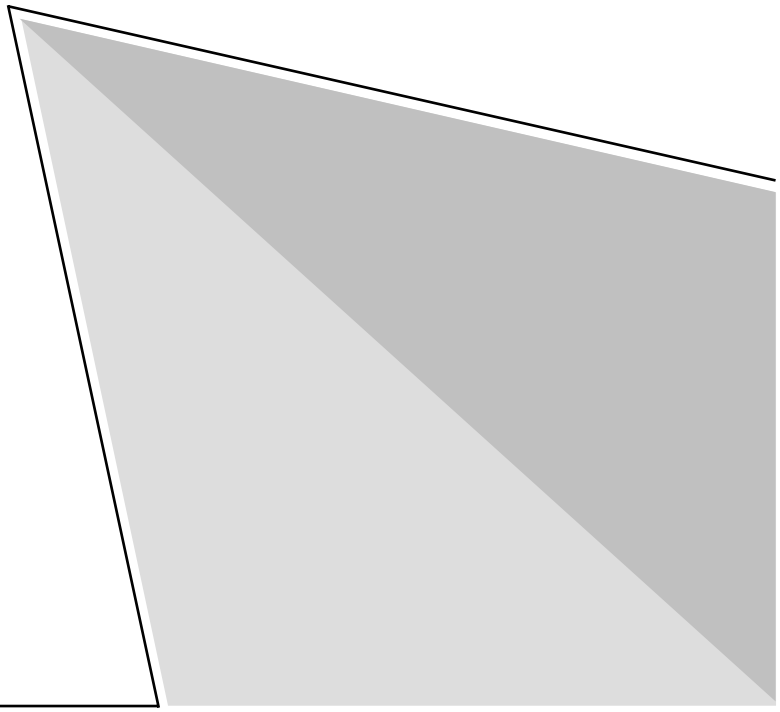
Fee-for-Service Advisory Structure

Illinois Department of Human Services

Division of Mental Health

June 25, 2005

~FINAL~



PARKER DENNISON & Associates, Ltd.

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EXECUTIVE SUMMARY

As part of the Memorandum of Understanding (MOU) defined role of the 'expert consultant', Parker Dennison & Associates, Ltd. (Parker Dennison) evaluated the pilot test phase of the fee-for-service conversion, summarizing impressions and recommendations in a report dated March 24, 2005. One aspect of this evaluation was the efficacy of the stakeholder input and advisory process for the fee-for-service transition.

Parker Dennison recommended that the advisory vehicle (which became known as the System Restructuring Initiative Group – SRI) be revised to avoid duplication by better integration with existing advisory structures, clarify its role, and modify membership to balance provider input through expanding consumer and other system stakeholder representation. As a preliminary option, it was suggested that the Illinois Mental Health Planning and Advisory Council (the Planning and Advisory Council) could be a suitable vehicle for longer term input since it appeared to have the representation and scope of work inclusive of the fee-for-service needs. DMH requested that Parker Dennison further research this option and recommend an appropriate body and operating process.

After receiving input from a combined total of twenty-six Planning and Advisory Council and SRI members, as well as review of by-laws and other documents, Parker Dennison concluded that the Planning and Advisory Council was not prepared to undertake the additional responsibility of the fee-for-service and related transition issues at this time. While the long term goal of integration is recommended, the immediacy of the needs and the issue learning curve supported the need to create a new body, referenced as the Collaborative Transitions Committee (CTC). This report details the structure, membership, communication, and leadership of this new body, and outlines an approach to move toward the long term plan of integration with the Planning and Advisory Council.

INTRODUCTION

Pursuant to the implementation of the mental health fee-for-service conversion, a Memorandum of Understanding (MOU) was executed July 2, 2004 by relevant House and Senate Legislative Committee Leadership, the Governor's Office of Management and Budget, and the Department of Human Services. In part, this MOU required that *"a steering group of the stakeholders in the conversion to fee-for-service payment methodology will be developed to represent the interests of the larger stakeholder group while facilitating timely discussion and decisions on matters requiring immediate resolution."* As part of the MOU defined role of the 'expert consultant', Parker Dennison & Associates, Ltd. (Parker Dennison) evaluated the pilot test phase of the fee-for-service conversion, summarizing impressions and recommendations in a report dated March 24, 2005.

