

Making Self Directed Care a Reality – Webinar

Mark Salzer:

At Temple University and I am going to be your host today for our exciting webinar in making self-directed care a reality at 2:30 Eastern time, but would like to give a couple more minutes for some colleagues to join us, and we should be getting started in just a couple of minutes.

Mark Salzer (2:53):

Ok everyone, and welcome to our webinar today entitled Making Self Directed Care a Reality, approximately a year ago Temple University in partnership with the Mental Health Association of Southeastern Pennsylvania and the Center for Mental Health Services Research and Policy at the University of Illinois in Chicago, received information from SAMHSA through their technology transfer engineering developed manuals regarding the implementation of self-directed care in mental health systems that we've been involved with.

Mark Salzer (3:37):

The purpose of this webinar is to provide a little bit of background on the information that we have documented in our manuals, and these manuals provide an in-depth detailed look at the policies, procedures and practices that municipalities and states can use to promote self-directed care. The webinar presentations will be given by Doctor Judith Cook who is professor and director of the Center on Mental Health Services Research and Policy in the Department of Psychiatry at the University of Illinois, and Erme Maula who's the program manager of the CRIF self-directed care project in Delaware County here in Pennsylvania and this is an program of Mental Health Association of Southeastern Pennsylvania.

Mark Salzer (4:33):

To kick off our webinar today we have a special guest Joseph Rogers who is chief advocacy officer of the Mental Health Association of Southeastern Pennsylvania who will be talking to us about the importance of self-directed care as a critical advance in promoting empowerment, self-determination, community integration and liberation and recovery of people who have experienced mental health issues.

Joseph Rogers Special Guest

Joseph Rogers (5:06):

Hello everyone Good afternoon. Thank you, I would like to thank Mark and Temple University and the collaborative, Judith Cook, and partner in crime Erme Maula for all the work they do for putting on the webinar. You know over ten years ago I met with the state here in Pennsylvania and met with the state office of mental health and proposed to them the idea that we might do a self-directed care demonstration project in Southeastern Pennsylvania.

The thinking that I had at the time was idea in the terms of trying to make our systems responsive to the individual but we seem at times not able to get able to get right there, and with somebody who has a mental health challenges, or a diagnosis of bipolar disorder I had experienced the mental health system personally and I myself many times struggling with the fact that it didn't really look at me as an individual. I'm treated even in private care settings, in private pay care settings, I'm still treated as a diagnosis as a number, as one of many, and not one many but as part of a whole.

And how do we get from treating people kind of in a cookie cutter fashion where there is only a limited amount of choices, even the best mental health systems in the country can pretty much offer you a limited menu of choices. How can we expand that menu how can we make it so that people have real choices, and that's what I was thinking when I met with our mental health people, how can we create a system of care where the individual is really in the driver's seat. And to me it seemed simple, but the concept of having people the ability to choose would really make a huge difference. So what we proposed was to create a project around self-choice, that would give the patients serious choices and resources, we call that freedom funds. Freedom funds that allow you to work towards integration based on your plan and based on your ability and what you want to see happen. With the help of a recovery plan but still it's your plan and you develop it and you make recovery plans, we talk about recovery plans, reroute plans, and things like that, but how do we fund those plans? You know in most cases it is something outside of their resources available. So our hope is that our experiment will enable, and you will hear more about it from the program in Texas, and you'll learn more about in the Delaware with Erme Maula. Again thank you everyone for being here.

Mark Salzer (8:48):

Thank you Joseph, and for those of you who were listening to Joseph he was actually calling in on his cellphone, so the reception caused him to break up a little bit. So I would like us to move on to our presentations from Dr. Cook and Erme. One thing I would like to say is that these are two, these are manuals that have been done on some research that has been conducted in partnership with Temple University and the mental health association of Southeastern Pennsylvania with the Delaware County Pennsylvania Office of Mental Health as well as Magellan. Judith Cook will talk about the work she did in Texas, the research was funded by the National Institute on Disability of Independent Living and Rehabilitation Research. And these are really manuals that followed up on the research to disseminate the kinds of things that we've learned about how to deliver and create effective programs out there.

The presentation will begin in a second, one thing I would like to let people know is that during the course of this presentation you'll be able to submit questions that you'd like to be answered. Either about what one of the presenter said or other questions related to the delivery of self-directed care. Please enter it in the chat feature of this WebEx system, and what I will do is go through those questions and select some of them for our discussion. At this time I would like to turn it over to Dr. Cook.

