Mid-State Health Network | 530 W. Ionia Street | Lansing, MI 48933 | 517.253.7525| F: 517.253.7552 | www.midstatehealthnetwork.org

From the Chief Executive Officer's Desk

Joseph Sedlock

Our country has taken a major step forward in helping to ensure that mental health emergencies are readily accessible through the establishment of the “9-8-8” suicide and crisis lifeline. This will replace a 10-digit suicide prevention lifeline number. The 988 suicide and crisis lifeline is operational now. The Michigan Department of Health and Human Services operates the Michigan Crisis and Access Line under contract with Common Ground. The goal is crisis intervention services for anyone, anytime, anywhere in Michigan.

Michigan’s Pre-Paid Inpatient Health Plans (PIHPs) and their partner Community Mental Health Services Programs (CMHSPs) and their provider networks are building better emergency services systems and investing in new or expanded programming for more comprehensive and robust crisis support and intervention services. In the Mid-State Health Network (MSHN) region, we are investing in a regional crisis residential unit that we hope to have open in late summer of 2023. In the near future, establishment of Psychiatric Residential Treatment Facilities (PRTFs) will be possible if the federal government approves Michigan’s plan. Several of our CMHSP partners are considering the local development of Crisis Stabilization Units (CSUs). CSUs are designed to provide a short-term alternative to emergency department and psychiatric inpatient admission for people who can be effectively stabilized through peer support and professional treatment services within 72 hours. All of these developments are very positive for the residents of our state.

None of these activities, as important and lifesaving as they are, replaces the need for psychiatric inpatient care. For many years now, MSHN has advocated for better access to local psychiatric inpatient care, and for State Hospital capacity and admission for those that require that level of care.

Many individuals who need psychiatric inpatient care in private local psychiatric hospitals or units in Michigan still can’t get it when it’s needed. Many individuals who need psychiatric inpatient care in our State operated hospitals and centers can’t get it when it’s needed. Many of these individuals get admitted to medical hospitals to keep them safe while waiting for a psychiatric inpatient admission. Many of these individuals remain – sometimes for days or weeks – in hospital emergency rooms. While they wait for the correct setting for treatment, many of these individuals are at great risk of psychiatric decompensation and other harm.

Our regional emergency services personnel are correctly exasperated with screening individuals as requiring medically necessary psychiatric inpatient admission only to be refused admission often due to capacity issues. To be sure, what we have come to call the “Workforce Shortage Issues”,heavily impact state hospitals, local psychiatric inpatient units, and our own emergency services personnel. And the cycle of screening resulting in approval for inpatient, lack of admission, resulting ER boarding (or release), and recurrent emergencies (and risk of harm) continues. Many of our emergency services people leave the job due to this.

In my view, this is ultimately a supply problem – there simply aren’t enough psychiatric beds available through local psychiatric inpatient hospitals or units or through our state hospitals and centers. The supply problem is driven by a number of factors.

This region will continue to deliver the best quality crisis intervention and support services we are capable of. Access to inpatient psychiatric care is not within the control of the public behavioral health system (PIHPs and CMHSPs). We will do everything we can to keep people safe and deliver treatment and support people need.

If these conditions were the case for cardiac care, our society wouldn’t tolerate it. Not for a hot minute.

Why do we continue to accept this kind of treatment for people with brain conditions?

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

MSHN Staffing Update

MSHN is pleased to announce the following staffing changes and new hires effective through February. Please join me in congratulating our staff and welcoming our newest members to the MSHN team.

- Shannon Myers has been promoted from the SUD Treatment Specialist to the Quality and Performance

Improvement Manager effective January 23, 2023. She is filling the vacancy from the promotion of Amy Dillion.

