Behavioral Health Managed Care Entities:

IMPORTANT PARTNERS IN PROMOTING COMMUNITY INCLUSION

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MHA
Mental Health America

THE TEMPLE UNIVERSITY COLLABORATIVE ON
COMMUNITY INCLUSION
of Individuals with Psychiatric Disabilities

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Section 1: Overview

Who We Are

Mental Health America (MHA) is the nation's oldest mental health and wellness advocacy organization, with more than 200 affiliates in 41 states. Since 1909, MHA has represented the perspective of and amplified the voices of people who have lived experience with mental health conditions. MHA is first and foremost an advocacy and public education organization. MHA affiliates have been instrumental in creating systems change that improves the lives of those with mental health conditions nationwide. Many MHA affiliates also provide a wide variety of community-based mental health services and supports for individuals across the life span, and for the families that are affected by behavioral health conditions. MHA affiliates have been pioneers in designing and implementing recovery-focused supports and services, especially in the areas of mutual self-help and peer delivered programs.

The Temple University Collaborative on Community Inclusion for Individuals with Psychiatric Disabilities (TU Collaborative) is a Rehabilitation and Training Center funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). Research at the TU Collaborative is focused on targeting obstacles that prevent people with psychiatric disabilities from fully participating in their communities; developing the service and supports consumers and communities need to promote full integration into all aspects of community life; and expanding the range of opportunities for people who have psychiatric disabilities to participate in their communities as active, equal members. Eloquently stated by Principle Researcher and Director Dr. Mark Salzer, the purpose of the TU Collaborative is to help people with psychiatric disabilities have "the opportunity to live in the community and to be valued for one's uniqueness and abilities like everybody else."[1]

Why Create a Toolkit for Behavioral Health Managed Care Entities?

Behavioral Health Managed Care Entities (BHMCEs), such as the member organizations of the American Association for Health and Wellness (ABHW), are the entities charged with managing healthcare dollars. Shared goals underlie this toolkit, such as the one succinctly articulated on the website of Beacon Health Care Options: "The problems are complex, but the goal is simple: build better outcomes for people who have behavioral health needs."[2] From MHA's perspective this is done by redefining behavioral health systems so that services support the declared hopes, dreams, and goals of people living with behavioral health conditions. This is also in sync with the stated raison d'être of TU Collaborative: to further the recovery of people with psychiatric disabilities by identifying barriers and creating opportunities for full participation in all aspects of community life.

The reason this toolkit is directed to BHMCEs is expressly because they have been pioneers in the developing, funding, building the evidence base for, and promoting the use of, recovery oriented services. In partnership with county and state mental health departments they have established a track record for the use of innovative recovery and peer services.

BHMCEs also have a history of hiring peer leaders within their organizations, being among the first leadership entities to infuse recovery values and programing into their own business models. They have translated the understanding that psychiatric rehabilitation and mutual support and self-help, guided by peers, are essential for community-based services. BHMCEs did this by not only listening to consumer advocates but incorporating national consumer-recovery leaders into their executive ranks, such as with Dr. Ed Knight, one of the giants in the consumer movement, as early as 2001.[3] BHMCEs have also facilitated the widespread adoption of recovery supports and services, and the hiring of peers, by the providers, and county and state mental health entities, with whom they contract.

Building upon this legacy, BMHCEs industry wide continue to be informed by guided by a number of outstanding national peer leaders, such as Sue Bergeson, National Vice President, Consumer and Family Affairs for OptumHealth Behavioral Solutions and winner of MHA's highest honor, the Clifford Beers Award.[4] BHMCEs have been instrumental in building the evidence base for the efficacy and return on investment (fiscally and clinically) of peer services.[5] They have been setting the stage for widespread insurance reimbursement for peer services and are helping to create positive feedback loop between funders (states, counties, and insurers), consumers, and contract agencies. And while it's clear that peers are the linchpin that connects payers, providers, and consumers to community inclusion, peer services, and the peer workforce, peers alone do not assure community inclusion.

Community inclusion for people with psychiatric disabilities is triadic—provider agencies and their staff, payers (including BHMCEs), and the individuals receiving services and supports. The work that individuals must put forth is too often overlooked or underestimated, and they are sometimes viewed as passive recipients. As elegantly put by Sue Bergeson, health activation and engagement is the "secret sauce" in recovery.[6]

Community inclusion is no longer an abstract concept; increasingly it is an explicit contracting requirement. In New York State, the 2015 request for qualification document for BMHCEs calls for "assuring full community inclusion."[7] As the practice of enhancing and assuring community inclusion becomes incorporated into all aspects of service payment, delivery, and participation, systems will increasingly seek outcomes that account for both clinical and quality of life measures. BMHCEs' unique role in fostering community inclusion will not necessarily be about spending more money or even saving money – rather, BHMCEs have the unique opportunity to provide the leadership to think differently about how and on what health care dollars will to be spent.

This constitutes the most important reason for this toolkit: the arena for health care delivery, payment models, and what constitutes medical necessity and covered services are in flux. The components (i.e. domains) of community inclusion provide many of the foundational elements for achieving the triple

aim of Affordable Care Act: better health care for individuals, better health for populations, and lower per capita costs.[8]

What is Community Inclusion?

Community inclusion is a concept that is becoming more familiar in the behavioral health lexicon. There is a developing body of literature, and with increasing frequently the term is appearing in counties' and states' managed care proposals (RFPs).[9] Community inclusion can be colloquially understood as the extent to which an individual can live like everyone else. As applied to behavioral health managed care entities (BHMCEs), community inclusion is a network management orientation that can yield better member outcomes without additional expenditures. Community inclusion is not necessarily adding new services or spending more money. While it may or may not *save* money, it's about rethinking services and supports and spending dollars differently to help assure that people with psychiatric disabilities have lives as fully participating citizens.

WHAT IS INCLUSION?