Dr. Judith Cook: Slide One (10:56); Self Directed Care Implementation Manual: A Comprehensive Mental Health Program Guide

Thank you for the introduction Mark, and welcome everyone to our webinar.

Slide Two (11:01): As Mark mentioned, we would like to acknowledge funding from not only NIDR but also the Center for Mental Health Services Substance Abuse and Mental Health Services Administration.

Slide Three(11:15): I'm going to be covering the basics of Self-Direct Care to make sure that we're on the same page about the kind of program that we're going to be describing today.

Slide Four (11:25): In self-care the funds that are ordinarily paid to a service provider

Slide Five (11:27): are controlled by service recipients. People develop personal recovery plans, and then they create individual budgets that show what dollar amounts they would like to spend in order to achieve their plans goal. Staff called support brokers are available to assist people with the purchases of services as well as material goods that have been budgeted in their plan. And finally an organization called fiscal

intermediary provides financial management services such as paying service providers and withholding payroll taxes.

Slide Six (12:02): The person centered plan helps people to identify who they are and how they'd like to live their lives. It also includes people's future goals based on what kinds of lives they'd like to have. It summarizes strengths that people bring to the pursuit of their goals, and also includes the barriers they feel might exist to their goal attainment. Finally the center plans also include action steps and timelines related to the individual's goals.

Slide Seven (12:38): The Individual Budget is directly connected to the person-centered plan. It's structures so that the line items relate directly to the goals the person has specified in their plan. IN SDC the program must be able to demonstrate a direct connection between achievement of goals and budgeted goods and services, and the budget is designed to document this link. The budget is also monitored by the participant and broker on an ongoing basis.

Slide Eight (13:10): What role does the support broker in all of this? Well the broker does many things; brokers help participants develop person-centered plans and budgets, and assist with navigating community resources, as well as managing the budget, recruiting, hiring, and negotiating rates with service providers, assisting with billing through the Fiscal Intermediary, but the most important thing to remember about the support broker is that they're always the co-pilot, never the pilot. These whole reason for being and activities in the program are designed to help the individual use the SDC program and help them use it in a way that furthers their recovery.

Slide Nine (13:56): You might be wondering what kinds of organizations run MH SDC Programs? The answer is that a variety of different types of organizations have been the home for these program. Sometimes it's a mental health advocacy organization such as Mental Health America of Southeastern Pennsylvania, or NAME of Collier County in one of the Florida SDC Programs. Sometimes it a regional Behavioral Health Authority, or non-process services agencies. Two self-directed care programs that are run by peer non for profit organizations, so there are many ways in which or places in which SDC programs can be located in terms of its organizational home.

Slide ten (14:44): One major difference in mental health SDC programs is whether the services are replacement or add-on. In some SDC programs some people get all of their traditional outpatient services through their self-directed budget, that was the case with; Florida, Pennsylvania, and Texas. But in other programs SDC budgets are used for add-on recovery services while the original tradition services remain intact, and that's the case for programs run in Maryland, Iowa, and Oregon.

Slide eleven (15:20): Another important feature of SDC is that participants can choose service substitutions. These are less restrictive goods and services that the participant chooses in order to achieve their recovery goal. For example may decide to replace formal services with more informal services. So instead of using a mental health agency van to get them somewhere, they might pay an individual such as a neighbor or colleague to drive them to a job interview. They also can replace services with "normal" community activities so instead of attending a weight management group at their mental health center, they might simply enroll in Weight Watchers or Jenny Craig. Service substitutions also include replacing public services with private ones, this is the case for example if a person wants a clinic service that is not readily available in their community mental health center. Many people in the Texas SDC program used their funds to visit a psychiatrist that had expertise in treating trauma for example, because that kind of psychiatrist was not available in their traditional system. Lastly people can use their SDC funds to replaces services with goods, for example a participant might replace using their peer benefits computer with a laptop purchased with their individual SDC budget. An interesting fact about these service

substitutions is that they are often cheaper than the original services that they're replacing. And that's part of what helps the SDC program achieve an important aspect called budget neutrality, which I will refer to in a minute.

