COMMUNITY INTEGRATION/SERVICE REFORM WORKGROUP 3/18/2013

Meeting Process:
Of the 103 registrants, 99 individuals attended.
To allow for processing in small groups, 10 tables were set "dining room" style, for 11 individuals each.
Random assignment to groups was assured by pre-numbering sequential packets that corresponded to numbers on each table.

COMMUNITY INTEGRATION/SERVICE REFORM was defined as encompassing:

- Becoming responsible for self and recovery
- Having as many educated choices as possible throughout a merged system
- Self actualization
- Safe, secure settings that care for basic needs
- Housing
- How we are doing (statewide, division, system)
- Needs assessments
- Program efficacy – meaningful impact
- Baselines
- Merger: trickle down of activity and information from central office down through system
- Where true community integration becomes concrete and tangible

5 challenge areas were developed for small group discussion and input:

- What might stand in the way of the Division taking action? Discuss obstacles that can be changed and make suggestions!
- What strengths does the Division have that can be leveraged to bring about change? And how can we leverage those strengths?
- What opportunities does the Division have? Discuss things that can we can take advantage of toward growth!
- What action steps need to be taken? Discuss things that can we can accomplish toward growth!
- What are potential outcome measures? How can we measure our accomplishments?

The meeting began at 10:20 due to a backlog in sign in at the security desk.

After introduction to the day, a large group Challenge was issued:

> In the area of Community Integration/Service Reform, what would be important for the Division to focus on? What should our goals be?

Input was recorded, and at 11:30 small groups began working on the 5 challenge areas.

Impact of process:

The groups developed lists of items that were important for the Division to focus on. At the end of the day, individuals prioritized those items by placing stickers onto items that each individual thought were most important to start with in systems change. Group(s) input is presented in running lists, using the language and order of their work sheets.

WORKGROUP CHALLENGES

Challenge! Group 1: What might stand in the way of the Division taking action? Discuss obstacles that can be changed and make suggestions!

DMHAS laws, regulations and licensure are not unified – Offices of licensing, contract monitoring and site reviews are not merged.
There is no merger at the county level – funding positions, there is political resistance
Laws and regulations not blended, separate departments.
Staffing regulations and Boards are not merged.
Agency payment not unified: funding, billing, RFPs funding sources remain separate.
Access issues: Long wait lists, including urban/rural access, transportation to services.
Availability of services: Housing First, for Homeless, Undocumented, Legal, $ needs to follow consumers.
Stigma exists in community, among providers, among peers.
DMHAS tries to do too much at once: "lofty" long term goals; Healthcare reform, ASO, Behavioral Health Homes, County Comprehensive Plans, Olmstead, Moving Children's Services – all too much at once.
Communication issues: Blended data base needed, no common language, Not person centered (Patient vs Client vs consumer vs person), coordination needs improvement with other Divisions and Departments,.
Workforce development issues: education and training on the merger, competencies, cross training, professional licensing.
Culture of silos remains throughout the system.
Need a uniform tracking system across services: mental health, addictions, homeless.
DMHAS has constantly changing priorities.
DMHAS Uses crisis management instead of long term planning.
Lack of follow-through and lack of a strategic plan to address the process.
Manpower resources: there is a lack of licensed people with basic competencies.
Funding remains DAS and DMHS. Not blended.
Need a realistic needs assessment: for the imbalance of resources, access to resources and eligibility criteria.
Division needs improvement in ability to make changes: Bureaucratic hurdles, politics, licensing and regs, and a clear vision of what integrated services should look like.

Challenge! Group 2: What strengths does the Division have that can be leveraged to bring about change? And how can we leverage those strengths?

