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From the Chief Executive Officer's Desk

Joseph Sedlock

Mid-State Health Network has been a leader in identifying the breadth and frequency of psychiatric inpatient hospital denials and related emergency room boarding of beneficiaries suffering with acute psychiatric illness, and in offering recommended solutions to these private sector issues, since its inception. The public behavioral health system is often wrongly scapegoated for these problems, even though they are completely outside of the control of the Pre-Paid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) that are required to screen publicly funded beneficiaries for admission to private hospitals across the state. Rather than step up atop my soap box on this topic, I wanted to provide some information about the “Michigan Psychiatric Care Improvement Project (MPCIP)."

MPCIP is the successor name of an initiative that began under a different name, the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD). The original group formed in 2017 as a direct result of Mid-State Health Network 2015/2016 data collection of inpatient psychiatric hospital admissions denials in the MSHN region. The State of Michigan used the MSHN-developed platform to gather similar information statewide. In the report published in 2017, there were 24,702 denials impacting 1,458 people suffering with acute psychiatric illnesses. The average was 17 denials by psychiatric hospitals/units per person.

The dialog and actions associated with improving access for beneficiaries to this critical level of care has taken many forms over these past several years – but bed inventory and volume of denials are largely unchanged.

The MPCIP initiative is focused on:

- **Standardizing medical clearance protocol (MISMART):** This is important because standardized communications, standardized criteria and common tools use between emergency departments in general medical hospitals, behavioral health (CMHSP) emergency services/pre-admission screening units, and psychiatric hospitals/units can greatly eliminate the need for unnecessary medical screening orders, expedite “medical clearance” to be admitted to a psychiatric inpatient unit, and avoid long delays at this potential bottleneck point. The state will be doing a “soft” roll out of the Mi-SMART medical clearance protocol beginning in late August 2021.

- **The Michigan Crisis and Access Line (MiCAL):** This is legislated through PA 12 of 2020, PA 166 of 2020 and establishes a statewide behavioral health crisis triage, support and information/referral service via phone, text and chat that is available statewide, 24 hours/day. The MiCAL service is intended to support every resident or visitor to the state, regardless of payer type, inability to pay, severity or any other characteristic. MiCAL will work with CMHSPs and PIHPs to ensure that in-person screenings for inpatient care (or other mobile crisis stabilization or in-person services crisis intervention services) are immediately available. Importantly, the national conversion to “9-8-8” (scheduled for July 2022) as the national three-digit number for mental health crisis and suicide intervention response will be woven into this statewide platform, including local response options.

- **Psychiatric Bed Treatment Registry:** This is also legislated through PA 658 of 2018, PA 12 of 2020, and PA 166 of 2020 and requires that the State develop an electronic service registry housing psychiatric bed availability, crisis residential service bed availability, and SUD residential treatment service bed availability in real time. The State is including the registry in the MiCAL project to streamline resource use. Today, CMHSP and PIHP emergency services personnel must call every psychiatric hospital/unit and request admissions (bed) availability and if available, provide an admission packet for the hospital to base an admissions decision on. There are more than 80 psychiatric hospitals/unit in Michigan, and 46 CMHSPs and 10 PIHPs all calling each other, every day, often multiple times per day, often on behalf of several

beneficiaries per day – and all of this time, waiting, and delay can be avoided by simply having a "bed board" available to know where the "open beds" are located.

- **Crisis Stabilization Units:** Required under PA 402 of 2020, the law codifies CSUs in the Mental Health code and requires MDHHS to develop, implement and oversee a certification process for CSUs – which can be in virtually any CMHSP, Med/Surg Hospital or other sites. The legislation incentivizes the development of these CSUs as an alternative to med/surg hospital emergency room utilization.

While these initiatives are important and needed, we have to remind the reader that real people are still unnecessarily delayed in accessing psychiatric inpatient care when they are most in need and at their most vulnerable points. We would not stand for anyone suffering an acute life-threatening asthma attack to be forced to wait for appropriate medical treatment. We would not stand for anyone suffering from an acute cardiac condition to be forced to wait for appropriate treatment. We would not stand for anyone suffering from an acute strep infection to be forced to wait for appropriate treatment.