Slide Twelve (17:09): So you might be wondering where the money is for Mental Health SDC Programs come from? And like all of our public health mental dollars in the United States today, two major sources are used Medicaid and State revenue, tax dollars. Many programs have used State general revenue which is combined with Medicaid in some fashion, so some programs have added on funds to Medicaid services, so Medicaid beneficiaries may receive additional money through state taxes or through a grant funding additional services. Sometimes the Total Cash-Out model is used in which Medicaid funds get pulled in with other funds such as state taxes, a grant that the program is able to win, private foundation funding, or community reinvestment dollars. In this was the case with two programs where not all those options, but different options were combined with Medicaid dollars, by both the SDC Texas and the SDC Pennsylvania program.

Slide Thirteen (18:15): The Ultimate Goal here in the SDC is that these programs be cost neutral, and to not cost any more than additional surfaces. Which is part of the reason that it is so popular with people on both sides of the aisle in both the political and the theoretical realm of clinical services.

Slide Thirteen/ Fourteen (18:40): One of the first published study was done at the original SDC Florida Program, look at people's outcomes the year before and the year after they joined the program. Participants spent significantly more days in the community in the year after joining the program than let's say in jails or psychiatric facilities. They scored significantly higher in global functioning in the year after program entry, and a high proportion of them were more engaged in productive activities such as working, receiving job skills training, volunteering, or being enrolled in postsecondary education, and people spent their money on both untraditional and nontraditional services. It may sound like an odd finding but some people argue that if people have control of their service delivery dollars, they would purchase traditional services, and that is simply not the case.

Slide Fifteen(19:41): AT UIC, we conducted a randomized control trial study of the Texas SDC Program with our Texas partners, where we compared the outcomes of people randomly assigned to the SDC Program with people assigned to the control condition. And looked at those outcomes at the baseline when they entered the study and 12 and 24 months later. We found that the SDC participants had significantly lower somatic symptoms, higher coping mastery, great self-esteem, higher self-perceived recovery, greater ability to ask for help and rely on social support from other people, greater perception of service delivery as client-driven, and finally had a greater likelihood of being employed then control clients.

Slide sixteen (20:34): We also found that the program was indeed budget neutral. Over the two years of the study average SDC participant spent an average of \$5, 240 per person, while the control participants had an average of \$5, 493 spent on them.

Slide Seventeen (20:56): And these differences were even larger for inpatient costs, where the average per person was \$295 dollars for the SDC, and over twice as high for the control group.

Slide eighteen (21:10): We also found that SDC participants were highly satisfied with the program, they were satisfied with their brokers. They thought the MH services that they were buying in the program were better than the ones they were receiving before for SDC, and though there were some complaints about what they could and could not purchase, 90% thought that generally the rules for allowable purchases were fair.

Manual One by Judith A. Cook (21:35)

Slide one (21:35): So the first manual that we will be introducing today in this webinar was created by my center is the Self Directed Care Implementation Manual: A Comprehensive Mental Health Program Guide.

Slide Two(21:46): This UIC manual is designed to showcase tips and tools from a number of several successful SDC programs in order to help people create their own SDC initiative from the ground up. You'll want to use this manual if you would like to learn how to mobilize your local community or State in order to embark on a SDC initiative. The manual describes how you might develop planning communities. How to develop a SDC program model based on your area's strengths and needs, funds in your area available, and the organizations willing to come together to host and operate the program. The manual describes how to staff and implement and run the program, covering the important roles of the program director and support broker. And finally the manual describes how to evaluate the program impact on lives of SDC participants.

Slide Three(22:50): It contains nine chapters introducing the reader to the (1) model of self-directed care and how it works, (2) describing how to get started describing the SDC Initiative, (3) describing the importance of being participant driven, both in the way the program is being planned and the way it's designed and it's being run and how the participants experience this, (4) it covers the SCD program structure, talking about the support directors and support brokers what kinds of job qualities they need and providing job descriptions for these folks, (6) it describes how to design budgeting and purchasing procedures and policies, that are fair yet keep the project budget neutral, (7) it also covers eligibility, recruitment, and enrollment procedures, and how to think about designing those for your individual program, chapter (8) is devoted exclusively to the key role of SDC supported brokers, and chapter (9) covers and evaluates how to accomplish positive outcomes for participants and how to maintain program fidelity.

