CMHA Community Mental Health Association of Michigan

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Connections for communities that care

2017 CAN FORTELL SOME DESIRABLE CHANGES FOR 2067

Ron Manderscheid, PhD
Executive Director
NACBHDD and NARMH

Make no mistake, it is a most daunting task indeed to be asked to look forward 50 years to 2067 and divine the future of behavioral healthcare. In fact, it probably is mission impossible. I am reminded of that very popular song from so long ago:

> *"Que, Sera, Sera! Whatever will be, will be.*
> *The future's not ours to see. Que, Sera, Sera!"*

One cannot see more than 10 to 15 years into the future with any degree of accuracy because of our very rapid and accelerating rate of social change. One can construct, however, several scenarios that represent potential futures that could arise by extrapolating current developments, and then envision a hoped-for future by 2067. That is the approach which I have followed here.

First, let me extend my very hearty congratulations to the Michigan Association of Community Mental Health Boards on reaching the half century mark. MACMHB's history spans the modern era in mental and behavioral health—from the implementation of the Community Mental Health Centers Act in the 1960s to the implementation of the Affordable Care Act in the 2010s. You have had many, many successes during that period, and you have accomplished unmeasurable good for the people of Michigan. Happy 50th Birthday, MACMHB!

Our journey into the future begins with an overview of several major transitions that are very evident today. These include the incorporation of recovery principles and peer support; the move toward community-level interventions; the addition of prevention and promotion regimens to our service systems; the integration of behavioral health and primary care; the adoption of managed care practices; and the movement toward bundled payment systems. If we also peer just around the corner toward the future, we can discern the very beginnings of care assisted by information technology; personalized medicine; and genetic interventions.

Recovery and Peer Support

The single transformation that likely will have the greatest long-term impact upon the future and upon the lives of those we will serve is the transition to a culture of care focused upon recovery and recovery-oriented systems. The possibility of recovery is a revolutionary change introduced to the field by primary consumers, the full impact of which cannot be overstated. Just think back to the 20th century before recovery—and hope— entered our lexicon. With recovery, we also have come to realize that at least three quarters of all behavioral health conditions are due to trauma. In this new culture of recovery, peer support is emerging as an essential service to help primary consumers throughout the behavioral health system. We also are moving rapidly into an era of self-determination and person-centered care, key hallmarks of the recovery process.

Moving forward, we must build a strong bridge between the recovery and medical models, so that they are not viewed as oppositional. Clearly, primary consumers should be able to make informed choices about the particular care they receive, and those who choose either model should have the hope of recovery. Clearly, this transformation will help to promote a much more pluralistic system in the future.

Our hope for 2067 is that every primary consumer of behavioral health services will not only have the hope of recovery but also the possibility and reality of full recovery.

Community-Level Interventions

Almost as revolutionary as recovery is the development of community-level interventions. With the appreciation that trauma underlies most behavioral health conditions also has come the realization that our communities represent the source

(Continued on page 18)

THANK YOU FOR SHARING YOUR VISION OF THE FUTURE!

Clint Galloway, Editor

The response to invitations for sharing your vision of the future of healthcare has been amazing! As a result, this theme has been extended to include the next issue of Connections, enabling us to include the numerous voices; thank you!

It is a stark affirmation that in spite of the rancor that surrounds much of the conversation about the future of healthcare, the heart and soul of caring for one another has not been daunted. When the focus is on the quality of care needed for the well-being of the people in our communities the path becomes clearer. The more we focus at the ground level—on what our neighbors are experiencing—the clearer our vision becomes of what needs to be done.

Once we are face-to-face with suffering, sacrificial endeavors trump seeking profit; these constitute the deepest and strongest chords we have as we weave the fabric of our communities tomorrow; the Connections for Communities that Care. Look in future issues of Connections for more articles echoing the themes you find here.

Treating the WHOLE Person

Lt. Governor Brian Calley

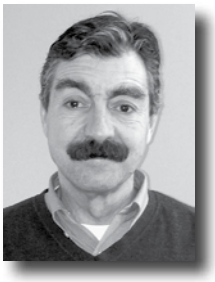
We have made progress in recent years improving mental health care in Michigan, but we have a long way to go. If we expect to build the best possible health care future, we need a system capable of effectively treating all aspects of a person's health, which includes both behavioral and physical health needs. Both are essential to living our best lives. No one would ever be looked down on for seeking treatment for a heart condition or diabetes and they shouldn't be for a mental health issue either.

Over the past year, there have been productive conversations about how to better treat the whole person by integrating our systems of care. While there are strong philosophical and practical positions on both sides of this issue, what matters most is ensuring that the maximum amount of resources go to direct care, and that the care provided is as effective as possible. By better integrating care, our primary goal must be to help more people live self-determined independent lives.

In order to find which system can provide more resources to care, the state budget called for a demonstration model in Kent County and up to three pilots in other counties. I am optimistic that we can find ways to improve health outcomes for Michigan residents, helping everyone receive the services and supports they need to realize their full potential. While this demonstration model and pilots are just a start, this is an opportunity to change our mindset and think creatively to provide better health care for everyone.

Although change is never easy, right now we have the opportunity to improve the lives of those around us through access to better health care. We can't let anything stand in the way of better outcomes for some of our most vulnerable people. There are certainly differing views on this topic but I hope we can find common ground in the desire to improve health care and outcomes in Michigan. If everyone adopts the mindset of treating the whole person, together we can truly enhance health and wellness for every person.

Fifty Years Down, Fifty More to Go



Robert Sheehan, CEO
Community Mental Health
Association of Michigan

With this edition of *Connections*, this Association marks its fiftieth anniversary. This is a milestone in the life of this Association and echoes the fiftieth anniversary, celebrated several years ago, of the national community mental health movement to which this Association traces its beginnings, and from which it draws its purpose. This anniversary is celebrated by an adherence to the principles that are core to our work and celebrated by a commitment to change and innovation, symbolized by our Association's new name and logo.

A history of boldness and innovation grounded in unchanging principles: Michigan's publicly managed behavioral health and intellectual/developmental disability (BHIDD) system is, and has always been, a community-based system of care. Formed at the start of the community mental health movement in the early 1960s, with the signing, by President Kennedy, of the federal Community Mental Health Act, this system has been tireless in its work to improve the lives of those whom it serves, their families and the communities in which they live. This Association, formed in the early days of this movement in Michigan, is driven by its mission to continually support the work of this system with the aim of ensuring the highest quality of life for Michigan's residents regardless of ability or disability.

As I have said over the past several years, when called on by the federal government with funding under the CMH Act, to design and operate a community-based mental health services system, Michiganders, in communities across the state, designed and built such a system. When called to adapt this system to serve as a service network to allow tens of thousands of Michigan's residents to leave the isolation of the state's psychiatric hospitals and developmental disability centers and return to their home communities, our system responded. When called upon to innovate, our system championed, refined and implemented a wide range of evidence-based practices (EBP) – from trauma informed practices to family psychoeducational practices, from dialectical behavioral therapy to medication assisted treatment – EBPs that ensured that high quality research-based care was woven throughout the public service delivery system.

Later in our system's life, when the state converted its Medicaid system, statewide, to a managed care system, our CMH system stepped up and took on the role of managing the state's Medicaid mental health services for adults, adolescents, and children; services to persons with intellectual/developmental disabilities, and persons with substance use disorders, making it the only state in the country managing the Medicaid benefit for all of these populations. The success of this partnership with the State of Michigan is underscored in the development of the broadest array of innovative community-based services in the country and the proven ability to control Medicaid costs and sustain that cost control every year since taking on that role in 1998. The success of the use of cost control efforts that used person-centered approaches and innovative clinical and community-based services and supports is highlighted in the report developed by our Association's Center for Healthcare Research and Innovation, which can be found at: https://www.macmhb.org/sites/default/files/attachments/files/Bending%20the%20cost%20curve-rev%20%282%29_0.pdf

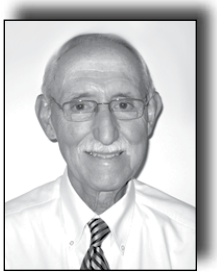
Most recently, before many knew of the value of health care integration (weaving behavioral health with primary care), our system has been pioneering a wide range of healthcare integration efforts. These efforts focus on clinical and service delivery integration – "on-the-ground" healthcare integration where care givers interact with consumers/patients, where it makes a difference in the lives of the persons served. The Center for Healthcare Research and Innovation's study on the public BHIDD system's healthcare integration efforts (found at https://www.macmhb.org/Information/center-healthcare-research-and-innovation%E2%80%99s-report-healthcare-innovation-initiatives-led) provided a picture of the depth and breadth of these initiatives, finding over 700 healthcare integration efforts that were being led by Association members.

