From the Chief Executive Officer's Desk

Joseph Sedlock

The Michigan Department of Health and Human Services (MDHHS) will require use of the Michigan-version of the Child and Adolescent Needs and Strengths (MichiCANS) assessment tool statewide beginning October 1, 2024. A “soft launch” was initiated on January 7, 2024 involving several Community Mental Health (CMH) sites across the state, including one in the Mid-State Health Network (MSHN) region. Observations and learnings during the soft launch period will help to inform finalization of formal requirements prior to the “hard launch (10/01/24).”

According to the developer of the tool, The Praed Foundation, the free CANS tool is in use in all 50 states (and in countries around the world) in child welfare, mental health, juvenile justice, and other settings. The tool was developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for monitoring of outcomes of services.

MDHHS will require Pre-Paid Inpatient Health Plans (PIHPs) to implement and CMHs to use a brief screening tool at the point of first contact with a child or youth through age 20, and a comprehensive version, designed to help identify areas of need, at the point of assessment. All versions support Family Driven, Youth Guided planning as required by Michigan law.

Currently, the public behavioral health system is required to use the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS). These will be retired when the MichiCANS is in full roll out/use. Also of note, Michigan’s Child Welfare System will use the MichiCANS for children in foster care.

While some domains covered by the MichiCANS vary by age, the instrument is intended to assess needs and strengths in life functioning, individual strengths, cultural factors, behavioral/emotional needs, risk factors and behaviors, family cultural factors and caregiver resources and needs domains. Each of these domains have several sub-domains that are included in the comprehensive assessment. The shorter “screener” is intended to assist with eligibility determinations and initial needs.

The regional and statewide conversion from one system or instrument for assessing infants, children, and youth to a whole new instrument, replacing “old” instruments in paper and/or electronic form with the “new” instruments, as well as clinical process flows will require significant resources, broad training, commitment to collaboration and problem solving. This region’s PIHP and CMH executive and clinical leadership are preparing for this statewide implementation.

MSHN would like to acknowledge Community Mental Health for Central Michigan for participating in the soft launch and their work to inform state and regional policy and future roll-out considerations.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Value Based Care National Environmental Scan

Mid-State Health Network's Strategic Plan includes goals and objectives to increase value-based care reimbursement models within the region. In November, the MSHN Board of Directors received a presentation that included Value Based Care payment approaches history, current environment, and future initiatives within the region and within the State of Michigan. Of note, MSHN has implemented multiple value-based projects that include Certified Community Behavioral Health Clinics (CCBHC), Opioid Health Homes (OHH), Behavioral Health Homes (BHH) and Project Assert Programs. The MSHN internal team requested consultation through TBD Solutions to conduct research on other national strategies related to substance use disorder (SUD) alternative payment models. The report was received in November and reviewed by the team in December. The report titled Alternative Payment Approaches indicates very few models have been developed with the SUD target population.

The report is available at: MSHN Alternative Payment Approaches

Substance Abuse and Mental Health Services Administration (SAMHSA) also released a report in December entitled *Exploring Value-Based Payment for Substance Use Disorder Services in the United States*. "Value-based payment (VBP) models pay health care providers based on the value rather than the volume of services. Use of these models has been concentrated in physical health services. However, due to the magnitude of substance use disorders (SUDs) in the United States, there has been a growing movement toward using VBP for SUD treatment and recovery services. VBP models have the potential to improve delivery of the integrated and coordinated care necessary for the complex and continuing needs of individuals with SUDs. This report explores the use of VBP for SUD services in the United States. The challenges to further develop and implement VBP for SUD treatment and recovery services are highlighted in this report and include the fragmentation between physical and behavioral health care; workforce and training issues; difficulties with measuring the quality of SUD treatment; limitations in data infrastructure and sharing capacity; and underinvestment in SUD treatment and recovery services. Potential solutions to these challenges include supporting care coordination, incentivizing provider training in SUD treatment, developing consensus on meaningful patient-centered outcome measures, and improving data and record-keeping infrastructures. Sustainable, long-term financial and stakeholder investment is needed to support these solutions. With such support, VBP models have promising potential to improve the quality and cost- effectiveness of SUD treatment and recovery services nationwide."

The report is available at https://facesandvoicesofrecovery.org.

Both the research reports indicate that Michigan is ranked high as compared to other states in implementing value-based care payment arrangements, with the Opioid Health Home (OHH) highlighted as a successful project that supports the SUD target population while including care coordination related to physical health and social determinates of health.

