# Michigan Department of Community Health
# Mental Health and Substance Abuse Administration

# FOCUSING A PARTNERSHIP FOR RENEWAL AND RECOMMITMENT TO QUALITY AND COMMUNITY IN THE MICHIGAN PUBLIC MENTAL HEALTH SYSTEM

# APPLICATION

**February 1, 2009**

Michigan Department Of Community Health

MDCH

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**Mental Health and Substance Abuse Administration**

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**January 30, 2009**
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## Introduction: Meeting the Challenge

The Application for Renewal and Recommitment (ARR) formally introduces new and enhanced expectations of performance, and revitalizes our commitment to excellence in the priorities and directions outlined in the August 12, 2008 Concept Paper. The ARR further executes 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 expectations herein were designed to better reflect the current expectations of the public mental health service recipients and other stakeholders to support choice-driven outcomes. Partnerships with people who receive services and their supporters (families, friends and advocates) are crucial to successful recommitment. The Michigan Department of Community Health (MDCH) has, therefore, established goals for improving their involvement and participation in local planning, implementation and evaluation of services. Similarly, other community partners, such as providers and local community representatives, need to be engaged if there is to be a successful local establishment of an effort that can ultimately achieve the elements of the MDCH vision outlined in the Concept Paper.

The ARR stresses the importance of the Prepaid Inpatient Health Plans (PIHPs) supporting greater personal autonomy, control and direction of the course of people's lives that require assistance from the public mental health system. The ARR asks PIHPs to further recommit to finding the best ways to assure that those with the greatest vulnerabilities and the least capacity to advocate for themselves are supported in ways that celebrate their humanity and recognize their right to a life with meaning and personal dignity. MDCH expects that PIHPs will join us in moving toward zero tolerance for poor care and for supports that do not recognize and celebrate personal dignity and self-worth.

With the ARR, MDCH invites the PIHPs and Community Mental Health Services Programs (CMHSPs), along with individuals receiving services, their supporters, and other community partners, to set a course together that achieves certain goals over a five-year period. The major focus of this multi-year effort is to improve the quality and appropriateness of care such that the people served by the public mental health system are supported to achieve true community membership. A secondary focus is to achieve administrative efficiencies that

ease the planning for, and provision of supports and services and preserve funds for, reinvestment during these difficult times.

Relationship to Program Policy Guidelines

The Program Policy Guidelines (PPGs), being issued simultaneously with the ARR, request the CMHSPs to submit data to MDCH on certain key areas that were addressed in the Concept Paper. These key areas are:

- Design plans for achieving systems of care for children;
- Improved quality of life for persons with developmental disabilities (DD);
- Implementation of the Recovery Enhancing Environment (REE) measure for adults with serious mental illness (SMI);
- Improved access to self-determination (SD) and independent facilitation of person-centered planning (PCP).

It is expected that as part of their environmental scan, PIHPs will work with their affiliate CMHSPs, as applicable, to aggregate and review that PPG data; and in response to the ARR, to develop and implement PIHP-wide plans that result in ongoing, measurable improvements which can assure the equity of opportunity and outcome across the CMHSPs making up the PIHP area.

Relationship to External Quality Review

An annual External Quality Review (EQR) of all Medicaid managed care organizations is required by the federal Balanced Budget Act (BBA, at 42 CFR 438.358. MDCH contracts with an EQR organization to conduct that activity. Some issues addressed by the Concept Paper that are already covered by the EQR will not require further attention in the response to the ARR, although it is expected that the PIHP is in substantial compliance with the BBA standard. For other issues that are common to the Concept Paper and ARR, such as assessing need and managing demand, coordinating and managing care, improving quality of supports and services, and achieving administrative efficiencies, MDCH expects enhancements in performance and practice. Where relevant, MDCH has identified the BBA standards that relate to the ARR section. As part of their environmental scans, PIHPs should review the relevant BBA standards, assure that they are in compliance, and build plans for improvement over and above the standards, as applicable.

Relationship to the Application for Participation

The 2002 Application for Participation (AFP) established a set of standards for the Medicaid specialty services and supports program. The AFP was added as an attachment to the MDCH/PIHP contracts. Some issues addressed by the Concept Paper that are already covered by the standards in the AFP and which have been achieved by the PIHP will not require further attention in the response to the ARR. However, MDCH does expect that the PIHP is in substantial compliance with the elements of the AFP standards as well as with their intent. But many issues outlined in the concept paper were raised because existing evidence indicated that they require improved follow-through, as well as enhancements to AFP elements. Those include: stakeholder partnerships, consumer choice and control, opportunities for integrated employment, assessing need and managing demand,

coordinating and managing care, and improving the quality of supports and services. As such, those are incorporated in expectations outlined in the ARR sections. Where relevant, MDCH has identified the AFP elements that relate to the ARR section. As part of their environmental scans, PIHPs should review their original AFP proposals for those issues and assess their progress up to this point in achieving their previously stated AFP plans.

Relationship to the MDCH/PIHP Contract, Mental Health Code and Medicaid Provider Manual
Some issues in the Concept Paper are already addressed by MDCH/PIHP contract, Mental Health Code, or Medicaid Provider Manual. In some of those cases, the ARR does not require further attention in the applicant's response, however it is expected that the PIHP is in substantial compliance with them. For other topics like PCP, SD, care management and coordination, and integrated employment, MDCH has raised its expectations of PIHP performance and, therefore, environmental scans and plans for improving quality are required.

It should be noted that each PIHP's response will be attached as performance objectives to their FY 10 contracts with MDCH.

## Instructions

The response to the ARR marks the commencement of a process that focuses on the quality and appropriateness of care within the denoted topic areas, provided to Medicaid beneficiaries receiving specialty supports and services managed by Michigan's PIHPs, and for other service recipients across the PIHP's participating CMHSPs. The quality improvement effort begins at the PIHP with "**Environmental Scans**" that address each of eleven topics described in the Concept Paper. The effort continues with the development and submission of **plans for improvement** that focus on areas that the PIHPs have identified as "weaknesses," or "challenges," as well as opportunities for improvement. MDCH will review the PIHP's response for sufficiency and rigor in addressing the PIHP's challenges, weaknesses and opportunities for improvement. MDCH may comment on them, seek clarification, or request that the PIHP strengthen and resubmit its plan; but will not approve or disapprove them. Instead, MDCH will negotiate the performance objectives on an individual PIHP basis that will be an attachment to their FY10 contracts; will periodically evaluate the individual progress of each PIHP against its own plans for improvement; and will take action as necessary if a PIHP fails to meet its performance objective. MDCH recognizes that during the implementation phase, adjustments may need to be made to a PIHP's milestones and timeframes. Otherwise, it will be looking for a good faith effort to achieve the improvements within the planned timeframes.