Reinforcing the commitment to its core mission while embracing innovation, the Association changes its name and logo: As you may remember from an earlier edition of *Connections*, our Association is changing its name. Our new name is the ***Community Mental Health Association of Michigan***. This new name retains the words "community mental health" to represent the association's link to the community mental health movement that, fifty years since its genesis, is in robust and continual development. However, you will notice that the name no longer contains the word "boards." While the Association is still

(Continued on page 18)

PROMISES MADE. PROMISES KEPT?

How well has Michigan's system of community-based mental health services met its promises over the past 50 years?



George Rouman, MSW

A promise is a declaration with respect to the future made by an individual or organization that something specific will occur or take place. We all make promises; to our loved ones, friends, co-workers, and so forth, and usually we intend to keep them. Often we fail, but not for lack of trying.

The contemporary political scene in America is fraught with promises made by our leaders and politicians, some of which unfortunately are only stated during election campaigns and intended to seek votes and cynically are never meant to be kept, while others are made with sincere ideological belief and intent, but are not in keeping with the principles and values of the mental health community.

As we prepare to celebrate the 50th anniversary of the Michigan Association of Community Mental Health Boards, it is important to recall the promises that were made by its precursor and inspiring legislation, the Community Mental Health Act of 1963, and by the community mental health programs that emanated from the Act and were intended to keep those promises. It is timely to reflect on whether all or most of these promises came to fruition.

"What can we do to achieve these goals? For one thing, those of us on the sidelines need to become more active."

It is obvious to the average observer that it is easier to make promises than it is to keep them. We all have made well-intentioned promises that we were unable to keep, sometimes from lack of commitment, sometimes from lack of leadership, sometimes from lack of resources. How well has Michigan's system of community-based mental health services met its promises over the past 50 years?

Clearly, we have kept the most important promise. We have moved from an institution-based system of care to one that is community-based, more normal and humane, and with emphasis on the provision of science-based methods of care and treatment. Persons with a mental illness, developmental disability, or substance use disorder are now afforded services in their own communities. The exodus of residents from our state hospitals was facilitated by the Act and by court decisions. We no longer place persons with a developmental disability in hospitals, and we retain just a few hospitals for persons with a severe mental illness.

In Michigan we have outpatient programs in all 83 counties, as well as partial day programs, supported employment, short term inpatient care, case management, 24 hour emergency services, and many specialty programs. This is a long way from the days of the child guidance clinics that once were virtually the only outpatient services for families. This is success by any measure, and is a significant achievement, but are there still obstacles to mental health care that remain?

Access to care is one thing but affordability is another. Many of our citizens live in or on the edge of poverty and are unable to afford the cost of care without adequate and affordable health insurance. For many of our consumers the Affordable Care Act with its enhanced Medicaid benefits is the key to receiving needed care and prevention services. The coverage and benefits of the private insurance markets are simply not available to them without the subsidies and other support available under the Affordable Care Act.

The goal of universal health care coverage seems elusive. Despite a consensus that this is a laudable goal, little progress has been made in reaching agreement on a plan acceptable to the members of our Congress. There are areas of major disagreement among our policy makers, based primarily on ideological differences that make compromise difficult, if not impossible. But whatever the ultimate solution, it seems likely that there will always be a role for government in the provision of comprehensive health insurance coverage to many of our citizens. Until we solve the issue of poverty in this country, financial and other support will be needed for millions of Americans. Our success in providing affordable health care is mixed.

Healthcare is just one of a number of needs that our mental health consumers have. Adequate and affordable housing, transportation services near their homes, employment that pays a livable wage and provides a work setting that accommodates special needs and values its employees, treatment rather than punishment and incarceration for persons with addictive disorders, opportunity for inclusion in their

communities including opportunities for volunteerism, and membership in local organizations are just some of these unmet needs. In other words we must continue to strive to provide for our mental health consumers the opportunity to receive the same benefits that the rest of us take for granted. Our record of achievement in these areas is mixed.

What will it take to meet some of these needs? A reordering of the priorities of our country will be required. As successful as our capitalist system has been for the majority of Americans, it has utterly failed those at the bottom of the income scale.

A greater focus is needed on correcting the huge disparity in income among our citizens. Developing a full employment economy or otherwise providing income support to those who remain unemployed, perhaps through a guaranteed annual income, would help reduce this disparity. We know from experience that holding a decent job has an ameliorating effect on mental illness. An increase in self esteem and a reduction of symptoms often results. We need to find a way to return to a time when a head of household could meet his or her family needs with their job. Although perhaps not realistic in the short term, in the long run meeting this goal would contribute to family stability and reduce the negative aspects of family breakdown and dysfunction.

The logjam in Washington among our elected representatives is a very serious problem. The current state of affairs with both major political parties unable to work with each other for the betterment of their constituents must stop before any meaningful change will be possible. Certainly there are many areas of healthcare in which they could agree. Increasingly we are hearing legislators on both sides of the aisle say that cooperation and compromise is necessary for any real accomplishments. We can only hope that this notion will eventually reach all members of Congress. There are certain principles that should guide them and us.

> Insist on full integration of persons experiencing mental illness, developmental disability and addiction disorders in our communities and in our personal lives.
>
> Provide the same access to social, economic, education and employment services as the general population.
>
> Treat addictions as health issues rather than crimes, thereby providing treatment rather than punishment.
>
> Even though we have made great strides in recent years, continue to work to reduce the stigma associated with these disorders and illnesses.
>
> Promote and support independent living with less reliance on congregate housing.

What can we do to achieve these goals? For one thing, those of us on the sidelines need to become more active. We need to communicate with our elected officials and insist that they deal honestly with the myriad of issues facing the general population and especially our consumers. We need to insist that as a nation we must share our great wealth more equitably across the board. We have no excuse. We are a wealthy nation. We are more than able to afford quality mental health services and the associated support services such as housing, employment, transportation and leisure activities.

In recent times we seem to have lost our sense of responsibility for others, for the general population, for the welfare of all Americans, instead focusing on our own individual needs and wants. We can and should share our resources with those of our fellow citizens in need, both personally and through our government. In keeping with the teachings of most major religions, our moral obligation is to those of our neighbors who are hungry, homeless, ill, feeling hopeless and alone.

How well, then, have we done in keeping the promises inherent in the Community Mental Health Act of 1963 and of the Michigan Association of Community Mental Health Boards? All in all we have made significant progress over the past 50 years. We have a more enlightened, successful and humane mental health system in place. We have improved access to care. We have improved our treatment services and programs. We have made limited but important progress in reducing the stigma associated with mental illness. But there remain areas of continuing need. We cannot be satisfied with our progress, but we must not be discouraged either. We can be proud of the accomplishments to date of the various community mental health boards and programs in Michigan and know that further steps will be taken in the future to meet the mental health needs of the citizens in our state.

Rouman's career has spanned 45 years as both a clinician and administrator in behavioral health; the last 40 of those as Executive Director of CMH for Central Michigan, a six county mental health authority headquartered in Mt. Pleasant. Since retiring in 2005, he has worked part time as a program administrator on the Central Michigan Mental Health Facilities Board.

The Age of Locally Driven Innovation

Scott Gilman, MSA, CBHE, Executive Director, network180

Lessons from the Past

Doc (Doc) Baker was the country doctor in the seventies TV series Little House on the Prairie. In many episodes he provided healthcare to the Ingalls family and residents of Walnut Grove. He usually traded his services for a chicken, dinner or even a pie. He had a moral contract with the Ingalls family and the community to provide services day or night, whenever they needed him. The healthcare system was simple, the treatment was state of the art for the 1870s and life expectancy was approximately 40 years.

Fast forward over one hundred years to today. We look back at some of the medical treatments provided in the 1870s as barbaric. People with disabilities and mental illness were frequently locked away in basements, attics or worse. While modern medical advances have doubled our life expectancy, what have we lost? As we search for national answers of what to fix in healthcare, how to have care for all, how to reduce skyrocketing costs, improve outcomes and patient satisfaction we can use the past to guide our future.

In several episodes Doc Baker brought food to families. He recognized that without nutrition his services would be wasted and it wasn't likely they would heal (food security). He frequently used his horse and buggy to give rides (transportation) and even took people into his home when they were homeless (safe and secure housing). He provided mental health therapy on a variety of emotional issues (integration) and used his genius and creativity to come up with all sorts of interesting solutions (local innovation). Doc Baker demonstrated the values and moral commitments of which we could all be proud. He was compassionate and fair. He addressed the social determinants of health. Each week he demonstrated the virtues and values our country is desperately working to infuse into today's healthcare debate in our states and in Washington.