MSHN implemented the OHH pilot in FY23 with Victory Clinic Services for Saginaw County and is in the process of expanding it further to the Jackson and Lansing communities for FY24. In addition, MSHN is reviewing applications for OHH certification in FY24 for Recovery Pathways of Essexville, Isabella Citizens for Health and Mid-Michigan Community Health.

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

Information Technology

Steve Grulke
Chief Information Officer

The Mid-State Health Network (MSHN) Information Technology (IT) team works with Zenith Technology Solutions (ZTS) and their analytics tool called Integrated Care Delivery Platform (ICDP) to continually update the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. ICDP is utilized to calculate many key performance indicators and metrics for the region that can also be stratified by Community Mental Health Service Providers (CMHSP) and Medicaid Health Plans. The system supports review and action related to the shared performance bonus metrics with the Medicaid Health Plans as part of the requirements in the Prepaid Inpatient Health Plan (PIHP)/Michigan Department of Health and Human Services (MDHHS) contract. MDHHS requirements are currently based on calendar year 2023 specifications, so the MSHN IT team worked with ZTS to update the HEDIS specifications in ICDP to match. MSHN and ZTS are now working to be prepared for when MDHHS starts reporting calendar year 2024 specifications.

The IT team also completed work with TBD Solutions to update the time and distance analysis for the region's annual Network Adequacy Assessment. In the past, time and distance calculations were performed on only the Medicaid individuals that MSHN served in the various service categories, as required by MDHHS. This year MSHN utilized a geographic distance calculation to provide the time and distance analysis for all individuals that reside in the MSHN region, regardless of whether they were served or not. This change allows MSHN to better understand access to services for anyone in the region that might want services. This new analysis will be used to report to MDHHS for the FY23 Network Adequacy Assessment in April 2024.

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Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is working to finalize Fiscal Year (FY) 2023 reports during February. The reports include:

- Financial Status Report (FSR) - The report outlines Medicaid and Healthy Michigan Program (HMP) funding received by the Prepaid Inpatient Health Plan (PIHP) and funding amounts subsequently used for expenses by each Community Mental Health Service Program (CMHSP) and for Substance Use Disorder (SUD) services. The report also shows the amount of savings the region will earn and use in the next fiscal year as well as identifying the maximum Internal Service Fund (ISF) the PIHP can earn. MSHN is projecting $0 savings which is unprecedented for the region. For the last several fiscal years, MSHN's region has boasted average savings of more than $40 M for use in the subsequent fiscal year. In addition, the region's ISF may fall slightly below the 7.5% savings maximum however the projected balance will exceed $50 M. ISF may be used to managed risk for the region. Typically, fiscal risk involves insufficient current fiscal year revenue as compared to expenses. To mitigate risk, the PIHP and CMHSPs must develop strategies aside from reducing services to align expenses with available revenue.
- Encounter Quality Initiative (EQI) - summarizes Medicaid and Healthy Michigan expense totals for MSHN and CMHSPs by Common Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS). The report is used by MDHHS for future rate setting purposes. Rate setting is conducted by MDHHS's actuarial firm and dictates the funding amounts associated with Medicaid and HMP enrollees.
- Legislative Report - Specific to SUD and include detailed expense information by individual provider. The report illustrates the number of providers supported through all MSHNs SUD funding and specifies the expense related to block grant service categories such as Treatment, Women's Specialty, and Prevention services.
- Medical Loss Ratio (MLR) - Calculates the percentage of revenue spent by the PIHP on claims and quality improvement. The federal threshold is 85% and MSHN has exceeded this number every past reporting cycle for Medicaid and HMP combined and anticipates the same for FY 2023.

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Behavioral Health

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

The Importance of Amplifying Autonomy Through Person-Centered Planning

Empowerment is an active and participatory process. Empowerment opens avenues to assist individuals in enhancing personal power and choice over resources, interpersonal matters, and life direction. It has been linked to improved health and well-being (Cattaneo & Chapman, 2010). We should expect that through greater empowerment, greater autonomy and sense of meaningfulness follow, ultimately leading to greater quality of life. When delivered authentically, person-centered processes and practices aim to empower individuals through prioritizing individuals' right to autonomy, one of the most important of the ethical principles. Respecting the individual's right to govern their own life and to receive and hear all needed information for the treatment experience, leads to an ingredient that Rogers (1957) referred to as a "necessary condition for change" where the individual views the counselor/worker as genuinely connected to their unique experience. Thus, the staff working with the individual should internalize the importance of utilizing the ethical principle of autonomy through the person-centered process, as the endorsement of empowerment, choice, and independence are directly related to outcomes (Carlisle & Neulicht, 2010).

