

**MSHN Substance Use Disorder (SUD)  
Oversight Policy Advisory Board Meeting**  
April 18, 2018 ~ 4:00 p.m.  
**Meeting Agenda**

- 1) Call to Order
- 2) Roll Call
- 3) ACTION ITEM: Approval of the Agenda for April 18, 2018
- 4) ACTION ITEM: Approval of the Minutes of February 21, 2018 (Item 4)
- 5) Public Comment
- 6) Board Chair Report
  - A. Welcome New Members
    - i) Robert Luce (Arenac)
    - ii) Ed Woods (Jackson)
- 7) Deputy Director Report
  - A. FY2018 PA2 Receipts & Payments (Items 7A-1/7A-2)
  - B. FY18 SUD Financial Summary Report, as of February 2018 (Item 7B)
  - C. SUD OPB Letters of Support (Items 7C-1/7C-2)
- 8) ACTION ITEM: FY18 Substance Use Disorder (SUD) PA2 Funding Requests/Contract Listing (Item 8)
- 9) Operating Update
  - A. 2016 MI Young Adult Survey Report (Item 9A)
  - B. Opioid CDC Guidelines (Items 9B-1/9B-2)
- 10) Other Business
  - A. MSHN 2019-2020 Strategic Planning Input & Feedback (Item 10A)
  - B. FY17 Compliance Report & FY18 Q1 Compliance Report  
(Items 10B-1/10B-2)
  - C. February Board Meeting Follow-up: Updated February 2018 PA2  
Funding Recommendations by County (Item 10C)
- 11) Public Comment
- 12) Board Member Comment
- 13) Adjournment

# MSHN

## SUD Oversight Policy Advisory Board



### MEETING LOCATION

Michigan Association of  
Community Mental Health  
Boards (MACMHB)  
426 S. Walnut, Lansing  
Upstairs Training Room

### TELE-CONFERENCE:

Call in: 1.888.585.9008  
Conference Room: 182 260 353

Please call/email Merre Ashley  
to confirm your attendance  
517.253.7525  
[merre.ashley@midstatehealthnetwork.org](mailto:merre.ashley@midstatehealthnetwork.org)



### UPCOMING FY18 BOARD MEETINGS

June 20, 2018  
August 15, 2018

All meetings will be held from  
4:00-5:30 p.m. at MACMHB  
unless noted otherwise.



MSHN Board Approved Policies  
May be Found at:  
<http://www.midstatehealthnetwork.org/policies/>

Substance Use Disorder (SUD) Oversight Policy Advisory Board

02.21.2018

**Mid-State Health Network SUD Oversight Policy Advisory Board**

**Wednesday, February 21, 2018, 4:00 p.m.**

**Michigan Association of CMH Boards (MACMHB)**

**Meeting Minutes**

**1. Call to Order**

Chairperson Hunter called the MSHN SUD Regional Oversight Policy Board of Directors Meeting to order at 4:00 p.m.

**Board Member(s) Present:** Lisa Ashley (Gladwin) (via phone), Bruce Caswell (Hillsdale), Larry Emig (Osceola), Steve Glaser (Midland), Richard (Dick) Gromaski (Bay), John Hunter (Tuscola), Jerry Jalszynski (Isabella), Carol Koenig (Ingham), Bryan Kolk (Newaygo), Tom Lindeman (Montcalm), Bob Luce (Arenac), Vicky Schultz (Shiawassee), Leonard Strouse (Clare), Sabrina Sylvain (Gratiot)(via phone), Debbie Thalison (Ionia), Kim Thalison (Eaton), and Kam Washburn (Clinton)

**Alternate Member(s) Present:** Laurie Brandes (Hillsdale), John Kroneck (Montcalm), Ken Mitchell (Clinton), Howard Spence (Eaton)

**Board Member(s) Absent:** Clark Elftman (Huron), Susan Guernsey (Mecosta), and Christina Harrington (Saginaw)

**Staff Members Present:** Joseph Sedlock (CEO), Amanda Horgan (Deputy Director), Dr. Dani Meier (Chief Clinical Officer), Carolyn Watters (Director of Provider Network Management), Trisha Thrush (Lead Treatment Specialist), Jill Worden (Lead Prevention Therapist) (via phone); Sherry Donnelly (Treatment & Recovery Specialist), Kari Gulvas (Prevention Specialist) (via phone), and Merre Ashley (Executive Assistant)

**2. Roll Call**

Ms. Merre Ashley provided the Roll Call for Board Attendance.

**3. Approval of Agenda for February 21, 2018**

Board approval was requested for the Agenda of the February 21, 2018 Regular Business Meeting, as presented.

**ROPB 17-18-008 MOTION BY DICK GROMASKI, SUPPORTED BY STEVE GLASER, FOR APPROVAL OF THE AGENDA OF THE FEBRUARY 21, 2018 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 16-0.**

**4. Approval of Minutes from the December 20, 2017 Regular Business Meeting**

Board approval was requested for the draft meeting minutes of the December 20, 2017 Regular Business Meeting, as presented.

**ROPB 17-18-009 MOTION BY LARRY EMIG, SUPPORTED BY KAM WASHBURN, FOR APPROVAL OF THE MINUTES OF THE DECEMBER 20, 2017 REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 16-0.**

**5. Public Comment**

- Mr. Dick Gromaski introduced Mr. Bob Luce, newly appointed to the SUD Oversight Policy Advisory Board by the Arenac County Board of Commissioners, filling the vacant seat formerly held by Ms. Virginia Zygiel
- Mr. Bruce Caswell introduced SUD Oversight Policy Advisory Board alternate member from Hillsdale County – Name?
- Mr. Kam Washburn introduced SUD Oversight Policy Advisory Board alternate member from Clinton County Ken Mitchell

**6. Annual Organizational Meeting**

- Election of Chairperson: Chairperson Hunter called for nominations from the floor, for the office of Chairperson

**ROPB 17-18-010 MOTION BY DICK GROMASKI, SUPPORTED BY KAM WASHBURN, TO NOMINATE JOHN HUNTER FOR THE OFFICE OF CHAIRPERSON. MOTION CARRIED: 16-0.**

**ROPB 17-18-011 MOTION BY DICK GROMASKI, SUPPORTED BY JERRY JALOCZYNSKI TO CLOSE NOMINATIONS AND CAST UNANIMOUS BALLOT FOR JOHN HUNTER AS CHAIRPERSON. MOTION CARRIED: 16-0.**

- Election of Vice-Chairperson: Chairperson Hunter called for nominations from the floor, for the office of Vice-Chairperson

**ROPB 17-18-012 MOTION BY JOHN HUNTER, SUPPORTED BY KAM WASHBURN, TO NOMINATE BRUCE CASWELL FOR THE OFFICE OF VICE-CHAIR. MOTION CARRIED: 16-0.**

**ROPB 17-18-013 MOTION BY JERRY JALOSZYNSKI, SUPPORTED BY KAM WASHBURN TO CLOSE NOMINATIONS AND CAST UNANIMOUS BALLOT FOR BRUCE CASWELL AS VICE-CHAIRPERSON. MOTION CARRIED: 16-0.**

- Election of Secretary: Chairperson Hunter called for nominations from the floor, for the office of Secretary

**ROPB 17-18-014 MOTION BY DICK GROMASKI, SUPPORTED BY BRUCE CASWELL, TO NOMINATE DEB THALISON FOR THE OFFICE OF SECRETARY. MOTION CARRIED: 16-0.**

**ROPB 17-18-015 MOTION BY KAM WASHBURN, SUPPORTED BY JERRY JALOCZYNSKI, TO CLOSE NOMINATIONS AND CAST UNANIMOUS BALLOT FOR DEB THALISON AS SECRETARY. MOTION CARRIED: 16-0.**

Chairperson Hunter congratulated Mr. Caswell and Ms. Thalison on their elections to officer positions.

## **7. Board Chair Report**

Chairperson Hunter stated he had nothing to report.

## **8. Deputy Director Report**

Ms. Amanda Horgan provided information and overview of materials related to the following:

- Subcommittee Report
  - All input taken into consideration; reports presented etc.
  - Workgroup considered closed; all reports covered
  - PA2 Notice of Funding Availability included in board member folders is county-specific, and includes additional information, as recommended by the subcommittee. This report will be provided each year at the February and August meeting.
  - The Provider Compliance Report will be provided quarterly, beginning at the next meeting in April. The report will include information specific to the subcommittee recommendations.

- FY2018 PA2 Receipts & Payments
- FY18 SUD Financial Summary Report, of December 2017

Following discussion, Ms. Horgan reported the budget amount included on the report will be adjusted to reflect the updated revenue amount during the FY18 Budget amendment process.

#### **9. FY18 Substance Use Disorder (SUD) PA2 Funding Requests/Contract Listing**

Ms. Carolyn Watters referenced the updated FY18 contract listing, provided in hardcopy within board member folders. She provided an overview of updated listing, and information included therein.

- Following discussion, it was established information pertaining to Montcalm County was inadvertently left off. The report will be revised and re-distributed.

**ROPB 17-18-016 MOTION BY JERRY JALOCZYNSKI, SUPPORTED BY DICK GROMASKI, TO APPROVE THE FY18 SUBSTANCE USE DISORDER (SUD) PA2 FUNDING REQUESTS/CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 16-0. ABSTAINED: KIM THALISON; ATERNATE HOWARD SPENCE VOTING ON BEHALF OF EATON COUNTY.**

#### **10. Operating Update**

Dr. Dani Meier provided updates and information on the following:

- Introduction of Sherrie Donnelly, Treatment and Recovery Specialist
  - Sherrie will lead recovery efforts for the region to provide resources to strengthen recovery supports across the region.
- Update on Block Grant Awards – Opioid State Targeted Response
  - Following discussion, Dr. Meier stated he would follow-up with members who voiced county-specific questions pertaining to block grant awards.
  - Members were encouraged to contact Dr. Meier with any questions or concerns related to grant-funded services.

Ms. Carol Koenig arrived 4:38pm

- Michigan County Opioid Prescription Rate and Number by PIHP
  - Following discussion, Dr. Meier stated he and his team would work to draft a distilled version ('fact sheet') of the Center for Disease Control (CDC) guidelines.

## 11. Other Business

Chairperson Hunter referenced the Board Member Roster, provided within meeting packets. He requested those that have terms expiring to work with their respective counties for re-appointment or replacement.

## 12. Public Comment

Mr. Gromaski provided members with copies of a letter from Bay Arenac Behavioral Health to the MSHN Board of Directors, stating this board should go on record as well.

Mr. Joe Sedlock addressed the board, stating that as an SUD Oversight Policy Board, it is proper to comment on legislation, and advocate for increased funding in partnership with the MSHN Board. To that end, he requested consideration of the following action:

- Draft correspondence to the MSHN Board of Directors, advocating for increased resources for opioid funding;
- Draft correspondence to the House of Representatives and Senate Health and Human Services Appropriations Committees, for 2019 funding to be realigned with that of 2018;
  - At the same time, go on the record in support of the bill currently in the House, dedicating a portion of liquor taxes to SUD treatment.

**ROPB 17-18-017 MOTION BY DICK GROMASKI, SUPPORTED BY CAROL KOENIG, TO APPROVE CORRESPONDENCE BE DIRECTED TO THE MSHN BOARD OF DIRECTORS AND MICHIGAN LEGISLATORS, REQUESTING THE 2019 BUDGET BE REVISITED AND ADVOCATING FOR AN INCREASE TO OPIOID FUNDING. MOTION CARRIED: 17-0.**

## 13. Board Member Comment

Mr. Bryan Kolk voiced concerns pertaining to Medical Marijuana.

Ms. Vicky Schultz addressed education of opioid overuse/over prescribing. Ms. Jill Worden advised of trainings being coordinated by Eaton RESA, to be held in 3 locations across the region. Further discussion ensued, pertaining to the possibility of launching a region-wide campaign to get the medical community engaged and educated.

Ms. Kim Thalison stated additional reporting and information on training events being coordinated by Eaton RESA will be made available at the next meeting. Ms. Horgan advised members that MSHN's SUD Provider Update, released weekly, contains training information as well.

**ROPB 17-18-018 MOTION BY DICK GROMASKI, SUPPORTED BY CAROL KEONIG TO ADJOURN THE REGULAR BUSINESS MEETING. MOTION CARRIED: 17-0.**

#### **14. Adjournment**

The MSHN SUD Oversight Policy Advisory Board adjourned at 5:34 p.m.

Meeting minutes submitted respectfully by:  
Merre Ashley, MSHN Executive Assistant

DRAFT

**Mid-State Health Network  
FY2018 PA2 Funding Summary by County**

County	Beginning PA2 Fund Balance	Payment Amount	Date Received	Payment Amount	Date Received	Payment Amount	Date Received	Payment Amount	Date Received	Total Amount Anticipated	Total Amount Received	Beginning PA2 Fund Balance and Receipts
Arenac	223,041									34,553	-	223,041
Bay	1,248,855									205,310	-	1,248,855
Clare	280,920									49,653	-	280,920
Clinton	595,340									126,760	-	595,340
Eaton	798,852									238,268	-	798,852
Gladwin	119,581									39,516	-	119,581
Gratiot	197,964									46,718	-	197,964
Hillsdale	176,547									50,136	-	176,547
Huron	357,628									63,579	-	357,628
Ingham	740,358									703,526	-	740,358
Ionia	413,617									73,514	-	413,617
Isabella	830,873									154,222	-	830,873
Jackson	1,198,732									319,767	-	1,198,732
Mecosta	541,452									87,244	-	541,452
Midland	574,204									150,863	-	574,204
Montcalm	494,985									98,624	-	494,985
Newaygo	250,827									73,870	-	250,827
Osceola	160,414									28,527	-	160,414
Saginaw	3,404,331									445,650	-	3,404,331
Shiawassee	639,929									98,985	-	639,929
Tuscola	387,326									55,841	-	387,326
	<u>\$ 13,635,774</u>	<u>\$ -</u>		<u>\$ -</u>		<u>\$ -</u>		<u>\$ -</u>		<u>\$ 3,145,119</u>	<u>\$ -</u>	<u>\$ 13,635,774</u>



**Mid-State Health Network  
FY2018 PA2 Expenditure Summary by County**

County	Beginning PA2 Fund Balance and Receipts	County Code	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD Payments	Ending PA2 Fund Balance
Arenac	223,041	06	12,181	10,637	11,012	12,298	8,326								54,454	\$ 168,587
Bay	1,248,855	09	20,280	18,688	22,339	20,450	17,407								99,163	\$ 1,149,692
Clare	280,920	18	-	8,925	-	12,305	7,519								28,749	\$ 252,171
Clinton	595,340	19	11,186	7,312	791	1,279	708								21,275	\$ 574,066
Eaton	798,852	23	19,545	15,410	16,494	16,286	15,502								83,237	\$ 715,615
Gladwin	119,581	26	-	11,087	-	11,413	6,432								28,932	\$ 90,649
Gratiot	197,964	29	5,813	16,616	6,336	12,163	7,924								48,851	\$ 149,112
Hillsdale	176,547	30	-	-	1,859	2,339	1,597								5,794	\$ 170,753
Huron	357,628	32	14	-	-	-	-								14	\$ 357,614
Ingham	740,358	33	37,836	33,232	33,180	29,793	32,450								166,491	\$ 573,867
Ionia	413,617	34	399	1,225	2,556	2,318	11,910								18,408	\$ 395,209
Isabella	830,873	37	1,849	31,326	3,232	30,218	12,833								79,457	\$ 751,415
Jackson	1,198,732	38	29,863	21,088	16,800	44,697	37,099								149,547	\$ 1,049,185
Mecosta	541,452	54	-	9,522	-	9,445	5,010								23,977	\$ 517,475
Midland	574,204	56	5,306	13,086	4,876	16,793	9,181								49,242	\$ 524,962
Montcalm	494,985	59	2,040	2,996	2,487	1,654	4,945								14,123	\$ 480,862
Newaygo	250,827	62	4,043	6,098	4,756	4,657	3,143								22,696	\$ 228,131
Osceola	160,414	67	-	4,476	-	4,494	1,641								10,611	\$ 149,803
Saginaw	3,404,331	73	20,233	33,000	31,809	49,315	39,203								173,560	\$ 3,230,771
Shiawassee	639,929	78	7,391	1,999	2,083	1,953	4,252								17,678	\$ 622,250
Tuscola	387,326	79	4,022	2,323	3,218	2,962	2,942								15,467	\$ 371,859
<u>\$ 13,635,774</u>			<u>\$ 182,000</u>	<u>\$ 249,045</u>	<u>\$ 163,828</u>	<u>\$ 286,830</u>	<u>\$ 230,022</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>1,111,725</u>	<u>\$ 12,524,049</u>

**Mid-State Health Network**  
Summary of PA2 Use of Funds by County and Provider  
October 1, 2017 through February 28, 2018