One aspect of the pilot test evaluation conducted by Parker Dennison was a review of the efficacy of the steering group which had become known as the System Restructuring Initiative Group (SRI). In the final report, Parker Dennison recommended that, *"the SRI structure be revised to clarify its role as advisory through integration with existing advisory groups, that the group become responsible for a wider range of mental health issues, and that its membership better reflect consumer and community voice."*

In order to ensure that the spirit of the original MOU was upheld and appropriate stakeholder input and advisory processes maintained, the Illinois Department of Human Services (DHS) and Division of Mental Health (DMH) requested that Parker Dennison prepare specific recommendations regarding an appropriate, ongoing mental health fee-for-service stakeholder advisory vehicle.

At the time the Field Test Evaluation Report was drafted, Parker Dennison briefly reviewed a description of the Illinois Mental Health Planning and Advisory Council (the Planning and Advisory Council) and suggested that this body might be an appropriate home for the fee-for-service stakeholder process. This report is a summary of the review of the Planning and Advisory Council to determine the viability of that recommendation, and makes more detailed recommendations regarding an ongoing mental health fee-for-service stakeholder advisory process consistent with the Evaluation Report recommendations.

METHOD

Over a period of three weeks, consultants Rusty Dennison and Susan Parker of Parker Dennison and Steve Day, Executive Director of the Technical Assistance Collaborative (TAC) reviewed a number of advance information documents and conducted a series of telephone interviews with key stakeholders. Documents reviewed included the MOU, the Field Test Evaluation Report, and the by-laws of the Planning and Advisory Council. Eleven hours of telephone interviews were conducted with 26 stakeholders including representatives from the Planning and Advisory Council, SRI, and DMH. Stakeholders included consumers, family members, advocates, providers, provider trade associations, and state staff. Below is a detailed list of interviewed stakeholders and their advisory structure affiliation (*indicates dual Advisory Council/SRI membership):

Mental Health Planning and Advisory Council

Linda Denson*
Mary Stecher
Mark Heyrman
Frank Ware*
Tonya Hoemke
Syd Weissman
Diana Knaebe
Dave Schanding
Chuck Johnson
Fred Friedman
Cheryl Boyd
Nonna Mannf
Linda Virgil

System Restructuring Initiative Group

Orville Mercer
Freddie Garnett
Brian Allen
Carole Craddock
Heather Eagleton
Marylynn Clarke
Lora Thomas

Division of Mental Health

Pat Hanrahan
Mary Smith
Dan Luchins
Fred Nirde
Bob Vyverburg
Chris Power
Lorrie Stone
Nanette Larson

Preliminary recommendations were then reviewed against MOU requirements and reviewed with DMH leadership.

DISCUSSION

At the time the Field Test Evaluation Report was drafted, Parker Dennison briefly reviewed a description of the Illinois Mental Health Planning and Advisory Council (the Planning and Advisory Council) and suggested that this body might be an appropriate home for the fee-for-service stakeholder process. A review of federal guidance and the Planning and Advisory Council's by-laws supported that it appeared to accomplish the recommendations made in the Field Test Evaluation Report including:

- At least 51% of the membership is comprised of consumers and their families;
- Regional representation including from regional planning advisory councils is included;
- More community agencies and state departments are represented; and
- Their scope as defined by federal Block Grant requirements includes a comprehensive view of mental health needs regardless of funding.

Given the substantial cost of time and resources to plan and participate in an advisory process, and with a core value of minimizing duplication, it seemed appropriate to recommend that the functions in the fee-for-service SRI be incorporated as a committee of the state-wide Council.

However, feedback from the 26 Council and SRI members interviewed was reasonably consistent in conveying that though the fit of the SRI functions with the Planning and Advisory Council was appropriate as a longer term vision, the Planning and Advisory Council was not prepared to undertake the immediacy and intensity of the fee-for-service advisory process.

