tbdSolutions

CSHCS/CMHSP Pilot: Improving Care for Children with Medicaid Coverage

Kent County, Michigan

September 2022

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MICHIGAN HEALTH ENDOWMENT FUND

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Executive Summary

TBD Solutions engaged a pilot effort in Kent County, Michigan, a Collaboration Project between Kent County Community Mental Health Authority (doing business as "Network 180"), and the Kent County Health Department (KCHD). Sponsored by the Michigan Health Endowment Fund, the context of the effort was a need for improved care and coordination for children (aged 0-21) and families who may qualify for Medicaid-funded services through Community Mental Health Service Programs (CMHSPs) and state's Children's Special Healthcare Services. Through the pilot's assessment and evaluation phases, the following opportunities for improvement were tested or identified as a future-state change:

- **Improvements through Collaborative, Team-based Approach.** By working together, KCHD and Network 180 became better-educated in the services and values of each system, which resulted in improvements in care coordination and identification of care gaps, which aided children and families in navigating these systems. Expand existing local process documentation to include key information about the services and eligibility criteria of CSHCS services at Network180, and CMHSP eligibility criteria at KCHD.
- **Impacts of Information Sharing and Notifications**. Data is currently siloed between the two entities. Shared information between CSHCS and CMHSP can lead to substantial service improvements and better experiences for parents. Nurses and clinicians working together across programs reduces the negative experiences of families bouncing between systems of care.
- **Clarifications in Funding Impacts**. Medicaid funding complexity creates challenges in siloed service systems. Understanding the types and definitions of funding in CSHCS and CMHSP programs assures that potentially eligible children are not denied access to either system.
- **Gaps in Respite Care**. For those eligible for services in both systems, a gap exists in respite care for children whose needs do not meet the intensity criteria of private duty nursing but are beyond the expectations of respite providers untrained in activities such as suctioning or feeding tubes.
- **Improved coordination for age transitions**. Children served in CMHSP care systems typically transition to adult services at age 18, whereas children served by CSHCS continue to qualify up to age 21 or longer for certain diagnosis.
- **Statewide Electronic Referrals for Children's Services**. Coordination of referrals, generally from CSHCS to CMHSPs, but occasionally in reverse, requires manual processes. Creation of bidirectional electronic referral mechanisms between local health departments and CMHSPs could make it easier for nurses and clinicians to make and track referrals.
- **Statewide Children's Service Resources**. Create cross-system learning for professionals across the continuum of children's services, including CSHCS, foster care, Children's

Protective Services, child welfare systems, and CMHSPs with online resources and statewide conferences.

Introduction

Children's Special Healthcare Services (CSHCS) is an assistance program through the Michigan Department of Health and Human Services (MDHHS) that offers referrals and coverage for children under 21[1] years old who have special healthcare needs. CSHCS allows Michigan families the opportunity to receive financial assistance for children with chronic conditions holding one or more of approximately 2,700 qualifying diagnoses[2] to improve outcomes and support quality of life. Eligibility may be established in one of several ways and is generally administrated by local county health departments (LHDs).

Many CSHCS-eligible children may also qualify for publicly funded behavioral health services through one of the 46 county-based Community Mental Health Service Programs (CMHSP) in Michigan. To receive CMHSP services, children with a qualifying intellectual/developmental disability, and/or a diagnosis of a severe emotional disturbance, may also receive services that can be complementary to those offered by CSHCS. There can be challenges in coordination between systems that presume primary services are provided exclusively through either CSCHCS or through a CMHSP.

The Michigan Health Endowment Fund (hereafter, "The Health Fund") sponsored a pilot Collaboration project in Kent County, Michigan, between the Kent County Health Department, the local LHD, and the county's CMHSP, Kent County Community Mental Health Authority, doing business as (d/b/a) "Network 180". The pilot effort utilized a four-step process to examine and pilot improvements to care coordination for children (aged 0-21) and families that may qualify for Medicaid-funded services through CSHCS and/or CMHSP.

Note: The CSHCS/CMHSP pilot period began in October 2020 and continued through June 2022 – at times during the height of the COVID-19 pandemic. Both Kent County Health Department and Network 180 staff had substantial impacts to their normative operations during this time.

[1] Children with cystic fibrosis, hemophilia, or sickle cell disease deemed eligible can receive services over the age of 21.

[2] Michigan CSHCS Qualifying Diagnosis Codes as of October 1st, 2021, found here: http://www.michigan.gov/documents/CSHCS-Diagnosis_Codes-11-2003_78380_7.PDF

Pilot Approach

TBD Solutions was selected as the project facilitator and researcher to work with representatives of Network 180, KCHD, and The Health Fund. TBD Solutions utilized a four-step rubric for project engagement.

Figure 1: *CSHCS/CMHSP Pilot Approach*

1. **Prepare**: Readying for engagement of the effort, a.k.a., "setting the table". This included establishment of the project team, communication plan, involvement of children and families served, creating a glossary of terms and definitions, and designing a project plan.
2. **Assess:** Examination of the status quo to inform considerations for the pilot.
3. **Evaluate**: Identification of gaps and key items for implementation during the pilot period.
4. **Design Action Steps**: Organizing steps for pilot engagement where possible, and finalizing recommendations based on pilot efforts and those that require broader engagement.

Prepare

Leading the CSHCS/CMHSP Pilot project were key members of the representative organizations:

- **Kent County Health Department**
  - Christine (Chris) Buczek, BSN, RN - Program Supervisor of CSHCS (through retirement in May 2021).
  - Brandi Berry-Lovelady, LLMSW – Program Supervisor of CSHCS (beginning in July 2021)
  - Lisa Kuiper, BSN, RN – CSHCS Public Health Nurse
  - Becky Doucette, BSN, RN – CSHCS Public Health Nurse (until February 2022 transfer to another KCHD department)
- **Kent County Community Mental Health Authority (d/b/a "Network 180")**
  - Kristin Spykerman, LMSW, CAADC - Chief Clinical Officer
  - Frank Florido, MSW – Children's System of Care Manager

- **The Health Fund**
  - Becky Cienki, MPH – Director, Behavioral Health
- **Michigan Department of Health and Human Services**
  - Jennifer Baumann, MA – State CSHCS Policy Specialist (invited)

A communication plan was established to outline how information regarding the pilot project would be shared, how decisions would be made, and the expectations for participation of workgroup members to remain solutions-oriented while always presuming positive intent.

