

[DEBBIE PLOTNICK] Mental health managed care entities as well as their county and state mental health partners, and that includes agencies, providers and folks who receive services and we'll also get a view from the field. We'll have one behavioral managed care entity respond to the toolkit that we'll be talking about in a few minutes.

So today's presenters, I'll tell you a little bit about them, we have Rick Baron from the Temple Collaborative, and he's the researcher and trainer in the mental health field, he's been in the field for a long time, he's been part of the Temple Collaborative since the beginning, he's currently the Director of Knowledge Translation for the Collaborative on Community Inclusion, and he will tell you more about the Collaborative as he explains the domains of community inclusion, what they are, and a little bit more about the work that the Collaborative does. But previously before Rick joined the Collaborative he was the director of the PEW Charitable Trust Grant Making program for health and human services agencies that served adults in the 5 county Philadelphia region, and prior to that for 25 years Rick was the executive director of Matrix Research Institute in Philadelphia where he was the principal investigator and project director on two dozen federally funded research and training programs, and they focus on employment for people with mental health conditions. Rick is really one of the field's great experts on employment. Rick is also the recipient of two of the NIDIRR Switzer independent research fellowships, and those focused on strategies to expand competitive employment opportunities for people with mental health conditions.

We're also very fortunate, and I thank very much Leslie Schwalbe, who is the Vice President of State and Local Government Programs with Optum Health for joining us today. I'll tell you a little bit about Optum. Optum is committed to helping make the health system work better for everyone and in collaboration with their partners Optum focuses on three drivers of transformative change: 1 is modernizing the health system infrastructure, 2nd is advancing care, and 3 is empowering consumers, and its through these strategies that Optum will achieve a healthier future and one that delivers improved healthcare outcomes and better healthcare experiences, and we're very lucky to have Leslie with us, she also brings a wealth of experience. Leslie is a healthcare executive with, as I said, years of experience working in and with state and local governments, health plans and community providers. Leslie is the past deputy director of the Arizona Department of Health Services, and there she was responsible for developing treatment and support services for people enrolled in Medicaid and in non-Medicaid behavioral health services. Today Leslie is a senior vice president with Optum, part of the United Health Group. So thank you to Rick and to Leslie.

And I'm Debbie Plotnick, I'm Vice President of Mental Health and Systems Advocacy at Mental Health America. Mental Health America is the nation's oldest advocacy organization, we just celebrated our 107th birthday. We used to be known as the National Mental Health Association. We have affiliates in 41 states, well over 200 affiliates, and many of them are still known as Mental Health Association and many more are known as Mental Health America, but

we're a big umbrella family, and we do advocacy education and have through our affiliates, many of them are also service providers. And my role at Mental Health America is to coordinate and to look at federal policies and state policies and to conduct grassroots advocacy on the ground. Prior to coming to Mental Health America as a national organization, I was director of advocacy at the Mental Health Association of Southeastern Pennsylvania in Philadelphia and there I conducted grassroots advocacy, much of the policy work, the same kinds of things I do today, as well as design programs for folks with mental health conditions in the five county area and the Philadelphia region and it's been my pleasure and privilege to work with the folks at the Temple Collaborative for some years now. So that's who you'll hear from today.

And I just wanted to talk a little bit before Rick gets into a lot of detail around the Temple Collaborative and the domains of inclusion to be clear on what we mean by inclusion because there's a lot of confusion out there and I love this graphic. As I thank Doris Hutchinson of Boston University for the idea behind this graphic, it's had a little bit of modification, but I think it very clearly when one looks at the bottom left circle what exclusion is, with folks on the outside, and then when folks are all together in one place and still on the outside, then we have segregation, and we can even have integration, but people are still together in a way where they're not interacting with others and at the top of course you can see how that's different when we have inclusion. And with that I'm going to turn it over to Rick.

