

# PROGRESS REPORT ON EFFORTS TO IMPLEMENT STUDY TO IMPROVE ADMINISTRATIVE EFFICIENCIES, SHARED SERVICES AND CONSOLIDATIONS

(FY2010 Appropriation Bill - Public Act 131 of 2009)

**April 1, 2010**

**Section 272:** (1) The department shall make efforts to implement the results of the study of current policies and allocation methodologies specified in section 272 of 2007 PA 123. These efforts to encourage administrative efficiencies shall apply to the following entities: (a) Local public health departments. (b) CMHSPs. (c) Substance abuse coordinating agencies. (d) Area agencies on aging. (2) The department shall consult with at least the following applicable organizations in implementing the results of the study: (a) The Michigan association of community mental health boards. (b) The Michigan association of local public health. (c) The Michigan association of substance abuse coordinating agencies. (d) The area agencies on aging association of Michigan. (3) The department shall submit a report on its efforts to implement the results of the study to the senate and house appropriations subcommittees on community health, the senate and house committees on health policy, the senate and house fiscal agencies, and the state budget director by April 1 of the current fiscal year.

*Michigan Department  
of Community Health*



**Jennifer M. Granholm, Governor**  
**Janet Olszewski, Director**

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
SECTION 272 BOILERPLATE REPORT**

**COMMUNITY MENTAL HEALTH**

**Option 1: Standardize Administrative Policies and Procedures.**

In May 2006 the MDCH MH/SA) executed a Memorandum of Understanding with the Michigan Association of Community Mental Health Boards (MACMHB) that outlined a working agreement between MACMHB and MDCH that created "The Standards Group" (TSG). TSG is a joint effort of the 18 pre-paid inpatient health plans (PIHPs), the MDCH, and the MACMHB to work with consumers, families and advocates to provide focused attention to the development of recommendations to MDCH for uniform and consistent administrative, programmatic and business practice standards for state-wide use in serving persons with mental illness and/or developmental disabilities and/or substance use conditions. This created a capacity to standardize practices that affect how services and supports are organized and delivered.

Accomplishments to date include:

- Development of Access Standards for CMHSPs and PIHPs. These Access Standards were included in the FY 2009 contracts.
- Development of Waiting List Guidelines. MDCH issued this guideline on April 15, 2010 as a draft technical advisory for 30 day public review and comment.
- Development of Needs Assessment Guidelines. This workgroup is currently meeting and is currently in the information gathering & analysis phase to determine core elements and requirements for community needs assessment with the final product expected by September 2010.
- Case management/Supports Coordination Core Competencies. This workgroup is currently meeting with the final product expected by September 2010.

Additionally, MDCH is working with the TSG and the PIHP Chief Information Officers forum in developing a web-based infrastructure for data reporting.

In April 2010 the MH/SA Administration began a process to reinvigorate administrative efficiencies by appointing a workgroup charged with reviewing various MDCH oversight functions and the requirements for PIHPs to provide oversight and to look for opportunities to consolidate those functions. The workgroup will complete its task by August 2010.

**Option 2: Account for Administrative Costs Consistently**

In February 2010, the MH/SA Administration issued revised administrative cost reporting requirements: *Establishing Administrative Costs within and across the CMH System*. These requirements apply to the entire community mental health system encompassing CMHSP and PIHP administrative gross costs and all fund sources thus consolidating what had been different requirements based on fund source. MDCH will continue to work with the community mental

health system to standardize local reporting and assure information is accurate, consistent and useful. These administrative functions are consistent with categories and costs used in other health care related organizations thus providing comparability to the administrative costs of similar organizations.

### **Option 3: Identify Disseminate Evidence-Based and Best Practices**

The MH/SA Administration established The Practices Improvement Steering Committee to provide guidance on the identification of and processes that will support the adoption and implementation of evidence-based and promising practices. Each PIHP has an Improving Practices Leadership Team (IPLT) which oversees its system change work to continually improve the type and quality of services which are available to adults and children served in the public mental health system. Consistent with federal transformation goals, MDCH has dedicated Mental Health Block Grant funds to support practice improvement for adults and children.