County and Provider	Case Management	Detox	Early Intervention	Outpatient	Prevention	Recovery Support	Grand Total
<b>Arenac</b>							
Peer 360 Recovery						9,569.00	9,569.00
Sterling Area Health Center					44,885.22		44,885.22
<b>Arenac Total</b>					<b>44,885.22</b>	<b>9,569.00</b>	<b>54,454.22</b>
<b>Bay</b>							
Bay Regional Medical Center DBA McLaren Bay					22,395.21		22,395.21
Boys and Girls Club Bay Region					33,586.00		33,586.00
DOT Caring Center, Inc.						621.00	621.00
Peer 360 Recovery						19,135.00	19,135.00
Sacred Heart Rehabilitation			1,692.73		4,193.70	3,364.69	9,251.12
Sterling Area Health Center					14,174.28		14,174.28
<b>Bay Total</b>			<b>1,692.73</b>		<b>74,349.19</b>	<b>23,120.69</b>	<b>99,162.61</b>
<b>Clare</b>							
Ten Sixteen Recovery			5,757.00		12,054.00	10,938.00	28,749.00
<b>Clare Total</b>			<b>5,757.00</b>		<b>12,054.00</b>	<b>10,938.00</b>	<b>28,749.00</b>
<b>Clinton</b>							
Community Mental Health Authority of Clinton, Eaton, Ingham				12,536.00			12,536.00
Eaton Regional Education Service Agency					3,929.16		3,929.16
St. John's Police Department					547.53		547.53
State of Michigan MRS	4,262.00						4,262.00
<b>Clinton Total</b>	<b>4,262.00</b>			<b>12,536.00</b>	<b>4,476.69</b>		<b>21,274.69</b>
<b>Eaton</b>							
Barry Eaton District Health					15,648.47		15,648.47
Eaton Regional Education Service Agency					63,326.23		63,326.23
State of Michigan MRS	4,262.00						4,262.00
<b>Eaton Total</b>	<b>4,262.00</b>				<b>78,974.70</b>		<b>83,236.70</b>
<b>Gladwin</b>							
Ten Sixteen Recovery			5,229.00		13,685.00	10,018.00	28,932.00
<b>Gladwin Total</b>			<b>5,229.00</b>		<b>13,685.00</b>	<b>10,018.00</b>	<b>28,932.00</b>
<b>Gratiot</b>							
Gratiot County Child Advocacy Association					38,753.37		38,753.37
Ten Sixteen Recovery			10,098.00				10,098.00
<b>Gratiot Total</b>			<b>10,098.00</b>		<b>38,753.37</b>		<b>48,851.37</b>
<b>Hillsdale</b>							
Family Counseling					2,792.32		2,792.32
McCullough, Vargas, and Associates					3,001.85		3,001.85
<b>Hillsdale Total</b>					<b>5,794.17</b>		<b>5,794.17</b>
<b>Huron</b>							
Huron County Health Department					13.85		13.85
<b>Huron Total</b>					<b>13.85</b>		<b>13.85</b>
<b>Ingham</b>							
Child and Family Charities					12,608.00		12,608.00
Community Mental Health Authority of Clinton, Eaton, Ingham		82,599.62					82,599.62
Cristo Rey Community Center					5,557.79		5,557.79
Mid-Michigan Recovery Services				55.17			55.17
Peer 360 Recovery						14,351.00	14,351.00
State of Michigan MRS	12,785.00						12,785.00
WAI-IAM, Inc. & RISE Recovery Community						3,982.19	3,982.19
Wellness, InX	7,335.05					27,216.80	34,551.85
<b>Ingham Total</b>	<b>20,120.05</b>	<b>82,599.62</b>		<b>55.17</b>	<b>18,165.79</b>	<b>45,549.99</b>	<b>166,490.62</b>
<b>Ionia</b>							
County of Ionia					7,878.44		7,878.44
Ionia County Community Mental Health						10,529.09	10,529.09
<b>Ionia Total</b>					<b>7,878.44</b>	<b>10,529.09</b>	<b>18,407.53</b>
<b>Isabella</b>							
Addiction-Mt. Pleasant				7,897.00	3,675.00		11,572.00
Sacred Heart Rehabilitation			1,127.49				1,127.49
Ten Sixteen Recovery			2,951.00		1,162.00	62,645.00	66,758.00
<b>Isabella Total</b>			<b>4,078.49</b>	<b>7,897.00</b>	<b>4,837.00</b>	<b>62,645.00</b>	<b>79,457.49</b>
<b>Jackson</b>							
Allegiance Health Foote Memorial					12,461.13		12,461.13
Family Service and Childrens Aid (Born Free)					67,096.29		67,096.29
Home of New Vision						69,989.72	69,989.72
<b>Jackson Total</b>					<b>79,557.42</b>	<b>69,989.72</b>	<b>149,547.14</b>
<b>Mecosta</b>							
Ten Sixteen Recovery			9,160.00		2,777.00	12,040.00	23,977.00
<b>Mecosta Total</b>			<b>9,160.00</b>		<b>2,777.00</b>	<b>12,040.00</b>	<b>23,977.00</b>
<b>Midland</b>							
Peer 360 Recovery						14,351.00	14,351.00
Ten Sixteen Recovery	861.00		15,807.00			8,041.00	24,709.00
The Legacy Center for Community Success					10,182.00		10,182.00
<b>Midland Total</b>	<b>861.00</b>		<b>15,807.00</b>		<b>10,182.00</b>	<b>22,392.00</b>	<b>49,242.00</b>

**Mid-State Health Network**  
Summary of PA2 Use of Funds by County and Provider  
October 1, 2017 through February 28, 2018

County and Provider	Case Management	Detox	Early Intervention	Outpatient	Prevention	Recovery Support	Grand Total
<b>Montcalm</b>							
Cherry Street Services						8,808.38	8,808.38
Sacred Heart Rehabilitation			563.24				563.24
Wedgewood Christian Services						4,750.89	4,750.89
<b>Montcalm Total</b>			<b>563.24</b>			<b>13,559.27</b>	<b>14,122.51</b>
<b>Newaygo</b>							
Arbor Circle					7,903.71	14,462.05	22,365.76
Newaygo County RESA					330.00		330.00
<b>Newaygo Total</b>					<b>8,233.71</b>	<b>14,462.05</b>	<b>22,695.76</b>
<b>Osceola</b>							
Ten Sixteen Recovery			5,281.00		5,330.00		10,611.00
<b>Osceola Total</b>			<b>5,281.00</b>		<b>5,330.00</b>		<b>10,611.00</b>
<b>Saginaw</b>							
10th District Court				6,060.00			6,060.00
First Ward Community Service					2,997.51		2,997.51
Parishioners on Patrol					5,000.00		5,000.00
Peer 360 Recovery						23,917.00	23,917.00
Sacred Heart Rehabilitation			1,127.49		20,648.28		21,775.77
Saginaw County Youth Protection Council					13,699.17		13,699.17
Saginaw Police Department					35,127.39		35,127.39
Ten Sixteen Recovery						54,384.00	54,384.00
Women of Colors					10,598.66		10,598.66
<b>Saginaw Total</b>			<b>1,127.49</b>	<b>6,060.00</b>	<b>88,071.01</b>	<b>78,301.00</b>	<b>173,559.50</b>
<b>Shiawassee</b>							
Catholic Charities of Shiawassee and Genesee					9,629.02		9,629.02
Sacred Heart Rehabilitation			563.24				563.24
Shiawassee County					3,224.19		3,224.19
State of Michigan MRS	4,262.00						4,262.00
<b>Shiawassee Total</b>	<b>4,262.00</b>		<b>563.24</b>		<b>12,853.21</b>		<b>17,678.45</b>
<b>Tuscola</b>							
List Psychological Services					554.02		554.02
Peer 360 Recovery						14,350.00	14,350.00
Sacred Heart Rehabilitation			563.23				563.23
<b>Tuscola Total</b>			<b>563.23</b>		<b>554.02</b>	<b>14,350.00</b>	<b>15,467.25</b>
<b>Grand Total</b>	<b>33,767.05</b>	<b>82,599.62</b>	<b>59,920.42</b>	<b>26,548.17</b>	<b>511,425.79</b>	<b>397,463.81</b>	<b>1,111,724.86</b>

Mid-State Health Network  
Summary of SUD Revenue and Expenses as of February 2018

	<u>Year to Date Actual</u>	<u>Full Year Budget</u>	<u>Remaining Budget</u>	<u>% to Budget</u>
Revenue				
Block Grant	5,626,371.00	12,841,377.00	7,215,006.00	43.81%
Medicaid	4,762,274.23	11,600,000.00	6,837,725.77	41.05%
Healthy Michigan	6,291,645.35	15,300,700.00	9,009,054.65	41.12%
PA2	1,111,724.86	3,145,119.00	2,033,394.14	35.35%
Totals	<u>17,792,015.44</u>	<u>42,887,196.00</u>	<u>25,095,180.56</u>	<u>41.49%</u>
Direct Expenses				
Block Grant	4,489,614.24	12,584,549.00	8,094,934.76	35.68%
Medicaid	4,158,897.47	11,070,008.00	6,911,110.53	37.57%
Healthy Michigan	6,152,995.32	14,524,644.00	8,371,648.68	42.36%
PA2	1,111,724.86	3,145,119.00	2,033,394.14	35.35%
Totals	<u>15,913,231.89</u>	<u>41,324,320.00</u>	<u>25,411,088.11</u>	<u>38.51%</u>
Surplus / (Deficit)	<u>1,878,783.55</u>			



Mid-State Health Network

Community Mental  
Health Provider Network

Bay Arenac  
Behavioral Health

CMH of  
Clinton, Eaton, Ingham  
Counties

CMH for Central Michigan

Gratiot Integrated Health  
Network

Huron Behavioral Health

Ionia County CMH

LifeWays CMH

Montcalm Care Network

Newaygo County  
Mental Health Center

Saginaw County CMH

Shiawassee Health &  
Wellness

Tuscola Behavioral  
Health Systems

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Edward Woods  
Chairperson

Irene O'Boyle  
Vice-Chairperson

Kurt Peasley  
Secretary

February 26, 2018

Mid-State Health Network Board of Directors  
Ed Woods, Chairperson  
530 W. Ionia, Suite F  
Lansing, MI 48933

RE: FY19 Appropriations re Community Substance Abuse

Dear Chairperson Woods,

On behalf of the Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Advisory Board, this correspondence serves to relay concerns, pertaining to the recently released fiscal year (FY) 2019 Budget Proposal.

During the SUD Advisory Board's regular business meeting on February 21, 2018, members discussed funding related to SUD within the governor's budget proposal; reductions specific to community substance abuse services cause grave concerns, given the precarious situation of the state's opioid epidemic. Should reductions occur to the Michigan Department of Health and Human Services (MDHHS) Community Substance Abuse appropriation, the potential for catastrophic ramifications to local communities and the state as a whole is real.

As MSHN's advisory board, we urge the MSHN Board of Directors to act swiftly, and advocate with state officials for additional investment in community substance abuse. Just as we must continue to battle the opioid epidemic, it is imperative we stand up now to maintain effective community-based SUD prevention, education and treatment programs for those we serve.

Respectfully,

John Hunter  
Chairperson  
MSHN SUD Oversight Policy Advisory Board

JH/ma



Mid-State Health Network

Community Mental  
Health Member  
Authorities

Bay Area  
Behavioral Health

CMH of  
Clinton, Eaton, Ingham  
Counties

CMH for Central Michigan

Gratiot Integrated Care  
Network

Huron Behavioral Health

The Right Door for Hope,  
Recovery and Wellness  
(Ionia)

LifeWays CMH

Montcalm Care Network

Newaygo County  
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Saginaw County CMH

Shiawassee Health and  
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Tuscola Behavioral  
Health Systems

Board Officers

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Irene O'Boyle  
Vice-Chairperson

Kurt Peasley  
Secretary

March 6, 2018

Michigan House of Representatives,  
Health and Human Services Appropriations Sub-Committee  
Michigan State House of Representatives  
P.O. Box 30014  
Lansing, Michigan 48909-7514

Dear Chairman Canfield, Vice Chairman Allor, and Representatives Bizon, Inman, Whiteford, LaSata, Yaroach, Faris, Kosowski, Yanez and Santana:

The Mid-State Health Network Substance Use Disorder Oversight Policy Board is writing to convey its request to restore FY 19 appropriations to the Michigan Department of Health and Human Services, Community Substance Abuse (Prevention, Education and Treatment Programs) to at least the FY18 (final) appropriation level.

Mid-State Health Network is a Prepaid Inpatient Health Plan (PIHP) with responsibility for Medicaid and Healthy Michigan funded services and supports to eligible beneficiaries in a twenty-one-county region within our State and is responsible for substance abuse prevention and treatment services (SAPT) also funded under Federal SAPT block grants. The Oversight Policy Board was established and operates under 2012 PA500 and 501.

The opioid epidemic is taking five lives per day in our State and is causing other catastrophic consequences to individuals, families and communities. While we recognize additional federal funding for combatting the opioid epidemic, we must request that the Michigan Legislature invest more, not less, in community-based substance abuse prevention, education and treatment programs.

On behalf of the Mid-State Health Network Oversight Policy Board, we join our Mid-State Health Network Board of Directors, the Community Mental Health Services Programs and SAPT providers in our region in requesting that the Michigan Legislature appropriate funds in the FY19 Community Substance Abuse line of the Michigan Department of Health and Human Services budget to at least the FY18 final appropriations level. Consideration of additional funding for these much needed and effective treatment and prevention services is also requested and encouraged.

Sincerely,

John Hunter, Chairperson

Mid-State Health Network Substance Use Disorder Oversight Policy Board

**Mid-State Health Network  
FY2018 PA2 Funding Recommendations - by Provider  
April 2018 Oversight Policy Board**

<b>Provider</b>	<b>PA2 County</b>	<b>PA2 Amount Recommended</b>	<b>*New Provider / Renewal Contract</b>
First Ward Community Center	Saginaw	7,045	Renewal
<b>GRAND TOTAL</b>		<b>7,045</b>	

\*New Provider / Renewal Contract:

New Provider could also indicate that provider did not receive PA2 funds from the identified county in FY2017

All recommendations related to PA2 request for proposals; contract term (4.1.18 - 3.31.19)



**Mid-State Health Network**  
**FY2018 PA2 Funding Recommendations - by County**

<b>County</b>	<b>Reserve Balance as of September 2017</b>	<b>Projected FY2018 Funding</b>	<b>Approved FY2018 Funding Recommendations</b>	<b>FY2018 PA2 Funding Request (April)</b>	<b>Projected Reserve Balance</b>
Arenac	223,041	34,553	124,794	-	132,800
Bay	1,248,865	205,310	283,036	-	1,171,138
Clare	280,920	49,653	77,398	-	253,175
Clinton	595,340	126,760	261,913	-	460,187
Eaton	798,852	238,268	587,481	-	449,638
Gladwin	119,581	39,516	102,276	-	56,820
Gratiot	197,964	46,718	137,581	-	107,100
Hillsdale	176,547	50,136	97,901	-	128,782
Huron	357,628	63,579	163,103	-	258,104
Ingham	740,790	703,526	505,166	-	939,149
Ionia	413,617	73,514	45,442	-	441,688
Isabella	830,873	154,222	251,909	-	733,186
Jackson	1,198,732	319,767	584,924	-	933,574
Mecosta	541,452	87,244	293,897	-	334,799
Midland	574,204	150,863	172,472	-	552,595
Montcalm	494,985	98,624	198,794	-	394,814
Newaygo	250,827	73,870	128,913	-	195,784
Osceola	160,414	28,527	95,211	-	93,730
Saginaw	3,404,331	445,650	880,977	7,045	2,961,959
Shiawassee	639,929	98,985	55,590	-	683,324
Tuscola	387,326	55,841	95,334	-	347,833
<b>Total</b>	<b>\$ 13,636,216</b>	<b>\$ 3,145,119</b>	<b>\$ 5,144,112</b>	<b>\$ 7,045</b>	<b>\$ 11,630,178</b>



**Mid-State Health Network**  
**Comparison of FY2017 and FY2018 PA2 by County and Provider**

County	Provider	FY2017 Approved PA2 Funds	FY2018 YTD Recommended PA2 Funds	April Recommended PA2 Funds	Detail of Services Provided
<b>Saginaw</b>					
	First Ward Community Center				
	PA2	49,655	75,379	7,045	Summer Activites (Amended amount from PA2 release)
	Block Grant	47,196	35,000	-	
	<b>Total</b>	<b>96,851</b>	<b>110,379</b>	<b>7,045</b>	
	<b>County Total</b>	<b>96,851</b>	<b>110,379</b>	<b>7,045</b>	
<b>Grand Total</b>		<b>96,851</b>	<b>110,379</b>	<b>7,045</b>	



# 2016 Michigan Young Adult Survey:

Substance Use Among Michigan's Young Adults

The Office of Recovery Oriented  
Systems of Care

Wayne State University School of  
Social Work



## Report Information



This report was commissioned by The Office of Recovery Oriented Systems of Care, Michigan Department of Health and Human Services.

This research was conducted by the Wayne State University School of Social Work.

This report was written by Elizabeth Agius, Brooke Dudek, Danielle Hicks, and Stella M. Resko.

This report was completed April 19th, 2017.

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## Executive Summary

Data based on responses from 1,568 Michigan young adults aged 18 to 25:

### Demographic Information

- Most respondents identified as female (75.1%) and the average age of respondents was 21.3
- Racially, most respondents identified as Caucasian/White (85.3%), followed by two or more races (5.6%), and African American/Black (5.3%) – the remaining groups make up less than 5% of the sample
- Most respondents were employed (76.3%) and attended school (68.6%) – over half of the sample (55.3%) attended college or vocational school full-time

### Perceptions about Ease of Access to Alcohol & Other Substances

- On a scale of 1 (probably impossible) to 5 (very easy), prescription pain relievers without a prescription ( $M=3.45$ ,  $SD=0.92$ ) were reported as the most difficult to access, followed by accessing marijuana ( $M=4.10$ ,  $SD=0.74$ ), and alcohol ( $M=4.24$ ,  $SD=0.75$ )

### Perceptions about Risk of Alcohol & Other Substances

- On a scale of 1 (no risk) to 4 (great risk), the use of marijuana ( $M=2.20$ ,  $SD=0.97$ ) was perceived to be the least risky, followed by alcohol ( $M=3.00$ ,  $SD=0.79$ ), prescription pain relievers used at higher doses or for different reasons than prescribed ( $M=3.24$ ,  $SD=0.82$ ), and the use of non-prescribed prescription pain relievers ( $M=3.40$ ,  $SD=0.74$ )

### Personal Behaviors and Experiences with Alcohol & Other Substances

Respondents were asked to provide information on their use of the following substances: alcohol, marijuana and/or hashish, prescription drugs with and without a prescription, as well as heroin

- Of these substances, the most frequently reported to use in the past 30 days was alcohol (72%), followed by marijuana (29%)

- Of the respondents who consumed alcohol in the past 30 days and reported on drinking behaviors (n=900), 70% engaged in binge drinking (n=632)
- Respondents reported they had driven a vehicle under the influence of marijuana and/or hashish (16%) more likely compared to under the influence of alcohol (5%)
- Twelve percent of young adults reported prescription drug misuse without a prescription and 9% of young adults reported prescription drug misuse (higher dose or different reason than prescribed) with a prescription in the previous 12 months
  - With regard to the type of prescription, those without a prescription most often misused stimulant medications, followed by pain medications. For respondents with a prescription, the most misused category of prescription drugs was pain medications, followed by sedatives/anxiety medications
- A small proportion (1%) of the sample reported heroin use in the past 12 months. Most of the respondents who reported using heroin in the past 12 months, also reported misusing prescription drugs in the past 12 months

### **Reasons for Alcohol & Marijuana Use**

- Provided with 16 possible responses, the most common reasons for alcohol use included 'to have a good time with my friends' (30.7%), followed by 'to relax or relieve tension' (18.7%), and 'because it tastes good' (15.2%)
- Provided with 14 possible responses, the most common reasons for marijuana use included 'to relax or relieve tension' (20.7%), 'to feel good or get high' (19.0%), and 'to have a good time with my friends' (14.5%)

## 2016 Michigan Young Adult Survey

The 2016 Michigan Young Adult Survey was designed to learn more about substance use behaviors of Michigan residents aged 18 to 25. A total of 1,570 web-based surveys were completed via Qualtrics. However, two out-of-state surveys were removed from the sample, as they do not meet the criteria for our target population. After removal of these responses, a total of 1,568 completed surveys were used for the analyses.

