

**Community Mental Health of  
Ottawa County  
2008 Systems Look**

# Goals and Objectives

## Four Central Tasks

Task One: Summary of the 2008 Systems Look

Task Two: Present System Change  
Recommendations

Task Three: Present Current Status of Implementing  
System Change Recommendations

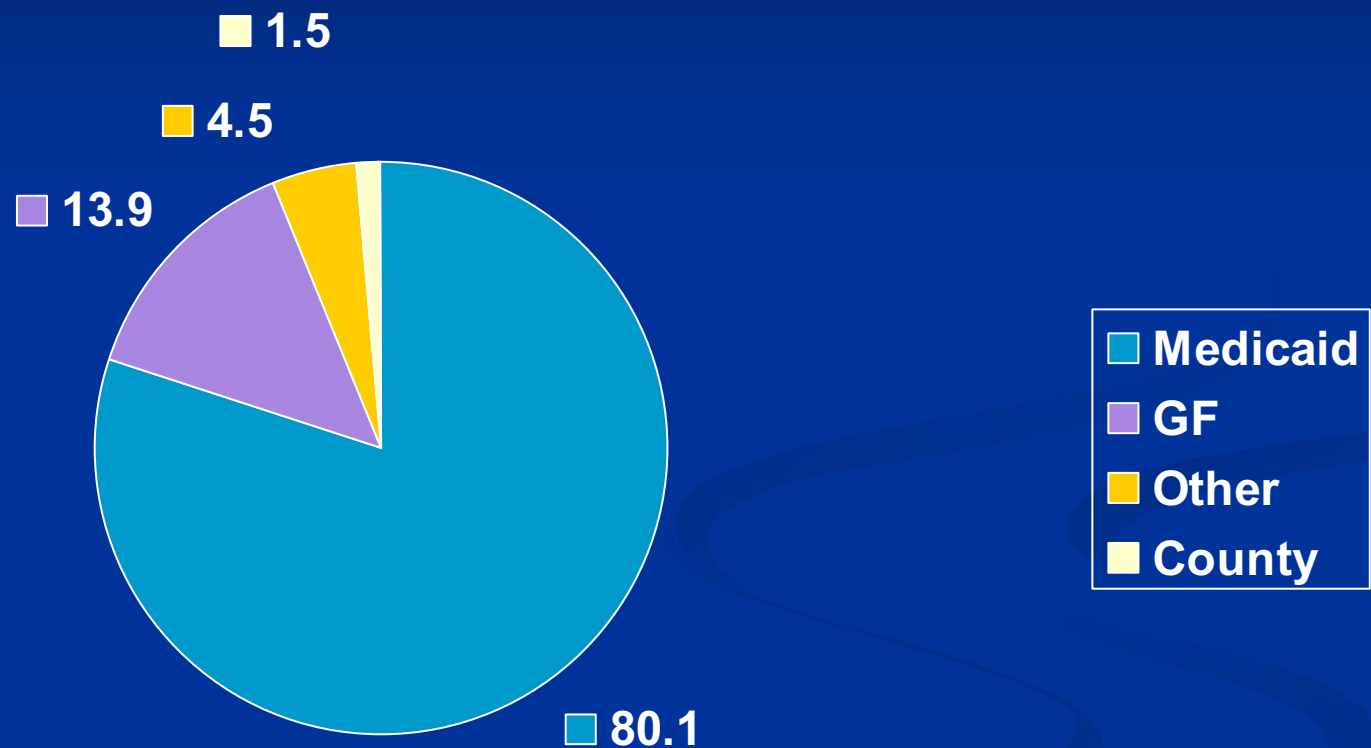
Task Four: Current Budget Situation

# Summary of the 2008 Systems Look

# SOMETHING TO CONSIDER

Mental Health Services  
were developed in the context of the  
**MENTAL HEALTH CODE**  
and not  
the **MEDICAID CONTRACT**

# Sources of Revenue



# Sources of Revenue

	<u>FY 06/07</u>	<u>FY 05/06</u>
Medicaid	\$ 25,078,659 (80.1%)	\$ 23,360,365 (78.3%)
State General Fund	\$ 4,355,683 (13.9%)	\$ 4,545,432 (15.2%)
Other	\$ 1,402,407 (4.5%)	\$ 1,447,181 (4.9%)
County of Ottawa	\$ 476,500 (1.5%)	\$ 476,500 (1.6%)
<b>Total Revenue</b>	<b>\$ 31,313,249</b>	<b>\$ 29,829,478</b>