Washington, the Race to Mediocracy

I am a strong supporter of Medicaid expansion and believe that everyone should be provided the medical and behavioral healthcare they need. That said, I recently read a blog by Jonathan Bush, CEO of Athena Health, written before the presidential election. The blog predicted that there would be gridlock post-election no matter who won. The gridlock would slow the pace of new red tape and regulations and present an incredible opportunity for locally driven innovation. Jonathan stated, "In my world (healthcare) innovation has been paralyzed by a six year race to comply with mandates from Washington. There is now one giant voice in all of our communities called the federal government; but aren't we more interesting than that and more diverse? Is driving everyone by force to some centrally-defined least common denominator really the best use of our collective energy? Aren't we a nation capable of many right answers? This is our chance!" I found this energizing. This was a point of view that I really had not considered, but it rang true. Are others suffering from regulation fatigue? Maybe our time has arrived! Can we rise to the challenge?

Many in healthcare are suffering from regulation and red tape fatigue. Paperwork, electronic health records and regulation fatigue distract us from providing the actual treatment and care that is needed. It's difficult to estimate the millions - even billions of dollars that are being redirected to ensure the regulatory compliance beast is happy. There is no question that our country deserves a healthcare system that protects patients and their rights. Protecting patients from harm and reducing waste is important, but it should not occur at the expense of innovation. We must work toward a system that rewards quality, satisfaction and outcomes over data and thoughtless compliance. We deserve a system that celebrates creative and unique solutions, a system that works in a variety of diverse neighborhoods and puts control of the system in the hands of individuals needing treatment and support along with their providers. But how do we accomplish something that seems so logical? This issue has divided our country for decades. How do we accomplish something with the moral commitment similar to the one Doc Baker had with the Ingalls family? Perhaps some of the answers lie within a public-private partnership.

The Promise of 298 and the Public Mental Health System

Network180, Mercy Health's Affinia Health Network and Pine Rest Christian Mental Health Services have developed The Total Health Collaborative (TTHC) as a potential 298 pilot project. This public-private model is based on the successes and failures of many integration efforts locally, in Michigan, and nationally. Using the principles of person-centered planning, the pilot is designed to put funding, responsibility and tools in the hands of the providers of care in exchange for providers assuming some financial risk. In order to address the unique needs of each individual, the pilot coordinates the best elements of physical healthcare together with private providers and the best elements of the public community mental

health systems including the social safety net. This includes a four tier clinical model that provides mental health interventions as early as possible. Care Management, a shared care plan and both medical and behavioral health homes provide the foundation for the pilot. The clinical components of this pilot are advanced with strong evidence supporting their use. Each has shown the ability to increase health, quality, outcomes, and satisfaction and reduce unnecessary cost. What's new is a total community effort to orchestrate health. What's also new is the ability to reinvest those savings back into supports and services.

The TTHC partnership places great value on our health plan partner(s) and the evolving role of payers. The goal was to design a model that would deliver results making it attractive to all payers. While our payer relationships are critical, we anticipate the ability to work with the state to identify areas of administrative burden that do not support outcomes or add value. The legislation calls for "all savings" to be reinvested into services. This is essential for sustainability, to continue to develop supports, new interventions and more importantly to provide flexibility in funding to address social determinants of health.

Network180 and our partners now have the opportunity to demonstrate synergy and measure the magic that can happen when behavioral and physical providers make a commitment to work together to deliver better care. In many ways our partnership represents the three legs of a stool (physical, behavioral, social). Our proposed pilot model outlines a process, not a final destination. We are dedicated to finding the best solutions for each individual and to achieve total health and independence for those with disabilities, substance abuse and mental health issues. We are also very excited that our state is looking forward and seeking federal waivers that allow for locally driven public-private solutions that reinvest public resources into communities. The proposed public-private risk bearing formula to successful integration efforts is fairly simple-but we must start with one brutal fact.

A Brutal Fact: We Can't Plan on More Money

Jim Collin's research presented in the book "Good to Great" noted that most successful businesses and non-profit ventures must start with the brutal facts. In healthcare we all must start talking, planning and behaving in a way that considers we will not have more money for healthcare, and most likely will have less. Mr. Collin's also introduced how successful companies were able to embrace two opposing processes at the same time. He labeled it "The Genius of the 'AND'." For example: opposing forces are continuity and change, conservatism and progressiveness, stability and revolution, predictability and chaos along with heritage and renewal.

As we consider our path forward we should be open to solutions on both ends of the healthcare equation.

*How can we grow services **and** reduce cost?*

*How can we improve outcomes **and** reduce administrative controls?*

*How can we avoid waste **and** increase flexibility in funding to address the social determinants of health?*

*How can we make sure there are resources to fund the best healthcare system in the world **and** make sure the patient has safe and affordable housing, food and medication?*

How can we implement technological wonders while keeping a moral commitment demonstrated by Doc Baker?

These all present great opportunities to be explored this fall and coming years as the 298 pilot process begins.

As the fresh winds of fall begin to blow it's exciting to think about the possibilities and the degree of innovation that can occur in a committed community. To succeed, a common vision of health is essential. While Doc Baker worked hard for a better future for the residents of Walnut Grove, he could never have imagined the lifesaving miracles we see in healthcare every day. Dream with me for just a moment as I close with one possible future.

Twenty years from now we will view health as a commitment to every member of our society. Science and technology have extended life expectancy to 120 years. The ratio of technology based healthcare to human based healthcare is 90% technology 10% human. Most common ailments are diagnosed and treated by technology. Physicians and medical systems are rewarded for health outcomes along with outcomes related to the social determinants such as lowering homelessness, increasing the number of days worked and reduced rates of addiction. Individuals with disabilities and their families are free to choose where they want to live, where they work, what they do for recreation and work. Communities have flexibility and significant variation in how their system is designed. Approximately 20% of funding is used for healthcare infrastructure and essential benefits, while 80% of funding is flexible and directed by providers of care governed by communities including social determinants. Funding is finally stable, predictable, and savings are redirected into health efforts. Like Doc Baker healthcare and the safety-net providers have state of the art medical treatments, tools needed, safe and secure housing, food security and the other remedies to address the social determinants of health. Those who need care get it when they need it. Many chronic diseases have been cured and are only a memory. Our country is proud of the resources dedicated to health and even more proud of the safety-net systems and supports in place for those not able to care for themselves, the elderly, those living with mental illness, disabilities or addictions. We did it! We rose to the challenge because no one anywhere knew more about what needed to happen in each of our communities than we did, the people living there and dedicated to making it so.

Person Centeredness

Supporting the Person in the Pursuit of Life, Liberty, and Happiness

Joe Stone, President,
Community Mental Health Association of Michigan

There is no greater privilege in the world than being a citizen of the United States of America. People are willing to risk life and limb to achieve and defend this cherished privilege. Yet, within this great society there remains one class of citizens who still do not enjoy the full freedoms and benefits of being a citizen, namely, those living with disabilities. To this day, in the public mental health system, life, liberty, and the pursuit of happiness are constricted to a limited range of freedoms by what can only be politely described as "parental" type controls exercised by those who mean well, but do not achieve well. The challenge ahead is for the entire system, top to bottom, to become truly person/citizen centered. My vision of the future is to live in a nation where all adults living with a disability achieve physical and mental health sufficient to empower them to achieve their dreams and desires for greater independence, greater personal responsibility, and full participation in the community.

The challenge is to somehow facilitate a "systems" epiphany; a system changing realization that the citizens served by the public mental health system do know and understand themselves, their needs, their dreams, their desires and that it is the system that no longer truly knows, understands, and embraces the person/citizen. The public mental health system has become a regulation and cost containment system. In my nearly 20 years of involvement in the system, having experienced countless hours of audits and thousands of pages of audit reports, never once do I recall a State auditor asking if the "people" are benefitting. I recall the saying of a retired outdoorsman and long-time Jeep owner/driver who would regularly quip, "Jeep wrote the book on 4-wheel drive; too bad they never read it!" The first step toward achieving fully person/citizen centered approach is for regulators, policy makers, and legislators, to read the book on "Person Centeredness", embrace it, and re-establish the person/citizen as the purpose and primary focus of the public mental health system.

The 298 process is the most recent example of the very disconnect that impedes the achievement of life, liberty, and the pursuit of happiness as a lived experience for all citizens. The 298 process created nothing new. The process did affirm at the grass roots level that the core values and principles held as essential elements of person/citizen centered system have fallen into disregard. State leadership admonished providers to get busy ensuring that these elements are fully exercised, while the Department, Governor, and legislature went in the very opposite direction: disregarding the core values and principles by passing new 298 language piloting the system ever closer to the privatization, by requiring pilots that combine the funding streams as a means to achieve health integration and cost savings. Cost savings are the primary value of interest to state leadership. It is not just the provider who must get busy embracing the core values and principles, but lawmakers and state policy makers who must also realize their actions disregard the persons/citizens for whom they are constitutionally required to provide with care. If the full citizenship of persons living with disabilities is to be realized, the system must regard the person and work to promote recovery.