Council Member Feedback

Central to understanding the feedback is an appreciation that the Planning and Advisory Council has had a long history, with each Director of DMH influencing the mission, functions, and ultimately the results of the Planning and Advisory Council based on his/her vision, priorities, and level of involvement. This has resulted in a track record of uneven value and impact of the Planning and Advisory Council and has contributed to Council member frustration, questioning of investment, and periodic lack of operational rigor. By member report, the Planning and Advisory Council has been in a period of lack of direction, inconsistent liaison and support from DMH, and membership flux for some time. In the past, the Planning and Advisory Council has also made efforts to obtain greater independence from DMH which has further compounded the issue of DMH support and guidance of the Planning and Advisory Council's activities. It is also apparent that there have been and continues to be many Council members with deep investment and commitment to the beneficiaries of the Illinois mental health system.

Interviews with Council members consistently conveyed the message that though they would like to have involvement in meaningful issues impacting the mental health system, there were several pre-requisites:

- The new Director of DMH must assert his/her investment in the mission of the Planning and Advisory Council and commit resources commiserate with that investment.
- DMH will need to invest time and resources in improving relations, communication, and meaningful involvement with the Planning and Advisory

Council. Central to this task is the need for DMH to designate a consistent staff liaison to the Planning and Advisory Council.

- The Planning and Advisory Council is in need of coaching and support to improve focus, operational functioning, and impact.
- Various leadership and membership issues should be resolved and stabilized including:
  - Roles and functions of DMH, the Planning and Advisory Council, Council Chairs and members should be reviewed and re-ratified to solidify focus,
  - The Planning and Advisory Council has a pending issue of needing to appoint a new co-chair.
  - The Planning and Advisory Council has added new consumer members in the past months but they have reportedly not been sworn in, oriented or trained.
  - Determining how implementation of DHS regional boundaries may affect regional representation/membership on the Planning and Advisory Council.
  - Council sub-committees should have better defined roles, products and more frequent meeting schedules.
- There is a steep learning curve to become conversant in the complexities of a fee-for-service reimbursement structure. Consumers and families were especially articulate in expressing the need for considerable training regarding the issues before feeling competent to provide input and advice regarding fee-for-service and related issues.

While the above issues would need to be successfully addressed to support the integration of fee-for-service advisory functions, they should be addressed regardless to maximize the contribution of the Planning and Advisory Council to the Illinois mental health system and to more effectively fulfill the federal expectations for the block grant process.

SRI Member Feedback

Though it has had a much shorter history than the Planning and Advisory Council, SRI has also had a somewhat uneven past. Created by Memorandum of Understanding mandate in reaction to a contentious initiation of the fee-for-service conversion, full membership, scope of work, and operating rules were not uniformly clear or agreed upon by all parties. This lack of clarity was compounded by timeline pressures, an untimely start, and a midstream change in consultants. The general role of SRI as contemplated in the MOU did not fully recognize the importance of consumers and their families in shaping the system that serves them, which contributed to a disproportionate representation of providers. While this interest was not counter to consumer interests, it nonetheless did not allow adequate consumer voice.

Despite the challenges experienced by SRI and its sometimes contentious operations, SRI members providing feedback were uniform in expressing their appreciation for the value it has served. Members felt that SRI did give them a forum to express their concerns with the fee-for-service conversion and the opportunity to communicate those concerns directly to DMH and other involved state Departments. In addition, there was particular appreciation for the effectiveness and contributions of the work groups that emerged under SRI in the early months of calendar year 2005. There was also an appreciation that through SRI participation, members have gained an extensive knowledge-base that if effectively focused can be important to the next phase of fee-for-service implementation. Participating SRI members also acknowledged that a re-alignment of membership that

worked to expand consumer and family participation while preserving the knowledge base was reasonable.