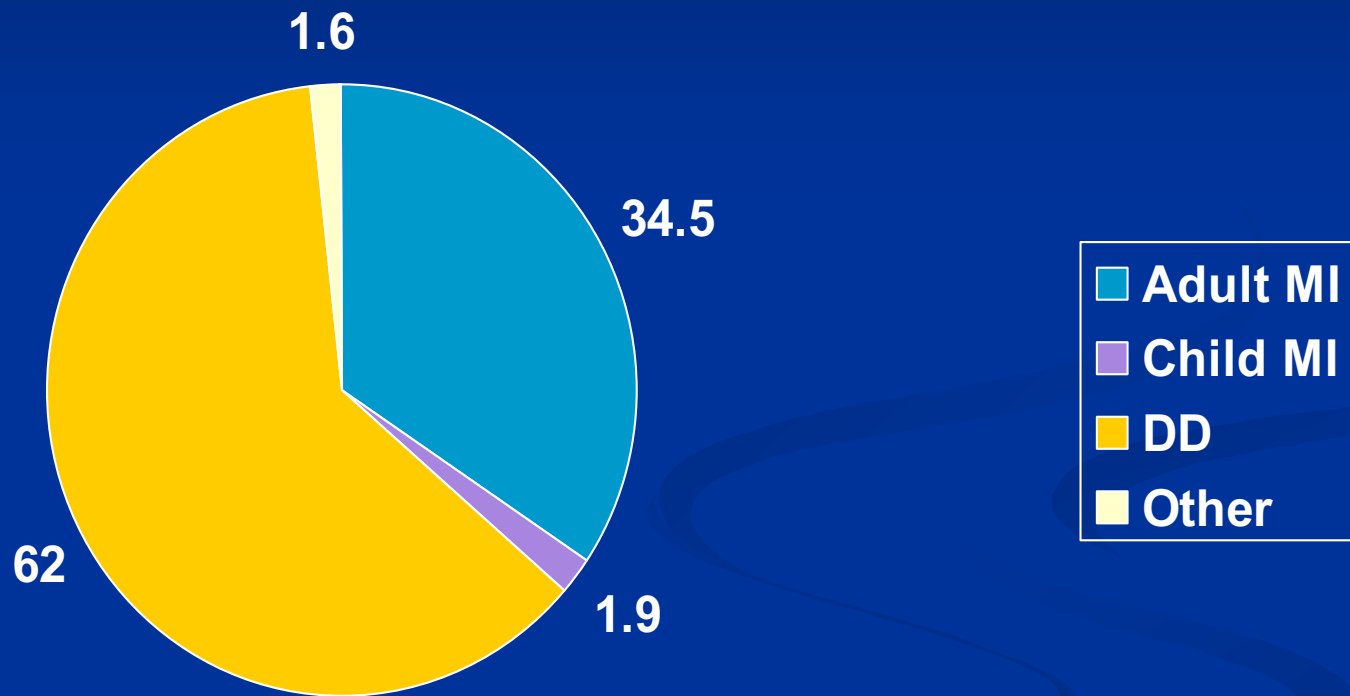
# Why Is This Important?

- 80% of all Revenue (Budget) can ONLY be used for Consumers who receive Medicaid

# Why Is This Important?

- This leaves only 20% of the CMH budget to address the following:
  - Moderate Mental illness
  - Severe Mental Illness for the non-Medicaid population
  - Jail Services/Diversion (since Medicaid cannot be used for those in jail)
  - Juvenile/Court services
  - Youth-to-Adult Transition for all non-Medicaid Consumers
  - Hospitalization cost for the non-Medicaid Population
  - All State Facility Costs regardless of funding source
  - All residential treatment costs for non-Medicaid Consumers
  - Co-occurring disorders (non-severe)
  - And the list goes on and on!

# Expenditures by Population



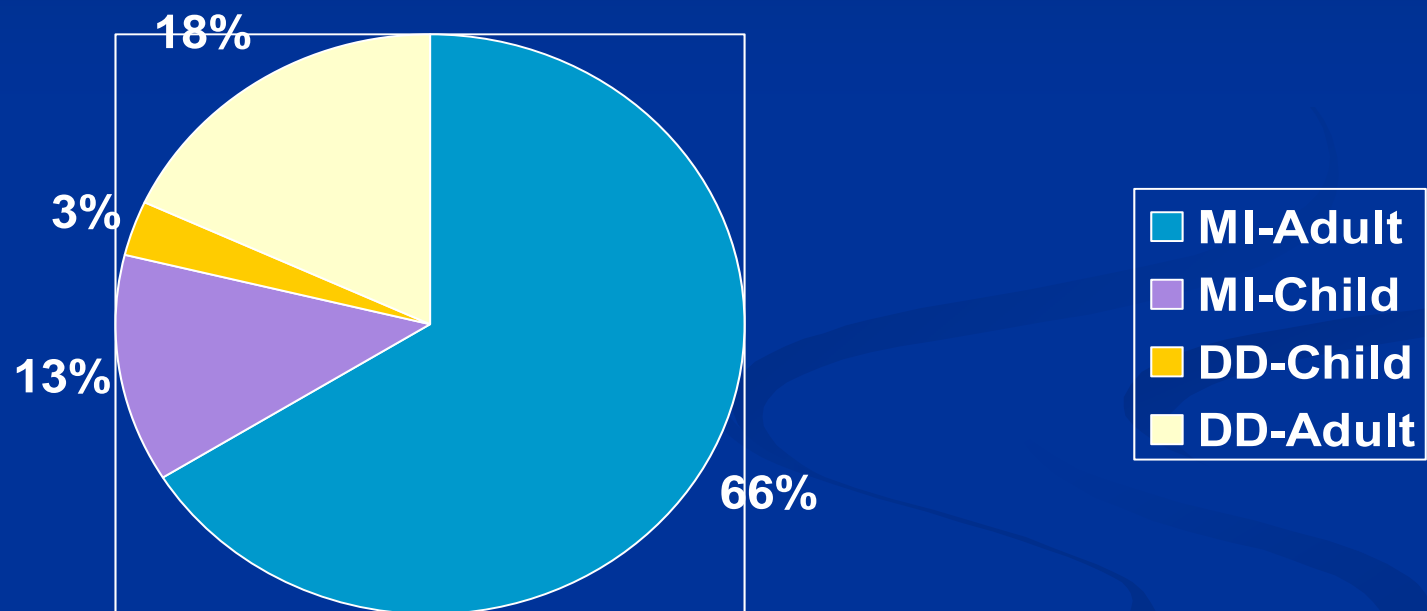
# Expenditures

	<u>FY 06/07</u>	<u>FY 05/06</u>
Adults with severe and persistent mental illness	\$ 10,803,615 (34.5%)	\$ 10,349,781 (34.7%)
Children with serious emotional disturbance	\$ 586,973 (1.9%)	\$ 530,932 (1.8%)
Persons with a developmental disability	\$ 19,426,643 (62.0%)	\$ 18,380,435 (61.6%)
Other	\$ 496,018 (1.6%)	\$ 568,330 (1.9%)
<b>Totals</b>	\$ 31,313,249 (100%)	\$ 29,829,478 (100%)

