Community Mental Health in Michigan: Evidence and Innovation

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Executive Summary

Introduction
The health care system is increasingly moving toward patient-centered care, evidence-based treatment, integration of service delivery, and value-based payment models. Committed to innovation, the Michigan’s community mental health (CMH) system has been leading the way in these areas as it delivers real value to people with mental illness and intellectual and developmental disabilities and their families.

Michigan’s community mental health system leaders have long looked to evidence and innovation to meet the needs of the population they serve while working to control costs. As the heart of the state CMH system, local community mental health service programs (CMHSPs or CMHs) are responsible for identifying needs and serving and supporting people in their communities who are living with serious mental illness or an intellectual or developmental disability. CMHs have sought out evidence-based strategies and pushed for new approaches that will enable them to better meet the needs of the population they serve. This report provides a strengths-based review of the community mental health system in Michigan, with a focus on its efforts to promote recovery, use evidence and innovation, integrate with physical health care, and control costs.

System Structure
The Medical Services Administration (Medicaid in Michigan) contracts with ten prepaid inpatient health plans (PIHPs) to manage Medicaid-covered specialty mental health, developmental disability, and substance abuse services. Each of the state’s 46 CMHs is affiliated with a PIHP and works to coordinate treatment and services in their respective areas, either by providing treatment directly or contracting with other mental health agencies and professionals for service.

Mental health funding comes primarily from two lines in the Michigan Department of Community Health appropriations budget: Medicaid mental health services and community mental health non-Medicaid (general fund/general purpose dollars). Medicaid mental health funding is paid through capitation-based rates to PIHPs, which then contract with CMHs. CMHs use the funding they receive from the PIHPs along with general fund dollars and local county funding to provide services and supports in the community, as well as to purchase services from state or local community hospitals and community residential services.

A Recovery-based System
While the health care system has been moving toward patient-centered care, especially with the increasing adoption of the patient-centered medical home model among primary care practices, the CMH system has been working since the mid-1990s to ensure that the people who are served guide the development of their own plans of service. A focus on recovery, along with a person-centered emphasis,
provides a guidepost by which those who work in the CMH system make decisions and do their work, according to the CMH directors and staff who participated in the interviews. Examples of this were offered in descriptions of efforts to create a culture of recovery, the use of person-led processes and peer supports, community integration efforts, and the support of health and wellness among CMH consumers and staff.

Evidence and Innovation
Increasing calls for evidence-based treatment in medicine and evidence-based practices in public health, along with stronger promotion of health care innovation, are guiding the future of the health care system. With recovery as a guiding principle in the community mental health system, CMHs turn to evidence-based practices and innovative solutions to deliver services, make the most efficient use of resources, and provide the greatest value for consumers and their families. A commitment to the use of evidence-based practices ensures that CMHs are delivering services that have a high probability of success. Mental health courts are showing up across the state as an evidence-based, innovative intervention to keep people with mental illness out of the criminal justice system. And multidisciplinary teams are being used by CMHs to better meet the variety of needs faced by their consumers.

Health Care Integration
Lawmakers and health insurers are promoting the integration of health care delivery across multiple service systems through patient-centered medical homes, accountable care organizations, and health homes for people covered by Medicaid. People with serious mental illness and intellectual and developmental disabilities often face unique challenges to accessing health care services, and providers in the CMH system have implemented unique solutions to address both the physical and mental health needs of the populations they serve. These initiatives range from establishing protocols and pathways for communication between providers, assisting consumers with navigating the health care system, co-locating physical and behavioral health services, and establishing Medicaid health homes that focus on people with serious mental illness.

Cost Control and Financing Strategies
The health care system is moving away from fee-for-service payment methods toward payment models that promote value and the efficient use of resources. For a decade and a half, the community mental health system in Michigan has provided Medicaid-covered services for people with serious mental illness and intellectual and developmental disabilities within a capitation-based payment structure. Interview participants described innovative strategies that they have implemented in payment, service delivery, and leveraging of funding to maximize the reach of the resources available. Many also described active utilization review and management strategies to limit the need for inpatient treatment.

Conclusion
Michigan’s community mental health system serves as a safety net and a champion for those with some of the most challenging mental and physical health conditions. Those who work in the system have a
clear focus on identifying and delivering the services that will provide the greatest value for consumers and their families. The advances in treatment and service delivery made within the community mental health system over the past few decades reflect many of the same changes that are currently being promoted within the broader health care system. The CMH system has often been out in front in efforts to put people at the center of the services they receive, try innovative service delivery strategies, integrate and coordinate care, and control costs within a risk-based payment model.
Introduction

The health care system across the United States and Michigan is ever in search of new and better strategies for improving care and lowering health care costs. The passage of the Affordable Care Act (ACA) has accelerated the pace of change and brought issues of access to care, population health, and health care costs to the forefront. Among those who work in health care and related fields, the Triple Aim\(^1\) has become a familiar mantra: better health, better care, and lower costs.

The health care system is moving increasingly toward patient-centered care, placing greater emphasis on evidence-based treatment, promoting integration of service delivery across providers, and moving away from fee-for-service payment models. Michigan’s community mental health system has been making great strides in these areas for decades and has, in many ways, been ahead of the curve.

Michigan’s community mental health system leaders have long looked to evidence and innovation to meet the needs of the population they serve while keeping costs low. Over the decades, the system transitioned from one that was primarily state-run, with most of the people with serious mental illness or intellectual and developmental disabilities living in institutions, to one that was far more community-based, with local community mental health boards and service providers working to meet the needs of local populations.

The public mental health system in Michigan continues to include a handful of psychiatric hospitals and inpatient treatment centers, but it is primarily made up of 46 local community mental health service programs funded mainly by Medicaid and the state’s general fund. Medicaid funds are distributed to the local CMHs by ten prepaid inpatient health plans (PIHPs), which receive a payment from the state that they then allocate among the CMHs in their regions.

As the heart of the state CMH system, local CMHs are responsible for identifying needs and serving and supporting people in their communities who are living with serious mental illness or an intellectual or developmental disability. With a requirement in state law that people receive treatment in the least restrictive environment\(^2\) and a conviction that living a life in recovery is not only desirable but possible, CMHs have sought out evidence-based strategies and pushed for new approaches that will enable them to better meet the needs of the population they serve.

A commitment to recovery and person-centeredness serves as a guiding star in Michigan’s CMH system. PIHPs and CMHs have strived to establish a culture of recovery in their programs, implemented person-led processes that give control to people who receive services, identified and implemented a plethora of evidence-based practices that support recovery, worked to integrate mental and physical health care, and used effective and sophisticated strategies for keeping costs low.

This work at the local level requires and benefits from strong relationships with a wide variety of local community partners. It also requires support from the Michigan Department of Community Health...
(MDCH), which has partnered with PIHPs and CMHs to promote a recovery-based system, integrate behavioral and physical health care, and implement new approaches to service delivery.

This report provides an overview of Michigan’s CMH system; describes key facets of the CMH approach to mental health treatment; and offers a picture of the implementation of the innovative, evidence-based approaches designed to provide value to people served by the system and their families.

**Methodology**

Public Sector Consultants Inc. conducted both primary and secondary research to prepare this report. PSC interviewed the directors and staff at 13 CMHs across the state to learn more about how the system is working in practice and what evidence these providers have of the success of the services they provide. PSC also conducted interviews with people who have received services from the CMHSPs to find out about their experience of care. In addition, PSC reviewed existing documentation on the public mental health system to provide an overview of the system and supplement information gathered during interviews with CMH directors and staff.

The same interview instrument was used across all interviews, and CMH directors and staff were asked to focus on one or two areas in which their CMH demonstrates particular strength. Thus, not all CMHs are represented in every section of the report. Attempts were made to ensure that relevant information shared in every interview is highlighted in the report, which also includes numerous vignettes that provide more detailed descriptions of innovative activities at each CMH. The report is not intended to act as a compendium of every activity happening at CMHs across the state, but to highlight those activities that best illustrate the strengths of the system.

A list of community mental health service programs that participated in interviews is available in the Appendix.
The Community Mental Health System in Michigan

Public mental health institutions and programs fall into three categories: (1) state-run psychiatric hospitals; (2) 46 community mental health service programs; and (3) ten prepaid inpatient health plans (PIHPs), covering all 83 Michigan counties, which manage Medicaid mental health care services.

State Hospitals
The State of Michigan currently operates three psychiatric hospitals for adults: the Caro Center, located in Caro, the Kalamazoo Psychiatric Hospital, and the Walter Reuther Psychiatric Hospital in Westland. The Hawthorn Center in Northville serves children exclusively, while the Center for Forensic Psychiatry in Ann Arbor serves persons who have been charged with a crime and are in need of treatment or assessment.

According to a statewide summary of community mental health service program costs, just over 1,300 residents were treated in state hospitals in fiscal year 2013. Two of the hospitals are located in the tri-county region around Detroit, and the Center for Forensic Psychiatry is in nearby Washtenaw County. The Caro Center and Kalamazoo Psychiatric Hospital lie in outstate areas. There are no state hospitals in the Upper Peninsula or in the northern Lower Peninsula.

Community Mental Health Service Programs
Community mental health service programs are the primary provider of public mental health services. The organizations work to coordinate treatment and services in their respective areas, either by providing treatment directly or contracting with other mental health agencies and professionals for service. They are also the predominant provider of mental health treatment in county jails. Each CMHSP develops and administers services at the local level. While extensive data collection is required by the state, the types of services offered are not uniform statewide.

Of the 46 existing CMHs, 39 are organized as independent authorities, formed by one or more counties as an organization that is legally separate from the county or counties that formed it. Five CMHs are agencies of county government: Allegan, Lapeer, Macomb, Muskegon, and Ottawa. Community mental health agencies are agencies of the county they represent, and all funding is appropriated within the county budget. Only two CMHs, Centra Wellness Network (formerly Manistee-Benzie CMH) and Washtenaw, are organizations, which are partnerships between two or more counties or a county and an institute of higher education. Like authorities, organizations are legally separate from the bodies that form them.

Community mental health service programs are governed by boards of directors, which must be representative of mental health service providers, recipients or primary consumers of mental health services, agencies and occupations that have working involvement with mental health services, and the
general public. At least one-third of the board members must be primary consumers or family members, and of that one-third, half must be primary consumers.

The individuals to be served by CMHs and the priority order in which they must be served are set in statute. The primary responsibility of CMHs is to treat people with serious mental illness or serious emotional disturbances who are in urgent or emergency situations. One of the following criteria must be met to qualify as an emergency situation:

- An individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
- An individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities, and this inability may lead in the near future to harm to the individual or to another individual.
- An individual’s judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

Serving persons who have severe forms of mental illness or emotional disturbance is the next priority. While still important, persons who have less severe mental illness or disturbances, or who merely exhibit a “diagnosable condition,” are a lower priority. In a time of budget crisis, it is reasonable to suppose that the system will continue to treat crises and severe cases, but possibly at the expense of those with less severe conditions. The risk, of course, is that, absent treatment, less serious cases of mental illness and emotional disturbance will worsen. Exhibit 1 gives a sense of CMHSP service priorities.
Prepaid Inpatient Health Plans

The Medical Services Administration (Medicaid in Michigan) contracts with ten prepaid inpatient health plans to manage Medicaid-covered specialty mental health, developmental disabilities, and substance abuse services. PIHPs are managed care organizations that receive capitated payments for each person in the plan. PIHPs are similar to Medicaid health plans and HMOs, but they are not responsible for a full scope of medical services. They are responsible for specialty services, which have been “carved out” of the Medicaid managed care benefit. Limited outpatient mental health services are available through Medicaid health plans for individuals with less severe conditions.

All community mental health service programs are affiliated with a PIHP, and contract with their respective PIHP to provide Medicaid-funded services for its members. The PIHPs contract with providers, provide gatekeeper services, and monitor the quality of services.

Primary Funding Sources

Mental health services in Michigan are financed through Michigan Department of Community Health appropriations, which undergo annual legislative approval. Mental health funding comes primarily from
the following two lines in that budget: Medicaid mental health services and community mental health non-Medicaid (general fund/general purpose dollars). Other items that fund mental health services include local county funds, CMH purchase of state services, CMH multicultural services, the federal mental health block grant, and CMH respite services.

CMHSPs use the funding they receive to provide services and supports in the community, as well as purchasing services from state or local community hospitals and community residential services. The most common services provided by CMHSPs are outpatient therapy, physician medication reviews, treatment planning sessions, and treatment in public and private psychiatric and private general hospitals.  

**Medicaid**

Medicaid mental health funding is paid through capitation rates to PIHPs. As a result of the Medicaid mental health waiver the state obtained in 1997, which allowed the provision and payment of mental health services through a managed care model, CMHSPs consolidated for the provision of waiver services to establish 18 PIHPs. A stipulation for the waiver made by the Centers for Medicare and Medicaid Services (CMS) was that each Medicaid-reimbursable mental health organization serve at least 20,000 clients. Because of the minimum client requirement, larger urban areas may be both a CMHSP and a PIHP. In 2013, the Michigan Department of Community Health, in partnership with CMHs, reduced the number of PIHPs from 18 to 10 to gain greater efficiencies. This consolidation went into effect in January 2014.

Because Medicaid mental health funding is linked to federal match funding, it has traditionally been “safer” when the budget is cut. In 2003, when the managed care waiver was up for renewal, the federal government required that Medicaid rates be actuarially sound. Factors used to determine fiscal year 2013–14 rates were: health insurance claim assessment, age, gender, and geographic region for the Temporary Assistance for Needy Families (TANF) and Disabled, Aged, and Blind (DAB) populations. The capitation base rate differs among PIHPs based on historical revenue requirements and estimated morbidity. The MDCH intends to redevelop the rate structure methodologies and adjustors to better reflect morbidity.

**General Fund**

Non-Medicaid mental health dollars are significantly more vulnerable to reductions because they are funded solely by state general fund/general purpose (GF/GP) dollars, which are spent entirely at the state’s discretion. Distribution of these funds has also been traditionally controversial, with no set formula used for allocation. Communities that had state institutions generally received greater amounts of non-Medicaid CMH funds, because of the need to provide services and supports for facility residents that were moved back into the community. In FY 1996–97, the Citizens Research Council developed a funding factor strategy that weighted the number of those eligible for Medicaid, estimates for the uninsured, and estimates for adults with serious mental disorders in each region. In addition to applying the formula, some funding was redirected to the four lowest-funded CMHSPs.
This funding formula was revisited in FY 2009–2010, when the budget was reduced by $40 million. Section 462 of PA 131 of 2009 required the Michigan Department of Community Health to report to the legislature on the formula that would be used to implement the reductions, including the factors used in the formula. The formula developed by the department incorporated the original factors from 1997 and added four additional factors. First, pro rata reductions were included, so all entities received an equally proportionate reduction. Second, funding to purchase services from state facilities was altered to remove those enrolled in Medicaid. Finally, homelessness and unemployment rates in each region were considered. As a result of this new formula, CMHSPs across the state received reductions ranging from 1.4 percent to 18.1 percent of their total GF/GP allocations. The additional factors were included to protect some of the larger CMHSPs from more severe reductions.

