

REQUEST FOR FUNDING

Minnesota Mental Health Action Group

Phase II

JUNE 2004 - MAY 2005

“[MMHAG’s] daunting task is to translate each of its broad recommendations into a series of explicit steps that will propel Minnesota toward the mental health system it needs. The months to come thus pose the greatest challenge the group will face,” said the *StarTribune* of the Minnesota Mental Health Action Group’s second phase. “...Reshaping the state’s approach to psychiatric care will help everyone—from health plans to patients to taxpayers. That’s why Minnesotans should keep their eye on this exciting effort.”

StarTribune Editorial, March 1, 2004

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I. WHAT IS MMHAG?

The **Minnesota Mental Health Action Group** (“Action Group” or “MMHAG”) is an inclusive, broad-based coalition of mental health providers, hospitals, health plans, consumer advocacy organizations, and the Minnesota Departments of Human Services and Health that have joined forces to transform Minnesota’s mental health system. MMHAG is an organizing body where interested people and organizations communicate and work collaboratively to make changes. **Commissioner of the Department of Human Services, Kevin Goodno, and former Citizens League of Minnesota Board Chair, Gary Cunningham,** co-chair the MMHAG Steering Committee (“Steering Committee”). The Action Group has formed **linkages with existing mental health projects, and brings groups together to coordinate** and communicate in order to establish a **shared vision and priorities** for all aspects of mental health, both public and private.

MMHAG is moving forward with a sense of urgency to improve access to care and services for people experiencing mental illness. More than **\$1.2 billion** is spent on mental health and chemical health services each year in Minnesota; yet, consumers and families are increasingly frustrated with problems they face with access to services, quality, and the fragmentation and complexity of the existing system that involves hundreds of public and private programs, activities, services, and funding sources. The problems and possible solutions have been well documented in dozens of past commissions and reports—MMHAG was created to **take action** to transform the system to better serve consumers and families, and improve quality and efficiency.

To the extent possible, MMHAG is **implementing changes without seeking legislation**, through the commitment of leaders of public and private mental health organizations to change the way they fund and deliver mental health care and services. Through MMHAG, those who experience mental illness and their families can partner with those who finance and deliver care and services to change the systems that serve them. Inevitably, however, some legislative changes will be needed, and MMHAG and the Minnesota Department of Human Services will work together to seek the **enactment of legislation during the 2005 legislative session** to remove barriers and reduce complexity of public programs and funding.

II. ACCOMPLISHMENTS

MMHAG has nearly completed its first year and is entering into its second and **final year**. MMHAG’s costs have been funded by **twelve hospitals and health plans** who have demonstrated a keen interest in improving Minnesota’s mental health system by providing funding totaling **\$157,000** to support MMHAG’s activities so far. Just as important, these organizations have contributed significant in-kind support and commitment through strong participation in MMHAG’s Action Teams, Work Groups, and Steering Committee.

Volunteers from the funding organizations are joined by virtually **hundreds of individuals** who participate in one or more of MMHAG’s **six Action Teams** and **twenty active Work Groups** by participating in meetings, reviewing materials, submitting comments or attending MMHAG public meetings.

MMHAG Action Teams:

- Public Private Partnership Model
- Fiscal Framework
- Coordination of Care and Services
- Standardized Assessment, Performance Measurement, Evidenced-Based Treatments and Outcomes
- Earlier Intervention and Secondary Prevention
- Workforce Solutions

(For MMHAG **Work Groups**, see Section XI)

Funding is now being requested to carry MMHAG through summer 2005, when its work will be completed.

The Foundation

MMHAG designed a strong infrastructure from the outset, upon which it has built steadily. In August 2003, MMHAG's Steering Committee began by building on the work and recommendations of many prior task forces, commissions and studies to articulate a **vision** for Minnesota's mental health system:

Minnesota embraces a vision of a comprehensive mental health system that is accessible and responsive to consumers, guided by clear goals and outcomes, and grounded in public/private partnerships.

Then MMHAG endorsed nine **guiding principles**:

The mental health system . . .