Slide Four(23:59): In the resources section of the manual is a number of helpful documents, you'll find the original State Legislature that established the first two SDC programs for mental health in the country, the Florida SDC Program. You'll find the job descriptions I alluded to earlier. You'll find forms procedures for creating the SDC Life Plan setting SMART Goals. Forms from the Texas SDC Program stating Participant Rights and allowable purchases, a fidelity assessment that you can use to assess SDC, a Relapse Prevention Plan that you might suggest that people use, the Satisfaction Survey that we used in our research at UIC. This is presented for you to necessarily pick up and use exactly as presented, because in some cases we present forms that were used by multiple programs, to give you a taste of how each program might have approached particular program functions differently. So they are designed to stimulate your thinking and to adapt and use for the initiative that you would like to mount

Slide Five (25:09): Our tips for the manual first of all is to read the manual in its entirety to understand the full dynamics of what you are trying to accomplish with a SDC initiative. This will make sure that you are ready to address some pretty common concerns, fears, and myths that people have with the facts and figures that are presented in the manual. You're going to want to use the manual in order to build a supportive SDC community, to nurture your allies, and to be as inclusive as possible as you are planning your program. We've designed chapter one so that each page can be torn out and used as a hand out to share in the community or with the committees you are working with. You're going to regularly check your progress and your process against the SDC values described in Chapter 2, it's easy to drift away from some of these values and start limiting participant's choices. Or coming up with operational procedures don't give them the flexibility that they need to receive the goods and materials they really do

require in order to recover. You're going to learn about various funding mechanisms that can support an SDC initiative in your community, you'll read about the very complicated CMS waivers that are available to fund different types of SDC. Even though we haven't yet seen one of these waivers used to fund any of comprehensive funds we have described in this manual but they're there and someone is going to step up and use it. How to train and nurture a recovery-oriented staff of brokers that embrace SDC values and principles. And also how to be ready for the inevitable ups and downs, the challenges, the times you want to tear your hair out, but also the times that you're really going to enjoy the ride and be glad that you put all the effort into it.

Slide Six(27:10): When Inspiration is needed you can turn to these SDC testimonials and once you read about how SDC has changed people's lives, and how they have responsibility and effectively used their budgets, and how creative and cost effective this approach is. I think it invigorates and helps to inspire you to deal with the more challenging moments of mounting an initiative.

Slide Seven (27:34): And I'd like to end my segment talking about ways you might tap our center's expertise here at UIC. We're pleased to announce that we have just been funded by the federal government for a new Center on Self Directed Recovery and Integrated Health Care, and part of that center will offer a podcast and webinar about how to implement SDC programs and how to use this manual. And also available through our new center will be telephone technical assistants that you can access , if you want more in-depth telephone consultations on designing a program, bringing people together to create an initiative, designing forms that are user friendly yet make sure your program is protected and can show that it uses funds responsibly. UIC staff are able to come out and do consultations for a fee, so these are two ways that you can tap our expertise here at UIC and you'll learn about some others from the Temple center in a moment.

Slide Eight(28:40): Finally I'd like to tell you how to access our manual, that I described today, and you'll do this but you won't be able to do it until tomorrow. On October 2nd you'll do this by visiting our website and clicking on Planning a Self-Directed Care Program? Link that you can find in the news and features section of the website. So you'll go to our top page and see our planning a Self Directed Care Program? click, and you'll be able to download the manual. So thanks for listening to information about our program and our research results, and the manual that we designed. Now I'd like me to turn it over to Erme Maula the director of the Pennsylvania SDC Program to hear what they find and have available.

Erme Maula: Mental Health Association of Southeastern Pennsylvania CRIF Self Directed Care Project, Delaware County, PA

Slide One (Title): We're really excited to be here with Judith and UIC Program to be able to talk about what we were able to develop in Pennsylvania and a lot of that is due to our collaboration with what was going on in Texas.

Slide Two: So just some common definitions that we'll use, or that we use in our program that we inherited the name the Consumer Recover Investment Fund, just talking about how people need to invest in their own recovery. SDC referring to self-directed care, which is as Judith said referred to in a lot of different ways and we'll define the way that we utilize it within our program. In Pennsylvania we use certified peer specialists (CPS) to be able to deliver the services of self-direction, and the CPS roll at the Mental Health Association of Southeastern Pennsylvania is referred to as a recovery coach. So our recovery coaches are trained both as certified peer specialists and WRAP facilitators to be able to walk along with someone on their recovery journey to be able to self-direct it. And freedom funds are the funds used within the self-directed care budget to purchase nontraditional goods and services outside of the clinical realm.

