From the Chief Executive Officer's Desk

Joseph Sedlock

I am _____ (fill in the blank).

I am continually struck by how that blank is filled in. For people served or supported by the public behavioral health system, too often the blank is filled in by naming the conditions we are living with and recovering from:

> I am schizophrenic. She is (or I am) autistic. He is (or I am) psychotic. We are suicidal. They are (or I am) intellectually or developmentally disabled. I am an addict/alcoholic.

When is the last time you heard a person fill in the blank as follows:

> I am cardiac. She is (or I am) COPD. He is (or I am) dementia. We are diabetes. They are (or I am) cancer.

Stigma, like racism, ableism, classism, and so much else, is perpetuated implicitly – in large measure by the language we use. One step – and in my view it's a big one – is to challenge the "blanks" people fill in their identity by.

People first language is a requirement of public behavioral health system employees across the State.

This should lead us to promote a change in our lexicon to reframe the reference to our diagnosis to person-first and strengths focused, such as:

> I am Joe, and I am recovering from schizophrenia. I am Sally, and I am (she is) living with autism. He is (or I am) John, and he is in treatment for psychosis. They are Mira, and they are adapting to life with developmental challenges. This is Herme, and he is living with and recovering from addiction.

This pattern of reference is common in other healthcare settings where we refer to the person experiencing the illness differently than we traditionally do in the behavioral health realm: Betty 'has' cancer. Sue is in treatment for emphysema. My mother has dementia. And on and on.

In most areas but sadly not all - we refer to the person that "has" a condition – not "is" a condition.

I am not my diagnosis. I am not my condition.

I am first a person. I have a name. I have a history. I have an identity.

My diagnosis will not define me.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Universal Credentialing Coming FY24

Public Act 282 of 2020 required Michigan Department of Health and Human Services (MDHHS) to create a Universal Credentialing program. MDHHS was tasked to establish, maintain, and revise, as necessary, a uniform community mental health services credentialing program. This program is intended to create uniformity in the state to streamline providing community mental health services and to enhance workforce development, training education, and service delivery. The Universal Credentialing program adheres to national standards from accrediting bodies that have been approved by the department and complies with the national certification standards for community mental health counselors and professionals. The Universal Credentialing program must be used for the following health care professionals: Physicians; Physician's Assistants; Psychologists; Licensed Master's Social Workers; Licensed Bachelor's Social Workers; Social Service Technicians as defined in section 18501 of the public health code; Social Workers granted a limited license under section 18509 of the public health code; Licensed Professional Counselors; Nurse Practitioners; Registered Nurses; Licensed Practical Nurses; Occupational Therapists; Occupational Therapist Assistants; Physical Therapists; Physical Therapists Assistants; Speech Language Pathologists, as well as Organizational Providers, except Residential Providers.

The Universal Credentialing process was built into the MDHHS Behavioral Health Customer Relationship Management (MDHHS BH CRM) system. This system houses many PIHP and Community Mental Health Service Provider (CMHSP) behavioral health business processes such as ASAM Level of Care, Critical Incident Reporting, and CMHSP Certification. The purpose of the CRM is to create a simplified, one-stop shop for stakeholders involved in the business processes contained within the system. For the Universal Credentialing process, the CRM allows both individual and organizational providers to electronically submit their credentialing applications. The BH CRM houses the applications which are viewable to CMHSPs and PIHPs. The Universal Credentialing CRM process was developed, reviewed, and tested by a collaborative workgroup of representatives from various CMHSPs and PIHPs across the state. The workgroup membership includes 11 agencies, of which MSHN and Bay-Arena Behavioral Health participate from our region. MSHN staff are working with Ten16 and Victory Clinic Services, as Substance Use Disorder providers, to test the application, submission, verifications and approval process.

The Universal Credentialing function is anticipated to begin roll out statewide in October 2023, by region, for regional training sessions first with PIHP and CMHSP staff before full implementation.

The MSHN region will be using the CRM to submit approximately 1,100 Contracted Organizational Providers, 100 Contracted Licensed Individual Practitioners and 1,100 Licensed Staff. MSHN along with our CMHSP partners and SUD providers will be assessing capacity to manage and implement the Universal Credentialing application through the MDHHS BH CRM.