In fiscal year 2013–2014, additional changes were made to the way funds are distributed to CMHs. Due to the anticipated increase in the number of people enrolled in Medicaid through the Healthy Michigan Plan (Medicaid expansion), proportional cuts were made to the general funds appropriated to CMHs. The assumption was that many uninsured people who received services from CMHs would become covered by Medicaid, those CMHs would receive additional Medicaid funds, and as a result, would need fewer general funds. The cuts were controversial, and some CMHs have indicated that these cuts led to reductions in and termination of services for a large number of people.
A Recovery-based System

Beginning with a national demonstration project in 2006, the patient-centered medical home model of care has been increasingly adopted by primary care providers across the country.\textsuperscript{10} This move toward patient-centered care demonstrates growing recognition of the need to involve patients in care and treatment decisions as well as to connect patients with community-based services. A principle of the PCMH model is a “whole person orientation,” wherein “the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.”\textsuperscript{11} As a recovery-based system, Michigan’s community mental health system has long placed an emphasis on the use of person-led processes and has worked with community partners to provide nontraditional services that will lead to better outcomes for their clients.

The U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as “a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”\textsuperscript{12}

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by SAMHSA, patients, health care professionals, researchers and others agreed on ten core principles undergirding a recovery orientation:\textsuperscript{13}

- **Self-direction:** Consumers determine their own path to recovery.
- **Individualized and person-centered:** There are multiple pathways to recovery based on individuals’ unique strengths, needs, preferences, experiences, and cultural backgrounds.
- **Empowerment:** Consumers can choose among options and participate in all decisions that affect them.
- **Holistic:** Recovery focuses on people’s entire lives, including mind, body, spirit, and community.
- **Nonlinear:** Recovery isn’t a step-by-step process but one based on continual growth, occasional setbacks and learning from experience.
- **Strengths-based:** Recovery builds on people’s strengths.
- **Peer support:** Mutual support plays an invaluable role in recovery.
- **Respect:** Acceptance and appreciation by society, communities, systems of care, and consumers themselves are crucial to recovery.
- **Responsibility:** Consumers are responsible for their own self-care and journeys of recovery.
- **Hope:** Recovery’s central, motivating message is a better future—that people can and do overcome obstacles.

The Michigan Department of Community Health has made a commitment to supporting a recovery-based public mental health system in Michigan. Several initiatives that have been implemented in Michigan’s public mental health system are aimed at creating an environment that supports recovery for
people with mental illness. In December 2005, the MDCH established a Recovery Council comprised primarily of mental health consumers. The council’s mission was to transform the public mental health system so that each person can achieve recovery.

The Recovery Council, which has since dissolved as of December 2013, recommended the measurement of CMH capacity to support recovery. The council selected the Recovery Enhancing Environment (REE) measure, developed by Priscilla Ridgway, PhD, a Yale-based researcher, to monitor systemwide progress on the implementation of a recovery-based system. The REE was implemented through surveys of public mental health system consumers who were asked to rate their level of involvement in their own recovery and how well their CMH programs demonstrate elements of a recovery-based system.

The REE was administered from May of 2009 through August 2010 in all 46 CMHSPs and their contract agencies. In total, 6,146 adults with serious mental illness participated in the survey. The survey found that 57 percent of those surveyed identified themselves as being actively involved in their recovery, 21 percent did not see themselves as involved in their recovery, and another 22 percent did not respond. The vast majority of respondents (between 82 and 92 percent at any given CMH) agreed that their program demonstrates the recovery elements identified in the survey.

Examples of Michigan’s recovery-based approach to community mental health were offered in descriptions of efforts to create a culture of recovery, the use of person-led processes and peer supports, community integration efforts, and support of health and wellness.

**A Culture of Recovery**

According to many interviewees, CMHs work to build a culture of recovery where the principles of recovery permeate their entire agency through staff trainings and the use of recovery-focused language in agency policies and other materials. Many agencies also work to share the message of recovery with the broader community through outreach messaging and programs, such as Northern Lakes CMH, which inserted its annual report into the community newspaper with a distribution of nearly 60,000 readers.

At Northpointe Behavioral Health in the Upper Peninsula, CEO Karen Thekan says of recovery, “It is an overall culture.” To ensure that agencies are successfully promoting a culture of recovery, she says, “The whole U.P. implemented a recovery-oriented satisfaction survey with consumers.” The survey asks consumers to indicate the degree to which they agree with statements such as, “I’m hopeful about my future” and “I am able to meet my goals,” says Thekan. The survey, which was recently implemented, is fielded on a quarterly basis. Only two quarters of data are available at this point, but Thekan says the results indicate that the providers are successfully supporting consumers in recovery.

At the Detroit Wayne Mental Health Authority (DWMHA), Felicia Simpson, contract manager for managed care operations, says the agency participated in the REE survey, and used the results to identify where it could strengthen its environment to better support recovery. They interviewed more than 1,000 consumers who participated in the survey to get additional feedback, and then hired a consultant to train recovery trainers, resulting in 18 certified recovery trainers. Between 2012 and 2014,
DWMHA recovery trainers have trained nearly 700 consumers, stakeholders, and staff on the recovery model and principles. “We have a recovery policy and we ensure that recovery principles are part of our system,” says Simpson.

St. Clair County Community Mental Health: Culture of Recovery

Debra Johnson, executive director of the St. Clair County CMH, says her agency has been working for more than a decade to ensure a recovery-oriented, person-centered environment for consumers. A culture of recovery is evident throughout the CMH, she says—in the use of peer supports, the CMH building itself, ongoing staff training, the language used by staff, and the information shared with the community.

Johnson notes that a focus on recovery began in earnest for the CMH in 2004 when “we contracted with META, now Recovery Innovations, to help us transform our organization to be more recovery focused. They provided training and consultation for our peer workforce.” Peers are now working with individuals and groups in a variety of program areas in the CMH.

Around the same time the CMH contracted with META, it was consolidating services from six of its sites into a single building. The organization kept its focus on recovery as it designed the new building, according to Johnson. “We designed this building to be a very welcoming environment. It’s a beautiful building! We also have a restaurant program in our building for people interested in learning to work in the culinary arts, and that helps with our job training and the placements we do in the community.”

A recovery environment is supported by ongoing staff training using the Keeping Recovery Skills Alive (KRSA) curriculum. There are 52 sessions (one for every week of the year), which are offered on a biweekly basis to staff. “Everyone on staff is required to participate,” Johnson says, emphasizing that it doesn’t matter what role the person plays and how often they come into contact with consumers.

She also notes the importance of using person-first language: “You put the person first. For example, you would say, ‘I work with individuals who have developmental disabilities,’ not ‘I work with the developmentally disabled.’ It’s respectful. You don’t refer to people by their illness.” The CMH has worked very hard to ensure that not only what gets said out loud, but also what is in writing uses this type of language. In 2008, the organization’s mission was revised to have a focus on recovery and the CMH continually reviews all organizational policies to ensure consistent use of the person-first approach.

“The importance of a recovery environment for promoting recovery in the people we serve cannot be overstated,” says Johnson. “It’s a philosophy and it is a way of doing business here.”
Northern Lakes Community Mental Health: 
Recovery Blueprint

Northern Lakes Community Mental Health, which covers a six-county region in Michigan’s northern Lower Peninsula, demonstrates a focus on creating an entire culture of recovery throughout its services.

Recovery has been a part of Northern Lakes CMH’s mission statement since 2003. In 2009, Northern Lakes formally expressed the concept of “recovery” as the overarching goal of its service system for people mental illness. The policy states that the goal of recovery starts with the belief that recovery is achievable and that all employees and service providers must project hope, communicate an expectation of recovery, and empower people to exercise choice and control over their lives, including the purchase of supports and services and choice in providers.

Northern Lakes CMH implemented a Recovery Blueprint, which is updated regularly, and focuses on the four major goals of health, home, purpose, and community. The Recovery Blueprint outlines the accomplishments from the past year while describing the next steps necessary to support these goals. It also includes who is responsible and the expected time frame for each item.

This blueprint puts all of its programs and services into a recovery context. Staff and service providers at all levels in the organization talk about recovery and recognize the work they are involved in as being a part of this overall goal. Recovery is then communicated by and to everyone, and discussed openly with those Northern Lakes serves, allowing consumers to more easily realize their individual goals.

This culture of recovery is evident when speaking to consumers from Northern Lakes. Everyone interviewed described their experiences as positive and that they knew they were working towards their personal recovery. One consumer interviewed describes her experience with Northern Lakes as “fantastic.” She says that “they helped me to become me again.” In her experience, the CMH started encouraging her to become more involved in opportunities and programs at the same time that she wanted to decrease her medications. She participated in an art project at the CMH where consumers created picture biographies to share their recovery stories, and in board meetings where she could provide her input on CMH services. This involvement and request for her input increased her self-esteem. Then Northern Lakes helped her towards her physical health goals; she lost over 100 pounds. “This helped my confidence, and it decreased my anxiety. I saw I had real possibilities,” she concludes.

...
**Person-led Processes**

Mental health service delivery is focused on the needs and preferences of individuals, encouraging consumers to play an active role in care planning instead of following a standardized plan, with those principles incorporated into the Mental Health Code in 1995. Throughout the interviews with CMH directors and staff, interviewees noted the importance of supporting consumer direction in the identification of the services they will receive in support of their recovery. Two of the primary ways in which people who receive services are supported in leading their own recovery are person-centered planning and self-determination.

**Person-centered Planning**

Michigan’s Mental Health Code establishes the right for all individuals to have their Individual Plan of Services developed through a person-centered planning (PCP) process. Person-centered planning, which is designed to allow mental health system consumers to express their personal needs and goals related to treatment, is a critical element in enhancing and promoting recovery in Michigan. While professionally trained staff has a role in the planning and delivery of treatment, the expressed needs and desires of the individual seeking treatment are the primary basis for the development of an Individual Plan of Services. For children in Michigan, the MDCH has supported a family approach to service planning that recognizes both the importance of the family in a child’s recovery and the fact that treatment services impact the entire family. Practice guidelines include essential elements of PCP and provide recommended strategies for carrying out the planning process based on the needs expressed by the individual.

St. Clair County CMH’s Debra Johnson says she was initially trained in person-centered planning through the Developmental Disabilities Institute before it was required by law: “If you believe in the philosophy of person-centered planning as I do, it just makes sense. It’s about meeting the person where they are, talking about their hopes, goals, and wishes.” Linda Kaufmann at Community Mental Health for Central Michigan states that person-centered planning is about assisting consumers in identifying what represents a meaningful life for them: “Recovery is not synonymous with no longer having a diagnosis; it’s living a life of your own design and choosing.”

**Self-determination**

Self-determination theory suggests that human beings grow, thrive, achieve goals, and feel greater well-being under conditions that support the fulfillment of basic human needs, including autonomy, competence, and relatedness to others.

According to the MDCH, self-determination is grounded in “the core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, should have access to meaningful choices, and control over their lives.” The department also provides four key principles of self-determination:

- **Freedom**: The exercise of the same rights as all citizens. People with disabilities, with assistance when necessary, will establish where they want to live, with whom they want to live and how their
time will be occupied. They do not have to trade their inalienable rights guaranteed under the Constitution for supports or services.

- **Authority:** The control of whatever sums of money are needed for one’s own support, including the reprioritizing of these dollars when necessary. This is accomplished through the development of an individual budget that “moves” with the person.

- **Support:** The organization of these resources as determined by the person with a disability. This means that individuals do not receive “supervision” and “staffing.” Rather, folks with disabilities may seek companionship for support and contract for any number of discrete tasks for which they need assistance.

- **Responsibility:** The wise use of public dollars. Dollars are now being used as an investment in a person’s life and not handled as resources to purchase services or slots. Responsibility includes the ordinary obligations of American citizens and allows individuals to contribute to their communities in meaningful ways.

In practice, people with disabilities who receive services from the public mental health system in Michigan are given the opportunity to direct a fixed amount of resources to purchase services to support their recovery. Each person who has a self-determination arrangement controls the use of the resources in his or her individual budget, determining, with the assistance of chosen allies, which services and supports he or she will purchase, from whom, and under what circumstances. The budget is developed based upon the individual plan of services and supports, which is developed through the person-centered planning process. Michigan law requires access to self-determination for anyone in the public mental health system.
Ed LaFramboise, executive director at Northeast Michigan CMH, describes the importance of person-centered planning and self-determination in supporting recovery. “Self-determination is something we use to engage people in living a life that they choose,” says LaFramboise, “and it starts with the person-centered planning process, which is critical to identifying what people want, where they want to live, how they want to live, and how we might support them in achieving outcomes that are important to them.”

LaFramboise says that when person-centered planning and self-determination became part of the CMH process, it represented a departure from historical way of working with consumers. “Historically in mental health,” he notes, “we dictated services to people based on assessments and evaluations. We would prescribe what we thought was in their best interest. But what we’re doing with person-centered planning and self-determination is trying to help people have an integrated lifestyle in their community. They tell you what they need to be an active member of their community.”

He emphasizes the level of control that consumers are given over their own lives through these processes, which differentiates the CMH system from the medical care system. “Person-centered planning has really changed our approach to allowing people to identify a lifestyle that is important to them and how we might assist them. Self-determination actually gives people control over dollars, in that they can purchase service from whomever they think is appropriate. We don’t fit the traditional health care model.”

A Northeast Michigan CMH consumer has a self-determination agreement that allows him to get assistance with some services, but he also runs his own business and serves as a fiscal intermediary for others with self-determination agreements. “There are two fiscal intermediaries in the area. I’m one of them. I receive support from self-determination, but I also help others deal with payroll and paying people to provide services.” He says of the support he receives from the CMH, “You couldn’t ask for anything more as far as the support I receive. Everyone has bent over backwards to help—with my business and with my own self-determination.”
Community Living Services (CLS), one of Detroit Wayne Mental Health Authority’s contracted agencies, has nearly 1,000 people supported through self-determination arrangements. Staff at DWMHA describe self-determination as “the basis for a purer form of person-centered planning to occur, wherein an informed choice of supports, housemates, and caregivers can be made.” While self-determination has been primarily used for people with intellectual and developmental disabilities, DWMHA is working to ensure that all CMH consumers are able to take advantage of the arrangement. The agency is focused on ensuring that people who receive services for mental illness, in addition to those with intellectual and developmental disabilities, are “fully embracing the concept of self-determination.”

