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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES

The Transformational News:

Michigan's Transition to a Recovery Oriented System of Care for Substance Use Disorders

From the Bureau Director's Desk

The integration of behavioral health and primary health care is a priority of the Michigan Department of Community Health (MDCH), the Behavioral Health and Developmental Disabilities Administration (BHDDA), and the Bureau of Substance Abuse and Addiction Services (BSAAS). This prioritization is necessary to improve quality of life and systems of care for people in the state of Michigan.

Health care changes and ensuing priorities bring renewed importance and relevance to the substance use disorder (SUD) service system transformation to a recovery oriented system of care (ROSC). Within ROSC transformation, health care integration is a key component and requires critical collaboration with a variety of community partners. Individuals suffering from addiction are often affected by mental health disorders and suffer from additional medical concerns and crises. Access to integrated behavioral health and primary health care is critical for these individuals, and their ability to achieve full and successful recovery, which includes health and wellness, and active engagement in the community. By creating a singular environment where SUD, mental health, and physical health can be accessed, we will have progressed a long way toward improving systems of care.

Health care integration is an integral part of ROSC transformation efforts, therefore, all necessary partnerships and engagements that promote health integration, are a top priority. Additionally, both the transformation to a ROSC and its incorporated priority of health care integration, fit very well with the MDCH strategic priorities to: 1) improve the health of Michigan's population; 2) improve the health care provided to our population; 3) lower the health care costs per person in Michigan; and 4) plan and implement health care reform if feasible.

To support ROSC transformation and health care integration, BSAAS included within the 2012 – 2014 Action Plan Guidelines (APG) for SUD service provision, directives to 1) continue ROSC transformation and 2) develop a quality improvement (QI) initiative pertaining to health care integration. Whether involved in these initiatives or not, everyone should think about how health care integration will impact them, their organization and their community. As we work toward integration, evaluate how these efforts impact your local ROSC transformation initiatives. The BSAAS ROSC Transformation Steering Committee (TSC) is also working to identify information that will prove helpful with health care integration and ROSC transformation, and to further identify how these initiatives complement one another. Thank you for your commitment to these important efforts.

Deborah J. Hollis

Collaboration: A Powerful Vehicle for Change

Prevention Works. Treatment is Effective. People Recover. When it comes to thinking and planning multiple minds are better than one! This national model of voices outlines the integration needed to impact and improve community health and wellness.

Community health is a concept encompassing all of the environmental, social, and economic resources, as well as the emotional and physical capacities that enable people in a geographic area to realize their aspirations and satisfy their needs (Miller, 2003).

There are many compelling reasons to promote broad community participation in addressing community health problems. At a practical level, many of the problems that affect the health and well-being of people in communi-

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Collaboration: A Powerful Vehicle for Change (continued)

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ties,-such as substance use disorders, poverty, obesity, and inadequate access, cannot be solved by any one person, organization, or sector working alone. Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying problems and develop effective solutions to address them.

Working together or collaborating with others is a positive way to develop improved performance and to deliver enhanced solutions. Collaboration allows the combination of different areas of expertise. Prevention has learned first hand that collaboration is a promising means of developing effective responses to many of the problems confronting communities. Taking the first steps forward requires people and organizations to adjust their ways of thinking and behaving. It also means establishing new systems and processes within organizations to facilitate and sustain collaborative efforts.

Key advantages:

- A focused application of knowledge and expertise
- More effective use of resources
- More relevant and effective solutions
- A higher level of commitment to action

"Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying problems and develop effective solutions to address them."

Collaboration gives voice to enhance effectiveness and efficiency of achieving challenging health objectives. Strengthening and empowering communities, families, and individuals, aided through collaboration offers greater access and a more powerful vehicle for change.

Denise Herbert, network180

Collaborative Dancing: A Provider's Perspective

It is said that it takes two to tango. That is partially true, but it may not be a very pretty dance. If you have watched enough episodes of "Dancing with the Stars," you know that it takes a lot of hard work, coordination, and commitment to a common goal. In a similar way, moving an agency and a community to embrace a ROSC requires much of the same. It can be awkward at first. We are being asked to dance with strangers, to unfamiliar music. We claim that we promote recovery and wellness, but formal treatment and prevention services reimbursement and policies have not made it easy to incorporate.

