Northeast Michigan Community Mental Health Authority Board
July 2018 Meetings

- **Board Meeting -- Thursday, July 12, @ 3:00pm**
- **Montmorency County & Presque Isle County Employee Recognition, July 24 @ 11:30am – Thunder Bay Golf Resort**
- **Alcona County & Alpena County Employee Recognition, July 26 @ 11:30am – APlex, Upper Conference Room**
- **Recipient Rights Committee Meeting* -- Wednesday, July 18 @ 3:15pm**

All meetings are held in the Board Training Room at 400 Johnson Street in Alpena except those indicated with a "*" which are held in the Administrative Conference Room

IF ATTENDING EMPLOYEE RECOGNITION, RSVP TO KAY KELLER AT 358-7701

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD
BOARD MEETING
July 12, 2018 at 3:00 p.m.
A G E N D A

I. Call to Order

II. Roll Call & Determination of a Quorum

III. Pledge of Allegiance .... All

IV. Appointment of Evaluator .... Gary Nowak

V. Acknowledgement of Conflict of Interest .... All

VI. Information and/or Comments from the Public

VII. Approval of Minutes .... (See pages 1-12)

VIII. Educational Session – Strategic Plan Review .... (See pages 13-17)

IX. July Monitoring Reports
1. **Budgeting 01-004 [2 months] .... (See pages 18-19)**
2. **Asset Protection 01-007 .... (See pages 20-32)**
3. **Community Resources 01-010 .... (See pages 33-34)**

X. Board Policies Review and Self-Evaluation
1. **Community Resources 01-010.......[Review] .... (See page 35)**
2. **Public Hearing 02-010 ....[Review & Self Evaluate] (See pages 36-37)**

XI. Linkage Reports
1. **Northern Michigan Regional Entity Update**
   a. **June 27, 2018 Meeting .... (Verbal Update)**
   b. **May 23, 2018 Meeting .... (See pages 38-43)**
2. **CMHAM**
   a. **CMHAM FY19 Dues .... (See page 44)**
   b. **CMH PAC Update .... (See page 45)**

XII. Operation's Report .... (See pages 46-56)

XIII. Chair's Report
1. **Planning for the CEO Evaluation .... (See page 57)**
2. **Employee Recognition Luncheons .... (See page 58)**

XIV. Director's Report
1. **Director's Report .... (Verbal)**
2. **RFP – Clubhouse .... (See page 59)**
3. **Third Level/ProtoCall Update .... (Verbal)**
4. **MidWest Recruiting .... (See page 60)**
5. **QI Council Update .... (See pages 61-69)**

XV. Information and/or Comments from the Public

XVI. Next Meeting – Thursday, August 9 at 3:00 p.m.

1. **Set August Agenda .... (See page 70)**
2. **Meeting Evaluation .... (All)**

XVII. Adjournment

MISSION STATEMENT

To provide comprehensive services and supports that enable people to live and work independently.

Northeast Michigan Community Mental Health Authority
Board Strategic Planning
June 14, 2018

Call to Order/Welcome Gary Nowak welcomed Board members and guests to the Planning Session at 12:20 p.m.

I.

Present:	Lester Buza, Bonnie Cornelius, Steve Dean, Alan Fischer, Roger Frye, Judy Hutchins, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak
Absent:	Albert LaFleche, Pat Przeslawski
Guests & Staff:	Lisa Anderson, Dennis Bannon, Carolyn Bruning, LeeAnn Bushey, Mary Crittenden Lynne Fredlund, Laura Gray, Margie Hale-Manley, Cheryl Jaworowski, Eric Kurtz, Cathy Meske, Mary Mingus, Linda Murphy, Anne Ryan, Nena Sork, Lauren Tallant, Jen Whyte, Peggy Yachasz

II. Pledge of Allegiance

Meeting attendees recited the Pledge of Allegiance as a group.

III. Appointment of Evaluator

Gary Nowak appointed Terry Larson as evaluator of this meeting

IV. Information and/or Comments from the Public

Diane Hayka reported the Board received two notes of thanks. Pied Piper sent a card acknowledging the donation made in memory of long-time Board member, Virginia DeRosia. Eileen Tank, Consumer Advisory Council member, thanked the Board for supporting her attendance at the recent NAMI conference in Traverse City.

V. Approval of Minutes

Moved by Roger Frye, supported by Judy Hutchins, to approve the minutes of the May 10, 2018 meeting as presented. Motion carried.

VI. myStrength Contract Approval

Cathy Meske reviewed the proposal presented last month related to the myStrength app available for use to empower individuals with resources where they can track various healthy elements such as sleep, mindfulness, meditation, etc. She reports the nice part is the tracking of activities allows for individuals receiving services the ability to share their activity reports with their clinicians. The annual cost is $11,000 with a two-year commitment and approximately $4,500 to $5,000 in set-up fees. Steve Dean inquired as to whether it is felt the consumers would use this application. Cathy Meske would like to see at least 25% usage for the individuals we serve. myStrength bases the fee on population and uses a formulary to determine costs. This application would be available to staff and family members and would augment the current wellness program offered by the agency. Cathy Meske reported there will be reports provided to determine what programs are being utilized and how many are using the app. ***Moved by Steve Dean, supported by Terry Larson, to approve the contract with myStrength as presented.*** Roll call vote: Ayes: Lester Buza, Bonnie Cornelius, Steve Dean, Alan Fischer, Roger Frye, Judy Hutchins, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak; Nays: None; Absent: Albert LaFleche, Pat Przeslawski. Motion carried.

Introductions were made at this point.

VII. Environmental Scan

Gary Nowak introduced Eric Kurtz, NMRE CEO.

Eric Kurtz informed Board members just earlier today he received word from the Board Association the legislature was going to proceed with the Section 298, after the earlier report of postponement.

Eric reviewed the Market impacts facing the behavioral health field in the next few years reviewing categories of Persons-Served, Technology, Workforce, Payment Reform, Regulatory and Quality.

Eric reviewed the federal initiatives impacting community mental health. He noted the Cures Act is driving much of this. He reports parity will impact the authorization processes used as each community mental health program has varying criteria to authorize in a consistent manner. For example, the initial inpatient authorization for one board might be two days and another six days. This will need to be addressed and become consistent. Eric also informed attendees of the upcoming electronic visit verification which will require providers to prove they were providing the service at a specific location with the individual receiving the services confirming the same. This may be done using GPS or other electronic means.

Eric reported the mandate to provide access to patient portals is part of the regulations associated with MIHealthData. Incentive payments are received through the Medicare program if the provider meets the criteria established in Meaningful Use.

Eric noted the 1115 waiver has been under development for several years and there are parts of the waiver focused on and enacted without the full waiver endorsed. He notes there are many Medicaid B3 services included and there is discussion proposing the B3 services be removed from this waiver and put into an I-waiver instead. In addition, all the habilitation support waivers are floating out there. He notes there is a danger we end up with about five different waiver guidelines.

The Home and Community Based rules are scheduled to become effective March 2019; however, this date might also be extended.

Eric reported next bullet addresses proposed rules that when changed the state will be able to dictate capacity and service availability and where these need to be located at such as clubhouse. This proposal is scheduled to be released in draft in 30 days.

Eric reported the Opioid/SUD crisis is hard to keep up with as so many entities are offering funding to provide services for certain initiatives. Eric reports he will reviewing all inquiries.

Eric reviewed the State Focus and Initiatives currently underway – 1) Focus on fraud, waste and abuse; 2) Class action suits; 3) Strict Adherence to Contract Compliance related to Autism, SIS, and Timeliness of Service; 4) SUC Opioid Health Home and 5) 298 and continued merged funding efforts. Eric reported there is a current class action suit in the state related to services provision in the autism program. He notes we have a current audit underway for our autism program with an exit conference scheduled for tomorrow.

Eric Kurtz reports the state has recognized the opioid issue in our region. All counties have been affected. . Eric report 1,100 individuals have been touched by substance use services in our 21-region. This is the number of individuals actually diagnosed not including those unknown to our services.

Mr. Kurtz reports 298 is somewhat contained to the three pilot sites at the moment. He notes he is very happy none of the NMRE's member boards elected to submit to be a pilot for 298.

Eric reviewed the regional initiatives noting the Regional Entity's member Boards work together to identify problem areas. He reported the grievance and appeals new rules now require individuals to have a one-stop process. This means the PIHP must be the initial contact as they are the Medicaid oversight agency for the region. Other target areas include 1) data warehouse usage; 2) tracking and monitoring over- and under-utilization of services; 3) reporting timeliness and accuracy; and 4) SUD Opioid Health Home. Eric reviewed some of the target areas being reviewed. He notes the range of services needs to be changed and a more realistic authorization be made. For example, in ABA services if 18 hours of service are authorized weekly, then there needs to be at least close to that amount provided. The child may qualify for that amount; however, the parents are unable to meet the qualified amount and we need to identify the actual agreed upon amount.

He reviewed the issues related to risk at local levels. He discussed the issues related with inpatient denials and crisis alternatives.

Judy Hutchins inquired about whether "subsection E" of the 298 was removed. Eric Kurtz noted the language was removed; however, this would not preclude them from paving the way in the future to contract with providers other than community mental health agencies.

The FQHCs are currently providing opioid treatments through MAT. He also notes Centra Wellness is also investigating options for providing MAT services. Eric notes the initial year of a physician providing this type of service limits the provider to 50 patients and expands to 100 the next year. He notes the proposed start date for a SUD Health Home is October 1, 2018.

Recessed at 1:30 p.m.

Resumed at 1:45 p.m.

VIII. Review of current Mission, Vision, Strategic Plan, Ends and Priority Needs identified at the Public Hearing

Lynne Fredlund emphasized the importance of strategic planning. The one-time of year when focus can be made on developing goals and shaping the future of services provided for the four-county area served by this agency. She notes the director's job is to do whatever she can to put in place the charges of the board as developed in Ends. She notes the Strategic Plan development we are focusing on today will be the Plan which will begin October 1. Today's goal will be to have a draft of the Plan prior to adjournment of this meeting.

<u>Mission & Vision Statement Review</u>

The Mission Statement was reviewed by Board members, "To provide comprehensive services and supports that enable people to live and work independently." Cathy Meske noted Mission statements are typically short and to the point. Steve Dean questioned whether "in the geographic region" should be identified. Lynne Fredlund reported this mission would cover services in our four counties and would be associated with the agency name.

Eric Lawson noted there are different types of people with different needs, some liking solitary existence and some liking social existence. Cathy Meske reported this mission provides the opportunity for community inclusion and independence and that would be identified by the individual served. She notes the mission is a broader view. Discussion about the benefits of adding to and leaving as is was enlightening. Cathy Meske reports all individuals have the potential to improve, the amount of improvement may be limited but still relevant. Judy Hutchins suggested revision "to live and work independently in a setting of their choice." Alan Fischer noted the mission does not indicate we are a behavioral health provider. Lynne Fredlund noted the agency is Northeast Michigan Community

Mental Health Authority and this is the Mission statement under the agency. Peggy Yachasz reported the use of “people” takes away some of the stigma associated with mental health.

Roger Frye suggests this Mission is sufficient.

Moved by Roger Frye, supported by Steve Dean, to leave the mission as is. Motion carried.

The Vision Statement was reviewed. Terry Larson suggested mental health be changed to behavioral health. Alan Fischer inquired as to the difference in meaning in mental health and behavioral health. Cathy Meske noted mental health is targeted at those with an actual mental health diagnosis. Alan Fischer noted behavior sounds more like character flaws versus mental health symptoms. Steve Dean suggested adding the words behavioral and

Moved by Steve Dean supported by Judy Jones to add the words “and behavioral” after mental in the Vision. Gary Nowak requested input from staff. Mary Crittenden reported there is a difference in the way we are treating individuals. Linda Murphy also provided input. Laura Gray cited a situation in which a child had a behavior issue and was not offered services because she did not have a mental illness. After discussion the motion was amended. ***Moved by Steve Dean supported by Judy Hutchins to add the words “and behavioral,” in the first sentence and, in addition, a period will be placed at the end of the sentence Recover. And add “and behavioral” in the last sentence.*** Motion carried. The Vision will now read…”Northeast Michigan Community Mental Health will be the innovative leader in effective, sensitive mental and behavioral health services. In doing so, services will be offered within a culture of gentleness and designed to enhance each person’s potential to recover. We will continue to be an advocate for the person while educating the community in the promotion of mental and behavioral health.”

The Core Values were reviewed briefly and Board members were satisfied with the values as printed.

Strategic Plan Document Review

Lynne Fredlund reviewed the Forces in the Environment Impacting Behavioral Health. Steve Dean questioned the title Competitors in the one bubble. Cathy Meske noted this bubble would not be needed. This could be removed.

Moved Steve Dean, supported Roger Frye, to remove the Competitors bubble from the Forces in the Environment. Motion carried.

The remaining categories included in the Forces in the Environment Impacting Behavioral Health remain relevant. There were minor revisions proposed to various elements under the sections of Payors/Payment Reform, Persons Served, Regulatory Changes, Workforce; and Technology.

Albert LaFleche arrived at 2:45 p.m.

Cathy Meske informed attendees the Technology bullet addressing patient portals is needed as the agency gets an incentive by meeting the goals through Medicare.

Lynne Fredlund reviewed the 2018 Goals established last year.

2018 Goals

1. To reduce the risk of metabolic syndrome in both adults and children. (continue)
2. To continue the partnership with Thunder Bay Community Health Services, Alcona Health Center and local school systems in order to provide school-based social work services for children. (continue)

3. Develop a trauma-informed community through education, assessment and participation in community initiatives. It was suggested to revise this statement to "Promote a trauma-informed community through education, assessment and participation in community initiatives. (revised)
4. To continue to expand services to all children and young adults with diagnoses with Autism Spectrum Disorders. It was suggested to revise this statement to "To continue to support and expand services to all children and young adults with diagnoses with Autism Spectrum Disorders. (revised)
5. Coordinate community education and partnerships in suicide prevention. (continue)
6. To increase Substance Use Disorder (SUD) services within the Agency, while partnering with local SUD providers to educate and reduce substance use in the community. (continue)
7. To collaborate with the Veteran's Administration assuring comprehensive behavioral health services are available. (continue)
8. To further utilize the Health Information Exchange (HIE) with Great Lakes Health Connect and local organizations in order to share critical health care information. (continue)
9. To keep current in education and hardware needs and to provide training for all staff using the new electronic health record (EHR). To provide IT support and hardware enabling staff to become more mobile while meeting the security needs and connectivity to the EHR. It was suggested to revise this goal to "To keep current in education and information technology (IT). (revised)

Recess at 3:04 p.m.
Resume at 3:17 p.m.

2018 Barriers Reviewed

Section 298 – eliminate.

Home and Community-Based Services – keep as is.

Integrated Healthcare – keep as is.

Funding – This will be revised to state "The contractual obligations to the Michigan Department of Health and Human Services (MDHHS) while staying within the Per Member Per Month (PMPM) formula provided by the PIHP. Cheryl Jaworowski voiced her concern related to the PMPM noting some of the member Boards are underspending by more than a million dollars and awarding bonuses to staff and our agency cannot balance the budget.

Jail Services – This will be revised to state "Limited use by law enforcement impacts the number of pre- and post-booking jail diversions."

Recruiting and Retention of Qualified Staff – keep as is.

Service Population – keep as is.

Add the following new barrier.
Residential Options – Decrease of family operated foster care resulting in the utilization of higher cost corporate specialized foster care placements.

The 2018 Opportunity statements were reviewed. Cathy Meske reported the continued EPB includes TRAILS, EMDR, etc.

Lynne Fredlund request input for other opportunities which might be added. Cathy Meske noted we now have a full complement of psychiatric services with the addition of the child psychiatrist.

Bonnie Cornelius suggested community outreach and education as an additional opportunity. Laura Gray noted it could be an opportunity to work with the local group to establish a NAMI group for families and individuals to work with. Board members requested the following opportunity be added: "Provide education to the community at large and support and promote local advocacy efforts."

Alan Fischer would like to look at the opioid epidemic and the recent mass shootings having increased the need for increased public support. Alan Fischer notes we need to take a whole new look at addiction treatment. Cathy Meske questioned if this should be classified as an opportunity or a challenge. It could be both.

Add to Barriers/Challenges:
Opioid Epidemic – The increasing opioid epidemic has strained community resources.

Increasing Violence in our Society – The increasing violence in our society is requiring communities to come together to develop a comprehensive community action plan.

In addition to listing the above in the Barriers/Challenges section an Opportunity statement might also address the opioid and violence issues. Cathy Meske suggested the opportunity be stated possibly as "Work collaboratively with the community partners in the region to address challenges related to the increasing opioid epidemic and increase in violence and anger dyscontrol."

Lynne Fredlund reviewed the Options section of the 2018 Strategic Plan. Cathy Meske addressed the bullet "Provide community members with training as it relates to Mental Health…" Alan Fischer inquired as to whether this is where we would want to expand the services. The bullet will be expanded to state "Provide community members and staff with training as it relates to Mental Health First Aid for youth and adults, suicide prevention, increasing violence in our society, co-occurring disorders and the effects of trauma on individuals."

Ends Monitoring Report and Policy Review

The Ends Monitoring Report was included in the Strategic Planning packet mailed to participants in advance. The Board's Mega Statement is "All people in the region, through inclusion and the opportunity to live and work independently, will maximize their potential." This statement will continue in the 2019 plan.

