Benefits of Public Mental Health System 2.0

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Description of Change	Mental Health Care Consequences	State Financial Benefits
1. Obtain Medicaid, Institutes of Mental Disease (IMD) waiver. • Medicaid would cover hospitalization in state hospitals and stand-alone psychiatric hospitals. • Create geographically accessible state hospitals, physically next to full-service hospitals. • Community hospitals should be formally limited to acute care	• The state must provide for adequate capacity for long-term mental health, inpatient care across the state. • Jails and prisons became the new mental hospitals after the state hospitals were closed in the 1990s. • Reduce premature, hospital revolving-door discharges. • Reduction in crisis management incidents, criminal justice interventions, and incarcerations (i.e., reduced jail population) • Reduction in police interventions, and criminal justice cases • Quality care of persons with severe mental illness, and improved potential for recovery	• Reduce cost of long-term care. • Reduce cost of hospitalizations. • Reduce criminal justice intervention. • Reduce jail and prison populations. • Emergency room and acute hospital overloading will be reduced. • Elimination of emergency room "boarding".
2. Obtain Medicaid, Inmate Exclusion Policy (IEP) waiver. • Medicaid would cover mental health care of incarcerated persons. • Jail mental health services Should be provided by local CMH. • Recipient health records would be integrated. • Medicaid funding should go to mental health.	• Coordination/continuity of care for persons incarcerated in jails. • Many are in jail pending trial and will return to the community when found not guilty or, after they serve a jail term, in a few months, they may be more angry, desperate and homeless. • The mental health condition of persons incarcerated will be generally improved while incarcerated and when released, rather than exacerbated. • CMH will have responsibility and incentive to improve care and prevent criminalization	• Fewer crisis and criminal justice interventions. • Reduce jail and prison populations and budget. • Reduce acute hospital overloading. • Reduce average cost of intensive services.
3. The public mental health system must provide mental health services to all persons in criminal justice, jails and prisons. • Needed services are not adequate, formularies are inconsistent, and there is no coordination of the transitions to different treatment settings. • Not all incarcerated persons have Medicaid, and needed services are not available from private health care providers. • Many inmates suffer from mental disturbances and the state must ensure that they have access to appropriate treatment to improve in incarceration and continue after discharge.	• The need to provide mental health services is a state obligation that must not be limited by the availability of Federal funding. • Many mentally ill persons engaged by the criminal justice system are there because there was no intervention before they exhibited criminal behavior. • Many persons in jail are not convicted of a crime but are awaiting trial (innocent until proven guilty). • Others in jails have short sentences and will return to the community more seriously ill when they are discharged and will have difficulty getting services after incarceration. • Jails and prisons do not have adequate mental health professionals or medication formularies, and the care is not coordinated with community professionals either when the person is incarcerated or when they are discharged.	• The benefits of quality care to all persons in need of public mental health services will far exceed the financial, social and human costs of failing to provide adequate and appropriate services. • Continuity of quality care, regardless of the treatment setting, is essential to improving (rather than exacerbating) the disability. Potential for rehab has been demonstrated by mental health courts.