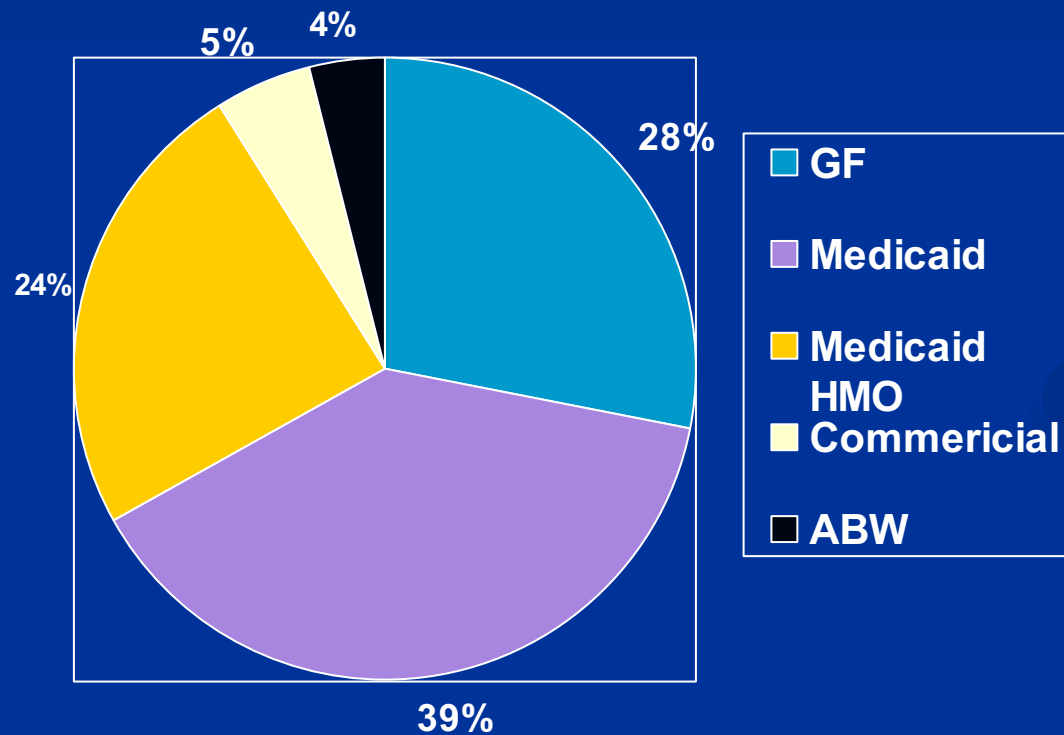
# Why is this Important?

- DD services make up over 62% of all Expenditures
- MI Child only accounts for 1.9% of all expenditures

# General Findings: Population Served



# General Findings: Population by Funding Source



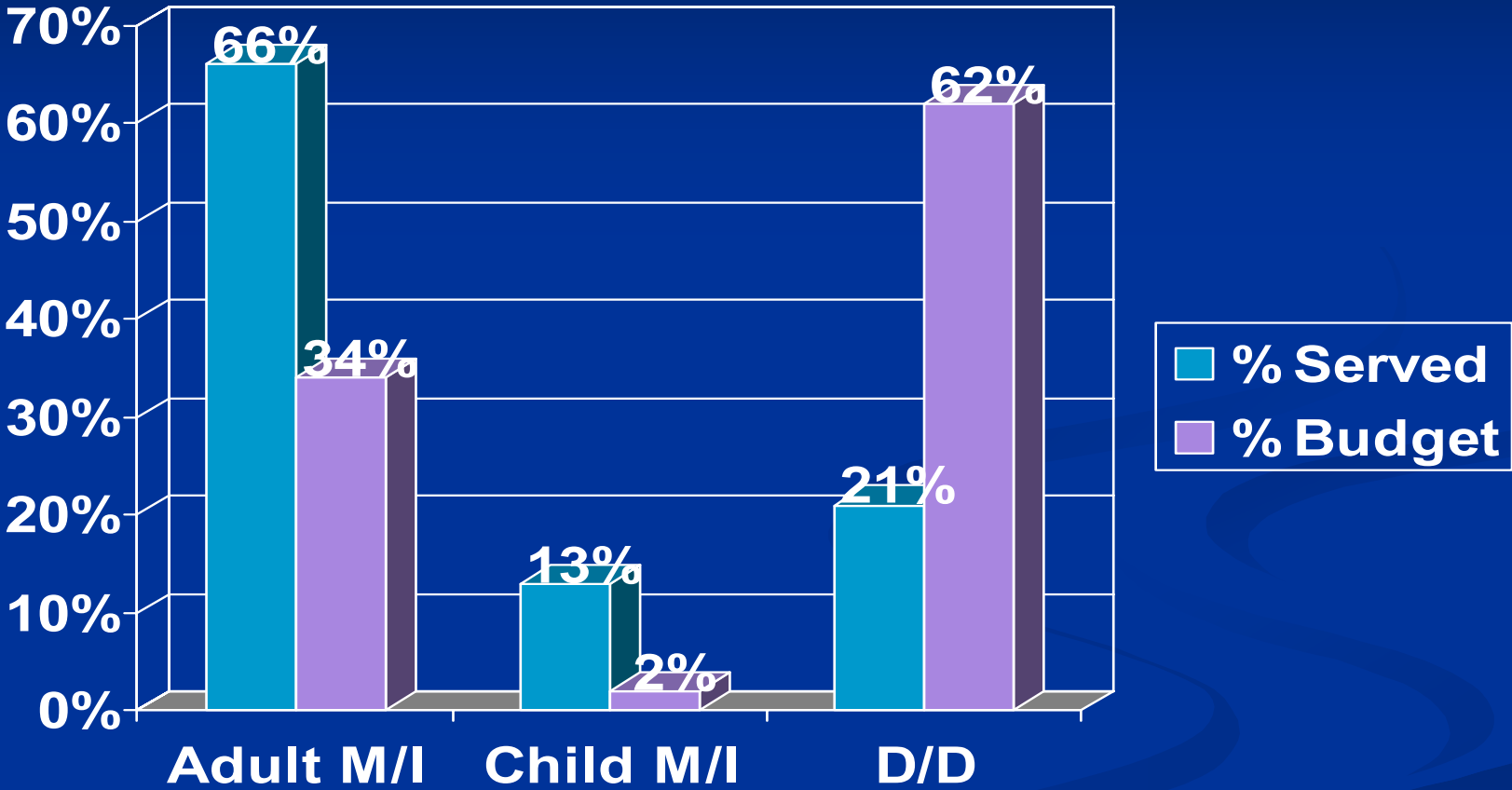
- 57% non-mandated Cases
- 39% Mandated Full Service requirements

