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DEPARTMENT OF COMMUNITY HEALTH
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TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), CMHSP Board Chairs, and Mental Health Advocates

FROM: Michael J. Head, Director
Mental Health and Substance Abuse Administration

SUBJECT: Concept Paper

We are pleased to share the final version of the Michigan Department of Community Health's (MDCH) Concept Paper, "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System." The Concept Paper is a stimulus for a dialogue to establish and improve local and regional partnerships. It sets the stage for issuance of the upcoming "Application for Renewal and Recommitment" (ARR). This paper does not exhaustively address every issue area. It represents a consensus on key issues for planning in the upcoming year, and a guide for our work.

Concurrent with issuing this Concept Paper, MDCH is preparing the FY 09 CMHSP Policy and Planning Guidelines and a review draft of the ARR. The ARR will eventually be submitted by each of the 18 Michigan Specialty Mental Health Program PIHPs as their commitment to achieving performance objectives outlined in the Concept Paper and further articulated in the ARR. The ARR is intended to incorporate elements from the FY 2002 Application for Participation (AFP), and to obtain status information and forward planning for PIHPs to be conducted during the winter of 2008/09. As part of the work to finalize the Application, MDCH will sponsor a series of forums and regional meetings during September and early October to discuss the framework of the ARR and to receive input prior to its finalization. It is expected that the final ARR will be transmitted to the PIHPs by November 1, 2008, with an expected submission of February 1, 2009.

Central to the planning and application process, CMHSPs and PIHPs will convene consumers, advocates, families and community stakeholders, involving them in the planning work and strengthening the developing partnerships that are central to realizing the "community benefit" areas specified in the original AFP submitted in 2002. It is important that local dialogue begin now if the many voices needing to be heard are to be included during this recommitment and renewal process. MDCH is committed to working with our partners to using all available venues to promote success in responding to the ARR, and for reaching greater levels of excellence in the quality of outcomes for those served.

We ask that you begin the process of local dialogue in order to address these issues and plan for the future of Michigan's public mental health system.

cc: Janet Olszewski, Ed Dore, MDCH Strategy Team, Mental Health and Substance Abuse Management Team

Michigan Department of Community Mental Health
Mental Health & Substance Abuse Administration

FOCUSING A PARTNERSHIP FOR RENEWAL AND RECOMMITMENT TO QUALITY AND COMMUNITY IN THE MICHIGAN PUBLIC MENTAL HEALTH SYSTEM

A CONCEPT PAPER
August 2008

Purpose Statement:

The purpose of this concept paper is to reinvigorate the public mental health system's commitment to its core concepts and values. We, who participate in services, who provide services, who support those who participate, who guide and administer, and we who lead, all constitute the partnership necessary to reach greater excellence in achieving the expected outcomes for participant consumers in the Michigan public mental health system. This paper charts directions the Michigan Department of Community Health (MDCH) will take to assure that community inclusion and participation, independence and opportunities for productive activity are realized by Michigan residents with serious mental illness (SMI), serious emotional disturbances (SED), and developmental disabilities (DD) receiving services and supports in this system of care[1]. This paper outlines the planning focus for activities such as the Fiscal Year (FY) 2009 annual Program Policy Guidelines (PPGs) for Community Mental Health Services Programs (CMHSPs), and the renewal of the Prepaid Inpatient Health Plans' (PIHPs) commitment to managing the specialty supports and services for Medicaid beneficiaries. The MDCH will use the results of this planning to support MDCH's request to the federal Centers for Medicare and Medicaid Services (CMS) for renewal of the 1915(b) specialty supports and services managed care waiver for FY 2010 and 2011. Ultimately, the MDCH contracts with CMHSPs and PIHPs and the Medicaid Provider Manual will reflect the direction articulated here, through policies, procedures, technical requirements, benchmarks and standards, and rewards and sanctions.

Background:

The foundation for partnerships and the goal for community membership for all individuals who require services and supports from the public mental health system is embedded in the Michigan Mental Health Code (Code), Public Act 258 of 1974 as amended. The roles and responsibilities of the state and counties are outlined. The Code requirement for a community, stakeholder and consumer "voice" is the keystone for planning and allocation of resources. Annually, each CMHSP must examine and evaluate the mental health needs of the county or counties it serves and submit both a plan and a budget for the program. Each year, MDCH issues the PPGs and related guidance containing the requirements and instructions to satisfy Code and legislative reporting requirements and to provide statewide policy direction.