Willing to embrace change and listen/ take advice from EBP
Leverage specialized expertise
Opportunity to dual license agencies (MH/Addictions)
Experienced workforce:
Leverage (finding equivalent methods to reduce barriers to credentials) transfer the strengths of one credentialed group to other group (MH/LCADC-CADC)
Update and re-align regs w/new and updated service opportunities
Streamline waiver process as applies to credentialing
Strong "leader" agencies that can transfer knowledge to other agencies that can implement by not necessarily create
Knowledgeable Div staff in addictions buried because MH is "favorite" child bring them out to share their expertise.
County level/local/regional expertise that flows both up and down
MH side has strong recovery support service programs that can be introduced to Addiction side
MH side has invested in the dev of infrastructure

Established programs for transition to housing and supportive services beyond treatment
Discussion includes "Workforce Development
Legislative Access
Research/ Evidence-Based Practices
Availability of Self-Help Centers
Recognition of Need of Stakeholder input
Crisis Housing
Availability of Emergency Serv.
Operate in every county
Both Divisions believe in wellness and recovery
Peer Support
Licensing reform
Ability to display reform to leadership
Medicaid Waiver
Housing Vouchers
Settling of Olmstead
Committed to "best practices"
Dedicated provider base (community)
Diverse provider resources/ expertise
Division has the ability to facilitate collaborations
Division has quality of leadership and staffing to meet the challenge of healthcare reform
Peer involvement with community driven recovery and wellness
Strong affiliations with national organizations ie.. national council, NAMI, MHA, USPRA
Division has the ability to shape the "Mission –Vision-Values"

Challenge! Group 3: What opportunities does the Division have? Discuss things that can we can take advantage of toward growth!

To truly make MH and AS an integrated system of care.
Improve and enhance co-occurring services through education and evaluation of services.
Increase services to homeless addictions clients through Supportive Housing.
Provide services to clients before they have to fail several times.
Improve care management to support clients in recovery
Develop a centralized bed availability system throughout the state for detox.
Consolidate licensing: process, regulations, staff and agencies.
Expanding the duration of agency licensing.
Integrate deemed status across addictions and mental health.
Begin sharing resources across both systems.
Use Multi-disciplinary/across systems/blended approach to earlier detection and intervention.
Re-evaluation of fee structure and assessment process.
Cross training and sharing of philosophies in administration of services.
Broader access to medication tracking data base.
Greater integration of mental health and addiction in community placements.
Make use of faith based and community services.
Explore non-medical and non-traditional based treatments.
Allow for licensure/centralized clinical privileges for doctors prescribing treatment/medication i.e.: methadone facilities.)
Expand the Crisis Diversion/EISS (early intervention support services) to include substance abuse clients.
Use the ICT (Interactive Community Technology) Program to improve engagement, retention, support recovery, reduce no-shows.
Streamline licensing for professionals between the 2 systems.

Open all services to both MH and SA clients.

Challenge! Group 4: What action steps need to be taken? Discuss things that can we can accomplish toward growth!

Safety- Boarding homes with families; staff abuse
Needs monitoring of consumer safety
Need to look at funding around safe housing for consumers
Need to increase case management
Access to services-
fee for services a barrier
Problem of undocumented clients being discharged without adequate housing and follow up in place of meds
Educate centralized admissions to available community resources to provide clients with least restrictive environments

1. Developing mentoring program
   utilize staff and consumers
   Research existing mentor programs
   Develop training access existing training
   Restore peer mentoring certificate program
   Utilize self-help centers
   Understanding crosses between wellness coaches and mentors
   Assisting with transition to community
2. Community as safe, welcoming, holistic, family oriented place
   Educate families by linking them to resources
   better/increased marketing
   more distribution of research and already existing solutions
   use social media/other media
   each county- have social media outlet
3. How do you access and link and treat in more streamlined way
   Utilize SBIRT at entry through all providers doors
   Link consumer to peer mentor for immediate engagement and education and support for family
   Use traditional marketing methods billboards, direct mail, buses, benches and Laundromats etc.
   developing how to guide which explains various county services
   Increase communication between providers (among each other) and with consumers county
   comprehensive plan for behavioral health care model
   invite all providers to this meeting.
4. Coordinate municipal, cty and other community plans
   Dual Licensing for provider agencies
   Assess agency for ability to provide both services
   Determine level of services avail in one agency and where referrals are made partnerships
   Submit applications for licensure
   DMHAS take assessment to licensing beds
   Medical models of MI and SA
5. Recovery as collaborative effort
   Workforce development training
   Fund globalized training
   Operationalize coordinate trained people
   Licensing S/A facilities
   Coordinate between licensing boards and reimbursement boards
6. Education- Doctors, schools, consumers, Hospitals Re: Stigma
   *Points of entry of consumers