- Kate Flavin will transfer from the Utilization Management Specialist to the SUD Treatment Specialist effective February 20, 2023.
- Evan Godfrey will begin employment on February 13, 2023, as the SUD Care Navigator and comes to MSHN with many years of experience working with the SUD population, most recently from Child and Family Charities as the Case Manager.
- Keely Hapanowicz will begin employment on February 13, 2023, as the Utilization Management Specialist and comes to MSHN with many years of experience as well, most recently from Sacred Heart Rehabilitation Center as the Director of Organizational Services. She is filling the vacancy from the promotion of Cammie Myers.
- Victoria Ellsworth will begin employment with MSHN on February 27, 2023, as the Habilitative Supports Waiver (HSW) Coordinator, supporting the region's HSW eligibility and application reviews. She comes to us with many years of experience, most recently as the Adult Case Manager for The Right Door for Hope, Recovery and Wellness. This position was previously filled by Tera Harris who transferred to SED/Autism Waiver Coordinator.
- Michael Bradley will begin employment on February 13, 2023, as the HCBS Waiver Coordinator and comes to MSHN with many years of experience with Genesee Health System and Lapeer County Community Mental Health. He is filling the position left vacant from Paul Duff's transfer.

MSHN is still looking to fill the Utilization Management Specialist position located on MSHN's website at: https://midstatehealthnetwork.org/stakeholders-resources/about-us/Careers.

FY22 Balanced Scorecard Key Performance Indicators Available

As directed by the MSHN Board of Directors, MSHN continues to strive for data driven metrics in our regional strategic planning and committee level decision making. The MSHN website has been updated to include performance on the FY22 key performance areas in Better Health, Better Care, Better Value and Better Provider Systems as well as specific indicators for Better Equity. MSHN's website data page also includes information related to enrollment, financial services, population served and site review results. Through PowerBI (MSHN's analytics reporting tool), the data presented allows for sorting by various elements, including, but not limited to: county, community mental health services programs, age and race. I encourage stakeholders to review the reports and provide feedback to MSHN through our link at: info@midstatehealthnetwork.org. ***FY22 Key Performance Indicators (KPI's) that met or exceeded targets are shown below.***

MSHN FY22 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Actual Value (%) as of September 2022	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	+10%	0% Decrease over FY20		1-10% Decrease	11-19% Decrease	20% or more Decrease
	Expand SUD stigma reduction community activities.	239 activities	144		>=144	<144 and >72	<=72
	Increase health information exchange/record sets	3	2		3	2	1
BETTER CARE	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	61%	58%		>=58%	0	<58%
	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.(FUH)	74%	70%		>=70%	0%	<70%
	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit.	Engagement: 32.24% *** (11-1-2021 thru 10-31-2022)	Above Michigan 2020 levels; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	96%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	7.5%	7.5%		> 6%	≥ 5% and 6%	< 5%
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	1%	<= 5%		<=5%	6%-10%	>=11%
Better Provider Systems	Managed Care Information Systems (REMI) Enhancements	3	4		3	2	1
	Implement and support Provider Stabilization (SUD Only) programs (95% approval)	100% for eligible applications	81%		>95%	80-94%	<79%
	Improve data availability	85%	100%		75%	50%	25%
	Implement and support Provider recruitment, incentives and retention programs (Goal of $10m)	6M	10m		>6m	3-6m	<3m

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 recently worked on evaluating the business phone system. The current phone system was not being very responsive to our needs for agility, timely customer service response, and correct routing and messaging. Zoom and Teams were compared and evaluated using the following criteria:

1. Ease of use
2. Portability of the existing numbers including the 800 numbers
3. Uninterrupted service during the transition
4. Cost factor
5. Various physical phone systems with the virtual and mobile devices
6. Administrative capabilities
7. Additional services such as workflow of calls and auto-attendants.
8. Security and ease of login from within our existing Active Directory
9. Reporting, analytics, and export of data to MSHN data warehouse

The result was that Zoom came out on top, and so over the next several weeks, MSHN will be transitioning to the Zoom phone platform.