[RICK BARON] Thank you very much Debbie. Oh Lord I can hear myself. Let's try to get the right slide up. There we go. Thank you very much Debbie sorry for the delay, and thank you Debbie for pulling this together, to Leslie for joining us, thanks for all of you out there who have joined us, thanks as well to the National Institute on Disability and Independent Living Research and Rehabilitation, our grant is a research and training center from NIDDLRR, we do an extraordinary amount of research and a great deal of training and technical assistance all focused around the issue of community inclusion for people with mental health conditions. This is our 13th year and I wanted to remind you that there is a wealth of information on our website at tucollaborative.org for all kinds of information that talks about how do we help people with mental health conditions participate more fully in their communities. So I wanted to talk a little bit more about community inclusion and then lead us back to Debbie and the particular project she's been working on, as one of our partners in the operation of the research and training center. One of our other partners is here in Philadelphia, it is the National Mental Health Consumer's Self-Help Clearinghouse at the Mental Health Association of Southeastern Pennsylvania where Debbie also worked for a number of years and the three of us have been working together around a number of issues for a number of years. But let me begin with the definition of community inclusion that comes from the director of the research and training center, Dr. Mark Salzer. He talks about community inclusion being the opportunity for people with mental health conditions to live in the community with the chance to be valued like everyone else. Our emphasis here is on participation, for people to be able to lead the

kinds of lives that they choose to lead by participating in a wide array of everyday activities in community settings, so they have an opportunity to live where they choose, to work in competitive employment, to attend churches or social events or civic activities in their community, and not only to be able to do that, but for the policies and programs and practices that are needed to support them in participating in community life to be readily available. That really is the challenge and what we think of as the challenge that will frame the next generation of community mental health policies, programs, and practices. How do we help people, not just say that people ought to be participating, but provide the facilitation and the supports people need as well as the encouragement to participate most actively in all aspects of community life. It suggests in some ways a greater balance between many of the activities that are part of the community mental health world, supported by behavioral managed care companies, from the emphasis on in-house programming and toward a series of programs and practices that more actively engage people in community participation. And it also means, we think, greater work on all of our parts to work with communities to help them to more actively seek out and facilitate the participation of people with disabilities and people with mental health conditions in particular. We begun talking about welcoming communities in the mental health field only recently, other disability fields have been looking at how do they work with the individuals and organizations across that whole array of domains to help people so they are welcoming people with enthusiasm into their activities. Now I need to go to the next slide. So part of what this means is some of it is around the fundamental principals of recovery, with which I imagine most of you are familiar: respect for the individual, empowerment and self-direction, a sense of hope rather than clinicity in their lives, Leslie and Debbie and I were talking the other day about how this in some sense not only reflects recovery but how community inclusion in some ways is what recovery is for, that is, that empowerment and help and respect ought to be in service of some individual goals people have for themselves and we think that those goals are primarily goals of community inclusion, of participation. It means that in looking at our programs and our services and our policies that we want a stronger supported pathway so that in-house activities, if we provide them, lead as quickly as possible to participation in the mainstream. There's a group in England, the Center for Community Inclusion, that talks about how in-house activities and activities that are solely for people with disabilities tend to reinforce notions of segregation unless they are part of a supported pathway to participating in the community the way everyone else does. And again, it means that our organizations are going to have to engage in ways that we haven't before with individuals and organizations in the community outside of the human services, outside of the mental health system, and start to work with them about how they can create a welcoming environment in a whole array of dimensions. How do we help churches, how do we help realtors, how do we help employers, how do we help YMCAs, how do we help hobby groups, how do we help the community say, "these are people we actively want to solicit participation from, and here's what we can do to welcome them." As I say, there are a lot of resources on our website that you can turn to, we're at tucollaborative.org, that talk about all of this, but as Debbie and I began to talk about the work we wanted to do together, we talked about the importance of

two things. Debbie really came to us with the notion that there was a large role for behavioral managed care entities to play, both in the way in which they structure their contracts with state and county mental health administrations and in the way they work with the agencies with whom they contract in the community. How do we get behavioral managed care companies, as Debbie had asked, to focus on this issue, and play a larger role in promoting community inclusion, and then, as we're doing that, how do we focus on the kinds of evaluation of how successful those efforts can be. And we've led to two publications, both of them are available at this website, that you see there, it's also in the chat (<http://bit.ly/1Ux51hQ>), a notion that Jared put there, and that is gonna take you through those publications, but we wanted to make sure you know about both our general website and about these two wonderful documents that Debbie has created. And with that, Debbie, I'm gonna turn it back to you.

