MIDD Briefing Paper

ES 2a Caseload Reduction for Mental Health

Existing MIDD Program/Strategy Review X **MIDD I Strategy Number ___2a_____ (Attach MIDD I pages)**
New Concept ☐ **(Attach New Concept Form)**
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: The MIDD I workload reduction strategy was designed to increase the number of direct service staff in participating community mental health (MH) agencies. By funding more or different staff positions, overall caseload size can be reduced with the goal of improving the frequency and quality of services delivered to clients. In 2008 when the workload reduction strategy (MIDD 2a) was implemented, the mental health agencies providing services in the system were given an allocation of the MIDD Strategy 2a funds based on the share of mental outpatient clientele they had enrolled. The funds were to be used to add direct service staff, including clinicians, vocational specialists, housing specialists and/or peers. The additional staff were added to reduce the workload of case managers/therapists providing outpatient treatment services in the mental health outpatient system. This paper proposes to continue this strategy and expand it to all the contracted out-patient treatment providers, including substance use treatment providers, under the new integrated Behavioral Health Organization.

Collaborators:

Name	**Department**

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	**Role**	**Organization**
Dana Ritter	CFO	BHRD

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

The MIDD I workload reduction strategy was designed to increase the number of direct service staff in participating community mental health (MH) agencies. By funding more or different staff positions, overall caseload size can be reduced with the goal of improving the frequency and quality of services

delivered to clients. This strategy is also aligned with goals of the Recovery and Resiliency-Oriented Behavioral Health Services Plan adopted through Ordinance 17553 in April 2013.

In 2008 when the workload reduction strategy (MIDD 2a) was implemented, the mental health agencies providing services in the system were given an allocation of the MIDD Strategy 2a funds based on the share of mental outpatient clientele they had enrolled. The funds were to be used to add direct service staff, including clinicians, vocational specialists, housing specialists and/or peers. The additional staff were added to reduce the workload of case managers/therapists providing outpatient treatment services in the mental health outpatient system. This paper proposes to continue this strategy and expand it to all the contracted out-patient treatment providers, including substance use treatment providers, under the new integrated Behavioral Health Organization.

A unique feature of the strategy is that it was targeted to the Medicaid funded outpatient mental health system. Targeting the Medicaid outpatient programs allowed King County to use the strategy funds as a matching fund for Medicaid doubling the amount of funding available to achieve the goals of the strategy, so $4 million of MIDD funds brought in a total of $8 million to be distributed to providers to reduce caseloads.

Peer Support Specialists are one of the many direct service staff types that contribute to reduction of the workload for case management and clinical staff. They provide a range of services in the community and at area MH agencies. They include youth peers, parent partners, and peers working with adults and older adults. One valuable aspect of a peer support specialists' work is the proof they provide to people also living with behavioral health issues, and to professional staff, that recovery is possible. Peer Support Specialists serving adults and older adults provide many types of one-on-one and group services.

Population of Focus: Children, youth, adults, and older adults receiving outpatient mental health services through the King County RSN.

Total number served (and Numbers Served annually): Year 5 Target: 16 agencies participating. 6 Month Progress: 17 agencies participating. Projected Percent of Annual Target: 106%

Outputs (annually): In the Fifth Annual report, it was reported that in April 2012, a new mental health agency, Atlantic Street Center, began participating in the workload reduction strategy. This is the first new agency participating since the strategy was implemented in November 2008. Over a four-year period, average caseloads have reduced 17 percent, from 42 clients per direct service staff member to 35. In contract reports submitted by providers, they explain the types of staffing increases made and the impact of those changes.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☐ **Crisis Diversion** ☐ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

The reduction of treatment caseloads provides for better treatment services ,promoting the achievement of recovery outcomes for clientele. Additionally, caseload reduction results in higher job

satisfaction for treatment staff, thereby reducing staff turnover, which is a critical system improvement in the mental health treatment system.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