The group approved the approach to **assess** the current systems through a combination of process mapping and interviews with family members and other stakeholders to understand opportunities for improvement. From this an **evaluation** of the findings lent itself to a variety of **action steps** to utilize in the pilot.

Assess

Document Review

As with many public benefit systems, there is extensive information available through entry/access points for assessment, service navigators and coordinators, and publicly available websites. The documents reviewed for the CSHCS/CMHSP Pilot Project primarily provide contextual and/or reference information, and support for individuals served, and examination was focused on guidance to aid coordination between those receiving service funding through CSHCS eligibility and those eligible for and receiving services through CMHSP. Examples of each are outlined below, and the list of documents reviewed is found in Appendix A.

Contextual Information	Reference Information	Support for Individuals Served
•Example: A document that describes the differences between pathways to- and types of Medicaid	•Example: A spreadsheet or list with names and contact information of other organization's staff	•Example: A document that prepares an individual served for an intake assessment

The amount of available information is extensive. Family members could not reasonably be expected to navigate eligibility in either system without the aid of LHD or CMHSP professionals to guide them. This compels the need for professionals in both systems to have at least tacit understanding of the services in the other, and to work together when coordinating care for those that could be or are eligible for services in both systems.

Several MDHHS presentations were included in the documentation review that provided information about the importance of collaboration between CMHSPs and CSHCS across

Michigan. At the state level, there is awareness of the need for collaboration between the two systems.

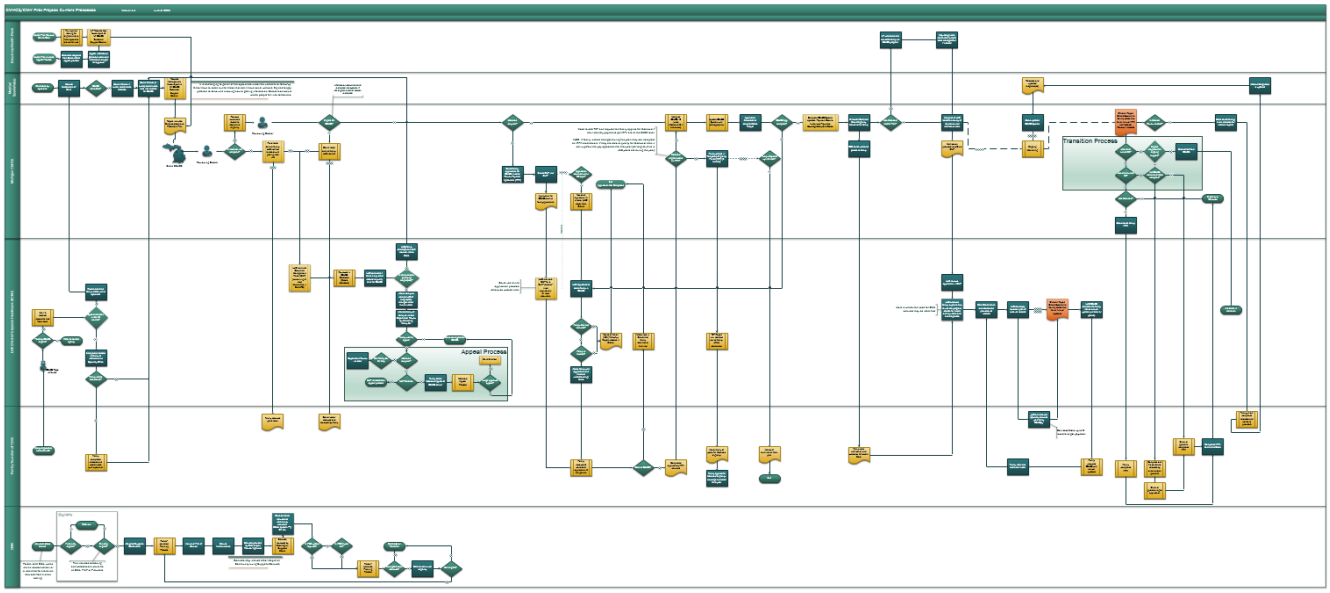
However, there were limited examples of collaborative documentation, service mapping, or structured referral relationships between KCHD and Network180. Documents existed in isolation to meet needs or improve communication between organizations. Where KCHD took much of its materials from state resources, the local CMHSP had documents designed and developed based on its local processes.

In both cases, there was minimal current documentation about CSHCS services and key contacts at Network 180, and the opposite was also true. Most materials available to staff described processes germane to the programs that they managed. Despite the intent of documents to improve communications between organizations, there were few instances where the actual communication channels between organizations were defined or formally agreed upon.

Process Mapping Status Quo

To consider potential changes, it was vital to first understand how people move through systems today. The pilot project workgroup articulated the current system design from a funding perspective in the consideration of improvements. Figure 2 provides a high-level perspective of the complexities of the current systems.[3]

Figure 2. ***CMHCS/CMH Pilot Project: Current Processes***



Key differences in the factors between CSHCS and CMHSP eligibility criteria:

[3] A readable version of this diagram is available upon request as a PDF from TBD Solutions.

- A child's diagnosis for CSHCS eligibility is decentralized and may come from a variety of sources, whereas CMHSP clinical eligibility determination is primarily centralized. Children are frequently identified as potentially eligible for CCHCS via:
    - Healthcare providers and social workers aware of CSHCS
    - Michigan Health Plan review of claims data for CSHCS eligibility
    - Families working with their LHD to seek CSHCS
- While a child's diagnosis for CSHCS eligibility is decentralized, MDHHS CSHCS doctors are responsible for final eligibility determination.
- Age transitions are not aligned. Children eligible for CSHCS services transition at age 21 to other funding, whereas CMHSPs define the transition age as 18 years old. Transition discussions for CSHCS begin around 13 to 14 years of age, while those for children in the CMHSP system begin at ages 16-17.

Network180 Medicaid funding is through a contract with its local regional entity, Lakeshore Regional Entity – a Prepaid Inpatient Health Plan (PIHP) located in Muskegon. Like many regional entities, managed care responsibilities such as eligibility determination are delegated to its CMHSP participants.

