Michigan Department of Community Health

Recovery Council Meeting

Friday, May 21, 2010

LCC West Campus, Lansing

I. Introductions
   a. Recovery Council Members: Regina Allen, Patrick Baker, Stephen Batson, Joel Berman, Tom Burden, Daniel Burleigh, Gerald Butler, Rich Casteels, Risa Coleman, Norman DeLisle, Jean Dukarski, MaryBeth Evans, Cheryl Flowers, David Friday, John Fryer, Colleen Jasper, Amelia Johnson, Irene Kazieczko, Carmela Kudyba, Cheryl LaPointe, Marlene Lawrence, Ruth Morad, Greg Paffhouse, Danielle Parpart, Fawn Preston, Marty Raaymakers, Phil Royster, Sherri Rushman, Sally Steiner, Dona Tatum, Kristen Taylor, Pamela Werner.
   b. Recovery Council Partners: Kendra Binkley, Kris Burgess, Sue Eby, Debbie Freed, Ann Marie Funsch, Michael Head, Michael Jennings, Pamela Lang, Su Min Oh, Deborah Reynolds, Alyson Rush, Felicia Simpson, Margaret Stooksbury, James Wargel, Anna Christianson, Sean Bennett, Jeanne White, Bob White, Clint Galloway, Matt Linihan, Karl Kovacs, Stacy Bart, Dr. Dillon, Steve Kuthman, Rosie Coleman, Sue Kennedy.

II. Announcements
   a. Phil Royster shares a farewell to the group as he is leaving the Council. Irene thanks Phil for all his work and dedication to the Council.

III. Director's Update – Michael Head
   a. Spoke about the Michigan Association of CMH Board spring conference – you can find slides of his presentation on the Board Association's website. At the conference, he spoke about peers and how organizations use peers and how MDCH helps organizations evolve in their utilization of peer specialists.
   b. A lot of the conference was about money – funding. Looking at expanding the Medicaid program earlier than 2014 so that we can support more people. What does recovery mean for people in the system? Thinks a recovery policy will help with these discussions. He knows putting together a recovery policy isn't going to be easy – please don't look at it as a "race to the finish line" – rather your ability to ground and establish a discussion for CMHs to fully incorporate recovery into their practices. He thinks it'll be a lot of work but he is really excited about it. This is an opportunity to continue the idea of hope. Important to have a policy that is actionable.
      i. Questions

1. Jean – How does the Department take action on policy that isn't being enforced?
    a. Mike – We use site review process and look at records. We should be looking more at people's experiences in the system rather than looking at records. REE is a good example of something that provides feedback from people in the system. We are re-thinking the site review process. People in the system should have a lot more authority about the way the service system works.
2. Marty – uncomfortable talking about site review process and recovery policy in the same breath. Understands there needs to be key result measures.
    a. Mike – It is important to talk to people and hear about their experiences in the system. Think about "quality improvement." Marty – I don't see the site review as quality improvement.
    b. Mike – trying to get at the actionable part – meaning if you put something in there, how are you going to know you have met that goal?
    c. Pat Baker – concerned about getting too focused on outcome measures. Thinks we need a statement of philosophy first.
        i. Mike – says if we measure something than people will do it.
        ii. Danielle – if we are trying to move the system forward and the goal is to help people get well, we can look at things like, are people achieving things or moving towards achieving things they want in their life.
        iii. Mike – how do we measure wellness or measure how wellness is evolving? More and more we want the organizations to "own" this and we don't want to force it on people.
        iv. Irene - important when putting together the guideline to be as concrete as we can be on what is the best way to measure things.
        v. Jean – mental health is not concrete and measurable. A diagnosis is not concrete.
            1. Mike – It is important to look at a variety of factors other than a diagnosis.

vi. Cheryl – diagnosis puts a label on people and this concerns her especially with kids. Mike agrees with this.

ii. Mike discusses the MDCH's process for policy – draft is looked at internally, sent out for 30-day review and comment and then MDCH looks at the comments and revises if necessary and then finalizes the policy and it is sent out as a technical advisory. He said the Council will see the recovery policy after the 30-day review and comment before the Department finalizes.

a. Marty – concerned about the time frame – and until we have a policy on the table, CMHs will still use the old ways of measuring. She is very frustrated with things moving slowly. She wants a policy to get out there as soon as possible and not take yet another year to do this.

i. Mike – He understands her frustration and appreciates people wanting to get the system moving. He says if you can do it more quickly than great.

ii. Norm – the REE points to the place where we want the policy. It's the actual experience that people have. This is the standard for the public mental health system – are people getting the quality they want. Move from outcomes to consumers' experience – you'll have better outcomes.

c. Irene – More on the MDCH process for policy making

i. What we are aiming to do is create something that will end up being an attachment to the contract.

ii. Handout – MDCH-MH&SA Procedures for the Development of Interpretive/Consultative/Informational Advisories

iii. If it is in the contract, than every CMH/PIHP will have the same requirements and they will be measured in the same way. You can go to the MDCH website and look at outcome measures we already look at.

iv. Example of the Person Centered Planning Practice Guideline was handed out.

d. Pat Baker –

i. Policy Can Define:

1. What is the direction, the purpose or intent, how something will be accomplished.

ii. Policy Statement May include

1. Summary
2. Purpose

3. Application
4. Policy statement
5. Definitions
6. Practice guidelines/procedures – how the organization is going to carry it out. Meet the intent of the policy.

IV. Break into groups. Each group should:
   a. Spend a few minutes looking at PCP policy and practice guideline- the background section and the essential elements.
   b. If there is one thing in the world that I can get into this recovery policy – what is it?
   c. Think through concepts and define them as clearly as possible.
   d. Focus on key concepts and not so much with word smithing.
   e. A workgroup will look at refining and putting together a draft – any Council member that wants to be a part of this group, let us know.
   f. All information from each workgroup is written on large post it note paper

V. Reporting of information:
   a. Each group reports out on the progress made on development of a recovery policy and practice guideline.

VI. Big group discussion
   a. Colleen – Some people don't like the word "consumer." What word would we use to describe the person?
      i. Council likes - individual, people or person
      ii. Bob White - glad he didn't see anything about multi-tasking. Also, body language means a lot. He also thinks that many Council members are texting and on their cell phones, and that is a concern to him.

VII. Volunteers to be on the committee to draft the guideline
   a. Irene, Pam, Colleen, Kendra, Pat Baker, Jean Dukarksi, Cheryl Flowers, Mary Beth Evans, Rich Casteels, Norm DeLisle, Pam Lang, Ann Marie Funsch, Carmela, Sherry Rushman, Marty, Greg Paffhouse, Alyson Rush, Anna Christianson.
   b. Irene – The stakeholder review goes out to everyone on the advocate list, Recovery Council members and partners, all CMHs, and peers.

VIII. Member comment
   a. Cheryl – we lost our co-chair for the Council and wants to know what is going to happen – is he going to be replaced?
      i. Irene – we need to go back and look at the process that we originally used.

IX. Public Comment

a. Sean Bennett – Urges the Council to act immediately. Wants the Council to recommend revisions to the Mental Health Code and MDCH Policy in regards to informed consent and physically intrusive treatment. The patient should have the final say about their own body and should never be subjected to electroshock surgery or psychotropic drugging against that person's consent. He would really like to see Michigan be a leader on this topic.

X. Irene thanks everyone for their time and work today.