

Terms of Engagement: Implementing a Change Process at the Local Level

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THE CHANGE PROCESS associated with the implementation of reform is unparalleled in the history of public MH/DD/SA since the beginning years associated with the federal community mental health initiative. Even then, the process was mostly hopeful and exciting for those involved. In the early 60's, change was characterized by key values and commitments underlying the terms of engagement—increased federal dollars, a greater voice for consumers, equitable care and commitment to all those served regardless of race, creed, illness, or color, and creativity and independence at the grassroots level. Talk to anyone involved in those years and you will hear tales of local advocacy efforts characterized by a few committed individuals who, with a few thousand dollars, lit a fire in the community and started the development of services for those with mental illness. It can be argued that there are parallel values underlying the current change process similar to that of the early 60's—social justice, equitable care for all, population-based services that focus on the overall health of the community and a real focus and voice for the consumer. However, now the terms of engagement have changed. There is no increase in dollars, the change effort is driven from the top down with little or no comparable grassroots movement, and the change process grew out of broad-based dissatisfaction with existing services.

The current terms of engagement are characterized by frustration, anger, and a power struggle between state and local officials. Feelings of loss and sadness make this change process especially challenging. Coupled with real technological, political, policy, and regulatory conflicts and barriers—those initiating change at the local level are challenged to find their best selves in order to hold out and continue to realize the values associated with the change effort.

Financing

The 03-04 fiscal year is especially challenging for the local area authorities/county programs. While this will be the first year of implementation for some Area programs, their administrative costs will be paid in the same method as previous years, i.e., a

cost-finding process that requires justification and documentation. This process contradicts the new mandated roles and functions, e.g., provider management, customer service, for which Area programs are trying to hire or rearrange existing staff.

These contradictory financing factors cause Area managers to engage in a variety of risk-taking behaviors during this year of planning and implementation exemplified by an “if-then” approach. Some area programs with enough “fund balance” are able to utilize these funds to begin to build the Local Management Entity functions necessary for successful operation in 04-05. Others have designs on paper, but are unable to make changes until the dollars are known and secure.

Provider Network Development

The transition of public service to private and nonprofit providers is one of the most sensitive areas of reform. The competing principles of choice versus sustainability, fragmentation of service versus one-stop shopping, manager versus provider play out in this transition and are difficult to balance and prioritize. Several issues further complicate the transition. First, requirements for provider credentialing/certification, rates for services, documentation or other regulatory requirements are not yet finalized. Without these key pieces of information, local managers have no information with which to attract, develop, negotiate, or contract with new or existing private or nonprofit providers. Some Area programs are “spinning out” their existing clinical staff to work in nonprofit agencies. They are unable to set the tone for differing expectations regarding service delivery and requirements without knowing and understanding what the new service paradigm will be.

Neither has the state fully defined and prioritized the “evidenced-based practice” called for in the State Plan. Area programs are left to “read the literature” and make their best decisions for a new treatment paradigm. For example, will private professionals be paid to participate on child and family teams—a known method for ensuring a “community action” approach to supporting children and families? The one clear expectation for evidence-

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based practice is the Assertive Community Therapy Team—a service, in reality, which will serve a very small percentage of the severe and persistent mental illness adult population and will not be readily available in rural areas due to the staff-to-patient ratios required to make it viable.

State Institutions

An example of how implementation does not match-up with policy goals relates to one of the fundamental precepts of the reform effort—that state institution dollars will “follow the patient” to the community. The state hospitals are to be a part of the continuum of service for the Area programs with Area programs determining admissions and discharges based on medical necessity. The Area authorities have been allocated “bed days”—a number of beds per catchment area. These beds are to serve the community and the Area program is to pay for additional beds out of their own budgets, if necessary. However, the dollars for the beds remain in the state hospital budget and the admitting physician at the hospital can admit a patient without penalty even if the Area program has other alternatives to serve the patient locally. The Area program, however, will be penalized if the number of bed days used exceeds the number allotted. This reverse incentive paradigm does not support the desire to move patients to community settings nor a strong community managing entity, which causes significant reliance on communication and relationships as the only means to determine best use of state hospital beds.