RECOMMENDATIONS

As the Illinois mental health system moves into its second year of transition to fee-for-service, it is evident that there is a need for an even greater focus on finding solutions to the complex issues inherent in a system change of this magnitude. There are various forums already available for general comment, advocacy and resolution of individual-specific issues. At times hard-won experience from the first year of the transition demonstrated that more effective, responsive, and palatable solutions to difficult issues were obtained as consumers, providers, and DMH worked collaboratively. *The following recommendations are predicated on the assumption that the system is prepared to move into the next stage of implementation and is most in need of a structure that does not just offer 'advice' or individual comment but rather serves as a catalyst for collaborative solutions and problem solving for the greater benefit of consumers, and the providers and the state authority that serves them.*

The analysis of the current structure and functioning of the Mental Health Planning and Advisory Council has led to the conclusion that this Council is not currently in a position to fulfill all the expectations and responsibilities for fee-for-service input and advice to DMH and the legislative Oversight Committee as detailed in the Memorandum of Understanding. Accordingly, we have three primary recommendations to address the need for long term and integrated stakeholder input and advice for major mental health system initiatives:

1. Continued development and enhancement of the Planning and Advisory Council to become sufficiently informed and effective to eventually incorporate all significant mental health system initiatives, including fee-for-service, SASS, and state hospital changes. Recognizing the magnitude of effort required to address development needs expressed by Council members, it is expected that it could take as much as a year of focused effort by DMH and the Planning and Advisory Council to prepare the Planning and Advisory Council to accept this additional responsibility.
2. Sunset the existing SRI and establish a new entity with revised membership to include more consumer and family representation, expanded focus and greater clarity of purpose and operating rules.
3. Create structural linkages and operational expectations between the Planning and Advisory Council and the new entity to enhance communication, knowledge-base development, and expanded input for both structures.

Since the underlying purpose of this report is to recommend an appropriate advisory structure for the fee-for-service initiative, we will focus our detailed recommendations on #2 and #3 above.

Structure

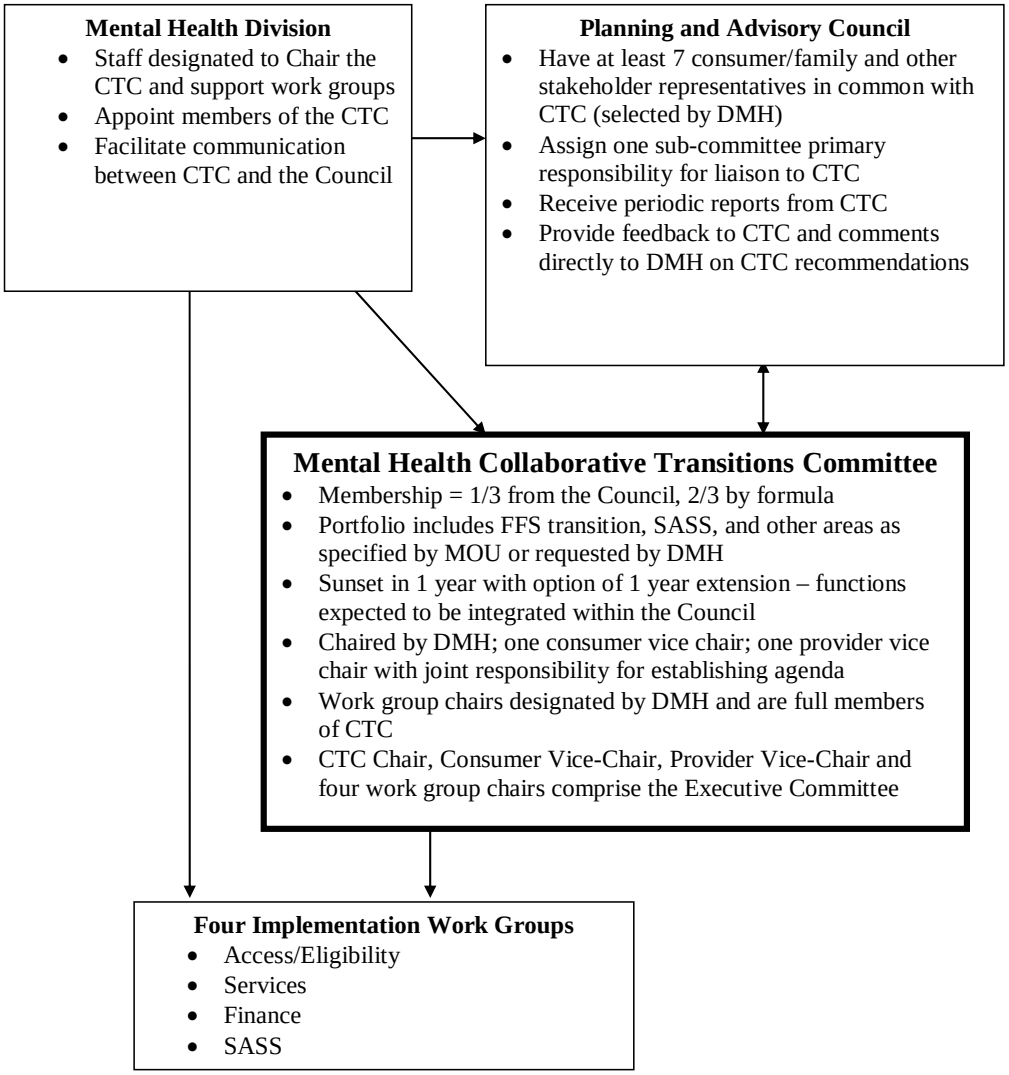
DMH's vision for the advisory structure, as reflected in the FY 06 MOU, includes a somewhat broader mandate than the previous SRI committee. It also includes new requirements for membership, with increased emphasis on consumers and families. Additional stakeholders, such as representatives of law enforcement, education, justice systems and local funding boards are also identified as required members.

