From the Chief Executive Officer's Desk

Joseph Sedlock

One of the things that characterizes the current public behavioral health system redesign legislation dialog is that they are focused on money, politics, and rhetoric. In my view, the discourse is not focused on the things that should be a part of any overhaul, redesign, or improvement initiative.

A major part of these discussions should be on improvements people we support and serve care most about. And a major part of these discussions should be focused on improvements for all citizens. There are a number of local and statewide initiatives that focus on these important structures.

Today's public behavioral health system in Michigan was designed as a specialty plan – meaning that only those individuals and families with the most severe forms of mental illness, most severe forms of emotional disturbance, those with intellectual and/or developmental disabilities and substance use disorders are eligible for services. Careful attention to what people who have access difficulties describe – more often than not – is with accessing care for mild or moderate conditions. It is the responsibility of Michigan's Medicaid Health Plans, where funding has been integrated for years, to serve these people. What is not being asked – or supported with data – is the question of "How's that going?"

Last week, a mass shooting event took place in Oxford, Michigan. Individuals lost their lives and many were wounded – and a whole community traumatized. I don't wish to politicize this event, but there is one fact to note related to the content of this article: the local CMHSP/PIHP, Oakland Community Health Network (OCHN), was at Oxford High School and the surrounding area within hours, providing supports and trauma-centered services to all people, regardless of eligibility for services. There were no Medicaid Health Plans.

As these discussions continue, reframing from rhetoric and catch-phrases that demonize the current public system or place blame or make unsupported assertions that the system is broken should change to a focus on facts. As important as individual stories are – and as horrific as many individual stories are - they most often represent exceptions (and often misdirected responsibility or blame). Time and time again, the public system intervenes to create better care and better health outcomes for people that fall through the cracks of private or even publicly supported health plans. OCHN's rapid and effective response noted above is just one example among thousands that demonstrate the community benefit and value of today's system.

At the level of system change, the massive changes that both the Senate and House proposals envision focus on important, but superficial, administrative and financial issues. The lenses we should be using are whether the proposed changes create better health, better care, better equity, better value, and better provider systems. The proposals that result should be based on verifiable facts and not on unsupported allegations, rhetoric, or anecdotes.

Michigan Senate Leadership has figured out how to allocate resources to help ensure passage of its version of reform/redesign. A supplemental allocation of more than $350M is tied to passage of SB 597 and 598. While I

disagree with most of the allocation intentions, it is a model for the future: incentivize and provide the resources needed for achieving the outcomes we value and/or the changes we – as people – seek.

Even without these incentives, the public behavioral health system – led by PIHPs and Community Mental Health Services Programs (CMHSPs) across the State - has innovated to create better health outcomes for people served; better care for those involved with their current services and supports – and the communities in which they live and work; better value for citizens and stakeholders; better equity (that still requires improvements); and a better provider system for delivering supports and services. Our recently published "Impact Report" backs these statements up. A short visit to any provider site in this region will provide even more robust evidence that the people we support get the benefit of better health outcomes, along with a better experience of services and supports.

I have been doing this work for a very long time. What has been consistently absent from the seemingly endless appetite for reform are: a focus on facts; an effort to stabilize the current system; an effort to incentivize the desired outcomes/performance; an effort to listen to the people we exist to serve and support, along with their circles of supporters; a focus on community benefit; and a focus on all citizens. MSHN is proud of our sister PIHP, Oakland Community Health Network, for focusing on the needs of a whole community.

Mid-State Health Network has been working to change the narrative to focus on what matters most to almost 60,000 individuals and families served in our region, and their communities across this 21-county region and the evidence of the exemplary performance of this Pre-Paid Inpatient Health Plan, our twelve Community Mental Health Services Program participants, and our more than 125 substance abuse prevention, treatment and recovery providers.

I don't think it's too much to expect that reform proposals be based on fact; I don't think it's too much to expect that we focus on the outcomes people value; I don't think it's too much to ask to stabilize and incentivize the current system to perform as the people of our state want. I don't think it's too much to ask that reforms focus on all people with mental, intellectual, developmental or substance abuse concerns.

