FREQUENTLY ASKED QUESTIONS

- What are we hoping to accomplish with this plan?
  - What problems or weaknesses will this plan address?
  - What strengths will it build on?
  - What is the driver of the plan? Is it a mandate? Is it to reduce costs?
  - How is this different from what we’re currently doing?

This idea is not yet a plan. The impetus behind the idea is to determine how we can be ready to deliver behavioral health services in a transformed healthcare environment such as the one delineated in the Affordable Care Act or ACA (also known as Health Care Reform). As the idea is further explored, a concrete plan will be developed that will build on our strengths as a behavioral health system and will carefully identify opportunities for improvement. This concept does not intend to reduce costs per se: its focus is on high quality services delivered in an equitable way, and administered with efficiency, transparency and accountability. The differences with respect to our current operation will be apparent as the plan is developed.

- How would centralized services work in this model?
  - How would specialty services work (subject matter expertise)?

These questions will be thoroughly analyzed during the plan development stage. These are key issues on which the success of any plan will rely heavily.

- How will the model truly ensure equity across CSAs?
  - Different communities have very different community-based resources.
  - How will this model ensure that unserved and underserved communities have increased access to services?
  - Concern about distribution of financial resources across CSAs
  - How will clients be better served in this new model?

It is too early in the process to answer these questions. However, achieving equity in terms of resource investment and services with a focus on unserved and underserved communities is a guiding principle of the process. Delivering a superior service experience to clients is a central aim of the concept.

- What are the criteria for determining CSAs?
  - Geography? Client density? Other?
  - How many CSAs will there be?
  - How will “community” be defined for the purpose of determining CSAs?
Concern that the first minority in a given area will be considered the “voice of the community” (What about “second minorities”?)

Geography, client density, community assets, County resources, are some of the issues that will be taken into consideration when determining CSAs. At this stage in the process we cannot answer the question about how many CSAs there will be; the answer to that question will depend on the analysis of geography, client density, etc. that will be performed to that effect. As we develop some possibilities we will be conferring with people from the community.

- **How much will this cost?**
  - **How will this be paid for?**

  It’s too early in the process to answer this question. There is no pre-determined budget. We are approaching this as cost neutral.

- **People really liked the Community Planning Committee and the 51% membership of consumers and families**
  - **Concern about building capacity in consumers/family members so that their participation is meaningful**
  - **Concern that it will be very hard to reach the 51%**
  - **Desire to reach out beyond the “usual suspects”**
  - **People think that this model will be more responsive to the needs of communities**

We foresee the need for resources to be directed to build capacity of clients and family members to participate meaningfully not only in the development of CSAs but in their continued operation. Outreach to stakeholders who are not currently engaged with BHRS will be actively pursued to ensure diversity and plurality of voices. We agree with the assertion that this model has the opportunity to be more responsive to the needs of communities.

- **The CSA model will improve access to services**
  - **Flexible hours approach is perceived as very positive**
  - **Concerns from staff about having to work after hours or on weekends, or having to do more with less**
  - **Same day access is also perceived as very positive**
  - **Concerns that this might not be feasible everywhere**

Flexible hours and same-day access are examples of ingredients of a “good and modern” addictions and mental health services system. We will work to find out what that could look like for our communities. This doesn’t necessarily mean that these aims will have to be accomplished by County staff, or that they will be accomplished in the same way in all CSAs; the whole idea is to be open to specific needs of specific communities. During the plan development phase we will explore these issues further.
- **Staffing issues**
  - Will there be enough resources to do the level of training and workforce development that the model will require?
  - Will training and workforce development also be available to community partners (agencies and consumers/family members participating in the Community Planning Committee)?
  - Will there be more flexibility in terms of staff work hours?
    - Telecommuting alternatives?

While it is still too early in the process to offer specifics about these questions, it is worth noting that another guiding principle of this idea is that whatever plan is developed, it will have to be realistic and give thorough consideration to human resources at all levels (County and community partners’ staff, clients/consumers, family members, etc.), and surrounding issues such as training and workforce development. This includes exploring different configurations of work schedules.

- **How will Access work in this regionalized model?**

This question will be answered during the plan development phase. It is hard to say at this point.

- **Is this working elsewhere? (Other counties or other industries)**

Regionalized, community-driven structures are not new in the healthcare/behavioral health arena. Since we want to develop a structure that is tailored to the particular make up and characteristics of our County, we want first to identify what do we think will work for us, and then search for similar models to build on their learnings.

- **Technology**
  - Access to data across systems
  - Adequate hardware and software
  - Use of technology for service provision
    - Social networks
    - Texting
    - Facebook, FaceTime, Skype, others
    - Telemedicine

While providing specifics is not possible at this time, we are acutely aware of the important role that technology will play in the future of everything, including behavioral care. As plans are developed, the intersection with technology will be explored with the flexibility it deserves.
• Integration
  o Will this plan help or get in the way of further integration between MH and SU, and with PC?
  o How will it be ensured that SU services are available at every CSA, at the level they are needed? (Concern about disparity in resources between AOD and MH)

The idea as it was conceived has integration at its core. The CSA structure is intended to further advance our work in providing integrated care.

• Related issues people are concerned about
  o Housing services
  o Transportation

These issues will be explored during the plan development phase. The BHRS leadership acknowledges their importance and relevance to the lives of those we serve.