For the last two years, Ten Sixteen Recovery Network has been taking intentional steps to change their own tune; and put their money and actions where their mouth is. It began with a tenuous reach out to members of the recovery community – inviting them out onto the floor. Ten Sixteen felt that if they were going to do this right, they had to start at the grass roots level, not with other community providers. They started by forming a Peer Advisory Council, asking local people with recovery experience what were the things that had been barriers. There was skepticism. There was caution. For those that took the first steps with Ten Sixteen, they shared their experiences. The agency began to look for the small, doable things that they could take action on. As they were done together, Ten Sixteen kept listening, learning, and adjusting. Slowly, the agency has been able to find a common ground that is respectful of all roles within the recovery process. It has forced change in how Ten Sixteen moves; twisting in ways that they were not used to. It has changed who they work with, how they view their facility, and the longstanding boundaries set by the treatment profession. Ten Sixteen is striving to be a community recovery center that has outpatient and prevention nested in what happens there, rather than being a clinic that has thrown in some coaching services on the side. They are not just adding new programs; they're embracing the new dance.

As Ten Sixteen has put themselves out there, they are discovering new dance partners. For example, since employment is a significant barrier for sustaining recovery, they were led to partner with a local company, MITECH+, to provide career counseling. As Ten Sixteen continued on that path, it led into a broader opportunity. They are now exploring a public-private venture with a local staffing agency to provide placement services for clients, while they provide a recovery coach for support. Both want to put people to work; the staffing agency has expertise in job finding; Ten Sixteen has expertise in equipping people with life skills. Their individual strengths play to a common commitment, leading to collaboration and innovation. This venture is getting strong support from the business communities and local foundations.

Now as healthcare integration is elbowing its way to the dance, the question comes again about the place for ROSC. But is it really different? ROSC is based on the understanding that SUDs require a holistic system of care to deal with a chronic, relapsing disease. The healthcare system has been refining disease management strategies for decades. There are opportunities, but it is scary; like going from the tango to the quick step.

For example, Ten Sixteen was just approached by a local health system to participate in the development of a comprehensive back pain program, similar to a specialized medical home. The health system recognized the need to have a SUD service provider at the table for their patients who developed an opiate dependency. The health system was struggling to find a physician for patients with chronic pain, whose care is more complicated. These patients' needs go beyond medical, a place where many practitioners have limited training or comfort. The health system is excited that Ten Sixteen has expertise and techniques to help them successfully work with these patients. Even though the health system is much bigger, the agency has something to contribute. It is early. Both are just starting to walk through the steps. Surely there will be injured toes and bruised bottoms along the way; however that isn't a reason not to try.

The music is playing. There are people struggling in the community who need help. Ten Sixteen has an opportunity to set the tone. Someone has to dance. It is not the time for wallflowers.

Sam Price, Ten Sixteen Recovery Network

SPOTLIGHT on ROSC Action in Michigan: Integration

In 1997 the idea of the University of Michigan partnering with the Washtenaw County Community Mental Health (WCCMH) to develop an integrated health-care delivery system model for Medicaid and indigent consumers was born. Through a comprehensive planning process, the creation of the Washtenaw County Health Organization (WCHO) was the culmination of negotiations, hearings and approvals by the county board of commissioners, the WCCMH board, U of M Health System, the regents of the U of M, the Michigan Department of Community Health, and Michigan's governor, attorney general, and legislators. The governing board was appointed in January of 2000 and was legally authorized in July of 2000. The U of M Board of Regents and Washtenaw County Board of Commissioners each appointed six members to the WCHO Board. The vision of the organization was always focused on integrated health.

The concept of providing an integrated health system for the most vulnerable citizens of the county began with the sharing of ideas, and the creation of a data warehouse that housed utilization information that ultimately lead to improving clinical practices for individuals who were most needy. Through this mechanism, the

county was able to develop programs to assist patients with accessing services and receiving supports that would ultimately reduce their service utilization and improve their health status. This included the implementation of a health navigator that followed clients with high mental health and physical health needs to assure they are able to access care.

