AN UPDATED PLAN FOR IMPLEMENTING RECOMMENDATIONS OF THE MICHIGAN MENTAL HEALTH COMMISSION REPORT

(FY2013 Appropriation Bill - Public Act 200 of 2012)

April 15, 2013

Section 458: By April 15 of the current fiscal year, the department shall provide each of the following to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director:

(a) An updated plan for implementing each of the recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004.

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. This report shall examine the potential impact that utilization of secure residential facilities would have upon the state's need for adult mental health facilities.

(c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
FY2013 APPROPRIATION ACT SECTION 458 BOILERPLATE REPORT

Implementation Status Report

Boilerplate Section (a) Report

(a) An updated plan implementing recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004.

Since 2005, the Michigan Department of Community Health (MDCH), through the Behavioral Health and Developmental Disabilities Administration (BHDDA), has focused on the overarching goal of Transforming Michigan's Mental Health System as well as implementing the seven goals outlined in the plan. To further refine and reinforce the Commission recommendations, MDCH issued a concept paper in 2008, an "Application for Renewal and Recommitment (ARR)", that was sent to the Prepaid Inpatient Health Plans (PIHPs). In responses that were due on June 1, 2009, the PIHPs had to conduct environmental scans and submit plans for improvement for eleven topic areas that addressed many system improvements, including access to and quality of services, and administrative efficiencies. They were required to involve multiple stakeholders, including consumers and their families in these activities. The plans for improvement span a period of five years. Until the beginning of FY12, MDCH teams had routine conference calls with PIHPs to monitor and guide them as they implemented their individual plans for improvement. For fiscal years 2012 and 2013, MDCH has asked that PIHPs report on their ARR progress in their annual quality improvement reports submitted to MDCH.

Recently, the Governor's Executive Order 2013-6 established a Mental Health and Wellness Commission. One of its functions is to review recommendations from the Granholm Mental Health Commission and other reports, such as long-term care. The report from the new Commission is due to the Legislature in December, 2013.

During FY13, implementation of the seven goals outlined in the plan continued as described in the following.

GOAL 1: PUBLIC AWARENESS

Public Education Campaign. In collaboration with the Michigan Association of Community Mental Health Boards (MACMHB) and other community partners, MDCH developed an anti-stigma initiative modeled on the federal Substance Abuse and Mental Health Administration's (SAMHSA) national anti-stigma campaign. Michigan launched the campaign on March 25, 2008, and it continues through 2013. The focus is to eliminate stigma, prejudice and discrimination within the behavioral health system. A statewide group was formed that included individuals with personal experience, family members, providers, advocates and department staff. The group meets quarterly to provide guidance and statewide leadership to expand current knowledge, improve

practices and provide technical assistance to a variety of stakeholders. A strength-based approach resource guide and toolkit was developed and placed on the MDCH website to assist PIHPs, Community Mental Health Services Programs (CMHSPs), provider agencies and other stakeholders in community education.

Suicide Prevention.

The MDCH/BHDDA Bureau of Substance Abuse and Addiction Services conducted a Suicide Prevention Prepared Communities workshop for prevention personnel from various regions of the state on four separate dates in June, 2012.

All of the participants reported that they found the workshop interesting and that it met their expectations. Most participants also indicated that the content of the workshop was valuable to them as professionals. Recommendations from the group included additional training opportunities, such as practical/clinical training in assessment and intervention techniques to use when interacting with suicidal and high risk individuals; specific methods such as QPR (question, persuade, refer), ASIST (applied suicide intervention skills training); specifics of how to bring communities together in order to fight suicide; and training in evidence-based practices that are available for treating suicide at the community level. As a result, a train-the-trainer session on SafeTalk occurred March 19-20 and March 23-24, 2013.

The Michigan Association for Suicide Prevention has begun work to update the Michigan Suicide Prevention Plan. This work is based on the evaluation of suicide prevention activities. Cross collaboration between state Administrations and Departments will occur throughout 2013 and 2014, to coordinate and improve efforts at the state and local levels.

GOAL 2: PRIORITY POPULATIONS AND EARLY INTERVENTION

Uniform Screening and Assessment. MDCH worked with The Standards Group (TSG) to develop a set of Access Standards aimed at making the screening and assessment process uniform across the access systems of Michigan's 46 Community Mental Health Services Programs (CMHSPs) and 18 Pre-Paid Inpatient Health Plans (PIHPs). Further, MDCH continues to provide training to CMHSP children's services staff on the use of the Child and Adolescent Functional Assessment (CAFAS) tool, the Pre-School Early Childhood Assessment (PECFAS) Tool, the Devereaux Early Childhood Assessment, Infant/Toddler (DECA I/T) and the DECA Clinical tool. MDCH/PIHP and MDCH/CMHSP contracts require the CAFAS (for children and adolescents ages 7 to 17) to be administered at intake, quarterly, annually and at service exit. MDCH is further moving to require the use of the PECFAS (children ages 4 to 7), DECA I/T (children ages 1 through 36 months), and the DECA Clinical tool (children ages 37 months through 47 months) as functional assessment instruments. The requirement to use the Pre-School Early Childhood Assessment (PECFAS) for children ages 4 to 7 years old is now part of the MDCH/PIHP/CMHSP contract. Currently, three CMHSPs are piloting an online version of both the DECA/IT and DECA Clinical tool. MDCH/BHDDA is also currently exploring the use of a standardized

assessment tool for persons with intellectual and developmental disabilities (I/DD). This tool will be implemented in 2014 to create a more standardized assessment across the state to uniformally determine a level of care.

GOAL 3: MODEL SERVICE ARRAY

Evidence-based Practices and Promising Practices.