- Is flexible to meet the needs of different populations, ages and cultures
- Provides the right care and service at the right time
- Delivers care and services in the least intensive site possible
- Uses a sustainable and affordable financial framework with rational incentives
- Is easily navigated by consumers and providers because it operates in efficient, understandable pathways
- Uses evidence-based interventions and treatment to produce the desired outcomes
- Employs effective health promotion and prevention strategies
- Has appropriate providers and service capacity
- Clearly defines accountability among all parties

MMHAG then promptly put out the **public invitation** for participation in the coalition's Action Teams. The Steering Committee (see current membership at Section XII) met nearly monthly over MMHAG's first ten months, and its Action Teams and Work Groups held many additional meetings. MMHAG approved **ten Action Priorities** (see Section XI), which were announced at a well-attended public meeting in February 2004.

The Build-Out

The March 2004 Steering Committee meeting yielded the formation of **Work Groups** to implement the priority actions identified by the Steering Committee and each original Action Team. These Work Groups will be the primary avenues to make the changes within organizations but also to identify any public policy changes that should be enacted during the 2005 legislative session.

III. IMPLEMENTING A CONSUMER ENGAGEMENT PLAN

MMHAG's goal is to transform the mental health system to **better serve consumers and families**. MMHAG has worked closely with Minnesota's consumer and family advocacy organizations, and some of the leaders from the advocacy community also serve on the Steering Committee. The following persons representing consumer organizations serve on the Steering Committee:

- Sue Abderholden, National Alliance for the Mentally III-Minnesota
- Kris Flaten, State Advisory Council on Mental Health and Subcommittee on Children's Mental Health
- Sandra Meicher, Mental Health Association of Minnesota
- Tom Peterson, Mental Health Consumer/Survivor Network of Minnesota

An informal **coalition** of advocacy organizations has also been convened to ensure that MMHAG keeps consumers in mind and to provide organized consumer participation in MMHAG activities.

IV. TRANSPARENCY AND BROAD PARTICIPATION

The welcome involvement of hundreds of interested people and organizations has been one of the most important aspects of MMHAG, to date. In August 2003, the formation of MMHAG was announced at the annual Minnesota Community Mental Health Conference, and additional interested persons and organizations were recruited to participate.

Action Teams worked on each priority area while communicating via **email, internet, telephone and United States mail** with persons and organizations interested in working in each area. MMHAG staff has sought to be proactive in addressing the unique challenges of each Action Team, through open and constant communication, and creative support activities. A **web site**, <http://www.citizensleague.net/mentalhealth/>, was established and **Yahoo! discussion groups**

were formed around specific topics. Additionally, regular updates were posted to the website to keep everyone informed and encourage participation.

V. DESIRED OUTCOMES

MMHAG's goal is the **transformation of Minnesota's mental health system** to better serve consumers and families, and improve quality and efficiency. Desired outcomes pursued by the **six Action Teams** include:

- A **different fiscal framework** for public and private mental health funding that creates rational incentives for the right care to be delivered in the right setting at the right time.
- **Coordination of care and services** so that the mental health system is easy for consumers and families to navigate and they receive the right combination of services to achieve the desired health and social outcomes.
- **Quality of care** for consumers, as measured by standardized assessment of performance and outcomes.
- **Earlier intervention** so that consumers are willing to seek, and able to access, help when needed.
- **Innovative workforce solutions** to assure an adequate supply of appropriately trained and qualified mental health professionals.
- **Public/private partnerships** to assure that all aspects of the mental health system are working to serve consumers and families.

MMHAG's Work Plan: Ten Action Priorities and Twenty Work Groups may be found in Section XI, at the end of this report.

VI. MMHAG STAFFING AND SUPPORT GOALS, AND DELIVERABLES BY SUMMER 2005

Goals

Phase II is the planned outgrowth of Phase I and focuses on three **goals**:

- Develop a **coordinated plan and timeline** for achieving mental health system reforms in each of the priority areas and follow up to ensure progress is made.
- Serve as change agents to bring about the desired reforms through organizing and leading Work Groups to **mobilize action around specific priorities**.
- Act collectively to seek needed **public policy changes**.

