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# **Wisconsin Public Mental Health and Substance Abuse Infrastructure Study**

## **Summit Addendum to Study Report**

**Prepared for the  
Wisconsin Department of Health Services by  
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# Mental Health and Infrastructure Summit Break-out Sessions

## Summary of Dialogue on Key Issues and Next Steps

More than 230 system stakeholders attended the MH/SA Infrastructure Summit held on December 3, 2009 in Stevens Point, Wisconsin and participated in facilitated break-out sessions designed to begin a dialogue on key issues and next steps. The questions posed to the stakeholders who participated in the five break-out sessions are listed and their comments are summarized and arranged thematically in this document.

### What do you think needs to happen to improve in each of the benchmark areas identified in the MH/SA Infrastructure Study?

#### A. Equitable Access to Services Across the State

##### 1. Develop Core Benefit Package

Stakeholders indicated that a core set of MH/SA services for adults and children would move towards a more equitable system and ensure service consistency statewide. Some also expressed interest in providing flexibility to define certain services regionally or locally.

##### 2. Increase Service Capacity

Stakeholders stressed the need to expand service capacity and reduce waiting lists, especially in certain areas (e.g., rural areas), for particular services (e.g., peer support, alternatives to institutional placement, outpatient therapy) and for certain populations (e.g., children with special needs). Use of telehealth was identified as a way to expand access to services.

##### 3. Develop Workforce

Stakeholders noted the need to address the lack of MH/SA providers and the number of culturally competent providers that accept Medicaid. Ways to develop the workforce that provides MH/SA services include coordination with the university system, incentives to develop MH/SA service providers, especially for children's services, and the use of different practitioners to form interdisciplinary teams to serve those with MH/SA issues.

##### 4. Revise Service Approach

Stakeholders commented on the need to focus on prevention and early intervention (e.g., ADRC and public health models) and to use wraparound and collaborative approaches, informal supports and dual-diagnosis treatment to form the foundation for a revised service approach. Focus should be on the three "E's" – who enters the system, what evidence-based practices they receive, and what the effective exit strategies for leaving the system are.

##### 5. Define Populations and Areas Served

Stakeholders identified the need to clearly define who is eligible for MH/SA services and how individuals transition through the system and exit the system to ensure statewide consistency. Some indicated services should be prioritized to those most in need (i.e., those needing acute services), while others

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indicated that underserved populations, especially those without health care coverage, should be prioritized.

### **6. Align System Incentives**

Stakeholders supported the establishment of better linkages, expanded services, and/or improved accountability for managed care programs, including Family Care, in order to reduce overall system conflict and ensure system incentives are aligned to support MH/SA service goals and outcomes.

## **B. Accountability for Outcomes**

### **1. Develop Outcomes**

Stakeholders expressed the need to have defined, meaningful and measurable outcomes to set service expectations, improve performance and guide reform. Outcomes may be viewed differently by different stakeholders and influenced by multiple providers. Outcomes should be meaningful to consumers and tied to quality of life issues.

### **2. Implement Evidence-Based and Best Practices**

Stakeholders indicated the need to implement best practices that are evidence-based, but also pointed to the need for greater clarity regarding what is meant by evidence-based practices and best practices. Some said more attention should be focused on practices that are innovative, flexible and effective, including building one-on-one relationships between staff and consumers. Resources to ensure fidelity to EBPs is important, along with better dissemination of EBPs, training of staff and technical assistance to counties in order to support statewide implementation.

### **3. Improve Data Systems**

Stakeholders stressed the need to improve the consistency, timeliness and overall quality of human services data collection and reporting to ensure that data is accurate, complete and meaningful for analysis and decision-making purposes. Resources will need to be dedicated to system improvements including staff training and quality control. Service systems and counties with good data collection and reporting should be reviewed to identify strengths and elements that can be incorporated into a common statewide data system.

## **C. Equitable and Affordable Funding for Services**

### **1. Increase and/or Realign Funding**

Stakeholders supported more resources to ensure equitable access to MH/SA services statewide, by increasing and/or shifting resources to prevention, early intervention and county-funded services. Realigning funding recognizes the current budgetary and economic conditions, while increasing funding for MH/SA reflects the desire to provide more resources to an under funded system in general. Specific ways identified by stakeholders to improve resource allocation for MH/SA included:

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- Restructuring community aids to achieve better transparency and accountability as to how community aids funds are spent and to provide more understandable information to highlight the need for MH/SA funding.
- Shifting funding and philosophy to front-end, community-based services from higher-cost, institutional placements, including those in the correctional system.
- Targeting certain resources to where the need is the greatest (e.g., funding for outreach in rural areas).
- Pooling funding sources to provide greater flexibility to effectively meet service needs.
- Integrating MH/SA services with physical health care to create a broader funding base to address resource needs.
- Establishing a tax or increasing taxes to fund MH/SA services.
- Defining state/county risk sharing to establish funding accountability for MH/SA services. Pursuant to the county Visions proposal, funding could be organized in tiers:
  - 1<sup>st</sup> Tier Benefit Package – Fully state funded
  - 2<sup>nd</sup> Tier Benefit Package – County/state funding (partnership)
  - 3<sup>rd</sup> Tier Benefit Package – County only funding

### **2. Revise Medicaid Funding and Funding Responsibility for Medicaid Match**

Stakeholders indicated the need for an improved Medicaid rate structure that provides adequate reimbursement for the cost of MH/SA services and broader service coverage. Stakeholders also indicated support for state funding of the nonfederal share of certain Medicaid services that are now funded by counties.

## **D. Efficiency of Service Delivery**

### **1. Streamline Requirements and Address Inefficiencies**

Stakeholders stressed the need to reduce redundancy, complexity and variation in program requirements in order to streamline the administration and improve the efficiency of MH/SA services. Specific examples include regulatory duplication between DHS and the Department of Regulation and Licensing, multiple client assessments, duplicated client information, redundancy or inconsistency in program certification, and variation in requirements for different funding sources. The need to address “no shows” (i.e., missed appointments) was also raised as an issue that impacts service efficiency.

### **2. Integrate and Coordinate between Systems and Services**

Stakeholders indicated that collaborative efforts could help reduce redundancy and fragmentation between service systems and within the MH/SA system and achieve potential economies of scale. Providing a continuum of care for children and adults based on needs (i.e., right services at the right

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level at the right time) would help address service delivery inefficiencies. Family Care was identified to illustrate that efficiencies in some areas lead to inefficiencies in other areas for the services that did not move to Family Care and remained with the counties.

### What key components do you think should be included in any MH/SA reform effort?

#### A. Scope of Reform

##### 1. Address Comprehensive Systems Reform

Stakeholders expressed interest in broadening the scope of reform to other parts of the human services system, including child welfare and juvenile justice, as well as including integration between MH/SA, physical health care and prevention services (e.g., public health). The scope of reform should include a wraparound approach that recognizes the importance of housing and education to individuals with MH/SA issues.

### What are your views on how potential MH/SA financing and service delivery reform should proceed and what do you think the next steps should be?

#### A. Approach to Reform

##### 1. Include Broad Stakeholder Involvement

Stakeholders supported the establishment of a broad-based steering committee to help develop, plan and guide the reform process. The process should include comprehensive stakeholder involvement from consumers and advocates; state, county and tribal officials; and private providers representing the MH/SA system and other related systems (child welfare, juvenile justice, long-term care, corrections, public health, education, etc.).

##### 2. Establish Vision and Set Goals

Stakeholders saw the need to first clearly define what reform encompasses and what it is intended to accomplish in the form of a clear vision and defined outcomes that are consumer-driven and shared among system stakeholders.

##### 3. Provide Strong Leadership and Support

Stakeholders indicated that reform required strong executive and legislative leadership supported by a consistent message and increased consumer and advocacy involvement to communicate the need for reform.

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### 4. Proceed with Initial Steps

While some questioned the feasibility of proceeding with reform in a time of economic downturn, others urged that reform could move ahead with initial, but important, steps to include:

- Development of a core benefit set that is uniform across the state.
- Reduction of burdensome requirements for service providers.
- Identification of what works well and can be implemented in a time of limited resources.
- Development of desired outcomes and collection of data necessary to measure the outcomes.

### 5. Manage Reform Effort

Stakeholders supported a deliberate approach to reform that takes into account all the implications of reform, including associated costs. Work plans that establish priorities and set reasonable expectations and timelines should be developed. Stakeholders indicated that reform should be implemented as pilot projects, with established benchmarks that are measured before reform is implemented more broadly.

## B. Potential Models

### 1. Explore Potential Models and Pathways

While only a few stakeholders commented on the specific models for system financing reform, those that did, stated a preference for Model A (county-based system) and voluntary Model B (county collaborative system) with appropriate system incentives and possible integration of MH/SA services with physical health care under Model D. It was stated that the models are simply a means to an end, and that expected goals for system reform will first need to be defined.

## Next Steps – What happens after the Summit?

Based on the initial dialogue and feedback at the MH/SA Infrastructure Summit, the Department of Health Services (DHS) plans to expand the infrastructure study steering committee to include broader stakeholder representation. The expanded steering committee will oversee the next phase of the project, which will focus on developing specific recommendations for advancing improvements to the public MH/SA services system in order to inform the next state biennial budget and other policy making processes.