Tuesday, November 6, 2019

House Appropriations Testimony

-Hello, my name is Connie Conklin and I am the Executive Director at Livingston County CMH.

-I would like to thank you for taking the time to hear from various perspectives as you try to work to make our mental health system even better.

-I have worked in the public mental health system for the last 32 years at both the local and state level.

-There have been several phrases and words that have been used in various avenues to describe our public mental health system that I will like to respond to:

1. The public mental health system has been described in Michigan is broken. Although, I do not believe that to be true, I do think we always have improvements we can make. What I think is helpful is to identify some of areas for improvement because only then can you improve them. I also do not think we try to tackle all areas at once. I wish I had a perfect model to promote but questions still remains about what exactly we are trying to fix. Is it access to our system? Is it access to psychiatric beds? Is it lack of service providers across all of our services? Is it underfunding? Is it structural? And why? I am a problem solver, tell me specifically what is broken, only then can we provide guidance on models. What I can't do anymore is spend countless energy defending what we do because I know that makes our system weaker. We need to close the debate and problem solve. We need to be thoughtful and proactive and not chase models that do not fit our continuum of services. We need to remember those we serve at every corner.

Here are some other things that I have heard and would like to respond to:

2. We need to integrate health care/whole health. There are many models the state has piloted that maximize the best of our public mental health system, our local communities and the health plans. State innovation model, CCBHC, Health homes, MC3 etc. These models have been proven successful so we should be investing more into them; but instead we are not. It seems to me we should build on the proven successes first before de-constructing it. I also am a firm believer in sharing risk and resources. It keeps everyone invested and there is less time spent pointing fingers at who did the other wrong.

3. The idea to combine different parts of the state departments to improve coordination. Medicaid office and the BHHDA office. What were the benefits when children's services

were combined with child welfare? What was lost in that process? What was gained? Just because you put someone in the same building or department does not mean they coordinate better. They offer different functions and specialty support to our system. It seems to me we should enhance their ability to work better together and to understand their unique expertise and not dilute the effectiveness of either; essentially we need to bridge the gap. You need funding to build strong programs and you need strong programs to ensure fiscal responsibility.

4. It has been said our system is duplicative and not efficient. In our region, we share the same electronic medical record, we have shared governance with accountability standards, we have an infrastructure that shares the best of what each CMH and the region does so we do not duplicate efforts and keep our administrative costs low. One county provides rights officers to our region, another county provides a unique PERS model the support individuals in their community, we share other positions so we are not duplicating, we have regional committees doing the work, we have regional policies to ensure consistencies. There are many examples of this around our state.

5. Comparison can be dangerous. I do not know the integral work of the health plans and they do not know the integral work of the public mental health system. It is always important to know what you are good at and do it the best you can. Our public system is good at supporting people with specialty services and care. If there are ways to combine our expertise into models that maximize the best of what we do, then let's do it. So share resources and risk versus move resources. That is what we do and have done with all of our other system partners.

6. Less is more. Reducing PIHPs and CMH has been suggested. In my experience, the more distance you create between the services and consumers, the less access they actually have.

7. The system is underfunded. This is one statement I believe to be true. Our CMH has primarily had a deficit in Autism funding. The reason for this is we have provided services not because we have mis-managed anything. A lot of the testimony I have heard talks about innovative programs to reduce hospitalization, increase jail diversion, enhance community based care options. We have had 64% cut in state general funds where we have had to fill the gaps with grant funding. We are now almost 89-93% federal funding and with the lowest Medicaid numbers in the state. That does not mean we do not have people that need our services. It just means that most of our funding can only serve those with Medicaid.

I did not have a choice if I wanted to I keep the "community" into community mental health, I needed to explore other funding options. We need to remember that Medicaid

and Healthy Michigan is a health plan. Many of the programs discussed here and other venues are funded using grants and other funding. The state does need to invest in complementing our federal dollars with state dollars versus the past practice of reducing state dollars whenever there is an increase of federal dollars and then expecting we can serve the community in the same ways.

Some examples of what we are doing with grants are:

- Jail Diversion grant-2016-outcomes since grant:
- Community Support MH specialist at school
- Project Assert-having a peer work in our Emergency Department.
- MC3-Therapist embedded in Pediatric practices, mental health consultation for primary care including child psychiatrist consultation.
- State innovation Model-Health care integration for high utilizers of Emergency Dept, increase access to primary care doctors.
- Specialty court grants
- Blended funding to serve children (ISD, SUD, CW, courts, public health)
- Substance use Engagement Center-open 5pm-9am weekends and 24 hours on weekends
- Senior services/Health care integration grants
- HUD grants for supportive housing.
- Great Lake connect-technology used to share information across health care and behavioral health.

All grants, all with positive outcomes. Time limited-sustainability is difficult. We need to invest with diversified funding.

8. Actuarial Sound - The rates are only as sound as what you put into them. For example,

- When the state adds "benefits" like the autism benefit, then you need to think long term.
- Autism benefits starts with 0-6. There are not enough providers.
- State expands to 0-21. There are still not enough providers in all areas of the state.

- State puts autism benefit in the capitation before there is any idea on much funding is actually needed. Here is the problem with this.
    - Some regions/CMH's have stronger service capacity due to various factors. For example, we went from serving 28 in 2016 to 119 in 2018 (and we do have different providers determining eligibility than providing the services to keep integrity of diagnosis). The funding allocation model does not consider this type of growth hence we are underfunded. The result:

Our CMH has had a deficit in 2018 of 1.7 million- **Autism 66%**
HMP 34%

Our CMH is expected a deficit in 2019 of 2.1 million- **Autism 85%**
HMP 15%

- There has been testimony of mis-management by some regions that have deficits. I can't mis-manage funding that I have not been given. I just am contractually obligated to provide services as I should. I have had to use local dollars to pay providers for a federal benefit. This should not occur. There was a recommendation for a supplemental for FY19 which we need desperately. We are only asking for reimbursement for the services we provided.

9. I have heard the people we serve are vulnerable. I probably have even said it. That is very far from the truth. The people we serve are resilient and strong. It is our system that has become vulnerable.

10. I do not think we need to blow up our system to improve it. We need to keep our eye on the ball about what needs to improve and just do it. We need to be open to options that make sense and listen to the reasons why some may not work. We need to learn from the positive things other states have done but be cautious of the lessons learned as well. We need to ensure any model evolves to better outcomes for the people we serve. I will be one of the first people to volunteer for something innovative or different if I think it might work. I am not a fan of trial and error especially when the people that rely on us to get it right are at risk to our "errors".

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As you move forward, please remember that Michigan does have a unique system that over the years has been at risk of being diluted to a pure medical model. Medical models are easy to predict and manage but they are not effective for everyone. Sometimes you need specialty care and that is what our public system offers. Thanks for your attention to this. If I can be of assistance, please do not hesitate to contact me. Your time is appreciated.

Respectfully submitted,

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