A consumer at Northern Lakes CMH says the organization encouraged her to take control of her own recovery:

At Northern Lakes CMH, the idea of recovery was very present. I really heard, “You will get better. Things will not be miserable. You are going to get better,” all the time. That has been the case for me. The CMH got me involved in my own treatment. There were always a lot of options provided for me to choose from, and they would support whatever I chose.

I learned to be my own advocate. I didn’t know how to be my own advocate. I had a case manager who encouraged me to make my emotions more visible and communicate what was going on with me. The case management was very consistent. They helped me when I needed help, and pushed me when I needed a push.
The Saginaw County Community Mental Health Authority is sharpening its focus on self-determination. According to Sandra Lindsey, the CEO of Saginaw County CMH, many of its consumers did not know how to figure out if a self-determined arrangement would be a good fit for them. In order to educate staff and consumers on available community options, the agency developed a workbook of choices to consider. “Some consumers had lived in congregate living situations for most of their adult lives, and had never been exposed to parts of the community that others enjoy and don’t even think about,” explains Lindsey. The workbook covers all sorts of topics from public transportation to churches to lease agreements, supported housing, and independent apartments. Lindsey adds that, “This workbook helped start the conversation between service providers and clients so there could be a more engaged process and we could better meet the needs of the client. It helped our consumers think about what they might want to try and then develop a plan to do the things they wanted.”

Saginaw County CMH created a new position to advocate for self-determination for any client of Saginaw County CMH, and not just those with intellectual or developmental disabilities. The position was also responsible for bringing the language and ideas of self-determination to all other employees at Saginaw County CMH. First, all new staff were trained in self-determination, followed by all established staff. Lindsey explains this process was because “some of the established staff were skeptical about self-determination because it seemed unsafe for many of the clients they knew so well and that they worked with regularly to live independently.” “However,” Lindsey notes, “there is just as much risk from living in an unhappy congregate situation than living on one’s own; the risks are just different.” All top management and administration were on board with the push for self-determination and this support was communicated out to everyone so that everyone was talking about it.

Saginaw County CMH invited community partners such as the Disability Network to help them determine reasonable expenses for individual budget items. Because resources are limited, Saginaw County CMH uses creative ideas to help its self-determination clients stay within their housing budgets, such as through shared living arrangements. Saginaw County CMH helps facilitate agreements between clients and potential roommates of their clients’ choosing. “The roommates,” Lindsey describes, “may be nondisabled and able to have reduced rent for helping our client with tasks such as yard maintenance, grocery shopping, or providing transportation.”

In most cases, families of self-determination consumers are very involved in the process. The families are never looking for CMH to pay for everything, but they are grateful for CMH’s help in the process, and that this new living arrangement provides their family member with an opportunity for an enhanced quality of life.

In one example, a woman who had been in and out of hospitalizations her entire life went into a self-determined arrangement a little over a year ago. She has not had a psychiatric hospitalization since. In another example, a woman bought a house for her brother, who was a client of Saginaw CMH. CMH helped arrange a roommate for her brother, and she saw her brother become much happier and have a higher quality of life living on his own than he did in the group home with people he did not want to live with. After her brother passed away, the woman allowed Saginaw CMH to continue to use the house for other CMH consumers in hopes it would increase others’ quality of life, like it did for her brother.

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Peer Supports

People who are living in recovery after receiving CMH services serve in a variety of capacities within the CMH system, including in paid staff and volunteer positions working with current consumers of CMH services. These “peers” are viewed as an essential component of CMH programs because of their ability to gain the trust of those receiving treatment based on shared experience. In addition, their knowledge of the treatment system from the perspective of the consumer allows peers to offer advice and insights that may not come from other treatment professionals.

Many CMH directors and staff spoke of the large number and variety of opportunities they offer for consumers to participate in their agencies. Many hire consumers as certified peer support specialists or peer coaches, while others hire consumers to serve in other capacities. Some of the examples provided include opportunities for consumers to meaningfully improve CMH services for themselves and others by serving on CMH boards of directors or committees, or by providing training to CMH staff on creating a positive and welcoming environment for consumers.

Certified Peer Support Specialists and Peer Coaches

Peer support specialists are individuals who have received treatment through the public mental health system and have received comprehensive training and certification that allows them to work with persons who are currently receiving treatment. The employment of peer support specialists has been an essential component of supporting the recovery of individuals served by the mental health system in Michigan since 1998, when community mental health block grant funds were first used to pay for these positions.

Peer support specialists are often included in the mental health treatment team and can facilitate the person-centered planning process. The assistance provided by these specialists is not limited to navigating the mental health system, but includes helping persons served obtain other supports that will contribute to their recovery, such as housing and vocational assistance. Detroit Wayne Mental Health Authority engages peers in a wide range of roles with 233 peer support specialists and 130 peer recovery coaches and a number of peer mentors and parent support partners. An important job of peers in any of these roles is to help connect consumers with services in the community, according to agency staff.

Some peer support specialists at St. Clair County CMH are trained to develop Wellness Recovery Action Plans (WRAP) for individuals with severe mental illness. These plans are designed in conjunction with a consumer who will identify the types of behaviors they engage in when they are not doing well mentally (e.g., talking too fast or shopping too much) and the ways that the peer support specialist can help them when they exhibit these behaviors.

Julia Rupp, executive director at Community Mental Health Services of Muskegon County, says of her organization, “We highly value people with lived experience.” Since Rupp came on board in 2012, the number of peer support specialists has doubled. “There is at least one peer support specialist on every
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team we have. More and more often, consumers are using a peer support specialist to work with them, especially in the person-centered planning process.”

Kalamazoo Community Mental Health and Substance Abuse Services:
Recovery Institute of Southwest Michigan

The Recovery Institute of Southwest Michigan is a peer-run, peer-delivered support organization incorporated as a nonprofit in 2006. The Recovery Institute, which is affiliated with Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS), has an agreement with Kalamazoo Valley Community College (KVCC) to provide classes on recovery. “KVCC has a permanent three-hour psychology course called Principles in Recovery that is designed for people with mental illness who are seeking peer support specialist certification,” states Jeff Patton, CEO at KCMHSAS. He notes that to become certified by the state as a peer support specialist, peers must have previous work experience. KCMHSAS and the Recovery Institute worked with the state to obtain an agreement that participation in the course can contribute toward that requirement. “The course is coordinated and taught by peers,” notes Patton, and it has gained student interest outside of those seeking peer support specialist certification. He indicates that “many people who are not in recovery, but who are earning a degree in psychology, have taken the course.”

The Recovery Institute also has an agreement with KVCC to provide training for peers to become health coaches. Patton says the health coaches are being trained to support CMH/health care integration efforts, especially to support access to care and to accompany people to appointments when needed. The course provides those who complete it with a health coach certificate. Through the training, taught by a primary care practitioner, peers learn health care terminology and become familiar with how medical practices operate. “When the state began looking at health care integration, I wanted to start at the peer level, because they tend to get left out,” Patton observes. “What we wanted to do was get troops on the ground to support people with mental illness getting access to good primary care. Coaches can accompany people to appointments or help them reschedule appointments when necessary. It helps keep people engaged in their health care.”
Without being certified as a peer support specialist, peers often serve as coaches for those currently engaged in CMH services. These trained peers are typically paired with a current consumer to offer specific types of support and guidance as the individual works toward recovery.

Peer supports do a lot of different things at the Saginaw County CMH, according to CEO Sandra Lindsey. Some co-lead treatment groups; one who “has a history with state hospitals and jails” presents often at conferences and leads a DBT (dialectical behavior therapy) peer group with a clinician. Some of the organization’s peer support specialists help with CMH patients who are admitted for inpatient psychiatric care. “When people are at their most fragile, the peers are their verbal and emotional interpreters. They know what it is like to be coming out of this acute state of psychiatric illness, and they are great at candid conversations with the treatment teams,” states Lindsey.

A peer support specialist at Clinton-Eaton-Ingham Community Mental Health Authority (CEI CMHA) says his job offers a great amount of variety and helps him maintain his recovery:

I occasionally work with clients one-on-one, but I’m also on a DBT [dialectical behavior therapy] team, I do a men’s group and an advanced group, and orientation for new members. I do a lot of public speaking and I’m a trainer in mental health first aid for youth and adults.

As far as maintaining my recovery, this is one of the key components of being a peer support specialist. Working with others keeps me motivated. I like working with borderline personality disorder consumers because I get to work with them for about a year, and they need a lot of help.

Another peer support specialist at CEI CMHA echoed these sentiments:

I feel that I can help the consumers by sharing what I have gone through. It motivates me to keep my medicine going and to keep on the right track as well as helping them see there is potential for recovery. I don’t get to work with people long-term, but if they do come back and visit, it’s nice to know when I’ve made a difference to someone.
A peer support specialist at Saginaw County CMH says her experience helps her “accept people as they are.” She adds:

*I have a lot to offer because I have been through so much. I think what makes a good peer support is the lived experience. Each one of us helps the entire team and organization. I work closely with the providers, and I do some case management too. I consider myself a professional. This is a professional position.*

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**Genesee Health System:**

**Peer Coaches**

Genesee Health System (GHS) is supporting consumers’ recovery through the use of Peer Health Coaches. GHS has had many certified peer support specialists, but they have added new positions called health coaches. The health coaches target “hot spotters,” individuals with multiple chronic physical and behavioral health needs who often end up in the emergency room multiple times within a few months. “Many of these consumers do not have natural or other supports, they have transient living arrangements, and they carry an array of psychosocial and physical health complexities,” Danis Russell, CEO of GHS explains. “Many are not engaged in services and are difficult to recruit for programs designed to help. The health coaches build relationships and ‘walk alongside’ individuals on their recovery journey.”

Health coaches help consumers enroll in Healthy Michigan, and they help address unmet needs consumers may have related to food, transportation, health care, medications, and safe housing. “By using individuals with lived experience as the focal point of the program, the individuals who need the services see people like them as a friend,” reports Russell. “It is more important to have the right skill set instead of the right credentials when hiring a health coach,” he adds. GHS has five health coaches, and for many of them, this is their first job, which comes with its own challenges, but “it is worth the risk and challenge, because the results are substantial,” Russell explains.

Although this is a new program, the initial results are striking. After three months of working with a peer health coach, the number of emergency room (ER) visits and admissions to detox, psychiatric inpatient, and residential substance use treatment all decreased, sometimes very significantly. For example, in 2014, 140 consumers experienced a total of 346 ER visits, which is an average of 2.5 per person. But after working with a health coach for at least three months, this same group had only 72 ER visits, an average of only 0.5 visits per consumer. GHS is excited about these initial results and the associated cost savings, and is looking to hire more peer health coaches.
Other Opportunities for Peers

While peer support specialists and coaches are fairly common fixtures within CMHs, many of the directors and staff who participated in interviews noted that they make a point to hire consumers to fill a broad range of roles within their organization. These consumers are supported in their recovery through the employment offered at the CMH while also serving as a successful example of recovery for consumers coming through the system.

At Kalamazoo Community Mental Health and Substance Abuse Services, CEO Jeff Patton says, “We have integrated peers throughout our system. When a person is coming in for services, their first contact is generally with a trained peer. We want a person with mental illness to be greeted by someone who also has a mental illness. A big focus of our program is to hire peers and make sure they are adequately trained. Not all of our peers are certified as specialists by the state, but we encourage this.” Similarly, Northern Lakes CMH created “greeter stations” a couple of years ago where peers are hired to greet people coming in to receive services.

A consumer at Northern Lakes CMH described some of the ways that she participates in the CMH:

I have taken part in their action group that meets monthly. It does planning for different events that the CMH offers. They do a recovery celebration every year, and the action group plans this and puts it together. I have also done a lot of volunteer work through the CMH. They have asked me to co-teach a class with the photo biography class. In the last few months, I was asked to join the Northwest Michigan Regional Entity Board of Directors. The board oversees all of the CMHs in the region.

They kept offering me opportunities I had never had before. It helped me with my self-confidence. As I got more active, it helped me do more. I was learning about myself and it all plays into my recovery.
Northpointe Behavioral Health: Use of Peers

At Northpointe Behavioral Health in the Upper Peninsula, the use of peers in service has been paramount to a recovery-based system. CEO Karen Thekan reports, "We hired consumers to work in our services well before peer support was a service required by the state." Northpointe hires former community mental health consumers to work in many different areas, including as employees in residential services, as contract reviewers, as community living support workers, and as traditional certified peer supports. In the past, Northpointe had a consumer at the local federally qualified health center (FQHC) to assist with referrals and questions about accessing services.

“Peers have a lived experience and can better connect with consumers. They connect in a different way than other service providers; they identify with the consumers and they really understand where they are coming from, because they have been there before,” Thekan explains.

She adds, “When we employ a previous or current consumer, that person often comes off of state benefits for the first time. They join our health insurance, and they talk about that experience with other consumers. A lot of consumers are afraid to come off state benefits, so this is important for them to see others are doing it.”

The Northpointe peer supports work in all three of its counties in a variety of roles and responsibilities. In Menominee County, the peer supports do one-on-one work to help the client with whatever they need. This might include housing support, setting and keeping a budget, or help with grocery shopping. Peer supports in Dickinson are trained in dialectical behavior therapy (DBT). One peer helps in the DBT group with a clinician, but another peer is able to do DBT one-on-one with clients. Peer supports are integrated into the assertive community treatment program, they are advocates for the consumer during person-centered planning, and they facilitate WRAP (Wellness Recovery Action Plan) groups, which help people identify wellness tools and strategies. Peer supports are also instrumental in ensuring the lobby is welcoming and they have trained all of the staff at Northpointe on being more recovery oriented.

Thekan also describes the use of a peer support that was recently added at the hospital: "A peer support connects with people when they are discharged from psychiatric hospitalization, and [he/she] follows up with them immediately after discharge. [He/she] ensures that they get connected to mental health services, whether it is through CMH or elsewhere. Northpointe's psychiatric readmissions rate used to be above the state target of 15 percent, since implementing a peer support in this way, recidivism has gone down below 3 percent in less than a year. Thekan is hopeful to keep this going and to continue to include peer supports wherever possible.

