MSHN
Mid-State Health Network
www.midstatehealthnetwork.org

Board Newsletter August 2020

From the Chief Executive Officer's Desk

Joseph Sedlock

Perhaps as board members, you wouldn't know that one of the key activities conducted by Mid-State Health Network and our substance abuse prevention providers is prevention and reduction of youth access to nicotine-containing tobacco products. In July 1992, Congress enacted the Alcohol, Drug Abuse, and Mental Health Reorganization Act, which includes an amendment, the Synar Amendment, aimed at decreasing youth access to tobacco. The amendment required states to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under 18 years.

Among other things, the Synar Amendment penalizes states with youth tobacco sales percentages higher than 20% by withholding a significant portion of State Substance Abuse Prevention and Treatment Block Grant funding, requires annual, unannounced inspections that provide a valid probability sample of tobacco sales outlets accessible to minors, requires retailer education to prevent youth access to tobacco, and take other actions intended to reduce/prevent youth access to tobacco.

Mid-State Health Network receives tobacco retailer lists from the State of Michigan: gas stations, bars, convenience stores, pharmacies, grocery stores, vending machines, hotels, restaurants – any establishment that is known to sell tobacco products. MSHN-contracted prevention providers must physically confirm these lists, errors corrected, closed retailers deleted, and new tobacco retailers added. This work alone consumes hundreds of person-hours each year. The MSHN-contracted providers also provide retailer education materials (in-store posters, worker training brochures/materials, etc.).

Mid-State Health Network contracted prevention providers must also deploy Youth Inspectors under provider-staff and law enforcement supervision to attempt to purchase tobacco products at a State-selected sample of tobacco retailers (using the confirmed retailer lists described above) which, in combination across the State, represent a statistically valid retailer sample. Youth Inspectors, who are individuals under legal purchasing age for tobacco products operating with parental consent, are paid for their work and are covered by Worker's Compensation Insurance during their work with our prevention providers.

The youth inspector reports on tobacco retailer compliance with ID checks at the point of sale. During a formal Synar check, if the Youth Inspector successfully purchases tobacco products, the retail outlet owner receives notice of the failed compliance check at a later date (they cannot be told they had a compliance check at the time). We are also required to conduct informal checks. During these non-Synar checks, retail clerks that sell tobacco products to underage Youth Inspectors may be issued a ticket by police. Retailer education is provided for all tobacco retailers, including that do not pass the compliance check.

All of these activities consume thousands of person-hours per year but have successfully prevented youth access to tobacco products in our region and across the State.

The table below shows the aggregate sales rate (compliance check fail rate) for the MSHN region:

Synar Compliance Check Year	Synar Sales Rate	Statewide Synar Sales Rate
2014	13.8%	18.0%
2015	7.5%	15.5%
2016	18.0%	13.1%
2017	11.8%	10.7%
2018	16.1%	9.9%
2019	11.9%	10.5%

The work performed by the MSHN-contract substance abuse prevention programs associated with reducing youth access to tobacco is often misunderstood, often goes unnoticed, and is often not highlighted. You can help! This month take a moment when you're in a retail outlet to thank the clerk for checking IDs of individuals attempting to purchase tobacco (or alcohol for that matter). Recognition goes a long way toward helping our providers in their retailer education activities and in promoting acceptance of ID checks as a necessary part of prevention underage youth access to tobacco.

Contact Joe with any questions, comments or concerns related to the above and/or MSHN administration at Joseph.Sedlock@mistatehealthnetwork.org.

Organizational Updates

Amanda Ittner, MBA

Deputy Director

While COVID-19 related questions from the field and new state guidance documents have started to decline over July, MSHN Leadership has started our planning and strategy for the future. What will be the new normal? What will the budget, staffing, and contractor resource needs look like next fiscal year?

These are the questions our administration is planning to address. Throughout the summer, our leaders typically go through planning for year-end and determining what the new year will bring, but this year will be even more challenging.

New Normal? Well, that's an ever-changing question. What we do know is that when our employees can return to the office and community-based work, they will be required to be screened for COVID-19, and administration is required to monitor and track screenings.

The screening process is to ensure the safety of the employees, visitors, and the community. In cooperation with the Chief Information Officer, MSHN has reviewed three different platforms for employee COVID screening and has selected a product that allows flexibility and ease for both the employee and administration. The product is in the development and testing phase and will be implemented for all staff when MSHN is ready for the new normal state of business.

