Behavioral Health Section 298 Workgroup Meeting Summary

March 30, 2016

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) convened a workgroup of 120 stakeholders on Wednesday, March 30, 2016, at the Lansing Community College West Campus. The group discussed Section 298 on delivering and financing behavioral health services from Gov. Rick Snyder's proposed fiscal year 2016 budget. The stakeholders represented individuals in service and their advocates, and various organizations, including community mental health service providers (CMHSPs), prepaid inpatient health plans (PIHPs), Medicaid health plans, behavioral health providers, and statewide advocacy organizations. During the meeting, the group reviewed the purpose and process of the workgroup, discussed the core values, and identified next steps. MDHHS asked Public Sector Consultants (PSC) to facilitate this and future Section 298 workgroup meetings.

WORKGROUP PURPOSE

Lynda Zeller, deputy director of MDHHS Behavioral Health and Developmental Disabilities, welcomed workgroup members and described the group's purpose and tasks. The purpose of the workgroup is to help provide MDHHS with information that helps with the design of a strengthened system that fulfills this End Statement as defined by MDHHS staff:

"To have a coordinated system of supports and services for people with developmental disabilities, substance use disorders, mental illness, and physical health needs. Further, the end state is consistent with stated core values, is seamless, maximizes percent of invested resources reaching direct services, and provides the highest quality of care and positive outcomes for the consumer."

The End Statement defines the behavioral health system's target populations, uses a set of core system values to guide its work, and assumes the World Health Organization's (WHO) definition of health, which is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

In order to reach this End Statement goal, the workgroup is tasked with three things:

- Develop and agree on the core values that a better system should reflect
- Develop a set of clear concepts to replace the current Section 298 boilerplate language in Governor Snyder's proposed budget for fiscal year 2017
- Create an outline of a plan for how Michigan's system should be strengthened for persons with behavioral health and/or developmental disability service and support needs

WORKGROUP PROCESS

Ms. Zeller provided an overview of the workgroup's expected process. She covered the general topics of each of the meetings, explained the use of background information, and shared MDHHS's commitment to transparency. Peter Pratt, PSC president, then discussed the workgroup's ground rules.

Meeting Topics

Ms. Zeller reported that over the course of four meetings from March to May 2016, the workgroup will:

- Develop and agree on a set of core values that provide a common foundation for the process
- Identify the aspects of the behavioral health system that are working well now and those that are not working well now—including unmet needs
- Discuss the elements of a system that reflect the core values, build on what is working, and address what is not working
- Determine what would be needed to deliver, administer, and pay for the desired system

After May 2016, more work will be needed on the workgroup's outlined plan to develop it more fully and give it more detail. MDHHS, along with the State Budget Office, will discuss the workgroup's recommendations and make final decisions on recommended next steps. The work needed after May 2016 will be largely determined by how much the workgroup is able to complete by the close of the fourth meeting.

Background Information (Facts Group)

Ms. Zeller explained that the workgroup would be provided background information to help inform the discussion. This background information is being informed by the Facts Group, led by Tom Landry, board chair of Michigan Protection and Advocacy Service Inc., and it is made up of state of Michigan staff, behavioral health and physical health stakeholders. As an example of the information the Facts Group is compiling, Ms. Zeller presented a chart showing the percentage of different populations (e.g., children, aged, disabled) that make up Michigan's Medicaid population, and a chart showing the percent of expenditures by each population group. Ms. Zeller shared that workgroup members can submit their suggestions of information they think should be a part of the background information provided by the Facts Group. Mr. Landry reported that, to date, 23 pages of suggestions have been given to the Facts Group for their consideration.

Transparency

Ms. Zeller stated that MDHHS is committed to transparency throughout this project. State staff then explained a plan for a Share Point website, available to the members. The attendees provided strong feedback about concerns with Share Point not being as easily accessible to the broader public. The attendees pointed out that the planned Share Point tool could contribute to concerns about lack of transparency.

MDHHS will work quickly to identify an alternative online, publicly accessible location with materials from the workgroup's deliberations.

