

Service Area Authorities Summit
Bozeman, MT
July 20, 2007

Opening and Introductions:

In attendance: Vernon Bishop, Martha Bottleson, Dan Aune, Molly Protheroe, Mike McLaughlin, Jacob Wagner, Tom Peluso, Tom Bartlett, Royalee Bishop, Charles Baker, Alexis Volkerts, Alice Hougardy, Bob Ross, Joan Daly, Senator Pease, Dee Holly, Bill Hodges

AMDD Staff: Joyce DeCunzo, Dennis Cox, MJ Fox, Antonia Klein, Jane Wilson, Cheryl Nystrom, Dan Ladd

Guests: Barb Mueske, Dennis Alexander, Tracy Velasquez,

Operationalize Collaboration-

Joyce DeCunzo led the discussion, beginning with the statutory mandate for collaboration between the SAA's and AMDD. Since the current contract is verbal, it can, and has changed over time. AMDD would like to discuss formalizing this.

The group discussed what collaboration means to each individual and the group, leading to how we can achieve it together. Joyce stated that it is important that each person has an opportunity to participate in the discussion. The group needs to assure that each person has the opportunity to briefly speak and we need to get a lot of ideas, then come to some agreement about the information given.

Assignment: Each person will take 2 cards, and after the leading statement, each person will write in 3 to 5 answers, then we will post the ideas as a group. As ideas are brought out, there will be agreements between individuals and these solutions should float to the top.

The question-

We Can Achieve Collaboration by...?

All answers-

1. Viewing it as a Biblical marriage-AMDD & SAAs as parents-Mental Health System as the children.
2. Develop SPECIFIC goals to move from the Medical model to the Recovery model that include integration of housing and employment. (2)
3. Acknowledge that we are all human and make mistakes. We each see things through our own eyes.
4. Ongoing open communication between AMDD and the SAAs. (6)
5. Working to include all participants in the process. Dialogue comes from the word dialectic- the process of change. (1)
6. Change will come with true listening and true sharing and respect.
7. Designating priorities. (4)

8. Being consistently present at the table.
9. Understanding and agreeing on Outcome measures of performance. (9)
10. Trust and Honesty. (5)
11. A commitment to transparent communication,
12. Active listening from all sides.
13. Choose the same process or plan to implement our goals.
14. Seeking diversity with substance.
15. By finding ways that AMDD can show it's commitment to the SAA process. (1)
16. By SAAs working with the LACs to identify community needs.
17. Having a clear process of joint decision-making. (7)
18. Including more young people in the collaboration process. (1)
19. Working together with designated joint workgroups to assure SAAs and AMDD are kept up on who's doing what, so that we can plan for the best use of funds. (2)
20. SAAs and AMDD work as a team to identify needs, develop plans, prioritize services, allocate resources, and measure outcomes. (15)
21. Making sure that all participants feel equal and not like a token person. (2)
22. Ensuring all collaborators have the necessary resources to fulfill their obligations. (3)
23. Being willing to set aside corporate goals for the larger process and vision. (6)
24. Remembering that the process is as important as the results.
25. Trusting the process and assuming good intent in the face of differing views. (4)
26. Solution based instead of problem based. (3)
27. SAA ideas and recommendations will be SERIOUSLY considered by AMDD. (3)
28. Agree to a model of conflict resolution that ensures respect and safety for all. (2)
29. Accepting compromise when necessary, celebrating incremental successes, steps, and changes, supporting each other in our disappointments. (2)
30. Collaboration acknowledging and accentuating culture and personal experience. (1)
31. Understanding the limitations of each group and participants.
32. By using good business practices.
33. Complete inclusion of all stakeholders when possible with AMDD. (5)
34. Agreeing on HOW to address the limitations of the partners.
35. Make the process more efficient for all the people involved. Less Red Tape.
36. Focus on strengths not just weaknesses.
37. Keep our commitments to each other. (in a timely manner) (1)
38. SAAs will comply with all requests for information and input from AMDD and vice versa. (7)
39. (&44) Recognizing and respecting limitations that may come from internal policies. (1)
40. Honesty goes with trust. (1)
41. Its WE not us vs. them. (2)
42. Continue bi-weekly phone calls with SAA Chairs and AMDD.
43. By producing joint written documents and communications.
44. &(39) Share limitations (internal or policy) so that others may understand them and not personalize them. (1)
45. Clarity around decision-making process (deleted)
46. Having clear and agreed upon procedures for collaboration. (5)
47. A real implementation of social contracts.