- As of October 1, 2009 all PIHPs are required to offer two of the SAMSHA endorsed evidence-based practices as a choice for adults with serious mental illness: Family Psycho-education and Integrated Treatment for Persons with Dual Mental Health and Substance Use Disorders. The Field Guide for Assertive Community Treatment (ACT) has been used widely across the state.
- Two evidence-based practices for children: Parent Management Training Oregon (PMTO) Model and Trauma Focused Cognitive Behavior Therapy (TFCBT) are being implemented in a number of CMHSPs.
- The Michigan Mental Health Evidence Based Practices (MiMHEBP) initiative has completed phase II of its plan to develop and disseminate psychotropic prescribing algorithms for major psychiatric disorders. Phase III, involves development of a software module can stand alone or operate within an established electronic medical record.

### **Option 4: Consolidate Structures**

The MH/SA Administration has focused on increasing administrative efficiency within the existing organizational structures. In February 2009, the *Application for Renewal and Recommitment* (ARR) formally introduced new and enhanced expectations of performance, and revitalized the public mental health system's commitment to excellence in the priorities and directions outlined for PIHPs as specified in the 2000 Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans, approved by the federal Centers for Medicare and Medicaid Services (CMS), that promised Michigan would select local managing entities that promote beneficiary freedom, participation and integration, while achieving system outcomes of efficiency, choice and community inclusion.

The ARR focused on 11 areas for improved performance. All 18 PIHPs are required to respond to the application and to develop plans for improvement in the areas identified. MDCH is monitoring these plans to assure that they are implemented. One of these is the priority for achieving administrative efficiencies as follows:

*"The public mental health system is responsible for operating as efficiently and effectively as possible in order to maximize the amount of dollars available for providing supports and services. Within the organizational structure of the PIHP and its affiliates and CAs, as applicable, ongoing attention to and capacity for continuous quality and process improvement and simplification is expected. Understanding individual, provider, stakeholder and staff experiences and involving them in such activities is essential. PIHP leadership must actively pursue CQI and/or simplification in the areas of paperwork reduction, electronic medical records (EMR), service cost variability, reciprocity in training and service monitoring, and uniformity in provider contractual requirements."*

Additionally, during FY 10 the MH/SA Administration established quarterly meetings with the PIHP directors to improve PHIP management and accountability. In addition activities are under way in partnership with the Michigan Association of Community Mental Health Boards to examine and develop recommendations for administrative efficiency.

### **Option 5: Increase Accountability for Outcomes**

The MH/SA Administration is focusing on the following:

#### **Sustainable Models of Collaboration**

- In FY 09, the Department of Human Services (DHS) and MDCH collaborated to use the SED Waiver to serve children in DHS foster care as a result of the Children's Right's Settlement.
- MDCH has utilized federal mental health block grant funds to support system of care planning across the state. Increasing mental health services to children in child welfare and juvenile justice was to be a special focus. This focus for mental health block grant funds continues in FY 10 and FY11.
- Two federal Substance Abuse and Mental Services Administration (SAMHSA) System of Care grants were awarded to two communities in Michigan—Ingham County and Kalamazoo County in 2006. In late FY09, a third Michigan community—Kent County was awarded a SAMHSA System of Care grant.
- MDCH has been working intensively with the Michigan Rehabilitation Services (MRS) and the Michigan Commission on the Blind (MCB) to better coordinate services to assist people who are jointly served by one of those agencies and the community mental health system. Joint approaches to education, training, and sharing information are in place

#### **Collaborative Models to Integrate and Coordinate Mental Health Services with Primary Health Care:**

- MDCH sponsors a Mental Health Advisory Committee (MHAC) consisting of medical directors from PIHPs and Medicaid Health Plans (MHP). The MHAC focuses on improving the coordination of care for their mutual recipients.