Public Employee Transitions

Another serious challenge in this reform effort is the fact that employees who, more often than not, are affected personally by the change, are the very staff who must make the change effort successful at the local level. Many staff are uncertain if they might be employed, where they might be employed, and what they might be doing. A typical Area program, currently employing 300 staff persons, will likely be employing 40 staff in the year 04-05. This fact makes the change process, dependent on leaders at the local level for its success, uniquely challenging. While an area program may have planned for the transition in its local business plan, and most staff have been well informed of the possibility of personnel change, the emotional overlay of this impact is like a death. Area program staff are individually and collectively at various stages of the grief process as they let go of the role they valued and nurtured for many years and embark in territory still murky at best. Many Area programs are experiencing unplanned, but not unexpected, staff flight as staff members make personal choices about where they fit or don't fit in the new system, thus creating vacancies in clinical positions that are impossible to fill due to their known short tenure. Gaps in a public system that already experiences an extreme workforce shortage is amplifying at an alarming rate, causing increased consumer and advocacy dissatisfaction. Public programs have no ability to offer incentives for continued stay during transition. Staff that remain are often functioning

in multiple roles—one in the old paradigm and one in the new. Staff that do remain in public service, albeit in nonprofit or private settings, have to develop a new way of thinking—one that will be ready to adjust to new clinical paradigms as the information regarding service definitions and best practices evolve. There is currently no plan of support except what may exist at a local level for assisting individuals with this transition.

Consumer and Family Involvement

The state reform effort places great emphasis on consumer and family involvement, requiring each local program to establish a local consumer and family advisory committee. While this focus is universally supported in theory, there has been little support for assisting both clinical staff and consumers in thinking through this new relational paradigm. The shift from a clinician-patient paradigm to one of public partnerships between service agencies and service recipients is a minefield. Traditional modes of relationships will need to shift and professionals have received little if any training in how to partner with those they serve. Consumer and family members often come to the table angry after years of inadequate service. Assisting professionals in dealing with and working through that anger in an open and nondefensive manner is a challenge. Consumers and families desperately need support in understanding the system they will be asked to influence at a decision making level and how to participate in an advisory role. The sensitivities in this area are significant as a breakdown in this arena could cause damage that might take years to repair in a local community.

Local Flexibility versus State-wideness

The age old public policy debate of state control versus local autonomy is front and center in the reform effort. The initial legislation, leading to Session Law 437, began as a proposal for complete county governance. Eventually the legislation shifted to a choice model between county government and an Area authority governance model, setting the tone for increased local accountability and oversight in MH/DD/SA service systems. Local business plans called for community stakeholder involvement and the local development of plans that included provider development, provider monitoring, and service innovations. Consumer and family committees were expected to be actively involved at the local level in determining what services were needed in their communities and how they would be evaluated. The state, however, was also charged with creating a consistent statewide service system. For example, the federal government had serious concerns about the lack of “statewide-ness” in Medicaid services in NC and providers were increasingly frustrated (and their businesses threatened) by the varied business and service practices across the state. Considerable investment went into local business plans only for communities to hear; as the state plan evolved their plans were not in keeping with state expectations. This one step forward, two steps back approach has added to a sense of frustration, immobilization, and demoralization at the local level.

Terms of Engagement

The potential benefits with this reform effort can far exceed the frustration associated with it. Some frustrations associated with change are inevitable—personal grief, staff flight, inadequate information. Knowing the terms of engagement—financing structure, service packages, rates for service, expectations for outcomes and best practice, role of the Area programs in

managing services and providers—are the key to managing this frustration. The values associated with reform increase the urgency with which these terms need to be more clearly and persuasively communicated. Leaders—state and local—must recommit to the idea that this effort is more than another political/bureaucratic exercise and that the lives of our most vulnerable citizens depend on how these terms of engagement are played out.

*“Sallie” and others
just like her
provide 80% of
all long-term care*

One of every 5 adults in NC is caring
for someone age 60 or older.



How can healthcare providers help?

- ▲ Ask your patients and those accompanying them if they have responsibilities providing care for someone
- ▲ Use the Caregiver Self-Assessment developed by the AMA at <http://www.ama-assn.org/ama/pub/category/5037.html>

Refer patients and caregivers to local resources

- ▲ North Carolina's Family Caregiver Support Program can provide help for caregivers of persons 60 or older.
- ▲ To locate local resources through your Area Agency of Aging visit <http://www.dhhs.state.nc.us/aging/fcaregr/fcjobs.htm>
<http://www.fullcirclecare.org> and
<http://www.eldercare.gov/>