Inclusion

Exclusion   Segregation   Integration
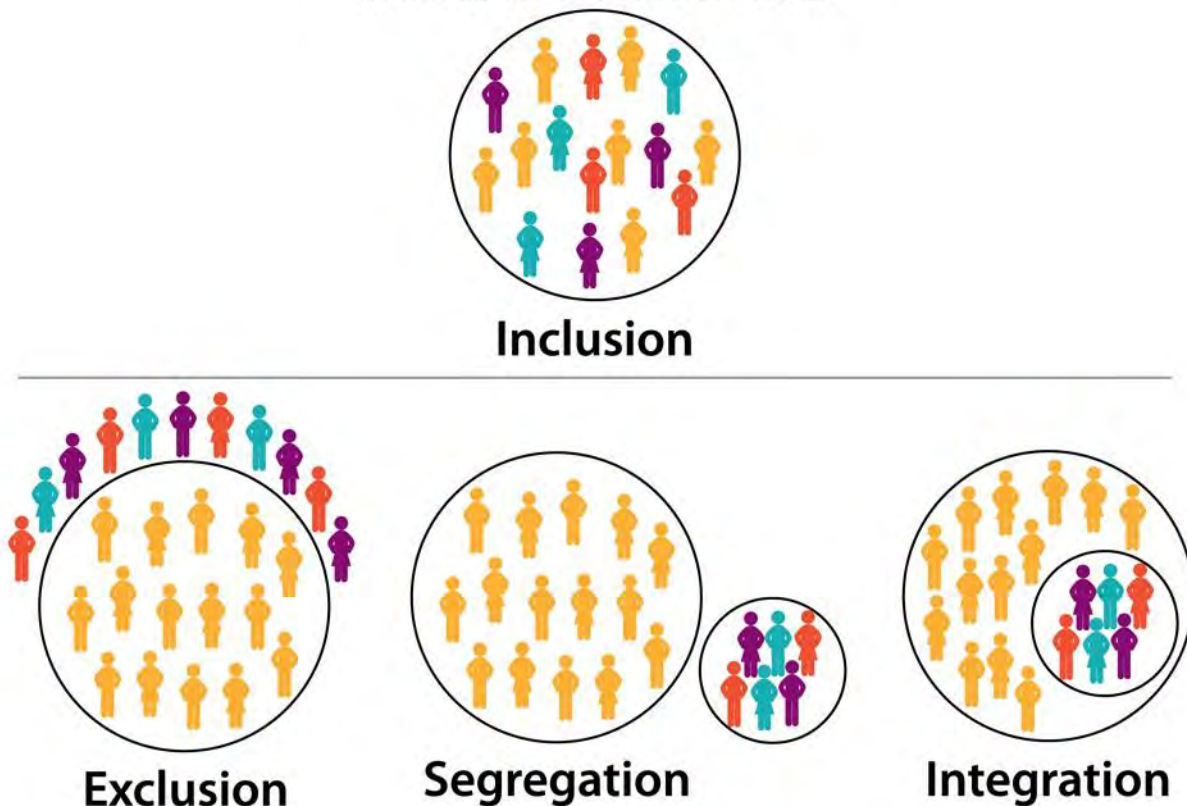
Community Inclusion Domains

Community inclusion seems like it should be easy to define – its eight domains feel intuitive: housing, employment, friends, education, health and wellness, religion and spirituality, family, and intimacy. The importance of these domains is self-evident; they're what everyone wants in their lives. But even when domains are touched upon individually in well managed, covered and reimbursable community services, still, a threshold that reaches full community inclusion is difficult to achieve.

Housing: Even when people are not being overtly excluded or segregated from the community at large, including living in institutional settings, their housing be in the community might be located in but not of the community. Examples include facilities such as personal care boarding homes, apartment

buildings for only persons with mental health conditions, or other mental health only congregate settings. These facilities may be located in a residential neighborhood, but allow for little or no interaction with other neighborhood residents. It is essential that the definition of living in the community be defined as helping people to live as they would like, choosing where, and with whom, and how they want to live.

Employment: A meaningful activity, such as work, school or community volunteering, is often ranked as the second most important component of mental health recovery. The vast majority of people with psychiatric disabilities who are receiving public mental health services report that they want to work, but their unemployment rate nationwide is eighty percent.[10] The value of employment training, vocational rehabilitation, and job supports is well recognized by service providers, payers and BHMCEs. While the behavioral health field has significantly moved away from sheltered workshops, people with psychiatric disabilities all too commonly are still steered into entry level jobs because it is widely believed by service providers and consumers alike that's all they can handle.[11]

Low stress, entry level jobs may represent an individual's choice, but when mental health provider agencies only direct people with psychiatric disabilities to employers, such as grocery or chain stores because "they hire people with disabilities"[12] this falls short of full community inclusion. The threshold for community inclusion means supporting people in applying for, achieving, and maintaining competitive employment based on their personal goals, preferences, and skills.

Education: For individuals with psychiatric disabilities, the path to competitive employment, just like for everyone else, includes training and education. Mental health service providers have long offered training programs to build office or computer skills. But programs run by mental health agencies were often, and still are, provided "in-house." These courses, with limited subject choices, are held inside of the mental health provider facility, and the students are only agency service recipients. A community inclusive approach is to encourage and provide supports for people to undertake their choice of training alongside other community members.

Because almost all people with psychiatric disabilities begin experiencing life-disrupting symptoms in late adolescence or early adulthood,[13] it is highly likely that people will experience significant educational interruptions, which of course can impede their employment goals. Therefore, including educational support services that will facilitate the completion or continuation of educational goals (such as getting a GED or obtaining college or graduate degrees) is another important component of community inclusion.