Ground Rules

Peter Pratt laid out the ground rules for the workgroup meetings. He stated that the group must work collaboratively and treat each other with civility and respect. He added that everyone can share their opinion, but they should not dismiss or denigrate others' opinions. Decisions by the workgroup will be reached by consensus, defined as approval by two-thirds of the attending members. Consensus will be assessed using red, yellow, and green notecards, which were provided to each participant. A green card means total approval of the item being discussed, a yellow card means approval with reservations or questions ("I can live with it"), and a red card means the person cannot support that item at all. Two-thirds approval will be reached through a combination of green and yellow cards, not through green cards alone.

CORE VALUES DISCUSSION

Ms. Zeller introduced the list of core values proposed by MDHHS staff. She explained that they were developed after reading historical documents, such as those from previous Mental Health Commissions and the Mental Health and Wellness Commission, as well as the behavioral health waiver applications to the federal government. She stated that the values will inform the development of the improved system, which serves several population groups with different needs. She explained that the values are meant to reflect core *system* values, not values for the *individual*. She added that the core values assume the WHO's definition of health (see above).

Mr. Pratt led the discussion about which core values are necessary to reach the End Statement. Workgroup participants received MDHHS's list of values prior to the first meeting. The workgroup reacted to the listed values, offered revisions to them, and added others that they felt were missing. The values below are the original list with the changes proposed during the workgroup meeting in underlined text. Rationale for the changes from participants, if provided, is included in discussion points beneath the proposed value. Participants were allowed to send additional feedback and core value wording before 5 PM on Thursday, March 31, 2016. Additional recommendations are included, in italics, as part of the discussion of the currently proposed values. The values are not listed in any order of significance.

- Person and family centered
  - *A commitment to true integration involves a person-centered approach focused on the promotion of independence and self-determination.*
- Person- and family-driven and youth-guided
  - Family-driven care and youth-guided care are the values consistent with MDHHS contracts and with the Substance Abuse Mental Health Services Administration (SAMHSA).
  - "Youth-guided" refers to youth having a say in the decisions and goals in their treatment plans. The older youth are, the more they should be involved in their treatment plans.
- Data-driven services and supports
  - A data-driven system supports the use of best practices and evidence-based practices.
- Community-based (health care, services, and support are local; recovery and community-based organizations; local leadership, control, and decision making)
  - "Community-based" is not well defined. It could be interpreted to suggest regionalization and determinations on health care facilities being in the community or outside of it. However, people live in neighborhoods and health care should be delivered and received locally.
  - Individuals should define their own community, which includes where people live, work, play, and worship.
  - Community-based care should include faith-based organizations.
  - Community should include college campuses and higher education.
  - Taken together, the values of "community-based" and "full community inclusion" cover what the individual wants and needs.
  - Providers should be community-based, and behavioral health and provider leadership should be from local communities.
  - *When the word "community" is meant to be locational, the words "local community" or "regional community" could be used instead.*
  - *Community-based care should encompass building and sustaining community-oriented systems of care to ensure the availability of a full array of safety net services to meet the people's needs. This idea reflects the unique ability of all Michigan communities to define and build supports and services that address the community and person-defined needs. CMHs meet the needs of the people served, not by only providing high-quality services but by supporting engagement of members of*

the community in providing services that grow a community's capacity to nurture and support its members.