- Collaborative models of electronic medical record sharing and a definition of the respective responsibilities for the primary and mental health care of mutual recipients have been developed.
- The MHAC disseminates information about health care integration initiatives and for examining the use of psychotropic medication including regular reports from the Pharmacy Quality Improvement Program (PQIP).
- Ten CMHSPs were awarded federal Mental Health Block Grant funds in FY 09 to in their service areas and this work continues in FY10.

#### Interagency Approach to Prevention, Early Intervention, and Treatment for Children:

- The Early Childhood Investment Corporation (ECIC), through the work of its external Board Advisory Committees has established Priority Outcomes and Benchmarks for Social and Emotional Health, Pediatric and Family Health, Family Support and Parenting Education and Early Care and Education.
- The Great Start Systems Team (GSST) began meeting in FY 09 to assist with collaboration between the ECIC and the state partner agency children's services managers.
- MDCH was awarded a Substance Abuse and Mental Health Services Administration Grant, Project Launch, which is focused on developing a system of care for children birth to 8 years of age that focuses on health and wellness including social emotional health.
- MDCH Medical Services Administration (MSA) in conjunction with the Michigan Chapter of the American Academy of Pediatrics is engaged in a spread strategy to train pediatric practices about standardized, validated developmental screening tools and incorporating them in the EPSDT well child visits.

#### Co-Occurring Mental Health and Substance Use Disorders:

In June 2008 MDCH created an Integrated Treatment Committee (ITC) with 21 invited stakeholders to address barriers and develop strategies for individuals with co-occurring mental health and substance use disorders, whether they are primarily served in the public mental health, public substance abuse, or Medicaid primary care system. The ITC developed a strategic plan for the system and is currently focusing on a work plan to address the challenges and barriers that were identified.

### **Substance Use Disorder Services**

#### **Option 1: Standardize Administrative Policies and Procedures.**

The most recent overhaul of administrative policies and reporting procedures took effect in FY 2006. At that time, a good deal of attention was paid to achieving consistency of policy between substance use disorders and mental health. This is the policy contained in the current MDCH contract with Substance Abuse Coordinating Agencies (CAs) and Salvation Army Harbor Light

(SAHL). Since adoption, the Bureau of Substance Abuse and Addiction Services (BSAAS) has taken the following steps to enhance standardization and consistency across CAs:

- Conducted workshops at the semi-annual meetings of the Michigan Association of Reimbursement Officers (a CMHSP group) and participated in quarterly meetings of the CA Information Technology and Data Committee, to provide clarifications, feedback, and updates regarding policies and procedures.
- Provide on-going consultation and technical assistance through contract managers.
- Provide corrections and clarifications through the review and approval of annual budgets and quarterly and annual expenditure reports, including the annual Administrative Expenditure Report and Section 408 Legislative Report.

### **Option 2: Account for Administrative Costs Consistently**

Standardization of policy and procedure (above) is of course an important means of improving the consistency of accounting for administrative costs. Nonetheless, during the past year we have become aware of some reporting inconsistencies and of some policy requirements that have different effects on CAs, particularly with respect to Access Management System (an administrative function). BSAAS has established a workgroup of State-level and CA staff to address these issues and to take a broader look at ways to improve policy and procedures. The workgroup's objectives are to:

- Increase the across-CA consistency and uniformity of administrative budgeting and expenditure reporting.
- Through the above, increase the comparability of reporting, and therefore fairness in comparisons.
- Identify opportunities to better align CA and CMHSP administrative reporting taking advantage of easy opportunities not extensive changes).

The workgroup's initial set of topics for consideration are:

- Classification of AMS (whether contracted or direct operated, whether face-to-face or phone)
- Classification of care coordination functions (non-clinical)
- Classification and fund source of the prevention coordinator
- Administrative reporting categories (including whether to retain, revise, or delete the current report)
- Alignment of CA/CMHSP administrative reporting models

The workgroup's report will be issued by the end of July 2010.