*Peer Providers
*Crisis Centers
Transition of Meds/ Different Doctors
Communication between levels of care, need electronic health records
Plight of methadone client trying to access care
Mental Health & Addiction consumers stigma
Change mindset of professionals
need for advance directives
HIPPA and State of NJ Laws become a barrier to communication for successful COC
Violence between Consumer to Consumer and Consumer to staff
Need to address safety
Develop community placements for clients with insurance issues to be more cost effective than keeping them in state hospital
Access clients needs by county to identify those areas with waiting lists for placement and services
Focus on relationship with Mental Health and DDD so that once clients are stabilized they can return to community more quickly
Provide more RFPs for Medically needy clients i.e.: insulin dependent diabetics.

Challenge! Group 5: What are potential outcome measures? How can we measure our accomplishments?

STATE

Set outcomes that are: Collectable, measurable, actionable, qualitative.
Increased dually licensed staff and agencies.
Stop setting the bar too high.
Increased integration of primary and behavioral health.
Monitor deliverables of the strategic plan - through family, consumer and provider objectives.
Decreased Stigma in MH and SA as measured by language change.
Measure the value from state dollars expended.
Increase the number of trauma informed clinicians in the community.
Increased understanding/integration with primary heath as measured by decrease in unscheduled contracts with primary care.
Increased number of providers in the networks.
Increased efficacy as measured by reduction of costs on expensive acute care services.
Increased communication and collaboration as measured by:
Numbers that show up at meetings
Direct communication that is standard
There is communication about medication between providers
Info sharing between ASO and non ASO providers
Decrease in misuse of prescription meds and use of street drugs.
Decrease in criminal activity
Decrease in tobacco use
Numbers of consumers educated on the meds they use
Increased use of Advance Directives
Demonstration of more understanding of Advance Directives
Increased number of Advance Directives that are registered
Have a SA screener in screening centers: measure reduction in inappropriate admissions.
Organize the SHOUT (Self Help Outcome Utilization Tracking according to Domains of Wellness.
Define outcomes for family, consumer and state.

Develop timelines for:
Access
Drop-out
Length of stay
Decrease in hospitalization
Decreased wait times
Increased access to care
Financial accessibility
Readmission
Reduction of SA
Reduction of relapse (SA and MI)
Reduce use of ER
Wait for services
Are you keeping people in treatment long enough to achieve their goals?
Use the outcomes within the EBPs in use.

CONSUMER

Reduction in tobacco use, increase in NRT and Quitline use.
Decrease in Boarding Homes, Increase in Supportive Housing.
Examine data on readmissions.
Increase of meaningful employment for consumers
Measure outcomes common to all EBPs:

- Minimized meds
- Increase in discharge form Partial Care
- Med adherence/compliance
- "Feeling better"
- Reduction in medical illnesses
- Abstinence
- Spirituality

When service is needed there is *choice,* it's in a timely manner, consumers feel understood.
Measure self-worth and self-esteem.
Reduction in being treated "like babies."
Increase in coming for appointments
Taking meds appropriately.
Reduction in violence
Reduced recidivism.
URIMS data decrease.
Perception of self impact
Increased efficacy – 1
Increase use of Supportive Housing and decrease the use of Boarding Homes - 2
Increase the number of trauma informed clinicians in the community – 1
Focus on young adults/adolescents (early intervention) – 2
Decrease use of ERs statewide - 2
Reduction in tobacco use, increase in NRT and Quitline use - 3