The KCHD is one of several entry points for CSHCS eligibility, and while they do provide guidance to Kent County parents, they do not determine program eligibility.

Interview Summary

From October 2020 through February 2021, TBD Solutions confidentially interviewed professionals, administrators, family members, and an individual served.

Figure 3: Interviewee Type
n=22

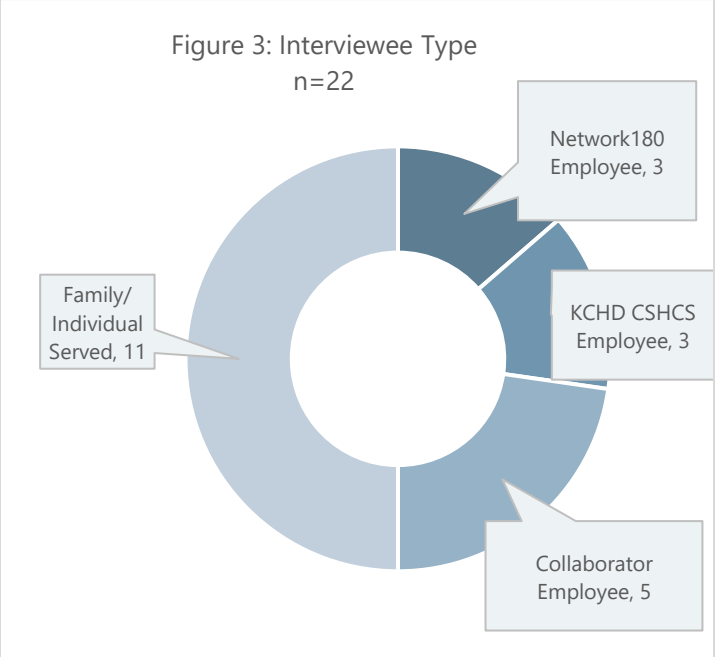


Figure 3 shows a breakdown of interviewees by type. Interviewees included families and individuals served, and clinical professionals and/or administrators working at or with the pilot participant organizations. "Collaborator employees" are administrators or professionals from organizations responsible for assessment, navigation, and/or treatment not employed by KCHD or Network 180.

Of the 10 family members and one CSHCS individual served, all are Kent County residents receiving support through CSHCS. Of those, 7 were also receiving services funded through

Network 180 and/or an affiliated provider. Table 1 displays the relationship of these interviewees to KCHD or Network 180.

Table 1	Served Through	
Interviewee #	**Network180 or Affiliated Provider**	**CSHCS w/KCHD**
1	•	•
2	•	•
3	•	•
4		•
5	•	•
6		•
7	•	•
8		•
9	•	•
10	•	•
11		•

Methods

Interviewees were contacted via a member of the CSHCS/CMH Project Steering Committee who provided project context and requested the individual reach out to TBD Solutions interviewers. Interviews took place over Microsoft Teams or via telephone. TBD Solutions utilized an interview guide with questions about the person's current role and process of engaging individuals with complex medical needs, access to services, gaps and pain points, innovations, age transitions, and change over time. A sample of the interview guide template can be found in Appendix B.

While translation services were planned for interviewees for whom English was a secondary language, no interviewees required these services.

As the interviews were engaged, a theme consistently emerged: The current services are inadequate to meet nursing and/or respite care needs, and those are negatively impacted by system navigation challenges and staffing shortages. In many cases, these areas of concern were discussed as requiring immediate improvement as recounted by interviewees[4].

[4] Adverse COVID-19 impacts to the direct care and health professional workforce shortage had clear impacts as acknowledged in several publications. Evaluation of these impacts was otherwise considered outside of the scope of the pilot to measure impacts.

Table 2	Services Needed as identified by Interviewee	
Interviewee #	Nursing	Respite
1	•	
2	•	•
3	•	
4	•	•
5	•	•
6		
7	•	•
8		
9	•	
10		
11	•	

Nursing and Respite

When asked, "What services do you wish you had but cannot get?", most individuals interviewed shared that they or their family member needed nursing or respite services. Some individuals who expressed a need for nursing were already receiving nursing services but indicated they wished they had more. Table 2 breaks down the services interviewees identified as a need for themselves or their family member.[5]

Interviewees described a desire for more hours of nursing services for their child so they could work more or get out of the house during the day. They recounted feeling limited in their allotment of nursing services and resorted to utilizing nursing services during the night. Prioritizing nighttime nursing services limited individuals in their ability to engage employment or daily activities during the day. Finding and receiving respite or childcare for children with medical needs was difficult for interviewees. (Statements in dialog bubbles are deidentified comments made by interviewees.)

"[They said] our situation was not medically necessary. A g-tube was not enough for nursing."

"There is a huge gap between nursing and respite care. A respite care worker told me they could not touch medical devices at all."

"People who do not get PDN (private duty nursing) but have significant medical services needs have difficulty getting respite or CLS (Community Living Supports)."

[5] Note: Interviewees were asked to share what services they felt they or their family member needed. The responses to this question are not interpreted as services an individual qualified for, were medically necessary, or were approved or denied.

Staffing

Most interviewees, especially administrators, shared a grave concern about staffing with shortages in nursing, case management, community living support professionals, respite care workers, daycare providers, and access center staff.

Although children are eligible and approved to receive care, there is inadequate staffing to provide the necessary supports and/or services. Additionally, interviewees expressed concerns about the poor quality of available workers, low wages offered, and frequent high turnover. One interviewee reported she did not trust some respite care workers in her home. Frequent turnover challenged families to trust new nurses, respite care workers, and case managers. Many families described fatigue at having to re-tell information about themselves or their family member over and over every time a new worker met with them.

Professionals shared that some families are left without nursing services and children unnecessarily remained in higher-cost/higher-levels of care as the only viable solution. Longer-than-necessary neonatal intensive care unit (NICU) stays added stressors for families navigating visiting hours, care for their other children, and managing employment expectations. These longer stays created avoidable expenses that could be curbed if staffing at the appropriate level of need were made available for in-home nursing services.

"There are a lot of resources. There are no workers, and they couldn't help me."

"The turnover is high and I have to re-explain our situation to the new person."

"For in-home nursing there isn't a lot of nurses."