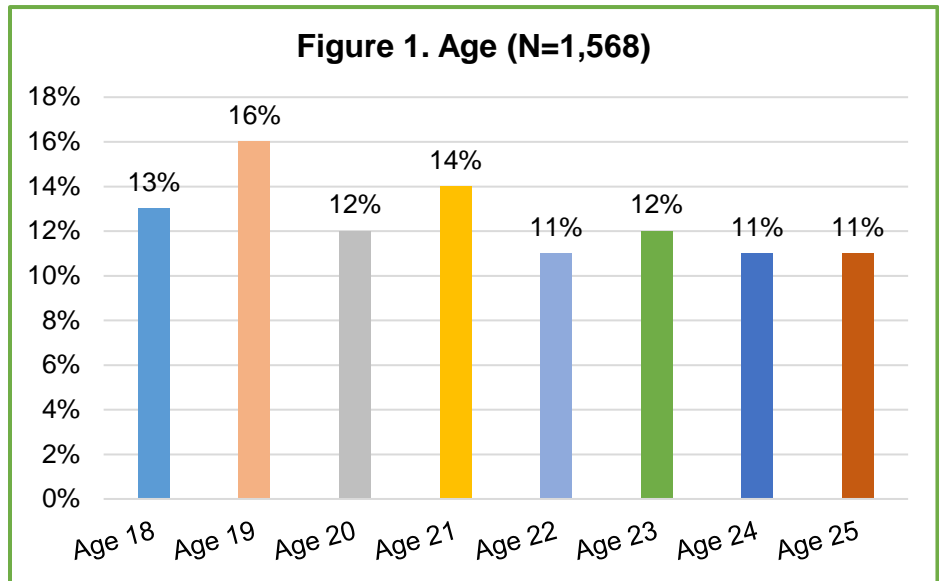
Data collection proceeded in two phases with the first phase of surveys collected between September 9<sup>th</sup>, 2015 and April 25<sup>th</sup>, 2016. The second phase of surveys was collected between November 26<sup>th</sup>, 2015 and April 30<sup>th</sup>, 2016. The first phase of the survey remained open when the second phase of surveys began, each version of the survey had an individualized link that respondents used to take the survey. Each survey contained the same questions with minor adjustments being made to the second phase. Each question was optional, therefore, discrepancies exist in the total number of responses per question. Skip patterns were also used on several questions, which changed the amount of respondents per question.

We recruited young adults for the survey using paid advertisements on Facebook, email, and social network advertisements to community partners. The Office of Recovery Oriented Systems of Care shared the survey with community partners including: schools, the higher education network and workforce development sites. Thirty-one percent of the sample was reached through Facebook advertisements, while 29% were referred to the survey through a friend or family member. Comparably, 28% were referred to the survey through their local college or university sending a flier or weblink. Three percent reported learning about the survey through a link on another website while 9% indicated other referral sources (e.g. coworkers, employer, other emails).

## Demographic Information

Respondents were asked to provide demographic information including gender, age, race, employment status, student status, and education level.

With regard to gender, most respondents identified as female (75.1%), followed by 23.9% male, and 1% transgender or other. The mean age of respondents was 21.3 (SD=2.30) and as **Figure 1** illustrates the distribution was evenly spread across the ages 18 to 25.



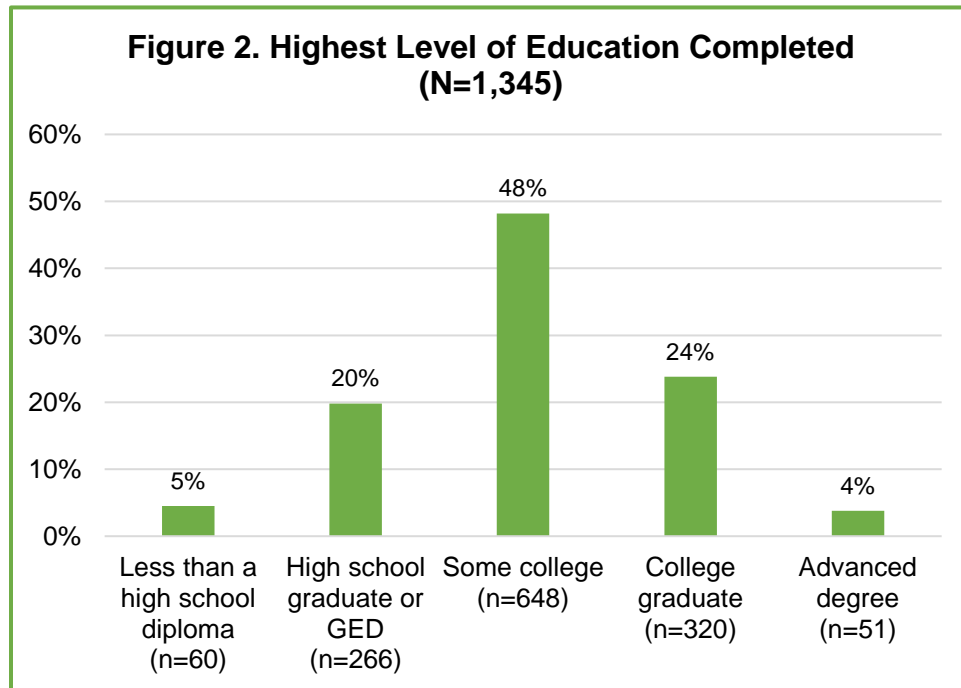
Respondents were also asked to indicate their race. Of the responses, most self-identified as Caucasian or White (85.3%), followed by 5.6% as two or more races, 5.3% as African American or Black, 2.5% as Asian, and 1.3% as American Indian or Alaska Native.

Examining employment status showed that three quarters of respondents were employed (76.3%), while 23.7% of respondents were *not* employed. More specifically, 46.2% of respondents were employed part-time, followed by employed full-time (27.4%) and self-employed (2.7%). Approximately 13.4% of respondents who were *not* employed also reported they were looking for employment (13.4%), while 10.4% indicated they were *not* looking for employment. These results in employment may be related to the fact that many of these individuals also attended school. Results regarding student status are found below.

Young adults were asked to indicate if they were a student and if so, what type of school they were attending. One-thousand and seventy-five (68.6%) young adults reported that they attended school. Of the 1,075 students, more than half of the young adults (55.3%) attended college or vocational school



full-time. Smaller portions of young adults attended school part-time (8.3%) or high school or a GED program (3.9%). Additionally, 1.1% indicated they attended some other type of school. In combination with student status, respondents were also asked to indicate the highest level of education they have completed. Results are shown below in **Figure 2**.



## Perceptions about Ease of Access to Alcohol & Other Substances

Respondents were asked to indicate the ease of access to alcohol, marijuana, and non-prescribed prescription pain relievers, for individuals their age in their community. Possible responses included: very easy, fairly easy, fairly difficult, very difficult, and probably impossible. Responses are shown below in **Tables 1, 2, and 3**. Overall, respondents indicated that the ease of access to prescription pain relievers without a prescription was most difficult ( $M=3.45$ ,  $SD=0.92$ ), followed by accessing marijuana ( $M=4.10$ ,  $SD=0.74$ ), and alcohol ( $M=4.24$ ,  $SD=0.75$ ).

**Table 1. Ease of Access to Alcohol for Ages 18-20 (N=1,286)**

	n	%	Mean
(5) Very easy	498	38.7%	4.24
(4) Fairly easy	647	50.3%	
(3) Fairly difficult	108	8.4%	
(2) Very difficult	20	1.6%	
(1) Probably impossible	13	1.0%	

For alcohol, 89.0% of respondents felt it was easy to access for 18 to 20 years olds in their community.

**Table 2. Ease of Access to Marijuana (N=1,284)**

	n	%	Mean
(5) Very easy	369	28.7%	4.10
(4) Fairly easy	722	56.2%	
(3) Fairly difficult	152	11.8%	
(2) Very difficult	14	2.6%	
(1) Probably impossible	7	0.5%	

For marijuana, 84.9% of respondents felt it was easy to access for individuals their age in their community.

**Table 3. Ease of Access to Prescription Pain Relievers Without a Prescription (N=1,282)**

	n	%	Mean
(5) Very easy	139	10.8%	3.45
(4) Fairly easy	510	39.8%	
(3) Fairly difficult	453	35.3%	
(2) Very difficult	150	11.7%	
(1) Probably impossible	30	2.3%	

For prescription pain relievers without a prescription, half of respondents (50.6%) felt they were easy to access for individuals their age in their community, while the other half (49.3%) thought it was difficult to access.

## Perceptions about Risk of Alcohol & Other Substances

Respondents were asked to indicate the risk of harming themselves physically or in other ways as a result of using alcohol, marijuana, or prescription pain relievers. Possible responses included: no risk, slight risk, moderate risk, and great risk. Responses are shown below in **Tables 4, 5, 6, and 7**. Overall, most respondents felt there was some level of risk with each substance. Respondents indicated they perceived the use of marijuana (M=2.20, SD=0.97) to be the least risky substance as compared to alcohol (M=3.00, SD=0.79) and prescription pain relievers (not prescribed: M=3.40, SD=0.74; prescribed: M=3.24, SD=0.82). Prescription pain relievers (M=3.40, SD=0.74) were perceived as the second least risky substance, while heavy, episodic use of alcohol was perceived as the most risky.

**Table 4. Level of Risk for 5 Alcoholic Drinks Once or Twice a Week (N=1,283)**

	n	%	Mean
(1) No risk	44	3.4%	3.00
(2) Slight risk	270	21.0%	
(3) Moderate risk	610	47.5%	
(4) Great risk	359	28.0%	

For alcohol, 75% of respondents felt having 5 alcoholic drinks once or twice a week was of moderate to great risk.

**Table 5. Level of Risk for Smoking Marijuana Once or Twice a Week (N=1,281)**

	n	%	Mean
(1) No risk	350	27.3%	2.20
(2) Slight risk	470	36.7%	
(3) Moderate risk	315	24.6%	
(4) Great risk	146	11.4%	

For marijuana, over 60% of respondents felt smoking marijuana once or twice a week was of no risk or only slight risk.

**Table 6. Level of Risk for Prescription Pain Relievers Not Prescribed and Used Occasionally (N=1,281)**

	n	%	Mean
(1) No risk	20	1.6%	3.40
(2) Slight risk	138	10.8%	
(3) Moderate risk	433	33.8%	
(4) Great risk	690	53.9%	

For prescription pain relievers, almost 90% of respondents felt using prescription pain relievers occasionally without being prescribed was of moderate to great risk.

**Table 7. Level of Risk for Prescribed Pain Relievers in Higher Doses or Different Reasons than Prescribed a Few Times Per Year (N=1,283)**

	n	%	Mean
(1) No risk	41	3.2%	3.24
(2) Slight risk	194	15.1%	
(3) Moderate risk	462	36.0%	
(4) Great risk	587	45.7%	

Additionally, over 80% of respondents felt using prescribed pain relievers at higher doses or for different reasons was of moderate to great risk.

## Personal Behaviors and Experiences with Alcohol & Other Substances

With regard to the respondents' behaviors and experiences involving alcohol and other substances, respondents were asked to indicate if they had used and how often they had used alcohol, marijuana, both prescribed and not prescribed prescription drugs, as well as heroin. Respondents were also asked if they used these substances while operating a vehicle. Respondents indicated if they had a medical marijuana card and how they obtained prescription drugs if they were not prescribed to them.

### Substance Use

#### Alcohol

For alcohol, respondents were first asked if they had at least one drink of any alcoholic beverage, such as beer, wine, a malt beverage, or liquor, within the past 30 days. With a total of 1,287 responses, approximately 72% indicated yes, 28% indicated no, and less than 1% indicated they did not know. Follow-up questions then assessed for risky drinking based on the National Institute on Alcoholism and Alcohol Abuse guidelines. If they indicated yes, females were asked on how many days they consumed *4 or more* drinks on a single occasion in the past 30 days, while males were asked on how many days they consumed *5 or more* drinks on a single occasion in the past 30 days. Of the 925 respondents who indicated they had consumed alcohol in the past 30 days, 900 answered the gender specific alcohol questions regarding binge-drinking behaviors.

- Of the 900 responses...
  - 68% of females engaged in binge-drinking over the past 30 days
    - Answers ranged from 0 to 24 days
  - 77% of males engaged in binge-drinking over the past 30 days
    - Answers ranged from 0 to 25 days
- For the females who reported binge-drinking over the past 30 days, the mean number of days this occurred on was 5.07
- For the males who reported binge-drinking over the past 30 days, the mean number of days this occurred on was 5.36

In sum, over the past 30 days 70% of the respondents who consumed alcohol also engaged in binge drinking. A slightly higher rate of males engaged in binge drinking (77%) compared to females (68%).

### Marijuana and Hashish

With regard to marijuana and hashish, respondents were asked on how many days in the past 30 they used either or both substances, as well as if they were a medical marijuana cardholder. Of 1,256 responses, 29% indicated they used marijuana or hashish. For those who used marijuana and/or hashish in the past 30 days, the mean number of days of use was 8.76. Respondents were also asked to indicate if they had a medical marijuana card regardless of whether that has used marijuana in the past 30 days or not. Of the 573 respondents who answered the question, only 4% indicated they had a medical marijuana card. Therefore, most respondents were accessing marijuana through other ways.

### Alcohol and Marijuana/Hashish Use While Driving

In addition to questions about alcohol and marijuana and/or hashish use, respondents were asked to indicate if within the past 30 days they had driven a vehicle after having too much to drink or after having used marijuana and/or hashish. Of the 628 eligible respondents for alcohol, 95% indicated they had *not* driven a vehicle after having too much to drink. Similar to alcohol, the majority of the 572 eligible respondents indicated they had *not* driven a vehicle after using marijuana and/or hashish (84%). However, the proportion of respondents who reported using marijuana and/or hashish and driving (16%) was more than triple the rate that reported they drove after they consumed alcohol (5%).

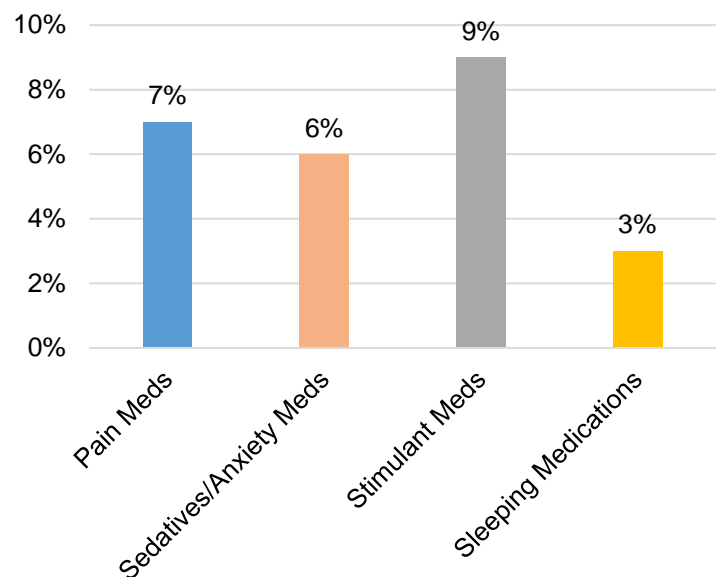
### Prescription Drugs

With regard to prescription drug use, respondents were asked if they had taken any of the following medications: prescription pain medications, sedatives/anxiety medications, stimulant medications, and sleeping medications, within the past 12 months. For each type of medication, respondents were asked if they had used the medication without a prescription, or if they did have a prescription, if they had used it at a higher dose or with a different reason than it was prescribed. For those who used prescription drugs without a prescription, these respondents were asked where they obtained the drug. **Table 8** below indicates the results for how many participants used a prescription drug without a prescription by type.

**Table 8. Use of Prescription Drugs Without a Prescription Over the Past 12 Months**

	<b>Pain Medications</b> (e.g. OxyContin, Vicodin, Tylenol 3 with Codeine, Percocet, Hydrocodone)		<b>Sedatives/Anxiety Medications</b> (e.g. Xanax, Valium)		<b>Stimulant Medications</b> (e.g. Ritalin, Adderall, Concerta, Dexedrine)		<b>Sleeping Medications</b> (e.g. Ambien, Halcion, Triazolam)	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Yes	88	7%	76	6%	109	9%	36	3%
No	1,152	91%	1,161	92%	1,119	89%	1,195	95%
Can't say, drug unfamiliar	21	2%	20	2%	22	2%	25	2%

Examining **Table 8** and **Figure 3** indicates the majority of respondents are not using prescription drugs without a prescription. However, the type of prescriptions most used by respondents are stimulant medications (9%), followed by pain medications (7%), sedatives/anxiety medications (6%), and sleeping medications (3%). For those who indicated they had used prescription drugs without a prescription, they were also asked where they obtained the medication from. Results for each type of prescription medication are shown on the following pages in **Table 9**.

**Figure 3. Percent Using Prescription Drugs Without a Prescription by Type****Table 9. Obtainment of Prescription Drugs Without a Prescription**

	<b>Pain Medications</b> (e.g. OxyContin, Vicodin, Tylenol 3 with Codeine, Percocet, Hydrocodone)		<b>Sedatives/Anxiety Medications</b> (e.g. Xanax, Valium)		<b>Stimulant Medications</b> (e.g. Ritalin, Adderall, Concerta, Dexedrine)		<b>Sleeping Medications</b> (e.g. Ambien, Halcion, Triazolam)	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Got if from a friend or relative for free	60	69%	52	68%	66	61%	25	73%
Bought it from a friend or relative	15	17%	10	13%	32	29%	1	3%

**Table 9. Obtainment of Prescription Drugs Without a Prescription**

	<b>Pain Medications</b> (e.g. OxyContin, Vicodin, Tylenol 3 with Codeine, Percocet, Hydrocodone)		<b>Sedatives/Anxiety Medications</b> (e.g. Xanax, Valium)		<b>Stimulant Medications</b> (e.g. Ritalin, Adderall, Concerta, Dexedrine)		<b>Sleeping Medications</b> (e.g. Ambien, Halcion, Triazolam)	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Took it from a friend or relative without asking	5	6%	5	7%	0	0%	1	3%
Bought it from a drug dealer or other stranger	1	1%	3	4%	8	7%	2	6%
Got it some other way	2	2%	3	4%	0	0%	1	3%
Don't remember	4	5%	3	4%	3	3%	4	12%

*Note. Respondents were also provided with the response option of "Bought it on the internet" but no respondents selected this option. Thus, it is not included in the table above.*

Regardless of the type of prescription drug (pain medications, sedatives/anxiety medications, stimulant medications, sleeping medications), most respondents indicated they got the drug from a friend or relative for free. With the exception of sleeping medications, the second largest source of prescription drugs were bought from a friend or relative. The young adults in our sample were most commonly obtaining prescription drugs without a prescription through friends and relatives. The type of prescription drugs that are most often taken from a friend or relative without asking are pain medications and sedatives/anxiety medications. The type of prescription drugs that are most often purchased from a drug dealer or other stranger are stimulants. In addition, those who were prescribed these medications were asked to indicate if they had used it at a higher dose or with a different reason than it was prescribed. The results are shown below in **Table 10**.

**Table 10. Use of Prescription Drugs With a Prescription at Higher Doses or for Different Reasons Over the Past 12 Months**

	<b>Pain Medications</b> (e.g. OxyContin, Vicodin, Tylenol 3 with Codeine, Percocet, Hydrocodone)		<b>Sedatives/Anxiety Medications</b> (e.g. Xanax, Valium)		<b>Stimulant Medications</b> (e.g. Ritalin, Adderall, Concerta, Dexedrine)		<b>Sleeping Medications</b> (e.g. Ambien, Halcion, Triazolam)	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Yes	79	6%	48	4%	32	3%	17	1%
No	1,164	93%	1,196	95%	1,211	96%	1,225	97%
Can't say, drug unfamiliar	18	1%	14	1%	14	1%	16	1%

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As Table 10 indicates, the majority of young adults are not prescribed these types of medications or they are not using their prescriptions at higher doses or for reasons other than the intended purpose of the medication. The type of prescriptions most abused by respondents are pain medications (6%), followed by sedatives/anxiety medications (4%), stimulant medications (3%), and sleeping medications (1%).

