Final Workgroup Report

Michigan Inpatient Psychiatric Admissions Discussion
Michigan Department of Health and Human Services
February 13th, 2018

Executive Summary

Over the last several decades, individuals with serious mental illness have increasingly been transitioned out of hospitals and into community-based settings. This shift from state to community-based service delivery has resulted in the shuttering of state hospitals across the country without sufficient increase in the availability of specialty, community-based psychiatric beds. As the number of inpatient psychiatric beds has decreased, health care providers have increasingly struggled to secure inpatient services for individuals who are in psychiatric crisis. Providers must frequently contact multiple facilities with no guarantee that an appropriate bed may be available. The lack of psychiatric beds has escalated the pressure on hospital emergency departments, which are called to serve individuals on voluntary and involuntary psychiatric holds while awaiting transfers to psychiatric facilities.

The State of Michigan and Michigan Legislature have pursued several strategies over the last few years to expand access to inpatient psychiatric beds and improve the quality of care for individuals who have experienced a psychiatric crisis. These strategies include: (1) expanding the number of psychiatric beds that are available through the Certificate of Need program, (2) approving funds to pursue the building of a new facility to replace the existing Caro Center, (3) establishing a new unit at the Center for Forensic Psychiatry, (4) collecting and examining data on the causes of denials for inpatient services, and (5) facilitating transitions of care through the Children's Transition Support Team pilot. Despite these various efforts, the crisis in access to inpatient psychiatric services has continued unabated.

In July 2017, Michigan Department of Health and Human Services (MDHHS) launched a new initiative, which is known as the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD), to respond to this crisis. As part of this initiative, MDHHS convened a workgroup that was primarily composed of providers and payers to investigate ongoing barriers to inpatient psychiatric services and produce a set of recommendations to overcome these barriers. The MIPAD Workgroup submitted its final recommendations to the department on October 31st, 2017.

MDHHS conducted an analysis of the statutory, regulatory, and fiscal impact of implementing the recommendations. MDHHS also reviewed each recommendation and identified whether the recommendation should be implemented on a short-term, medium-term, and long-term timeframe. Based upon this analysis, MDHHS has identified 19 of these recommendations for short-term action and will work with stakeholders to implement the short-term recommendations in 2018. The short-term recommendations are highlighted in the table below.

MDHHS will continue to seek to engage stakeholders throughout the implementation process by convening specific workgroups or delegating implementation to existing forums. MDHHS is also currently exploring opportunities to collaborate with the House CARES Task Force on improving access to inpatient psychiatric services for Michigan residents. Finally, MDHHS will seek to use grant funding from the Michigan Health Endowment Fund to jumpstart the implementation of the recommendations.

Number	Recommendation
1.02	The Michigan Certificate of Need Commission should review and potentially revise the Certificate of Need standards for Psychiatric Beds/Services to ensure that the methodology accurately captures the true level of need for psychiatric services and can make accurate need predictions based on population estimates.

Number	Recommendation
1.03	Community hospitals should develop the capability for patients to receive assessment and begin treatment while awaiting inpatient placement whether that is in a state facility or community hospital. This could include leveraging telehealth capabilities along with telehealth payment structures.
1.04	The Michigan legislature should require all community short-term acute care hospitals with children's inpatient specialties to implement and maintain child/adolescent psychiatric programs to ensure that care for children can be provided throughout the state. This requirement should be complimented by grant funding or other incentives to establish and continue providing this service.
2.02	The state legislature should work with professional associations and third-party payers to re-examine the reimbursement for services by limited license professionals.
2.07	MDHHS and other payers should incentivize the development of specialized behavioral health care units.
3.06	MDHHS should amend Prepaid Inpatient Health Plan (PIHP) contracts to ensure standardized practices are prescribed for screening and communication.
3.08	The legislature should increase funding and capacity for Therapeutic Treatment Foster Care (TFC), which includes addressing funding and licensing issues.
3.09	MDHHS should increase the use of creative solutions for addressing the psychiatrist shortage to include loan repayment.
3.10	MDHHS should require PIHPs to have crisis stabilization services that are available 24/7 and commensurate with community need.
3.11	MDHHS and its community partners develop a standardized set of definitions for inpatient psychiatric denials and admissions.
3.14	MDHHS should expand the use of telemedicine through the Medicaid Provider Manual.
4.02	MDHHS should implement the following strategies to educate providers and payers about confidentiality laws and regulations that affect the sharing of behavioral health information: • Conduct education and outreach efforts to inform the provider community on the importance of inter-organizational communication and the qualitative impacts of such communication • Provide education to the payer and provider community regarding Public Act 559 and its impact on communication and coordination of care for the delivery of mental health services • Encourage the adoption of the Behavioral Health Consent Form as a mechanism to assist with information sharing • Engage statewide associations to assist with education of providers and payers
4.03	MDHHS should integrate requirements for health information sharing and care coordination into departmental policies, programs, and contracts. This strategy should include contracts with MHPs, PIHPs, and other contractors, providers, or service agencies (e.g. public and private foster care provider agencies).

Number	Recommendation
4.04	MDHHS should create a workgroup to develop and pilot a single statewide medical clearance algorithm. • This workgroup should review the work that has already been done across the state in implementing medical clearance criteria and any data as to its efficacy and other outcomes. Examples include the medical clearance pilots in (1) Kent County and (2) Macomb/Oakland/Wayne. • This workgroup should also address the different needs of specific populations, such as (1) early childhood, (2) older children, (3) adolescents, (4) geriatric patients, (5) individuals with developmental disabilities, and (6) children in foster care.
4.05	MDHHS should create a workgroup to develop a standard referral packet for hospital admissions, which would be used when requesting an inpatient bed. A standard referral packet would reduce the paperwork that was being exchanged during hospital admissions and improve transitions of care for the individual.
4.06	MDHHS should create a workgroup to support the ongoing development of standards for hospital admissions. The workgroup should: • Develop standard criteria for admission to inpatient behavioral health units • Differentiate between community hospital unit and state hospital unit capabilities • Outline expectations for psychiatric acuity and general medical acuity for different behavioral health crisis settings (e.g. IMDs, those within a general medical/surgical hospital, etc.)
4.08 (B)	MDHHS should work with other state agencies and external partners to investigate and address cross-county barriers to involuntary hospitalization through the following strategies: • Collaborate with stakeholders to address payment issues when the county of the hospitalization is different from the individual's assigned PIHP and CMHSP.
5.02	MDHHS should encourage the PIHPs to develop and implement new payment methodologies (e.g. tiered rate) that (1) would promote and incentivize greater access to inpatient psychiatric services and improve outcomes for all populations and (2) address barriers to care for specific populations. The PIHPs should collectively explore consistent payment methodologies that address factors such as length of stay, intensity or acuity, and geographic factors. MDHHS should work with the PIHPs to ensure consistency in the base rate paid for inpatient psychiatric services.
6.01	MDHHS should work with providers and payers to establish a web-based resource to identify available inpatient psychiatric beds by gender, acuity, age, and diagnosis. This system should be similar to "bed boards" that have been implemented in other states. Inpatient psychiatric hospitals, including state facilities, should populate the registry with updated information about bed availability at a regular interval at "X" time after discharge. Users should include PIHPs, CMHSPs, acute care hospitals, inpatient psychiatric hospitals, and employees/caregivers with other appropriate providers. The registry should be expanded in the future to include available beds at crisis residential, sub-acute detoxification, and other treatment settings. MDHHS and its external partners should also establish a shared governance and oversight committee that includes representatives of the different users of the registry.

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Workgroup Membership

The following individuals participated in the main workgroup for the Michigan Inpatient Psychiatric Admission Discussion. The charter for the main workgroup is included in Appendix A of this report. The membership lists and related charters for the steering committee and sub-workgroups are also included as appendixes within this report.

Workgroup Members	
Amy Zaagman	Michigan Council for Maternal and Child Health
Andy Hotaling	Forest View
Belinda Chandler	Michigan College of Emergency Physicians
Beth Nagel	Michigan Department of Health and Human Services
Bill Slavin	NorthCare Network
Bob Sheehan	Community Mental Health Association of Michigan
Brie Elsasser	Michigan Department of Health and Human Services
Carolyn Watters	Mid-State Health Network
Cathy Meske	Northeast Michigan CMH Authority
Cindy Kelly	Michigan Department of Health and Human Services
Dave Schneider	Michigan Department of Health and Human Services
Dillon McGough	Michigan Health and Hospital Association
Dr. Angela Pinheiro	CMH for Central Michigan
Dr. Bill Sanders	Pine Rest Christian Mental Health Services
Dr. Carmen McIntyre	Wayne State University School of Medicine
Dr. Debra Pinals	Michigan Department of Health and Human Services
Dr. George Mellos	Hawthorn Center
Dr. Scott Monteith	Together Health Network / Michigan Psychiatric Society
Eric Kurtz	Northern Michigan Regional Entity
Erin Emerson	Michigan Department of Health and Human Services
Jackie Boyd	Michigan Department of Health and Human Services
Jane Shank	Association for Children's Mental Health
Jared Welehodsky	Michigan Department of Health and Human Services
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John Kettley	Michigan Medicine
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Kevin Fischer	National Alliance on Mental Illness/Behavioral Health Advisory Council
Kelly Domagala	Pine Rest Christian Mental Health Services

Workgroup Members	
Kirstie Sieloff	Governor's Office
Kris Kraft	Blue Cross Blue Shield of Michigan
Kristen Jordan	Michigan Health and Hospital Association
Kristy Moore	Bay-Arenac Behavioral Health
Laura Appel	Michigan Health and Hospital Association
Paige Fults	Michigan Health and Hospital Association
Lisa Grost	Michigan Department of Health and Human Services
Lisa Williams	West Michigan Community Mental Health
Lynda Zeller	Michigan Department of Health and Human Services
Mary Berry-Bovia	Michigan Emergency Nurses Association
Mary Chaliman	Michigan Department of Health and Human Services
Matt Ellsworth	Michigan Department of Health and Human Services
Matt Lori	Michigan Department of Health and Human Services
Phil Kurdunowicz	Michigan Department of Health and Human Services
Rhonda Brink	Pine Rest Christian Mental Health Services
Sarah Hirsch	Southwest Michigan Behavioral Health
Sheri Falvay	Michigan Department of Health and Human Services
Stacie Bladen	Michigan Department of Health and Human Services
Stacey Hettiger	Michigan State Medical Society
Tiffany Stone	Michigan Association of Health Plans
Tom Renwick	Michigan Department of Health and Human Services

Discussion Facilitator	
Phil Kurdunowicz	Michigan Department of Health and Human Services

Introduction

Background on Challenges for Inpatient Psychiatric Access in Michigan

Over the last several decades, individuals with serious mental illness have increasingly been transitioned out of hospitals and into community-based settings. This shift from state to community-based service delivery has resulted in the shuttering of state hospitals across the country without sufficient increase in the availability of specialty, community-based psychiatric beds. The Michigan Department of Health and Human Services (MDHHS) currently operates four state psychiatric hospitals and one forensic center that have a grand total of 772 beds.[1] The number of psychiatric beds in community hospitals have also fallen precipitously over the years: community hospitals in Michigan had a collective capacity of 3,041 adult beds and 729 child/adolescent beds in 1993,[2] and this capacity has dwindled in 2017 to 2,197 adult beds and 276 child/adolescent beds.[3] Maps that display the locations of inpatient psychiatric units in Michigan can be found in Appendix B.

