



# Connections

— for communities that care

## THE DIFFICULTY, NECESSITY, AND OPPORTUNITY OF CHANGE

*A Message from Lynda Zeller*

We are pleased that Lynda Zeller, Deputy Director of the Behavioral Health and Developmental Disabilities Administration (BHDDA) in the Michigan Department of Community Health (MDCH) is using Connections to communicate with our system of care. The BHDDA provides policy leadership for public mental health, developmental disabilities, and substance use services. As Deputy Director, Zeller also will lead efforts relative to the Department's strategic priority to implement a plan to promote the integration of behavioral and physical health. (This edition of Connections includes four articles addressing this issue.)

Zeller has more than 25 years of experience in the field of mental health – serving individuals with mental illness, developmental disabilities, substance use disorders, and children with emotional disturbances. She has served in executive positions with Lifeways PIHP, Hope Network, and Kent Health Plan. Most recently, she served as the Health Services Administrator for the Michigan Department of Corrections (MDOC), which included all health, behavioral health and dental services for the State's correctional system.

**T**he Michigan public system of behavioral health and developmental disabilities services has grown and changed significantly. The result is an array of services and degree of community integration that provides example and inspiration to many other states. Our lives as individuals and communities have been enriched. We have much to celebrate. Even so, today's challenge is to remember this is a journey not a destination. From our vantage point today, it's also easy to forget that our travels to this celebrated spot were, at varying times, difficult, fearful, exhilarating and contentious. Then and now: Change is difficult.

“All systems must expand and grow, or they will contract and fall into a state of decay.” This is a quote from a book



I am reading called *Deep Change: Discovering the Leader Within*, by Robert E. Quinn of the University of Michigan. The book stresses the need for all healthy organizations to circulate continuously through four phases: Initiation Phase, Uncertainty Phase, Transformational Phase and Routinization Phase. While the transformation that resulted in today's broad community service arrays and peer supports were revolutionary, we as a system must continue to grow and change if we want to remain relevant and healthy.

I believe it is necessary for our current system (BHDDA, CMHSP, CAs and Providers) not just to respond and react to health reform around us; but also to boldly initiate, even when it leads to an unsettling phase of uncertainty before transformation, and then finally settling again into a routine. Together we must initiate change, not just in the areas that feel positive all around and are non-disruptive, but also in those more sensitive areas. It is tempting to solely focus on consensus models such as trauma oriented care, self determination, and recovery, while avoiding trickier challenges like evolving affiliations to fully synthesized and integrated managed care organizations; or equally tricky, developing standards of reciprocity of monitoring systems, crossing provider, CMHSP, PIHP and State boundaries.

There is much we can and should do now, regardless of how healthcare reform progresses, or how quickly. With tireless

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## CHANGE (from page 1)

focus on improving service and access to health care from the consumer standpoint and minimizing administrative duplication, it is possible even now to transform our system further toward recovery, resilience, self determination, and community integration. And, the stronger and more efficient our system is, the better able we will be to positively impact any new system of integrated care, funding or management. Change is necessary.

While we are working on our own system of care, we of course cannot ignore the broader healthcare system. As concepts such as dual eligible managed care systems and person centered medical/behavioral health homes are considered, we need to think carefully and self critically about our public behavioral health/DD/SUD/SED system's unique strengths and opportunities. We also need to consider the unique skills and tools of physical health managed care systems, and also where their systems lack tools necessary for behavioral health and developmental disabilities. We need to think critically about how we might maximize and best synthesize both. The common goal for all of us is better access to physical health care and prevention, even

**“The common goal for all of us is better access to physical health care and prevention, even while strengthening the self determined, community integrated, responsive, recovery oriented services and supports for consumers.”**

and associations. I am very happy that the Board Association has developed two health reform groups, one of which is focusing on consumer education and the other which is focusing on the system ideas/structures. I am hopeful this will maximize the effect of communication efforts with limited time and resources. Any other ideas you have for methods that can reach broader groups of stakeholders given these limitations are appreciated. I am thankful that I am not alone on this journey, but alongside a broad range of dedicated providers, consumers, families and agencies. Because change is difficult. Yet, change is necessary. And change provides opportunity. ■■

while strengthening the self determined, community-integrated, responsive, recovery oriented services and supports for consumers. Change is opportunity.

In closing, I am deeply honored and humbled to be in this position at this most important time. I will do my very best to provide the leadership and communication that is so important. I acknowledge that the many changes at the federal and state level are confusing. Connecting and communicating with all of

you will be one of my greatest personal challenges this year. I will need help from a broad range of organizations

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## Frequently Asked Questions (FAQs) Dual Eligibles and Relationship to CMH Services

Note: This document was prepared by MDCH for publication in *Connections*. For more complete information on the dual eligibles (Medicare/Medicaid) planning project, please go to <https://janus.pscinc.com/dualeligibles/>

**Q:** What are the goals of the “duals” project as it relates to persons served in the CMHSP system?

**A:** The goals are to improve quality and access to physical and behavioral health services and supports for persons eligible for both Medicaid and Medicare. Navigating the healthcare system and accessing needed care involves two very different systems. Coordinated care can simplify this process and provide more efficient services. Another important goal is to reduce costs by streamlining and eliminating duplicative administrative functions.

**Q:** I've heard that persons with developmental disabilities and mental illness will lose today's array of services if care coordination covers both physical and behavioral health, rather than support being separately coordinated through the CMHSP system as it is today. Is this true?

**A:** No. The plan is to include a full range of person centered, recovery oriented benefits for populations served today by the CMHSP system. The services in the existing state plan and waivers provide an excellent foundation to build upon and streamline.

