

#8 Quality Improvement Plan:

After the completion of the Southeastern Partnership's environmental scan related to coordinating and managing care, the PIHP identified challenges or areas for improvement. A theme arose around strengthening and supporting the existing collaborative efforts and for enhancing specialization for identified gaps or special populations. Meaning, ensuring targeted collaborations with a specific purpose instead of generalized collaborations regarding the following populations served:

Children and families in multiple systems of care

Although the Southeastern Partnership already has multiple community collaborations and programs, such as Wraparound, Early On, and a youth aging out of foster care collaboration, the PIHP recognizes the need for taking a leadership role in facilitating a work plan to increase targeted collaborations and partnerships within each individual community to address the needs of children actively involved in multiple systems of care. Stakeholder input stressed the desire for improved collaboration between us and any possible referral source in the community. The PPG also shows a need for increased partnering with DHS, school systems, and the juvenile justice system.

Individuals with DD who have complex co-morbid conditions

Again, the individual CMH's within Southeastern Partnership have implemented collaborations and programs to improve the coordination between agencies, but the PIHP recognizes the need for further improvements. Areas already being explored include utilizing motivational interviewing techniques, gentle teaching techniques, multi family groups, and a quality of life assessment tool. Each county is also already participating in ten year plans to end homelessness. These plans are collaborative efforts to house community members of all backgrounds but includes a section specifically addressing people with developmental disability. The collaboration has shared administrative practices, shared outcomes and integrated funding. Expanding appropriate housing options and expanding staff trainings beyond core required trainings continues to be explored.

Individuals with SMI (under served/co-occurring/increased physical disabilities/dementia)

The Southeast Partnership continues to develop partnerships between the CMH's and community clinics as a means to ensure integrated care is available to SMI folks who do not receive the full spectrum of CMH services. The CMH provides consultative support to primary care physicians regarding medications and trainings on issues specific to mental illness. An area identified in need of more resource (time, service, etc) is the aging population. Stakeholders expressed a need for housing, services, and staff targeted toward individuals with SMI experiencing physical decompensation and/or signs of dementia. Physical decompensation can lead to nursing home placement and behavioral challenges can lead from the nursing home to inpatient psychiatric units. Increased coordination between CMH, VA services, substance abuse services, nursing home services, hospitals, and housing agencies (need barrier free) could create more community based solutions and an improved quality of life.

Areas of improvement were also identified for:

Coordination across CMHSP boundaries

The PIHP recognized coordination of care is not always seamless internally or across the affiliation boundaries. Processes have already been created to streamline the COFR process. The PIHP will ensure the processes are well defined and well rolled out to ensure all CMH staff, therefore the folks served, are aware services can be sought across CMH boundaries.

Coordination with primary care

Integrated healthcare clinics exist in the Southeast Partnership. We are also working toward improved incorporation of personal health reviews into the person centered planning process. And, we are currently participating in a disease management pilot project. Challenges do arise throughout the CMH's with transportation from rural areas, and limitations of community doctors willing to accept Medicaid and partner with the CMH. The PIHP will consult and support throughout the affiliation to ensure further development of integrated health initiatives including substance abuse services.

2009 APPLICATION FOR RENEWAL AND RECOMMITMENT TO QUALITY AND COMMUNITY IN
THE MICHIGAN PUBLIC MENTAL HEALTH SYSTEM
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ATTACHMENT A TEMPLATE
Milestones and Timeframes

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ARR Section Number: 8

Note: add more rows as needed

Milestones	Baseline Data (where applicable)	Timeframe for Achieving Milestone: Begin* and end dates	Comments
Develop regional catalogue of all existing partnerships/collaborations		6/09-8/09	Create one comprehensive listing
Complete gap analysis of partnership/collaboration catalogue to ensure care coordination is occurring in each county		8/09-11/09	Analyze for each county and also collectively as an affiliation
Develop a menu of services for orientations, website, clinical staff, etc.		10/09-1/10	Youth & Adult listing all possible services if found medically necessary, include reference to community resources also
Ongoing orientations/trainings regarding available services/processes, including contact information (like a 'CMH 101' and 'SA 101' in the schools, juvenile system, community clinics, etc)		1/10-9/14	Orientations/trainings ongoing. Consider having Customer Service, clinical, Finance/PRU present
Improve website access to information, services offered, collaborations		12/09-4/10	Maintenance and updates will be ongoing. Each department/county is responsible to submit website info to be updated
Explore a secured communication mechanism between providers to share information regarding a shared consumer		5/10-12/10	Explore after Encompass 2.0 installation
Convene group to explore the PIHP's role in collaboration with nursing homes, community based solutions, future need for SMI population		2/10-4/10	Include the existing Housing Workgroup
Explore further developments of integrated care initiatives throughout the Southeast Partnership	Currently, DD- at least 27% co-morbid MI- at least 236 assigned to integrated clinics	10/09-9/14	Expand integrated service scope to address the multiple physical health, mental health, substance abuse needs
Streamline COFR process to improve service delivery across CMH boundaries		6/09-12/09	Finalize standardized process and roll out to affiliation