### **Option 3: Identify Disseminate Evidence-Based and Best Practices**

The DCH Bureau of Substance Abuse and Addiction Services is able to keep up-to-date on national evidence-based and best practice through its participation in national initiatives such as NIATx200, the State Prevention Framework/State Incentive Grant program, the national Fetal

Alcohol Spectrum Disorders program, and the national networks for State-level specialists in SUD treatment, prevention, women's services, and medication-assisted treatment services. BSAAS has disseminated evidence-based and best practices through several channels:

- Through the implementation of the Strategic Prevention Framework, State Incentive (SPF/SIG) Grant, BSAAS has developed and implemented an evidence-based planning model that has resulted in: a) building of prevention capacity and infrastructure at the state and community-level; b) preventing the onset and reducing the progression of substance abuse, including childhood and underage drinking; and c) reducing substance abuse and related problems in communities. CAs are now required to submit Action Plans that incorporate the SPF/SIG planning model that includes: a) needs assessment; b) assessment and building of capacity; c) strategic planning; d) implementation planning; and e) evaluation.
- Required CAs to allocate 90 percent of their prevention funding to evidence-based programs and services. Evidence-based programs and services are defined as those programs and services that have been found to be effective as indicated in: a) a National Registry of Effective Programs; b) a peer review journal reporting positive effects on the target outcome; and c) a publication of documented effectiveness supported by research or review of informed experts.
- Established an Evidence-based Practices Workgroup for the purpose of educating CAs and prevention partners on identifying and selecting appropriate evidence-based programs, policies and practices that are germane to their prevention needs and goals.
- Issued Technical Assistance (advisory) and Policy (required) documents. In FY 2009 and 2010, documents were issued on Residential Services, Women's Services, Fetal Alcohol Spectrum Disorders, and Enrollment Criteria for Methadone Maintenance and Detoxification.
- The major initiative--moving toward a Recovery Oriented System of Care has involved dissemination of best practice documents and expert presentations related to systems transformation and recovery.
- During biennial on-site monitoring visits to CAs, staff provided information and data on best practices, and verified that CAs are implementing evidence-based and best practices as required.
- At quarterly meetings of the CA Outcomes Committee, staff provided data presentations reflecting apparent adherence and non-adherence to best practices as seen in client admission/discharge and encounter data.

#### **Option 4: Consolidate Structures**

The Savings and Reinvestment Workgroup was convened in February 2009, consisting of CA, provider, and state staff. Its purpose is to identify opportunities to reallocate existing financial and human resources to areas of better return on investment. The workgroup identified over 30 such opportunities, ranging from quite modest to very substantial. One example, a pilot project was conducted for providers with contracts with multiple CAs, the "home CA's" administrative compliance audit can be accepted without multiple on-site visits. Financial audits were exempted from this project. The pilot demonstrated that consolidation of monitoring audits among CAs with shared providers has mutual benefits.

## **Option 5: Increase Accountability for Outcomes**

For the past two years, DCH has included data on treatment services outcomes and cost-related performance in various published reports. DCH has also presented outcome and performance data to CAs and others in committee meetings, during on-site monitoring visits, and in periodic special mailings. Based on internal discussions and discussions with CA and provider personnel, development has begun on a CA “report card” that will include both administrative and services performance measures. DCH expects to begin implementation on a pilot basis at the start of FY 2011.

## **PUBLIC HEALTH ADMINISTRATION**

### **Option 1: Standardize administrative policies and procedures**

Michigan was the first state in the nation that implemented a process for accreditation of local health departments. This process was begun in the late 1990’s and continues today. Each health department is assessed every three years for compliance with a set of accreditation standards developed by state and local stakeholders. This structured process ensures that each health department is assessed in the same manner and against a common set of standards.