Behavioral Health Treatment Episode Data Set (BH TEDS) reporting is a major Michigan Department of Health and Human Services (MDDHS) request. MSHN Substance Use Disorder (SUD) providers have been consistently reporting accurately at over 99%. This fiscal year MDHHS changed the requirement for SUD Provider Network submissions so that in addition to the submission of admission and discharge records, a yearly update of records for consumers being served for periods longer than one year will also be required. The managed care software has been updated to reflect the new requirement and SUD providers are completing these as required. The Community Mental Health Service Program (CMHSP) participants submit completed BH TEDS to MSHN. MSHN aggregates the records for submission to MDHHS and have generally been over the 95% target set by MDHHS. MSHN's system validates these records according to the requirements provided by MDHHS. One challenge for the region in data validation is the identification and accuracy of the social security number (SSN). A new SSN validation is being added in the next few weeks to help avoid the master patient identifier problems.

For further information or questions, please contact Steve at Steve.Grulke@midstatehealthnetwork.org

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is working to finalize Fiscal Year (FY) 2022 reports during February. The reports include:

- Financial Status Report (FSR) - The report outlines Medicaid and Healthy Michigan Program (HMP) funding received by the 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 Funds (ISF) the PIHP can earn. MSHN is projecting to fully fund its ISF and reach the 7.5% savings maximum.
- 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 Michigan Department of Health and Human Services (MDHHS) for future rate setting purposes.
- Legislative Report – Specific to Substance Use Disorder (SUD) and includes detailed expense information by individual provider. The report illustrates the number of providers supported through all MSHN's 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 for every past reporting cycle and anticipates the same for FY 2022.

The Finance Team continues work on the following:

- MSHN's FY 2022 Financial and Single Audits conducted by Roslund Prestage & Company.
- MSHN's Staffing Stabilization Reviews – MSHN's Board approved $13M in special "grant" funds for use in addressing the region's staffing crisis. SUD providers awarded grant dollars, were required to submit supporting documentation to ensure funds were used for the manner intended.
- Direct Care Worker (DCW) Premium Pay Reviews – MDHHS funded an extra $2.35/hour for DCWs plus 12% employer administrative fees for certain service codes. SUD providers were required to submit supporting documentation to ensure the extra $2.35/hour was passed on to the DCW. Beginning in FY 2023, Premium Pay was deemed permanent and is now included in MSHN's Medicaid capitation funding.

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

Behavioral Health

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

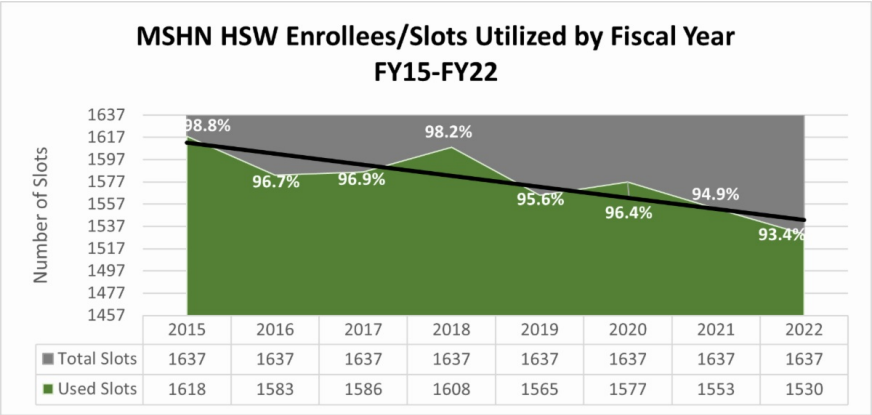
Regional Habilitation Supports Waiver Use Continues to Struggle

The Michigan Department of Health and Human Services (MDHHS) makes available the Habilitation Supports Waiver (HSW), under Section 1915(c) of the Social Security Act, to eligible individuals through the Pre-Paid Inpatient Health Programs (PIHPs) and Community Mental Health Services Programs (CMHSPs), often referred to as a C-Waiver benefit, “Hab Waiver,” or HSW benefit. The HSW benefit includes an additional 15 services a beneficiary can receive to address habilitative goals. The HSW Benefit is limited to a pre-determined number of slots allotted to each PIHP region. The entire state of Michigan has 8,268 slots as allowed by the Centers for Medicare and Medicaid Services (CMS). The Mid-State Health Network (MSHN) region has 1,637 of those slots and according to the CMS-approved MDHHS C-Waiver application, each PIHP region is to maintain a minimum 95% HSW slot utilization. If this utilization is less than 95% for three consecutive months, the PIHP is subject to a corrective action plan to increase slot use.

