# **Key Objectives for**

# **Transformation of the Michigan Mental Health System**

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Below are seven key objectives with supporting details for transformation of the Michigan public mental health system. These objectives will help establish a context in which the system is more efficient, quality of care is improved, and the system is driven to achieve quality of life of Michigan citizens.

## Effective legislative governance

Legislators must function as the board of directors of the mental health system. Unfortunately, there is much to understand and oversee about the mental health system and legislators do not have the time and expertise to learn and make decisions about the system on their own. In addition, with term limits, when a legislator does learn about mental health care, most likely they are replaced by somebody else who does not understand.

* Represent the interests and concerns of Michigan citizens

Michigan citizens are the stakeholders of the mental health system, and legislators, as a board of directors, must represent the interests of the citizens in the funding and oversight of the mental health system.

* Legislators must ensure that the system is doing the right thing and doing it well

This means having meaningful and objective measures and indicators of the quality and availability of services and ensuring that corrective and remedial action is taken for problems.

* Ensure that persons with disabilities have opportunity to be the best they can be

The legislature must have a clear vision for the mental health system that persons with disabilities deserve opportunities for quality of life within the limits of their disability.

* Independent oversight agency to support legislative governance

The legislature must be supported by an agency with the clear purpose of supporting legislative oversight and assessment of needs independent of other government organizations and priorities.

## Budget based on need.

The mental health budget is currently determined based on historical levels, political pressures, flawed actuary analysis and budget restrictions. The budget must be based on the need for mental health services, reflecting quality of life of Michigan citizens. If needs cannot be met, limits on services must be precise and consistently applied.

* Objective state-wide assessment of needs and unmet needs

An objective, professional assessment of need is required to determine the state-wide needs for mental health services and the scope of needs that are not being met. Need must include early intervention to mitigate the immediate and long-term effects of disabilities. Based on NIMH and census data, 100,000 persons with serious mental illness in Michigan are receiving no treatment.

* Defined symptoms and levels of disability covered by the budget

If the budget does not fully address the need, then it must define specifically what services and recipients will be covered, and this must be clarified by a specification of the services and needs that will not be included to establish accountability for the budget decisions. Persons in need of services and others who aware of persons in need of services must be able to demand access to entitled.

* Support for sustained individual improvement

Budgets must include sustained services for persons who improve so that they achieve and continue to achieve the best they can be. Over the past couple years, across Michigan 10,000 persons with mental illness were discharged regardless of their continuing need for services due to reductions in general funds in the mental health budget.

* Services to all qualified persons in need, regardless of ability to pay

Services, for the most part, are now available only to persons on Medicaid. The Michigan Mental Health Code charges the state with providing adequate and appropriate services regardless of ability to pay. Medicaid does not address all the needs nor include all of the people in need. General funds are essential to an adequate and equitable mental health system.

## Objective legislative and public oversight

A legislative oversight agency must ensure that legislators are objectively informed about (1) the performance of the mental health system to fulfill budget objectives for all qualified persons in need and (2) the impact of the mental health system on other government budgets and services, community collaborations and the general public.to and to ensure that each qualified citizen receives adequate and appropriate services.

* Ensure adequate and appropriate services within the scope defined by the budget

Operation of the system must be independently assessed to ensure that the system is meeting the needs that are addressed by the budget, and to ensure that over and under utilization are appropriately managed.

* Independent rights protection and assurance of true services entitlements

Recipient rights should be separated from the organizations accountable for management of services so that misconduct as well as systemic problems are independently identified and resolved. Furthermore, Medicaid must be treated as a true entitlement rather than a subjective selection.

* Require provider compliance with FOIA and Open Meetings

All providers of public mental health services must be subject to Freedom of Information and Open Meetings to support accountability to the public.

* Objective evaluations of provider performance, quality of care, corrective action and remedies

Audits, inspections and identification of problems must be performed, corrective actions must be appropriately determined and enforced, and damages must be appropriately compensated to ensure that services to individuals are adequate and appropriate and providers are held accountable. Too often the remedy for neglect, incompetence or violation of rights is education or counseling of the staff with no compensation to the injured recipient(s).