The Practice Improvement Steering Committee (PISC) has continued to fulfill its charter in relation to the current status of evidence-based practice implementation and other efforts to improve service-provider practices. A primary focus of the group has been to address sustainability and outcome efficacy for those practices being implemented across the state. Consistent with federal transformation goals**,** MDCH/BHDDA has dedicated Mental Health Block Grant funds to support practice improvement for providers serving adults and children. Beginning October 1, 2009, all PIHPs were required to offer two of the Substance Abuse and Mental Health Administration (SAMSHA)-endorsed evidence-based practices (EBP) as a choice for adults with serious mental illness: Family Psychoeducation (FPE) and Integrated Dual Disorders Treatment (IDDT) for persons with co-occurring mental health and substance use disorders. Additionally, a Field Guide (technical assistance manual) for Assertive Community Treatment (ACT) has been used widely across the state in a quality improvement initiative designed to improve ACT services. Training and support for Supported Employment (SE), Motivational Interviewing (MI), and Dialectical Behavior Therapy (DBT) have also continued. In 2007, the Centers for Medicare and Medicaid Services (CMS) established peer support services as an evidenced-based practice. Michigan currently has 1,104 peers who have been trained to become Certified Peer Support Specialists (CPSS). CPSS have received additional training to provide a variety of EBP interventions in partnership with other providers including ACT, DBT, FPE, and IDDT. Over 700 CPSS have received continuing education in additional evidence based practices, including Wellness Recovery Action Planning (WRAP) and/or the Chronic Disease Self Management Program (CDSMP). These are intended to assist individuals in developing a health and wellness plan and healthy lifestyles to improve quality of life, while at the same time decreasing health care costs. Initiatives mirror the Governor's health and wellness message and focus on promising practices, including smoking cessation and tobacco recovery. Over 550 CPSS attended training and are implementing cessation classes within local and regional areas. In 2012, MDCH received an award from the Michigan Cancer Consortium for its smoking cessation efforts. Research was conducted by Stanford University to evaluate the effects that CPSS have in leading CDSMP groups with persons who have mental health and/or co-occurring substance use disorder. The results were very positive. Data collection and interpretation are in the final stages. A journal article has been submitted with a publication date set for late summer of 2013.

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. Almost all of the 46 CMHSPs across Michigan have clinicians already trained or in training for PMTO, and 35 CMHSPs have clinicians

and supervisors trained or in training for TFCBT. In addition, PMTO has expanded to provide a Parenting Through Change (PTC) group model, and is providing a two-day skill-based training on PMTO tools to non-certified clinicians and staff. The wraparound model (a promising practice) is being provided to children and their families across the state as well, and is a key component in the implementation of the MDCH 1915(c) SED Waiver. Michigan is also providing parent support partner training which is a promising/innovative practice that has grown both within Michigan and nationally.

PISC Subcommittees include Measurement, Family Psychoeducation (FPE), Parent Management Training-Oregon Model (PMTO), Assertive Community Treatment (ACT), and Supported Employment (SE), with additional work groups recently established to address co-occurring Mental Illness and Developmental Disabilities, and Trauma. Since April 2011, the previously separate COD Change Agent Leaders (CAL) group and Co-Occurring Disorders: Integrated Dual Disorder Treatment (COD: IDDT) subcommittees, were successfully merged into the current Co-Occurring Change Agent Leaders (CoCAL) subcommittee, in order to integrate resource-efficient efforts to advance co-occurring disorders treatment in what have been historically bifurcated mental health and substance abuse provider arenas.

At the regional level, each PIHP has an Improving Practices Leadership Team (IPLT), which oversees its systems-change work to continually improve the type and quality of services available to adults and children served in the public mental health system. The IPLTs are also responsible for overseeing the implementation of evidence-based practices within the region, including any affiliate CMHSPs.

Currently, there are 34 CMHSPs who have clinicians trained in Parent Management Training Oregon (PMTO) Model and 35 CMHSPs who have clinicians trained in Trauma-Focused Cognitive Behavior Therapy (TFCBT). In FY 12, 316 children were provided PMTO and 467 children were provided TFCBT.

Supports and Services for Persons with Dementia and their Caregivers.

MDCH/BHDDA continues to provide resources, (curriculum, competencies guide, and other materials), technical assistance, and regional educational forums for workforce development for mental health, aging, and long-term care professionals. Partnerships with Eastern Michigan University's Alzheimer 's Disease Education Program and Lansing Community College's Mental Health and Aging Project (MHAP), provide a variety of seminars and workshops related to both mental illness and dementia. A library of hard to find older adult behavioral publications and media is housed at the MHAP. An annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. MDCH/BHDDA partnerships include collaborative work with the Michigan Assisted Living Association, providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia. MDCH/BHDDA's "Concepts and Elements of Dementia in Person-Centered Training" for the Michigan Alliance of Person-Centered Communities, which was provided to a coalition of organizations working in long-term care. This was a

targeted educational module designed for Assertive Community Treatment for individuals with dementia concurrent to their existing mental illness, including identification, assessment and behavioral interventions. Efforts will continue throughout 2013 and 2014.

Recent successful efforts to provide education on mental illness, substance misuse, and dementia to primary care professionals align with the department's integrated health initiative. MDCH/BHDDA has begun work with the Geriatric Education Center of Michigan (GECM) and the Center for Rural Health. Providing behavioral health information at regional GECM sites and through the monthly teleconference "grand rounds" has reached new multi-disciplinary primary care audiences. Collaboration with GECM has extended to their "Alzheimer's Disease and Related Disorders Supplemental Training Grant," with enhancements to curriculum and relevant case studies (e.g., cases of persons with physical and mental health issues and accompanying dementia), and expansion of training participation to mental health professionals, which builds on MDCH strategic direction for improved Integrated Health.