For an individual to be eligible for the HSW benefit, they must have active Medicaid, meet the criteria as an individual having an intellectual and/or developmental disability, reside in a community setting (own home, family home, or an adult foster care home), if not for HSW services, would need an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and chooses to participate in HSW services in lieu of ICF/IID services. Since these services are habilitative in nature, the individual has a person-centered focus of working on goals and objectives that help them learn new skills to develop and use in their community. Services include Community Living Supports, Enhanced Medical Equipment and Supplies, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Goods and Services, Out-of-Home Non-Vocational Habilitation, Personal Emergency Response System, Prevocational Services, Private Duty Nursing, Respite, Supported/Integrated Employment, Fiscal Intermediary, Non-Family Training, and Overnight Health and Safety Support.

Since February 2020, the MSHN region has operated near or below the 95% threshold and has implemented corrective action efforts to increase HSW slot usage. Chart 1 below shows the decline in slot utilization over the last 8 fiscal years but without formal corrective action until FY2020.

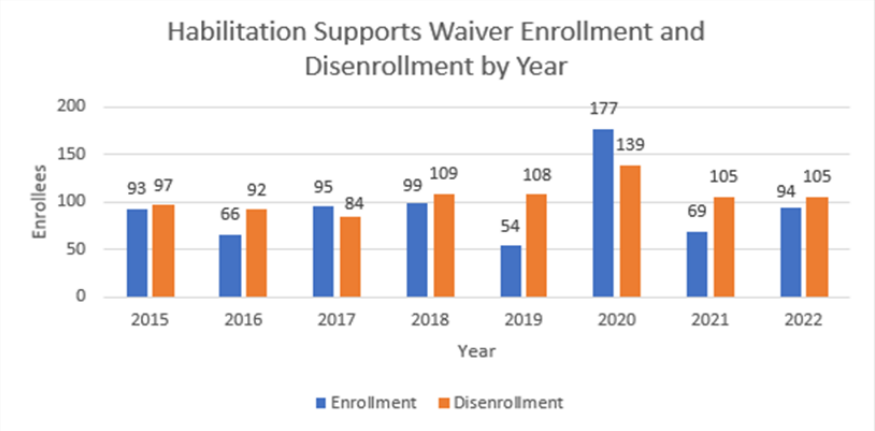
Chart 1: MSHN HSW Enrollees/Slots Utilized by Fiscal Year, FY15-22



MSHN has addressed the corrective action plan through the following list of activities:

- Monthly analysis of disenrollments and disenrollment reasons and reporting to CMHSPs. See Chart 2 Habilitation Supports Waiver Enrollment and Disenrollment by Year.
- Analysis of trends related to initial and recertification file submissions and pend backs.
- Using Supports Intensity Scale (SIS) data to identify service areas that align with HSW beneficiaries.
- Using encounter data (cost of services) to identify potential HSW beneficiaries.
- Encounter data regarding individuals who received a habilitative service (Community Living Supports, Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment) within the last year, but were not on HSW.
- Reviewing individuals that will be aging off the Behavior Health Treatment/Autism Benefit.
- Reviewing individuals potentially eligible for the 1915(i) State Plan Amendment services.

Chart 2: Habilitation Support Waiver Enrollment and Disenrollment by Year



What can be seen in Chart 2 is that disenrollments have outpaced enrollments. MSHN continues to work to identify contributing factors to this decline. Since the individuals receiving the HSW are among the most vulnerable, changes in health status (nursing home) and death are often contributors to disenrollments. There are

approximately 397 individuals on the HSW that are age 60 or older, so health status and aging issues are critical elements. Guardian/family choice has also contributed to some disenrollments, so there is a likely need to reinvigorate efforts to help educate on the benefits in the HSW.

