

THE CENTRAL CONNECTION

A newsletter for members of the Community Mental Health for Central Michigan provider network



10th Annual Direct Support Professional Conference

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The 10th Annual Direct Support Professionals Conference was held September 15 at the Pohl Cat Conference Center in Mt. Pleasant. The Conference is partially funded by grant dollars and supplemented by donations from Listening Ear Crisis Center, McBride Quality Care Services, Women's Aid Service, The Arc of Central Michigan, and Community Mental Health for Central Michigan. The presenters this year were Dave Hingsburger, Morgan Monte and Dixie Keane.

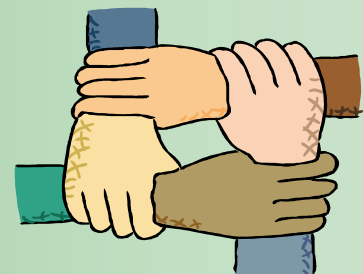
The purpose of the conference is to honor, support and recognize Direct Support Staff for the many contributions they make to improve the lives of individuals with disabilities.

Many Direct Support Professionals were nominated for awards that were presented at the conference. The winners were chosen by a committee of consumers of mental health services. Awards were presented by Myron Denman and Reverend Ron Vredveld.

Congratulations to the following winners.

AWARD	WINNER	EMPLOYER/PROVIDER
Best Advocate	Nora Smith	McBride Quality Care Services
Fundraising	Laura Humphrey	Personal Assistance Options
Recreation/Leisure	Burnett Mays-Gossett	McBride Quality Care Services
Natural Supports	Phyllis Boetscher	Listening Ear Crisis Center
Golden Heart	Tara Tardiff	
Medical Support	Jamie Dagenais	Listening Ear Crisis Center

Thanks to all those who helped to make this conference possible, and to all the Direct Support Professionals who are heroes ... everyday.



A Culture of Gentleness

The new fiscal year brings with it continuing commitments between Community Mental Health for Central Michigan and the Michigan Department of Community Health to improve mental health services. There is ongoing emphasis on positive approaches to helping our consumers who sometimes behave in ways that put themselves or others at risk of harm. While positive support is not new, we are committed to furthering our efforts to educate everyone on what forms this can take and how it can be rewarding for both consumers and staff.

Our goal is to foster a “culture of gentleness” “wherein force is not used”. This is possible as we identify what has led to a challenging behavior, what might be reasons for a behavior and what that behavior may be communicating. In order to do this it is essential that we have involvement from others who interact with and observe the consumers, often on a daily basis.



The Department of Community Health has provided procedures to follow as we address consumer behavioral issues. Specifically, it requires among other things that we always use the least intrusive and least restrictive intervention possible and that we always first use positive behavior supports with interventions designed to develop the consumer’s functional abilities. “As a last resort when there is documentation that neither positive behavior supports and interventions nor other kinds of interventions were successful” there could be proposed a behavior treatment plan with intrusive or restrictive interventions. This BTC would then be reviewed and approved or disapproved by the Behavior Treatment Committee. The BTC also reviews numbers of behaviors and interventions while a plan is being implemented. This information helps determine the effectiveness of the interventions, when changes may be needed, and when less restrictive or intrusive techniques may be used.

Physical management is no longer allowed to be part of a behavior treatment plan. It can only be “used on an emergency basis when the situation places the individual or others at imminent risk of physical harm”. Physical management has been removed from currently approved behavior treatment plans and will not be approved in any new plan.

The Behavior Treatment Committee is required to monitor that the direction that has been described is being followed. For that purpose we have asked that the direct care professionals who work with our consumers fill out the Behavior Treatment Data Form (# 919) each time they use an intervention that is intrusive, restrictive or an emergency physical intervention. These forms will be reviewed by the case manager/supports coordinator and forwarded on to the Behavior Treatment Committee which will give recommendations and identify trends that suggest training opportunities. Data will be reported to the CMHCM Performance Improvement Committee and to MDCH.

Community Mental Health for Central Michigan is training our staff and providers in how to foster a culture of gentleness and will be adding additional information about positive behavior supports to the GenTrain manual for providers to use as they train their own staff. We encourage questions and feedback at any time.

Definitions from CMHCM Policy:

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug that is not a standard treatment or dosage for the individual’s condition.



A Culture of Gentleness (cont.)