A central expectation of the work that is conducted by the PHIP to develop their response to the ARR is an expanded engagement of individuals receiving services, their family members, and advocates as primary stakeholders who must be afforded a central role in the development of the environmental scans, the design of the plans, their implementation, and in the periodic evaluation of the progress. PIHPs may use existing structures such as Quality Improvement Councils, Improving Practices Leadership Teams, and other standing advisory

committees in developing their responses, where these groups contain meaningful membership of these primary stakeholders. Additional involvement must include other community partners such as providers and local community representatives. However, since some of the topic areas address a single population or an initiative that impacts certain, but not all, populations, the PIHP will likely need to utilize more than one group of stakeholders. Regardless of the numbers of groups or stakeholders, it is expected that the PIHP will provide the supports and accommodations necessary to result in meaningful involvement of its stakeholders.

**Target Organizations and Populations**

The ARR targets PIHPs. Any CMHSPs that are affiliates, and substance abuse coordinating agencies (CAs), or networks and providers that provide Medicaid specialty supports and services to Medicaid beneficiaries are also subject to the environmental scans and the plans for improvement that will be managed by the PIHP. Some sections of the ARR, however, are not pertinent to beneficiaries who have a substance use disorder (SUD) only and receive only substance abuse treatment services. Those are: Section 3, Active Engagement, and Section 4, Consumer Choice and Control. Section 3 addresses only individuals with DD, although it is expected that PIHPs will eventually have the capacity to actively engage any adult who is vulnerable. All sections except Section 5, Employment, are intended to include children and youth and, where applicable, their parents.

**Environmental Scans**

Environmental Scans for each of the eleven sections of the ARR are to be done by the PIHP with its stakeholders using, where applicable, the FY 02 AFP promises; current FY 09 data and information gleaned from the CMHSP PPGs; 2008 CMHSP needs assessment data; Performance Indicator data; and more qualitative data from any recent surveys, focus groups or hearings. Again, the scope of the scans is the entire PIHP Medicaid service responsibility: populations and service providers. For each topic area in the ARR, the scans must evaluate the PIHP's current strengths and successes in meeting the expectations outlined in the section. The scans must also determine where there are challenges in meeting the expectations. Finally, the scans should identify, regardless of whether there are strengths and successes, areas that present opportunities for improvement.

It should be noted that some sections of the ARR are more developmental as MDCH expects to work with its stakeholders to further refine its expectations. Those sections are Section 2, Improving the Culture of the Systems of Care, subsections Culture of Gentleness, Trauma, and Resiliency for Children with serious emotional disturbance (SED) or a developmental disability (DD); and Section 3, Active Engagement. There is specific information requested through the 2009 CMHSP PPGs on one aspect of Active Engagement – activities outside the home for adults with DD – and in the ARR, PIHPs are being asked to address that. However, PIHP scans for the other above-referenced sub-sections of Section 2 will be more interpretive and qualitative.

As much as possible, the scans should result in baseline data and information from which improvement can be planned and measured. **Environmental scans are not to be**

**submitted to MDCH; however, they must be available for electronic submission if requested by MDCH.** During its review of the PIHP's ARR response MDCH may request that the environmental scans of one or more topic areas be submitted in order to better understand the plans. In addition, during a regularly-scheduled or special site visit, MDCH may request evidence (written documents or verbal stakeholder attestation) that verifies the scans occurred. As noted above, it is expected that the PIHP will involve stakeholders (especially individuals receiving services, their family members, advocates, but also provider and community representatives) in the environmental scan process.

**Quality Improvement Plans**

Quality Improvement Plans will be developed for each of the 11 topic areas and will focus on the challenges, or areas for improvement in meeting the expectations in the topic areas that were identified in the environmental scan process. The plan for each topic area should begin with an agreed-upon **description** of what the PIHP believes it needs to do in order to meet the expectations of the topic area. Attached (Attachment A) to the narrative in table format, should be the **milestones** that will be achieved over time, **baseline data** as applicable, and the **timeframes** for achieving the milestones and meeting the expectations. Finally, attach (identified as Attachment B) a **list of stakeholders** involved in the environmental scan, the design of the plan, and its implementation. A quality improvement plan and Attachments A and B must be submitted by the PIHP for each of the 11 ARR sections. Templates for these attachments can be found on pages 33 and 34 of this document. More detail on each part of the plans follows:

1. **The description** of the PIHP's plan for improvement is limited to a 500-word narrative (approximately two pages of size 12 font) per topic area. It should clearly identify the Section number and briefly identify the weaknesses or challenges and areas for improvement. The main focus should be on what methods will be employed to make improvements and achieve the expectations identified in the ARR section, and what methods will be used to measure success (e.g., consumer satisfaction survey, utilization data, etc.).

2. In Attachment A table (identified with the Section #), list the **milestones**[1] that will be used to measure progress toward meeting the expectations in the ARR section.

3. Wherever references are made in the narrative or the milestones to improving (increases or decreases) the numbers or percents over time, the PIHP must list in the Attachment A table the **2009 baseline data and information**. If the PIHP's plan for Section 1 calls for a 5% increase each year of individuals receiving services to be involved in advisory committees, the PIHP must provide the number who are currently (2009) involved.

[1] "**Milestones** are constructed to reassure travellers that the proper path is being followed, and to indicate either distance travelled or the remaining distance to a destination." (Wikipedia)

4. The Attachment A table must list the **timeframes** (begin dates and end dates) that identify specific months and years (not to exceed five years or September 30, 2014) for achieving each self-identified milestone and for meeting the overall MDCH expectation described in the ARR. Some activity must commence June 1, 2009, and by October 1, 2009, the plans for each section will be in implementation.

5. Attachment B table (identified with the Section #) must identify the stakeholder categories of representatives and the numbers in each involved in: *i*) the environmental scan; *ii*) the design of the plan; and *iii*) the implementation of the plan (tracking progress relative to milestones and timeframes, evaluating other measures of success). Individuals' names do not need to be submitted with the plan. However, the PIHP should maintain the list so that MDCH may contact people on it in order to discuss the scan or the plan. Instead of names on the submitted list, the PIHP should list for each category the numbers, any diversity represented and the county or counties represented. For categories (c), (d) and (e), provide the names of the organizations represented and the counties they cover. The categories are:
    a. Individuals receiving services and whether they are adults with SMI (including those with co-occurring SUD), youth with SED, people with DD, and people with SUD (only).
    b. Family members of individuals receiving services.
    c. Advocates (state or local) whose focus is serving people with SMI, SED, DD, SUD or co-occurring mental illness and substance use disorder (COD); and those advocates that address civil rights and poverty/welfare.
    d. Contract providers of public mental health services to any of the above-referenced populations.
    e. Community representatives who are relevant to the topic areas.