# General Findings: Population Served

Population	2006/2007	2005/2006
Adults with severe and persistent mental illness	2042 (66%)	1938 (65%)
Children with serious emotional disturbance	393 (13%)	401 (13.5%)
Persons with a developmental disability	A: 562 (18%) C: 107 (3%)	625 (21%)
<b>Total Served</b>	<b>3104</b>	<b>2964</b>

# Why Is This Important?

## Population Served Compared to Budget

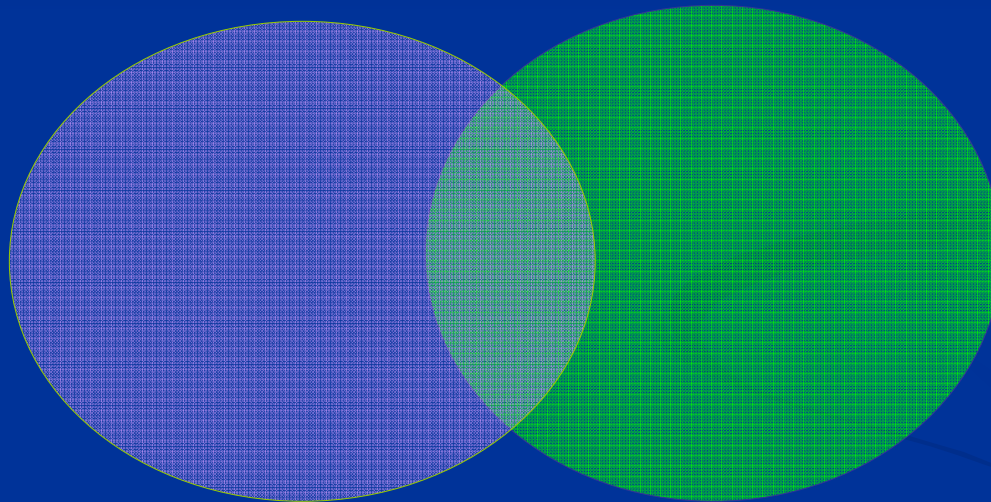


# System Look Data and General Findings

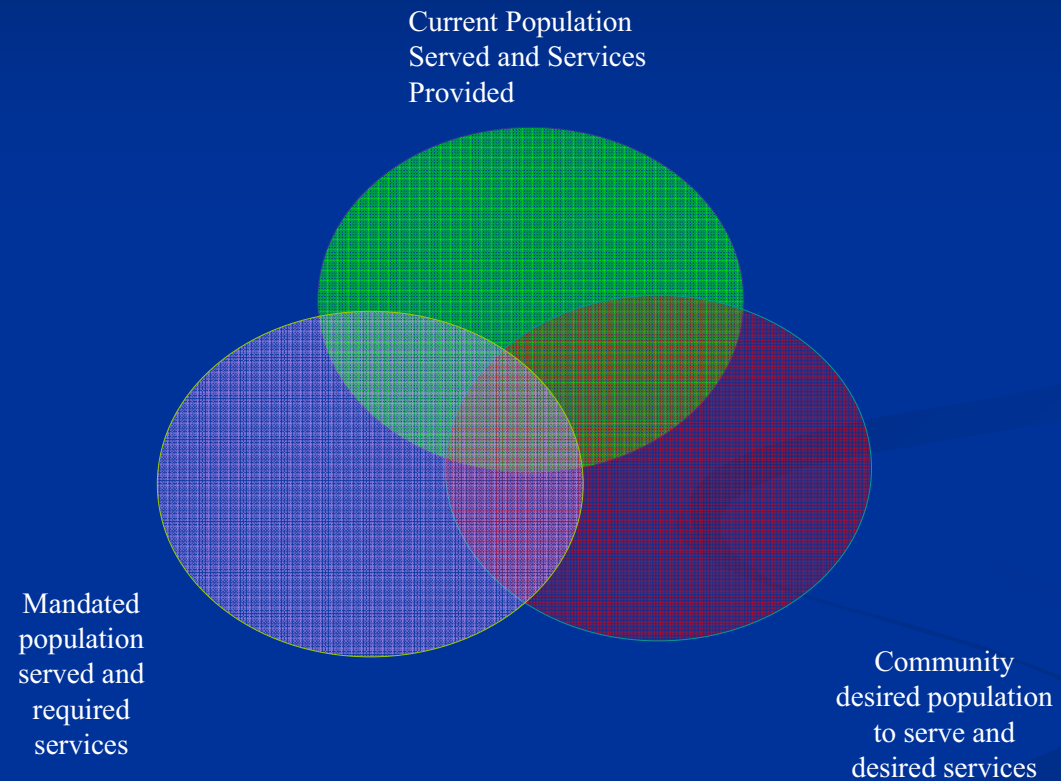
# Systems Look Relational Representation