And there is much taking place in these arenas. Policy makers and stakeholders should be investing in and expanding: Certified Community Behavioral Health Centers, Behavioral Health Homes, Opioid Health Homes, State Innovation Models, and so many other demonstrations that have consistently demonstrated the health outcomes, care experiences, value, equity, and provider competency and quality outcomes I believe are the foundation to an effective, efficient, and valuable public behavioral health system for now and for our future.
In the midst of all of this, several young people have died, several more seriously injured, parents, school staff and the community traumatized. The PIHP and CMHSP safety net must be preserved so that the kind of response demonstrated by OCHN as a Community Mental Health Services Program are never in doubt; so that there is never a question as to which "plan" to call; so that all citizens of our state have access to the safety net, community benefit, and the many services and supports we provide to those in need.

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 Sarah Surna has accepted the position of Prevention Specialist. Sarah comes to us from Barry-Eaton District Health Department where she worked as the Community Health Promotion Specialist. Her start date was November 18th. 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 Financial Specialist, Medicaid Event Internal Auditor and with the recent announcement of retirement from Forest Goodrich, MSHN's Chief Information Officer (CIO), we have posted the CIO position as well. Job Descriptions are located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers. To apply, please send cover letter and resume to amanda.ittner@midstatehealthnetwork.org.

MSHN Receives Final Report from Health Services Advisory Group

Michigan Department of Health and Human Services (MDHHS) contracted with the Health Services Advisory Group, Inc. (HSAG) as its External Quality Review organization (as required by Managed Care Rules) to conduct compliance reviews of its contracted PIHPs responsible for the delivery of Medicaid waiver benefits for people with intellectual and developmental disabilities (IDD), serious mental illness (SMI), serious emotional disturbance (SED), and prevention and treatment services for substance use disorders (SUDs). MSHN demonstrated compliance in 55 of 65 elements, with an overall compliance score of 85 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and state regulations. Availability of Services Standards and Assurance of Adequate Capacity Standards were the sections that MSHN will need to work closely with our CMHSPs to ensure appropriate follow up over the winter. The MSHN Board can expect to receive a revised Network Adequacy Assessment in the spring/summer that will include additional data points such as time and distance standards assessments as well as an updated directory on the MSHN website that will include more details on Cultural Capabilities and Accessibility. The full report can be found on our MSHN website at: https://midstatehealthnetwork.org/HSAG Compliance Report.

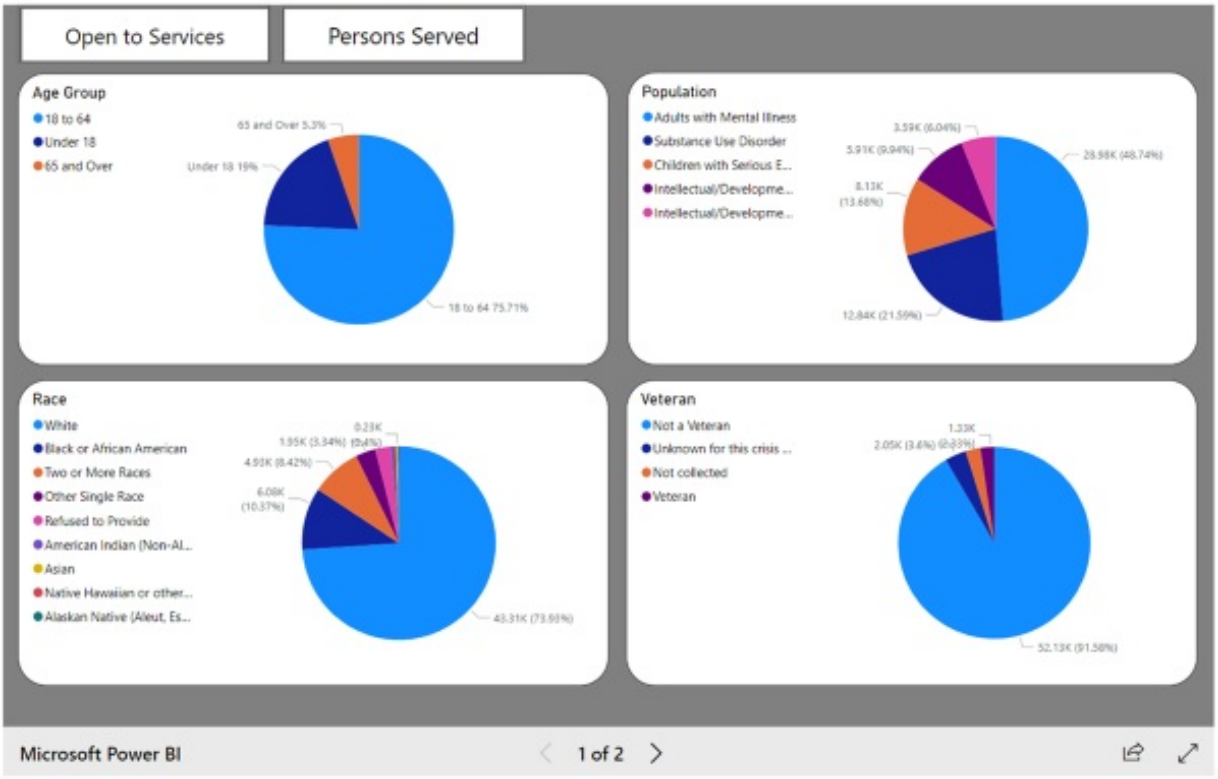
For further information or questions, please contact Amanda at Amanda.Ittner@midstatehealthnetwork.org