We should not stand – not even for a hot minute – for anyone suffering from an acute psychiatric illness to have to wait for appropriate treatment in the most appropriate setting.

Mid-State Health Network supports and applauds the work being done to improve access to psychiatric inpatient care for beneficiaries. The improvements described here are important and, in some ways, herculean in scope. BUT, we cannot forget that real people, suffering very real – often life threatening - illness, in real places, with real families and real roadblocks – must be treated effectively at the onset of their acute symptoms.

We would never stand for this with any other health condition. All the rhetoric around health integration ignores the stigma and discrimination against mental illnesses that are built into the current healthcare delivery system – and this, too, must be addressed. And eliminated.

For further information or questions, please contact Joe at Joseph.Sedlock@midstatehealthnetwork.org

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Welcome to MSHN's New Team Member

MSHN is pleased to announce that Sheryl Kletke will fill the vacant Executive Assistant position. Sheryl comes to us with over 20 years of experience from Community Mental Health Authority of Clinton, Eaton and Ingham and begins her employment with MSHN on June 7, 2021.

Please join us in welcoming the newest member to the MSHN team!

Mid-State Health Network is still looking for qualified candidates to fill the Office Assistant Position. Job Descriptions are located on MSHN's website. To apply, please send a cover letter and resume to amanda.ittner@midstatehealthnetwork.org.

Complex Care Management Proposal Ready for MDHHS

Over the last few weeks, the final version of the PIHP proposal to provide complex care management for the unenrolled has been presented and supported by the Community Mental Health Association of Michigan with the intent to present to MDHHS Director Elizabeth Hertel in June. But if you are wondering, how many Medicaid individuals chose to not participate in a Medicaid Health Plan for physical health reside in Michigan? Well, see below chart for Fiscal Year 2019 enrollment numbers as provided by MDHHS's data tool from Milliman called the Drive Tool.

PIHP	All Members	Not enrolled in a Medicaid Health Plan for Physical Health	% unenrolled members to total member
C.M.H. Partnership of Southeast Michigan	128,515	40,138	31.23%
Detroit Wayne Integrated Health Network	696,949	199,154	28.58%
Lakeshore Regional Entity	284,665	94,393	33.16%
Macomb County C.M.H. Services	201,572	61,341	30.43%
Mid-State Health Network	407,618	121,811	29.88%
NorthCare Network	71,246	26,813	37.64%
Northern Michigan Regional Entity	130,104	41,525	31.92%
Oakland Community Health Network	187,368	58,700	31.33%
Region 10 Prepaid Inpatient Health Plan	205,925	52,606	25.55%
Southwest Michigan Behavioral Health	218,366	73,838	33.81%
Total	2,532,328	770,320	30.42%

Our region is supportive of efforts to increase care coordination and integrated services for the Medicaid and Healthy Michigan population of which, about 30% of enrollees have opted out of a Medicaid Health Plan in the MSHN region. MSHN intends to work with the CMHSPs to engage and activate people, their providers, and natural supports to better understand and manage their health and wellness including non-medical social determinants, drivers of poor health, and avoidable spending. The benefits of the proposal will provide for complex care management of individuals who currently don't have a benefits manager through their physical health provider and/or care management by MDHHS as part of their Fee for Service program. With the PIHPs providing plan level development and oversight with coordination at the service delivery, the outcomes will result in reduced emergency department use, reduced hospital and reduced inpatient stays, increased preventive care services, and increased coordination with primary care physician. This has proved evident in the resulted performance and outcomes measures monitoring in the MSHN region on the individuals currently receiving complex care management.