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Community Integration

There is a strong link between recovery and community integration, which includes housing, employment, education, health status, recreation, spirituality, and civic engagement, among other things. Community integration leads to presence and participation in the community, which contributes to a sense of well-being and recovery.22 The importance of community integration has been codified in law and regulation, including in the Americans with Disabilities Act and the Department of Justice’s “Integration Regulation.”23

The community mental health system’s emphasis on recovery thus necessitates working to help the people it serves establish a life of their choosing within their community. This means that much of what CMHs do is grounded in the local community, where they play a key role in supporting people in participating in mainstream activities and opportunities in the communities where they live through connections with community partners.

Several CMH directors and staff who participated in interviews described their work as taking a “whole person approach.” That is, they do not simply address a person’s mental illness or disability, but work with them to build and support a life that allows them to live in recovery. Debra Johnson at St. Clair County CMH says, “We do a lot of trainings on community resources. We are expected to connect people with the services they need. We need to address the whole person. We find them a house, funds for food, help them get furniture, and many other things.” Northpointe Behavioral Health recently created a position for a director of community inclusion, who will be responsible for ensuring community inclusion in the agency’s home and community-based services.

At Detroit Wayne Mental Health Authority, opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community guides, according to staff. They note that their work with consumers and community partners allows them to support involvement in “less formal aspects of community inclusion, such as neighborhood gatherings, book club meetings, salons, coffee shops, and book groups.” Julia Rupp at CMH Services of Muskegon County says, “We do training that is not just about connecting people to the services we pay for, but any service and resource that they need, any natural support they need—whether it be finding a church or finding lost family members. We are really strong on this and we are very proud of our supports coordinators.”
A married couple who have developmental disabilities shared their story of successfully living in the community with support from CMH for Central Michigan.

“We have a mentor through CMH and we love her. She does all of our CMH paperwork and she helps me with the checkbook and stuff. She pretty much does a lot for us when she can be available. We see her about once or twice a month. We also have people who come and help us at night and sometimes during the day, like if one of us has a doctor appointment. We have good staff that help us out every day.

“We do things in the summer time like going to concerts in Saginaw. We go to my parents’ family reunion every summer in Marysville. We go to Tigers’ games.

“I was in the institution for 19 years in Mt. Pleasant. My husband went in when he was 12 and got out when he was 26. That’s where we met. We got married in ’88. Now we’ve been married 26 years and we renewed our vows this summer. We’ve come a long way.”

Many of those interviewed described how they help the consumers they work with find suitable housing and employment and reach education goals, often through the use of evidence-based practices such as permanent supportive housing, supported employment, and supported education.

Housing
Many of the interviewees said that helping the people they work with, especially those with intellectual and developmental disabilities, find and obtain suitable housing is an important part of their work. Many indicated owning rental properties with units that they are able to lease at affordable rates to people with intellectual and developmental disabilities and mental illness.

Northeast Michigan CMH was well involved in the closing of mental institutions in the state in the late 1970s, according to Ed LaFramboise. At that time, the CMH helped establish 21 group homes in a four-county area, but has been working ever since to reduce the number of and the need for those homes as they help people live more independently. There are now only nine group homes in the region. LaFramboise reports that about 25 percent of the people they serve with intellectual and developmental disabilities are living independently. Helping people find suitable housing involves working directly with landlords in the region, says LaFramboise: “We have to have relationships with the landlords.”

A few of the partners with whom Detroit Wayne Mental Health Authority contracts have successfully supported people with mental illnesses and intellectual and developmental disabilities move into less
restrictive environments based on the preferences of the consumers. At its peak, Community Living Services had 250 six-bed homes. Today, only 90 of these homes remain. The number of people living in these licensed homes has decreased significantly over the past decade from 1,013 in 2003 to 467 in 2013. Neighborhood Service Organization’s Older Adult Services program has moved nearly 1,000 people out of nursing homes into less restrictive settings, according to DWMHA staff.

Northpointe Behavioral Health built a residential home about ten years ago that has three components. It is licensed as a 16-bed home. Eight of the beds have 24-hour residential care. Five are in a transitional living space that allows for more independence: “People have their own bedroom, but there is a lot of common area. There is a focus on teaching independent skills and cooking,” says CEO Karen Thekan. The other three “beds” are individual apartments, each with its own kitchen, living area, and bedroom. Thekan says the idea of the home was to provide a continuum of living arrangements so people could be supported in moving toward greater independence, “eventually into their own place in the community.” She notes that parents and guardians often “feel safer knowing their adult child is being cared for” and sometimes stand in the way of a person moving out of this supported care environment. Thekan says that staff “work one-on-one with the guardians to work through their resistance,” and when they see their children building the skills necessary to live more independently they typically become more comfortable with the idea.

**Employment**

Regular employment is a key component of recovery, according to many of those who participated in the interviews. Earning a paycheck and contributing to the community impacts the well-being of people with intellectual and developmental disabilities or serious mental illness. Many of the interviewees spoke of success using supported employment, an evidence-based practice.

Community Mental Health for Central Michigan recently received accolades from the Michigan Department of Community Health for its success in helping people obtain employment. The organization serves six counties and has four staff implementing supported employment, which helps people with mental illness find jobs. According to the MDCH, CMH for Central Michigan has achieved 107 competitive integrated placements for 76 people with a retention rate of 91.4 percent. This work has involved partnerships with 92 different employers. Linda Kaufman, CMH for Central Michigan’s executive director, says, the supported employment model “does not put many precursor activities in front of getting employment. It’s not about trying to make sure people are ready. They get about the task of trying to find employment right away. And then try to supplement what the employer needs to get the person up to speed to do the work.” This, she notes, requires direct partnerships with local employers: “It involves conversations and meetings with employers to get them on board.”

Community Mental Health Services of Muskegon County has onsite vocational rehabilitation services and employment specialists on their teams to support youth and adults with mental illnesses and developmental disabilities. For people with developmental disabilities, a broader array of employment supports are used, according to Julia Rupp, executive director.
Greg Paffhouse, CEO at Northern Lakes CMH, described the transitional employment program offered through the agency’s affiliated clubhouses, Club Cadillac and Traverse House. Through this program, people with serious mental illness receive vocational training and support and are placed jobs secured by the clubhouse in community locations, where they are guaranteed to earn minimum wage or above. These positions typically last for six to nine months; at the end, the consumer may decide to apply as a competitive employee with the same employer or a different one. The program has resulted in “significant levels of employment,” according to Paffhouse. Many employers in the community have demonstrated a willingness to work with Northern Lakes and its consumers, says Paffhouse: “It is often not even contracted; it is just organizations that are willing to work with us to accept a placement. We have had positions at local hardware stores and local restaurants. These jobs give them something to put on their resume to show that they have skills, and they get references, people who are willing to vouch for them. Once they get one [job], they can build on it.”

**Education**

A few CMH interviewees described efforts to help consumers obtain greater levels of education in support of their recovery goals. For example, Jeff Patton, CEO at Kalamazoo Community Mental Health and Substance Abuse Services described a health-focused campus that is being developed in partnership with Kalamazoo Valley Community College and Bronson Healthcare. The campus, which will sit on 13 acres of land donated by Bronson near Bronson Methodist Hospital, will include a KCMHSAS psychiatric clinic and two KVCC facilities—one for culinary, health career, and food safety programs and another for food sustainability, innovation, production, and distribution. Patton says KCMHSAS’ presence in the campus “integrates the people we serve into the mainstream of our community.” He also notes that the KVCC facilities will provide opportunities for people with intellectual and developmental disabilities and mental illness to “get training and employment in food production and culinary arts. We would have people in our system that may go to KVCC and some may want to become chefs and this training opportunity will be there.”
Detroit Wayne Mental Health Authority:  
_Supported Education_

Community Mental Health service providers assist consumers in reaching many different goals, including education. Educational attainment, for many consumers, is part of their path to wellness and recovery, as well as better employment opportunities. Detroit Wayne Mental Health Authority (DWMHA) is helping its consumers reach their educational goals through funding for a Supported Education Program (SEP), a promising practice under SAMHSA, which is administered by a DWMHA contract agency. SEP is a six-month specialized course that focuses on preparing and supporting consumers to obtain college degrees and be successful in college. SEP provides an orientation to an academic lifestyle; it helps prepare students to manage mental health symptoms in an academic setting; it helps improve test-taking skills and reduces test anxiety; it helps students learn how to write academically appropriate essays and give oral presentations; it helps resolve defaulted student loans; it helps students obtain financial aid and scholarships; it develops a career plan and assistance registering for college classes; and it improves computer proficiency skills.

DWMHA partners with Wayne State University and Wayne County Community College to provide this program. The colleges provide space for classroom instruction, which benefits consumers by familiarizing them with a college setting. Wayne State University conducted outcome evaluations and then helped redesign the curriculum to address program weaknesses identified in the evaluations.

The program has served 372 consumers since it began in 2011, and has seen big successes already. It has helped 150 consumers secure financial aid support, helped two-thirds of participants apply to a college, and over 30 consumers register for college classes. The DWMHA notes that many more consumers may have registered for classes, but because the SEP class ends months before the next college semester begins, it is difficult for the program to know who has enrolled in college and who has not.
Health and Wellness

People with serious mental illness are often overweight due in part to poor health habits and side effects of medication. The prevalence of smoking also tends to be higher among those with mental illness than the general population (36 percent compared with 21 percent).24 Community mental health service programs have sought ways to support the health and well-being of their consumers as well as their staff through programs that promote physical activity and smoking cessation. The Detroit Wayne Mental Health Authority recently participated in a health and wellness grant to help people in recovery “practice health and wellness through smoking cessation and exercising. We are focusing on prevention and early intervention as a part of the overall recovery.”

At Northpointe Behavioral Health, CEO Karen Thekan says the CMH decided to partner with the YMCA to bring health programming to its consumers when a report was released with the finding that people with serious mental illness die an average of 25 years earlier than people without mental illness. “We started with a trainer from the YMCA onsite,” she says. “Our customers don’t feel comfortable going to the Y or a gym. The trainer worked with a core group of people, and as people became comfortable, they integrated it back into the YMCA.” Thekan says the effort engaged CMH staff as well: “As an offshoot, we have a group of nurses who embraced this and have continued a walking group for the past two years. The walking group is based at Northpointe, which is how we get people more involved, but the eventual goal is to get it back into the community and get them over to the Y.”

Julia Rupp at CMH Services of Muskegon County found that “if we wanted our supports coordinators to better coordinate health care services, we needed them to better understand their own health care needs.” Through a block grant from the Michigan Department of Community Health, the agency implemented “Better Together,” a program that initially paired interested staff members with health coaches. Coaches came from Access Health, a community-sponsored accountable care organization in Muskegon; the local health department; and Hackley Community Care, a federally qualified health center. Staff would work with their coaches to develop and implement a plan for improving their health, and become trained to act as coaches themselves; then those staff members would partner with a client and act as their health coach. Eventually, clients became health coaches and were paired with other clients. “Everything we did, we did it together,” says Rupp. “That’s why it is called Better Together.” In addition to coaching, the program included nutrition classes, yoga, hula hooping, walking groups, and smoking cessation. Rupp notes, “We all need to get healthy; it supports a recovery culture when we work right alongside each other.”

Northern Lakes Community Mental Health is among the partners in a Centers for Disease Control Community Transformation Grant received by the Lung Association in Michigan in late 2013 to implement a 12-month smoking cessation project. The grant is one of five CDC grants in the country, and the only one focused on people with mental illness. “Smoking is a major contributor to early mortality among people with serious mental illness,” according to Greg Paffhouse, which led the agency to “make it a priority to help the people we serve and our staff to stop the use of tobacco products.” The project’s primary goals are to train mental health professionals to better screen for tobacco use, support and assist persons with mental illness to stop using tobacco, and assist Northern Lakes Community
Mental Health to realize its vision as a tobacco-free culture. In September 2014 the agency designated all of its campuses as tobacco free.

A few of the CMH interview participants indicated using the In Shape program to help increase their clients’ physical activity levels. In Shape is designed for people who have a serious mental illness and a medical issue like obesity, high cholesterol, or heart problems. Debra Johnson at St. Clair County CMH says, “People are referred for In Shape from any of our programs. We have consumers get clearance from their doctor, and then a physical trainer develops a workout program with them. It starts out very intensively, but the exercises are things people can do without going to the gym.” The program has seen favorable results, including weight loss, decreased blood pressure, increased flexibility, and increased cardiovascular capacity among program participants.

At Saginaw County Community Mental Health Authority, a group of consumers worked together to develop a wellness drop-in center where people with mental illness can participate in health-related activities. Sandra Lindsey, the agency’s executive director, notes that the center offers “wellness and cooking tips, an exercise room, and fellowship. The design of the center came from consumers; it is consumer run. They are their own nonprofit, and they are really vigilant about health. They bring in speakers. It is open Monday thru Friday. They serve about 25 people a day and it has not even been open a full year yet. They are in the process of building the program toward a seven-day per week schedule.”
Evidence and Innovation

Health insurers and policymakers are calling increasingly for the use of evidence-based treatment and practices in medicine as well as in public health to promote positive health outcomes and effective use of financial resources. The Affordable Care Act directed new funding toward comparative effectiveness research to help identify what works in health care and also planned $900 million in spending to support implementation of evidence-based public health practices through Community Transformation Grants. The ACA also created the Innovation Center within the Centers for Medicare and Medicaid Services to support states in planning for and implementing new payment and service delivery models, including those that bridge provider systems and promote better-coordinated care.

With recovery as a guiding principle, CMHs turn to evidence-based practices as well as innovative solutions to deliver services and make the most efficient use of resources. A commitment to the use of evidence-based practices ensures that CMHs are delivering services that have a high probability of success. Mental health courts are showing up across the state as an evidence-based and innovative intervention to keep people with mental illness out of the criminal justice system. And multidisciplinary teams are being used by CMHs to better meet the variety of needs faced by their consumers.

Use of Evidence-based Practices

There is a wide variety of evidence-based and promising practices available to those who work in the community mental health system. In 2005, the Michigan Department of Community Health, in partnership with the state’s PIHPs and CMHSPs, convened Improving Practice Leadership Teams (IPLTs) to develop a statewide system of practice improvement. In 2009, the MDCH Practice Improvement Steering Committee compiled a compendium of evidence-based and promising practices for use in the public mental health system. CMHs across the state have made good use of these practices. Those who participated in the interviews often noted the number and breadth of evidence-based practices in use at their agencies.

Some of the evidence-based practices used more widely are Applied Behavioral Analysis (ABA), assertive community treatment (ACT), dialectical behavior therapy (DBT), family psychoeducation, integrated treatment for co-occurring disorders, mental health first aid, and the Parent Management Training-Oregon model (PMTO). As noted earlier, many CMHs have also implemented evidence-based practices to support consumers in obtaining employment, housing, and education.