**The ARR Response Submission**

PIHPs should combine the 11 ARR quality improvement plans and their Attachments A and B into one Word document. **An overall description and summary, not to exceed 1000 words, of the PIHP's total quality improvement effort must precede the 11 separate topic plans.** Each section plan and attachments must be clearly labeled with the section number. The document must be clearly labeled with the PIHP name, and the name, telephone number, and E-mail address of a person who MDCH can contact for questions. **The document must be emailed to DCH-ARR-PPG-Responses@michigan.gov at MDCH by 5:00 p.m. on June 1, 2009.** A separate attestation form, attached to the ARR as Attachment C, must be signed by the executive director or chief executive officer (CEO) of the PIHP, executive director or CEO of any CMHSP affiliates, and stakeholders, at least seven of whom were individuals who have or are currently receiving public mental health services, who were involved in the environmental scans and quality improvement plans development. The signed form should be scanned and E-mailed to the above address at MDCH by **5:00 p.m. on June 1, 2009.**

## SECTION 1
## Partnering with Stakeholders in the Design, Delivery and Evaluation of the Public Mental Health System

Inherent in the success of the renewal and recommitment to quality and community in Michigan's public mental health system is partnering with stakeholders in its design, delivery and evaluation. Since 1974, Michigan CMHSPs have been required by law to include primary consumers and family members of primary consumers on their boards. For more than a decade, CMHSPs and PIHPs have been contractually required to have consumer advisory committees to provide input on various functions, especially the quality management processes. CAs have also been expected to develop and expand meaningful opportunities in planning, monitoring and program development by program participants, the recovery community, families and minority communities. The time has come to improve stakeholder "involvement" by increasing the number of opportunities and opening them to larger and more diverse groups, and by providing the support and accommodations necessary to ensure the involvement is meaningful.

It is the expectation of MDCH that individuals who receive public mental health services, their supporters (family, friends, and advocates), providers, and other interested groups will be partners at the state level, and with PIHPs, CMHSPs, CAs and their providers, not only in this comprehensive quality improvement undertaking but continuously over time. MDCH challenges the PIHPs to develop innovative methods to recruit, support and retain stakeholders; and to develop ways to involve stakeholders so that they feel their participation is meaningful. Further, MDCH expects that the PIHP's partners will represent the rich diversity of its communities and include populations often over-looked such as older adults and those with dementia, and people with COD. Finally, MDCH encourages PIHPs to consider local small business owners, as well as corporation executives, as potential long-term partners.

### Environmental Scan
Evaluate the ways individuals receiving services, their family members, advocates, providers and community representatives are currently involved in the PIHP boards, councils, and committees; whether they are ongoing or ad hoc, and the frequency of their meetings. Indicate whether the purpose(s) of these forums are for advising or making decisions on the design, delivery, or evaluation of supports and services (including quality assurance), or administrative functions (e.g., access, customer services, recipient rights). Review the categories of stakeholders (i.e., individuals served, family members, advocates, providers, community representatives) and the numbers in each. Determine how individuals and family members are supported and accommodated to assure they have meaningful participation. Analyze the strengths, challenges, and opportunities for improvement of the PIHP's stakeholder involvement and the role of the PIHP in facilitating the involvement.

### Quality Improvement Plan
Submit a plan with milestones and timeframes for addressing the challenges and opportunities for improvement identified above and for:

- increasing primary consumer, family member and advocate stakeholder involvement
- increasing numbers of types of involvement
- increasing numbers of stakeholders
- increasing the diversity of stakeholders
- improving the support and accommodation for involvement that need to be made

Wherever references to “increases in numbers” are made, include the 2009 baseline numbers and the percent of increase for each year of the plan.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **AFP (see** 1.7 Consumer/stakeholder involvement, 2.1 Stakeholder and Community Input, 3.9 Quality Management) and **other Medicaid, Mental Health Code and Contract requirements.**

## SECTION 2
## Improving the Culture of Systems of Care

As articulated in the Customer Services Standards and the Access Standards that are attached to the MDCH/PIHP and CMHSP contracts, public mental health agencies must assure a welcoming and caring culture where individuals who come to the door or who are already served are valued as whole people and are treated with respect and dignity. The standards require that individuals, and their representatives as applicable, be provided with access to complete and understandable information about service array, provider options, costs of services, and rights to due processes.

MDCH expects the public mental health system to go a step further than the standards by promoting an unconditional "culture of gentleness" wherein positive supports and approaches are the norm regardless of the challenges an individual may present. Positive interventions are used to address individuals' responses of resistance and expressions of frustration and pain. Positive interventions emphasize developing skills for assessing the antecedents of challenging behavior, for identifying clinical factors, and to rule out physical, medical, environmental, and trauma-based conditions that might be the cause of the behaviors. These interventions stress broad understanding of ways to interpret behavior as communication about that person's experience. Moving the system toward exclusive use of positive interventions will require expanded training and guidance that encourages and enables staff to respond to people with understanding and compassion, and to provide positive support for those who must express their needs through challenging behavior.

A culture of gentleness also presumes that public mental health staff work within a trauma-informed system of supports. All staff need to be taught to recognize and understand how past experiences of trauma and stigma invade so many of the lives of those requiring support, driving them to act out of desperation and in defense of themselves. Understanding the long-range impact of major trauma and the indelible marks that are left on one from traumatic experiences can improve the effectiveness of clinical and supportive interventions. In order to develop a trauma-informed system of supports, the PIHP must develop and adopt a formal policy statement about the importance of recognizing the role of trauma in individuals' experiences, and to take that into account in all aspects of all program operations. In addition, the PIHP must identify responsible leader(s) and utilize a plan for developing, implementing, monitoring and continuously improving the effort to support a trauma-informed system of care. The PIHP must develop procedures for identifying individuals who have been exposed to trauma and to include trauma-related information in planning services with them; for inquiring about and respecting individual preferences for responding in crisis situations; assurances that each person is asked about crisis preferences, and their responses are available to all appropriate direct service staff. Finally, the PIHP must develop a written de-escalation policy that minimizes the possibility of re-traumatization, and includes reference to an individual's statement of preference for crisis response.

To ensure better outcomes for children and their families, a local community system of care must be developed. A system of care for children/youth and their families is defined as the

organization of public and private services within the community into a comprehensive and interconnected network in order to accomplish better outcomes for all children (infants, toddlers, and youth) and their families. To that end, all partners (stakeholders) need to be actively engaged in the analysis and the ongoing planning and evaluation for the system of care. It is anticipated that the development of a system of care will lead to improved access to an array of community-based mental health services for children/youth with SED and DD.

Efforts by persons with SMI to pursue a pathway toward recovery must be supported by a public mental health system that fosters a culture that recognizes and values recovery as a central component of treatment and support. Elements of recovery involve the projection of hope and the expectation of recovery, not discouragement, toward persons with mental illness histories, no matter their current status. The elements include recognizing and moving away from identifying those receiving services as "cases" and other responses that objectify individuals. They include increasing personal knowledge of, and approaches to, addressing illness through adherence to health-promoting activities that assist resiliency, as well as those which invoke sanctuary when that is needed. Recovery culture begins with a belief that recovery is possible, worthwhile, and achievable for virtually everyone, over time. CMHSPs and PIHPs will be expected to apply the REE measure as part of their planning, as a method to gauge and promote local awareness of how current operations support or inhibit opportunity for recovery.