Case management is the primary model of service delivery in public community mental health in the United States (US) and among comparable countries around the world (i.e. Australia, United Kingdom (UK), etc.).[1] Caseload size is highly variable in the US, ranging from caseloads of 10 to 25:1 in intensive case management models such as Assertive Community Treatment (ACT), to 40-50:1 in standard outpatient mental health settings. [2] Data clearly suggests that there has been upward movement in caseload size since the introduction of managed care. Although King County data also demonstrates great variability in caseloads across agencies and types of service provided, average caseload fits within the ranges reported above with average caseloads of 40:1 (MIDD 4th Annual Evaluation Report, year 3). Studies have suggested that caseloads in excess of 20 to 30 would result in reactive case management, with deficiencies in service planning, support for families and caregivers and liaison with other services.[3] When faced with high caseloads, case managers are more likely to deal with crises and immediate problems[4] with a resulting negative impact on activities such as timely response to client needs, documentation of work, receptiveness to urgent client needs, contact during hospital admissions, home visits and advocacy.[5]

In addition to the impacts cited above, there is evidence that higher caseloads are also associated with increased work-related stress, especially stress associated with workload and professional self-doubt. Higher caseload was also associated with lower case manager personal efficacy.[4] Increased job stress can exacerbate issues of staff burnout and pose problems with the recruitment and retention of case managers[6], in addition to impacting health and safety outcomes and the quality of care provided to

[1] Burgess P, Pirkis J. The currency of case management: benefits and costs. Curr Opin Psychiatry 1999; 12: 195–199.

[2] King, Robert (2009) Caseload management, work-related stress and case manager self-efficacy among Victorian mental health case managers. Australian and New Zealand Journal of Psychiatry, 43(5), pp. 453-459.

[3] Intagliata J. Improving the quality of community care for the chronically clinically mentally disabled: the role of case management. Schizophr Bull 1982; 8: 655–674.

[4] King R, Le Bas J, Spooner D. The impact of caseload on mental health case manager personal efficacy. Psychiatr Serv 2000; 52: 364–368.

[5] King, R., Meadows, G., & LeBas, J. (2004). Compiling a caseload index for mental health case management. Australian and New Zealand Journal of Psychiatry, 38, 455-462.

[6] Evans, S., Huxley, P., Gately, C., Webber, M., Means, A., Pajak, S., et al. (2006). Mental health, burnout, and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry , 188*, 75-80.

clients.[7] These findings support the need for active management of caseloads to minimize risk of overload.[2]

Although not the subject of a formal research study in King County, the issues outlined above have been reflected anecdotally by outpatient mental health provider agencies, as well as individual clinicians throughout King County, which led to the development of the initial MIDD Strategy 2a to specifically address workload reduction.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

MIDD Strategy 2a addresses the negative impact of large caseloads as described in #1 above by providing dedicated funding to enable agencies to add additional staff and reduce caseload size. The strategy was intended to address the following program goals as part of the larger system goal of reducing the number of people with mental illness who use more costly interventions such as jails, emergency rooms and inpatient care:

- Achieve a reduction in outpatient caseloads to allow case managers to see clients more regularly to assist them to achieve greater stability and recovery, as well as be more responsive to clients who are in crisis.

- Decrease case manager turnover due to high caseloads, thus creating a more stable and effective workforce.

Sixteen provider agencies were asked to develop and implement a specific plan for reducing staff workload to address variations in agency size, case mix and workload allocation among agency staff. Agencies were given some latitude in determining what positions would provide the most impact toward reducing caseloads in their setting, though workload reduction plans required approval by the County. Workload reduction plans incorporate a variety of professional and paraprofessional positions such as peer support specialists, housing specialists, mental health clinicians, case managers, intake specialists, nurse practitioners, etc.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

The primary focus of MIDD Strategy 2a was to increase the number of direct services staff and improve services delivered to individuals in recovery for mental health issues. Evaluation efforts to date have assessed whether staff-to-client ratios went up, stayed the same or went down (MIDD Seventh Annual Evaluation Report, year 6). Evaluation data over a four-year period shows average caseloads were reduced by 17 percent (MIDD Fifth Annual Report, year 4). Evaluation also reported an increase in number of direct service providers attributed to strategy funding with the highest number recorded at

[7] Priebe, S., Fakhoury, W., Hoffman, K., & Powell, R. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social Psychiatry Psychiatric Epidemiology , 40*, 223-232.

145 additional staff system-wide in March of 2011 (MIDD Fourth Annual Report, year 3), which is an increase from the initial 110 additional system staff proposed in the original plan for this strategy.