48. Sharing the credit.
49. All of our conversations begin with the premise that the purpose is to serve the communities and people. (6)

RESULTS- highest priority voted on by group-

1. SAAs and AMDD work as a team to identify needs, develop plans, prioritize services, allocate resources, and measure outcomes. (15)
2. Understanding and agreeing on Outcome measures of performance.(9)
3. Having a clear process of joint decision-making. (7)
4. SAAs will comply with all requests for information and input from AMDD and vice versa. (7)
5. Ongoing open communication between AMDD and the SAAs. (6)
6. All of our conversations begin with the premise that the purpose is to serve the communities and people. (6)
7. Being willing to set aside corporate goals for the larger process and vision. (6)
8. Having clear and agreed upon procedures for collaboration. (5)
9. Trust and Honesty. (5)
10. Complete inclusion of all stakeholders when possible with AMDD. (5)
11. Designating priorities. (4)
12. Trusting the process and assuming good intent in the face of differing views. (4)
13. Ensuring all collaborators have the necessary resources to fulfill their obligations. (3)
14. Solution based instead of problem based. (3)
15. SAA ideas and recommendations will be SERIOUSLY considered by AMDD. (3)
16. Develop SPECIFIC goals to move from the Medical model to the Recovery model that include integration of housing and employment. (2)
17. Working together with designated joint workgroups to assure SAAs and AMDD are kept up on who's doing what, so that we can plan for the best use of funds. (2)
18. Making sure that all participants feel equal and not like a token person. (2)
19. Agree to a model of conflict resolution that ensures respect and safety for all. (2)
20. Accepting compromise when necessary, celebrating incremental successes, steps, and changes, supporting each other in our disappointments. (2)
21. Its WE not us vs. them.(2)
22. Working to include all participants in the process. Dialogue comes from the word dialectic- the process of change. (1)
23. Including more young people in the collaboration process. (1)

24. By finding ways that AMDD can show it's commitment to the SAA process. (1)
25. Collaboration acknowledging and accentuating culture and personal experience. (1)
26. Keep our commitments to each other. (in a timely manner) (1)
27. Recognizing and respecting limitations that may come from internal policies. (1)
28. Honesty goes with trust. (1)
29. Share limitations (internal or policy) so that others may understand them and not personalize them. (1)

Current and Long Term Planning:

Joyce DeCunzo, AMDD Update: Copy of Budget Narrative is attached, Addendum # 3, and a hard copy was handed out during meeting, and is available on department website:

Highlights. http://leg.mt.gov/content/publications/fiscal/fr_2009/fr_b/program_33.pdf

Projects and workgroups to be created:

- RFP's are being developed for drop in centers- and recovery grant
- Community Liaison Officer- job descriptions are being created.
- BHIF's; 72 hour workgroup; MHSP workgroup; Suicide prevention workgroup.
 - Each work groups role will be sorting out the most efficient way to receive input and implement it quickly. AMDD is asking each of the SAA's to talk with individuals who might have interest in one of these topics and would have the trust of SAA's to work with AMDD.

Chemical Dependency Programs- New monies will be used to expand residential services beyond what is available at MCDC. The treatment of meth takes longer than the treatment of other addictions. All new facilities will be co-occurring capable. Individual can get both mental health and chemical addiction treatment in same setting.