**Q:** What is the timing for when the plan needs to be completed and submitted to the Governor and the federal government?

**A:** The plan is due to the federal government by April 2012. Rumors about a deadline for sending the plan to the Governor by September 2011 are not true. We are still in the planning phase of this process, soliciting input from the public, and are working under the federal deadline of April 2012.

**Q:** I've heard there are workgroups being planned to start in late fall to provide more in-depth input into the State plan. Will consumers and families, providers, CMHSPs and PIHPs be represented on the workgroups?

**A:** Yes. There are workgroups that will start this fall to seek more in-depth input on various topics. The state will include representatives of consumers, providers and CMHSP/PIHPs in those workgroups. The number of workgroups and topics are still to be determined.

**Q:** I've heard a rumor that something is changing for dual eligibles on November 1, 2011. What is changing, and how does this affect the planning for the duals project due to the federal government in April 2012? Where can I go to get details on this change?

**A:** The November 1 change is NOT related to the duals planning project. On November 1, persons with Medicaid who also become Medicare eligible can “opt in” to a Medicaid HMO. Up to this point, a person had to drop their Medicaid HMO coverage once they became eligible for Medicare. Now they can keep that coverage only if they CHOOSE to keep it (by opting in). Medicaid beneficiaries can call 1-800-642-3195 if you are dually eligible and wish to find out more.

# CONSIDERATIONS FOR A NEW GENERATION OF QUALITY HEALTH CARE IN MICHIGAN

ROBERT SHEEHAN, EXECUTIVE DIRECTOR, CMH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES

*Lynda Zeller acknowledged that one of the “trickier challenges” we face is “evolving affiliations to fully synthesized and integrated managed care organizations.” That is exactly the challenge I asked Bob Sheehan to address. This is new territory. Most of us will have to read and re-read this very carefully if we desire to catch a glimpse of the future because, as of now, it doesn’t exist. The learning curve has just spiked! And if we want to be a part of the future we will have to do some critical thinking that involves a lot of new acronyms! However, Sheehan has provided us with some buoys to navigate our way. If we want the new system of care to retain what Zeller referred to as “an inspiration to many other states”, Sheehan lays out the characteristics and principles to consider in designing new structures.*

*This article not only addresses the integrated managed care organization, referred to as an Accountable Care Organization (ACO) but also addresses the need to develop medical homes which are often a core component. We need to understand both of these concepts, ACO and medical home. In this article we will see various models of each of these entities. Which would we prefer to have available to the people in our community? What kind of changes do we need to make so that becomes reality? What kind of challenges do we face? This is the tricky part. – Clint Galloway, Editor*

**T**he movement toward greater integration between primary healthcare and behavioral healthcare, long an aim of Michigan’s public behavioral healthcare system, has been recently fueled by the growing body of research linking quality of life and lifespan to improvements in such integration, and national healthcare reform via the Affordable Care Act (ACA). To be effective, this integration needs to be systemic, transforming the system of care from the administrative structures that manage the care to the teams of professionals delivering the care. Thus, this synthesis of services can evolve to many forms; two of them, **Patient Centered Health/Medical Homes** and **Accountable Care Organizations** are discussed in this article.

While these two health delivery structures differ in many dimensions, they are complementary forms—in fact one, the Health Home, is often at the heart of the other, the Accountable Care Organization, that assure that quality care reaches the individuals needing services. The actions needed by the state’s public behavioral healthcare system (the state’s PIHPs and CMHSPs) to pursue opportunities in these areas are similar and build upon each other, thus warranting a set of related actions that are driven by a common set of principles.

**Patient Centered Health/Medical Homes (PCHH):** The PCHH is an approach to providing comprehensive health care by fostering a partnership between the individual and his/her identified lead health provider. A PCHH must reflect a number of key principles:

- **personal physician**
- **physician-led team which takes collective responsibility for care**
- **a whole-person orientation**
- **care is coordinated and/or integrated** across all elements of the complex healthcare system
- **quality and safety**
- **enhanced access** to care,
- **payment to the providers** appropriately recognizes the added value provided to patients who have a patient centered health home

**Accountable Care Organization (ACO):** ACOs are groups of providers, including primary care physicians, specialists, and hospitals, that agree to be held accountable for the cost and quality of care delivered to a specific population or group of beneficiaries in exchange for financial rewards for cost savings, assuming that certain quality outcomes and consumer protections are met. A PCHH is often a core component of an ACO. The payments may be made in a capitated, case rate, or other methods outside the more traditional fee-for-service system.

In order for an ACO to function effectively, it needs to have a large enough collaboration of providers to cover the continuum of care across different healthcare settings (outpatient, inpatient, rehabilitation) to effectively measure performance outcomes, and to be able to manage overall costs (per patient or per enrollee) and fiscal and clinical risk.

**Roles of PIHPs/CMHPS in forming and operating PCHHs:** PIHPs/CMHSPs have the opportunity to play key roles in the formation and operation of three broad types of PCHHs:

- **Specialty PCHH:** For the **Specialty Behavioral Health Population** (those with mental illness, emotional disturbances, developmental disabilities, or substance use disorders), CMHSPs and PIHPs would likely become the **lead health provider/convenor of the PCHH**, ensuring that the bulk of the consumer’s health care needs are met through a coordinated physical and behavioral healthcare team.

