respite services to people with intellectual/developmental disabilities | Pilot one ICF/MR group home or cottage on campus to be used solely for crisis respite services | 2013 2014 2015 2016 2017 | BIDD |
| h) Partner with CSUs operated by CMHCs to furnish crisis-oriented, specialized behavioral services on an as-needed basis for people with dual diagnosis of SMI/IDD | Crisis services provided at CSUs for persons with dual diagnosis | 2013 2014 2015 2016 2017 | BCS, BIDD |

## *Objective 2.3 Increase statewide availability of safe, affordable and flexible housing options and other community supports for individuals*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Acquire sufficient staff time, training and resources to continue the development of service linkages with multiple housing partners at the state and regional levels | Support staff assigned to DMH Division of Housing and Community Living | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |
| b) Identify and coordinate an array of supportive services needed to sustain individuals in permanent housing in local communities | By 2017, at least 500 persons received supported housing services/ supports across the state | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |
| c) Provide Bridge Funding for supported housing | At least 20 individuals received Bridge Funding to secure supported housing each year | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |

## *Objective 2.4 Provide community supports for persons transitioning to the community through participation in the Bridge To Independence project*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Expand ID/DD Waiver services to enable individuals with IDD residing in DMH facilities to transition into the community using Bridge to Independence services | By 2016, 138 people transitioned from ICF/ MRs to community | 2013 2014 2015 2016 2017 | BIDD |
| b) Increase number served in ID/DD Waiver each year from those on the waiting list | ID/DD Waiver enrollment increased by 5% each year | 2013 2014 2015 2016 2017 | BIDD |
| c) Transfer people with SMI from nursing homes to community using Bridge To Independence services | By 2016, 72 people transitioned from nursing facilities to community | 2013 2014 2015 2016 2017 | BCS, BIDD |
| d) Transition Coordinators will establish interagency, multidisciplinary transition teams at the state ICF/MRs to assist individuals in making a seamless transition to community-based services | By 2014, five Transition Teams operating | 2013 2014 2015 2016 2017 | BIDD |

## *Objective 2.5 Provide long-term community supports*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Expand PACT teams to support the integration and inclusion of persons needing long-term psychiatric care | By 2017, five additional PACT teams funded across the state | 2013 2014 2015 2016 2017 | BCS |
| b) Provide Community Support Teams to promote and support the independent living of individuals served | 15 Community Support Teams funded and developed across the state | 2013 2014 2015 2016 2017 | BCS |

## *Objective 2.6 Provide supported employment services*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Increase number of individuals assisted with employment | By 2017, at least 500 individuals with SMI/SED/ A&D/IDD obtained jobs | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |
| b) Assist in the reentry of individuals with mental illness into in the workplace | By 2017, Employment Specialists employed by DMH certified providers | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |
| c) Increase supported employment for individuals with IDD and decrease reliance on Work Activity Services | Number of people transitioned to supported employment from Work Activity | 2013 2014 2015 2016 2017 | BIDD |

## *Objective 2.7 Expand specialized services when funds become available*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Increase and improve integrated treatment service options for co-occurring disorders in adults with SMI and children/youth with SED (SMI/A&D, SED/A&D, SMI/IDD, SED/IDD) | Number of co-occurring integrated treatment sites increased | 2013 2014 2015 2016 2017 | BCS, BIDD, BADS |
| b) Increase the number of transition-aged youth/young adults with SED served in the four MTOP project sites | By 2016, increased by 200 youth with 50 youth per year | 2013 2014 2015 2016 2017 | BCS |
| c) Increase availability of in-home respite for caregivers of individuals with SED | Number of respite providers added and number served | 2013 2014 2015 2016 2017 | BCS, BIDD |

## *Objective 2.7 Expand specialized services when funds become available*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| d) Expand early intervention assessments for children 0 - 5 years of age in CMHCs for identification of developmental disabilities including SED | Implementation and number tracked of children who receive a Preschool and Early Childhood Functional Assessment Scale (PECFAS) | 2013 2014 2015 2016 2017 | BCS, BIDD |
| e) Initiate statewide guidelines to assess individuals with an intellectual/developmental disability for dementia to determine appropriate care approaches | Policy for dementia screenings developed and implemented within all DMH facilities | 2013 2014 2015 2016 2017 | BIDD, BCS, BMH |