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include prohibiting communication with others to achieve therapeutic objectives, prohibiting ordinary access to meals, using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Restrictive techniques include the use of a drug or medication when it is used as a restriction to manage, control or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition.

Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management will only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, will not be included as a component of a behavior treatment plan. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances

Working Together to Improve Quality

Quality is Everyone's Responsibility...

Best practice, quality improvement, risk management and an improved support system for consumers are talked about each day. But what would happen if a group of providers, consumers and CMH employees worked collaboratively on problems we collectively deal with every week, like medication errors, medical protocols, line of sight supervision, choking, micro-enterprise ideas, community involvement and a list of other common issues and goals.

Would coming together system wide improve our agencies, our performance, our whole support delivery system, would it improve the lives of consumers? Someone once said, "No matter how long you have been working on something, if something better comes along, CHANGE." Well we have such an opportunity.

Community Mental Health for Central Michigan and the provider agencies are proposing an opportunity for providers, consumers and CMH employees to come together to focus on issues of mutual interest. There are not prescribed areas to focus on, except focusing on improving quality and minimizing risks for consumers across the CMH system. Since quality is not an accident but the wise choice of options, we could follow the statement of the father of quality improvement, W. Edward Deming, "Quality is everyone's responsibility."

We will be contacting you in the coming weeks about your participation in a system wide approach to improving quality.



Patty Duke

Mark your calendars for Thursday, May 13, 2010! You won't want to miss the opportunity to hear Academy Award winning actress, Patty Duke, deliver her story of success, loss and living with mental illness! Look for more information in the coming months.

For more information on this Speaker/Performer, please visit www.apbspeakers.com.

Supported by funds from Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, through a grant from Michigan Department of Community Health

New CMHCM Employee's and Providers

Jolene Eaton – Crisis Stabilization Specialist, Midland Sag. Rd.

Brooke Hill - Crisis Stabilization Specialist, Midland Sag. Rd.

Melissa Moe - Crisis Stabilization Specialist, Midland Sag. Rd.

Janna Nordeman - Crisis Stabilization Specialist, Midland Sag. Rd.

Emily Taylor - Crisis Stabilization Specialist, Midland Sag. Rd.

Lanelle Brown – Registered Nurse -Gladwin

Smith AFC, Gladwin County

Michigan Mental Health Code “vs.” Employees’ Right To Know

Chances are you've heard of the “Bullard Plawecki Employee Right to Know Act”. This legislation guides employers as they develop policies about personnel records. You may NOT remember that the Bullard-Plawecki Act has implications for sharing information about disciplinary action from an employee's personnel file (as may need to happen when that employee has violated a right protected by the Michigan Mental Health Code).

The Michigan Mental Health Code (MCL 330.1782) states that a recipient of mental health services on whose behalf a rights investigation has been initiated, the person who filed the complaint (if different), and the recipient's guardian (if applicable) must be provided with specific information about “action taken” by the service provider in response to a substantiated rights violation. That may include corrective and/or disciplinary action against an employee. A report summarizing the results of a rights investigation, containing specific information about what corrective and/or disciplinary information was administered to which employee, would be sent to the recipient, complainant (if different), and guardian (if applicable).

According to the provisions of the Bullard-Plawecki Act (specifically, MCL 423.506), before releasing information about disciplinary action, an employer must inform the employee that this information is going to be released. This can occur in one of two ways:

By providing the employee with a written notice that information will be released at the time corrective and/or disciplinary action is given (for a current employee)

(For a former employee) By sending a written notice to the employee's last known address, by first class mail. This notice shall be mailed on or before the date information from the employee's personnel record will be divulged.

As an employer AND a provider of mental health services, you must comply with the Michigan Mental Health Code and the requirements of the Bullard-Plawecki Act. If you have any questions, please feel free to contact me (kstableford@cmhcm.org, 989-772-5938).

--Kris Stableford, Rights Officer, CMHCM

Rights Training Improvements

The Rights Office at CMHCM is constantly striving to make the initial training required for all Direct Support Professionals (DSPs) more interesting and useful. A change your staff will notice starting in October is the addition of consumer rights co-trainers, all of whom are recipients of mental health services. The majority of consumer co-trainers have completed training in public speaking. We are confident consumer co-trainers will very capably answer questions and share their experiences with the mental health system, and that participants will benefit from getting consumers' perspectives during rights training.