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# Newaygo County Mental Health: 30 Years of Integrated Care

Greg Snyder, CEO, Newaygo County Mental Health

*Realizing the importance of addressing physical as well as mental health issues in the pursuit of quality care, some behavioral health agencies have already taken steps to address primary care needs—Newaygo is one of those agencies. Greg Snyder consented to sharing the story of how they have been assuring that individuals seeking behavioral health services also have their physical health needs addressed.*

**I**n 2006 a study, entitled *Morbidity and Mortality in People with Serious Mental Illness*, was released. It came as no surprise that the findings substantiated that persons who have a mental illness die younger than the general population. The surprise was that they die 25 years younger than the general population!

Mental illness, substance abuse, and physical health issues seldom occur in isolation. They frequently occur together, along with a significant number of general medical illnesses such as heart disease, cancer, diabetes, and neurological illnesses. Consequently, mental health issues, substance use, and general health issues are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. Moreover, mental and/or substance use (M/SU) problems and illnesses frequently affect and are addressed by education, child welfare, and other human service systems.

Improving the integration of mental health and substance use health care with general health care depends upon the effective collaboration of all mental health, substance use, general healthcare, and other human service providers in coordinating the care of their patients. Ignoring the need for coordinated care would not be an acceptable decision on the part of this agency. Coordination of all systems is vital to not only cutting costs, but far more importantly, to improving quality of life.

For over thirty years NCMH has had a primary physician on staff. Dr. Gunnell has provided monitoring of psychiatric medications in conjunction with psychiatric staff

and emergency medical consultation. As a primary physician in White Cloud, he has treated a large percentage of mental health consumers in his primary setting. This unique expertise has allowed us to lay the foundation for integrated care, even prior to the morbidity study.

## Current Integration Efforts

Over the past few years NCMH psychiatric services have significantly grown to include four RNs who provide medication teaching, monitor blood pressure, weight, BMI, and coordinate health issues with primary physicians, including lab results and other health issues reported to the NCMH medical staff. Our medical team has been instrumental in the identification of several emergent medical needs such as stroke and heart attack, in which the person came here and did not seek medical attention.

Beginning in early 2010, Family Healthcare – an FQHC (Federally Qualified Health Center) covering three counties – approached NCMH to discuss mental health services in the White Cloud school teen health clinic. This was an exciting opportunity. The White Cloud teen health clinic provides for all of the medical care needs of those middle and high school students whose parents have authorized their participation.

Presently, there are 537 students enrolled at the teen health clinic. NCMH clinician Melanie Pell states, “I currently have 25 kids who I see regularly or are on my case load.” This number fluctuates somewhat, however, depending on referrals in and out of the clinic, kids dropping out of school, moves, and other factors. NCMH provides psychiatric consultation for the physician assistant (PA), as needed. Initially, it was expected that the NCMH clinician would be on site at the clinic 20 hours per week. Due to consultations, walk-ins, coordination with families and teachers, this position averages 30 hours per week during the school year and 3 days per week in the summer.

Together with school staff and medical staff, the NCMH clinician provides coordinated and holistic treatment to children and families. Those children and families needing mental health services beyond the health clinic, such as psychiatric, home-based, case management, or other specialty mental health services, are assisted to receive services at the NCMH office.

The overwhelming success of this venture has inspired NCMH and Family Healthcare to look



Ron Hill receives primary care from Robert Gunnell, MD at Newaygo County Mental Health.

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# “If You Put Your Mind To It, You Can Do It!” –Janice Wilson

Renee Keswick, Communications & Public Relations Manager, Genesee County CMH

*Janice Wilson's is a story of why primary care and mental health services need to be integrated just as our lives are integrated. To heal is to be made whole, and the services we need should respect and reflect that wholeness. –Editor*

**A**bout a decade ago, Janice Wilson, now 52, faced a multitude of issues that seemed insurmountable. She now knows that she had been bipolar for a long time before the symptoms overtook her.

Janice had been employed at a job where she worked on machinery before her bipolar disorder took hold. She knew she wasn't well, and her employer asked her to see a psychiatrist. She followed her employer's request, but didn't believe she needed treatment. She refused the medication that was recommended, believing she could handle everything on her own. As she continued to become more ill, she eventually lost the job that had sustained her.

Things continued to go downhill. Janice began to take up to 60 sleeping pills a day and fell in with a dangerous crowd – living in a variety of unsafe places. Eventually, she found herself in a dangerous situation where she was being held against her will. Upon being freed from the situation by police, she was hospitalized as a means of assisting her to grapple with her growing symptoms.

At the hospital, while undergoing the beginnings of her mental health treatment, she met a mental health hospital liaison professional who was able to help her get into mental health treatment with Genesee County Community Mental Health. Janice also was helped to enroll in a transitional housing program that provided her with daily support and encouragement. She lived there for seven months building confidence and working through paperwork to apply for income assistance and benefits. When her benefits were approved, she worked with her Community Mental Health case manager to find more suitable and stable housing. Janice moved to an apartment.

As she began her journey to recovery, Janice honestly admitted she had gained a great deal of weight. She weighed 238 pounds – over 80 pounds from where she had been. A visit to the doctor also showed that she had very high cholesterol that needed treatment. Janice attributes some of the weight to the poor eating habits while her mental illness was at its peak. Some of it came from the medication she was currently taking to control her symptoms. At one point, she decided to

go off the medication and found herself again struggling with serious symptoms of her mental illness. Janice was not paying her bills. She was eating fatty foods, fast food, and candy. Janice says, “At that point I was basically living and eating at convenience stores. I had always taken care of myself and had a strong will. I decided it was time to do something about my situation.”

Janice went back on medication, working with the doctor to choose those that would cause the least amount of weight gain. She was determined to lose the weight. Janice realized that she could not be truly successful on her own. She was not a breakfast eater and was limiting herself to one meal a day consisting of mostly unhealthy foods. She came to realize this wasn't good for her. She lost weight, but her cholesterol was not under control.