Friends: Isolation and a dearth of friends are very common for people with psychiatric disabilities. Some people are so isolated that they report interacting with very few people. Sometimes an individual reports that their only friend is their therapist. Others claim that their only friends are those with whom they attend programing or know through service agencies. Other times people name only service staff members as being their friends. Many agencies do help people to attend community activities, such as going to sporting events, museums, or concerts, but these may or may not be activities of the individual's choosing—they are just the ones that are available. Clearly, it is not representative of community inclusion when agency service recipients are transported in an agency van, as group, from the agency location, and back again. Supporting people to engage in activities that represent what it is that they enjoy doing, at locations of their choosing, with people who have shared interests, will help to build enduring friendships.

Religion and Spirituality: For many people, close friendships are forged within their faith communities. But mental health providers and those within provider agencies rarely ask (let alone support) people with psychiatric disabilities to engage in religious and spiritual activities or to become   fully participating members of their faith communities. Supporting people in meeting their religious and spiritual needs is also an important part of service provision, and is necessary to help people to fully participate in communities of their choosing. Transportation to church, synagogue or mosque is an important way to

support people's spiritual goals. But equally important is helping them to engage in meaningful ways with their fellow congregants, such as being included in the receptions that follow services, study groups, and congregational outings.

Health and Wellness: Spirituality, engaging with nature, and physical fitness or exercise activities often top the list of what people say they need to achieve or to help maintain their health and wellness. These are all examples of personal medicine, commonly defined as what is most important in a person's life that they use to support their health and wellbeing. Community mental health provider agencies often have exercise equipment, weight management resources, and smoking cessations programs on site. People with psychiatric disabilities surely can benefit from such on-site services, given with the high incidence of metabolic disorder[14] and the high levels at which they smoke.[15] But more community inclusive ways of helping people would be joining a local Weight Watchers or Freedom From Smoking group. Another often overlooked way to help individuals with psychiatric disabilities to improve their health and wellness is by increasing their access to recreation and leisure activities. Some of the best examples of how to do this are through free or low-cost community sport teams, visits to local, state, and national parks, or joining local community walking or running groups.

Family: The good news is that families are no longer considered the enemy. Community mental health payers, providers, and BHMCEs support family education programs and seek to increase family involvement. However, when attending to family services, supports, and programming, it is almost always parents (and sometimes the spouses) of people with psychiatric disabilities to who are the intended audience. Family not only means having parents or a partner, but it also means *being* a parent or intimate partner.

Intimacy: A widely repeated aphorism regarding mental health recovery is that the most important components are "a safe place to live, a job, and a date on Saturday night." While it is clearly acknowledged that intimacy and intimate relationships are essential to everyone's overall health and wellbeing, providers, payers, and individuals receiving services often find it more difficult to address issues of intimacy and provide needed supports for intimate relationships than any other domain of community inclusion. People with psychiatric disabilities face intimacy issues that are the direct effects of their illnesses and side effects of their medications, such as lack of libido, sexual dysfunction, inability to achieve orgasm, and the disproportionate degree to which they experience social isolation.[16]

Community Inclusion and the ADA

The Americans with Disabilities Act (ADA), the *Olmstead* case, and subsequent cases require that services be provided in the most integrated setting reasonable for individuals with psychiatric disabilities. This includes providing adequate services and supports to avoid creating a risk of institutionalization. Community inclusion is in line with this mandate for community integration by helping individuals in making goals for increased participation in community life and supporting them to meet those goals. By promoting community inclusion, BHMCEs can ensure that the vision of the ADA and *Olmstead* become a reality.[17]

Section 2: Action Items for Promoting Community Inclusion as a BHMCE

Action Item 1: Adopt an organizational vision statement that includes community inclusion

A powerful step that BHMCEs and the organizations with which they contract might take is to add the principles of community inclusion to their vision statements. This should include explicitly recognizing that community inclusion of individuals with behavioral health needs as being of paramount importance to the provision of health care. Vision statements might include examples of how BHMCEs and those they contract with can work together to effectively promote community inclusion within their own organizations, within agencies they contract with, and with the governmental and insurance entities with which they contract. Their vision statements might also pledge to work with stakeholder communities to change policies and practices to support this vision and to enhance community inclusion by helping:

- Legislators and regulators ensure that policies best support community inclusion and facilitate linkages between consumers, systems of care, and communities.
- Payers, including state governments, to contract in ways that both allow for maximum flexibility necessary to promote community inclusion and to reward its promotion.
- Advocates and stakeholders (individuals and providers) evaluate and recommend policies that best support community inclusion, and to engage with the community to decrease discrimination and increase support.
- Community groups understand how best to include and support individuals as they pursue their community inclusion plans.
- Employers, educators, and landlords avoid discrimination and support individuals to ensure that they are successful in meeting their personal goals in ways that result in be fully included.
- Families to be supportive of their loved ones and helping them to achieve their life and community inclusion goals.

Action Item 2: Train and Engage

This action item provides additional training on community inclusion for staff of BHMCEs as well as staff members at contract agencies, and ideas for practices that promote community inclusion. It also includes guides to engage consumers in pursuing community inclusion.

Here are some resources that could be used in trainings:

1. Offer the following two-part webinar on community inclusion from the U.S. Psychiatric Rehabilitation Association to BHMCE staff and network providers. The first 90-minute session reviews key principles and their research base. The second 90-minute session focuses on innovative practices in the domains of employment, housing, religion, social life, and consumer-run programming, among other areas.

2. Distribute the Provider Community Inclusion Check-list from the Temple University Collaborative (Appendix A) and ask for feedback on successes and barriers related to community inclusion in practice.[18] Use this in quality improvement and supporting best practices.

3. Distribute the CDC's Positive Parenting Tips to providers that work with children, or with adults with behavioral health needs who have children, so that they can assist parents in

supporting the community inclusion of their children. An added benefit from facilitating the inclusion of one's children is helping parents interact with other parents.