4. **Consolidate direct care provider contract management and claims processing.** • At the state level—one contract per provider • Provider paperwork could be reduced for cost savings, timeliness, and accountability. • CMHs will provide professional services for treatment planning and prescribe support services, billed to state by the service provider. • State will be responsible for service capacity, availability, geographic proximity, and quality. • The number of levels of delegation by contract must be reduced to improve efficiency, effective management and accountability.	• Provider agencies will no longer be too big to fail with more providers to choose from (and local monopolies can be avoided) • Timely placements, quality of service as well as adequate worker wages will be a clear, state responsibility. • State-wide access to service locations will improve recipient choice as well as service availability. • Providers will each have one contract. Contract terms and specialty services will be consistent across the state. • Actions for neglect and abuse and inappropriate care will be more timely and more effective, as a result of state accountability.	• Reduce the cost of contract management with fewer contracts to manage and negotiate. • Economies of scale will be improved through capacity management and specialized care availability and oversight. • Optimize service capacity and vacancies to improve efficiency and more timely placements. • Reduced contractual barriers to accountability
5. Consolidate PIHP/CMH Information Systems • Centralize development and operations. • Establish CMHA for leadership/consensus on system design and enhancement. • Integrate Health Records • Integrate direct care data capture. • Consolidate clinical billing systems. • Enhance on-line data capture and queries	• Dramatic reduction in the number of information systems, the number of provider contracts and diversity in the quality, scope and functionality of systems. • Consistent user interfaces and training requirements • Greater flexibility of skilled personnel job placements • Greater ability to continually improve the scope, quality and timely systems adaptation and improvements. • Improved direct-care reporting and accountability.	• Reduced cost of administration • Elimination of redundant costs of many different CMH/PIHP information systems and services. • Improved coordination, efficiency and quality of related services • Improve timeliness and cost of necessary changes and advanced utilization of technology
6. Consolidate administrative operations for economies of scale. • Purchasing services should be consolidated for acquisition of commodity products and services to leverage competitive pricing. • Some accounting and payroll functions could be consolidated for economies of scale.	• There are many occurrences of the same administrative functions, independently designed, staffed and managed throughout the many CMH and PIHP organizations. • Services could be outsourced much as is common in many other businesses for economies of scale and expertise. • These might be consolidated in conjunction with consolidation of information systems. • Consolidated administrative services could enable providers to improve automation and consistency	• The redundancy of the same fundamental services and duplication of effort requires unnecessary management attention and is a waste of money. • Redundancy may create unnecessary delays and inconsistency in operations that require more attention to audits
7. Ensure that formularies are consistent across treatment settings. • Formularies are inconsistent for jails, prisons and hospitals, including and state hospitals and hospitalization for physical medical treatment	• Persons who suffer from a mental illness must be provided consistent medical treatment based on their individual responses to medications, including generic variations. Changes in medication may have serious persistent consequences. • Changes in treatment settings and treatment provider frequently cause medication errors and inappropriate changes.	• Reduce risk of relapses due to medication inconsistencies. • Relapse results in costs associated with crisis resolution, serious injuries or criminal behavior and difficulty with recovery to a prior level of functioning

8. Provide services to all persons in need of public mental health services. • The system must be managed and accountable to ensure access of all persons in need of mental health services. • Services must continue when recipient income disqualifies them from Medicaid. • Each CMH must be responsible and accountable for all of the public mental health care in its assigned, geographic area. • The state must be accountable for the hundreds of thousands of persons with mental health problems who receive no mental health care, and the consequences to those persons, their families and others whose lives are disrupted as a consequence.	• All persons in need of public mental health services include the full scope of mental health disorders. • Intervention must occur, if possible, as soon as a person exhibits (or experiences) symptoms of a persistent mental disturbance/disability. • Accountability must not be frustrated by contractual separation of management authority, and budget interests. • There must not be overlapping responsibilities for mental health services or independent funding and management of specialized mental health services that cause confusion, competition or gaps in access to, and coordination of appropriate services without accountability. • Families and others in the community will realize reasonable quality of life without the stresses, frustrations, employment and financial problems and possible violence that result from an inadequate metal health system.	• The average cost of care per recipient will be dramatically reduced, first for new recipients, and, in the long term, for everyone. • The cost of crisis services, criminal justice interventions and domestic abuse, hospitalizations, criminal behavior, incarcerations and jail and prison populations will be reduced, dramatically. • Many persons who now improve through mental health court, will improve before criminal violation.