[DEBBIE PLOTNICK] Thank you Rick. Let me share my desktop and get back to the slideshow so bear with me for one moment while I start the slideshow. So thank you Rick and thank you for that introduction, as Rick mentioned, we've created several products, one is the toolkit you see on the screen right now, and this is particularly directed at behaviorally health managed care entities because we think you're a very important partner in promoting community inclusion. They're not the only partner, but they certainly are very very important. And the reason that I came to the Temple University Collaborative with the concept of reaching out to the behavioral managed care entities is that they have a long history of working very successfully to promote recovery with county and state behavioral health departments they've really been pioneers, they've created some of the programs and created a lot of the evidence-based in showing that recovery-focused services make a difference in people's lives, so that they are something that reflect recovery values and something that is good value for folks receiving services, folks paying for services, and getting people back into life, which of course reflects the value of recovery. Behavioral health managed care entities have really provided tremendous leadership over a long period now and creating as I mentioned the evidence-based especially in peer services, so they've been great partners in being able to keep the data if you will, and that really helps shore up the evidence base. But one of the things that really struck me as the most important reason to partner with behavioral health managed care was their long history of bringing people with lived experience into leadership positions, people who were very high executives in the companies, the companies asking individuals who've been there and done that, who understand what it's like, and who understand what it is that people want and need. So that's why we reached out especially to the managed care entities, but they're not the only partners. Other important partners of course are the people that we all work together, it is very much a partnership where we all intersect. Mental health providers agencies, folks themselves who receive services, it's very important that we think about what are the things that they need to be thinking about so that there needs to be cultural shifts that happen with the providers, with the payers, with the recipients of services to use community resources and the resources themselves, as Rick was saying, need to undergo culture shifts. And the culture shift begins with, as Rick said, thinking about not just using site-based services, supports that

are just for folks with mental health conditions, but people entering into the community and using the kinds of training supports that anyone else would use, and if they need some assistance, supporting them in using those community resources. And that service recipients themselves really need to come to expect to use the resources, and the resources need to be welcoming, as Rick mentioned.

So from our toolkit, and I just pulled a couple of the Action Items, and I'll go through them very briefly so you can get an idea, and there's much more detail in the toolkit so I do encourage you downloading it. One of the things that we thought was a really easy one, although maybe not and we'll hear from Leslie in a few minutes, is for entities, all of the above, but certainly behavioral health managed care entities, and the organizations with which they contract, to add the principals of community inclusion to their own vision statement. And this would include explicitly recognizing the value of community inclusion and what it means for and to people with behavioral health needs so that that was a step that is an item that might be the first one to take – or not. But we certainly think that an action item that would be beneficial for all would be training and engaging with folks, and this would be for staff, for staff of state and local mental health authorities as well as for behavioral health managed care entity staff and providers within their networks and providers with whom they contract with. There's some wonderful resources, again on the Temple Collaborative website, they've designed some online training programs and each program is designed specifically for the groups that I just mentioned, so if you work for an agency it would be for you, if you're a county or state it would be for you, and they've designed this with the College of Recovery and Community Inclusion, and you can get links to all of those courses from the Temple Collaborative website. There's also fabulous information for folks who use the services. There's wonderful guides for people with mental health conditions, two of which I've mentioned here, but there are others: the Practical Guide for People with Mental Health Conditions Who Want to Work, and research shows that that's just about everybody, but that doesn't mean that everyone is. The other one is a Practical Guide for People with Disabilities Who Want to Go to College, so as I said there's even more great resources on the website.

Another action item – and this one's a little bit more difficult and it will take a little bit more working along the way and I hope Leslie will talk a little more about this – is contracting with community providers, and this holds true for behavioral health managed care entities and for state and local counties if you will, payers who contract with agencies or go back and forth with the managed care entities, that in the contract it's clearly outlined the importance of community inclusion and the expectation that community inclusion practices will be part of service delivery. And as I said, there's far more in the toolkit getting into specifics, but we think it's very very important to prioritize the use of the programs and practices and tools that empower and activate consumers. So, supports for sure, but supports that put the person at the center and help them become even more engaged in their recovery journeys, and some of these that Rick already mentioned, of course, there's shared decision making and self-direction

are really the keys to what is described -- and you'll read about this more in the toolkit -- is personalized and personal medicine. People who want to know the difference between personalized and personal -- check out the toolkit and go into a little section about that.