Autonomy is fundamental to the spirit of caring and respect. It is the individual practice of exercising judgment and control over one's choices, which is the lead goal of person-centered planning. This diverges from the paternalistic medical model that aims to assess, identify, diagnose, and treat a condition. The medical model will continue to have a place in supports and services as it is an important linkage to targeting care and facilitating outcomes, but the primary importance of individual empowerment through recognizing an individual's right to autonomy should be prioritized first. Person-centered planning is a process that builds on the individual's capacity to participate in activities that promote community life and honor their preferences, choices, and abilities (MCL 330.1700(g)). The Michigan Department of Health and Human Services (MDHHS) recognizes this process through codifying these principles in its Person-Centered Planning Policy. The policy states "Person-Centered Planning is a highly individualized process designed to identify and respond to the expressed needs and desires of an individual receiving services. Person-Centered Planning is an umbrella term for the activities of discovery, developing, and planning of an individual's supports while aiming to achieve the individual's ideal life goals" (MDHHS PCP Policy, 2024, p.1).

The person-centered process should be brought to bear through reframing the therapeutic relationship with the individual to acknowledge their importance in the decision-making process, thereby redistributing the power between the individual and the worker. There is greater individually driven direction due to the process of empowerment, and the importance of the worker as facilitator of this goal helps achieve informed choice and consent. Each worker, therefore, should feel empowered to engage the individual in a trusting therapeutic relationship. The therapeutic relationship with the individual is established through the worker's expression of authenticity, genuineness, and sharing a positive stance through warmth and autonomy, which best positions the individual for an improved outcome (Bedics et al., 2012). The person-centered process is a deliberate partnership between the individual, support persons of their choosing, and those who are paid to provide services to that individual (MDHHS PCP Policy, 2024). It starts with providing necessary information and support to ensure that the individual directs the process to the maximum extent possible and is empowered to make informed choices and

decisions to co-produce a flexible plan that is representative of the individual's goals, hopes, strengths, and expectations. Empowerment is active and participatory, and the person-centered planning process is a powerful catalyst to the greater development and expression of autonomy and improved quality of life.

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

Utilization Management & Care Coordination

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Chief Population Health Officer

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Substance Use Disorder Services and Supports in Jail Settings

Individuals with Substance Use Disorders (SUD) may engage in behaviors or actions that result in contact with the criminal justice system (i.e. arrest and/or incarceration). Justice system involvement creates barriers to assessment and treatment initiation, or disruption to continuity of medication-assisted treatment (MAT) or other forms of SUD treatment. Once in jail, individuals have access to very few, if any, services and resources which puts them at risk for relapse and death once released back into the community. Incarcerated services are a vital resource for individuals that can promote and sustain the recovery process. One of MSHN's SUD strategic priorities for FY 2024-2026 is to increase access to treatment and re-entry treatment for the criminal justice involved population.

The MSHN Utilization Management (UM) team has implemented a new SUD Incarcerated Services benefit plan for FY24, with input and collaboration from other MSHN content experts. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities), so substance abuse prevention and treatment block grant funding is used to provide services to incarcerated individuals. The SUD Incarcerated Services Benefit Plan was created to ensure incarcerated individuals receive necessary services within allowable funding parameters. MSHN is pleased to be able to increase access to vital recovery services for individuals with criminal justice system involvement.

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

Substance Use Disorder Policy, Strategy and Equity

Dr. Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

Algorithnic Bias in Health Care

Many of us are now familiar with how algorithms in social media determine what content we see. If an individual is interested in vintage cars, for example, an algorithm on Facebook will integrate that preference and will prioritize vintage car related content in what that individual sees on their Facebook feed.

Algorithms are defined as mathematical models used to inform decision-making, and are widely used in housing, banking, education as well as in medical care. Recent advances in AI (artificial intelligence) have added to the digital transformation of health care that's been underway for over two decades and was accelerated by the pandemic. Algorithms in health care are used for diagnosis, treatment, prognosis, risk stratification, and allocation of resources, drawing from massive, digitized health databases to discover new insights and to support clinical decision making.