Question and answer discussion around budget. Narrative attached: **Addendum # 3;**

SAA Representatives to current LTP Committees: See Addendum #1 for list of names;

This group needs to elect a chairman of the committee. AMDD will appoint a field staff as the point person to get first meeting together and will have this emailed to persons on the current list, including Martha Bottleson.. Dan will have identified a field staff by Tuesday (MJ Fox). MJ will suggest 3 or 4 dates that which would be acceptable. This group will be scheduling phone conferences and face to face committee meetings before each Summit. Perhaps the evening before the next summit over dinner and then present their work at the Summit. **They will have a draft plan to present by January summit.**

Tom Bartlett- presented written recommendations to AMDD and Summit members. See Addendum #2

Next Summit will be on October 19, 2007 (this is being changed, new future date will be sent out ASAP). 10-3 pm. We will again be meeting in Bozeman, hosted by the Eastern SAA.

January Summit is scheduled for January 17th, 2008 Thursday. Minkoff and Cline possibly. Emphasis on co-occurring. Dinner on Wednesday, LRP-Wednesday afternoon.

Adjourn 3:00 pm.

Addendum #1-provided by Charles Baker:

Montana SAAs Long Range Action Planning Committee

Where are the SAAs going and how are we going to get there?

Eastern Service Area Authority LRAPC Members				
<u>Name</u>	<u>SAA Office</u>	<u>Email</u>	<u>Phone</u>	<u>Town</u>
Alice Hougardy	ESAA Chair	alicehougardy80@hotmail.com		
Bill Hodges		bhodges@co.bighorn.mt.us		
Dee Holley		pholley@mcn.net		
Central Service Area Authority LRAPC Members				
Joe Moll		mircale2@msn.com	452-4582	
Kathleen Hartman		kompi@mtintouch.net	759-5788	
Vernon Bishop		vernonbishop@bresnan.net		
Tom Peluso		tompeluso@msn.com	585-8959	Bozeman
Lenore Stiffarm		lstifarm@ttc-cmc.net	673-3566	
Western Service Area Authority LRAPC Members				
Charles Baker (point		charles@wsaamt.org		Hamilton

person for WSAA)				
Alexis Volkerts		alexisv@mtadv.org		Missoula
Marty Onishuk		monishuk@aol.com		Missoula
Jennifer Robohm		Jennifer.robohm@umontana.edu		Missoula
Patrick Wayne				
Kay Jennings		kayjennings@qwest.net		Missoula

Previous Planning Documents:

- TAC report
- Whitefish report
- President's New Freedom Commission report
- Surgeon General's report
- NAMI grading the states
- MMHA report
- MAP
- Montana Olmstead draft report
- Interim Committees reports
- MHOAC reports

Which of these documents should be used by the LRAPC?

To Do:

Organization of Committee:

Should there be an equal number of members from each SAA?

Should each member have one vote or should each SAA two designated delegates (similar to SAA Summits)?

Should there be a designated chairman for this committee or should the chair rotate among the SAAs?

Should there be a designated secretary for this committee?

Should this committee get a budget from the SAAs for support and development?

Representation of Other Mental Health Organizations on this committee:

Should the LRAPC invite other organizations in Montana (especially the following: MHOAC, SOC/KMAs, AMDD, CMHCs, Legislature, NAMI-MT, MMHA, CALM4Us, MAP) to have designated members on this committee?

Would this tend to make the committee unwieldy?

Would this keep this process transparent?

Would this help stakeholder by-in?

Are there any other organizations that could be on this committee?

Proposed Long-Term Agenda:

Foundational

Agree on the following:

Number and scope of the reports

Timeline for the reports
Preliminary Definition of "Recovery" in Montana using Federal Consensus Statement
Preliminary Quality of Life and Quality of Service indicators to measure system Transformation
Formal, informal or no representation from stakeholder groups

First report (by January 2007):

broad strokes of 2-year, 4-year, 6-year, 8-year and 10-year goals.

Also agreement on which of the previous reports or parts of reports are "foundational" or "canonical."

