Concepts we support in any redesign effort

We are fighting to protect what is best for individuals and families served across the state, we believe that is a PUBLIC SYSTEM:

- Has the care expertise and proven ability to develop and implement evidence-based and promising practices
- Best understands the complex needs of the people served.
- Maximizes the amount of resources going into care for people – does not take profit off the top. We want the dollars to follow the person.
- Has a proven record of high performance
- Has a transparent policy-making and decision-making process, ensured by the Open Meetings Act and FOIA
- Has longstanding and deep partnerships with community organizations across a range of sectors: education, law enforcement, judiciary, housing, employment, public health, aging services, among many others

Public system must have:

- CMHs at the central role of care & serve as the local network managers
  - CMHs retaining risk, clinical, quality, and financial management functions in their traditional and proven role as a comprehensive specialty services network organizer
  - CMHs receive capitated or sub-capitated payment arrangement to best allow for coordination of care.
- Maintains local control, governance & local decision making tied to local elected officials
- Protects the safety net role that is tied to the community – people in need of services and community partners know who to turn to in a crisis

Potential Models & key concepts to support:

- State/Regional publicly run risk-bearing entity (PIHPs are regional risk-bearing entities)
- Public / private partnership that forms a joint entity which is jointly governed and managed.
- Publicly run system that has a private partner come along side and work collaboratively

  - Any model should fully fund CCBHC & BHH/OHH models, to ensure continuation and expansion of patient-center integration initiatives.
  - Any model must have a focus on access to care and the appropriate intensity and duration of services and supports
  - Clarity as to risk-bearing and savings retention by CMHs
  - Clarity as to how SUD services are managed and organized at the state and local levels

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Much Accomplished – More to Do

Accomplishment over the last 5 years

Throughout its history, Michigan's public mental health system has been an innovator in system design and processes. This system continues to develop a wide range of design and process refinements that are goal- and outcome-oriented, implemented with sound redesign principles and approaches. We have listened to concerns and continued to establish solutions.

Over the last 5+ years CMHA and its members have looked at gaps in the system of care and have worked with the Michigan Department of Health & Human Services (MDHHS) and key legislative leaders to help close those gaps:

Much Accomplished:

On the ground / real integration & access to care

- **Established 36 Certified Community Behavioral Health Clinics** – CCBHCs adopt a standard model to improve the quality and availability of addiction and mental health care, they also provide care to people regardless of ability to pay — those who are underserved; have low incomes; are insured, uninsured or on Medicaid; and active-duty military or veterans.

- **Developed 40 County Health Home Models** – The Behavioral Health Home (BHH) and Opioid Health Home (OHH) provides comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness, serious emotional disturbance or opioid use disorder. For enrolled beneficiaries, the BHH or OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care.

Started over 650 CMH lead healthcare integration initiatives across Michigan. Work around **physical health-informed BHIDD services, co-location, and identification of super-utilizers** underscore the variety and maturity of these efforts.

Crisis services

- **Crisis stabilization units:** Public Act 402 of 2020 creates crisis stabilization units. These units are designed to better treat and assess individuals who are experiencing a mental health crisis versus keeping them in

an emergency department for several days, which can quickly turn into weeks. Crisis stabilization units would be appropriately staffed to better handle behavioral crisis services while a permanent placement can be found for the person in need.

- **Psychiatric residential treatment facilities for children and adolescents:** Public Act 285 of 2020, requires MDHHS to establish psychiatric residential treatment facilities for Medicaid patients under the age of 21. These new non-hospital facilities would serve as a step-down for children who still require intense services while meeting their treatment needs.

- **Statewide crisis line:** Public Act 12 of 2020, Michigan Crisis and Access Line (MiCAL) staff will provide Michiganders with crisis and warm line services, informational resources, and facilitated coordination with local systems of care (Community Mental Health Services Programs [CMHSPs], Prepaid Inpatient Health Plans [PIHPs], and other applicable entities). MiCAL will be staffed 24 hours a day, seven days a week, and will offer support through phone, text, and chat.

- Michigan's public mental health system has designed and operate over 60 **mobile mental health crisis units.** Mobile crisis units deploy trained professionals to help respond to people experiencing a mental health crisis with compassion and clinical expertise. Mobile crisis teams are able to help police officers with a wide range of behavioral health challenges, anything from a domestic violence call to a case involving a mentally ill person.

Access to Care

Things that have helped address the issue:

- CCBHC – Reduced wait times, must serve all regardless of ability to pay and payer
- DCW increase ($2.35/hour increase) has helped stabilize workforce
- Enhanced telehealth capabilities

Residential care & crisis services

Things that have helped address the issue:

- Psychiatric residential treatment facilities (PRTF)
- Crisis stabilization units (CSU)
- MiCAL
- Mobile crisis teams with law enforcement

Inpatient Services

Things that have helped address the issue:

- Psychiatric residential treatment facilities (PRTF) (once up and running)
- Crisis stabilization units (CSU) (once up and running)
- Inpatient Bed registry (PA 658 of 2018)

More to do:

Access to Care

Gaps still exist:

- Workforce (at all levels)
    - Lack of workforce in rural areas
    - Ability to recruit master level professionals (social work, psychology, speech therapy, occupational therapists) – child and adult practitioners
    - Lack of adult and child psychiatrists
    - Lack of nursing staff
    - Insufficient loan repayment options to attract clinical staff (NHSC loan repayment program)
- Inadequate Medicaid health plan mild/moderate benefit
    - Lack of Access to care / lack of availability to psychotherapy and psychiatry
    - No data or reporting requirements available on performance
- Lack of SUD providers
- Funding to meet demand for services
- Lack of funding to provide Prevention Services
- Inability to bill commercial insurers for care coordination services
- Need to address racial/ethnic disparities in behavioral healthcare.

Residential care & crisis services

Gaps still exist:

- Funding to implement PRTF and CSU statewide
- Rural care/options (lack of funding for ACT teams, etc)
- Funding for full-time 24/7 crisis center services
- Lack of crisis, respite, and moderate-term residential options for children and adolescents who need a higher level of care than in-home care but less intense than inpatient. CMHs are seeing a significant increase in children and adolescents in the ED, being dropped off by foster parents for whom the behavior challenges are beyond what they feel that they are able to handle

Inpatient Services

Gaps still exist:

- Inpatient units ability to deny access to care (milieu, physical layout, etc)
- Lack of bed availability (especially in northern MI)
- Long wait times
- Lack of specialized settings (children, I/DD etc)
- Workforce professionals
- Interstate compact agreement to place involuntary placements outside of the State of Michigan

Non-Medicaid Based Services

- Inadequate array of standard mental health services in benefit of commercial mental health and addiction services (which covers roughly 80% of all Michiganders)
- Lack of funding of CMH general fund dollars & local dollars (via local match draw down phase out – section 928)