## State-level consolidation—one system

There is extensive duplication of effort throughout the mental health system with multiple levels of delegation to contractors and multiple contractors at each level resulting in inefficiencies, inconsistencies, delayed improvements and impediments to accountability.

* Administrative activities and provider contracts

Some contractors currently report to and comply with different requirements from multiple contracting agencies, and each PIHP or CMHSP operates like an independent business. Consolidation includes business functions of accounting, personnel, purchasing, contract management, information systems and advances in technology and practices.

* Advanced and efficient information systems

Information systems continue to provide improvements in the delivery of services and operating efficiencies. These improvements are implemented over and over again as each organization implements their own “innovations.”

* One mental health system (state-wide efficiency, consistency and accessibility)

Currently, recipients are tied to their county of residence and their particular provider(s). They are not free to travel or relocate across the state. When a recipient receives services outside their CMH catchment area of residence, payment must be negotiated between the involved CMH organizations. The quality of services depends on local CMH oversight, the performance of the direct care providers and their employees, and not a Michigan consistent and seamless system of care. The state must ensure the quality of services delivered by local providers and caregivers across the state. The public mental health system standard of care must extend to disabled persons in jails and prisons, particularly to those persons awaiting trial or appeal and those adjudicated Not Guilty by Reason of Insanity. There must be one formulary for consistent access to medications.

* Reduce paperwork, audits and diverse contract requirements

Consolidation of provider contract management will reduce contract negotiations, paperwork, diversity of contract terms, reporting confusion and redundant audits—and it will save money.

* Leadership in clinical practices and technology advances

There are continuing improvements in clinical practices and supporting technologies that should be evaluated and deployed by the state organization in collaboration with local organizations to set appropriate priorities and achieve timely implementation.

## Community collaboration.

Local CMH organizations must work closely with their communities to address local mental health needs, identify persons in need of treatment, fulfill the local needs for mental health services and align with local circumstances and challenges.

* Collaboration with community agencies and regional advisory boards

Collaboration includes integration of mental health services with schools, law enforcement, courts, hospitals, churches, other organizations and families in order to improve community quality of life. This is critical to early intervention and harmonization of community living. Local community mental health boards must focus on the delivery of mental health services that improve the quality of life of persons in need of services and their communities rather than on efforts to restrict services and other expenses to meet budget constraints.

* Early intervention

Local mental health services must reach out and, respond to family and community concerns, provide timely treatment and services for early symptoms, reduce the severity and adverse consequences of un-treated disabilities. Prompt, effective treatment will reduce the long-term severity of the disability and reduce the cost of mental health services.

* Access to housing, transportation, employment and community social and recreational activities

Persons with disabilities need to be able to live in and participate in their communities in order to realize successful lives in the community. Public supports must be developed in collaboration and cooperation with other community agencies.

## Quality care incentives, no delegation of risk

Managed care is great to eliminate risk for financial managers, but it places all the risk (and denial of care) on the persons to be served and burdens shifted to other citizens and organizations. PIHP organizations were established to meet Medicaid requirements for adequate risk pools. However, PIHPs have effectively delegated risk to Community Mental Health Services Programs (CMHSP) and core providers in violation of the risk pool requirement. The risk that the budget is exceeded must belong to the state. The state must be accountable for inadequate funding, system integrity and system failures

* Remove conflicts of interest—no denial of appropriate care

Core agencies or Community Mental Health Services Programs (CMHSP) are stuck with inadequate budgets such that professionals have a conflict of interest in defining adequate services for recipients. Cost cutting has priority over quality and adequacy of care. The Michigan Mental Health Code, Section 1116, requires “…the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state…regardless of ability to pay”.

* Eliminate cost shifting

Tight budgets and delegation of risk drive cost shifting to other budgets including criminal justice, nursing homes, hospitals, schools and families. The mental health system must be billed for the cost of incarceration and treatment of mentally ill persons in jails and prisons that are in need of mental health treatment. This does not increase the state budget but provides an incentive for the mental health system to reduce the risks of criminalization.