Correspondingly, providers of services for people with SUD must evolve toward a strengths-based, co-occurring capable, recovery-oriented system of care. This entails the provision of services that are specific to the needs and goals of the individual; that are stage-based, and that incorporate both principles and services that support recovery. Furthermore, providers of services to people with COD must develop these capabilities as well.

While it needs to become a community campaign to replace publicly-held perceptions and beliefs, reducing stigma and its impact starts within an improved culture of the public mental health system. PIHPs must engage their provider networks, together with individuals receiving services, their families, advocates, providers, and other community representatives, to identify and discuss the prevalence and type of stigma individuals with DD, SMI, SED, or SUD face within the public mental health system and the community at large.

**Environmental Scan**

Using information and data from feedback from service applicants, service recipients, their families, advocates and providers, and for recovery the REE, evaluate the PIHP's culture to determine its strengths, challenges and opportunities for improvement in promoting:

1. A welcoming environment that is physically comfortable and emotionally safe and that allows sufficient time and support for individuals to express and explore their situations and circumstances.

2. A culture of gentleness in which staff are trained and mentored in, and routinely use, positive and supportive methods for assessing and addressing the needs of individuals who express themselves through challenging behaviors.

3. Awareness that individuals seeking or receiving services may have experienced trauma, and take measures to understand the trauma and to avoid re-traumatizing.

4. A system of care for children with SED and children with DD that partners with community providers to evaluate and plan for better youth and family access to an array of mental health services on an ongoing basis.

5. An expectation of recovery for adults with SMI, people with SUD, and people with COD.

6. Anti-stigma awareness and efforts both within the PIHP and within its communities

**Quality Improvement Plan**

Submit a plan with milestones and timeframes that:

- Addresses any of the PIHP's challenges, and opportunities found during the environmental scan of each of the **six elements** above.
- Expresses the PIHP's intent to participate in training and technical assistance efforts focusing on culture of gentleness, trauma, and stigma and to comply with future contractually-agreed upon policy initiatives or requirements.
- Commits the PIHP to making changes, identified through the REE, that will ensure a recovery-enhancing environment.
- Identifies how, where applicable, the CMHSP affiliates' Children's System of Care planning will be coordinated throughout the affiliation.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates, providers and community members were involved in designing the plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with existing standards relevant to this section, including the **EQR** (see Standard VI), the **AFP** (see 2.10 Agency Practices/Recovery, 2.5 Accommodations, 3.1.8 Access to Care/Accommodations**), the MDCH/PIHP Contract** (see Customer Services Standards, Attachment 6.3.1.1; Access Standards, Attachment 3.1.1; and the Technical Requirement for Behavior Treatment Plan Review Committees, Attachment 1.4.1) and **other Medicaid and Mental Health Code requirements.**

## SECTION 3
## Assuring Active Engagement

For many individuals with DD served by the public mental health system, their ability to communicate preferences, to express their personal goals, and to advocate effectively for themselves is challenged. These individuals live with ongoing and critical need for supports and services, interventions, or medical care that *may* require up to 24-hour assistance. They must be afforded the supports - such as skill-building, transportation, and assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) - to engage in activities that are chosen by them and meaningful to them. At the same time, the activities must provide them opportunities to have involvement and participation in the community and with friends and family, to be productive, and to be independent at the highest level of personal capacity and interest. No matter where individuals reside – at home with family, in group homes, or in places of their own – the appropriate mix of supports, services, interventions and/or medical care must also be provided, when needed, to assure that they are able to function at their highest possible capacity.

There are no formal definitions of "active engagement" and the term should not be construed as reconstituted "active treatment.' In fact, in order to be meaningful to the person, active engagement must be individually-defined, deriving from excellent person-centered planning. One person may find intrinsic reward spending two hours in a shop looking for a birthday card for his mother, while another would rather volunteer for two hours at the local animal shelter. For people with even the most profound impairments, the very act of going, with the necessary assistance, to the store and pharmacy to buy their own groceries and medications, engages them in daily activities where they will have opportunity to interact with people outside their homes, and be stimulated by the sights, noises, temperature changes, and smells in the environment. MDCH, along with The Standards Group (TSG), will develop definitions of, and standards for, active meaningful engagement that incorporate supports, learning, skills development, treatment, health and other related services that promote and facilitate supported independence, community inclusion and participation, and productivity, including employment and volunteerism. Therefore, the ARR and the responses to it focus on just one aspect of active engagement that has been addressed by the PPGs: the extent to which individuals with DD participate in chosen activities outside their homes.

Training, mentoring and guidance of direct care staff and case managers/supports coordinators are critical to the success of actively engaging people. Opportunities for renewal and extra support for staff that provide this care must become priorities for administrators and clinical specialists.

Person-Centered Planning presents the organizing principles for the development of individualized support plans that incorporate active engagement. Through the active involvement of those who know the person best, the PCP process can identify how to actively engage the individual when the individual might otherwise be left to repetitive "standardized" experiences that have no meaning and are so minimal as to constitute neglect or abandonment.

**Environmental Scan**

Using information from the FY 09 CMHSP PPG data collection regarding the activities in which adults with DD were engaged in FY 08, evaluate the PIHP's current strengths, challenges and opportunities for improvement in being able to promote and provide occasions for adults with DD to participate in meaningful, chosen, activities within and especially outside of their homes. The evaluation should include assessing staff's knowledge, skills, and abilities to assist individuals in finding meaningful activities. It should also identify and describe barriers that exist with respect to the individuals' or families' interest, attitude and willingness to engage in activities outside the home.

**Quality Improvement Plan**

Submit a plan with milestones and timeframes that:

- Addresses the challenges and opportunities for improvement in providing access to activities outside their homes that are meaningful to, and chosen by, adults with DD.
- Describes any training, mentoring and guidance for staff that will take place in this effort.
- Describes what strategies will be used with individuals and their families to promote their choice of and participation in activities outside their homes.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates, providers and community members were involved in designing the plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section including, the **AFP (see** 2.3.4 Care Management and 2.10 Agency Practices) and **other Medicaid, Mental Health Code and Contract requirements.**

## SECTION 4
## Supporting Maximum Consumer Choice and Control

Assurance of a range of meaningful choices through the services and supports made available to the individual is an obligation of the Michigan public mental health system. The PCP process must facilitate individual expression of personal preferences and desired outcomes for their life. This opportunity for individual expression is central to developing goals and with identifying the right mix of services and supports to achieve these goals, whether those supports are provided through the public mental health system or obtained from natural and community-available options. These personally-defined benchmarks for a life with meaning are what excellent person-centered planning (PCP) ought to achieve[2]. PCP is an ongoing process of unfolding discovery, not simply a planning event that results in choosing services to be authorized through the use of public funds. Increased direct control over the manner in which services and supports are provided accompanies the expansion of meaningful choices, so that these supports and services can successfully assist an individual to have an improved quality of life, defined within the context of their personal preferences.