# Goal 3 Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers

## *Objective 3.1 Establish equitable and timely access to services statewide*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Implement planning lists procedures to better identify the types and locations of needed services/supports in order to increase options for home and community-based service provision | Utilization of integrated planning lists for BIDD and BMH | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD, BMH |
| b) Develop strategies to address barriers to timely access | Strategies developed to reduce average length-of-wait times in community service programs | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BMH |
| c) Increase access to mental health care/services through expanded use of telemedicine | By 2014, all 15 CMHCs have access to telemedicine/telehealth | 2013 | 2014 | 2015 | 2016 | 2017 | BCS |
| d) Develop a searchable database on DMH's Web site for the public to locate available services in their community | Database developed and available on DMH website | 2013 | 2014 | 2015 | 2016 | 2017 | IS, OCS, Director of Public Information |
| e) Implement statewide system of standardized assessment for persons in the ID/DD Waiver for use in determining level of service needs for people to live successfully at home and in the community | Standardized assessment tool identified and implemented | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD |
| f) Develop ID/DD Waiver rate-setting methodology to ensure provider reimbursement rates are appropriate and equitable for the services being provided | New service rates established | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD |

## *Objective 3.2 Expand and increase effectiveness of interagency and multidisciplinary approaches to service delivery*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Increase partnership activities between local entities and community providers such as hospitals, holding facilities, CSUs and CMHCs to establish triage, treatment, and diversion plans | MOUs and documentation of outreach and action accomplished through mutual efforts | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS, BMH |
| b) Collaborate with the Veterans Administration (VA) to increase the provision of A&D services to veterans within the local community | Contracting of two or more regional CMHCs and free-standing programs with the VA for bed space for veterans in the community | 2013 | 2014 | 2015 | 2016 | 2017 | BADS |
| c) Expand MAP teams for children and youth with SED and IDD | By 2017, MAP Teams available in all 82 counties | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD |
| d) Increase the utilization and practice of Wraparound for children and youth with SED and/or IDD | Wraparound model utilized by each certified CMHC for those children/youth and their families deemed necessary | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD |
| e) Expand adult MAP teams as funding is available | By 2017, at least one adult MAP Team available in all 15 CMHC regions | 2013 | 2014 | 2015 | 2016 | 2017 | BCS |
| f) Facilitate work with state and local partnerships to increase jail diversion programs | Increased number of jail diversion programs, mental health courts, holding facilities and CIT programs | 2013 | 2014 | 2015 | 2016 | 2017 | BCS |

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| g) Continue partnership with the Mississippi Transportation Initiative | Increased availability of transportation | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD |
| h) Develop strategies to facilitate integration of mental illness, IDD, and addiction services with primary health care | Seek funding sources to increase use of integrated services | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADA |
| i) Continue development of multi-agency comprehensive approach for substance abuse prevention among adolescents | Developed joint efforts with community partners | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BIDD, BADS |
| j) Conduct person-centered planning training at all DMH facilities and with all DMH certified providers and other interested parties (advocates, individuals, families) directed at developing resources for individuals transitioning from institutional care to the community | By 2014, training conducted at all 12 DMH facilities | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD, BCS |
| k) Implement person-centered planning as tool to move people from institutional settings to the community | Number of PCPs conducted and number of successful transitions | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD, BCS |
| l) Utilize person-centered planning as tool to support planning for individuals living in the community | 100% of all community service programs participating in person-centered planning | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD, BCS |
| m) Develop collaboration between faith-based organizations and mental health system to enhance access to services | Piloted a faith-based Emotional Fitness Center between a local faith-based organization and a mental health provider | 2013 | 2014 | 2015 | 2016 | 2017 | BCS, BADS |

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| n) Begin work with the Department of Rehabilitation Services to increase supported employment services for people with IDD and SMI | MOU or interagency agreement developed | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD, BCS |
| o) Continue to provide support and assistance to promote certification of holding facilities in each county | Technical assistance provided to five counties per quarter | 2013 | 2014 | 2015 | 2016 | 2017 | BCS |
| p) Initiate meeting with Department of Education to discuss ways in which school districts can provide support to students returning to the local districts from an institution | Meeting held and future plans delineated | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD |
| q) Partner with appropriate agencies to develop educational materials to educate DMH and CMHC staff, adults with an intellectual/developmental disability, and families/caregivers on the signs of dementia and related disorders | Partnerships and materials developed, materials disseminated | 2013 | 2014 | 2015 | 2016 | 2017 | BIDD, BCS |

# Goal 4 Implement use of evidence-based or best practice models and service outcome measures

***Objective 4.1 Analyze the efficacy and cost benefits associated with implementation of evidence-based or best practices***