In 2004, creating a "medical home" was explored. It was hoped that clients would feel more comfortable receiving services at their primary care clinic, and would be better served in the community. WCHO began by partnering with Packard Health Clinic, a local "safety net" primary care clinic that served our mutual clients. The model began with a full time person, with a Master of Social Work (MSW) degree,

providing counseling and case management, and four hours of psychiatric time per week. Psychiatric services fell into three categories: consultation and referral back to the primary care provider (PCP); co-management with PCP; and specialty care for individuals with more serious psychiatric needs. In the first 18 months, 18% of clients served had a substance use disorder and 14% had a serious mental illness. Other disorders for this population included hypertension, asthma, diabetes, depression and coronary heart disease. Clients reported high satisfaction with the program.

The WCHO Board included this objective as part of their strategic plan: *To expand the sites where the delivery of health care for indigent and Medicaid consumers includes physical health, mental health, and substance abuse services for persons with a developmental disability, mental illness or addictive disorders.* The WCHO expanded the integrated health sites to four more clinics with similar staffing models. Additionally, the concept of creating a medical home at the CMH was explored and through a grant from Blue Cross Community Foundation, a nurse practitioner (NP) clinic was created at the CMH sites. This program had a NP on site during clinic hours one or two times a week for four hours. Appointments were scheduled and there was walk in capacity. Clients were self-referred as well as referred by CMH staff. Primary care was delivered on site. The NP was supervised by an off-site primary care physician. Clients who participated in the program had either a primary serious psychiatric disorder or a co-occurring substance use disorder. About 68% had an identified primary care physician. 70% of the clients had one or more visits, and the no show rates were low (10%). Reasons for visits ranged from obtaining a physical exam to diabetes, hypertension/cardio vascular disease, obesity, COPD, education and wound/foot care.

> "The concept of providing an integrated health system for the most vulnerable citizens of the county began with the sharing of ideas..."

The WCHO continues to explore other mechanisms for integrating physical health with the mental health and substance abuse populations. A prime example is the Hamilton House Engagement Center, which was opened in 2009 as a sobering facility. This program serves individuals in active addiction with the hope of engaging that person into treatment and connecting them with the recovery community. Originally, the program setting was in a licensed adult foster care facility. Required to provide health appraisals, the program receives assistance from physicians and nurses in recovery who volunteer their time to assess clients. Additional help from emergency departments and PCPs, who are able to complete the assessments, was utilized. The WCHO also received a grant from the MDCH to implement a disease management project, which provides more focused

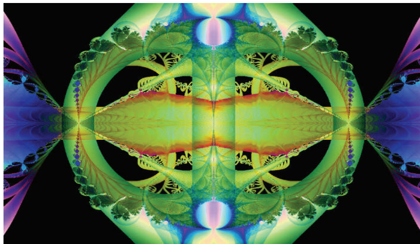
care support by nurse practitioners at the CMH site. A subsequent grant was awarded by SAMHSA to expand the disease management program at the WCHO.

Current efforts include participating in a countywide healthcare initiative that has brought two major health systems, the county health plan, mental health and substance abuse agencies, and primary care clinics together to address the potential changes that would be realized with the Affordable Healthcare Act. Several workgroups have been initiated with the task of assessing the current needs and potential impact of increased Medicaid eligible populations. Each workgroup consists of multiple agencies and multidisciplinary members. It is hoped that by coming together to address current problems, all can begin to plan together for the future. Integrated healthcare is a necessary reality in Washtenaw County. The community efforts flow nicely into the ROSC transformation change that has been implemented this year. (See the *Transforrnational News*—September 2010.)

Marci Scalera
Washtenaw Community Health Organization

What Is A Recovery Oriented System of Care?

A ROSC is not a program; it is a philosophical construct, a set of values and principles, by which a behavioral health system (SUD and mental health) shapes its perspective on how they will address recovery from alcoholism, addiction and other disorders. A ROSC is the basis of the development of the SUD service system. Its philosophy completely encompasses all aspects of SUD recovery services, including program structure and content, agency staffing, collaborations, partnerships, policies, regulations, trainings and staff/peer/volunteer orientation.



ROSC, SUD service entities, as well as their collaborators and partners, cooperatively provide a flexible and fluid array of services. People should be able to move among and within the system's service opportunities, without encountering rigid boundaries or silo-embedded services.