There are a range of options and mechanisms to facilitate choice and control. However, it is of utmost importance to recognize the federal BBA requirements that entitle individuals to their choice of Medicaid providers. Through PCP, individuals can determine how the services and supports can assist them in meeting their life goals and can individualize that support to meet their needs. PCP that is meaningful is at the heart of supporting choice and control. Effective PCP is derived from the individual's knowledge and understanding of PCP, from informed choice, and from genuine support from throughout the system (administrative level, providers, etc).

Independent facilitation of the PCP process can result in an improved experience for both the individual and their chosen participants, and for the agency charged with plan development and implementation. All individuals must be informed about, and have access to, the independent facilitation of the PCP process except those receiving only short-term outpatient services or medications. In order to be accessible to the individual, the independent facilitators must be available across the service area. A list of independent facilitators and their credentials must be given to individuals who are pre-planning their PCP process.

Maximum choice and control is often obtained through arrangements that support self-determination, enabling the individual to control his/her access to provider arrangements

[2] "Individuals," for purposes of the discussion of and requirements for person-centered planning and independent facilitation, means adults with serious mental illness, adults with co-occurring serious mental illness and substance use disorder, children with serious emotional disturbance, and people with developmental disabilities who are served by the public mental health system. Arrangements that support self-determination as a matter of policy are available to adults. Similar arrangements that offer direct control over providers of services are available to the parents or legal guardians of minor children.

and specifically tailored service options through the control of an individual budget composed of the funds that make up the costs of authorized supports and services. Direction and control over these funds allows the individual, often with support from chosen family members and friends, to directly manage their direct care workers and providers, and to achieve greater value in the outcomes of services obtained. All individuals in each CMHSP and across every PIHP must be fully informed of, and provided expanding opportunities to choose to participate in, consistent and easy access to arrangements that support self-determination. Direct control over the resources allotted for supports and services allows for the person, with chosen allies, to achieve power to control provider arrangements so that services match personal preferences. Inherent in arrangements supporting SD is authority over the use of an individual budget so that the person may achieve efficiency and best value outcomes on their own personal terms.

MDCH will develop markers and apply them to existing policy that gauge the effectiveness of PCP; how PCP is applied when working with children, youth and families; the availability of independent facilitators; and the access to, and use of, arrangements supporting SD for adults. Technical guidance will expand from MDCH outreach efforts to learn successful practice methods in other locales. Therefore, the ARR and the PIHP responses to it will focus on only the subjects of the data collected through the FY 09 PPGs.

**Environmental Scan**

Describe and analyze the extent to which PCP is practiced well, for individuals with DD, and separately for adults with mental illness. Apply consumer stakeholder feedback as a yardstick in gauging the experience of the individual of focus in the PCP process to better delineate the elements of success and need for improvement, by population group. Using information from the FY 09 CMHSP PPGs, evaluate the extent to which the PIHP has implemented arrangements that promote SD (including the availability of fiscal intermediaries) and PCP independent facilitation. From the PPG Self Determination Table #6, determine the methods and scope of training and mentoring that is provided to individuals who receive services, their family members, staff, and providers, and whether it is sufficient and effective. Finally, identify the PIHP's strengths, challenges, and opportunities for improvement in assuring availability of SD arrangements, fiscal intermediary services, and independent facilitation of PCP.

**Quality Improvement Plan**

Submit a plan with milestones and timeframes that:

- Outlines plans for improving the PCP experience and outcomes for persons with DD and for persons with MI so that elements of the environmental scan of current practices can be improved.
- Addresses the challenges and opportunities for improving access to SD arrangements, fiscal intermediaries and independent facilitation of PCP.

- Includes the 2009 baseline numbers from the PPGs and targets increasing the penetration (i.e. percentages) of individuals using SD arrangements, the availability of fiscal intermediaries, and opportunity for the use of independent facilitation of PCP for each year of the plan.
- Describes how feedback (e.g., satisfaction, quality of life survey or other methods gathering direct feedback) will be obtained from the individuals who use these arrangements in order to determine the kinds of further improvement that could be made.
- Describes any training, informational materials, or technical assistance that will be given to individuals, family members, staff and providers.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates and providers were involved in designing this plan, and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR** (see Standards VI & VII), **AFP (**see 2.2 and 3.2 Person Centered Planning and 2.11 Self Determination), Person-centered Planning Guideline, Attachment 3.4.1.1; Self-determination Policy and Practice Guideline, Attachment 3.4.3; and Customer Services Standards, Attachment 6.3.1.1 of the **Contract, and other Medicaid and Mental Health Code requirements.**

## SECTION 5
## Expanding Opportunity for Integrated Employment

For the past 20 years, employment as a route to both gaining an income and obtaining and enhancing community membership, has been a stated goal for each person who depends upon the public mental health system. With employment, one's personal capacity to choose and control one's life direction becomes significantly real. The Medicaid benefit package offered through the specialty supports and services plan provides many options for supporting the development and maintenance of employment where that is a goal for any adult served. Often the support includes individuals being given the chance to learn about opportunities for employment, to consider those opportunities during the PCP process. The PIHP must assure that individuals served in workshop settings routinely have opportunities to explore and access community opportunities for employment. It is expected that, as one of the highest priorities, public mental health agencies will actively assist adults served to obtain competitive work in integrated settings* and provide the supports and accommodations that are necessary.

PIHPs must regenerate their partnerships with other entities providing employment supports to all covered population, such as community employers, Michigan Rehabilitation Services (cash match), Intermediate School Districts, Michigan Commission for the Blind, Centers for Independent Living, Michigan Works, employment service providers, temporary services, and/or other agencies. Involvement of local business must be garnered; and local barriers to employment for persons with mental illness or DD must be explicitly addressed as a community project. The PIHP must have adequate staff who are trained and charged with job development; assigned to assist individuals in retaining supported employment opportunities; and assigned to assist people with Social Security benefits to understand and use work incentives to start or return to work.

System-wide adoption of the evidence-based practices for supported employment for persons with mental illness is also expected. Other existing programs, especially Clubhouse, Supported Employment, Assertive Community Treatment (ACT), and Co-occurring Disorders: Integrated Dual Disorders Treatment (COD: IDDT), must have an active focus on competitive employment.

*"Competitive work in integrated settings means work in the community for which anyone (with or without a disability) can apply and that pays at least minimum wage."

### Environmental Scan

Review existing agreements, as well as informal relationships, with such community entities described above to determine the breadth and depths of the employment partnerships. Evaluate staff capacity for assisting individuals with job development and retention and Social Security Benefits. Analyze current employment status data (in quality improvement file), supported employment service data (in encounter files), and Performance Indicator data for all the PIHP's adult service recipients to determine need for interventions. Finally, identify the

PIHP's strengths, challenges and opportunities for improvement in assuring access to, and assistance with, obtaining and retaining employment for all adults who choose it.