In this report, we refer to the new advisory structure (and successor to the SRI) as the Mental Health Collaborative Transitions Committee (CTC). This is intended to reflect the somewhat broader mission, focus on results and solutions, and new membership of

the Committee. As will be noted below, the new structure is intended to have shared membership and formal communications with the Planning and Advisory Council as well as communications directly to DMH. This will assure improved communications between CTC and the Planning and Advisory Council, and is intended to reduce the potential for duplication of advisory input efforts. The overlapping membership and communications protocols are also designed to facilitate growth and development on the part of the Planning and Advisory Council, especially in the area of fee-for-service reimbursement issues.

The recommended structure of CTC maintains the three currently existing Work Groups (Access/Eligibility, Services, Finance), one additional work group for SASS, and can accommodate future work groups that may be necessary from time to time. These will continue to work with DMH staff and will continue to provide input on specific design and implementation solutions conveyed to the CTC for its deliberations and advisory input to DMH.

Figure 1
Mental Health Collaborative Transitions Committee (CTC)
Structural Relationship to DMH and the Planning and Advisory Council



The CTC is formed specifically for the purpose of providing input and advice to DMH on defined issues related to the transition to fee-for-service and related system design and implementation solutions. As such, the CTC does not have the generic and system wide advisory functions related to mental health system planning, evaluation and movement towards system transformation that are delegated to the Planning and Advisory Council. The CTC is also time limited, and has responsibilities related to legislative oversight, as well as advising DMH on fee-for-service implementation. For these reasons, this report recommends that the membership of the CTC to be appointed by the Director of DMH, and for the Chair to be a designated staff person from DMH, ideally the Project Manager for the fee-for-service imitative. As a senior staff member of DMH, the designated chair will also have a direct relationship with other DMH staff assigned to support the activities of the four Work Groups. From the perspective of "chain of command," the Chair of the CTC will report directly to DMH, and will be the primary communication link with both DMH and the Work Groups.

The CTC has a direct advisory relationship with DMH, and will focus on fee-for-service transition and implementation issues in a manner similar to the previous SRI committee. However, the Legislative intent and also the vision of DMH is that the newly-constituted CTC will facilitate and emphasize the input and advice of stakeholders that traditionally have not had a significant voice in DMH policy formulation and program design. This desire to strengthen the voice of consumers, families and stakeholders from other systems is the basis for the new membership model outlined below.

The desire for more effective input from previously disenfranchised stakeholders is also a reason this report calls for overlapping membership and close relationships and communications with the current Planning and Advisory Council. This inter-relationship with the Planning and Advisory Council is reinforced in this report by having a full one third of the members with dual membership. Designating the DMH chair and two vice-chairs, one representing consumers and the other providers, establishes a committee structure that encourages collaboration. The vice-chairs will work with the DMH staff designated as Chair to: (a) establish priorities for discussion topics and agendas; (b) assist to determine the proper focus, sequencing and product development of the four Work Groups; and (c) assist with communications to the Planning and Advisory Council. By having the four work group chairs as sitting members of the CTC, they will be able to directly communicate work group results, accept new assignments and requests from CTC, and facilitate prioritization of efforts. The Chair, two vice-chairs, and four work group chairs would comprise the Executive Committee and will be called to deliberate issues that in the judgment of the Chair, cannot wait until the next scheduled meeting of the CTC, and will assist in establishing priorities for CTC. Any member of the Executive Committee of the CTC may be called upon to testify or otherwise provide information to the legislature.

