Robert Gordon keynote to the Community Mental Health Association of Michigan
Tuesday, October 22, 2019
9-10 am

- On one of my first days on the job back in January, one of my first conversations was with Bob. I remember it because I was walking into the office, I didn't have a coat, and it was like twenty degrees. You are blessed to have such a brilliant and passionate advocate.
- Since January I have gotten a new coat, and I have had hundreds more discussions. There is no issue I hear about more than behavioral health. I don't care if you are a Republican or a Democrat, you are from Southeast Michigan or the Western UP, you want a strong behavioral health system. That is because this work is not an abstraction. It is not somewhere else. It about improving life for our friends, our families, and our neighbors.
- Let me begin with their stories:
    - About a young man with autism, who works retail. He lives in an apartment downtown, where he gets to listen to the music he likes, pick his roommates, and decide his own schedule—all thanks to his CMH.
    - About the woman with severe depression who is doing better because she has found a psychiatrist she connects with, and because she has a case manager who connects with her if she misses appointments. Her local clubhouse supports her, and so does a great peer support specialist
    - About the boy with anxiety, ADHD, violent outbursts, and a long history of trauma, who not only receives treatment himself, but whose whole family gets the counselling, training, and respite services they need so he can live at home, attend his local middle school, and play soccer.
    - And about the mother of two who has grappled with heroin dependence for a decade. Rather than throwing her in jail, a local drug court helped her get Medication Assisted Treatment and return to her children. Now she's working toward her best life.
- Helping people lead their best lives is what all of you in this room do each and every day. The value that animates your work is one I talk about a lot at MDHHS. It is the belief that every human being has dignity and deserves respect.
- That value is rooted in every great faith. It is rooted in our country's Constitution as it has evolved through 200 years of struggle for civil rights.
- For me personally, it is rooted in the lessons of my father: an Army veteran, a Yankees fan (sad this week), and a psychiatrist. While he had a part-time private practice that allowed me to grow up with great privilege, my Dad also always worked in New York City's public system. When I was a kid, he was the therapist working with homeless individuals on the Bowery, one of the original skid rows. I remember my father naming with respect the clients he counseled, Mr. Thomas, Mr. Lopez, always Mister. I remember the deep affection he felt for his co-workers and his clients alike. He worked there for more than a decade, until the program was shut down by a Mayor named Rudolph Giuliani. After that my dad went on to work for the city's Human Resources Administration arranging services for the people we now call returning citizens. He retired from that job a year ago, at age 81. I talked to him the other day and he is trying to figure out how to go back. As for you, it was not just a job. It is a calling.

- When I was in my 20s I helped to stand up AmeriCorps, the national service program. My boss at the time, a wonderful man who died too young named Eli Segal, used to call national service a "Swiss Army knife" because it did so many different things. CMHs are like that too. You coordinate, manage, and often provide care. You train staff. You offer a 24/7 crisis system for all Michiganders. You do jail diversion and pre-admission screening. You lead innovations in integrating behavioral health and physical health. Above all, you know your community, you know your people, and you fight for them.
- Part of our success will be identifying what we need to do better. And I will get to that. But first I want to say what is already working well in Michigan today:
    - We have one of the strongest public behavioral health systems in the country;
    - We have long been a national leader in de-institutionalization;
    - We are one of the only states to codify person-centered planning in law; and
    - We have a statewide commitment to serve not only those with Medicaid, but all people in crisis, building community continuums of care on behalf of all residents.
- Many other states are trying hard to create things we already have. What people in this room have already built.
- You succeed despite challenges. Demand has grown, especially around services for opioids and autism, while resources have not kept up. Because of pay rates and a competitive job market, you struggle to attract and retain trained professionals and direct care workers. And you operate in an enormously complex landscape—PIHPs, CMHs, MHPs, LPCs, PRTFs, QRTFs, OH-bots, PIP-bicks, and… well, I'll stop there.
- These complexities contribute to challenges in the lives of the people we serve. Here, too, I'll tell some stories.
    - About the man whose sister with intellectual disabilities, cerebral palsy, and epilepsy now faces a reduction in services. He worries about her going from a place she has made home, and going to… well he doesn't know if there is a place that will take the rate now on offer.
        - We must do better.
    - About the homeless single parent who desperately wants to enter treatment for SUD, but can't find a placement that will accept her and her child, and so the family is split up.
        - We must do better.
    - About the 10-year old boy with severe mental health challenges who has been to the emergency room 10 times in the last year. His mother doesn't know where else to take him, the EDs can only stabilize him briefly, and the last time he was stuck there for days waiting for a bed.
        - We must do better.
    - About the parents who have raised over a half million dollars to build a group home where their disabled son can lead a full life with other men his age. It's a heart-warming story, but how have we ended up in a place where parents are founding their own nonprofits just to make sure their children get the care they need?
        - We must do better.
- And I really mean that WE must do better. I am not here to lay these problems at your feet. At the Department I am privileged to lead, full of civil servants who share your values and your extraordinary dedication, we must do better. And we need to act in partnership—with the

Legislature, with the diverse stakeholders represented in this room, and most of all, with the people we serve.