Aware of Janice's determination to lose weight and get healthy, her case manager, referred her to the newly formed InShape® program at Genesee County Community Mental Health. InShape is a project that integrates support for physical health with mental health services. This was in August of 2009.

Janice recalls; “One of the first things the InShape team encouraged me to do was to eat properly. I now make sure I eat vegetables, fruits and lean protein. I eat six small healthy meals a day rather than the one meal.” She worked with a trainer twice a week. One of the things she liked most was water aerobics. Janice committed to a schedule of regular workouts at the InShape gym.

Through the InShape program, Janice became involved in a local running group in Flint that was training for the Crim Race. Her participation in this group really resonated with her. Staying fit was fun! In 2010, Janice participated in her first Crim Race, finishing the 10 mile walk/run and receiving a medal for her efforts. Janice felt exhilarating pride. She had accomplished something beyond her dreams!



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# The EVOLUTION of Recovery in St. Clair County

Michael McCartan  
Executive Director, St. Clair County CMH

*The concept and principles of “recovery” have been transforming and improving the quality of services to those with substance use disorders and mental illness for some time. However in Michigan, we have developed a community based system of care that also provides services to those with developmental disabilities. Many of these individuals and their families objected to using “recovery” as the goal or objective of their services. This article is a great story of how one agency addressed these concerns. – Editor*

**T**he community mental health movement represents one of the most profound examples of extending human rights to groups historically stigmatized and excluded from the mainstream of American life: individuals with mental illness and developmental disabilities. But as the state psychiatric hospitals were slowly emptied and individuals moved back into their communities, the simple concept of recovery tended to be overlooked. The caretaking approach of the institutions subtly shifted to the emerging community mental health system.

This caretaking, or dependency, model was challenged by the people who used services. As the liberation movements of the 1960s and 70s swept through the ranks of people with disabilities, a concept of true recovery began to emerge.

The notion of recovery that emerged went beyond recovery from a disease – although it also meant being “cured” wherever possible. Recovery evolved to include being able to live a satisfying life and contributing to one’s community. It means living with authentic hope for a better tomorrow.

Recovery is a journey of forging new attitudes, values, roles and skills that help a person transcend the effects of mental illness or developmental disability. Those effects are not

only narrowly clinical. They are also profoundly social and political insofar as people have to recover from the impacts of discrimination, unemployment, the lack of opportunities for self-determination, and shattered dreams – not to mention the unintended consequences of some treatments. In other words, recovery is profoundly personal as well as sociological in nature.

In 2004, we at St. Clair County Community Mental Health undertook the project of making our entire organization, from top to bottom, recovery focused. We wanted to institutionalize the concept of recovery, to build it in to how everyone in our agency felt, thought and acted. We began by hiring META Services, now called Recovery Innovations, of Phoenix, to review our operations and begin to alter our organizational DNA. META trained key staff members and individuals who used services and they in turn trained every single member of our staff in the dynamics of recovery: hope, choice, community, empowerment and spirituality.

It wasn’t always easy. What about people with developmental disabilities, who by definition live with chronic lifelong conditions that begin before age 21? Some parents and advocates objected to the concept of recovery, arguing that it minimized the needs of their children and created false hopes. Still, all of us are aware of the sometimes unimaginable and inspiring accomplishments of people with developmental disabilities, from independent living to stunning mobility achievements to acting on TV shows. So we carefully considered our recovery philosophy. While our organization defined “recovery” as a process that enabled all individuals to experience life to the fullest and have input in the decisions that affected their daily lives and futures, we also wanted to be as inclusive as possible. We acknowledged that it is both possible and likely that individuals with serious mental illnesses will recover and live fulfilling lives with appropriate treatment. We also could see the issue from the point of

**“The community mental health movement represents one of the most profound examples of extending human rights to groups historically stigmatized and excluded from the mainstream of American life – individuals with mental illness and developmental disabilities.”**

view of the dedicated advocates for adults and children who live with developmental disabilities. We did not want any of the persons we serve to feel a sense of exclusion as a result of semantics. So, we looked to our community partners at The Arc for their input. Ultimately, we expanded our vision statement to include the word “discovery” along side “recovery.” Both are strength-focused words that reflect the sense of encouragement, hope, and optimism we sought as the banner to lead our staff, those we serve, and our community forward into a future that anticipates the best from

all persons. The compromise received widespread encouragement from local advocates, and we in St. Clair County have come to use the term “discovery” to refer to the journeys of individuals with developmental disabilities to expand their realms of what is possible.

A few years ago, Carlena Schlinkert, who was born with cerebral palsy, moved into her own apartment at the age of 52, after a life spent primarily in institutions.



Hope and Choice are key pathways to recovery and Carlena credited her CMH team with holding the hope for her and giving her the power of personal choice when her dream of independent living seemed impossible to achieve.

“One day, Jody [Jody Bresee, Carlena’s clinician from St. Clair County CMH], asked me about my dreams for the future,” said Carlena. “I laughed at her, and told her it just couldn’t happen. She said, ‘Why would you say that?’ And I just laughed and said, ‘Look where I’m at.’ But Jody asked again, and I told her I wanted to get out of the nursing home and live on my own. No one else ever took me seriously about that...but Jody did. I remember the day she called me up and said ‘Carlena, how would you like to have your own place?’ I smiled the biggest smile ever and said ‘SWEET!’”

“A lot of people said I couldn’t do it,” said Carlena, displaying characteristic spunk. “But here I am, aren’t I? I was born a fighter, and weighed only three and a half pounds. I’ve been a fighter ever since. I may need some help, but that is not going to stop me!” It is that type of spirit and confidence that exemplifies the SCCCMH vision of a recovery focused environment.