Sub-End

Services to people with a Mental Illness

1. **We expect that children with a serious emotional disturbance served by Northeast will realize significant improvement in their conditions.**
    a. **75% of all children who participate in services (targeted case management, outpatient counseling, Home-Based Services and Wraparound) will show a 20 point decrease in CAFAS scores at the end of their 3rd quarter review. 90% of children will show a 20 point or more decrease in CAFAS at termination of children's services.**

       Status: *The mid-point of fiscal year 2018 ended with 26 out to 37 cases showing at least a 20 point decrease in CAFAS scores by termination. Out of the remaining 11 cases, two moved out of the area and two were sent to residential treatment by the judicial system before services were completed. Therefore, for those individuals completing services as planned, 70% have shown a 20+ point decrease in their CAFAS scores, with a range of improvement between 20 and 70 points.*

Lynne Fredlund invited Lauren Tallant to provide attendees with the progress toward Sub-Ends #1. Lauren reports her Department has been staff challenged this past year and is just now fully staffed. The staffing issue was a contributing factor to service provision. Cathy Meske reports the reports related to CAFAS was easily obtained in our Majestic system; however, the state has required the agency to put the CAFAS information on their website and reports are not easily obtained. This report includes data collected from departments other than Home-based as it includes wraparound, children's case management, etc. Cathy Meske notes this is the first time in four years this department is fully staffed. Lauren Tallant noted an additional position was added due to the increase in demand. Bonnie Cornelius inquired as to what the reason for the increase in cases. Lauren reports the Medicaid expansion and service awareness have resulted in increased demand.

2. **Employment opportunities for persons with mental illness promote recovery and independence. The provision of the Evidence Based Practice Supported Employment will lead to increased employment opportunities.**

   Achievement of this sub-end will be confirmed by monitoring employment status of those individuals enrolled in Supported Employment for persons with mental illness.

   a. **During the fiscal year 2017-2018 an additional 48 individuals with mental illness will be given an opportunity for paid employment. This increase will be based on the actual end count of individuals given this opportunity on September 30, 2018. Current enrollment as of September 30, 2017 is 63 individuals, and of those individuals, 40 (63%) are employed in part- and full-time positions.**

      Status: *Current enrollment as of March 31, 2018 is 61 individuals and of those individuals served from October 1, 2017 through March 31, 2018, 47 individuals with mental illness became employed in part- or full-time positions.*

      Lynne Fredlund invited Mary Mingus to provide attendees with an update. Mary reports the sub-ends reported on is specific to the Evidence Based Practice. She reports initially the goal was to reach four individuals per month and if the current trend continues the end result will be 90 individuals receiving an opportunity, almost double the goal. Mary reports this goal is a sustainable goal and might not need to be a focus in the future. Steve Dean requested clarification about 'opportunity' and 'enrolled'.

<u>**DD Consumer Services**</u>

3. **During the fiscal year 2017-2018, three percent (3%) of employed individuals with an intellectual/developmental disability will retain employment for six (6) months or longer. In addition, there will be a five percent (5%) increase for individuals having the opportunity for competitive employment. As of September 30, 2017 we have 109 persons employed. A successful end will be 114 persons served will have had opportunities for paid, competitive employment.**

   Status: *The fiscal year began (October 1, 2017) with 106 people in supported employment [there was actually an error in reporting 109 as a couple individuals had dropped and one was unable to continue employment due to health]. As of April 30, 2018, 115 individuals have been provided an opportunity for employment and 97 are currently in paid employment. This sub-end may be a difficult one to reach given the current changes with the Home- and Community-Based Rules mandate planning, etc.*

Lynne Fredlund invited Margie Hale-Manley to provide the update with attendees related to this sub-end. Margie noted the number from September 30, 2017 should have been 106 instead of 109 as three individuals were closed successfully from the Agency, which is a success. She reviewed the statistics related to those employed receiving at least minimum wage. She notes the individuals with micro-enterprise average $7.97 per hour. She notes this sub-end has been in existence for several years and regardless if this continues as a sub-end, the department will continue to strive to keep pushing forward. With the new rules coming out, some of the data will be impacted. Mary Mingus noted the rate restructuring impact has many unknowns as well.

4. **During fiscal year 2017-2018 an additional five percent (5%) of persons served with an intellectual/developmental disability will have been given the opportunity to live in a semi/independent community living setting. As of September 30, 2017 we have 81 individuals who have been given the opportunity to live in a semi/independent living setting. A successful end will be 85 served will have this opportunity.**

   Status: *The fiscal year began October 1, 2017 with a census of 81. As of April 30, 2018,86 individuals have been given the opportunity to live independently or semi-independently.*

   Lynne Fredlund invited Peggy Yachasz to provide attendees with an update. Peggy reports the numbers included in this report are for all I/DD individuals served who are in their own living quarters. She reports *Indeed* has been helpful in staff recruitment as the younger generation does not use a newspaper to look for employment. She also reports some individuals can be on the waiting list for a subsidized housing for two years or more. In addition, if a barrier free housing is required this waiting list can be much longer. Peggy Yachasz reports this ends has been part of the plan for several years and regardless if this remains in the plan, the agency will continue to work toward least restrictive environments for those served.

<u>Financial Outcomes</u>

5. **The Board's agency-wide expenses shall not exceed agency-wide revenue at the end of the fiscal year (except as noted in 6.A, below).**

   Status: *As of September 30, 2017, revenues exceed expenses by $113,581. As of March 31, 2018, revenues exceed expenses by $72,132.*

6. **The Board's major revenue sources (Medicaid and Non-Medicaid) shall be within the following targets at year-end:**
   a. **<u>Medicaid Revenue</u>: Expenses shall not exceed 100% of revenue unless approved in advance by the Board and PIHP.**
   Status: *As of September 30, 2017, Medicaid funds were overspent by $15,043. Healthy Michigan funds were overspent by $127,991 and Autism funds were underpaid by $435,402. We are awaiting full reimbursement for the net amounts owed to us: $578,436 from NMRE to settle the annual contract. This is expected to be received by June 15, 2018. As of March 31, 2018 Medicaid funds are underspent by $245,119 and Health Michigan funds are overspent by $101,498. These are all expected to balance to $0 or with a small surplus by year end resulting in a cost settlement with the NMRE from available Medicaid and Healthy Michigan risk funds.*

   b. **<u>Non-Medicaid Revenue</u>: Any over-expenditure of non-Medicaid revenue will be covered by funds from the Authority's fund balance with the prior approval of the board.**

Status: *As of September 30, 2017, General Funds were underspent by $71,055. Of this amount $40,494 was carried forward to FY18 and $30,561 will be lapsed back to MDHHS upon cost settlement. Note that Northeast received a one-time transfer of General Funds in the amount of $100,000 from AuSable Valley Community Mental Health during FY17 or the Authority would have experienced an over-expenditure of General Funds by year end which we plan to carryforward to FY19 (5% carryforward is allowed). We have begun the process of identifying uses for these funds to augment usage in FY18 with remaining amounts.*

Lynne Fredlund invited Cheryl Jaworowski to provide an update. Cheryl reports at the end of March there was a net income of $72,132. She reported the current autism audit could impact the status related to non-Medicaid. There could be services identified which would need to be transferred from a Medicaid expense to a GF expense. She also notes this agency does not receive any funding for SUD services.

Community Education

7. **The Board's public education and communication strategy will include the following:**
   a. **At least one Report to the Community annually.**
   Status: *The Annual Report was completed in May 2018 and is posted to the Agency's website, distributed through e-mail as well as hard copies available for offices, commissioners, collaborative members and those requesting hard copy.*
   b. **Will continue to develop and coordinate community education events and/or cross-systems training events.**
   Status: *Amanda Sola presented on early detection of Autism Spectrum Disorder to Alcona Health Center Behavior Providers on October 3, 2017; Mary Crittenden presented on Depression at First United Methodist Church on October 4, 2017; Peggy Yachasz did a presentation to Pathways Community Mental Health in Marquette on the Monitor/Response System on October 1, 2017; Peggy Yachasz attended the Alpena County Human Services Coordinating Council's October 18, 2017 meeting and provided a presentation on the Monitor/Response System; Nena Sork presented on the topic "Pressure to Be Perfect" on February 10; Amy Thompson and Peggy Yachasz provided a presentation to AuSable Valley on the Monitor/Response System used in the Supported Independent Living Program on March 9 and April 25; Peggy along with Sharon Brousseau went to AuSable Valley and presented to clinical staff, consumers and family members the benefits of the monitoring system [AuSable Valley will be starting a similar program up in June]; Carolyn Bruning, Margie Hale-Manley, Teresa Kowalski, Becky Lahner, Angela Stawoway and Peggy Yachasz did a presentation about Intellectual/developmental disability services offered by the Agency to parents of children attending Pied Piper Opportunity Center and the school's Transition Coordinator on March 21.*
   c. **Will continue to offer training opportunities in Mental Health First Aid for children and youth and also training opportunities in trauma and the effects of trauma on individuals and families.**
   Status: *Three individuals were trained to provide Mental Health First Aid Training in both youth and adults [only two remain certified – Carlene Przykucki and Mary Schalk]. The Adult Mental Health First Aid Training course was offered October 20 & 27 with 18 individuals completing the course. Adult Mental Health First Aid Training was conducted February 20 & 27, March 6 & 13 targeted for NEMROC employees with 15 completing the training. Youth Mental Health First Aid training was offered in Montmorency County on February 14 and March 3 with 8 completing the training.*

In addition, under a contractual arrangement, Partners in Prevention (PiP) provided the Living Works 3.5-hour safeTALK suicide prevention training in Onaway on January 25 to two participants and on February 5 in Hillman to 17 participants. PiP also provided an overview of how trauma affects children to 12 participants in foster parent PRIDE training coordinated through DHHS and held at Child & Family Services on March 10. PiP also provided a 90-minute training on Trauma-Informed Strategies to 15 participants in a staff training at Alpena Childcare and Development Center on March 5. In Presque Isle County, PiP delivered a six-week, 12-hour course addressing Caring for Children Who Have Experienced Trauma to 15 individuals, including Montessori School Director, Hope Shores Alliance staff, foster parents, grandparents and childcare providers.

Cathy Meske reviewed the status for the sub-ends related to Community Education. She reports Peggy Yachasz's program went to Pathways and AuSable Valley and presented information about the SIP Monitoring Program and as a result AuSable Valley will be starting up their own program. This is a great testament to this wonderful program offered here.

Moved by Terry Larson , Albert LaFleche to accept the Ends Monitoring Report as presented. Motion carried.

Update from Consumer Advisory Council

Lynne Fredlund introduced Laura Gray, Chair of the Consumer Advisory Council. Laura reported two of the Consumer Advisory Council members attended the recent NAMI conference in Traverse City. Laura Gray reported she attended sessions to learn more about the Assisted Outpatient Treatment (AOT) process versus the Alternative Treatment Order (ATO). She reported the AOT was developed based on Oakland County's development and this has not worked in other counties. She reported there are ways to get around the bugs. She reports she attended a session "Decriminalizing Mental Illness: Fixing a Broken System" and it is hoped there will be changes to address the need for corrected forms.

Laura Gray stressed the importance to getting a local NAMI Group re-established in the region. There are 10 different family training modules available through NAMI. She reports there is a local group of individuals working to get this established, "Exploratory Team to Form an Alpena Area NAMI." The next meeting will be June 26 at 6:30 p.m. in room 107D at the Besser Tech Center at the Alpena Community College. The group will need to apply to become a new affiliate and there are many documents to fill out to get approved to be a fully endorsed. She notes the group is looking for individuals to serve on the board, become a member of NAMI, attend meetings, etc.

IX. Other Agency Topics

MI Residential Placement Increase

Nena Sork reported the Agency is losing small "Mom and Pop" residential settings. Large conglomerates are buying up the properties to manage and along with that comes an increase in rates. She notes in one home alone the increase was $218,000. She reports another residential provider will be closing due to health condition. If we place in the residents in a corporate-run residential setting the average daily cost of $85/day will increase to $192/day. She stressed the importance of promoting local development of "Mom and Pop" residential homes. Nena Sork volunteered to be the contact person if any individual would want to start the process of preparing to become a licensed residential provider.

Co-occurring Disorder Treatment/Where are we?

Mary Crittenden, Supervisor of ACCESS, CRS and ESU, discussed co-occurring disorders and the treatment the agency is providing to individuals receiving services as well as barriers. Co-occurring

disorders is the presence of both a mental health and substance use disorder in an individual. Substance use is on the rise and as of 2014 7.9 million Americans met criteria for co-occurring disorders. NeMCMHA has 660 individuals open to the Agency who have indicated a substance use disorder. She notes it is important for the Agency to get their staff trained in this field so they will be able to work with individuals who present with co-occurring disorders, be able to educate all individuals regarding the risks of substance use regardless of diagnoses and be able to identify the warning signs of substance use so interventions can be done in early stages. She reports the Agency does have an Integrated Dual Disorder Treatment (IDDT) group led by two Masters Level clinicians. In addition, substance use treatment can be discussed in individual therapy. If an individual does not want to address their substance use with us, referral options are provided. Referral options for alternative treatments may include referrals to such programs as AA, Multiple Pathways including recovery yoga, LifeRing, Restoration Service, Women for Sobriety, individual or group therapy at Catholic Human Services and possibly inpatient treatment. Mary reports under contract NeMCMHA must have an individual working in our main office certified in substance use therapy. Mary noted in our recent audit, it was noted the number of individuals we provide SUD services to was a small section. We were not cited, however, it would be best to increase service provision to this population group. Mary provided attendees with the requirements of an individual prior to applying to be certified. It is the agency's want to get training to the clinicians to provide the needed services. She would like to propose development of a new End. Cathy Meske reports the Agency might want to look at being a provider for substance use disorder treatment in the future. In order to do that, we need to have a workforce qualified to provide the services.

Steve Dean noted in the last page of the article Board members reviewed included the statement, "The mental health field needs to take a lead role in educating the public about dysregulated anger and its treatment as well as working closely with schools and law enforcement to build a system of early identification and treatment for what is, without exception, the most dangerous emotional dysfunction one can have."

Cathy Meske reported the Board's focus should include the impact of the changes in the upcoming regulations which will impact the budget for compliance with the rules.

Development of New Ends

Lynne Fredlund noted Ends are outcomes. She notes there must be elements included in the Ends – 1) Intended Effects, 2) Intended Recipients and 3) Intended Benefit. Per the Carver model, Ends deserve deliberation.

Steve Dean & Nena Sork left at 5 p.m.

Deliberation on the current Ends/Sub-Ends began with the CAFAS end. Cathy Meske noted the difficulty with the state reporting process is it is difficult to get at some data. This Sub-End will be modified slightly to identify progress for children at termination rather than at the end of the third quarter.

Sub Ends 2 – Mary Mingus notes the state's focus is on retention not sustaining. Mary notes this will continue regardless and would no longer be needed. Cathy Meske notes this has been in existence from beginning and would no longer be a challenge.

Gary Nowak reported the employment sub-ends with both be removed. In addition, the sub-end #4 will also be removed.

Cheryl Jaworowski requested to add a sub-end under finance to locate additional funding sources to support training for staff and of co-occurring – this was determined to be a means.

Increase staff competencies as it relates to substance use treatment. Will become n Sub-End. Lynne Fredlund reported as evidenced by .. (will be determined by staff).

Eric Lawson left the meeting at 5:15 p.m.

Judy Hutchins voiced concern about homelessness. Cathy Meske noted the NEMCSA program has the homeless slots and manages this for our community. Mary Mingus notes our case managers do a good job of referring individuals to appropriate points for service. NEMCSA also has the Rapid Re-Housing Program which they manage. Mary reports it is difficult to fix what an individual does not want fixed. Another option is providing options for individuals to secure a bed in another homeless shelter in another county where they haven't burnt their bridges.

Increasing local community placements for persons with mental illness and I/DD will be developed as a Sub-End.

Expand community education to include suicide, SUD and violence in our society will be incorporated into the existing Sub-End.

Lauren Tallant noted working with DHHS and the school system to work on identifying trauma in children services. There might also be an End specifically targeted at children.

Gary Nowak requests more articles published in the newspaper. Change 6. b. to read something like "Will continue to develop and coordinate community education and public relations." Terry Larson suggested the addition of periodic articles and press releases

X. Wrap Up

Gary Nowak thanked all staff and participants for attending this meeting.

XI. Information and/or Comments from the Public

There was no information or comments presented.

XII. Meeting Evaluation

Terry Larson noted it was a long but good meeting with all contributing.

XIII. Adjournment

Moved by Terry Larson, supported by Roger Frye, to adjourn. Motion carried.
This meeting adjourned at 5:40 p.m.

____
Alan Fischer, Secretary

____
Gary Nowak, Chair

Diane Hayka
Recorder

Northeast Michigan Community Mental Health Authority

STRATEGIC PLAN
2018-2019

Mission:

To provide comprehensive services and supports that enable people to live and work independently.

Vision:

Northeast Michigan Community Mental Health will be the innovative leader in effective, sensitive mental and behavioral health services.

In so doing, services will be offered within a culture of gentleness and designed to enhance each person's potential to recover. We will continue to be an advocate for the person while educating the community in the promotion of mental and behavioral health.