Overall, 17% of young adults reported using prescription drugs without a prescription or at a higher dosage or different reason than prescribed. For young adults who obtained prescription drugs without a prescription, they most often did so through a friend or relative. The most commonly misused categories of prescription medications varied by whether respondents had a prescription or not. For respondents without a prescription, the most abused category of prescription drugs was stimulant medications, followed by pain medications. For respondents with a prescription, the most abused category of prescription drugs was pain medications, followed by sedatives/anxiety medications.

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## Heroin

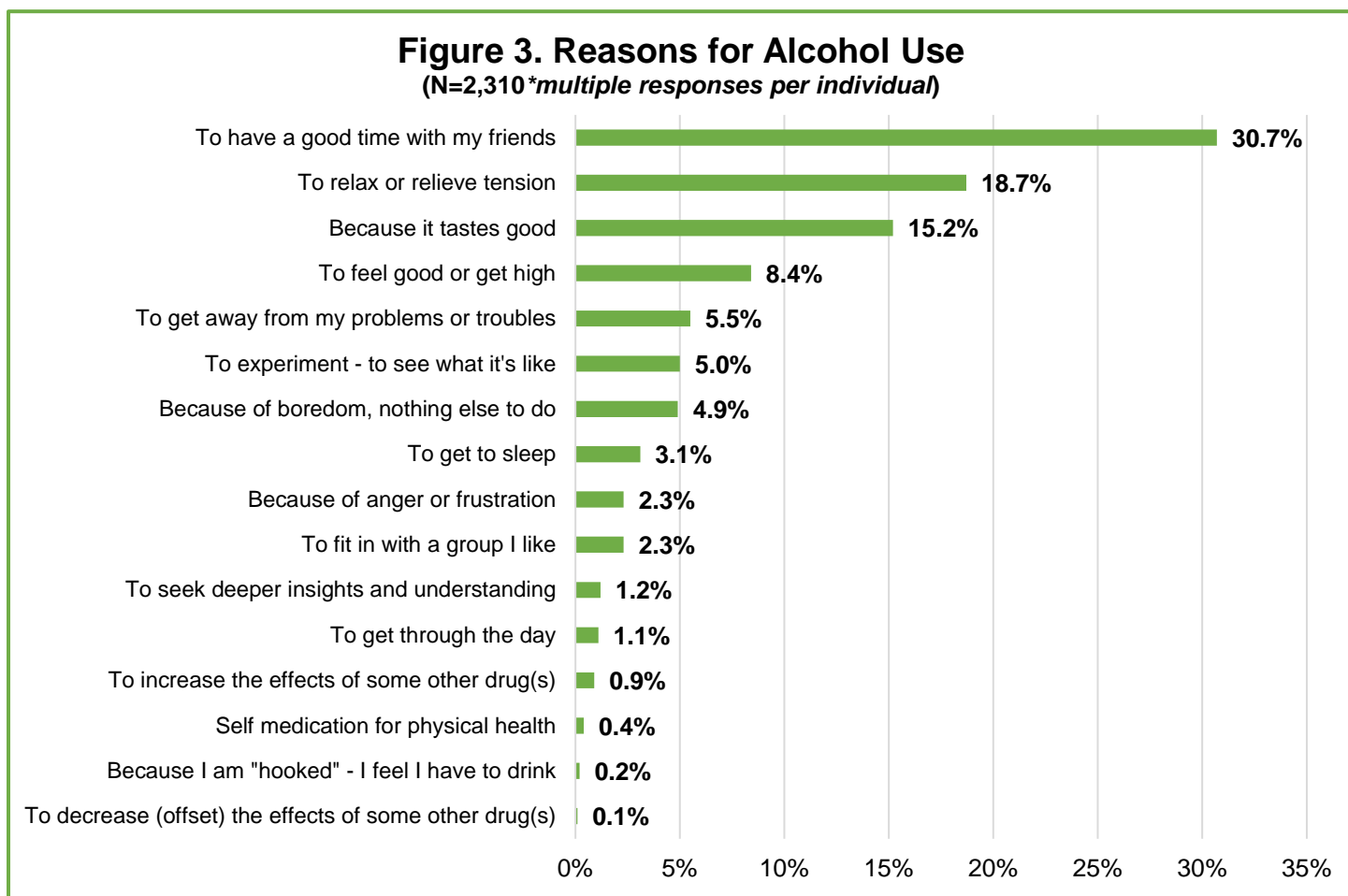
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For heroin, respondents were asked if they had used any form of heroin, even once, within the past 12 months. Only 1% of 1,262 respondents reported they used heroin, while 99% indicated they did *not* use heroin. Of the 13 respondents who indicated using heroin in the past 12 months, most also reported non-medical use of prescription drugs. Nine respondents reported using a prescription drug without a prescription and 8 respondents reported using a prescribed medication at a higher dose or for a different reason than it was prescribed.



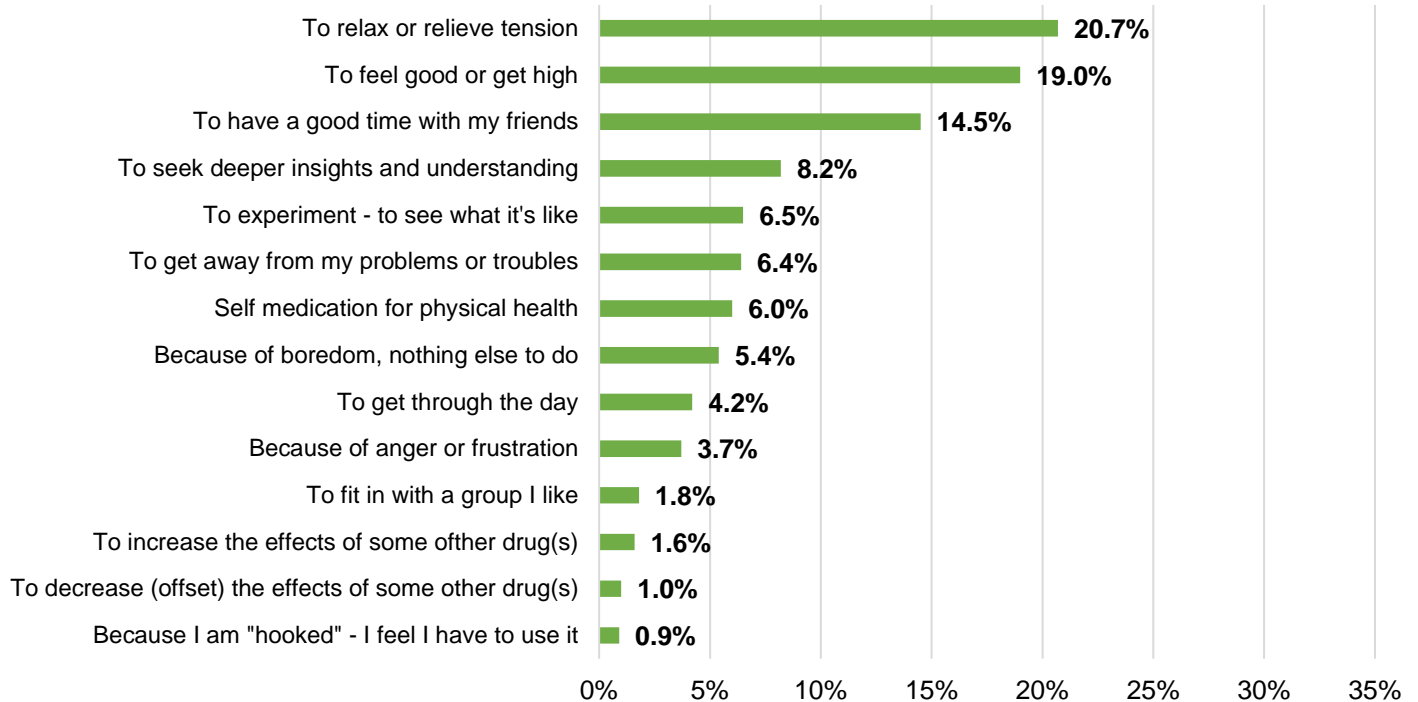
## Reasons for Alcohol & Marijuana Use

Respondents who used alcohol or marijuana were asked about the reasons they used these substances. For alcohol, respondents were provided with 16 possible options, shown below in **Figure 3**. While for marijuana, respondents were provided with 14 possible options, shown in **Figure 4**.



By far, the most common reason for using alcohol among respondents was “to have a good time with my friends.” The second most common response was “to relax or relieve tension” (given half as often as the number one response), followed closely by “because it tastes good.” On the opposite end, the least common responses, making up less than 1% in combination, were “self-medication for physical health,” “because I am ‘hooked’ – I feel I have to drink,” and “to decrease (offset) the effects of some other drug(s).” Results given as the reasons for marijuana use are shown in **Figure 4**, below.

**Figure 4. Reasons for Marijuana and/or Hashish Use**  
(N=1,104 \*multiple responses per individual)



For marijuana, the three most frequently reported reasons, in order, were: “to relax or relieve tension,” “to feel good or get high,” and “to have a good time with my friends.” The least common responses included “because I am ‘hooked’ – I feel I have to use it,” “to decrease (offset) the effects of some other drug(s),” “to increase the effects of some other drug(s),” and “to fit in with a group I like.”


Both alcohol and marijuana responses reflect young adults are using these substances for: release of tension, to have a good time with friends, and to feel good or get high. In each category those responses were rated in the top four reasons why young adults are using alcohol and marijuana.

## Conclusion & Implications

The survey yielded some interesting results. From a methodological standpoint, we were able to reach a good number of young adults through social media. The survey will be revised slightly, based on the results, and will be launched again in an effort to get additional data on this hard-to-reach population. Additional partners will be recruited, including outreach to college and universities, in an effort to reach greater numbers of respondents. While the sample is small and not generalizable, it does provide good, local data that we otherwise lack. The data will continue to be shared across the State to use as a planning tool for prevention and treatment efforts.

The survey found that alcohol continues to be the prevalent drug of choice among young adults, which is not surprising since the Centers for Disease Control and Prevention reports the level of binge drinking among 18-25 year olds is about 28%. However, the level was significant higher in this sample with 70% reporting binge drinking in the past 30 days. Binge drinking in national data sets is known to be higher among college versus non-college attending young adults, and also higher among those with higher family incomes. As we gather more data we will explore this point. This data will be shared with the Fostering Success Michigan Higher Education Consortium in hopes they can use it to improve programming around binge drinking.

Within this sample, the perception of risk for marijuana was low. Data generally confirms that as perceptions of risk about marijuana decline, use of marijuana increases. Data from the National Institute on Drug Abuse shows marijuana use in this age group is increasing. Our state sample shows that 29% say they used marijuana in the past 30 days. Only 4% of the sample affirms they have a medical marijuana card, so the use is still mainly illicit. A higher number of young adults admit to driving after using marijuana; which can have dangerous consequences. While policy in this area is rapidly evolving, strategies to mitigate harmful consequences should be a high priority. The Michigan State Police has recently obtained data on marijuana involved crashes, this data has been shared and should be used in addition to this report. For young adults, marijuana use can have lasting consequences due to potential for impaired brain development. Despite its perception as a “safe” drug, evidence shows otherwise.



State and national data underscore that opioid usage is at a record high and continuing to grow. This young adult sample shows 3 - 9% use rates in the past year for various prescription drugs without a prescription. While low, these numbers are higher than what we have seen in high school use rates taken from the Michigan Profile for Healthy Youth (MiPHY; 3-4% for 2016). The National Survey on Drug Use and Health rates for prescription drug use were around 4% in 2014. The study's sample found usage rates for pain relievers (7%) and stimulants (9%). This is a troubling sign in a young population and could signal a continuation of the current opioid crisis. Prevention and treatment efforts that are tailored to this population at this specific stage could go a long way to slowing the opioid crisis.

# NONOPIOID TREATMENTS FOR CHRONIC PAIN

Item 9B-1

## PRINCIPLES OF CHRONIC PAIN TREATMENT

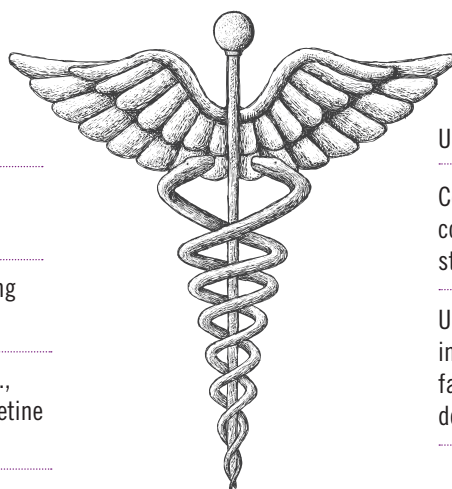
Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

Use nonopioid therapies to the extent possible

Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)

Focus on functional goals and improvement, engaging patients actively in their pain management

Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)



Use first-line medication options preferentially

Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies

Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

## NONOPIOID MEDICATIONS

MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

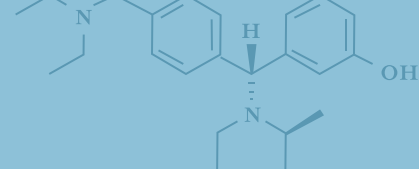
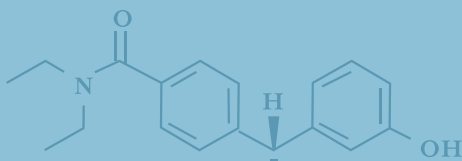


U.S. Department of  
Health and Human Services  
Centers for Disease  
Control and Prevention

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

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## RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

### Low back pain

**Self-care and education in all patients;** advise patients to remain active and limit bedrest

**Nonpharmacological treatments:** Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

#### Medications

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

### Migraine

#### Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

#### Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

### Neuropathic pain

**Medications:** TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

### Osteoarthritis

**Nonpharmacological treatments:** Exercise, weight loss, patient education

#### Medications

- First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

### Fibromyalgia

**Patient education:** Address diagnosis, treatment, and the patient's role in treatment

**Nonpharmacological treatments:** Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

#### Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin





# PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Item 9B-2

## ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

**IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN** (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

## BEFORE PRESCRIBING

### 1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

- Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = “no pain”, 10 = “worst you can imagine”)
- Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = “not at all”, 10 = “complete interference”)
- Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = “not at all”, 10 = “complete interference”)

### 2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

### 3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

### 4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

## WHEN YOU PRESCRIBE

### START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- If prescribing  $\geq 50$  MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- Avoid  $\geq 90$  MME/day; consider specialist to support management of higher doses.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calculator, go to [TurnTheTideRx.org/treatment](https://TurnTheTideRx.org/treatment).

### 50 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

### 90 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

## AFTER INITIATION OF OPIOID THERAPY

### ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals ( $\leq 3$  months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

## TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to [findtreatment.samhsa.gov](https://findtreatment.samhsa.gov). Additional resources at [TurnTheTideRx.org/treatment](https://TurnTheTideRx.org/treatment) and [www.hhs.gov/opioids](https://www.hhs.gov/opioids).
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at [www.samhsa.gov/medication-assisted-treatment](https://www.samhsa.gov/medication-assisted-treatment).
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage ( $\geq 50$  MME/day), concurrent benzodiazepine use.

## ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:  
[www.cdc.gov/drugoverdose/prescribing/guideline.html](https://www.cdc.gov/drugoverdose/prescribing/guideline.html)

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):  
[store.samhsa.gov/MATguide](https://store.samhsa.gov/MATguide)

NIDAMED: [www.drugabuse.gov/nidamed-medical-health-professionals](https://www.drugabuse.gov/nidamed-medical-health-professionals)

ENROLL IN MEDICARE: [go.cms.gov/pecos](https://go.cms.gov/pecos)

Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

## JOIN THE MOVEMENT

and commit to ending the opioid crisis at [TurnTheTideRx.org](https://TurnTheTideRx.org).

TURN  
THE  
TIDE

SUD Oversight Policy Advisory Board Meeting Packet: April 2024



The Office of the  
Surgeon General





# MSHN Strategic Planning Framework: 2019-2020 Update

Internal Leadership, Council/Committee Planning Document – Not for Publication

## **INTRODUCTION AND BACKGROUND**

MSHN conducts strategic planning at least every two years. The current plan covers fiscal years 2017 and 2018. This strategic plan update is intended to guide organizational and regional operations for fiscal years 2019 and 2020. This version of the document is for use by MSHN leadership, MSHN regional councils and as a framework for MSHN board of directors planning.

Planning takes in to account the environmental variables impacting our industry and our operations, known public policy directions and a host of volatile factors in both arenas like to or already impacting the region and the organization.

Planning also takes in to account the established strategic goals, strategic objectives and implementation activities already in place in the existing strategic plan. Themes identified during the past two years relating to the science of our work and to emerging national, statewide, regional and organizational competency, effectiveness, efficiency, capacity, and accountability are also considered particularly important in this planning process.

Finally, there are several high-visibility initiatives taking place within our state that directly impact regional and organizational operations. Of particular impact are the Section 298 Financial Integration Pilots, the Section 298 Policy Recommendations, the Home and Community Based Waiver Transition, the House of Representatives CARES Task Force Recommendations, the recommendations of the Governor's Diversion Council, and the recommendations of the Governor's Autism Council (to name just a few).

## **MISSION AND VISION**

"The mission of Mid-State Health Network is to ensure access to high quality, locally-delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members."

"The vision of the Mid-State Health Network is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership. Mid-State Health Network organizes and empowers and 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."

## **PROCESS AND TIMELINE**

The current process update takes place over a lengthy period as depicted in the following graphic.



**Strategic Goals:** For the current planning process, participants will use the current MSHN board-approved strategic goals as the starting point for planning.

- Strategic goals are the broadest and longest term. Strategic goals are those that set a course or direction for the region and the organization to pursue. Strategic goals are established by the MSHN board of directors with input from MSHN leadership, the regional Operations Council, and other regional Councils and Committees.

**Strategic Objectives:** For the current planning process, participants will use the current regional strategic objectives as the starting point for planning.

- Strategic objectives are based on strategic goals and are broad milestones or major activities that will be taken in pursuit of a particular board-approved strategic goal. Strategic objectives are approved by the MSHN board of directors, but are developed collaboratively by MSHN Leadership and the Regional Operations Council based on input from their respective organizations and regional Councils and Committees.

