Mid-State Health Network

October 2017 Newsletter

From the CEO's Desk

Joseph Sedlock

Chief Executive Officer

The worst mass murder in our country's modern history was just committed a few days ago in Las Vegas, Nevada. This horrifying event, involving the murders of nearly 60 people and the serious injury of 500 others naturally causes us to question the motives, precursors and factors in the mind of the perpetrator(s).

Unfortunately, the occurrences of mass shootings in our country also spawns criticism of the nation's mental health system; often in the absence of any evidence of perpetrator mental illness, and often in direct contradiction to the facts of a particular critical incident. We are providing below some misperceptions that are common in relation to mass shootings and mental illness along with some evidence-based facts. These are drawn directly from a chapter of a book published by the American Psychiatric Association in 2016. A link to that chapter is provided at the end of this article.

Common Misperceptions:

- "Mass shootings by people with serious mental illness represent the most significant relationship between gun violence and mental illness."
- "People with serious mental illness should be considered dangerous."
- "Gun laws focusing on people with mental illness or with a psychiatric diagnosis can effectively prevent mass shootings."
- "Gun laws focusing on people with mental illness or a psychiatric diagnosis are reasonable, even if they add to the stigma already associated with mental illness."

Evidence-Based Facts:

- "Mass shootings by people with serious mental illness represent less than 1% of all yearly gun-related homicides. In contrast, deaths by suicide using firearms account for the majority of yearly gun-related deaths."
- "The overall contribution of people with serious mental illness to violent crimes is only about 3%. When these crimes are examined in detail, an even smaller percentage of them are found to involve firearms."
- "Laws intended to reduce gun violence that focus on a population representing less than 3% of all gun violence will be extremely low yield, ineffective, and wasteful of scarce resources. Perpetrators of mass shootings are unlikely to have a history of involuntary psychiatric hospitalization. Thus, databases intended to restrict access to guns and established by guns laws that broadly target people with mental illness will not capture this group of individuals."
- "Gun restriction laws focusing on people with mental illness perpetuate the myth that mental illness leads to violence, as well as the misperception that gun violence and mental illness are strongly linked."
- "Stigma represents a major barrier to access and treatment of mental illness, which in turn increases the public health burden."

We are inclined to believe that the perpetrators of mass shootings must be "crazy." Their actions can certainly justify such a conclusion. But we must take a stand to differentiate the actions of people that we can't rationally understand (and call "crazy") from people with brain illnesses. We must resist blaming people with mental illnesses for perpetrating violent crimes, including mass shootings. The evidence just doesn't support it. Blaming the mental health system is equally inappropriate. People with mental illness are not dangerous. And they are not the people we should most be worried about in this debate.

For more information, please follow this link.

Please contact Joe Sedlock with questions or concerns related to the above information and/or MSHN Administration at Joseph.Sedlock@midstatehealthnetwork.org.

Organizational Updates

Amanda Horgan

Deputy Director

Welcome to MSHN's Medical Director
Mid-State Health Network is pleased to announce that Zakia Alavi, MD, has been named its Chief Medical Officer. Dr. Alavi onboarded with our organization in September 2017 and officially stepped into her new part-time role with us on October 1. Dr. Alavi is a Diplomate of the American Board of Psychiatry and Neurology in adult, child and adolescent psychiatry. She is also a member of the American Academy of Child and Adolescent Psychiatry and the Michigan State Medical Society. Dr. Alavi works as an Assistant Professor in the Office of Medical Education, Research and Development and the Department of Pediatrics and Human Development in the College of Medicine at Michigan State University. Dr. Alavi joins our organization in partnership and

collaboration with our Addictions Medical Director, Dr. Bruce Springer.

Mid-State Health Network gratefully acknowledges the contributions of Dr. Roderick Smith from Bay-Arenac Behavioral Health as our Medical Director for the past three years. Dr. Smith has been an asset to our organization, to our region, and to the recipients served. Dr. Smith will continue in his role as Medical Director of Bay-Arenac Behavioral Health as our valued colleague.

Please join us in celebrating Dr. Smith's contributions and in welcoming Dr. Zakia Alavi to our organization.

Please contact Amanda Horgan with questions or concerns related to MSHN organization and/or the above information at Amanda.Horgan@midstatehealthnetwork.org.

Information Technology

Forest Goodrich

Chief Information Officer

Much of the difficult work for MSHN staff is complete, and PCE Systems is working with the design materials to create a Managed Care Information System and workflow that meets these specifications. PCE Systems is on track to provide MSHN staff a training version of the system with data included during early November. We have started communications with the SUD providers and CMHSPs regarding system conversion and training. We are working on securing training dates and locations to be held in January. The project is on schedule with a go-live date of February 1, 2018.