- Michigan is no stranger to efforts to improve our behavioral health and IDD system. Moving from 55 CMHs to 46 CMHs as MCOs to 18 PIHPs to 10 PIHPs. Then HCBS waiver implementation followed by the HMP launch. (You cannot escape acronyms.)
- Most recently, for almost four years, our state has focused on one idea of how to do better. That idea – the so-called carve-in to Managed Care – proposed moving money from the PIHPs to the Medicaid Health Plans. The Section 298 pilot projects were established to test this concept.
- The aim of these pilots was laudable: to bring people together around an approach that would preserve what's best in our system, create financial savings that could be reinvested in services, and drive better outcomes for patients. Due to their incredibly hard work, the participants found a way forward on many issues.
- But after 19 months of negotiations, it is clear that there will be no consensus on fundamental issues. And as someone who has always had questions about whether the carve-in is the right solution, I do not believe it is my place to force the pilots forward.
- And so as many of you have heard, we are canceling the Section 298 pilots.
- I know this news may feel frustrating to some of you who spent so much time on that process. But that time was not wasted.
    - You built connections that had not existed before.
    - You taught us an enormous amount to inform future efforts.
    - And you created innovative partnerships between CMHs and Medicaid Health Plans. The Health Plans are critical parts of the health care infrastructure in Michigan, and very much the Department's partners alongside CMHs. Innovative partnerships with diverse entities will be critical our path forward. Given our shared goal to integrate frontline care, we will do everything we can to support collaborations born of section 298.
- I know many of you are delighted by the demise of section 298. Some of you might wish we could be done with discussions of system change. You may be skeptical of the motives for change. You may think the system works well enough. You may believe the path forward is incremental change and increased funding.
- Let me tell you one point we can agree on. The system does need more funding. When I came to town in January, your Medicaid rates for 2019 were already set. But as the year went on, we looked at the data and saw the rates were insufficient. We requested $50 million more in 2019. One of many problems we have with the budget is that it failed to fund that $50 million. I hope you and Bob will keep fighting for it.
- For 2020, our Medicaid rates reflect an estimated increase of $134 million. And that will mean relief you and your residents need and deserve.
- If I can mention one smaller item you may not know about: As part of the agreement to build a new psychiatric hospital in Caro, Governor Whitmer insisted on $5 million for community-based outpatient services, for individuals who might be placed in a state hospital, or who are in a hospital ready to be discharged and could be served nearer their loved ones. Is that money enough to get people out of emergency rooms where they do not belong? No. Is it a small but important victory? Yes.

- We need more such victories, and we'll fight for them. But there is limit to the funding we will see here in Michigan. This is a state, after all, that has not yet agreed to fix potholed roads that most of us drive each day.
- Much as money matters, pressing for it is not enough.
- Very briefly now, I want to do three things: make a case for why we need fundamental system changes; describe some of the values behind those changes; and tell you the process we envision to get them done.
- Let me start by restating strengths of our current system which we must build on:
    - a strong commitment to person-centered planning and self-determination that allows individuals to live fulfilling lives in their communities as much as possible
    - a well-developed public system that is deeply connected to local communities and plays critical safety net and crisis functions for all Michiganders, not just Medicaid beneficiaries;
    - a comprehensive benefits package, particularly with the recent addition of autism benefits;
    - and most important, thousands of stories like the ones I started with, about residents whose lives are better because of the system's work.
- Now to the challenges. I used to have a boss who joked that when you had a hard problem in public policy, what you really needed was a blue-ribbon panel. Didn't matter who was on it, but the most important thing was that the panel be blue-ribbon.
- Well, we have had a lot of blue-ribbon panels on behavioral health in Michigan, including the Section 298 workgroup, the CARES Taskforce, the Mental Health Diversion Council, the Michigan Inpatient Psychiatric Care Improvement Project, and the Altarum projects. These many workgroups are a testament to how many leaders in our state care about progress on behavioral health. And they give us a great foundation on which to build.
- Informed by their work, I want to describe the challenges we face:
    - First, individuals experience gaps in care because of our system's separate managed care entities, networks, and payment processes for physical and behavioral health. Too often, doctors don't communicate information to each other. Too often, individuals have two care managers trying to do the same job, or otherwise they have none at all. Too often, patients don't get the coordinated care they need.
    - Second, multiple payors means that when the people in this room not only improve patient outcomes but also reduce the costs of physical health care, the savings are captured by health plans, not reinvested in behavioral health care. In a system so badly stretched, you are denied resources you have earned through your success. Residents are denied behavioral health resources needed for theirs.
    - Third, many individuals cannot find the right services. Residents should have choices, but today, even experienced navigators can struggle to locate one option. If you don't like that option, your only resort is an appeal. The services people get often depend on the quality of their advocacy (and hence their resources), not the level of need.
    - Fourth, for some services, no amount of expertise or advocacy will suffice. I touched on one example earlier, intensive outpatient services that keep individuals in the community. But there are others.
        - We are short psychiatrists.