Applied Behavior Analysis

Applied behavior analysis (ABA) is an evidence-based therapy that focuses on how environmental factors affect behavior. The therapy consists of a series of tools and teaching methods used by a trained and certified behavioral health professional to work with children with autism and their parents. The professional works closely with parents to set goals and implement a treatment plan that is adapted to
the learner’s needs as necessary. Along with goal-setting, objective measurement of progress is a critical element of ABA therapy. In April 2013, Michigan began covering applied behavior analysis for young children (aged 18 months through five years) with autism spectrum disorders (ASD) through the Medicaid and MIChild programs. PIHPs in Michigan are responsible for providing ABA therapy to children covered by Medicaid who meet diagnostic criteria for the therapy.

A consumer whose nearly six-year-old son is receiving ABA from St. Clair County CMH described her family’s experience with the therapy:

We were the first family to receive applied behavioral analysis program services from the CMH. The therapists come five days a week, one hour a day before school. The difference in my son is humongous. It’s like having a whole different child. He was nonverbal before we started; now he has at least 150 words.

The therapists and I track the data together. There is a book that stays at my house where I can track information and share notes [with the therapists]. We call ourselves “Team Steven.”

I think the one-on-one work is especially helpful. We also use positive reinforcement. And one skill builds on another. He still has fits, but less often and less dramatic. Having language means he can tell me what he wants.

**Assertive Community Treatment**

Assertive community treatment is an evidence-based team treatment approach that is designed to “provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness.” One of the primary goals of ACT is to prevent people with serious mental illness from having to seek treatment in an inpatient setting by helping them develop skills for living in the community while managing their mental illness. ACT services are customized for each individual and are delivered by a team of practitioners with background and training in social work, rehabilitation, counseling, nursing, and psychiatry, who are available 24 hours a day. The staff-to-consumer ratio is at least 1:10. ACT team members are responsible for the development of the consumer’s person-centered plan and for supporting consumers in all aspects of community living, including:

- Symptom management
- Housing
- Finances
- Employment
- Medical care
- Substance abuse issues
- Family life
- Activities of daily living
Dialectical Behavior Therapy

Dialectical behavior therapy is an evidence-based practice used primarily to treat people who are chronically suicidal, who often have multiple diagnoses, and who have difficulty staying engaged in mental health treatment. DBT consists of three main modes of treatment (all of which must be present): individual psychotherapy, skills training (provided in a group setting), and around-the-clock phone assistance. DBT was initially introduced in Michigan’s community-based programs in fiscal year 2007. DBT is provided by a team, one member of which is expected to be a certified peer support specialist.

A consumer at St. Clair County Community Mental Health described her experience with DBT and St. Clair County CMH:

I started going there in 2010. I’ve been in and out of counseling and therapy for the majority of my life. And this is the first agency that has actually helped me. I feel like people are truly invested in me getting well. And figuring out how to work with me and how to make their programs work for me.

DBT absolutely helped me change my life. They gave me a ton of coping skills to understand that my day doesn’t have to get better but I can do what I can to make sure it doesn’t get worse. It’s really wonderful. They have taught me so much. I have an awesome support group there and a great doctor. I absolutely love it there.

When I got there I was very, very sick. I’m definitely on the road to recovery now.
Integrated Treatment for Co-occurring Disorders

Quite often, mental illness is accompanied by a co-occurring substance use disorder or addiction. Estimates of people with co-occurring disorders in the public mental health and substance use systems range from 50 to 70 percent. Historically, it has been challenging for individuals with co-occurring disorders to receive treatment for both disorders at the same time or in a single setting. This has led to separate and usually uncoordinated care. CMHs in Michigan have been working to implement Co-Occurring Disorders: Integrated Dual Disorder Treatment (COD: IDDT), an evidence-based practice that helps people who have both a serious mental illness and a substance use disorder. The practice includes:

- Individualized treatment based on the person’s current stage of recovery
- Education about the illness
- Case management
- Housing assistance
- Financial management assistance
- Counseling designed especially for people with co-occurring disorders

Family Psychoeducation

Family psychoeducation (FPE) is an evidence-based practice that engages consumers and their families and supporters in a partnership with treatment providers to maximize the use and effectiveness of available mental health services. FPE provides consumers and their families with information about what mental illness is and how it is treated. It also helps families understand outpatient treatment programs, prescribed medications, how to cope with alcohol or other drug abuse problems, and how to manage the symptoms of the mental illness.

The Michigan Department of Community Health has implemented FPE services in Michigan through its federal community mental health block grant. As of fiscal year 2009–10, all prepaid inpatient health plans were required to include FPE in their service array.

Mental Health First Aid

Mental health first aid is an education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to children or adults who are experiencing an acute mental health crisis or are in the early stages of one or more chronic mental health problems. Training in mental health first aid, which is delivered by a certified instructor, introduces participants to risk factors, warning signs, and symptoms for a range of mental health problems, including comorbidity with substance use disorders; builds participants' understanding of the impact and prevalence of mental health problems; and provides an overview of common support and treatment resources for those with a mental health problem. After completing the course and passing an examination, participants are certified for three years as a Mental Health First Aider.

Community Mental Health Services of Muskegon County received a federal grant, which it will use to train area teachers in Mental Health First Aid. Julia Rupp, executive director, says that Muskegon has
“more mental health first aid trainers than anywhere else, and has trained more people than any other county.”

Greg Paffhouse at Northern Lakes Community Mental Health says that the agency’s mental health first aid classes “are always in demand. I wish we had more trainers.” He indicates the training has been provided to people working in health care, education, and law enforcement, among others. “Unanimously, people come away more aware of the critical importance of mental health and have greater comfort of talking with someone if they think the person has a mental condition or is experiencing a crisis.”

**Parent Management Training-Oregon Model**

Parents play a vital role in improving and maintaining their children’s mental health. Parent Management Training-Oregon Model is an evidence-based approach that is tailored to help the parents of children—from preschool through adolescence—with serious behavior problems. Through PMTO, parents receive training in the provision of appropriate care, instruction, and supervision of their children. The five core components of PMTO are encouragement, limit setting, problem solving, monitoring, and positive involvement. The MDCH has incorporated extensive tools to ensure that implementation of PMTO in the state adheres to the model.
Community Mental Health for Central Michigan: Evidence-based Practices

At Community Mental Health for Central Michigan, Linda Kaufmann says that evidence-based practices (EBPs) play a prominent role in the services they provide: “We have over 30 evidence-based practices at our CMH and have a unique way of implementing them and making them part of ongoing services. We’ve seen a lot of success because of the evidence-based practices we have.”

The CMH has developed a grid of all of the EBPs in place in Central Michigan. For each EBP, the grid includes the criteria required for training and/or certification to provide the services, the target population for the service, frequency of fidelity monitoring required, and a lead subject matter expert, who is responsible for ensuring solid implementation. Kaufmann notes, “From my perspective, EBPs make mental health centers stand out. I can’t tell you how often I’ve received calls from people with private insurance who want what we have to offer. The newest thing that all mental health centers are providing is ABA. We’re getting lots of calls about that from people with private insurance. There are very few places providing this for people with private insurance.”

Kaufmann is clearly excited by the opportunities presented through the use of evidence-based practices and considers her CMH to be an early adopter: “We were one of the first to use Parent Management Training—Oregon Model. And we’re just getting started with Mom Power [a parenting and attachment skills group for mothers receiving Medicaid] with the University of Michigan; it is actually showing a difference in the frontal lobe of the brain after just ten weeks of therapy. It’s very exciting.”

Highlighting the importance of maintaining fidelity to the model when implementing evidence-based practices, Kaufmann described the use of multisystemic therapy (MST): “We will be the first tri-county team (three different CMHs) to provide MST services. A second team has been in existence in CMH for Central Michigan for several years with great success. It is a very expensive program and it’s very intensive. Fidelity to the model is constantly occurring. While we have an internal supervisor, that supervisor is also evaluated on a constant basis.”

The idea is that the caseload is no more than three to four families per clinician, but the clinician is available 24/7 to each family. The service is reserved for youth who are likely to have an out-of-home placement. You are helping the family build supports around themselves and their children. The family court judge has been able to document millions of dollars of savings due to MST.”
Mental Health Courts

Mental health courts, modeled after drug courts, have been developed in response to the overrepresentation of people with mental illness in the criminal justice system. The courts divert select defendants with serious mental illness, serious emotional disturbance, or intellectual and developmental disabilities into judicially supervised, community-based treatment. Each mental health court is a partnership between a trial court and a community mental health service program. In some cases, more than one geographically distinct jurisdiction will partner to create a regional mental health court.

Eight mental health courts were established in Michigan in 2009 through a pilot program jointly funded by the State Court Administrative Office and Michigan Department of Community Health. An evaluation of the pilot found significant benefits from the courts,\(^{41}\) and the legislature codified the structure of mental health courts in legislation in 2013 to expand the program statewide (Public Acts 274–277 of 2013). The number of mental health courts in the state has since expanded to 23, including two regional mental health courts and three courts focused on juvenile offenders.\(^ {42}\)

An evaluation of mental health court data through September 2013 found lower recidivism rates, improved employment status and education levels, and improved quality of life and mental health among those who successfully completed the program.\(^ {43}\) One year after admission into the mental health court program, participants had a recidivism rate of 4 percent, compared to 22 percent for a comparison group. Even four years after admission to the program, when the participants would have been free of the court’s jurisdiction for three years, the recidivism rate for participants was statistically significantly lower than that for a comparison group.

Interviewees in Detroit-Wayne, Genesee, Grand Traverse, Kalamazoo, Muskegon, Saginaw, and St. Clair County listed partnerships in mental health courts among the accomplishments of their agencies. They were excited by the success of these programs and the potential for helping the people served by these courts live a life in recovery. They also credited the judges with whom they work for their strong contributions to the success of the mental health courts.

Debra Johnson at St. Clair County CMH states, “We have a very successful mental health court program. We’re very involved with our probate court. It has been so incredibly effective and we have data to show reduced recidivism rates. The judge checks on the progress of the people going through the program and participates in a graduation ceremony with those who complete the program.”

“We call our mental health court a mental health recovery court,” says Kalamazoo Community Mental Health and Substance Abuse Services CEO Jeff Patton. The court has been in existence for six years and represents a true partnership between the CMH as the court system, according to Patton. “In most courts established by the judiciary, the court makes referrals to the mental health system. They don’t make referrals to us; we’re there as part of the court proceedings. We have peers and mental health professionals as part of the court team. The peers really differentiate our court from other mental health courts.” Patton says that case managers and supports coordinators from the mental health
system are trained by the judge on court proceedings to enable them to most effectively help the people in the program. An evaluation of the Kalamazoo Mental Health Recovery Court shows not only reductions in jail days among program graduates, but also reductions in inpatient stays and use of emergency departments.

Danis Russell, CEO at Genesee Health System says, “We had one of the first mental health courts in the state. It began with a very collaborative judge in the county.” Based on decreased jail days and hospitalizations as well as lower than average costs per client, Russell estimates that the Genesee mental health court has led to more than $1.1 million in total savings.

**Multidisciplinary Teams**

Care provided by multidisciplinary teams is broadly seen as a promising strategy for increasing access to care, improving the quality of care delivered, and reducing costs. In research on the effectiveness of care delivered by teams in medical settings, positive outcomes have been found in terms of increased capacity to serve patients, improvements in chronic health measures, and cost savings. People with mental illness and intellectual and developmental disabilities often require a variety of services and supports that may be provided by a number of professional staff and peers. Organizing teams around the people receiving services helps to ensure that these services are well coordinated, according to some interviewees. In community mental health, a multidisciplinary team is likely to consist of case managers, nurses, therapists, peers, and others, including providers from outside the organization. Team composition often varies depending on the needs and express desires of the person receiving services.
Community Mental Health Services of Muskegon County: Multidisciplinary Teams

Community Mental Health Services of Muskegon County redesigned its service delivery approach to use multidisciplinary teams to improve communication, coordination, and quality of services, without increasing costs. Through the CMH’s utilization management system, the agency found that there were several very frequent users of services, but the services were not being well coordinated to maximize their effectiveness. To provide better care for the people the CMH serves, the CMH developed a multidisciplinary team for each of the CMH’s populations. There is an autism team, two high-intensive teams, and teams for adults with serious mental illness, children with serious emotional disabilities, adults with developmental disabilities, children with developmental disabilities, and those with co-occurring disorders.

Each team is made up of different providers depending on the intended population, but each team has case managers, therapists, nurses, supports coordination, and peer supports. Other providers on the teams include occupational therapists, employment specialists, housing specialists, behavior technicians, and community living support (CLS) providers. The CMH employs most of the providers on the teams, but some partner agencies employ some of the team members. Each consumer may not work with every member on his or her multidisciplinary team, but they have access to everyone on the team, and providers who are not working directly with a particular consumer can provide consultation support. In this way, the nurses and peers are fully embedded on the team, instead of as ancillary supports. Embedding providers into the team improves coordination of services and ensures that services are working together to help reach the client’s goals, even when the service provider is not employed by the CMH. Julie Rupp of CMH Services of Muskegon reports, “This model gives better team expertise, more cohesiveness, and the services are better. We are no longer ‘throwing’ services at people and seeing what works.”

Each multidisciplinary team receives team supervision and support, including those not employed by the CMH, such as the CLS providers. “For the CLS providers,” Rupp describes, “we can provide more training to the paraprofessionals, and we can pay them more this way. We pay our partners to get the best of the best CLS workers on our teams. This ended up being cost neutral because the quality of care was so much better; we were using less of the service per client.”

For the autism team, the CMH invited everyone it contracted with to provide services for children with autism to help plan the autism program together. “Several agencies were interested in working together on this,” Rupp explains, “and they agreed together what the model, including supervision and training should look like.” Because of the increased training, full-time employment, and improved supervision and support, the autism team has not had any staff turnover in 18 months, including from the CLS providers on the team.
Health Care Integration

The provision of services to people whose needs span multiple service systems has long presented a challenge to the health care system. Individuals with serious mental illness often have comorbid medical conditions, take several medications, and see multiple health providers. A 2006 study found that people with serious mental illness die an average of 25 years earlier than those without a mental illness, largely due to preventable physical health conditions.\textsuperscript{45} According to the study, lack of appropriate treatment for these conditions stems from a number of system-related issues, including stigma and discrimination against people with serious mental illnesses, poor coordination of physical and mental health services, lack of capacity to meet the needs of people with serious mental illness, lack of adequate health care coverage among those with serious mental illness, and inadequate provision of necessary preventive services to people with serious mental illness. In addition, some of the medications that are often prescribed to treat mental illness contribute to poor physical health with side effects that lead to weight gain, diabetes, and insulin resistant metabolic syndrome.\textsuperscript{46}

When physical and behavioral health care providers work to deliver services collaboratively, the chances for positive health outcomes improve greatly.\textsuperscript{47} A principle of the patient-centered medical home model is that “care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).”\textsuperscript{48} In more recent attempts to integrate care, accountable care organizations (ACOs) have been created to form integrated networks of providers that span multiple systems. The Affordable Care Act, which promotes the expansion of ACOs, also calls for the creation of health homes for people with multiple chronic conditions who are covered by Medicaid to improve coordination of the care they receive.