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[1] People with co-occurring SMI and substance use disorders (SUD) are included among these service recipients, as well as individuals covered by the Medicaid program with SUD whose services are the responsibility of the prepaid inpatient health plans. References throughout the paper to individuals receiving services include adults and children, and the families of children, unless otherwise noted.

In 2000, MDCH submitted to CMS a Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans that explained why a competitive bid-out of these Medicaid managed supports and services was not desirable nor practical. The plan, ultimately approved by CMS, promised a selection methodology that would be a "more promising vehicle for attaining the outcomes (efficiency, choice and community inclusion) sought by the state, HCFA and system stakeholders." The plan proposed to build on the service system structure established under the Code, and further indicated "The state also believes that beneficiary freedom, participation and integration can best be promoted through a local managing entity (the specialty PHP) that has specific *statutorily prescribed equity and justice functions.*"

CMS' approval of the Plan for Procurement and the 1915(b) waiver application submitted in 2001 led to MDCH's development of a procurement process in 2002 called the "Application for Participation" (AFP). The AFP not only defined the administrative structures that applicants needed to have in place, but also contained requirements that reflected what MDCH anticipated would be in the final regulations of the federal 1997 Balanced Budget Act (BBA) for managed care organizations. Primarily, the AFP articulated the vision found in the Plan for Procurement and the waiver application and requested that applicants demonstrate that they already had the policies, procedures and practices, or had plans for immediate development to implement the vision. The AFP responses were promulgated by attaching them to the contracts between MDCH and the 18 selected PIHPs.

The BBA requires a state to engage an external quality review organization (EQRO) to measure the states' Medicaid managed care organizations' compliance with the law. Michigan's PIHPs have been annually reviewed by an EQRO since 2004. The process includes a report on compliance, plans of correction, and a follow-up review by the EQRO to determine the outcomes of the implementation of the plans of correction. Work to promote improvement based upon the EQRO process has strengthened PIHP quality since that time.

Accomplishments:

In many ways, Michigan's public mental health system is among the best in the nation, due in no small part to the partnerships and open communication evident in most of the Michigan system. Improvements have been driven by facets such as flexible funding, an enriched service array, and increased consumer protection, along with contractual agreements that incorporate statewide policy, AFP commitments, and BBA compliance. Since the 2002 AFP process, the PIHPs, CMHSPs and their providers have demonstrated a commitment to increasing consumer, family and advocate involvement in advisory committees and quality management systems. The EQRO reviews and MDCH-conducted site reviews show marked improvement in compliance with the BBA, Medicaid standards, and contract elements such as the person-centered planning policy and requirements for data accuracy and completeness. The system has embraced the move toward implementing evidence-based, best and promising practices, as evidenced by participation of more than 11,000 clinicians in training sessions. Incorporation of consumers through the training and certification of over 400 peer support specialists now being hired through CMHSPs and PIHPs represents a commitment to recovery-based culture change unmatched by most states. There are individual CMHSPs and providers who have aggressively assisted individuals to obtain employment in integrated settings and reside in their own homes where they may live

independently often with support. Arrangements that support consumer control over the provision of services to realize self-determination are flourishing in several areas. Some CMHSPs have been on the forefront in partnering with provider organizations in their service areas to establish "systems of care for children," and several are implementing community plans to reduce homelessness. The PIHPs have joined with MDCH and financed an effort to develop standards that make certain processes more uniform across the state, such as access to the public mental health system. PIHPs and CMHSPs have been exploring how to standardize cost allocation and cost reporting methodologies, and to achieve administrative efficiencies.

The Challenge:
These accomplishments must be acknowledged and applauded, and they must provide the basis for furthering the drive toward excellence. In the spirit of the Michigan Mental Health Code, we are calling all partners to work to make necessary improvements. MDCH has selected 11 areas on which to focus our partnership for improvement. Much of the rationale for improving those particular areas comes from the direct voices of consumers of services and their families. Evidence to support these directions is outlined as follows:

Consumer and family testimony before the Governor's Mental Health Commission (2005) resulted in the Commission making 71 recommendations for improvements that included:

- Better integrating and coordinating mental health and primary health care
- Reducing barriers to treatment of co-occurring mental health and substance use disorders
- Offering supported employment to persons with serious mental illness
- Better obtaining consumer and family input
- Eliminating the use of juvenile and criminal justice systems as providers of last resort
- Improving access to and quality of services to children
- Linking service payment to the quality of care delivered
- Reaching out to older adults, persons with dementia, and their caregivers
- Addressing homelessness among individuals with serious mental illness
- Achieving uniformity of service availability across the system and across funding streams (e.g., Medicaid and general fund)

A series of regional dialogs held in 2006 between MDCH and over 300 people with developmental disabilities and their families provided evidence that they:

- Do not realize they have the right to choice of providers
- Have not received accurate and complete information about services and supports
- Obtain case management/supports coordination from workers whose caseloads are so large that the workers do not have the time to listen to them and take actions on behalf of consumers that best address their needs and preferences
- Need support to engage in preferred and meaningful activities during the day and evening, whether they live in their own home or in a group home
- Want to have real work
- Would like widespread availability of the self-determination approaches

The Recovery Council, established in December 2005, identified the experiences of adults with mental illness including:

- Stigma against people with mental illness including the "discrimination of low expectations" is common; even in the CMH system, features such as "staff only" bathrooms and unwillingness to publish the names of consumer board members adds to stigma.
- Recovery as a cultural value needs to become embedded in the system. Many service providers and consumers do not know of or understand the principles of recovery or the promise they present.
- Person-centered planning for persons with mental illness does not truly represent individual goals and preferences, and support for "Wellness Recovery Action Planning" is not available.
- Peer specialists need to be widely available to support individuals in their recovery journeys, and they need to be involved based on individual selection.
- Too many consumers live in substandard housing.
- Housing options need to be expanded beyond the typical AFC and other segregated housing options. Independent housing options with supports need to be increased.
- Consumers live in poverty. Finding opportunities for real jobs with living wages and benefits ought to be a goal and employment supports toward that end a regular feature of each CMHSP.
- Opportunities for service arrangements that support self-determination are not available for people with mental illness.
- Case managers, psychiatrists and all mental health workers must concentrate on being "hope givers" not "hope takers" in their relationships with consumers.

Information that MDCH receives through the Mission-Based Performance Indicator System, the encounter and quality improvement (demographic) data submissions, and the various cost reports, provides further evidence that despite promises made, progress is, on average, slow. Evidence includes:

- Employment: In FY'07, only 8.71% of adults with DD and 9.11% of adults with SMI served were competitively employed; further, there are marked disparities in the levels of supported employment across CMHSPs.
- Housing: In FY'07, only 11.86% of adults with DD were living in a private, unlicensed setting without family; 28.74% of adults with SMI lived in such settings.
- Costs: In an FY'06 analysis of costs for services for which there was high volume of utilization and high expenditures, a wide range of variability was found in all services across the PIHPs. For example, the range of costs of Targeted Case Management across the PIHPs was $80 an hour to $416 an hour. The reasons for the variability are still being explored.

Finally, MDCH has received substantiated reports and allegations of:

- Repeated use of force to inflict prone restraint upon individuals who predictably present challenging behaviors.
- What can be classified as neglectful worker performance in residential programs caring for individuals with severe and multiple impairments, resulting from apparent weaknesses in staff supervision, performance monitoring, job orientation and training.

Examples include excessive staff social conversation and use of cell phones during duty assignments; residents being left aimless instead of engaged; and failure to file incident reports.

- Informal denials of services to individuals with apparent serious mental health needs, including agency decisions to discharge individuals with known histories of ongoing mental health care needs, when symptoms abate.
- Individuals with severe and complex disabilities receiving inadequate clinical interventions, and little or no active engagement.
- Lack of availability of true person-centered planning, independent facilitation of person-centered planning, and access to arrangements that support self-determination under the policy.

Meeting the Challenge:

MDCH will assess the extent to which CMHSPs and PIHPs have followed through on commitments made, especially in the 2002 AFP, as well as in previous PPGs, and in the MDCH-CMHSP or PIHP contracts. Ascertaining progress on critical dimensions of development is essential to gauging overall system evolution and transformation, and to chart the future course. While progress has been significant over the past several years in several areas, monitoring activities, anecdotal reports and performance indicator data paint a picture of unevenness in practices and therefore in opportunity. For example, Michigan residents experience unfairness of access and inequity in the manner in which they are received and responded to in the face of their need for mental health assistance. Recent work to refine access processes will improve fairness of opportunity, but what occurs with planning and service provision once an individual has achieved access must be of equal concern.