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 worked on upgrading our backend servers. The Structured Query Language (SQL) data and report servers were upgraded and databases were moved and some reorganization and standardization of tables were completed. The PowerBI servers were upgraded and databases and tables were normalized to provide faster results. With this upgrade, the process of loading the data into the new tables needed to be updated to the new targets and in some cases for other changes that were put off previously. During this same time we also moved our File Transfer Protocol (FTP) server to a new version so the transfer of data would be faster and more secure. Most of these changes were required because Microsoft was phasing out the older version that we were using. The IT team created a new Autism Benefit Waiver database, tables and reporting process on one of these new servers because the Michigan Department of Health and Human Services (MDHHS) Waiver Support Application (WSA) discontinued tracking the Autism Benefit information.

The IT Team also added eleven (11) new performance measures for the Behavioral Health Homes (BHH) in the Integrated Care Delivery Platform (ICDP) data analytics tool. The next steps are to finalize a new attribution file that will allow ICDP to know which individuals are to be included in the BHH dataset and deploy the measures to production.

The following measures have been developed and are currently in process of being validated:

- (AAP): Access to Preventative / Ambulatory Health Services
- (AIF-HH): Admission to a facility from the Community
- (AMB): Reduction in Ambulatory Care: Emergency Department Visits
- (CBP): Controlling High Blood Pressure
- (CDF-HH): Screening for Depression and Follow-Up Plan
- (COL-HH): Colorectal Cancer Screening
- (FUH-HH): Follow up After Hospitalization for Mental Illness (both 6-17; and 18+ years of age)
- (IET-HH): Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (both 14 day; and 34 day)
- (IU-HH): Inpatient Utilization

- (PCR-HH): Plan All-Cause Readmission
- (PQI92-HH): Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

MDHHS has incorporated changes in the way they roll-up race and ethnicity fields within the 834 enrollment files. Specific changes are to clean up the categories being used for health disparity analyses, and to combine race and ethnicity fields to make sure that the Hispanic population has an accurate representation in their analyses. MSHN has worked with Zenith Technology Solutions (ZTS) to update the race and ethnicity logic within the Integrated Care Delivery Platform (ICDP) to match the roll-up logic that MDHHS has implemented. This work has been completed within the data analytics tool and the race/ethnicity dimensions included. Work is currently being done to add this demographic information to the Performance Measure data extracts as well.

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 beginning close-out activities for Fiscal Year 2023 (FY 23).

FY 23 – Close-out activities include the following:

- Processing and paying the remainder of claims for dates of service on or before September 30, 2023. Finalizing claims provides a more accurate picture of MSHN's Substance Use Disorder expense information included on preliminary fiscal year-end reporting.
- Finalizing Fiscal Monitoring and Oversight of providers - MSHN conducts abbreviated and full reviews for providers on an alternating fiscal year schedule.
    - Abbreviated Reviews - Providers not under a Corrective Action Plan have an abbreviated review every other year alternating with full reviews. This type of review includes an attestation from the provider affirming policies and procedures as well as its Certified Public Accountant (CPA) audit has been completed.
    - Full Reviews - As the name suggests, includes a comprehensive review of various fiscal areas to ensure MSHN contract compliance. Some items evaluated include policies and procedures, Provider board approved financials, and liability insurance confirmation. In the event discrepancies arise, providers may be subject to recoupments.
- MSHN Administrative Expense – in addition to item one (1) above, MSHN engages with staff to ensure all administrative expenses such as travel vouchers (which include mileage, conference expense, and so on) have been processed and paid.
- MSHN Block Grant Expenses - Although other final fiscal year-end reporting occurs in February, Block Grant expenses are finalized early November which allows Michigan Department of Health and Human Services (MDHHS) to meet federal reporting due dates.
- MSHN and Community Mental Health Service Providers (CMHSPs) Interim Cost Settlement – MSHN is obligated to cover allowable CMHSP Medicaid and Healthy Michigan Plan (HMP) expenses. Any dollars in excess of CMHSP expenses must be returned to MSHN. The region typically completes 85% of its preliminary cost settlement transactions in mid-November. If CMHSP expense exceeded revenue provided by MSHN, the PIHP is responsible for sending additional funds to cover the costs.
- MSHN and MDHHS Interim Reporting – November is the month MSHN also submits an interim Financial Status Report (FSR) to MDHHS. This report includes a breakdown of Medicaid and HMP expenses by CMHSP and MSHN. It outlines revenue, expenses, potential savings amounts, and Internal Service Fund (ISF) calculations.