As previously discussed, Great Lakes Health Connect is a health information exchange entity and has a majority of hospital providers contributing information to the exchange. MSHN has agreed to participate with this exchange to provide MSHN staff with physical health information. This aligns with the strategic plan and our continuing effort to obtain health care data, and make it available for treatment coordination and healthcare operations. MSHN utilization management staff have been trained on the software and have begun evaluating it.

This time of the year brings extra work for technology staff at MSHN and with the CMHSPs because we approach the MDHHS year-end reporting deadline. The additional work is ensuring that all data is submitted and of the best quality possible, as well as new data elements/reporting requirements for the new year.

Please contact Forest Goodrich with questions or concerns related to MSHN Information Technology and/or the above information at Forest.Goodrich@midstatehealthnetwork.org.

Finance News

Leslie Thomas

Chief Financial Officer

The Finance Department has completed its Fiscal Year 2016 Financial Audit and Compliance Examination. Although MSHN's auditors have completed their work, we have been unable to finalize the Compliance examination due to one CMH not submitting a final report. MSHN delays submission to MDHHS in order to ensure our final Compliance Exam contains all adjustments from our CMHSPs. These items will be presented to the board of directors in the near future. We have developed numerous fiscal reports for presentation to MSHN's Operations and Finance Councils. The intent of the reports is to provide more useful information for decision making purposes. It also enhances accountability for the information being reported to and by MSHN on an interim basis.

Finance staff is heavily involved in the Managed Care Information System (MCIS) implementation by participating in team meetings and providing data and process information to PCE (IT vendor).

For Fiscal Year 2017, MSHN projected a $1.3 million dollar deficit in block grant funding. MSHN requested an increase from MDHHS to cover this deficit, and was granted the additional funding.

MDHHS has increased SUD Medicaid and Healthy MI funding for Fiscal Year 2018. This increase is needed since MSHN covered nearly $4 million in SUD spending with savings for Fiscal Year 2016 and project the same for Fiscal Year 2017. There has also been an increase in the number of consumers receiving services, which also drives costs. MSHN continues to work with certain Substance Abuse Prevention and Treatment (SAPT) providers in assessing their fiscal payment arrangements. Numerous efforts have been made to resolve provider concerns as it relates to contract changes, and to also provide technical assistance needed in order to reach certain utilization and spending targets. MSHN has implemented several cost containment efforts related to SUD services to ensure consumers receive medically necessary services in the most fiscally responsible way.

Please contact Leslie Thomas with questions or concerns related to MSHN Finance and/or the above information at Leslie.Thomas@midstatehealthnetwork.org.

Utilization Management

Dr. Todd Lewicki, PhD, LMSW

Utilization Management & Waiver Director

MSHN Overall Penetration Rate Increasing

Mid-State Health Network (MSHN) reviews penetration rate data relating to Medicaid, Healthy Michigan Plan (HMP), and MSHN as a coordinating agency (CA) for persons with substance use disorders (SUD). Penetration rate is a metric use in understanding the degree to which persons eligible for Medicaid or Healthy Michigan in a catchment area actually access services. Those that access services "penetrate" the system. The percentage reported is composed of the number of persons in Services as the numerator over the total eligible in a catchment area as the denominator. The target for growth is 10% and the MSHN Utilization Management Committee (UMC) reviews the data and discusses efforts around continuing to improve opportunities for services for eligible persons. In the percent change (to same time last year) through May 2017, the MSHN

Community Mental Health Service Program (CMHSP) Medicaid penetration rate is at 1.62%, continuing to trend up steadily since August 2016. The MSHN CA has been trending up notably since October 2016, with an 18.16% spike in April, and a May rate of 11.22%. For HMP, MSHN has also seen a steady increase since March 2016, going as high as 12.56% in February 2017, with a May rate of 10.73%. MSHN CA penetration rate has been the most notable with 39.15% in May. This means that when combining the Medicaid and HMP total penetration rates, MSHN is at 3.56% for CMHSP consumers, and 26.81% for the SUD system. In general, this shows steady increases in serving all eligible individuals in the MSHN region. This may also be indicative of more persons with SUD more actively reaching out for treatment, but that this number is rising.