Second report(s) (by June 2008):

Montana consensus on "Recovery"

Process of integration of substance abuse treatment into SAA oversight

Process of integration of children's mental health into SAA oversight with SOC/KMAs

Road-map for developing community services survey, planning, development, oversight (shared with SAAs and AMDD)

Road-map for developing institutional services survey, planning development, oversight
(shared with SAAs and AMDD when appropriate)

Third report (by November 2008):

Agree on Legislative agenda for 2009 session

CSB--I see the LRAPC being the Joint SAA Legislative Committee while the state legislature is in session

Fourth report (by June 2009):

Planning for 2009-2010 cycle

Addendum #2- written feedback presented from Tom Bartlett:

Mental Health Funding Recommendations

By Tom Bartlett

Priority One: Make access to and reporting of services rendered as simple and efficient as possible. Eliminate every bit of bureaucracy as possible. Bureaucracy in its self is inefficient and restricts productive results.

Adult Mental Health Care Worker Increase: \$716,675 per year of biennium

Identify how many workers currently qualify for the increase in wages to \$8.50 per hour. Calculate how much of the allocation will be used by this group and retain an additional 5% of these funds for new hires that would fit in to this bracket. From there apply 95% of the remaining funds to mental health care workers above this pay grade across the board. The 5% of this amount not applied initially would be available for new hires in this group.

Behavioral Health Inpatient Facilities: \$3,000,000 in Fiscal 2009

I don't think we should concern ourselves with planning for this program at this time. Let's focus on the most immediate programs that need planning for now.

Mental Health Drop In Centers: \$371,647 per year of biennium

With "The Hub" in Billings receiving \$50,000 per year that leaves \$321,647 for other communities in the state. One possibility might be to fund each of the other major communities – Bozeman, Helena, Great Falls, Missoula, Butte and Kalispell received \$40,000 per year (\$240,000) that would leave \$81,647 to be allocated to smaller communities. Obviously this would leave some towns without or it would be spread too thin to be effective. All of this would be dependent on some entity providing a facility.

Suicide Prevention: \$400,000 per year of biennium (adults and children)

I believe a major priority should be that a statewide phone number, definitely a 3 digit number if possible be selected and listed on the first page of every telephone book of the state. This special response number should be manned at one location by at least three experience mental health professionals 24 hours a day. If someone calls they should never find themselves being put on hold.

Services for Mentally Ill Offenders: \$371,647 per year of biennium

Refer to restrictions of HB 2(2007SS). Allocate 60% of funding to provide treatment services to this population at Medicaid rates, (at MHSP rates at a minimum). The other 40% could then be allocated to the appropriate training programs of correctional officers, etc.

Expand Mental Health Service Plan: \$2,601,531 per year of biennium

Obtain realistic numbers from providers on the individuals that meet qualifications for MHSP but are being turned away from services for lack of funding. Trust them they know more than your projections tell you. Then add 50% to that number as a projection of the number of additional cases that will present themselves in fiscal 2008. Remember we have a growing population. Also, there will be new veterans returning from Iraq and Afghanistan with mental illness problems that the V.A. does not want to accept responsibility for.

Don't hold back funding on a month by month or quarter by quarter basis. The individuals approved for treatment now will reduce costs later when they could decompensate into a crisis situation.

AMDD will be centralizing authorization for MHSP client intake approvals, and it is vitally important that this centralization in Helena make the process quick and efficient. The lives and health of these individuals depend on you to get it done as fast as humanly possible.

Electronic communications for intake approvals will be the most efficient method. If they work extremely well for the Sheriff's Department in Missoula without privacy infringements, they ought to work for AMDD. Call Sheriff Mike McMeekin if you like at 406-258-3305.

Provider Rate Increase: \$1,200,000 in year one, \$2,500,000 in year two

The realities are as I understand it that these funds can only be applied to Medicaid services. I would like to see these rates structured so that providers of services like MHSP, case management, PACT, crisis response teams and other services receive higher reimbursements on Medicaid services to assist them in covering these other services.

My personal preference would be that 90% of this increase should go to the mental health centers and split based on the population area they serve. Being on the Board of Visitors has made me painfully aware of how grossly underpaid staff positions are in our mental health field. Staff turn over is immense which effects the quality of service to clients. How can we not care about these dedicated people? Plus, the fact is that these organizations are serving the vast majority of clients falling under the AMDD umbrella of coverage.