4. Inform providers that they can give consumers the following two guides from the Temple University Collaborative to assist them in their community inclusion:
    a.   *A Practical Guide for People with Mental Health Conditions Who Want to Work*
    b.   *A Practical Guide for People with Disabilities Who Want to Go to College*
    These comprehensive guides run through all steps of applying for employment and education, including the necessary mindset, social supports, community resources, and even the legal environment.

5. Take advantage of online line training courses on community inclusion from The College of Recovery and Community Inclusion
    a.   Encourage your staff members to take courses designed especially for managed care organizations.
    b.   Encourage the state and local agencies for whom care is managed and the administrators of the agencies with which your company contracts to take the community inclusion course designed for them by The College of Recovery and Community Inclusion.

Action Item 3: Review Medical Necessity and Utilization Management

This section provides guidance for reviewing medical necessity and utilization management criteria to ensure and explain what community inclusion is, signal its importance, foster its promotion, and not accidentally restrict its pursuit.

1. Medical Necessity Criteria: Review the existing treatment philosophy and medical necessity definitions so that they promote community inclusion to the highest possible degree.

    - In addition to emphasizing the provision of appropriate clinical services for the best outcomes, treatment philosophy should also reflect that appropriate services promote community inclusion. Community inclusion should be explicitly stated as one of the goals of benefit provision.

    - Likewise medical necessity should be defined to include services and supports that not only address clinical behavioral health needs, but which also enables and supports individuals in successfully pursuing the life they want in the community.

    - Outpatient services should take this definition into account and allow for:

        o   Community inclusion planning, which includes helping individuals to define their goals, and helping them decide what steps they need to take to realize these goals, and must also include outlining ways in which the care team may best support them.

        o   Helping individuals to gain necessary skills to pursue community inclusion, such as using public transportation, applying for jobs, and finding desirable social activities.

        o   Support, including attending the first few sessions of a new activity with an individual or helping an individual obtain something they need to increase their

community inclusion, such as obtaining a driver's license.

2. Utilization Management Review: treatment planning requirements and review criteria.

- Treatment planning requirements should include community inclusion planning, i.e. identifying the individual's goals and how to achieve them, and supporting their community inclusion as part of treatment.

- Utilization management criteria should not restrict providers from offering community-based training or other supports that will directly advance an individual's community inclusion goals, especially when these supports cost as much as the amount of in-house services (i.e. computer classes and recreational activities) that would otherwise be provided for this level of need over the course of treatment.

Action Item 4: Modify Job Descriptions

This section provides guidelines for reviewing how a BHMCE defines staff roles internally and for working with providers to draft contracts that promote community inclusion as an underlying goal of their services and are prepared to effectively support members to increase their community inclusion.

Review internal staff roles, and those within contracted agencies, and provider organizations, in order to ensure the prioritization of community inclusion as a specific goal of services. This may differ for each staff role. For example:

- BHMCE staff should provide the managerial and administrative support for community inclusion.

- Community mental health centers should coordinate with providers to promote community inclusion.

- Clinicians should take into account the individual's community inclusion goals in treatment planning and ensure that services support individuals' community inclusion goals.

- Case managers should assist with the coordination of treatment, supports, services based on individuals' community inclusion goals, and with an objective of assisting the individual in establishing a maximally independent life that they want in the community.

- Peer specialists, rehabilitation practitioners, and other staff should help an individual in planning their community inclusion goals, determining necessary supports, providing those supports, and measuring the individual's progress.

Create, foster, encourage positions within your organizations and those you contract with such as those at the Pioneer Center for Human Services in McHenry, IL. Community inclusion has been so much a part of the fabric of their service provision that they employ a Community Inclusion Manager to oversee a staff of Community Inclusion Specialists.

This position is arguably one of the best ways that providers can promote community inclusion. It ensures that there are processes and policies in place to make sure activities fall in line with the concept.

Additionally, this job description is comprehensive in the way that it looks at community inclusion as it takes into account resiliency and recovery in addition to rehabilitation.

One way that this description could be modified might be to indicate that lived experience with a mental health condition would be a plus. While this position clearly is not a Peer Support Specialist role, it might be helpful for understanding the value of community inclusion as well as be helpful in mitigating any barriers that the client might face.

Pioneer Center for Human Services
Community Inclusion Specialist

Position Summary

The function of the Community Inclusion Specialist is to provide services and support necessary to assist the client to achieve and maintain rehabilitative, resiliency and recovery goals. The Community Inclusion Specialist facilitates skill building, identification and use of natural supports, and use of community resources.

Essential Functions

• Provide community support services for assigned clients.
• Assist in reestablishing natural community supports for assigned clients.
• Maintain proper documentation.
• Scheduling appointments.
• Driving.
• Telephone support.
• Community research.
• Performs all other duties as assigned by Supervisor.

Action Item 5: Contracting with Community Providers

This section is designed to help to announce a BHMCE's commitment to promoting the community inclusion of its members, introduce the idea of community inclusion to its staff and network providers, and distribute a community inclusion measurement tool that is useful in conceptualizing and promoting community inclusion.

Community inclusion is a commonly misunderstood concept. When contracting with community providers, it is important to clearly explain its importance and to outline your expectations for their adoption of community inclusion practices. A letter like the one included in Appendix B could be a good place to start. Please note that this letter is not a catch-all and should be modified to meet your organization's needs.

When contracting with community providers, prioritize the use of programs, practices and tools that empower and activate consumers. Shared decision making and self-direction are the keys to personalized and personal medicine. While sounding similar, there are important distinctions between these two sets of concepts.