Information Technology

Forest Goodrich
Chief Information Officer

Mid-State Health Network and CMHSP staff are wrapping up the BH-TEDS and encounter reporting for fiscal year 2021 by getting everything processed and into the MDHHS CHAMPS system prior to December 31, 2021. This year-end processing is going smoothly and should be complete with no concerns and with high rates for reporting timely. At the same time, the first quarter of services are being reported successfully while incorporating several significant changes by MDHHS relative to service codes and modifiers being used. These changes help MDHHS track information better for their internal use and reporting.

Several new dashboard reports have been posted to the website to assist stakeholders by using interactive visual graphs. Below is an example of persons served and characteristics used for rate comparison across the region.



Please use this link to go Mid-State Health Network website for more information.
https://midstatehealthnetwork.org/stakeholders-resources/about-us/dashboard-information/embedding-powerbi-reports

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 working on an FY 2022 Budget Amendment to be presented during the January 2022 Board of Directors' Meeting. MSHN's typical process includes presentation of the current fiscal year's amended budget and the upcoming fiscal year's original budget during September's Board Meeting. As previously reported, MDHHS disseminated the final Rate Certification letter later than usual which resulted in MSHN developing fiscal assumptions for the FY 22 budget. Our new rate estimates indicate a significant revenue increase which will likely be offset by higher CMHSP spending especially related to staff retention efforts. In addition, the final Rate Certification and FY 22 MDHHS payments have provided additional information on the impact of Certified Community Behavioral Health Center (CCBHC) revenue. CCBHC demonstration sites are The Right Door, Community Mental Health Authority of Clinton, Eaton and Ingham Counties, and Saginaw Community Mental Health, and each are at different phases of the certification and implementation process, although CCBHC funding was disbursed by MDHHS beginning in October 2021.

In addition, Finance is working on fiscal reconciliation and other key business processes related to CCBHC. This work is being developed as we move throughout the fiscal year and receive updated guidance from MDHHS regarding reporting expectations. Lastly, MSHN has developed a process for tracking PIHP staff time involved with CCBHC. This tracking will allow MSHN to accurately report whether or not the nominal administration funding

calculated by MDHHS will cover associated PIHP expenses.

