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From the Chief Executive Officer's Desk

Joseph Sedlock

A colleague (and friend) recently raised some questions that prodded me to spend some focused time pondering. And to offer the following thoughts.

It is part of my official role at Mid-State Health Network (MSHN) to speak for the organization, an obligation that I take very seriously. In that role, it's important to me personally and professionally to lead this organization and this region – in doing the right thing, the right way, for the right reasons.

Our culture has seemingly deepened its divides over what's "right." As a public entity which exists to serve all people with behavioral health needs, we have much to do. A top priority among them is our focus on embracing, celebrating, inviting, and creating diversity, striving for inclusion of all and pursuing equity – especially as it relates to eliminating health disparities - in our organization, in our region, in our state, in our country, and in our world. MSHN has a moral, ethical (and I would argue legal) duty to eliminate disparities in health outcomes experienced by the individuals, families, and communities we exist to serve.

The MSHN Board established a strategic priority of "Better Equity." To pursue this priority, and on behalf of MSHN:

- I commit to the work of eradicating the causes and consequences of disparities – especially disparities in access to specialty behavioral health services and related health outcomes.
- I commit to welcoming and inclusion of all.
- I reject actions – or inactions - that marginalize, mistreat, discriminate against, disenfranchise, or in any way introduce bias to our services and support systems.

I am committed personally and professionally to these things. But MSHN needs your help, your partnership, your voice, and your advocacy.

We will call out – and ask that you call out – conditions, policies, practices, and actions/inactions that result in advantages to some over others, bias or discriminatory impacts such as racism, sexism, ableism, ageism, and other conditions that contribute to personal, familial, community, and societal conditions that impact the mental wellness of individuals and communities.

None of us can do this alone. I am asking that you join me and join MSHN as an ally in this work; in becoming better; in being better.

The residents of our region deserve nothing less.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Health Services Advisory Group (HSAG) External Quality Review

Health Services Advisory Group (HSAG), contracted by the Michigan Department of Health and Human Services (MDHHS) to conduct oversight of the Pre-paid Inpatient Health Plans (known as the External Quality Review), finalized the review of Mid-State Health Network (MSHN) in July. For FY2022, HSAG reviewed the following areas to ensure compliance with the Managed Care Rules.

- Provider Selection & Credentialing
- Confidentiality and Privacy
- Sub Contractual Relationships & Delegation
- Practice Guidelines
- Health Information Systems
- Quality Assurance and Performance Improvement Program
- Grievance and Appeal System

MSHN staff, along with the Community Mental Health Service Providers, provided a multitude of documents for review and conducted system demonstrations. The results of the review should be available by October 2022. MSHN expects the results of the review will demonstrate successful compliance and application of the regulations, with a few areas needing some improvements. The Board of Directors will receive the full report in September.

Certified Community Behavioral Health Clinics (CCBHCs) Provide for Expanded Services to the Mild to Moderate

CCBHCs continue to provide expanded services throughout the region, not only to the underinsured but also to the mild to moderate population. The term “mild-to-moderate” is broadly used to refer to the 20 or fewer visits of outpatient therapy provided by Medicaid Health Plans (MHPs) or Medicaid fee-for-service (FFS) to individuals with mental illnesses other than serious mental illnesses.

The Michigan Department of Health and Human Services (MDHHS) describe such services as being “designed to treat beneficiaries with mild to moderate mental health needs and maintain beneficiaries with stable mental health conditions.”

MDHHS is trying to understand more about what the mild to moderate population looks like from a CCBHC service point of view for rate setting and departmental planning purposes. They plan to review the data to see if there is reason to shift Medicaid funds to cover the costs of the mild to moderate population for CCBHCs in future years. They also plan to use the data to see how CCBHCs define mild to moderate and how individuals may move along a functional continuum between levels of care, i.e., moving from the mild to moderate category to severe and vice versa. There are many factors that can affect an individual’s level of functioning such as following through with treatment, consistently following healthy patterns, stressors, resources, and using natural supports that help maintain stability.