MDCH will partner with CMHSPs, especially through PIHP systems, to renew previous priorities and directions, to formally introduce new dimensions of performance, and to renew our commitment to excellence in all of these priorities, directions and dimensions. We will set standards that better reflect the expectations of the public mental health system consumer and family stakeholders to support choice-driven outcomes. Partnerships with consumers, their families and their representatives are crucial to successful recommitment. We will therefore establish goals for improved consumer involvement and participation in local planning, implementation and evaluation of services. Similarly, other community partners need to be engaged if there is to be a successful local establishment of an effort that can ultimately achieve the elements of our vision outlined in this concept paper. We acknowledge the importance of supporting greater personal autonomy, control and direction of the course of one's life when one requires assistance from the public mental health system. Further, we will recommit to finding the best ways to assure that those with the greatest vulnerabilities and the least capacity to advocate for themselves are supported in ways that celebrate their humanity and recognize their right to a life with meaning and personal dignity. We will move toward zero-tolerance for poor care and for supports that do not recognize and celebrate personal dignity and self-worth.

We will set this course together and we will aim for developing benchmarks that can, over a five-year period, give us clear objectives. The major focus of this multi-year effort is to improve methods that assure the quality and appropriateness of care such that consumers

are supported to achieve true community membership. A secondary focus is to achieve administrative efficiencies that ease the planning for and provision of supports and services and preserve funds for reinvestment during these tight times. The following provides a preview of the contents of the FY'09 PPGs and related policy guidance, and ultimately the Application for Renewal and Recommitment to be issued in the coming months.

Guiding Principles:

The previous PPGs, the 2000 Plan for Procurement, the 2002 AFP, MDCH's internal strategic planning activities and various publications have similar vision statements and service goals. They can be summarized thus:

All people in Michigan will have access to a public mental health and substance abuse services system that supports individuals with mental illness, emotional disturbance, developmental disabilities, and substance use disorders. Of highest priority to the system is its obligation to serve individuals who have the greatest and severest needs. The system will provide adults the supports and services necessary to be healthy and safe and successfully:

- Contribute to their communities,
- Earn an income in a non-segregated, community setting,
- Live in their own homes,
- Have full community inclusion, meaningful participation and membership,
- Have friendships and relationships, and
- Have a self-defined fulfilling life.

The system will provide children and their families the supports, services and advocacy necessary for the child to be healthy and safe and successfully:

- Live with a supportive birth or adoptive family,
- Participate in their neighborhood community school,
- Play an active role in the neighborhood and community activities,
- Enjoy childhood and have friendships and relationships, and
- Develop and prepare for adult life.

Issue Areas:

In order to achieve the vision, certain improvements must be made in Michigan's public mental health system. The following are the top issue areas for developmental improvement on which MDCH, along with consumers, families, advocates, CMHSPs, PIHPs, providers and other stakeholders will be focused over the next five years.

1. Improving the Culture of Systems of Care

As articulated in the Customer Services Standards and the Access Standards, public mental health agencies must assure a welcoming and caring culture where individuals who come to the door or who are already served are treated with respect and dignity. They are provided with access to complete information about service array, provider options, costs of services, and rights and due processes. There must be zero tolerance for applicants or individuals receiving services to be ignored and or rudely addressed.

A "culture of gentleness" must be fostered wherein force is not used to subdue consumer responses of resistance and threat to current experience. Force cannot be the intervention of choice to deal with consumer expression of frustration and pain. Instead, the emphasis must be on developing skills for assessing the antecedents of challenging behavior and for identifying clinical factors, including medical and psychiatric illness issues that may contribute to a behavior. There must be broad understanding of ways to interpret behavior as

communication about that person's experience. There must be expanded training and guidance that encourages and enables staff to respond to consumers with understanding and compassion, rather than fear or condemnation, and to provide positive support for those who must express their needs through challenging behavior.

Public mental health staff will better perform to support those with intensive needs if they work within a trauma-informed system of supports. All must learn to recognize and understand how past experiences of trauma invade the lives of those requiring support, driving many to act out of desperation and in defense of themselves. Understanding the long-range impact of major trauma and the indelible marks that are left on one from traumatic experiences can assist those in clinical and supportive roles with improving effectiveness. Being trauma-informed means imbuing a personal awareness in those providing services of the ways that their interactions and interventions may inadvertently re-invoke a trauma experience for an individual. With awareness, they can more successfully assure support and safety for all. Learning to be vigilant for signs of trauma and understanding the positive responses that provide an environment of protection and support must become basic in staff capacities at all levels.