System Navigation

A pressing concern woven into each interview was eligibility and navigation within CSHCS and CMHSP systems. Interviewees expressed confusion about the purpose and service array of community resources. When discussing services, interviewees would often express their confusion about which organization coordinates which services. They would share that they have tried to understand where to go for help and "feel lost" or "on their own" to decipher these community resources. Even after they were able to determine which system to engage to meet their needs, they felt challenged to know how to ask the right questions or which words to use to express their needs.

Administrators expressed confusion about the services provided by various community services, the roles of payor v. provider, and the source of truth on eligibility for waivers or other programs.

Based on interviewees' experiences, entities work together at a high-level or to resolve complex cases but do not consistently provide "forward-facing" system navigation to individuals served.

"I have never known the difference between N180, Spectrum community, CSHCS."

"I have been the one to do the digging. They don't offer you information without asking."

"Then we went back and forth [between CSHCS and Network180] and were told different stories. We bounced from person to person."

"There are [more services] that are offered and it's sometimes hard to understand… I get to the point where I don't want to fight for it."

"MI Choice (Medicaid Waiver) has been a puzzle. Bouncing back and forth (between systems) isn't helpful."

Other: Changes Over Time

Interviewees were asked to describe how services had changed over the last five years. Interviewees' reports of change over time did not have significant trends. Individuals served reported positive, negative, and no change over the last five years with no strong correlation among any trend. However, interviewees who reported a positive change in services in the last five years tended to mention their improved skills and knowledge of the system. They reported getting better at their job or better at finding services for their child.

Other: Age Transitions

Interviewees were asked to describe the process for transitioning to adult services (at age 18 years of age) or out of CSHCS (at 21 years of age). Interviewees reported the transition was difficult or they expected it to be difficult for their child. Many reported they were instructed, or they instruct families to begin transition discussions at age 16.5 to ensure needs such as guardianship are addressed. Some interviewees reported being unaware of transition to adult services and felt their child's care was disrupted because of the abrupt transitions in care. Families often identified the school as their primary source to discuss transitions, as the school connects individuals to other organizations and legal services.

Evaluate

Interviewee: Innovation & Improvement Ideas

Over the course of interviews, individuals described improvements that would be helpful as they continue to seek care and coordination of services for their child and have profound impacts that could make their lives and jobs more livable. While some of these ideas come with substantial implementation challenges, each was considered for potential inclusion in the

CSHCS/CMHSP Pilot Project, whether feasible for immediate inclusion or identification for future consideration and funding.

Interviewee innovation and improvement recommendations were considered through the lens of the following Sustainability Rubric:

Purpose

- What purpose does this innovation fill?
- How will success of this innovation be measured

Funding and Sustainability

- How will this innovation be funded?
- How will this innovation sustain itself?

Timelines

- Is this innovation able to begin now?
- Is this innovation a 5-year goal?

Responsibility

- Who will implement this innovation day-to-day?

Oversight and Quality Improvement

- Who will oversee the quality of this innovation?
- How will this innovation be monitored for ongoing improvement?

Liaison Or Navigator Position

Interviewees, most often individuals served, shared the need for someone who could help them navigate the complexities of eligibility and services. Although the system of services includes several organizations (e.g., CMHSPs, providers, LHDs, hospital systems), interviewees felt there was a need for a person who could coordinate care across all systems.

Interviewee Quotes about Navigation

"I wish there was a person that could be streamlined across everything."

"They need somebody to talk somebody through the advice on what to do first or next…"

"You need an interpreter to help, they don't hear and misunderstand."

Considerations

For this innovation, considerations include the changes in service flow, funding and responsibility, overlap with current coordination services, and connectivity. Each consideration is outlined below with questions for further exploration.

Changes in Service Flow	Funding and Responsibility	Overlap of Current Services	Connectivity
• Who receives/is eligible for navigation services? • When does navigation begin (i.e., With CSHCS or Network180 services?) • When does navigation end?	• Who pays for navigation? • Who is responsible for providing navigation? • Who is responsible for staffing navigation services? • Who is responsible for "authorizing" navigation?	• Who already provides this service/role? • How is this service different than Supports Coordination, Targeted Case Management, or Nursing Case Management?	• Will a navigator access records? How? • How will a navigator note findings or needs? • Who, at each organization, will a navigator communicate with? • How will a navigator connect with case workers, support coordinators, and nurses?

Uniform Process for Referrals or Decision Tree

Interviewee Quotes about Decision Tree

"More description information, decision tree on when to go the CMH or MI Choice route for transition route. Everybody needs to be on board."

Interviewees, specifically administrators, expressed a desire for uniform processes to refer to or a decision tree to guide their next steps with an individual. From their perspective, they felt it would be easier to navigate systems if they had a process that other organizations utilized. A uniform process or decision tree indicates system navigation issues were not exclusive to individuals served; Administrators also struggled knowing where to go next.

Documents reviewed for this project indicated a need for uniform and collaboratively developed documents and processes. Although both organizations produced documents with in-depth contextual or reference information, most materials were not collaboratively developed. A uniform process for referrals or decision tree would be one way to meet the needs identified in interviews and in the document review.

Considerations

For this innovation, considerations include addressing complex cases, ownership, and understanding roles. Each consideration is outlined below with questions for further exploration.

Addressing Complex Cases	Ownership	Understanding Roles
• How will "typical" processes be captured? • How will "exceptional" processes be addressed?	• Who decides when changes are made to a decision tree? • Who makes changes to the decision tree? • Who "owns" the decision tree?	• What are the current roles of Network180 and CSHCS? • What does the current process for referrals look like? • How will roles/referrals change?

Develop "Gap" Services

Both administrator and individuals served shared there was a need for a service between Network180's respite services and Private Duty Nursing. This service, as proposed by interviewees, should provide some medical intervention such as tube suctioning and G-tube feedings but not replace more intensive nursing services.

Interviewee Quotes about "Gap" Services

"They should have a transition person who can do the respite care who can help medically."

"Wherever [a service] falls, that is the gap. If we could somehow provide that [missing service], it would be huge."

Considerations

For this innovation, considerations include service definition, eligibility, funding and ownership, and staffing and workforce. Each is outlined below with questions for further exploration.