Slide Three (31:09): And similar to Judith I'd like to really thank all of the partners that I've been able to work with and we've been able to work with throughout this project, and without them we wouldn't be able to move forward. It's really been an honor to bring together Magellan behavioral health services as a Medicaid-managed care organization along with the Office of Behavioral Health in Delaware County, with the Collaborative at Temple University, and the Mental Health Association of Southeastern Pennsylvania to bring together both government and insurance and research all together with a service provider. It has really be an experience that a lot of people will take in as a model to implement programs throughout the country.

Slide Four (32:03): Our three basic philosophies of implementing our program is that we're based on the idea that recovery is possible, we're really talking specifically about mental health recovery. Although we incorporate people with a drug and alcohol diagnosis, mental health diagnosis is the primary challenge that people come in with. And we also believe in peer support and find peer support to be the lynchpin to help people move forward in their recovery, and what they often have been missing with their clinical services. And then the idea of self-direction, so self-directed care for us has two different meanings. One, is just the philosophy on how we deliver our services. Peer support is a Medicaid-billable service in Pennsylvania and needs to fall into the medical necessity and clinical guidelines that are set forth by the state, but we've really been able to incorporate those in a recovery-oriented way to be able to help people self-direct their own lives and their own recovery plans. But, self-directed care also refers to the very specific SDC program of how people can manage their budgets.

Slide Five (33:22): So similar to a lot of the other programs and the Texas program and looking at the idea of support brokering within person-directed support services, a lot of people look at support brokering as a way that people higher and manage their budgets. And we wanted to take that and incorporate that into what we use in Pennsylvania around certified peer specialists and peer support. So for us, recovery coaches really marry the two concepts of delivering peer support services, who are trained to be able to help you broker those supports and the budget within your self-directed care budget.

Slide Six (34:07): And we really wanted to change the idea of person-centered planning, which we think of as really important, but what we've found working with people who have been in the system a long time, that you just created these concentric circles of support around people, which made them not feel like they could actually move forward in their life and in their recovery. So, changing that idea to be more that the person is at the front of that arrow, and us as supports really behind them moving them forward. And changing that dynamic really helps people understand that it's not just about staying stagnant where you are, but figuring out what you need in your life to be able to move forward in your life. And what do those supports look like, whether they're financial or clinical.

Slide Seven (34:52): So our self-directed care process, you know, is really just a peer support process. It's really focusing on the hopes and dreams figuring out how to develop the skills and tools in all of the life domains that somebody has to figure out what sort of clinical supports do you need to be able to move forward towards those hopes and dreams, and then how do we expand the natural and community supports to do that. And then how do we figure out, when we walk alongside somebody, how can we expand the resources they have to move forward in their lives?

Slide Eight (35:30): The activities that people identify really need to fit into this recovery plan that they develop along with their recovery coach. We recognize that recovery plans can change over time. And that the recovery coaches can help educate participants about the concepts and processes of recovery. Our experience was that by entering into what started off as a randomized control study, similar to Texas, people were introduced to peer support for the first time, and introduced to the idea of recovery and

choice for the first time in a way that they had never in their life been introduced to. So it was really eye opening for our coaches to be trained in a way to say “If you had no boundaries or barriers, what would your life look like?” And for people who had been living with mental health challenges the majority of the life, to really get to think about that. And not knowing how to think about that and being supported around the feelings and everything that come along with changes in your life. So the other unique characteristic of our recovery coach, similar to support brokering, is the idea of being able to help the individual learn how to track their budget, how to analyze actual utilizations from the end claims data from the insurance company, and incorporate that into their recovery plan.

Slide Nine (37:00): So in Pennsylvania we have an MA-billable service for peer support, which is one of the ways that we’ve helped sustain the program and deliver it within our context. It’s also helped us create jobs for peers, but help enhance certified peer specialists in a way that really directs their peer support delivery service to be more self-directed. By giving people access to their claims data over a two year period of time, as well as the time that they are within the project, allows them to see, not only how much services cost, but to be with a recovery coach to ask the question of “How does this service help me in my recovery, and if not, how do I evaluate it? How do I see if it’s really the service that I find necessary for me, and is there another service outside of the system that might be better to meet these needs, or how to I advocate for myself to get more satisfaction out of the service I provide?” So it’s really taken on a different angle of providing that information so that people can really be empowered in making decisions in their life.