Lastly, MDHHS and MSHN also recognize that MSHN is not the only PIHP not meeting the 95% threshold. There is a total of five PIHPs (50% of the PIHPs) in Michigan that are experiencing declines in HSW slot utilization. This may be pointing to other factors of significance. For purposes of this article, prevalence refers to the proportion of individuals meeting HSW criteria (but not receiving the HSW) and incidence refers to the number of new individuals being introduced on the HSW. It is possible that incidence is declining due to declining prevalence, that is, fewer persons are being diagnosed with an IDD condition, and do not meet ICF/IID level of need. While this has not yet been substantiated, it is possible for this effect being encountered throughout the state will result in further assessment of prevalence of IDD in Michigan. In the meantime, MSHN continues its efforts to increase HSW utilization as noted.

If you have questions about the HSW benefit and slot utilization, please contact Todd Lewicki at todd.lewicki@midstatehealthnetwork, or your local CMHSP Lead HSW staff person.

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

MSHN Care Navigators: Additional Support for Special Populations

As board members are aware, MSHN recently made some staffing changes within the Utilization & Care Management Department in order to strengthen and expand integrated health and complex care operations. As part of these changes, the existing regional Veteran Navigator position was moved into the Utilization & Care Management Department and a new Substance Use Disorder Care Navigator position was created. The overarching goal of both Navigator positions is to provide outreach and engage with individuals belonging to priority populations, assist them in accessing needed resources, and ensure comprehensive care coordination is occurring among providers and community partners that are supporting the individual.
The following table provides an overview of each Navigator position, contact information, population(s) served, and type of supports provided.

VETERAN NAVIGATOR – TAMMY FOSTER *Tammy.Foster@midstatehealthnetwork.org* **Phone: 517-483-2742**	
POPULATION(S) SERVED	SERVICES/SUPPORTS PROVIDED
Veterans & Military Families (VMF)	• Connects VMF with behavioral health, SUD, and other physical/medical health services • Assists with navigating benefits and other community supports (e.g., housing, social, financial, educational, legal) • Assists individuals with applying for veteran's benefits for which they may qualify • Acts as a liaison with the Veteran's Administration and local Veteran's Service Officers (VSOs) • Provides military competency education and training • Provides support and technical assistance to MSHN CMH and SUD providers to enhance their work with VMF
SUD CARE NAVIGATOR – EVAN GODFREY *Evan.Godfrey@midstatehealthnetwork.org* **Phone: 517-657-3358**	
POPULATION(S) SERVED	SERVICES/SUPPORTS PROVIDED
Individuals under supervision of the Michigan Department of Corrections (MDOC) Individuals with IV Drug Use Pregnant Individuals with Substance Use Parents At Risk of Losing Children due to Substance Use	• Connects individuals belonging to SUD priority populations with behavioral health, SUD, and other physical/medical health services • Assists with navigating benefits and other community supports (e.g., housing, social, financial, educational, legal) • Facilitates transitions of care between settings and ensures effective care coordination is occurring between SUD provider organizations, such as from residential to outpatient treatment • Coordinates referrals from MDOC, court systems, and other community partners • Provides training and support to MSHN CMH and SUD providers about PIHP access and referral processes, including special requirements for priority populations

Please join us in welcoming Tammy and Evan to the Utilization & Care Management Department. Please connect with either of them for any questions or to refer individuals for care navigator support.

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

Substance Use Disorder Policy, Strategy and Equity

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

The Intersection of Substance Use, Human Trafficking & Harm Reduction

For Mid-State Health Network to be best positioned to provide access to high quality prevention, treatment and recovery services for Substance Use Disorders (SUD), it's critical that we understand the populations who are impacted as well as the ever-evolving cultural and systemic forces that may influence the delivery of, and/or access to, care.

An important contextual dimension to the epidemic of substance misuse is its intersection with human trafficking. Most of us are aware of the 300 year transatlantic slave trade that brought millions of enslaved Africans to the Americas as forced labor. Though the slave trade was officially abolished in the 19th century, the exploitation of human beings for labor and sexual purposes has continued into the present in the U.S. and globally, manifesting today as forced labor, domestic servitude, and/or sexual exploitation.