The person/citizen will only exercise the full benefit of citizenship when they experience the full scope of choice and opportunity. The Mental Health Code wisely requires citizens, persons served, and family members to be on the Board of Directors of each CMHSP, and perhaps ironically, limits the representation of elected officials. The Code goes on to require that the services offered locally by the CMHSP be based on a local needs assessment that is reviewed annually. The Mental Health Code places value on the person/citizen having the opportunity to create programs of service, care, education, and support that fit the needs of the persons/citizens living in the community. If true person/citizen centeredness is to be achieved in the future, then beginning at the highest levels, the focus must change from uniform services to uniform opportunity to benefit, grow, and become more independent. There is no guarantee of quality, choice, or outcomes in a uniform service system. The public mental health system should create uniform opportunity, where the person/citizen has an array of life choices and decisions to be made to help fashion the life that best fits their needs and dreams.

The future of person/citizen centeredness must move beyond the notion of being a treatment system and a "safety net" system as both concepts define the system too narrowly. The system must be broadened, becoming a comprehensive system, embracing the full span of life styles, careers, and living arrangements. A full and complete life has many facets, of which "safe" is not the one that comes to mind if a person/citizen is to live fully and thrive. With risk comes reward. The system must become an incubator for personal growth, vibrancy, and the full exercise of life, liberty, and the pursuit of happiness. The role of the provider in the future must not be limited to state and federally prescribed activities but encouraged to go with the person/citizen down a conventional or unconventional path to recovery, including taking risks that build strength of character, courage, and wisdom.

The future must be free of treatment programs favored by a bureaucracy comfortable with those things familiar and embrace innovative and creative options driven by persons/citizens served in the system. Sustaining historically beneficial methods does not advance the cause but rather, compartmentalizes treatment, com-

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A Peek at the Future of Healthcare?

David Neal, MSW

With the political turmoil that exists today, it is difficult to know what direction funding for health care will go. Conservatives at state and federal levels would like to significantly reduce Medicaid and other support programs. On the other hand, liberals are pushing for expanded health care for all Americans. It appears the American voters do not support either of these extremes. This conflict will probably continue as long as health care costs rise which they are expected to do. However, this is only part of the story about health care; let's take a peek. We'll discover that the one constant in this field is Change.

Increasing Pace of Change

The rapid pace of change may be the major challenge for health care providers and consumers. There have been significant changes in health care over the past fifty years. Back then many folks did not have any health care coverage and those that did often had very little mental health or substance abuse benefits. Medicare and Medicaid did not exist. Today there is a growing mandate that everyone have some type of insurance and that it include mental health services.

> "The rapid pace of change may be the major challenge for health care proviers and consumers."

In 2000, Washtenaw County and the University of Michigan formed the Washtenaw Community Health Organization (WCHO) to integrate physical and behavioral health services for community mental health consumers. Other CMH agencies looked askance at this development. While Michigan Medicine and University Hospital supported this project, most of the physical health departments took a hands off approach and "let psychiatry do their thing." Now, seventeen years later, all CMH agencies have some integrated health services. Today, Michigan Medicine's physical health providers and St. Joseph Mercy Health System, who did not want to join the WCHO, are eager to coordinate care with Washtenaw CMH. In addition, the two health systems are partnering to provide coordinated health care. Both are jointly operating Chelsea Community Hospital. Can we hope that in the future all health systems and CMHs will stop competing with each other and partner to provide coordinated care?

New technology is allowing research to move faster and to explore areas never thought possible a few years ago. CMS and other federal agencies have set a goal to get research findings into practice sooner than has occurred in the past; however, research itself is one of the more competitive professions. Researchers are always competing for name recognition and grant support. Too often projects get labeled "evidence-based" without being replicated in different settings. In the future it will be important to constantly evaluate new research findings and be prepared to implement those that are appropriate. Agencies will need to be flexible and able to make changes quickly. Those that can, providing leadership in new models and funding arrangements will do well.

Change does not come easy or without costs. Staff members are usually comfortable providing services in their traditional manner whereas change requires re-training and learning new interventions. Staff may be threatened and feel that others think they are not providing "good" services. Agencies must be prepared to provide the necessary support including dollars for staff to make changes and handle resistance that will occur.

Change may be even more threatening to consumers. Many consumers are happy with their providers and the services they are receiving. They are most comfortable with what they have versus something new.

Integrating Services

The integration of physical and behavioral health care services would appear to be one direction that will continue. Research has shown that persons with serious mental illness die twenty-five years sooner because of the lack of physical health care. On the other hand, between thirty and forty percent of persons seeking physical health services have a substance abuse or a mental health disorder that often interferes with the care they receive. Studies have shown that when physical and behavioral health services are well integrated, costs do not rise and may even be reduced; however, there is no clear model for every commu-

(Continued on page 16)

"You want a revolution? I want a revelation.

So listen to my declaration: We hold these truths to be self-evident that all men are created equal. And when I meet Thomas Jefferson, I'm 'a compel him to include women in the sequel! "

*– Lin-Manuel Miranda**

Linda Rosenberg, MSW, President & CEO
National Council for Behavioral Health

I never thought of myself as a hip-hop fan. Paul McCartney's "Yesterday" is more my musical comfort zone. But I admit, I *love* "Hamilton." It's not just the beat or the sly, witty use of lyrics. Hamilton isn't just ABOUT revolution. It IS revolution. By doing what he loved – what he passionately believed in – Lin-Manuel Miranda turned musical theater on its proverbial ear. But he also instilled a sense of justice and purpose in an entire generation with his rally cry for freedom and change.

Today, we in behavioral health are also engaged in a revolution. We have seen a tragic twist in world-view. Medicare and Social Security were long considered untouchable, and those who depended on them – many of them the most vulnerable in our society – were ensured a path to treatment and hope. Now, we find that the poor, the elderly, those struggling with mental illness and addiction are considered politically expendable.

Today, WE must be the revolution. We need the tenacity of Lin-Manuel Miranda and the vision of Alexander Hamilton.

"I am the one thing in life I can control.
I am inimitable; I am an original.
I'm not falling behind or running late.
I'm not standing still: I am lying in wait."

With the failure of the Senate health bill, massive Medicaid cuts appear to be off the table in the short term. But these words have never been more true. We cannot stand still, we must lie in wait.

The first and most important thing we must do is reach consensus that health care is a fundamental human right. This is about more than physical and mental health, this is about the economic health and security of our nation in a global marketplace of goods and ideas.

We have danced around this issue for decades, taking one step forward and three steps back. We are a nation of haves and have-nots, with the rich getting richer and the rest of us treading water or falling farther down the economic ladder.

For the first time since we began tracking life expectancy in this country, we are losing ground. Suicides, drug overdoses and alcohol-related disease are the main drivers of these "deaths of despair."

THIS is our revelation.

Health care – including for mental illnesses and addictions – is a fundamental human right to be enjoyed by all. But we must fight to defend our revelation. We must commit to our own self-evident truths.

I believe we are inching ever closer to a single-payer health care system. Increasingly, we understand that we can no longer sustain a system in which more treatment equates to better care; when we do what's good for business at the expense of what's good for health; and when what we pay for health care depends on where we live, how much we earn or how we get our insurance—if we get it at all.

We are talking more openly about mental health and addictions. Long-held beliefs and damaging stigmas are beginning to crack. People and organizations – even large companies – are choosing to freely share their stories. People are united in sharing their experiences and celebrating their differences.

"There's a million things I haven't done.
Just you wait, just you wait."

Now is the time for DO. Maybe not a million things. We must be strategic.

Mental Health First Aid is part of the revolution of DO. Ten years ago, we saw the public's interest and willingness not only to talk about mental illnesses and addictions, but to do something to help. Today, more than a million people have been trained, and that number is growing every day. And we're not alone. A partnership with Lady Gaga's Born This Way Foundation will train an additional 150,000 First Aiders by the end of the year. The Association of Chiefs of Police is calling for 100 percent of all sworn officers to be trained. And Michigan hasn't been left behind. Over 40,000 Michiganders have been trained, including almost 1,000 in Public Safety and Veterans' Mental Health First Aid.

For mental health and addictions to be equal parts of a universal health care system, the movement for integrated services must continue. In the "new normal" of the health environment, our industry is being asked to move to productivity-based compensation, to work in a general medical practice, to care manage a caseload of people with diabetes and to use a registry to enter blood pressure and PHQ-9 or DLA-20 results. The electronic health record we're buying must not just talk to other behavioral health organizations but to the rest of health care.

Integration isn't a concept, it's a way of doing business. Treatment is being viewed as a single, integrated function.

We are seeing the health management of populations divide into two groups — the 5 percent with multiple chronic conditions and the 95 percent with less complex conditions. For the 95 percent, this means online services that include online behavioral health treatments like 7 Cups and primary care-focused medical homes delivering collaborative care. For the high-cost 5 percent of the population, this means expanding their management to include overall wellness and providing online social supports and self—management tools like myStrength, in addition to caring for their chronic physical and psychiatric conditions.