Another area, another action item, is to modify the job description for folks who work for the contracting agencies and who provide services that really prioritize community inclusion. Some of the ways to begin would be to review the staff roles and to review how staff roles are or are not delineated and to see how community inclusion is delineated in provider contracts. But not only do you need to do this, there needs to be support, there needs to be administrative and managerial support for engaging in community inclusion activities. This has to do with being sensitive to managing, for example, peers, with things that are appropriate to peers and to their jobs that they do. This kind of job description that's a little bit different needs to be coordinated with the providers, there's also an important role for clinicians to take into account the community inclusion goals of the people they're working with, to solicit them, to find out, to ask them what they are. And as they go through a clinical relationship, to come back again and say, "How are you meeting your community inclusion goals?" and I'll talk a bit more about that when I get to the measure in a few minutes. Case managers really play an important role here in assisting to coordinate treatment supports and services, but not just any ones, not the ones that are regularly offered, but the ones that meet individuals' community inclusion goals. So as job descriptions are modified, it's very important to again come back to what is it that the individual who's receiving services wants and needs.

And of course peer specialists play an incredibly important role here as to rehabilitation practices and other staff in supporting people to plan their goals, determine which supports are necessary and which ones they like, and then providing support as they go along the way. And as I said I'll get more into measuring in a few minutes.

I just wanted to give a little taste of one of the examples that we have in the toolkit. This is a job description, again for your action item for creating job descriptions. This is a job description from the Pioneer Center in Illinois and they have a staff position that is community inclusion specialist. They also have a supervisor who supervises with the role of making sure community inclusion is a priority. So you can see more things like these job descriptions in the toolkit so I won't go into much detail there.

But this is one that I think is essential for really making a difference and after Leslie gives us some feedback I'll come back to why it is so important to measure the quality of community inclusion services. And of course there are ways to incentivize doing the measures for community inclusion and I'll get to what the details are about that in a minute. But some of the ways to further that is to incentivize additional reimbursements for using community inclusion by providing additional reimbursement again by progress. These are incentives Behavioral Health Managed Care Entities and county and state partners and even agencies can take in rewarding an increase in community inclusion because as Rick said community inclusion is what recovery is for and is a great way to see how people have progressed in their recovery. Another issue is to measure which providers are doing a great job that again is another incentivizing

role. Of course providing additional reimbursement to programs that have progressed for folks who are meeting and coming up with community inclusion goals and progressing in their community inclusion goals.

So what are we talking about with community inclusion goals? I'm afraid it didn't translate well on the slide so please do go and look at the toolkit because you'll see the entire measure there. It is really quite a wonder tool. It is easy to use. It is a 26 item measure. It asks questions that peer specialists, case managers, clinicians, and individuals themselves can work on individually or together in measuring how folks are increasing their community inclusion. It does that by asking how many days in the past 30 days did the person themselves engage in activities, the degree of importance of the activities to the person, and whether or not they engaged in these activities with or without support. All these activities are things that we all do and things that everyone does at some time. They really give a good connotation of how people are engaging with the rest of the community. Some of the 26 items include going to the library, going grocery shopping, going to a restaurant or coffee shop either by yourself or with others, going to a place of worship, engaging in a recreational activity, and of course recreational activities include playing sports, going to a sporting event, going to a park, engaging in a nature walk, or taking a walk by yourself, and of course one that Rick is really an expert in is working for pay, employment, how many days in the past month did people work for pay. Or work toward a degree that will help further their vocational goals, or take a degree, that will help their educational or vocational goals. Or how many days did they take a class, a class in the community, perhaps a yoga class or a photography class or any other class in the community? How many days did the person volunteer to assist others in need in the community, informal or formal volunteering programming? How many days in a month did people get together with friends or with their family, or how many days did they entertain those friends or family? So there's both passive and active getting together whether it's visiting and participating or entertaining themselves. Another important way to measure community inclusion is how many days folks engage in a civic or political activity which is certainly important in this election year. I'm going to turn things over to Leslie now and she is going to give a response from managed care, from the industry, about what some of the things mean. I'm going to turn it over to Leslie.