For further information or questions, please contact Amanda at Amanda.Ittner@midstatehealthnetwork.org

Information Technology

Forest Goodrich
Chief Information Officer

Automating and integrating information between CMHSP participants electronic medical record systems (EMRs) and MSHN managed care information system (MCIS) has been a focus over the last several months. Several key initiatives that the Information Technology Council members and MSHN staff have been working toward are:

- Exchanging the LOCUS results automatically every day between CMHSP participants and MSHN. This reduces the manual process of combining these results and eliminates the manual upload of LOCUS files monthly.
- CMHSP participants submit client files directly to Michigan Health Information Network (MiHIN). This provides for consumer health information to be added to electronic medical record systems quickly. MSHN has been doing this function as a part of a broader exchange effort with MiHIN and will continue for the SUD providers and MSHN staff using its managed care information system.
- CMHSP participants receive hospital providers admission, discharge, transfer (ADTs) directly into their electronic medical record systems.
- CMHSP participants receive COVID-19 test results directly into their electronic medical record systems.

Each of these processes improves the speed at which information can get into electronic medical record systems and reduces the amount of manual effort needed to support those processes ongoing.

All required documentation has been submitted to support the Health Services Advisory Group review process. This is a thorough review of how BH-TEDS and encounter data gets collected and submitted to MDHHS. The desk audit is scheduled for June 22nd.

For further information or questions, please contact Forest at forest.goodrich@midstatehealthnetwork.org

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is gearing up for Fiscal Year (FY) 2021 and 2022 budgets. Our budget process consists of working with CMHSPs, Internal Departments, and review of Substance Use Disorder (SUD) spending to accurately estimate expense information. Revenue projections are derived from MDHHS rate setting information. Once we account for revenue and expense components, MSHN can determine the potential savings for FY 2022. This process requires significant human resources and our Financial Manager and Financial Specialist perform the multiple tasks very efficiently.

MSHN's Finance Team is also in the process of conducting and expanding its current Fiscal Monitoring and Oversight process to include implementation of a Risk Assessment Tool. This tool is a collaborative effort between Finance, Provider Network, and Quality/Compliance Departments. The tool's goal is to complement current clinical processes used to evaluate program efficacy and compliance. In addition, the tool will be used for assessing providers seeking empanelment with MSHN.

MSHN Finance Team members are also engaged in its FY 2020 Compliance Examination being conducted by Roslund Prestage & Company (RPC).

For further information or questions, please contact Leslie at Leslie.Thomas@midstatehealthnetwork.org

Behavioral Health

Todd Lewicki, PhD, LMSW, MBA
Chief Behavioral Health Officer

How Policy and Advocacy Partner in Bettering Care for Individuals Served

How language is used in daily life forms the basis for attitudes toward others, cultural competence, and for the opportunity to put the person first; to advocate for inclusivity and recognition. Words and phrases that are used to describe or refer to disability are no different in effect when used. Language plays a critical role in the interpretation, understanding, and recognition of persons with a disability (Dunn & Andrews, 2015). Beatrice Wright (1987) notes that a vital concept central to human dignity is that an individual is just that, a unique entity and not an object. Person-first language, for example, puts the person first, or an "individual with a disability" (as opposed to a disabled individual). This reduces bias, improves cultural competence, and recognizes that the individual is more than their disability. Key policies implemented through the Michigan Department of Health and Human Services (MDHHS), Mid-State Health Network (MSHN), and its partner Community Mental Health Programs (CMHSPs) embody the philosophy of person-first advocacy, through person-centered planning (PCP) practices and home and community-based service (HCBS) orientation, among many other examples.

HCBS waiver policy for persons with intellectual and/or developmental disabilities (IDD) has sought to improve and increase opportunities for inclusion, integration, choice, and freedom in everyday life rather than the experience of isolation and segregation in institutional settings. This policy support and contemporary research supports evidence that HCBS systems of care reduce unmet healthcare needs, reduce racial disparities in access to care, increase cost-effectiveness of care, and improve outcomes for individuals with IDD (McLean et al., 2020). HCBS policies that focus on advocacy recognizes the individual's uniqueness and dignity through a person-first approach. Person-first approaches are successful and while policy drives the efforts toward these positive outcomes, the words that support policy shape how attitudes and cultural competence are brought into reality.