Penetration rate is often a challenging measure to evaluate as it is difficult to isolate specific PIHP and CMHSP initiatives or variables that influence the individual choosing to request services, either through the CMHSP or for SUD services. While it is difficult to isolate reasons for serving an increased number of individuals, the MSHN CMHSP system has been working actively on efforts toward outreach, co-location of services (e.g. a therapist who is given space in a physician's office), increased collaboration with physicians, new satellite offices, work with the school system, decreasing the impact of stigma, CMHSP rebranding, and work with local coalitions. MSHN and its partners will continue to look at what factors positively impact increasing services to eligible individuals, and provide the depth of understanding necessary to bring about positive change at the local level.

Population Health & Integrated Care Updates
Skye Pletcher, LPC, CAADC & Todd Lewicki, PhD, LMSW

FY17 has been a year of growth and expansion at MSHN in the areas of population health and integrated care. There is continued focus on increasing MSHN's understanding of the health needs of the individuals in our 21 counties and finding innovative ways to achieve the goal of the Triple Aim: better health, better care and better value.

Care Coordination with Medicaid Health Plans
One of MSHN's population health and integrated care initiatives include monthly meeting participation with each of the 8 Medicaid Health Plans (MHPs) in the MSHN region, for the purpose of care coordination for identified mutual high-risk members.

Members are identified using risk criteria which include: number of emergency room visits in the past 12 months, lack of engagement with a primary care physician in the past 12 months, total number of inpatient hospital admissions for physical health and/or behavioral health reasons in the past 12 months, and total number of chronic health conditions (including behavioral health and physical health conditions). During FY17, MSHN participated in 96 monthly care coordination meetings with our MHP partners and participated in developing joint care plans for 116 high-risk individuals. Outcomes of

these care coordination efforts include:

- 88% of individuals with a joint care plan saw a primary care physician within the last 12 months (as of September 2017);
- 77% of individuals with a joint care plan experienced a reduction in emergency room utilization; &
- 75% of individuals with a joint care plan experienced a reduction in inpatient hospital admissions.

Please contact Dr. Todd Lewicki with questions or concerns related to MSHN Utilization Management and/or the above information at Todd.Lewicki@midstatehealthnetwork.org.

Treatment & Prevention

Dr. Dani Meier, PhD, MSW

Chief Clinical Officer

MSHN Veteran Suicides

Kevin Thompson, LLMSW, Sgt. USMC (Sep) & Dani Meier, PhD, MSW

Part of MSHN's strategic plan includes improving access and delivery of services to Veterans, active military and military families. The recent Veterans Affairs' report, "Suicide Among Veterans and Other Americans, 2001-2014," offers the most current and comprehensive analysis yet of Veteran suicides in the U.S., examining more than 55 million records from 1979 to 2014 (The full report can be viewed HERE).

Despite Michigan's VA Medical Centers, multiple Community Based Outpatient Clinics (CBOCS), and MSHN's 12 CMHSPs and 100+ regional substance use disorder (SUD) programs, Michigan ranks 19th in the U.S. for Veteran suicides. Of Michigan's 1,300 identified suicides in 2014, 213 were Veterans across the age spectrum. The challenge is not a lack of services, but breaking down stigma towards mental illness and addictive disorders, both from the public and from Veterans themselves. Veterans' experience embarrassment and shame about their struggles (e.g. with reintegration post-deployment). Many Veterans relied on their internal strengths to get them through the rigors of military training and combat. Having witnessed the worst of humanity after multiple tours of duty, it's hard for Veterans to realize, much less accept, that the biggest danger they face post-deployment is themselves. It's a danger that is amplified when Veterans won't ask for help.

Suicide awareness and the reduction of stigma is critical for Veterans and for providers who sometimes inadvertently perpetuate stigma. MSHN's Veteran Navigator, USMC Veteran, Sgt. Kevin Thompson, came on board this past summer from The Right Door. He is tasked with acting on the MDHHS Strategic Plan for Veterans, which includes raising awareness, reducing stigma, and building military cultural competence in our provider network.

Age Group	Michigan Veteran Suicides	Michigan Total Suicides	Midwestern Region Total Suicides	National Total Suicides
Total	**213**	**1,300**	**8,702**	**41,425**
18-34	46	370	2,411	10,732
35-54	73	479	3,304	15,473
55-74	67	350	2,299	11,637
75+	27	101	688	3,583

Please contact Dr. Dani Meier with questions or concerns related to MSHN Clinical Operations and/or the above information at Dani.Meier@midstatehealthnetwork.org.