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

Behavioral Health

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

Make This Holiday Season a Resilient One

The holiday season, a time when many people look forward to attending celebrations and gatherings with friends and family. It is a time to get together and reconnect with loved ones and enjoy the best of the season and catch up. It is a time of appreciation, reflection, excitement, renewal, support, and COVID-19 stress. The holidays can also be challenging for many. Conflicts may arise out of these gatherings, new or old, affecting emotional well-being and mood, and possibly increasing a sense of isolation (Dale et al., 2021). Since the COVID-19 pandemic's official "beginning" on March 11, 2020, this holiday season marks the second under a cloud of concern and anxiety for the wellness and health of those same family and friends, especially considering the relative unknown implications of the newest COVID-19 variant, omicron. The focus of this article is to acknowledge the realities of the psychological effects of the COVID-19 pandemic and to further identify factors and self-care routines that help reduce stress and insulate all from the corrosive effects of post-traumatic stress.

The psychological distress many have felt over the last year and 9 months has continued to elevate, resulting in one of the most significant encounters with peritraumatic distress humanity has simultaneously experienced. Peritraumatic distress is emotional and physiological distress experienced during (and possibly after) a traumatic event (Jang et al., 2021), which is important to note since the pandemic is still ongoing. Its impact can be felt in burnout, depression, anxiety, and insomnia, among other symptoms. During the holidays, COVID-19's isolating influence on individuals may serve to intensify peritraumatic distress. Resilience, or resources an individual possesses internally to counteract perceived stress, is thought to play a large role in counteracting the effects of traumatic experiences (Ye, et al., 2020). Connection to others is especially important to resilience and well-being.

Self-care, while perhaps cliché on the surface, is vital to individual wellness. Self-care has in fact been found to decrease peritraumatic stress and is especially recommended as a set of techniques intended to target the experienced stressors of the COVID-19 pandemic (Miller et al., 2021). In fact, better self-care was related to positive changes in sleep (Werner et al., 2020). Self-care comes in many forms. The Centers for Disease Control and Prevention (CDC) notes several signs and symptoms that are related to stress reactions: feeling chronically tired, low motivation, feeling powerless/hopeless, irritable, sad, problems concentrating, or sleeping (HCPro, 2021). Recommendations for self-care routines include staying on track/keeping a routine, exercising daily, scheduling time for yourself, eating a healthy diet, getting adequate sleep, seeking counseling, changing thought patterns, and reaching out to others.

Social support, even perceived support, can help individuals reframe and cope better with the negative effects of stress (Szkody et al., 2021). Alternatively, negative coping styles of self-isolation and avoidance contribute to increases in anxiety and depression as well as a sense of loss of control. It is important to point out that an individual's perception of isolation and loneliness play a significant role in overall wellness; it is in being connected to others in supportive ways (even if simply believed to be present and available) that becomes vital to better quality of life and even more so during this holiday season, even in the midst of a self-isolating event such as the COVID-19 pandemic. The holidays are a good time of year to remember to take care of yourself and renew connections safely to help increase the positive effect of support from others you value.

References:

- Dale, R., Budimir, S., Probst, T., Stippl, P., and Pieh, C. (2021). Mental health during the COVID-19 lockdown over the Christmas period in Austria and the effects of sociodemographic and lifestyle factors. *International Journal of Environmental Research and Public Health, 18* (7), 3679-3794. doi.org/10.3390/ijerph18073679
- HCPro.com. (2021). Managing the emotional toll of COVID-19. *Case Management Monthly, February 2021*, 7-9.
- Jang, Y., You, M., Lee, M., Lee, Y., Han, J.O., and Oh, J.H. (2021). Burnout and peritraumatic distress of healthcare workers in the COVID-19 pandemic. *BMC Public Health, 21,* 2075, doi.org/10.1186/s12889-021-11978-0
- Miller, J.J., Barnhart, S., Robinson, T.D., Pryor, M.D., and Arnett, K.D. (2021). Assuaging COVID-19 peritraumatic distress among mental health clinicians: The potential of self-care. *Clinical Social Work Journal, 49*, 505-514. doi.org/10.1007/s10615-021-00815-x
- Szkody, E., Stearns, M., Stanhope, L., and McKinney, C. (2021). Stress-buffering role of social support during COVID-19. *Family Process, 60*, (3), 1002-1015. doi: 10.1111/famp.12618
- Werner, A., Kater, M.J., Schlarb, A.A., and Lohaus, A. (2020). Sleep and stress in times of the COVID-19 pandemic: The role of personal resources. *Applied Psychology: Health and Well-Being, 13*, 935-951. doi: 10.1111/aphw.12281
- Ye, Z., Yang, X., Zeng, C., Li, X., Wang, Y., Shen, Z., and Lin, D. (2020). Resilience, social support, and coping as mediators between COVID-19 related stressful experiences and acute stress disorder among college students in China. *Applied Psychology: Health and Well-Being, 12*, (4), 1074-1094. doi:10.1111/aphw.12211