* Obtain and Medicaid, IMD Waiver

The Institutes for Mental Disease (IMD) exclusion of Medicaid coverage, penalizes hospitalization in state hospitals and stand-alone psychiatric hospitals. This restricts hospital access for the most seriously ill persons and those in need of long-term, intensive care. Many persons are prematurely discharged or denied access to community hospitals creating risks to themselves and others in the community as well as failure to achieve potential recovery. Michigan must establish small, locally accessible state hospitals across the state to meet this critical gap in appropriate treatment.

* All providers must bill the state payer

The state administration must contract with and pay service providers directly for services delivered to qualified recipients across the state. This places funding responsibility and financial risk clearly on the state and ensures that services are consistent and accessible across the state. In addition to accountability, costs of contract administration, provider reporting and payment processing will be reduced, and services will be seamlessly accessible across the state. Inefficiency and fraud must be managed by audits and oversight, not incentives to deny services.

* Do it right and save money

Timely and appropriate care reduces the severity of initial and long-term cost of care, not only for the mental health system, but for organizations subject to cost shifting. It also improves the quality of life of recipients, their families and others who may be involved with persons in need of services including peers, employers, neighbors, retailers, and social groups.

## Professional-quality care

Implementation of the mental health system should focus on quality of care not on cost cutting and denial of services and responsibility.

* People first culture, person-centered treatment planning

Treatment plans and the cultural attitudes should give first priority to recipients of services and quality of life. Employees at all levels must be committed to improving the lives of disabled people, their families, and the communities where they live.

* Professional judgement

Professionals must be allowed and required to apply their professional education and experience to ensure quality treatment and support. Audits and reviews (not prior authorization) must be used to identify fraudulent, unnecessary or inappropriate actions for corrective action.

* Certification of direct care employees

Minimum wage direct care workers are not qualified with technical and inter-personal skills or aptitude to provide quality care. These are difficult and demanding jobs and recipients deserve better. Certification should set and enforce appropriate standards, and ensure adequate skills, aptitude and performance.

* Competitive workloads, wages and benefits, offering personal fulfillment.

Good caregivers cannot be acquired or retained on wages and benefits that cannot support their quality of life and workloads that limit quality of care. The system currently suffers from high turnover, unqualified workers, unpredictable work schedules and inter-personal work demands with much lower pay and greater stress than fast-food employees and unskilled laborers. The mental health system should be a preferred employer of skilled and dedicated employees. In the long term, quality care will reduce total costs.

* Professional oversight of direct care

Direct care workers require oversight by professionals who are qualified to evaluate the delivery of services and needs for guidance or treatment plan adjustments. Over the past several years of budget reductions, case managers staffing and qualifications have been cut back resulting in reductions in oversight and support. Overwork and under pay have driven may good people out of the public mental health system.

* Support for sustained improvement

Service goals must be to improve and sustain recipients to be the best they can be. This requires professional leadership in treatment planning and delivery. These are life-long afflictions. Oversight and as-required assistance must continue when a recipient improves, even though direct care workers may no longer be needed. Mental health budget constraints caused discharge of at least 10,000 persons in need of services in the past several years. Without sustained support, many discharged persons will return later with more intensive needs after suffering an unnecessary relapse.

* Consistent formulary

Some persons who suffer from mental illness have found helpful medications—many after lengthy trials of alternatives. However, when the treatment settings change, the medications may be unavailable. Hospitals, nursing homes, jails and prisons each have their own cost saving formularies resulting in changes in medications that may have significant, long-term consequences. The potential increase in costs of medications from uniform formularies will be offset by reduced, long-term cost of care in addition to the improved quality of life of persons affected and those around them.

* Collaborative care

Failure of inter-disciplinary, collaborative care not only increases costs, but it results in many unnecessary errors and relapses, both psychiatric and physical. Coordinated (integrated) care is not achieved by consolidation of funding sources. Doctors and other professionals have demanding jobs and are not compensated for collaboration, particularly when the recipient has complex needs and does not accept their need for treatment. Collaboration must be lead by doctors and supported by other personal care and therapy professionals for harmonization of expertise. While collaboration can be time-consuming (expensive) and, in many cases, may not affect treatment, failure of collaboration can increase severity and complexity of illness and have major adverse consequences. The cost of collaboration will be more than offset by more effective treatment and fewer relapses---and fewer deaths.