In addition, our Leaders have been reviewing budgets and expenditure needs for the remaining fiscal year and planning for the fiscal year 2021. Discussion on future demand for services related to COVID-19, related trauma and addressing health disparities have been just some of the topics being evaluated, along with possible areas to reduce administrative expenses such as in-person conferences, meals, and provider onsite training facility cost, while still ensuring sufficient training needs are met by encouraging virtual participation.

MSHN faces a challenging year ahead, but we are thankful for our Board of Directors, Community Mental Health Partners, and Substance Use Disorder Network that has continued to manage our region's resources effectively while ensuring sufficient funds to meet the increasing demand and providing quality essential services.

Contact Amanda with any MSHN Organizational related questions at Amanda.Ittner@midstatehealthnetwork.org

Information Technology

Forest Goodrich

Chief Information Officer

Mid-State Health Network technology staff spent most of the time this period supporting MDHHS audit processes and developing reports for managers that can assist with COVID-19 tracking, Military service tracking, and health disparities evaluation throughout the region.

A review process was conducted of several health screening tools that can easily be implemented for staff to use to ensure safety with office-based and community events. The selected tool is setup and ready for use as needed.

The health information exchange work with MDHHS and MiHIN continues as we are engaging in two new pilot projects: care coordination and electronic consent. We also completed work on a standard template for admission, discharge and transfer transactions for Behavioral Health (BH ADT). Information Technology Council is developing a plan for providing this data in the exchange during fiscal year 2021.

Contact Forest with any questions, comments or concerns related to the above and/or MSHN Information Technology at forest.goodrich@midstatehealthnetwork.org

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Finance

Leslie Thomas, MBA, CPA

Chief Financial Officer

MSHN's Finance Team has been working diligently to support its Community Mental Health Services Programs (CMHSPs) and Substance Abuse Prevention and Treatment (SAPT) providers. MSHN has developed regional guidance based on MDHHS and Governor issued mandates related the following:

- Direct Care Worker (DCW) Wage Increases – As reported in June Board Newsletter, per legislative mandate MSHN's regional guidance outlines distribution of $2 per hour increase for DCW workers providing in person residential services and fund an additional 12% to cover administrative items such as taxes. The DCW premium pay funding was initially set to expire on June 30, 2020 but has since been approved through the end of this fiscal year (September 30, 2020). The legislative mandate also includes premium pay distribution to SAPT Residential and Withdrawal Management programs in the same manner as CMHSP DCW. Further, MSHN is reimbursing Personal Protection Equipment (PPE) expenses purchased in the identified settings. MDHHS has funded MSHN's region for DCW premium pay through June 30, 2020. The last quarter will be funded prior to the end of this fiscal year.
- SAPT Provider Network Fiscal Assistance – MSHN issued over $1.5 M to its SAPT network since April to ensure continued operations and stabilize the network for the provision of ongoing consumer service needs. Granting of funds were contingent on completion of a cash advance request form, reasonableness determination of the amount requested, and continuation of rendering medically necessary services. Providers receiving other federal funding to cover the same expenses and same period are not eligible for a MSHN stabilization payment. MDHHS has made no provisions for the provider stabilization payments as the expectation is to use current per eligible per month (PEPM) dollars as needed. MSHN financial position is sufficient to utilize current year funding for meeting stabilization payment needs.

In addition to the funding measures above, MDHHS and Center for Medicare & Medicaid Services (CMS) relaxed rules associated with telehealth service delivery during the COVID-19 pandemic. Typical telehealth services require two-way communication consisting of audio and video between the clinician and consumer. The relaxed rules allow audio only telehealth which means a simple phone call to a consumer is acceptable for service delivery. The relaxed standards have allowed clinicians, peers, and consumers to safely engage in treatment.