Prescriptions for Mentally Ill Offenders: \$950,000 in year one

Individuals in this group should be able to acquire their prescriptions from pharmacies at the same co-pay rate as the MHSP prescription plan. In addition they should be encouraged to have their psychiatrist sign them up on pharmaceutical companies free medication programs when possible.

72 Hour Crisis Care: \$2,000,000 per year

I've heard it mentioned that you plan on having a single person responsible for contacting all of the hospitals, community mental health centers and jails in Montana to explain this new program. This is very unrealistic and most likely to be ineffective. Having been in the hospital supply business for 11 years I know how difficult it can be to coordinate meetings just with hospital administrators and/or emergency room supervisors.

I would recommend putting together a brief professionally done brochure, mailed out at least twice to each hospital administrator and emergency room supervisor, mental health centers and jails explaining as clearly as possible how the program will work. With emphasis on ease of psychiatric Telemed support and rapid reimbursement for services provided. **Without an understanding of these two features this program will never function as intended.** There should be a contact number in BOLD FONT where they can get more specific information. They need to know why they should involve themselves in this program.

This is another area where electronic communication for admissions will be extremely important. From what Charles Baker tells me the software system used by the State is extremely secure with regard to privacy issues.

Meth Treatment: \$2,000,000 per year

I would hope that there would be a more cooperative effort both ways between mental health centers and chemical dependency clinics. From what I've seen there still seems to be a lack of trust between these providers.

How the money should be spent in this category I'm not qualified to answer.

MHSP Prescriptions: \$6,300,000 in year one

If it's possible I would suggest holding back at least half of this amount for year two. There will very probably be more individuals enrolled in MHSP in 2009.

Community Liaison Officers: \$129,522 in year one, \$145,000 in year two

With six major communities in Montana and all the surrounding areas I find it hard to believe that five CLOs can handle the workload on a half time basis. I would suggest that one of the CLOs cover both Butte and Helena since they are the two urban areas closest together, but that's going to be extremely difficult. However, neither of these two cities has a psychiatric facility and is more likely to have a higher number of MSH discharges.

There will be a considerable amount of commuting time involved to see that those discharged from MSH have access to community services. And, this will not be a one time contact and you're done. Possibly the program can build in an allowance for overtime pay so that these people don't get burnt out and discouraged. AMDD should provide them with every tool necessary, including computers to assist them in helping individuals leaving MSH.

Service Area Authorities: \$115,000 per year

I suggest the following distribution for each SAA to be divided up into three equal payments – January 1, June 30, and July 1 of each year.

Eastern SAA: \$49,000

Central SAA: \$33,000

Western SAA: \$33,000

Each year the SAAs shall provide an annual budget to AMDD upon a date requested by AMDD and an annual report of actual expenditures.

Addendum #3; AMDD Budget Narrative

ADDICTIVE & MENTAL DISORDERS DIVISION

- Behavioral Health Program Facilitator
New full-time position to work on service provision to mentally ill or addicted offenders. AMDD and the Department of Corrections will share the position, with AMDD providing the FTE and DOC the funding. The purpose of the position is to coordinate treatment approaches between the agencies.
 - Budget impact: **\$158,968 for the biennium**
 - **Staffing:** 1 modified FTE

- **Meth & Chemical Dependency Expansion**
Implementation of five community and two reservation residential facilities for treatment of people with addictions. The community-based programs will provide residential treatment and supportive living services to eight adults per facility, with an average length of stay of 6-9 months. Each facility would serve 10-12 individuals annually.
 - **Budget impact:** \$4 million for the biennium
 - **Staffing: 1 new FTE to monitor and assist with management and train providers**

- Strategic Prevention Framework State Incentive Grant
Provides federal appropriation authority for the prevention grant awarded July 1, 2005. The federal funding is vital to Montana in achieving infrastructure and capacity for prevention by expanding knowledge, skills and abilities of both state and community prevention personnel.
 - **Budget impact:** \$4,664,000 for the biennium
 - **Staffing:** 2 modified FTE