9. Direct care staff must be certified and receive competitive, living wages. • Support staff must be certified as qualified across the state, independent of job changes. • Certification must be managed as a state program with continuing education and a standard of performance. • Compensation, benefits, leadership and work schedules must be appropriate to the dignity and respect of persons qualified and responsible for the care of vulnerable people. • Jobs must be viewed as career opportunities.	• Certification will reduce staff turnover and improve quality of care. • Poor performers can be prevented from job-hopping across providers. • Skill level of workers can be improved and sustained. • Job satisfaction, stress reduction and potential for advancement, can improve quality of care and retention. • Quality of care will enhance recipient recovery, and it will reduce the general level of intensity of services. • Direct care workers must have pay levels of skill and quality of care, with educational opportunities for career advancement.	• Staffing shortage may be minimal with more attractive jobs. • More stable staff reduces turnover to reduce costs of recruiting and training. • Higher quality of care will reduce the cost of care and improve recovery. • A living wage will reduce the number of workers on public assistance
10. Mental health treatment must include therapy for rehabilitation and recovery. • Therapy must be available for early stages of mental disturbance to mitigate severity. • Therapy must be a dominant form of treatment, complemented by medications, and community living supports as appropriate improve mental state and quality of life. • Therapy requires professional skill along with collaboration of direct care workers.	• Therapy for the brain is essential just as it is essential for stroke, PTSD, developmental disabilities and substance abuse. • Therapy may be sufficient for some mild forms of disturbance. • Many persons who suffer from a mental illness will improve their ability to manage the symptoms through therapy. • See the book, "*Healing—Our Path from Mental Illness to Mental Health*," by Thomas Insel, M.D., past Director of the National Institute of Mental Health. Dr. Insel reports the importance of therapy as an essential component of mitigation/recovery from mental disturbances/disabilities.	• Children's brains are constantly developing, and appropriate interventions will mitigate long-term severity of a disability. • Therapy will reduce the crises, suicides, hospitalizations, criminal behavior, incarcerations, and injuries to self or others. • Therapy will enable persons to be the best they can be.

11. **An independent, mental health, oversight and accountability organization is essential**. • Must have administrative and legal authority to assess system performance, investigate problems, bring legal actions to enforce corrective actions for adequate and appropriate care, and accountability to the public. • Must have a board of directors that is dedicated to the availability and quality of mental health care across the state, representing the service concerns of communities, without political influences or conflicts. • Must regularly report to the legislature and public the status of populations with inadequate or unmet needs for public mental health services. • Must include management of recipient rights services along with appeals and resolution of grievances. • Should operate offices across the state for local oversight and investigations. • The oversight must include utilization management for both under and over utilization	• Independent oversight and accountability are essential to hold the administration and the legislature accountable for proper funding and management of the mental health system that respects the rights and needs of citizens with serious disabilities who are unable to assert their rights and compete for appropriate assistance and services on their own. • This need for appropriate funding, management, protection of rights and response to needs cannot be asserted by CMH organizations because they are held responsible for the shortcomings of the system without the ability to take corrective action or enforce adequate funding and appropriate business organization and management. • CMHs have created customer service organizations to hear concerns of recipients, families and others because the problems are not addressed by the offices of recipient rights. • Recipient rights has become a "damage control function" that shields the administration, at all levels, of the system from public accountability and criticism. The CMH function must be removed and reformed to properly serve and protect the rights of recipients and represent proper public interests. • The CMH/PIHP organizations are unable to make the legislature and the administration recognize and appreciate the problems of the current mental health system and the responsibility of the state for more effective organization and management of the system and appropriate funding to address true nature and scope of needs for mental health services.	• Inadequate oversight and accountability are responsible for most of the inadequacies of the mental health system and the excessive Michigan operational, care and social costs. • Accountability is essential for the long-term revitalization and sustained operation of a quality mental health system that meets the needs of hundreds of thousands more Michigan citizens and provides their families and many other affected indirectly, with a better, more productive life in the future. • Timely intervention for all persons in need will result in lower cost of care when compared to costs if they are otherwise admitted later, in crisis and more severely ill. • Early intervention will also reduce the demand for crisis intervention, criminal justice intervention, and court action for criminal or civil disposition.