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

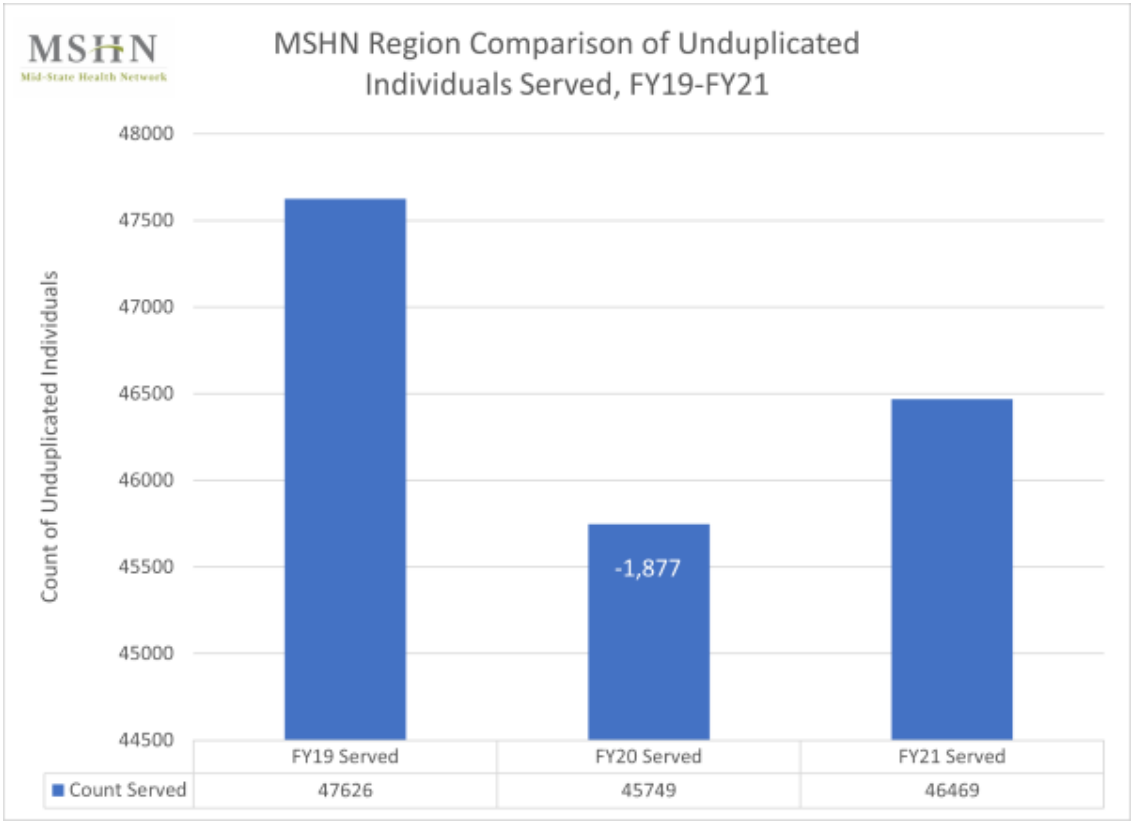
Skye Pletcher-Negrón, LPC, CAADC
Director of Utilization and Care Management

Fiscal Year 2021 Comparative Year in Review: Utilization Trends in Community Mental Health Services