Children with SED and their families must be the focus of specific effort to foster and promote resiliency. Improvement in resiliency and the development of protective factors have been shown to dramatically improve outcomes for children and families and increase the likelihood of children with mental health disorders to go on to productive adulthood. Evolution of local community cultures which cross organizational boundaries to assure support for children and families is the central pathway to better serving many children with SED.

Efforts by persons with mental illness to pursue a pathway toward recovery must be supported by a public mental health system that fosters a culture which recognizes and values recovery as a central component of treatment and support. Elements of recovery involve the projection of hope and the expectation of recovery, not discouragement, toward persons with mental illness histories, no matter their current status. The elements include recognizing and moving away from identifying those receiving services as "cases" and other responses that objectify individuals. They include increasing personal knowledge of and approaches to addressing illness through adherence to health-promoting activities that assist resiliency, as well as those which invoke sanctuary when that is needed. Recovery culture begins with a belief that recovery is possible, worthwhile and achievable for virtually everyone, over time. CMHSPs and PIHPs will be expected to apply the Recovery Enhancing Environment Measure as part of their planning, as a method to gauge and promote local awareness of how current operations support or inhibit opportunity for recovery.

Development of a culture of recovery must include expansion of a culture that resists and reduces the stigma associated with those who possess a mental illness label. While it needs to become a community campaign to replace publicly-held perceptions and beliefs, reducing stigma and its impact starts within the culture of the public mental health system. No effort to address stigma can ignore the fact that stigma underlies many of the day-to-day ways that those paid to plan, manage and provide services choose to conduct their work. Finally, the

public mental health agency will be culturally competent to meet the diverse needs of the local citizens, including individuals who have hearing impairments.

2. **Assuring Active Engagement**

For many of the most vulnerable people we serve, their ability to communicate preferences, to express their personal goals and to advocate effectively for themselves is muted. These individuals live with ongoing and critical need for support and medical care that requires up to 24-hour assistance. Their lives must be supported through meaningful engagement, rather than being left to be aimless or thrust into activities that routinely offer a convenience for their caregivers and do not promote their opportunity for meaningful involvement and participation at the highest level of personal capacity and interest. A culture of neglect cannot be allowed to disguise itself as 'personal choice'. In residential care, in supports and activities during the day, and especially where personal relationships are so lacking, individuals with intensive needs and an inability to effectively self-advocate and extricate themselves from uncaring and harmful environments, must have their opportunity and their right to effective and appropriate support with personal dignity overseen and guided with extra effort. Whether for residential care or daytime activities, standards for active engagement that incorporate learning, skills development, and productivity, including employment and volunteerism, need to be developed and applied.

Staff training and guidance, as well as external oversight, must be strengthened. Opportunities for renewal and extra support for staff who work in these care settings must become priorities for administrators and clinical specialists. Mechanisms for individualized support derived from the principles of person-centered planning and self-determination must be applied. Given the preponderance of persons with mental health system experience among the homeless population, addressing the homeless in the local community is an additional opportunity to actively engage those who are or ought to be supported through the public mental health system.

3. Supporting Maximum Consumer Choice and Control

Meaningful person-centered planning (PCP) is at the heart of supporting consumer choice and control, and evidence must be derived from knowledgeable consumer experience of PCP. PCP, including access to independent facilitation, must be well-supported in all systems and environments. The PCP process must align resources with expectations and while natural supports must be considered, they cannot be assumed to supplant what is the responsibility of the public mental health system. All consumers in each CMHSP and across every PIHP must be fully informed of, provided expanding opportunities for, and consistent easy access to arrangements that support self-determination. Direct control over the resources allotted for supports and services allows for the person, with chosen allies, to achieve power to control provider arrangements so that services match personal preferences. Inherent in arrangements supporting self-determination is authority over the use of an individual budget so that the person may achieve efficiency and best value outcomes on their own personal terms. Markers to gauge the effectiveness of local options for assuring quality in the access and use of arrangements supporting self-determination will need to be developed and applied per existing policy. Methods to assure arrangements supporting self-determination for persons using services and supports to respond to mental illness must be

clearly defined and made available. Consumers, peers and advocates must be deeply involved in assisting each CMHSP and PIHP to achieve success in these endeavors. Barriers will ultimately be overcome through a willingness to embrace options supporting self-determination; technical guidance will expand from outreach efforts to learn what has worked in other locales.