**Implementation Tactics:** For the current planning process, participants will not address implementation tactics.

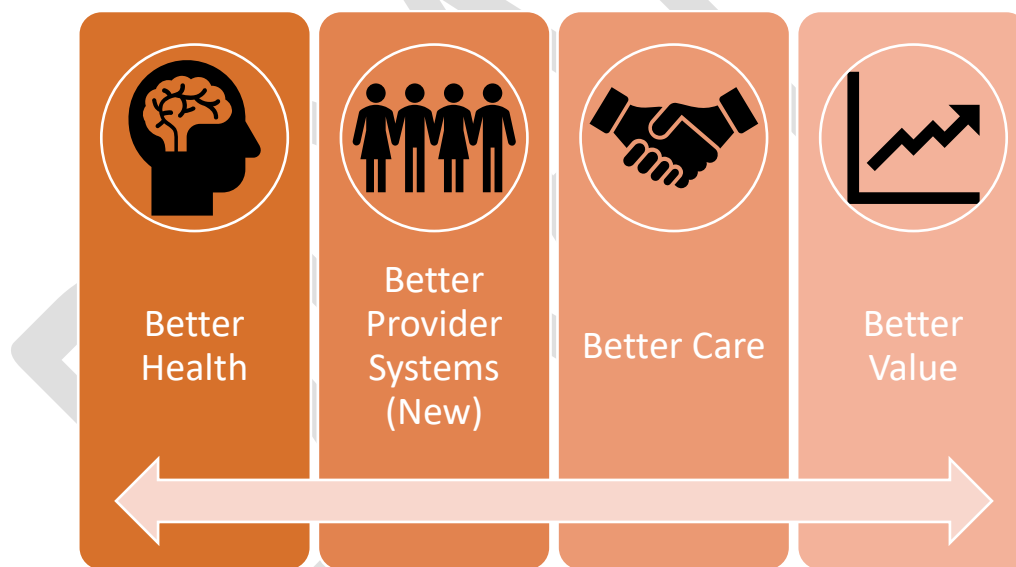
- Implementation tactics are based on strategic objectives and are the specific management actions that will be taken to achieve the strategic objectives. Implementation tactics and related planning is the responsibility of regional and organizational management and includes the assignment of time-frames and responsibility within the organization for carrying out the tactical activity. MSHN leadership typically undertakes planning in partnership and collaboration with its councils and committees, especially the Operations Council.

## STRATEGIC PLANNING FRAMEWORK – The Quadruple Aim

The current strategic plan is based on the “Triple Aim.” The Institute for Healthcare Improvement developed this national framework as an approach to optimizing health system performance. The IHI’s believe is that new designs must be developed to simultaneously pursue three dimensions: Improving the health of populations (Better Health), improving the patient experience of care, including quality and satisfaction (Better Care), and reducing the per capita cost of health care (Better Value). In recent years, a fourth dimension, better provider satisfaction (reframed for our purposes to “Better Provider Systems”) has seen a lot of attention in the literature, although it’s addition has not been endorsed by the IHI.

Better provider satisfaction is an important aspect of improving health, care experiences and value. Providers that are better equipped via training and resources, better positioned via stabilization of workload expectations and ever-evolving performance expectations, and more capable via reduced compassion fatigue (burnout), actually improve the other “aims.” MSHN does not have a direct connection to the provider workforce, so some of the aspects of improved provider satisfaction or not possible for MSHN. Nonetheless, MSHN proposes to add this fourth dimension to its strategic activities for the FY19-20 period and to provide regional leadership on these and related strategic goals.

These four dimensions, or “aims”, together are referred to as our “Strategic Priorities”.



The Institute for Healthcare Improvement has developed specific recommendations for simultaneous and sustained improvement in all “aim” areas. As an organizing framework for regional strategic planning and improvement of the healthcare system we are responsible for and participate in, roles and responsibilities for addressing all areas of the aim are delineated in our strategic plan based on our regional collaborative structure and our internal/external partnerships, responsibilities and accountabilities.

The pages that follow separate each “aim” for individual planning focus. Listed with the aim area are the current, MSHN board-approved strategic goals and strategic objectives. The following 2019-2020 recommendations are made with the support of the MSHN Leadership and MSHN Operations Council.

## STRATEGIC PRIORITY: BETTER HEALTH<sup>1</sup>



### STRATEGIC GOALS AND OBJECTIVES:

**MSHN will improve its population and integrated health activities and will develop a comprehensive integrated care/population health management plan**

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#### *2019-2020 RECOMMENDATION – RETAIN WITH MODIFICATION –*

*MSHN will improve its population and integrated health activities and will implement a BOARD APPROVED comprehensive integrated care/population health management plan.*

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*MSHN will procure a Managed Care Information System and related components*

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#### *2019-2020 RECOMMENDATION – COMPLETED, DISCONTINUE ADOPT THE FOLLOWING REPLACEMENT GOAL:*

*MSHN will expand the use and adoption of the Regional Electronic Medical Information (REMI) System and other applicable software platforms in use across the region to support improved population health outcomes, coordinated and integrated care activities, effectiveness and efficiency.*

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*MSHN will develop and establish a measurement portfolio to improve use of data in monitoring regional performance metrics and to assist in decision making internally and at the Council, Committee and Board levels*

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#### *2019-2020 RECOMMENDATION – RETAIN WITH MODIFICATIONS, AS FOLLOWS:*

*MSHN will EXPAND IMPLEMENTATION of ITS measurement portfolio to ADD VALUE TO PROVIDER OPERATIONS AND WILL IMPROVE use of data in monitoring regional performance metrics THT WILL assist in decision making internally and at the PROVIDER, Council, Committee and Board levels.*

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*MSHN will establish the organizational capacity to carry out its contractual responsibilities for improved care coordination with Michigan's Medicaid Health Plans*

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#### *2019-2020 RECOMMENDATION: Complete, discontinue*

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<sup>1</sup> Text in BOLD ALL CAPS are MSHN Board Approved Strategic Goals from the 2017-2018 Strategic Plan. Italicized text represents MSHN Leadership and Operations Council objectives supporting achievement of Strategic Goals. Plain text represents MSHN Leadership implementation strategies.

**MSHN will improve behavioral health treatment/service outcomes inclusive of all populations served.**

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*2019-2020 RECOMMENDATION: Retain/Continue WITH MODIFICATION:*

*MSHN will improve behavioral health SERVICES AND SUPPORTS, inclusive of all populations served.*

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*Implement standardized assessment tools across the region for all populations served*

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*2019-2020 RECOMMENDATION: Continue but move to “Better Care” Strategic Priority.*

*\* Note additional considerations include that while implementation of some standardized assessments is complete, several are at early stages of implementation.*

*\* The Global Assessment of Individual Need (GAIN) will be required to be implemented for the substance use disorder treatment population.*

*\* Federal parity requirements may have implications for standardized assessment use and related utilization management decisions.*

*\* Need to monitor legislative initiatives (Medicaid block grants, Medicaid work requirements, etc.)*

*\* Potential area for board presentation/education.*

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*Implement required elements of the Home and Community Based Service Final Rule with the goals of improved independence, community integration and freedom*

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*2019-2020 RECOMMENDATION: Retain but move to “Better Care” Strategic Priority*

*On a regional basis, effectively and efficiently implement public policy initiatives including, but not limited to, Section 298 Policy Recommendations, MIPAD Inpatient Access Recommendations, Federal Parity Regulations, Federal Medicaid Managed Care “Mega-Rules”, CARES Task Force Recommendations to the extent these public policy initiatives are addressable by the PIHP or CMHSP Participants in the region.*

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*MSHN Implements a regional strategy to impact opioid use disorders*

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*2019-2020 RECOMMENDATION: Continue*

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KEY BOARD PLANNING CONSIDERATIONS AND QUESTIONS:

Based on current knowledge of environmental variables impacting the nation, state, region and organization, what additional strategic goals are most important to pursue in FY 19 and FY20?

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To implement the strategic goals, what strategic objectives are most important to pursue in FY 19 and FY20?

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## STRATEGIC PRIORITY: BETTER PROVIDER SYSTEMS



This is a new focus area and there are no current board approved strategies.

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### 2019-2020 Recommendations:

\* MSHN ENHANCES EXISTING QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT SYSTEMS THAT PROMOTE CONTINUOUS IMPROVEMENT AND ENHANCED ACCOUNTABILITY FOR CLINICAL AND FISCAL PERFORMANCE

\* MSHN ENGAGES IN ACTIVITIES TO SIMPLIFY ADMINISTRATIVE COMPLEXITY AND ENHANCE PROVIDER SATISFACTION

\* MSHN ENSURES THAT IT ENGAGES A PROVIDER NETWORK WITH ADEQUATE CAPACITY AND COMPETENCY

\* MSHN WILL CREATE A FORUM FOR ADDRESSING PROVIDER WORKFORCE CONCERNS INCLUDING BUT NOT LIMITED TO WELLNESS/SELF-CARE, WORKFORCE SAFETY, ATTRACTION AND RETENTION OF A WELL QUALIFIED WORKFORCE.

MSHN WILL ADVOCATE FOR PUBLIC POLICIES THAT PROMOTE AN ADEQUATELY COMPENSATED, SAFE AND EFFECTIVE WORKFORCE.

MSHN WILL CREATE FORUMS TO EFFECTIVELY ADDRESS TRAUMA IN THE WORKFORCE, INCLUDING SECONDARY TRAUMA AND COMPASSION FATIGUE PREVENTION AND SUPPORTS.

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### KEY BOARD PLANNING CONSIDERATIONS AND QUESTIONS:

Based on current knowledge of environmental variables impacting the nation, state, region and organization, what additional strategic goals are most important to pursue in FY 19 and FY20?

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<sup>2</sup> Text in BOLD ALL CAPS are MSHN Board Approved Strategic Goals from the 2017-2018 Strategic Plan. Italicized text represents MSHN Leadership and Operations Council objectives supporting achievement of Strategic Goals. Plain text represents MSHN Leadership implementation strategies.

To implement the strategic goals, what strategic objectives are most important to pursue in FY 19 and FY20?

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## STRATEGIC PRIORITY: BETTER CARE



### CURRENT STRATEGIC GOALS AND OBJECTIVES:

#### **MSHN WILL IMPROVE ACCESS TO CARE**

*MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region*

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*2019-2020 RECOMMENDATION: Continue*

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*MSHN ensures expanded service access and utilization for ex-offenders through collaborative efforts with the MDOC, Community Corrections and other jail/prison stakeholders*

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*2019-2020 RECOMMENDATION: Continue*

---

*MSHN ensures expanded service access and utilization for veterans through collaborative efforts with the Veterans Administration at both the state and federal levels*

---

*2019-2020 RECOMMENDATION: Modify, as follows: MSHN ensures expanded service access and utilization for veterans AND MILITARY FAMILIES through IMPLEMENTATION OF THE REGIONAL AND STATEWIDE VETERAN AND MILITARY FAMILY MEMBER STRATEGIC PLAN.*

*2019-2020 RECOMMENDATION: Consider adding a strategic goal: \* MSHN takes actions to improve access to psychiatric inpatient care, reduce denials and improve emergency and crisis support continuum of care available in the region and across the State.*

*2019-2020 RECOMMENDATION: Consider adding a strategic goal: \*MSHN and participating CMHSPs establish processes to assist individuals served in maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.*

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<sup>3</sup> Text in BOLD ALL CAPS are MSHN Board Approved Strategic Goals from the 2017-2018 Strategic Plan. Italicized text represents MSHN Leadership and Operations Council objectives supporting achievement of Strategic Goals. Plain text represents MSHN Leadership implementation strategies.

## IMPROVE THE ROLE OF MSHN CUSTOMERS AND KEY STAKEHOLDERS IN MSHN OPERATIONS

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*2019-2020 RECOMMENDATION: Continue*

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*Implement regional educational opportunities and input sessions around new initiatives and ongoing operational matters*

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*2019-2020 RECOMMENDATION: Discontinue; replace with: MSHN will create and implement opportunities to involve consumers in population health activities, quality improvement and utilization management systems.*

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*Stakeholder feedback demonstrates effective, efficient and collaborative operations*

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*2019-2020 RECOMMENDATION: Continue*

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*MSHN will improve and integrate stakeholder and consumer input systems*

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*2019-2020 RECOMMENDATION: Continue, with modification, as follows: MSHN will improve and integrate stakeholder and consumer input and utilize compiled input to improve system performance, and provide feedback to stakeholders on systems improvements made.*

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## ENHANCE ORGANIZATIONAL QUALITY AND COMPLIANCE

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*2019-2020 RECOMMENDATION: Continue with modification: \*Enhance REGIONAL Quality and Compliance*

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*MSHN implements its approved Quality Assessment and Performance Improvement Plan, and specific Performance Improvement Plans, to improve quality and care across the region*

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*2019-2020 RECOMMENDATION: Continue*

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*MSHN will provide leadership on improving the consistency and implementation of person-centered planning in the region*

---

*2019-2020 RECOMMENDATION: Continue, but promote to strategic objective and include self-determination and independent facilitation.*

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*2019-2020 RECOMMENDATION: Consider adding a strategic goal: MSHN will lead a process for collaboration with local law enforcement, high schools and colleges/universities to establish protocols for the engagement, screening, assessment and engagement of high risk individuals so that community safety systems are enhanced and individuals in need of services and supports are effectively engaged.*

*2019-2020 RECOMMENDATION: Consider adding a strategic goal: MSHN will address deficiencies in its Provider Network Adequacy Assessment in partnership with CMHSP Participants and Providers.*

---

KEY BOARD PLANNING CONSIDERATIONS AND QUESTIONS:

Based on current knowledge of environmental variables impacting the nation, state, region and organization, what additional strategic goals are most important to pursue in FY 19 and FY20?

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To implement the strategic goals, what strategic objectives are most important to pursue in FY 19 and FY20?

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## STRATEGIC PRIORITY: BETTER VALUE



### CURRENT STRATEGIC GOALS AND OBJECTIVES:

#### **PUBLIC RESOURCES ARE USED EFFICIENTLY AND EFFECTIVELY**

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*2019-2020 RECOMMENDATION: Continue*

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*Implementation of the region's utilization management plans demonstrate achievement of defined goals*

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*2019-2020 RECOMMENDATION: Discontinue*

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*2019-2020 RECOMMENDATION: Consider adding:*

- \* MSHN monitors and provides reports and recommendations to improve the financial health of the region and its CMHSP participants*

- \* MSHN manages adequate risk reserves to meet current and future fiscal and utilization risk*

- \* MSHN leads efforts to explore opportunities to achieve reduced administrative costs in the region (decreased horizontal and/or vertical administrative duplication)*

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#### **REGIONAL PUBLIC POLICY LEADERSHIP SUPPORTS IMPROVED HEALTH OUTCOMES AND SYSTEM STABILITY**

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*2019-2020 RECOMMENDATION: Continue*

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*MSHN Board members reflect high degrees of satisfaction with MSHN operations and board development activities*

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*2019-2020 RECOMMENDATION: Continue*

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<sup>4</sup> Text in BOLD ALL CAPS are MSHN Board Approved Strategic Goals from the 2017-2018 Strategic Plan. Italicized text represents MSHN Leadership and Operations Council objectives supporting achievement of Strategic Goals. Plain text represents MSHN Leadership implementation strategies.

*MSHN Develops and implements plan for PIHP Accreditation*

---

*2019-2020 RECOMMENDATION: MSHN is in the process of implementing a review of the benefits and effort involved in pursuing this strategic goal. MSHN Operations Council will review the results of this analysis and make a recommendation in April 2018, prior to the Board Strategic Planning sessions in May 2018.*

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*MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure*

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*2019-2020 RECOMMENDATION: Continue*

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*MSHN will expand capability to conduct fiscal planning and analysis*

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*2019-2020 RECOMMENDATION: Continue*

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*MSHN's Provider Network Management Systems are effective and efficient*

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*2019-2020 RECOMMENDATION: Continue – consider adding an activity: Evaluate the effectiveness of regionally organized fiscal intermediary and inpatient provider performance monitoring systems developed in prior years.*

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KEY BOARD PLANNING CONSIDERATIONS AND QUESTIONS:

Based on current knowledge of environmental variables impacting the nation, state, region and organization, what additional strategic goals are most important to pursue in FY 19 and FY20?

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To implement the strategic goals, what strategic objectives are most important to pursue in FY 19 and FY20?

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# Compliance Summary Report

October 2016 - September 2017

Prepared By: MSHN Compliance Officer – January 2018  
Approved By: MSHN Compliance Committee – January 10, 2018  
MSHN Board – March 6, 2018  
Reviewed By: Quality Improvement Council – January 25, 2018  
Operations Council – February 12, 2018

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# Monitoring and Auditing

## Mid-State Health Network Internal Audits

The 2017 (calendar year) Mid-State Health Network monitoring and oversight review of the Community Mental Health Service Provider's (CMHSP) and the Substance Use Disorder Service Providers (SUDSP) included a review of the Delegated Managed Care Functions as well as the Program Specific Requirements to ensure compliance with federal and state requirements.

### CMHSP Delegated Managed Care Reviews

#### CMHSP Delegated Managed Care Functions

This review included sixteen (16) standards and one hundred forty-four (144) elements. The full review consisted of an on-site visit to the CMHSP Participant to conduct consumer chart reviews, review and validate process requirements, review of new standards since the last audit, analysis of performance and encounter data, interviews of staff, and monitoring of the FY16 desk-audit corrective action plans as applicable.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs).