Fiscal Year 2019 (FY19) was the last full fiscal year before COVID-19 affected services to individuals in the Community Mental Health Service Provider system (CMHSP). In FY19, the Mid-State Health Network (MSHN) region served 47,626 unique (unduplicated) Medicaid-eligible individuals. Table 1. Percent Change in Number Served, shows there was a 3.94% drop from FY19 to FY20, from 47,626 to 45,749 individuals served. Then, as the pandemic continued from FY20 into FY21, the number of individuals served rose 1.57% to 46,469. This total is 2.43% less than FY19 but growth continues to show progress toward recovery, reaching and serving more individuals toward pre-pandemic levels. Six of the twelve MSHN CMHSPs, in the process of increasing services, have since exceeded in FY21, their number served total for FY19. The CMHSPs can be credited with focusing on care to individuals, despite the many challenges brought on by the COVID-19 pandemic. In partnership with the Michigan Department of Health and Human Services (MDHHS) and MSHN, the CMHSPs expanded service capabilities through telehealth, increased health precautions, and face to face services.

Table 1. Percent Change in Number Served

Community Mental Health	FY19 Served	FY20 Served	Percent Change FY20	FY21 Served	Percent Change FY21
Bay-Arenac Behavioral Health	5015	4451	-11.25%	4498	1.06%
CEI CMH	9286	9099	-2.01%	8953	-1.60%
CMH for Central Michigan	8624	8443	-2.10%	9001	6.61%
Gratiot Integrated Health Network	1638	1598	-2.44%	1679	5.07%
Huron Behavioral Health	1096	995	-9.22%	1015	2.01%
Ionia-The Right Door	2285	2050	-10.28%	1960	-4.39%
LifeWays CMH	7144	7178	0.48%	7234	0.78%
Montcalm Care Network	2046	1941	-5.13%	2190	12.83%
Newaygo CMH	1967	2076	5.54%	1984	-4.43%
Saginaw County CMHA	6508	6205	-4.66%	6335	2.10%
Shiawassee County CMHA	1965	1584	-19.39%	1608	1.52%
Tuscola Behavioral Health Systems	1213	1112	-8.33%	1129	1.53%
Duplicated Count	**48787**	**46732**	-4.21%	**47586**	1.83%
Unduplicated Count	**47626**	**45749**	-3.94	**46469**	1.57%



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

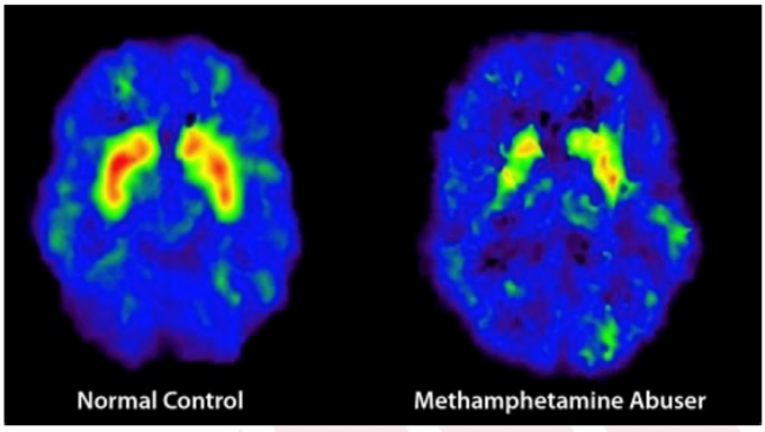
Rise in Stimulants & Methamphetamine-Induced Psychosis (MAP)

According to the Centers for Disease Control and Prevention (CDC), provisional data indicates that the drug overdose epidemic in the United States has broached 100,000 deaths for the first time ever in a 12-month period. Overdose deaths rose 29% to 78,056 from April 2019 to April 2020 and jumped to 100,306 in the subsequent 12 months. In Michigan, the death toll rose nearly 20% in that same timeframe. While not entirely surprising in the context of a global pandemic with new expressions of trauma and isolation, a lesser-known piece of the unprecedented death toll is the rise in illicit stimulant use, in particular cocaine and methamphetamine.