Personalized medicine (sometimes called precision medicine) is a well understood concept and becoming widely employed in many areas of medicine, most notably in oncology. Based on a person's genetic profile and the results of environmental influences (epigenetics), medications and treatments may be tailored to address specific diagnoses, individual profiles, and responses. But with respect to psychiatric conditions, personalized medicine is in its infancy[19] in that distinctions within diagnostic categories are often subjective, and there are not as yet precise diagnostic tests.[20]

At this point in time, psychiatric medication prescribing is still imprecise, but finding the best medication regime is often essential for an individual's recovery. This underscores the importance of more than one set of expertise in the process of determining what medications to use; i.e. the prescribing clinician and the individual for whom medication is prescribed. Tools to facilitate feedback and enhance interaction between prescriber and person include SAMHSA's Shared Decision Making in Mental Health Decision Aid, and the Common Ground ™ computer program, developed by Dr. Patricia Deegan and the University of Kanas School of Social Welfare, is utilized by provider organizations nationwide and funded by many states and counties.

Personal medicine goes to the heart of community inclusion in that it is maximizes aspects of each domain of the individual's life that they feel helps them to maintain and enhance their wellness. Examples of personal medicine might include a going to work, doing yoga, playing music with friends, being in nature, playing with their children or pets—the possibilities are as varied as the individuals themselves. Many agencies, counties, and state entities encourage the use of the Wellness Recovery Action Plans (WRAP) to help people create personal wellness toolboxes. BHMCEs and provider agencies often train their peer employees to use WRAP, and could also train staffers to become facilitators.[21]

Another important component of personal medicine is determining what it is that individuals want and don't want when they are not well. One such tool is the TU Collaborative Advance Self-Advocacy Plan. This helps people determine in advance of a crisis or period of acute symptoms what treatments and supports have worked for them in the past and what it is that they want, should they need it, in the future. An important outcome of creating such a plan is helping individuals to create and use psychiatric advanced directives (PADs). BMHCEs can play an important role in seeing that providers ask for and honor PADs. Seeing that federal law is more widely applied in psychiatric facilities, ensure that all facilities that receive Medicaid or Medicare funds offer advance directives.[22]

Action Item 6: Measuring Quality of Community Inclusion Services

Use the Community Participation Measure or other indicator of community inclusion in quality improvement. This can be effective in in many ways beginning with the following:

1. Measuring the community inclusion promotion of individual providers or mental health centers to determine which providers are performing well and which need assistance. Best practices can be taken from the best performing providers and shared with providers who may need some assistance promoting community inclusion.

2. Incentivizing effective care by providing additional reimbursement for use of the community inclusion measure in treatment, or by providing additional reimbursement based on progress in community inclusion of members treated.

3. Identifying areas where community inclusion is strong and where it is weak. For example, the BHMCE may find that their members are doing well in the spirituality aspect of community inclusion, but not in housing, and could use this information to support housing programs for the members.

4. Using this tool can help people to determine and to articulate what it is that they would like to participate in, as well as what it is that they are doing. This can assist individuals and providers identify which community resources to seek out.

5. This tool may also be used to as an ongoing way to measure changes in community inclusion as a means to evaluate the effects of services and supports.

Excerpt from the Community Participation Measure

A. How many days during the past 30 days did you do the following activities without a program staff person going with you:	B. Number of Days (without a staff person)	C. Do you do this activity?			D. Is this activity important to you?	
		Enough	Not Enough	Too Much	Yes	No
9. Go to a library.	___ (# of Days)	1	2	3	1	0
15. Go to a 12-step / self-help group for substance use problems.	___ (# of Days)	1	2	3	1	0

The complete Community Participation Measure can be found in Appendix C.

Action Item 7: Addressing Shared Risk and Answering Requests for Proposals

Community inclusion does come with some risk as members take chances and make a life for themselves in the community. The Temple University Collaborative created a toolkit on managing risk, called Managing Risk in Community Integration: Promoting the Dignity of Risk and Supporting Personal Choice. This toolkit includes risk assessment tools and support plans.

Below is sample language that can be used in response to a Request for Information (RFI) from a state or county agency to ensure that the resulting Request for Proposals (RFP) reflects a focus on community inclusion and supports its promotion. This section also contains a checklist to evaluate opportunities and barriers to promoting community inclusion from the RFP.

Some of the following language may be helpful in a response to a Request for Information. Although much of this depends on the State Medicaid Plan, eventually the plan may be amended to provide the desired flexibility.

Sample Language for RFPs

We urge the State/County Department of Mental Health to ensure that the Request for Proposals encourages applicant behavioral health managed care entities (BHMCEs) to best promote the community inclusion of the individuals they serve.

We do so by looking beyond symptom reduction to ask if the members we serve are getting the chance to "live like everyone else" within the community at large. To fully embrace the concept of community inclusion, we ask ourselves: "Do individuals' lives exist mostly within their homes or inside the mental health system, or do they get to live, work, learn, and play like others in their community? Is this the best way to help our consumers to establish independent lives in the community and live like everyone else?"

When individuals are more engaged in the community, they are more successful in their recovery and generally find their lives more meaningful. With community inclusion's focus on independent living, education, and competitive employment, inclusion makes our communities more successful as well.

As such, we believe that community inclusion is not only what individuals with behavioral health conditions and their communities want, but also what they need.

To best promote community inclusion, we believe the RFP should contain the following provisions:

(1) Community Inclusion as a Goal Throughout
(2) Use of Risk-Adjusted Capitated/Per Member Per Month Payment, Or Flexible Billing Codes
(3) Include Community Inclusion as a Quality Measure and Incentivize
(4) Provide Contacts with Other Agencies and Funding

More information to include in this letter can be found in Appendix D.

The following Evaluation Checklist may also be helpful for measuring the efficacy of community inclusion efforts.

