

Please Refer to the Budget Forms and Instructions

Peer Delivered and Operated Services

The MDCH contract requires CMHSPs to have, as part of its service array, at least one consumer-delivered or operated service.

Peer-operated Support Services are defined as:

Service activities intended to provide recipients with opportunities to learn and share coping skills and strategies, move into active assistance roles, and to build and/or enhance self esteem and self confidence.

Such services may include:

- < consumer run drop-in centers
- < other peer-operated services (e.g., peer-run hospital diversion services)

Additional examples include:

- < consumer owned and run businesses
- < “Project Stay” peer support services
- < housing programs run by consumer organizations

The criteria to evaluate CMHSP contract compliance includes:

- < Evidence that services or supports are delivered by primary consumers to existing or prospective primary consumers. (Therefore, professionally led self help groups would not constitute compliance.)
- < Evidence that services or supports are alternatives or in addition to existing Medicaid covered CMHSP services such as PSR Clubhouse, ACT teams, etc.
- < Evidence that if the service or support is to be delivered in the same site or facility as a PSR Clubhouse, day program, etc. that the services or supports are:
 - occurring at times outside of the “ordered day” or socialization component of the clubhouse
 - occurring at times outside of the day program schedule
 - publicized and made available to persons other than clubhouse members or day program participants
 - those in which consumers have exclusive decision making authority over the planning and implementation of the service and support (i.e., professional staff are involved only as consultants at the request of consumers and not part of the actual service delivery)
- < In the case of self help organizations or activities, the group must consist of non-professionals who have control of the purpose and content of the discussion and evidence of CMHSP direct financial or in-kind support (e.g., donation of building space, phones, travel expenses, etc.) In addition to formal referral agreements.

Evidence of best practice includes:

- < The person providing the service or support is a member/employee of a group or organization external to the CMHSP which decides its own mission, goals, methods, and use of resources (both human and financial).
- < In the case of organizations:
 - the organization’s governing body is comprised exclusively of persons who are primary consumers;
 - all of the organization’s employees are comprised exclusively of persons who are primary consumers; and
 - the organization has a formal contractual relationship with the CMHSP with an identified liaison responsible for advocacy, consultation and support to the consumer organization.
- < With respect to self help groups, the group has multiple members which meet regularly and are offered in addition to other consumer operated and delivered services.
- < The organization or group is well integrated into the community

Co-Occurring Disorder Information

SUB-GROUPS OF PEOPLE WITH COEXISTING DISORDERS

Patients with "Dual Diagnosis" - combined psychiatric and substance abuse problems - who are eligible for services fall into four major categories.

PSYCH. HIGH SUBSTANCE HIGH Serious & Persistent Mental Illness with Substance Dependence	PSYCH. LOW SUBSTANCE HIGH Psychiatrically Complicated Substance Dependence
PSYCH. HIGH SUBSTANCE LOW Serious & Persistent Mental Illness with Substance Abuse	PSYCH. LOW SUBSTANCE LOW Mild Psychopathology with Substance Abuse

Source: Kenneth Minkoff, MD

TWELVE STEP PROGRAM FOR IMPLEMENTATION OF A COMPREHENSIVE,
CONTINUOUS, INTEGRATED SYSTEM OF CARE

Kenneth Minkoff, MD May, 2001

Step 1: Develop a structure and process for integrated system planning

- a. Empower the structure within the system organization
- b. Utilize quality improvement technology
- c. Identify measurable outcomes (system, program, clinical practice, clinical competency, and consumer; structure, process, clinical outcome, satisfaction.)

Tool: Cline, C., Principles of strategic planning for system and service integration.

Step 2: Build consensus on clinical principles

- a. Utilize Minkoff's principles of successful intervention
- b. Formal process of consensus building

Tool: Consensus documents: AACP, Mass., Arizona, etc.

Step 3: Build consensus on financing principles

- a. Build the system initially utilizing existing resources
- b. Integrated services do NOT require blended funding
- c. Co-occurring disorder services can be provided within each funding stream, contract, service code, and intervention.

Tool: Sample funding and reimbursement policies for contracts and service codes.

Step 4: Identify priority populations

- a. Use the four quadrant model, with IVA and IVB subgroups
- b. Priority populations are IVA and II (NIH); IVB (responsibility to be determined); III (those who are homeless, or involved with corrections, protective services, HIV, pregnant and parenting women)

Tool: National Consensus; NY Quadrant IV Report; Treatment Matching Paradigm

Step 5: Develop program standards

- a. DDC standards for all programs
- b. Incorporate into regulations, licensure, contracts, and certification
- c. Develop DDE standards for all addiction programs, mental health acute care, day treatment, case management, and housing
- e. Set goals for DDE capacity: approximately 20% of addiction capacity; 30-40% of mental health capacity.

Tools: ASAM PPC 2R DDC, DDE standards; Minkoff's description of DDC-CD, DE-CD, DDC-NIH, DDE-MH; Program competency assessment tool.