#### Performance Variables for Consideration

- Changes to monitoring tool related to scope of review for specific standards

#### Status:

- 12 of 12 CMHSP full site visits completed by MSHN staff
- 10 of 12 Corrective Action Plan's received from the CMHSP's
- 8 of 12 Corrective Action Plan's reviewed and approved by MSHN staff

Delegated Managed Care Functions	2015 Results	2017 Results	Performance Comparison
Information and Customer Service	89.6%	97.9%	8.3%
Enrollee Rights & Protections	99.1%	100.0%	0.9%
24/7/365 Access <sup>1</sup>	94.8%	98.5%	3.7%
CMHSP Provider Network (sub-contract providers)	95.5%	97.8%	2.3%
Service Authorization & UM	90.8%	100.0%	9.2%
Grievance & Appeals	95.8%	97.7%	1.9%
Person Centered Planning & Documentation	97.5%	98%	0.5%
Advance Directives <sup>2</sup>	95.8%	N/A	N/A
Coordination of Care/Integration <sup>3</sup>	97.9%	97.5%	-0.4%

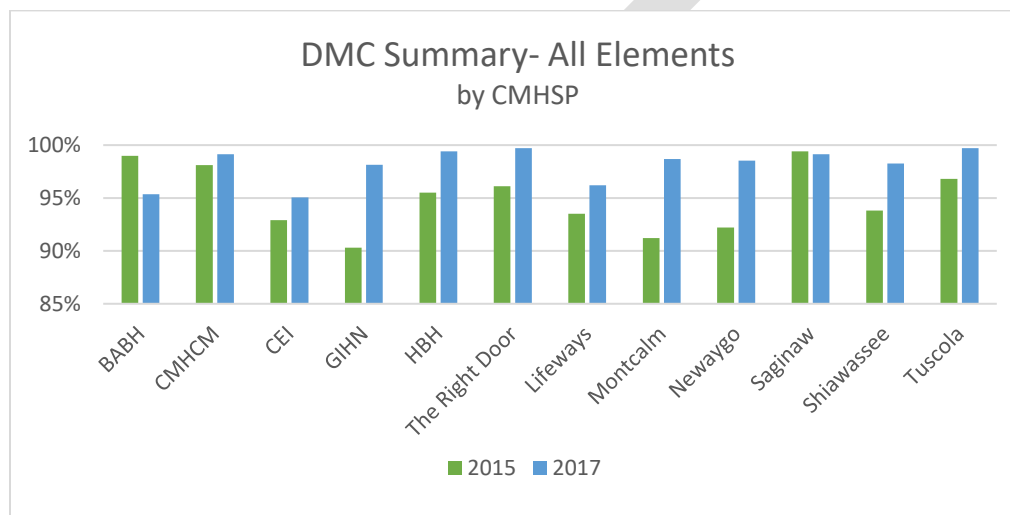
<sup>1</sup> Access Policy revisions resulted in new standards in 2016

<sup>2</sup> Advance Directives standards were combined with Customer Services standards in 2017

<sup>3</sup> Coordination of Care/Integration of Behavioral & Physical Health Services section was updated in 2017 to include three (3) additional standards focusing on coordination of follow-up after hospitalization, follow-up of shared members with the MHP through ICDP, CC360, and/or MIHIN. As a result of the additional standards, a slight decrease was noted from 2015 to 2017



Delegated Managed Care Functions	2015 Results	2017 Results	Performance Comparison
Behavior Treatment Plan Review Committee	88.3%	98.5%	10.2%
Consumer Involvement	98.6%	100.0%	1.4%
Provider/Staff Credentialing	90.3%	95.4%	5.1%
Quality & Compliance	98.1%	99.1%	1.0%
Ensuring Health & Welfare/Olmstead	97.7%	99.1%	1.4%
Information Technology	100.0%	100.0%	0.0%
Trauma Informed Care <sup>4</sup>	N/A	96.8%	N/A



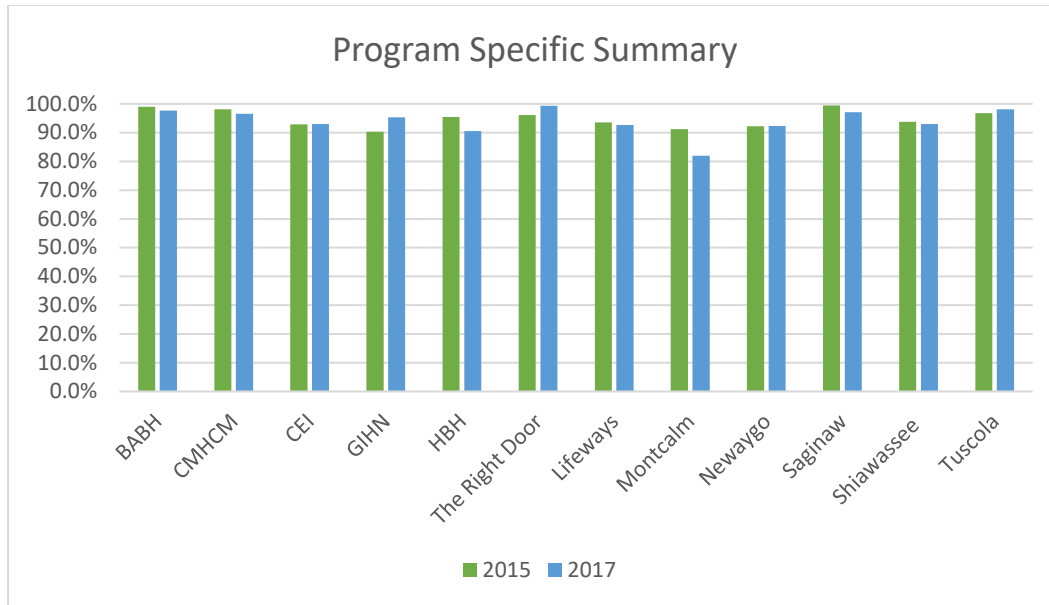
### CMHSP Program Specific Site Review

This review included ten (10) standards and a total of eight-five (85) elements. The focus of this section was to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Program Specific Requirements.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs).

Program Specific	2015 Results	2017 Results	Performance Comparison
Jail Diversion	93.8%	95.3%	1.5%
Assertive Community Treatment (ACT)	98.1%	100%	1.9%
Self Determination	95.4%	97.3%	1.9%
Peer Delivered and Operated Services (Drop-In)	100.0%	91.7%	-8.3%
Home Based Services	95.0%	98.3%	3.3%
Clubhouse Psycho-Social Rehabilitation	100.0%	96.4%	-3.6%
Crisis Residential Services	93.1%	85.6%	-7.5%
Targeted Case Management	91.7%	97.5%	5.8%
Habilitation Supports Waivers	95.0%	96.7%	1.7%
Autism Benefit/Applied Behavioral Analysis	86.7%	87.7%	0.0%

<sup>4</sup> New Trauma Informed Care resulted in new standards in 2017



Ensuring excellent quality and identifying areas for opportunity is completed in partnership with the CMHSPs. The number of charts reviewed during each onsite visit is generally between five (5) and eight (8). Administrators, supervisors, and direct care team members are available for guidance, interviews, and discussion during the 2-day onsite reviews. However, this does not include the time spent preparing for an extensive quality assurance and performance improvement review. Each of MSHN's CMHSP partners did an excellent job assisting in the process.

### **CMHSP Training**

Regional trainings were conducted during this past year that included topics such as:

- Autism
- Home and Community Based Waiver Rules

### **CMHSP Noteworthy Strengths**

The CMHSPs are focusing on Better Health/Integrated Treatment. The Integrated Health Care chart review consistently demonstrated diligent efforts to improve overall health outcomes. Together, the CMHSPs are demonstrating dedication to ensuring overall better health for our consumers. Examples include onsite wellness programs, community-based workout/exercise opportunities, and clinical interventions including trauma-based yoga.

Community Mental Health for Central Michigan developed an enhanced integrated healthcare program and is generating data that evidences overall improvements to focus areas including diabetes. Leadership has provided ongoing support to their teams to ensure the services are provided, data is collected, and outcomes are shared. Information sharing has, per interviews with key staff, been instrumental in ensuring accurate data. Both consumers and those providing direct services can see accomplishments throughout treatment/engagement.

The CMHSPs are consistently leading community efforts to enhance trauma-informed interactions with a variety of stakeholders including local police departments, Department of Health & Human Services, legal systems, and schools. It is evident that there is a focus on evidence-based practices such as *No Harm Done* which strives to protect children from unintended consequences after traumatic events. Several examples of excellent trauma-informed practices are present throughout the region.

Saginaw CMHSP, for example, helped their community's healing process after a tragic event. The Saginaw team worked with their local law enforcement, training and educating, and has since built a strong partnership in which law enforcement even reach out to Saginaw CMHSP for assistance when mental health is a factor.

Another example of regional excellence includes supporting team members and ensuring secondary/vicarious trauma impacts are prevented and/or treated appropriately. Upon evaluation of internal surveys in which staff were asked questions regarding supports, training, and competence, many CMHSPs have implemented internal supportive practices such as education on the impact of treating trauma survivors, open-door supervision, and company morale activities.

Overall, the CMHSPs have implemented practices to ensure that members have 24/7/365 access to the SUDSP screening and referral. Consistently, the CMHSPs share recommendations, strengths, and concerns regarding collaboration of care with the SUDSPs. This is demonstration of a growing partnership with a shared goal of ensuring consumers receive excellent care for co-occurring disorders.

### CMHSP Opportunities

An enhanced focus for 2018 includes efforts to ensure quality care services, based on data-driven outcomes, are consistently provided/maintained throughout the region. Enhancement opportunities are discussed with the CMHSPs and other stakeholders so the reviews accurately & effectively capture the dedication to overall improved health through cost-effective, quality care services. The 2017 review analysis indicates growing opportunities including:

- Enhancing Person-Centered Planning Documentation and/or Delivery - Electronic Medical Records (EMR) are an excellent way of ensuring consumers are protected by indication that they were notified of their rights, benefits, etc. However, EMRs also unintentionally create an avenue for limited narrative and human error (checking the wrong box). The amended Person-Centered Planning Policy includes guidelines for improving both documentation and service enhancement.
- Continue Enhancing Coordination of Care Efforts with SUDSPs - the CMHSP Participants and the SUDSPs should continue enhancing their relationships to ensure that every individual served receives medically necessary services that are unique to the individual. Methods of continued enhancement may include:
  - Increasing number of signed Coordination of Care Agreements with SUDSPs;
  - Education and information on services/programs within both the CMHSP and SUDSP network;
  - Developing mutual clinical goals that will require efforts of all, such as reducing the number of opioid-related deaths, increasing dual-enrollments, enhancing discharge planning and referrals.

## SUDSP Delegated Managed Care Reviews

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### SUDSP Delegated Managed Care Functions

This review included ten (10) standards and a total of one hundred fifty-two (152) elements. The full review consisted of an on-site visit to the SUDSP to conduct consumer chart reviews, review and validate process requirements, review new standards added since previous audit, analyze performance and encounter data, interview staff, and monitor FY16 desk-audit corrective action plans as applicable.

### SUDSP Treatment Quality Assurance

MSHN completed 19 full SUDSP treatment provider reviews and 18 interim reviews in 2017. Note, many providers may have more than one licensed site. The number of charts reviewed during each onsite visit is a 5% sample, with a minimum of two (2) and maximum of eight (8) for each licensed site.

Prior to 2017, reviews were conducted at each licensed site. As a result, data includes multiple site reviews for one provider. Therefore, a comparison of 2015 and 2017 data would not be an accurate reflection. MSHN will utilize 2017 reviews as a baseline for comparison in upcoming years.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating SUDSPs (19 full reviews completed at time of report)).

Delegated Managed Care Functions	# of Standards in each Section	2017 Results
Access and Eligibility	6	68.5%
Information and Customer Service	21	83.7%
Enrollee Rights and Protections	15	86.3%
Grievance and Appeals	18	56.6%
Quality and Compliance	12	68.1%
Authorizations/UM	4	66.7%
Individualized Treatment & Recovery Planning & Documentation	12	74.8%
Policy and Procedure Review	37	80.4%
Coordination of Care	11	55.1%
Provider Staff Credentialing	16	59.9%

### SUDSP Treatment Training

Regional trainings were conducted during the quarterly SUDSP meetings and other venues and included topics such as:

- Staff Credentialing and Recredentialing
- Recovery Oriented Systems of Care
- Grievance and Appeals
- Trauma Informed Care
- Preventing Opiate Overdose
- The Relationship of Social Determinants of Health and the Effect of Trauma and Related Responses to Care
- Women's Specialty Services
- Sub-Regional Coordination of Care Planning between Recovery Residence and Outpatient Providers
- Acupuncture Certification (NADA)
- Promoted statewide training opportunities to provider network such as ASAM Level of Care

### **SUDSP Treatment Noteworthy Strengths**

The SUDSP network is expanding the internal service array to include programming that meets the needs of individual consumers based on medical necessity. Expansion efforts include implementing group/individual therapeutic services, hiring Peer Recovery Coaches, developing effective case management practices, and ensuring team members receive training in evidence-based programming that meets the needs of the population.

MSHN providers have implemented practices to meet opioid-abuse prevention and treatment goals. This is evidenced by enhanced service arrays offered by Medication-Assisted Treatment Providers, implementation and oversight of neo-natal exposure programming, increased number of consumers dually enrolled in treatment & recovery programs to ensure all needs are effectively addressed.

MSHN expanded services by securing SUDSP Recovery Residence contracts with a variety of providers who help secure safe environments for persons in treatment and recovery from the disease of addiction. Collaboration with housing providers has begun and is in a growing process that includes understanding what information can and should be shared to ensure coordination of care.

### **SUDSP Treatment Opportunities**

- Increase data-driven outcome reporting
- Enhance use of evidence-based programming
- Improve Continuum of Care Efforts
- Develop practices that support coordination of care efforts

### **SUDSP Prevention Quality Assurance Reviews**

This review included five (5) standards and a total of thirty-four (34) elements. The desk review consisted of policies and procedures, performance, reporting, and administration. MSHN has completed 35 of 35 desk reviews as of December 30, 2017.

<b>SUDSP Prevention Programming</b>	<b># of Standards in each Section</b>	<b>2017 Results</b>
<b>General Standards</b>	10	88.7%
<b>Evaluation &amp; Performance Improvement</b>	2	83.6%
<b>Designated Youth Tobacco Use Representative</b>	8	96.5%
<b>Reporting</b>	4	96.8%
<b>Administration</b>	10	81.2%

In order to effectively ensure quality, Mid-State Health Network Prevention Specialists complete an onsite program observation review to assess provider for excellent professional behavior, facilitation skills, community resource knowledge, and general evidence-based program delivery. As of November 30, 2017, 35 onsite reviews were completed.

The Michigan Prevention Data System is used to ensure compliance with respect to utilization and fidelity. Prevention Specialists conduct monthly reviews to ensure timeliness of data input. An overall outcomes report will be included in the January 2018 quarterly report as the FY17 Provider Outcome Reports are due in December 2017.

### *SUDSP Prevention Training*

Regional trainings are conducted during the quarterly SUDSP meetings and other venues and included topics such as:

- Motivational Interviewing
- Trauma Informed Practices
- Analyzing MiPHY
- Coalition Improvement
- Engaging Youth
- State of Marijuana

### *SUDSP Prevention Noteworthy Strengths*

- Providers consistently demonstrate expert content knowledge of community resources and referral systems
- Providers consistently demonstrate excellent professional behaviors including preparation and timeliness
- Facilitation styles are appropriate for the intended audience with consideration of demographic & cultural factors
- Increased focus on opiate abuse prevention as demonstrated through newly established partnerships with regional health care providers that focus on:
  - Opioid Prescription Policies
  - Prevention of Abuse Trainings
- Increased partnerships with schools as indicated by an increased number of schools allowing prevention programming during the school year and participation in the Michigan Profiles Healthy Youth (MiPHY) survey

### *SUDSP Prevention Opportunities*

- Enhance regional Prevention Coalition relationships
- Increase MiPHY Participation
- Increase delivery of evidence-based programs that improve academic performance and health
- Implement monthly MPDS accuracy checks

## *MSHN Quality Assurance & Performance Improvement (QAPI)Next Steps*

The scope of the 2018 Delegated Managed Care Site Review work plan includes:

- Full reviews for SUDSPs who received a full review in 2016;
- Corrective Action Plan Compliance follow-up of full reviews completed in 2017 for both CMHSPs and SUDSP;
- New Standards for CMHSPs - Home and Community Based Service requirements for onboarding new providers and ensuring existing providers are coming into compliance; Encounter/Data submission;
- New Standards for SUDSPs - ASAM Level of Care verification; Financial Audit; Medication-Assisted Treatment Policy Changes; MPDS Compliance Verification;
- Develop a SUDSP Advisory Group to inform data analysis and performance improvement strategies;
- Improving the review process by enhancing the quality of services evaluation to data-driven outcomes;
- Develop and implement process for quarterly compliance and quality reports that include all relevant departments such as prevention, utilization management, and recipient rights.

# Monitoring and Auditing

## Mid-State Health Network External Audits

### **MDHHS Habilitation Supports Waiver Site Visit Report: February 27<sup>th</sup> - March 7<sup>th</sup>**

The Michigan Department of Health and Human Services (MDHHS) conducted a follow up review on-site for our region from February 27, 2017 through March 7, 2017. The purpose was to review the status of the required corrective action plans from the review completed during Fiscal Year 2016 for the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW), the Children's Waiver Program (CWP) and the Wraparound Fidelity review.

Note: The SEDW, CWP and Wraparound Fidelity review is the responsibility of the CMHSP and therefore the follow up review was completed at the CMHSP's, not at MSHN.

The 2017 site review included the review of beneficiary files, staff records and home visits to ensure the required plans of correction were implemented and effective in correcting the identified issues.

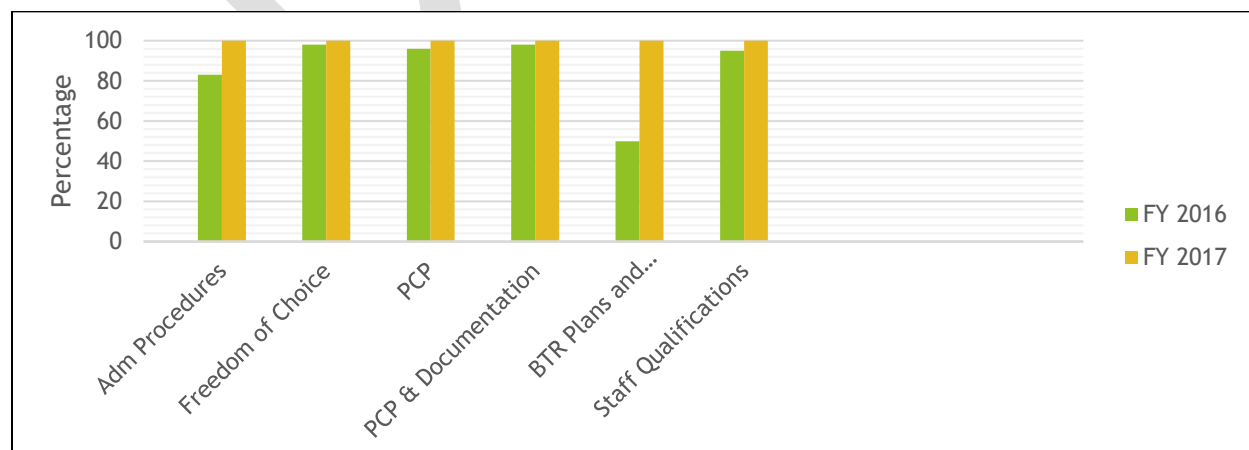
#### **Summary of the findings:**

- A. Administrative Procedures (1 element): 100%
- B. Freedom of Choice (2 Elements): 100%
- C. Implementation of Person Centered Planning (6 Elements): 100%
- D. Plan of Service and Documentation Requirements (1 Elements): 100%
- E. Behavior Treatment Plans and Review Committees (1 Elements): 100%
- F. Staff Qualifications (4 Elements): 100%
- G. Home Visits/Training/Interviews (1 home): 100%

#### **Next Steps:**

MSHN received a status of full compliance with all required plans of correction for FY2017. No further action is necessary at this time regarding the plans of correction. During the FY2016 site review, MSHN was found to have repeat citations (from the FY2014 review) for eleven standards. MSHN will be monitoring the repeat citations to ensure full compliance during the next review. A full review by MDHHS of all standards will be completed for MSHN during FY2018.

#### **Comparison of Results Full Review for FY2016 and Follow Up Review for FY2017:**





## **MDHHS Substance Use Site Review Report: February 27<sup>th</sup>**

The Michigan Department of Health and Human Services (MDHHS) completed a follow up review at Mid-State Health Network (MSHN) on February 27, 2017 to determine compliance with the required corrective action plans that resulted from the full review completed during Fiscal Year 2016 for Substance Use Disorder Services.

During FY2016, MSHN was determined to be in full compliance with eleven out of thirteen standards. MSHN was found to be in partial compliance with two standards and required to submit a plan of correction.