Media representations of trafficking often portray the kidnappings of young, middle-class white girls and women, the "Taken" movie trilogy, for example, which grossed over $373 million in the U.S. According to the U.S. State Department's 2021 "Trafficking in Persons Report," however, the women and children most likely to be victims of human trafficking tend to be marginalized and vulnerable individuals, often people of color including immigrants, and people living in poverty. Moreover, as vulnerable as these populations are, those living with a substance use disorder are even more susceptible to exploitation by traffickers who use drugs and alcohol as a means of control. Individuals with a SUD may be more susceptible to manipulation and exploitation by traffickers, as they'll tolerate

dangerous or exploitative situations in order to access drugs or alcohol. Conversely, individuals who have been trafficked may be at increased risk of *developing* substance use disorders as a result of the past or ongoing trauma they have experienced as a consequence of being trafficked.

Harm reduction—the public health approach endorsed by MSHN, Michigan Department of Health and Human Services (MDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and others—focuses on reducing the negative consequences of substance use. It can also be applied to individuals who have been trafficked. Criminalizing individuals who have been trafficked and are engaged in illegal activity (like prostitution, possession of illegal drugs, and/or undocumented labor) punishes the victims, not the traffickers, and perpetuates the systemic abuse of vulnerable populations by those who profit from their exploitation.

The U.S. State Department offers the following recommendations to address the intersection between trafficking and SUD:

Whenever trafficking survivors with substance use issues are identified, referral to safe, ethical treatment programs and facilities is essential. Trauma-informed care prevents re-exploitation and re-traumatization and promotes recovery ... Healthcare professionals can coordinate efforts to identify victims and survivors who are vulnerable to substance use, or present with substance use issues. Emergency room admissions for overdose also present opportunities to screen for human trafficking.

MSHN seeks to collaborate with community partners—hospitals, health care clinics, and law enforcement—to ensure that those caught in the cycle of addiction and exploitation receive specialized and trauma-informed care to establish a safe pathway to recovery.

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

2021 Drug Abuse Warning Network (DAWN) Data on Drug-related Emergency Department Visits

The Substance Abuse and Mental Health Services Administration (SAMHSA) has "released an analysis of the *2021 Drug Abuse Warning Network (DAWN)* data on drug-related emergency department visits. Of the top drug-related reasons for emergency visits, alcohol (42 percent) was the most common. Other substances included: opioids (15 percent), methamphetamine (11 percent), marijuana (11 percent), and cocaine (5 percent). In 2021, the Drug Abuse Warning Network (DAWN) identified 141,529 (unweighted) drug-related emergency department (ED) visits from 52 participating hospitals.

Weighted National Estimates for the Top Five Drugs in Drug-Related ED Visits

Key Findings by Drugs:
The top five drugs involved in drug-related ED visits in 2021 were alcohol (39.33% of all drug-related ED visits), opioids (14.07%), methamphetamine (11.02%), marijuana (10.78%), and cocaine (4.71%). Fentanyl-related ED visits rose throughout 2021, peaking in quarter 4. Heroin-related ED visits rose from quarter 1 through quarter 3 and declined in quarter 4. All other top drugs peaked in quarter 2 and declined in quarters 3 and 4.

Key Findings by Age, Sex, Race, Ethnicity, and Census Region
Patients aged 18 to 25 had the second highest percentage of ED visits related to marijuana (26.80%) and fentanyl (16.90%). Males had a higher percentage of ED visits for all top five drugs as compared to females, however, the difference was much smaller (54.04% males vs. 45.94% females) for ED visits related to other opioid pain medications and their combinations. Black or African American patients had the highest percentage of ED visits related to cocaine (44.19%), and the second highest percentage of ED visits related to marijuana (23.87%) and heroin (20.35%).