Since 2008, the Michigan Department of Community Health has been working with community mental health programs to integrate physical health and mental health.\textsuperscript{49} Innovative efforts to integrate mental health care with physical health care are taking shape in CMHs across the state to enable them to address both the physical and mental health needs of the populations they serve.

Health care integration occurs along a continuum. Detroit Wayne Mental Health Authority indicates that 16 providers of adult services are “participating on some level with primary care.” The organization has developed a scale to assess the level of integration being used by these providers, with “1” being “minimal collaboration” and “6” being “fully integrated.” Twelve providers are at a level 3 (basic onsite co-location) or above, with three working at the fully integrated level.

The health care integration initiatives described by interviewees range from establishing protocols and pathways for communication between providers to assisting consumers with navigating the health care system to co-locating physical and behavioral health services to establishing Medicaid health homes that focus on the needs of people with mental illness.
Communication Among Providers

Establishing and improving channels of communication between primary care providers and behavioral health providers can help ensure that people with mental health problems receive appropriate treatment as well as improve the coordination of services. Several of the interview participants indicated having some type of mechanism for communication with primary care providers or emergency departments in place, including use of electronic medical records and protocols for phone consultation.

Northeast Michigan CMH director Ed LaFramboise says his agency works with primary care providers to make sure the physical health needs of consumers are addressed: “There are people who are coming to us for prescriptions for their mental illness, but we know those medications can have a significant impact on their physical health, so we partner with their primary care providers to make sure people are getting care for those issues.” LaFramboise indicates that the providers communicate regarding routine follow up as well as more pressing issues: “It may involve our doctors—two psychiatrists—and PAs talking with the primary care doctors to make sure people are getting the follow up and labs they need. We’ve also developed a protocol for primary care providers to get access to our PAs and psychiatrists. If a primary care provider has a patient in psychiatric crisis, they can call to get a master’s [degree] level provider on the phone immediately and, if needed, one of our psychiatrists can get back to them within an hour.”

LaFramboise goes on to describe a strong relationship with the local hospital: “The hospital has an inpatient unit that delivers psychiatric services, so we’re in constant contact with them about people who have been admitted who will need discharge planning and follow-up after discharge. We also do screenings for patients at the hospital seven days a week, so we have nurses there on a regular basis. We also have staff who interact with emergency room providers when patients arrive in psychiatric crisis.”

CMHs have had varying success with attempting to share electronic health record information. Many indicate that this has been challenging because the systems cannot easily communicate with one another. Debra Johnson at St. Clair County CMH says her agency is “working on trying to generate EMR-based reports that we can share with primary care providers.” Clinton-Eaton-Ingham CMH has connected its electronic health record (EHR) system with Great Lakes Health Connect (GLHC), the state’s largest health information exchange. Chuck Dougherty, the CMH’s manager of information services, says: “We’re working closely with GLHC, and we have been getting lab results, office visit transcriptions, and some other information through our connection with them. We don’t scan it in. It goes directly into our EHR; it’s really integration.” Dougherty says CEI is also working with the Ingham County Health Department’s FQHC (where CEI has co-located staff) to “connect their NextGen EHR to our CMH EHR.”

Eric Kurtz, Washtenaw Community Health Organization director, reports that the organization is participating in a health information exchange and is “exchanging all of our admissions and discharges. We can transfer information with major hospitals and most safety net providers. We can share the entire record over the exchange.” Through a shared electronic health record system, the organization is able to share even more information with some of its partners. Kurtz describes: “With some of the
safety net clinic providers, we share the whole medical record that we use together. It is full integration, and we can share pharmacy and lab information.”

**Navigation Assistance**

The health care system can be challenging to navigate for anyone, but CMH providers find that those with mental illness or an intellectual or developmental disability have an especially difficult time accessing primary care services and maintaining strong connections with these providers. Some CMHs have developed innovative strategies to assist their clients with accessing physical health care services, including partnering with Medicaid health plans to offer care management, and using health coaches and other navigators to help their clients make and keep appointments.

The Genesee Health System peer health coaches described earlier offer a specific example of navigation assistance, as do peer support specialists in general. Network180 in Grand Rapids has partnered with the local Medicaid health plan to identify shared patients and help them get the physical and behavioral health care services they need.
Network180: Care Management Pilot

According to Chris Smith, Network180’s deputy director of programs, the agency’s care management pilot was born out of the recognition that “for people with mental illness and comorbid conditions, our traditional case management system was struggling to keep up with the health care side of things for consumers. We share about 3,300 consumers with Priority Health, and we wanted to find a way to serve people from a more holistic perspective.”

The care management pilot is designed to facilitate shared treatment planning, communication, and collaboration among an individual’s behavioral health and physical health care providers. It is staffed by a full-time clinical care manager and a half-time care management support specialist from Network180, and a behavioral health case manager and nurse case manager from Priority Health.

Partnership has been crucial, says Smith: “There hasn’t always been a clear path for connection between mental health and physical health. From Priority’s side, they didn’t really understand Network180 and how to access our services. We’ve been collaborative with Priority from the beginning in terms of developing the process for delivering services and the criteria for eligibility.” Criteria include a combination of certain psychiatric diagnoses and medical conditions as well as utilization of inpatient or crisis residential services in the past 12 months or five or more emergency department visits in the past 12 months.

The team continues to collaborate as they identify patients, enroll them in the pilot, and carry out the work. Network180 pulls together a list of consumers every quarter that may be eligible, and Priority Health reviews their own data to identify utilization and physical health diagnoses. Patients are then prioritized based on acuity. Network180 staff engage consumers directly to get participation, and once the consumer signs a consent form, the team develops a coordinated care plan driven by the Network180 clinical care manager and the behavioral health case manager at Priority Health.

According to Smith, “the team meets two times a month to pull together everything they know about the consumer as far as utilization, primary care, engagement with an existing case manager, how current providers are sharing information, and more to identify concerns, red flags, and gaps.” She says this is a more systems-focused process: “We look at what the system can do to better help the person. Our case manager reaches out to our providers; the Priority case manager reaches out to their providers. All the providers are involved in developing a coordinated care plan.”

The role of the peer support specialist is very important to the success of the pilot, says Smith: “The peer does a lot of one-on-one coaching, and goes to medical appointments if needed, or helps make phone calls. The peer even helps make grocery lists if the person is diabetic, for example. The peer work is one of the biggest strengths of the program. Our case manager mostly does system level work, calling doctors’ and other providers’ offices.”

A consumer who has received case management services through the initiative indicates that it has led to significant improvements in the management of his diabetes: “When I first started, my HbA1c was at 14; then it went down to 9.5; now it’s at 8.0. My main case manager comes by every week and they help me set up meds, make grocery lists. I’m so glad I have them. I don’t know what I’d do without them. Everyone I’ve come into contact with at Network180 has been very helpful over the years. And they’re still helping me out with my physical health and my mental health.”

Two tools are used to measure patient activation and wellness. The preliminary results are promising just six months into the program. Among the 80 people enrolled, use of emergency departments has dropped significantly and patient activation has increased among a large majority.
Co-location of Services

Community mental health service programs across the state are working closely with primary care providers and hospitals to bring physical health and behavioral health services under one roof. Behavioral health providers in primary care settings can help identify and connect people with mild and moderate mental health challenges to mental health services. Providing physical health services in a behavioral health setting helps remove barriers to accessing primary care services for people who are most comfortable receiving care at the CMH. The Affordable Care Act has authorized $50 million in grants for eligible community-based, behavioral health settings to provide coordinated and integrated services through the co-location of primary and specialty care. However, this is yet to be appropriated and funded. 50

Bidirectional Co-location

When describing efforts to integrate care, CMH directors and staff referred most often to planned or existing co-location arrangements, wherein behavioral health providers are embedded in primary care locations and vice versa (bidirectional co-location).

Debra Johnson at St. Clair County CMH says a local hospital is “changing its free clinic to a Medicaid clinic, and we’re hoping to locate that clinic in our building. We’re also co-located in one private primary care doctor’s office; we have one of our staff people in his office.” Linda Kaufmann at CMH for Central Michigan notes, “We’ve had some of our staff in private doctors’ offices where they’ve paid us to come because so many times people come to their primary care provider for behavioral health issues. We’re also working with an FQHC and an FQHC Look-Alike site who are on the cusp of having us in their locations. A third FQHC will be putting one of their physicians in our CMH site.”

Staff at the Detroit Wayne Mental Health Authority described an initiative designed to provide behavioral health consultation in pediatric practices in Wayne County. DWMHA received the grant, which was awarded jointly by the Michigan Department of Community Health and the Flinn Foundation, and subcontracted the work to Starfish Family Services. Screening Kids in Primary Care Plus (SKIPP) is a demonstration project that provides funding for a behavioral health consultant (BHC) specializing in pediatrics to be embedded in a pediatrician’s care team. Through the initiative, DWMHA indicates that BHCs have introduced and supported the use of screening tools for patients up to adulthood, provided short functional assessments for mental health care referrals, and provided psychoeducation, action plans, referrals, and follow up visits. Initially two BHCs were located in four sites across the county; with funding renewed, one BHC will continue to provide services in two of the original locations through September 2015.

Greg Paffhouse of Northern Lakes CMH says his agency has had “staff embedded in a primary care/pediatric clinic in Grayling for three years, and we have a strong relationship with Grayling Mercy hospital. Our staff can help with care management and referrals, including getting someone linked to CMH services.” The CMH participates in the Michigan Child Care Collaborative (MC3) program in partnership with the University of Michigan and pediatric practices in the region to increase primary care physician comfort, knowledge, and abilities in treating mental health problems. The program
includes “Just-in-Time” phone consultations with child psychiatrists regarding behavioral and pharmacologic management of patients, educational services via webinars, case review, and telepsychiatry evaluation and treatment for children and families with complex mental health concerns. Paffhouse says, “this is a program that community physicians value a lot.” He also notes, “It is going to expand because of [Governor Snyder’s] Mental Health and Wellness Commission. Along with other MC3 sites, we have had great success, so they want to expand it.”

Saginaw County CMH has a close working partnership with the local FQHC, Health Delivery Inc. (HDI), reports CEO Sandra Lindsey. “We speak often and deeply about the people we share. We have about 1,000 patients in common.” Through an 18-month planning and discussion process, the CMH and FQHC developed a co-location strategy: “We sent mental health professionals to the FQHC sites, and they provided primary care treatment in the mental health center. We developed a strategy to make the mental health center a billable site for the FQHC, so it became self-sustaining.” Saginaw County CMH also provides behavioral health consultation services in pediatric clinics in the county, including those run by HDI, and the support has been well received, states Lindsey: “Once we’re there, they don’t want us to leave. It started with one day a week, and is now a few days a week. We’ve had a lot of success with that with an enthusiastic response from families and youth.”
Clinton-Eaton-Ingham Community Mental Health Authority: Co-location and Onsite Primary Care Services

Clinton-Eaton-Ingham Community Mental Health Authority has several co-location initiatives underway, and also provides primary care onsite through an FQHC Look-Alike health center. Barb Starling describes the co-location initiatives: “On the adult side, we have three mental health therapists—MSWs—working within FQHC health centers in Lansing. We also have a therapist co-located at McLaren Multispeciality Clinic, and another at Sparrow Family Health Center in Mason. These are all working toward using the behavioral health consultant (BHC) model when the appropriate billing codes are turned on in Michigan. For now, we use short-term cognitive behavioral therapy model with patients, including warm handoffs from medical providers.” Starling notes that CEI also has “programs for children that are co-located within the Ingham County Health Department’s FQHC sites. And a CEI social worker is also embedded in the Michigan State University Clinical Center as well as at the Sparrow Family Center, using a behavioral health consultant model.”

CEO Robert Sheehan adds that “the use of BHCs in a primary care setting represents a shift from a specialized independent practice behavioral health care model to an integrated care model, helping to address a wide range of behavioral health issues, including those related to primary health concerns.” According to Sheehan, the BHC serves as more than a specialty mental health therapist by supplementing traditional full-session psychotherapy with brief encounters for a large number of primary care patients and providing a range of other educational and coaching behavioral health care techniques to assist the patient/consumer in addressing both behavioral health and primary care needs. The BHC also assists the primary care providers in identifying and responding to behavioral health issues that have an effect on the patient’s physical health status.

In 2013, through collaborative efforts between CEI, Michigan State University, the Sparrow Family Medicine Residency program, and the Ingham County Health Department’s FQHCs, an FQHC Look-Alike was designed and opened its doors within the main campus of CEI to provide full-scale primary care services to its consumers. Chris McDaniel, director of adult mental health services, says: “We have found a lot of stigma in the community about treating patients with serious mental illness, developmental disabilities, or substance use disorders, so we brought an FQHC into our building to help people be more secure and more trusting.”

This clinic, staffed by primary care staff provided by the FQHC and a nurse care manager provided by CEI, is designed to serve the chronic, acute, and well-check needs of CMH consumers who have little or no access to primary care. According to CEI CMHA staff, consumers and their families have reported significant improvements in the health status of those consumers who have been served at the clinic, and have offered positive feedback on the consumer-centered approach used by the joint FQHC-CEI clinical team. The mother of a consumer at CEI says the onsite FQHC has served her daughter well:

“My daughter has been receiving services from CEI since she was 2; she’s now 38. My daughter has severe cerebral palsy, she’s legally blind, and she has serious mental illness issues. She needs support with eating, diapering, and turning at night. She also has mild cognitive impairment. What I’ve seen with my daughter is that doctors out in the field don’t know anything about CP. She has gone through so many doctors because she fires them because they don’t understand her verbally or what she needs.

When she told me she was going to get services from the Birch Health Center at CMH, I suggested a coordinated meeting to talk about my daughter’s needs to keep her out of the hospital. We’re all working together, coordinating some of her care, and making sure she stays healthy. Through all of this and since her last hospitalization, she has finally agreed to physical therapy, speech therapy, and occupational therapy, and she was very happy with the results. Her main goal was that she could pet her dog, and she succeeded.”
Onsite Primary Care Services

Some of the CMH program directors and staff described opening primary care clinics and providing other health care services at their CMH sites. The Traverse Health Clinic, an FQHC in Traverse City, opened a second location in Northern Lakes CMH in 2013. CEO Greg Paffhouse says the clinic has seen 106 people in the past year, and has a current case load of 92. With recently awarded funding from the federal Substance Abuse and Mental Health Services Administration, the clinic will go from being open two days a week to five days a week.