MDCH/BHDDA directs the "Nursing Home Training on Dementia Care" which is in its third year. Dementia Educators develop staff skills in dementia care in 20 selected nursing homes in Michigan, and act as consultants and mentors to co-train facility staff for sustainability. They teach non-pharmacological approaches and interventions to reduce and prevent distressed and challenging behaviors by residents with diagnosed dementia, with an anticipated outcome of reduced discharges to hospitalization because of behaviors. This work now coincides with a 2012 national CMS initiative to reduce use of psychotropic drugs for nursing home residents with dementia.

Overall efforts will continue to collaborate with Medical Services Administration and Office of Services to the Aging to better improve integrated efforts of Behavioral Health and Physical Health particular to the increasing aging population.

Quality Management System. MDCH has continued to refine the Mental Health Quality Management System through the Mental Health Quality Improvement Council that has representatives from consumer, advocacy and provider organizations and PIHPs and CMHSPs. The Quality Management System takes its direction from the "Quality Strategy" that is approved by the Centers for Medicare and Medicaid Services for oversight of the 1915(b)(c) waivers. This includes not only what MDCH does to oversee quality, but also the work of the External Quality Review Organization (EQRO) that reviews the PIHPs' compliance with the federal Balanced Budget Act standards. The Council in particular analyzed all the MH Commission recommendations to determine those that would be relevant to the Council's work. The Council provided advice and oversight in MDCH's efforts to develop and publish on its web site a summary of quality measurements of the PIHPs that is more user-friendly to

consumers, families and advocates. This “fingertip” report is updated quarterly. In the past year, the Council focused on streamlining the site review process

Web-based information infrastructure. MDCH collaborated with PIHPs and CMHSPs to develop a web-based reporting system for individual-level critical incidents that commenced October 1, 2010. This system was designed to replace the aggregate-level sentinel event and death reporting. Critical incidents – suicide, non-suicide deaths, emergency medical treatment and hospitalizations due to injury or medication errors, and arrests – are reported within 60 days after their occurrence. MDCH developed an internal process for analyzing, tracking/trending, and follow-up on events that involve vulnerable people. This system was refined in 2012 and will continue through 2013.

Interagency Approach to Prevention, Early Intervention, and Treatment for Children. The implementation of Project LAUNCH continues. Early childhood mental health consultation is one of the services being provided to childcare providers in the Saginaw community. In addition, an early childhood mental health consultant is placed at three pediatric offices to assist with assuring administration of age-appropriate screening tools, mental health assessment, anticipatory guidance for parents, and referral to mental health and/or community services as needed.

MDCH in partnership with the Michigan Department of Human Services (MDHS), Wayne County Department of Human Services and Detroit-Wayne County Community Mental Health Agency (D-W CCMHA) was awarded a Flinn Foundation grant to implement the Screening Kids in Primary Care Plus (SKIPP) model during 2012-13.

SKIPP will be evaluated by the Michigan State University Institute for Health Care Studies. The Institute will develop data collection processes, analyze the data, and provide recommendations regarding SKIPP’s replication. The Institute will analyze the data on number of children screened, assessments conducted, and referrals provided in targeted practices. The Institute will also develop a satisfaction survey to be used with the six primary care providers and their staff to understand their satisfaction with the training, implementation of screening and Mental Health Consultation services.

The MDCH’s Medical Services Administration, BHDDA and Public Health in conjunction with the Michigan Chapter of the American Academy of Pediatrics, and MDE Early On, implemented an ABCD grant to pilot the use of standardized, validated developmental screening tools for young children by physicians during EPSDT well child visits. The Screening Committee is continuing to bring together stakeholders to provide training and technical assistance to primary care providers in the implementation of developmental/social-emotional screening. Recently, the Michigan Academy of Family Physicians has joined the Screening Committee to facilitate training and technical assistance to their members.

Project Launch is implementing a child mental health consultation model for childcare providers and utilizing an evidenced based practice curriculum, Center for Social Emotional Foundations for Early Learning (CSEFEL) to train childcare providers in social emotional health and then provide coaching/child mental health consultation. This is a model and approach that has demonstrated effectiveness in preventing

children being expelled from child care and helping to support a path to success in coming to school ready to learn. Early childhood mental health consultation in childcare, primary care and foster care is one of the services that is supported by the federal Substance Abuse and Mental Health Services Administration.

MDHS and MDCH implemented the DHS Incentive Payment effective July 1, 2012. This provides incentive funds under the Mental Health Specialty Services and Supports Medicaid Managed Care Waiver to the PIHPs to serve DHS Children who are in Child Protective Services Risk Categories 1 and 2 and children in DHS foster care when the PIHP provides either home based services or wraparound services or provides two or more mental health services per month. This is intended to increase access to children in the DHS system to effective mental health services so that these children can remain in the community, achieve permanency and improve in functioning in home, school and community.

On March 18, 2013, the Michigan Autism Disorders (ASD) State Plan was released to the public. This ASD State Plan was created by development and advisory committees representing the Departments of Community Health, Education, Human Services, and Licensing and Regulatory Affairs, parents, adults on the autism spectrum, educators, agency/organization professionals, health care providers, university faculty, state grant project staff, and state government personnel. The plan addresses recommendations for improving services and outcomes for children and adults across the life span. The Michigan Autism Council, which was established by Executive Order in July of 2012, is responsible for overseeing the implementation of the ASD State Plan.

MDCH submitted an amendment to its Medicaid Managed Care Specialty Services and Supports Waiver and a 1915(i) State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to add applied behavior analysis (ABA) as a Medicaid coverage for children with ASD ages 18 months through 5 years of age. A similar amendment has also been submitted to CMS to add ABA as a covered service for MIChild recipients. This new service was approved by CMS and effective April 1, 2013.