4. **Expanding Opportunity for Integrated Employment**

For the past 20 years, employment as a route to both gaining an income and obtaining and enhancing community membership has been a stated goal for each person who depends upon the public mental health system. With employment, one's personal capacity to choose and control one's life direction becomes significantly real. The benefit package offered through the specialty supports and services plan provides many options for supporting the development and maintenance of employment where that is a goal for adults served. Yet, performance in developing supported and integrated employment is uneven; and the numbers of real outcomes are staggeringly small. It is expected that, as one of the highest priorities, public mental health agencies will actively assist adults served to obtain competitive work in integrated settings and provide the supports and accommodations that are necessary. Partnership with other agencies providing employment supports must be regenerated; involvement of local business must be garnered; and local barriers to employment for persons with mental illness or DD must be explicitly addressed as a community project. System-wide adoption of the evidence-based practices for supported employment for persons with mental illness is an expected achievement across all PIHPs and CMHSPs.

5. **Assuring Opportunity for Needed Treatment for People in the Criminal Justice System**

The 2004 Mental Health Commission Report provided several recommendations relative to diversion programs, including more formal understandings of the shared responsibilities of the public mental health system and the judicial system (including law enforcement, defense and prosecuting attorneys, judiciary, corrections and probation). Correspondingly, MDCH, in its Implementation Plan, promoted encouragement of local collaboration and community ownership using the Criminal Justice/Mental Health Consensus Project Report as a blueprint.

The community's joint response to adults with mental illness, children with SED, and individuals with DD who are involved or at risk of involvement with the criminal justice system should be collaborative, informed, competent, and accountable. CMHSPs in many areas are partnering with the justice community in jail diversion, prisoner re-entry, mental health court pilots, and in-jail mental health services. On a statewide basis, progress will come from expanded understanding of successful models and through a focus upon establishing more precise performance standards. The expected collaboration must assure that individuals with SMI are treated rather than simply punished because they are perceived as a public nuisance, even when their offense requires incarceration. This effort must be informed through the inclusion of the perspectives of individuals who have experience with mental illness and justice involvement, and represented by broad local collaboration which best uses the knowledge, skills and financial resources available across both the mental health and justice systems. While there are significant resource allocation issues to be considered in

determining priority for services, there is ample evidence that many individuals who now become involved with the criminal justice system also fit within current mental health service priorities.

6. Assessing Needs and Managing Demand

The Michigan Mental Health Code instructs the development and reporting of needs data, yet the current methods fall short of meeting the intent of the Code. It must be the case that community needs assessments are performed to better quantify existing un-served and under-served populations such that their needs and characteristics are clearer. Gaining a clearer sense of who will arrive at the doors of the public mental health agencies within 12 months, 24 months, and within five years is important to planning. CMHSPs need to use the information from community needs assessments to plan and manage the demand for services, and resource decisions will be better prioritized and more clearly justified to internal and external parties. Waiting lists for individuals residing in the CMHSP area who are ineligible for Medicaid services but who meet the Mental Health Code definition of priority population and have or may be expected to request services must support the demonstration of need in each community.

7. Coordinating and Managing Care

Supports coordination and management of care are essential elements of assuring that people with multiple and persistent needs have them addressed successfully. This includes services brokering and access in a system of care where children are involved with the Michigan Department of Human Services (MDHS) for abuse and neglect, or in family foster care. Expanding the application of "System of Care" principles and practices for children and adolescents will be expected, so that those whose involvement cuts across school, MDHS, probate/juvenile court and CMHSP jurisdictions are effectively supported within their families. Supports coordination that can respond to individuals with DD who have complex or at-risk situations exacerbated by the loss of natural caregivers, limited communication skills and having challenging behaviors, and dual diagnoses, cannot be accomplished where caseloads are excessive. Individuals with SMI receiving inadequate or maintenance-only services, or with co-occurring substance use disorders or physical disabilities, require extra outreach and care coordination. Public mental health agencies must assure follow-along for individuals with SMI whose symptoms have improved, and must be cautious to not prematurely discharge them from service or impede an easy return to service simply because of administrative considerations. Better coordination of care must occur across CMHSP boundaries when individuals move to a location in a different catchment area so that the enrollment process is streamlined and necessary supports and services are not interrupted. Finally, the supports coordination/care management function needs to be vested with an expectation that coordination with primary health care will be a standard practice, assuring that individuals will have access to treatment of co-morbid conditions which can lead to increased physical disability and untimely death.