[LESLIE SCHWALBE] Hi good morning for those of you out in the West. Thank you Debbie and thank you Rick from Temple University Collaborative and Mental Health America. This is really a great opportunity for us to collaborative and begin the discussion of really moving community inclusion for individuals with psychiatric disabilities. This discussion is really how to do it, given this wonder toolkit quite frankly. The toolkit is, for us, another great example of collaboration for and among those between research, efficacy, and implementation in terms of how do we actually move forward and as Rick said early, how do we really help people get to where recovery is and what recovery is for.

In talking about this it is really a kind of an exciting opportunity for us because we get to say what we like about the toolkit and maybe what we don't like, what can be easily implemented, what could be harder. And you know I don't think there's anything that can be said that we

don't like the toolkit because it is just packed full of information, it is extremely nifty and handy in terms of all the hyperlinks. When we use this internally in a large managed care company we can have all this information at our finger tips quite frankly. It helps us, and one of the incredible things about it is, there are clear domains to help us focus. And those domains, when you think about where healthcare is right now and you think about the larger issue overall with a person's healthcare wellness and ability to achieve personal medicine and personal goals it really aligns nicely also with the social determinants of health focus that we see on the healthcare side or the whole integration of physical and behavioral health services. It is really kind of a specialization to some extent of those social determinants for people with certain mental health conditions.

The action items and steps are really quite excellent. Just from our perspective again, they are clear and concise. There's great examples in there. You actually pointed out a couple, Debbie, of the things that we like as well. In particular, I'll start out with action item #7, the RFP input. It is true that often states do look to managed care organizations and behavioral health managed care organizations to solicit input into what should we be looking for people with mental health conditions? And so the information you've put together in action item #7 is great, the language is great, and we plan on using that with our sister health plan, United Healthcare. Action item #4 with the job descriptions, again another great example of how we can change our own job descriptions internally whether it is our field care advocacy, whether it is our peer support specialist, whether it is case managers, we are really happy to see this language come about. What do we think can be easily implemented? I think changing those job descriptions for those field care advocates and possibly peer support specialists and potentially adding community inclusion specialists as a position is also possible. The training we believe can be done given all the information that is out there and available is really going to be quite key. I think that working with providers is going to be the real key to making this successful. Depending on what the requirements are of the state or local community, we really have to work together with providers to design what the inclusion service system looks like, what the actual focuses might be for certain populations, whether it be housing or employment or for others who are more advanced in their recovery it could be other issues as well. So it is going to be key that we work with providers to determine the best way they can help people with their community inclusion goals.

Something that might be harder to implement, the one question I have, is on the measurement tool. How often and how frequent should we be doing this type of tool? I think if we believe it is going to be a good indication of people doing better in their care then we should do it more often but that might lead to the being tool being maybe a little bit too long so I just have that question of the implementation of the measurement tool. I think that is a good follow up question and thought that we can do afterwards.

What else can we do to develop and disseminate the toolkit? We can internally at Optum get this to our peer workers or peer advocates or providers anyone we're working with and our sister company United Healthcare and we will do that. We will be happy to create and do additional work with the Temple Collaborative and MHA about making additional presentations

because I think that's a lot of the way that people learn about evidence that is now out there and how it can actually do something about it based upon very comprehensive toolkit. I think also we should consider more fully depending the community inclusion specialist role that you've identified in here. I think you're onto something there. I see a lot of similarity with case management type of work but this really puts a different and more focus on the community inclusion aspect.

Another question I have about this is how can this be used for persons with substance abuse disorders as well and how do we get this toolkit to them? Overall, we are just extremely excited to see the next steps and continue working with you in a sense of helping you develop it. Thank you very much!