The SKIPP Initiative, which is funded by a Flinn Foundation Grant, is a partnership between MDCH (children's mental health), MDHS, the Detroit-Wayne CMH Agency, and the MSU Institute for Health Care Studies, Starfish (a private non-profit agency in Detroit providing mental health services), The Michigan Chapter of the American Academy of Pediatrics (AAP), and four large pediatric practices in Wayne County. The use of standardized developmental screening tools as part of well child visits to identify children early with social emotional issues or autism are being supported in the four practices. Behavior Health Specialists are assigned to be at the practices to follow up with children who screen positive - to do an initial assessment, anticipatory guidance and link to services. This model is being evaluated by MSU Institute for Health Care Studies and is a model of integrated care for children that MDCH would like to spread and sustain. It is also a model being used in the federally funded Project Launch initiative in Saginaw.

MDCH is working closely with local agencies, state staff, legislative members, MDHS and the justice system to identify children who may be falling between systems gaps,

and initiate intensive services building upon current and new structures. This will continue throughout 2013 and 2014.

GOAL 4: DIVERSION

Jail Diversion.
Jail diversion is one of Governor Snyder's top strategic priorities. The MDCH/ Michigan Department of Corrections (MDOC) Jail Diversion Workgroup, which formed in February 2012, was tasked with developing strategies to divert seriously mentally ill offenders from incarceration into treatment activities. A subsequent Action Plan was finalized in July, 2012, resulting in the Governor issuing Executive Order 2013-7 allowing the formation of a 14-member Mental Health Diversion Council within MDCH to provide further examination of mental health issues and to develop, implement methods to divert justice-involved individuals with mental illness and or substance abuse problems into appropriate treatment services.

At this time, Jail Diversion programs continue to operate in each CMHSP and PIHP. While diversion programs and services vary by size and location, they all have the same goal in common: diverting individuals who have a serious mental illness, including those with co-occurring substance use disorder, or who have a developmental disability and have contact with the criminal justice system around misdemeanors or non-violent felony offences. Screening and assessment for mental health intervention are provided to determine whether appropriate services can be offered in the community as an alternative to serving jail time. Law enforcement and the judiciary make the final determinations.

FY-12 data reported by the CMHSPs and PIHPs indicates that the number of pre-booking diversion incidents with adults having mental illness totaled 2,721 (up from 2,608 in FY-11). The number of pre-booking diversion incidents with those having developmental disabilities totaled 36 and the number of pre-booking diversion incidents with those having a co-occurring SUD totaled 602. The number of post-booking diversion incidents of adults with mental illness totaled 872 (down from 1,068 in FY11), the number of post-booking diversion incidents with those with developmental disabilities totaled 141, and the number of post-booking diversion incidents with those having co-occurring SUD totaled 1,722. MDCH/BHDDA will continue to be available to provide technical assistance and consultation via national, regional and local resources, identify training opportunities, and keep CMHSPs/PIHPs in touch with each other to offer individual and specific assistance when requested or as needed

GOAL 5: STRUCTURE, FUNDING, AND ACCOUNTABILITY

Statewide Standards. MDCH has co-sponsored The Standards Group (TSG) with the MACMHB and has as members consumers, and advocates along with MDCH and PIHP representatives. TSG has produced the Access Standards recommendations for standardizing the purchasing of health information technology and recommendations for improving the self-determination policy. More recently, TSG has developed standards

for CMHSP waiting lists and it is continuing work on developing core competencies for case managers and supports coordinators.

MDCH has begun an effort to increase the accountability of PIHPs by introducing contract language that is specific about MDCH expectations of the PIHPs to monitor their provider networks. Continued efforts will occur within the performance of the new PIHP regions to include monetary sanctions, incentives and withholds based on regional performance and accountability. The effort is complimentary to another activity to examine MDCH's and other site review processes to assure that all aspects of quality are being monitored, and ensure fewer redundancies.

Standards for Performance. MDCH, through the quality management system overseen by the Quality Improvement Council, continually refines standards for performance and provides training to the CMHSPs and PIHPs at least quarterly. Standards are in place for:

1) Timeliness of access to the public mental health system
2) Recidivism
3) Competitive employment

In addition, practice standards for the Medicaid covered services described in the Medicaid Provider Manual are continually updated.

Sustainable Models of Collaboration. The Serious Emotional Disturbance (SED) Waiver is a collaborative effort of MDCH, CMHSPs, MDHS, and Juvenile Justice in that it is jointly funded by county childcare funds, local CMH general funds, state MDHS general funds and Medicaid, and serves children from the various systems. In FY-11, 261 children in foster care were served under the SED Waiver and were assisted in reaching permanency though the provision of effective mental health services that met the child's needs. Twelve counties participated in the MDHS SED Waiver Pilot (Wayne, Oakland, Macomb, Genesee, Ingham, Saginaw, Kent, Kalamazoo, Washtenaw, Clinton, Eaton and Muskegon). An SED Waiver amendment was approved effective April 1, 2012 by the Centers for Medicare and Medicaid (CMS) to expand the waiver to an additional twenty counties: (Allegan, Arenac, Bay, Midland, Isabella, Livingston, Grand Traverse, Leelanau, Roscommon, Wexford, Marquette, Cass, Van Buren, Gratiot, Berrien, St. Clair, Jackson, Hillsdale, Calhoun, and Newaygo). This expansion increases the number of children in foster care who can be served to at least 411. In FY-13, additional general funds are contributed to increase the numbers of children in foster care who can be served. The SED Waiver is utilized to provide intense mental health services to children in the juvenile justice system. In FY-11, 75 of these children were served, many through collaborative funding using the childcare fund to match Medicaid for the SED Waiver services provided by CMH.

In FY-12, funds were offered for CMHSPs to develop joint projects with community partners to provide evidence-based and/or promising practices to children with SED who are also involved with the juvenile justice system. One of the performance targets specifically addresses increased access for DHS abused and neglected children. The SED Waiver Project has expanded to 36 Michigan counties. For FY-13, 267 children

have been served as of March 16, 2013. Preliminary data from an evaluation completed by Michigan State University indicates that graduates of the SED Waiver demonstrate an average decrease of 39 points on the Child and Adolescent Functional Assessment Scale - nearly twice the decrease of 20, which is considered clinically significant. In addition, more youth remain in the community - 98% of graduates were residing in the community.