Competence in PCP practices also share an important spotlight with HCBS in recognizing the individual and in the promotion of better care. The Institute of Medicine (2001, p. 3) specifically identifies person-centered care that "is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions." The MDHHS and MSHN PCP policies not only share this sentiment but require it. The individual is at the center of their own services, not a passive participant in them. As a result, the service provider, in their recognition of dignity and respect for the individuals they serve, must use the PCP process, especially as enacted through the therapeutic relationship, and will lead toward a reduction in symptom severity, improve quality of life, and increase overall service satisfaction (Hamovitch et al., 2018).

Philosophies, principles, and practices are the ways that important policies are made real. Words are used to convey their intent and focus. MDHHS, MSHN, and CMHSP implementation of these policies is critical in providing better care through the recognition of the person-first. These person-first principles recognize respect for the individual's values, preferences, and needs, integration, support, involvement, and access in their care. While policy may seem dry, each is an important collection of words that convey important intent that furthers the efforts in advocating for individuals in culturally competent, dignified, and person-first ways.

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

Utilization Management & Care Coordination

Skye Pletcher, LPC, CAADC

Director of Utilization and Care Management

The Mid-State Health Network (MSHN) Utilization Management (UM) team supports Community Mental Health Services Programs (CMHSP) UM processes and is responsible for key administrative and clinical service utilization functions for the substance use disorder (SUD) treatment and recovery system, some of which include:

- Overseeing access to all levels of SUD services and supports
- Providing assistance, information, and referrals to individuals seeking services
- Monitoring service utilization and conducting authorization reviews
- Providing technical assistance to the SUD Provider network related to access, authorization, service delivery, and utilization

SUD providers submit authorization requests through MSHN's managed care information system, REMI. Most authorization requests are automatically approved by REMI if the fall within specific established guidelines, however when the amount of services being requested exceeds the historical utilization range then the authorization is directed to the UM department for review to confirm the services are medically necessary. The table below indicates the total number of authorizations processed in the REMI system during Q1-Q2 of fiscal year 2021, including those that were automatically approved and those that required UM review.

FY 21	Auto Approved	UM Review Required	Total	Percent of Total Authorizations Requiring Review
Q1	7777	882	8659	10.1%
Q2	8878	812	9690	8.4%

Additionally, the UM Department recently began collecting and monitoring phone data to assess the volume of calls received and time spent providing support to SUD providers and persons seeking services. The table below summarizes UM Department phone activity for the months of March and April 2021.

Month	Total Calls	Average Calls Per Week	Total Time (Hour: Min)	Average Call Duration (Min: Sec)
March	844	211	46:27	03:30
April	1068	214	85:27	04:48

The phone data is a helpful tool for the analysis and identification of further opportunities for improved departmental operational efficiencies. MSHN has been an innovator in making and supporting sound decisions based on data analysis in efforts to ensure its participating members access to high-quality, locally delivered, effective, and accountable SUD services.

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

Treatment & Prevention

Dr. Dani Meier, PhD, LMSW
Chief Clinical Officer

America's "Silver Tsunami" & SUD

Between 2011 and 2030, 10,000 Baby Boomer will turn 65 per day. By 2050, 88 million Americans are projected to be over 65 and 19 million will be over 85. This is often called a "silver tsunami" to connote the huge impact of such major demographic change.

Aging brings with it a number of challenges including loss (of spouses, friends, extended family), financial stressors, and declining health (often associated with loss of mobility and independence). The COVID-19 pandemic has also exacerbated social isolation and heightened anxiety and depression as death rates for older adults soared. The American health care system was already stretched thin and had multiple holes before the pandemic, but those deficits stand out even more now.

Among the gaps that we know about are penetration rates for older adults (OAs) with substance use disorders. There are, for example, 17 millions scrips written annually for insomnia meds (benzodiazepines) which have the highest rate of abuse. Benzos are often accompanied by opioid scrips for pain which leave OAs at high risk for overdose and death. Adding alcohol compounds the danger for OAs to overdose.

Over the past 10 years, Michigan has experienced a 179% increase in OAs entering the public SUD treatment system. During this period, admissions for alcohol as the primary drug of choice rose from 1,478 in 2009 to 4,120 in 2018. Admissions for cocaine use for older adults rose 275%, heroin

admissions rose 87%, and opioid overdoses for OAs over 65 rose 130% between 2013 to 2017.