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Establish a DMH Evidence-Based and Best Practices Evaluation Council to analyze cost benefits of EBP/BP models, support implementation and training, and evaluate effectiveness and efficiency of models | Council reports and recommendations made | 2013 | 2014 | 2015 | 2016 | 2017 | Representative from each programmatic bureau, Clinical Services Liaison |
| b) Develop a summary of grant programs which currently use EBP/BP models - Inventory of existing EBP/BPs | Grant programs summary developed | 2013 | 2014 | 2015 | 2016 | 2017 | DMH Evidence-Based and Best Practices Evaluation Council |
| c) Develop a report of cost benefit for at least one program in each service population based on comparative national data | Cost benefit report developed | 2013 | 2014 | 2015 | 2016 | 2017 | DMH Evidence-Based and Best Practices Evaluation Council |
| d) Based on analyses, make recommendations regarding programmatic and cost effectiveness of programs | Report of recommendations developed | 2013 | 2014 | 2015 | 2016 | 2017 | DMH Evidence-Based and Best Practices Evaluation Council |

## *Objective 4.2 Support implementation and training of evidence-based or best practices*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Increase the frequency of workforce development opportunities offered to providers (by DMH) focused on EBP/BP models | At least 5% increase in EBP/BP training opportunities each year and demonstrated increase in knowledge of participants | 2013 | 2014 | 2015 | 2016 | 2017 | BWDT, BMH, BIDD, BADS |
| b) Increase the use of e-learning to ensure Central Office staff are well informed and competent in EBP/BP models applicable to their division responsibilities | 10 hours of CEs required each year | 2013 | 2014 | 2015 | 2016 | 2017 | Bureau Directors |
| c) Involve stakeholders by conducting focus groups with consumers, family members and providers regarding their perspective for changes/recommendations | Report of survey results with feedback from stakeholders | 2013 | 2014 | 2015 | 2016 | 2017 | DMH Evidence-Based and Best Practices Evaluation Council |
| d) Develop an e-library of relevant articles, books, etc., to assist in the full implementation of EPB/BP models | Access to e-library at all DMH facilities | 2013 | 2014 | 2015 | 2016 | 2017 | IT, Clinical Services Liaison |

## *Objective 4.3 Evaluate the effectiveness and efficiency of the evidence-based or best practice models relevant to the required service outcomes*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Develop an assessment process to evaluate specific positive service outcomes for each of the core services and DMH consistent with the system-level performance measures developed by the Legislative Strategic Planning Committee | Assessment process developed | 2013 | 2014 | 2015 | 2016 | 2017 | BQMOS, DMH Evidence-Based and Best Practices Evaluation Council |
| b) Incorporate positive service outcome evaluation criteria into the program review process conducted by the DMH monitoring team | Evaluation of service outcomes are reported in monitoring reports | 2013 | 2014 | 2015 | 2016 | 2017 | BQMOS |
| c) Analyze outcomes to refine effective utilization practices and identify deficits and make adjustments as needed | Report findings to the DMH Strategic Planning Subcommittee | 2013 | 2014 | 2015 | 2016 | 2017 | BQMOS, DMH Evidence-Based and Best Practices Evaluation Council |
| d) Review any plan of correction for programs offering core services that are utilizing EBP/BPs but have failed to accomplish positive service outcomes | Plans received and determined if acceptable by BQMOS | 2013 | 2014 | 2015 | 2016 | 2017 | BMH, BCS, BIDD, BADS, BQMOS |
| e) Establish a Clinical Research, Development and Training Collaborative to ensure timeliness in adoption of the most effective and efficient practice models available | Yearly report to DMH Strategic Planning Subcommittee | 2013 | 2014 | 2015 | 2016 | 2017 | BWDT, IT, Clinical Services Liaison |