[DEBBIE PLOTNICK] Thank you Leslie. We really appreciate Optum's feedback on this. Coming from a large managed care entity, it means a great deal to us as we move forward. Thank you for mentioning that the toolkit and monograph I'll talk about in a few minutes are designed as web documents so that they have hyperlinks throughout that provide more information and resources. Some of the actions items that I didn't make slides about Leslie mentioned as being her favorite so for all our listeners on today's webinar please do take a look at it. We provide really extensive checklists and some sample language to put in request for proposals, what states and local entities some of the things they can ask for in their proposals, as well as those responding to those requests can put community inclusion as the goal and make sure that it is promoted throughout. We also give an example of under our action item for policy implementation we give a very in-depth example of New York State as it redesigned its Medicaid program and redesigned its Medicaid program to promote things that are community inclusion and recovery goals. Those lists again can be found in the toolkit as well as hyperlinks to where you can see some of the things they requested, some of the things that were in there, and how to find information on all the things I spoke about earlier, shared decision making, and how to link to evidence based practices and so on and forth. So we designed this document as a living breathing document and Leslie's feedback on how we can make it better and how we can work to disseminate it and who else we may bring into the process is greatly appreciated because we hope this will be as I said a living breathing document and not something that is static. So again, thank you for that.

I just wanted to take a minute to talk a little bit more about the community inclusion measure. I created a little monograph after I was at a policy meeting. The outcome of the policy meeting was rather remarkable in that this particular meeting created a turnabout in a policy perspective and is a relatively short and rather easy read. Again it downloadable at the Temple Collaborative website that is linked here. It's just telling a little story. It features some of the most amazing and accomplished experts in the behavioral health field like Dr. Ron Manderscheid and of course our own Temple Collaborative's Rick Baron and some folks that are high up in Health and Human Services and people who look at quality measures as well as a number of the large national advocacy organizations like Mental Health America, our colleagues at NAMI, our colleagues at the Depression and Bipolar Support Alliance, and our

colleagues at the National Council. In this monograph I just tell the short story about how when folks who were diving very deeply into the weeds, and if you're a geek there is a little bit of geeky-ness about quality measures and how they came to be, and again its hyperlinked so you can learn about the national quality forum if you like and really look at that closer or not and just read the story of how once people began to think about measuring community inclusion instead of the usual measures that people think about of when people think about quality. They tend to think of clinical measures. Clinical measures are extraordinarily important. Clinical measures to the individual such as how long are folks staying out of the hospital, are folks engaging in treatment and things like that, are there scales that we measure clinical outcomes getting better and better. They are certainly important, but when you start to measure if people for are getting back into life and you can see that they're going out with their friends more often, they're looking for work, that they're back in school then you can really measure recovery. So, just a little plug to download and read the monograph.

And then we wanted to leave time, and I know, I'm hoping Jared has some questions and comments from the folks who are listening today, because what we would like to do is provide whatever technical assistance we have and to solicit your responses and your feedback, so Jared, you have questions and comments for us?

[JARED PRYOR] So we actually haven't had anyone ask any questions during the webinar, so I guess at this point if any of the attendees want to ask questions of the panelists they can go ahead and type it into the chat and I'll relay them to the panelists.

[RICK BARON] Debbie, let me pick up where we're hoping for some response on the last topic of quality measures, and particularly, the Temple University Community Participation Measure. One of the things we're finding among the agencies that are using the measure is that it can serve multiple purposes. For an agency just getting started, looking at community participation issues, implementing the measure with all or a sample of the people being served, provides and agency a kind of baseline measure of, how well are they doing? How much participation is there in community life? And not only how much participation is there, but how much more, and in what areas does the service recipient population say it wants to be involved. So as an agency, you can have an opportunity to kind of figure out where people are, where the emphasis is, where you might want to start. If everyone says, "I'm doing fine but I'd really rather have a job," then it provides you a kind of focus for some of the community inclusion initiatives as an agency. And then it also allows you to measure individual progress as you move forward. Leslie, you were gonna make a point?

[LESLIE SCHWALBE] Yeah, yeah no that's perfect, because we, you know, I'm glad to hear that you're collecting those comments, and the understanding of what provider agencies might be doing at this time, and I hope we can have, you know, there's access to that kind of, you know, anecdotal as well as, you know, evaluation-type work. But then, secondly, I'm wondering, is it

necessary and is it possible or probable that we sometimes may need a kind of a readiness checklist, for ourselves, from our, you know behavior health managed care company or from providers you know to make sure we're ready to not only work with people, to help develop the community participation goals but also able to --, I'm sorry I'm not sure how much you heard of it, but what I was trying to suggest is a way to having to measure our own readiness to participate in the community inclusion goal setting process with members that we may, with people that we see.