Key Findings from Sentinel Hospitals, April 2021 – November 2021
Monthly trend analysis revealed decreasing trends of alcohol, methamphetamine, marijuana, and heroin-related ED visits, and increasing trends of fentanyl and unspecified narcotic analgesics. The top six drugs involved in polysubstance ED visits (i.e., visits related to more than one drug) in sentinel hospitals were alcohol, methamphetamine, marijuana, cocaine, heroin, and fentanyl. While the majority of alcohol-related ED visits were due to alcohol alone, a significant percentage of methamphetamine, marijuana, cocaine, heroin, and fentanyl-related ED visits involved at least one other drug. Alcohol was the most common additional drug involved in methamphetamine, marijuana, and cocaine-related polysubstance ED visits, while methamphetamine was the most common additional drug involved in heroin and fentanyl-related polysubstance ED visits.

Figure 5.B.2 Top five drugs involved in **alcohol-related** polysubstance ED visits (N = 5,353)

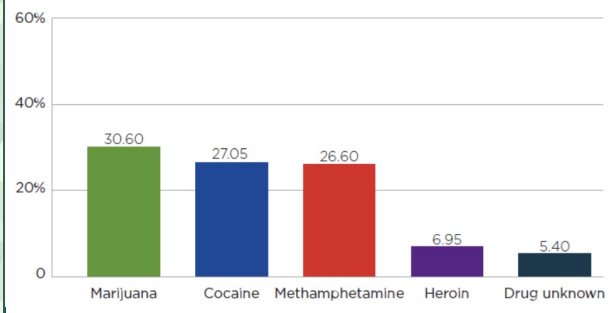


Figure 5.B.3 Top five drugs involved in **methamphetamine-related** polysubstance ED visits (N = 4,027)

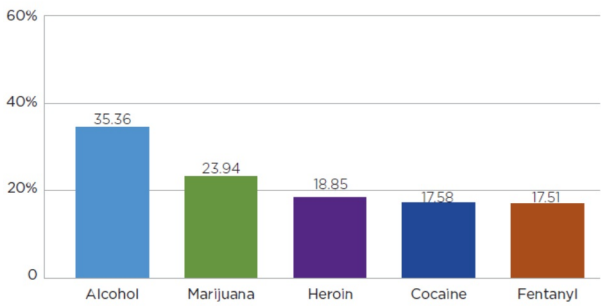


Figure 5.B.5 Top five drugs involved in **cocaine-related** polysubstance ED visits (N = 2,722)

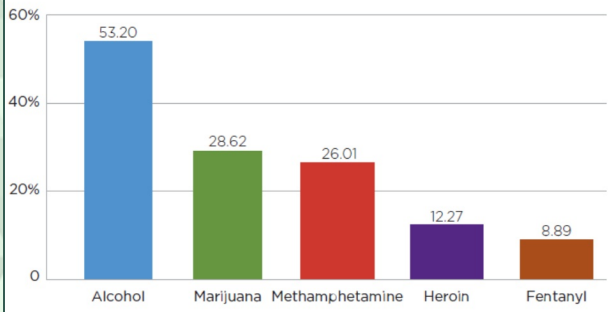


Figure 5.B.5 Top five drugs involved in **cocaine-related** polysubstance ED visits (N = 2,722)

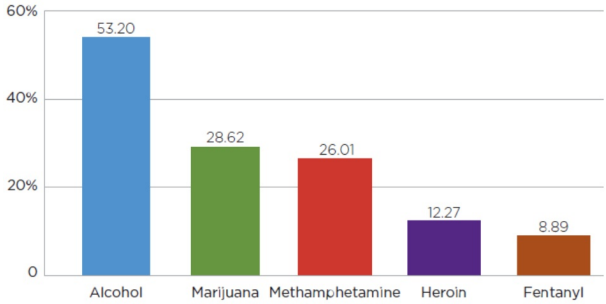


Figure 5.B.6 Top five drugs involved in **heroin-related** polysubstance ED visits (N = 1,560)