As the number of inpatient psychiatric beds has decreased, health care providers have increasingly struggled to secure inpatient services for individuals who are in psychiatric crisis. Providers must frequently contact multiple facilities with no guarantee that an appropriate bed may be available. Mid-State Health Network's (MSHN) recent study on inpatient psychiatric bed denials has provided empirical evidence of this trend. From March 2016 to March 2017, Community Mental Health Service Programs (CMHSPs) in the MSHN region reported 31,107 instances of community-based psychiatric inpatient denials, which impacted 1,676 individuals: as a result, each individual on average was denied access to inpatient services over 18 times within one year.[4]

The lack of psychiatric beds has escalated the pressure on hospital emergency departments, which are called to serve individuals on voluntary and involuntary psychiatric holds while awaiting transfers to psychiatric facilities. Michigan emergency departments experienced 52,671 visits from 34,517 Medicaid beneficiaries who had a principal mental health diagnosis in 2016.[5] While only a fraction of these visits ultimately required an inpatient admission, the combined impact of these visits created immense pressure on emergency departments and contributed to boarding of psychiatric patients. For example, when the American College of Emergency Physicians surveyed a group of 328 emergency department medical directors across the United States, 80% of the medical directors reported routine psychiatric patient boarding.[6] Another study found that the total emergency department length of stay was significantly longer for psychiatric admissions (1,089 minutes, 18 hours) when compared to non-psychiatric admissions (340 minutes, 5.6 hours).[7]

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[1] Michigan Department of Health and Human Services. State Hospital Inpatient Census. January 24, 2018.
[2] Michigan Department of Health and Human Services. Michigan Certificate of Need Psychiatric Inpatient Standards, Effective September 1993.
[3] Michigan Department of Health and Human Services. Michigan Certificate of Need Psychiatric Inpatient Standards, Effective August 2017.
[4] Mid-State Health Network. Final Report for the Psychiatric Inpatient Denial Data Collection Pilot.
[5] Michigan Department of Health and Human Services. Query of MDHHS Data Warehouse for Number of Emergency Department Visits by Medicaid Beneficiaries with Mental Health Diagnosis.
[6] American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey 2008.
[7] Nicks, B. A., & Manthey, D. M. (2012). The Impact of Psychiatric Patient Boarding in Emergency Departments. Emergency Medicine International, 2012, 1-5

Hospital emergency departments are also frequently under-resourced and do not have the physical plant or staffing to treat multiple individuals in psychiatric crisis at the same time and keep them safe. This problem is particularly acute for individuals with complex needs, which includes (1) aggression or behaviors, (2) intellectual and/or developmental disabilities (including Autism Spectrum Disorder), (3) substance use disorders, and (4) medical co-morbidities. Individuals with complex needs are also the most likely to be denied admission for inpatient psychiatric services.

History of State-Level Efforts to Improve Access

The State of Michigan and Michigan Legislature have pursued several strategies over the last few years to expand access to inpatient psychiatric beds and improve the quality of care for individuals who have experienced a psychiatric crisis. Several of these initiatives are described in greater detail below.

- The Certificate of Need Commission added 370 additional psychiatric beds to the statewide pool to specifically address the needs of specialty populations. The specific allocation of new specialty beds by sub-population is outlined below.
    - 110 Beds for Adults Living with Intellectual/Developmental Disabilities
    - 20 Beds for Children or Adolescents Living with Intellectual/Developmental Disabilities
    - 110 Beds for Geriatric Psychiatric Patients
    - 110 Beds for Adults with Severe Mental Illness Living with Comorbid Medical Conditions
    - 20 Beds for Children and Adolescents Living with Severe Emotional Disturbances and a Comorbid Medical Condition
- The Michigan Legislature approved funds to pursue the building of a new facility to replace the existing Caro Center. This new facility should expand the State of Michigan's capacity to provide inpatient psychiatric services and improve the quality of care.
- MDHHS opened an eighth unit with 34 new beds at the Center for Forensic Psychiatry on January 5th, 2017, and the unit is already operating at full capacity.
- MDHHS partnered with MSHN to quantify the number of inpatient psychiatric denials and examine the reasons for the denials. MSHN worked with the Behavioral Health and Developmental Disabilities Administration and Certificate of Need Commission to develop and pilot a data collection instrument which could be used to collect information on denials. MSHN piloted this instrument with the 12 Community Mental Health Service Programs within their region. MDHHS has now adopted this survey instrument and is expanding data collection statewide, which should (1) improve the ability of the department to understand the scope of the problem and (2) ultimately inform statewide discussions on solutions to persistent barriers in access to inpatient psychiatric services.

- One of the challenges that the psychiatric hospitals are confronting is assisting individuals with mental health needs with transitioning back to the community. Many individuals who have been admitted for an inpatient psychiatric stay encounter barriers when returning back to the community such as lack of housing and access to community-based mental health services. MDHHS implemented a pilot to test new strategies for overcoming barriers that individuals face when returning home. The pilot, which is known as the Children's Transition Support Team, focused on identifying and resolving barriers that children and youth who were admitted for an inpatient stay at the Hawthorn Center encounter when attempting to return to the community. This pilot will help inform ongoing efforts at State of Michigan hospitals and other community inpatient psychiatric facilities to improve transitions of care for individuals who are recovering from a psychiatric crisis.

Launch of the Michigan Inpatient Psychiatric Admissions Discussion

In July 2017, MDHHS launched a new initiative, which is known as the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD), to respond to this crisis. As part of this initiative, MDHHS convened a workgroup that was primarily composed of providers and payers to investigate ongoing barriers to inpatient psychiatric services and produce a set of recommendations to overcome these barriers. This report summarizes the findings of the workgroup and identifies the next steps for implementing the workgroup's recommendations.

Overview of the Workgroup Recommendations

MDHHS convened the MIPAD workgroup in order to identify a series of short-term, medium-term, and long-term recommendations for addressing persistent barriers in access to inpatient psychiatric services. Due to the urgency of this crisis, MDHHS set a goal of identifying recommendations for action before the end of 2017. MDHHS also created a steering committee to help coordinate workgroup discussions and support the development of recommendations. The charters for the main workgroup and steering committee are included as appendixes to this report.

The workgroup established five sub-workgroups to explore specific aspects of the inpatient psychiatric access problem. The five sub-workgroups are described below. The charters for the sub-workgroups are also included as appendixes to this report.

- The **Physical Plant Sub-Workgroup** focused on exploring barriers to inpatient psychiatric services that are related to the physical plant of Michigan's state psychiatric hospitals and private psychiatric hospitals.

- The **Staffing and Team-Based Care Sub-Workgroup** identified challenges for hiring and retaining adequate, qualified, and appropriately trained staff to support the delivery of inpatient psychiatric services.

- The **Continuum of Care Sub-Workgroup** explored ways to expand the availability of treatment options across the continuum of care in order to allow individuals to receive services in the most appropriate setting for the individual's health and wellness needs. The sub-workgroup also identified strategies for reducing potential barriers to treatment in specific residential settings.

- The **Interoperability Sub-Workgroup** examined whether variance in specific clinical and administrative processes across health care providers impedes information sharing and inhibits access to inpatient psychiatric services.

- The **Financing and Reimbursement Sub-Workgroup** identified challenges that current financing and reimbursement methodologies create for delivering inpatient psychiatric services. The sub-workgroup also supported the work of other sub-workgroups by reviewing draft proposals and evaluating the potential impact on financing and reimbursement of service delivery.

The sub-workgroups concluded their meetings and made a series of 42 recommendations to the workgroup in October 2017. The key findings and recommendations of the sub-workgroup are summarized in the following pages of this report. The workgroup submitted the recommendations to MDHHS for review and consideration.

As part of the MIPAD initiative, MDHHS has also collaborated with stakeholders to explore the possibility of establishing a psychiatric bed registry in Michigan. A psychiatric bed registry is a web-based resource where providers and payers can search for available psychiatric beds in near-real time. MSHN and Health Management Associates partnered together to publish a report that summarized considerations for developing a registry in Michigan. The MIPAD workgroup reviewed the report and expressed its support for proceeding with the design phase of the registry.

MDHHS worked with the Michigan Health and Hospital Association and other partners to host several meetings to discuss the design of the registry. The key findings from these meetings are summarized under the Workgroup Discussion on the Psychiatric Bed Registry page of this report. The workgroup also made a final recommendation in support of developing a psychiatric bed registry in Michigan.

Physical Plant Sub-Workgroup

Purpose of the Sub-Workgroup

The sub-workgroup focused on exploring barriers to inpatient psychiatric services that are related to the physical plant of Michigan's state psychiatric hospitals and private psychiatric hospitals.

Key Findings from the Sub-Workgroup Discussions

The key findings from the Physical Plant Sub-Workgroup are summarized below.

- Most community hospitals are not designed to care for individuals who are violent, aggressive and/or intellectual or developmentally disabled as well as individuals who need long-term rehabilitative stays. Most often these patients are referred to the state facilities.

- The current Michigan Certificate of Need Psychiatric Beds and Services standard predicts need with a methodology built upon inpatient utilization data. If not enough patients are able to utilize inpatient care, then this data will not accurately predict true "need." As it is, certain areas of the state are predicted to have enough or even an over-supply of psychiatric inpatient beds, while patients wait for long periods of time for a bed.

- Michigan's state-run psychiatric hospitals are operating at full capacity, and there is a 200 person waitlist on most days. In the absence of programs to care for individuals who need longer-term or complex care, many patients end up waiting in a hospital emergency room for placement in a state facility.

- In a community hospital emergency room, patients are stabilized and often do not receive treatment until inpatient placement.

- Michigan has a shortage of children's psychiatric inpatient capacity, which is causing children and adolescents to be boarded in emergency departments and not receiving appropriate care in a timely manner. The emergency department is not a safe and therapeutic environment for a child in need of inpatient psychiatric care. If a community hospital has invested in children's specialty and sub-specialty medical care, then they should also invest in psychiatric inpatient care for children.

- The State of Michigan's psychiatric hospitals are all located in the mid and southern area of the state. Citizens that live in the northern Lower Peninsula and the Upper Peninsula must travel many hours to receive care in the state's facilities. Often local law enforcement transport citizens to state hospitals, and this puts a strain on personnel and budgets. Further, family and community supports are not incorporated into the care for these citizens due to the distance.

The recommendations from the sub-workgroup are included on the next page.

Recommendations from the Sub-Workgroup

Number	Recommendation
1.01	In order to care for individuals with more complex health needs, community hospitals should (1) implement security measures to keep individuals and staff safe and (2) redesign old/outdated infrastructure throughout the facility. This recommendation includes both security for personnel (including recovery coaches and certified peers) and adequate technology to implement safety features. The re-design of psychiatric units and emergency departments should follow best practices such as (1) trauma-informed design and (2) designs with increased flexibility (e.g. rooms that can convert between single and double beds to allow for gender separation, nurse stations that can be expanded when additional rooms are needed and still allow for auditory and visual monitoring, etc.).
1.02	The Michigan Certificate of Need Commission should review and potentially revise the Certificate of Need standards for Psychiatric Beds/Services to ensure that the methodology accurately captures the true level of need for psychiatric services and can make accurate need predictions based on population estimates.
1.03	Community hospitals should develop the capability for patients to receive assessment and begin treatment while awaiting inpatient placement whether that is in a state facility or community hospital. This could include leveraging telehealth capabilities along with telehealth payment structures.
1.04	The Michigan legislature should require all community short-term acute care hospitals with children's inpatient specialties to implement and maintain child/adolescent psychiatric programs to ensure that care for children can be provided throughout the state. This requirement should be complimented by grant funding or other incentives to establish and continue providing this service.
1.05	The State of Michigan should build a 50-bed psychiatric inpatient hospital in the northern-most area of Michigan's Lower Peninsula. While the new facility is being planned and constructed, the state should partner with a community hospital to provide state psychiatric care in this currently unserved community.

Staffing and Team-Based Care Sub-Workgroup

Purpose of the Sub-Workgroup

The sub-workgroup identified challenges for hiring and retaining adequate, qualified, and appropriately trained staff to support the delivery of inpatient psychiatric services.

Key Findings from the Sub-Workgroup Discussions

The sub-workgroup focused on identifying issues and brainstorming solutions for serving individuals with complex health needs who are the most likely to be denied inpatient care. In particular, the sub-workgroup sought to develop a framework for establishing appropriately staffed specialty programs which address the level of care and intensity of service needs of individuals with complex needs. If such specialty units existed, special needs patients would more timely access to critical inpatient psychiatric services, which would reduce the pressure on general psychiatric units and emergency departments. The key findings from the sub-workgroup are included below.

- There are four sub-populations of individuals who confront unique barriers in accessing inpatient psychiatric services. Individuals in these sub-populations represent the majority of inpatient denials. These individuals need enhanced and specialized care provided by trained professional staff.
    - Individuals with intellectual and/or developmental disabilities
    - Individuals recovering from a substance use disorder
    - Individuals with high and severe behaviors
    - Individuals with medical co-morbidities
- Professional staff who provide services on inpatient psychiatric units are compensated at the same level as staff on medical/surgical units despite the challenges of developing and managing a safe ambulatory milieu with an ever changing mix of behaviors and diagnostic complexities. Professional staff in inpatient psychiatric units are also more likely to be physically and/or emotionally traumatized than those on medical/surgical units. The combination of these factors leads to burn-out and high turn-over rates. Further, compensation at academic centers and state hospitals is not as competitive as the private sector, which creates significant challenges for recruiting and retaining staff.
- Facilities encounter substantial challenges with recruiting and retaining staff with special psychiatric inpatient care competencies, which include medical, substance use, behavioral analysis, geriatric psychiatry, child psychiatry, general psychiatry. The lack of staff with these competencies inhibits the ability of facilities to serve individuals with complex health needs.
- Certain types of professional staff (MSWs and psychology PhDs) cannot be reimbursed under state law for services that are rendered before supervision hour criteria are met, which acts as a deterrent to new graduates working at inpatient psychiatric facilities.