**Quality Improvement Plan**

Submit a plan with milestones and timeframes that:

- Addresses the challenges and opportunities for improvement in assuring access to, and assistance with, obtaining and retaining employment for adults who choose it.
- Identifies what new partnerships will be pursued and/or existing partnerships enhanced.
- Describes any training for staff and individuals that will occur.
- Provides 2009 baseline information on each population's aggregate employment status and aggregate supported employment service experience and the percent of increases for each year of the plan.
- Identifies how the PIHP will integrate the focus of competitive employment in other services, such Clubhouse, ACT, and COD: IDDT.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals who receive services, their family members, advocates, providers, and community employers were involved in designing this plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **AFP (see** 2.4 Employment) and **other Medicaid, Mental Health Code and Contract requirements.**

## SECTION 6
## Assuring Opportunity for Needed Treatment for People in the Criminal Justice System

The 2004 Mental Health Commission Report provided several recommendations relative to diversion programs, including more formal understandings of the shared responsibilities of the public mental health system and the judicial system (including law enforcement, defense and prosecuting attorneys, judiciary, corrections and probation). Correspondingly, MDCH, in its Implementation Plan, promoted encouragement of local collaboration and community ownership using the Criminal Justice/Mental Health Consensus Project Report as a blueprint.

The community's joint response to adults with SMI, children with SED, individuals with DD, and Medicaid enrollees with SUD who are involved or at risk of involvement with the criminal justice system should be collaborative, informed, competent, and accountable. The public mental health system should be partnering with the law enforcement and justice communities in jail diversion, prisoner re-entry, mental health court pilots, drug treatment courts, community-based inpatient psychiatric treatment of prisoners, and in-jail mental health services as evidenced by signed memoranda of agreements that describe the roles, responsibilities and cross-training of all partners. The expected collaboration must assure that individuals[3] are appropriately screened to determine their need for treatment, and are provided appropriate treatment rather than simply punished even when their offense requires incarceration. This effort must be informed through the inclusion of the perspectives of individuals who have experience with populations involved and justice involvement, and represented by broad local collaboration which best uses the knowledge, skills and financial resources available across both the mental health and justice systems. Further, the effectiveness of this effort will be dependent upon changes made as a result of ongoing review and feedback from judges, Michigan Department of Human Services (MDHS), sheriffs and others. On a statewide basis, progress will come from an evolving and expanded understanding of successful models and through a focus upon establishing more precise performance standards.

### Environmental Scan

Evaluate the scope and sufficiency of the PIHP's (and its affiliates' and CAs, as applicable) partnership with the law enforcement and justice communities, and MDHS in its service area. Determine whether people who are served by, or would be eligible for services in, the public mental health system and who have become involved with law enforcement or in the criminal/juvenile justice system, are diverted and treated, or screened and adequately treated during their time in jail. Review and analyze data and information that is collected and submitted to MDCH on jail diversion and corrections related status. Identify what, if any, mechanisms are used to obtain ongoing review and feedback from judges, MDHS, sheriffs, individuals receiving services, their family members, advocates and providers, on the

[3] Individuals served or un-served by the public mental health system who have serious mental illness, serious emotional disturbance, developmental disabilities, substance use disorders, or a co-occurrence of two or more of these disorders/disabilities.

collaboration efforts, and what is done to make improvements as a result of the feedback. Identify the PIHP's successes, challenges, and opportunities for improvement in these efforts.

**Quality Improvement Plan**

Develop and submit a plan with milestones and timeframes that:

- Addresses the challenges and opportunities for improving the collaboration with local law enforcement agencies, criminal/juvenile justice systems, and MDHS in the screening, diversion, and treatment of individuals served, or are eligible to be served, by the public mental health system.
- Includes how data and feedback will be used in the process of determining what future improvements will be made.
- Includes the 2009 baseline data, and the percent increase for each year of the plan.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals who receive services, their family members, advocates, providers, and community employers were involved in designing this plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **AFP (**see 2.8.2, 2.8.3 Public Interest) and **other Medicaid, Mental Health Code and Contract Requirements.**

## SECTION 7
## Assessing Needs and Managing Demand

This ARR section supplements ongoing requirements (see box below) relative to outreach and access through improvements in assessment of need and in understanding and managing service demand.

The needs of the community must be better determined and the needs, characteristics and interests of un-served and under-served populations must be clearly understood. It is also necessary that the PIHP understand and respond to the implications of service utilization (such as engagement and retention) and evolving best practice requirements for all populations served. The PIHP should use data from the annual needs assessment performed by CMHSP, and affiliate CMHSPs and CAs as applicable, to identify the area's un-served and underserved individuals[4] and their needs. Furthermore, the PIHP should develop a plan for how these needs will be addressed including increased access to services.

Gaining a clearer sense of trends in access, utilization and future service demand is important to planning and resource management. Of particular concern is the expected need for intensive services and support by individuals who will need the services of the public mental health system within 12 months, 24 months, and within five years. The ability to manage this emerging demand will, in part, depend upon the effectiveness and savings associated with better outcomes and improved practices. Service capacity also must be managed in a manner consistent with the Medicaid regulations and the MDCH/PIHP contracts, and in the context of local circumstances.

### Environmental Scan

Using data and information from the 2008 CMHSP annual needs assessment(s) and the response(s) to the 2009 PPGs, evaluate the PIHP's current strengths, challenges and opportunities for improvement in being able to meet the needs of the area's Medicaid beneficiaries who will require supports and services, or who are currently receiving supports and services but will require a different array or amount, scope and duration of them. The evaluation must take into account the needs and demands that will emerge within 12 months, within 24 months, and within five years.

### Quality Improvement Plan

Submit a plan with milestones and timeframes that:

- Identifies the steps the PIHP will take to address its risks and vulnerabilities in being able to meet the needs of 1) new Medicaid beneficiaries who are likely to make demands for supports and services in the next 12 months, within 24 months and within five years; and 2) existing recipients of Medicaid services who will need a different

[4] "Individuals means those who are eligible for Medicaid and are adults with serious mental illness, children with emotional disturbance, people with developmental disabilities, people with substance use disorders, and people with co-occurrences of any of these disorders/disabilities.

array or amount, scope and duration of services within 12 months, 24 months, and five years.
- Provides, where applicable, 2009 baseline numbers and the percent of increases for each year of the plan.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates, providers and community representatives were involved in the design of this plan, and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR** (see Standards V, VII)**, AFP (**see 2.3.1 Care Management, 3.1 Access to Care, and 3.5 Service Array) and **other Medicaid, Mental Health Code and Contract requirements.**

## SECTION 8
## Coordinating and Managing Care

Coordination and management of supports and care are essential elements of assuring that people's multiple and persistent needs are addressed successfully. This includes services brokering and access in a system of care where children are involved with MDHS for abuse and neglect, or in family foster care. Expanding the application of "System of Care" principles and practices for children and adolescents will be expected, so that those whose involvement cuts across school, MDHS, probate/juvenile court and CMHSP jurisdictions are effectively supported within their families. Care coordination and management must be sufficient to respond to individuals with DD who have complex conditions or at-risk situations due to the loss of natural caregivers, limited communication skills, challenging behaviors, and dual diagnoses. Individuals with SMI who are under-served, receiving "maintenance-only" services, or have co-occurring SUD or physical disabilities, or who are older adults, or are people with dementia, require extra outreach and care coordination. Public mental health agencies must assure that individuals with SMI whose symptoms have improved are not prematurely discharged from service, have an easy return to service, and receive follow-along. Better coordination of care must occur across CMHSP boundaries when individuals move to a location in a different catchment area so that the enrollment process is streamlined and necessary supports and services are not interrupted. Finally, the supports coordination/care management function needs to be vested with an expectation that coordination with primary health care will be a standard practice, assuring that individuals will have access (including transportation) to screening and treatment of co-morbid conditions which can lead to increased physical disability and untimely death.