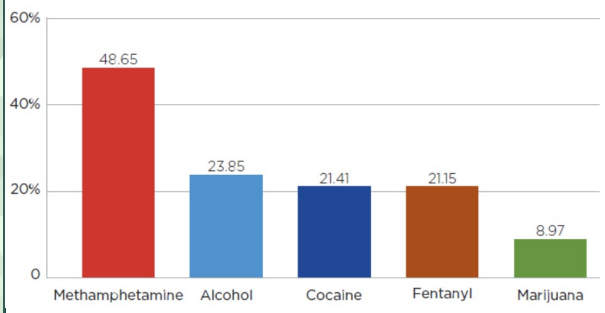
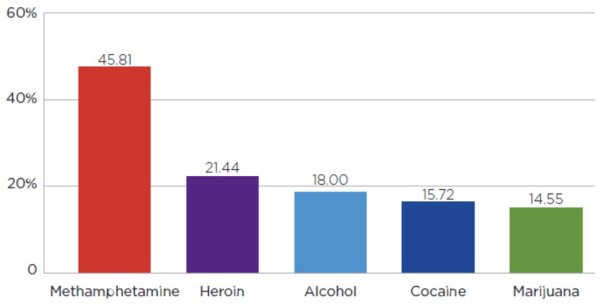


Figure 5.B.7 Top five drugs involved in **fentanyl-related** polysubstance ED visits (N = 1,539)



To help support individuals with SUD needs that have interactions with Emergency Departments in hospitals to be connected to SUD treatment services and community resources, MSHN contracts with SUD providers to implement and coordinate Project ASSERT programs across the region. Project ASSERT (Alcohol and Substance Use Services, Education, & Referral to Treatment) is a nationally recognized, evidence-based program that uses motivational interviewing to encourage patients and family members to seek care for risky use of substances. It also helps patients access primary care, clinical preventive services, and treatment for alcohol and substance use disorders. Project ASSERT is currently present in 11 counties in the MSHN region. This includes Midland, Clare, Gladwin, Mecosta, Osceola, Gratiot, Isabella, Arenac, Montcalm, Ingham, and Eaton counties. MSHN continues to look for ongoing opportunities to expand Project ASSERT to other counties in the region as well.

Additional information is available at 2021 DAWN Data.

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

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

Medicaid Event Verification Site Reviews

Mid-State Health Network (MSHN) has a process for conducting Medicaid Event Verification monitoring and oversight within the Provider Network that is in accordance with the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Medicaid Verification Process.

As part of the review, the following attributes are tested:
A.) The code is allowable service code under the contract
B.) Beneficiary is eligible on the date of service
C.) Service is included in the beneficiary's individual plan of service or in the treatment plan
D.) Documentation of the service date and time matches the claim date and time of the service
E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
F.) Amount billed and paid does not exceed contractually agreed upon amount, and
G.) Modifiers are used in accordance with the HCPCS guidelines.

The following are the average compliance percentages for each attribute reviewed for the CMHSPs for FY2022.

A	B	C	D	E	F	G
99.96%	99.98%	99.70%	98.44%	91.26%	98.19%	86.21%

The following are the average compliance percentages for each attribute reviewed for the SUD Providers for FY2022.

A	B	C	D	E	F	G
99.85%	100%	95.55%	97.21%	94.28%	100%	87.57%

As a result of the reviews demonstrating the provider network understanding how to submit accurate claims, MSHN has made the following changes to the MEV site review process to begin in FY2023.

- Community Mental Health Service Participants (CMHSP):
  - Moved from requiring a sample of 5% of the beneficiaries served (with a maximum of 50) to a review of 20 beneficiaries from each CMHSP.
- Substance Use Disorder (SUD) Providers:
  - Reviews are now coordinated with the Delegated Managed Care site reviews requiring a full review completed biennially and interim review completed during non-full site review year.
  - Sample size will consist of a minimum of 8 beneficiaries during the full review.
  - Sample size will consist of a minimum of 2 beneficiaries during the interim review.

In addition to the above changes, a guidance document is being developed to aid the provider network in providing appropriate supporting documentation for each of the attributes, identify what results in a finding and requires a corrective action plan, as well as provide guidance to providers on when claims will be required to be voided.

These changes will increase efficiencies by making the review process consistent for each CMHSP, provide time for additional education and training during the reviews, and allowing for more time to review improvements and corrections implemented to ensure compliance with state and federal standards and MSHNs policies. Overall, these changes will promote a move towards a process of quality improvement versus focusing solely on corrective action.

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.