Contact Leslie with any MSHN Finance related questions, comments at Leslie.Thomas@midstatehealthnetwork.org

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Behavioral Health

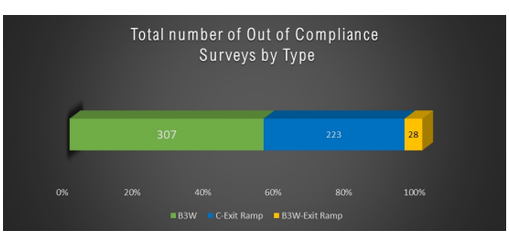
Dr. Todd Lewicki, PhD, LMSW, MBA

Chief Behavioral Health Officer

The coronavirus pandemic has brought much uncertainty and adversity to the world, not to mention important national initiatives, such as the Home and Community-Based Services (HCBS) Rule Transition. Mid-State Health Network (MSHN) has continued to work with the Michigan Department of Health and Human Services (MDHHS) to ensure that it brings its waiver programs into compliance, further ensuring that there are approved plans and improvements in place that promote services in more inclusive settings, expand person-centered planning, and enhance community access. This transition has been underway since March 17, 2014. The pandemic has not slowed MSHN's progress because of expanded MDHHS policy (i.e., "COVID policies") and the hard work and ingenuity of the MSHN HCBS team.

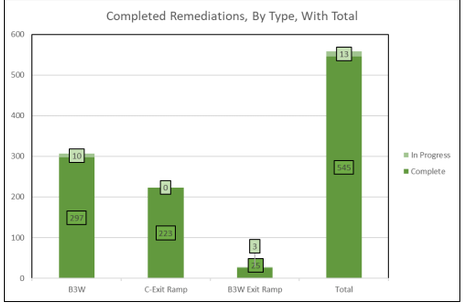
In March 2020, as the pandemic spread through Michigan, the MSHN HCBS team created enhanced review processes of corrective action plans (CAPs) and remediation evidence by including "virtual onsite visits (virtual OSVs). These reviews were completed to allow recipients, service staff, and HCBS staff to visually inspect improvements to residential and community service settings to ensure that CAP remediations were appropriately implemented while remaining safe and socially distanced. This work entailed three-part coordination among the provider, the Community Mental Health Services Program (CMHSP), and MSHN. It was facilitated through a video link to the provider setting to observe the parts of the CAP remediation that required actual visual confirmation, such as a physical modification to the setting.

The following graph shows the total number of out of compliance surveys the HCBS team has been recently working on, by status of waiver:



The C-Waiver covers the Habilitation Supports Waiver (HSW) residential and non-residential settings and the B3-Waiver (now referred to as the 1915i-Waiver) covers Managed Specialty Services and Supports. The cases that included the term "exit ramp" were cases initially identified as heightened scrutiny (HS), or those settings may not be home and community based (based on survey responses). Following an analysis of HS surveys, MDHHS de-escalated some of these to "out of compliance." Surveys that have undergone this process are given the separate designation of "exit ramp surveys" by MDHHS and MSHN. Previously, MSHN HCBS staff had addressed and closed issues relating to 1,007 C-Waiver surveys, with the remaining 558 surveys receiving attention over the last 12 months, including the four months affected by the pandemic.

The next chart shows the status of the completion of these 558 survey remediations.



As of July 31, 2020, the MSHN HCBS team has completed 97.6% of the 558 required remediations with 13 CAPs left to remediate fully. The HCBS team efforts to date are 99.2% complete (1,553 out of 1,565); completion of the remaining 13 surveys is expected to occur in the next 1-2 weeks. This significant progress was not held up by the coronavirus pandemic, further supporting individuals served within the MSHN region to achieve the fullest integration and freedom within their communities.

Contact Todd with any questions, comments or concerns related to the above and/or MSHN Behavioral Health at Todd.Lewicki@midstatehealthnetwork.org.

Utilization Management & Integrated Care

Skye Pletcher Negrón, LPC, CAADC

Director of Utilization and Care Management

Population Health and Addressing Inequities

Addressing population health is the key to reducing health disparities and achieving health equity. By studying the overall health of a specific group, Mid-State Health Network (MSHN) and its Community Mental Health Service Provider (CMHSP) partners can work on reducing the impacts that race, home environment, income, and education have on an individual's ability to be healthy. Implementing effective population health strategies can specifically impact individuals' health and lead to overall better health outcomes regardless of the conditions in which people are born, live, learn, work, play, worship, and age (social determinants of health (SDH)). This conceptualization of total person well-being for all individuals regardless of race, income, social standing, gender, sexual orientation, or other factors is the foundation for the MSHN vision statement:

"The vision of Mid-State Health Network is to continually improve the health of our communities through the provision of premier behavioral healthcare and leadership. Mid-State Health Network organizes and empowers a network of publicly-funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region."