MSHN formed a regional workgroup that has begun to discuss regional standardization, identification, and reporting regarding the mild to moderate population. There is agreement that diagnosis and level of functional impairment are important parts of the definition and identification of applicable groups. However, some challenges exist with the electronic management systems being able to capture and gather the data in a way that can identify this population. MSHN will continue to work with the CCBHCs to support expanded services and increased data reporting.

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

Information Technology

Steve Grulke
Chief Information Officer

The Information Technology (IT) department assisted with the Michigan Department of Health and Human Services (MDHHS) reviews. These reviews were conducted by the Health Services Advisory Group (HSAG) during the last two months. The first review was the Performance Measure Validation (PMV) review. We have not received the final written report, but the exit interview sounded like there were no IT areas that will require follow up. More recently, the Compliance review was held, where there was a finding that will require some work by the MSHN contractor, PCE Systems, to enhance their system and get it certified to handle the Application Programming Interface (API) to the managed care information system in order to meet the new requirements.

IT staff have completed 15 updates to the REMI system that include provider portal dashboards, report enhancements and Opioid Health Home process changes. The Network Adequacy Assessment was completed, updating all data for the current fiscal year, adding new measures to demonstrate telehealth and COVID 19 impact along with a time and distance analysis. The Mid-State Health Network offices were updated with a Team Alert system for emergency notifications with e911 capabilities.

There is continued work on the Michigan Health Information Network (MiHIN) eConsent process with the Recovery Center and the submission of Substance Use Admission Discharge & Transfer messages. The process of putting Social Determinates of Health data together has started and will continue, along with the development of reporting formats. There will be work on analyses for the impact of the 1915(i) SPA changes. There are a few surveys that have results that will need to be compiled and reported on 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 has developed draft revenue information for its Fiscal Year (FY) 23 Budget to be presented during the September 2022 Board of Directors Meeting. The revenue calculations were based on several assumptions provided by MDHHS in the Draft Rate Certification letter. Based on the draft MDHHS document, MSHN performed a comprehensive analysis and adjusted the Medicaid eligibles numbers to more reasonably approximate FY 23 regional revenue. The State's draft appears more optimistic on the number of Medicaid eligibles, especially since the Public Health Emergency (PHE) will likely end in early FY 23. If you recall, a PHE was declared in FY 20 and one feature of the declaration is suspension of Medicaid Disenrollments. Once the PHE ends, MSHN anticipates a slow downward trend in average enrollments, and thus regional revenue, beginning in early to mid FY 23. Our adjustment is intended to prevent a mid-year requirement to decrease expenses.

In addition, FY 23 expense information is being collected from Community Mental Health Service Programs (CMHSPs) and MSHNs Leadership members have been participating in internal budget meetings to develop projected departmental costs. Further, MSHNs Finance Team is reviewing anticipated provider expense data to incorporate into the budget.

Lastly, the Direct Care Worker (DCW) Premium Pay Increase of $2.35/hour plus 12% administrative fees will remain in effect for FY 23. At this time, MDHHS has not issued guidance on ongoing provider stabilization for FY 23.

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

Behavioral Health

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

HCBS Rule Transition Enters Important Final Phases

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) published a set of rules for the delivery of Home and Community Based Services (HCBS) through Medicaid waiver programs. Through these rules, the Centers for Medicare and Medicaid Services aimed to improve the experience of individuals in these programs by enhancing access to the community, promoting the delivery of services in more integrated settings, and expanding the use of person-centered planning. Michigan Department of Health and Human Services (MDHHS) developed a statewide transition plan to bring its waiver programs into compliance with the new regulations while continuing to provide vital services and supports to Michigan citizens.

Since 2014, MSHN has worked with its partner Community Mental Health Services Programs (CMHSPs) and their provider systems to bring about compliance with the HCBS Rule. Final compliance with the Rule has a due date of March 17, 2023. This means that all applicable service providers must be in full compliance with the Rule, or they will not be able to receive Medicaid funds for services after that due date. Mid-State Health Network (MSHN) continues its work to address the Rule transition and is on track to meet the full requirements of MDHHS and CMS.