- Linguistic and cultural competence (rural, urban, race, ethnicity). Multiculturalism: Various cultures in society merit equal respect; culturally relevant, community-driven (recognize tribal nations)
  - This includes valuing diversity and diverse communities.
  - The system needs to recognize, work with, and respect tribal nations. Tribal nations have small numbers, but they are sovereign nations, which deal directly with the federal government.
  - *Community includes the elements of daily life that an individual chooses to participate in, and should be inclusive of race, ethnicity, faith, gender, and all other subcategories of our population.*
- Availability of a diverse set of services based on people's needs
- Full community inclusion, engagement, and participation (encompassing consumer desires)
  - This includes people with disabilities; there should not be segregated communities for people with disabilities.
  - The idea of community inclusion is not all encompassing. The system should strive for engagement and active participation, based on the individual's self-determination.
  - *There should be an expectation of community engagement through representation of people in the behavioral health system on the board governance of any managing entity.*
- Freedom and choice; people control who is in their lives
  - Freedom and choice are part of everyone's core values. People deserve to choose who should or should not be in their lives. The behavioral health system currently determines who and what is in a person's life too often.
  - *This should include honoring individual and family choices and preferences.*
- Evidence-based or best practices
- Public oversight and accountability and focus on the public interest
- Service array accountable to public and the people and families receiving services
- Long-term solutions
  - The end goal should be to develop a lasting solution for the behavioral health system with which we can move forward.
- ~~-~~ Meaningful participation and engagement defined by the person; ensuring each individual reaches their fullest potential ~~Productivity~~
  - ~~-~~ The term "productivity" is used synonymously with "being billable." Productivity has a negative connotation for providers because services they see as being valuable and meaningful to individuals and families may not be billable, and are therefore not part of providers' assessed productivity.
  - ~~-~~ *This includes meaningful employment. People should be supported to gain and maintain employment, as is called for in Employment First. Meaningful employment is tied to better health and quality of life outcomes.*
- Promoting independence and embracing self-determination
  - The word "independence" does not fit with requiring community-based services and should be removed from the list of values.
  - The idea of "independence" connects strongly with core values of freedom and choice and should remain part of the list of values.
  - The word "promoting" does not adequately encompass the value of self-determination. Instead, consider the words "encouraging," "ensuring," "embracing," and "supporting" to go in front of self-determination.
- Recovery and resiliency-oriented (recovery-based, including peers, drop-in centers)
  - Recovery is about connecting to people.

- The word "oriented" is not strong enough to convey that individuals in behavioral health services are members of society and that people in services are people first and foremost.
- The word "recovery" does not encompass all of the target populations in the behavioral health system, such as those with developmental disabilities. People with developmental disabilities should have services focused on habilitation, not on recovery.
- *Clubhouses and clubhouse programs should be included as part of the recovery-based, resiliency-oriented system.*
- *Recovery and resiliency could be two separate values to better differentiate the philosophical and service delivery aspects.*
- *Alternative wording of the value could read, "Focused on recovery and highest level of functioning (maximum potential)" because people with intellectual and developmental disabilities (IDD) do not recover from their disability.*

- Use peer supports and recognize their value
  - Peer supports are a growing and important group of professional providers. People in services are often willing to share information with their peer supports that they would not share with their clinicians.
  - Some agencies use the bare minimum number of peer supports required by the waiver instead of recognizing their value and investing in more of these non-degreed professionals.
  - This value should include the use of recovery coaches.
  - *This should also include the full spectrum of peer-delivered services, including parent support partners and youth peer support specialists.*
- Retain non-degreed professionals (e.g., peer support specialists and recovery coaches)
- Prevention-prepared communities
- Prevention services
  - Prevention services can help avoid the need for intense behavioral health services.
- Strengthened families and their communities
  - *Participation in the community benefits activities that promote local collaboration and community health and wellness.*
- Whole person and environment focus
- Integration of all/total/holistic care for the individual and individuals with co-occurring disorders
  - This includes more than just behavioral and physical health care services. It needs to consider social determinants of health and anything a person needs to be successful.
  - This reiterates that health (as defined by the WHO), is not the absence of disease or infirmary.
  - *People who receive supports and services should have the support necessary to achieve love, belonging, and healthy relationships, which are an important factor in health outcomes.*
  - *A focus on whole person care involves the integration of clinical specialization and community inclusion to decrease fragmentation and support the achievement of an individual's health and wellness goals.*
  - *The integration of whole person care can be best achieved in an environment where the model of care supports a single integrated care team informed by integrated physical, behavioral, and social data. A fully integrated care model supports the connection between physical, behavioral, and social elements and promotes optimal health.*
- Individual satisfaction with care
  - This includes the triple aim of "simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities." (Institute for Healthcare Improvement)

