

Central Service Area Authority Board Meeting

Board of Investments – 2401 Colonial Drive --- Helena

Friday, July 27, 2007 -- 10:00 AM to 3:00 PM

Call to Order, Introductions, Welcome New Members

Chair Tom Peluso called the meeting to order at 10:10 AM. A quorum was present. Board members and visitors introduced themselves.

Board Members Present: Dan Aune, Vernon Bishop, Martha Bottelson, James Gustafson, Mike McLaughlin, Gary Mihelish, Joe Moll, Marlene O'Connell, Tom Peluso, Molly Protheroe, Anita Roessmann, Matthew Stewart, Lenore Stiffarm, Gary Travis, Jacob Wagner, David Young,
Board Members Absent: Kathleen Hartman, John Kultgen, Lee Lembke, Mike Menahan, Dolores Plumage

AMDD: Jane Wilson, Dan Ladd, Dennis Cox

Others Attending: Dennis Alexander, Commonweal Consulting; Jeffry Krott, CSAA Alternate; Tom Lythgoe, Jefferson County Commissioner; Shane J. Jordan

Staff: Ellen Cox, CSAA Recording Secretary

Minutes

Motion: Lenore Stiffarm moved to approve the June 29, 2007, Meeting Minutes as presented. Second by Gary Travis. Approved.

Treasurer's Report -- "Annual Internal Audit Taskforce"—Mike McLaughlin

Mike noted that June ended the fiscal year. He is in the process of clearing up outstanding FY '07 expenses. Tom Peluso suggested a trial internal audit. There is a standing internal audit committee which will be reconvened to do this.

Motion: Lenore Stiffarm moved to accept the Treasurer's Report as presented, subject to audit. Second by Martha Bottelson. Approved.

Prioritize Agenda Items, Including Additions/Deletions—Board Members

Delete

- Chair Tom Peluso suggested reprioritization of items so that action items are addressed before reports. Accordingly, news from local advisory councils was parked.

Discussion

- LACs need to be heard because information from them needs to guide action items addressed by the Board.

Add

- Appointment of a representative to the Mental Health Oversight Advisory Committee (MHOAC)
 - Jeffrey Krott, Lenore Stiffarm, and Jacob Wagner were nominated by email by Board members. Vernon Bishop was nominated but declined. These names will be conveyed to the Governor for consideration.

Work Plan Task Group Reports—Dennis Alexander, Commonweal Consulting

Topics the Board worked on at the June Board Meeting were taken directly from the SAA mission statement. Information gathered at the June Board Meeting was readdressed during July via six separate teleconferences. Several Board members participated in these. All the information gathered from the teleconferences was transcribed and added to the work done at the June Board Meeting (6 handouts). Board Members divided themselves into three work groups to review the work so far, and to create an action plan for the completion of items. The Board regrouped and each workgroup reported back.

Assignment for today:

1) REFINE ideas for action steps—are these things you want to do for next year?

2) ASSIGN-everyone take responsibility for getting these things done.

Do not eliminate and then add other items. If you add something, responsibility to get it done must be assumed. Include: action item, who's responsible to get it done, timeline measurable outcomes.

Discussion

- Where are ESAA and WSAA in similar planning? ESAA is doing similar work; Dennis not sure about WSAA. A lot of planning is going on state-wide. The biggest challenge is getting the three SAAs on the same page, using the same language and taking the same (agreed upon) position.
- All three SAAs should be using same study protocols and dynamics so that info can be meshed.
- SAAs were formed to act together but to also respond to the unique needs of each service area.

Dennis addressed the Overarching Role of a Board of Directors. It is to

- *Guide
- Govern
- Protect
- Accountability (be accountable)

Discussion

- Does CSAA Board have conflict of interest problem? Ninety percent of this Board consists of consumers and family members. There is no conflict of interest because the interests of Board members are consistent with the mission of the Board.
- *Guide: Each Board member has a copy of Roberts Rules of Order in their CSAA Handbook. Board members need to read and adhere to them at meetings. Vice Chair/Parliamentarian Martha Bottelson, in her role as Vice Chair, will act to keep us in adherence.

Work groups reported back to the Board:

Collaborate and Coordinate

- Group members commented that the work group session was helpful because it was quickly apparent that each came to the group with differing assumptions.
- Due to the rural nature of some counties, more than one county will probably want to go together to form an LAC (like Teton/Pondera).
- Two or more established LACs could work together to help get a new LAC up and running.