Service Definition	Eligibility	Funding and Ownership	Staffing and Workforce
•What is the service? •Does this service exist in Michigan? •Is there an existing Medicaid service similar to this one? •What is provided in the service? •How is this service different than those provided in Self-Directed service arrangements?	• Who is eligible for this service? • Who is eligible for this service AND other existing services?	• Who pays for gap services? • Who "authorizes" gap services? • Who (which entity) provides gap services?	•Who (which professional or individuals) provides this service? •How does this service add to or provide relief to current staffing crises?

CSHCS/CMHSP Pilot Workgroup: Innovations & Improvement

The CSHCS/CMHSP Pilot Workgroup thoughtfully reviewed the information learned in the assessment phase in evaluating processes, current workflows, and interviewee feedback for potential improvements. The Workgroup selected the following efforts as recommendations to pursue as divided between those that could be included within the pilot, and those that would require additional research, funding, and/or policy changes.

CSHCS/CMHSP Pilot Actions

Improve Connection between LHD and CMHSP Professionals

- Update and share professional contact information (i.e., phone numbers, emails) working with Network 180 Children's Services[6] and KCHD's Children's Special Healthcare Services (CSHCS) to share key professional contact information.
- With improved connections between KCHD and Network180 professionals, share information about cases that may be eligible for services in both systems.
- Expand existing local process documentation to include key information about the services and eligibility criteria of CSHCS services at Network180, and CMHSP eligibility criteria at KCHD.

[6] Children served in Michigan's public behavioral healthcare system may have eligibility determinations based on a severe emotional disturbance diagnosis, and/or an assessed intellectual and/or developmental disability.

Referral and Follow-up Processes, and Case Consultation

- Establish processes for referrals between the Network 180 access and CSHCS department nurses:
    - Professionals to be contacted for 'warm-handoff' referrals.
    - Process for coordinating care (e.g., discussing potential eligibility for services, additional information to navigate systems, etc.).
    - Procedures to coordinate on case engagement (e.g., no-shows, challenges with making contact, missing proof documentation, etc.).
    - Assisting families with CMHSP and CSHCS navigation.
    - Assisting families with navigating Medicaid programs and associated eligibility.
    - Performing shared-case reviews.
- Communication between both systems to engage questions about on-going engagement, age transitions, gaps in care, etc.
- Review data regularly to understand how referral and information sharing between data systems could be automated (though not implemented as part of this effort).
- Examination of cohort characteristics to consider ways of improving population health.

Information Sharing

- Consider mechanisms for utilizing a shared-client record and ensure shared-clients have coordinated care between both systems.
    - Establish Business Associate Agreements between Network 180 and KCHD modify consents to share information.
    - Establish methods to exchange documentation for the benefit of coordinated care for shared clients.

Future Action Steps

The following ideas were reviewed for consideration, but deemed as recommendations for future actions that would remain outside of the pilot project:

Advocacy to improve Respite Gap Services

- A clear gap existed between the types of respite for which skilled, private duty nursing was required, and where physical needs were substantially lesser, but required some intervention, such as suctioning, feeding tubes, or other semi-skilled supports.
- Make recommendations for the gaps in respite care.
- Explore disparities in service array youth served by waivers and those not served by waivers.
- Provide cost analysis to clearly articulate funding between systems, advocating for additional funding for per diem care-giver respite.
- Recommendation that a full, statewide gap and cost analysis is engaged that can result in policy changes that compel:

  - Additional education and increased rate (modifier) for persons providing greater levels of trained support during respite services; or,
  - Creation of a new service array between those persons whose needs to not justify nursing, but who must otherwise have some intervention by support professionals to do low-to-intermediate physical care.

Notification System

- Establish an electronic notification process that functions across both systems when new referrals come through, equipped to identify clients who may also access services through the other system

Statewide Conference

- Develop a statewide Children's Conference with the purpose of educating, spreading awareness, and facilitating relationship development

Statewide Electronic Referrals

- Construct a process to send referrals electronically between CMH and CSHCS/LHD systems in the state
- Develop mechanism for tracking referrals that occur across the state

Actions Steps for CSHCS/CMHSP Pilot

The CSHCS/CMHSP Pilot Workgroup commissioned two functional workgroup charters whose purpose was to engage action steps as identified – a Clinical Assessment Workgroup and an Electronic Referral Workgroup, each with a discrete set of pilot criteria to investigate.

Clinical Assessment Workgroup

A challenge arises when a child (or transitioning adult) is assessed and found to potentially be eligible for both the CSCHCS and CMHSP systems. At present, there is no statewide criteria for briefly screening and/or assessing eligibility for CMHSP services by CSHCS systems, nor for CSHCS systems by CMHSPs. A Clinical Assessment Workgroup (CAW) made up of KCHD and Network 180 clinical representatives (nurses and clinicians) was convened to consider solutions.

- How eligibility occurs in each system.
- If an amalgamation of shared questions could be designed to help screen and/or assess for potential eligibility in the other system.
- Use this information to inform a "warm referral" between the CSHCS and behavioral health systems within the context of the Kent County CSHCS/CMH Pilot.

The Clinical Assessment Workgroup began with a review of the comparison between their KCHD CSHCS and Network 180 care systems.

Table 3 – System Comparisons	CSHCS coordinated by KCHD	Network 180
Age of Children's Eligibility	0-21 (up to age 26 for some)	0-18
System Entry Points	Multiple - Health Plan examination of claims/diagnosis - Specialists - Cold calls to LHD who assists in navigation	One, Network 180, for non-Autism I/DD For Autism, multiple points of entry
Referral Sources	Multiple	Multiple
Eligibility Determination	State CSHCS Office review based on specialist diagnosis	Network 180
Planning	Planning/needs based on specialist diagnosis, with navigation assistance provided by KCHD	Network 180 provides planning and authorization for services, provided by the CMHSP or contract providers

Services	CSHCS provides financial support for an array of chronic conditions based on severity and resource need.	CMHSP provides payment of and provision for services, including Supports Coordination, CLS, Respite

As the CAW members discussed their variations and similarities, each organization became keenly aware of the eligibility requirements and processes for accessing CSHCS- or CMHSP-funded services. This collaboration represented a profound and successful pilot impact. Both KCHD and Network 180 dialog created improvements that aided families and individuals served through the updating of contact lists, improved references to each other's processes in their internal process documentation, and considerations for 'warm referrals' to help families navigate entry into the system.