MIDD evaluation to date has not systematically looked at the impact of caseload reduction on the quality of client care or the impact on case manager turnover/staff morale; however, there is anecdotal evidence that there have been favorable outcomes related to services for clients. For example, an agency used Strategy 2a funds to hire Licensed Practical Nursing staff to increase their ability to provide health and wellness services to clients and coordinate basic health care services. This resulted in reduced workload for current staff, as well as specialized health care services for clients (e.g. smoking cessation, metabolic screening, etc.) and coordination of care with both internal medical providers and external primary care services. Another agency used MIDD funds to hire a Parent Peer Support Specialist who supports and connects with other parents of children receiving services, providing a bridge between the professionals and family and assisting families to navigate multiple, complex systems (MIDD Sixth Annual Report, year 5).

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Although MIDD strategy 2a does not describe a service and is not a particular evidence-based practice model to be delivered, it does incorporate elements of several evidence-based practices that have a research base, such as Assertive Community Treatment (ACT), Intensive Case Management (ICM) that incorporate reduced (smaller) caseloads as part of the model in order to improve continuity of care and individualized attention[8] for clients in behavioral health treatment.

In addition, although Strategy 2a does not currently prescribe the type of position that agencies include in their Workload Reduction Plans other than that the positions must be direct service positions, many agencies have chosen to use funding for various types of peer support staff as a means to reduce caseload and improve client engagement and participation in services. Consumer-driven services have emerged as a best practice in expanding the continuum of care of beneficial services, with a growing body of research demonstrating consistently positive results.[9]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

As described in #3 above, the MIDD Fifth Annual Report, Year 4, reported that over a four-year period, average caseloads have reduced 17 percent from 42 clients per direct service staff member to 35. Anecdotal evidence from agencies through contract reports and site reviews have also described a positive impact on staffing ratios and enhancements to programming. Going forward, it would be expected for caseloads to remain at this level.

[8] William O'Donohue, Nicholas A. Cummings (2011). *Evidence-Based Adjunctive Treatments*. Academic Press, 341.

[9] Salzer, M. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. Psychiatric Rehabilitation Skills, 6(3), 355-383.

Future outcomes of this strategy that would be important to assess going forward include the concrete impact on service delivery and client outcomes (i.e. Do clients receive more and better services? Do they experience better recovery outcomes?, as well as the impact on staff satisfaction and turnover rate.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☒ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☐ **Immigrant/Refugee**
☒ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☐ **Anyone**	☐ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**
☒ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.
The population includes anyone receiving outpatient mental health services through the publicly-funded system.

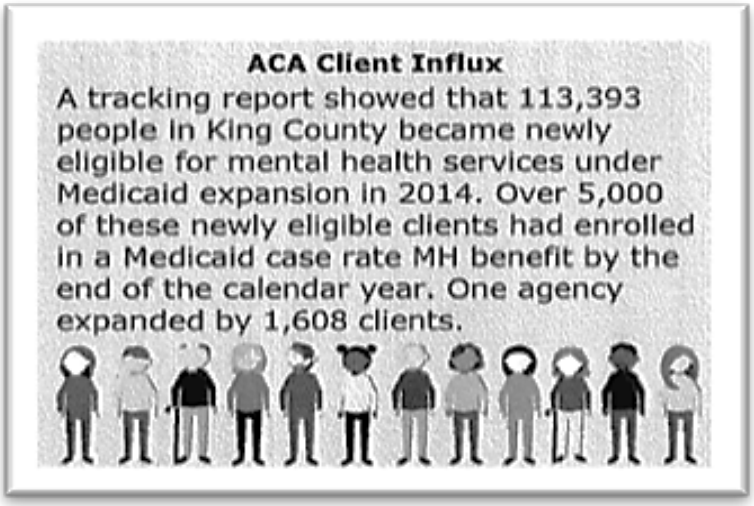
2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**:
County-wide
The caseload reduction funds were provided to mental health providers whose clinics are located throughout King County.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**
The key collaboration is with treatment providers who are the recipient of the funds and who need to use those funds to hire direct service staff.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

MIDD Seventh Annual Report, Year 6, identifies two key issues that have impacted agency caseloads, despite the availability of MIDD monies to alleviate out-of-control growth: 1) the recent influx of newly eligible clients through the Affordable Care Act (ACA), and 2) the long-standing challenges of hiring and retaining qualified staff to provide care within our mental health system.