Technologically focused and data-driven, care is increasingly transparent and the results of care are increasingly public. Every federal agency involved in paying for health care—the Centers for Medicare and Medicaid Services (CMS), Health Resources and Service Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA)—and every national standard setting and accrediting body, including the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) and the National Committee for Quality Assurance (NCQA), is working on behavioral health performance indicators and outcome measures.

Performance anonymity won't last. We have to show results.

If we don't keep score, we'll never know if we're winning the game. If we don't measure it, we can't manage it or improve it and in the future, we won't be paid for it. When we use data to help us make decisions about what services to provide, we avoid shoot-from-the hip mistakes. We know our costs, and we say no to reimbursement rates that are inadequate. Whether performance is tied to compensation or not, openly shared knowledge of one's performance and the performance of others is a key to improving performance.

But, as U.S. health care continues to evolve, community-based mental health and addictions services are struggling. Support for community-based services is a significant challenge. We recognize the gravity of the addiction crisis and the many people who have untreated mental health problems, and we know the solution is not simply more beds. Beds are a critical part of the continuum of care, but they are only part of the solution. But, it is undeniable that anything with bricks and mortar pays better, and parity is more easily applied.

States responsible for increasingly complex Medicaid programs have turned to commercial managed care, moving responsibility and risk to a third parity. Promised savings too often come from the already slim-to-no-margins of community-based services. The more squeezed community providers are financially, the more difficult it is for them to recruit and retain staff because of painfully low salaries. The result is limited access to what we know are effective community treatments. Too often families are left bearing the burden of caring for loved ones and local police and jails become the people and places of last resort.

We've done good things in this country – but we need to do more. We've supported behavioral health services for veterans and increased funding for health centers, but nobody has done that for nonprofit, community-based behavioral health organizations. The National Council was an early and vocal advocate of the Certified Community Behavioral Health Clinics (CCBHCs) championed by Michigan's Sen. Debbie Stabenow and authorized under The Excellence Act, which align effective practice with adequate payment.

"The plan is to fan this spark into a flame."

The National Council, our member organizations, and the larger behavioral health field have come a long way in the past years. We are a political force to be reckoned with, we're actively breaking down stigma with programs like Mental Health First Aid, we have made lasting alliances with influential individuals and organizations and we're leveraging our influence. None of this would be possible without raising our voices.

Advocacy is our birthright and our privilege. It was true in Hamilton's time and it is true today. And we must exercise that privilege. We know that every voice, every viewpoint, every person matters. Together, we have done great things. Together, we will achieve more than we ever dreamed.

"I know that we can win, I know that greatness lies in you. But remember from here on in, history has its eyes on you." ⁘

(*Credit all quotations in red to Lin-Manuel Miranda, creator of *Hamilton*.)

THE DEVELOPMENT OF A *NEW PARADIGM*

Clint Galloway, Editor

This issue, as well as the next, is dedicated to the theme of envisioning the future of quality healthcare. Why has this generated such a prolific response? Somehow it seems to be the right question at the right time. Health literally means to be whole or complete which implies that attention and care must be focused on both the physical body and the interior; subjective, invisible experience of awareness. Sometimes this latter part is referred to as the mind but it is much more than the flow of thoughts or the experience of feelings. In ancient Greece, medicine intertwined both the physical and the spiritual components of life. Such is not the standard practice of healthcare today. What happened?

Modern healthcare has a bittersweet history, liberally sprinkled with what would have been considered miracles by those ancient physicians if they were to tour any of our modern hospitals. These "miraculous" achievements have been made possible by those considered to be the architects of the modern, scientific, materialistic world in which we find ourselves. Some three to four centuries ago, Polish astronomer Nicolaus Copernicus, French philosopher Rene' Descartes, Italian astronomer Galileo Galilei, and English physicist Sir Isaac Newton gave us a new way of understanding our world. Instead of relying on the promulgations of religious authorities we started to investigate the material world discernible to our senses for ourselves.

Every school girl and boy can now explain much of the world they see every day, and many within the modern industrial countries most affected by this scientific revolution have at their disposal the means to instantly connect with others who are far away. The contrast between modern life and medieval life is incomprehensible. So what's the rub? Despite vigorous denial by many, our daily activities are largely shaped by the unconscious perception that what is available to our senses is all there is—just surfaces. We compete for "stuff," we measure our success and value by salary and bank accounts; these are the hallmarks of a materialistic culture. "We love so the things that separate us, one from the other." The success of manipulating the world composed of surfaces with the breathtaking advances in dealing with smaller and smaller entities, has fueled the belief that even our interior experiences are the product of physical entities: the mind is nothing more than the product of the brain (See Daniel Dennett, *Consciousness Explained*). At best, neuroscientists admit that our interior experience—consciousness—remains a "hard problem."

As with all paradigms, shocking experiences can bring us out of our illusion. Yes, all worldviews have an illusory affect in that they skew our view. This was one of the primary points in Thomas Kuhn's, *The Structure of Scientific Revolutions*. We never have a complete picture of the universe in which we are immersed. Kuhn argued that shifting our understanding is not one of simply adding more information; rather, something emerges that requires us to reframe our understanding. That is why Einstein could never quite accept some of the theories of quantum physics—it was "too spooky."

I submit that the delivery system of community mental health in the state of Michigan has been developing a body of evidence-based care that defies this penchant to reduce the experience of wellbeing to physical interventions. Yes! There are corollaries between neurobiology and the subjective experiences individuals have, but this does not reduce all behavior and experiences to neurological causation.

This brings me back to the question of why the prolific response? For well more than five decades, the paradigm of materialism has been coming under challenge, and to repeat, some of the best evidence has been coalescing around the effective healthcare strategies developed within the community mental health arena. Much of our work has focused on the critical importance of relationships, i.e. community.

Mind-Brain-Community is the organism that needs addressing. Let's go further. In a world that is increasingly shrinking via communication networks, our wellbeing is impacted by national/cultural transactions, and the physical environment. Community is just the nesting place—we need to locate our being in the cradle of humanity. Until we do, we won't have a sense of really belonging, a sense that is essential. This is kindergarten knowledge for social workers but they are precisely the ones whose knowledge has been negated in a culture obsessed with medical "bells and whistles."

All one has to do to validate this claim is examine the salaries. Remember, counting the money is calculating the value in a materialistic culture. So why do people go into social work? Because they have a different set of values; they are pursuing matters of the heart. The successes in this endeavor are more difficult to quantify, but the means of doing so are emerging and as they accumulate, the larger healthcare community is beginning to take notice. The people who were asked to share their vision of the future of healthcare in *Connections* are very much aware of this alternative set of values and appreciate having a venue to tell their stories; that is what *Connections*

(Continued on page 15)

The Future of Behavioral Healthcare in Michigan

By **Tom Watkins**

I have witnessed the public community mental health system unfold, in one capacity or another, for the past 40 out of 53 years it has existed since President John F. Kennedy's signing of the Community Mental Health Act of 1963.

I have been a therapist, a program coordinator, director of a local CMH agency, deputy director of administration and chief deputy and director of the former Michigan Department of Mental Health under Governor Blanchard. After four years as President and CEO, and leading the transition from the former Wayne County Community Mental Health Agency to the Detroit Wayne Mental Health Authority (DWMHA), it is time to move on. The DWMHA is now an independently governed, $700 million dollar "Authority." On August 31, 2017, I stepped down to explore new opportunities.

"What is the niche you do better and cheaper than anyone else?…Staying even is falling behind and you will disappear…"

I have both witnessed and helped facilitate change that has led to progress for this organization from its beginnings four decades ago. When I took the job with DWMHA I brought forth a set of guiding principles (http://www.dwmha.com/files/2515/0186/6904/Authority_Guiding_Principles.pdf) that I believed could provide a foundation upon which our system of care could be developed going forward. These guiding principles say that we exist to serve and support individuals with mental illness, developmental disabilities and substance use disorders. Everything we do should be toward that end. We must always ask ourselves: How do our actions help the people we are committed to serve?

Change Management that Leads to Progress

The improvements the DWMHA team has made to both operations and service are remarkable, universally acknowledged and I expound upon and lay out challenges that lie ahead in a recent Dome Magazine article (http://domemagazine.com/tomwatkins/tw081117); numerous national recognitions, awards and documentaries the DWMHA has produced can also be found in our Annual Report (http://dwmha.com/files/2814/7940/6323/Annual_Report_2015-2016_Website_Copy.pdf).

The landscape of community mental health is forever changing. As we look to the future the one certainty we can predict is that there will be constant pressure to adapt and change, or become irrelevant. Change is never easy, but producing change that adds value to the consumer and taxpayer on both a short term and long term basis is far more difficult.

Decisions that benefit consumers and taxpayers vs. the "system" will take us down a path that will add value and make a difference. If power, control, politics and ideology drive policy decisions in the coming years, I predict future policy makers will have a huge mess to clean up down the road.