- Coordinated, seamless system of supports and services
  - This includes community linkages and community connections. Coordination has to focus on the whole person, which is more than physical health and behavioral health services only. For example, people in services may need help with finding housing, getting a driver's license, or applying for insurance.
- Real and full-time coordination of care
- Maximize percent of invested resources reaching direct services
  - Any efficiencies providers or administrators gain should remain within the system and go back into providing services and supports.
- ~~Reasonable~~ Optimal availability and access to a full array of effective care
  - The word "array" is preferred over "continuum," because a continuum assumes that people can graduate from a set of services, and that a person would move across the continuum as a part of their recovery. This idea does not represent many people's service experience or expectation of experience.
  - The availability and access to a full array of effective care should be outcome-driven and evidence-based.
  - *There needs to be a community safety net for vulnerable people.*
- Services ~~available~~ offered driven by individual's need and desire
- Highest quality of care, supports, and services by a robust, trained, and experienced workforce
  - People need to be properly paid and honored for their work.
  - *Employees should be well trained and well compensated.*
- Properly honored/paid/trained workforce (justly compensated)
- Independent person-centered planning facilitation
  - Independent facilitation of the plan is the only way to ensure a truly individualized, person-centered plan that will identify all necessary services and supports.
- Sufficient levels of services
  - The clients' need for the level and frequency of services must be considered. For example, if there are only five days of respite available, offering one day to five families is not necessarily sufficient to meet a family's actual need; one family may require all five days of respite.
- Efficient delivery of services with reinvestment in services to people
- Positive outcomes for the person ~~consumer~~
  - This should include positive outcomes for the family, because when children are in services, the outcomes are often family-based.
  - The word "person" is preferred over "consumer," because it puts the person at the front, and not just as a consumer of services.
  - The words "individual" and "member" could also be used in place of "consumer," because people buy their services, they do not just consume them, and because people are members of communities.
- Meaningful employment and education opportunities
  - *This value should be two separate values of "individual integrated employment" and "integrated educational opportunities with needed supports." There is a history of segregated employment and subminimum wages allowed in Michigan for people in the behavioral health system. People in this system have been led from high school into sheltered work environments, which may not allow them the opportunity to reach their full potential.*
- System addresses physical health needs, mental illness, substance disorders, co-occurring disorders
- Trauma-informed system of care

- Trauma-informed care should be the expectation of the behavioral health system, not the exception.

- Habilitative supports and services
  - This encompass that not all people are served in a recovery-based system, especially when those individuals have developmental disabilities, from which they will not recover.
- Choice, transparency (access to information, open meetings), accountability
- Early identification services (focus on children)
- Equity of care, services, and supports across the state
  - Some services and supports are only available in certain counties.
  - The service availability expectations need increase, not decrease, to accommodate this core value.
- Readily available information/outreach about care, services, and supports
  - People are unable to find information about the behavioral health system when they need it. There is a stigma against the mental health system, so information should be available when it is needed.

Additional discussion and refinement of these core values will be needed to clarify and remove any conflict or contradiction among values. MDHHS and PSC staff will revise the list of values for clarity and organization. Any revisions to the list will be provided to the full workgroup.

END STATEMENT REVISIONS

During the discussion on the core values, some workgroup participants shared their thoughts on, and recommendations for, revisions to the current End Statement (on page 1). The comments made by participants are below. If comments were sent via e-mail within two days of the end of the workgroup meeting, they are included in italics.

- The End Statement does not adequately express the value of being a community-based system.
- The target populations should be those with physical health needs, mental illness, substance disorders, and co-occurring disorders.
- *The End Statement should identify the target population as people with developmental disabilities, substance abuse disorders, mental health needs, and those with physical health needs.*
- The End Statement should include a sensitivity about tribal nations.
- The End Statements should include a focus on outcomes for families, not just the individual. Many children are in services with family-oriented goals.
- The End Statement should include children and youth with serious emotional disturbance (SED) and IDD and their families.

MDHHS will review these recommendations and revise the End Statement as necessary.

NEXT STEPS

Ms. Zeller closed the meeting by reiterating the purpose of the workgroup, providing a reminder of what is to come in future meetings, and thanking everyone for their commitment and effort on this project.

The next meeting, which will be held at a location to be determined at 12:30 PM on April 11, 2016, will include a conversation on what is working well in the current system and what is not working well. During that meeting, the group will review the revised set of core values, based on the feedback provided during the first meeting. Additionally, workgroup participants may offer suggestions for background information for the Facts Group by sending requests to ShippyD@michigan.gov before the next Facts Group meeting on April 25.