Evaluation Checklist

☐ Focus on Community Inclusion
  - o   Uses Community Inclusion as an Outcome Measure
  - o   Pays Extra for Improvement in Community Inclusion

☐ Flexibility in Billing
  - o   Capitated Rate with Risk Adjustment
  - o   Bundled Payment
  - o   If Billing Codes, Then:
    - ▪   Community Inclusion Planning and Support
    - ▪   Use of Peer Specialists
    - ▪   Individual and Group
    - ▪   Transportation and Care in Community
    - ▪   Interactions in the Community
    - ▪   Non-in-person, Such as Phone and Texting

☐ Includes Inter-Agency Contacts and Alternative Funding Sources
  - o   Contains contacts with housing, education, and labor agencies
  - o   Contains provisions for accessing alternative funding sources

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Action Item 8: Policy Implications, Making the Most of Evidence-Based Practices, Evolving Payment Systems and Regulatory Guidance

One of the most importance concepts in the evolving health care policy landscape is Evidence-Based Healthcare. As mental health policy moves towards requiring value based payment and prospective payment systems, which are based on outcomes, rather than set rates for specific clinical, practices or support services, the use of evidence-based practices (EBPs) becomes increasingly important. BHMCEs have an unprecedented opportunity to grow the use of psychiatric EBPs, which are all of which are highly indicative of community inclusion. These include permanent supported housing, supported employment, supported education, and family psychoeducation.

As states increasingly move to require managed care in their Medicaid programs, and public mental health systems undergo radical systems transformations, BMHCEs along with other community stakeholders, such as individuals with lived experience, those currently receiving services, and providers, play an increasingly important role in designing new systems. Once such example where this has recently occurred is New York, As can be seen from the list below of required services for New York's Health and Recovery Plans (HARPs) program for individuals with significant behavioral health needs required components include community based clinical services, reflect community inclusion principles and stress EBPs:

- o Psychosocial rehabilitation
- o Community Psychiatric support and treatment (CPST)
- o Residential supports/Supported housing
- o Crisis intervention
- o Peer supports
- o Habilitation
- o Respite/Crisis respite
- o Case Management
- o Supported employment
- o Education support services
- o Self-Directed services
- o Non-medical transportation
- o Family support and training

These types of community integration fostering programs are being actively promoted by the federal government. Recent directives from the Center for Medicare and Medicaid Services (CMS) bear this out. For example, in June of 2015 CMS issued an informational bulletin entitled Coverage of Housing-Related Activities and Services for Individuals with Disabilities explicitly directs payment for housing supports that "achieve optimal community integration" (albeit using the old term—community integration). This document encourages states to utilize their 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice State Plan Option to pay for housing related supports, services, and activities.

A number of states along with their BHMCEs are employing a growing number of ways to create the flexibility to enhance community inclusion using Medicaid resources under 1115 Waivers, Among the creative models are Oregon's Coordinated Care Organizations (COOs), which allows for flexible spending and in lieu of services that are paying for community fitness nutrition and cooking classes (along with transportation and clothing/equipment to attend), repairs to housing, and best of all the beloved catch-all category "other," approval of which is at the discretion of the Care Coordinator.[23]

BHMCEs are utilizing the savings realized in Medicaid saving and additionally furthering the use of promising and innovated programs, and practices. One example is extending the use self-direction through the use of reinvestment dollars in non-traditional ways of looking at what is considered to be

medically necessary as does Delaware County Pennsylvania's Consumer Recovery Investment Fund – Self Directed Care (CRIF-SDC) Program. This program allows its participants to further their own community inclusion by using a portion of realized Medicaid savings to purchase things that constitute personal medicine for them (like yoga classes) or help them get to work (a car battery), or purchase a community concert subscription.

BMHCEs play an important role in managing public and private dollars, along with the growing array of community providers, especially peers, and with the participation of, and guidance from, those they service. In doing so, BHMCEs are furthering community inclusion and recovery as they re-envision behavioral health services.

Conclusion:

It is a most exciting, hopeful yet turbulent, time for BMHCEs, service delivery systems, and for individuals with psychiatric disabilities. New and different service models are being developed and implemented in states nationwide. Payment and service delivery models, what constitutes medical necessity and definitions of covered services and supports are all in flux. But BMHCEs working with their state Medicaid authorities, those whom they serve, and providers, are making increasing use of community resources. They are being guided by community inclusion principles. They are utilizing all the domains of community inclusion, and thus are providing the foundational elements for achieving the triple aim of Affordable Care Act: better health care for individuals, better health for populations, and lower per capita costs.

Section 3: Appendices

Appendix A: Provider Community Inclusion Checklist from the Temple University Collaborative[24]

- ☐ I assist people in finding and maintaining housing in the communities they wish to live in and that meet their interests.
- ☐ I provide support, encouragement and guidance for people to pursue additional education.
- ☐ I provide information on volunteer opportunities and encourage them to be aware of community issues and vote.
- ☐ I encourage people to discuss their religious/spiritual beliefs and assist them with locating a place of worship.
- ☐ I assist people in securing affordable and reliable transportation, including creative strategies involving car- and ride-sharing with friends and family members.
- ☐ I learn about community resources that are available to persons in recovery and encourage people to utilize these resources.
- ☐ I have access to information about entitlements and benefits.
- ☐ I enhance my relationships with local human service agencies and develop reciprocal relationships with them by giving and receiving resources. I provide consultation to them on how to best support persons in recovery.
- ☐ I develop reciprocal relationships with community businesses, educational institutions, religious organizations, recreational organizations, and other entities.
- ☐ I link individuals I serve to vocational assistance, job training, and job placement services.
- ☐ I encourage and assist people to participate in recreational and physical activities.
- ☐ I encourage and assist people with developing relationships and making friends with other persons in recovery and individuals in the community.
- ☐ I provide information on how to establish and maintain intimate relationships, and discuss barriers (including medication side effects), and strategies to overcome these barriers.
- ☐ I provide encouragement and assistance to parents in recovery to help them maintain custody of their children and to enhance their well-being and that of their child(ren) (e.g. encouragement to participate in peer support groups for parents, assist them to find a peer advocate, parent training).
- ☐ I provide information and support to allow persons to maintain their physical health (e.g. assist them in securing health insurance, discuss healthy diets and exercises).
- ☐ I encourage and support people in making their own decisions about their behavioral health treatment, including true participation in treatment/recovery planning, completion of psychiatric advanced directives or another type of crisis plan, and assistance in identifying their interests and desires without imposing my opinions about what is or what is not feasible.
- ☐ I encourage and support individuals in recovery to start self-help, mutual-aid groups at my agency and provide resources to ensure the long- term success and independence of such groups.
- ☐ I learn about various stigma-busting efforts, including low-cost/low-technology strategies, that can be initiated with the providers in my agency and within the larger community.