Mandated population served  
and required services

Current Population Served  
and Services Provided



# Figure One: Systems Look Relational Representation



# Review of Work Group Findings

Mandated/Required Services

Greg Hofman, Work Group Chair

# Work Group Participants

- Greg Hofman-Quality Improvement
- Betty O'Rourke-DD Services
- Jane Longstreet-MI Services
- Albert Doorn-Residential Services
- Jennifer Luzum-Administrative Services
- Gentry Mohr-Recipient Rights
- Michael Brashears-Administration

# Work Group Charge

- Analysis of regulatory and contractual requirements and obligations to determine the following:
  - Who is CMHOC required to serve?
  - What Services are CMHOC required to provide?
  - Are there different service requirements for different funding sources (Medicaid, General Fund)?
- What MOU's (Memos of Understanding) are CMHOC engaged in?

# Data/Resources Utilized

- Medicaid Provider Manual and Contract
- Mental Health Code
- Administrative Rules
- General Fund Contract
- MOU's
- Letters of Agreement

# General Findings: General Fund

- No entitlement besides Crisis services, Jail Diversion, Transition from youth to adult
- May receive all Services provided by CMH if funds allow
- CMH should utilize waiting list for General Fund consumers to provide services
- Utilizes all Mental Health Code definitions for eligibility and mandated services

# General Findings: Medicaid/Medicare

- Provides a comprehensive array of services for Medicaid recipients who meet eligibility criteria and medical necessity criteria in the context of person-centered-planning and Self Determination.
- Utilizes the vague Mental Health Code eligibility definitions
- **Prioritizes Services for the “Most Severe”**  
The previous appendix providing a level of care model and a clear definition of “most severe” was removed from the Medicaid Contract.
- There is no universally accepted criteria utilized to define “Most Severe”

# General Findings: Medicaid/Medicare

- Provides distinction between the role of Medicaid HMO providers and PIHP obligations
- Allows for the utilization of B3 services as replacement to traditional Medicaid required services
- Residential Services are not a Medicaid entitlement, but serves as a method that can be utilized to meet the needs of the “Most Severe”
- Medicaid Contract requires the utilization of EBP’s but is unclear as to which EBP’s are mandated

# **Review of Work Group Findings**

*Analysis of Current Services Provided to  
Specific Populations*

**Patrick O'Rourke, Work Group Chair**

# Work Group Participants

- Joan Brown- Fiscal Services
- Stacie Hamstra- DD Services
- Rick Hunter- MI Services
- Pat O'Rourke- Crisis/Access Services
- Barbara Sychowski- MI Services (Nursing)
- Tracy Taylor- QI
- Julie Zenk- Fiscal Services
- Patricia Genesky- Administration
- Michael Brashears- Administration

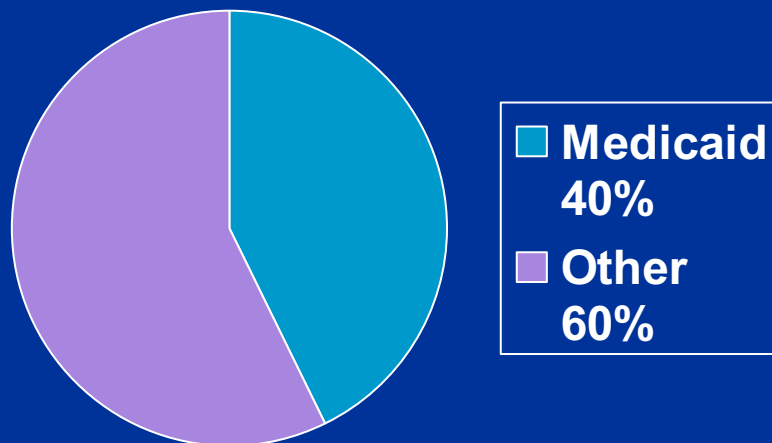
# Work Group Charge

- **Current analysis of the array of services to determine the following:**
  - **Who CMHOC is currently serving in relation to:**
    - Funding source
    - Population
    - Diagnosis
  - **What Services, by funding source, are currently being provided in order to determine:**
    - Frequency and scope of services provided
    - Number of services provided
  - **If the development of service bands or level of care can be identified and developed based on the above information**
  - **Provide recommendations related to possible changes to both who CMHOC is currently serving and how services are delivered**

# Data/Resources utilized

- Breakdown of Consumer costs for FY 2007 by population and age group was the starting point for the reports requested by the Work Group
- Breakdown of Consumer costs for FY 2007 by population and funding source. Funding source categories used for this report were determined by the Work Group
- Breakdown of Consumer costs for FY 2007 by population, service category, and funding source. Service categories were determined by the Work Group
- Breakdown of Consumer costs for FY 2007 for each population by service category, fund source, and diagnosis category. The detail was also provided for each group
- Summary Report for costs of services by program and activity code for FY 2007 was provided to the work group committee