Prior to the third accreditation cycle, which began in 2006, accreditation standards were closely reviewed and winnowed down to only those standards that are required by statute, federal program requirements, administrative rules and departmental policies. This was done as an effort to reduce the administrative burden on both state and local health departments as funding for public health continued to shrink.

In preparation for the fourth accreditation cycle, which began in 2009, standards were again reviewed to simplify and reduce as many requirements as possible.

MDCH contracts with 45 local health departments through the Comprehensive Planning and Budgeting Contract (CPBC). This concept resulted from a state/local initiative and establishes a common contractual framework and guidance for budgeting for dozens of different programs from three state agencies.

### **Option 2: Account for administrative costs consistently**

The Public Health Administration (PHA) relies on a variety of funding sources to carry out its responsibilities. The largest fund source for PHA activities is federal grants. Each federal grant has its own requirements and limits on administrative costs. That, coupled with the fact that state funding provided to local health departments is program based and not focused on supporting infrastructure, makes it extremely difficult to account for administrative costs consistently. Local health departments have the flexibility to use state funds, local funds, fees or any combination for administrative costs, further increasing the difficulty of assessing these costs in a consistent way.

MDCH contracts with 45 different local health departments, many of which are captured by other political subdivisions with their own budget, finance and administrative cost policies and procedures. It is difficult to establish standard administrative cost procedures when MDCH provides less than 50% of the funding for these programs.

### **Option 3: Identify and disseminate evidence-based and best practices**

MDCH - PHA has developed a contract with the Michigan Association for Local Public Health (MALPH) to establish, populate, maintain and make available a database of public health best practices for those programs commonly administered by local health departments.

MDCH – PHA, along with the Michigan Public Health Institute (MPHI), MALPH, Michigan Department of Agriculture (MDA), the Michigan Department of Natural Resources and Environment (DNRE) has also been engaged in the Robert Wood Johnson Foundation funded Multi-state Learning Collaborative (MLC) grant process for several years. Integral to this process is the dissemination of information on quality improvement and assistance to local health departments on developing and implementing their own quality improvement projects. At the end of each cycle, a showcase is held where each funded project displays and describes the process they went through and the results they achieved. Through this process best practices are shared with other health departments not only in Michigan but in other MLC states as well.

Michigan’s Accreditation Program Quality Improvement Supplement includes opportunities for local health departments to present information on their own best practices and quality improvement projects. These practices and projects are included on the MPHI Accreditation website.

MDCH – PHA – Office of Public Health Preparedness (OPHP) maintains a web based system for health alerts called the Michigan Health Alert Network (MiHAN). This website is also used for sharing of best practices around preparedness planning. Documents and ideas are posted on the site for use by health departments, tribes and hospital preparedness entities once they have been identified as a best practice. This reduces duplication of effort for many agencies.

### **Option 4: Consolidate structures**

MDCH – PHA is in the process of changing the Administrative Rules around the requirements for local health departments’ medical direction. In today’s shrinking budget atmosphere, it is advisable for health departments to “associate” for the purpose of sharing medical direction. One such arrangement was completed in 2009 with five health departments covering eight counties sharing one fully qualified, full time medical director.

The Administrative Rule that requires full time medical direction for any jurisdiction with more than 150,000 residents was developed in the 1970s. With the advent of widespread electronic communications, it is now possible to cover a larger area with one medical director. This Rule is in the process of being changed so that health departments with less than 250,000 residents will only need to have 16 hours of medical direction to meet the requirements.

In Livingston and Jackson counties, the Boards of Commissioners have a legal agreement to share the services of their Health Officer and Medical Director.

Smaller health departments frequently contract with other health departments or agencies to provide services in a more cost effective way. Some examples of this include the Breast and Cervical Cancer Control Program, family planning and dental services.

In Tuscola and Huron Counties, they are sharing the services of their Environmental Health Officer.