Slide Ten (38:15): Similar to Texas we delivered our freedom funds through an SDC card, which was a paid card that was delivered to each individual with their name on it, and it didn’t identify them as someone with a mental health challenge. We found that this really helped create responsibility of the funds. People had to identify what the recovery plan is and what services or goods would helpful in that plan, and that plan had to be approved on several different levels, including the managed care level, and the individual was responsible for only purchasing the items that were approved, to help them move forward in their recovery. They were able to do that by using this card in their name and keep the receipts, and a lot of people felt really dignified to make those purchases on their own and feel what they would say is normal.

Slide Eleven (39:16): Some of the “asks”, and we have hundreds of different examples, but you know, depending on what their life goals were, and what the real specific smart steps are to be able to reach those goals, these are some of the goods and services that fell into here. Some people also did access some very specialized clinical services. So, if people found a provider that was not in the list of providers with our insurance company, they could use the funds to pay for a specialized provider to get services. But we found that people really looked for using cost to cover transportation, education, really enhancing their literacy so that they could move towards getting jobs and being more incorporated into the community, were really the places that people used freedom funds for.

Slide Twelve (40:12): In the middle of the project, of our randomized control study, Temple University went out and here is just some of the qualitative data that people had. They really felt good about being able to pick and choose what they really wanted, and to decide what they needed and what they didn’t. They wanted to decide how they wanted their treatment, to be able to speak up about that. They didn’t realize they could have refused some of the services they were receiving or to ask to enhance them in certain ways. They were also given opportunities and skills to be able to push back to different providers and say, “Where are these rules coming from? Can we talk about what the regulations are, and can we think about different ways to provide services and access services? That would actually make me feel better in my own recovery.” So it had felt really good to be able to deliver this service and see its impacts

that it's had on people. We've seen that simple purchases have really made huge impacts on people's recovery. Where someone may not have ever left their home except to go to appointments, but something as simple as a bus pass or a digital camera gave them enough incentive to be able to leave their home and do something meaningful, which led to them getting more training and socializing outside of the home. People making better choices and asking more questions about the choices that they have in terms of socialization, and trying out new things, but as well as accessing those clinical services.

Slide Thirteen (42:00): So the manual that we put together, or that Temple University put together that we assisted in, really takes everything that we did and put it into a manual with our forms and the process that we use to be able to create a self-directed peer support program and to provide a model of what some of that documentation would look like in a Medicaid service. So with that I'm going to pass it back to Mark.

Mark Salzer: Question and Answer 1 (42:52)

We have two questions, the first one comes from Nancy Brookes from [Sweet land?] who is associated with the Florida SDC program that really has been a pioneer in this area. She writes "In particular to do this, I would like to know if SDC states have changed over time and what barriers do you see that we need to address as advocates?"

Judith's Answer (43:19):

Thanks Nancy, that's a great question, and I think Nancy is motivated to ask that question because she is in a state that has had two of the longest running SDC programs in the country. I think that the early barriers are often the unfamiliarity of the local community and service providers and administrators and legislators with the model, the myth that surrounds SDC, you know people in recovery can't make good decisions about purchases and so forth and so on. I think probably people can guess about all of those earlier barriers. I think what's interesting is that the second generation program questions are related to how people are going to be able to exit the program, so that other individuals can get served. So, are there exit criteria? At what point do you judge together, the participant and the broker and the program director, that people's goals have been achieved? So, I think that is one of the second generation questions. And I think another second generation question has to do with, now that we have pilot programs and they're successful, how do we now take things to scale and expand those pilot programs to other communities or other parts of the state?

Mark Salzer: Question and Answer 2 (44:45):

Alright, terrific Judith. And for those of you sending in questions, keep them coming. The next question we have is "How do participants in self-directed care find out about resources outside of traditional services that might be available to them?" and they also write "Is there a database with programs with complementary modalities or something similar to that, that they can use?"