Core Values:

- **A Person-Centered focus shall be at the heart of all activities.**
- **Honesty, respect and trust are values that shall be practiced by all.**
- **We will be supportive and encouraging to bring out the best in one another.**
- **Recognition of progress and movement toward a continuously improving environment is a responsibility for all.**
- **We prefer decision-by-consensus as a decision-making model and will honor all consensus decisions.**

Forces in the Environment Impacting Behavioral Health

Payors/Payment Reform

- **Reimbursement based on health outcomes**
- **ACA**
- **Health system insurance plans**

Persons Served

- **Aging population and other demographic changes**
- **Expansion of coverage**
- **Increasing comorbid conditions**
- **Individuals served accessing health information**

Quality Improvement

- **Health and safety**
- **Minimizing waste, fraud and abuse**
- **Right amount of scope & duration of service**

Regulatory Changes

- **Home and Community-Based Services Rule**
- **Potential carve-in of specialty behavioral health**
- **1115 waiver application**

Workforce

- ***Shortage of qualified staff* of all types of disciplines (professional as well as direct care)**
- **Aging workforce**
- **Competing with the private sector (lower pay)**
- **Challenging work environment**
- **Evidence-Based Practices**
- **Training of staff to address current environment**

Technology

- **Electronic EHR**
- **Data Analytics**
- **Increase Mobile Capabilities**
- **Self-Management Tools/Consumer Portal**

Goals:

1. **To reduce the risk of metabolic syndrome in both adults and children.**
2. **To continue the partnership with Thunder Bay Community Health Services, Alcona Health Center and local school systems in order to provide school-based social work services for children**
3. **Promote a trauma-informed community through education, assessment and participation in community initiatives.**
4. **Support and expand services to all children and young adults diagnosed with Autism Spectrum Disorders.**
5. **Coordinate community education and partnerships in suicide prevention.**
6. **To increase Substance Use Disorder (SUD) services and training within the Agency, while partnering with local SUD providers to educate and reduce substance use in the community.**
7. **To collaborate with the Veteran's Administration assuring comprehensive behavioral health services are available.**
8. **To further utilize the Health Information Exchange (HIE) with Great Lakes Health Connect and local organizations in order to share critical health care information.**
9. **To keep current in education and information technology (IT).**

Barriers/Challenges:

Home and Community-Based Services – NeMCMHA will need to work with our providers to assure compliance with the rules for all.

ABA Expansion – Qualified providers, either in-person or through a telehealth arrangement, are limited in this program area.

Integrated Healthcare – The Health Information Exchange (HIE) is not progressing as rapidly as previously anticipated. Data provided is not sufficient to address real time queries on health information of the populations served. Current restrictions of Personal

Health Information (PHI) specific to Substance Use Disorders/treatment does not address the total needs of the individual in an HIE venue.

Funding – The contractual obligations to the Michigan Department of Health and Human Services (MDHHS) while staying within the Per Member Per Month (PMPM) formula provided by the PIHP.

Jail Services – Limited use by law enforcement impacts the number of pre- and post-booking jail diversions.

Recruiting and Retention of Qualified Staff – Local competition for positions has made it difficult to recruit.

Service Population – If service delivery is modified to include the mild to moderate population, current staffing level is insufficient.

Residential Options – Decrease of family operated foster care resulting in the need to contract with more expensive corporate specialized foster care placements.

Opioid Epidemic – The increasing opioid epidemic has strained community resources.

Increasing Violence in our Society – The increasing violence in our society is requiring communities to come together to develop a comprehensive community action plan.

Opportunities:

Work collaboratively with the community partners in the region to promote integrated services, develop shared services and improve consumer accessibility, health outcomes and efficiencies.

Introduce new Evidence-Based Practices (EBPs) and training in the delivery of services.

The infrastructure of NeMCMHA is relatively strong, with excellent facilities, dedicated staff, continued IT investment and a balanced budget.

Provide education to the community at large and support and promote local advocacy efforts.

Work collaboratively with the community partners in the region to address challenges related to the increasing opioid epidemic and increase in violence and anger dyscontrol.

Take advantage of training opportunities provided by MDHHS.

Options:

The Agency must continue to strengthen its relationships with other partners of the market and reinforce its niche in intensive services for people with serious mental illness, serious emotional disturbance and intellectual/developmental disabilities, including those whose disabilities co-occur with substance use. The Agency must strategize to become a valued partner and be indispensable in the pursuit of quality, accessible health care at a lower cost. Options to be considered:

- **Shared psychiatric consultation with staff at other clinics**
- **Easy and consistent flow of individuals and information between behavioral health and primary care providers**

- **Growth of health care awareness and services in CMH services through enhanced training in health coaching and the use of data analytics**
- **Work closely to assure people with a serious mental illness or intellectual/developmental disability are receiving all necessary primary and behavioral healthcare. Expand telemedicine services as it relates to pediatric and adult services.**
- **Provide community members and staff with training as it relates to Mental Health First Aid for youth and adults, suicide prevention, increasing violence in our society, co-occurring disorders and the effects of trauma on individuals.**
- **Continue to be a member of Human Services Collaboratives.**

Plan:

Community Partners will be essential for NeMCMHA as we continue to be successful in the provision of integrated, comprehensive physical and behavioral health services. Northeast will continue to work collaboratively with the major primary health care providers and the Medicaid Health Plans (MHPs) to ensure the requirements to meet the health care reform challenges are met. Joint ventures will be established with community partners to provide seamless systems of care that eliminates duplication, lower costs, ensure quality care and achieve superior outcomes.

The Ends Statements reflect methods of monitoring population groups and department specific goals.

Ends:

All people in the region, through inclusion and the opportunity to live and work independently, will maximize their potential.

Sub-Ends:

Services to Children

1. **Children with serious emotional disturbances served by Northeast will realize significant improvement in their conditions.**
    a. **90% of all children who participate in service (targeted case management, outpatient counseling, Home-Based Services and Wraparound) will show 20 point or more decrease in CAFAS scores at completion of services.**

Services to Adults with Mental Illness and Persons with I/DD

2. **Individuals needing independent living supports will live in the least restrictive environment.**
    a. **Development of 2 additional contract residential providers within our catchment area to increase capacity for persons requiring residential placement.**
    b. **Development of additional supported independent services for two individuals currently living in licensed Foster Care.**

Services to Adults with Co-Occurring Disorders

3. **Adults with co-occurring disorders will realize significant improvement in their condition.**
    a. **75% of those persons with a diagnosed substance use disorder will have one objective in their plan of service addressing treatment options or services.**
    b. **100% of those persons prescribed Buprenorphine for opioid dependence will have an objective in their plan of service addressing medication assisted treatment.**

Financial Outcomes

4. **The Board's Agency-wide expenses shall not exceed Agency-wide revenue at the end of the fiscal year (except as noted in 6., below).**
5. **The Board's major revenue sources (Medicaid and Non-Medicaid) shall be within the following targets at year-end:**
    a. **Medicaid Revenue: Expenses shall not exceed 100% of revenue unless approved in advance by the Board and the PIHP.**
    b. **Non-Medicaid Revenue: Any over-expenditure of non-Medicaid revenue will be covered by funds from the Authority's fund balance with the prior approval of the board.**

Community Education

6. **The Board will provide community education. This will include the following:**
    a. **Disseminate mental health information to the community utilizing available technology and at least one Report to the Community.**
    b. **Develop and coordinate community education in Mental Health First Aid for adults and youth, trauma and the effects of trauma on individuals and families, suicide prevention, co-occurring disorders and the increasing violence in our society.**
    c. **Support community advocacy**

The Ends will be monitored by the Board at least semi-annually.

The Strategic Plan will be reviewed by the Board at least annually.

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Eight Months Ending May 31, 2018
66.7% of year elapsed

		Actual May Year to Date	Budget May Year to Date	Variance May Year to Date	Budget FY18	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 71,321	$ 81,644	$ (10,323)	$ 122,405	58.3%
2	Private Contracts	27,476	38,664	(11,188)	57,967	47.4%
3	Grants from Local Units	197,053	179,378	17,676	268,932	73.3%
4	Interest Income	7,417	4,869	2,548	7,300	101.6%
5	Medicaid Revenue	16,120,442	16,972,643	(852,202)	25,446,242	63.4%
6	General Fund Revenue	513,754	500,504	13,250	750,381	68.5%
7	Healthy Michigan Revenue	972,413	849,194	123,219	1,273,154	76.4%
8	3rd Party Revenue	399,718	227,903	171,815	341,683	117.0%
9	SSI/SSA Revenue	323,634	320,407	3,228	480,370	67.4%
10	Other Revenue	33,972	34,378	(406)	51,541	65.9%
11	**Total Revenue**	**18,667,200**	**19,209,583**	**(542,384)**	**28,799,975**	**64.8%**
	Expense					
12	Salaries	8,207,158	8,602,461	395,303	12,897,243	63.6%
13	Social Security Tax	372,019	407,984	35,965	611,670	60.8%
14	Self Insured Benefits	1,493,124	1,863,544	370,420	2,793,919	53.4%
15	Life and Disability Insurances	146,509	153,831	7,322	230,631	63.5%
16	Pension	654,163	684,432	30,269	1,026,135	63.8%
17	Unemployment & Workers Comp.	149,810	170,791	20,981	256,059	58.5%
18	Office Supplies & Postage	29,280	35,759	6,479	53,611	54.6%
19	Staff Recruiting & Development	92,719	75,498	(17,221)	113,190	81.9%
20	Community Relations/Education	1,072	2,141	1,069	3,210	33.4%
21	Employee Relations/Wellness	39,129	46,704	7,575	70,021	55.9%
22	Program Supplies	268,041	324,779	56,738	486,925	55.0%
23	Contract Inpatient	708,303	660,997	(47,306)	991,000	71.5%
24	Contract Transportation	80,289	69,605	(10,683)	104,356	76.9%
25	Contract Residential	3,122,057	3,133,367	11,309	4,697,701	66.5%
26	Contract Employees & Services	1,980,097	1,845,711	(134,386)	2,767,183	71.6%
27	Telephone & Connectivity	75,508	86,651	11,143	129,912	58.1%
28	Staff Meals & Lodging	18,241	26,585	8,344	39,857	45.8%
29	Mileage and Gasoline	290,158	287,997	(2,161)	431,780	67.2%
30	Board Travel/Education	10,414	9,749	(665)	14,616	71.3%
31	Professional Fees	29,261	29,477	216	44,194	66.2%
32	Property & Liability Insurance	74,325	29,057	(45,269)	43,563	170.6%
33	Utilities	120,891	136,798	15,908	205,095	58.9%
34	Maintenance	123,231	167,184	43,952	250,650	49.2%
35	Rent	176,698	175,854	(844)	263,649	67.0%
36	Food (net of food stamps)	38,941	62,587	23,647	93,834	41.5%
37	Capital Equipment	10,866	31,749	20,883	47,600	22.8%
38	Client Equipment	21,433	13,992	(7,441)	20,978	102.2%
39	Miscellaneous Expense	66,629	64,746	(1,883)	97,071	68.6%
40	Depreciation Expense	187,158	182,232	(4,926)	273,212	68.5%
41	Budget Adjustment	-	(172,680)	(172,680)	(258,890)	0.0%
42	**Total Expense**	**18,587,522**	**19,209,583**	**622,061**	**28,799,975**	**64.5%**
43	**Change in Net Position**	**$ 79,677**	**$ -**	**$ 79,677**	**$ -**	**0.3%**

	Contract settlement items included above:	
44	Medicaid Funds Under Spent	183,688
45	General Funds Over Spent	(8,197)
46	Healthy Michigan Funds Over Spent	(121,667)

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Seven Months Ending April 30, 2018
58.3% of year elapsed

		Actual April Year to Date	Budget April Year to Date	Variance April Year to Date	Budget FY18	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 65,019	$ 71,362	$ (6,343)	$ 122,405	53.1%
2	Private Contracts	23,177	33,795	(10,618)	57,967	40.0%
3	Grants from Local Units	157,834	156,787	1,046	268,932	58.7%
4	Interest Income	3,834	4,256	(422)	7,300	52.5%
5	Medicaid Revenue	14,113,993	14,835,159	(721,166)	25,446,242	55.5%
6	General Fund Revenue	422,890	437,472	(14,582)	750,381	56.4%
7	Healthy Michigan Revenue	877,888	742,249	135,640	1,273,154	69.0%
8	3rd Party Revenue	346,308	199,201	147,107	341,683	101.4%
9	SSI/SSA Revenue	282,186	280,056	2,131	480,370	58.7%
10	Other Revenue	30,675	30,048	627	51,541	59.5%
11	**Total Revenue**	**16,323,804**	**16,790,385**	**(466,581)**	**28,799,975**	**56.7%**
	Expense					
12	Salaries	7,203,592	7,519,093	315,501	12,897,243	55.9%
13	Social Security Tax	326,945	356,604	29,658	611,670	53.5%
14	Self Insured Benefits	1,286,384	1,628,855	342,471	2,793,919	46.0%
15	Life and Disability Insurances	128,023	134,458	6,435	230,631	55.5%
16	Pension	575,583	598,237	22,654	1,026,135	56.1%
17	Unemployment & Workers Comp.	131,918	149,282	17,364	256,059	51.5%
18	Office Supplies & Postage	22,229	31,255	9,026	53,611	41.5%
19	Staff Recruiting & Development	84,713	65,990	(18,723)	113,190	74.8%
20	Community Relations/Education	1,122	1,871	749	3,210	35.0%
21	Employee Relations/Wellness	37,222	40,822	3,600	70,021	53.2%
22	Program Supplies	237,940	283,877	45,937	486,925	48.9%
23	Contract Inpatient	625,593	577,753	(47,840)	991,000	63.1%
24	Contract Transportation	71,157	60,840	(10,318)	104,356	68.2%
25	Contract Residential	2,733,287	2,738,760	5,472	4,697,701	58.2%
26	Contract Employees & Services	1,711,329	1,613,268	(98,061)	2,767,183	61.8%
27	Telephone & Connectivity	66,134	75,739	9,605	129,912	50.9%
28	Staff Meals & Lodging	13,862	23,237	9,375	39,857	34.8%
29	Mileage and Gasoline	249,663	251,728	2,064	431,780	57.8%
30	Board Travel/Education	8,698	8,521	(177)	14,616	59.5%
31	Professional Fees	25,999	25,765	(234)	44,194	58.8%
32	Property & Liability Insurance	65,648	25,397	(40,251)	43,563	150.7%
33	Utilities	104,772	119,570	14,798	205,095	51.1%
34	Maintenance	106,974	146,129	39,155	250,650	42.7%
35	Rent	155,931	153,707	(2,224)	263,649	59.1%
36	Food (net of food stamps)	35,251	54,705	19,455	93,834	37.6%
37	Capital Equipment	9,625	27,751	18,125	47,600	20.2%
38	Client Equipment	21,243	12,230	(9,013)	20,978	101.3%
39	Miscellaneous Expense	61,390	56,592	(4,797)	97,071	63.2%
40	Depreciation Expense	164,203	159,283	(4,920)	273,212	60.1%
41	Budget Adjustment	-	(150,933)	(150,933)	(258,890)	0.0%
42	**Total Expense**	**16,266,430**	**16,790,385**	**523,956**	**28,799,975**	**56.5%**
43	**Change in Net Position**	**$ 57,375**	**$ -**	**$ 57,375**	**$ -**	**0.2%**

	Contract settlement items included above:	
44	Medicaid Funds Under Spent	228,377
45	General Funds Under Spent	31,707
46	Healthy Michigan Funds Over Spent	(133,137)

Northeast Michigan Community Mental Health Authority
Monitoring Report

POLICY CATEGORY: Executive Limitations
POLICY TITLE AND NUMBER: Asset Protection, 01-007
REPORT FREQUENCY & DUE DATE: Annual, July 2018
POLICY STATEMENT:
The CEO may not allow assets to be unprotected, inadequately maintained nor unnecessarily risked.

Accordingly, he or she may not:

1. Fail to insure against theft and casualty losses at:
    - Actual cash value less any reasonable deductible for vehicles
    - Replacement value less any reasonable deductible for personal and real property; and,
    - Against liability losses to board members, staff or the organization itself in an amount greater than the average for comparable organizations.
   - **Interpretation**
     A broad program of insurance or self-insurance is to be in place providing protection against these potential losses. Coverage is to be at replacement value. The level of liability coverage is to be "above average."

   - **Status**
     Northeast has been a member of Michigan Municipal Risk Management Authority (MMRMA) since 1982. The program provides coverage at or above the prescribed levels. Please see Attachment A - "Coverage Overview." Presently, personal and real property owned by the Board is insured at replacement value; however, vehicles are covered at actual cash value.

2. Allow unbonded personnel access to material amounts of funds.
   - **Interpretation**
     Any employee with access to agency funds is to be covered by fidelity bond.

   - **Status**
     MMRMA provides blanket employee fidelity bond for all employees at the level of $1,000,000. See attached "Coverage Overview (Attachment A, Page 3, Line 16)."

3. Unnecessarily expose the organization, its board or staff to claims of liability. The CEO's annual report shall include a risk analysis summary.
   - **Interpretation**
     The organization is to be managed and services are to be provided in ways that reduce exposure to liability.

   - **Status**
     The agency's Risk Management Plan is attached; it includes notes evaluating our status relative to each of the six major areas of risk covered by the plan.

4. Make any purchase wherein normally prudent protection has not been given against conflict of interest. Make any purchase of over $250 without having obtained comparative prices and quality. Make any purchase over $5,000 without a stringent method of assuring the balance of long term quality and cost; further, such purchases over $5,000 not included in the Board's capital equipment budget, shall require Board approval. Orders shall not be split to avoid these criteria.
   - **Interpretation**
     Management is to assure that purchasing decisions are made following a consistently applied procedure that meets these restrictions. The procedure should not be so onerous that savings that might accrue from it are lost to bureaucratic oversight.

   - **Status**
     The organization uses a policy that places much responsibility for purchasing at the staff level we hold responsible for budget performance—supervisors. When a proposed purchase exceeds the noted levels, additional approvals are required.