- 72-hour SDMI for Hospitals & Statewide Support
Provides funding for up to 72 hours of crisis stabilization care for adults with severe disabling mental illness who are uninsured. Care can be provided in a community or hospital setting based upon the individual's needs. Also will provide funding for contracted televideo services to implement a system of psychiatric support for community hospital emergency rooms, jails, nursing homes, and other existing community sites where individuals commonly present during a psychiatric emergency. The goal of this initiative is to provide short-term stabilization close to the individual's home, family, and community supports as an alternative to transport and stabilization at the Montana State Hospital.
 - Budget impact: **\$4,065,540 for the biennium**

- **Mental Health Community Services Development**
Provides for five half-time positions in community settings to mentor current and recently discharged patients, assure that they get to referred services, and provide help in accessing needed services and resources in the community. The goal is to provide community support for patients discharged from Montana State Hospital in meeting the recommendations of the hospital discharge plan and re-integrating into the community

- **Budget impact:** \$274,522 for the biennium
- **Staffing:** 2.5 FTE (5 half-time positions)
- **Additional Home & Community-Based Waiver Slots**
This proposal provides for 20 additional slots to the HCBS Waiver for Individuals with SDMI. The slots are targeted for individuals who are currently served under the SLTC Waiver for the elderly and physically disabled who can be more appropriately served with services for individuals with serious mental illness.
 - **Budget impact:** \$1, 606,000 for the biennium
- **Provider Rate Increases**
Rate increases to providers serving Medicaid and non-Medicaid eligible recipients. The anticipated amount of the increase is an additional 2.5% above current rates each year.
 - **Budget impact:** \$3,800,613 for the biennium
- **Direct-Care Worker Wage Increase**
Additional funds to AMDD to raise wages and related benefits for direct-care workers.
 - **Budget impact:** \$1,433,350 for the biennium
- **Behavioral Health Inpatient Facilities**
One-time-only funding in the second year of the biennium for services provided in a Behavioral Health Inpatient Facility. This is a facility of 16 or fewer beds that provides a secure site for inpatient treatment. It is intended as a community alternative for patients who would otherwise be transported to Montana State Hospital.
 - **Budget impact:** \$3,563,417 in FY2009
- **Mental Health Drop-in Centers**
Partial funding for mental health drop-in centers throughout the state. Drop-in centers provide a safe place for consumers to gather for socialization, as well as an opportunity for peer support services and access to other needed mental health or community services.
 - **Budget impact:** \$743,294 for the biennium
- **Suicide Prevention**
Funding for a comprehensive statewide suicide prevention program, which must include a coordinator, suicide reduction plan, and support for a toll-free 24-hour hotline.
 - **Budget impact:** \$800,000 for the biennium
 - **Staffing:** 1 new FTE
- **Mentally Ill Offender Assistance Program**
Funding for mental health services for adult offenders under the supervision of the community corrections division in the Department of Corrections. The services may include case management, treatment, transition support, and medication monitoring. Funding may also be used to provide training to community probation and parole officers about mental

illness and chemical dependency and about how to help offenders enroll in public benefit programs.

- **Budget impact:** \$743,294 for the biennium

- **Mentally Ill Offender Drugs Program**

Funding for this new program may be used only to provide a prescription benefit for offenders leaving secure care who meet the criteria for serious mental illness and who have not been enrolled in public benefit programs. Benefits may include a 60-day supply of medications and other short-term medication purchases for offenders who become unstable and need medications and who are not eligible for other public prescription drug programs.

- **Budget impact:** \$950,000 for the biennium

- **Mental Health Services Plan**

Additional funding for state-funded mental health services for adults who are not eligible for Medicaid, have incomes under 150% of the federal poverty level, and have been determined to have a severe disabling mental illness. It is expected that the program will transition to a fee-for-service model and that reimbursement will be available to an expanded provider group by the second year of the biennium.

- **Budget impact:** \$5,203,062 for the biennium
- **Staffing:** 3 FTE authorized but not funded to manage benefits provided to enrollees in this program.

- **Service Area Authority Grants**

Segregated funds in the current AMDD budget to allow for increased payments to Service Area Authorities. This did not include a new appropriation.

- **Budget impact:** \$230,000 for the biennium