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

Behavioral Health

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

An Update to Conflict Free Access and Planning Efforts

Mid-State Health Network (MSHN) wishes to provide an update to Conflict Free Access and Planning (CFAP) developments, with the most substantive update occurring on September 18, 2023. In a brief review, the Centers for Medicare and Medicaid Services (CMS) has advised that case management services must be free of conflict. This means there must be a separation of duties, case management from direct service provision, and separation of eligibility determination from direct service provision. It requires that assessment and service planning are separate from the direct delivery of services, with the goal of objectively separating (or "firewalling") potential assessment/eligibility/monitoring, direct service provision, and financial oversight conflicts a case holder or agency may have. Essentially, eligibility decisions should be separate from service provision and there should be robust oversight and monitoring. Additional expectations include that anyone conducting evaluations and the plan of care cannot be related to the individual by blood or marriage, there must be a grievance and appeal system as well as tracking and documenting the experience of the individual served. The Michigan Department of Health and Human Services (MDHHS) has continued to explore CFAP, gathering feedback and insights from beneficiaries and their families, the Conflict Free Access and Planning Workgroup, MDHHS staff, and external stakeholders (advocacy organizations and other natural supports).

To date, there have been over 3,000 responses coded from the shared feedback and insights of these groups. This

is important to emphasize as this approach is qualitative. Qualitative research is focused on how people experience life, exploring the meaning assigned to these moments and experiences. Please note that there is no summary data showing aggregate counts of each grouped theme, but the top five themes are ranked from the category with the most coded data to the least and, the top five were then separated out. The top three themes directly relate to input on the personal experiences of the individual, strongly signifying that these top three priorities are in the voice of the individual served, which aligns with the tantamount importance of hearing the individual and representing their wants in services and supports through a person-centered process. This report shows the priorities identified to date, as this project is still gathering more responses, so this is a snapshot of current themes. The following themes of importance emerged in the investigation process:

1. Access: people should easily get the services and supports they need.
2. Continuity: the consistent and stable presence and connection between services and supports.
3. Autonomy: people can make their own decisions about their planning, services, and supports.
4. Viability: providers can stay in business.
5. Stringency: The system complies with the Conflict Free Access and Planning Rule.

Access is not only the top theme gleaned from the feedback, but it is also a top concern for MDHHS and the Prepaid Inpatient Health Plan/Community Mental Health Service Provider system. Access involves timeliness and ease of access to services. This importance was underscored in the feedback as being contemporary under the current system of services as well as for any future system. A noted concern discussed the amount of time it could take to receive services between providers, thus it is a priority to ensure that services and supports are delivered seamlessly, simply, and without delay.

The second priority, continuity, relates to the individual's experience with redundancy in the system. Often, the individual has had to share their story more than once, despite the organization already having the information. So, processes need to be improved to reduce or eliminate this effect.
The third most top concern is autonomy. Autonomy is of great importance and is represented as such in all professional ethical principles. Autonomy is the individual's freedom to make their own decisions. This principle aligns with informed consent practices and sharing options around services and supports. Consent is a legal concept in that the individual consenting must be able to understand the information and consequences (i.e., risks and benefits) of a decision. When an individual may not have the ability to make a voluntary and informed decision, a legally appointed guardian may be involved in protecting the individual by choosing for them. While the consent process is legally driven, the assent process (the expression of agreement) is a process related to autonomy. Thus, involving the individual in choice through consent or assent is of great importance.

The fourth priority is viability, or the system maintaining adequate staffing and provider network capacity. Since the COVID-19 pandemic, there has been a staffing shortage, creating difficulties for individuals accessing services and for systems in ensuring there are alternatives and choices for individuals.

Lastly, the fifth most top priority is stringency, or protections against conflict of interest. This priority area is split in terms of perceptions about whether current system stringencies (i.e., safeguards) are sufficient.