Erma's Answer (45:23):

This is Erma, and one of the things that we found is that it takes a lot of training to get our recovery coaches or support brokers to train them to think outside of the box, and to think about, not only how do you do support circles, but how do you issue-generated support circles, and how do you figure out who needs to be at the table to come up with different ideas. So, some of it is really learning better ways to do community integration and to finding out what is in your community and learning how to do some door-knocking, to do that together. So, part of peer support is not doing for you but doing with you, so sometimes we do a lot of resource sharing. So if someone does find a database around complementary

healing modalities, then we share that with other people, but that's how we want to mirror how natural supports can be created.

Judith's Answer (46:23):

And this is Judith, I'd just like to chime in, and I've also turned my webcam on so hi everyone! I think the support broker is key, and learning from each other, the program participants learning from each other, "This helped me." "This is a great massage therapist." "I found a trauma-oriented clinician that is willing to come to my home." those are some of the things that happened with Texas SDC. One of the things that Erme, and I didn't get a chance to talk about, is that SDC programs have their own provider networks, and over time they develop lists, we have one of the SDC website, of alternative services like cooking classes and personal trainers that will work with a group of people in order to reduce costs, herbal remedies. All of those things can be a part of the provider network that the program assembles, and they do that in order to help participants make their budgets, because for each provider there is a cost, and what that provider offers. And finally I'd like to point out that the purchasing policy that each program has lists the number of things that you can purchase and things that you are not able to purchase. By looking at those, it stimulates participants to say stuff like "Oh wow, yes that's right, I can join the Y!" or "Oh peer providers, of course! I can hire somebody to drive me to my job interview, rather than use a cab." So, those are the kinds of things that we are talking about in learning about alternative resources.

Mark Salzer Question and Answer 3 (48:02):

Great, thank you Erme and Judith. We have two questions and it has to do what happens to remaining funds, Oh it's actually the same question repeated, "What happens when clients/peers exit self-directed care?"

Judith's Answer (48:25):

Well I can answer that in terms of how the Texas SDC program operated. People budgeted and spent quarter by quarter. So funds that weren't spent in the first quarter rolled over into the second and the third and the fourth. But at the end of that time period, if people didn't spend their funds, they lost them and started over again with their new budget at the beginning of their next year of program participation. We did it this way because of accounting difficulties and also because some of the funding streams do require that some money be spent by the end of the fiscal year.

Mark (49:04):

Erme, would you like to add what happens in Pennsylvania?

Erme (49:10):

So, similarly, we had dates that outlined the project. So, if someone didn't accrue or had access to freedom funds one month and decided not to use them, we allowed them to roll those over until they were able or wanted to use them or had a reason to use them. But the funds will eventually run out at the end of a project period and then we just won't have access to them after that, until we move forward hopefully to a waiver or a different type of demonstration project in Pennsylvania

Mark Question and Answer 4 (49:43):

Great, and Erme it's wonderful to see you. We have another question actually to both Erme and Judith. The person asks "Can you speak about the differences between the different two types of SDC you presented, self-directed care in Delaware County and self-directed care in Texas" I guess I would say one

of my first reactions from knowing both the types of SDC that we're talking about, is that there are numerous differences between the two different types of SDC, and in fact, and Judith and Erme I know you've gotten to know programs around the country. There are so many differences we could almost have a whole webinar just on differences between all the different SDC programs. Are there a couple of differences that come to mind between what we've done in Pennsylvania and in Texas?

Judith's Answer (51:06):

Sure, one of the differences between the two programs that I think is a dramatic difference, is that in Texas in order to set the size of the budget, which was around 4,000 dollars, we took the average that was being spent for the services of people in the outpatient service delivery system in the area where we ran the program. So, this was an average across thousands of people, and that average turned out to be about 4,000 dollars. I think I'll let Erme talk about how they determined what people had to spent

Erme's Answer (51:42)

Our SDC budgets were based on each individual's' historical claims data over a two year period of time. So the budgets were vastly different. And another big differences is that we require that our support brokers and recovery coaches be peers, where I believe in Texas it was coincidental whether someone was a peer or not.

Mark Salzer Question and Answer 5 (52:07):

Terrific and you can see some of the manuals for more information about each of these programs. Another question that we have has to do, this one is actually directed to Erme. How do recovery coaches in SDC, how do they interact with the individuals managed care plan? So how did our program interact with Magellan in this case in Delaware County around getting approvals for purchases or those kinds of things?