To meet this final due date, MSHN has worked through a multitude of activities targeting the following numerous provider statuses: in compliance, out of compliance, compliance validation, heightened scrutiny (a setting with

institutional or isolating characteristics), heightened scrutiny cases deescalated to out of compliance only, follow-up with survey non-responders, and provisional application approvals (providers new to a CMHSP). Each category has brought with it a complex array of tasks requiring attention to ensure HCBS Rules were understood and applied properly to the environment and the participants being served.

At present, the overall HCBS compliance timeline is nearing completion. MSHN is following up with 10 non-responding providers to ensure surveys have been completed remediations addressed. This will occur within the next two weeks, well ahead of the MDHHS-set date of August 31, 2022. After this, MSHN will turn its attention toward notifying MDHHS of the status of every setting and related participant on a final tracking sheet by September 15, 2022. Lastly, MDHHS requires that each Pre-Paid Inpatient Health Plan (PIHP) complete the transition of participants to compliant settings by March 1, 2023. Following the completion of the HCBS Rule transition process, CMS and MDHHS have tasked the 10 PIHPs with annual monitoring and evaluating of network providers for continued compliance. MDHHS is working with the PIHPs on a process that will guide the PIHP/CMHSP system in ensuring that providers remain in compliance with the HCBS Final Rule.

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

Certified Behavioral Health Clinics and Health Homes Overview

In recent years the State of Michigan has rolled out several innovative care management program models in select regions of the state that are designed to improve health outcomes for individuals with behavioral health and substance use disorders. This article is meant to provide an overview of these programs, the similarities, and differences between each, and how they are being implemented in the MSHN region.

Certified Community Behavioral Health Clinics (CCBHC)
Program Overview: Increase access to high-quality behavioral health care for all Michiganders and integrate behavioral health with physical health care. CCBHCs were implemented in the MSHN region as of 10/1/2021 and 9,817 individuals have been enrolled in CCBHC services to date.

Services	Eligibility	Locations in MSHN Region
• Crisis Services including mobile crisis • Screening, Assessment, Diagnosis • Patient-Centered Planning & risk assessment • Outpatient mental health and substance use • Primary care screening and monitoring • Targeted case management • Psychiatric services • Peer Support, Family Support, Counseling • Mental health care for members of the armed forces and veterans	Any person with a mental health or substance use disorder, regardless of residency or ability to pay	Clinton-Eaton-Ingham CMH The Right Door Saginaw CMH **Additionally, LifeWays is not participating in the MDHHS CCBHC demonstration project but is able to provide services through a SAMHSA CCBHC expansion grant*

Opioid Health Homes (OHH) & Behavioral Health Homes (BHH)
Program Overview: An intensive care management program for Medicaid beneficiaries with high needs and chronic health conditions. Health Homes address barriers to care such as the social determinants of health (e.g., housing, transportation, food assistance, employment assistance, etc) and provide enhanced access and coordination.

Services	Eligibility	Locations in MSHN Region
• Comprehensive Care Management • Care Coordination • Health Promotion • Comprehensive Transitional Care & Follow-up • Patient & Family Support • Referral to Community and Social Support Services • Multidisciplinary team of primary care, behavioral health, nurse care manager, and peer support providers	Medicaid or Healthy Michigan beneficiaries who live in the defined service area and who have a diagnosis of Opioid Use Disorder for OHH services, or a Serious Mental Illness or Serious Emotional Disturbance for BHH services	OHH: Victory Clinical Services, Saginaw (effective 10/1/22) BHH: To be determined in partnership with MSHN CMHSP Participants (effective 4/1/23)

The implementation of these programs will expand the availability of person-centered, family-centered, trauma-informed, recovery-oriented, integrated "whole person" care to more individuals in our region. MSHN is pleased to partner with CMHSPs and SUD Providers to offer these expanded services.

