

MACMHB

# *Provider Alliance*

## Newsletter – Spring 2009

*The mission of The Provider Alliance is to provide a means to act as a group on matters affecting Michigan's public mental health system.*

### Uniform Provider Contract Moves Forward

Bob McLuckie, President

#### Mission Accomplished

Development of a "Uniform Provider Contract" was commissioned by the MACMHB Contract and Financial Issues Committee. CFI formed a Workgroup with the charge: *"To identify the components used by the CMHSP and PIHP system to purchase mental health services and supports that could be standardized, statewide. The workgroup will report its progress and recommendations to the CFI Committee at each bi-monthly meeting."* Of the 13 Workgroup members, 3 represented the Provider community. These were Jim Tuinstra, Bob McLuckie, and Robert Stein, General Counsel for the Michigan Assisted Living Association.

The Uniform Contract Workgroup has now completed its task. The proposed contract has been constructed to honor the standards of simplicity, consistency with law and DCH standards, and serviceability in use. Broad-based input was gathered and drafts of works in progress distributed to ensure key stakeholders had an opportunity for input. The final draft was pilot tested by several PIHP and CMH agencies with good reviews. The document will be conveyed to CFI at its June 18 meeting. Now.... *Let's see if this baby will fly!*

#### Yes. There is a Mandate for Uniformity.

The need for uniformity across *the Michigan CMH service delivery system* is emphasized 33 times in the report of the **Governor's Mental Health Commission**. The call for uniformity is articulate and insistent: uniform services and supports; clinical uniformity and data submission; uniform operational definitions and service selection guidelines; a uniform unobtrusive way of standardizing administrative and performance monitoring; uniform medical necessity criteria; uniform methodologies for statewide use in the protection of recipient rights ...etc ...etc ...etc. The uniform Provider Contract is an important reply to the Commission's call to *"institute uniformity and minimize variation"*.

The **ARR** includes a strong demand for achieving administrative efficiency and specifically indicates *"reciprocity in training and service monitoring, and uniformity in provider contractual*

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*requirements*” as expected design features of our renewed service delivery system and as evidence of our recommitment to quality.

The ARR requires PIHPs to submit a plan with milestones and timeframes that includes, in part, “development of reciprocal agreements or arrangements among PIHPs or within an affiliation for training and service monitoring, and provider contractual requirements.” It’s clear: Uniformity is not just a nice (but naive) idea or an ideological construct. There is a powerful mandate for uniformity.

### **Obstacles? ..... Where?**

Vince Lombardi reminded us; *“Obstacles are what you see when you take your eyes off the goal.”* Or... If we want a uniform contract we will have one; if we don’t want to achieve this goal all we need do is focus our discussions on objections and enumeration of the forces that prevent our moving to adoption of the contract.

“The contract as presented does not offer sufficient protection from risk.”

“We like our consultants’ contract better.”

“Our County Attorney says she can’t support the uniform contract.”

“Our existing contract has all the legal language. It covers all the potential issues.”

We’ve worked together a long time..... Providers and their CMH/PIHP Contract Agency partners have dealt very effectively with lots of issues and impediments. We’re a pretty good team. We don’t need volumes of precise contract language to tell us where to focus and how to work together. At its core, our field of endeavor is one of cooperation and partnership. We help people overcome. We understand the path we’re on. Together we accomplish important things.

If the Uniform Contract is not adopted the key obstacle will likely be our consenting to let our vision wander from our goal. Some might call it “unwillingness to move forward”, but it’s not. It’s simply the distraction of busy schedules, competing issues, and perhaps our spunky egos. I see no real obstacles. *Let’s get this done.*

### Please Support the Uniform Provider Contract

### **Special Thanks ...**

To Mike Head and the DCH staff for calling for greater uniformity.

To the agencies that adopted the Uniform Contract and are using it now. They are Oakland County CMH, LifeWays, St Clair County CMH, CMH Services of Muskegon County, and CMH for Central Michigan.