Deliverables: June 2004 - May 2005

- Prepare for and convene five Steering Committee meetings between June 2004 and May 2005.
- Support the activities of the Work Groups around Action Priorities.

- Continue to implement communications and focused consumer engagement plan.
- Document specific implementation strategies for mental health system reform.
- Direct legislative and public policy.
- Prepare presentation of final report of MMHAG activities to the public.
- Dissolve, formally, MMHAG including appropriate transition planning.

VII. BUDGET

Start-up funds raised for the creation and support of MMHAG, its Steering Committee, Action Teams and community engagement have been stretched farther than the original timeframe of six months for Phase I. At the one-year mark, the Citizens League of Minnesota—MMHAG’s fiscal agent and a key coalition partner—now seeks additional funds to build on MMHAG’s exciting progress. This funding would further support professional staffing, an ongoing comprehensive communication and focused stakeholder engagement process, and incidental costs such as meeting expenses, copying and travel. A total of \$165,000 is necessary to accomplish MMHAG’s goals through the completion of the group’s work in May 2005.

VIII. STAFFING

Collaborative staffing for MMHAG will continue to be anchored by three organizations:

- **Citizens League of Minnesota**
Sean Kershaw, President
- **Halleland Health Consulting**
Michael Scandrett, Public Policy Director
Deanna Mills, Community Health Director
- **Departments of Health and Human Services (key staff, as noted, and others as needed)**
Sharon Autio, Health Care Program Manager (DHS)
Glenace Edwall, Health Care Program Manager (DHS)
Christine Eilertson, Policy Director (DHS)
Candy Kragthorpe, Program Administration Coordinator (MDH)

IX. PROPOSED EXPENSES

Expenses	Costs	Narrative
Steering Committee Staffing	\$125,000	Policy Strategist, Project Coordinator and administrative support. Supplemental in-kind staffing will be provided by state agency staff, and other persons and organizations.
Meeting Expenses	\$5,000	Food and miscellaneous meeting expenses. Assumes there are minimal charges or no expense at all for the meeting space.
Copying/Printing	\$5,000	Costs for copying and distributing meeting materials, and printing a final report.
Communications	\$30,000	Costs including continued web site development, assistance with media relations, and public awareness and consumer engagement activities.
TOTAL	\$165,000	

X. PROPOSED CONTRIBUTIONS

Contributor	Phase I Donation	Phase II Request
Allina Health System	\$15,000	\$10,000
Blue Cross and Blue Shield of Minnesota	\$50,000	\$25,000
Children's Hospital and Clinics	\$10,000	\$10,000
Fairview/University Hospital	\$15,000	\$10,000
HealthEast	\$10,000	\$10,000
HealthPartners	\$5,000	\$25,000
Medica	\$10,000	\$25,000
Metropolitan Health Plan	\$10,000	\$10,000
North Memorial	\$10,000	\$10,000
Preferred One	\$10,000	\$10,000
Regions Hospital	\$10,000	\$10,000
UCare Minnesota	\$2,000	\$10,000
TOTAL	\$157,000	\$165,000

XI. WORK PLAN: TEN ACTION PRIORITIES AND TWENTY WORK GROUPS

Top Ten Priorities from Phase I (not in priority order)	Phase II Work Groups: Purpose and Leadership	
	Focus of Energy Now	Focus of Energy Later
1. Increase the public’s awareness of mental health care and provide education and support for screening and earlier intervention.	<p>1a: Implement a statewide public education effort to reduce stigma related to accessing mental health services and provide education, training and support to families, community-based providers, and natural helpers to children and adults who may be experiencing mental health problems.</p> <p><i>Responsibility: Work Group co-chaired by Carol Woolverton (MDH) and Deborah Saxhaug (MACMH)</i></p> <p>1b: Enhance preschool mental health consultation and screening.</p> <p><i>Responsibility: Work Group co-chaired by Glenace Edwall (DHS) and Gayle Kelly</i></p> <p>1c: Consistently screen persons who have physical illnesses with a high incidence of co-morbidity with mental illness.</p> <p><i>Responsibility: Work Group chaired by Sandra Meicher (MHAM)</i></p>	<p>1e: Professional education and cross-training on mental health screening, use of standardized and evidence-based screening tools, accessing mental health consultation, and referrals and follow-up.</p> <p><i>Responsibility: Work Group chaired by [TBD]</i></p>