Step 6: Develop clinical practice guidelines

- a. Guidelines include screening and assessment, treatment matching and treatment interventions, treatment programs, psychopharmacology, and outcomes
- b. Utilize participatory processes to finalize the guidelines
- c. Phase in implementation

Tools: Arizona, New Mexico Practice Guidelines; Chart Audit Tool

Step 7: Implement universal screening, access, and identification

- a. All programs responsible for screening and identification
- b. Recommend screening tools, include trauma screening and sensitivity
- c. Require culturally competent welcoming, access, and screening
- d. Develop criteria for low threshold identification
- e. Establish reporting requirements and include in MIS

Tools: Screening tool packet; MIDAS, ME Screening Form

Step 8: Establish responsibility for integrated continuity of care

- a. Match systems, programs to client quadrant
- b. Continuity of integrated case management at varying levels of intensity from individual clinician to ACT
- c. Use practice guidelines to describe interventions
- d. Phase in implementation

Tools: Treatment Matching Paradigm

Step 9: Develop consensus on required competencies for ad clinicians

- a. System wide or program specific
- b. Include attitudes and values, as well as knowledge and skills
- c. Include cultural competency and trauma sensitivity
- d. Establish mechanism for evaluation of competencies that is objective and easy to attain success

Tools: Competency Lists; Arbour Competency Examination

Step 10: Develop system wide training plan

- a. Develop curriculum for staff
- b. Identify trainers and supervisors for all settings
- c. Develop train the trainer curriculum
- d. Implement training, and plan for ongoing supervision
- e. Encourage opportunities for cultural staff exchange

Tools: Available curricula; Train the trainer curriculum; Curriculum case material

Step 11: Establish structures for interprogram care coordination

- a. Administrative and clinical leadership
- b. Service area specific
- c. Case responsibility to support clinicians
- d. Review procedures to promote collaboration

Step 12: Develop model for a comprehensive array of programs and services

- a. Assign responsibility to each existing program to develop DDC and/or DDE programming for defined population(s)
- b. Develop range of triage and acute care services: emergency services, DDC crisis beds, DDC/DDE Inpatient and partial, DDC/DDE detox
- c. Develop range of models for continuous integrated case management, including flexible outpatient services, various case management intensities, and ACT/CTT as best practices
- d. Develop range of models for day programming and psychosocial rehabilitation services, beginning with implementation of stage specific groups in NM settings, MH/trauma groups in CD settings
- e. Develop range of housing models, including wet, damp, dry concept
- f. Utilize independent and group supported housing models as well as staffed models
- g. Needs assessment to match existing resources and plan for new ones

- h. Begin implementation with small step increments in recontracting with providers, in negotiating with MCOs, in program level changes
- i. Interconnect system, program, clinical practice and competencies

Comprehensive Program Array

- <Program Categories
- <Addiction System (ASAM PPC2R)
- <DDC-CD
- <DDE-CD
- <AOS
- <Mental Health System (Minkoff)
- <DDC-MH
- <DDE-MH
- <Peer Involvement/Cultural Competency

Dual Diagnosis Capable: DDC-CD

- <Routinely accepts dual patients, provided:
- <Low NM symptom acuity and/or disability, that do not seriously interfere with CD Rx
- <Policies and procedures present re: dual assessment, rx and d/c planning, meds
- <Groups address comorbidity openly
- <Staff cross-trained in basic competencies
- <Routine access to MM/MD consultation/coord.
- <Standard addiction program staffing level/cost

Dual Diagnosis Enhanced: DDE-CD

- <Meets criteria for DDC-CD, plus:
- <Accepts moderate MH symptomatology or disability, that would affect usual rx
- <Higher staff/patient ratio; higher cost
- <Braided/blended funding needed
- <More flexible expectations re: group work
- <Programming addresses MH as well as dual
- <Staff more cross-trained/ senior MH supervision
- <More consistent on site psychiatry/psych RN
- <More continuity if patient slips

Addiction Only Services: AOS

- <Not standard for addiction services
- <Does not meet DDC criteria
- <Dual diagnosis accepted irregularly
- <Dual diagnosis not routinely addressed in treatment, nor documented
- <Appropriate for a narrowing group of clients

Dual Diagnosis Capable: DDC-MH

- <Welcomes people with active substance use
- <Policies and procedures address dual assessment, rx & d/c planning
- <Assessment includes integrated MH/SA HX, substance diagnosis, phase-specific needs
- <Rx plan: 2 primary problems/goals
- <D/C plan identifies substance specific skills
- <Staff competencies: assessment, motiv.enh., rx planning, continuity of engagement
- <Continuous integrated case mgt/phase-specific groups provided: standard staffing levels

Dual Diagnosis Enhanced DDE-MH

- <Meets all criteria for DDC-MH, plus: Supervisors and staff: advanced competencies

<Standard staffing; specialized programming:

- a. Intensive addiction programming in psychiatrically managed setting (dual inpt unit; dry dual dx housing, supported sober house)
- b. Range of phase-specific rx options in ongoing care setting: dual dx day treatment; damp dual dx housing
- c. Intensive case mgt outreach/motiv.enh.: CTT, wet housing, payeeship