To Lynn Guernsey, hard working and eminently talented Chair of the Workgroup.

To Lisa “The Workhorse” Morse, Legal Counsel from St. Clair CMH. Without her tireless work.....

To Robert Stein, General Counsel of the Michigan Assisted Living Association, who provided legal expertise based on many years of work with CMH/Provider contracts.

**Thank you** to all of the members of the Contract Workgroup.

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## **Alert: Member Survey - AFC Licensing Concerns**

Several of our members have expressed concern over alleged adverse actions (or implied threats of same) by members of the staff of the Division of Adult Foster Care Licensing of the Michigan Department of Human Services. Reportedly these adverse actions include demotion of the AFC license to “provisional” status; A very serious action against the direct service providers’ standing under Michigan licensing statute.

As best we understand it, our members’ concerns relate to circumstances involving the placement of persons from state institutions or other persons with very significant treatment needs. Reportedly the AFC Licensing Consultant may take the position that an individual is not appropriate for the specific residential placement arrangement when the CMH placement agency actively supports the arrangement as proper. This circumstance originates from each agencies’ desire to support proper practice based on their own rules and guidelines. In such circumstances the direct service provider can be placed in the middle of these competing rules, with the provider being held accountable to presumably contradictory standards. The conflict can be very tough to reconcile.

Mike Vizena, Robert Stein (MALA General Counsel), and Bob McLuckie met with one Provider Alliance member agency that has been put in such a predicament. We have heard from others with similar concerns. **A survey about this concern will be sent to you via email soon.** Please respond. We need your reply to help us determine the extent of this concern.

If you prefer, rather than responding to a survey you may (at any time) email a description of your specific circumstance to Georjean Knapp at [gknapp@macmhb.org](mailto:gknapp@macmhb.org). Be sure to put “Licensing Issue” in the subject line.

## **Teresa’s Story: From Institution to Independent Living**

### **(Or Never Underestimate the Possibilities)**

By- Teresa Smith, ASI Customer Services Representative  
& Stephanie Oles, Interviewer and Writer

Teresa is living in her own home. She owns it. It’s in her name. It’s a two bedroom house with a large back deck located in a serene neighborhood. Teresa has lived in this home for almost ten years. She has a cat named Baby who she considers to be her roommate. She receives 8 hours a week of staff to support her in the community. She works part time as a Customer Services Representative and Administrative Assistant and serves on the board of directors of the company she has hired to provide staff support. She runs a greeting card business out of her home and this keeps her very busy.

In her early childhood Teresa lived in two state institutions in Michigan. She returned to her family when institutional living failed her. In her early twenties she moved from her family’s home to a group home that housed 16 people. Later she lived in a couple of apartments that she shared with roommates. Most of her adult life she had to share a bedroom yet that changed when she was able to move into independent living.

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### **Teresa's Memories of the Past:**

Teresa speaks in a solemn tone. There's a far away look in her eyes: *"The institutions were very hard to live in. We were in locked halls. It was a mess. One of the institutions was run by nuns and they physically abused me."* (Teresa pauses to collect her memories.) *"The group home was also a hard place to live, but I only lived there for a year. I had to share a bathroom with three people, and I had to share a room. We had to go to bed at 9pm even if I was not tired. Lights always went out a 9pm no matter what. I was forced to go out in the community to other peoples' appointments. The hardest thing was having a roommate, and when the roommate was having behaviors she would throw things and almost hit me. I never had privacy."*

### **Her Life Now:**

She leans forward and smiles: *"I feel like a butterfly. I can come and go, and do what I need to do. I don't have to answer to a roommate. I don't have to answer to anyone but myself. I can blare music when I want to and not worry about people getting upset. I can choose what I want for dinner; Same with breakfast and lunch. I like to put up decorations that I like in my home, my embroidery, family pictures, and other crafts that I make. I garden and think gardening is better than therapy. When something is bothering me I can go out and dig in the dirt and feel better. It's cheaper than therapy. I have flower beds, vegetable beds, and a memorial flower bed for my mom and dad. I really do love the life I am living even though there are challenges."*