Substantial evidence has emerged, however, demonstrating that these broadly used algorithms have built-in

biases that have harmed certain populations and communities. A December 2023 article in the *Journal of the American Medical Association* (JAMA) affirmed that bias exists in the development and use of algorithms which can lead to negative health outcomes for historically marginalized populations including individuals with lower income and/or individuals from communities of color.

For example, one algorithm used the dollar amount an individual *spent* on health care as a proxy for *illness*, which resulted in prioritizing affluent white patients. Similarly, dermatological models that lack sufficient skin color representation could exacerbate disparities in cancer diagnoses, while language models can absorb harmful or inaccurate associations and conclusions within medical notes. As digitalization of health care becomes more widespread, algorithmic bias may perpetuate and compound health inequities in behavioral health and substance use disorder treatment as well, two domains of health care already plagued by health outcome disparities, with overdose death rates in Black and Native American communities, for example, 2-3 times the death rate of their White counterparts.

The Algorithmic Accountability Act passed in 2022 requires companies to identify bias in their algorithmic automated systems and to fix any discrimination or bias they find. Similar legislation was passed to address algorithm bias in consumer privacy protection, policing and financial services. To promote health care equity for patients and communities, Dr. Martin Chin and his colleagues suggested guiding principles to ensure an equity lens is applied to how algorithms are developed and are implemented. These include transparency, engagement with patients to foster trust, and monitoring to establish accountability for promoting fairness and equity in health outcomes.

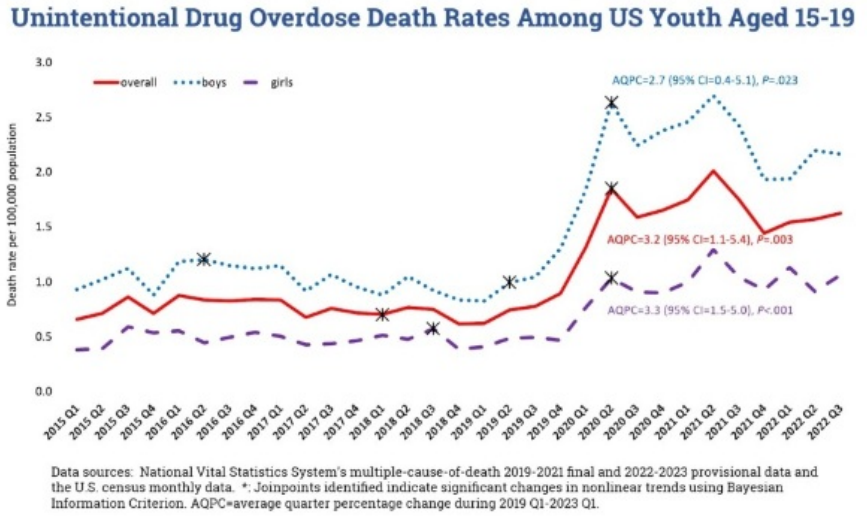
Contact Dani with questions, comments or concerns related to the above and/or MSHN SUD Treatment and Prevention at Dani.Meier@midstatehealthnetwork.org

Substance Use Disorder Providers and Operations

Dr. Trisha Thrush, PhD, LMSW
Director of SUD Services and Operations

Adolescent Substance Use Disorder Services

According to the National Institute on Drug Abuse, in 2022, an estimated 2.2 million people between the ages of 12 and 17 had a substance use disorder in the past year, with 265,000 having an opioid use disorder, according to the latest National Survey on Drug Use and Health, which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, previous data have reported a dramatic rise in overdose deaths among teens between 2010 and 2021, which remained elevated well into 2022. This increase is largely attributed to illicit fentanyl, a potent synthetic drug, contaminating the supply of counterfeit pills made to resemble prescription medications.



Data sources: National Vital Statistics System's multiple-cause-of-death 2019-2021 final and 2022-2023 provisional data and the U.S. census monthly data. *: Joinpoints identified indicate significant changes in nonlinear trends using Bayesian Information Criterion. AQPC=average quarter percentage change during 2019 Q1-2023 Q1.

Residential treatment is one part of a broader continuum of care for adolescents with substance use disorders, in addition to treatment provided in outpatient specialty care, primary care, and other settings. Often, locating a provider who has the capacity and availability to provide adolescent SUD services can be a challenge.

Using the FindTreatment.gov database maintained by SAMHSA, and SpyFu, a search analytics company that compiles data on search engine advertisements, researchers identified a list of 354 centers across the U.S. that indicated they provided residential addiction treatment services to people under the age of 18 to include in the analysis. Of the 354 centers identified, 160 (45%) of these facilities confirmed they provided residential treatment to patients under the age of 18.