Erme's Answer (52:46):

So there were several different points where we had interaction. First is that the services delivered by the recovery coach are Medicaid billable services, so that service time is paid for through the manage care association. Another way it was interacted is when you came up with your recovery plan, although that was kept in house, that when the individual had a request for freedom fund utilization or request for freedom funds, they had to with the assistance of the coach come up with a um fill up some paperwork to figure out how show that it was medically necessary to help their recovery move forward, and that documentation was sent to case managers that MCO who either approved it or didn't approve it and sent it back. So there was a lot of interaction just on a daily basis, and with Magellan and MHA both sat on the operations team to figure, so they were both part of the operations team to decide how do we roll out different parts of the program.

Mark Salzer Question and Answer 6 (53:58):

Great, thank you Erme. I'm going to answer two questions that came in.

Mark's Answer (54:00):

One was why aren't people with alcohol and drug use primary diagnosis without a mental health disorder not included?

I can speak for what we've done in Delaware County our primary focus was people with mental health

issues and what qualifies serious mental health illness in particular is schizophrenia spectrum disorder, bipolar disorder, and major depression. We did allow those individuals that have co-occurring issues as well, I could imagine there being a study at some point that looks at the impact of self-directed care with those with primary alcohol and drug use diagnosis. Just both of these studies and projects focus on people with serious mental health issues.

Somebody else asked if there were any programs like this in VA currently that involve peer run programs that utilize route facilitators and peer recovery coaches?

But this is the first I've heard of SDC. I actually use to work in VA myself and had two tours of duty in the VA system, my understanding is that VA has been talking about self-directed care to some extent but to what veteran populations they are talking about rolling it out with, I don't know whether this is part of the Health Home initiatives that are happening in VA. But my understanding is that there has been a discussion of self-directed care models within the VA system.

Mark Salzer Question and Answer 7(55:45):

This next question I have is for you Judith do you have any input on seniors in self-directed care? I'm referring to long-term participation in SDC for those who are unable to work. As an aging adult being productive is valuable to recovery. SDC offers the senior the opportunity of making goals and trying to be productive in their community.

Judith's Answer (56:10):

Yes, I think that SDC is a fantastic model for seniors because the emphasis is on productive activities and whether it is paid, unpaid, or volunteer verse a job, is not really what it is about or what the emphasis is on, I think it is a great model for seniors, and I think there is a lot of interest for it. In the original study that SDC came out of Medicaid and it was developed for people with a number of vulnerabilities and one of them was for older citizens. And so in a study called the cash and counseling study one of the major groups that got SDC and benefited from it were elderly individuals.

Mark Salzer Question and Answer 8(57:04):

So this is Mark again we actually got a little bit further clarification from Nancy Sweet land with that question but unfortunately we're coming close to the end, so we're maybe going to have to get back to you later Nancy. And I also got clarification on what the VA stands for, that person was actually asking for programs in Virginia, and there goes where my head is, I was thinking they meant Veterans Administration. So Judith or Erme do you know of any programs in Virginia? I do not know of any programs in Virginia nor have I heard any discussions of programs in Virginia.

Erme's Answer (57:47): There is a very small social SDC program run of Mental Health America run by Patrick Henry for people with diagnoses of schizophrenia which looks very different from the two programs we've been talking about, but is a very small program in Alexandria.

Mark Salzer Closing Notes (58:14):

Terrific that is great new knowledge Erme. So through Mental Health America, Patrick was involved with the Florida SDC with help of getting it launched. I want to thank you for joining us and again remember that we have these two manuals that provide great information about SDC from a psychological standpoint and implementation standpoint. We will be releasing these manuals I believe within the next couple of weeks, so everybody who signed up for this webinar will be getting an email saying that the

manuals are available and that you can download them. As Dr. Cook mentioned we are all be available to answer any additional questions that you might have regarding the implementation of self-directed care both the policies and the implementation issues as well. So we are happy to hear from you and we are happy to help, all of us are very committed to self-directed care and it's revolutionary in how mental health services are delivered. Again I would like to thank my co-presenters or really the primary presenters Judith and Erme for doing such a wonderful job, and being such terrific partners and collaborators. And obviously we also would like to thank our vendors SAMHSA and the National Institute of Living and Rehabilitation Research who have really helped us do this cutting edge research and cutting edge efforts to get the information out there. So thank you again for joining us feel free to contact us with more questions or criticisms we're happy to hear from you, and have a great rest of your day.