8. Improving the Quality of Supports and Services

It is our goal to improve supports and services, and that outcome measures that support community membership are identified and used. Supports and services must meet Medicaid standards and all providers meet qualification and credentialing requirements. Maximum

staffing ratios for certain intensive services, such as case management, need to be established. Evidence-based, promising and best practices should be available to anyone receiving public mental health services. In particular, integrated treatment for co-occurring disorders should be available statewide, and each public mental health agency should employ peer specialists who have defined roles in the organization. Public mental health agencies should use measurement to determine whether their consumers are achieving the outcomes they desire and take steps to continually improve supports and services when they find that achieving outcomes falls short. We will work with public mental health agencies to improve their analyses of, and resulting actions to prevent reoccurrences of, sentinel events and critical incidents. We will work with public mental health agencies to increase the involvement of consumers, families and advocates in the dialog, decision making, and evaluation of supports and services at all levels of the system.

9. Developing and Maintaining a Competent Workforce

Perhaps the most formidable barrier to achieving excellence in outcomes for persons who require intensive and ongoing support through the public mental health system are those presented as we seek to assure a stable, competent and sufficient workforce. The knowledge, skills and abilities of the public mental health system workforce must be expanded over the next several years if we are to realize the outcomes described in this concept paper. These include identifying and assuring core competencies for case managers and supports coordinators that include helping people to develop reasonable and meaningful goals. Training and ongoing support for competency in providing positive behavior supports must be assured across the community system if those with challenging behaviors are to be supported within a culture of gentleness. Case managers, supports coordinators, group home providers, clinical specialists and especially direct care workers must receive training and support to demonstrate competency in positive behavioral supports, communicating with people with limited verbal skills, and promoting healthy lifestyles for the people they serve. Finally, the system must look for creative ways to recruit, train and retain a stable, competent workforce.

10. Achieving Administrative Efficiencies

While the primary focus of the future efforts is to improve the quality and effectiveness of care, there are certain administrative efficiencies that can be prioritized to better preserve the most public dollars for service provision and to reduce the distraction that inefficient administrative practices cause. MDCH will outline expectations for a locally-conducted examination of where a consolidation of functions, such as information systems, can be beneficial, especially within a PIHP affiliation or a multi-county CMHSP. MDCH will move to support development of electronic medical records technology within its capacities to do so. MDCH is also aiming to provide expectations for how much variability can be tolerated in the cost per unit of certain services. Finally, CMHSPs and PIHPs will be expected to work together to develop provider contracts and reporting protocols that contain common requirements and reciprocal recognition of provider training and monitoring.

11. Rewarding and Correcting Performance

As part of this continuous quality improvement effort, MDCH, together with consumers and stakeholders, intends to move toward technology that can allow MDCH to identify, recognize

and celebrate local (PIHP, CMHSP, provider and consumer) successes and exemplary actions. In this endeavor, MDCH will use performance indicators, measurable standards, and consumer, family, advocate and provider feedback. MDCH response will come in the form of publicizing successes and developing tangible rewards for exemplary performance. Likewise MDCH will seek to develop corrective performance objectives and, if indicated, sanctions for poor performance.

Summary:

This concept paper has identified important elements of development on the route to achieving an excellent public mental health system in Michigan. These elements will comprise the priority policy focus areas for performance enhancement in the community system for the coming five years. MDCH recognizes that in the next fiscal year, the system will be addressing these elements at a baseline level. Subsequent focus will be aimed at effecting progressive development that can be identified in measurable ways, as well as through experiential reports from those native to a given area. Several of the issues presented here involve more than the application of simple technology or practice implementation. They constitute directions that require a continuing discourse addressing the fundamental principles and values associated with their implementation. All partners need to be prepared to engage in this discourse and to trust that movement forward does not require that everyone in leadership positions must completely understand and reach a high personal comfort level, before setting out on new journeys. It is implicit that CMHSPs, PIHPs and those in their networks are at various points on the continuum for achieving the goals of these focal elements. MDCH is committed to providing leadership and resources as available, and to serving as a partner with CMHSPs, PIHPs, consumers, advocates and providers, to achieve excellence in the dimensions outlined in this concept paper.