5. Fail to protect intellectual property, information and files from loss or significant damage.
   - **Interpretation**
     The organization will protect work products (primarily clinical records, management and financial records) from fire or other potential causes of loss.

   - **Status**
     The organization uses an electronic medical record (EMR). Case records are maintained in electronic format with controlled access. This matter has received considerable attention since the advent of HIPAA. Only designated personnel have access to maintenance of electronic records. Key to success is staff training and compliance with these procedures. Our policies 3810 and 5200 ("Confidentiality—Disclosure & Security of Information" and "Consumer Records") detail these procedures. Staff are trained at time of hire and periodically thereafter. These clinical records are backed up and stored off-site. Information stored on agency computer systems is backed up nightly. The same high standard of security and privacy is being upheld with the EMR system as it was with the past paper chart system.

6. Receive, process or disburse funds under controls which are insufficient to meet the board-appointed auditor's standards.
   - **Interpretation**
     Agency policies regarding internal controls and separation of duties will be followed; these policies will take into account the Auditor's advice.

   - **Status**
     Policies 4300, 4310, 4315, 4330 (among others) document these controls which are followed by employees. There has never been a significant loss of agency funds with the exception of very minor and infrequent shortages of petty cash accounts.

7. Invest or hold operating capital in insecure instruments, including uninsured checking accounts and bonds of less than AA rating, or in non-interest bearing accounts except where necessary to facilitate ease in operational transactions.
   - **Interpretation**
     Operating funds are to be managed only according to the organization's cash management policy.

   - **Status**
     All cash reserves are maintained according to our cash management policies. Since all cash is invested in either CD's or our interest-earning checking account as needed, there is a risk of loss due to maximum insurable FDIC rules. Four local banks are used to spread the FDIC risk.

8. Endanger the organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission, including changing the name of the organization or substantially altering its identity in the community.
   - **Interpretation**
     The mission of the organization, as established by the Board, must guide service provision and the interface with the community.

   - **Status**
     Over the past several years, we have worked hard to sharpen the focus of the organization to address the mandates of the mental health code and, due to general fund shortages, limit service to the "must serve" populations (versus "may serve"). Recognizing and observing this limitation has been somewhat painful—for consumers, Board members, staff and community partners. We must (and, I believe, do) excel in supporting people with the most severe disabilities in the community. We will have to continue to identify appropriate referral sources for people who do not meet our eligibility criteria. Since October 1, 2014 we have been responsible for Access Services locally. That has permitted us to make immediate referrals for individuals who are not eligible for our services.

9. Subject facilities and equipment to improper wear and tear or insufficient maintenance.
   - **Interpretation**
     The physical assets of the organization will not be abused and will be regularly maintained both for safety reasons and to extend their useful lives as much as possible.

   - **Status**
     The organization's policies require regular inspection and maintenance of all facilities and significant equipment.

     The organization uses a fleet of 65 vehicles. Fleet vehicles generally have a service life of 120,000 miles and/or five to six years of service. After June & July vehicle trade-ins are complete, all vehicles will have less than 120,000 miles of. The Agency is committed to providing quality transportation in the four-county area.

Board Review/Comments

Reasonableness Test: Is the interpretation by the CEO reasonable?

Data Test: Is the data provided by the CEO both relative and compelling?

Fine-tuning the Policy: Does this report suggest further study and refinement of the policy?

Other Implications: Does this report suggest the other policies may be necessary?

MICHIGAN MUNICIPAL RISK MANAGEMENT AUTHORITY
COVERAGE OVERVIEW

Member: **Northeast Michigan C.M.H.S.** **Proposal No: Q000011573**

Date of Original Membership: **July 29, 1982**

Overview Dates: **July 1, 2018 To July 01, 2019**

Member Representative: **Cheryl Jaworowski** **Telephone #: (989) 358-7737**

Regional Risk Manager: **Michigan Municipal Risk Management Authority** **Telephone #: (734) 513-0300**

A. Introduction

The Michigan Municipal Risk Management Authority (hereinafter "MMRMA") is created by authority granted by the laws of the State of Michigan to provide risk financing and risk management services to eligible Michigan local governments. MMRMA is a separate legal and administrative entity as permitted by Michigan laws. **Northeast Michigan C.M.H.S.** (hereinafter "Member") is eligible to be a Member of MMRMA. **Northeast Michigan C.M.H.S.** agrees to be a Member of MMRMA and to avail itself of the benefits of membership.

Northeast Michigan C.M.H.S. is aware of and agrees that it will be bound by all of the provisions of the Joint Powers Agreement, Coverage Documents, MMRMA rules, regulations, and administrative procedures.

This Coverage Proposal summarizes certain obligations of MMRMA and the Member. Except for specific coverage limits, attached addenda, and the Member's Self Insured Retention (SIR) and deductibles contained in this Coverage Proposal, the provisions of the Joint Powers Agreement, Coverage Documents, reinsurance agreements, MMRMA rules, regulations, and administrative procedures shall prevail in any dispute. The Member agrees that any dispute between the Member and MMRMA will be resolved in the manner stated in the Joint Powers Agreement and MMRMA rules.

B. Member Obligations – Deductibles and Self Insured Retentions

Northeast Michigan C.M.H.S. is responsible to pay all costs, including damages, indemnification, and allocated loss adjustment expenses for each occurrence that is within the Member's Self Insured Retention (hereinafter the "SIR"). **Northeast Michigan C.M.H.S.**'s SIR and deductibles are as follows:

Table I

Member Deductibles and Self Insured Retention

COVERAGE	DEDUCTIBLE	SELF INSURED RETENTION
Liability	N/A	$75,000 Per Occurrence
Vehicle Physical Damage	$1,000 Per Vehicle	$15,000 Per Vehicle $30,000 Per Occurrence
Fire/EMS Replacement Cost	N/A	N/A
Property and Crime	$1,000 Per Occurrence	N/A
Sewage System Overflow	N/A	N/A

The member must satisfy all deductibles before any payments are made from the Member's SIR or by MMRMA.

Member's Motor Vehicle Physical Damage deductible applies, unless the amount of the loss exceeds the deductible. If the amount of loss exceed the deductible, the loss including deductible amount, will be paid by MMRMA, subject to the Member's SIR.

The **Northeast Michigan C.M.H.S.** is afforded all coverages provided by MMRMA, except as listed below:

1. Sewage System Overflow
2. Specialized Emergency Response Recovery Coverage
3.
4.

All costs including damages and allocated loss adjustment expenses are on an occurrence basis and must be paid first from the Member's SIR. The Member's SIR and deductibles must be satisfied fully before MMRMA will be responsible for any payments. The most MMRMA will pay is the difference between the Member's SIR and the Limits of Coverage stated in the Coverage Overview.

Northeast Michigan C.M.H.S. agrees to maintain the Required Minimum Balance as defined in the Member Financial Responsibilities section of the MMRMA Governance Manual. The Member agrees to abide by all MMRMA rules, regulations, and administrative procedures pertaining to the Member's SIR.

C. MMRMA Obligations – Payments and Limits of Coverage

After the Member's SIR and deductibles have been satisfied, MMRMA will be responsible for paying all remaining costs, including damages, indemnification, and allocated loss adjustment expenses to the Limits of Coverage stated in Table II. The Limits of Coverage include the Member's SIR payments.

The most MMRMA will pay, under any circumstances, which includes payments from the Member's SIR, per occurrence, is shown in the Limits of Coverage column in Table II. The Limits of Coverage includes allocated loss adjustment expenses.

TABLE II
Limits of Coverage

Liability and Motor Vehicle Physical Damage	Limits of Coverage Per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
1. Liability	15,000,000	N/A	N/A	N/A
2. Judicial Tenure	N/A	N/A	N/A	N/A
3. Sewage Systems Overflows	0	N/A	0	N/A
4. Volunteer Medical Payments	25,000	N/A	N/A	N/A
5. First Aid	2,000	N/A	N/A	N/A
6. Vehicle Physical Damage	1,500,000	N/A	N/A	N/A
7. Uninsured/Underinsured Motorist Coverage (per person)	100,000	N/A	N/A	N/A
Uninsured/Underinsured Motorist Coverage (per occurrence)	250,000	N/A	N/A	N/A
8. Michigan No-Fault	Per Statute	N/A	N/A	N/A
9. Terrorism	5,000,000	N/A	N/A	5,000,000

Property and Crime	Limits of Coverage Per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
1. Buildings and Personal Property	8,894,761	350,000,000	N/A	N/A
2. Personal Property in Transit	2,000,000	N/A	N/A	N/A
3. Unreported Property	5,000,000	N/A	N/A	N/A
4. Member's Newly Acquired or Constructed Property	5,000,000	N/A	N/A	N/A
5. Fine Arts	2,000,000	N/A	N/A	N/A
6. Debris Removal (25% of insured direct loss plus)	25,000	N/A	N/A	N/A
7. Money and Securities	1,000,000	N/A	N/A	N/A
8. Accounts Receivable	2,000,000	N/A	N/A	N/A
9. Fire Protection Vehicles, Emergency Vehicles, and Mobile Equipment (Per Unit)	2,000,000	10,000,000	N/A	N/A
10. Fire and Emergency Vehicle Rental (12 week limit)	1,000 per week	N/A	N/A	N/A
11. Structures Other Than a Building	5,000,000	N/A	N/A	N/A
12. Storm or Sanitary Sewer Back-Up	1,000,000	N/A	N/A	N/A
13. Marine Property	1,000,000	N/A	N/A	N/A
14. Other Covered Property	10,000	N/A	N/A	N/A
15. Income and Extra Expense	5,000,000	N/A	N/A	N/A
16. Blanket Employee Fidelity	1,000,000	N/A	N/A	N/A
17. Faithful Performance	Per Statute	N/A	N/A	N/A
18. Earthquake	5,000,000	N/A	5,000,000	100,000,000
19. Flood	5,000,000	N/A	5,000,000	100,000,000
20. Terrorism	50,000,000	50,000,000	N/A	N/A

TABLE III

Data Breach and Privacy Liability, Data Breach Loss to Member, Electronic Media Liability, and Breach Mitigation Expense Coverage

Limits of Coverage

Retroactive Dates:
For Coverage A-- Data Breach and Privacy Liability Coverage: 07/01/2013
For Coverage C -- Electronic Media Liability Coverage: 07/01/2013

Data Breach and. Privacy Liability, Data Breach Loss to Member, E:lectronic Media Liability, and Breach Mitigation Expense	Limits of Coverage Per Occurrence/Claim	Annual Aggregate	
	Member	Member	All Members
Coverage A – Data Breach and Privacy Liability Coverage: Each Claim:	$5.000,000. Included in the limit above	$5,000,000	$25.000.000
Coverage B – Data Breach Loss to Member Coverage: Each Unauthorized Access:	Included in the limit above		
Coverage C – Electronic Media Liability Coverage: Each Claim:	Included in the limit above		
Coverage D – Breach Mitigation Expense Coverage: Each Unintentional Data Compromise:	Included in the limit above		

The total liability of MMRMA shall not exceed $5,000,000 per Member aggregate Limit of Liability for coverages A, B, C, and D, in any coverage period.

The total liability of MMRMA shall not exceed $25,000,000 for All Members aggregate Limit of Liability for coverages A, 8, C, and D, from July 1, 2018, to June 30, 2019.

TABLE IV

Data Breach and. Privacy Liability, Data Breach Loss to Member, Electronic Media Liability, and Breach Mitigation Expense Coverage

Deductibles

Data Breach and Privacy Liability, Data Breach Loss to Member, Electronic Media Liability, and Breach Mitigation Expense	Deductible Per Occurrence/Claim
	Member
Coverage A – Data Breach and Privacy Liability Coverage: Each Claim:	$25.000
Coverage 8 – Data Breach Loss to Member Coverage: Each Unauthorized Access:	$25.000
Coverage C – Electronic Media Liability Coverage: Each Claim:	$25.000
Coverage D – Breach Mitigation Expense Coverage: Each Unintentional Data Compromise:	$25.000

TABLE V

Specialized Emergency Response Recovery Coverage

Limits of Coverage

Specialized Emergency Response Expense Recovery	Limits of Coverage per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
	N/A	N/A	N/A	N/A

TABLE VI

Specialized Emergency Response Recovery Coverage

Deductibles

Specialized Emergency Response Expense Recovery	Deductible per Occurrence
	Member
	N/A

D. Contribution for MMRMA Participation

Northeast Michigan C.M.H.S.

Period: July 01, 2018 To July 01, 2019

Coverages per Member Coverage Overview:	$90,369
Stop Loss Coverage:	$4,275
Member Loss Fund Deposit:	$15,000
TOTAL ANNUAL CONTRIBUTIONS:	$109,644

E. List of Addenda

1. Stop Loss Program Participation Agreement

This document is for the purpose of quotation only and does not bind coverage in the Michigan Municipal Risk Management Authority, unless accepted and signed by both the authorized Member Representative and MMRMA Representative below.

Accepted By:
Northeast Michigan C.M.H.S.

[signature]
Member Representative

5/23/18
Date

Proposal No:
Q000011573

MMRMA

[signature]
MMRMA Representative

5-16-2018
Date

ADDENDUM

STOP LOSS PROGRAM
PARTICIPATION AGREEMENT

Optional

The Stop Loss Program limits the Member's cash payments during a July 1 – June 30 year for those costs falling within the Member's SIR. The Stop Loss Program responds only to cumulative Member SIR payments, including damages, indemnification, and allocated loss adjustment expenses, within a July 1 – June 30 calendar year. The paid costs include payments for any coverage provided to the Member by MMRMA provided that the costs are actually paid within the July 1 – June 30 period. On July 1 of each year, the Member's paid costs accumulate from zero.

If the Member has chosen to participate in the Stop Loss Program, and if the Member's paid costs exceed the member's entry point, the Stop Loss Program will pay, until July 1, all costs that would, in the absence of the Stop Loss Program, be paid from the Member's SIR. **Northeast Michigan C.M.H.S's** entry point is **$150,000**. Withdrawing Members do not participate in the Stop Loss Program after the date of withdrawal.

The Member agrees to be bound by MMRMA rules relating to the Stop Loss Program.

Accepted by:

Member Representative

Date: 5/23/18

MMRMA

Authorized Representative

Date: 5-16-2018

NeMCMH Risk Management Plan
2017/2018

Northeast Michigan Community Mental Health Authority (NeMCMHA) is a member of a five Board PIHP called the Northern Michigan Regional Entity (NMRE). NeMCMHA provides services to consumers living in the Alcona, Alpena, Montmorency and Presque Isle Counties. Northeast is subject to surveys and audits from the State of Michigan, CARF and the NMRE.

Northeast Michigan CMH Mission Statement:

To provide comprehensive services and supports that enables people to live and work independently.

Risk Reduction Efforts

NeMCMHA is committed to reducing risk in all areas of service. In order to provide the services promised in our Mission Statement, NeMCMHA expends time, finances and creativity in the prevention, reduction and monitoring of risk areas.

Financial Risk:

1. Annually a budget is developed for the upcoming year. This is completed every August prior to the beginning of a new fiscal year. Various supervisors of programs and the Finance Director complete this budget. The budget is shared and approved by the Board of Directors.
2. Supervisors receive monthly statements showing actual operational results as compared to their approved budgets. All operational results are reviewed monthly by finance staff and the Management Team.
3. As changes in the budget are needed, amendments are completed and reported to the Board of Directors for approval.
4. Annually a CPA Audit is completed. For the last 10 plus years, all audits completed have resulted in an unqualified audit. A representative of the CPA firm reports the results of this audit to the Board of Directors.
5. Monthly budget reporting to the Board.
6. Compliance hotline to report potential risks areas. Compliance forms are available on site for reporting compliance violations.
7. There continues to be a growing dissonance between the expectations of the Michigan Department of Health and Human Services (MDHHS) and its willingness/ability to pay the cost of those expectations, this risk applies primarily to General Fund but more recently Medicaid dollars have been affected and the NeMCMHA has had to make cuts in various areas of the budget. NeMCMHA will collaborate with the MDHHS and with the Community Mental Health Association of Michigan (CMHAM) in addressing this risk.

Environmental Safety Risk:

1. An external authority completes safety site reviews on every site. These reviews and recommendations of these reviews are addressed as identified.
2. NeMCMHA has a Safety Committee to review various areas of risk. This committee focuses on the reduction of staff injury risk. The Safety Committee looks at staff safety with regard to vehicle safety and physical environment. The Committee reviews all accident reports submitted by staff. Once reviewed, areas of potential risks to other staff are identified and recommendations for improvement are submitted.
3. This committee is responsible for ensuring the Environment of Care Manual and Emergency Flip charts are up to date. These flip charts allow staff easy access to what to do in the event of emergency. Emergency Flip Charts are located at all sites.
4. The Safety Committee is a Standing Committee to the Quality Improvement (QI) Council and all areas of improvement are filtered to and from the QI Council.

5. Emergency drills are conducted at all work sites on all shifts.
6. NeMCMHA has an assigned infection control nurse.

Technology Risk:

1. NeMCMHA has a network usage policy 3600, which is designed to protect employees, partners and the Agency from illegal or damaging actions by individuals, either knowingly or unknowingly.
2. NeMCMHA has installed a spam filter/virus protection server for all incoming email and has an internet firewall protection server for browsing the internet.
3. NeMCMHA uses an encryption email server for confidential emails to outside emails.

