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Good morning Madam Chairwoman and Subcommittee members,

My name is Shannon Striebich and I currently serve as the President of St. Joseph Mercy Oakland in Pontiac, and as interim leader for St. Mary Mercy Livonia, both part of Trinity Health - Michigan. I am joined today by Kristyn Spangler, Behavioral Health Program manager at IHA, a multi-specialty physician group and wholly owned subsidiary of St. Joseph Mercy Health system, and a member of Trinity Health. Thank you for the opportunity to address this subcommittee today. Throughout my career, and in my current role, I have routinely seen first-hand the crisis that exists in our communities because of the lack of adequate access to behavioral health services.

(I would like to share the experience of care for the markets served by St. Joseph Mercy Oakland and St. Mary Mercy Livonia, as they are where I spend the majority of my professional time; I imagine that similar experiences can be found in many communities across our State).

Typically, behavioral health patients are transported to St. Joseph Mercy Oakland's emergency department by law enforcement, community EMS, families, group homes or in some cases they present on their own. The Emergency Department (ED) team evaluates the patient, treats any medical issues, which allows the patient to move forward with mental health services. The patient is then evaluated, assessed by a social worker who coordinates with a Psychiatrist to determine appropriate disposition of the patient. If the patient requires inpatient psychiatric treatment, and is uninsured or on Medicaid, Common Ground, a 24 hour emergency crisis service agency, determines their placement in Oakland county. A similar process is followed at St. Mary Mercy Livonia with the Detroit Wayne Mental Health Authority which is both the Community Mental Health Agency and the Prepaid Inpatient Health Plan.

Common Ground has twelve beds for adults and one for adolescents to assess patients and determine the best course of treatment and follow up. Due to the sheer volume of behavioral health patients, patients wait in ED's in "line" to go to Common Ground for further evaluation or placement determination.

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At St. Joseph Mercy Oakland we evaluate an average of 18 new behavioral patients each day. In addition, on average we are holding 9 patients a day in our ED. These patients are usually here on a petition and certification (involuntary admission), which requires a 1:1 staff ratio within arm's length to keep patients safe. It is not uncommon for patients to be in our ED's for days and sometimes weeks. Attached to this written testimony are several examples of cases that we have recently seen in the ED.

There are a number of reasons for long length of stays in our ED's at both St. Joseph Mercy Oakland and St. Mary Mercy Livonia. Some of these include: patient complexity, lack of adolescent inpatient psychiatric facilities, lack of geropsych inpatient facilities, lack of state beds (currently there is a six month to one year waiting list at all three state facilities), additional time for patients who reside in a different county than the one the hospital is located need to be need to be evaluated by the agency in the county they reside. There are also specific gaps in available services in communities like Livonia, where partial programs where patients can participate in daily group therapy versus individual therapy is not available in the immediate community.

One initiative that seeks to address behavioral health issues in the community and provides an alternative to inpatient hospital care is the development of a partnership between St. Joseph Mercy Oakland, other hospitals and Common Ground to dedicate resources to develop a mobile behavioral health team. Mobile Health and other Common Ground programs seek alternative treatments to traditional inpatient psychiatric care. With a focus on crisis stabilization, this program recognizes that not every patient requires traditional inpatient psychiatric hospital care. Alternative programs include placement in structured behavioral health environments that are cost effective, increase access to those in need, and do not compromise quality or safety. If appropriately funded these mobile teams consist of a community outreach element that is proactive rather than reactive which often leads to a visit to the Emergency Department. In some instances mobile teams have been deployed to interact with communities, provide education about these alternative programs, etc.

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Shifting quickly to Substance Abuse disorders at St. Mary Mercy Livonia we partner with Growth Works, and the Conference of Western Wayne to offer patients in a variety of units across the hospital including the ED, Intensive Outpatient, Medical Floors, Behavioral Health Unit and the Chemical Dependency Unit, Peer Recovery Coaching that offers support and resources for those struggling with addiction for up to a year. The peer-to-peer relationship offers real life experiences in addiction and recovery, ensuring patients and families that they are not alone in this journey. Over 1,200 patients have been offered coaching since May 2018 with more than 1050 initially accepting this program.

I now want to turn Kristyn who can describe additional efforts that we have engaged in with our Physician partners to address behavioral health needs in a primary care setting prior to a crisis that might result in a trip to the Emergency Department.

Good morning, Chairwoman Whiteford and subcommittee members, I am Kristyn Spangler and I serve as the Behavioral Health program manager at IHA, one of the largest multi-specialty medical groups in Michigan. I've worked the front line in behavioral health care for more than 20 years. As you may know, nearly 1 in 2 people will suffer from a mental health condition at some point in their life and 1 in 5 U.S. adults experience mental illness each year. Suicide is the second leading cause of death for young people between the ages of 10-34 and 90% of suicides can be attributed to mental illness.

In Michigan, anxiety disorder and depressive disorders are the most common mental health conditions, and the most likely to go untreated. Half of Medicaid enrollees, one third of privately insured, and one fifth of Medicare enrollees do not receive care for these conditions.

There are many reasons why access to treatment for mental illness is inadequate. There is a shortage of clinical providers, costs can be prohibitive, and stigma plus symptoms of mental illness can make a person reluctant to seek care. A recent study in Michigan demonstrated a 3-4 month wait to see a psychiatrist and many people pay out of pocket because often mental health providers do not bill insurance because reimbursement is low. Low reimbursement also contributes to the inadequate number

of providers. There continues to be a stigma of having a mental health diagnosis on their insurance record.