To put the five priorities into perspective, MDHHS stated that the four options that that Conflict Free Access and Planning Workgroup reviewed were not to be considered the only options; the intent of the review of the four options was for the workgroup, in context, to review and provide feedback for inclusion into the current process of gathering input from these multiple sources to inform a CFAP plan that is comprehensive of all perspectives while complying with CFAP rules. For there to be a successful end-process, it should include the top priorities of access, continuity, autonomy, viability, and stringency. MDHHS intends on modifying the timeline for CFAP implementation as it completes the gathering of feedback and input on system change. There will be another feedback session for individuals and families as well as a provider survey that will be forthcoming. More will be learned in the October 2023 CFAP Workgroup meeting. If you have feedback to share regarding conflict free access and planning, please share with MDHHS at: mdhhs-conflictfreeaccess@michigan.gov.

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

Utilization Management & Care Coordination

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

Statewide Utilization Management Collaboration

The ten Prepaid Inpatient Health Plan (PIHP) regions in Michigan are diverse in many ways, including size of region, number of participating Community Mental Health Service Programs, and the ways in which they conduct operations. Despite these differences, the PIHPs have a robust history of collaboration to ensure a strong public mental health system throughout the state.

In another step to enhance collaboration efforts between regions, a PIHP Utilization Management (UM) Workgroup was formed earlier this year, comprised of the UM Directors from each PIHP. The workgroup exists to assure effective and consistent statewide UM policies, procedures, and practices among the PIHPs in Michigan. The UM Workgroup will also support compliance with the Michigan Department of Health and Human Services (MDHHS) PIHP contract, and related federal and state laws and regulations. Some of the responsibilities and priorities set by the PIHP UM Workgroup include the following:

- Sharing of resources such as UM policies, procedures, and benefit plans
- Evaluate proposed models of conflict-free access and planning (CFAP) and provide feedback to the CFAP

workgroup
- Continue to implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Develop statewide inter-rater reliability processes to ensure medical necessity criteria and utilization management authorization guidelines are being interpreted and applied consistently throughout the state
- Enhance care coordination processes between PIHP regions to ensure smooth transitions and continuity of care for individuals receiving services when they move from one region to another

The intent of the workgroup is not to develop a "one size fits all" approach; each PIHP will still maintain its own decision-making authority for regional UM operations. The UM workgroup aims to share resources, develop best practices, and creating administrative efficiencies. MSHN looks forward to continuing to build upon the existing foundation of collaboration with its fellow PIHPs.

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

"Treatment Resistance" and the Promise of Psychedelic Research

Substance use disorders (SUD) and mental illness (MI) are among the leading causes of disability in developed countries. In the U.S., close to 50% of Americans will meet criteria for a Diagnostic and Statistical Manual of Mental Illnesses (DSM-V) disorder at some time in their lifetime (AMHF), and suicide rates increased 36% in the U.S. from 2000 to 2021 with a record 49,000 completed suicides in 2022. That's the same year the U.S. saw nearly 110,000 overdose deaths (CDC). Some of this reflects "treatment resistance," i.e., patients who see no improvement despite varied strategies used to alleviate their suffering. The limitations of currently available treatments creates pressure to innovate new treatments. Or perhaps to consider ancient ones.

For many centuries, plant-based psychedelic substances were used by indigenous communities in North and South America to promote healing, but these practices were abolished or driven underground by European colonization. In the 1950s and early 1960s, reports on the unique potency of psychedelics led many in the psychiatric establishment to regard lysergic acid diethylamide (LSD) and psilocybin as powerfully effective medications in clinical practice for treating depression, anxiety, trauma, alcoholism and drug addiction, among other ailments (Harvard Gazette, 2019), resulting in tens of thousands of patients receiving psychedelic psychotherapy. Moreover, clinical research with LSD was one catalyst to unpacking the role of neurotransmitters in the brain (Pollan) which is foundational to our current understanding of the neurobiological roots of mental illness and addictions—formerly viewed as purely psychological—and to generations of FDA-approved psychotropic medications.

The backlash against the 1960s counterculture, however, contributed to the War on Drugs unleashed in the 1970s with disastrous impacts like mass incarceration especially for people of color, and a closed door to research with potentially life-saving drugs that were, once again, driven underground.