# General Findings: Population Served



- The Majority of individual served (1875/3104) were not Medicaid Consumers
- CMHOC is providing a healthy non-Medicaid mental health benefit
- CMHOC may not be reaching Medicaid recipients in need of service

# Intensity of Services Provided

## Adult MI



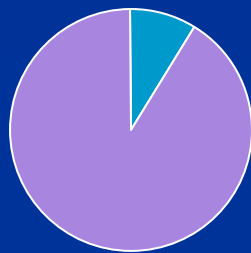
## MI Child



- The Majority of MI adult and MI child services are of low intensity
- CMHOC is not providing the full array of services to these groups

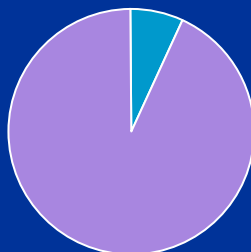
# Intensity of Services Provided: DD

**DD Adult**



■ Non-Enhanced	9%
■ Enhanced	91%

**DD Child**



■ Non-Enhanced	7%
■ Enhanced	93%

- DD Adults and Child Consumers are mostly receiving the full array of covered services

# Why is this Important?

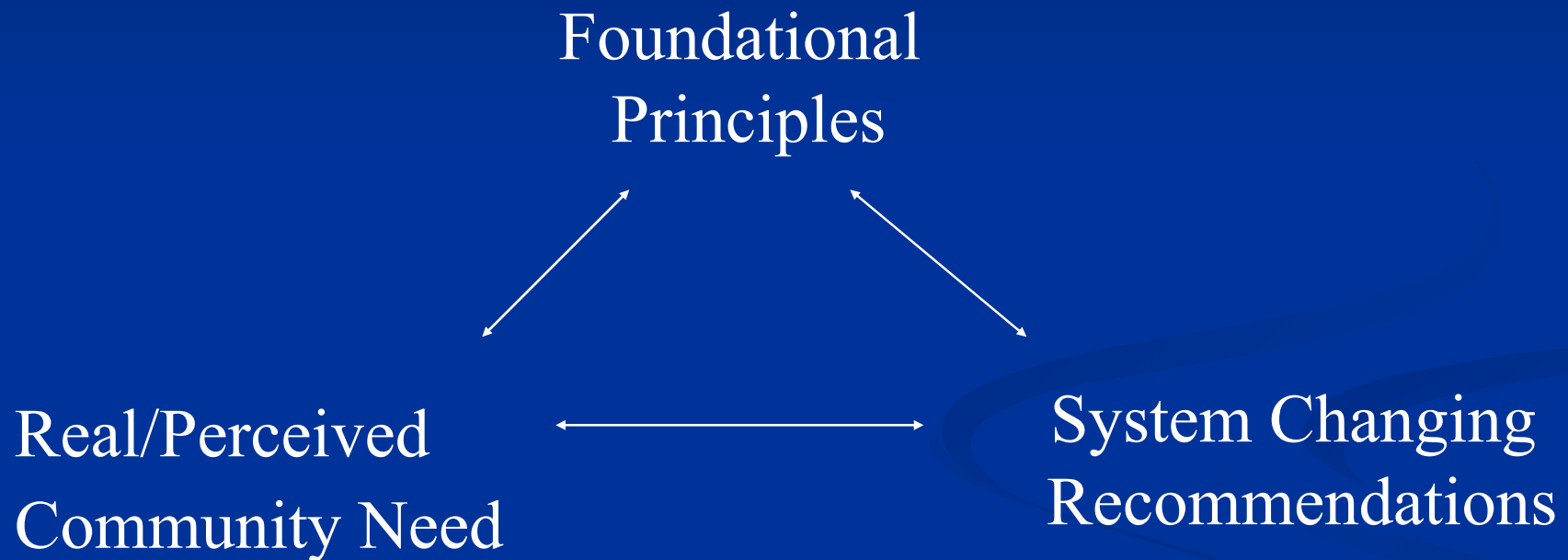
- CMH is utilizing valuable resources to serve a large group of Consumers who are:
  - Not the most severe
  - May have other resources to receive and pay for care
  - Do not have an entitlement to receive CMH services

# System Change Recommendations

# Recommendation Structure

- Foundational Principles
- System Changing Recommendations
- Community Engagement: Addressing Real and Perceived Community Need

# Interrelationship



# Foundational Principles

- We must protect and ensure the provision of the mandated full array of services for the “Most Severe” who are eligible for our services:

*Protect the Core*

- We must engage the community to define and participate in a community mental health benefit for individuals who are not deemed “Most Severe”:

*Address Community Need and Fit*

# “Protect the Core”

- Operationally define “Most Severe”
  - Develop and utilize research validated tools to determine severity of illness/disability and level of service need
  - Develop clear eligibility guidelines based on above stated tools and funding source
- Decide which core services (mandated) should be directly operated or contracted out based on service bands and cost.
  - Outpatient Services
  - Residential
  - Crisis Residential
- Determine the feasibility of reorganizing the DD system of care based on individual budgets, Person-Centered-Planning, Medical Necessity, and Self Determination

# “Protect the Core”

- Require Medicaid HMO, Medicaid Straight, and Commercially Insured Consumers to exhaust their respective benefits before they access CMH Services
- Develop predictable criteria for General Fund Consumers to access directly operated services
- Retain appropriate Medicaid and General Fund Risk reserves to address unanticipated increases in utilization and/or costs
- Reallocation of Resources to ensure a high quality “Core” of Services

# Address Community Need and Fit

- Educate the Community on the current CMH Community Benefit and Collaborations
- Allow the Community to have input into developing a General Fund benefit based on need
- Initiate community outreach efforts which support the co-location of services (Holland Rescue Mission, School System, DHS, Public Health, etc.)
- Partner with community organizations in addressing MH/DD gaps in services. Partnering includes sharing the cost and providing the location for additional services

How do we accomplish  
this?