The MDCH has been working intensively with the Michigan Rehabilitation Services (MRS) and the Michigan Commission for the Blind (MCB) to coordinate services to assist people who are jointly served by one of those agencies and the community mental health system. Building on an interagency agreement signed in 2009, joint approaches to education, training, and sharing information are in place.

MDCH/BHDDA has realigned the state from 18 PIHPs to 10 new Regional Entities effective January 1, 2014. In addition, the passing of Public Acts 500 and 501 of 2012 will incorporate the remaining seven Coordinating Agencies into the 10 newly defined regions effective October 1, 2014. BHDDA continues to partner with Medical Services Administration (MSA) on the Dual Eligible demonstration and has designated four regions to initiate the project. Data Analysis reporting structures, electronic exchange of clinical information as well as rate structure are being explored and refined for the newly created PIHP regions. In addition, there is an overall commitment to further simplify both the contractual agreements and the site review process, while assuring safety and quality oversight for vulnerable individuals. Provider agencies are currently, and into future, looking at models of integration including Health Homes/Medical Homes and formal partnering with Primary care, Health Maintenance Organizations (HMO's) Rural Health Clinics, and Federally Qualified Health Centers (FQHC's).

Office of Recipient Rights (ORR)

The ORR Director reports directly and solely to the director of MDCH.

MCL 330.1754 at subsection (4) was amended effective January 3, 2007 to read:

> *"The director of the state office of recipient rights shall report directly and solely to the department director. The department director shall not delegate his or her responsibility under this subsection."*

The state and local rights offices should engage in education, training, evaluation and assistance to primary and secondary mental health consumers in navigating the public mental health and other human services.

This recommendation has not been fully completed, although ORR proposed code amendments would require rights offices to provide education, training and assistance in rights protection processes to consumers and family members.

Since 2009, MDCH-ORR has been a partner with the Michigan Family-to-Family Health Information and Education Center in presenting "Helping Families and Young Adults Protect Their Rights." This is a five-hour session for anyone who wants a better

understanding of complaint processes including timelines, complaint procedures and what someone could expect during the processes under:

- Children's Special Health Care Services
- Community Mental Health Services
- Medicaid
- Special Education Services

Participants in the training receive resource information for groups and organizations available to assist in protecting an individual's rights. Basic information is provided on how to gain access to what makes someone eligible under each system. Presenters include the MDCH-ORR Information and Referral Specialist, representatives from the MDCH Children's Special Health Care Services and Michigan Protection and Advocacy Services and an Administrative Law Judge from the State Office of Administrative Hearings and Rules.

Additionally, MDCH-ORR has established a toll free number for information and referral services for use by consumers and family members as has most, if not all, local CMHSP rights offices.

The MDCH-ORR website highlights where to report suspected abuse and neglect with links to the 46 CMHSPs and approximately 70 licensed private psychiatric hospitals' rights offices as well as the DHS toll free numbers.

Fair Hearings. Medicaid eligible beneficiaries are able to request state administered administrative fair hearings processes if they are not satisfied with the amount, scope, or duration of services; or if services are denied, reduced or eliminated. MDCH staff meet with the administrative law judges that conduct those fair hearings as necessary to clarify Medicaid policy. In the course of their work, the administrative law judges regularly review clinical assessments and clinical opinions of cases. MDCH also requires CMHSPs to implement a local grievance process for individuals who are non-Medicaid eligible recipients. Those individuals have the right to subsequently submit a request for an Alternative Dispute Resolution Process to the Behavioral Health and Developmental Disabilities Administration, if the CMHSP's local dispute resolution process is unsatisfactory.

GOAL 6: SERVICE INTEGRATION

Collaborative Models to Integrate and Coordinate Mental Health Services with Primary Health Care.

Many efforts across the state PIHP/CMHSP system have emerged for collaboration of behavioral health and primary care. Some of these initiatives have been through Health Home pilot project, as well as local collaborations with primary care, FQHCs, Hospitals, and Rural clinics. The Legislature, in December of 2012 enacted Public Acts 500 and 501, directing that the coordinating agencies' functions for substance abuse delivery be combined with the regional PIHPs by October 1, 2014. To further coordinate and support local care, MDCH's MSA/BHDDA have coordinated efforts to create the Clinical

Advisory Committee (CAC) comprise of CMHSP Medical Directors with the intent to improve cross system communication.

During the past year, the MHAC has been a forum for presentations by recipients of block grant funds investigating new models for integrating mental health and general physical health care. These models have varied in both scope and success, providing important information for the medical leadership as it explores the implementation of medical homes.

Beginning in FY-09 and continuing through FY-14, MDCH has supported PIHPs and CMHSPs across the state of Michigan with targeted funding to develop Integrated Healthcare services. In FY-12, MDCH, in cooperation with Michigan's PIHPs and CMHSPs, set priorities that began an intentional and coordinated statewide effort to include physical, substance, and mental healthcare into one seamless service. Strategic priorities for 2011-2014, emphasizing the importance of Four Key Healthy Behaviors and Four Key Health Indicators, remain. Additionally, access to excellent and compassionate Behavioral Health and Developmental Disabilities services and the progression to adopt electronic health records continue to remain top priorities.

In FY-12, due to developmental variations of Integrated Health services across the state, each PIHP completed a comprehensive assessment tool and chose at least one area specific to the individual needs of the PIHP to build upon and enhance with one year of federal Community Mental Health block grant funding. Additionally, Consumer-Run Drop-In Centers (DIC) were encouraged to apply for funding to enhance individual DIC goals and programs promoting healthy behaviors and ideas. With this non-competitive block grant opportunity, a new requirement for goals and objectives that resulted in measurable outcomes for both PIHPs and DICs began. Technical assistance through the National Council for Community Behavioral Healthcare and MDCH was provided to each applying PIHP during the development of goals and objectives. Coaching and technical assistance continues through FY-13.