Insurance and Liability Risk:

1. Internal claims verification and documentation reviews.
2. Quarterly the NMRE's Compliance Director reviews claims of the previous quarter to ensure staff adhere to required documentation standards and individual plans of service are followed.
3. Adequate Insurance Coverage – NeMCMHA is a member of Michigan Municipal Risk Management Authority (MMRMA), which provides broad coverage for the organization and staff.
4. Independent contractors are required to have the appropriate insurances to complete the services requested.

Consumer Risk:

1. NeMCMHA has policies in place, which safeguard individuals' served funds.
2. NeMCMHA has a sentinel event policy, including protocols to follow in the event an individual served by the Agency has been involved in an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. These events are reported to the state, reviewed, analyzed and recommendations are identified and implemented.
3. Incident Reports are completed on individuals served involved in any unusual incident.
4. Death reports are completed on all deaths of an individual served by CMH when manner of death is indeterminate. The Recipient Rights Officer reviews every death report that is presented.
5. A CMH psychiatrist completes death reviews post mortem when death is by drug overdose.
6. Behavior Support Committee (BSC) meets monthly to review proposed behavior plans and approved behavior plans.

Record Review:

1. Record reviews are completed by supervisors on a monthly basis to ensure records contain the appropriate information and staff are documenting services as policy demands.
2. Quarterly, the Regional Entity's Compliance Director, during the claims review, reviews the documentation to ensure compliance with documentation standards.

Potential Risk:

- Annually the Risk Management Committee selects from identified potential risks areas, at least one area to analyze and present recommendations for risk reduction in that area.

NeMCMHA through their ongoing processes; outside audits, surveys and self-assessments continue to demonstrate its commitment to protect its human, financial, and goodwill assets and resources through the practice of effective risk management. The Board, management and staff of NeMCMHA are committed to safeguarding the safety of individuals receiving services, staff, and anyone who has contact with the organization.

NeMCMHA continues to strive to improve its risk management program. Every year, new and innovative ways of reducing risk are identified and added to the list of efforts.

Annually the Risk Management Committee will review the Risk Management Plan.

Northeast Michigan Community Mental Health Authority
Monitoring Report

POLICY CATEGORY: Executive Limitations
POLICY TITLE AND NUMBER: Community Resources, 01-010
REPORT FREQUENCY & DUE DATE: Annual: July 2018
POLICY STATEMENT:

With respect to the attainment of Northeast Michigan Community Mental Health Authority, the CEO may not fail to take advantage of collaboration, partnerships and innovative relationships with agencies and other community resources.

- **Interpretation**

The agency will develop and maintain collaborative and productive relationships within the community; we will be actively represented on Community Collaboratives (CCs). Further, agency staff will actively participate on appropriate community coordination/planning groups. Wherever possible, "wrap-around" approaches to serve families and children with complex needs should be pursued.

- **Status**

There are four CCs in the four-county area, one representing each county. The Director is presently a member of the Executive Committee of the Alpena County Human Services Coordinating Council (HSCC), Carolyn Bruning is a member of the Montmorency County Community Collaborative, Alcona County Community Collaborative, Alpena HSCC and the Presque Isle HSCC. In addition, we have staff actively representing the agency on the Homeless Coalition, ESD Transition Planning Council, CAN (Child Abuse & Neglect) Teams, EPSDT (Early & Periodic Screening, Diagnostic and Treatment), Headstart, Early Headstart, Children's Closet, Child Death Review Team, Wraparound Community Teams, Great Start Collaborative, Northeast MI Trauma-Informed Action collaborative, Alpena Public Schools Trauma initiative and Alpena, Montmorency DHHS trauma partnership with Children's Trauma Assessment Center (CBAT) and Catholic Human Services. Northeast staff are members of the Substance Use Coalition and Northeast staff is scheduled to participate in training specific to adolescent substance use. We are also members of Alpena County Prevention Council. We sent additional staff to be trained in Critical Incident Stress Management and debriefing; bringing the total to five who are active in the CISM Team of Northeast Michigan, responding to community critical incidents. The Director is in the process of collaborating with District Health No. 2 and the Alpena County Community Emergency Response Departments to be included in the Community Emergency Response Plan.

We participate in several community partnerships, in addition to contracting with Partners in Prevention to provide education to the community, including the schools on the effects of trauma, suicide prevention and Adult and Youth Mental Health First Aid. During the First and Second Quarter of FY 18, 33 community members participated in Mental Health First Aide and 8 community members completed Youth Mental Health First Aid. In addition 42 individuals were trained on the effects of trauma on children. NeMCMHA staff has provided mental health training for two of our local jail staff (Montmorency and Alpena).

Two NeMCMHA staff are participating in the MDHHS sponsored training by University of Michigan "TRAILS" (Transforming Research into Action to Improve the Lives of Students) model. "TRAILS" provides free training to school professionals in core concepts of cognitive behavioral therapy (CBT) and mindfulness – two evidence-based strategies shown to reduce anxiety and depression in youth. TRAILS is unique in that school partners receive not only classroom instruction, but also are provided a personal coach (trained CMH staff) who helps

implement a CBT- and mindfulness-based skills group to students in need, right at school. We contracted with Alcona Health Center (AHC) to provide additional outpatient counseling services in a school identified by Alpena Public Schools up to two days per week.

NeMCMHA, Partners in Prevention and other community partners are providing community-wide suicide awareness/prevention training during FY18. NeMCMHA has partnered with Presque Isle Suicide Prevention Task Force to increase suicide awareness and prevention and trained 19 individuals in Onaway and Hillman using 'safeTALK' from Living Works.

NeMCMHA staff is a member of the new Family Recovery Care Team (Catholic Human Services, Alpena/Montmorency County DHHS, Courts and Freedom Recovery Center) targeting families involved with DHHS Child Welfare services and have a caregiver identified as having a substance use disorder or concern that substance abuse is present in the home. This project is a result of the Health Endowment Fund grant awarded to Catholic Human Services.

Board Review/Comment

Reasonableness Test: Is the interpretation by the CEO reasonable?

Data Test: Is the data provided by the CEO both relative and compelling?

Fine-tuning the Policy: Does this report suggest further study and refinement of the policy?

Other Implications: Does this report suggest the other policies may be necessary?

EXECUTIVE LIMITATIONS
(Manual Section)

COMMUNITY RESOURCES
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved:	July 12, 2007

●1 POLICY:

With respect to the attainment of Northeast Michigan Community Mental Health Authority "Ends," the CEO may not fail to take advantage of collaboration, partnerships and innovative relationships with agencies and other community resources.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

PUBLIC HEARINGS
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved	July 14, 2016

●1 POLICY:

The Authority shall conduct public hearings of its response to the Michigan Department of Health and Human Services Annual Submission (a.k.a. – PPGs) prior to its submission, and for its adoption of its annual budget at or before the beginning of the fiscal year.

The Annual Submission public hearing may be conducted by the Director at a time and date necessary to accommodate a timely submission of required documents; Board members will be invited to participate in the hearing as well as members of the public.

The public hearing regarding the adoption of the budget shall be conducted by the Chair of the Authority at a meeting of the Board of the Authority.

The hearings shall adhere to these guidelines:

Annual Submission (PPGs) Hearing:
This hearing will be scheduled to be conducted as soon as possible after the release of the guidelines by the Department of Health and Human Services. The purpose of the hearing will be to explain to the public the requirements of those guidelines and the likely effect on local mental health programs; further, to receive public input from members of the public about ways to meet the intent of the guidelines and to offer opportunities for the public to suggest other priorities, as well.

Annual Budget Hearing:
This hearing will be conducted during either the September or October meetings of the Board of the Authority. The purpose of the meeting will be to adopt in public session a budget for the fiscal year that incorporates and supports the Ends adopted by the Board and reflects program adjustments that may have been included in the response the Department's Program Policy Guidelines.

Required Notice for Public Hearings:
Ten days advance notice of public hearings shall be required. The notice shall be placed in all area newspapers and shall include information about the purpose of

the hearing and the form of input members of the public may offer. Depending upon the type of hearing, specific invitations may be sent to interested parties such as county commissions, mental health service providers, the medical societies, boards of education, mental health advocacy organizations, etc.

Format of Hearings:
Hearings shall be conducted in such fashion as to assure that members of the public receive adequate information about the matter to be acted upon, and have sufficient opportunity to offer suggestions and alternative points of view.

The Hearing shall be documented, noting the names of participants, their affiliations, if any, and a summary of the input offered.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

Annual Submission (PPGs): Guidelines released annually by the Michigan Department of Health and Human Services in which the Department introduces new directions it intends the public mental health system to move and gathers information from community mental health services programs regarding their level of readiness for such transitions. This annual submission also includes the annual needs assessment required by the Mental Health Code as well as statistical information about services offered and provided.

Fiscal Year: October 1 through September 30

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM, MAY 23, 2018
CROSS STREET CONFERENCE ROOM, GAYLORD

BOARD MEMBERS IN ATTENDANCE:	**Carol Crawford, Roger Frye, Ed Ginop, Annie Hooghart, Randy Kamps, Gary Klacking, Terry Larson, Gary Nowak, Jay O'Farrell, Dennis Priess, Richard Schmidt, Karla Sherman, Joe Stone, Don Tanner, Nina Zamora**
STAFF IN ATTENDANCE:	**Karl Kovacs, Eric Kurtz, Mary Marlatt-Dumas, Brian Martinus, Cathy Meske, Stewart Mills, Diane Pelts, Christy Pudvan, Rik Rambo, Dee Whittaker, Carol Balousek**
PUBLIC IN ATTENDANCE:	**Chip Cieslinski, Trina Edwards**

CALL TO ORDER
Let the record show that Chairman Randy Kamps called the meeting to order at 10:01AM.

ROLL CALL
Let the record show that all Board Members were in attendance for the meeting on this date.

PLEDGE OF ALLEGIANCE
Let the record show that the Pledge of Allegiance was recited as a group.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST
Let the record show that no conflicts of interest were expressed with any of the meeting agenda items.

APPROVAL OF PAST MINUTES
The minutes of the April meeting of the NMRE Governing Board were included in the materials for the meeting on this date.
MOTION MADE BY DON TANNER TO APPROVE THE MINUTES OF THE APRIL 25, 2018 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, SECOND BY JOE STONE. MOTION

APPROVAL OF AGENDA
Let the record show that Eric Kurtz proposed adding "Partners in Excellence Award" and "MDOC Update" to the agenda for the meeting on this date.
MOTION MADE BY DON TANNER TO APPROVE THE AGENDA FOR THE MAY 23, 2018 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED, SECOND BY JAY O'FARRELL. MOTION CARRIED.

CORRESPONDENCE
1. Community Mental Health Association of Michigan (CMHAM) Strategic Plan for 2018-2023.
2. Paper "Defining the Role of Michigan's Public Mental Health System in Healthcare Transformation: The Association's Part of this Effort" from CMHAM, approved by its Executive Board April 30, 2018.
3. The CMHAM Strategic Plan 2018-2023 slide presentation to the Member Assembly, Spring 2018.
4. A request made under the Freedom of Information Act to the NMRE by Andrea Rizor, staff attorney for m Michigan Protection & Advocacy Services, Inc. dated May 9, 2018 for the last three assessments of

network adequacy for the region. A regional capacity assessment has not been done at the PIHP-level since 2014 but was included in the NMRE's Strategic Plan; the CMHSPs do individual needs assessments. This was communicated to MP&A with no response back to date.

5. A letter from Kendra Brinkley from MDHHS to Eric Kurtz dated May 15, 2018 indicating the FY18 2nd Quarter ABA Quality and System Improvement report for NMRE indicating two areas of noncompliance. A Plan of Correction is due to the Department by May 30, 2018. This topic will be discussed in detail later in the day's meeting Agenda.

ANNOUNCEMENTS

Let the record show that no announcements were made during the meeting on this date.

PUBLIC COMMENTS

Let the record show that no comments were made from the public during the meeting on this date. NMRE staff and public in attendance were introduced to the Board.

REPORTS

Board Chair Report/Executive Committee

Let the record show that no meetings have occurred, and no report was given on this date.

CEO's Report

The NMRE CEO Report for May 2018 was included in the materials for the meeting on this date. Mr. Kurtz highlighted the readiness meeting held on April 20th regarding the Opioid Health Home. Everything is moving at a very fast pace to have it up and running October 1st. Enhancements to IT, and additional staffing is needed (equivalent of 3 FTEs). The NMRE is moving forward with securing office space and transitioning to NMRE direct employed staff. Mr. Kurtz discussed the PCE cross-disciplinary roundtable meeting on May 8th. The purpose of gathering regional staff was to share information, concerns, and fixes pertaining to PCE software and modules. Additional meetings will be scheduled. It was noted that these discussions will be very beneficial to Northern Lakes CMH as they plan for implementation. Mr. Kurtz discussed his meeting May 14th with Gabe Schneider (Munson lobbyist) regarding advocacy efforts. The Day of Recovery Education, held on May 11th, was a big success with approximately 120 in attended.

Mr. Tanner asked where things stand with MDHHS-PIHP Contract negotiations and the Medicaid savings issue. Mr. Kurtz responded it was not addressed in Amendment No.2 to the FY18 Contract (later agenda item). He noted Chip Johnston has had some conversations with Lynda Zeller on the topic and he is also discussing it with Alan Bolter and Bob Sheehan at CMHAM. Mr. Tanner asked whether Mr. Kurtz has heard about any current lawsuits; Mr. Kurtz responded he heard something coming from Network 180 but was unaware of the status. Mr. Tanner called the matter "very frustrating."

Dennis Pries noted that Grand Traverse County's liquor tax balance is approaching $1M. Carol Crawford responded the Board of Commissioners and city officials are aware of the amount and a coalition has been formed to make determinations.

MOTION MADE BY GARY NOWAK TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY CHIEF EXECUTIVE OFFICER REPORT FOR MAY 2018, SECOND BY ANNIE HOOGHART. MOTION CARRIED.

SUD Board Report

The minutes from the May 7, 2018 meeting of the NMRE Substance Use Disorder Oversight Board were included in the materials for the meeting on this date in draft form. Liquor tax requests were recommended and were presented for approval.

1. Grand Traverse County for Dann's House in the amount of $30,000.
2. Alcona, Alpena, Oscoda, Montmorency, and Presque Isle Counties for Hidden in Plain Sight program provided by Catholic Human Services in the amount of $2,112 per county for a total request of $10,560.
3. Each of the 21 counties in the NMRE region for Keith Graves training provided by Catholic Human Services in the amount of $335 per county for a total request of $7,035.
4. Each of the 21 counties in the NMRE region to establish for Community Anti-Drug Coalition training at a cost of $380 per county for a total request of $8,001.

MOTION MADE BY ROGER FRYE TO APPROVE THE LIQUOR TAX REQUESTS RECOMMENDATION OF THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON MAY 7, 2018, SECOND BY TERRY LARSON. MOTION CARRIED.

Financial Reports

The NMRE Monthly Financial Report for March 2018 was included in the materials for the meeting on this date. Deanna Yockey reported that eligible have remained constant for six months into the year; revenue is following. Medicaid surplus of $2.81M is offset by HMP deficit of $900K ($1.91M). Medicaid ISF was reported as $6.6M and Medicaid savings was reported as $4.2M. Healthy Michigan ISF was reported as $5.4M. Overall, the NMRE is in a favorable financial position. Community reinvestment strategies are in process to address the Medicaid surplus. Cathy Meske spoke about increased residential placement costs. Karl Kovacs commented on the development of Supported Independent Placement (SIP) homes as an alternative to specialized residential. Joe Stone requested a summary of how the surplus funds are being spent which Mr. Kurtz agreed to provide and add as a standing item to future Board meeting agenda. Mr. Kurtz noted the report shows the NMRE $1M over budget for mental health; this reflects money out the door for autism due to the change in funding and not an actual overage. SUD Block grant over-expenditures are being closely monitored by NMRE; courts/probation officers have been pushing individuals into residential treatment. Staff is looking at ASAM criteria and adhering to appropriate levels of care. Bringing this in line opens block grant to enhanced prevention services.

Mr. Kamps asked about the eligible and revenue graphs pertaining to DAB and TANF. Ms. Yockey clarified the revenue included use tax that is no longer being collected.

MOTION MADE BY JOE STONE TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY MONTHLY FINANCIAL REPORT FOR MARCH 2018, SECOND BY ED GINOP. MOTION CARRIED.

NEW BUSINESS

FY18 MDHHS/PIHP Amendment No.2

A memorandum dated April 24, 2018 from John Duvendeck at MDHHS to PIHP Executive Directors introducing Amendment No.2 to the FY18 MDHHS/PIHP Contract, the Amendment Summary Page, and the edited FY18 MDHHS/PIHP Contract were included in the materials for the meeting on this date. The signed Amendment is due to the Department by June 1, 2018. Mr. Kamps asked Mr. Kurtz if 1) he recommends it be signed, and 2) if there is anything contained in the amendment the Board should be aware of; Mr. Kurtz responded "yes" to both. The Centers for Medicare and Medicaid Services (CMS) reviewed the waiver and added technical corrections; the biggest one deals with program integrity/OIG interplay. Beginning FY19, quarterly reporting to the OIG will be required, consistent with MHPs. Mr. Tanner asked if the current contract still "violates federal law and the mental health code." Mr. Kurtz responded the language in question still exists. Mr. Tanner asked whether the OIG has any interest in the matter. Mr. Kurtz responded there are two opposing sides to the issue. Other changes in the Amendment include Medical Loss Ratio replacing the administrative cost report and the (required) use of the GAIN assessment to stage individuals into appropriate ASAM level of care.