# Two System Approach

## ■ CMH Enhanced Services

- Mostly directly operated
- Focused and prioritized for the most severe
- Utilizes Team Model in the delivery of services
- Does not directly operate low-band required services such as Traditional Outpatient services, Respite, etc.
- May not directly operate high cost services such as residential services, crisis residential, and hospital services

## ■ Community Benefit/General Fund Services

- Mostly contracted out or co-located
- Provided within an extended Crisis Services model
- Leverages other community resources in addressing service gaps

CMH Core Service  
“Enhanced Services  
for the Most Severe,  
Requiring the provision of multiple services  
and/or a Team Approach”

**Low intensity  
Service Band  
Services and  
Community  
General Fund  
benefit**

# System Change Recommendations

## MI Programs

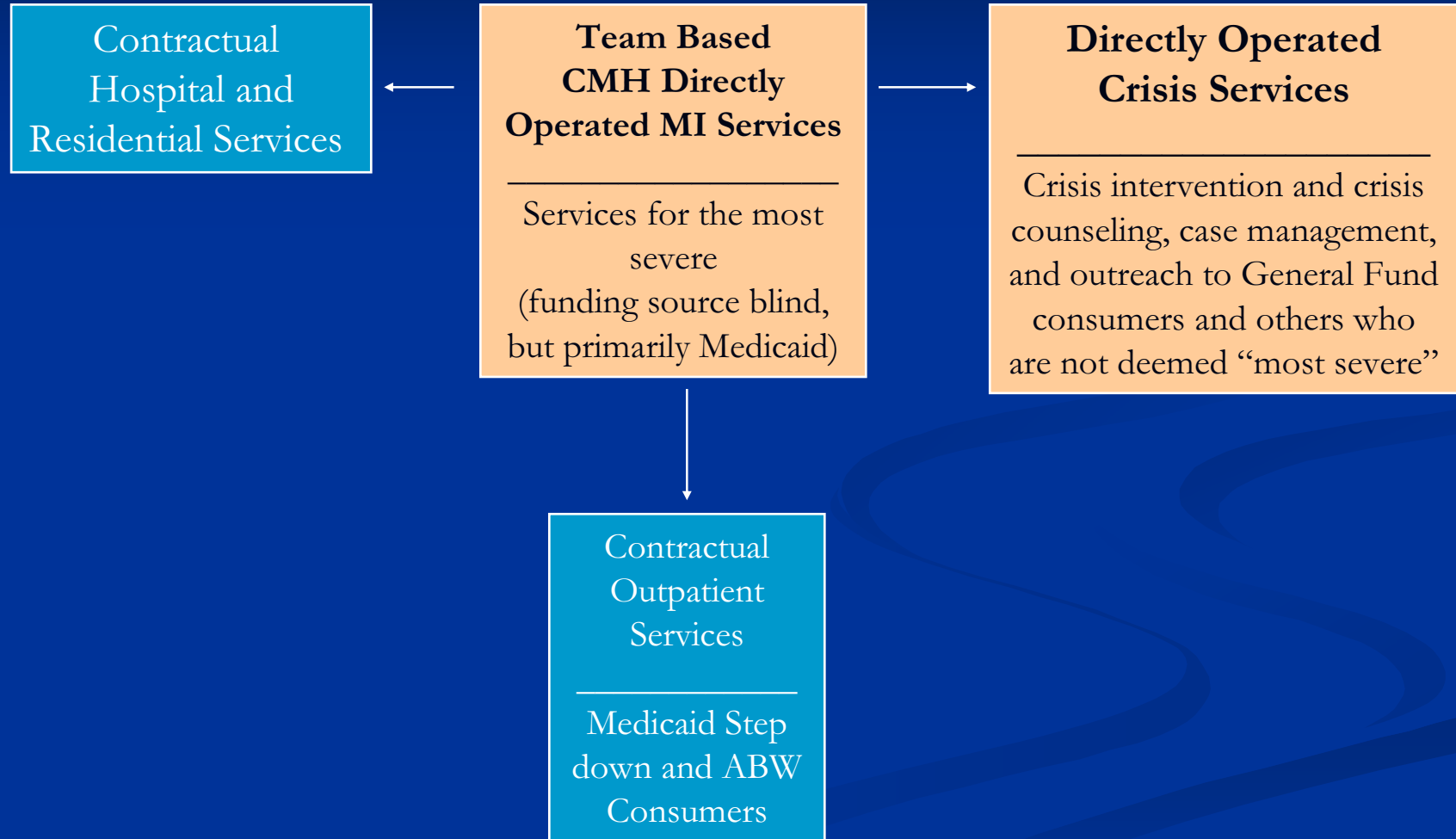
- Develop multidisciplinary teams to provide directly operated core services for the “most severe”
- Contract out all traditional outpatient MI services - the “outpatient alone group” and have these services monitored and authorized by the contract department
- Examine the feasibility of contracting out all residential services. (currently 98% of residential services are provided by contractual vendors).
- Develop Children Services team and program