The CPSS initiative is strategically involved in the Michigan Pathways to Better Health Project as a partner with the Chronic Disease Division at MDCH. One area of collaboration includes the sharing of resources with the Michigan Community Health Worker Alliance on the role of health navigation to assist individuals in primary care settings particularly FQHCs. CPSS working at Hackley Community Care Center in Muskegon are assisting individuals with a mental illness and additional chronic conditions with employment, housing, transportation to medical specialty appointments, and understanding and navigating complex medical systems. Additional tasks include leading health and wellness classes to encourage self-management and support personal choice and responsibility using an educational model.

Interagency Cooperation with the Michigan State Housing Development Authority (MSHDA)

MDCH is part of an interagency team (MSHDA, MDCH, and MDHS) that reviews projects that are developed with Low Income Housing Tax Credits and develops the Qualified Allocation Plan (QAP) that determines how these resources are distributed. The current QAP incentivizes the development of permanent supportive housing.

In addition, MSHDA provides loans using HOME dollars to developers for the new construction or rehabilitation of units that are rented to homeless individuals or families to make permanent supportive housing units more affordable.

MDCH participated in a Home Ownership coalition for people with disabilities. This program has achieved full integration with MSDHA's down-payment assistance and home ownership counseling program. USDA Rural Development loans were also integrated with MSHDA's down payment assistance through this coalition.

Co-occurring Mental Health and Substance Use Disorders
Statewide Implementation Activities for Evidence Based Practices and Best Practice in Integrated Behavioral Health and Substance Abuse Services:

The Department of Community Health Bureau of Mental Health Services has maintained an ongoing statewide initiative for the implementation and sustainability of evidence based and best practices for addressing co-occurring behavioral health and substance use disorders for over 10 years.

Formal activities include for co-occurring treatment includes:
- Established the Michigan Fidelity Assessment Support Team (MIFAST)
- Integrated Dual Disorder Treatment (IDDT)
- Dual Disorder Capability in Mental Health Treatment (DDCMHT)
- Dual Disorder Capability in Addiction Treatment (DDCAT)
- Co-occurring Change Agent Leadership (CoCAL)

The MIFAST Team was originally formed 6 years ago with the assistance of the (SAMSHA), through the Ohio Substance and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE). The purpose of the formation of MIFAST was to put in place a review team that is accessible to programs for the purpose of assisting them in developing and sustaining IDDT teams that practice with a high level of fidelity. The MIFAST team does this by conducting technical assistance conferences to help agencies develop an implementation plan for IDDT, followed by an on-site visit to determine the degree to which the agency has achieved implementation by fidelity scoring of the 26 protocols, and providing technical assistance to aid in the improvement of areas that are shown to need further development. The MIFAST team was developed over seven years ago when 17 individuals, who were nominated by Primary Inpatient Health Plans (PIHP) from all regions of the state, were trained to conduct fidelity reviews with high inter-rater reliability. Of the 17 reviewers, seven remain and are considered "lead reviewers" for the purpose of conducting on-site reviews. The MIFAST has access to a number of persons qualified to aid with technical assistance and staff development activities when areas are identified by the review process as needing improvement. In addition to the seven original members of MIFAST, a number of assistant reviewers have been trained and added to the team to assist with on-site reviews requested by providers. Two individuals are certified peer specialist (also known as: persons with lived experience), one of which is working to become a Lead Reviewer. A complete breakdown of comparable site-review scores beginning in 2006 is available in a separate report.

The MIFAST team has added the DDCMHT site review process to its menu of assistive activities. The MIFAST team underwent formal training through SAMSHA in order to provide system wide review of "dual disorder" treatment capabilities across all programs at the outpatient level of care. In 2012, eleven agencies requested site-reviews of their outpatient treatment programs. Each site was provided with a scoring report and a work plan with suggested activities for enhancing supports and services in each area reviewed. A separate report contains the actual scoring data for those reviews.

The 2013 plan for MIFAST IDDT is to:

- Ascertain the number of IDDT teams practicing across the State Of Michigan
- Determine the number of IDDT teams who have 4 or more IDDT site Reviews since 2006
- Determine the number of protocols that consistently score above a 4 and organize site reviews to target areas that score below 3.1
- Provide both review and technical assistance for areas below 3.1 in site reviews and follow up
- Initiate site reviews for IDDT teams who have not yet participated or have had <3 reviews
- Conduct DDCMHT site reviews for all outpatient level of care programs
- Including second review of the agencies visited in 2012
- Initial review of agencies who did not have a site review in 2012
- Recommend and offer the DDCMHT site review process in lieu of the IDDT agencies who have had 4 visits
- Encourage PIHPs to develop DDMHT site review teams internally and provide outcome scoring to DCH
- List dual diagnosis competent agencies on the National Listing of competent programs (we currently have nine listed).
- Conduct DDCAT site reviews for outpatient level of care programs
- Conduct MIFAST inter-rater reliability enhancement training for veteran and new reviewer team members
- Recruit and induct peer specialists or persons with lived experience into the review team as consultants to MIFAST and as part of the site review process

The Co-occurring Change Agent Leadership Committee (CoCAL) has evolved out of ongoing initiatives to create and ability to address co-occurring mental and substance use disorders (M/SUD) since Michigan's participation in the SAMSHA Dual Disorder Policy Academy that met in Maryland in 2003. Initial activity for integrated treatment began when the Michigan COD Policy Academy was initiated as a continuum of the SAMSHA Policy Academy in 2003. To further the development of co-occurring capable systems the state contracted technical assistance for use of the Comprehensive Co-occurring Integrated Systems of Care (CCISC) and involved all PIHP in the Assessment, Planning and Tracking of the degree to which agencies are able to address the co-morbid exacerbations of M/SUD in all programs at all levels of care. Included in the CCISC model was the development of a cadre of change agents in each organization, as well as champions who were able to manage and track implementation. The CoCAL committee is the outgrowth of those early structural elements of implementation.