Danis Russell at Genesee Health System says, “We started integration more than 12 years ago. We had the local FQHC in our building in 2001. That was before the push for integration.” Russell notes that the CMH eventually decided to open its own FQHC and began that process in 2007. “We were discouraged from doing this,” he states, “because we were told that mental health shouldn’t be doing primary care. But the Parks study had just come out about how people with serious mental illness die 25 years earlier than the general public, and we had to do something.” Genesee Health System received approval from the Health Resources and Services Administration in 2012 to become an FQHC for special populations—those who are homeless and those living in public housing. Their homeless clinic opened in October 2012 and the public housing clinic opened in August 2014. According to Russell, the clinics have increased access to care: “We are seeing about 12 to 18 patients a day in the clinics. This is a population that wouldn’t have gotten health care without us. They don’t go to the emergency department or to the doctor. They ignore their needs until the last moment.”

Community Mental Health Services of Muskegon County has an onsite pharmacy, lab, and health center. “We staff the lab,” Julia Rupp says, “It is part of the health center, and it is a partnership with the FQHC. They provide the midlevel providers and physicians; we provide the labs and nurses. Our psychiatrists are in the health center and the FQHC primary care providers are there, too. Our medical director is also located in the health center.” Similar to Northern Lakes, the CMH in Muskegon will be expanding the availability of its onsite health center with recently awarded funding from SAMHSA: “The grant will allow us to expand our clinic to five days a week and we will be able to add a dental chair operatory.” While the grant application was submitted two years ago, SAMHSA only recently came through with funding. Rupp says the CMH decided not to wait for the funding to implement some of its plans: “We have already accomplished a lot of things we wrote into the grant.”

Northpointe Behavioral Health has an onsite lab. Karen Thekan says, “The local hospital donated lab chairs and trained our nurses for free. It had been a long time since our nurses had done blood draws. Now we can do blood draws on site. We don’t do this frequently, but there are some people who refuse to go to the hospital. After conducting a blood draw on one man, we discovered an untreated thyroid problem. His health has improved dramatically with treatment.” Thekan says that billing for the lab services is the main drawback to the lab work: “One of the problems in this work is the billing codes. We’ve made the choice to use GF money because Medicaid doesn’t allow us to bill for a medical service.” Thekan adds that because of this, the CMH is unable to provide the service more widely: “We want to do more but we’ve had to limit it to those who absolutely need it and haven’t gotten lab work
done in years.” One of the consumers who participated in an interview is among the clients who have received lab work at Northpointe Behavioral Health:

I am afraid of blood draws, and it was very good to be able to have that done at the CMH. One nurse held my hand; they gave me a lot of support. I had never had a blood draw for over 20 years. My results were pretty good, too.

All I can tell you is that, down to the receptionist, this is a beautiful place to be. I have been to many other places, but this is the only place where I have seen my own life again. I didn’t realize I wasn’t living. I realized through the CMH that there is happiness. There is light in my life now. They have taught me a lot. You have to be willing to work with them. You can’t do it alone, and they can’t do it alone.

Clinton-Eaton-Ingham Community Mental Health Authority has an onsite pharmacy stemming from a long-standing partnership between CEI CMHA and St. John Pharmacy, a subsidiary of St. John Providence Health Systems. Through this partnership, the CMH has provided in-house pharmacy services to its consumers for over a decade. The pharmacy dispenses over 14,000 prescriptions per month and makes over 1,100 medication deliveries per month to CEI locations throughout the region, according to CEO Robert Sheehan. Sheehan says the partnership between CEI And St. John Pharmacy “fosters primary and behavioral care integration and improved quality of care in a number of ways.” He notes that having the pharmacy located on CEI’s main campus, which serves nearly 2,500 consumers, improves the medication compliance rate. Medication compliance is also enhanced by allowing consumers to fill all prescriptions onsite, not just those prescribed by a CEI psychiatrist, and by dispensing medications in formats that best meet the needs of each consumer. For example, using blister packaging and other unit dose systems can assist in ensuring that the correct dose is taken at the correct time. An extensive sample stock program along with a patient assistance program ensures that consumers without insurance can access needed medication. Sheehan says the pharmacy notifies clinicians of potential drug interactions and alerts prescribers when prescriptions are not filled or when medications are requested to be refilled too early. The pharmacy also has a 24 hour/day on-call service for questions and emergency prescription deliveries.
The Center for Integrative Medicine (CIM) is a partnership between Network180 and Spectrum Health. The CIM was developed based on research conducted by Dr. Corey Waller, Network180's medical director for substance abuse and a former emergency department physician. Scott Gilman, executive director at Network180, says that Dr. Waller “saw a lot of drug-seeking behavior among patients in the ER, so he worked with Spectrum to collect data and he identified high ER utilizers.” Dr. Waller's research led him to identify approximately 950 patients who had visited the emergency departments in Spectrum Health Butterworth or Blodgett hospitals more than ten times each. These patients were responsible for more than 20,000 total visits in a single year, with a total cost of $40 to $50 million.

In partnership with Network180, Dr. Waller and Spectrum Health developed the CIM to use a biopsychosocial model of care for high utilizers who were identified at area emergency departments. A biopsychosocial model of care addresses biological, psychological, and social factors that contribute to a person's illness. A six-month pilot of the center with 30 patients demonstrated an 85 percent decrease in visits to emergency departments among the patients and a savings of about $1 million.

The pilot led to the establishment of the CIM full time. According to Gilman, the CIM is staffed by Dr. Waller, a physician assistant, and two social workers. The social workers are staff of Network180. "It's a pretty intensive environment," he says, adding, "They do a brief screening, then social workers do a more detailed assessment, and then the patients have two to four sessions with interventions. If they need more services, our staff work to authorize them for more care at Network180." After about six months, patients are discharged to a primary care medical home.

The partnership between Network180 and Spectrum Health has been critical to the work, according to Gilman: "One of the most important things is that Spectrum is really supporting this. There are no codes for a lot of this work. Network180 has put resources on the table, too. We had to create a brief intervention code. What we do is still not fully paid for. Spectrum has really paid for the infrastructure part of this. It wouldn't be possible without them."
**Medicaid Health Homes**

The Affordable Care Act provides states with the opportunity to receive an enhanced federal match by establishing health homes for Medicaid beneficiaries with complex health needs. Health homes are intended to integrate physical and behavioral health care services as well as long-term services and supports. To be eligible to receive health home services, Medicaid beneficiaries must have either (1) two chronic conditions, (2) one chronic condition and be at risk of developing another, or (3) a serious mental illness. Potential participants in the program are identified by the state, and the health home providers are responsible for reaching potential participants and enrolling them in the health home. Health home services must include comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social support services.

States must submit a state plan amendment (SPA) to the Centers for Medicare and Medicaid Services to implement a health home program in the state. Michigan submitted an SPA to CMS to select three pilot counties to provide Medicaid health homes for people with serious mental illness beginning in July 2014: Washtenaw Community Health Organization, Northern Lakes CMH, and Centra Wellness. Because they have been implemented so recently, little is known about the success of the efforts, but the CMH directors are hopeful that they will be able to meet the needs of a large number of people with co-occurring conditions including mental illness or substance abuse disorders. According to the interviews, Northern Lakes has 25 people fully enrolled currently but is looking to expand that to 300. Washtenaw Community Health Organization has 194 people enrolled, with a target population of 864.

While not officially designated as a health home, Saginaw County CMH is acting as a “shadow” site, implementing health home enrollment and care coordination procedures and quality measures. The CMH has been actively working to integrate physical and behavioral health with Health Delivery Inc. for several years, and will use a recently awarded SAMHSA grant for primary and behavioral health care integration (PBHCI) as well as an expansion of its System of Care funding (also from SAMHSA) to continue these efforts. The System of Care funding is designed to support the delivery of services to children and youth with serious emotional disturbances and their families. Among other things, Saginaw County CMH is planning to co-locate mental health consultation and active treatment in five pediatric practices and an obstetrics and gynecology office.

The PBHCI funds will support the CMH’s efforts to act as a Medicaid health home, including the expansion of FQHC primary care services in the CMH. CEO Sandra Lindsey says, “We have only just started to formally enroll people in our health home. Ten people are enrolled in our shadow pilot. These are people with both serious mental illnesses and multiple chronic diseases. We are trying to move their care to the clinic at CMH to manage their weight, blood pressure and glucose levels, and cholesterol.” She adds, “We have already seen a benefit to providing psychiatric consultation to the health home team. Our providers are helping mid-level primary care team members understand these complex patients and their needs much better. For example, psychotrophic medications can have an effect on the way other medications, like those for pain, are metabolized in the body. These insights have helped the primary care providers differentiate between drug-seeking behavior and legitimate pain relief.”
The Washtenaw Community Health Organization was created in 2000 to sponsor and develop integrated physical and mental health care. CEO Eric Kurtz describes how this effort has not been easy, going through several iterations and building on each effort before moving on to the next.

The WCHO started this work by delivering psychiatric services for those with serious mental illness, serious emotional disturbance, and intellectual and developmental disabilities. The University of Michigan handled the physical health side. Due to issues with braided funding for this model, however, the WCHO had to redesign this effort and it began placing social workers and psychiatrists at high volume safety net and community clinics. The primary care physician (PCP) at the clinics would consult with the psychiatrist regarding community resources and medications. Kurtz explains, “This was the start of the co-location model, and this is still going on. Co-located care turned out to be great for the clinics that were seeing mild and moderate mental illness, which we do not get paid for, but those with serious mental illness see us as their health home. Unfortunately, our goal of treating those with serious mental illness until they can be treated in the community just did not happen.” Although the CMH health home model was still years to come, the WCHO continued its efforts to provide integrated care for more people.

Then, the WCHO worked with health plans on their “deep end” clients in a targeted disease management program through a two-year grant from MDCH. Kurtz reports that for many people with serious mental health challenges, chronic diseases were going undiagnosed and untreated. Additionally, several medications are precursors to chronic diseases (e.g., psychotropic medications) such as obesity and diabetes. The disease management program targeted individuals with mental illness and a chronic physical health issue such as COPD, diabetes, or heart disease. The CMH connected these clients to a primary care practice, and offered them additional support through smoking cessation groups, walking groups, and diabetes groups.

In 2010, the WCHO received a four-year SAMHSA Primary and Behavioral Health Care Integration grant. This grant provided funding to place physicians and nurse practitioners in the CMH setting. Kurtz describes this as “an ideal setup for the people who see CMH as their place for health and wellness, and who were not engaging with PCPs in the community.” Although this SAMHSA grant has ended, the WCHO is continuing to provide these services. “Even though we have limited general fund dollars and no dedicated funding stream, this is our mission, it is what our board expects us to do,” Kurtz reports.

In addition to the onsite integrated care for its clients, Washtenaw became a pilot health home site in July 2014. Individuals are identified by the state as meeting criteria, and then the CMH is paid a monthly fee per member for a set of administrative services including linking clients to services, registering clients, communication activities such as talking on the phone and physician consultation, and for offering prevention activities. Approximately 200 people have enrolled so far, and many of these people are the same individuals identified in the Primary and Behavioral Health Care Integration grant program.

All of these efforts help different mental health populations meet their mental and physical health care needs. Kurtz reports that “although these activities likely reduce ER admissions, these savings go to hospitals and primary health care costs; they are not reducing CMH costs—at least not yet.”
Cost Control and Financing Strategies

The health care system is moving away from fee-for-service payment methods toward payment models that promote value and the efficient use of resources. Many newer payment models are based on capitation rates, wherein providers receive a per member per month payment with which they must provide all of the health care services needed by their patients. Since 1998, the community mental health system in Michigan has provided Medicaid-covered services for people with serious mental illness and intellectual and developmental disabilities within a capitation-based payment structure, using sophisticated payment strategies, implementing innovative cost-saving service delivery strategies, and carefully managing the use of high-cost services.

PIHPs are considered managed care organizations as described in Title XIX of the Social Security Act. They serve in this role for the Medicaid Specialty Services and Supports Program authorized by Section 1915(b) and 1915(c) federal waivers. PIHPs, either directly or under contract, are required to provide a broad spectrum of services for Medicaid enrollees in their regions with a monthly payment from the state based on a variety of factors, including the number of people who are eligible for Medicaid in the PIHP region.

Exhibit 2 shows the relative Medicaid rate increases in the CMH system compared to those of Medicaid Health Plans and the Consumer Price Index for health care. While not an exact indicator of the cost of services provided, the rate increases do demonstrate to a large degree the ability of the CMH system to provide a comprehensive set of services for a growing population of Medicaid enrollees with relatively modest payment increases.

Exhibit 2. A Comparison of PIHP Rate Increases to Medicaid HMO Rate Increases and Changes in the Consumer Price Index for Medical Care

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>PIHP</th>
<th>Medicaid HMO</th>
<th>Consumer Price Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>2.4%</td>
<td>0.0%</td>
<td>3.6%</td>
</tr>
<tr>
<td>2007</td>
<td>2.0%</td>
<td>5.0%</td>
<td>7.1%</td>
</tr>
<tr>
<td>2008</td>
<td>2.5%</td>
<td>4.2%</td>
<td>–1.0%</td>
</tr>
<tr>
<td>2009</td>
<td>2.9%</td>
<td>4.0%</td>
<td>–0.1%</td>
</tr>
<tr>
<td>2010</td>
<td>4.0%</td>
<td>4.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>2011</td>
<td>1.4%</td>
<td>0.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>2012</td>
<td>1.2%</td>
<td>1.7%</td>
<td>2.9%</td>
</tr>
<tr>
<td>2013</td>
<td>1.25%</td>
<td>1.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>2014</td>
<td>1.25%</td>
<td>2.5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>2015</td>
<td>1.5%</td>
<td>2.5%</td>
<td>Not available</td>
</tr>
</tbody>
</table>

NOTES: Public Sector Consultants Inc. extracted data from the Bureau of Labor Statistics website to obtain historical consumer price index data for medical care for the Detroit-Ann Arbor-Flint region as a comparison to the statewide PIHP and Medicaid HMO rate changes. Calculation of the annual consumer price index change was performed by Public Sector Consultants. The Detroit-Ann Arbor-Flint CPI data is collected bi-monthly, in February, April, June, August, October, and December. To approximate the fiscal year data available for the PIHP and Medicaid HMO rate increases, PSC calculated the percent change in the CPI from October of one year to August of the following year.
PIHPs work closely with the CMHs in their regions to devise a payment strategy that ensures services are available to all who need them throughout the region. The PIHP, as the Medicaid payer, makes a risk-based capitated payment to a network of community-based comprehensive behavioral health care providers (the CMHs). The payments to the CMHs are managed using active financial risk management approaches, including routine, detailed analysis of the fiscal status of each CMH and the pooling of funds across CMHs within the region to address areas of high demand, according to interview participants.