You will also be noticing that DSPs will be leaving training with a new and improved Certificate of Completion (designed by Rights Advisor Jane Gilmore). Until recently, some providers had a company-specific certificate and other providers relied on a more generic form. The new form will be given to ALL participants to document successful completion of rights training.

End of Year Billings

September 30, 2009 marked the end of another fiscal year! All claims and invoices that have not been submitted for services provided through September 30, 2009 must be received no later than November 29, 2009 to be considered for payment. We appreciate your prompt attention to ensure all outstanding claims are submitted as soon as possible.

Contract Renewals

Contract Management is in the process of sending contracts out for the new fiscal year. Contract language has stayed the same (unless otherwise noted) from last year. Once you receive your contract, your timely review, signature and return is appreciated.



Recipient Rights Training Requirements for Contract Providers with Special Certification.

As your CMHCM contract states all providers and staff must receive initial recipient rights training from Community Mental Health for Central Michigan recipient rights staff. Recipient rights training must be completed before or within 30 days after being employed.

Recipient rights training from other community mental health service providers may be accepted with prior approval from the CMHCM Office of Recipient Rights. These requests are evaluated on an individual basis.

Recipient rights training that is required annually per your contract, can be completed in the home using CenTrain. Rights Advisors from CMHCM are also available to present refreshers to staff who have received initial training, if you are interested in making those arrangements please contact: please contact Kris Stableford at the CMHCM Office of Recipient Rights (kstableford@cmhcm.org, 989-772-5938).

Crisis Mobilization Intervention Team

The Crisis Mobilization Intervention Team (CMIT) is a centralized team of CMHCM staff providing emergent and urgent crisis services to residents of Midland, Isabella, Clare, and Gladwin counties. The services are provided face-to-face or by phone and the team will be staffed on a 24 hour / 7 day per week basis and will have the ability for rapid physical response in all four counties. Community members can access the CMIT team by calling the four local Community Mental Health clinics. These services are available to anyone who requests, with a priority of serving Medicaid and indigent individuals/families.

These crisis intervention services are defined as unscheduled activities for the purpose of resolving a crisis or an urgent situation requiring immediate attention. The services will respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provisions of inpatient or other protective environments for treatment. Services include assessment, diagnosis, crisis counseling, treatment and/or referral during crisis interventions and preadmission screening to ensure rapid referral and linkage to appropriate interventions.

Crisis services will be provided primarily from CMH offices or local hospitals /emergency rooms; however the team does have the ability when appropriate to provide the services in other community locations. These community locations could include local shelters, police stations, and primary care doctor's offices.

Primary activities of the CMIT

Crisis assessment is the core activity of the crisis team which involves assessing individual's crisis state. Elements of this assessment would include (precipitating factors, risk factors, mental status, substance use, current and past mental health, current and past medical, problem areas, legal status, trauma history, consumer engagement/desires, etc).

The CMIT will also complete preadmission screening tools to determine appropriate level of care and if needed provide authorization for hospitalization for Medicaid/indigent consumers and complete continuing stay reviews to determine if they continue to meet Medicaid guidelines for hospitalizations.

The CMIT team also provides crisis stabilization activities intended to stabilize an individual's acute or severe psychiatric symptoms. These services are designed to assist individuals for them to remain in the least restrictive environment. The primary outcome is to assist individual in establishing equilibrium in their life so they can avoid unnecessary high acuity services and coordinate linkage into a longer treatment option.

Stabilization activities can be provided by the team for up to 30 days. CMIT will provide coordination and linkage with identified ongoing treatment should occur as soon as feasible in the process. The stabilization services could also occur as a step down or bridge between high acuity and community based treatment. The CMIT member will complete a referral, person centered plan and assessment for all consumers that are opened for the 30 day period. CMIT team will provide referral and linkage which can occur at any place in the crisis continuum. These interventions are intended to ensure that the individual is connected to appropriate resources addressing their individualized needs. CMIT will assess for appropriate resources and will determine for eligibility for CMHCM services by utilizing the centralized access protocol.

The CMIT will also provide brief crisis stabilization. These services are short term in nature with the primary intention of crisis resolution without follow up mental health services. Services would be limited to 30 days in duration and would be open to individuals seen by CMIT for an initial crisis assessment. By definition individuals qualifying for these services would be exhibiting a mild to moderate clinical presentation and would have a LOCUS range of 12 – 16.