Define & Develop/Manage & Monitor—Molly Protheroe

- Martha Bottelson spoke briefly about the 10 criteria SAMSHA uses to define recovery. I wrote a recovery workbook based on them.
- There are 10 criteria that SAMHSA uses to define recovery—we need to stay aligned with SAMSHA New Freedom Commission—future large grants may depend on this.

Discussion

- SAAs are legal organizations created by statute. They are unique because the majority of their membership consists of consumers and family members.
- CSAAs must collaborate with AMDD who carries out.
- SAAs collectively make decisions, but they need to provide structure for representatives of the group.
- SAAs need to be aligned with AMDD's process to be effective.
- AMDD knows what the SAAs want: SAAs came together in January during the Legislature with one voice.

- Issues are different now: We need to speak with one voice which comes out of the group process.

Act as Agents/Promote Consumer and Family—James Gustafson

- Montana Mental Health Association (MMHA) has about 8 hrs of video –suggested use of that resource rather than investing in new; also NAMI “In Our Own Voice” available.

Dennis will get results of group meetings written up and sent to Ellen, who will distribute to Board members.

Board Recommendations to AMDD for The Implementation of Plans for the Delivery of Mental Health Services Funded by The 2007 Legislature—Board Members and AMDD

Because of time constraints, Tom suggested we begin with items that were SAA priorities: Seventy two hour Presumptive Eligibility (72 HPE), Behavioral Health Inpatient Facilities (BHIF), Mental Health Service Plan (MHSP), Drop-in Centers.

Dan Ladd indicated that AMDD is nearest decision points on the following items: MHSP, 72 HPE, mental health community service development, home and community based service waivers, and mental health drop-in centers.

MHSP

Lou Thompson and Joyce DeCunzo have been talking with the Mental Health Centers (MHCs). MHSP fee-for-service could be up and running by January 2008. A task force is being planned, to include stakeholders—SAAs, MHCs, and others. The concept is to phase in physicians, Federally Qualified Health Centers (FQHCs--link to information about FQHCs: <http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf>) and all providers next July (start of FY 2009). There is a need to keep providers in place. The 2007 Legislature mandated a move to fee-for-service in the second year of the biennium. The first year, 2008, will be status quo.

The base budget for MHSP is approximately \$5 million. The bump given by the Legislature was \$2.6 million but that is now diminished by \$1.4 million which will cover costs of psychiatrists, community clinics, rural clinics, lab and x-ray, general practitioners, staffing related to eligibility, and IT. The actual increase available for services will be \$1.2 million.

MHCs currently provide about double in services than what they get paid. MHSP funds are finite, so there is a need to distribute compassionately and by priority. It has been recommended that eligibility be expanded to cover suicidal ideation, PTSD, and anxiety disorders in addition to what is currently covered.

There is still a need for monitoring of people who are emergent in their recovery. It was suggested that when the transition to fee-for-service is made, everyone has a treatment plan that is monitored.

MHSP-Funding Use Recommendations from Dan Aune was handed out.

Discussion

- The uninsured and vulnerable are the people being served by MHSP.

Motion by Anita Roessmann: The Central Service Area Authority (CSAA) recommends initiation of a structured acuity system to identify and manage points of access to the Mental Health Service Plan (MHSP). Determination of acuity must be made within 24 hours so that the level of service to people, who are regularly on and off Medicaid, is maintained. Second by Vernon Bishop. Approved.

- This is a complex issue. Increased complexity = increased cost. The Legislature says 5000 people/month must be provided for.

- Currently, MHCs are getting paid about half of the Medicaid rate.
- Up until now, MHSP has been identical to Medicaid system (medical model). Medicaid does not allow for acuity levels.
- CSAA is proposing that consumers and providers work together to decide on what level of acuity a person has. The current system says the physician is responsible for the patient. When patients make more decisions, physicians are put on a completely different position.
- If MHSP does move to 3 levels, another level of administrative complexity is added.
- It will be necessary to have a quick turn around in determination of acuity level, or a person may be in MSH before the case is even seen.
- Concern that government can't do as well as CMHCs.
- Services in rural areas are more costly than in urban areas.
- Triage has been done around services and will continue under an acuity system.
- Each Mental Health Center gets a pot of money to administer and all do it in a different way. As of July 1, 2008, MHCs will no longer get a pot of money. Instead, people will come to MHCs with MHSP card and will be told that they need to choose the services they will receive.