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

Substance Use Disorder Policy, Strategy and Equity

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

Stigma Reduction & Language: The Disease of Addiction is not a form of "abuse"

Several of MSHN's Substance Use Disorder (SUD) Clinical Team attended the 2022 conference in July, put on by Detroit-Wayne County Association of Substance Abuse Providers. One of the presenters was Dr. John Kelly, Professor of Psychiatry and Addiction Medicine at Harvard Medical School and the Founder/Director of the Recovery Research Institute at Massachusetts General Hospital. Dr. Kelly did an excellent job of reviewing the state of substance use disorders (SUD) epidemiologically and the state of the art in terms of treatment practice for SUD.

Dr. Kelly and other presenters also spoke to the importance of eliminating stigma associated with having a SUD. Stigma, as we know, is an attitude, discrimination, or prejudice directed towards an individual or a group—in this case, individuals living with a substance use disorder—and it's recognized as one of the most common barriers to a person seeking proper care, support, and treatment for an SUD.

Stigma can manifest in different ways: Social stigma is characterized by individuals, family members or groups reinforcing or inflating stereotypes of stigmatized people like those living with addictions. These judgmental stereotypes include outdated misconceptions, not unlike stigma for mental illness: Namely, an expectation is promulgated that people with SUD should just pull themselves up by their bootstraps, make different choices and stop their harmful behavior. And when they don't, they're judged as weak-willed and/or morally defective. This social stigma has structural and personal impacts: Structural or institutional stigma manifests in laws and institutional policies that marginalize people with the disease of addiction. Nowhere has this been more manifest in the U.S. than in the so-called War on Drugs which criminalized drug use and incarcerated millions of Americans for SUD-related non-violent crimes including possession, disproportionately impacting poor people and people of color. And even for those who never broke the law, structural stigma has manifested in policies that discourage individuals with an SUD from accessing treatment for fear that they may lose their jobs, lose access to student financial aid or have their children taken away.

Social and structural stigma has an intra-personal impact on individuals living with SUD as well, inducing feelings of shame and embarrassment about their substance misuse. Individuals, in effect, absorb negative attitudes about themselves and believe that they are indeed weak or morally flawed, and shame keeps them closeted from disclosing their SUD, much less from seeking treatment.

Consistent with the goal of reducing stigma, Dr. Kelly shared that the National Institute of Health is promoting a change in administrative names in FY23 with elimination of the word "abuse" from leading federal agencies that focus on SUD like the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), and others like the Center for Substance Abuse Treatment (CSAT). When we think about other applications of the word "abuse"—child abuse, sexual abuse, domestic abuse—these are criminal

activities that provoke strong negative feelings in our culture. By contrast, we do not use the word abuse in describing other diseases—diabetes or childhood obesity, even though there may be behaviors patients engage in that could exacerbate their disease process. NIDA acknowledged this in response to my inquiry last week, responding that *"NIDA's name, established by Congress in 1974, uses terms that are now considered stigmatizing. NIDA is exploring options for changing the Institute's name to eliminate stigmatizing language."*

The nature of language is that it evolves over time. Most who work in the behavioral health field have long since dropped referring to individuals with mental illness as crazy or someone with an SUD as a drug addict or a drunk. MSHN supports this evolution in how we talk about individuals with mental illness and/or substance use disorders. Whether they are our family members, neighbors or fellow Michiganders we've never met, they deserve their dignity and our support and respect as they work their way to recovery and healthy lives.

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

Drug Overdose Deaths Rise, Disparities Widen: Differences Grew by Race, Ethnicity, & Other Factors

According to the Centers for Disease Control and Preventions (CDC) Vital Signs report released 7/19/2022, drug overdose data shows troubling trends and widening disparities between different population groups. In just one year, overdose death rates increased **44%** for Black people and **39%** for American Indian and Alaska Native (AI/AN) people. Most people who died by overdose had no evidence of substance use treatment before their deaths. In fact, a lower proportion of people from racial and ethnic minority groups received treatment, compared with White people. Some conditions in the places where people live, work, and play can widen these disparities. For instance, areas with greater income inequality—a larger income gap between the rich and the poor—have higher rates of overdose deaths. Comprehensive, community-based prevention and response efforts should incorporate proven, culturally responsive actions that address disparities in drug overdose deaths and the inequities that contribute to them.