MOTION MADE BY DENNIS PRIESS TO APPROVE THE AMENDMENT TWO (NO.2) TO THE CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE NORTHERN MICHIGAN REGIONAL ENTITY FOR FISCAL YEAR 2018, SECOND BY CAROL CRAWFORD. MOTION CARRIED WITH ONE OPPOSITION VOTE RECORDED FROM MR. TANNER.

It was noted this is a good time to discuss the supplemental payment distribution and what to do in the event the NMRE lapses Medicaid to the State.

NMRE Autism Sanction Letter

The letter to Eric Kurtz from Kendra Binkley at MDHHS dated May 15, 2018 was included in the materials for the meeting on this date under Correspondence. Mr. Kurtz distributed a document showing regional compliance with timeliness of services. He acknowledged, as a region, we can do better. The letter identifies two areas with which the NMRE is out of compliance.

1) Data shows 132 open cases were approved for ABA services, 292 of which have active Plans of Services. Of the remaining 35, 24 individuals have not received ABA services for greater than 90 days.

2) Data shows of 156 cases receiving ABA services in Q4 FY17, 115 were out of compliance with the amount, scope, and duration authorized in the Plan of Services.

A shortage of BCBAs in the region was noted (7-8 currently). In terms of services not being delivered at the authorized level, it was noted that likely half is due to client/family cancellations. Mr. Kurtz intends to address the matter with the Department. It was also mentioned that an autism services provider is currently under OIG investigation and is over 200 days behind in billing in some cases. Diane Pelts expressed frustration that no consideration is given for services that have been performed (with proof available) but have not been billed from the provider.

Regional Waiver Coordinator, Stewart Mills, was in attendance and summarized the handout. There is a region-wide capacity issue. Mr. Kovacs asked whether the NMRE's ruralness is a factor or is this systemic through the State. Mr. Mills responded that it's a bit of both. Travel distance and client/family cancellations are both factors affecting provider retention.

Mr. Tanner asked if other PIHPs received a similar letter. Mr. Kurtz was unaware of any other letters at the time of the meeting. A plan of correction is due to the Department from the NMRE by May 30, 2018. The NMRE must "improve in areas of concern by 60% within 180 calendar days of this notice." Failure to comply could escalate the penalty from level C to level D sanctions. Level D would "delay" 25% of total Medicaid funding.

Mr. Kamps commented, "It appears we've been put on double-secret probation." He expressed faith in staff to handle appropriately. He offered the support of the Board to legislators if needed.

SUD Liquor Tax Requests

Let the record show his was addressed and moved under the SUD Policy Board update earlier on the Agenda.

298 Call for Action

Mr. Kurtz was contacted by Bob Sheehan, and was informed legislators are not going to remove language from the 298 pilot sites that would restrict contracting to local CMHSPs. Ms. Sherman asked if advocacy efforts are needed. Mr. Kurtz responded yes, they are. An amended target date of October 1, 2019 has

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been proposed. Mr. Kamps noted that there is a high learning curve for legislators and many don't fully understand the issue.

Mr. Kamps asked what is needed to expand the Behavioral Health Homes the NMRE region. Mr. Kurtz responded all that is need is a revision to the current language to include all 21 counties. Board Members agreed to contact legislators to make the ask.

Partners in Excellence Award
Diane Pelts discussed follow-up to the regional meeting held during the Spring Board conference. She distributed information about the proposed nominated program. The application is due to the Association by June 1st. Mr. Sherman congratulated Ms. Pelts on the great work.

<u>OLD BUSINESS</u>

Opioid Health Home
Mr. Kurtz distributed the "Opioid Health Home" proposed policy on this date. Mr. Kovacs acknowledged a proposal to legalize recreational marijuana has a lot of momentum but can still be fought; not a foregone conclusion. Though the legislature can pass the "marijuana legalization citizens' initiative," it looks as though the proposal will be on the November 2018 ballot. A lot of information is available. Mr. Kovacs shared information from District Health Department #10 with the Board. Christie Pudvan, NMRE Prevention Coordinator, shared a PowerPoint presentation developed by the NMRE and approved by the Office of Recovery Oriented Systems of Care. She will present to the Board on the topic in June.

MDOC Update
Mr. Kurtz informed the Board that, although NMRE withdrew from the Michigan Consortium for Healthcare Excellence (MCHE), he is still open to participating in this effort. He noted nothing has been produced to review to date, but he will keep the Board apprised of developments.

<u>PRESENTATION</u>

NMRE FY17 Financial Audit
Trina Edwards, CPA, from Dennis, Gartland & Niergarth was in attendance to present the audit reports for fiscal year 2017. The cover letter to Board Members, Financial Statements report, and the Single Audit Act Compliance report (for SUD block grant and STR grants) were included in the packet for the meeting on this date. The NMRE's total net position was shown at $17,749,857. The net position increased by $1,763,589 during the fiscal year, primarily related to the performance-based incentive payment and PA2 funds collected and unspent at the end of the fiscal year. Ms. Edwards summarized the remainder of the report and offered to answer questions. Mr. Tanner asked whether governmental accounting standards (GASB) were used, to which Ms. Edwards responded "yes."

Ms. Edwards noted the Compliance Examination has not closed as the last report from CMHSPs was received the week before. Overall, the NMRE performed very well.

MOTION MADE BY DON TANNER TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY AUDIT REPORTS FOR FISCAL YEAR 2017 AS REVIEWED ON THIS DATE, SECOND BY GARY NOWAK. MOTION CARRIED.

<u>COMMENTS</u>

Board
Mr. Stone asked whether anyone was disappointed in Lynda Zeller's presentation at the Spring Board Conference, to which Board Members indicated a resounding "yes."

Mr. Stone also informed the Board that CMHAM started a gun violence workgroup; a white paper has been developed. The charge is mainly addresses stigma steered to mental health consumers every time there is an incident. Ms. Meske indicated she will send suggested edits to Mr. Sheehan.

Staff
Mr. Kovacs noted several recent incidences of good collaboration between the CMHSP Boards and NMRE.

MEETING DATES
The next meeting of the NMRE Board of Directors is scheduled for 10:00AM on June 27th in the Cross Street Conference Room in Gaylord.

ADJOURN
Let the record show that Mr. Frye adjourned the meeting at 11:51AM.

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CMHAM Formula Calculations for Member Dues for Fiscal Year 2018-2019

A	B	C	D	E	F	G	H	I
CMHSP	Total Revenue/Cost FY 15	Total Revenue/Cost FY 16	Variable Base (All Dues Capped at $27,558)	Remaining Spread (cost /1000*.045)	Proposed FY 19 Dues based on FY 16 Allocations (All Dues Capped at $27,558)	FY 18 Assessed Dues based on FY 15 Allocations	Change in Dues Amount from FY 18 to FY 19	%age change from FY 18 to FY 19
Allegan	25,250,375	26,746,229	11,960	1,204	13,164	13,096	67	0.51%
AuSable Valley	20,934,672	21,434,372	9,303	965	10,268	10,245	22	0.22%
Barry	9,622,516	10,965,299	9,303	493	9,796	7,078	2,718	38.41%
Bay-Arenac	55,082,060	43,437,163	11,960	1,955	13,915	17,097	(3,182)	-18.61%
Berrien	41,771,001	44,443,601	11,960	2,000	13,960	13,840	120	0.87%
Centra Wellness NW (Mans B)	13,158,821	13,191,304	9,303	594	9,897	9,895	1	0.01%
Clinton Eaton Ingham	123,385,560	105,848,189	19,934	4,763	24,697	25,486	(789)	-3.10%
CMH for Central MI	90,034,127	86,525,839	17,276	3,894	21,170	21,328	(158)	-0.74%
Copper Country	14,807,790	15,362,399	9,303	691	9,994	9,969	25	0.25%
Detroit-Wayne	755,060,842	733,263,886	22,558	32,997	27,558	27,592	(34)	-0.12%
Genesee	147,773,201	129,930,075	19,934	5,847	25,781	27,592	(1,811)	-6.56%
Gogebic	6,317,251	6,531,543	6,645	294	6,939	6,929	10	0.14%
Gratiot	12,270,530	12,343,808	9,303	555	9,858	9,855	3	0.03%
Hiawatha	15,391,746	14,936,273	9,303	672	9,975	9,996	(20)	-0.21%
Huron	9,782,092	12,607,691	9,303	567	9,870	7,085	2,785	39.31%
Ionia- The Right Door for Hope	12,503,772	12,222,885	9,303	550	9,853	9,866	(13)	-0.13%
Kalamazoo	73,972,724	77,225,073	14,618	3,475	18,093	17,947	146	0.82%
Lapeer	19,531,250	19,620,055	9,303	883	10,186	10,182	4	0.04%
Lenawee	17,672,181	18,063,415	9,303	813	10,116	10,098	18	0.17%
LifeWays	59,050,103	62,088,885	14,618	2,794	17,412	17,275	137	0.79%
Livingston	28,173,338	28,963,231	11,960	1,303	13,263	13,228	36	0.27%
Macomb	251,346,170	237,726,388	22,558	10,698	27,558	27,592	(34)	-0.12%
Monroe	29,561,955	29,817,822	11,960	1,342	13,302	13,290	12	0.09%
Montcalm	14,078,080	14,972,758	9,303	674	9,977	9,937	40	0.41%
Muskegon- HW	61,522,062	59,453,795	14,618	2,675	17,293	17,386	(93)	-0.54%
Network180 (Kent)	140,433,623	139,621,468	19,934	6,283	26,217	27,592	(1,375)	-4.98%
Newaygo	12,005,253	11,989,916	9,303	540	9,843	9,843	(1)	-0.01%
North Country	44,417,478	43,004,160	11,960	1,935	13,895	13,959	(64)	-0.46%
Northeast Michigan	27,005,381	26,802,613	11,960	1,206	13,166	13,175	(9)	-0.07%
Northern Lakes	62,171,347	59,997,134	14,618	2,700	17,318	17,416	(98)	-0.56%
Northpointe	18,135,625	17,190,311	9,303	774	10,077	10,119	(43)	-0.42%
Oakland	332,089,234	306,853,573	22,558	13,808	27,558	27,592	(34)	-0.12%
Ottawa	40,549,282	37,495,082	11,960	1,687	13,647	13,785	(137)	-1.00%
Pathways	35,494,924	34,745,638	11,960	1,564	13,524	13,557	(34)	-0.25%
Pines	11,873,508	11,961,355	9,303	538	9,841	9,837	4	0.04%
Saginaw	74,731,650	74,548,424	14,618	3,355	17,973	17,981	(8)	-0.05%
Sanilac	18,204,032	17,797,637	9,303	801	10,104	10,122	(18)	-0.18%
Shiawassee	18,352,970	18,681,560	9,303	841	10,144	10,129	15	0.15%
St. Clair	61,914,774	52,956,289	14,618	2,383	17,001	17,404	(403)	-2.32%
St. Joseph	18,163,148	15,785,785	9,303	710	10,013	10,120	(107)	-1.06%
Summit Pointe	46,517,223	46,998,238	11,960	2,115	14,075	14,053	22	0.15%
Tuscola	17,379,290	17,364,684	9,303	781	10,084	10,085	(1)	-0.01%
Van Buren	19,550,501	21,325,423	9,303	960	10,263	10,183	80	0.78%
Washtenaw	81,026,410	74,235,717	14,618	3,341	17,959	20,922	(2,963)	-14.16%
West Michigan	21,868,271	21,838,220	9,303	983	10,286	10,287	(1)	-0.01%
Woodlands	11,832,489	12,246,690	9,303	551	9,854	9,835	19	0.19%
Totals:	**3,021,770,632**	**2,901,161,895**	**568,686**	**130,552**	**656,735**	**661,882**	**(5,147)**	
PIHP'S- 10					25,040	25,040	0	

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Gary Nowak

SUBJECT: CMH PAC Update

DATE: July 2, 2018

Northeast Board members and Management staff contributed to the recent CMH PAC campaign. As an incentive, Board having more than a 50% contribution rate were eligible for a drawing for the Detroit Tiger Suite tickets. The amount raised from our efforts totaled $946.00. Boards had until June 22 to get their dollars into this campaign to determine eligibility for the drawing. Northeast had enough contributors to qualify for the drawing.

The CMHAM conducted their drawing for the incentive and Sanilac County CMH was the lucky Board winning the Tiger tickets this year.

Thanks to all participants!

	Program	Consumers served June 2018 (6/1/18 - 6/30/18)	Consumers served in the Past Year (7/1/17 - 6/30/18)	Average Since January (1/1/18 - 6/30/18)
1	**Access / Crisis / Prescreens**	50 - Routine 2 - Urgent 94 - Crisis 50 - Prescreens	675 - Routine 2 - Emergent 7 - Urgent 1029 - Crisis 483 - Prescreens	57 - Routine 0 - Emergent 1 - Urgent 99 - Crisis 44-Prescreens
2	**Doctors' Services**	1146	1599	1139
3	**Case Management**			
	Older Adult (OBRA)	125	174	132
	MI Adult	238	374	239
	MI ACT	34	45	34
	Home Based Children	7	13	6
	MI Children's Services	123	221	123
	DD	340	373	337
4	**Outpatient Counseling**	211(37/174)	524	215
5	**Hospital Prescreens**	50	483	44
6	**Private Hospital Admissions**	25	259	21
7	**State Hospital Admissions**	0	4	0
8	**Employment Services**			
	DD	79	120	99
	MI	54	84	55
	PSR Clubhouse	58	67	59
9	**Peer Support**	69	80	67
10	**Community Living Support Services**			
	DD	148	156	149
	MI	195	249	195
11	**CMH Operated Residential Services**			
	DD Only	60	62	60
12	**Other Contracted Resid. Services**			
	DD	35	37	35
	MI	30	32	30
13	**Total Unduplicated Served**	1127	2343	1156

	Unduplicated Consumers Served Since July 2017
Alcona	257
Alpena	1473
Montmorency	226
Presque Isle	302
Other	72

	Program	Consumers served May 2018 (5/1/18 - 5/31/18)	Consumers served in the Past Year (6/1/17 - 5/31/18)	Average Since January (1/1/18 - 5/31/18)
1	**Access / Crisis / Prescreens**	57 - Routine 2 - Urgent 110 - Crisis 42 - Prescreens	701 - Routine 2 - Emergent 5 - Urgent 982 - Crisis 468 - Prescreens	59 - Routine 0 - Emergent 0 - Urgent 100 - Crisis 42-Prescreens
2	**Doctors' Services**	1153	1596	1138
3	**Case Management**			
	Older Adult (OBRA)	127	171	133
	MI Adult	235	372	239
	MI ACT	34	45	34
	Home Based Children	5	10	6
	MI Children's Services	133	227	123
	DD	340	375	336
4	**Outpatient Counseling**	236 (42/194)	531	215
5	**Hospital Prescreens**	42	468	42
6	**Private Hospital Admissions**	20	253	20
7	**State Hospital Admissions**	0	4	0
8	**Employment Services**			
	DD	82	120	102
	MI	55	85	55
	PSR Clubhouse	59	68	59
9	**Peer Support**	70	82	67
10	**Community Living Support Services**			
	DD	148	156	149
	MI	197	248	195
11	**CMH Operated Residential Services**			
	DD Only	60	62	60
12	**Other Contracted Resid. Services**			
	DD	35	37	35
	MI	30	32	30
13	**Total Unduplicated Served**	1146	2355	1161

	Unduplicated Consumers Served Since June 2017
Alcona	259
Alpena	1481
Montmorency	233
Presque Isle	298
Other	70

Northeast Michigan Community Mental Health Authority
Employment Report
May 1, 2018 to May 31, 2018

DIVISION/DEPARTMENT NAME

Administration/Support Services	64
Vacancies	5

PROGRAMS

Psychiatry & Nursing Support	11
MI Adult Outpatient (ACCESS-CRS-ESU)	8
DD Clinical Support	3
Vacancies	0
DD Integrated Employment	16
MI Integrated Employment	3
Clubhouse	5
Vacancies	1
DD Case Management	13
MI Adult Case Management	14
MI Adult A.C.T.	8
Geriatric Services	12
Home-Based Child	11
DD ABA Program	14
Vacancies	8
Peer Support Services & MNA	7
DD SIP Residential	51
DD Community Support	31
Blue Horizons	10
Brege	12
Cambridge	12
Harrisville	12
Mill Creek	12
Pine Park	12
Princeton	12
Thunder Bay Heights	12
Walnut	12
Vacancies	15