Members

The membership of the CTC is expected to be broadly representative of consumers, families and other stakeholders in the mental health system throughout the state of Illinois. Based on the vision and expectations of DMH, as well as the requirements of the MOU, at least 51% of the membership must be consumers and/or family members (including consumer advocacy groups).

This report calls for a 21-member CTC, 11 of whom (52%) will be consumers and family members. Family members who are parents of children or adolescents with serious

emotional disturbance will be included, as well as parents or other family members of adults with serious mental illness.

At least thirty-three percent (total of seven members) of the CTC are expected to be current members of the Planning and Advisory Council. The overlapping members should include at least one of the Planning and Advisory Council Co-Chairs, the Chair of the Planning and Advisory Council committee designated as liaison with the CTC, and five at large members. Within these parameters, the Director of DMH will select members from the Planning and Advisory Council who will also serve on the CTC.

There must also be representation of law enforcement, judicial systems, education and local funding boards. The current Planning and Advisory Council already has representatives from these stakeholder groups, and to the extent possible these could also be designated as representatives from the Planning and Advisory Council serving on the CTC. In addition, since the Planning and Advisory Council will be regularly reviewing and providing input on issue analyses and recommendations from the CTC, there will be continuous opportunities for input from these categories of stakeholders.

To be effective, the CTC must also have adequate proportional representation from all geographic regions of the state; must be racially and culturally/linguistically diverse; and must represent the varying characteristics of rural, suburban and urban environments. This report calls for at least three members from each of the five Planning Regions currently in use by DMH. In addition, at least five of the total number of CTC members should be African American or Hispanic/Latino representatives. Finally, at least three of the 21 CTC members should represent rural/farm areas of the state; at least three should represent suburban/small city areas of the state; and at least three should represent urban areas of the state.

Provider representation is also important to the CTC, and this report calls for at least five provider members, at least one from each region. It is recognized that providers will have some specific issues with regard to fee for service implementation that are more specific or technical than appropriate for CTC deliberations. These issues can be referred to one or more of the Work Groups for discussion. This method has demonstrated success during the pilot test phase of the fee-for-service conversion, with more than 150 representatives of the thirty pilot providers actively involved in the various work groups. Providers also represent the interests of their consumers and their communities, and this type of input adds to their value as members of the CTC.

Figure 2 displays how the membership of the new CTC can be constituted to meet all of the above criteria. The matrix allows for some latitude in geographic and other representation categories, while at the same time assuring that the overall totals of representation meet the necessary criteria in the MOU plus the additional criteria recommended in this report. It should be noted that most of the members will meet two or more criteria for membership, which makes it possible to meet all the criteria for diverse representation within a 21-member committee. For example, a primary consumer member of the CTC might live in Region 2; might live in a small rural community; might also be a member of the Planning and Advisory Council; and might be African American or Hispanic/Latino. This person would meet the membership criteria in four separate categories. Though it is not anticipated to be an issue, should DMH find that meeting all criteria in the matrix is not feasible, they should make best effort to do so and actively solicit input from any groups not represented.

Figure 2 – Membership Matrix

Category	Reg. 1	Reg. 2	Reg. 3	Reg. 4	Reg. 5	Total
Consumers						**At least 6**
Family members of adult consumers						**At least 3**
Family members of child/adoles. Consumers						**At least 2**
Sub-total						*No less than 11*
Members of the Planning and Advisory Council						**At least 7**
African American and Hispanic/Latino representatives						**At least 5**
MH Providers	**1**	**1**	**1**	**1**	**1**	**5 - 1 from each region**
Rural						**At least 3**
Sub-urban						**At least 3**
Urban						**At least 3**
Sub-total						*No more than 10*
Total	At least 3	At least 3	At least 3	At least 3	At least 3	21

Reporting and Communications Pathways

The CTC will be structurally independent of the Planning and Advisory Council. It will report to and be responsible to communicate with DMH directly through the designated staff member functioning as Chair of the CTC. The CTC will receive operational recommendations from the four Work Groups, and it will primarily focus its advice and recommendations to DMH on topics discussed by the Work Groups. The pathway of communication will primarily be from the Work Groups to the CTC and then to DMH. DMH may initiate this pathway of communication by providing information and raising issues to one or more of the Work Groups, and/or by asking the CTC to provide input and advice on specific policy or program design questions.