- "Frontline staff" are key members of the clinical team and often include behavioral technicians, care assistants, child care staff. Inpatient psychiatric facilities confront a number of challenges with recruiting, training, and retaining sufficient frontline staff to provide high-quality care. These challenges include establishing a competitive wage structure, providing adequate training and support, and addressing caregiver trauma that is associated with safety events.

- The sub-workgroup members concurred that the delivery of high-quality care in inpatient psychiatric units is based upon (1) the use of evidence based/supported and/or best practices, (2) family and person-centered care, (3) trauma informed care, and (4) transition support with commitment to community inclusion.

- State of Michigan hospitals and community inpatient psychiatric facilities provide uniquely different types of services, which are described below.

    - Admissions and discharges to State of Michigan facilities are approved and managed by local Community Mental Health Service Programs.

    - State of Michigan hospitals focus on providing long-term service with emphasis on psychosocial rehabilitation (adults) and habilitation in the context of school (children) with transition to significantly modified community care. Most community inpatient psychiatric facilities focus on short-term service with an emphasis on rapid lysis of behaviors with medication and return to relatively unmodified community care.

    - Patients who are served at State of Michigan hospitals typically have a substantial history of other inpatient stays and have exhausted all other options for service.

    - Patients who are served at State of Michigan hospitals frequently have a history of high and severe behaviors (e.g. aggression) or complex medical needs.

Recommendations from the Sub-Workgroup

Number	Recommendation
2.01	The state hospital system and community hospital systems should improve the hiring and retention of qualified and competent staff by implementing the following strategies: • Developing evidence-based onboarding and ongoing training for staff hired to specialty units • Compensating staff with specialty training appropriately and competitively • Developing retention strategies such as a levels-associated compensation structure with merit and senior criteria. Other retention and compensation strategies may include (but are not limited to) loan forgiveness. • Developing position descriptions that support a self-directed, bottom-up work team
2.02	The state legislature should work with professional associations and third-party payers to re-examine the reimbursement for services by limited license professionals.

Number	Recommendation
2.03	MDHHS should work with clinical and business leaders at public, private, and university hospitals to form an ongoing consortium which espouses the ideas herein, improves them, monitors progress, and reports to appropriate entities in order to encourage and support the development and maintenance of specialty units.
2.04	The state hospital system and community hospital systems should increase the adoption of effective and evidence-based practices for delivering team-based care by implementing the following strategies: • Incorporating the delivery of specialized behavioral health treatment, care, and services into hospital mission statements • Developing a bottom-up and self-directed "proof of concept" manualized model based upon the gap analysis for specialized behavioral health care units, and considering evidence from healthcare literature • Establishing guidelines that unit models are multi-disciplinary, trauma-informed, person-centered, family-driven (youth-guided) dedicated to use of evidence-based/supported methods and reflect integrated pro-active safety systems with patient activation • Developing transition support services in order to guide the community in developing sophisticated continuum of care aftercare plans that make re-admission less likely • Ensuring that "frontline" staff ratios reflect severity of illness and intensity of service • Developing substantial and evidence based onboarding and ongoing training for staff hired to specialty units • For specialty units, actively engage a performance improvement model in the context of integrated safety systems
2.05	Community hospital systems should conduct a "gap" analysis in regard to providing specialized behavioral health care units.
2.06	The state hospital system and community hospital systems should affiliate with university systems to share model planning, progress, and outcomes.
2.07	MDHHS and other payers should incentivize the development of specialized behavioral health care units.

Continuum of Care Sub-Workgroup

Purpose of the Sub-Workgroup

The sub-workgroup explored ways to expand the availability of treatment options across the continuum of care in order to allow individuals to receive services in the most appropriate setting for the individual's health and wellness needs. The sub-workgroup also identified strategies for reducing potential barriers to treatment in specific residential settings.

Key Findings from the Sub-Workgroup

The key findings from the Continuum of Care Sub-Workgroup are summarized below.

- The sub-workgroup members also noted that inpatient psychiatric beds may sometimes be available but that the inpatient psychiatric unit does not have sufficient staff or staff that are appropriately trained to address the needs of the individual.

- The sub-workgroup members also noted that there is a lack of continuity of care when the individual is discharged from one program or department to another resulting in the individual not receiving services in a timely fashion or receiving limited follow-up of services, which contributes to recidivism.

- The sub-workgroup members noted that (1) the limitations on mental health services at jails and jail diversion efforts and (2) ongoing barriers to accessing community-based services contribute to the increased demand for inpatient psychiatric services. The sub-workgroup members specifically highlighted that the shortage of crisis residential and after-care programs elevates the demand for inpatient psychiatric services.

- The sub-workgroup members also emphasized the role that staffing shortages and lack of specialized trainings for staff have across all service domains, which includes psychiatry, social work, nursing, behaviorists, and behavioral technicians.

- The sub-workgroup members also highlighted barriers that individuals encounter when attempting to access inpatient psychiatric services in another county. The sub-workgroup indicated that this issue is related to the County of Financial Responsibility requirements.

- The sub-workgroup members also indicated that Michigan does not have standardized pre-screening processes across the state.

Recommendations from the Sub-Workgroup

Number	Recommendation
3.01	MDHHS should work with Prepaid Inpatient Health Plans (PIHP) to increase the availability of short-term community intensive treatment programs throughout the state.

Number	Recommendation
3.02	The corrections and juvenile justice systems should complete validated mental health screenings and referrals for further assessment/treatment for (1) children prior to entering the juvenile justice system and (2) adults with behavioral health concerns including substance use disorders entering county jails.
3.03	The State of Michigan should require a state-mandated standardized training for the direct care workforce which includes all disciplines (potential licensure or accreditation).
3.04	The State of Michigan should establish standards for the provision of psychiatric support in all emergency departments (admission, treatment, discharge), which should include (1) using telepsychiatry, (2) assist in managing medications, (3) developing an Emergency Medical Treatment and Labor Act (EMTALA) compliance team to review emergency department cases and perform site visits, and (4) embedding CMHSP providers in emergency departments with Medicaid reimbursement for services provided.
3.05	The State of Michigan should expand crisis intervention teams and require law enforcement staff to be trained in Mental Health First Aid or equivalent.
3.06	MDHHS should amend PIHP contracts to ensure standardized practices are prescribed for screening and communication.
3.07	The State of Michigan should establish accountability standards for care coordination between criminal justice and behavioral health systems to ensure the continuity of care (which includes developing medication formulary that allows for medications to follow the individual) from community to jail.
3.08	The legislature should increase funding and capacity for Therapeutic Treatment Foster Care (TFC), which includes addressing funding and licensing issues.
3.09	MDHHS should increase the use of creative solutions for addressing the psychiatrist shortage to include loan repayment.
3.10	MDHHS should require PIHPs to have crisis stabilization services that are available 24/7 and commensurate with community need.
3.11	MDHHS and its community partners develop a standardized set of definitions for inpatient psychiatric denials and admissions.
3.12	MDHHS should develop state capacity for clinical coordinators for high acuity patients to access intensive wraparound services after discharge or upon need.
3.13	MDHHS should ensure seamless transitions of care from all settings by allowing Medicaid payment to follow the recipient regardless of where the individual is served in the community.
3.14	MDHHS should expand the use of telemedicine through the Medicaid Provider Manual.
3.15	MDHHS and its external partners should engage medical students in psychiatric rotations at a diverse set of locations.
3.16	MDHHS and its external partners should complete a crisis adequacy assessment for the entire continuum including call centers, mobile crisis, crisis stabilization, Crisis Response Units, inpatient psychiatric units, and law enforcement. MDHHS should also establish a forum or center for sharing best practices, identifying centers of excellence, providing trainings, and establishing performance indicators and guidelines.

Interoperability Sub-Workgroup

Purpose of the Sub-Workgroup

The sub-workgroup examined whether variance in specific clinical and administrative processes across health care providers impedes information sharing and inhibits access to inpatient psychiatric services.

Key Findings from the Sub-Workgroup

The key findings from the Interoperability Sub-Workgroup are summarized below:

- The sub-workgroup noted that that are system-level barriers across Michigan which interfere with the quality and efficiency of service delivery to individuals who require inpatient psychiatric services. These artificial barriers include breakdowns in communication, non-standardized workflows, or lack of clear expectations for care. These inefficiencies lead to unnecessary poor outcomes for our Michigan residents in crisis such as longer emergency department wait times, disjointed outpatient care, and differential care experiences which are dependent upon where the individual lives in Michigan.

- The sub-workgroup defined interoperability as the ability of providers across the system to exchange and make use of information in order to operate in conjunction with each other.

- The sub-workgroup identified the following barriers to interoperability in the delivery of services to individuals who are experiencing a psychiatric crisis:

    - Barriers that are related to the information exchange

        - Variation in existing state and federal privacy laws that govern the confidentiality of behavioral health information

        - Lack of uniformity in the application of these laws

        - Variance in the use of health information technology and health information exchange in the coordination of care

    - Barriers that are related to pre-admission processes, which includes (1) acute medical setting evaluations and medical testing or medical clearance and (2) referral packets

    - Barriers that are related to criteria for inpatient and other crisis setting admissions

        - Variation in admission criteria standards

        - Variation in expectations around psychiatric and medical acuity

        - Variation in definitions of the level of service for acute care hospitals with inpatient psychiatric units, freestanding psychiatric hospitals, and State of Michigan hospitals

Recommendations from the Sub-Workgroup

Number	Recommendation
4.01 (A)	MDHHS should work with its external partners to encourage broader and more consistent use of technology that supports health information sharing through the following strategies: • Achieve statewide adoption of Admit, Discharge, and Transfer (ADT) notifications for inpatient psychiatric stays, improve the data quality and usability for ADT messages, and explore policy, regulatory, and contractual changes to support the attainment of these goals. This recommendation includes all inpatient, emergency care, and crisis residential settings. • Promote the sharing of the medication information through the statewide health information exchange infrastructure.
4.01 (B)	MDHHS should work with its external partners to encourage broader and more consistent use of technology that supports health information sharing through the following strategy: • Pursue adoption of statewide encrypted email to support inter-organizational communication. MDHHS should identify user groups as broadly as possible to include all individuals who may be involved in the individual's care team.
4.02	MDHHS should implement the following strategies to educate providers and payers about confidentiality laws and regulations that affect the sharing of behavioral health information: • Conduct education and outreach efforts to inform the provider community on the importance of inter-organizational communication and the qualitative impacts of such communication • Provide education to the payer and provider community regarding Public Act 559 and its impact on communication and coordination of care for the delivery of mental health services • Encourage the adoption of the Behavioral Health Consent Form as a mechanism to assist with information sharing • Engage statewide associations to assist with education of providers and payers
4.03	MDHHS should integrate requirements for health information sharing and care coordination into departmental policies, programs, and contracts. This strategy should include contracts with MHPs, PIHPs, and other contractors, providers, or service agencies (e.g. public and private foster care provider agencies).
4.04	MDHHS should create a workgroup to develop and pilot a single statewide medical clearance algorithm. • This workgroup should review the work that has already been done across the state in implementing medical clearance criteria and any data as to its efficacy and other outcomes. Examples include the medical clearance pilots in (1) Kent County and (2) Macomb/Oakland/Wayne Counties. • This workgroup should also address the different needs of specific populations, such as (1) early childhood, (2) older children, (3) adolescents, (4) geriatric patients, (5) individuals with developmental disabilities, and (6) children in foster care.

Number	Recommendation
4.05	MDHHS should create a workgroup to develop a standard referral packet for hospital admissions, which would be used when requesting an inpatient bed. A standard referral packet would reduce the paperwork that was being exchanged during hospital admissions and improve transitions of care for the individual.
4.06	MDHHS should create a workgroup to support the ongoing development of standards for hospital admissions. The workgroup should: • Develop standard criteria for admission to inpatient behavioral health units • Differentiate between community hospital unit and state hospital unit capabilities • Outline expectations for psychiatric acuity and general medical acuity for different behavioral health crisis settings (e.g. IMDs, those within a general medical/surgical hospital, etc.)
4.07	MDHHS should collaborate with its external partners to develop a universal voluntary admission form and process for use to all inpatient behavioral health settings. This form should be similar to the use of standardized involuntary forms such as the petition and certification forms.
4.08 (A)	MDHHS should work with other state agencies and external partners to investigate and address cross-county barriers to involuntary hospitalization through the following strategy: • Collaborate with the State Court Administrative Office (SCAO) to issue clarifying guidance around the following question: Does the location of the setting where a person is evaluated for a petition and certification and the location of the related inpatient hospital unit have an impact on which court hears the case?
4.08 (B)	MDHHS should work other state agencies and external partners to investigate and address cross-county barriers to involuntary hospitalization through the following strategy: • Collaborate with stakeholders to address payment issues when the county of the hospitalization is different from the individual's assigned PIHP and CMHSP.
4.09	MDHHS should work with its external partners to address barriers in identifying and engaging individuals who are responsible for consenting for inpatient treatment for children with specific needs (i.e. unaccompanied unadjudicated minors, unaccompanied refugee minors, children in foster care). This recommendations includes addressing issues of timeliness with emergency guardianship or child protective services.