# Goal 5 Utilize information/data management to enhance decision making and service delivery

## *Objective 5.1 Maximize reporting potential of collected data*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Refine/evaluate reports on client level data from CDR for appropriateness/clinical-programmatic | Reports reviewed for appropriateness | 2013 | 2014 | 2015 | 2016 | 2017 | Clinical/service staff<br>IS Staff |
| b) Modify CDR to allow for capturing length-of-wait data | Included "waiting" as a service in order to track length of wait | 2013 | 2014 | 2015 | 2016 | 2017 | IS Staff |
| c) Disseminate monthly reports when/where necessary (admissions, discharges, recidivism) | Reports produced and disseminated | 2013 | 2014 | 2015 | 2016 | 2017 | IS Staff |
| d) Generate other needed reports based on data elements currently collected for client tracking | Reports produced and disseminated | 2013 | 2014 | 2015 | 2016 | 2017 | IS Staff |
| e) Expand reporting capabilities of the CDR by creating procedures for requesting one-time reports | Availability of ad hoc reports | 2013 | 2014 | 2015 | 2016 | 2017 | IS Staff |
| f) Eliminate duplication in data collection and reporting (electronic and manual) | Streamlined data collection among bureaus and divisions | 2013 | 2014 | 2015 | 2016 | 2017 | IS Staff |
| g) Create applications for viewing and creating reports from website | Website reporting | 2013 | 2014 | 2015 | 2016 | 2017 | IS Staff |

## *Objective 5.2 Develop/expand an electronic collection and reporting system for new reports*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Determine what software/program will be used across all bureaus/facilities | Report summarizing recommendations | 2013 2014 2015 2016 2017 | DMH Representative |
| b) Determine what new reports are required (i.e., Annual Operational Plan, Certification Visit Reports, Provider Management System, Outcome, Managed Care, Disparity Data, etc.) and for whom (i.e. Central Office, C & Y, CMHCs, etc.) | Recommendation made on needed reports | 2013 2014 2015 2016 2017 | Executive Director, Bureau/Division Directors |
| c) Define data for required report | Data elements identified | 2013 2014 2015 2016 2017 | DMH Representative |
| d) Design standardized reports with timelines for implementation | Reports designed | 2013 2014 2015 2016 2017 | DMH Representative |
| e) Implement collection and reporting | Reports produced | 2013 2014 2015 2016 2017 | DMH Representative |

## *Objective 5.3 Establish an electronic exchange of health information between DMH facilities and programs, and MS Health Information Network (MSHIN)*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Determine DMH participation cost for MSHIN | Calculation of cost per facility to participate in MSHIN | 2013 2014 2015 2016 2017 | DMH Representative |

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| b) Determine DMH facilities to join MSHIN | As approved by DMH, number of facilities which join MSHIN | 2013 2014 2015 2016 2017 | DMH Representative |
| c) Report MSHIN Board actions quarterly | Make recommendations for changes/revisions based on the Board's actions | 2013 2014 2015 2016 2017 | DMH Representative |
| d) Determine communication pathway among HIE and EHR | Post evaluation, provided recommendation of pathways | 2013 2014 2015 2016 2017 | DMH Representative |

## *Objective 5.4 Establish electronic health record (EHR) systems at DMH facilities and programs (as mandated and approved by DMH)*

| Action Plan | Performance Indicator | Target Year | Responsibility |
|---|---|---|---|
| a) Develop strategy and priority for implementing EHR systems at DMH facilities and programs | Implementation activities and time frame developed | 2013 2014 2015 2016 2017 | Goal Objective Leader, DMH Electronic Health Record Committee |
| b) Pursue adoption, implementation and upgrades (A/I/U) of EHR | 100% implementation of EHR at qualifying programs | 2013 2014 2015 2016 2017 | Goal Objective Leader, DMH Electronic Health Record Committee |

## *Objective 5.5 Develop a Health Information Technology (HIT) strategy for DMH including policies, standards, and technical protocols while incorporating cost-saving measures*

| Action Plan | Performance Indicator | Target Year | | | | | Responsibility |
|---|---|---|---|---|---|---|---|
| a) Perform Network Security Audit | 100% participation and remediation of network security of DMH Central Office and facilities | 2013 | 2014 | 2015 | 2016 | 2017 | Goal Leader and Facility Director (or as designated) |
| b) Standardize IT Policies and disaster recovery Standard Operating Procedures (SOPs) | Review and standardization of 100% of IT policies and SOPs | 2013 | 2014 | 2015 | 2016 | 2017 | Goal Leader and Facility Director (or as designated) |
| c) Determine future technology needs | Standardization of technology use and dollars saved | 2013 | 2014 | 2015 | 2016 | 2017 | Goal Leader and Facility Director (or as designated) |

# Future Goals

## Fiscal Year 2018 and Beyond…

The goals and objectives for Fiscal Years 2013-2017 are the foundation of the Department of Mental Health's Strategic Plan. However, long-range planning is an essential component of any strategic plan. This section includes generalized objectives for Fiscal Year 2018 and beyond. With the successful completion of short-term objectives, it is expected that these longer-range objectives will become more specific as the time for implementation them moves closer.