TOTAL: 377

ADMINISTRATION/SUPPORT SERVICES

Name	Position
Meske, Cathy	**Director**
Rajasekhar, Paul	**Medical Director**
Arora, Monika	Psychiatrist
Standen, Carrie RNP	Nurse Practitioner
Wirgau, Jeffery PA-C	Physician Assistant
Barbeau, Dayna	Customer Services
Bruning, Carolyn	**Administrative Assistant**
Florip, Ann (PT)	Accounting Clerk
Rifenbark, Tonya (PT)	SIS Assessor
Bushey, LeeAnn	**Administrative Assistant (Supervises Peers & MNA)**
Hayka, Diane	Executive Secretary
Sork, Nena	**Chief Operating Officer**
Crittenden, Mary	*ACCESS-CRS-ESU Supervisor/Team Lead*
Murphy, Linda	*OAS/OBRA Coordinator/Team Lead*
Mingus, Mary	*Community Employment Coordinator/Team Lead*
Yachasz, Peggy	*SIP Coordinator/Team Lead*
Pilarski, Amy	**Project Coordinat**or
Pollard, Mark	**SD Supervis**or
Elowsky, Teresa	SD Coordinator
Keller-Somers, Felonie	SD Coordinator
Whyte, Jennifer	**Compliance Officer**
Fredlund, Lynne	Quality Improvement Coordinator
Hewett, Ruth	**Recipient Rights Officer**
Vacancy (PT)	Recipient Rights Advisor
Jaworowski, Cheryl	**Finance Director**
Anthony, Joell (PT)	Staff Accountant
Cadarette, Connie	Payroll Specialist
Piontkowski, Kathy	Statistical Clerk
Patterson, Larry	**Accounting Supervisor**
Stanton, Brenda	Staff Accountant
Anderson, Mable (PT)	Accounting Clerk
Thomas, Doreen	Accounting Clerk
Kearly, Nancy	**Reimbursement Officer**
Dumsch, Carol	Reimbursement Clerk
Lundholm, Julie	Reimbursement Clerk
Vacancy	Reimbursement Clerk
Sherman, Marcy (Contract)	Reimbursement Clerk
Skowronek, Jane	Reimbursement Clerk
Greer, Richard	**Facility & Fleet Supervisor**
Carr, David	Maintenance I
Fleming, Jerry	Maintenance I
Wirgau, Alan	Maintenance I
King, Patrick (PT)	Housekeeper I/Maintenance II – Alpena Office
Tovey, Beth	Housekeeper I – Alpena Office
Bannon, Dennis	**IS Director**
Wiitala, Richard (Contract)	IS Consultant
Blandford, Mark	SQL Administrator/Data Analyst
DeRosia, Ann	Systems Administrator
Lepper, Jason	Systems Administrator
Roussin, Donna	IS Data & Training Technician
Kozlow, Edward	Information Systems Technician
Anderson, Lisa	**Human Resources Manager**
Keller, Kay	Human Resources Assistant
Rouleau, Tina	Human Resources Specialist-Benefits/Payroll
Domke, Genevieve	Human Resources Specialist-Training/Special Projects

McConnell, Jamie	**Office Manager**
Vacancy	Clerical Support Staff
Brousseau, Patricia	Clerical Support Staff
Lane, Sara	Clerical Support Staff
LaCross, Cathy	Clerical Support Staff
Seguin, Sharon	Clerical Support Staff
Vogelheim, Rose	Clerical Support Staff
Boldrey, Peggy (PT)	Clerk Typist II – Hillman Office
Brege, Barbara (PT)	Clerk Typist II – Fletcher Street Office
Vacancy (PT)	Clerk Typist II – Fletcher Street Office
Vacancy (PT)	Clerk Typist II – Rogers City Office
Hartman, Molly (PT)	Clerk Typist II – Rogers City Office
Norman, Michelle (PT)	Clerk Typist II – Hillman Office

Services Reporting To:

Team Lead-Crittenden, Mary — ACCESS-CRS-ESU Supervisor

PSYCHIATRIC NURSING SERVICES

Orozco, Lisa	*Psychiatric Nursing Supervisor*
Dehring, Donald	Psychiatric Nurse
Taylor, Lisa	Psychiatric Nurse
Wozniak, Tina	Psychiatric Nurse
Hentkowski, Nancy (PT)	Licensed Practical Nurse
McGee, Maggie (PT)	Licensed Practical Nurse

MI ADULT OUTPATIENT

Brege, Linnea	BHC/CR Clinician
Challender, Elsie (Ruth)	CRS Clinician
Curry, Renee	CRS Clinician
Dumsch, Danica	CRS Clinician
Hamilton, Sarah	CRS Clinician
Jensen, Samantha	CRS Clinician
Knoch, Michelle	CRS Clinician
Slaght, Stephen	CRS-Hospital Discharge Clinician

DD CLINICAL SUPPORT

Anderson, Carolyn	Registered Nurse
Hardies, Mary	Registered Nurse/Infection Control Nurse
Schimmel, Joan	Registered Nurse

Services Reporting To:

Team Lead-Mingus, Mary — Community Employment Coordinator

MI INTEGRATED EMPLOYMENT

Gilmore, Steve	Employment Specialist
Miller, Zackeria	Employment Specialist
Garlanger, Sherry	Employment Specialist

CLUBHOUSE

Konieczny, Lisa	Clubhouse Generalist
Niemetta, Jeffrey	Clubhouse Generalist
Walter, Frank (PT)	Community Employment Job Coach
Borchard, Rod (CAS)	Driver
Wilkins, Thomas (CAS)	Driver

DD INTEGRATED EMPLOYMENT

Name	Position
Hale-Manley, Margaret	***Community Employment Coordinator***
Collins, Kimberly	CE Assistant
Kowalski, Teresa	CE Assistant - PI
Stawowy, Angela	CE Assistant
Barbeau, Jessica	CE Supervisor
Rygwelski, Brandi	Job Coach - PI
Spencer, Melinda	Job Coach-PI/MON
Cool, Roger	Job Coach
Kensa, Ann (PT)	Job Coach
Ludwig, Alyssa (PT)	Job Coach
Vacancy (PT)	Job Coach
Prevost, Cheyenne (PT)	Job Coach
Robb, Kayla (PT)	Job Coach
Srebnik, Cindy (PT)	Job Coach
Spaulding, Daniel (Cas)	Peer Mentor
Wellman, Kelly (Cas)	Peer Mentor

Services Reporting To:

Team Lead-Murphy, Linda — OAS/OBRA Coordinator

GERIATRIC SERVICES

Name	Position
Brenton, Pam	OBRA /Older Adult Services Registered Nurse
Gohl, Laura	OBRA/Older Adult Services Case Manager
Kaiser, William	OBRA/Older Adult Services Clinician/Case Manager
Kwiatkowski, Mariah	OBRA/Older Adult Services Case Manager
Minnick, Martha	OBRA/Older Adult Services Case Manager
Vacancy (PT)	OBRA/Older Adult Services Clerical Support Staff
Knopf, LeAnn (PT)	OBRA/Older Adult Services Clerical Support Staff
Atkinson, Thomas	Older Adult Services Support Worker
Carriveau, Jackie (PT)	Older Adult Services Support Worker
Hochrein, Pat (PT)	Older Adult Services Support Worker
McDonald, Tammie	Older Adult Services Support Worker
Rembowski, Bernadine (PT)	Older Adult Services Support Worker

MI ADULT CASEMANAGEMENT & DD PSYCHOLOGIST

Name	Position
Witkowski, Katherine	*CSM/SC Supervisor*
Ross, Bailey	Psychologist
Vacancy	Case Manager
Edgar-Travis, Alisha	Case Manager
Harbson, Jessica	Case Manager
Herbek, Chelsea (Split)	Case Manager
Miller, Megan	Case Manager
Ross, Nancy	Case Manager
Stepanski, Ingrid	Case Manager
Stephan, Melissa	Case Manager
Dziesinski, Nancy	MI Community Support Worker
Paad, Renee	MI Community Support Worker
Murphy, Katie (PT)	MI Community Support Worker
Watson, Dylan (PT)	MI Community Support Worker

HOME-BASED CHILD

Tallant, Lauren	*Children's Services Supervisor*
Gajewski, Maribeth	Clinician/Case Manager
Garbutt, Sarah	Clinician/Case Manager
Hasse, Julie	Clinician/Case Manager
Herman, Nicole	Clinician/Case Manager
Kruzell, Brian	Clinician/Case Manager
Stahlbaum, Caitlin	Clinician/Case Manager
Standen, Tommy	Children's Home Based Clinician
Susewitz, Ami (PT)	Home Based Case Manager
Eagling, Michelle (PT)	Home Based Assistant
Herriman, Kurt (PT)	Home Based Assistant

DD CASEMANAGEMENT

Lahner, Becky	*Support Coordinator Supervisor*
Vacancy	Support Coordinator – Hillman
Brousseau, Sharon	Clinician/Case Manager
DeRoque, Linda	Support Coordinator – Presque Isle
Dickins, Jill	Support Coordinator – P.I./Alpena
Lang, Cheryl	Support Coordinator – Alpena
Leeck, Tamara	Support Coordinator – Blue Horizons
Lis, Frank (Split)	Case Manager
Vacancy (Split)	Case Manager
Morford, Margaret	Support Coordinator – Alpena
Schackmann, Debbie	Support Coordinator – Alpena
Standen, Jane	Support Coordinator – Alpena
Wilkinson, Cailey (PT)	Support Coordinator – Alpena

APPLIED BEHAVIORAL ANALYSIS PROGRAM (6 FT, 8 PT)

Sola, Amanda	*ABA Program Supervisor*
Sawasky, Jocelyn	Assistant Behavior Analyst
Smith, Erin	Assistant Behavior Analyst
Latz, Kori	Behavior Technician
Lundquist, Jessica	Behavior Technician
Ziroll, Kurt	Behavior Technician
Benson, Julie (PT)	Behavior Technician
Kensa, Tori (PT)	Behavior Technician
Morgan, Angela (PT)	Behavior Technician
Ranshaw, Brooke (PT)	Behavior Technician
Trotter, John (PT)	Behavior Technician
Valley, Michelle (PT)	Behavior Technician
Vacancy (PT)	Behavior Technician
Vacancy (PT)	Behavior Technician

MI ADULT A.C.T.

Vacancy	*ACT Clinical Services Supervisor*
Vacancy	ACT Registered Nurse
Jackson, Amy	ACT Registered Nurse
Taylor, Cassidy	ACT Social Worker
VanTrump, Olivia	ACT Registered Nurse
Misel, Joann	ACT Clerical Support Staff
Gersewski, Marlene	MI Community Support Worker
Wilson, Karen (PT)	MI Community Support Worker

Services Reporting To:

Team Lead-Yachasz, Peggy — SIP Coordinator

PEER SUPPORT SERVICES & MONDAY NIGHT ACTIVITIES

Bushey, LeeAnn	*Peer Support Supervisor*
Gapske, Amber	Peer Support Specialist
Murphy, Barbara	Peer Support Specialist
Vacancy (PT)	Peer Support Specialist
Vacancy (PT)	Customer Service-Peer Support
Szott, Judy (PT)	Customer Service-Peer Support
Millard, Linda (CAS)	MNA Co-Coordinator
Jenson, Julie (CAS)	MNA Co-Coordinator

DD SIP RESIDENTIAL

Campbell, Linda	*SIP Supervisor*
Danielson, Jolie	*SIP Supervisor*
Grochowski, Karen	*SIP Supervisor*
Schuelke, Amanda	*SIP Supervisor*
Thompson, Amy	*SIP Supervisor*
Vacancy	*SIP Supervisor*
Benac, Susan	SIP Worker
Brenner, Karen	SIP Tech
Clay, Kaydee	SIP Worker
Vacancy	SIP Worker
Hamlin, Michelle	SIP Worker
Keetch, Brandinn	SIP Worker
Keller, James	SIP Tech
Kline, Lori	SIP Worker
Oliver, Jackie	SIP Worker
Pernie, Debra	SIP Worker
Potvin, Paula	SIP Worker
Richardson, Tamara	SIP Tech
Schillerstrom, Norman	SIP Worker
Skiba, Melissa	SIP Worker
Welch, Carol	SIP Worker
Werda, Monica	SIP Tech
Williams, Christine	SIP Tech
Wozniak, Corinne	SIP Worker
Wysocki, Christine	SIP Worker
Zygaj, Sandra	SIP Worker
Ballard, Renee (PT)	SIP Worker
Bevan, Brianna (PT)	SIP Worker
Bowers, Samantha (PT)	SIP Worker
Boyle, Laura (PT)	SIP Worker
Brun, Wendy (PT)	SIP Tech
Cohoon, Patrick (PT)	SIP Worker
Dunn, Tracy (PT)	SIP Tech
Gambrel, Beatrice (PT)	SIP Worker
Hall, Keli (PT)	SIP Worker
Hirschenberger, Mary (PT)	SIP Worker
Hochrein, Hailey (PT)	SIP Worker
Kazyaka, Kelly (PT)	SIP Worker
Koppenol, Marla (PT)	SIP Worker
Miller, Kayla (PT)	SIP Worker
Simpson, Bill (PT)	SIP Worker
Sharp, McKenna (PT)	SIP Worker
Sommerfeld, Paige (PT)	SIP Tech

Snyder, Quintin (PT)	SIP Tech
Sutkay, Sara (PT)	SIP Tech
Wenzel, Kim (PT)	SIP Tech
Vacancy (PT)	SIP Worker
Vacancy (PT)	SIP Worker
Vacancy (PT)	SIP Worker
Vacancy (PT)	SIP Worker
Vacancy (PT)	SIP Worker

DD COMMUNITY SUPPORT

Vacancy	*CSS Supervisor*
Pickard, Phil	*CSS Supervisor*
St John, Patti	*CSS Supervisor*
Abbert, Lance	CS Worker
Dziesinski, Steve	CS Worker
Fleming, Monica	CS Worker - PI
Grulke, Bonnie	CS Worker - PI
Hampson, Sandy	CS Worker
Lamble, Kristine	CS Worker
Mills, Cindy	CS Worker
Siebel, Deborah	CS Worker
Snedden, Brenda	CS Worker
Twite, Susan	CS Worker
Baumgarten, Lisa (PT)	CS Worker - MON
Collins, Douglas (PT)	CS Worker
Cook, Tamara (PT)	CS Worker
Creekmore, Krista (PT)	CS Worker - MON
Daniel, Jessica (PT)	CS Worker – PI
Fras, Monica (PT)	CS Worker
Jakey, Lisa (PT)	CS Worker - MON
June, Rick (PT)	CS Worker
Krajniak, Amanda (PT)	CS Worker - PI
Kuznicki, Melissa (PT)	CS Worker
LaPere, John (PT)	CS Worker
Moldenhauer, Dennis (PT)	CS Worker
Parson, Laurie (PT)	CS Worker - MON
Peltier, Lisa (PT)	CS Worker
Purol, Mariah (PT)	CS Worker - PI
Rasche, Rick (PT)	CS Worker
Shepherd, Crystal (PT)	CS Worker - MON
Soldenski, Konnie (PT)	CS Worker
Tracey, Karena (PT)	CS Worker - MON

DD GROUP HOMES

Hale-Manley, Margaret ***CE Coordinator/Homes Supervisor***

BLUE HORIZONS (5 FT/5 PT)

Smart-Sheppler, Renee	*Home Supervisor*
Barkley, Carrie	Residential Training Worker
Bruski, Christie	Residential Training Worker
Filipiak, Kathy	Residential Training Worker
Parsell, Kayla	Residential Training Worker
Bellenir, Roseann (PT) Night Worker	Residential Training Worker
Brown, Kayla (PT)	Residential Training Worker
Jones, Linda (PT) Night Worker	Residential Training Worker
Lakin, Alicia (PT)	Residential Training Worker
Worth, Courtney (PT)	Residential Training Worker

BREGE (7 FT/5 PT)

Name	Position
Smith, Ann – Supervisor	
Colorite, Julie	Residential Training Worker
Kortman, Kaitlyn	Residential Training Worker
Petit, Danielle	Residential Training Worker
Schultz, Courtney	Residential Training Worker
Sorrells, Lori	Residential Training Worker
Wirgau, Randy	Residential Training Worker
Carper, Ashton (PT)	Residential Training Worker
Vacancy (PT)	Residential Training Worker
Kruczynski, Linda (PT)	Residential Training Worker
Marx, Dawn (PT)	Residential Training Worker
Szumila, Mindy (PT)	Residential Training Worker

CAMBRIDGE (7 FT/5 PT)

Name	Position
Hunt, Tina	*Home Supervisor*
Kuligowski, John	Residential Training Worker
LaBonte, Elizabeth	Residential Training Worker
Lake, Hank	Residential Training Worker
Matthews, Lani	Residential Training Worker
Reed, Jody	Residential Training Worker
Wojda, Kathy	Residential Training Worker
Dodge, Ellarie (PT)	Residential Training Worker
Gutzman, Nicole (PT)	Residential Training Worker
Guy, Nicole (PT)	Residential Training Worker
Spencer, Jessica (PT)	Residential Training Worker
Wirgau, Courtney (PT)	Residential Training Worker

HARRISVILLE (7 FT/5 PT)

Name	Position
Reynolds, Bob	*Home Supervisor*
Anderson, Geraldine	Residential Training Worker
Duterte, Ma-Gina	Residential Training Worker
Lancaster, Kim	Residential Training Worker
Mahalak, Elke	Residential Training Worker
Nelson, Sam	Residential Training Worker
Vacancy	Residential Training Worker
Cummins, Duane (PT)	Residential Training Worker
Moldenhauer, Brooke (PT)	Residential Training Worker
Moran, Starlene (PT)	Residential Training Worker
Newland, Lori (PT)	Residential Training Worker
Windsor, Natalie (PT)	Residential Training Worker

MILL CREEK (7 FT/5 PT)

Name	Position
Matthews, Julie	*Home Supervisor*
Anderson, Lisa	Residential Training Worker
Belt, Donna	Residential Training Worker
Burns, Sandy	Residential Training Worker
Cole, Candy	Residential Training Worker
Rifenbark, May	Residential Training Worker
Rock, Nancy	Residential Training Worker
Luebben, Sara (PT)	Residential Training Worker
Picotte, Wayne (PT)	Residential Training Worker
Simmonds, Katherine (PT)	Residential Training Worker
Storms, Teresa (PT)	Residential Training Worker
Vacancy (PT)	Residential Training Worker

PINE PARK (7 FT/5 PT)

Cumper, Lois	*Home Supervisor*
Buckingham, Linda	Residential Training Worker
Vacancy	Residential Training Worker
Parent, Amy	Residential Training Worker
Penn, David	Residential Training Worker
Safford, Denise	Residential Training Worker
Tinker, Rebecca	Residential Training Worker
Graber, Dana (PT)	Residential Training Worker
Jobe, Betti (PT)	Residential Training Worker
Ploe, Linda (PT)	Residential Training Worker
Ridgeway, Kathleen (PT)	Residential Training Worker
Sewell, Linda (PT)	Residential Training Worker

PRINCETON (8 FT/4 PT)

LaMay, Cindy	*Home Supervisor*
Fleck, Christine	Residential Training Worker
Lefebvre, Rose	Residential Training Worker
Ranger, Patti	Residential Training Worker
Rinard, Cathy	Residential Training Worker
Smith, Judy	Residential Training Worker
Vermeulen, Joanne	Residential Training Worker
Wilson, Tonya	Residential Training Worker
Justice, Stephani (PT)	Residential Training Worker
Smith, Andrea (PT)	Residential Training Worker
Stoinski, Anna (PT)	Residential Training Worker
Urban, Kasandra (PT)	Residential Training Worker

THUNDER BAY HEIGHTS (7 FT/5 PT)

Fletcher, Rhonda	*Home Supervisor*
Behring, Jan	Residential Training Worker
Bunch, Lora	Residential Training Worker
Cordes, Valerie	Residential Training Worker
Gilbert, Cindy	Residential Training Worker
Greene, Debra	Residential Training Worker
Holland, Onnalee	Residential Training Worker
Cumper, Chelsey (PT)	Residential Training Worker
Cuzzort, Treva (PT)	Residential Training Worker
Hawley, Michelle (PT)	Residential Training Worker
Saddler, Nancy (PT)	Residential Training Worker
Tucker, Katelyn (PT)	Residential Training Worker

WALNUT (8 FT/4 PT)

Kissane, Heidi	*Home Supervisor*
Brado, Gail	Residential Training Worker
Donajkowski, Tamara	Residential Training Worker
Dorr, Judy	Residential Training Worker
Gutzman, Star	Residential Training Worker
Longpre, Melissa	Residential Training Worker
Tadajewski, Jackie	Residential Training Worker
Webster, Ashley	Residential Training Worker
Vacancy (PT)	Residential Training Worker
Ostendorf, Kayla (PT)	Residential Training Worker
Standen, Angela (PT)	Residential Training Worker
Waligora, Melissa (PT)	Residential Training Worker

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Diane Hayka

SUBJECT: Director's Evaluation

DATE: June 30, 2018

At our meeting next month, we will complete the Director's evaluation. According to Policy 03-004 "Monitoring Executive Performance," this is based upon Ends and Monitoring Reports provided to the Board over the course of the year. These monitoring reports were distributed to you in your monthly Board packets.