Financing and Reimbursement Sub-Workgroup

Purpose of the Sub-Workgroup

The sub-workgroup identified challenges that current financing and reimbursement methodologies create for delivering inpatient psychiatric services. The sub-workgroup also supported the work of other sub-workgroups by reviewing draft proposals and evaluating the potential impact on financing and reimbursement of service delivery.

Key Findings from the Sub-Workgroup

The key findings from the sub-workgroup are summarized below:

- Community hospitals struggle to operate inpatient psychiatric units due to several structural challenges, which includes (1) the challenges that a low and sporadic censuses creates for maintaining adequate staffing, (2) overall lack of psychiatrists and other key staff members, (3) the substantial capital requirements for making necessary physical plant changes to establish inpatient units, and (4) the impact of low reimbursement rates on the financial sustainability of operating these units.

- Current payment and financing structures (including Hospital Rate Adjustment (HRA) payments) are not flexible enough to incentivize admissions of individuals with complex needs.

- Coordinating benefits for Medicaid enrollees who require an inpatient stay but also have medical co-morbidities is particularly challenging under the current payment structure. PIHPs are generally responsible for providing coverage for inpatient psychiatric stays while Medicaid Health Plans are responsible for providing coverage for physical health-related admissions. The barriers around coordinating benefits for this population leads to worse health outcomes for individuals.

- Stigma and cultural barriers still exist and have a significant impact on the ability to secure inpatient placements for individuals with complex needs.

Recommendations from the Sub-Workgroup

Number	Recommendation
5.01	As MDHHS is updating the HRA payment methodology to bring it into compliance with the managed care rule, MDHHS should incorporate new metrics into the methodology that include more timely utilization of inpatient psychiatric services. MDHHS should also explore future opportunities to incorporate new metrics into the methodology that include outcomes related to quality and increased access to care. The metrics should be consistent on a statewide basis but also allow some flexibility in distribution by the PIHPs. MDHHS should continue to engage hospitals, PIHPs, and other stakeholders in the development of the new HRA payment methodology.

Number	Recommendation
5.02	MDHHS should encourage the PIHPs to develop and implement new payment methodologies (e.g. tiered rate) that (1) would promote and incentivize greater access to inpatient psychiatric services and improve outcomes for all populations and (2) address barriers to care for specific populations. The PIHPs should collectively explore consistent payment methodologies that address factors such as length of stay, intensity or acuity, and geographic factors. MDHHS should work with the PIHPs to ensure consistency in the base rate paid for inpatient psychiatric services.

Workgroup Discussion on the Psychiatric Bed Registry

Overview of the Statewide Discussion on the Registry

As part of the MIPAD initiative, MDHHS has also collaborated with stakeholders to explore the possibility of establishing a psychiatric bed registry in Michigan. A psychiatric bed registry is a web-based resource where providers and payers can search for available psychiatric beds in near-real time. Mid-State Health Network and Health Management Associates partnered together to publish a report that summarized considerations for developing a registry in Michigan. The MIPAD workgroup reviewed the report and expressed its support for proceeding with the design phase of the registry.

MDHHS worked with the Michigan Health and Hospital Association and other partners to host several meetings to discuss the design of the registry. The key findings from the design discussions are included below. A diagram that summarizes the proposed design features for the registry is included in Attachment I. The workgroup also made a final recommendation to the department to encourage the development of a psychiatric bed registry in Michigan.

Key Findings from the Design Group Discussions

The key findings from the design discussion are summarized below:

In order to achieve effective implementation of the registry, inpatient psychiatric facilities and their community partners will need to achieve some level of standardization of (1) key clinical processes such as pre-admission screening and medical clearance and (2) definitions for different levels of acuity.

The registry should be designed in a way that prioritizes finding placements for individuals who have been waiting the longest.

The registry should initially focus on collecting information on the availability of beds at acute care hospitals with inpatient psychiatric units, freestanding psychiatric hospitals, or partial hospitalization services. The registry could be expanded to include crisis residential settings or detoxification services.

Recommendation from the Workgroup

Number	Recommendation
6.01	MDHHS should work with providers and payers to establish a web-based resource to identify available inpatient psychiatric beds by gender, acuity, age, and diagnosis. This system should be similar to “bed boards” that have been implemented in other states. Inpatient psychiatric hospitals, including state facilities, should populate the registry with updated information about bed availability at a regular interval at “X” time after discharge. Users should include PIHPs, CMHSPs, MHPs, acute care hospitals, inpatient psychiatric hospitals, and employees/caregivers with other appropriate providers. The registry should be expanded in the future to include available beds at crisis residential, sub-acute detoxification, and other treatment settings. MDHHS and its external partners should also establish a shared governance and oversight committee that includes representatives of the different users of the registry.

Next Steps for the MIPAD Initiative

Analysis and Implementation of the Recommendations

The MIPAD Workgroup submitted its final recommendations to the department on October 31st, 2017. MDHHS conducted an analysis of the statutory, regulatory, and fiscal impact of implementing the recommendations. MDHHS also reviewed each recommendation and identified whether the recommendation should be implemented on a short-term, medium-term, and long-term timeframe. The definitions of short-term, medium-term, and long-term are included below. The results of the analysis are also included in Attachment J of this report.

- Short-Term: MDHHS will work with stakeholders to implement this recommendation by the end of 2018.
- Medium-Term: MDHHS will work with stakeholders to implement this recommendation by the end of 2019.
- Long-Term: MDHHS will work with stakeholders to implement this recommendation by the end of 2022.

Based upon this analysis, MDHHS has identified 19 of these recommendations for short-term action and will work with stakeholders to implement the short-term recommendations in 2018. MDHHS will continue to seek to engage stakeholders throughout the implementation process, which may take the form of convening specific workgroups or delegating the implementation of these recommendations to existing workgroups or forums.

Alignment with the House CARES Task Force

On July 12th, 2017, Representative Tom Leonard, Speaker of the Michigan House of Representatives, launched the House C.A.R.E.S. Task Force. The legislative task force held several meetings across the state in order to gather input from individuals and health care professionals on strategies to improve mental health services in Michigan. On January 17th, 2018, the task force published its final report with 42 recommendations for action on this issue. MDHHS is currently working with the House to explore opportunities for alignment and collaboration on statewide efforts to improve access to inpatient psychiatric services for Michigan residents.

Grant from the Michigan Health Endowment Fund

Due to the urgency of the crisis in access to inpatient psychiatric services, MDHHS searched for partners that could provide crucial assistance with accelerating the implementation of breakthrough solutions that emerged from the workgroup. As part of this effort, MDHHS submitted an application for the Special Projects & Emergency Ideas grant from the Michigan Health Endowment Fund in order to secure resources to support short-term action on the recommendations. In response to this application, the Michigan Health Endowment Fund awarded the grant to MDHHS, and MDHHS will use the funding from this grant to jumpstart the implementation of several short-term recommendations.

Appendixes

The following appendixes are included in this report to provide additional context and background information on the workgroup and the recommendations.

Appendix A: Workgroup Charter

Purpose of the Workgroup

MDHHS has convened the workgroup in an effort to develop short-term and long-term recommendations for improving access to inpatient psychiatric services. The workgroup will develop several recommendations for action for the Michigan legislature and MDHHS.

Workgroup Responsibilities

The workgroup will be responsible for the following tasks:

- Identify and discuss key issues that are related to inpatient psychiatric services;
- Launch several sub-workgroups to (1) examine specific issues and (2) develop draft proposals to address each issue; and
- Review the proposals from each of the sub-workgroups and make final recommendations to the Michigan legislature and MDHHS.

Workgroup Facilitator

Phil Kurdunowicz will serve as the facilitator for the workgroup.

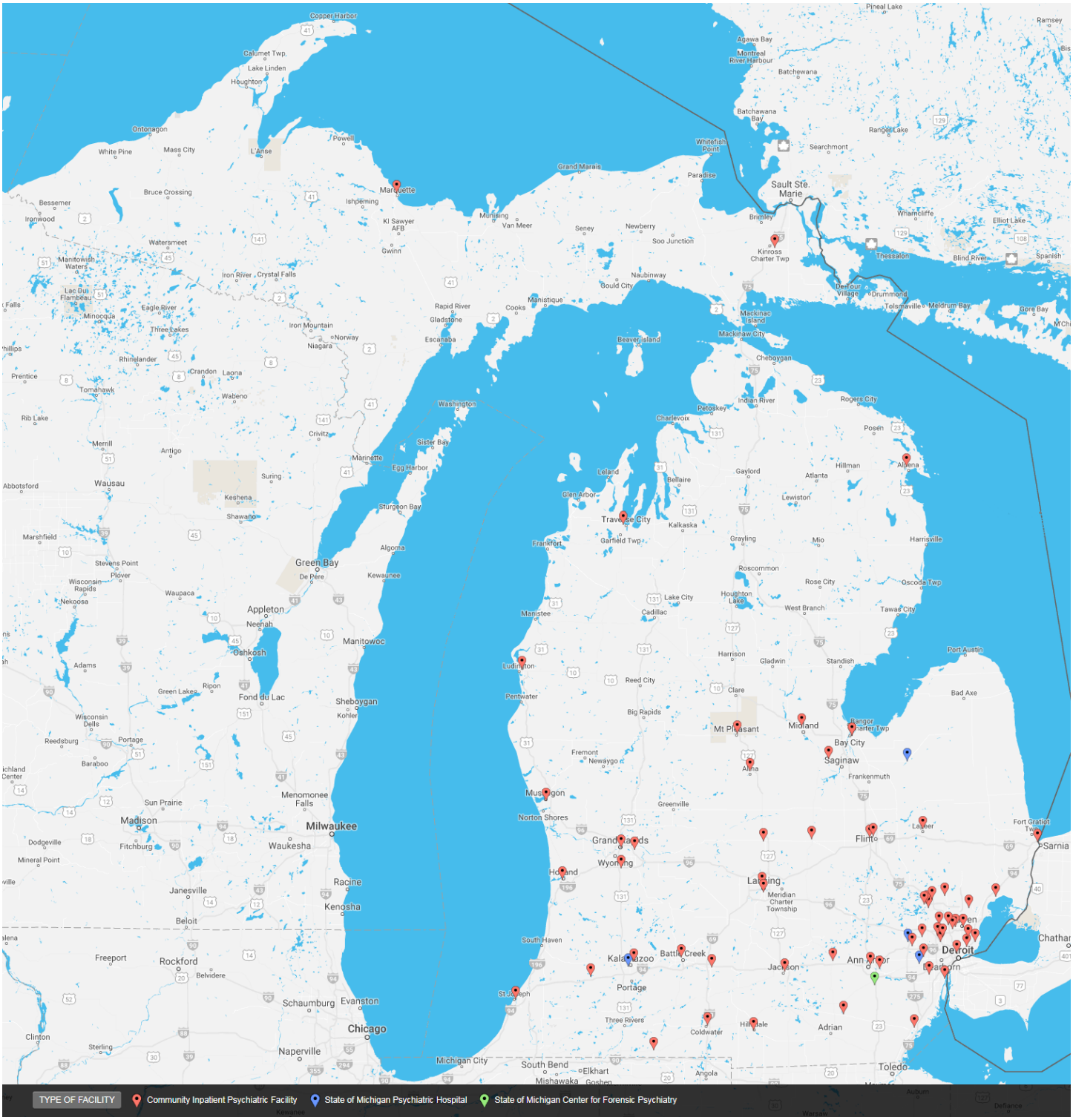
Workgroup Membership

Workgroup Members	
Amy Zaagman	Michigan Council for Maternal and Child Health
Andy Hotaling	Forest View
Belinda Chandler	Michigan College of Emergency Physicians
Beth Nagel	Michigan Department of Health and Human Services
Bill Slavin	NorthCare Network
Bob Sheehan	Community Mental Health Association of Michigan
Brie Elsasser	Michigan Department of Health and Human Services
Carolyn Watters	Mid-State Health Network
Cathy Meske	Northeast Michigan CMH Authority
Cindy Kelly	Michigan Department of Health and Human Services
Dave Schneider	Michigan Department of Health and Human Services
Dillon McGough	Michigan Health and Hospital Association
Dr. Angela Pinheiro	CMH for Central Michigan
Dr. Bill Sanders	Pine Rest Christian Mental Health Services
Dr. Carmen McIntyre	Wayne State University School of Medicine