Currently, the CoCAL has goals and objectives for the continuance of implementation, sustainability and improvement of the standards of practice for integrated treatment. It does this on two levels and through at least four defined activities. Level one is the goal of insuring that co-occurring treatment is the standard of practice and applied consistently across all regions, PIHP, and provider agencies funded through the Department of Community Mental Health Block Grant. The second level is to provide activities and resources to all regions, PIHPs, and provider agencies for staff development and training with regard to evidence based and best practices at the contact level of care.

The CoCAL currently has four defined work groups organized around its goals.

- COD Workforce Development
- COD Outcomes Work Group
- MIFAST Activities
- Systems Integration & Funding

The COD Workforce Development activities include:

- Annual Co-occurring Conference planning
- Staff Training and Development

The Annual Co-occurring Conference is intended to bring together staff from administrative and practice levels and provide them with the best examples of co-occurring mission, vision, policy and practice initiatives, as well training on evidence based practices developed and adapted for co-occurring treatment. A sub-committee formed from this work group meets to review submissions from presenters who wish to participate in this conference. Reviews are conducted to determine if presentations meet the goals of the conference for integrated treatment, evidence based and meet standards for strength-based and recovery characteristics. Plenary speakers are also reviewed and chosen based on their ability to meet the goals of the conference. Staff training and development is provided through this workgroup through a defined process.

The process includes:

- Ascertainment of regional, PIHP, agency/local staff development and training needs
- Development of a plan for regional training to meet annualized requirements for IDDT staff training according to the protocol
- Development of a plan to meet the outcomes of ascertainments on training needs for various regions, PIHPs and agency/local levels
- Support local Change Agent activities and provide a pathway for them to inform and assist the state

The outcomes work group has the goal of tracking both the degree of implementation of co-occurring capable supports and services as well as the efficacy of co-occurring treatment. Outcome data that demonstrates the degree to which co-occurring M/SUD is being addressed comes from specific protocols in the DDCMHT and IDDT site review data as well as self-assessment tools for agencies still using the CCISC tools. Additional outcomes measure would come from the Quality Improvement reporting

process at the agency level, training records of staff who provide co-occurring supports and services; record reviews that include treatment plans, progress notes and plan reviews, etc. Outcome measures on the efficacy of co-occurring treatment include measures, such as improved functioning over the course of treatment (as evidenced by various instruments such as the LOCUS, or Self Sufficiency Scale), movement from lower levels of treatment readiness to higher levels over the course of treatment, reduction in psychiatric symptoms as effects ability to achieve reduction in substance use and its consequences for employment, homelessness, legal issues, etc.

MIFAST activities, as explained above, are reviewed by the COCAL to determine the degree to which agencies that have IDDT teams have the capacity to serve individuals with this very high level of severity. CoCAL members receive and disseminate information on the progress of this initiative for use in planning annualized staff development and training activities as well as decide on review strategies to aid in their implementation efforts.

The goal of the Systems Integration & Funding work group was to get a clear guideline for use of utilization code and modifiers for use across all integrated supports and services. Further, to assist agencies to understand when and how to use the codes. This work group completed its task and the product was forwarded to the Medicaid editing group.

Moving forward, the CoCAL Committee is planning additional goals for 2013 and beyond with regard to “Motivational Interviewing” that include:

- Expanding the Motivational Interviewing internal trainer project by using trainers developed through a state funded initiative to strengthen Supervisor Skills for observing, coaching and enhancing Motivational Interviewing skills with the people they supervise.
- Location of web based training modules on Motivational Interviewing in the Improving Practices learning website.
- Location of the Video Assessment of Simulated Encounters (VASE-R) on the Improving Practices learning website so that people have access to an assessment tool that is easy to use and can give them a reliable assessment of the degree to which on-line training has enhanced their understanding of the application of Motivational Interviewing.

Statewide Implementation Activities for Evidence Based and Improving Practices
The Department of Community Health Bureau of Mental Health Services has maintained an ongoing statewide initiative for the implementation and sustainability of evidence based and best practices across all programs and levels of care.

Formal activities include:

- Practice Improvement Steering Committee (PISC). The PISC meets quarterly to plan and track activities for improving the evidenced based and best practices service delivery across the state.
- Michigan Association of Community Mental Health Boards (MACMHB) Staffing and Training

Homelessness

The MDCH Homeless Programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. Recent innovations include using PATH dollars to leverage other resources to establish a Housing Resource Center in Detroit and throughout the state; and to establish a program called Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) for people who are homeless to ensure that they receive an expedited process to receive their SSI and SSDI benefits. All of these programs provide outreach to people (approximately 6,000 per year) who are homeless to find and sustain housing.

GOAL 7: CONSUMER INVOLVEMENT

MDCH has focused on integration of services and supports for people with lived experience based on a foundation of recovery. Systems transformation efforts include uniting the voice of individuals who have a substance use disorder and/or mental health needs. Initiatives developed and implemented by BHDDA are based on a strong partnership with people served by the public mental health system. The public mental health system is most effective when the individual receiving services has equal involvement and responsibility in creating, participating and choosing services and supports designed to meet their needs. Since 1996, the Mental Health Code has required that the Individual Plan of Service is developed from a person-centered planning process. The process provides an environment of support to maximize choice by having the individual develop goals and objectives based on community inclusion and participation, independence, productivity, recovery and resiliency. SAMHSA's adult mental health block grant funds have provided the opportunity to develop innovative policies and practices to strengthen the recovery voice statewide.