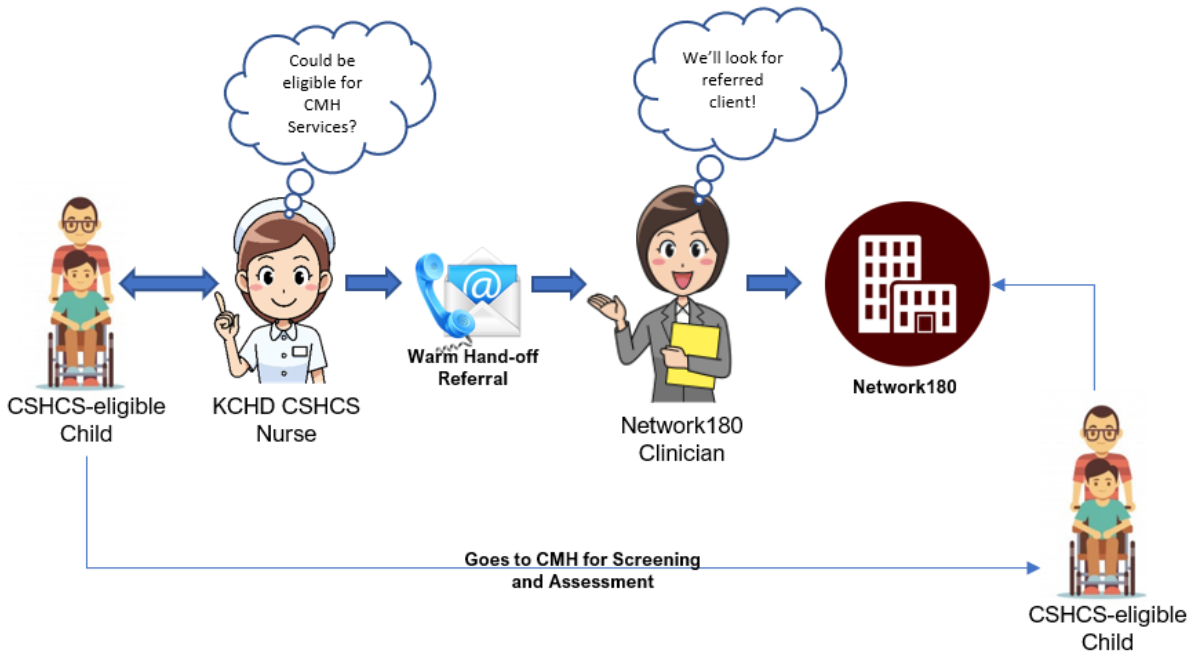
Electronic Referral Workgroup

Intake and screening at CMHSPs of persons considering CSHCS eligibility may initially conclude the primary diagnosis of a child (or transitioning adult) already served in one system rules out further eligibility. An Electronic Referral Workgroup (ERW) was charted to consider the potential of an information systems solution: An automated reminder of referral source to highlight the need for more careful considerations in assessing for necessary services to address diagnoses that are secondary, tertiary, quaternary, etc. A systems solution that efficiently provides notification of the referral from one system to the other and includes contact information for navigation and/or determination professionals could be helpful.

The ERW considered two unique cases for which consent to share information will support the Connections between LHD and CMH and improve Referrals/Follow-up/Case Consultation using client information.

Case Scenario 1: Referral

While this can happen the other way around, most referrals are from the LHD to the CMH. In this scenario, a nurse knows who her contacts are at Network180 and has consent to share information on an existing client that she believes may be eligible for services.



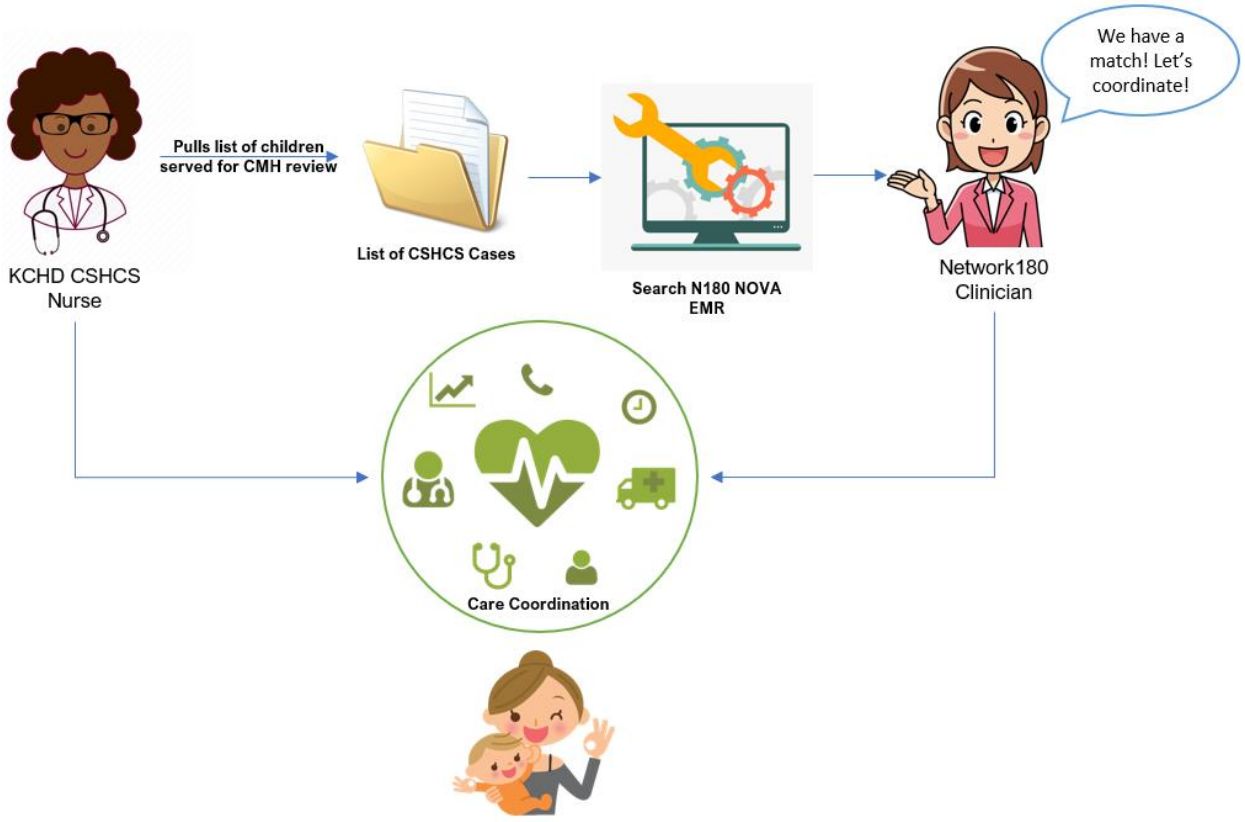
CMH services are largely tied to Medicaid eligibility, including where else a person may already be receiving services. A warm hand-off helps clinicians know that they should use extra care in considering the child's financial and clinical eligibility apart from the diagnosis and services received through CSHCS.