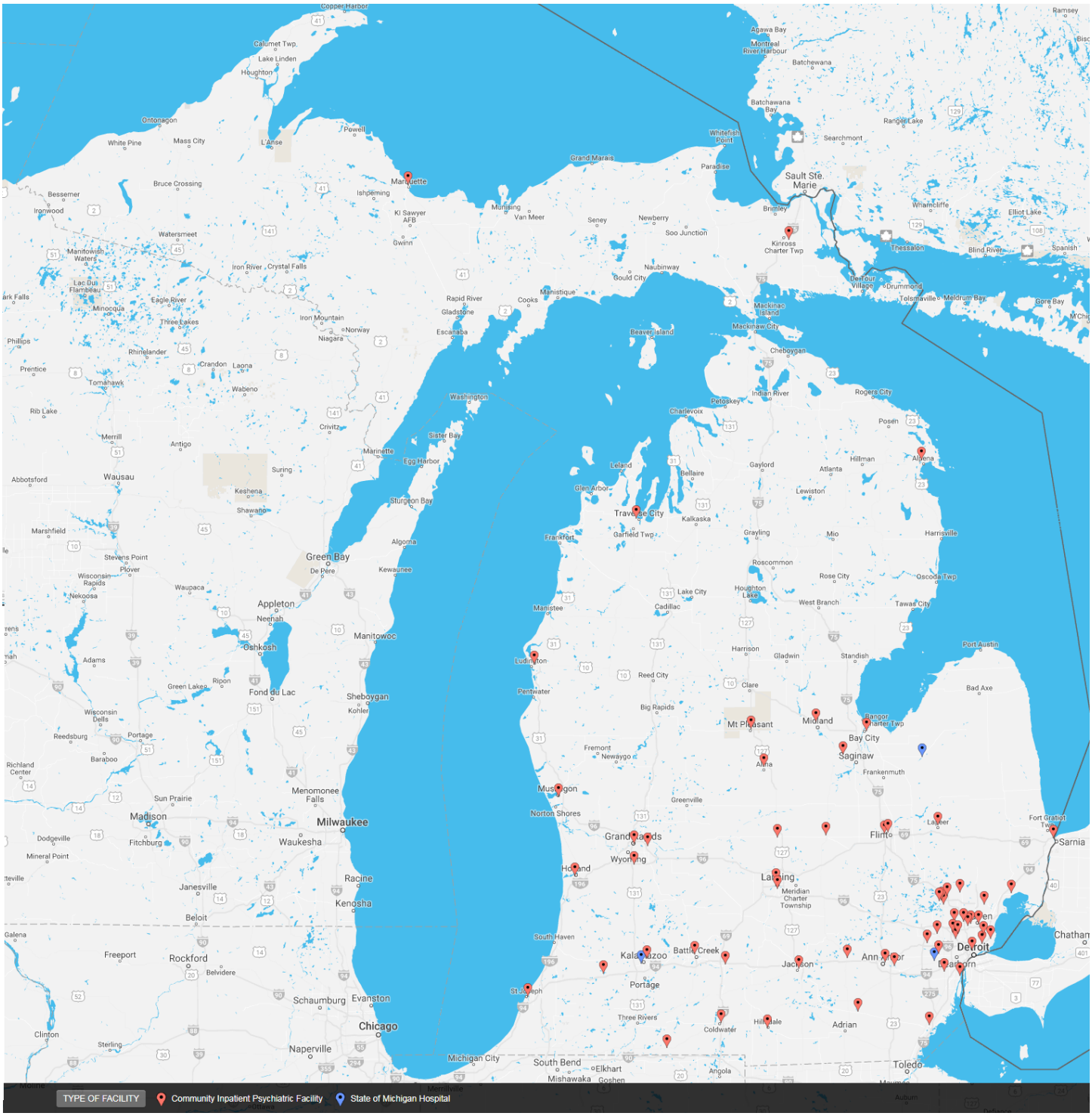
Workgroup Members	
Dr. Debra Pinals	Michigan Department of Health and Human Services
Dr. George Mellos	Hawthorn Center
Dr. Scott Monteith	Together Health Network / Michigan Psychiatric Society
Eric Kurtz	Northern Michigan Regional Entity
Erin Emerson	Michigan Department of Health and Human Services
Jackie Boyd	Michigan Department of Health and Human Services
Jane Shank	Association for Children's Mental Health
Jared Welehodsky	Michigan Department of Health and Human Services
Dr. Jeanette Scheid	Michigan Department of Health and Human Services
Joe Sedlock	Mid-State Health Network
John Kettley	Michigan Medicine
Jon Villasurda	Michigan Department of Health and Human Services
Kathy Wahl	Michigan Department of Health and Human Services
Kevin Fischer	National Alliance on Mental Illness/Behavioral Health Advisory Council
Kelly Domagala	Pine Rest Christian Mental Health Services
Kirstie Sieloff	Governor's Office
Kris Kraft	Blue Cross Blue Shield of Michigan
Kristen Jordan	Michigan Health and Hospital Association
Kristy Moore	Bay-Arenac Behavioral Health
Laura Appel	Michigan Health and Hospital Association
Paige Fults	Michigan Health and Hospital Association
Lisa Grost	Michigan Department of Health and Human Services
Lisa Williams	West Michigan Community Mental Health
Lynda Zeller	Michigan Department of Health and Human Services
Mary Berry-Bovia	Michigan Emergency Nurses Association
Mary Chaliman	Michigan Department of Health and Human Services
Matt Ellsworth	Michigan Department of Health and Human Services
Matt Lori	Michigan Department of Health and Human Services
Phil Kurdunowicz	Michigan Department of Health and Human Services
Rhonda Brink	Pine Rest Christian Mental Health Services
Sarah Hirsch	Southwest Michigan Behavioral Health
Sheri Falvay	Michigan Department of Health and Human Services
Stacie Bladen	Michigan Department of Health and Human Services
Stacey Hettiger	Michigan State Medical Society
Tiffany Stone	Michigan Association of Health Plans
Tom Renwick	Michigan Department of Health and Human Services

Appendix B: Maps of Inpatient Psychiatric Facilities in Michigan

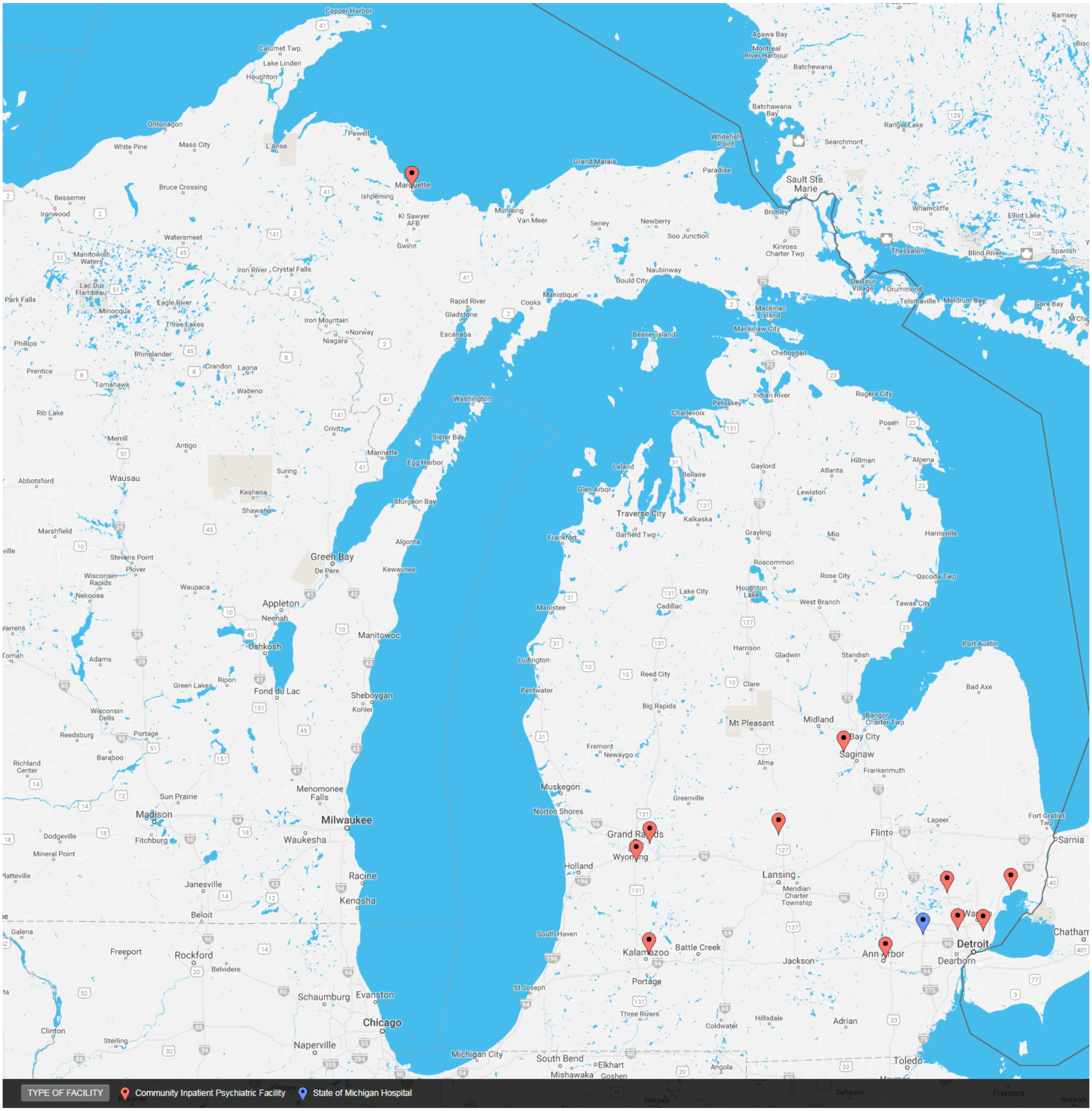
Map of All Community Inpatient Psychiatric Facilities and State of Michigan Hospitals



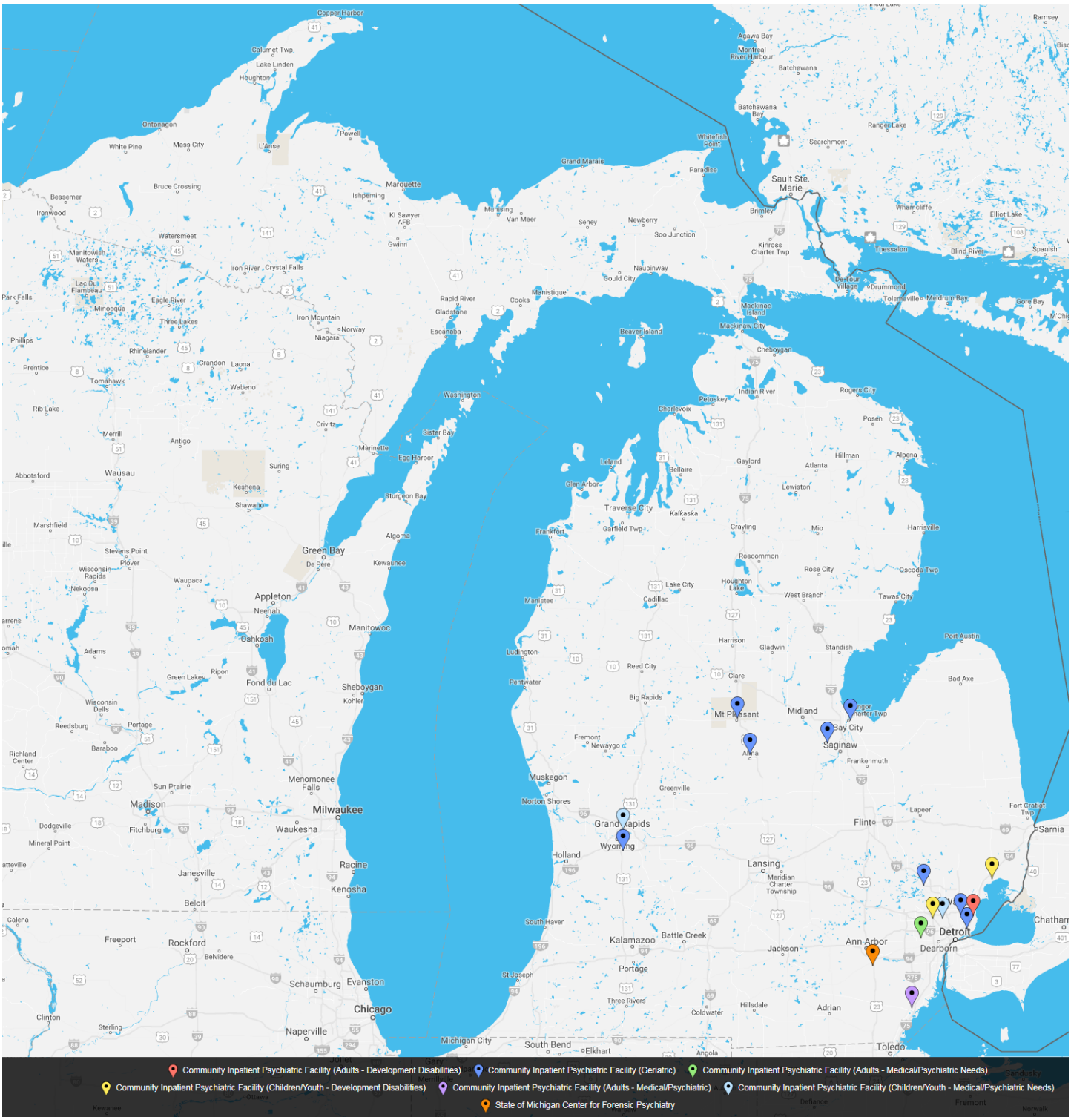
Map of Community Inpatient Psychiatric Facilities and State of Michigan Hospitals for Adults