According to the Centers for Disease Control and Prevention (CDC), social determinants of health (SDH) affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants of health include things such as: the availability of resources to meet basic needs (e.g. safe housing and food), access to healthcare service, level of education, employment, transportation, social support, language and literacy, and economical and financial resources. SDH are not generally included in the traditional health care service delivery system, yet they strongly influence the overall health outcomes of individuals or populations.

MSHN's Population Health and Integrated Care plan includes a focus on addressing access to care, particularly regarding racial and ethnic disparities. Beyond the requirement to address racial and ethnic disparities on contractually required metrics, MSHN is committed to identifying and addressing other health disparities where they exist in the region and ensuring all individuals have the resources and opportunities needed to be healthy. During FY21-22, MSHN has updated its Population Health and Integrated Care Plan and will present to its Board of Directors to include the focus areas identified above and through the following actions:

- Continue to gather and analyze regional data on health disparities;
- Form focus groups and learn from people of color and other at-risk groups who experience health disparities with negative health outcomes;
- Seek to understand the lived experience of people in the region as it relates to accessing treatment services, supports, and barriers to health and recovery; MSHN will work with community partners, people in recovery, and its CMHSP and Substance Use Disorder Services Provider (SUDSP) networks to form additional focus groups as needed.
- Consider establishing an advisory group that provides input regarding strengths and opportunities for improvement in our system.

Contact Skye with any questions, comments or concerns related to the above and/or MSHN Utilization Management at Skye.Pletcher@midstatehealthnetwork.org.

Treatment and Prevention

Dr. Dani Meier, PhD, LMSW

Chief Clinical Officer

Racial Bias in Healthcare

As Michigan and the nation face heightened awareness about the need to address racial disparities across multiple systems—the criminal justice and healthcare systems in particular—MSHN's Clinical Team has been digging into the scientific literature on racial disparities. The findings are revealing.

For example, several studies examine how pain is treated differently for white vs. black patients. A 2016 study found that false beliefs based on race (like that "black people's skin is thicker than white people's skin") were considered accurate or probably accurate by 76% of laypersons in the study. Even more striking, the same was true for 50% of medical students and medical residents, the future doctors of America. This contributes to the under-dosing of black patients struggling with legitimate pain issues.

Other studies offered more evidence that black patients are regularly undermedicated and are less likely to be medicated for pain in accordance with World Health Organization (WHO) dosing guidelines and are less likely than white patients to be referred to a pain specialist. Instead, many were treated with suspicion, and black patients were subjected to more drug tests than white patients and were more likely than white patients to be referred for a substance abuse assessment.

In the SUD treatment field, one study revealed that black patients being treated with methadone for Opioid Use Disorder were consistently dosed at 40 mg or less, below the clinically effective dose for methadone, 60 mg or higher. This likely contributed to the more rapid rise in opioid overdose deaths for black Americans, an increase of 84% from 2014-2016 vs. a 45.8% rise in overdose deaths for white Americans. Similarly, between April and June, as overdoses rose during the coronavirus pandemic, the average monthly rate of emergency responses for opioid overdoses among black residents in Michigan was 219.8 per 100,000 residents compared to 123.4 among white residents. Similar differences in access, utilization, and care in SUD treatment can be found for Latinos and other populations of color in the United States.

MSHN is committed to understanding the underlying reasons for underserved and marginalized populations being less likely to access, engage, and stay in treatment for substance use disorders. That knowledge will inform MSHN's planning and action steps with providers and community stakeholders to move our region towards health equity for all Region 5 citizens.

Contact Dani with questions, comments or concerns related to the above and/or MSHN SUD Treatment and Prevention at Dani.Meier@midstatehealthnetwork.org.

Provider Network

Carolyn Tiffany, MA

Director of Provider Network Management Systems

The region continues to work on reciprocity and efficiency efforts in support of the MDHHS (Michigan Department of Health and Human Services) Reciprocity and Efficiency Policy. The Community Mental Health Service Participants (CMHSPs) and MSHN have collaborated to develop a regionally organized provider monitoring process for Autism providers under contract with multiple CMHSPs in the region. This ensures a single audit of core/administrative standards and the application of common consumer record and personnel record standards across the system.