To help all of our staff exhibit the same strengths as Carlena’s team, SCCCMH instituted bi-weekly small-group forums led by trained staff members who focus on a wide range of recovery concepts. The effort is called “Keeping Recovery Skills Alive,” and as executive director I am certainly not exempt. I attend a KRSA group led by our Deputy Director, Debra Johnson, and I am convinced the meetings help us all maintain our focus.

We made a commitment, as an agency and as individuals, to treat all people with dignity and respect. One of the ways we achieve this is to avoid collapsing multi-dimensional people into their disabilities. All of our staff uses exclusively person-first language and we encourage others from the community, including local media representatives, to follow our lead.

Perhaps the most telling signs of our agency commitment are the changes that were made to our mission and vision statements. We adopted the vision statement: “*Promoting Opportunities for Discovery & Recovery.*” The first sentence in our mission statement reads: “*We embrace a mission which recognizes that all people have the capacity to discover, recover, change, grow and develop their thinking, beliefs and behaviors.*” The mission statement also highlights our dedication to promote choice and responsibility – key notions in order to truly encourage an everyday atmosphere embracing the likelihood of both discovery and recovery.

We regularly highlight the accomplishments of the people we serve through newsletters directed to specific groups: individuals with developmental disabilities, adults with mental illness, families of children served, our provider network, and community leaders. Each fall, through our local Empowerment Awards, we recognize adults and children who live with developmental disabilities, mental illnesses, emotional

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disorders, or co-occurring disorders who have excelled at various pathways to recovery and discovery. Each spring, our annual report highlights an element of recovery. This year, the theme focused on the importance of making good choices on one’s road to recovery. It featured stories about a man with a developmental disability, a woman with a mental illness and a mother whose child was born with a developmental disability—all of whom made good choices that have resulted in lives defined by the concepts of discovery and recovery. The annual report is distributed through the local newspaper throughout the community to help break down the barriers of stigma by allowing the public to see inside the lives of these individuals—to see the whole person, not just his or her differences.

Ideally, our goal as providers of mental health services is to create opportunities and environments that empower people to recover and discover the full potential in their lives. Those opportunities and environments allow the people we serve to focus on what only they can accomplish: Recovery. ■■

# Writing the Next Song

Ed Kiefer, LBSW Senior Training Consultant  
The Center for Positive Living Supports

**W**hen I was 24 years old I fulfilled my dream to move out west. I moved there before finding work, which quickly led me to the nearest temporary employment agency. The first job I took was working for a building contractor with the unofficial title, “gopher.” “Go for this...and go for that,” I often heard on the job site. When I returned from lunch the first day my boss said, “You came back?” He informed me that the last 3 people that the temp agency sent digested their lunch somewhere else that day and the days to follow. After a long, hot summer day of labor-induced exhaustion I placed my weary rear on the grass of a nearby tavern under a shade tree. This was the designated spot where my roommate was supposed to pick me up. She was running late but I never received a text message from her because it was 1995.

While waiting in the cool grass I began to feel a burning sensation on my legs. I looked down to find a mass of red fire ants using my legs as an “all you can eat” buffet. I quickly brushed off my unwelcome guests and made my way into the tavern. It was there I found air conditioning, root beer on draft, and a not-so-cliché conversation with the bartender. She informed me that she had a relative who was a residential manager of several group homes and he was hiring. I thought to myself, “This must be my opportunity... what are the odds that they are hiring?” Turns out the odds were pretty good. I found out later there was a permanent, running ad in the local newspaper to address the excessive turnover among caregivers.

I was hired as a “30-hour Roving Relief Habilitation Aide.” When someone didn’t show for a shift for any multitude of reasons, I was your man. Often I was called to work at the agency’s “Behaviorally-Intensive Children’s Group Home”. On my first day, I made my way up the cement ramp that led to the front door. As I knocked on the door, I was able to glance through the door’s window that would reveal my first impression. I saw two female staff awkwardly escorting Steve, a naked, adolescent boy who was covered in his own feces. In the brief moment while the caregivers were preoccupied I contemplated, “What if I get into my car and drive off...working for that contractor wasn’t so bad...could I digest my lunch somewhere else?” My thoughts were interrupted by a barely audible, “Come on in!”

I spent the next two years working in this home, eventually becoming the home manager. The kids living in the home felt very unsafe and scared and the label “behaviorally-intensive”

implied these were bad kids that needed to be fixed. Although Steve was unable to verbally tell us, he actively pursued a sense of nurturance from his caregivers going as far as grabbing a hold of my arm with intentions of placing my hand on his head for comfort. Our programmed response – my response – was “handshakes only, Steve.” Steve found ways to get touch into his life. Unfortunately, these more aggressive ways became classified as “target behaviors” and the focus of our energies.

Steve’s roommate, Devon, moved into the home having reasons to be scared of others. When Devon first moved in he had a small keyboard in his closet. I asked if he would mind if I got it out. From there, Devon slowly began to enjoy this time with me as we began to write simple songs together. He enjoyed it to the point that he would record our “studio time” and share these recordings with others, including his parents.

In an effort to reduce Devon’s “target behaviors” a question was asked of us, “What are Devon’s favorite things to do?” The group concurred that playing the keyboard would be at the top of the list. This meant Devon would only be able to play the keyboard at the end of the day if he earned enough tokens for “behaving” throughout the day. He was frequently reminded, “Remember your tokens, Devon” when he began to show signs of stress. Because the words, “remember your tokens” did not reflect an acknowledgement of his sadness, his need for unconditional support, or that it was in fact okay to have a difficult moment, he would often feel less safe and more frustrated resulting in aggression. It was in these moments that people often relied on trained physical intervention techniques. Other reactions could include more informal, often improvised, strategies that reared their heads out of staffs’ feelings of fear. Devon taught many that if you fight with fight, you will get more fight. I remember coming in to my morning shift and reading in the log book, “Devon received all his tokens and became physically aggressive after getting his keyboard! We need a new plan!!” How could this be?