### **Summary of Findings (two elements):**

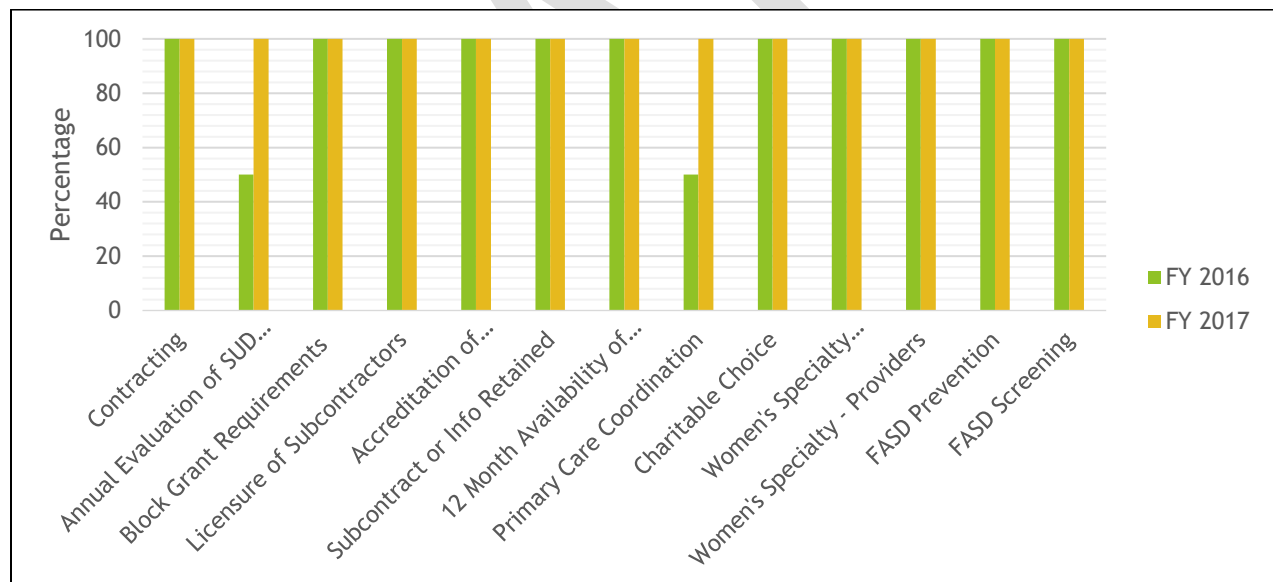
(Scoring: 2 = Full Compliance (100%); 1 = Partial Compliance (50%); 0 = Non-Compliance (0%))

- Annual Evaluation of SUD Services: 100%
- Primary Care Coordination: 100%

### **Next Steps:**

MSHN received a status of full compliance with all required plans of correction for FY2017. No further action is necessary at this time regarding the plans of correction. A full review by MDHHS of all standards will be completed for MSHN during FY2018.

### **Comparison of Results Full Review for FY2016 and Follow Up Review for FY2017:**



## **MDHHS Autism Site Visit: May 23<sup>rd</sup> - May 24<sup>th</sup>**

The Michigan Department of Health and Human Services completed the Autism ABA Site Review on May 23, 2017 through May 24, 2017. During the review MDHHS sampled and reviewed sixty-nine records for all required performance measures, including provider credentialing, in accordance with the Prepaid Inpatient Health Plan (PIHP) contract: General Statement of Work 7.0 Provider Network Services, attachment P 7.1.1, and Medicaid Provider Manual requirements outlined in, Behavioral Health & I/DD Chapter, Section 18 ABA.



### **Summary of Findings:**

- A. IPOS Addresses Needs
  - a. There is a Comprehensive Individualized ABA Behavioral Treatment Plan: 94%
  - b. Addresses Risk Factors: 92%
- B. Services and Supports are Provided as Specified in the IPOS: 25%
- C. Providers of the ABA Services meet Credentialing Standards: 1%
- D. Ongoing Determination of Level of Service has Evidence of Measurable and Ongoing Improvement in Targeted Behaviors: 87%

Note: The percentages were calculated by dividing the total number of charts that received a score of “yes” (full compliance) by the total number of charts reviewed for all elements in each section.

### **Next Steps:**

MSHN was required to submit a plan of correction for all standards that were determined out of compliance with the requirements.

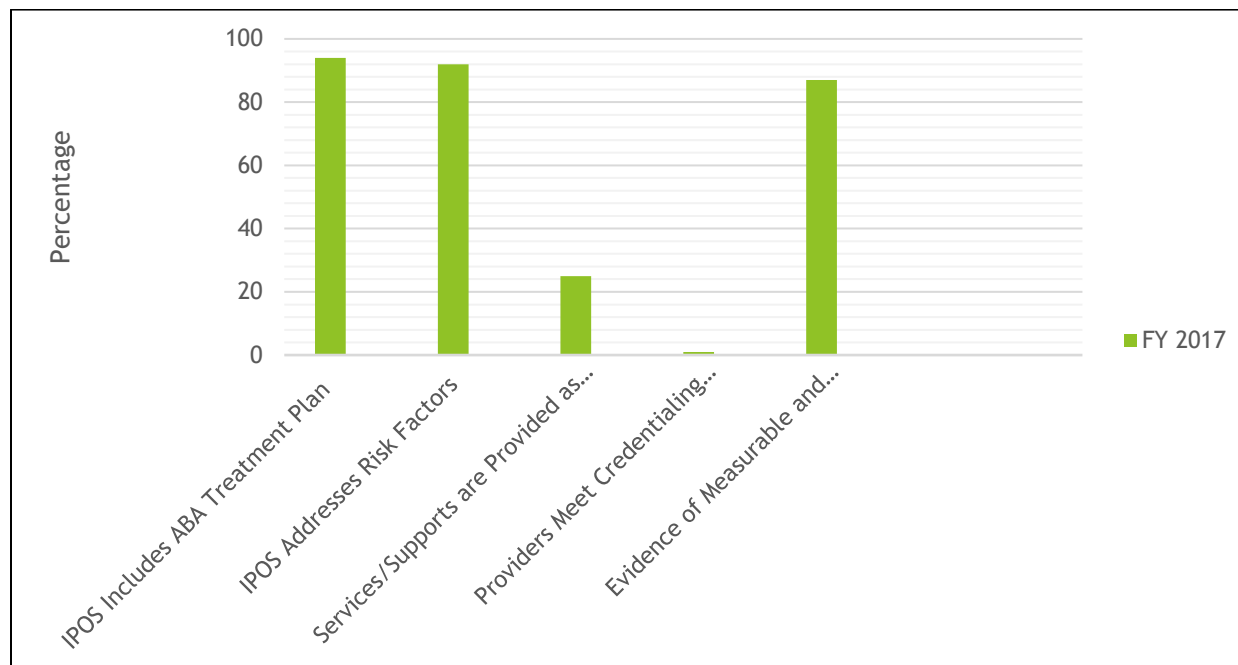
This included providing the following:

- Provide written policies and procedures to ensure:
  - The Individual Plans of Service address the needs of each beneficiary
  - That beneficiaries’ amount, duration, and scope of ABA services are delivered in accordance with their individualized plan of service
  - Beneficiaries’ ongoing determination of level of ABA service is occurring every six months in accordance with the policy requirements
- Provide written credentialing policies and procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform autism ABA services within Michigan’s Medicaid Program
- Ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements
- Provide oversight regarding delegated credentialing or re-credentialing decisions
- PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider

The submitted plan of correction was approved by MDHHS and the effectiveness of the plans of correction will be reviewed during the next scheduled MDHHS site review.

### **Results Full Review for FY2017:**

(No comparison was available as the last full review was completed in 2014 and the standards have changed)



### **MDHHS - Health Services Advisory Group (HSAG) - Performance Measurement Validation (PMV) Report: July 18th**

Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration, conducted the validation activities for the prepaid inpatient health plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients.

HSAG completed MSHN's review onsite on July 18, 2017.

#### **Data Collection and Analysis:**

For this review, HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). To conduct the on-site review, HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing and review of data reports.

#### **Summary of Findings:**

Performance Indicators (12 Elements): 100%

Compliance was assessed through a review of the following:

- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports

- Supporting documentation
- Evaluation of system compliance

Data Integration, Data Control and Performance Indicator Documentation (13 Elements): 100%

Denominator Validation Findings (7 Elements): 100%

Numerator Validation of Findings (5 Elements): 100%

#### **Strengths:**

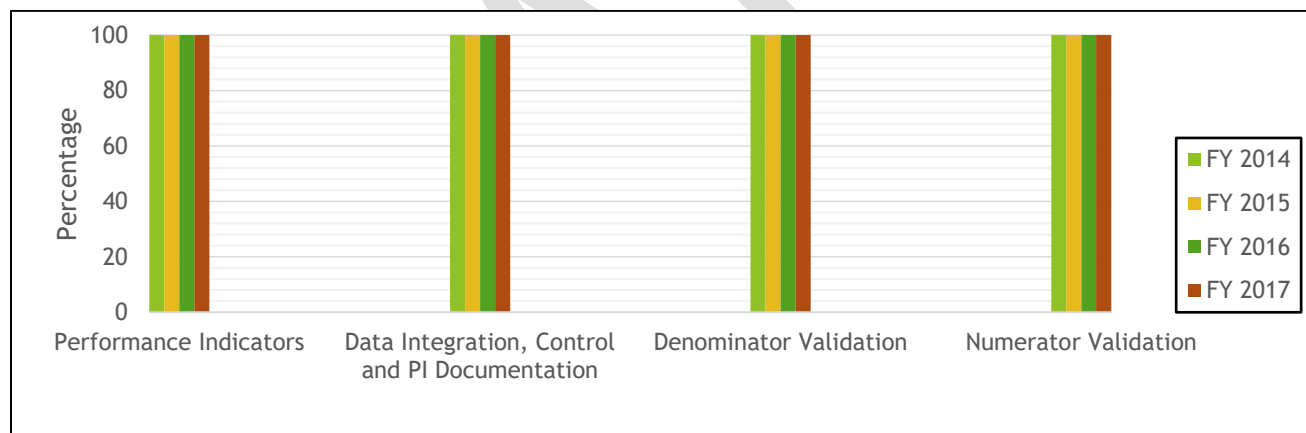
HSAG noted that MSHN maintained a solid team with years of relevant experience gained primarily through working for previous PIHPs. Staff members were very familiar with all processes related to performance indicator (PI) and BH-TEDS measures and data reporting requirements. The robust validation processes in place ensured that only complete and valid data were submitted to the State by the PIHP. As in the prior year, the PIHP demonstrated a strong commitment to the performance indicators and quality data reporting.

#### **Next Step(s):**

MSHN will continue to monitor performance and review areas for improvement. No corrective action is required to be submitted to HSAG for this review and HSAG did not identify any areas of improvement for MSHN.

#### **Comparison of FY2014, FY2015, FY2016 and FY2017 Results:**

(HSAG completes a full review each year for the PMV site review)



#### **MDHHS- Health Services Advisory Group - Compliance Monitoring Review**

The Health Services Advisory Group did not complete the Compliance Monitoring Review as part of this review cycle for FY2016/2017.

This review will be completed during FY2017/2018.

#### **MDHHS - Health Services Advisory Group -Performance Improvement Project (PIP) Report: Validation Year 4: September 2017**

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked,

analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

The PIP study topic is: *"Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications."*

The FY2016-2017 PIP Summary Report analyzed the data for Remeasurement Two Period (October 1, 2015 - September 30, 2016) and reviewed the identified barriers, interventions and goals that were established by MSHN.

#### **Summary of Results:**

- I. Select the Study Topic (2 Elements): 100%
- II. Define the Study Question(s) (1 Element): 100%
- III. Define the Study Population (1 Element): 100%
- IV. Select the Study Indicator(s) (3 Elements): 100%
- V. Use Sound Sampling Techniques (6 Elements): N/A for this study topic
- VI. Reliably Collect Data (4 Elements): 100%
- VII. Analyze Data and Interpret Study Results (8 Elements): 100%
- VIII. Improvement Strategies (4 Elements): 100%
- IX. Assess for Real Improvement (4 Elements): 100%
- X. Assess for Sustained Improvement (1 Element): 100%

MSHN showed an increase from Remeasurement One Period to Remeasurement Two Period of 77.5% to 80.4%. This demonstrated a statistically significant improvement during the remeasurement period, exceeding the identified goal of 79% by 1.4 percentage points and showed an overall improvement of 6.7 percentage points above the baseline of 73.7%.

#### **Strengths:**

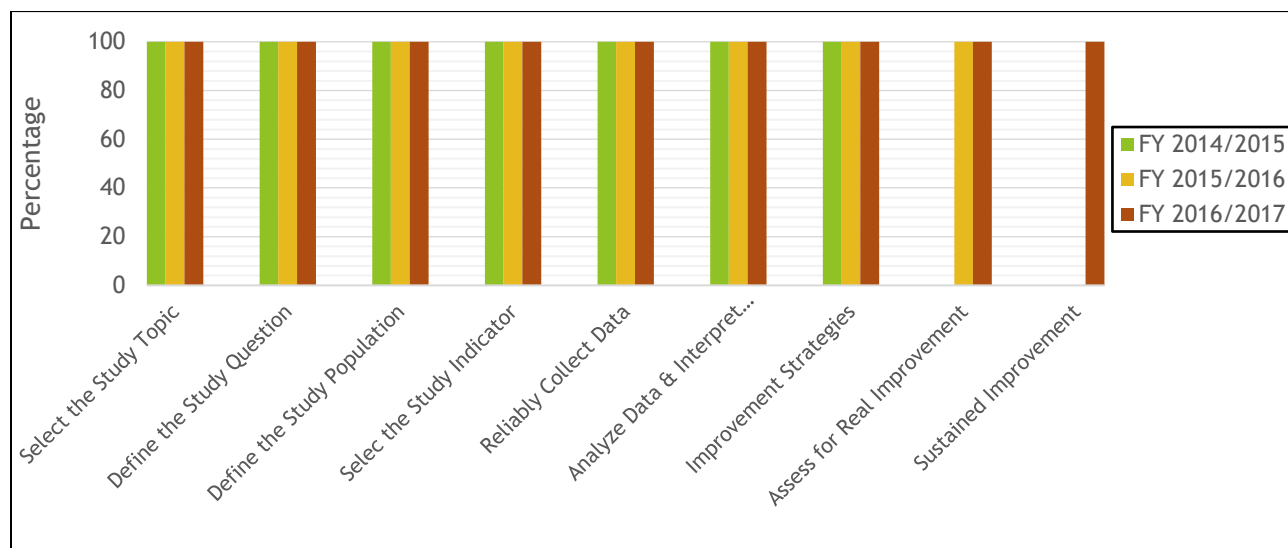
MSHN received a "Met" validation score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the PIP design, appropriate analysis of the results, implementation of system interventions that were related to barriers identified through quality improvement processes, and achievement of a statistically significant and sustained improvement in the study indicator rate over the baseline.

#### **Next Steps:**

MSHN is not required to submit a plan of correction for the PIP. MSHN will continue to utilize the Quality Improvement Council to complete a causal/barrier analysis at least annually and development appropriate interventions to address any new barriers.

### Comparison of FY2014/2015, FY2015/2016 and FY2016/2017 Validation Results:

(HSAG completes a full review each year for the PIP)



Note: Assessment for Real Improvement was not measured during FY2014/2015

Note: Sustained Improvement was not measured during FY2014/2015 and FY2015/2016

## Complaint/Compliance Reporting

### Customer Services:

The total number of Customer Services Complaints in FY2016 was 264. The total number of complaints made during FY2017 was 200, which was a decrease of 28% from FY2016.

#### **Total Customer Services Complaints: (200)**

Origin of Complaint: *(the percentage indicates the percent the origin of the complaint represents of the total complaints)*

MDHHS (11) (5.5%)  
Hospital (3) (1.5%)  
Consumer/Guardian/Family (62) (31%)  
MSHN Staff (7) (3.5%)  
RCAC Member (1) (0.5%)  
CMHSP Staff (10) (5%)  
SUD Provider Staff (87) (43.5%)  
Court (2) (1%)  
Other (13) (6.5%)  
Unknown (4) (2%)

Category of Complaint: *(the percentage indicates the percent the category represents of the total complaints)*

Authorizations (13) (6.5%)  
Authorizations Denial (2) (1%)  
CareNet Concerns (5) (2.5%)  
Consumer Discharge (10) (5%)

Grievance and Appeals (31) (15.5%)  
 Dissatisfied Consumer (32) (16%)  
 Information (33) (16.5%)  
 Insurance Coverage (6) (3%)  
 LEP Assistance (1) (0.5%)  
 Member Handbook (5) (2.5%)  
 Notification Letter Inquiry (8) (4%)  
 Performance Indicators (35) (17.5%)  
 Provider Practices (7) (3.5%)  
 Recipient Rights (6) (3%)  
 Sentinel Events (1) (0.5%)  
 Site Review Process (1) (0.5%)  
 Other (Program Specific, Crisis Services, Reports, Finance, LEP, etc.) (3) (1.5%)  
 Uncategorized (1) (0.5%)

**Conclusion/Resolution:** *(the percentage indicates the percent the conclusion/resolution represents of the total complaints)*

Resolved with the Consumer/Family (62) (31%)  
 Resolved with CMHSP/SUD Provider (97) (48.5%)  
 Resolved with MDHHS (11) (5.5%)  
 Resolved with MSHN (7) (3.5%)  
 Resolved with Other (Court System, etc) (23) (11.5%)

### **Compliance**

*The total number of Compliance complaints in FY2016 was 20. The number of Compliance complaints made during FY2017 was 16, which was a decrease of 22% from FY2016. However, in FY2017, the amount of compliance complaints requiring reporting to the Office of Inspector General increased by 67%.*

### **Total Compliance Concerns/Complaints: (16)**

**Origin of Complaint:** *(the percentage indicates the percent the origin of the complaint represents of the total complaints)*

MDHHS (0) (0%)  
 Consumer/Guardian (1) (6.3%)  
 MSHN Staff (0) (0%)  
 CMHSP Staff (10) (62.5%)  
 SUD Provider Staff (3) (18.7%)  
 OIG (1) (6.3%)  
 Other (1) (6.3%)

**Type of Complaint:** *(the percentage indicates the percent the category represents of the total complaints)*

Abuse/Neglect (0) (0%)  
 Audit/Review (2) (12.5%)  
 Confidentiality (1) (6.3%)  
 Credentialing/Qualifications (2) (12.5%)  
 Federal Inquiry (0) (0%)  
 Hospitalizations (0) (0%)  
 Suspected Fraud/Abuse (10) (62.5%)  
 Treatment/Services: (1) (6.3%)

**Conclusion/Resolution:** *(the percentage indicates the percent the conclusion/resolution represents of the total complaints)*

Resolved with the Consumer (1) (6.3%)

Resolved with CMHSP/SUD Provider (9) (56.3%)  
Resolved with MDHHS (0) (0%)  
Resolved with OIG (1) (6.3%)  
Referred to Office of Health Service Inspector General (OHSIG) (5) (31.3%)  
Still Pending Resolution (5) (31.3%)

#### Compliance Line:

Compliance calls are received through the Compliance Line, the main line of MSHN or through the direct line to the Director of Customer Services, Compliance and Quality.