The BHDDA received a SAMHSA grant through the Bringing Recovery Supports to Scale Technical Assistance Center for supporting our efforts to incorporate peer delivered services into the behavioral health workforce. This grant brought together state level staff and peers from the mental health and substance use disorder service systems to create a plan to support those efforts in Michigan. The plan identified processes to ensure peer involvement in state level decision-making, a way to inform providers of the benefits of using peers, developing talking points to educate stakeholders about recovery, identifying outcome measures that support recovery and creating a leadership academy for developing peers to be able to move into leadership roles.

Michigan is nationally recognized for training, employing and certifying a peer support specialist workforce. In addition to supporting individuals in the public mental health and substance abuse system of care, specific outreach to partner with local and state veterans administration offices. Over 60 Veterans across the state are CPSS and attend ongoing training in wellness, recovery and trauma related trainings. In 2012, a Veterans Policy Academy was supported by SAMHSA that includes several Veterans, individuals from the legislature, MDCH Director's office, MDHS and state and county

drug court system. The academy team is implementing a comprehensive plan to improve Veterans services statewide.

Working in partnership with the Association for Children's Mental Health, MDCH has also been training and certifying parent support partners to work with parents that have children with a serious emotional disturbance. In FY-12, there are fourteen counties participating and forty-four certified parent support partners. Over 50% of these parent support partners are employed by CMHSPs.

Psychiatric Advance Directives. In 2012, the Office of Consumer Relations, MDCH continues to provide direction and technical assistance with PIHPs, CMSHPS, provider agencies and primary individuals on creating and implementing an Advance Directive. Advance Directives have been an instrumental tool in documenting the supports an individual needs during crisis evaluations and/or hospitalizations. The Advance Directive offers the opportunity for persons to choose a person to make decisions for you if necessary. The document is developed by the person and put into a legal document.

The Advance Directives law gives voice to consumers when they are unable to advocate for themselves.

Boilerplate Section (b) Report

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. This report shall examine the potential impact that utilization of secure residential facilities would have upon the state's need for adult mental health facilities.

Secure Residential Facilities. As in previous reports for this section, a preliminary analysis and limited feasibility study regarding the establishment of secure residential facilities (fewer than 17 beds) was conducted. That report indicated that few states utilize "locked" residential facilities and those states that have residential facilities for consumers with certain high-risk characteristics incorporate high staff to consumer ratios, certification requirements and extensive in-facility programming rather than placing a reliance on security. Further, because of the constraints on personal liberty that locked settings entail, such residential programs should be developed and operated through the state, and individuals be assigned to such arrangements only pursuant to a court order (i.e., alternative treatment order) or other legal directive (e.g., parole requirement). Finally, secure residential settings would appear to hold the most promise for certain individuals in state hospitals that have serious or significant past forensic involvement, and/or for seriously mentally ill individuals who are being released or paroled from a state correctional facility. Even in these situations, the establishment of such settings would not necessarily affect state hospital utilization, generate savings or reduce costs.

A newly formed DHS-DCH workgroup is examining operational practices that support and hold accountable licensed facilities that serve high-risk consumers, some of whom might be determined candidates for a secure facility. Through the 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans, a public policy section includes collecting information including the number of individuals with a primary disability, serious mental illness, serious emotions disturbance and intellectual and developmental disability within licensed beds of less than 6 or greater than 13. This will begin the process for data analysis to determine community integration and overall need.

Boilerplate Section (c) Report

(c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed non-serious into treatment prior to the filing of any charges.

Mental Health Court Program. In FY-09, appropriations for both the State Court Administrator's Office (SCAO) and MDCH included funding for implementation of a pilot mental health court program. MDCH funds supported treatment costs and Judiciary funds supported court operations. Boilerplate for each agency required collaboration and joint development of guidelines for the operation and evaluation of these pilot courts. Correspondingly, in collaboration with the SCAO, a joint application was issued, applicant proposals reviewed, and nine pilot mental health court programs project sites approved and funded for FY09 implementation.

MDCH contracted with MSU to conduct an outcome evaluation for Mental Health Courts spanning 2009-2011. Evaluation results of eight pilot sites were released in September 2012 and indicated the following:

- Long-term outcomes assessed using three time periods:
  - One year prior to mental health court admission;
  - The period of involvement in mental health court;
  - One year following discharge from mental health court.

- Participant characteristics at admission: 678 individuals admitted into the mental health courts prior to 12/31/2011. Average age of admission was 35 years of age; two-thirds were male and 67% Caucasian. Majority were unemployed at admission (91%) and 20% were homeless. 40% admitted with a primary diagnosis of bipolar disorder, 29% schizophrenic/psychotic or delusional disorders (21%) 12% other such as developmental or personality disorders.

- Average length of stay was 276 days of those admitted; of 450 discharged, 43% successfully completed. Successful completions were typically older (average age of 39 years) and had misdemeanant/civil offenses. Younger participants combined with a felony offense were predictive of a lower chance of successfully completing.

- 406 (60%) of the 678 admitted into mental health court screened positive for a current substance abuse problem. Of the 406, 185 (46%) did not receive any formal substance treatment in the year prior to mental health court.

- 70% of participants received substance abuse treatment within CMH at some point in time (pre, during, post mental health court) SUD service utilization generally increased during mental health court participation but declined post mental health court with 28% of those discharged receiving a SUD treatment service after mental health court.

- Prior to mental health court, 81% spent an average of 39 days in jail. During mental health court, 54% spent an average of 24 days in jail. Of the 450 discharged 149 participants were jailed post mental health court, averaging 23 days in jail.

- Recidivism data: During Mental Health Court (MHC): 55 (8%) were charged with a new offense and 46 convicted. Of the 46, 10 were convicted of a felony offense.

Post-MHC: 44 (6.5%) participants were charged with a new offense. Examining both during and post mental health court periods: as of 12/31/2011, 14% of participants had been charged and convicted of a new offense since admission into mental health court. Of 93 convicted, 30 were convicted of a felony offense.