In addition to this communications process between the Work Groups, CTC and DMH, there will also be formal protocols for communications between the CTC and the Planning and Advisory Council. These protocols are designed to assure maximum participation of the Planning and Advisory Council in the system design and implementation process, while at the same time maintaining the integrity and independence of the separate CTC advisory process. The communications protocols are also designed to provide meaningful opportunities for the Planning and Advisory Council to exercise its role as an effective planning, advocacy and oversight body representing the interests of consumers, families and other stakeholders in the mental health system in Illinois.

This new set of communications protocols are intended to function as follows:

- The Planning and Advisory Council will assign responsibility to one of its standing committees to receive and review materials and communications from

the CTC and to advise the Planning and Advisory Council on policy or implementation issues emanating from the CTC. Reports from this committee with regard to CTC progress to date and issues addressed will become a regular part of the Planning and Advisory Council quarterly meetings.

- The Planning and Advisory Council will designate one of its members to be the official liaison between the Planning and Advisory Council and the CTC. It is recommended that this representative be the Chair of the Planning and Advisory Council committee designated with the responsibility to receive and review information and recommendations from the CTC and to process that information for review by the whole membership of the Planning and Advisory Council.

- The CTC will develop a regular monthly schedule of meetings and agenda items. Based on this, the designated Planning and Advisory Council committee will develop its own schedule of monthly meetings to dovetail with the CTC schedule. This will allow information from the CTC and its working groups to flow expeditiously to the Planning and Advisory Council soon after it is discussed at the CTC. For example, if the CTC meets regularly in the first week of the month, then the Planning and Advisory Council's designated committee would schedule its meetings in the third week of the month, allowing a brief but sufficient period for meeting minutes and associated materials to be assembled and transmitted from the CTC to the Planning and Advisory Council's designated committee.

- The CTC will routinely submit all working papers, agendas, meeting minutes, recommendations and other relevant documents to the Planning and Advisory Council liaison for review and discussion by the Planning and Advisory Council committee. The Planning and Advisory Council's designated committee will review these materials and respond to the CTC before its next meeting with any questions and recommendations. Thus, in any given month the CTC will have sent current materials and information to the Planning and Advisory Council, the Planning and Advisory Council committee will have reviewed and commented on these materials and the review and comment information will be transmitted back to the CTC for its consideration. As applicable, the CTC may forward input and advice from the Planning and Advisory Council or its designated committee to one or more of the work group for their consideration.

- At the regular quarterly meeting of the Planning and Advisory Council there will be a standing agenda item for discussion of the items under consideration by the CTC. The designated liaison and her/his committee will take responsibility for preparing and circulating relevant summary materials to the membership of the Planning and Advisory Council, and for leading a discussion of major policy and program design issues on which the Planning and Advisory Council may wish to provide input and advice directly to DMH. During this regular quarterly meeting a representative of the CTC will report to the Planning and Advisory Council about: (a) progress to date on issues being addressed by the CTC and its working groups; and (b) the ways in which information and feedback from the Planning and Advisory Council and its designated committee have influenced the deliberations of and advice generated by the CTC to DMH and the Legislative Oversight Committee. At this meeting the DMH liaison to the CTC will also report to the Planning and Advisory Council on the ways that Planning and

Advisory Council input and advice have influenced program design and implementation by DMH.