A particularly confounding side effect of rising methamphetamine use has been a complex of medical symptoms that's been called Methamphetamine Psychosis (MAP), something that's become pronounced in the post-ephedrine chapter of meth production and the rise of phenyl-2-propanone (P2P) meth which is a more pronounced neurotoxin than the old meth. MAP refers to when individuals' meth intoxication includes psychiatric symptoms that can fall into three domains: 1) psychotic symptoms like delusions, hallucinations, and paranoia, 2) affective symptoms like severe depression, suicidality and anxiety, and 3) psychomotor symptoms like motor hyperactivity. For a majority of those with MAP, the symptoms resolve within a month of cessation of meth use, but 10-28% experience MAP after six months or longer of abstinence, and 5-7% of users experience MAP even during long-term abstinence.[1]

When these individuals present in emergency rooms (often transported by law enforcement due to erratic behavior in the community), they present a dilemma for medical staff. By definition, their psychotic symptoms are drug-induced so do not meet criteria for inpatient psychiatric hospitalization, but neither are traditional SUD withdrawal management (detox) and residential providers trained in dealing with patients experiencing psychotic symptoms nor do most have psychiatrists on staff. While there is generally consensus by the medical, behavioral health and SUD treatment professionals involved that the patient needs an immediate intervention to prevent harm to themselves or others due to their altered mental state, consensus is lacking as to which system of care (behavioral health or substance use) should take the lead in providing treatment. We've received reports from around the region and the state that individuals with a provisional diagnosis of MAP have been stuck in emergency rooms for extended periods as a care plan is being sorted out. Considering the time frame for psychotic symptoms to subside, this clearly is not good for the individual, for Emergency Department (ED) staff and for other patients in the ED.

Skye Pletcher, MSHN's Director of Utilization Management and Health Integration initiated development of a practice guideline to facilitate better referral streams to appropriate treatment settings, and this work is being continued by a MSHN workgroup that includes Skye, Dr. Trisha Thrush (Lead Treatment Specialist), Dr. Todd Lewicki (Chief Behavioral Health Officer) and myself. We have incorporated input from MSHN SUD Medical Director, Dr. Springer, and are also pulling from the medical literature including research gleaned from the 2021 Annual Stimulant Summit in October. Upon completion of this clinical practice guideline, it will be distributed to Region 5 CMHSPs, SUD providers, and hospital emergency departments to not only improve more rapid referrals for care but also to increase provider competency in the treatment of methamphetamine intoxication and withdrawal, with or without symptoms of psychosis.



[1] Wearne TA, et al. Front Psychiatry. 2018; 9:491

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

Quality, Compliance & Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC
Chief Compliance and Quality Officer

MSHN Regional Consumer Advisory Council

Dan Dedloff
Customer Service and Rights Manager

The Regional Consumer Advisory Council (RCAC) was established to facilitate meaningful, region-wide consumer involvement regarding MSHN policy development, service development, service delivery, service evaluation, and quality improvement activities. The RCAC is an advisory group consisting of primary and secondary consumers representing adults with mental illness, adults with developmental disabilities, children with mental illness, children with developmental disabilities, and individuals with substance use disorders. Participants are comprised of members from each of our twelve Community Mental Health Service Providers (CMHSPs) across the Mid-State Health Network region.

The RCAC meets bi-monthly and has met through remote video teleconferencing since the beginning of the pandemic. The responsibilities of the RCAC include, but are not limited to, providing representation, and fostering effective communication on behalf of the local consumer councils; advising on the strategic plan; system advocacy efforts for public behavioral health; advising on regional initiatives such as person-centered planning, health care integration, recovery, and other consumer-directed options; consumer involvement opportunities; and region-wide stigma reduction.

During Fiscal Year 2021, the RCAC reviewed and provided feedback regarding a variety of topics, including: Quality Improvement Performance Measure Reports, Consumer Satisfaction Survey results, MSHN's 2022-2023 Strategic Plan, the Annual Compliance Summary Report, the Consumer Handbook, the Quality Assessment and Performance Improvement Plan, and advocacy opportunities for the proposed Public Behavioral Health System Redesign. The group typically provides feedback in the form of open group brainstorming discussions and this feedback enables MSHN to continue to be connected to consumer needs and to shape practices in alignment with regional consumer best practices.

In addition, among the upcoming goals for Fiscal Year 2022, the Council has identified a focus on advocacy regarding the Public Behavioral Health System Redesign and increasing consumer involvement on the council and other local consumer advisory groups.

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.