2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

The key barrier to implementation of the strategy is the lack of available staff resources. The lack of available qualified staff is the primary challenge. Mental health provider agencies continue to tell BHRD that they are having significant problems recruiting and retaining qualified staff.

Remedies for the lack of staff are increases in funding that allow for increased staff wages, and more educational programs that provided the needed knowledge and skilled based training for individuals who wish to work in the behavioral health system.

An additional barrier to implementation is that there are at least twice as many providers that will be eligible for funds from this strategy under the new Behavioral Health Organization that will be implemented in 2016. The amount of funding needed from the MIDD II will double and the amount of Medicaid match funds from the state may not be available for double the amount of local funds.

3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?

There are no specific unintended consequences if the strategy is implemented.

4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?

The consequence of not implementing the strategy is that caseloads for clinicians will on average be over 50 persons per clinician. Additionally, the clinician will have to be prepared to provide support for all of the needs of their clientele without the assistance of specialists (e.g., housing specialists, vocational specialists, or peer support workers).

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

This strategy was put into place due to a lack of funding for behavioral health services that resulted in providers receiving inadequate funding to deliver services under the Medicaid program. If increased funding were provided by the federal and state governments for behavioral health would address the health services with the state legislature and congress is needed.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This strategy enhances the services provided to individuals receiving services in the behavioral health system. The increased staff capacity and the staff with specialty knowledge like vocational or housing contribute to recovery outcomes and health improvements for people in the service system. Improving the health and wellbeing of county citizens is the focus of all of the county initiatives.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

As stated above, enhanced staffing in the treatment system promotes more effective treatment and improved recovery and resilience outcomes for individuals in treatment.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

Strategy 2a, as part of the behavior health outpatient program, targets identified populations with multiple barriers to access and a high need for services to address mental health, substance use disorder and other needs like trauma history, i.e. persons of color, refugee/immigrant, persons with disabilities, etc. and prioritizes services to people in their own language. Emphasis is also placed on cultural responsiveness in addressing the unique perspectives and impact of mental health and substance use disorder within different populations. The proposed expansion would fund additional agencies that provide services within and specifically tailored for marginalized and underserved communities.

F. Implementation Factors

1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)**?**

The resource needed to implement the strategy is qualified staff. When agencies hire additional staff there often is a need for additional office space and equipment.

2. Estimated ANNUAL COST. More than $5 million Provide unit or other specific costs if known.

In order to implement the caseload reduction strategy throughout the behavioral health provider network the funds will need to be increased significantly over the original strategy. The total funds needed will be $7.5 million as long as the state can provide a match of an equal amount for a total amount of $15 million available to distribute to behavioral health providers. There is a risk that the state may not have Medicaid funds available to match the all of the MIDD funds.

3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

See discussion above; the state allows King County to use the MIDD funds to match Medicaid funds so the funds available to the strategy are doubled with the use of Medicaid funds.

4. TIME to implementation: Less than 6 months from award

a. What are the factors in the time to implementation assessment?

Historically, agencies were notified of the funding available and were required to submit a plan as to number and type of staff they would be adding to their outpatient program. That process has taken two months in the past. Once the plan is approved the recruitment and hiring of qualified staff may take another two to four months.

b. What are the steps needed for implementation?

See the information directly above.

c. Does this need an RFP? No, the funding is provided for existing outpatient providers in the BHRD network.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Strategy Title: Improve Quality of Care

Strategy No: 2a - Caseload Reduction for Mental Health

County Policy Goal Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

As a result of state mental health funding allocation decisions, the funding King County Regional Support Network (RSNs are counties and groups of counties that manage publicly funded mental health services through contracts with the state) receives for mental health services have not kept up with the increased costs of providing those services. This has led to increases in the size of community mental health center case loads over the years, compromising quality of care and negatively impacting the system's ability to hire and retain staff.