[RICK BARON] It's a good question, I think part of the answer maybe to use the toolkit, and we should probably be doing that as well, but if you look at the 10 or so suggestions that are in the toolkit, you can sit down and say "Well do we have community inclusion as one of the missions of our agency, have we done our own sort of policy scan to see what kinds of policies we may have, or practices that either support or serve as a barrier to community inclusion. Is our staff trained in this direction, are we saying to peer specialists 'We want to expand your role to include your working with people around their community inclusion goals.'" Do we want to say that to our case management personnel as well? Are we using the most current support technologies that move people more rapidly into housing and jobs and social life in the community?

[JARED PRYOR] We have a few questions from the chat, I didn't know if you guys wanted to jump in and start answering those.

[RICHARD BARON] Yeah, sure.

[JARED PRYOR] First question we have is from Elene, she asks "Is there a reason why you use the term 'case manager' and not 'care manager'. That term has less of a medical feel. Is this a payment issue?"

[DEBBIE] This is Debbie, I used that and I used it only because that is often what you see in job descriptions that currently exist and in services that are often provided. Certainly it is not with the intention to be medical model or not, it is merely the term of ours. So all suggestions are welcomed on ways to be better and I like "care managers" so thanks for bringing it up Elene.

[JARED] We have another question from Judith "How may we access your expertise in our community. Will you come to a retreat where we develop our value statement?"

[RICK] You betcha! (laughter) One of the things we're charged with doing as a Research and Training center, and that includes certainly those of us who are Temple as well as Mental Health America, as well as our other partners at the Clearinghouse, is not only to do the research and develop materials, but to get out into the field and help people translate the research and develop activities into programs in the field. Yes, we would very much like to

welcome the opportunities to talk further. We can do tech consultations over the phone, we're happy to come out to agencies and work with them, and if the retreat is in a particularly attractive place then count me in!

(Laughter)

[JARED] We also have a question from Patty, "As both a provider and a parent, I'm hoping we include consumers own sense of their quality of life as increased inclusion. It is so important, but done poorly it can create the opposite of what we believe is possible." I think that's more of a statement

[DEBBIE] This is Debbie, sure I think that the intention here is to always put the person first. So it isn't necessarily what other people think is important, that is why all throughout the toolkit, at each step, the action items say "Engage with the person to find what their goals are. To look at what is important to them." And when you download the toolkit and you see the measure you'll see that it asks the person themselves who is looking at the 26 items, how important each item is to them. So I think that you'll see Patty that that has been taken into account as the person being the ultimate expert in what matters and how much it matters. Thank you for that question.

[RICK] But you know there is another issue that local agencies are going to have to struggle with, and that individual practitioners need to struggle with; I think in the Mental Health field we have done such a good job of discouraging and demoralizing people that we have the perception that people are not motivated to move away from what I often refer to as the "Overly warm embrace of the mental health system". We've created a comfortable environment and the longer you were in the system the more comfortable that set of supports and services segregated, though they are, may seem. And I think agencies have some work to do with consumers and consumer groups have some work to do, to work together with agencies to create a vision of what's possible, and not accept the; there's a sociologist named Susan, who many years ago talked about the subculture of psychiatric disability. That's part of what community inclusion is trying to take apart, and to help people in those areas that they want to participate more fully in everyday community life, move away from that subculture and get the supports they need to do so.

[JARED] Okay so next question that we have is from Linda, "Where is community inclusion in the process of becoming an evidence based practice?"

[RICK] You want me to do it Debbie? I think we're a long way away. I think we are struggling to help managed care companies, community mental health center, psychiatric rehabilitation programs/peer operated programs, and even peer specialists training programs to look at this issue and create more job descriptions, more explicit programs, more measures of success. I

think over the next 5 to 10 years we'll see a movement towards a greater adoption of these principles and really have the opportunity to do more intensive research to show its effectiveness, so that it can be exactly like you're saying, an evidence based practice. I think the theory is good, and I think the potential is there, I think we have a way to go and we're hoping to work with many of you in the field to move in that direction.