### Environmental Scan

Evaluate the PIHP's current strengths, challenges and opportunities for improvement in assuring that care management and supports coordination adequately address the needs of people with multiple and persistent needs as identified above and listed here:

a. Children and their families who have involvement in multiple systems of care.
b. Individuals with DD who have complex co-morbid conditions and/or in at-risk situations.
c. Individuals with SMI un-served, labeled "maintenance-only", or have co-occurring SUD or physical disabilities or who are older adults, or are people with dementia.
d. Coordination of care across CMHSP boundaries.
e. Coordination with primary health care.

### Quality Improvement Plan

Submit a plan with milestones and timeframes that:

- Addresses any challenges and opportunities for improvement identified in a through e above.
- Describes any training, mentoring and guidance that will be provided for staff who will facilitate this effort.
- Provides 2009 baseline numbers of people (a through c) whose lives will be improved by this quality improvement effort, and the percent of increase per year.

- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates, providers and community representatives were involved in designing this plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR (**see Standard XIII, Coordination of Care)**, AFP (**see 2.9 Coordination and Collaboration, 3.4 Case management and Supports Coordination) and o**ther Medicaid, Mental Health Code and Contract requirements.**

## SECTION 9
## Improving the Quality of Supports and Services

It is goal of MDCH to improve supports and services, and ensure that outcome measures that support community membership are identified and used. While PIHPs are routinely visited by MDCH to determine whether supports and services meet basic Medicaid standards, and whether all providers meet basic qualification and credentialing requirements, MDCH considers these to be minimum expectations. PIHPs heretofore must demonstrate that they are regularly monitoring and managing their provider networks with even more rigor than the state employs to assure that the highest quality of supports and services are provided, that individuals are afforded maximum choice and control over their lives, and that they are in the process of achieving the outcomes they desire. There must be assurance that individuals who are the most vulnerable are receiving intensive supports and services, and that the PIHP oversight of those supports and services is likewise comprehensive and ongoing, assuring the health and welfare, and promoting active engagement for those most vulnerable.

Over the last several years, MDCH has provided support to PIHPs for adopting evidence-based, promising and best practices with the goal that these be available to anyone receiving public mental health services in this state. In addition to continuing to expand this adoption effort, public mental health agencies will need to use measurement to determine whether the services and supports provided to people are actually leading to achievement of the outcomes they desire; and to take steps to continually improve supports and services when they find that achieving outcomes falls short. Finally, public mental health agencies need to rapidly respond to critical incidents and sentinel events and improve their analyses of them, and resulting actions to prevent reoccurrences.

### Environmental Scan

Review the processes and outcomes of the PIHP's provider network management and monitoring to determine whether quality and appropriateness, choice and control, and achieving outcomes are being routinely addressed at the individual and provider level. Include in the review the scope, frequency, relevance and effectiveness of the PIHP's monitoring of supports and services for those individuals who are the most vulnerable. Analyze the evidence-based, promising, and best practices that are currently available within existing time and distance standards throughout the PIHP's service area[5]. Identify how the IPLT is involved in implementing these practices and the steps taken to sustain them. Include in the analysis the number of staff that have been or are currently being trained in the practice and the number of individuals who have utilized each of the models. Identify whether the outcomes of any or all service and supports are measured, formally or informally. If not formally, determine what would be the impact of implementing formal outcome

[5] Family Psycho-education (FPE), Co-occurring Disorders: Integrated Dual Disorders Treatment (COD:IDDT), Dialectical Behavioral Therapy (DBT), Assertive Community Treatment (ACT), Supported Employment for Adults with Serious Mental Illness, Illness Management, and any other evidence-based, promising, or best practice (PIHP to identify practices)

assessments (for all populations). Evaluate the speed and effectiveness of the response to critical incidents and sentinel events, and the actions taken to prevent further occurrences of them. Determine the extent to which individuals receiving services, their family members, advocates and providers are involved in advising the ongoing improvement of the quality of supports and services. Identify the PIHP's strengths, challenges and opportunities for improvement.

**Quality Improvement Plan**

Submit a plan with milestones and timeframes that:

- Addresses the challenges and opportunities for improvement in:
  - PIHP's management and monitoring of their provider networks for evidence of quality and appropriateness of care, individual choice and control, and progress in achieving individual outcomes.
  - The PIHP's monitoring of supports and services to people who are the most vulnerable, including the use of residential care settings that purport to address those with challenging and intensive support needs.
  - Identifying, implementing and sustaining evidence-based, promising and best practices.
  - Measuring outcomes.
  - Responding to critical incidents and sentinel events.
- Provides 2009 baseline data wherever increases are referenced and the percent of increase planned for each year.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates and providers were involved in the design of this plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR** (see Standards I, II, III, IV, VI, VII, and VIII), **AFP (**see 2.1 Stakeholder and Community Input, 2.7 Health and Safety, 3.5 Service Array, and 3.9 Quality Management), Quality Assessment and Performance Improvement Program, Attachment 6.7.1.1 of the **Contract and other Medicaid and Mental Health Code.**

## SECTION 10
## Developing and Maintaining a Competent Workforce

A key to achieving excellence in outcomes for persons who require intensive and ongoing support is to assure a stable, competent and sufficient workforce whose values, knowledge, skills, and abilities are developed and supported. This includes sufficiency in leadership and administration, as well as in the provision of direct care, supports and clinical services.

Developing and maintaining a competent workforce involves:

- Leadership in continuously promoting and reinforcing the organization's values, and in supporting diversity and inclusion.
- Strategies for recruitment and succession planning that includes working with local university and community college educators to re-design curricula and internships; attracting new employees; and recruiting employees who are representative of the community and the people receiving services.
- Ongoing staff development and support that utilizes effective training technology, leadership (clinical and administrative) support for development and training, and recognizes the need to make changes in agency policy and practices to support training, on-going mentoring and coaching.
- Effective supervisors who have the knowledge, skills and abilities to hire the best person for each job; provide the individualized supports the worker needs; and regularly evaluate and respond to the worker's performance and training/continuing education needs.
- Strategies for retaining good competent workers that include treating them with dignity and respect, and providing them optimal employment features such as adequate pay and benefits, opportunities for renewal and advancement, recognition of good performance, flexible hours options, involvement in decision-making, and a safe, supportive environment.