Map of Community Inpatient Psychiatric Facilities and State of Michigan Hospitals for Children and Youth



Map of Community Inpatient Psychiatric Facilities and State of Michigan Hospitals with Specialty Beds



Appendix C: Steering Committee Charter

Purpose of the Steering Committee

The steering committee will assist MDHHS with planning for and facilitating workgroup and sub-workgroup discussions on access to inpatient psychiatric services.

Steering Committee Responsibilities

The steering committee will assist MDHHS with the following tasks:

- Review the identified topics for the workgroup;
- Develop charters for the workgroup and sub-workgroups;
- Facilitate workgroup and sub-workgroup discussions; and
- Support the formation of recommendations by the workgroup to address issues that are related to access to inpatient psychiatric services.

Steering Committee Facilitator

Phil Kurdunowicz (MDHHS) will serve as the facilitator for the steering committee.

Steering Committee Membership

Steering Committee Members	
Amy Zaagman	Michigan Council for Maternal and Child Health
Andrew Hotaling	Forest View
Beth Nagel	Michigan Department of Health and Human Services
Bob Sheehan	Community Mental Health Association of Michigan
Cathy Meske	Northeast Michigan CMH Authority
Cindy Kelly	Michigan Department of Health and Human Services
Dave Schneider	Michigan Department of Health and Human Services
Dr. Carmen McIntyre	Wayne State University School of Medicine
Dr. Debra Pinals	Michigan Department of Health and Human Services
Dr. George Mellos	Hawthorn Center
Dr. Scott Monteith	Together Health Network / Michigan Psychiatric Society
Eric Kurtz	Northern Michigan Regional Entity
Erin Emerson	Michigan Department of Health and Human Services
Jared Welehodsky	Michigan Department of Health and Human Services
Joe Sedlock	Mid-State Health Network

Steering Committee Members	
John Kettley	Michigan Medicine
Jon Villasurda	Michigan Department of Health and Human Services
Kelly Domagala	Pine Rest Christian Mental Health Services
Kristin Jordan	Michigan Department of Health and Human Services
Laura Appel	Michigan Health and Hospital Association
Lisa Grost	Michigan Department of Health and Human Services
Lynda Zeller	Michigan Department of Health and Human Services
Matt Lori	Michigan Department of Health and Human Services
Phil Kurdunowicz	Michigan Department of Health and Human Services
Rhonda Brink	Pine Rest Christian Mental Health Services
Tom Renwick	Michigan Department of Health and Human Services

Appendix D: Sub-Workgroup Charter (Physical Plant)

Purpose of the Sub-Workgroup

The Physical Plant Sub-Workgroup will focus on barriers to inpatient psychiatric services that are related to the physical plant of Michigan's state psychiatric hospitals and private psychiatric hospitals.

Sub-Workgroup Responsibilities

The sub-workgroup will be responsible for the following tasks:

- Examine specific issues (listed below) related to the physical plant of state psychiatric hospitals and community hospitals; and
    - Does the current physical capacity of Michigan's five state psychiatric hospitals adequately meet the needs of Michigan residents who (1) have behavioral health needs and (2) require either a short-term or long-term psychiatric stay?
    - What are the physical plant issues that inhibit community hospitals from creating or expanding inpatient psychiatric units?
- Draft change proposals that will address the aforementioned issues and submit the draft proposals to the main workgroup for consideration.

Sub-Workgroup Facilitators

The co-facilitators for the sub-workgroup will be Beth Nagel and John Kettley.

Sub-Workgroup Membership

Sub-Workgroup Members	
Allen Jansen	Pine Rest Christian Mental Health Services
Amanda Doane	Michigan Department of Health and Human Services
Annette Hartner	Children's Hospital of Michigan
Beth Nagel	Michigan Department of Health and Human Services
Cindy Kelly	Michigan Department of Health and Human Services
Dave Jahn	War Memorial
Joanie Blamer	Northern Lakes Community Mental Health
John Kettley	Michigan Medicine
Julie Yaroch DO	ProMedica
Kathy Young	Borgess Health
Mary Munson	Cass County Community Mental Health aka Woodlands
Sari Abromovich	Harbor Oaks Hospital

Sub-Workgroup Members	
Steve Savage	Acadia Health
Tim Roberts	Henry Ford Health System

Appendix E: Sub-Workgroup Charter (Staffing and Team-Based Care)

Purpose of the Sub-Workgroup

The Staffing and Team-Based Care Sub-Workgroup will focus on identifying challenges for hiring and retaining adequate, qualified, and appropriately trained staff to support the delivery of inpatient psychiatric services.

Sub-Workgroup Responsibilities

The sub-workgroup will be responsible for the following tasks:

- Examine specific issues (listed below) related to the hiring and retention of adequate, qualified, and appropriately trained staff; and
    - Do current reimbursement strategies support the delivery of inpatient psychiatric services to individuals with varying levels of acuity or medical/psychiatric needs?
    - Many individuals in psychiatric crisis present at hospital emergency departments and stay for extended periods of time while awaiting transition to more appropriate psychiatric settings. Do current reimbursement strategies support the delivery of emergent/first-level services to individuals who are temporarily being served in an emergency department and are awaiting transfer to a more appropriate setting?
    - What are the staffing-related challenges (i.e. number of staff, type of staff, training, and skills) that state psychiatric hospitals and community hospitals confront when attempting to deliver inpatient psychiatric services to individuals with medical and/or behavioral needs in a way that (1) is person-centered, youth-informed, and family-driven, (2) supports team-based service delivery, and (3) promotes a culture of safety for individuals and care providers?
- Draft change proposals that will address the aforementioned issues and submit the draft proposals to the main workgroup for consideration.

Sub-Workgroup Facilitators

The co-facilitators for the sub-workgroup will be George E. Mellos, MD and Kelly Domagala.

Sub-Workgroup Membership

Sub-Workgroup Members	
George E. Mellos, MD	Hawthorn Center
Jane Lozen	Henry Ford Health System
Karl Kovacs	Northern Lakes Community Mental Health
Kelly Domagala	Pine Rest Christian Mental Health Services

Sub-Workgroup Members	
Kim Batsche McKenzie	Michigan Department of Health and Human Services
Lynn Doyle	Ottawa County Community Health
Margay Britton	Michigan Medicine
Mindie Smith	Beacon Specialized Living Services
Rick Murdock	Michigan Association of Health Plans
Sara Lurie	CMHA-CEI
Sarah Hirsch	Southwest Michigan Behavioral Health
Sheila Marcus	University of Michigan
Stephanie Brady	Ascension Michigan

Appendix F: Sub-Workgroup Charter (Continuum of Care)

Purpose of the Sub-Workgroup

The Continuum of Care Sub-Workgroup will focus on exploring ways to expand the availability of treatment options across the continuum of care in order to allow individuals to receive services in the most appropriate setting for the individual's health and wellness needs. The sub-workgroup will also identify strategies for reducing potential barriers to treatment in specific residential settings.

Sub-Workgroup Responsibilities

The sub-workgroup will be responsible for the following tasks:

- Examine specific issues (listed below) related to the availability of treatment options across the continuum of care; and
    - What is the current availability of crisis stabilization and response services on a statewide basis?
    - What is the current availability of the following treatment options on a statewide basis? The sub-workgroup may also explore other treatment options for crisis stabilization and response that are currently being used in different areas of the state.
        - Mobile crisis teams
        - Crisis residential
        - Other residential settings that (1) can function as a lower-intensity setting than inpatient care and (2) can serve people for a length of stay that is greater than 14 days but is still short-term and transitional
        - Partial hospitalization
    - What are the legal, licensing, and other regulatory barriers that inhibit the use of the following treatment options?
        - Therapeutic foster care homes or other residential settings that (1) can function as a lower-intensity setting than inpatient care and (2) can serve people for a length of stay that is greater than 14 days but is still short-term and transitional
- Draft change proposals that will address the aforementioned issues and submit the draft proposals to the main workgroup for consideration.

Sub-Workgroup Facilitators

The co-facilitators for the sub-workgroup will be Lynda Zeller and Cathy Meske.

Sub-Workgroup Membership

Sub-Workgroup Members	
Angela Pinheiro M.D.	CMH for Central Michigan
Bernard "Ben" Biermann	Michigan Medicine
Beth Kowal	Helen DeVos Children's Hospital
Brenda VanWallaghen	Children's Hospital of Michigan
Brittany Pietsch	NorthCare Network
Bruce Nester	Henry Ford Health System
Carlynn Nichols	The Children's Center
Carol Moore	Sinai-Grace Hospital-Detroit Medical Center
Cathy Meske	Northeast Michigan Community Mental Health
Cheryl Bupp	Michigan Association of Health Plans
Debra Pinals M.D.	Michigan Department of Health and Human Services
Destiny Al Jallad	Turning Leaf Behavioral Health Services
Gwenda Summers	CMHA-CEI
Jane Shank	Association for Children's Mental Health
Jill Matson	Autism Alliance of Michigan
Jim Johnson	Region 10 PIHP
Jon Villasurda	Michigan Department of Health and Human Services
Ken Ratzlaff	Beacon Specialized Living Services
Kevin Fischer	NAMI Michigan
Kim Borja	Michigan Department of Health and Human Services
Kristy Moore	Bay Arenac Behavioral Health
Kristie R. Schmiege	Hegira Programs, Inc.
Lisa Grost	Michigan Department of Health and Human Services
Lisa Schirmer, Ph.D.	Pine Rest Christian Mental Health Services
Lynda Zeller	Michigan Department of Health and Human Services
Lyndsay Martin	Hope Network
Maria Thomas	Michigan Medicine
Mark Puckett	HealthSource Saginaw
Matt Schroeder	Michigan Medicine
Renee Gonzales	Michigan Department of Health and Human Services
Sheri Falvay	Michigan Department of Health and Human Services
Stacey Hettiger	Michigan State Medical Society
Dr. Kristyn Stewart	Blue Cross Blue Shield of Michigan
Tony Kim	Community Living Services Inc.
Travis Atkinson	TBD Solutions

Sub-Workgroup Members	
Victor Hong	University of Michigan
William Helbley	Riverwood Center (Berrien Mental Health Authority)
William Slavin	NorthCare Network

Appendix G: Sub-Workgroup Charter (Interoperability)

Purpose of the Sub-Workgroup

The Interoperability Sub-Workgroup will focus on examining whether variance in specific clinical and administrative processes across health care providers impedes information sharing and inhibits access to inpatient psychiatric services.

Sub-Workgroup Responsibilities

The sub-workgroup will be responsible for:

- Examine specific issues (listed below) related to the interoperability of clinical and administrative processes across providers; and
    - Does the variance in medical clearance processes and other criteria for admission across health care providers create barriers to securing inpatient services for individuals in psychiatric crisis?
        - Medical Packet for Admission
        - Other Criteria for Admission
    - Do state and federal privacy laws that govern the confidentiality of behavioral health information create barriers to sharing information during transitions of care?
- Draft change proposals that will address the aforementioned issues and submit the draft proposals to the main workgroup for consideration.