In the future, the goal is to have indicators built into CMH systems whereby they can see not only the CHAMPS eligibility for CSHCS, but also electronic indicators for referrals.

Case Scenario 2: Finding Shared Clients for Care Coordination

Whereas the first scenario has the client's full understanding of the potential eligibility for CMH services, this next business case does not.

In this scenario, care coordination opportunities exist with clients that are receiving services funded through CSHCS that *may* also be receiving services through the local CMH. The LHD in this case has the "bulk" of the potentially eligible beneficiaries, so they would produce a list of clients that would allow CMH to verify whether they are their clients, too. If so, care coordination between the organizations can improve addressing areas of coordination and reduction in gaps in care.



Results

An important difference between CSHCS and CMHSP information systems is centered around where eligibility determination occurs. For Network 180, it is their proprietary electronic medical record system, "NOVA", provided by PCE Systems. For CSHCS services, it is an Oracle system that is managed at the state level. This limiting factor would need to be overcome if statewide system changes were to be adopted to facilitate the electronic referral.

An additional challenge was the determination regarding how information can and should be used. In the use cases described, KCHD and Network 180 considered how best to engage sharing of client information using a Business Associate Agreement (BAA). After substantial dialog, Network 180 determined that, unless unsolicited information was to be shared, their use of the MDHHS standard consent form (MDHHS-5515) was all that was necessary. TBD Solutions agrees that, for purposes of coordinating information regarding cases for which a child or transitioning adult may have eligibility in both systems, this is adequate. However, for a future state where lists of clients from one system could result in intentional outreach efforts, state guidance may be required, or the enactment of BAAs across CMHSPs with their LHDs.

Finally, it was confirmed that CSHCS eligibility criteria did appear as a funding source that could be reviewed by Network 180 staff, but the workflow did not lend itself to ready use. Better will

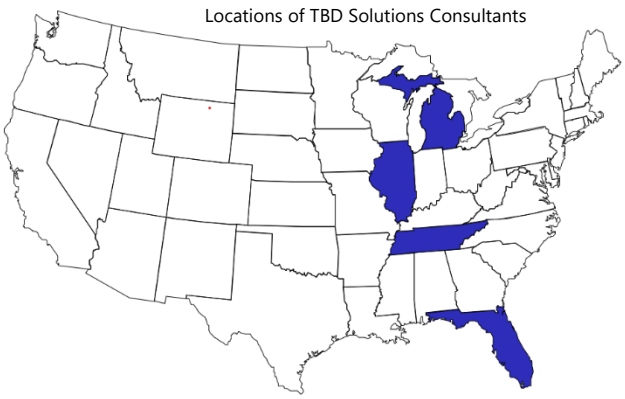
be the full and statewide implementation of electronic referrals to aid organizations in sharing information independent of EMRs.

Summary

The research and recommendations from the Kent County CSHCS/CMHSP Pilot demonstrated opportunities for systems improvements. As the MDHHS redesign has emphasized alignment of children's services into a separate department, there is considerable hope that similar standardization and integration of disparate support systems can be simplified to better serve children and families.

To implement recommend changes across the state, there are considerable challenges with increasing the number of care providers, funding for gap services, and improvements in data systems. Still, the greatest integration and improvement again proved to be those actions of personal investment, as professionals from Kent County Health Department and Network 180 worked together to consider solutions and gained a better understanding of each other and the services they each provide.

About:



TBD Solutions LLC is a 100% veteran- and woman-owned consultancy based in Grand Rapids, Michigan, serving a national client base. Employing a human-centered approach with customers, TBD Solutions is known for its affable excellence as human service systems experts. Their services include comprehensive project and process management, policy and funding expertise, clinical and crisis system design, tailored strategic planning, insightful research and analysis, outstanding education and training, and data science compelling information utilization and visualization products that drive decisions. The company's team of experts serves multiple states, partnering with a diverse array of governmental, for profit and non-profit clients in California, Colorado, Florida, Kansas, Maryland, Michigan, Nevada, New York, Ohio, Oregon, Virginia, and Wisconsin.

Remi Romanowski-Pfeiffer, MSW, served as project co-lead, lead researcher and primary contributor to the Kent County CSHCS/CMHSP Pilot Project final report. Remi leverages her passion for people, attention to detail, and inquisitive personality to help further understand a problem and potential solutions. She values centering an d tuning into the perspectives of people served to support organizational strategy, as they are the most important stakeholder and should be at the nexus of strategic considerations. Remi's areas of expertise include organizational assessments, policy analysis and development, process improvement, and thoughtful engagement of stakeholders in decision-making at every level.

Jason Radmacher, MBA, served as project co-lead and author of the Kent County CHSHS/CMHSP Pilot Project final report. Jason has decades of leadership experience in governmental entities, private industry, health plans, and as a military commander with over 27 years of Air Force service. His career in executive leadership includes administrative expertise, organizational design and strategy, human resources, health information technology, revenue cycle management, data use, and managed care systems. Jason provides relational coaching for executives, engaging presentations, and expert consultation from his leadership position as the company's co-founder and CEO.

