**MH Services Strategic Planning Meeting Notes**
**Subcommittee on Adult Clinical Subgroup**
**December 07, 2012**

**INTRODUCTION:** Meeting began at 09:00 AM.

- Review of meetings' agenda.
- Timeline and report structure changes.
- Professional writer acquired to compile all information.
- Committee report outline due a week from now.
- Priorities, goals, objectives, activities.
- Review of the Subcommittees' report format.
    - Addressing workforce development needs.
    - Include individuals with dual disorder needs.
    - Long-term and short-term goal objectives.

Review of issues for cross work group discussion:

- New services.
- Improved services in certain settings.

**SUMMARY OF DISCUSSION:** The following is an edited summary of the meeting:

C&A:

- Transitioning of youth to adult-complicated for families.
    - No case coordination.
    - Dealing with many systems-how to navigate.
    - Historically young adult services fell in to the child and adolescence service.
        - Mental health agencies' continuity/connection between the child and young adult service. Case management. Linking services.
    - There is a need for a separate young adult services.
    - Grey area of the age 18-21.
    - Continuity of care agreements.
    - Workforce knowledge of developmental issues specific for the age group. How we help children to become adults.
    - Young adult housing.

- Solutions:
    - Collaboration/bridge between youth and adult service provider that begins when youth becomes 15 or 16 years old to ensure smooth transitioning.
    - Workforce trained to manage that crossover transitional piece.
    - Specifically working toward goals for transition age youth.
    - Coordinated care world-specialized services that are different to young adults.
    - Carve out services for youth in transition.
    - Gaining back skills that were interrupted because of their illness, including those that may not be medically necessary and may not be Medicaid billable. Funding issue for this population.
    - Aging out youth need housing structure.

C&A's strategic priorities review:

- Develop and implement mechanisms to assess the service needs of all individuals with mental illnesses across all systems that they interface and than develop services accordingly.
- Require effective care coordination of all providers.
- Develop system outcomes that focus on a triple aim of improving the health of the individuals with mental illnesses or at risk of mental illnesses, improving the patient's experience and decreasing costs over time.
- Create flexible funding streams necessary to achieve identified outcomes.
- Assure that prevention and early intervention strategies exist across a coordinated system of care.
- Ensure that individuals with mental illnesses or at risk of having mental illnesses have access to a mental health system that is based on identified needs, is fully funded, care is coordinated, produces effective outcomes, and is outcome driven.

Goals:

- Thorough review of our funding options.
- Identifying changes that would be recommended.
- To purposefully look at funding of C&A and Adult funding and make sure that transitional age services are not interrupted and that funding continues to flow.
- To look at transitional age models in other counties and states.
- Education stand point-age group between 14 and 22 years old.
    - Mental health department to be involved early on in the transition planning.
    - Infrastructure and environment for individuals with mental health needs in transitioning into adulthood.
    - Evidence based planning.
    - Age at what and individuals are transitioning.
- To create a consistent age across systems.
- Age specific services.

Adult Continuum of Care issues:

- Ability to offer RAP orientation.
- Importance of linkage and care coordination.
- Workforce development.
- Outcomes.
- Suicide prevention.
- Value of the state hospital.

Develop and implement mechanisms to assess the service needs of all individuals with mental illnesses across all systems that they interface and than develop services accordingly:

- To develop a universal assessment mechanism/survey that could be used in a point in time to collect information on needed services from both treatment provider and an individual level.
- Quick assessment, sampling, needs assessment to determine what the clinical profile of the people in the system is.
- Needs assessment of individuals currently serve.
- Looking at already existing models.
- Individual assessment, data collection, or system snapshot from the provider perspective?
- Do we engage our professional consumers, our recovery support specialists, and have them be working on aw ay to get individual input into service assessment need. We need to hear from the consumers, as well as the providers.
- One objective to do a survey from the system perspective, and providers (point in time)
- To develop individual needs assessment method.
- Point in time can capture what the system thinks what services need to be there and also what social determinants are missing such as housing, employment, etc.
- Is there a way to build in recovery-oriented system of care, person centered planning through outcomes? And outcomes would be quality care that ensures patients' satisfaction.

- How to hold system accountable for the values that we aspire to, without having to create some cumbersome assessments of an individual.
- Satisfaction as an outcome-usually overly reported by patients.
- Outcome measuring by an indicator of a quality of life.
- Will the universal assessment tool fit all the settings that you might want to collect data in?
- Universal assessment:
    - Short term-where is the system now?
    - Long term-develop the services accordingly to the assessed needs.
        - Activities:
            - Developing point in time survey to collect data information on system.
            - Survey individuals perceived treatment needs, both what services are beneficial and what the gaps are.
            - Social determinants.
- Identifying already existing sources of information.
- Review what data we have now.
- Point in time-captures a moment for people who go through multiple systems. Less chance of duplication throughout all of the systems (From a system and client perspective. All must contain not only the clinical service needs but also social determinants).
    - Develop a way to assess the needs.
    - Assess the needs (implement).
    - Plan accordingly (develop service).
- Care coordination:
    - Add on of bidirectional care. Holistic model (social determinants).
    - Linkage in an adequate way to meet the needs. Protocol? Almost like an interface, engagement; meeting and merging.
    - Goal-outcome of care coordination.
    - From service oriented to person oriented. Meeting person's needs in different domains.
    - Means to better access.
    - More ease of delivering the service and accountability.
    - More access on outcome, safety and quality of care.
    - Some level of standardization among all providing entities.
    - Care coordination as a clinical service or as a structure within the system?
    - Ensure a person centered approach so that all needs are addressed in a coordinated way.
    - Person centered-to move from service centered. When person is in the middle it is easier to focus on service needs and social determinants. Ensuring that all needs are met with coordinated care.
    - As a person centered service where there is a clear responsibility of someone, or some provider or some managed care company that has outcomes that they are responsible for, that will incentivise them to coordinate the care of all the different providers that the individual might need. Need for one responsible entity.
    - Ensuring that services are person centred and holistic.

    - Objectives are to develop care coordination model to assure that the person has access to all services supports needed.
        - Creating standards for this model.
    - To utilize the model
        - Identifying entities that have care coordination responsibility.
        - Developing incentives for outcomes.

- System outcomes:
    - Decreasing cost over time (person and population related).
    - Reinvestments. Strategic investments.
    - Defining standards that we would measure our outcomes with.
    - To collect and analyse the data on outcomes and use it to incentives outcomes.

- Do we use outcome measuring as a tool for contracting? (Short-term goal)