Sub-Workgroup Facilitators

The co-facilitators for the sub-workgroup will be Andy Hotaling and Carmen McIntyre, MD.

Sub-Workgroup Membership

Sub-Workgroup Members	
Andrew M. Bazakis	Covenant Health Care
Andy Hotaling	Forest View
Christine Gebhard	North Country Community Mental Health
Cindy VanKampen	North Ottawa Community Health System
Julia Rupp	HealthWest
Dana Lasenby	Detroit Wayne Mental Health Authority
Dr. Carmen McIntyre	Wayne State University School of Medicine
Dr. Scott Monteith	Together Health Network / Michigan Psychiatric Society

Sub-Workgroup Members	
Jeanette M Scheid MD, PhD	Michigan Department of Health and Human Services
Jennifer Peltzer-Jones PsyD, RN	Henry Ford Health System
Joseph P. Sedlock	Mid-State Health Network
Liz Kline	CMH for Central Michigan
Naomi Ishioka	Michigan Emergency Nurses Association
Nicole Figueroa	Michigan Medicine
Patricia Chambon	Children's Hospital of Michigan
Rhonda Brink	Pine Rest Christian Mental Health Services
Sandi Miller	EPMG

Appendix H: Sub-Workgroup Charter (Financing and Reimbursement)

Purpose of the Sub-Workgroup

The Financing and Reimbursement Sub-Workgroup will focus on identifying challenges that current financing and reimbursement methodologies create for delivering inpatient psychiatric services. The sub-workgroup will also support the work of other sub-workgroups by reviewing draft proposals and evaluating the potential impact on financing and reimbursement of service delivery.

Sub-Workgroup Responsibilities

The sub-workgroup will be responsible for the following tasks:

- Examine specific issues (listed below) related to the financing and reimbursement of inpatient psychiatric services; and
    - How do current special financing mechanisms for inpatient psychiatric services impact access to and delivery of inpatient psychiatric services?
    - What types of incentives and disincentives are created by current financing and reimbursement methodologies for providers of inpatient psychiatric services? How does these incentives and disincentives affect the delivery of services to individuals with complex needs or challenging behaviors?
    - How do current financing and reimbursement methodologies support the delivery of high-quality care to individuals with behavioral health needs?
- Draft change proposals that will address the aforementioned issues and submit the draft proposals to the main workgroup for consideration.
- Review change proposals from other sub-workgroups and evaluate the impact of the proposed change on financing and reimbursement of service delivery.

Sub-Workgroup Facilitators

The co-facilitators for the sub-workgroup will be Amy Zaagman, Eric Kurtz, and Kristen Jordan.

Sub-Workgroup Membership

Sub-Workgroup Members	
Amy Zaagman	Michigan Council for Maternal and Child Health
Andrew Schalk	Michigan Department of Health and Human Services
Anya Eliassen	Oakland Community Health Network
Barbara Kellam	Henry Ford Health System
Cass Wisniewski	Hurley Medical Center

Sub-Workgroup Members	
Chris Pinter	Bay-Arenac Behavioral Health Organization
Debbra S Fox	DMC/Sinai Grace Hospital
Eric Kurtz	Northern Michigan Regional Entity
Kristen Jordan	Michigan Department of Health and Human Services
Lisa Williams	West Michigan Community Mental Health
Lisa Hutchings	Children's Hospital of Michigan
Maria Kwiatkowski	Priority Health
Mary Martin	University of Michigan
Tom Elzinga	Pine Rest Christian Mental Health Services
Tiffany Stone	Michigan Association of Health Plans

Appendix I: Summary of the Registry Design Discussion

SUMMARY OF THE REGISTRY DESIGN DISCUSSION

MID-MICHIGAN REGION

MICHIGAN INPATIENT PSYCHIATRIC ADMISSIONS DISCUSSION (MIPAD)

USERS

- Hospital ED Staff
- Hospital Inpatient Staff
- CMHSP Staff
- PIHP Staff
- Psychiatric Hospital Staff
  - Private
  - State

NORMS

- The system should prioritize finding placements for individuals who have been waiting the longest.

FIELDS FOR PATIENT CHARACTERISTICS

- Gender
- Age
- Acuity (Medical, Diagnosis, Behaviors)
- Insurance Coverage
- Location

SERVICE TYPES

- Immediate Priority
  - Acute Med/Psych
  - Inpatient Psych
  - Partial Hospitalization
- Future Priority
  - Crisis Residential
  - Detox
- Should Not Be Included: ACT
- Included But Questionable: IOP

FUNCTIONALITY

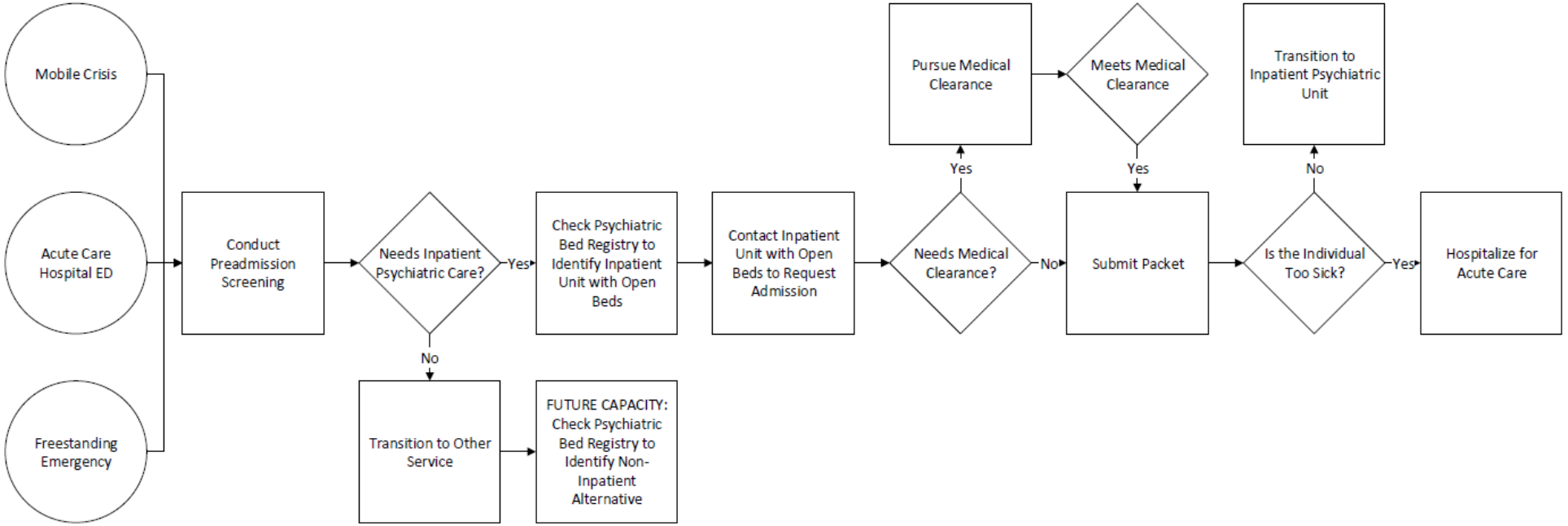
Requested Profile Functionality for the Destination Facility
- The destination facility should be able to report the availability of their beds by the following schema: available, near available, in process.
- The destination facility should be able to report beds that are "near available", which could be defined as "within the next 12 hours".

Requested Search Functionality
- Users should be able to search for beds by gender, age, service type, and location.
- Users should have the option to search for open beds versus search for all beds.
- When the results are displayed, users should be able to see facilities that do not have available beds but otherwise meet the required characteristics.
- When the results are displayed, available beds should be grouped according to specialization (e.g. pediatric, adult, geriatric, etc.).
- When the results are displayed, users should be able to see the time stamp for the last update for each inpatient unit.

Requested Notifications Functionality
- Users should be able to set up notifications that are uniquely tailored to the individual patient.
- The group expressed interest in being able to include "acuity" in the notification filter but noted that more work is needed to define acuity levels.
- Users should be able to create and manage multiple notifications, and the user should be able to uniquely identify each notification.
- Users should be able to toggle notifications on and off and also be able to manually set expiration dates for notifications.
- Users should have the option to receive notifications by email or text.

Requested Analytical Functionality
- Being able to analyze the frequency of updates across hospitals would be useful, but it does not have to be disaggregated by age or service type.
- Being able to analyze the search history and notification history by age and service type would be extremely useful.

Non-Essential Functionality – The registry is not required to have the following functionalities: (1) transmit protected health information, (2) upload, view, or download packets, or (3) upload, view, or download hospital-specific forms, admission criteria, or medical clearance.



Appendix J: Analysis of the Workgroup Recommendations

The MIPAD Workgroup submitted its final recommendations to the department on October 31st, 2017. MDHHS conducted an analysis of the statutory, regulatory, and fiscal impact of implementing the recommendations. MDHHS also reviewed each recommendation and identified whether the recommendation should be implemented on a short-term, medium-term, and long-term timeframe. The definitions of short-term, medium-term, and long-term are included below. The results of the analysis are included in the table below.

- Short-Term: MDHHS will work with stakeholders to implement this recommendation by the end of 2018.
- Medium-Term: MDHHS will work with stakeholders to implement this recommendation by the end of 2019.
- Long-Term: MDHHS will work with stakeholders to implement this recommendation by the end of 2022.

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
1.01	In order to care for individuals with more complex health needs, community hospitals should (1) implement security measures to keep individuals and staff safe and (2) redesign old/outdated infrastructure throughout the facility. This recommendation includes both security for personnel (including recovery coaches and certified peers) and adequate technology to implement safety features. The re-design of psychiatric units and emergency departments should follow best practices such as (1) trauma-informed design and (2) designs with increased flexibility (e.g. rooms that can convert between single and double beds to allow for gender separation, nurse stations that can be expanded when additional rooms are needed and still allow for auditory and visual monitoring, etc.).	Community Hospital Systems	No	Yes	Yes, Will Require Additional Funding	Medium-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
1.02	The Michigan Certificate of Need Commission should review and potentially revise the Certificate of Need standards for Psychiatric Beds/Services to ensure that the methodology accurately captures the true level of need for psychiatric services and can make accurate need predictions based on population estimates.	MDHHS and Certificate of Need Commission	No	Yes	No, Will Not Require Additional Funding	Short-Term
1.03	Community hospitals should develop the capability for patients to receive assessment and begin treatment while awaiting inpatient placement whether that is in a state facility or community hospital. This could include leveraging telehealth capabilities along with telehealth payment structures.	Community Hospital Systems	No	Yes	Yes, Will Require Additional Funding	Short-Term
1.04	The Michigan legislature should require all community short-term acute care hospitals with children's inpatient specialties to implement and maintain child/adolescent psychiatric programs to ensure that care for children can be provided throughout the state. This requirement should be complimented by grant funding or other incentives to establish and continue providing this service.	MDHHS and Legislature	Yes	Yes	Yes, Will Require Additional Funding	Short-Term (Linked to 2.07)
1.05	The State of Michigan should build a 50-bed psychiatric inpatient hospital in the northern-most area of Michigan's Lower Peninsula. While the new facility is being planned and constructed, the state should partner with a community hospital to provide state psychiatric care in this currently unserved community.	MDHHS and Legislature	No	No	Yes, Will Require Additional Funding	Long-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
2.01	The state hospital system and community hospital systems should improve the hiring and retention of qualified and competent staff by implementing the following strategies: • Developing evidence-based onboarding and ongoing training for staff hired to specialty units • Compensating staff with specialty training appropriately and competitively • Developing retention strategies such as a levels-associated compensation structure with merit and senior criteria. Other retention and compensation strategies may include (but are not limited to) loan forgiveness • Developing position descriptions that support a self-directed, bottom-up work team	State Hospital System and Community Hospital Systems	No	Yes	Yes, Will Require Additional Funding	Medium-Term
2.02	The state legislature should work with professional associations and third-party payers to re-examine the reimbursement for services by limited license professionals.	MDHHS, Legislature, Professional Associations, and Third-Party Payers	Yes	Yes	Yes, Will Require Additional Funding	Short-Term
2.03	MDHHS should work with clinical and business leaders at public, private, and university hospitals to form an ongoing consortium which espouses the ideas herein, improves them, monitors progress, and reports to appropriate entities in order to encourage and support the development and maintenance of specialty units.	MDHHS and Hospital Partners	No	No	Yes, Will Require Additional Funding	Medium-Term (Linked with 2.05 and 3.16)