### Goal 1 Maximize efficient and effective use of human, fiscal, and material resources

*Explore the use of fiscal intermediaries as a method of allowing individuals greater control over how and where they receive services*

*Obtain new funding for emerging services*

*Increase flexibility in use of funds to support new and innovative services*

### Goal 2 Continue transformation to a person-driven, community-based service system

*Include a self advocate on the Board of Mental Health*

*Develop certification for Transition/Community Resource Peer Specialist (Bridger)*

*Determine need for certification of peer specialists in other specialized areas such as Disaster Relief, Housing, Dual Diagnosis, Forensics, Crisis Intervention, Young Adult, and Family*

*Utilize Consumer Satisfaction Survey data as a resource in measuring a program's overall performance*

*Promote the inclusion of information about the importance of consumer and family involvement into curricula for areas of study such as social work, psychology, counseling, etc.*

*Create a seamless system of community care for individuals with mental health needs*

*Provide crisis services statewide for IDD and A&D*

*Assess need for emerging services*

*Expand the growth of service capacity for existing home and community-based waivers and expand the populations served by the waiver programs*

## **Goal 3** Improve access to care by providing services through a coordinated mental health system and in partnership with other community service providers

*Implement a "No Wrong Door" (single point of entry) approach to accessing information and referral services*

*Integrate mental health care/services with primary health care*

*Increase availability of services at partner locations*

*Implement a true system of care to wrap all services around individuals and their families*

*Increase collaboration and funding from local governments*

## **Goal 4** Implement evidence-based or best practice models and service outcome measures

*Incorporate evidence-based or best practices in all services supported with funding from DMH*

*Establish a research and development center*

*Establish a "Statewide Learning Community" to assist programs in maintaining competent staff*

## **Goal 5** Utilize information/data management to enhance decision making and service delivery

*Increase scope of data analyses by employing a full-time Data Analyst*

*Develop electronic identification card system*

# Implementation

With the Board of Mental Health's approval of the Strategic Plan, work will begin on FY 2013 action plans on July 1, 2012. As in the previous years, implementation of the Plan is goal-based. Goal leaders and team members are assigned to each of the five goals. These dedicated individuals will work on FY 2013's action plans to meet measurable and observable performance indicators.

While progress is ongoing, quarterly reports will be developed and presented to the Board. Reports will also be posted on DMH's Web site for the public. Quarterly reports provide a tracking mechanism to show progress and areas which need to be addressed.

Funding continues to be a roadblock to full implementation of a more community-based and recovery-focused system. Research, partnerships and creative thinking are necessary to overcoming this and other challenges. By working with partners statewide, we can reach our ultimate goal of supporting a better tomorrow for individuals who have mental illness, intellectual or developmental disabilities, substance abuse problems, and Alzheimer's disease and other dementia.

# Acknowledgements

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Listed below are individuals who contributed to specific sections of the revised Strategic Plan.

***Goals, Objectives, and Action Plans***

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# Acronyms

| | |
|---|---|
| A& D | Alcohol and Drug |
| BADS | Bureau of Alcohol and Drug Services |
| BCS | Bureau of Community Services |
| BIDD | Bureau of Intellectual and Developmental Disabilities |
| BMH | Bureau of Mental Health |
| Board | Board of Mental Health |
| BP | Best Practices |
| BQMOS | Bureau of Quality Management, Operations and Standards |
| B2I | Bridge to Independence |
| BWDT | Bureau of Workforce Development and Training |
| C & Y | Children and Youth |
| CDR | Central Data Repository |
| CIT | Crisis Intervention Training |
| CMHC | Community Mental Health Centers |
| CO | Central Office |
| CSU | Crisis Stabilization Unit |
| CQL | Council on Quality and Leadership |
| DMH | Department of Mental Health |
| EBP | Evidence-Based Practice |
| EHR | Electronic Health Records |
| HIE | Health Information Exchange |
| ICF/MR | Intermediate Care Facilities for the Mental Retarded |
| IDD | Intellectual/Developmental Disabilities |
| IS | Information System |
| IT | Information Technology |
| ITS | Information Technology Service |
| LPC | Licensed Professional Counselor |
| MAP Teams | Making-a-Plan Teams |
| MSHIN | Mississippi Health Information Network |
| MOU | Memorandum of Understanding |
| MTOP | Mississippi Transitional Outreach Program |
| OCS | Office of Consumer Support |
| PACT | Program of Assertive Treatment |
| SED | Serious Emotional Disturbance |
| SMI | Serious Mental Illness |
| SOP | Standard Operating Procedures |