Top Ten Priorities from Phase I (not in priority order)	Phase II Work Groups: Purpose and Leadership	
	Focus of Energy Now	Focus of Energy Later
	<p>1d: Broaden mental health screening for the aged.</p> <p><i>Responsibility: Work Group co-chaired by Atashi Acharya (SACMH/VOA) and Sue Wenberg (MN BOA)</i></p>	
<p>2. Develop a new statewide funding and payment model that is consumer-centered and promotes high quality, efficient care provided at the right time in the right setting.</p>	<p>2a: Develop funding and payment model; assure model coordinates public funding.</p> <p><i>Responsibility: Work Group co-chaired by John Zakelj (DHS) and Don Allen (DHS)</i></p>	
<p>3. Move to a regional system for publicly funded, community-based services.</p>	<p>3a: Transition the current state-supervised, county-administered system into a system with a standardized set of mental health services available within a geographic region.</p> <p><i>Responsibility: Work Group chaired by Citizens League</i></p> <p>3b: Redirect a majority of Regional Treatment Center funding to more flexible, community-based services.</p> <p><i>Responsibility: Work Group chaired by Sharon Autio (DHS)</i></p>	<p>SC: Work in close partnership with private sector funders and providers as part of the local regional approach.</p> <p><i>Responsibility: Steering Committee</i></p> <p>SC: Redefine the State's roles as funder, regulator and provider.</p> <p><i>Responsibility: Steering Committee</i></p>

Top Ten Priorities from Phase I (not in priority order)	Phase II Work Groups: Purpose and Leadership	
	Focus of Energy Now	Focus of Energy Later
<p>4. Address workforce shortages.</p>	<p>4a: Use shared care models between psychiatrists and primary care providers to support the provision of mental health services. Identify legislative/regulatory barriers.</p> <p><i>Responsibility: DOER/DHS/CMS to convene meeting with state integrated services group</i></p> <p>4b: Address licensing and credentialing barriers to expand scope of practice and increase existing Rx prescribers. Address credentialing issues for use of interns.</p> <p><i>Responsibility: DHS to plan meetings and address</i></p>	<p>4c: Address university and college recruitment and admissions process to increase supply and variety of mental health professionals. Develop training - fellowship programs that are more flexible for nurse practitioners and doctors to practice in the community.</p> <p><i>Responsibility: Recommend to University of Minnesota for direction/leadership</i></p> <p>4d: Identify strategies to assure a culturally competent workforce, e.g. examine entrance requirements, outreach programs, etc., and to facilitate best practices to retain J-1 visa professionals.</p> <p><i>Responsibility: MDH</i></p>
<p>5. Coordinate care and services in the public and private mental health systems.</p>		<p>5a: Diagram working models of coordination and develop sample working agreement for use by health plans, providers, and local agencies to combine essential service components into a comprehensive care plan.</p> <p><i>Responsibility: Work Group chaired by Ron Brand</i></p>

Top Ten Priorities from Phase I (not in priority order)	Phase II Work Groups: Purpose and Leadership	
	Focus of Energy Now	Focus of Energy Later
		<p>(MACMHP)</p> <p>5b: Assure that service coordination is built into practice protocols and expected of providers.</p> <p><i>Responsibility: Work Group chaired by Ron Brand (MACMHP)</i></p>
<p>6. Establish outcomes for care.</p>	<p>6a: Promote the use of streamlined, standardized measurement tools for use across the entire system to produce useful quality data.</p> <p><i>Responsibility: Work Group co-chaired by Sue Abderholden (NAMI) and Cheryl Hosely (Wilder)</i></p>	<p>SC: Designate an independent authority to compile, integrate and report on data that is collected.</p> <p><i>Responsibility: Steering Committee</i></p>
<p>7. Expand opportunities for partnerships between education systems and mental health providers to increase consultation and earlier interventions addressing the continuum of mental health needs for students and their families.</p>	<p>7a: Enhance school mental health screening.</p> <p><i>Responsibility: Work Group co-chaired by Cindy Shevlin-Woodcock (DOE) and Marikay Litzau (DOE)</i></p> <p>7b: Create a policy framework that creates pathways to integrate mental health services and education systems.</p> <p><i>Responsibility: Work Group co-chaired by Mark Kuppe (HSI) and Mark Bezek (Fergus Falls PS)</i></p>	