MDCH has been in discussions with the Michigan Association of Counties (MAC) and MALPH to establish a process for an organized discussion on the opportunities around consolidation of structures as they pertain to public health. A meeting is planned for the summer or fall of 2010 to bring together county commissioners and health department leadership to discuss ways to save money and increase efficiency by consolidation of some public health services and/or staff.

Three district health departments are contracting with a fourth health department to provide inspections of body art facilities.

Two health departments are sharing a computer server for their electronic medical record systems.

### **Option 5: Increase accountability for outcomes**

In 2008, the MDCH – PHA implemented performance based funding criteria for federal immunization funding. In 2010, Michigan was given an award for having the second highest immunization rates for children in the nation.

In 2009, the Michigan Accreditation Program for local public health implemented a Quality Improvement Supplement to assess quality improvement efforts at the local level. This assessment focuses on the development and measurement of meaningful goals and objectives in the public health setting.

MDCH – PHA has done a lot of work to improve sub-recipient monitoring to ensure that funds granted to other agencies are spent properly and that desired outcomes are achieved. This process will be enhanced in the fall of 2010 by the addition of expenditure testing for high risk agencies.

## **OFFICE OF SERVICES TO THE AGING**

### **Option 1: Standardize Administrative Policies and Procedures**

OSA continues to maintain, and update as necessary, a standardized system of administrative policies and procedures that govern the administrative operations of AAAs. This system is

comprised of Operating Standards for Area Agencies on Aging, Administrative Rules for State and Local Programs on Aging, Code of Federal Regulations, 45CFR Part 1321.11, OMB Circulars A-110 and A-122, area plan approval criteria, and issuance of Transmittal Letters to provide guidance on implementing policy directives. AAAs continued to conform to this standardized system of administrative policies and procedures.

### **Option 2: Account for Administrative Costs consistently**

OSA developed and implemented a procedure for Agency Wide Reports in response to PA 123 of 2008 Section 1417. The reports contain 1) the total allocation of state resources made to each AAA by individual program and administration, and 2) detailed expenditures by each AAA by individual program and administration, including both state funded resources and locally funded resources. These Agency Wide Reports have been consistently prepared and submitted by OSA.

### **Option 3: Identify and Disseminate Evidence-based and Best Practices**

Four of the largest AAAs have developed and participate in a South East Michigan Collaborative for pooled bulk purchasing of products and services to support their operations. Several AAAs collaborate with county based aging service providers and local governments to achieve efficient use of voted senior millage resources with respect to state and federal resources used to implement service delivery systems under locally developed area plans.

One AAA sponsors a “Best Practices” annual conference for staff in nursing facilities and other LTC settings intended to promote improvement in the quality of care provided. Several AAAs conduct bi-monthly or quarterly coordination meetings with a range of local organizations including aging service providers, tribal organizations, centers for independent living, to share best practices and develop collaborative strategies for improving services to older persons and achieving program efficiency.

OSA presented the MiDEAL cooperative purchasing program to all area agencies and service providers in the Michigan Aging Network. Many had already been participating in conjunction with local units of government. Some cost savings have been achieved through use of MiDEAL.

### **Option 4: Consolidate Structures**

Two AAAs continue to be components of multi-purpose agencies. Two AAAs continue to be components of local health departments. One AAA is co-located with a 211 program. One AAA is co-located with a PACE program, a 211 program, and a senior nutrition service provider in part to achieve administrative efficiency. Two AAAs are in discussion with a local center for independent living (CIL) regarding co-location.

### **Option 5: Increase Accountability for Outcomes**

OSA continues to conduct an annual Program Outcome Assessment of each AAA. Ongoing refinements to the area planning process include a requirement for each AAA to establish program development objectives directly related to the adopted goals of the State Plan on Aging developed by OSA. The annual Program Outcome Assessments address program development objectives for each AAA and provides accountability for outcomes.