## *Required Reading ~*

**Reassessing the Impact of Managed Care in the Developmental Disabilities Sector by Robert Gettings. National Policy Consortium on Developmental Disabilities, Policy Insights Bulletin, March 2009, Vol. 1, Issue 1.**

For more than three decades, Robert Gettings has led the National Association of State Directors of Developmental Disabilities Services. He is one of this nation's leading experts on public policy as it impacts people with intellectual and developmental disabilities. This article summarizes research focusing primarily on the experiences of the four states (Arizona, **Michigan**, Vermont, and Wisconsin) which currently operate specialized developmental disabilities services under the umbrella of a Medicaid long-term services plan. The information is based, in part, on publicly available documents. The written materials were supplemented by information from a series of interviews with a cross section of stakeholders in each of the four states. Those interviewed from Michigan include Mike Head, Bill Allen, Dohn Hoyle, Dave LaLumia, and Bob McLuckie.

~ **FIND IT:** Google the title, or go to the NLCDD website at <http://www.nlcdd.org>.

**The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection. February 2009, Centers for Medicaid and Medicare Services & the National Direct Service Workforce Center**

Across the country, states are grappling with how to meet the escalating demand for long-term care services while at the same time reorienting their home and community based service delivery systems to meet higher quality standards and to also serve persons with more and more complex support needs. A growing number of states are realizing that a commensurate emphasis on **workforce policy** is essential to achieving these goals. As more and more states launch efforts to improve workforce quality and stability, policymakers are hampered by a lack of ongoing, reliable state-based information about their direct care workforce. This White Paper discusses the state of the direct service workforce and its role in long-term care systems change. The paper proposes that

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states collect a minimum data set of information on the workforce, including numbers of direct service workers, turnover and vacancy statistics, and average worker compensation. It argues that this information is essential in order to assess the magnitude of workforce issues, design appropriate responses, and measure the impact of policies over time. Lack of a consistent and detailed dataset on this workforce has hindered the ability of advocates and systems change agents to clearly articulate the dimensions of the long-term care workforce crises. *Articles such as this provide key information that should become “talking points” for advocates of efforts to strengthen the direct support workforce.*

~ **FIND IT:** Google the title or check the NDSW Resource Center at [www.dswresourcecenter.org](http://www.dswresourcecenter.org)

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## WHO WE ARE:

**THE PROVIDER ALLIANCE** membership consists of all MACMHB affiliate members who provide direct services. We represent more than fifty agencies that serve thousands of adults and children each day. If you are a provider of direct services and an MACMHB affiliate member, you are now a member of THE PROVIDER ALLIANCE.

## What We Believe

- 1. RECOGNITION:** Direct service providers are the foundation of Michigan’s community mental health and substance abuse treatment system. We know the service delivery system intimately; as it touches the daily life experience of the persons and families we serve. Our insight and knowledge are essential to maintaining an effective service delivery system.
- 2. STRENGTH:** An effective community services system is built on strong capable direct service providers. To be worthwhile The Provider Alliance must contribute to the strength and capability of its members.
- 3. RATIONALITY:** Successful service delivery requires judicious use of resources. Regulatory mechanisms must be sensible and uncomplicated. Bureaucracy must not create waste or hinder provision of services. Resources must be concentrated on enhancing the lives of the persons we serve.
- 4. ACTION:** Without action, ideas are worthless. With focused action, a few can have great impact. TPA members act together so that our energies produce results.
- 5. CONTRIBUTION:** An effective community mental health system requires partnership. Our activities focus on sustaining a dynamic partnership that provides clear benefit to persons served, their families, provider agencies, and managing authorities.

For More information call Amy Zaagman or Georjean Knapp at the MACMHB offices.

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