Discussion of Fee for Service

- Treatment plans are required by statute.
- Consumers are often unaware that they have a treatment plan.
- "I don't remember being at a meeting where a treatment plan was written" (several people concurred).
- Treatment plans are used to control a client's activity and are not helpful to recovery.

Motion by Tom Peluso: *Every Mental Health Service Plan (MHSP) participant must have a treatment plan which is to be written by the treatment team in consultation with the consumer.*
Seconded and approved.

Discussion of Treatment Plan/Recovery Plan

- There is no definition of *recovery plan*.
- *Treatment plan*—does not necessarily contain a recovery aspect.
- WRAP plans are defined.
- *Treatment plans* don't have any meaning for consumer's daily life—actually, to preserve financial support for the consumer, don't want to show recovery in treatment notes.
- *Treatment plans* are for the people who do the business part of mental health care.
- Recovery marker system (is the person getting better?) is much more valuable than *treatment plan*.
- Model is out there: Illness Management and Recovery is a best practice model. Would be great if this was instituted at the same time as fee for recovery. A link to it is: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/>

72 HPE

- This issue has precedent; it was practiced by managed care.
- The idea is that people who present in crisis need to have an asset in community to help them stabilize the crisis.
- AMDD initiated this.
- Compensation scheme: 1st day \$600, 2nd \$300 3rd day \$200.
- If person has private insurance, Medicaid, or personal assets, 72 HPE would not be charged. It would only serve people in crisis who don't have assets to pay for service.
- At this time, a person has to have SDMI for 72 HPE.

Motion by Mike McLaughlin: The Central Service Area Authority (CSAA) recommends AMDD put \$60,000 towards each Crisis Response Team (CRT) in the state and encourage others to get started by offering \$90,000 for the first year for start-up funds for communities where a CRT is needed. The CSAA recommends that AMDD use 72 Hour Presumptive Eligibility (HPE)

funding to support CRTs and crisis stabilization, to begin immediately. Second by Martha Bottelson. Approved.

BHIFs

- BHIFs are secure facilities for voluntary and court appointed patients.
- Bozeman has land for a BHIF and an architect (John McKittrik); codes and rules for construction are needed.
- Facility could be completed in 10 months.
- The problem is that available money is only for services, not for building.
- The longer building waits, the more likely the funding will become unavailable.

Motion by Lenore Stiffarm: The Central Service Area Authority (CSAA) requests AMDD create the rules necessary to begin building a Behavioral Health Inpatient Facility (BHIF) within 45 days. Second by Joe Moll. Approved.

Discussion of BHIFs

- Possibility: Say to hospitals: If you create new beds, would you create 9 BHIF beds? Hospitals could collect the one time only money. The advantage of this would be that there would be outcomes to show the legislature.

More Discussion

- There is not enough money allotted to 72 HPE to fund crisis stabilization.
- WSAA recommendation: MHC takes on stabilization after person presents at hospital. \$1100/2days—community collaboration.
- Lewis and Clark Co CRT goes to hospital at this time to intervene.
- Highest hospital costs are emergency situations.
- Important for people to get a physical evaluation -- initial visit to ER is good for that.
- Don't forget about outcomes and measurement of outcomes—this is the info AMDD has to take to the legislature.
- We need to remember peer crisis models.

Miscellaneous

Chairman Peluso reminded the Board that when he calls for agenda items, he needs input.

Discussion

- Suggested that when SAA chairs meet bimonthly by phone, they need to set up collaborative agenda that reflects the decision points of AMDD.

Next CSAA Meeting agenda: 2 hours for AMDD issues.

Agenda Items Not Addressed at This Meeting

- Network of Care, and Recovery From the View of Consumers and Family Members—Gary Mihelish
- SAA Summit Meeting Report—Vernon, Martha, Mike, Tom, Jacob
- LAC reports—Various

Meeting Was Adjourned at 3:35 PM

Next CSAA Board Meeting is August 24, 2007, at the Board of Investments Meeting Room, 10 AM to 3 PM.