Top Ten Priorities from Phase I (not in priority order)	Phase II Work Groups: Purpose and Leadership	
	Focus of Energy Now	Focus of Energy Later
8. Correct financing dysfunctions.	<p>8a: Change the most significant dysfunctions in the financing system: determine which services are under-paid and develop a plan for making key services sustainable, including dealing with uncompensated care.</p> <p><i>Responsibility: Work Group co-chaired by Ron Brand (MACMHP) and Eric Larson (APS)</i></p>	<p>8b: Provide technical assistance to providers who bill for public services.</p> <p><i>Responsibility: Work Group co-chaired by Glenn Andis (Medica) and Chuck Heinecke (UBH)</i></p>
9. Develop a model mental health benefit set and promote its adoption by both public and private payers.	<p>9a: Develop model benefit set. Promote its adoption by public and private payers.</p> <p><i>Responsibility: Work Group co-chaired by Karen Lloyd (HealthPartners) and Louise Brown (CMHP)</i></p>	
10. Establish a statewide public-private partnership where common understandings of mental health system changes are understood and actions initiated.	<p>SC: Develop an action-oriented forum where leaders are empowered to be catalysts for mental health system changes within their own organizations and among their peers.</p> <p><i>Responsibility: Steering Committee</i></p>	<p>SC: Set goals for the private and public mental health system changes and recommend proposed legislative changes.</p> <p><i>Responsibility: Steering Committee</i></p>

XII. STEERING COMMITTEE

ABDERHOLDEN, Sue	Executive Director	National Alliance for the Mentally III-Minnesota
ALEXANDER, Gordon	President	Fairview-University Hospital
ANDIS, Glenn	VP Public Programs and Behavioral Health	Medica Health Plan
BRADDOCK, Mary	Director, Child Health Policy	Children's Hospitals and Clinics
BRAND, Ron	Executive Director	Minnesota Association of Community Mental Health Programs
CUNNINGHAM, Gary	Co-Chair/Former Board Chair	Citizens League of Minnesota
DICKSON, Karen	President, Minnesota Psychiatric Society and MN Medical Association, Board of Trustees	Nystrom & Associates
DORFMAN, Gail	Hennepin County Commissioner	Board of Commissioners
ERICKSON, Marti	Senior Fellow	Children, Youth and Family Consortium
EWALD, David	Executive Director	Minnesota Association of Resources for Recovery and Chemical Health
FLATEN, Kris	Chair, State Advisory Council	State Advisory Council on Mental Health and Subcommittee on Children's Mental Health
GOERING, Paul F.	Medical Director, Psychiatry	United Hospital
GOODNO, Kevin	Co-Chair, Commissioner	Minnesota Department of Human Services
HEGLUND, Peggy	Director	Yellow Medicine County Social Services
HOISINGTON, Sue	Executive Director	Hazelden Mental Health Center
KUPPE, Mark	Director of Behavioral Health	Human Services Incorporated
LEPINSKI, Steve	Executive Director Chair, Children's Mental Health Partnership	Washburn Child Guidance Center
MEICHER, Sandra	Executive Director	Mental Health Association of Minnesota
OPHEIM, Roberta	Ombudsman	Office of Ombudsman for Mental Health and Mental Retardation of Minnesota
PETERSON, Tom	Executive Director	Mental Health Consumer/Survivor Network of Minnesota

REITAN, Colleen	Executive Vice President, Operations	Blue Cross and Blue Shield of Minnesota
SIEBERT, Patricia M.	Managing Attorney	Disability Law Center
ULMER, Denny	Director	Bemidji Regional Interdistrict Council
WOOLVERTON, Carol	Assistant Commissioner	Minnesota Department of Health
ZIMMERMAN, Donna	VP, Government Public Relations	HealthPartners