Appendix B: Sample Letter for Contracting with Community Providers

Our organization is committed to promoting the community inclusion of the members we serve. Community inclusion is not just providing opportunities to members of your behavioral health network—it means providing these opportunities within the community, and with other members of the community.

We do so by looking beyond symptom reduction to ask if the members we serve are getting the chance to "live like everyone else" within the community at large. To fully embrace the concept of community inclusion, we ask ourselves: "Do individuals lives exist mostly within their homes or inside the mental health system, or do they get to live, work, learn, and play like others in their community? Is this the best way to help our consumers to establish independent lives in the community and live like everyone else?"

While our primary business is to efficiently manage behavioral health care services, we are also in the business of helping individuals with behavioral health needs lead full, meaningful lives in the community. We look forward to working jointly on this goal in the work we do together.

We invite you to join us in ensuring that individuals are engaged in their communities. Community inclusion is not about increasing spending, so we recommend that you look at your practices, policies, and the way you are currently using funds to see if there are ways to better support community inclusion. For example, instead of hosting a computer class for consumers within a behavioral health care agency, how might consumers be supported in finding and attending a computer class out in the community? Instead of buying a van to transport consumers to events out in the community, how can they be supported in learning how to use available transportation to attend events that are meaningful to them out in the community?

*Measuring community inclusion is important to us. We have attached a community inclusion measure **(Appendix C)** that you may feel free to use in your efforts to promote community inclusion. We find this measure particularly useful for helping consumers plan their goals in the community, determine the necessary supports to get there, and then track their progress toward community inclusion. This measure also takes into account the concept of self-direction. Consumers should have the ability to influence their care and should feel empowered to engage with their communities in ways that they find meaningful.*

We appreciate your feedback. We know that a number of barriers exist and creativity will be key in promoting successful community inclusion. Please share with us any barriers you face or innovative strategies you pioneer. We are dedicated to supporting your efforts toward community inclusion and would like to share your best practices throughout our organization.

Thank you for your part in promoting the community inclusion of our consumers!

Appendix C: Community Participation Measure

Below is the Temple University Collaborative Community Participation Measure. It helps to illuminate the core concepts of community inclusion and demonstrate how easy it is to measure. It can be used for helping an individual plan out their recovery and the supports they need, and then measure their progress in attaining those goals.

(Please note: This community inclusion measure is adult focused. For those engaged in treatment or early intervention with children, the same concepts can be applied but adjusted to be developmentally relevant: to what extent is the child able engage in age-appropriate community and social activities? In addition, community inclusion for children may be promoted in part by supporting parents in fostering their child's community inclusion.)

- Now I am going to ask you about different activities you might have done **during the past 30 days** without a staff person going with you. Please indicate the **number of days** during the **past 30 days** you have participated in each activity outside of your home without a staff person going with you. (Example: You went to five self-help meetings for substance abuse (5) in the past 30 days.)

- **INTERVIEWER NOTE**: If respondent has NOT done an activity in the past 30 days, the number of days would be 0. See the Library example below.
- If respondent did NOT want to do the activity in the past 30 days, indicate: "Enough."
- If respondent wanted to go to the Library, but did the activity 0 times during the past 30 days select: "Not Enough."

  - Is this activity important to you? (**Yes**, this activity is important to you or **No**, this activity is not important to you).

Community Participation Measure with Sample Responses

A. How many days during the past 30 days did you do the following activities without a program staff person going with you:	B. Number of Days (without a staff person)	C. Do you do this activity?			D. Is this activity important to you?	
		Enough	Not Enough	Too Much	Yes	No
9. Go to a library.	_____ (# of Days)	1	2	3	1	0
15. Go to a 12-step / self-help group for substance use problems.	_____ (# of Days)	1	2	3	1	0

A. How many days during the past 30 days did you do the following activities without a program staff person going with you:	B. Number of Days (without a staff person)	C. Do you do this activity?			D. Is this activity important to you?	
		Enough	Not Enough	Too Much	Yes	No
1. Go shopping at a grocery store, convenience store, shopping center, mall, other retail store, flea market, or garage sale.	(# of Days)	1	2	3	1	0
2. Go to a restaurant or coffee shop.	_____ (# of Days)	1	2	3	1	0
3. Go to a church, synagogue, or place of worship.	_____ (# of Days)	1	2	3	1	0
4. Go to a movie.	_____ (# of Days)	1	2	3	1	0
5. Go to a park or recreation center.	_____ (# of Days)	1	2	3	1	0
6. Go to a theater or cultural event (including local school or club events, concerts, exhibits and presentations in the community).	_____ (# of Days)	1	2	3	1	0
7. Go to a zoo, botanical garden, or museum.	_____ (# of Days)	1	2	3	1	0
8. Go to run errands (for example, go to a post office, bank, Laundromat, dry cleaner).	_____ (# of Days)	1	2	3	1	0
9. Go to a library.	_____ (# of Days)	1	2	3	1	0
10. Go to watch a sports event (including bowling, tennis, basketball, etc.).	_____ (# of Days)	1	2	3	1	0