The past culture of support I experienced led me to believe food, drinks, tobacco, stickers, tokens, money, and keyboards were the rewards. For Devon, placing the electronic musical device in front of him was what we saw as his reward. Looking back, what I learned from Devon was that it was the unconditional time spent building a friendship that was most valuable to him. After Devon moved out of this home it would

be years before I would see him again. The first words out of his mouth upon being reunited were, “Hi, Ed! Can we write a song together?”

When the home I managed eventually closed I was asked to become part of the training department. I trained on numerous topics including curriculums that support both contingency plans and the use of physical management. This was right in my wheelhouse as I had spent the prior two years learning how these strategies were used with the children I supported. On day one, of my two-day trainings, I would spend the day teaching our new employees ways in which they could treat people with dignity and respect. At the end of day one, I would inform my students to wear comfortable clothes and shoes for the following training day. The reason for the preparatory statement was to enable me to teach them various techniques of physical management as a way of supporting someone. People left day two of my training with a lasting impression that became evident when I was reviewing incident reports. Many people put what they learned in day 2 ahead of day 1, not because they were bad employees, but because the culture allowed and supported it.

Moving back to Michigan in 2003 and getting a job as a support coordinator with Macomb-Oakland Regional Center opened my eyes to a different way of supporting people. The principles of *Gentle Teaching*, founded by Dr. John McGee, were a refreshing approach which was much more consistent with how I felt we should treat those we support and others in our own lives. Additionally, the six elements of *Safe, Loved, Praise, Demand, Transitions*, and *Structure* are at the heart of what we focus on for those needing The Center’s support. It is these same principles that are currently embedded in the state of Michigan’s commitment to “Creating Cultures of Gentleness.” It has been a privilege to be part of a team that is comprised of people who humbly admit to past mistakes, and know that with each mistake a lesson is learned. As we continue to support each other in this journey, we continue to learn from the people we support and those that support them.



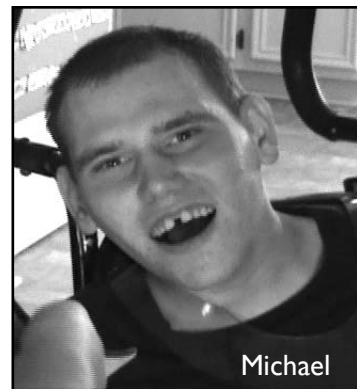
Marian

Marian was discharged from Mt. Pleasant (MPC) in July 2008. Her story illustrates what happens when a solid foundation is present: extensive services are not needed.

While at the Mount Pleasant Center, Marian was restrained – once every three days on average – for aggressive behavior. Since her discharge from MPC, she has never been restrained, physically or mechanically; nor has she been admitted for psychiatric hospitalization. She remains in the same home today. Marian’s success can be attributed to good transition planning

and the direct service provider having a solid commitment and foundation in providing a culture of gentleness for those served.

Michael never lived at MPC. He lived in his parental home until June 2010. While in his family home and at school, Michael would often wear a helmet and was restrained



Michael

in a wheelchair due to his aggression. Within days of his move from his parental home, Michael became so aggressive that he was admitted to the hospital. After a second trip to the hospital, The Center’s services were requested. The contract provider for the CMHSP strongly supports a culture of gentleness; given the foundation already established, the Center’s Mobile Response Training Unit was deployed within 7 days of the formal request. The team member was able to successfully demonstrate and mentor caregivers in supporting Michael in a way that was much deeper than what they had been doing. Now that Michael feels safe and loved in his new home he waves with a smile when his mom leaves after visiting.

The closure of Michigan’s last public institution for intellectual disabilities marks the end of our state’s 150 year chapter of institutionalization. Proudly our state stands behind Creating Cultures of Gentleness for everyone with a developmental disability receiving mental health services. Let us be reminded that even though those institutional doors are closed, we must be diligent so they do not reopen in our communities. We can write the next chapter, or as Devon would prefer, “the next song,” together. ■■

Editor’s Note: The Center for Positive Living Supports was established in early 2009 in response to the need for a “safety net” for those individuals who were being discharged from Mt. Pleasant Center, Michigan’s last public institution that housed individuals with developmental disabilities. MPC closed on September 10, 2009, with all but ten of its former residents returned to their home communities.

The Center’s services are designed to assist in the support of individuals at risk of being placed in a more restrictive environment. The two major service components offered by The Center include a statewide training initiative and individualized crisis response services. These services are for Community Mental Health Services Programs (CMHSPs) who are committed to and have initiated training efforts in creating a “culture of gentleness” for those individuals served.

The Center’s activities focus on supporting relationship-building in safe, respectful and nurturing environments. The goal is to facilitate successful community living by validating each individual’s humanity, offering an environment where the person feels safe, and building connections to others.

## A NEW GENERATION *(from page 3)*

- **General Population PCHH:** In this PCHH model, the CMHSP/PIHP would be a partner potentially involved in the care of an individual if a behavioral health care need arises.
- **Specialty Patient Centered Health Neighborhood (PCHN):** Akin to the PCHH is the Patient Centered Health Neighborhood, which uses the structure of the PCHH and adds to it a range of other human services that are outside of what is traditionally covered in an integrated healthcare plan, but are key to the health of the specialty population. These services would include employment/vocational services, housing, transportation, and community living supports. Because Michigan's CMHSP/PIHP system currently provides or coordinates these services, the CMHSP/PIHP is well suited to serve as the convener of such a PCHN for the specialty behavioral healthcare consumers.