        - We are short drug treatment providers to meet demand in some areas hard hit by the opioid epidemic, like Metro Detroit and the UP
        - Michigan does not have a crisis respite system.
        - Then there are our direct care workers. These individuals do demanding and intimate work, showing love for individuals all of us love. For this they are usually paid near the minimum wage. Of course we face shortages and turnover.
    - Fifth, the challenges are especially acute when our own complex systems must coordinate with other complex systems: foster care, schools, prisons and jails. The challenges here are even greater—but so too are the opportunities.
    - Finally, I would be less than truthful if I did not speak to governance and management issues. In recent year, the state has spent millions of dollars closing the books in the behavioral health system, with $14 million more needed to close out Fiscal Years 2018 and 2019. Because these are dollars to address spending beyond budgeted rates, there is no federal match. All of us would like to do better. In truth, the state has few options to address performance problems within PIHPs, which after all face no competition within their regions. PIHPs feel they have few options to address performance problems within CMHs. CMHs feel they have few options to address performance problems among providers. And providers often feel they get too few of the dollars coming from the state while they struggle with too many differences and complexities across PIHPs and CMHs. It is not good for anyone. Inadequate accountability makes public institutions less sustainable both financially and politically. And it hurts the people we are here to serve.
- Now, considering all the challenges I've outlined, we could tackle one or another problem with one or another reform. But if we truly want to serve the whole person seamlessly; if we truly want to capture more of the dollars we're spending today for behavioral health; if we truly want to expand choice, rationalize spending, and create manageable but meaningful accountability, then we will need bold reform, including financial integration. The 298 pilot structure was not the solution, but that does not mean we should stop trying. The carve-in was not the right path to financial integration, but there are other paths—including other paths that increase choices for residents; that leverage competition to improve outcomes; and that better honor the convictions of the people in this room.
- As I have said, we will build on the best of what we already have:
    - A strong public system offering critical crisis safety net and community benefit services
    - The learning from the listening sessions and work groups of recent years
    - And our core commitments: person-centered, community-based, recovery-oriented, culturally competent care, aimed at self-determination and community inclusion.
- In the coming weeks, my team and I will announce details about our vision for a stronger, more sustainable behavioral health system. It will take careful collaboration with all of you: CMHs, PIHPs, health plans, families and individuals served, providers, advocates, and more. And we will work closely with leaders in the legislature. Republican and Democrat, every member I talk with wants the system to work better.
- We'll be laying out a framework and direction for change so that we can actually move forward this time, rather than go through another round of blue-ribbon meetings.
- But we will need all of your thoughts, input, and expertise in order to move forward effectively, so that a changed system works for our people and our state. We will let you know soon how we see this process unfolding.

- Truth be told, you are not going to agree with everything we say. Policymaking is hard, and people balancing different interests in good faith will reach different conclusions. But this I can promise with confidence: we will listen to the voices in this room, and we will find a sound path forward.
- So we look forward to finding that path with you. So our brothers with developmental disabilities can stay in the places they call home. So our sisters living with severe depression have the support to live stable and dignified lives. And so our sons and daughters stay out of the emergency room and on the soccer fields with their peers.
- The road will turn, but the individuals we serve will always be our north star. They point the way. They are the reason we work. And they are the reason we will succeed in building a system that works better for all Michiganders.