PIHPs are allowed to maintain an Internal Service Fund to protect against overspending of the region’s Medicaid capitation payment. Since the PIHP is fully responsible for the first 5 percent of overspending, and half of the next 5 percent of overspending (the state is responsible for the other half), the ISF is capped at 7.5 percent of the PIHP’s capitation payment. Within these risk parameters, PIHPs and CMHs work to make the most effective and efficient use of their resources.

CMH directors and staff who participated in interviews described innovative strategies that they have implemented in payment, service delivery, and leveraging of funding to maximize the reach of the resources available. Many also described active utilization review and management strategies to limit the need for inpatient treatment.

**Subcapitation Payment Strategies**

A few CMH directors and staff spoke of sophisticated subcapitation payment techniques used at the PIHP and CMH levels with service providers and program areas. For example, because its region covers such a large population, the Detroit Wayne Mental Health Authority subcontracts with five Managers of Comprehensive Provider Networks (MCPNs), which, in turn, contract with direct service providers. The DWMHA has developed what they believe is an innovative strategy for providing actuarially sound subcapitation payments to the MCPNs based on the count and risk scores of active consumers (anyone who has received services in the past 120 days) served by the MCPN. The risk factors used to develop the scores include the diagnoses and living arrangements, which serve as proxies for level of service need.
Clinton-Eaton-Ingham Community Mental Health Authority: Cost Control

Before the state’s PIHPs were consolidated from 18 to ten, the Clinton-Eaton-Ingham Community Mental Health Authority served as a PIHP for an eight-county region. As a PIHP, CEI CMHA worked closely with the CMHs in its region to carefully monitor and manage the region’s Medicaid spending, using what CEO Robert Sheehan calls “leading edge financial management pillars”:

- Sub-capitated, shared-risk financing of each of the CMHSPs in the region—assuring local responsibility and autonomy
- Accurate revenue and expenditure forecasting, across all of the parties in the region, months prior to the beginning of each fiscal year, to allow for full year fiscal and clinical planning
- Active fiscal and risk management through regular reviews of region-wide revenues and local, CMH-specific expenditures and utilization trends
- Active management of the pooled revenue and risk reserve, allowing for the rapid, real-time reallocation of funds among individual CMHSPs based on intra-year and multi-year expenditure and utilization patterns
- Retaining a focused, modest risk reserve made possible by these active fiscal management approaches

Pam Keyes, who served as chief financial officer when CEI CMHA was a PIHP, notes, “We’ve always maintained a very small risk reserve due to very active fiscal and risk management across the region. We were able to reserve what we considered a current year of Medicaid savings, which we trended out for the year to handle ebbs and flows.” Sheehan adds, “This allowed us to keep a right-sized and modest risk reserve and send the largest amount of revenue possible to services.”

At the beginning of each fiscal year, CMHSPs were required to submit a Medicaid Spending Plan to the PIHP, using their sub-capitated revenue projections as the base. Keyes says, “We requested expense budgets from CMHSPs to forecast how we would do financially over the year. This allowed us to plan ahead regarding service expansion or contraction.” With a strong estimate of spending needs for the year, Sheehan says, the PIHP was “able to set some money aside to support CMH initiatives related to integrated care, population health, and outreach to underserved and under-served populations.” Keyes adds, “It enabled us to support health care integration with targeted funds that could be requested by CMHSPs in the region that were seeking to implement innovative community- and person-centered integration efforts.”

Sheehan says a key component of the active fiscal management approach was the submission of quarterly Medicaid financial status reports (FSRs) by all CMHSPs in the region to the PIHP. The CMHSPs were required to explain any variances between the FSR and the CMHSP’s original spending plan. If a CMHSP was unlikely to spend its full capitated payment, it was required to notify the PIHP so those dollars could be redirected to CMHSPs with spending deficits. Likewise, those CMHSPs that were projecting deficit spending were required to notify the PIHP so that additional funds could be obtained, either from lapsed funds from other CMHSPs, Medicaid savings, or from the PIHP’s Internal Service Fund. By reviewing and projecting revenues and spending on a quarterly basis, the PIHP was able to reallocate Medicaid revenues to different areas of the region as needed throughout the year.

As a CMHSP, CEI CMHA has simulated population-based subcapitation by allocating funding increases and cuts to those population-based programs in its service array, according to current CFO Stacia Chick: “When we do the trending of revenues before the fiscal year begins, we’re able to see at the CMHSP level if there is a deficit or excess of funding available. Then we allocate the projected surplus or deficit across consumer population areas, ensuring a ‘shared gain’ or ‘shared burden’ approach.” The CMH also actively manages spending and revenues for programs with the greatest utilization and expense volatility, notably inpatient and crisis or highly specialized residential care. Says Chick, “We have a meeting once a month at CEI to review the most volatile services in the CMH. Each director comes in with a budget for their program so we can see how each is doing and we address any issues. Clinical and fiscal leadership sit in the room together, so any decisions that are made to change practices and affect costs are not purely fiscal or clinical decisions. This is active clinical and fiscal management.”
Innovative Service Delivery Strategies

As described throughout the report, CMHs are implementing a wide variety of evidence-based practices and service delivery strategies that are leading to cost savings, not only for the CMH but for the broader community in which they work. These include the use of peer health coaches at the Genesee Community Health Center for people with chronic physical and mental health conditions, the implementation of mental health courts, use of evidence-based practices such as multisystemic therapy, and Network180’s care management pilot and Center for Integrated Medicine, among others.

Some interviewees spoke of innovative service delivery methods that have led to cost savings for their CMHs. For example, Linda Kaufmann described how the CMH for Central Michigan implemented a same-day access policy. She explained that the state has a requirement that people be assessed within 14 days of calling a CMH, but CMH for Central Michigan was experiencing a high rate of missed or cancelled first appointments. Now, she says, “we have people come in the same day they call if they are able to, and we’ve reduced our average length of time between call and assessment from ten days to three days.” While half of these appointments used to result in no-shows or cancellations, now that rate is less than 25 percent. Kaufmann says the change has led to improvements in consumer engagement, and “we know we are saving money because it’s rescuing about 30 percent of our assessment specialists’ time.”

At Northeast Michigan CMH, the agency has implemented a personal emergency response system that allows people to live independently, but have ready access to assistance when needed. It is a telephone monitoring system used to assist people who have communication challenges. A call center is staffed by people who monitor open telephone lines overnight. “We know the people who call into the center very well. We know how they communicate and understand when they are pleading for help or simply asking for assistance,” says LaFramboise. Most of the time, the call center staff can get to their house faster than police, fire, or ambulance, he says, and first responders can be contacted to respond immediately to a person’s need. “The other option,” according to LaFramboise, “is to pay somebody to sit in that house waiting for someone to need help.” The system is saving the CMH a lot of money. The cost of the system is $3,100 per month plus the cost of staffing in urgent or emergent situations. The cost to staff a person’s home for eight hours a night for 30 days is about $8,000. “Clients love it,” states LaFramboise. “It allows people a level of independence otherwise not available.”

Leveraging Public Funding

Clinton-Eaton-Ingham Community Mental Health Authority (CEI CMHA) has worked with partners at the county level to leverage and stretch public resources, enabling them to serve more children with serious emotional disturbances. Through an agreement with the counties of Clinton, Eaton, and Ingham, county Child Care Fund dollars are used to purchase mental health services from CEI CMHA for youth who are under the jurisdiction of the court and/or DHS. CEI CMHA is able to use these funds as the local/state match for the federal share of Medicaid funding for the Children with Serious Emotional Disturbance waiver slots. Children and adolescents who are not enrolled in the SED Waiver are served with Child Care Fund dollars only.
As a result of this leveraging, every dollar that the county spends on mental health services for children in the SED Waiver results in $5.70 in mental health services for these children and $2 in mental health services for children not enrolled in SED Waiver slots. Since the inception of this program in 2004, CEI CMHA has served over 2,000 more children and adolescents who would not otherwise have received services. This represents a 51 percent increase in the number of at-risk children, adolescents, and their families who receive services, including psychotherapy, psychiatry, case management, mentors, parent supports, and respite, as well as crisis residential and psychiatric inpatient care.

**Active Utilization Review and Management**

Many of the people who participated in interviews described active utilization review and management strategies that enable them to make the most efficient use of resources. Linda Kaufman at CMH for Central Michigan describes a process her agency uses to assist in determining the level of services a person needs. This includes a LOCUS (Level of Care Utilization System) score and clinical diagnosis, as well as clinical judgment. She says it helps assessment specialists identify the most appropriate services. Kaufman notes: “With fee-for-service there’s not a focus on prevention and recovery and whole health like there is with risk-based financing. We do a lot to make sure we have the right amount of services at the right time for the right person.”

Ed LaFramboise at Northeast Michigan CMH says his agency focuses on inpatient hospitalization as a cost driver: “We’re very aggressive about trying to keep people out of hospitals by doing preventive activities, providing intensive case management to the people most at-risk of hospitalization, and doing whatever we can to keep the length of stay as short as possible for people who do end up in the hospital.”

At Northpointe Behavioral Health, CEO Karen Thekan says, “Utilization management is everyone’s job. It’s a continual focus.” She also described a focus on hospitalization to keep costs down: “We’ve cut our state inpatient costs in half this year. We identified a nurse to be a case manager for state hospitalization. She automatically becomes the case manager if someone goes into the inpatient state hospital. She calls the state hospital every week to make sure patients are discharged when they should be. This has helped a lot with our state hospitalization rates.”

Northern Lakes CEO Greg Paffhouse says that cuts to general fund dollars for community mental health along with a lower Medicaid budget for his CMH this year has put additional pressure on the agency to closely review spending: “We are looking at things such as our costs for specialized residential care, what rates we pay, what community inclusion we provide, and the length of inpatient care. We are doing utilization management to ensure people are getting the care they need, but avoiding additional days of care.”
Conclusion

Michigan’s community mental health system serves as a safety net and a champion for those with some of the most challenging mental and physical health conditions. Those who work in the system have a clear focus on identifying and delivering the services that will provide the greatest value for consumers and their families. The advances in treatment and service delivery made within the community mental health system over the past few decades reflect many of the same changes that are currently being promoted within the broader health care system. The CMH system has often been out in front in efforts to put people at the center of the services they receive, try innovative service delivery strategies, integrate and coordinate care, and control costs within a risk-based payment model.

Interview participants demonstrated an unwavering commitment to recovery for people with mental illness and intellectual and developmental disabilities. In addition, a commitment to doing what is needed to promote recovery through the use of evidence-based practices as well as innovative solutions echoed throughout the interviews. Participants routinely described being ahead of the curve: “We were doing that before the state required it” was a common refrain.

Efforts to integrate mental and physical health care, while supported and championed by the Michigan Department of Community Health, were led by forward-thinking CMH leaders seeking to address premature mortality among the people they serve. Working within a risk-based capitated system and with the uncertainty of general fund appropriations, CMH leaders are ever aware of the need to use resources efficiently and effectively. The result has been the development of a sophisticated payment system among PIHPs and CMHs, and the use of innovative service delivery strategies and leveraged financing. CMH staff often noted, however, that innovations in service delivery are most easily supported by general funds, which do not carry the same restrictions as Medicaid funding. And many indicated that the ability to use additional Medicaid billing codes would bolster their health care integration efforts. Regardless, interview participants indicated a clear intent to continue to use evidence and innovation to meet the needs of their clients.

The position of CMHs within the community is critical to their ability to meet the needs of the people they serve, according to interview participants. The importance of partnerships with stakeholders throughout the community was evident throughout the interviews—to assist clients with obtaining employment, education, and housing, and other community integration activities; to promote health and wellness; in the development of mental health courts; and in health care integration efforts. Greg Paffhouse at Northern Lakes CMH says, “Mental health is only as effective as its community partners. With the people we serve, it is not traditional ‘come to the office and get your therapy,’ but really we have to look at vocational, housing, and basic needs, too. It requires relationships with the Michigan Department of Community Health, the Department of Human Services, the local health department, schools, employers, and law enforcement, to name a few.” Debra Johnson notes that the St. Clair County CMH has been closely involved in the county’s community service coordinating body: “Our
coordinating body has over 200 organizations, and CMH staff are on most of the work groups. We’re really able to use this group to identify solutions to problems that come up in the community.” Sandra Lindsey of Saginaw County CMH adds, “CMH is close to the heartbeat of the community. As a group, we have mastered other systems—how they are funded and how they work so we can leverage community resources effectively. The CMH is at the intersection of cross-system integration. This leadership is what the public mental health system is about.”
Appendix

Directors, staff, and consumers from the following community mental health service programs participated in interviews:

- Community Mental Health for Central Michigan
- Clinton-Eaton-Ingham Community Mental Health Authority
- Community Mental Health Services of Muskegon County
- Detroit Wayne Mental Health Authority
- Genesee Health System
- Kalamazoo Community Mental Health and Substance Abuse Services
- Network180
- Northeast Michigan Community Mental Health
- Northern Lakes Community Mental Health
- Northpointe Behavioral Health
- Saginaw County Community Mental Health Authority
- St. Clair County Community Mental Health
- Washtenaw Community Health Organization
Endnotes

1 The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance, with the goals of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of care.

2 MCL 330.1708.


4 MCL 330.1208.

5 MCL 330.1208(3).

6 MCL 330.1100(a)(25).


9 Ibid.


15 The report of findings from the survey cautioned that inadequate sample sizes and nonrepresentative samples in most locations resulted in a positive response bias which needs to be kept in mind in interpreting the survey’s findings.

16 MCL 330.1712

17 MDCH, Practice Improvement Steering Committee, Compendium of Michigan’s Evidence-Based Best and Promising Practices. Available online at www.michigan.gov/documents/mdch/Practice_Improvement_Steering_Committee_Meeting_11_9_09_302903_7.pdf (accessed 12/17/14)


33 Ibid.

35 Ibid.

36 Ibid.

37 DHHS. *About Evidence-Based Practices KITs*.

38 Ibid.


40 Ibid.


45 Mauer. *Morbidity and Mortality in People with Serious Mental Illness*.

46 Ibid.


48 Patient Centered Primary Care Collaborative. *Joint Principles of the Patient-Centered Medical Home*.


52 Ibid.