A. How many days during the past 30 days did you do the following activities without a program staff person going with you:	B. Number of Days (without a staff person)	C. Do you do this activity?			D. Is this activity important to you?	
		Enough	Not Enough	Too Much	Yes	No
11. Go to a gym, health or exercise club, including pool, or <u>participate</u> in a sports event (including bowling, tennis, miniature golf, etc.).	_____ (# of Days)	1	2	3	1	0
12. Go to a barber shop, beauty salon, nail salon, spa.	_____ (# of Days)	1	2	3	1	0
13. Use public transportation (for example, buses, Broad Street Line, subway) (This does NOT include mental health agency vans).	_____ (# of Days)	1	2	3	1	0
14. Go to a 12-step / self-help group for mental health issues.	_____ (# of Days)	1	2	3	1	0
15. Go to a 12-step / self-help group for substance use problems.	_____ (# of Days)	1	2	3	1	0
16. Go to another type of support group in the community (for example, overeaters anonymous, gamblers anonymous) (Specify name of group:_____)	_____ (# of Days)	1	2	3	1	0
17. Go to a consumer-run organization or advocacy group/organization (This includes NAMI or any other organization that is completely run and operated by mental health consumers OR an organization or group	_____ (# of Days)	1	2	3	1	0

that advocates for rights and services for mental health consumers).						
18. Go to a social group in the community (for example, a book club, hobby group, other group of people with similar interests) (Specify name of group: _____)	_____ (# of Days)	1	2	3	1	0

A. How many days during the past 30 days did you do the following activities without a program staff person going with you:	B. Number of Days (without a staff person)	C. Do you do this activity?			D. Is this activity important to you?	
		Enough	**Not Enough**	**Too Much**	**Yes**	**No**
19. Work for pay.	_____ (# of Days)	1	2	3	1	0
20. Go to school to earn a degree or certificate (for example: GED, adult education, college, vocational or technical school, job training).	_____ (# of Days)	1	2	3	1	0
21. Take a class for leisure or life skills (for example, classes for cooking, art crafts, ceramics, and photography).	_____ (# of Days)	1	2	3	1	0
22. Participate in volunteer activities (in other words, spend time helping without being paid).	_____ (# of Days)	1	2	3	1	0
23. Get together in the community or attend an event or celebration with family or friends (for example, a wedding, bar mitzvah).	_____ (# of Days)	1	2	3	1	0
24. Entertain family or friends in your home or visit family or friends in their homes.	_____ (# of Days)	1	2	3	1	0
25. Go to a community fair, block party,	_____					

community clean-up day, or other community event or activity.	(# of Days)		1	2	3		1	0
26. Go to or participate in civic or political activities or organizations.	_____ (# of Days)		1	2	3		1	0

Appendix D: Additional Information to Include in Letters Regarding RFPs

1. Include Community Inclusion as a Goal Throughout. Individuals with mental health needs recover most effectively when all stakeholders work to facilitate their community inclusion. As part of this, it is important that both the contracting entities and the BHMCE understand that the goal of the provision of mental health services is to get individuals back into the community and living like everyone else, not only symptom and inpatient utilization reductions. To reflect this, the RFP should mention community inclusion as the goal throughout.

2. Use Risk-Adjusted Capitated/Per Member Per Month Payment, and the use of flexible Billing Codes. [*If the state has already received a waiver:* We hope that the Medicaid waiver will be applied in this RFP so that services will be paid for through a risk-adjusted, capitated rate.] [*If the state does not already have a waiver:* We hope that the Department will apply for a Medicaid waiver to allow for payment of mental health services through a risk-adjusted, capitated rate. In the meantime, we hope that the Department will allow billing for the full range of services needed to promote community inclusion. This should include, for example, CPT codes allowing for as many options as possible in care coordination, psychiatric rehabilitation, and use of peer specialists. In particular, it is essential that billing be allowed for support to be provided through telephone and text, in the community and not only at the clinic, and allow contact with individuals other than the consumer as part of care coordination. Alternatively, the RFP could allow flexibility through an "in lieu of" services waiver, in which you allow us to provide supports that promote community inclusion in lieu of providing some amount of inpatient services.[25]] If our care is to mean more than symptom reduction, care teams will need the flexibility to support consumers in planning and pursuing their personal goals for what they see as recovery and how they want to join in community life.

   For example, instead of providing classes for consumers at the community mental health centers, we aspire to help our consumers gain the skills and confidence they need to go to engage in classes in the community and work toward establishing independent, self-directed lives. We will be most able to help our consumers if the payment system in the RFP allows flexibility to fully support consumers and address their individual needs.

3. Include Community Inclusion as a Quality Measure and Incentivize. The community inclusion of individuals with mental health needs is really the goal of the mental health system and, as such, should be measured and incentivized. Attached you will find a community inclusion measure – a brief survey for consumers to fill out that evaluates their progress toward achieving their goals in the community, and that was adapted from a survey that was cross- validated against recovery, quality of life, and meaningfulness in life measures.[26] When community inclusion is specified as a desired outcome, it will help systems to supports consumers in pursuing meaningful lives out in the community.

   As part of understanding community inclusion as a goal, successful promotion of community inclusion should be incentivized. Fostering community requires creativity at all levels and this level of attentiveness and engagement should be rewarded – especially when it leads to better lives for the consumers served.

4. Interagency Cooperation. Community inclusion is best promoted by inter-agency cooperation. As service provision moves from inside of community mental health centers to support individuals out in the community, we hope to collaborate with other agencies. For example, if we stop providing classes inside the centers and instead help individuals take classes at a local community college or university, we would benefit from strong relationships with the state and county departments of education. The same is true with housing and other agencies. Contacts with other agencies would also facilitate access to alternative funding streams that could benefit

consumers as they pursue community inclusion. It would be ideal if the Department could support inter-agency coordination to promote community inclusion as part of the contract.

Evaluating the extent to which the Request for Proposals supports community inclusion and identify opportunities and barriers to promote community inclusion within your organization. Opportunities to promote community inclusion should be communicated to BHMCE staff and network providers to support their efforts.

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