#### Customer Services Line:

Customer Service calls are received through the Customer Services Line, the main line of MSHN or through the direct line to the Customer Services and Rights Specialist.

## Training / Communication

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### Internal

#### MSHN Quality Improvement Council

Reviewed and Approved MSHN Compliance Plan on August 24, 2017  
Compliance Policies

#### MSHN Operations Council

Reviewed and Approved MSHN Compliance Plan on September 18, 2017  
Compliance Policies

#### MSHN Compliance Committee

Reviewed and Approved MSHN Compliance Plan on October 30, 2017  
Compliance Policies

#### MSHN Staff

Received Compliance Training on November 9, 2017  
Compliance Plan  
Compliance Policies

#### Board of Directors

Received and approved MSHN Compliance Plan on November 7, 2017  
Received Compliance Training on November 7, 2017

### External

MSHN Compliance Plan and Compliance Line Available on Website

MSHN Customer Service Line Available on Website

MSHN Contact information located in Consumer Member Handbook "Guide to Services"



# Quarterly Compliance Summary Report

October 2017 – December 2017

Prepared by: MSHN Quality Assurance & Performance Improvement Department – January 2018



During the 1<sup>st</sup> Quarter of Fiscal Year 2018, Mid-State Health Network conducted monitoring and oversight reviews of the Community Mental Health Service Participant's (CMHSP) and the Substance Use Disorder Service Providers (SUDSP). This included a review of the Delegated Managed Care functions as well as the Program Specific requirements to ensure compliance with federal, state, and contractual requirements. As MSHN has used a calendar year vs. fiscal year schedule for reviews, all Q1 results were included in the MSHN Annual Compliance Summary Report (FY17).

The following table outlines the number of audits conducted, CAPs approved, referrals to Compliance Officer during FY18, Q1.

	Full Audits Conducted	Interim Year Audits Conducted	CAPs Approved	Compliance Referrals
CMHSP	3	0	2	0
SUD	4	2	26	0

## CMHSP Delegated Managed Care Reviews

### Delegated Managed Care Functions

This review included sixteen (16) standards and one hundred forty-four (144) elements. The full review consisted of an on-site visit to the CMHSP to conduct consumer chart reviews, review and validate process requirements, review of new standards since the last audit, analysis of performance and encounter data, interviews of staff, and monitoring of the FY16 desk-audit corrective action plans as applicable. Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs).

### Performance Variables for Consideration

- Changes to monitoring tool related to scope of review for specific standards

### Status

- 3 full site reviews completed by MSHN staff (9 completed in FY17)
- 3 Corrective Action Plans received from the CMHSP's
- 2 Corrective Action Plans reviewed and approved by MSHN staff

Delegated Managed Care Functions	2017 Results
Information and Customer Service	98.8%
Enrollee Rights & Protections	100.0%
24/7/365 Access <sup>1</sup>	98%
CMHSP Provider Network (sub-contract providers)	100%

<sup>1</sup> Access Policy revisions resulted in new standards in 2016

Service Authorization & UM	100%
Grievance & Appeals	100%
Person Centered Planning & Documentation	100%
Advance Directives <sup>2</sup>	N/A
Coordination of Care/Integration	100%
Behavior Treatment Plan Review Committee	100%
Consumer Involvement	100%
Provider/Staff Credentialing	97.4%
Quality & Compliance	100%
Ensuring Health & Welfare/Olmstead	100%
Information Technology	100%
Trauma Informed Care <sup>3</sup>	100%

#### Program Specific Site Review

This review included ten (10) standards and a total of eight-five (85) elements. The focus of this section was to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Program Specific Requirements. Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs, 3 in FY18 QTR 1).

Program Specific	2017 Results
Jail Diversion	100%
Assertive Community Treatment (ACT)	100%
Self Determination	100%
Peer Delivered and Operated Services (Drop-In)	100%
Home Based Services	100%
Clubhouse Psycho-Social Rehabilitation	NA
Crisis Residential Services	66.7%
Targeted Case Management	100%
Habilitation Supports Waivers	98.3%
Autism Benefit/Applied Behavioral Analysis	85.6%

#### CMHSP Training

Regional trainings conducted during 1<sup>st</sup> Quarter of FY2018:

- Not Applicable

<sup>2</sup> Advance Directives standards were combined with Customer Services standards in 2017

<sup>3</sup> New Trauma Informed Care resulted in new standards in 2017

### CMHSP Noteworthy Strengths

The CMHSPs consistently focus on improving outcomes for the consumers served within the Mid-State Health Network region. Supporting evidence for this can be found throughout the consumer charts reviewed during the audit process. Progress notes are consistently tied directly to consumer-driven goals and reviews are consistently completed within the required timeframes. Examples of exemplary support service outcomes include:

- The Right Door for Hope, Recovery, and Wellness team supported a consumer's family reunification and permanent housing after decades of institutionalized living, void of natural support systems. Today, this person is thriving in an environment that supports the individual's unique strengths and challenges.
- Montcalm Care Network assisted a consumer with obtaining and maintaining services after years of homelessness, likely the result of psychiatric condition(s). Today, this person lives independently, maintains relationships, and is compliant with medications that dissolve potentially dangerous symptomology.

### CMHSP Opportunities

A review of the FY18, 1<sup>st</sup> quarter quality and compliance reviews indicates a few shared opportunities for enhancing services. The following enhancement opportunities have been identified by either MSHN and/or the CMHSP team members:

- Addressing Electronic Health Record (EHR) system *over-reliance* (also reported in the FY17 Annual Compliance Summary) - These systems are an excellent resource for compliance, quality, and data management. However, human errors occur and there are times these errors result in unintentional consequences, not generally noticed/corrected until an audit. Checking the wrong box may result in overlooking a need to assist with primary care physician obtainment, trauma-specific goals/treatment, and developing crisis plans. Potential practices, aimed to reduce the impact of unintentional errors, could include adding an accuracy component to internal review practices, working with the EHR system management team to develop/enhance validation features, developing peer review practices, team trainings and/or incentives.
- Enhancing Person Centered Planning practices – Consistently, objectives are not measurable, outcome measurements are not identified, and timeframes are not realistic for the goal/objective but reflect review/authorization mandates. MSHN recommends ongoing training and support for team members and/or utilizing peer review practices, and/or enhancing internal review protocols to ensure goals are Specific, Measurable, Attainable, Realistic, Time-Limited.

## SUDSP Delegated Managed Care Reviews

### Delegated Managed Care Functions

MSHN has completed four (4) full SUDSP reviews and two (2) interim reviews in FY18 Quarter 1. The number of charts reviewed during each onsite visit is a 5% sample, with a minimum of two (2) and maximum of eight (8) for each licensed site.

MSHN conducted full SUDSP reviews for the following providers Quarter 1 FY18:

- Housing: Rise Recovery, Randy's House of Greenville
- Treatment: Lexington Counseling Center (IMPACT) – Jail based program, The Right Door for Hope, Recovery, and Wellness.

Delegated Managed Care Functions <sup>4</sup>	# of Standards in each Section	2017 Results
Access and Eligibility	6	91.7%
Information and Customer Service	21	86.9%
Enrollee Rights and Protections	15	83.3%
Grievance and Appeals	18	70.8%
Quality and Compliance	12	87.5%
Authorizations/UM	4	100%
Individualized Treatment & Recovery Planning	12	100%
Policy and Procedure Review	37	100%
Coordination of Care	11	100%
Provider Staff Credentialing	16	87.5%
Recovery Housing	10	90%

### Opportunities for Regional Improvement

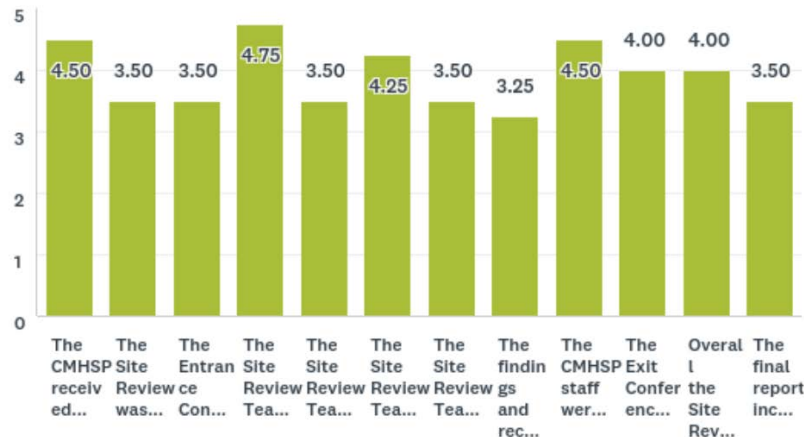
Training & Technical Assistance Referrals: While monitoring, the QAPI team identifies areas where providers could benefit from additional training and technical assistance from MSHN specialists. In the last quarter, MSHN made the following referrals for providers to receive training and technical assistance:

# of Referrals	MSHN Unit Referred to:	Topics
3	SUD Treatment	Housing, Coordination of Care, ASAM
1	SUD Customer Service	LEP, Recipient Rights

<sup>4</sup> Recovery Housing providers were subject only to Recovery Housing section of the Delegated Managed Care Function review tool.

### Satisfaction Survey Results

MSHN encourages provider feedback relative to the monitoring and evaluation process. A survey is provided at the end of the review and results are reviewed for overall process improvement as well as an opportunity to address provider specific feedback warranting follow-up. The following charts represent survey responses from CMHSP staff who participated in the review during FY18, Q1.



Survey Questions	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total	Weighted Average
The CMHSP received sufficient information to properly prepare for the site review	0.00%	0	0.00%	0	0.00%	0	50.00%	2	50.00%	2	4	4.5
The Site Review was well organized	0.00%	0	25.00%	1	25.00%	1	25.00%	1	25.00%	1	4	3.5
The Entrance Conference was valuable and informative of the process	0.00%	0	25.00%	1	25.00%	1	25.00%	1	25.00%	1	4	3.5
The Site Review Team conducted the site review in accordance with the agenda	0.00%	0	0.00%	0	0.00%	0	25.00%	1	75.00%	3	4	4.75
The Site Review Team utilized the appropriate review tools to conduct the site review	0.00%	0	0.00%	0	25.00%	1	25.00%	1	50.00%	2	4	3.5
The Site Review Team were knowledgeable regarding their respective areas	0.00%	0	25.00%	1	25.00%	1	25.00%	1	25.00%	1	4	4.25
The findings and recommendations were appropriate and related to an identified standard to agree/disagree with the findings prior to finalization	0.00%	0	50.00%	2	0.00%	0	25.00%	1	25.00%	1	4	3.25
The Exit Conference provided a strong summary of expectations of the final report	0.00%	0	0.00%	0	0.00%	0	50.00%	2	50.00%	2	4	4.5
Overall the Site Review process was valuable	0.00%	0	0.00%	0	25.00%	1	50.00%	2	25.00%	1	4	4
The final report included documentation and supporting evidence of findings and recommendations	0.00%	0	0.00%	0	50.00%	2	50.00%	2	0.00%	0	4	3.5
											Answered	4
											Skipped	0

### Open Ended Response Summary:

MSHN could do the following to improve the process:

- Many things were reviewed twice in different areas and citations were also duplicated. Example: auditor looked at autism staff training and then credentialing looked at autism staff training. One auditor found compliance, once found non-compliance.

MSHN Action: MSHN has contacted the CMHSP to review concerns and follow up with any additional clarification needed. During a CMHSP review, the MSHN ABA specialist reviews the

ABA program specific credentialing/training requirements, whereas, MSHN QAPI team reviews the overall CMSHP training/credentialing requirements. While they are not reviewing the exact items, they do conduct a review on the same personnel and their personnel files. MSHN staff has updated the monitoring tools which provided additional clarification to existing standards and removed any standards that could be considered duplicative.

- Some reviewers appeared to scrutinize performance rather than consultation. Example: Auditor reviewed same chart as MDHHS did and citations that MDHHS did not.

MSHN Action: MSHN has contacted the CMHSP to review concerns and follow up. In addition, MSHN is implementing PCE in 2018 which will expand the search criteria for files selected. It should be noted that it is not the practice of MSHN to review the same files, however, this was an unusual circumstance as at the time of file selection, there was not another file that met the criteria for review. While there is some overlap between the MDHHS review tools and the MSHN review tools, the MDHHS tool provides for a more broad/high level review. The MSHN tool is a more in-depth, specific review of program standards as PIHPs role in quality assurance is to take a “deeper dive” into files and reviews. MSHN then compiles the results which are available to MDHHS. It should be noted that MDHHS has reviewed MSHN tools as part of their site review.

- The final report had many areas which were difficult to interpret.

MSHN Action: MSHN contacted the CMHSP to review concerns and follow up. Additionally, feedback will be used to ensure that the final reports are better understood. MSHN is implemented PCE in 2018 and will utilize the monitoring module. This may provide additional clarification as well.

- The case selection was sent and then changed/updated prior to site visit.

MSHN Action: MSHN contacted the CMHSP for additional information and follow up. MSHN is implementing a managed care information system in 2018 and it should provide a more detailed process for pulling cases to ensure that sample files are for all programs. The current sampling process uses coding in CareNet and occasionally selects files that have that may not be specific to program intended.

- The entrance was very brief. It would have been helpful to go over each item in depth.

MSHN Action: MSHN contacted the CMHSP for additional information and follow up. MSHN entrance conference typically includes introductions and a review of the agenda provided to the CMHSP prior to the visit. MSHN QAPI team will work with the CMHSP contact prior to reviews to ensure entrance conference needs are met.

- Staff was available from other sites when they were scheduled for interviews and MSHN staff did not meet with them. Suggest having a more accurate agenda and stick to it and meet with staff at scheduled times.

MSHN Action: QAPI staff has created a more in-depth agenda and a process for informing CMHSPs prior to the review if a meeting with staff is necessary or if a contact number for a few quick questions would be more ideal. This has been utilized the last few reviews with positive feedback.

- Streamline any questions requiring additional information through the contact person to ensure limited disruptions to the clinical programs prior to the scheduled review time in which they had previously set aside.

MSHN Action: QAPI staff has created a more in-depth agenda and a process for informing CMHSPs prior to the review if a meeting with staff is necessary or if a contact number for a few quick questions would be more ideal. This has been utilized the last few reviews with positive feedback.

**A Strength of the site review process was:**

- Timely and thorough
- I appreciate being able to submit information ahead of time for review
- MSHN staff was very polite and professional (I worked primarily with Amy & Melissa)
- MSHN staff was helpful and courteous
- MSHN was responsive to questions to assist in preparing for the review. Discussion during the review was informative and solution based. Staff were easy to work with. It was a pleasant experience.

**As a CMHSP, I could have improved the process by:**

- Have more specific documentation ready ahead of time.
- It would be helpful for our organization to allow multiple individual access to Box to ensure we can continue to upload information when our main contact is gone.
- Sending additional information prior to the survey. I think we sent a lot, but if we'd known some of the information would have been asked for additionally onsite, more could have been sent ahead of time.
- Due to having CARF review a week prior to the DMC review, we could have improved the process by having things uploaded to Box sooner. Maybe we could work more closely with MSHN staff on the agenda to come up with a more specific agenda with expectations on our part as well as MSHN's.
- Making more space available for interviewing staff. Reviewing main contact people to ensure the most accurate information was being presented. It would be helpful to hear from MSHN on what could improve the process.

**SUDSPs- October 1- December 2017: 0 responses**

The survey results were compiled January 2018, just after the 1<sup>st</sup> quarter. No SUDSP Surveys were completed. In response to the low response level, MSHN QAPI staff will begin encouraging SUDSPs to complete the survey by including survey in exit conference discussion and follow up after sending the final reports. MSHN will reevaluate the responses during the next quarterly report. In addition, MSHN will work with SUD Advisory Committee to address review concerns, promote use of the surveys, and identify process enhancement opportunities.



### QAPI Project Status

**Fiscal Intermediary Regional Monitoring:** In Progress. The FI monitoring team met 1/10/18 and reviewed and revised the regional monitoring tool. Teams were established for each FI. The FI specific teams have established a site review schedule. The full monitoring team will meet on February 12, 2018 to finalize the tool and Regional monitoring procedure which will include teams, schedules, and sampling methodology.

**Inpatient Regional Monitoring:** In Progress. The PIHP Inpatient Regional Monitoring team is met on 01/11/18 to finalize the clinical chart review. Most of the review dates and contact information has been shared by CMHSPs and compiled. MSHN is still waiting on a few late responses. The next steps will include a regional meeting to determine roles and responsibilities, develop the FY18 review schedule, finalize the plan for reports/data sharing.

**Updated QA Review Tools:** In Progress. CMHSP tools have been approved and are in use. SUDSP tools have been updated for 2018 and final drafts are awaiting approval. Upon approval, The SUDSP tools will be available to providers on the MSHN website and MSHN will continue to provide the tools at least 30-days prior to the scheduled review.

**Substance Use Disorder – Provider Advisory Council (PAC):** The applications were reviewed and members have been notified of the results. The 1<sup>st</sup> council meeting is scheduled for 02/08/18. MSHN intends to host a quarterly meeting with a focus on quality and compliance strengths, concerns, and opportunities. In addition, MSHN will partner with this group for future review practices including audit tool edits, training recommendations, process improvements.



**Mid-State Health Network**  
**FY2018 PA2 Funding Recommendations - by County**

<b>County</b>	<b>Reserve Balance as of September 2017</b>	<b>Projected FY2018 Funding</b>	<b>Approved FY2018 Funding Recommendations</b>	<b>FY2018 PA2 Funding Request (February)</b>	<b>Projected Reserve Balance</b>
Arenac	223,041	34,553	111,379	13,415	132,800
Bay	1,248,865	205,310	228,145	54,891	1,171,138
Clare	280,920	49,653	77,398	-	253,175
Clinton	595,340	126,760	38,193	223,720	460,187
Eaton	798,852	238,268	196,263	391,218	449,638
Gladwin	119,581	39,516	88,618	13,658	56,820
Gratiot	197,964	46,718	119,263	18,318	107,100
Hillsdale	176,547	50,136	45,455	52,446	128,782
Huron	357,628	63,579	140,962	22,141	258,104
Ingham	740,790	703,526	328,207	176,959	939,149
Ionia	413,617	73,514	45,442	-	441,688
Isabella	830,873	154,222	251,909	-	733,186
Jackson	1,198,732	319,767	537,738	47,186	933,574
Mecosta	541,452	87,244	150,781	143,116	334,799
Midland	574,204	150,863	137,602	34,870	552,595
Montcalm	494,985	98,624	188,794	10,000	394,814
Newaygo	250,827	73,870	128,913	-	195,784
Osceola	160,414	28,527	31,360	63,851	93,730
Saginaw	3,404,331	445,650	809,280	71,697	2,969,004
Shiawassee	639,929	98,985	55,590	-	683,324
Tuscola	387,326	55,841	47,286	48,048	347,833
<b>Total</b>	<b>\$ 13,636,216</b>	<b>\$ 3,145,119</b>	<b>\$ 3,758,578</b>	<b>\$ 1,385,534</b>	<b>\$ 11,637,223</b>