[DEBBIE] This is Debbie I'd like to add something to that, Jared can I just add on to Rick's comment there with respect to evidence based practices. I think of community inclusion as in what we hope will become an evidence based principle, if you will. Along the lines of principles of recovery, principles of wellness. Rather than one practice there would be many practices that would feed into the principle. And then I want to echo what Rick said about how we hope that you will all help us get there. So thank you, go ahead Jared, please.

[JARED] "What are the thoughts of others using this toolkit, i.e. another MCO, or providers, etc.? And is the toolkit available to the public?"

[DEBBIE] Well we hope that other behavioral health MCO's are using the toolkit, and we thank our friends at the association for behavioral health and wellness who helped with a lot of input into the toolkit and it has been disseminated to their members so we hope to hear more feedback and that's something that we'll actively solicit.

The answer to "is the toolkit available to the public?", thank you for that question you bet it is. It can be downloaded right from the Temple Collaborative site, and I believe you have that information available on the page on how to get there, tucollaborative.org. It's under resources and the toolkit, the monograph, and many other things are downloadable right from the Temple Collaborative's website.

[JARED] And the link is also available at the top of the chat, it will take you directly to the two documents that were discussed in today's presentation. So our next question "Will you go with us to our area's provider, such as the health systems of State of Massachusetts, public health, and the DMH?"

[RICK] (laughter) Sure! I think we'll work however we can with people in the field to make the case for, develop the policy surrounding, locate the funding involved, around any of these initiatives around community inclusion. To help train staff, to help design mission statements, all of the issues that are addressed in the toolkit are the ones that the folks at Mental Health America, and the folks here at Temple would be delighted to help out with.

[JARED] "Would it be possible to get a list of ideas that other organizations are active, being found to be successful?"

[DEBBIE] As I say in the toolkit, there's many other resources that we didn't speak about today, and there's also I believe some links to the Temple Collaborative and contact information for me I believe, I'm Debbie at Mental Health America, to send us what you think should be included. Because as I said this is an interactive tool.

[RICK] Also in the last few moments, there are some other resources on the website that I'll point out. One that the Mental Health Association of Southeastern Pennsylvania and the Clearinghouse developed for us about two years ago was a document, I think it's called "In the Middle of Things". It was a review of peer operated programs that had done some innovative work around community inclusion. From the same group, on our website, we have a document that looks at innovative programs, both peer and professional, and religious groups have done together to help connect to both the spiritual and social life of mainstream congregations. Those are two areas in which there are models that you can look at for some of this work and there are probably others that I'm not remembering right now.

[JARED] We can answer one more question before we go, "Does the toolkit contain a fiscal instrument to compare net income from work with government subsidies"?

[RICK] Um, no.

[DEBBIE] No I'm afraid it doesn't, in fact we'd love one!

[LESLIE] That's an interesting question.

[RICK] I do think if you go to any of the local programs or state programs that look at the issue of work incentives for people on SSI and SSDI, there are probably tools there that help people compare "What happens to me if I go to work?" in terms of overall income. And there are in many states agencies that have been established with a mixture of state and federal funds that help individuals answer that question, essentially "how do I use the work incentive provisions under the SSA system to make sure I don't lose track as I attempt this one particular area of integration that is going back into competitive employment." But certainly call and we can direct you to that.

[JARED] This is actually all the time we have for the webinar, but I've recorded all the questions that were asked and if possible the panelists can respond to them via either email or a document that we put out. If they do that, they'll be put on our website and announced to everyone who registered so people will be able to access that document.

[DEBBIE] I hope I have time to thank everybody, to say how grateful we are to have the collaboration with Rick Baron at the Temple Collaborative, the folks here at Mental Health America, and for our input from Leslie Schwalbe, how important it is to have industry input and

how gracious she and the folks at OPTIM have been. So we are very appreciative, and thank you very much for the folks who took the time today to learn a little bit more about this. So please do use the Temple Collaborative Website, and please do send us emails. Thank you so much for your technical assistance Jared.

Thank you!