ROSC differs from traditional service systems in the following ways:

- The goal of treatment extends beyond abstinence or symptom management to helping people achieve a full, meaningful life in the community.
- Prior treatment is not viewed as a predictor of poor treatment outcomes and is not used as grounds for denial of treatment.
- People are not discharged from treatment for relapsing or confirming their diagnosis.

- Post-treatment continuing care services are an integrated part of the service continuum rather than an afterthought.
- Focus is on all aspects of the individual and the environment, using a strength-based perspective and emphasizing assessment of recovery capital.
- Prevention services are integral to the promotion of healthy choices and community, and the reduction of stigma associated with SUD and MH disorders.

Some of the implications for recovery services and supports are:

- Greater emphasis on outreach, pre-treatment supports, and engagement.
- More diverse menu of services and supports available for people to choose from.
- More assertive efforts by providers to connect individuals to families and natural supports.
- Expanded availability of non-clinical/peer-based recovery supports.
- Initiated post-treatment recovery check-ups.
- Shifted service relationships from an expert-patient model to a partnership-consultation approach.

Services that support recovery and resilience focus on what we know works:

- Emphasizing more on continuity of care: effective prevention, assertive outreach and engagement, treatment, and ongoing monitoring and support.
- Establishing a continuum of care whose services are holistic and integrated, culturally responsive, and whose systems are anchored in the community.
- Expanding availability of non-clinical services, such as: peer supports, prevention, faith-based initiatives, etc.
- Helping to prevent the onset of substance use disorders.
- Taking a public health approach by helping to create healthy communities.
- Reaching out more assertively to families and communities impacted by substance use disorders.
- Providing more assertive post-treatment monitoring and support.
- Focusing on a partnership consultation approach rather than an expert patient model.
- Valuing and using the lives and experiences of other people in recovery to help others on the journey.

Hopefully you now understand some of the reason for the transformation to a recovery oriented system of care and have a better of what is means when you hear "ROSC".

Please visit the BSAAS ROSC website at www.michigan/mdch-bsaas for more information on Michigan's ROSC efforts.

Michigan SUD Service System Highlights

On September 12 and 13, 2011, the BSAAS convened the Twelfth Annual Substance Use Disorder Conference. The theme this year was "Time for Change."

With all that is taking place, such as ROSC transformation and health care integration, we are definitely experiencing changing times. These changes raise many questions and call for great innovations. As we continue to create new partnerships and imagine tremendous possibilities, it is important that we recognize those among us who rise to the challenge time and time again.

This Year's Award Winners

Yarrow Halstead
"Giving Back Award"

Denise Herbert
"Preventionist of the Year"

Mark Witte
"Treatment and System Transformation Award"

Derrick Hayes
"Collaborative Partner of the Year"

Congratulations,
and thank you all for what you do.

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Problem Gambling Help-line
800-270-7117 (24/7)

We're on the Web
www.michigan.gov/mdch-bsaas

Excerpts from the Bureau of Substance Abuse and Addiction Services 2009-2012 Strategic Plan

Vision: A future for the citizens of the state of Michigan in which individuals and families live in healthy and safe communities that promote wellness, recovery, and a fulfilling quality of life.

One of our priorities:
Establish a Recovery Oriented System of Care (ROSC)

The Bureau of Substance Abuse & Addiction Services (BSAAS) is working to transform the public substance use disorder service system into one that is focused on supporting individuals seeking recovery from chronic illness. A ROSC requires a transformation of the entire service system to one more responsive to the needs of individuals and families that are impacted by addiction. To be effective, a recovery-oriented system must infuse the language, culture, and spirit of recovery throughout the entire system of care. The values and principles that are developed must be shaped by individuals, families, and community stakeholders.

Michigan's ROSC Definition

Michigan's recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.

Adopted by the ROSC Transformation Steering Committee, September 30, 2010

Key Dates and Upcoming Events

November 18, 2011 - Parenting Awareness Conference (Lansing)

November 29, 2011 - Implementing Effective Drug Abuse Prevention Strategies

December 1, 2011 - ROSC TSC Meeting

Other Training Events
Information on workshops, conferences and other educational/training opportunities can be viewed at
www.MI-PTE.org