For more information, please contact our main office: (616) 226-2700 or (877) 823-7348, or email us at info@TBDSolutions.com

Appendix A – Reviewed Documents

Document Name	Summary
Who to Call Document	This document provides a list of phone numbers, names of individuals (as available), and is organized by issue or topic.
CSHCS and Mental Health Presentation: Working Together to Service Children and Families with Complex Medical Needs	This slide deck was presented at a Michigan mental health conference. It outlines the Mission and Goals of CSHCS, shared concerns of CSHCS and CMHs in Michigan, eligibility for CSHCS, and identifies what is not covered by CSHCS. This presentation was for CMH or other mental health provider staff to help them understand more about the services provided (and not provided by CSHCS) and the need to coordinate with CMHs. This presentation also introduces other collaborative efforts such as Family Center for Children and Youth with Special Health Care Needs and the CSN Fund.
MDHHS: Authorization to Disclose Protected Health Information	The Authorization to Disclose Protected Health Information was used by CSHCS for adult clients who wish to share healthcare information with their parent or guardian.
Bridges Eligibility Manual	Summarizes MDHHS department policy, CSHCS responsibilities, communication to local office, local office responsibilities, who to contact about medical eligibility, and financial eligibility factors.
CSHCS Life Cycle Poster Presentation	This presentation discusses the process for CSHCS eligibility/renewal, common errors that delay eligibility, consequences of delayed enrollment, care coordination activities provided by CSHCS to alleviate care stressors, and transition planning timelines and processes.
CSHCS Program Logic	This document outlines CSHCS activities at the state level utilizing a logic model. People, funding, and other resources are outlined in this document, but CMH services are not specifically highlighted.
Home Care Children's Program (HCC): A Pathway to Medicaid	A Pathway to Medicaid document reviews the process for uploading documents to CHAMPS for determining eligibility. Some of the documents include a medical report, description of life at home (24hr Plan of Care), Individual Education Plan (IEP), CMH Plan of service or assessments, and identification of services the individual wishes to receive but cannot access.

Kent CMH Contacts	This document was developed by CSHCS of Kent County to outlines names, agencies, phone numbers, emails, and roles of CMH, provider, and CSHCS staff.
Family Preparation Work Sheet for First Requests for CMH Services (For a Child that is Currently Medicaid Eligible)	The preparation worksheet was provided to parents served by CSHCS who are seeking services from CMHs. The document assists parents by outlining what information they should be prepared to provide to the CMH, including any current diagnoses, language and communication skills, learning/school needs, current resources they have at home, and potential follow-up questions.
Family Preparation Work Sheet for First Requests for CMH Services (For a Child that is NOT Currently Medicaid Eligible)	This preparation worksheet provides similar guidance to those seeking CMH services for their child. However, this document provides considerations for when the child is NOT Medicaid Eligible/was denied Medicaid coverage.
Parent Support Group Meetings	This document displays past parent support groups.
Pathways to Medicaid	As a repository, the Pathways to Medicaid document outlines the main avenues an individual can use to access Medicaid and the basic information about each route (e.g., eligibility, priority categories, sequencing).
Basics for CSHCS: Accessing Community Mental Health Services for Children	The contents of this presentation were from 2018 and it was presented by an MDHHS Contractor and a Specialist from the Behavioral Health and Developmental Disabilities Administration. It outlines eligibility determination for CSHCS and CMH services (for both Medicaid and Non-Medicaid eligible individuals); purpose and overview of CMH services, children's waiver program, supports to those with developmental disabilities; resources for a child with unmet needs; differentiates between Michigan waivers including Children's Waiver Program, Habilitative Supports Waiver.
Transitions to Consider at 18	This document provides a high-level overview and definition of programs and services such as SSI, Medicaid, Adult Home Health, and CMH services for parents or individuals turning 18 and in-need of a summary of services available to them. The document also provides contact information and provides steps to accessing services from each program and service.

Appendix B – Sample CSHCS/CMHSP Interview Guide

The following is a sample of the interview guide designed by TBD Solutions and approved by the

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- **Purpose:** We want to learn more about CSHCS/CMH services and their current collaboration. This conversation will be used to improve the collaboration between Kent County Health Department and Network180.
- **Privacy:** Our conversation today is private; what you say will be shared with the Health Department and Network180, but they will not know it came from you. The group is aware we are speaking to you, but what you share will be anonymized. You can opt out at any time.

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1. **PROCESS:** Tell me about your role with [Organization]. Tell me how you engage with children with complex medical needs.
2. **PROCESS:** Explain what the current process looks like for an individual to get services from Network180/CSHCS?
3. **GAPS/PAIN POINTS: What are the areas of difficulty? Where is the system not working smoothly?**
    a. **What does the intake and eligibility process look like for individuals served?**
    b. **What services do individuals try to get but cannot receive?** (e.g., How do guidelines/policies/resources play into services?)
    c. **What does care coordination/collaboration between organizations look like** (doctor, CMH, CSHCS, etc.)? **How were the services coordinated between organizations?** (e.g., Information exchange, retelling my story, congruent information)
4. **INNOVATIONS: What worked well between CSHCS and the CMH? Is there a difficulty you have encountered that is now resolved?**
    a. **What resources are helpful for you or your staff? For individuals served?**
    b. **Who (what individuals served) are best connected between the two systems?**
5. **TRANSITIONS: What does it look like when a person served turns 18? What does the transition look like when an individual turns 21? Are there any changes in services?**
6. **CHANGE OVER TIME: How have services changed over the last five years?**
    a. **How are services different now than then (Same, more difficult, easier, etc.)**

Concluding: Do you have any additional comments that you feel would be important for us to know? Thank you for taking the time to share with us and improve coordination between the two organizations.

Appendix C – Summary of Experiences of Persons/Families Served

	Service Experience[7]			Service Need		Change in Services Overtime			Staffing
Interviewee #	Received Network180 Services or a Provider	Received KCHD-coordinated CSHC Services	Denied Services by Either Network180 or CSHCS	Nursing Services as a Need	Respite Services as a Need	Services Improved in Last 5 Years	Services had Declined in Last 5 Years	Serviced had Not Changed in Last 5 Years	Impacted by Staffing Shortage/ Turnover
1	●	●	●	●			●		●
2	●	●	●	●	●			●	●
3	●	●		●			●		
4		●	●	●	●	●[8]			●
5	●	●	●	●	●		●		
6		●						●	
7	●	●		●	●		●		
8		●							
9	●	●	●	●			●	●	●

[7] The interviewee reported they received services from the organization at least once prior to the interview.
[8] The individual had received services for less than 5 years, however they commented on the change in services over time.

10	•	•				•			
11		•		•		•			