So here we go—my predictions, suggestions and ideas to help promote a mental healthcare system that is responsible for the care and support of hundreds of thousands of our fellow vulnerable citizens. Physical healthcare will not stand separately from behavioral healthcare. It needs to be integrated into a single delivery system. We need to treat the whole person; the mind is connected to the body—it is foolish to proceed as if they are disconnected.

Some of the ideas presented here have been articulated by others. Some are bolder than others, and a few purposely push the envelope to force policy innovation, making others rethink long held positions. All are offered as a way to better serve vulnerable people while maximizing value to the taxpayers.

Advocacy/Collaboration "Innovative Initiatives"

- Pass legislation that mandates the health plans and public mental health systems find administrative efficiencies, without impacting consumer care/service, of at least 5% which would be redirected to consumer service. With a budget of $2.6 billion for behavioral health systems and $9 billion for Medicaid Health Plans, $580 million would be redirected.

- Stop the stigma of mental illness and demand Congress appropriate money to research the causes of serious mental illness, developing responses to these disorders that wreak havoc on individuals, families and society. Advocate groups need to make this their next "big thing."

(Continued on page 14)

Watkins *(from page 13)*

- Digital technologies and Artificial Intelligence will change social interactions and behavioral health services profoundly. More and more consumers of behavioral health services are digital natives, having grown up using technology on a daily basis. Chatbots, intelligent personal assistants, artificial intelligence-supported messaging apps or voice controlled bots—all are forecasted to replace simple messaging apps soon. In healthcare, (behavioral health) these could well take the burden off of medical professionals in regards to easily diagnosing health concerns or quickly solving health management issues.

Read about the evolution of bots as health assistants: http://medicalfuturist.com/chatbots-health-assistants/

- The Governor should call on Michigan's universities, the tech community and professional behavioral health workers to design apps that take the lead in developing technology-based apps to meet the needs of over 300,000 citizens in Michigan using the public behavioral health system of care—helping them not just live, but thrive in society. Foundations should put up significant "prize" money to develop technology approaches that would lead to:
  - Enhanced quality of life for those using public mental health and substance use services
  - Reduced length of time in state, public, and private hospitals
  - Reduced suicides
  - Other measurable improvements in quality of life and saving tax dollars
- Survey behavioral health professionals, consumers and their families about their most frustrating problems, then seek assistance from university professors and grad students to do the research that addresses these real life issues. Tie university funding to helping to address real life needs that impact people in our state.
- Arrange to have regular meetings between leaders of the public and private (profit and non-profit) health plans around ways we can work together to meet the needs of society's most vulnerable people. Fostering better relationships between the two entities can only benefit consumers.

Suggestions "Thinking Outside the Box"

- Study how the public policy to close state hospitals en masse in the 90's contributed to today's problems (jails and prisons being the de facto psychiatric hospitals). What are the "lessons learned" that policy makers should take into consideration in their march to turn $2.6 billion dollars over to the private/profit-making health plans?
- We should radically change where and how traditional mental health services are provided. Gone are the days of the traditional fifty minute therapeutic hour in an office. We need to adapt mobile technology to meet the behavioral healthcare needs of our community going forward.
- Stop paying lip service and truly engage consumers and behavioral healthcare advocates on an equal plane. This means assuring the consumer mantra, "nothing about us without us," is not simply a slogan but a reality. Look to fund advocacy organizations at an adequate level to enable them to hold the system accountable. Without their eyes, ears and noses in our business the system will slip off track and the consequences will be as devastating to people's lives as they will be costly to repair.
- The behavioral health community must find ways to more effectively engage employers to meet the needs of the ever changing workforce while helping to increase worker productivity and reducing employer cost. The silos between employers and health professionals needs to be breached. We need to partner with employers around behavioral health awareness, acceptance, prevention, and recovery in and out of the workplace. Employers should be viewed as allies not adversaries.
- Commission a study that shows the good, the bad and the ugly—what is working well (and what isn't) in the public mental health field— under the auspice of public control. What is working (and not working) in the private/ non-profit and profit health plans. Use this data to make public policy going forward.
- Create legislation that no state administrative official, legislator or legislative staffer involved in the transfer of public money to the private/profit-making health plans can accept a job, contract, or any form of remuneration from the industry for a period of two years after leaving state service.
- Move to have non-violent persons in our prison system with serious mental health disease transferred out of corrections and into a proper behavioral health program when appropriate.
- Hold local profit and non-profit hospitals accountable to serve persons with serious and acute mental health issues in their communities (it is a known fact that games are being played to avoid serving these citizens). The State needs to get serious about using all the tools at its disposal, including Certificate of Need, Licensing,

and tax policy. Penalties include revoking tax exempt status from nonprofit hospitals not serving the public need, invoking significant financial penalties, etc. It is unacceptable that persons with mental illness in need of a hospital setting are being denied service.

Predictions "Mental Healthcare in Michigan"

- We are going to see a massive consolidation of public and private healthcare and behavioral healthcare organizations. One thing is very certain: escalating costs, fewer resources and pressure for efficiecy will result in fewer and bigger private companies, taking over smaller and less powerful public agencies.
- We will see significant consolidation driven by the notion that integrated, consolidated systems are more efficient than large numbers of public and nonprofit organizations; well-positioned hospitals and national insurance companies buying provider organizations while well-run, efficient and entrepreneurial provider groups consume other nonprofits.
- If public providers of behavioral health service wish to survive in a new world order they must find new, non-traditional partners and take on an aggressive entrepreneurial spirit. What is the niche you do better and cheaper than anyone else? If you don't have one you will be irrelevant going forward. Staying even is falling behind and you will disappear going forward.
- The trend to integrate physical and behavioral health care is real and moving forward, it is not a matter of "if," but "when and how." We must truly work to find ways to fully integrate all services that benefit the consumer and taxpayer.

Going Forward

The vision, values and dedication of the public behavioral health community in Michigan are second to none. Never shy away from advocating for what is right. There are leaders among you. Stand up and be willing to lead going forward. We must always act as though the decisions we make will impact someone we love—because ultimately it will.

When I took the reins of the Detroit Wayne Mental Health Authority I presented a mantra that we would be: Consumer—and community—focused, data-driven and evidence-based in all we do. We need to encourage all in the behavioral health and healthcare business to adopt this mantra. I know the road ahead seems uncertain. It is for this reason I implore you to not simply sit back and adapt to change, but to boldly lead it!

While I am leaving my role at DWMHA, I am not leaving the field. Collectively, we need to join with advocates to change what needs to be changed while preserving the value—and the values—of the public mental health system. There are so many good people, past and present—at DWMHA, CMH, PIHP, MACMHB, MDHHS, advocate groups, providers, and more—that I have worked with over the years. Thank you for your support, friendship and for standing up for what is right. Together we have and will continue to make a difference!

Tom Watkins served as the president and CEO of the Detroit Wayne Mental Health Authority from 2013-2017. Follow him on Twitter @tdwatkins88

Galloway *(continued from page 12)*

is all about. Furthermore, they realize that these same values reside in everyone, even though we often betray them.

I would be remiss if I didn't cite an unexpected ally in challenging the paradigm of materialism: physicists! It is a rare month that goes by without an announcement of a new development in the world of physics. As they acquire the means to explore both small and large phenomena, a number of them are beginning to talk about the phenomenon of consciousness. In the realm of consciousness, we cannot measure cause and effect but we can discuss corollaries and similarities.

Many of the natural phenomena in our universe engender concepts we would use in discussing positive **relationships**, **networks**, **organisms**, etc. Dean Radin, senior scientist at the Institute of Noetic Sciences, titled his book written two decades ago, *The Conscious Universe*. Over three decades ago, Ken Wilber published *Quantum Questions* which contains the mystical writings of the very individuals who reframed physics in the twentieth century: Heisenberg, Schroedinger, Einstein, De Broglie, Jeans, Planck, Pauli and Eddington. This book had a powerful impact on me when I read it in 1984. Frank Wilczek, a recipient of the Nobel Prize in Physics, penned *A Beautiful Question: Finding Nature's Deep Design* just two years ago, providing a hint of where science is going.

The very best and most beautiful qualities we find in our humanity, Wilczek finds in the cosmos. These are powerful allies in the push to shape a new paradigm, one that validates the interior awareness that "We Are One." From that awareness flows not just acceptance, but inclusion and compassion for all. It heals, and that is what we're all about.

nity or provider. The unique strengths and weaknesses of health services in a health system and community need to be taken into account when developing new models.

One challenge is getting behavioral health services into primary care settings and getting physical health services to persons with serious behavioral health disorders who usually have difficulty going to primary care clinics. Initial studies show that having a behavioral health provider as part of the primary care team is most effective. This model requires a larger clinic and is not feasible in all settings. Quick consultation and/or intervention by a behavioral health specialist can be effective for other clinics. The referral model that is often used today is least effective.