A new area of focus is with organizational provider credentialing and procurement procedures. As stated in the MDHHS Reciprocity and Efficiency Policy,

Providers will be offered efficiencies in purchasing processes within or between PIHP systems, which may include any of the following:

1. Readily available centralized provider application processes and procurement information, such as through PIHP websites and/or CMHSP website links.
2. CMHSP (or PIHP) cross-sharing of provider application information or provision of common elements within PIHPs/between CMHSPs.
3. Publication of provider selection processes for the PIHP region.
4. Readily available PIHP or CMHSP contact information for specific provider contracting and selection procedures.

Regional discussions regarding organizational provider credentialing resulted in a recommendation from CMSHP participants to develop a standard/regional organizational provider application. Currently, providers with sites spanning multiple CMHSP catchment areas must complete multiple provider applications.

CMHSP participants and MSHN will soon implement a web-based provider application that allows a provider to complete one form, upload all required documentation, and submit to selected CMHSPs, which promotes administrative efficiencies.

Contact Carolyn with any questions, comments or concerns related to the above and/or MSHN Provider Network Management at Carolyn.Watters@midstatehealthnetwork.org.

Quality, Compliance and Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC

Director of Quality, Compliance and Customer Service

The Behavioral Health and Developmental Disabilities Administration (BHHDA) revised, in partnership with the statewide Quality Improvement Council, the performance indicator system to address the Center for Medicare and Medicaid Services (CMS) concern that the performance on these indicators consistently meets or exceeds the standards, and therefore are not informing quality improvement.

The review of the performance indicators resulted in revisions to two indicators and the development of one new indicator specific to individuals receiving substance use disorder services.

The following are the two revised and the one new performance indicators:

- ***Indicator #2a****: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, DD-adults, and DD-children).*
  - This indicator was revised from the previous one by adding that it includes a “new” person, clarifying that a “biopsychosocial” assessment was required versus just an “initial” assessment and adding that the request was “non-emergent” versus a “first” request for service.
  - The assessment process is especially crucial for individuals seeking services for mental illness or intellectual and developmental disabilities, and the completed assessment is critical for person-centered planning.

- ***Indicator #2b****: The percentage of new persons during the quarter receiving* a *face-to-face service for treatment or supports within 14 calendar days of* a *non-emergency request for service for persons with Substance Use Disorders.*
  - #2b is a new indicator developed to reflect the emphasis of transitioning individuals who are approved for SUD services directly to ongoing face-to-face services.

- ***Indicator #3****: Percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing* a *non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, DD-adults, and DD-children).*
  - This indicator was revised from the previous one by adding that it includes a “new” person, clarifying that it covers starting an ongoing medically necessary covered service during the quarter, and adding that the assessment was a “non-emergent biopsychosocial” assessment versus just an “assessment.”
  - The amount of time between the professional assessment and the delivery of medically necessary treatments and supports addresses a different aspect of access to care than Indicator #2a. Delay in the delivery of necessary services and supports may exacerbate symptoms and distress, poorer role functioning, and disengagement from the system. The timely start of ongoing services is critical to the engagement process, connecting the consumer to services and supports while the person is motivated towards treatment.

The focus for the first year of review is access to care as this is a key performance component in the Medicaid managed care regulations. These new indicators track the timeliness of access of **all** individuals who request and are referred on for specialty behavioral health services.

In addition to the revisions to the performance indicators, CMS recommended removing the current exception methodology used in the performance indicator system to understand each indicators’ true performance better. This revision means that exceptions previously used to exclude individuals such as no-shows or individuals who request appointments outside the 14-day window will no longer be excluded from the reported cases.

In addition to removing the exceptions, it was also recommended to remove the 95 percent threshold for the first year of implementation, enabling the use of data at the state, region, and county levels to discover areas in which timeliness to access can be improved. It also allows for comparisons within and across regions and may highlight the impact of natural barriers to access (distance/transportation in rural areas, for example). The data collected during the first year will be used as a baseline to determine a standard/threshold. The new indicators were implemented effective April 16, 2020.

Contact Kim with any questions, comments or concerns related to MSHN Quality, Compliance and Customer Service at Kim.Zimmerman@midstatehealthnetwork.org