# System Change Recommendations

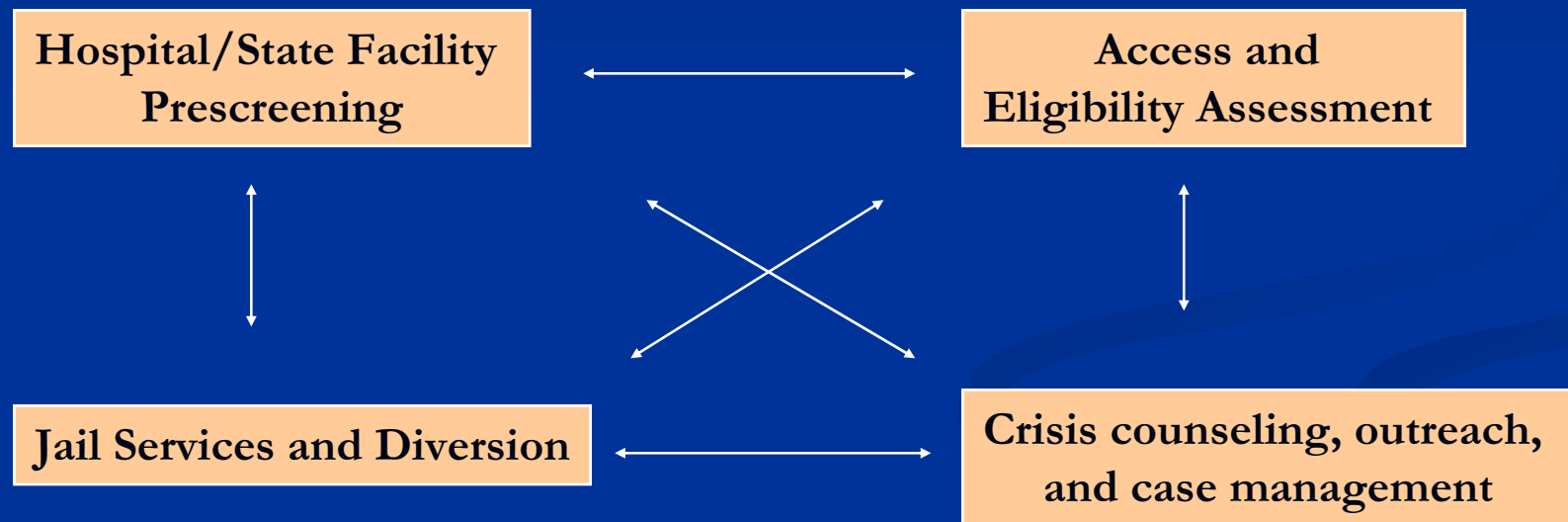
## Access and Crisis Services

- Reorganize the Crisis Services Department to provide eligibility screening and extended Crisis services
  - Develop and utilize research validated tools to determine severity of illness/disability and level of service need and eligibility
  - Develop crisis counseling, case management, and outreach services for General Fund and other Consumers who do not meet eligibility for CMH directly operated services

# MI Service Array/Continuum



# Access/Crisis Service Array



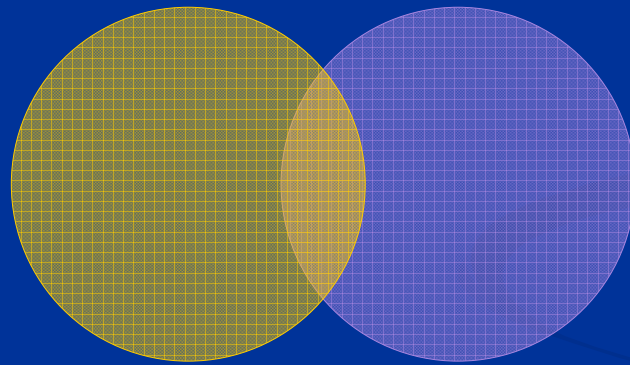
# What Does This Mean for Staff?

- Current Case Management, Outpatient Services, and Medication Services staff will be reassigned to form Multidisciplinary Teams in Holland, Grand Haven, and Hudsonville.
- Access/Crisis staff roles, responsibilities, and the services provided will be redefined.
- Residential Services will be contracted out (if feasible).

# DD Services

Total service array except residential and facility services  
are directly operated and contractually provided

Directly Operated



Contractual

# System Change Recommendations

## DD Services

- Develop a Community Based Services (CBS) model and curriculum.
- Develop a Community Living Supports (CLS) authorization system and limits based on medical necessity
- Develop a level of care or service bands based on individual budgets, self determination, and medical necessity.
- Directly operate authorizations for Respite Services and establish limits for Respite services based on medical necessity and severity.

# What Does This Mean for Staff?

- Training related to DD Services Model and Curriculum
- Supports coordination based on medical necessity and not choice alone
- Educating contractual providers about DD Services philosophy, model, and authorization for increase in services.
- Assessing which service should be primarily operated directly by CMH.

# Current Status of Implementing System Change Recommendations

# Implementation Status

- Work Groups have been formed to assess and implement all System Look Recommendations.
- Implementation of recommendations will occur throughout FY 2009.
- The goal is to have as many recommendations implemented by the end of January 2009.

# Current Budget Situation

# Current Budget Situation

## Current Year

- We have a current deficit of approximately \$400,000. I have avoided layoffs by the utilization of reserves and a transfer of money from Muskegon CMH
- Our deficit is primarily due to overspending of General Fund dollars for Consumers who do not have an entitlement for the majority of CMH services
- Our Deficit is also due to over expenditures of CLS and residential services

## Current Budget Situation Next Year (Starts October 1<sup>st</sup>, 2008)

- Estimated \$400,000 deficit
- Same projected causes as this current year
- We cannot expect to utilize reserves or depend on a transfer of funds from Muskegon CMH

This is why system change is needed  
now!