These communication protocols are not intended to create additional layers of bureaucratic process or advisory input; or to delay the provision of advice and input to DMH on the part of the CTC. We also recognize that the Planning and Advisory Council will need to make due deliberations on the recommendations affecting them, and may require some time to align their operations to fulfill the mutual expectations with CTC. CTC will provide input and advice to DMH and the Legislative Oversight Committee concurrently with the transmission of information to the Planning and Advisory Council, and DMH is expected to act on the input and advice provided by the CTC whether or not the Planning and Advisory Council provides additional advice or commentary. The Planning and Advisory Council should not delay program design or implementation activities pending its own review of CTC recommendations.

Nonetheless, the additional review and input by the Planning and Advisory Council will assure DMH receives as much representative input to its program design and system transition processes as possible. This should increase the amount of "buy-in" and support for DMH by a wide array of consumers, families and other stakeholders during the sometimes difficult transition process. It should also provide opportunities to envision and review how specific elements of the transition process relate in a more general sense to overall mental health system transformation.

At the same time, the communications process between the CTC and the Planning and Advisory Council will assist the current Planning and Advisory Council to strengthen and enhance its functions of mental health system planning, evaluation and oversight. An intentional outcome of this process should be a more informed and effective Planning and Advisory Council that can perform all necessary advisory functions on behalf of DMH without reliance on separate advisory input structures.

MEETING PROTOCOLS

To assist with the effective and efficient operation of the CTC, the following recommendations outline procedures for structuring and running the meetings. The CTC should review these recommendations, make modifications and approve a set of operating rules as a part of its first meeting or planning retreat.

- **Format**—Meetings will generally be held in the mornings on a monthly basis in a face-to-face format, with the location alternating between the Chicago and Springfield areas. It may sometimes be necessary to adjust the schedule or location based on legislative schedules, the volume of pending business or holidays. Telephone meetings may also be indicated based on these same factors.

- **Attendance**—Members of the CTC should make every effort to attend meetings in a consistent manner to facilitate effective, on-going discussions of complex matters. If a member is unable to attend, the Chair should be provided with advance notice of the absence whenever possible, by email (or phone if email is not convenient to the member). The member may send a substitute who is generally informed regarding the issues before the CTC and capable of representing the constituency of the member. The Chairs should also be advised of who will be attending in a member's place.

    - **Invited Guests**—The Chair and Vice-Chairs may invite guests to participate based on the topics to be covered. Invited guests may fully participate in the discussions, but are not eligible to vote on any recommendations. Invited guests should be introduced at the start of each meeting and reflected on the agendas, whenever possible.
    - **Other Guests**—CTC meetings are open to all interested parties, and a ten minute public comment period will be held at the close of each meeting for guests to offer comment.

- **Representation Function**—All members should understand and agree to represent the constituency of their membership category (urban provider, family, primary consumer, etc.), and should seek out input from other constituency stakeholders. CTC meetings should not be used to address individual needs or issues of any member. Member names, phone numbers, and email addresses along with their membership category should be posted in the DMH website as one method to facilitate input from constituents.

- **Recommendations**—Issues where DMH has requested recommendations, or where the CTC wishes to provide recommendations should be brought to a vote. The majority vote shall be represented in the minutes, and minority positions should also be reflected in the minutes with the reason(s) for the dissenting votes. Only members are eligible to discuss and vote on recommendations.

- **Minutes**—A DMH staff member should be assigned to record minutes. Minutes from the previous meeting shall be emailed at least five business days prior to the next meeting to facilitate rapid review and approval. Approved minutes should also be posted on the DMH website.

ACTION STEPS/TIMELINE

Action	Approximate Timeline
1. Forward copy of report to Planning & Advisory Council and SRI (arrange phone meeting to discuss if requested)	Upon acceptance of the report by DMH
2. Determine CTC candidates per matrix	July 15, 2005
3. Appoint Consumer and Provider Vice-Chairs	July 15, 2005
4. Solicit candidates, obtain concurrence	July 29, 2005
5. Convene 1-1.5 day retreat with CTC Executive Committee and full membership. a. Finalize operating rules b. Orient members new to fee-for-service c. Set/confirm priorities for the CTC and the four Work Groups d. Establish regular meeting schedule	August, 19, 2005
6. Sunset SRI	September 2, 2005
7. Regularly scheduled meeting(s)	September, 2005
8. Work already in progress in the Work Groups will continue uninterrupted with current priorities	On-going