Alarming as these numbers are, one can view the increased admissions of older adults into SUD treatment as a step in the right direction. It's a sign of improved information about addiction as a disease (not a moral failing) as old attitudes and stigma start to shift. MSHN is working to increase access and engagement in SUD prevention, treatment and recovery programming to the older adult population that often flies under the radar.

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

Provider Network

Carolyn Tiffany, MA
Director of Provider Network Management Systems

Training Reciprocity for Direct Care Support Professionals

The Statewide Training Guidelines Workgroup (STGW) is made up of training professionals, and representatives at the provider, CMH, PIHP, and state levels to build the necessary structure to implement statewide training reciprocity for Direct Support Professional (DSP) training standards to support training reciprocity efforts. STGW is a committee of the Community Mental Health Association of Michigan (CMHAM). With support of the Regional Entity CEO Group, STGW has created over 30 training vetting tools and training guidelines which establish a uniform set of outcomes/competencies accepted statewide. This supports the plan developed by PIHPs to support training reciprocity primarily the direct care workforce – ensuring training and competency development with follow the DSP and be recognized by new employers.

To date, there have been 91 trainings submitted for review by STGW from providers, CMH's, and PIHPs across the state. Within the MSHN region, there have been 25 trainings submitted for approval by STGW, making up over nearly 30% of the trainings being vetted as reciprocal across the state. MSHN and CMH Training Coordinators meet quarterly and work toward completing the vetting of all CMH level DSP trainings by 9/30/2021. We acknowledge the great work and collaboration of the CMHs to support this process.

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

Quality, Compliance & Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC
Director of Quality, Compliance and Customer Service

New Mediation Services Grant

Public Act 55 of 2020 created a new statewide behavioral health mediation services grant that states mediation must be offered as a dispute resolution option and provided to the persons served by Michigan's public mental health system for the resolution of concerns "related to planning and providing services or supports to the recipient." In response to the Public Act, changes were made to the Mental Health Code (MHC) that ensures a recipient, or his or her individual representative, is offered an opportunity to request mediation to resolve a dispute between the recipient or his or her individual representative and the community mental health services program (CMHSP) or other service provider under contract with the community mental health services program.

Mediation is defined in the MHC as a confidential process in which a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable resolution. A mediator does not have authoritative decision-making power.

The recipient has the right to request mediation at any time and the process can be completed at the same time as a local dispute resolution, local appeal or a state Medicaid fair hearing.
Once mediation is requested, the process must begin within 10 business days of the request. The mediation must be completed within 30 days after the date the mediation was recorded unless the parties agree in writing to extend the mediation period for up to an additional 30 days. The mediation process may not exceed 60 days.

If the dispute is resolved through the mediation process, the mediation agency will prepare a legally binding document that includes the terms of the agreement. The document will be signed by the recipient or their individual representative, the CMHSP, and the contracted service provider of the CMHSP, if an involved party in the mediation. This document is enforceable in any court of competent jurisdiction in Michigan.

If the dispute is not resolved through the mediation process, the mediation agency will prepare a document indicating a resolution was not reached, which will be provided to all parties.

The Behavioral Health and Developmental Disabilities Administration (BHDDA) is in the process of

drafting mediation language that will be incorporated into the Fiscal Year 2021 Pre-Paid Inpatient Health Plan (PIHP) and CMHSP contracts.

The provider that has been selected to fulfill the requirement of mediation under contract with the Michigan Department of Health and Human Services (MDHHS) is Oakland Mediation Center. Staff from the Oakland Mediation Center will be coordinating statewide mediation implementation and service delivery and will be reaching out to all CMHSP Directors to schedule regional meetings for the purposes of introduction and information sharing.

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

Our Mission:

To ensure access to high-quality, locally-delivered, effective and accountable public behavioral health & substance use disorder services provided by its participating members

Our Vision:

To continually improve the health of our communities through the provision of premiere behavioral healthcare & leadership. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently, and effectively addressing the complex needs of the region's most vulnerable citizens.

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