**Roles of PIHPs/CMHSPs in forming and operating of ACO:** PIHPs/CMHSPs have the opportunity to play key roles in the formation and operation of two broad types of ACOs:

- **Specialty/Safety Net ACO:** In this model, the **PIHP/CMHSP serves as the convener or co-convener** of a number of healthcare providers – primary care, inpatient, specialists, and behavioral healthcare providers – to serve the specialty population (persons with serious mental illness, developmental disabilities, emotional disturbance, or substance use disorders).

The Specialty/Safety Net ACO could also serve other community members who are in need of social supports: those with low incomes, the unemployed, and persons with disabilities. This broader ACO, providing housing, employment, and other human services (non-traditional health care services) is often known as a Community Care Organization (CCO)—akin to the Patient Centered Health Neighborhood, but with the greater scope of an ACO.

- **General Population ACO:** This model provides the full range of health care services for the general market. In this model, the **PIHP/CMHSP is a partner in the ACO and not, in all likelihood, the convener of the body.** While the range of services provided through this type of ACO are those traditionally found in a managed healthcare system, the focus on “Triple Aim” measures may cause this ACO to purchase non-traditional services from this CMHSP.

**The use of a CMHSP/PIHP, as specialty PCHH or convener of a specialty ACO, goes beyond the current coordination efforts with primary care providers for these specialized populations.** Recognizing the specialized nature and complexities of behavioral health care delivery, the complexity and chronicity of the health care needs of the persons in these populations, and the inability of systems not designed to care for these needs to serve them, this model would use the PIHP/CMHSP, where the members of these populations currently receive the bulk of their health care services as the healthcare hub. In the role of the hub, the PIHPs/CMHSPs bring primary care into the behavioral healthcare setting to form a patient centered health/medical home for these populations with chronic mental health and developmental conditions.

This model differs from the model used for enrollees without chronic conditions, which uses the primary care provider as the hub for the enrollees' health care. This latter system, designed to meet short term, mild to moderate mental health needs, is ill-suited to meet the needs of this more involved population. **Rather, the PIHP/CMHSP as the specialty PCHH or specialty ACO convener proposal uses the risk-bearing and well-developed multi-disciplinary team approach employed by Michigan's PIHP/CMHSP system to integrate a wide range of health care and social supports to promote the health, the quality of care, and control the cost of health care to those with chronic health conditions.**

As the federal Centers for Medicare and Medicaid Services (CMS) noted in their November 16, 2010 State Medicaid Directors' Letter (10-024) providing guidance on how states may take advantage of the new Medicaid Health Home state option,<sup>1</sup> “...there is a growing movement toward interdisciplinary team-based approaches. Services such as care coordination and follow-up, linkages to social services, and medication compliance are reimbursed through a ‘per member per month’ structure.” This description is an apt description of Michigan's PIHP and CMHSP system and builds on the strengths of this system.

**Strengths and momentum of CMHSP relative to the demands of the ACA:** Michigan's PIHP/CMHSP system has long been involved in work that fits well with the demands of the ACA and the integration of primary and behavioral healthcare. These strengths include:

- A long (four decades) track record of providing services in the manner promoted by the ACA: **a non-traditional, patient/consumer-centered array of multidisciplinary team-based, community-based services and supports to persons with chronic mental health, developmental, and substance use disorder conditions.**
- The PIHP and CMHSP system has, over the past several decades, **taken a system that was heavily hospital based and made it almost entirely community-based**—fitting well with the quality, outcome, and cost control aims fostered by the ACA.
- The work that the PIHP/CMHSP system has done – to foster the health of persons with severe and persistent mental illnesses, co-occurring substance use disorders, developmental disabilities, and children and youth with serious emotional disturbance and those with mild forms of these conditions – **controls the overall health care costs of these patients.**
- PIHP/CMHSP work to further integration of primary and behavioral care:
  - ♦ Co-location:
    - PIHP/CMHSP behavioral care provider at a primary care site
    - Primary care providers at a PIHP/CMHSP behavioral care site
  - ♦ Joint educational efforts of behavioral and primary care providers
  - ♦ Assistance for CMHSP consumers, by PIHP/CMHSP, in connecting with primary care providers

- ◆ Healthy lifestyles education, by consumers, with consumers
  - ◆ Health checks, by PIHP/CMHSP staff or contractors, within the behavioral healthcare visit
  - ◆ Coordination of care between emergency departments within local hospitals and the PIHP/CMHSP system
  - ◆ Addressing the needs of high utilizers of healthcare resources
  - ◆ Use of an in-house pharmacy to foster the coordinated management of physical health and mental health medications
  - ◆ Active involvement in state and local electronic medical record technology initiatives
  - ◆ Community healthcare coalitions
  - ◆ A full array of mental health and substance use services
  - ◆ Systems to assure and measure rapid access to care
  - ◆ A wide array of evidence based and promising practices, across all populations
  - ◆ A strong set of consumer engagement, governance, and person centered planning practices
  - ◆ A long history of care management with enrollees with high levels of need, complexity, and cost
  - ◆ A large panel of high performing mental health and substance use disorder providers
- The PIHP/CMHSP system has many of the components of a **Patient Centered Health Neighborhood:**
    - ◆ Community based, evidenced based practices
    - ◆ Help to consumers in accessing community resources and supports needed to maintain wellness and participate in social, educational and vocational activities
    - ◆ Housing assistance
    - ◆ Transportation assistance (for non-medical Medicaid covered service)
    - ◆ In-home private duty nursing for special health needs (HSW enrollees)
    - ◆ Sub-acute detoxification
    - ◆ Wraparound services
    - ◆ Jail diversion
    - ◆ Jail-based services

There is no doubt that the next generation of health care available to individuals with complex needs who we have served in the public behavioral health system of care, will be significantly improved by integrating these services with primary care. However, we must be diligent as we develop these forms that transcend their behavioral needs to retain the best practices that have evolved in our existing system.