12. **Each CMH must operate a CCBHC.** • Each CNH will ensure that persons in need will receive mental health services by being linked to appropriately funded sources based on their needs and financial circumstances. • Each CMH must be accountable for addressing the needs for services in their catchment area with state accountability for adequate funding and enforcement. There should not be competing CCBHCs in the same geographic area.	• There are obligations of insurance companies that may be underutilized (e.g., mental health parity) to provide some mental health services associated with physical health care. • There may be grant programs that are not widely understood to meet some needs for services. • Some persons recognize a need for care, but do not understand what professional they need or are available for proper diagnosis or treatment. • There is a need to provide referrals and also to follow up to ensure that each referral is received and services are provided.	• A CCBHC can enhance early intervention for access to treatment that mitigates longer-term consequences and reduces the risk of increased burden on families, the mental health system, and other government services. • Many persons currently have unmet needs because there is no place to go, unless thy are in crisis and qualify for Medicaid.

13. Collaborate with schools for CMH to provide mental health services to children. • Teachers and other personnel must appreciate the value and identify children in need. • CMH must be actively involved with schools and provide mental health services in the school to minimize transportation issues. • See Northpoint presentation: https://cmham-web.ungerboeck.com/wp_service/api/Documents/DownloadFile?docClass=C&docSequence=17705&docVersion=1	• Many children have mental problems that interfere with learning and may progress to more serious problems including persistent mental illness, suicide or criminal behavior. • Students who have persistent mental health problems should have a coordinated transition to adult care. • Bullying and suicides are serious problems in schools that should be addressed as symptoms of mentally disturbed children. There may be a need for medications, but more important is therapy that will help children resolve their fears and anger in other ways and develop a positive future. • Supports can be sustained when recipients are not in school.	• Early intervention may avoid or reduce more serious long-term problems and improve education. • Many students will have more productive adult lives. • Teachers will be relieved to link needed mental health services, reducing stress and improving their attention to teaching. • Teachers can return to teaching.
14. Eliminate "managed care," and operate on the basis of fee for service based on need. • CMH budgets must be based on specification of funded services, analysis of state-wide needs, and projected CMH recipients served. • Services must be provided based on an approved treatment plan, developed on the basis of appropriate, professional judgment. • Funded services must be defined with public accountability for unmet needs. • The prescribed services will be delivered by an appropriate provider in the state-wide contract-provider network. • Providers will bill the state for the service provided, according to the prescription and their contractual obligations. • The state will validate CMH service referrals with billing analysis and peer reviews. • Adequate and appropriate care must be provided based on the best, professional judgement of treating professionals, and not on "medical necessity" that is determined by consideration of budget savings or financial incentives (under Medicaid rules).	• This is not "managed care," it is "rationed care." Those who are employed by the system must restrict care to comply with a grossly inadequate budget, and we deny access to care except for those that are a danger to themselves or others or are unable to take care of their basic needs. This is disguised as "medical necessity," that is more-often less accommodating, depending on the budget. In contrast, we "normal people" expect our healthcare to intervene if we are at risk of becoming ill or disabled. We expect our insurance to keep us from becoming bankrupt when we become injured or seriously ill. Now we only care for mentally disturbed people if they are on, and continue to be on Medicaid, in other words, they must already be bankrupt, or they must become bankrupt and dangerous to qualify. • Services must be based on need, not based on budget constraints. • Professionals must provide care based on their best professional judgement, and a public specification of funded services based on professional treatment decisions, not cost analysis of non-professional bureaucrats. • State and CMH budgets must be developed on the basis of actual state-wide need for services and the ability of CMH to achieve early intervention to avoid the development of more severe symptoms with increased disability and cost of services. • Note that denial of early intervention is a source of increased, long-term cost and long-term care.	• Eliminates the denial of adequate and appropriate services based on budget constraints rather than need based on objective, professional diagnosis and treatment that will yield savings from improved outcomes and quality of life. • There will be some initial increase in budget requirements, but this will be offset over time by the reduced average cost of care, criminal justice encounters, reduced jail and prison populations, reduced hospitalizations, reduced crisis interventions, and reduced cost of public assistance of people who realize more normal, productive lives. These savings will support appropriate increases in mental health budgets for any on-going cost increases such as appropriate salaries and mental health therapy • CMH and providers will become preferred employers.