Large case load sizes negatively impact a case manager's ability to maintain regular contact with consumers. Regular contact allows the case manager to: assist consumers in developing their own illness management strategies; provide psycho-education; provide motivational interviewing for pursuing supported employment services; monitor fluctuations in symptoms so that medication adjustments can be recommended; and provide other treatment services that contribute to consumers' stability and recovery. With very large case loads, case managers are limited in their ability to provide routine rehabilitation services and instead primarily respond to crises.

◊ *B. Reason for Inclusion of the Strategy*

Dedicated funding to enable agencies to add additional staff and reduce case load sizes would have a substantial benefit for those being being served as well as for those providing the services. Decreased case loads would enable case managers to respond more quickly when their clients are in crisis. Clients could be seen sooner after being discharged from jails or hospitals. More time could be spent with clients to meet their goals and to provide the supports they need. This strategy is consistent with the goal of reducing the number of people with mental illness who use more costly interventions such as jails, emergency rooms, and inpatient care.

◊ *C. Service Components/Design*

Case management services may be provided in different ways and by varied staff across the network of RSN contracted mental health providers. Services such as money management, helping individuals shop for food or take care of their

apartments, medication management, vocational services, and education may be provided by mental health case managers, peer counselors, vocational specialists, or financial workers, depending on the agency. Additional funding will be provided to decrease outpatient caseloads at community mental health agencies, across the system. Planning is still taking place to determine how to take into account the variation across the system in how, and by whom, case management services are provided. Among the variables are the following:

- Variation in case load sizes that are reported to be from 20 or 25 to as large as 80 clients per case load
- Case mix-- the relative severity of consumers' illnesses within and across caseloads
- Different models for providing services (for example, if one agency has a vocational specialist providing vocational services and another has the case manager provide that service, the responsibilities and workloads for the case managers are different, and case load size could be adjusted accordingly)
- Some agencies pay higher salaries and may have higher caseloads, while others have kept lower caseloads, but pay lower salaries.

There will need to be ongoing discussions with stakeholders to determine the best way to achieve the goals of this strategy, including determining how case management caseloads will be measured, and which staff providing which services should be considered in determining case loads.

◊ *D. Target Population*

Children, youth, adults, and older adults receiving outpatient services through the King County Regional Support Network.

◊ *E. Program Goals*

- Lower outpatient mental health case loads to allow case managers to see consumers more regularly to assist them to achieve greater stability and recovery, and to be more responsive to consumers who are in crisis, particularly those who are in, and exiting from, jails and hospitals.
- Decreased case manager turnover due to high caseloads, which will lead to a more stable and effective work force as well as savings related to training and orientation of new staff.

◊ *F. Outputs/ Outcomes*

- Addition of up to 110 new staff, including peer counselors, mental health professionals, and supervisors.
- Reduction of system-average case loads by a percentage yet to be determined. (Original calculations on the estimated percentage decrease did not include some variables identified in discussions with mental health providers, such as supervisory positions needed to support new case managers and additional space requirements).

- The expected outcomes of lower caseloads are reductions in emergency room utilization, hospital admissions, criminal and juvenile justice involvement, and prevention of out of home placement for children.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sept- Dec 2008	Provide funds to contracted mental	$1,750,000

	health agencies to begin hiring additional case managers.	
	Total Funds 2008	**$1,750,000**
Jan – Dec 2009	Continue ramp-up of staff, complete by end of year. $3,500,000 will be MIDD funds and $1,500,000 will be additional federal matching funds.	$5,000,000
	Total Funds 2009	**$5,000,000**
Ongoing Annual	**Total Funds**	**$7,000,000**

Ongoing total funding assumes additional federal matching funds. MIDD Action Plan funds will be $4 million, and federal match will be $3 million.

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

- 16 RSN mental health outpatient providers and subcontracted youth service providers.
- As many as 110 new case managers and supervisors added.

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

Supervisor training for staff moving into new role: Ongoing while staffing increases are underway.

◊ *C. Partnership/Linkages*

RSN Mental Health Provider agencies and subcontracted agencies.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

- Stakeholder Process to develop implementation strategy: May-July 2008
- Contracts amended: August 2008
- Agencies begin hiring process: September 2008
- Case load reduction completed: December 2009

◊ *B. Procurement of Providers*

Proposed timelines Not Applicable

◊ *C. Contracting of Services*

Existing contracts amended: August, 2008

◊ *D. Services State Date(s)* September 15, 2008