

My name is Lisa Hinkson and I am the Chief Executive Officer for Hiawatha Behavioral Health, providing support and treatment in Chippewa, Mackinac and Schoolcraft counties here in the Upper Peninsula.

I have 3 major areas of concern regarding the current Community Mental Health system in Michigan.

First, since the advent of Managed Care and the State's dependence on Medicaid funding, we have seen a transition from serving everyone in our community with mental health needs to serving only those who meet "specialty criteria", those with only the most severe and persistent forms of mental illness, serious emotional disturbance and developmental disability. This has left the majority of our citizens with no access to help. There are almost no private sector providers to fill the gap, especially since many of the individuals needing services can be counted among the working poor – those who have no health insurance and cannot afford to pay the high cost of accessing what few specialists may be available in the region. Medicaid expansion is critical for this population and the UP as a whole, however, without adequate providers (who can provide services without all the costly mandates the CMH system operates under), expanding Medicaid alone will not provide a solution.

The second major concern is adequate funding. The Upper Peninsula has received reductions in Medicaid for the past several years, as a result of a "demographic factor" applied during the allocation process. This has resulted in our current Medicaid funding position being at 2008 levels, while costs for utilities, food, fuel, health insurance, state purchased services and unfunded mandates have continued to climb, unabated. At this point, I believe 4 out of the 5 CMH Boards up here are running in deficit positions, despite staff and benefit reductions, and other efficiency measures they have taken. Service demand has been increasing steadily and, given the entitlement status of services under Medicaid and the incredibly broad benefit plan, either the plan is not affordable or the system requires a significant investment in new revenues to sustain it.

My third concern ties in with both the first and second issues I have spoken about and that is the failure of the state to recognize the vast difference between rural and urban service delivery. What works economically in Detroit does not necessarily translate well in the UP. In the past, the UP CMH Boards did an excellent job of providing services in creative ways to make them affordable and available. With the push for the utilization of "evidence-based practices" the state is emphasizing rigid fidelity to models without consideration of economies necessary to make these practices affordable or even feasible with small number of participants. Often times, the philosophy scales but the structure does not. I will provide an example – Crisis Stabilization and Crisis Residential. Several years ago, Hiawatha Behavioral Health provided individuals an option to receive crisis services in a two bedroom apartment that was attached to a group home we operated, rather than be admitted into a psychiatric hospital. Because of its proximity to the group home, we had ready access to a pool of trained management and staff and could turn the service on or off, as demand indicated. We had tried to contract this out previously but there simply wasn't enough volume to retain staff for the contractor. Licensing required that the apartment be licensed since it was attached to a licensed facility; DCH would not allow crisis stabilization to occur in a licensed facility, even though the apartment was not used as part of the group home. And the "fidelity" requirements for Crisis Residential required management by a full time master's level staff, plus aide staff, plus a set number of nursing hours per resident AND psychiatric availability on site. If we were able to divert 100% of our hospital admissions, we would serve only 1.3 people per day, at a

cost of roughly \$400,000 per year. Most of our psychiatry is provided via televideo, which excludes our ability to provide either service according to the model. Given that 70% of rural counties in America have no access to adult psychiatry and 95% have no access to child psychiatry, this requirement leaves rural America dead in the water in terms of making these services available. In contrast to "fidelity" considerations, the response from consumers for this modified service we provided was 100% positive and saved our system significant costs when compared to a hospital stay. This is just one example of a one-size-fits-all mentality that is hindering access to reasonable services to more citizens.

I appreciate your time, I wish you well in your efforts to improve our system and I thank you for this opportunity to speak to this commission.