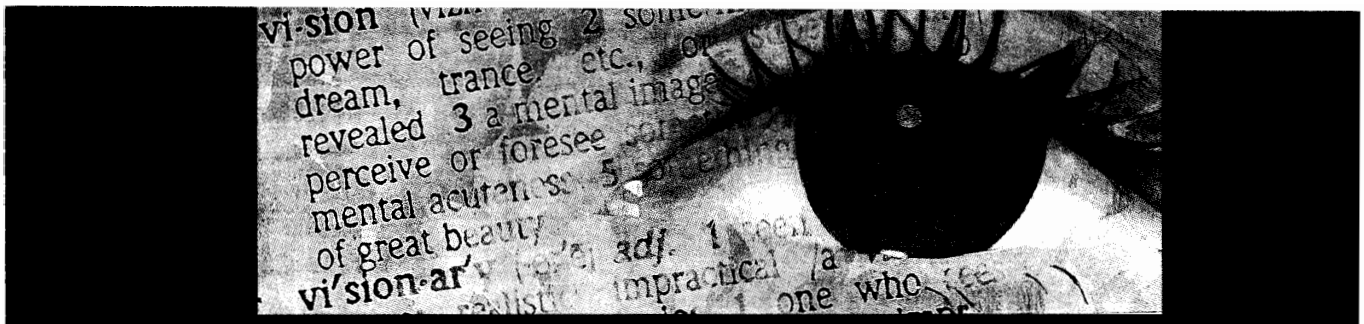

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Public Behavioral Healthcare: Managing to Change

NEW PUBLIC MANAGED behavioral healthcare initiatives are beginning all across the country, including planning efforts, waivers, and major procurements. Public behavioral health departments need to reorganize to administer these programs effectively. Provider systems are also changing, as evidenced by the frequency of mergers, acquisitions, and joint ventures of providers. The number of states involved in major new initiatives has accelerated in recent years and will likely be sustained over the next decade with more Medicaid reforms, implementation of Medicare changes, and continued deinstitutionalization. Public officials and provider managers are acquiring new skills and responsibilities, and learning new operating procedures. This paper discusses some dynamics of this "cultural change" and describes options and recommendations for the future of public behavioral healthcare systems.

Managed care has many benefits. Three primary motivations drive the need for managed care in behavioral health services.

- More effective and accountable use of scarce resources
- Reduced cost of government
- Privatized government functions

In some public behavioral health agencies, the shift to managed care is sought or welcomed by leadership. In others it is resisted, forced on agencies by Medicaid reforms or directives from senior executives or elected officials. Many argue that radical change is good for government, because it forces the reexamination of policies and procedures. Virtually everywhere that managed care initiatives are undertaken, senior officials show urgency for the reforms but are anxious about how to implement them. Three reasons for the resistance to change are common.

Change is hard and time consuming. A basic law of systems states that change requires energy. Personal improvement, like organizational change, is not easy and requires commitment and resources. People develop reasons not to change and excuses for delays. "This too shall pass" is often heard in advance of large reorganizations. Change in large organizations often includes the need for new procedures, new relationships, and changes in reporting methods, all of which take considerable staff time and energy.

Power and influence changes. New managed care systems will involve significant shifts in power and influence within the public mental health authority. Change of this magnitude is rarely seen as a win-win proposition by those affected. Managers will have a new relationship with a managed care organization, and more limited control over day-to-day decisions. Managed care requires new ways of managing.

Resources are redistributed. Change in the distribution of existing resources, including jobs, provider reimbursement, and consumer benefits, is probably the greatest source of resistance to change in mental healthcare (or any organization). This is the most difficult resistance to overcome, even with a clear, unambiguous rationale based on valid data. Employees and providers, with the best of motives but unmistakable self-interest, are often a loud source of resistance, while consumers may fear the loss of valued programs and arbitrary benefit limits.

The leaders of public behavioral health agencies may not know whether to resist or embrace the changes of managed care. But the economics of implementing managed care in public behavioral health delivery systems are too compelling to resist for long.

Ideally, the first states and public agencies to implement managed behavioral healthcare provide a road map for those that follow. To some extent this is occurring; however, there are enough differences among each state or county so that each must chart its own course. Variations include

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