Drug overdoses are preventable. The growing overdose crisis, particularly among people from racial and ethnic minority groups, requires tailored prevention and treatment efforts. These efforts should be designed to restore optimal health for all. The CDC recommends public health professionals, healthcare providers, policy makers, and communities can consider:

- Improving access to treatment and recovery support services by offering telehealth and similar options that help people start and continue treatment and care over time. This is especially important for people from racial and ethnic minority groups, who encounter more barriers to accessing services.
- Offering structural support such as housing assistance, transportation assistance, and childcare to help reduce barriers to accessing and staying in treatment and recovery services.
- Combining culturally appropriate traditional practices, spirituality, and religion, when appropriate, with proven substance use disorder treatment.
- Creating culturally tailored campaigns that help raise awareness and reduce stigma around treatment and recovery.
- Offering support groups and opportunities for community connection to help reduce stigma and mistrust.
- Reducing criminalization of substance use disorders.
- Linking people to treatment from a variety of settings (such as primary care, syringe services programs, and healthcare settings during incarceration).
- Improving access to programs that address past and prevent future trauma and other risk factors for substance use.

The MSHN Substance Use Disorder clinical team supports these recommendations and regularly looks for opportunities to support them within the region. The advent of the MSHN Regional Equity Advisory Committee for Health (REACH) group is also advantageous to supporting these items and offering recommendations and support for ways MSHN can enhance its supports for individuals most impacted by the noted disparities.

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

Annual Review of the Quality Assessment and Performance Improvement Program

The Quality Assessment and Performance Improvement Program (QAPIP) consists of a plan/description and review of effectiveness of the Pre-Paid Inpatient Health Plans (PIHPs) activities in accordance with the Michigan Department of Health and Human Services (MDHHS) QAPIP Technical Requirement. The purpose is to have a quality improvement program to monitor, evaluate and improve performance as it relates to care. This is completed

through various measures for effectiveness, efficiency, and outcomes.

MDHHS began requiring the PIHPs to submit the QAPIP and annual evaluation for review beginning in Fiscal Year 2021. Per Title 42 of the Code of Federal Regulations (CFR) §438.330(e), a State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program (QAPIP) of each PIHP.

The Michigan standards state that the QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. The responsibilities of the Governing Body include monitoring, evaluating, and making improvements to care through oversight and approval of the QAPIP annually; routinely receiving and reviewing written progress reports describing performance improvement projects undertaken, the actions taken, and the results of those actions; formal reviews on a periodic basis (but no less frequently than annually) of written reports on the operation of the QAPIP; and submission of a written annual report to MDHHS.

MDHHS utilizes a checklist to facilitate the annual review of the primary activities of each PIHP's QAPIP.

Those primary activities include the following:

- Performance Measures
- Performance Improvement Projects (PIPs)
- Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Event Management
- Behavioral Treatment Review
- Member Experience with Services
- Practice Guidelines
- Credentialing and Re-Credentialing
- Verification of Services
- Utilization Management
- Provider Network
- Long-Term Services and Supports (LTSS)

The QAPIP plan includes a description of each activity and quality initiative, including a performance goal(s) and/or objective(s) for each area in the QAPIP work plan. The QAPIP evaluation/report includes an annual analysis of the progress of each quality initiative or activity in the QAPIP plan and workplan.

MDHHS reviews how each PIHP uses the annual evaluation/report results to support the creation of goals and objectives for the upcoming QAPIP plan.

The Fiscal Year 2022 QAPIP review by MDHHS indicated that MSHN's QAPIP included the standards identified within the MDHHS QAPIP Technical Requirement and that no follow up action was required. The MDHHS reviewer also stated that Mid-State Health Network (MSHN) did a "superb job on your QAPIP; it was extremely well written, and the flow made it easy to read. Out of all the PIHPs, Mid-State is the only plan that incorporated all of the required information into their QAPIP."

MSHN will continue to utilize the feedback provided by MDHHS during the annual QAPIP review to enhance our QAPIP and quality improvement efforts.

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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