Of the 160 residential addiction treatment facilities found to provide treatment to young patients, the researchers found that 66 facilities (41%) were for-profit, and 94 facilities (59%) were nonprofit. For-profit treatment centers were more likely to have space immediately available (77%) compared to nonprofit facilities (39%) but at roughly triple the cost (on average, $1,211 reported daily cost for for-profit facilities vs. $395 for nonprofit facilities). 65 facilities (40%) estimated the number of days until a bed opened. The average wait time for a bed in a for-profit

facility was 19 days, and the average wait time for a bed in a nonprofit facility was 31 days.

Supporting increased access and utilization of SUD services for the adolescent age group is a MSHN strategic plan goal for FY24-25. The MSHN SUD Team has evaluated the accessibility of adolescent services across the 21-county region and identified areas in need of support. To assist in supporting this strategic goal, the MSHN SUD Team has implemented a request for proposals for FY24 to support the expansion of adolescent services for withdrawal management, residential, and outpatient ASAM levels of care. The goal is to make adolescent services accessible for all those in need across the MSHN region.

Source: Residential addiction treatment for adolescents is scarce and expensive | National Institute on Drug Abuse (NIDA) (nih.gov)

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

Quality, Compliance & Customer Service

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Behavioral Health Quality Program

The Michigan Department of Health and Human Services (MDHHS) Behavioral Health Quality Program is undergoing changes to align with national standards for healthcare quality. Healthcare quality has several variations and modalities for achieving a high value healthcare system. Each variation includes a common set of elements and strategies used to achieve quality healthcare within an organization. The Agency for Healthcare Research has identified six dimensions for healthcare quality.

- Healthcare should be safe for the individual, free from actual or potential bodily harm.
- Healthcare should be effective. Clinical practice guidelines should achieve the desired outcomes ad be supported by scientific evidence.
- Healthcare should be person centered. The individual's needs and preferences will be met, and the services received will be educational and supportive.
- Healthcare should be timely. The individual should receive care when it is needed while minimizing delays.
- Healthcare should be equitable. Individuals with different characteristics, conditions, and preferences should receive equal quality of care.
- Healthcare should be efficient. The quality of care delivered, benefits received should be maximized compared to resources used.

The Center for Medicare and Medicaid Services (CMS) has developed a National Quality Strategy (NQS) that incorporates the dimensions of healthcare quality to achieve quality across all systems of care. CMS has prioritized four areas within the NQS which include equity and engagement, outcome and alignment, safety and resiliency, interoperability, and scientific advancement. Each priority has goals and objectives designed to improve quality across all systems of healthcare.

Performance measures are used to evaluate if the desired outcomes have been achieved. The CMS NQS has implemented the Universal Foundation which is a set of performance measures that focus on priority clinical areas and support services. The Universal Foundation is used to standardize and align impactful measure sets across programs that drive quality improvement across systems of care.

The selection criteria used for the Universal Foundation includes the following:

- The measure is of a high national impact..
- The measure can be benchmarked nationally and globally.
- The measure is applicable to multiple populations and settings.
- The measure is appropriate for stratification to identify disparity gaps.
- The measure has scientific acceptability.
- The measure is feasible and computable (or capable of becoming digital).
- The measure has no unintended consequences.

MDHHS has developed a Comprehensive Quality Strategy (CQS) for 2023-2026 that aligns with the NQS for all Michigan Medicaid programs, and in accordance with the 42CFR 438.340 Managed Care State Quality Strategy includes the following elements:

- State defined network adequacy availability of service standards (438.68 and 438.206), and examples of evidence based clinical practice guidelines (438.236).
- Goals and objectives for continuous quality improvement, taking into consideration the health status of all populations served (438.310).
- A description of the metrics and performance targets used to measure performance and improvement.
- A description of the performance improvement projects with a description of the interventions proposed to improve access, quality, or timeliness of care for individuals served by the PIHP.

MDHHS has developed the following project goal and objectives as part of the CQS:

Goal: Update the quality assessment and performance improvement program for the Specialty Behavioral Health

System.

- Create a valid/reliable system to measure performance for contracted PIHPs that aligns with state and national systems.
- Establish consistent data collection, analysis, and reporting protocols.
- Promote comparability, transparency, and accountability in the behavioral health system.
- Support integrated care.
- Ensure consumer experience is a core component of quality.

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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