Today, the pendulum has swung back and we're in a renaissance of interest in psychedelics' usefulness to treat a variety of psychiatric conditions (Neuropsychopharmacology) including relief from despair in patients with terminal cancer. In 2017, the U.S. Food & Drug Administration (FDA) granted the study of Methylenedioxymethamphetamine-assisted therapy (MDMA) as a treatment for Post-Traumatic Stress Disorder (PTSD) "breakthrough therapy" status, a designation that allows the development of promising experimental drugs to be fast-tracked. Psilocybin-assisted therapy for treatment-resistant depression was granted breakthrough status in 2018. Then in June of this year, the FDA issued guidance for more broadly developing psychedelic drugs for treatment of medical conditions including psychiatric and substance use disorders (FDA) and MDMA is on track to receive approval as the first new treatment for PTSD in two decades (Nature).

Johns Hopkins' Center for Psychedelic & Consciousness Research and the University of Michigan's Michigan Psychedelic Center (MPsyC) are engaged in this work (in partnership with, among others, the Mayo Clinic), as is the Center for the Neuroscience of Psychedelics (CNP), a partnership that includes Massachusetts General Hospital's Department of Psychiatry, Harvard University and Medical School, and the Broad Institute, a Massachusetts Institute of Technology-Harvard collaboration. CNP's mission is to understand how psychedelics enhance the brain's capacity for change (i.e., to foster neuroplasticity), to optimize current treatments and create new treatments for mental illness, and to make the term "treatment resistant" obsolete, an outcome that long-suffering patients would surely welcome.

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

SAMHSA Releases New Data on Recovery from Substance Use & Mental Health Problems Among Adults in the United States

The Substance Abuse and Mental Health Services Administration (SAMHSA) released the *Recovery from Substance Use and Mental Health Problems Among Adults in the United States* report on 9-20-2023. This report provides data on adults in recovery from their substance use and/or mental health problem and provides policy recommendations identified for supporting recovery.

Using data from the *2021 National Survey on Drug Use and Health (NSDUH)*, this report shows that 70 million adults aged 18 or older perceived that they ever had a substance use and/or mental health problem. For substance use specifically, of the 29 million adults who perceived that they ever had a substance use problem, 72.2% (or 20.9 million) considered themselves to be in recovery or to have recovered from their drug or alcohol use problem. For mental health, of the 58.7 million adults who perceived they ever had a mental health problem, 66.5% (or 38.8 million) considered themselves to be in recovery or to have recovered from their mental health problem.

Recovery is characterized by continual growth and improvement in one's health and wellness while managing setbacks, which are a natural part of life.

The current report leverages data to examine the factors – such as spirituality, treatment, insurance coverage and social supports – that support recovery from substance use and mental health problems more clearly. Through this effort, SAMHSA can better achieve its vision that people with, affected by or at risk for mental health and substance use conditions receive care, achieve well-being and thrive.

The report also identifies the resilience that people in recovery develop as they reported few impacts on their behavioral health during the COVID-19 pandemic.

Key findings include:

- Adults who participated in at least one government assistance program, had lower levels of education, or had a lower family income relative to the federal poverty level were generally more likely to be in substance use recovery, but less likely to be in mental health recovery.
- Mental health recovery tended to be more common among adults who were insured or heterosexual.
- The percentage of adults in mental health recovery was significantly higher among those who received any mental health treatment in the past year, including inpatient, outpatient, prescription, or virtual care. The percentage of adults in recovery from either substance use or mental health problems was also lower among those who felt that they needed mental health treatment but did not receive it in the past year.

Overall, the findings reveal that recovery is real and that with a range of holistic, individualized support, people with mental health and/or substance use conditions can and do overcome these challenges and live productive lives in our communities.

Full report is available here.

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

Performance Improvement Project

The Prepaid Inpatient Health Plans (PIHPs) are required to conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, the PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," are also assessed according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

MSHN's Performance Improvement Project for 2022 through 2025 is: *Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population.*

The baseline data for 01/01/2021 through 12/31/2021 was 65.04% for the percentage of new persons who are Black/African- American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. The baseline data for 01/01/2021 through 12/31/2021 was 69.49% for the percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. This data will be compared to the remeasurement period one data for the time of 01/01/2023 to 12/31/2023.

For calendar year 2023, the following interventions were identified to show improvement in the rate:

- Increase the workforce through recruitment of student interns and recent graduates from colleges and universities with diverse student populations, and external contractors to provide services.
- Implement appointment reminder system.
- Implement/modify process for coordination between providers (warm hand off).

During this measurement year, MSHN received a “Met” score on all elements reviewed. A “Met” score indicates high confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.

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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