It is desirable for persons with severe mental health and substance use disorders to go to the community for primary care when they are able. Those consumers that are not functioning well enough to go to a community clinic need to receive primary care as part of their service from the community mental health team. Clinical nurse specialists are showing success in providing this care.

Persons with developmental disorders usually have significant physical health issues which require specialists and multiple health care visits. Often their care has not been well coordinated between physical health providers. Behavioral health care is often provided by community mental health agencies and some by other community providers. There is no clear model on how care can be coordinated by the multiple providers these consumers often see. Better coordination would save money and improve care.

> **"The integration of funding is the most important issue facing policy makers and health care systems."**

Social determinants of health care are factors that affect consumer's ability to benefit from health care services and drives up costs. It will be important for health systems and providers to develop cooperative arrangements with other resources to assist consumers. Health systems who can achieve this will be leaders in the field.

Funding Health Care; Moving to Value Based

The integration of funding is the most important issue facing policy makers and health care systems. When services are integrated in a cost effective manner, cost shifting will occur. It may be that additional behavioral health services will reduce physical health cost or vice versa. It is essential for funders to provide incentives to providers to incur additional costs and/or loss of revenue. In the past it has been difficult to get either physical or behavioral health providers to voluntarily address this problem. It will probably require finding a new administrative structure/process where all funders and consumers have a voice in making decisions about how funding should occur.

The failure to integrate behavioral health dollars in Michigan has often created significant problems for consumers. HMOs have been responsible to provide care for those with mild to moderate disorders and community mental health agencies for those with severe disorders. Consumers often move between these categories or do not fit neatly into a category that both sides agree upon. Consumers have suffered when either says they should be seen by the other side. A new model must prevent this declining responsibility from occurring. Furthermore, providers will need to have the capacity and funding to serve consumers when their symptoms improve or regress.

The future will bring new models for reimbursing providers. Fee for service based on a fee code encourages overutilization. Providing services or doing procedures that are not necessary occurs. It is natural for providers to desire to maximize revenue. On the other hand, capitated models provide incentives for agencies to limit services especially when budgets get tight. CMS is now encouraging "value-based" models. Friday Facts of August 4th reports on CMS's desire to explore this model. The challenge here is to find meaningful ways to measure value and quality. Most of these projects have focused on quality measurers for physical health while limited attention has been paid to behavioral health measurers. A value based model will provide an incentive to health care systems to organize services in a manner that provides quality outcomes in the most cost effective way. Reimbursement is not restricted to providing a service that meets a fee code. Providers can be flexible in providing the exact service that an individual or community best needs. Finding new meaningful models is a major challenge. In the near future there will be multiple projects to develop new models for reimbursement. Providers will be challenged to re-organize services to meet the changing reimbursement models which will likely hold them accountable for costs and quality.

Changing Technology

Electronic medical records will also have a major impact on improving quality care. Old paper records often created problems. Clinicians did not get their notes written in a timely manner and when they did, the hand writing was often difficult to read and sometimes misread. Records were often lost when being transferred from one clinician to another. Records passed through many hands which put confidentiality at risk. Today any clinician within a digital system who has reason to view a record can do so immediately. The clinician knows what is being done for the patient and how they are responding. The electronic record will know if someone accesses a record without a need to do so. In addition, critical medical in-

formation can be shared across health systems. The full electronic record is not shared, only significant information for continuity of care. The challenge is what information needs to be shared and how these systems will be developed and deployed. The availability of this critical information to providers will improve care and reduce costs.

Including Peers

The role of peers will continue to expand as they demonstrate their value as part of a health care team. The role of mentors in AA has long been an important part of a consumer's recovery. For a number of years Michigan has provided training to certify peers for CMH agencies. CMH agencies have found creative ways for how these consumers can assist other consumers in their recovery. Physical health providers are beginning to involve consumers to provide services. The challenge is to find how consumers can be used and to provide training and oversight for them. More important is reimbursement. Will these individuals be paid staff, volunteers, paid volunteers, or compensated in other ways?

Changing the Structure

Fifty or more years ago, health care services existed in silos. Hospitals stood alone with community doctors having "privileges" to treat their patients there. Doctors were primarily independent working alone in their offices. There were no inpatient beds for mental health patients in the community; these individuals needing hospitalization went to state hospitals or private free standing psychiatric hospitals. Psychiatrists and psychologists primarily used psychoanalysis and saw their patients three to five times a week which limited the number of individuals they could see. There were no social workers, nurses, or others in private clinics or solo practice. There were five or six consultation centers where patients discharged from a state hospital could be seen for medication checks. CMH agencies did not exist. Twelve or more child guidance clinics provided more access to services for children than for adults. It is amazing how things have changed and how services are now available for adults. CMH services are available in every county and organize not only the behavioral health services but the support services needed for persons to live in the community. In the eighties HMOs assumed responsibility for providing physical health and limited mental health services for Medicaid beneficiaries. This was an immediate success in improving access and quality.

Policy makers are still struggling to find a way to bring CMHs and HMOs together, a system where consumer's care is well coordinated among all of the providers. Financial incentives for providers to do this must be developed. There is still a long way to go. It will be difficult for agencies or individual providers to exist outside a system of care. The future will likely bring more consolidation and larger systems of care.

The first challenge is to bring all of the behavioral health services together in a system to organize care. Is it time for CMH agencies to take on this challenge? The original vision was for CMH agencies to serve all persons in the community who needed behavioral health care. They were diverted from this vision when the priority was to get consumers out of the state hospitals. Patrick Barrie believed that the CMHs had accomplished that goal and that it was time for them to find a new mission and vision.

Why does Medicaid funding have a model where physical health services are contracted to private HMOs and behavioral health services for persons with serious behavioral health disorders to public CMH agencies? What will be the new model that truly brings behavioral health services together with physical health? Could a new model be a "public health system" with an independent Board? This board would then contract with physical and behavioral health providers and ensure that coordination of care would occur and funds used in the most cost effective manner. HMOs and CMHs could each appoint their representatives including consumers. It would be important that behavioral health representatives have an equal voice on the Board and that consumers be well represented. This model has the potential of bringing the strengths of both systems together; each could learn from the other. This would be a challenge to establish but maybe well worth the effort to do.

Fifty years ago folks never imagined or dreamed that so much progress would be made in the delivery of physical and behavioral health care services. There is no doubt that the next fifty years will bring about even more progress than the past fifty. While we can dream about it, we cannot begin to know what the outcome will be; we only know it needs dreaming and action.

David Neal has had a distinguished career in the Department of Psychiatry at the University of Michigan Medical Center as an Assistant Professor of Social Work. His accomplishments and awards are too numerous to list. His expertise in the role social work plays in the delivery of effective services and the complexities involved when they intersect with public policy and funding have made him a rare commodity, sought after for presentations.

The State of Michigan has tapped Neal to serve in various positions—the Governor's Mental Health Statute and Program Review Commission prior to the writing of the Code in 1974, and the State of Michigan Advisory Council, which he chaired for several years.

Whereas Neal's work has been recognized by numerous professional organizations, those honors do not capture the complete picture of why he is so effective. His life revolves around many centers that comprise his social networks, understanding that every life has multiple facets and we will not be successful in our work until we help the individuals we serve make numerous connections. Neal has a family, a church community, six years in the armed services and an avid interest in sports. He has been a Mid-American Conference football official, and a Big Ten Conference football timer and replay communicator.

All of these endeavors require a dedicated focus, depth of understanding and a warm sympathetic relationship to those around him.

Sheehan *(continued from page 3)*

led by the members of the Boards of Directors of the state's public Community Mental Health centers (CMHs) and public Prepaid Inpatient Health Plans (PIHPs) – with Board members making up 2/3 of the Association's Member Assembly – the Michigan Mental Health Code (the state law under which the public BHIDD system in Michigan is governed) has not, for years, used the term "Board" to describe the local and regional organizations that make up the public BHIDD system. Additionally, none of the Association's members have the word "Board" in their names.

In addition to the new name, you will notice in this edition of *Connections*, a new Association logo. Over the past year, the Association worked to develop its new logo; a logo that stands out from the crowd; a logo that represents the Association's commitment to innovation, boldness, professionalism, accessibility and a person-centered approach to service (the latter two traits underscored by the letter C in the form of a person with his or her arms outstretched).

You will start to see the new name and logo appear in a number of ways and venues. As we noted earlier, rather than a grand announcement of the new name and logo, you will see them appearing in any of a number of uses, including on our newly redesigned website, in conference materials (starting with the Fall Association Conference), on letterhead (soon to be designed), and in all of the ways that our new name and distinctive logo will work to underscore the visibility of this Association.