### Environmental Scan

Evaluate the PIHP's (affiliate CMHSPs, CAs, and/or contract agencies, as applicable) effectiveness in developing and maintaining competent professional staff, certified peer supports specialists, other paraprofessionals, and direct care workers, addressing the elements listed above, as well as others the PIHP considers key. Review turnover rates for staff who provide direct care and treatment. Identify the PIHP's (and/or contract agencies') strengths, challenges and opportunities for improvement.

### Quality Improvement Plan

Submit a plan with milestones and timeframes commencing that:

- Addresses the identified challenges and opportunities for improvement in developing and maintaining a competent workforce using all five of the elements listed above and others the PIHP considers key.

- Provides 2009 baseline numbers, wherever increases in numbers are planned (e.g., increased number of staff to be trained), and percent of increase for each year of the plan.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates and providers were involved in designing this plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section, including the **EQR (**see Standard IV, Staff Qualifications and Training**, AFP (**see 3.4 Case Management and Supports Coordination) and **other Medicaid, Mental Health Code and Contract requirements.**

## SECTION 11
## Achieving Administrative Efficiencies

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.

### Environmental Scan

Evaluate the PIHP's recent and current CQI efforts that have been aimed at achieving administrative efficiencies and effectiveness. Address any efforts taken to simplify or consolidate administrative processes and functions, including but not limited to paperwork, EMRs, service cost variability, reciprocity in training and service monitoring and uniformity in provider contractual requirements across the PIHP's network of affiliates, managed comprehensive provider networks or core contract agencies, as well as with other contracted providers. Determine the extent to which individuals receiving services, their family members, advocates and providers have been part of the CQI or simplification processes. Identify the successes, the challenges, and the opportunities for achieving further efficiencies.

### Quality Improvement Plan

Submit a plan with milestones and timeframes that:

- Addresses the opportunities for administrative efficiencies that were identified in the scan.
- Includes CQI and/or simplification of paperwork, implementation of an EMR system, variability in service costs, and development of reciprocal agreements or arrangements among PIHPs or within an affiliation for training and service monitoring, and provider contractual requirements.
- Provides 2009 baseline data, wherever increases or decreases are referenced, and the expected percent increase or decrease for each year of the plan.
- Describes how (methodologies, frequency of involvement, level of authority in decision-making, and accommodations for involvement) individuals receiving services, their family members, advocates and providers were involved in designing this plan and their strengthened role in its implementation.

MDCH expects that PIHPs will continue to be in substantial compliance with the standards relevant to this section including the **AFP (**see 3.8 Provider Network Configuration, Selection and Management) and o**ther Medicaid, Mental Health Code and Contract requirements.**

Appendix A

## ACRONYM QUICK REFERENCE

| | |
|---|---|
| ACT: | Assertive Community Treatment |
| ADLs: | Activities of daily living |
| AFP: | 2002 Application for Participation |
| ARR: | 2009 Application for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System |
| BBA: | Federal Balanced Budget Act of 1997 |
| CAs: | Substance Abuse Coordinating Agencies |
| CEO: | Chief executive officer |
| CFR: | Code of Federal Regulations |
| CMHSPs: | Michigan's (46) community mental health services programs |
| CMS: | Federal Centers for Medicare and Medicaid Services |
| COD | Co-occurring mental illness and substance use disorder |
| COD: IDDT: | Co-occurring Disorders: Integrated Dual Disorders Treatment |
| CQI: | Continuous quality improvement |
| DD: | Developmental disability (ies) |
| EMR: | Electronic medical record |
| EQR: | External quality review of Medicaid managed care organizations |
| IADLs: | Instrumental activities of daily living |
| IPLTs: | Improving Practices Leadership Teams |
| MDCH: | Michigan Department of Community Health |
| MDHS: | Michigan Department of Human Services |
| PIHPs: | Michigan's (18) Prepaid Inpatient Health Plans |
| PPG: | Program Policy Guidelines |
| REE: | Recovery Enhancing Environment measure |
| SED: | Serious Emotional Disturbance |
| SMI: | Serious Mental Illness |
| SUD: | Substance Use Disorder |
| TSG: | The Standards Group |

ATTACHMENT A TEMPLATE
**Milestones and Timeframes**

PIHP Name: _____E-mail of Contact Person:_____
ARR Section Number: ___
Note: add more rows as needed

| Milestones | Baseline Data (where applicable) | Timeframe for Achieving Milestone: Begin* and end dates | Comments |
|---|---|---|---|
| | | | |

* At least some of the quality improvement activities must begin June 1, 2009. The plan must be fully in implementation no later than October 1, 2009.

ATTACHMENT B TEMPLATE
**Stakeholder Characteristics**

PIHP Name: _____E-mail of Contact Person_____
ARR Section Number ___
Note: add more rows as needed

| Stakeholder Category | # Per Population Type* | Type of diversity represented**, | County(ies) Represented | Involvement*** |
|---|---|---|---|---|
| Individuals receiving services | SMI =<br>SED =<br>DD=<br>SUD = | | | |
| Family members | SMI =<br>SED =<br>DD=<br>SUD = | | | |
| Advocates | SMI =<br>SED =<br>DD=<br>SUD = | | | |
| Contract providers (list organization names): | | | | |
| Community representatives (list organization names) | | | | |

*Population type: adults with serious mental illness (SMI) including people with co-occurring substance use disorders, children with serious emotional disturbance (SED), people with developmental disabilities (DD), people with substance use disorder (SUD). For each category, enter the number of representatives for each of the four populations
**Diversity: note any racial, ethnic or cultural diversity that is represented
*** Involvement: enter ES for environmental scan, QIP for quality improvement plan, and IP for implementation of the plan

ATTACHMENT C TEMPLATE
**Attestation Form**

Signature on this form attests to the Michigan Department of Community Health that the PIHP, in good faith, performed an environmental scan of its service area for each of the eleven sections of the Application for Renewal and Recommitment (ARR) sections. As a result, and with the assistance of the stakeholders listed in each section's Attachment B, the PIHP has developed and is now submitting a quality improvement plan for each of the eleven sections. These quality improvement plans represent the PIHP's and stakeholders' best intentions to commence quality improvement activities June 1, 2009 and to achieve the expectations that are described in the ARR as well as the PIHP's own milestones.

PIHP Name: _____

Note: more rows may be added as needed. The name and signature of each CMHSP affiliate must be on this form, as applicable. "Representation" refers to the categories in Attachment B

| Printed/Typed Name | Signature | Title/Representation | Date |
|---|---|---|---|
| | | PIHP CEO or Executive Director | |
| | | PIHP Chief Operating Officer | |
| | | Chairperson of PIHP (CMHSP) Board of Directors | |
| | | CMHSP affiliate Executive Director as applicable | |

| Printed/Typed Name | Signature | Title/Representation | Date |
|---|---|---|---|