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
2.04	The state hospital system and community hospital systems should increase the adoption of effective and evidence-based practices for delivering team-based care by implementing the following strategies: • Incorporating the delivery of specialized behavioral health treatment, care, and services into hospital mission statements • Developing a bottom-up and self-directed "proof of concept" manualized model based upon the gap analysis for specialized behavioral health care units, and considering evidence from healthcare literature • Establishing guidelines that unit models are multi-disciplinary, trauma-informed, person-centered, family-driven (youth-guided) dedicated to use of evidence-based/supported methods and reflect integrated pro-active safety systems with patient activation • Developing transition support services in order to guide the community in developing sophisticated continuum of care aftercare plans that make re-admission less likely • Ensuring that "frontline" staff ratios reflect severity of illness and intensity of service • Developing substantial and evidence based onboarding and ongoing training for staff hired to specialty units • For specialty units, actively engage a performance improvement model in the context of integrated safety systems	State Hospital System and Community Hospital Systems	No	Yes	Yes, Will Require Additional Funding	Medium-Term
2.05	Community hospital systems should conduct a "gap" analysis in regard to providing specialized behavioral health care units.	Community Hospital Systems	No	Yes	Yes, Will Require Additional Funding	Medium-Term (Linked with 2.03 and 3.16)
2.06	The state hospital system and community hospital systems should affiliate with university systems to share model planning, progress, and outcomes.	State Hospital System and Community Hospital Systems	No	No	May Require Additional Funding	Medium-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
2.07	MDHHS and other payers should incentivize the development of specialized behavioral health care units.	Prepaid Inpatient Health Plans	No	No	Yes, Will Require Additional Funding	Short-Term (Linked to 1.04)
3.01	MDHHS should work with PIHPs to increase the availability of short-term community intensive treatment programs throughout the state.	MDHHS	No	Yes	Yes, Will Require Additional Funding	Medium-Term
3.02	The corrections and juvenile justice systems should complete validated mental health screenings and referrals for further assessment/treatment for (1) children prior to entering the juvenile justice system and (2) adults with behavioral health concerns including substance use disorders entering county jails.	MDHHS, Michigan Department of Corrections, and Legislature	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Medium-Term
3.03	The State of Michigan should require a state-mandated standardized training for the direct care workforce which includes all disciplines (potential licensure or accreditation).	MDHHS and Legislature	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Will Not Be Implemented[8]
3.04	The State of Michigan should establish standards for the provision of psychiatric support in all emergency departments (admission, treatment, discharge), which should include (1) using telepsychiatry, (2) assist in managing medications, (3) developing an Emergency Medical Treatment and Labor Act (EMTALA) compliance team to review emergency department cases and perform site visits, and (4) embedding CMHSP providers in emergency departments with Medicaid reimbursement for services provided.	MDHHS and Legislature	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Medium-Term (Linked to 3.14)

[8] MDHHS has developed a managed care system for publicly-funded specialty behavioral health services. As part of this system, MDHHS has delegated the responsibility for ensuring that publicly-funded direct care providers have appropriate training to the PIHPs.

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
3.05	The State of Michigan should expand crisis intervention teams and require law enforcement staff to be trained in Mental Health First Aid or equivalent.	MDHHS, Michigan State Police, and Legislature	Yes	Yes	Yes, Will Require Additional Funding	Medium-Term
3.06	MDHHS should amend PIHP contracts to ensure standardized practices are prescribed for screening and communication.	MDHHS	No	Yes	No, Will Not Require Additional Funding	Short-Term
3.07	The State of Michigan should establish accountability standards for care coordination between criminal justice and behavioral health systems to ensure the continuity of care (which includes developing medication formulary that allows for medications to follow the individual) from community to jail.	MDHHS, Michigan Department of Corrections, and Legislature	Not Required But May Be Beneficial	Yes	No, Will Not Require Additional Funding	Long-Term
3.08	The legislature should increase funding and capacity for Therapeutic Treatment Foster Care (TFC), which includes addressing funding and licensing issues.	MDHHS, Children's Service Agency, and Legislature	Yes	Yes	Yes, Will Require Additional Funding	Short-Term
3.09	MDHHS should increase the use of creative solutions for addressing the psychiatrist shortage to include loan repayment.	MDHHS and Legislature	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Short-Term
3.10	MDHHS should require PIHPs to have crisis stabilization services that are available 24/7 and commensurate with community need.	MDHHS	No	Yes	Yes, Will Require Additional Funding	Short-Term
3.11	MDHHS and its community partners develop a standardized set of definitions for inpatient psychiatric denials and admissions.	MDHHS	No	Yes	No, Will Not Require Additional Funding	Short-Term
3.12	MDHHS should develop state capacity for clinical coordinators for high acuity patients to access intensive wraparound services after discharge or upon need.	MDHHS	No	Yes	Yes, Will Require Additional Funding	Medium-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
3.13	MDHHS should ensure seamless transitions of care from all settings by allowing Medicaid payment to follow the recipient regardless of where the individual is served in the community.	MDHHS and Legislature	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Medium-Term
3.14	MDHHS should expand the use of telemedicine through the Medicaid Provider Manual.	MDHHS and Legislature	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Short-Term (Linked to 3.04)
3.15	MDHHS and its external partners should engage medical students in psychiatric rotations at a diverse set of locations.	MDHHS	No	No	No, Will Not Require Additional Funding	Medium-Term
3.16	MDHHS and its external partners should complete a crisis adequacy assessment for the entire continuum including call centers, mobile crisis, crisis stabilization, Crisis Response Units, inpatient psychiatric units, and law enforcement. MDHHS should also establish a forum or center for sharing best practices, identifying centers of excellence, providing trainings, and establishing performance indicators and guidelines.	MDHHS	No	No	Yes, Will Require Additional Funding	Medium-Term (Linked to 2.03 and 2.05)
4.01 (A)	MDHHS should work with its external partners to encourage broader and more consistent use of technology that supports health information sharing through the following strategies: • Achieve statewide adoption of Admit, Discharge, and Transfer (ADT) notifications for inpatient psychiatric stays, improve the data quality and usability for ADT messages, and explore policy, regulatory, and contractual changes to support the attainment of these goals. This recommendation includes all inpatient, emergency care, and crisis residential settings. • Promote the sharing the medication information through the statewide health information exchange infrastructure.	MDHHS and Health Information Exchange Partners	No	Yes	Yes, Will Require Additional Funding	Long-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
4.01 (B)	MDHHS should work with its external partners to encourage broader and more consistent use of technology that supports health information sharing through the following strategy: • Pursue adoption of statewide encrypted email to support inter-organizational communication. MDHHS should identify user groups as broadly as possible to include all individuals who may be involved in the individual's care team.	MDHHS and Health Information Exchange Partners	No	Yes	Yes, Will Require Additional Funding	Long-Term
4.02	MDHHS should implement the following strategies to educate providers and payers about confidentiality laws and regulations that affect the sharing of behavioral health information: • Conduct education and outreach efforts to inform the provider community on the importance of inter-organizational communication and the qualitative impacts of such communication. • Provide education to the payer and provider community regarding Public Act 559 and its impact on communication and coordination of care for the delivery of mental health services • Encourage the adoption of the Behavioral Health Consent Form as a mechanism to assist with information sharing • Engage statewide associations to assist with education of providers and payers	MDHHS	No	Yes	No, Will Not Require Additional Funding	Short-Term
4.03	MDHHS should integrate requirements for health information sharing and care coordination into departmental policies, programs, and contracts. This strategy should include contracts with MHPs, PIHPs, and other contractors, providers, or service agencies (e.g. public and private foster care provider agencies).	MDHHS	No	Yes	Yes, Will Require Additional Funding	Short-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
4.04	MDHHS should create a workgroup to develop and pilot a single statewide medical clearance algorithm. • This workgroup should review the work that has already been done across the state in implementing medical clearance criteria and any data as to its efficacy and other outcomes. Examples include the medical clearance pilots in (1) Kent County and (2) Macomb/Oakland/Wayne Counties. • This workgroup should also address the different needs of specific populations, such as (1) early childhood, (2) older children, (3) adolescents, (4) geriatric patients, (5) individuals with developmental disabilities, and (6) children in foster care.	MDHHS	No	Yes	Yes, Will Require Additional Funding	Short-Term
4.05	MDHHS should create a workgroup to develop a standard referral packet for hospital admissions, which would be used when requesting an inpatient bed. A standard referral packet would reduce the paperwork that was being exchanged during hospital admissions and improve transitions of care for the individual.	MDHHS	No	Yes	Yes, Will Require Additional Funding	Short-Term
4.06	MDHHS should create a workgroup to support the ongoing development of standards for hospital admissions. The workgroup should: • Develop standard criteria for admission to inpatient behavioral health units • Differentiate between community hospital unit and state hospital unit capabilities • Outline expectations for psychiatric acuity and general medical acuity for different behavioral health crisis settings (e.g. IMDs, those within a general medical/surgical hospital, etc.)	MDHHS	No	Yes	Yes, Will Require Additional Funding	Short-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
4.07	MDHHS should collaborate with its external partners to develop a universal voluntary admission form and process for use to all inpatient behavioral health settings. This form should be similar to the use of standardized involuntary forms such as the petition and certification forms.	MDHHS	No	Yes	Yes, Will Require Additional Funding	Medium-Term
4.08 (A)	MDHHS should work other state agencies and external partners to investigate and address cross-county barriers to involuntary hospitalization through the following strategies: • Collaborate with the State Court Administrative Office (SCAO) to issue clarifying guidance around the following question: Does the location of the setting where a person is evaluated for a petition and certification and the location of the related inpatient hospital unit have an impact on which court hears the case?	MDHHS and Attorney General's Office	Not Required But May Be Beneficial	Yes	No, Will Not Require Additional Funding	Medium-Term
4.08 (B)	MDHHS should work other state agencies and external partners to investigate and address cross-county barriers to involuntary hospitalization through the following strategies: • Collaborate with stakeholders to address payment issues when the county of the hospitalization is different from the individual's assigned PIHP and CMHSP.	MDHHS and Attorney General's Office	Not Required But May Be Beneficial	Yes	No, Will Not Require Additional Funding	Short-Term
4.09	MDHHS should work with its external partners to address barriers in identifying and engaging individuals who are responsible for consenting for inpatient treatment for children with specific needs (i.e. unaccompanied unadjudicated minors, unaccompanied refugee minors, children in foster care). This recommendations includes addressing issues of timeliness with emergency guardianship or child protective services.	MDHHS and Children's Service Agency	No	No	No, Will Not Require Additional Funding	Medium-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
5.01	As MDHHS is updating the HRA payment methodology to bring it into compliance with the managed care rule, MDHHS should incorporate new metrics into the methodology that include more timely utilization of inpatient psychiatric services. MDHHS should also explore future opportunities to incorporate new metrics into the methodology that include outcomes related to quality and increased access to care. The metrics should be consistent on a statewide basis but also allow some flexibility in distribution by the PIHPs. MDHHS should continue to engage hospitals, PIHPs, and other stakeholders in the development of the new HRA payment methodology.	MDHHS	No	No	No, Will Not Require Additional Funding	Medium-Term
5.02	MDHHS should encourage the PIHPs to develop and implement new payment methodologies (e.g. tiered rate) that (1) would promote and incentivize greater access to inpatient psychiatric services and improve outcomes for all populations and (2) address barriers to care for specific populations. The PIHPs should collectively explore consistent payment methodologies that address factors such as length of stay, intensity or acuity, and geographic factors. MDHHS should work with the PIHPs to ensure consistency in the base rate paid for inpatient psychiatric services.	MDHHS	No	Yes	May Require Additional Funding	Short-Term

Number	Recommendation	Responsible Entity	Statutory Change	Regulatory Change	Fiscal Impact	Priority
6.01	MDHHS should work with providers and payers to establish a web-based resource to identify available inpatient psychiatric beds by gender, acuity, age, and diagnosis. This system should be similar to "bed boards" that have been implemented in other states. Inpatient psychiatric hospitals, including state facilities, should populate the registry with updated information about bed availability at a regular interval at "X" time after discharge. Users should include PIHPs, CMHSPs, MHPs, acute care hospitals, inpatient psychiatric hospitals, and employees/caregivers with other appropriate providers. The registry should be expanded in the future to include available beds at crisis residential, sub-acute detoxification, and other treatment settings. MDHHS and its external partners should also establish a shared governance and oversight committee that includes representatives of the different users of the registry.	MDHHS, External Partners, and Technology Vendor	Not Required But May Be Beneficial	Yes	Yes, Will Require Additional Funding	Short-Term (Development) and Medium-Term (Implementation)