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Testimony of
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Thank you Chairwoman Whiteford and members of the Subcommittee. I am Angela Pinheiro a board-certified psychiatrist and Medical Director for Community Mental Health for Central Michigan. Nationally, I am a member of both the National Council Medical Director Institute and the Integrated Care Advisory Council for the Center of Excellence for Integrated Health Care Solutions.

Today, I am testifying on behalf of the Michigan State Medical Society. MSMS is a professional association representing approximately 15,000 Michigan physicians and medical students practicing in all specialties and practice settings in our state.

MSMS supports strategies to improve access to mental health services in Michigan that ensure each person can receive the person-centered care he or she needs when and where it is needed. Such access requires a seamless, integrated system responsive to the needs of patients across the entire spectrum of symptom severity. A system grounded in collaborative care and evidence-based approaches provides the expertise necessary to treat patients who are experiencing mild to moderate symptoms where they are most likely to seek care combined with the ability to rapidly access subspecialty care to effectively intervene when symptoms become more severe and returning care oversight back to the patient's medical home when symptoms have stabilized. Adding barriers to the smooth transition between levels of care based on pre-defined populations of being either mild to moderate or being severe is dangerous. Patients don't "stay" within a particular symptom severity, and this is particularly true when appropriate treatment is not available.

Michigan's current public mental health system is focused mainly on those with serious symptoms and diagnoses who also have had a significant functional decline. Relying solely on that approach is akin to treating individuals only after the first heart attack or treating those with opioid used disorder only after an overdose. As with heart disease, substance use disorders, and other chronic diseases, research teaches us that prevention, early identification and aggressive evidenced-based early intervention is essential if we hope to positively influence the course of the disease and impact the rate of disability. Mental illness is no different. For example, research indicates the rate of recovery and full time employment for those developing schizophrenia spectrum disorders can be doubled if appropriate treatment is offered within a few weeks of onset of psychosis. Based on outcomes of various studies, the World Health Organization recommends that treatment start within 12 weeks of onset. The duration of untreated psychosis in Michigan, however, is over 52 weeks; this is due in great part to the lack of screening, early identification and the unavailability of evidenced-based treatment that patients with early psychosis can access prior to functional decline.

Another example comes from the Altarum Report, *Access to Behavioral Health Care in Michigan*, published July 2019, demonstrating the high percent of those with bipolar disorder or recurrent depression, conditions which can easily progress and become disabling, who are currently not receiving treatment regardless of insurance type. The percent that do not have access to early intervention for those conditions is not known but can be assumed to be even higher. I cannot stress enough that without developing an integrated system to ensure early and seamless access to appropriate treatment and level of care, MSMS and other organizations representing health care professionals and patients will be back here year after year asking for reforms and more funding to help stem the consequences of a fragmented mental health system. Merely changing financial structures or adding providers without developing a new fundamental service delivery structure will not address our mental health crisis.

Four key pillars are necessary to support such an integrated service delivery structure:

1. Support for primary care providers (PCPs) in the delivery of mental health services by turning on the Medicaid codes for the Collaborative Care Model (CoCM)

   a. Over 50 percent of all mental health care is already delivered by a PCP, and 70 percent of all primary care visits have mental health drivers. Primary care has become the de facto mental health care system for most patients. This is where patients and their families initially seek help, it may be where they feel most comfortable receiving care, and it provides the best opportunity for screening, prevention, early identification and treatment. PCP access to psychiatric consultation is critical as most PCPS do not receive extensive clinical training in behavioral health and are not familiar with short-term therapeutic interventions.

   b. The CoCM is an evidenced-based model that has shown superior efficacy to treatment as usual in over 80 randomized trials. Outcomes have also surpassed those models having a behavioral health specialist or a psychiatrist co-located with the PCP and seeing individual patients. It is based on systematic screening, treatment to target concepts and uses a team approach with the PCP overseeing care including treatment for medical conditions and prescribing medications, the behavioral health care manager/specialist providing care management and short-term interventions, and the psychiatrist acting as a consultant, reviewing diagnoses and medication regiments. Using this model, a psychiatrist is able to care for many times the patients he or she could by seeing each one face-to-face.

   c. The traditional approach of referring patients out for mental health care is not effective for many patients. Over 50 percent of patients referred do not follow-up and only approximately one-third engage in ongoing treatment. Even insured youths are unlikely to follow-up with as few as 18 percent completing one visit 180 days after being referred out.

   d. Medicare utilizes the CoCM codes and commercial insurers are beginning to follow suit.

2. PCP and Community Mental Health (CMH) Agency communication and collaboration on mutual patients by enabling the PCP to be central in the referral process for subspecialty mental health care through CMH and providing standing to appeal an adverse determination.

a. PCP interaction with the CMH is necessary to close the referral loop, forward necessary records and actively coordinate treatment for co-existing mental and physical illnesses if the patient is eligible for CMH services, and arrange for alternative timely treatment interventions if the patient is determined ineligible for services through the CMH. Currently, many CMHs do not accept referrals from PCPs; instead, requiring the patient to contact the CMH to assess eligibility.

b. When there are adverse physical health care determinations, PCPs can seek recourse on behalf of the patient. This recourse does not currently exist if the CMH refuses to accept the patient. By providing PCPs standing to appeal, they can advocate on behalf of their patients through a formal mechanism such as reviewing the case with the CMH Medical Director.

3. Evidence-based mental health and substance use screenings and early intervention are encouraged and routinely available to persons of all ages including, but not limited to, children and adolescents prior to any functional decline.

4. Billing and coding policies that enable physicians, psychiatrists regardless of setting, and other health care providers to get reimbursed for providing more cost-effective team-based integrated care that includes screening, case management, consultation, and other related care.

There are many other components necessary to achieve a seamless system of care for future discussions, including, but not limited to, integration at all levels of care, vertically and horizontally, including with the criminal justice system, state level interdepartmental coordination, and shared accountability from within state government to the boots on the ground.

We respectfully request MSMS and other primary care organizations be included as integral members in the mental health system redesign process.

Thank you for your time and consideration. I'm happy to answer any questions.