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<sup>1</sup>On Nov. 16, 2010, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors Letter providing guidance on how states may take advantage of the new Medicaid Health Home state option enacted as part of the Affordable Care Act. This provision of the law creates a new option for states to enroll beneficiaries with two or more chronic conditions, including serious mental illness or substance use disorders, into healthcare homes for the coordinated treatment of their conditions. The state option to provide health homes to Medicaid beneficiaries with chronic conditions became effective on Jan. 1, 2011. To take advantage of this option, states must submit a State Plan Amendment (SPA). ■■

## *Newaygo (from page 4)*

toward the integration of NCMH clinicians in other FQHC clinics in Newaygo County. In the fall of 2011, Family Healthcare will open a second teen health clinic in the south end of the county in Grant. We are presently looking for the right candidate for that position and will conduct all interviews in coordination with the FQHC.

Discussions with Family Healthcare continue in large part to the overwhelming success of the collaborative efforts of the past year, but also due to the commitment of the CEO, Kathy Sather, in the treatment of the whole body. Through the development and collaboration of programs such as that in the White Cloud schools with Family Healthcare, all parties hope to be able to impact the quality of life of those served. NCMH believes that, ultimately, the overall health of Newaygo County can be impacted through the continuing growth of such collaborative efforts.

### **On site Integration Efforts**

In very recent months, ongoing discussions have occurred with Dr. Gunnell regarding expansion of NCMH to include primary care services to CMHSP consumers who have no identified physician, or who have been refused access to primary health providers. Sadly, due to a number of factors, including co-occurring disorders, some persons have been unable to return to their primary physician's office. NCMH is looking forward to the opening of a primary healthcare setting within NCMH in the fall of 2011. This clinic would be prepared to serve those persons identified within existing and new cases who are without a primary physician. A very brief survey conducted showed persons with COPD, obesity, history of cancer, seizures, heart disease, and other major health issues going without treatment. We are committed to filling the gap for those who have complicated and coexisting, physical health, mental health, and substance abuse issues.

### **Conclusion**

Mental health and physical health issues do not occur in isolation. Through integration/coordination of care, the body and mind are treated together and made whole again. As a member of the community and advocate for those NCMH is charged to serve, we remain committed to continue to increase integrated care in this small rural county through ongoing development of partners committed to quality care. We do this because we must.

### **Integrated and Coordinated health care goals:**

- A. To make integrated healthcare services more accessible to those receiving or needing mental health services.
- B. To coordinate services for these consumers so that all agencies involved are communicating with a continuum of services to provide for the variety of consumer needs incurred.
- C. To provide effective, affordable, driven, and medically necessary services.
- D. To reduce the health care risks of the consumers served by the healthcare community in Newaygo County. ■■



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## You Can Do It *(from page 5)*

Janice continues with her training for the Crim. She's developed a strong personal bond with her running mates. With a broad deep smile Janice shares, "I am the only one in our group on a fixed-income. All the others are attorneys and other professionals." Janice and her friends run and walk three days a week. She says the group has "adopted" her. "They took me shopping and bought me two new pairs of running shoes and running clothes. I have never been around such a group of beautiful people. They treat me very kindly!"

Janice is down to 162 pounds (a weight loss of 76 pounds) and plans to get down to her old weight of 153. She works out and runs 4 days a week for about an hour each time. Her cholesterol is decreasing and her doctor has taken her off the cholesterol medication. "I'm going to get up off the couch and keep my health up and look good!" Janice declares. She confesses that some days she doesn't want to go to her workouts, but she goes anyway. She doesn't want to simply stay in her apartment all day. Janice uses monthly bus passes to keep her out and about and active.

Janice plans on joining in the Crim race again this year. She admits that these days she "has some muscles." With a smile, she proudly relates; "Recently a gentleman told me he didn't wish to arm-wrestle me." When asked for advice for those just getting started, Janice replied, "If you put your mind to it, You Can Do It!"

The Genesee County Community Mental Health InShape Pro-

gram supports the integration of primary physical health care with mental health services. Janice is just one success story. There are many others. For more information contact Shanté Burke, Manager of Health and Wellness at (810) 496-5740 or [sburke@gencmh.org](mailto:sburke@gencmh.org). ■■

## e-connections

The advocacy groups listed below are pleased to announce the creation of a state-wide information service which is designed to share announcements concerning policy, procedures, activities, and celebrations of individual achievement for those with developmental disabilities. This is a collaboration of three advocacy groups – *ddAdvocates of Wayne County*, *Friends of the DD*, in Washtenaw County, and the *Town Hall Coalition of Ottawa County* – and is designed to foster information and communication between consumers, stakeholders, advocates, CMHSPs and providers within the DD community.

The main web site will be [ddadvocates.com](http://ddadvocates.com), which will host articles, announcements and features, and will also host a blog where comments can be posted. Individuals wishing to subscribe can send an e-mail to [ddadvocates@gmail.com](mailto:ddadvocates@gmail.com) or [tbird49424@gmail.com](mailto:tbird49424@gmail.com) requesting to be added.