In response to some of these issues IHA implemented the Collaborative Care Model in 2015. IHA has enrolled over 2,400 patients in this model and over 90 IHA primary care providers across 10 locations have Collaborative Care in their office. It was similarly implemented in 2016 throughout Mercy Health Physician Partners, a multispecialty physician network in Grand Rapids, Muskegon, Holland and the Lakeshore.

The objective of this model is to improve access and outcomes in a cost effective manner. Collaborative Care embeds a behavioral health specialist into a primary care office. The behavioral health specialist partners with a consulting psychiatrist to team with the primary care physician in assessing mental illness, identifying pharmacological treatments, and providing evidence based behavioral interventions for patients with depression and anxiety. Rigorous research shows that this model is more effective than traditional primary care or even co-locating a therapist in the physician's office.

Several studies have been published regarding Collaborative Care including a Mayo clinic study that found that collaborative care patients experience remission from depression in 86 days, 528 days faster than traditional care. In an Ohio analysis 35% of patients had a 50% reduction in depression symptoms. At IHA 64% of the enrollees respond with a 50% decrease in symptoms. This looks like 39 more depression-free days every six months, versus people not in collaborative care at their doctor's office. Michigan residents become more productive at work, better equipped to sustain relationships, and more involved in their communities.

Medicare approved reimbursement for practice codes in the Collaborative Care Model in 2017. Several other payers have followed suit. Medicaid, however, does not pay for Collaborative Care despite the evidence base and associated demonstration of cost savings.

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In summary we make these recommendations:

1.) We urge Medicaid to begin reimbursing for Collaborative Care to increase access to behavioral health care.

2.) We urge Funding mobile stabilization and crisis teams that work in the community to prevent visits to the acute care setting and the ED including the effective use of trained lay people such as community health workers, peer support specialists, and recovery coaches.

3) We have too few mental health providers - and even fewer that accept Medicaid in their offices. Allowing non-physician providers to practice to the full extent of their training and professional certification will help to fill in some of the gaps created by the current and projected future shortage of psychiatrists. Cost, however, remains a barrier to service and needs to be addressed, as it prevents patients from properly accessing treatment. Earlier intervention prevents escalation, unnecessary ED visits, unnecessary hospitalizations, etc.

4.) We urge funding school based behavioral health care to allow for earlier intervention and treatment.

5.) Restoration of funding included in the FY '20 budget but eliminated by Executive action for a Substance Abuse Disorder program at St. Mary Mercy Livonia; a collaborative partnership between Growth Works, St. Mary Mercy Hospital, and Western Wayne County Law Enforcement, Judicial system and Western Wayne county Council of Governments.

6.) Address the paucity of providers, by creating incentives to encourage clinicians to pursue behavioral health as a career path, and remain in practice in Michigan through expanded psychiatry residency slots, tuition relief/loan repayment, etc.

Thank you for the opportunity to share our thoughts with this committee. We would be happy to answer any questions.

Example Cases of behavioral health patients transported to St. Joseph Mercy Oakland ED

Case #1

We had a 19 year old, aggressive and violent patient, brought to us by the police from his group home. The physical presence/size of this patient made him intimidating. No facility would accept this patient. He had no family. He had many outbursts of violence, and Oakland County Sherriff's Dept. had to help multiple times to assist in managing him. He was placed in restraints countless times, released, only to become violent again. There was talk of sending him to the jail; in that scenario, the fear of him hurting someone else, or being hurt by others out of not understanding his illness was great. After much hard work by the team at St. Joes, and collaboration between the psychiatrist and the ED MD, we were able to medicate him appropriately and get him out of restraints. Because of his violent history throughout his life, He stayed with us for 3.5 weeks, until we could find a group home to accept him. His previous group home refused to take him back. Once medicated, his demeanor significantly changed and he was cooperative. He was finally placed in a group home with a 1:1 caregiver.

Case #2

Male patient brought to ED by police (passing multiple hospitals on the way). History of schizophrenia, developmentally delayed, and autistic. This patient was extremely violent, and unable to communicate. He was transported from his group home who could not control him. The patient, before we were able to

find the right combination of medications, was so violent that he was able to lift the bed that he was restrained to. His group home workers came to visit him and two of his workers were witnessed by SJMO staff, both verbally and physically abusing him. Recipient rights complaints were filed on his behalf. Finding a new placement for him stretched into weeks. We tried music therapy, which he responded to, and appropriate medications. His violent outbursts became a little less pronounced, and ultimately MORC placed him a in another group home after a 3 week stay. Keep in mind, this all occurred in a busy level II Trauma center.

Case #3

Male patient brought to St. Joes by police, who had been released from one of the State facilities after a 2 year stay. He was extremely violent, and psychotic. There was an order from the medical and psychiatric doctors to maintain a 4 foot distance from him. It is difficult to render care for anyone with those restrictions and to keep everyone safe. Again, he was made a direct admit by Wayne County, but no facility one would take him. After a long 3 week stay, a local facility agreed to take him since he had gone for 2 days without a violent outburst. Busy ED departments, with so much activity and noise all the time, are not the appropriate place for vulnerable behavioral medicine patients.