The new name and logo underscore that, in the midst of the innovation required for our system to respond to an ever changing environment (both opportunities and threats), our system and this Association have never forgotten our roots in the community mental health movement – a civil rights movement in every sense of the word. A movement that is grounded in the commitment to the dignity of the person and to each person's right, regardless of ability or disability, to self-determination, full citizenship, community inclusion, and equality of opportunity.

We look forward to taking on the challenges that lie ahead, the innovations that our association and system will lead, and our continued commitment to the deep roots, proud traditions, and value-based core of the community mental health movement.

Manderscheid *(continued from page 1)*

of most of that trauma. The negative social and physical health determinants—poverty, discrimination, poor education, no job—now are recognized as major factors in poor health status and poor behavioral health status. In fact, one's zip code is highly predictive of how long one actually will live.

Thus, behavioral health now is in the very early phases of developing and implementing community-level interventions to combat these negative determinants. This change will require the adoption of population health approaches and public health strategies, in addition to our more traditional clinical interventions. As we go forward, more behavioral health providers also will have public health training and will be working in the community rather than in an office.

Our hope for 2067 is that we will be able to address our communities' negative social and physical health determinants in an effective manner, that trauma will be greatly reduced as a result, and that far fewer people will experience any behavioral health conditions.

Prevention and Promotion Regimens

One of the major advances made by the Affordable Care Act is to begin the transition from treatment only to prevention and treatment care systems. We already have introduced broad-based screening for depression and alcohol abuse, and we are implementing interventions for first episode psychosis. This work is exceptionally important. But we also must develop and implement interventions that promote positive mental and physical health. Wellness programs being operated by primary consumers and wellbeing programs being developed in the health care field represent very important early steps in this direction.

An immediate challenge going forward is how we will make these programs available to all people in our communities and particularly all who seek behavioral healthcare. Corporate America now is achieving some good progress in implementing a culture of wellbeing in the workplace. We can learn much by observing these efforts.

Our hope for 2067 is that disease prevention and health promotion efforts will be available to all Americans, and that behavioral health will become a leader and essential provider for these interventions, both in the community and in the care system.

Integration of Behavioral Health and Primary Care

Probably no other topic has consumed as much emotional energy from the behavioral health community recently as the effort to integrate mental health, substance use, and primary care services. Although the policy history of this issue extends into the past for more than three decades, actual efforts to bring about integrated care have been underway for only a small fraction of that time. Because of the severe problem of premature mortality in persons with a mental health or a

substance use condition, good integrated care must be a top priority for our field.

As we go forward, it will be very important to move beyond the coordinated care model toward full integration. Full integration means availability of a fully integrated treatment team, including a behavioral health provider and a peer support specialist, as well as integrated funding. Although some may not favor integrated funding, once accomplished, such funding likely will increase resources available for behavioral health compared to traditional carve-out models. These fully integrated delivery systems can be operated out of the behavioral health or primary care sectors. Another step just being initiated now is to extend integrated care beyond health to social services, a move that I have called the integration of everything.

Our hope for 2067 is that all consumers who need primary care services and social services will receive them when they are needed, and that every American will have a health or medical home that incorporates good behavioral health services.

Adoption of Managed Care Practice

Like care integration, managed care extends back about 30 years in our field. Originally encompassing only a small segment of behavioral health—inpatient care—it has expanded in recent years to encompass most of private sector behavioral health care and a large segment of care provided through the public sector. Most state Medicaid systems currently operate under a managed care model. Currently, it is being transformed rapidly from an external review process to one in which care providers manage themselves.

Looking forward, it is not an exaggeration to say that managed care will become ubiquitous in health and behavioral health care. As this happens, we must work to assure that all consumers receive the care and support they need at a reasonable cost. As population health approaches become more common and managed care moves toward self-management, behavioral health providers will be making these decisions themselves.

Our hope for 2067 is that managed care will fulfill the promise of bringing needed health and social services to all at a reasonable cost.

Move Toward Bundled Payment Systems

As a result of many of the developments noted above—recovery, care integration, managed care, prevention and promotion regimens—and facilitated by the focus on person-centered care, we now are beginning to move rapidly away from encounter-based payment systems. In their stead, we are developing systems based upon annual, pre-arranged capitation or case rates which are much more compatible with care delivered through a health or medical home. These systems will offer much more flexibility than more traditional payment systems.

As we develop more experience with these new capitation and case rate systems, it will be important to extend them also to encompass a full range of social services—housing, jobs, and social supports. Although it now seems intuitively obvious, we have learned from recent research that health and behavioral health services are less effective when social service needs are not met.

Our hope for 2067 is that bundled payment systems will have evolved sufficiently so that they are flexible and broad enough to meet the full range of consumers' needs.

Other Important Near-Term Developments

Our picture of the future would be very incomplete if we did not address the emerging roles of information technology, personalized medicine, and genetic interventions.

Information technology currently plays a huge role in our lives, particularly via its applications—APPS— and its social media. Both of these tools are beginning to be harnessed to provide outreach, care, and support to behavioral health clients. We also are on the cusp of beginning to understand the role of virtual reality in care delivery. As behavioral health providers adopt these technologies, the nature of our care also is likely to change in ways that we do not fully understand today.

Personalized medicine—the customization of drugs to the physiology and genetics of the person receiving them—is now in its infancy. Imagine a world in which drugs would always be effective and not have adverse side effects. Clearly, behavioral health will be confronting this reality in the intermediate- term future.

A small fraction of behavioral health conditions are known to be genetically-based. As we advance in our understanding of genetics, we also will advance in our application of technologies to alter precursors or genes so that the probability of such illnesses is greatly reduced. Just thinking ahead a little, imagine a future in which some of our more intractable diseases simply did not exist. Amazing!

Our hope for 2067 is that we will be able to harness each of these technologies effectively and that the personal and the interpersonal will remain central in all of our work.

Turning the Page

I hope that I have whetted your appetite for what is to come and have created the elements of a desired future for 2067. Clearly, the possibilities seem almost boundless, but must be governed by each of the actions we take every day, including today. I know that MACMHB will play a central role in the creation of this desired future.

Ron Manderscheid, PhD is currently executive director of the National Association of County Behavioral Health & Devopmental Disabilities Directors: www.nacbhdd.org (rmanderscheid@nacbhdd.org); and a past president of ACMHA:The College for Behavioral Health Leadership: www.acmha.org

Community Mental Health Association of Michigan
426 S WALNUT
LANSING MI 48933
Telephone: 517-374-6848
www.macmhb.org

Non-Profit Org.
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Stone *(from page 8)*

partmentalizes financial and human resources, and limits choice. The cost of sustaining such programs is burdensome, particularly so when these become little used programs sustained because the model is entrenched in the bureaucracy. These treatment monoliths have become the "Maginot line" in mental health, sustaining old thinking and associated costs, while restricting the ability of local CMHSP's to implement service innovations needed on the front line where the battle against poverty, stigma, and other obstacles to life, liberty and the pursuit of happiness is waged. In the future, services must be person/citizen centered; based on a person/citizen informed menu of options, driven by local circumstances. The future must not be about sustaining the past because the system fears the unknown and favors the familiar. Even in failure knowledge can be advanced. The system must embrace risk taking, just as the persons/citizens served do every day on their journey to recovery.

To an extent, the system that touts person centeredness has become the enemy of person centeredness. The burden of ever growing regulation is costly and it inhibits true person/citizen centeredness. Imagine if you will, Billie, who desires nothing more as her next step toward greater independence than to make her own lunch. Billie's favorite lunch is a cheese sandwich: slice of white bread, slice of cheese, slice of white bread. Before program staff, who stand ready to help Billie achieve this person/citizen centered goal, can begin they must first consult somewhere between 4000 and 5000 pages of laws, rules, regulations, contracts, and guidelines, and hold at least three meetings (assessment, pre-planning, and planning) to ensure they will do the services properly, document it properly, and report it properly. Of course, somewhere along the line "best practice" directs that the provider must "encourage" the person to consider making the sandwich with whole wheat bread (at least 12 grams of fiber) serve it with fruit (preferably Michigan cherries or apples) and so on. Somehow, preparing a twenty-five cent cheese sandwich that must be served on a twenty-five hundred dollar plate with garnish seems to be overly burdensome, expensive, and is somewhat less than in keeping with the spirit of being person/citizen centered. If the future is to be about the person/citizen, and also be about the wise stewardship of public funds, efforts must be made to re-invent the system and shed a few thousands pages of rules and regulations. Streamlining the processes will allow familiar lunches to be made and enjoyed in a timely manner while saving countless dollars wasted in processes that do not add tastiness to the sandwich or value to the system. The future must be more about outcomes than process.

The Michigan public mental health system has done well and we should all be encouraged by the progress to date. Yet future progress is not guaranteed if we continue to be focused on systems and not people. The future must be about the citizen, the person, fully engaged in life: a life spent in the exercise of liberty and in the pursuit of happiness.