Provider Network Updates

Carolyn T. Watters, MA

Director of Provider Network Management Services

MSHN Regional Inpatient Operations Workgroup

In February, the MSHN Operations Council commissioned an ad hoc, temporary, workgroup charged with making recommendations to MSHN and participating CMHSPs on the standardization of clinical and administrative procedures, forms, tools and systems associated with psychiatric inpatient care, provider network procurement (including contracting), provider network management (including provider performance monitoring and performance improvement), and other related systems. The workgroup was made up of staff representing Emergency Services Operations, Clinical Operations, Provider Network Operations, and Finance Operations. The workgroup met monthly; in September, work was concluded and the workgroup set forth a final set of recommendations to the MSHN Operations Council, which includes the following:

- Adoption of the regional inpatient contract;
- Adoption of the statewide inpatient monitoring protocol; &
- Development of a strategy to negotiate/achieve the lowest rate per hospital.

Upon approval from Operations Council, we expect that CMHSPs to execute the regional inpatient contract for any new contract or contract renewal, occurring on or after April 1, 2018, with all CMHSPs utilizing the contract by October 1, 2018. We appreciate the time and effort of all workgroup members who participated.

Quality Assurance and Performance Improvement

Over the past several months, two Quality Assurance and Performance Improvement (QAPI) staff were added to the Provider Network Management team. Their primary responsibility is to manage the entire site review process in accordance with MSHN contractual obligations and related MSHN policies and procedures. They conduct on-site and desk audits of both CMHSPs and SUD providers, ensuring compliance with delegated functions, clinical care and documentation. Additionally, the QAPI team will lead intra-regional reciprocity efforts in support of the statewide inpatient monitoring protocol adopted by all 10 PIHPs. Other exciting improvements on the horizon include the implementation of an auditing module in the Managed Care Information System which will streamline the process for documenting results of audits, and the development of qualitative and quantitative reports and supporting the development of a provider scorecard. Please help me in welcoming Amy Dillon and Melissa Davis to the

Provider Network Management team.

Please contact Carolyn Watters with questions or concerns related to MSHN Provider Network Management, and/or the above information, at

Carolyn.Watters@midstatehealthnetwork.org.

Quality, Compliance & Customer Service

Kim Zimmerman

Director of Quality, Compliance and Customer Service

Regional Consumer Advisory Council Update

The Regional Consumer Advisory Council (RCAC) provides a direct link to MSHN Leadership and the Board of Directors for consumer input. The Consumer Advisory Council includes representatives from all CMHSP Participants, and represents the populations served by our region, including individuals with mental illness, developmental disabilities, substance use disorders and children's services.

The Council elected to increase their meeting frequency during this past year, moving to meeting every other month, instead of quarterly meetings. The Council made this decision to ensure more timely review of information related to services, policies, processes and survey results. The additional meetings also allow for a more thorough review of information, and allows the members to provide feedback on current issues.

Some of the recent accomplishments of the Council included review and input on the following:

- FY17 Mental Health Statistics Improvement Program(MHSIP) and the Youth Satisfaction Surveys (YSS) completed for consumers who receive services from Home Based programs and Assertive Community Treatment (ACT) programs;
- Substance Use Disorder satisfaction survey results for FY17;
- Performance Indicators summary report reviews for FY16 Q4, FY17 Q1 and Q2;
- Grievance and Appeals summary report for FY16 Q3 & Q4 and FY17 Q1 & Q2;
- Behavior Treatment summary report for FY17 Q1 and Q2;
- Compliance Summary Report for FY16;
- Quality Improvement Council/Customer Services Committee scorecard reports;
- Review of MSHN policies and procedures related to Customer Service;
- Recovery Assessment Scale (RAS) satisfaction survey summary report for FY17 (consumer survey); &
- Recovery Self-Assessment Survey summary report for FY17 (MI program supervisory survey).

The Council also received periodic updates and education on the following:

- MSHN's Strategic Plan

- MSHN's Strategic Plan;
- Section 298 Legislation and Advocacy Efforts; &
- MSHN Balanced Scorecard.

The Council has been working on increasing the communication from the local level advisory councils to the regional council. The Council now has dedicated time during each of the meetings to discuss what consumer involved efforts are happening locally at each CMHSP, and each member is taking the information from our council back to their local committees for review and feedback. The Council is continuing to work on additional efforts to increase communication and consumer input.

Please contact Kim Zimmerman with questions or concerns related to MSHN Quality, Compliance or Customer Service at Kim.Zimmerman@midstatehealthnetwork.org.

Mid-State Health Network (MSHN) exists to ensure access to high-quality, locally-delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

STAY CONNECTED