If any of you would like copies of any of the monitoring reports prior to the August Board meeting, please contact me or feel free to drop by the office to review this material.

2018 EMPLOYEE RECOGNITION

30 Years

Mable Anderson, Accounting Clerk

Valerie Cordes, Residential Training Worker, Thunder Bay

Kristine Lamble, Community Support Worker

Joeann Vermeulen, Residential Training Worker, Princeton

25 Years

Susan Benac, Supported Independence Program Worker

Monica Fleming, Community Support Worker

Doreen Thomas, Accounting Clerk

20 Years

Patricia Brousseau, Clerical Support Staff

Jill Dickins, Supports Coordinator

Elke Mahalak, Residential Training Worker, Harrisville

Lisa Orozco, Psychiatric Nursing Services Supervisor

Konnie Soldenski, Community Support Worker

15 Years

Ellarie Dodge, Residential Training Worker, Cambridge

Christine Fleck, Residential Training Worker, Princeton

Nancy Kearly, Reimbursement Officer

Elizabeth LaBonte, Residential Training Worker, Cambridge

Julie Lundholm, Reimbursement Clerk

Michelle Norman, Clerk Typist II

Tina Rouleau, Human Resources Specialist

Linda Sewell , Residential Training Worker, Pine Park

Carol Welch, Supported Independence Program Worker

Monica Werda, Supported Independence Program Technician

10 Years

Dennis Bannon, Information Systems Director

Karen Brenner, Supported Independence Program Technician

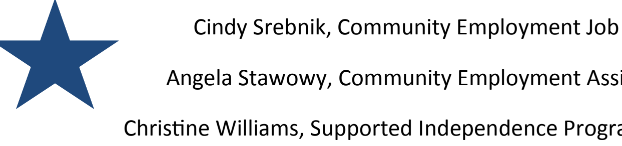
Debra Dubey, Housekeeping

Julie Hasse, Home Based Clinician/Case Manager

Becky Lahner, Support Coordination/Case Management Supervisor

Linda Ploe, Residential Training Worker, Pine Park

Nancy Ross, RN Case Manager



Cindy Srebnik, Community Employment Job Coach

Angela Stawowy, Community Employment Assistant

Christine Williams, Supported Independence Program Technician

Karen Wilson, Community Support Worker

6 Years Bridged

Olivia VanTrump, Assertive Community Treatment RN

5 Years

Carolyn Anderson, Registered Nurse

Thomas Atkinson, Older Adult Services Support Worker

Tracy Dunn, Supported Independence Program Technician

Alisha Edgar-Travis, Case Manager

Marla Koppenol, Supported Independence Program Worker

Edward Kozlow, Information Systems Technician

Melissa Kuznicki, Community Support Worker

Mariah Kwiatkowski, OBRA/OAS Case Manager

Alicia Lakin, Residential Training Worker, Blue Horizons

Dennis Moldenhauer, Community Support Worker

Laurie Parson, Community Support Worker

Katherine Simmonds, Residential Training Worker, Mill Creek

Amanda Sola, Applied Behavior Analysis Program Supervisor

Daniel Spaulding, Peer Mentor

2018 Employee Recognition Luncheons

(Employee, a Guest & their Supervisor)

Thunder Bay Golf Resort

July 24, 2018   11:30 am -1:00 pm

Montmorency & Presque Isle Counties

APlex, Upper Conference Room

July 26, 2018   11:30 am –1:00 pm

Alcona & Alpena Counties

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Cathy Meske

SUBJECT: RFP - Clubhouse

DATE: July 2, 2018

Based on our previous conversations and our most recent presentation to the Board of Directors by Mary Mingus regarding the Light of Hope Clubhouse, I am suggesting the Board entertain a motion allowing me to develop an RFP for the day-to-day operation of our Clubhouse. We currently have an existing lease arrangement that runs until 2021. This will need to be taken into consideration in the writing of the RFP.

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Cathy Meske

SUBJECT: MidWest Recruiting

DATE: July 2, 2018

As you are aware, it took us a very long time to retain a child psychiatrist. We were successful using MidWest Recruiting and Marketing campaign. I request the Board approve entering into another marketing campaign for a board certified adult psychiatrist. The proposal from MidWest is $6,491.34 for this services. We recommend approval.

QI Council Minutes

For Meeting on 05/21/18
10:15 AM to 11:30 AM
Board Training Room

Meeting called by: Margie Hale-Manley
Type of meeting: Monthly
Facilitator: Margie Hale-Manley
Note taker: Diane Hayka via dictation on digital recorder
Timekeeper: Lynne Fredlund

Attendees: Genny Domke, Lynne Fredlund, Joe Garant, Teresa Kowalski, Cathy Meske, Christine Taylor, Judy Szott, Jen Whyte

Absent: Donna Roussin

QI Coordinator: Lynne Fredlund

Guests: LeeAnn Bushey

Agenda Topics

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Review of Minutes

Discussion:
By consensus, the minutes of the February 19, 2018 meeting were approved as presented.

Conclusions:

Action items:

Person responsible:
Diane Hayka via digital recorder

Deadline:
ASAP

Management Team

Discussion:
Cathy Meske reported Management Team met on March 5, April 9 and May 7, 2018 since this group’s last meeting. Cathy Meske reported the NMRE will be giving this Agency some carryforward dollars to use in some additional computer upgrades and staffing. An incentive payment will also be passed on to this Agency amounting to approximately $177,000. She notes some of this will be used to cover expenses associated with myStrength. She informed Council members myStrength is an “App” to be used by staff, family members, individuals served by the agency, etc. This focuses on healthy living and provides a method to tracking a person’s activities such as sleep, mindfulness, exercise to encourage better awareness.

Cathy Meske reports with the new budget year process about to begin, contracts are being reviewed and "Evergreen" clauses in contracts will be eliminated in most contracts. Cathy also noted the contract for after hours on-call services is also being reviewed. Currently the contract is held by the NMRE with Third Level Crisis Center. There are two providers in the area for that type of service and investigation is being conducted to determine best options. Two estimates have been received from the vendors – Third Level and ProtoCall.

Cathy Meske reported the Annual Report was finished and will be disseminated to providers in the near future. She also reported a recent safety concern was handled through a QA process with clerical staff and received some suggestions. She noted workstations may be changed to allow staff to be eye level with individuals served.

Cathy Meske reported policy is reviewed and it was noted there have been instances where protocol or processes are being revised without noting the procedure identified in the policies.

Cathy Meske reported the April meeting addressed the Hepatitis A Plan noting Rich Green, Lynne Fredlund, Mary Hardies and she have worked to finalize the plan. The Plan talks about the importance of sharing the Hepatitis A Information with the individuals we serve.

In March, it was noted the e-mail system is now a cloud-based system. The Respite policies have been revised. She noted Cheryl Jaworowski had informed Management Team of some grant opportunities available through the MMRMA. The Performance Improvement Selections were also reviewed at the March meeting.

Margie Hale-Manley introduced Jen Whyte, Compliance Officer, to Council members. She reported Christine Taylor will be retiring June 1. Staff attending the meeting have met Jen Whyte; however, Joe Garant, NEMROC Representative had not had a prior opportunity.

Conclusion:

Action Items:
Report Monthly

Person Responsible:
Director

Deadline:
ASAP

Consumer Advisory Council

Discussion:
Cathy Meske reported the Council met on April 9, 2018. She notes council members have been focusing on attempting to get a local NAMI group re-established in Alpena. She reports the Board approved sending two council members to a NAMI Conference recently held in Traverse City. They will be coming back with information on how to move forward with the organization of a new group. Cathy Meske notes new requirement of NAMI groups is they must be a 501c3 organization in which there are added costs.

Cathy also reports the Day of Recovery was held on May 11th. Northeast had the largest group of individuals attending the Day of Recovery. She notes council members were informed of the Strategic Planning session to be held in June and their role in this session. Lynne Fredlund will be facilitating that event.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Director

Deadline:
ASAP

CARF Committee

Discussion:
Lynne Fredlund reported the CARF Committee met May 16th. The CARF Conformance Report has been received and it is due June 30th. When the report is submitted, we must attest we are in conformance with the standards. She reports the standards have been sent to the appropriate departments. The new books were received the end of April. The prep guide goes over all the standards we are bound to. She notes evidence books are maintained so there are either copies of forms or information on where the evidence is located for the standard.

Lynne Fredlund reported there is one standard Ruth Hewett is checking on related to consumers requesting their record through the patient portal.

Lynne Fredlund reported the supported employment for those individuals with mental illness is offered through an evidence-based practice fidelity which is typically more stringent than the required standards. She will be working with Mary Mingus to determine there is evidence to support the standards for this section.

She reports she is working with Rich Greer to assure we are in conformance. There has been a matrix developed to track needed drills, etc. which will be a much cleaner way in presenting evidence to CARF reviewer than handing them several sheets of paper related to the drill.

Lynne Fredlund reported training for staff will occur in the fall, included in the Annual Staff Training modules. The Board will be trained closer to the review time, most likely in January/February. The review will be conducted between March and June of 2019. They must give us a 30-day notice when scheduled.

Conclusion:

Action Items:
Report Quarterly

Person Responsible:
Lynne Fredlund

Deadline:
ASAP

Customer Satisfaction Committee

Discussion:
Margie Hale-Manley reported the Customer Satisfaction Committee met in March to compile the data from the survey results from the I/DD survey. From the results a brochure was made, which was presented to the Board at their March meeting. Margie had brochures available for council members. She reported of the 129 surveys completed, 99% indicated they were satisfied with the services they receive. Comments were also favorable.

Individuals are provided the survey document at the time the invitation is sent out for their annual Person-Centered Planning meeting.

Lynne Fredlund noted the question related to whether the individual felt safe in telling someone about things they did not like about their services and 30 individuals did not respond to this question and other questions had very few individuals leaving the question unanswered. Lynne also noted the other question with 20 unanswered related to whether people listen to what they had to say. Teresa Kowalski reported she had assisted a family member in completing this survey and encouraged responses to all questions. Lynne suggested maybe future surveys include

another option for response such as 'unable to determine' for those individual who may not be able to communicate a response.

Margie notes there are about 300 surveys sent out.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Margie Hale-Manley

Deadline:
ASAP

Resource Standards & Development Committee

Discussion:
Genny Domke reported this committee met in March and May. She reports they are still working on keeping the 'Picture Board' going with different events. The Committee also continues with the Random Act of Kindness. The Chili Cook Off was a big hit. Theme days are being identified for various Fridays. Majestic's first birthday was celebrated. The Committee has placed a suggestion box in the mail room to get input from staff on what they would like the Committee to focus on. She also notes the Committee works with the EAC on featuring various webinars; however, during the summer months this will be limited. The annual staff training will be in two phases this year. Phase I will include seven classes in June and Phase II will contain the remaining seven or eight classes held in the fall.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Genny Domke

Deadline:
ASAP

Risk Management Committee

Discussion:
Lynne Fredlund reported the Risk Management Committee met on February 26th. Lynne reported the Behavior Support sub-committee reviewed reports from December through February with Bailey Ross presenting. Lynne Fredlund informed Council members of the protocol for the Behavior Support Committee to review a certain percentage of annual programs to determine appropriateness. By year end all programs will have been reviewed. She also noted for those individuals discharged from Caro with a mental illness diagnosis, behavior programs are not allowed. In these cases, behavior guidelines are established and the committee also reviews the guidelines.

Lynne Fredlund reviewed the Recipient Rights report to Risk Management Committee noting the Recipient Rights Committee had met on January 24, 2018.

Lynne Fredlund notes Risk Review Committee continues to meet for ongoing reviews. There was one sentinel event reviewed during this time period.

The Risk Management Committee also reviewed the Grievance and Appeals 1st Quarter report. Lynne noted grievances are not a rights protected complaint. There were four grievances during this period which involved

Clubhouse, ACT and medication issues. There was one Second Opinion for initial services and the denial was upheld. There were two local appeals during this report period with one still pending at the time of the report.

Lynne Fredlund noted Dayna Barbeau, Customer Services, has recently taken on the task of handling grievance and appeals and will be presenting the quarterly reports to the Risk Management Committee in the future.

Lynne Fredlund reported this Committee actually met just prior to this Council meeting today with the next meeting scheduled for August.

Conclusion:

Action Items:
Report Quarterly

Person Responsible:
Lynne Fredlund

Deadline:
ASAP

Safety Committee

Discussion:
Teresa Kowalski reported the Safety Committee met in March and April. She noted the Safety Committee received follow up to a concern they had regarding the number of incidents at site #19 as reported during their January meeting. These incidents occurred in a semi-independent setting with individuals residing there having medical conditions and the majority of the incidents due to falling. She notes one resident at that site who was medically fragile has been relocated to another facility so the incidents should be decreasing.

She reports handwashing signs must be posted at all worksites and homes. Mary Hardies has found vinyl stickers to be applied to the mirrors in the bathrooms.

Teresa Kowalski noted the Environment of Care policy related to Transportation was reviewed and Management Team had requested some minor revisions. The Committee developed language to meet the needs of the request.

She also reported maintenance staff have begun the installation of the eye wash stations. The stations will be attached to existing faucets in all locations. In addition, maintenance staff must have a lockout/tag-out procedure. Rich Greer will be ordering boxes with locking devices and only maintenance staff will be authorized to turn off circuit breakers. He has developed a training procedure to address proper process for lockout/tag-out.

Teresa reported the Safety Committee addressed the procedures to be used for a 'Bomb Threat.' The steps will be customized to address the individual phone numbers for each site and will be printed on yellow paper and laminated. She also noted there was a concern related to carbon monoxide detectors and whether there was a policy to address need/usage. The Committee responded to the concern by suggesting the licensing manual be followed. Teresa also notes the phone number for the Poison Control was also verified with a correction needed on materials distributed by the NMRE. Lynne Fredlund also noted a CARF standard requires prescribers to provide individuals with contact information for the Poison Control Center and requested this information also be provided to Lisa Orozco so she can update any material they may have.

Teresa Kowalski also noted the Committee received a concern related to the Fuelman Cards used to gas agency vehicles. The list included in the vehicle is outdated and some of the stations no longer participate. Rich Greer volunteered to get updates listings of Fuelman locations placed in vehicles.

Teresa reported the April meeting addressed updates on the Injury and Fall Report and placement of handwashing signs.

Teresa Kowalski reported concerns related to snow removal at the Hillman and Rogers City office. The current snow removal provider at the Hillman Office has not cleared the sidewalks making the entryway accessible. Cathy Meske reported the snowfall received in April was big and people were instructed to stay at home and off the roads. There should have been no need to shovel out vehicles, etc. Our maintenance department did a phenomenal job to removing the snow as quickly as they could. Teresa also noted staff assisted in snow removal as well. Lynne Fredlund noted the Emergency Preparedness plan will be expanded to address extreme situations where, for example, SIP staff cannot get out to respond to individuals they must reach for medication administration and meals.

Teresa addressed the implementation of Code Yellow in conjunction with a Bomb Threat and have this be added to the Bomb Threat Procedures. In addition, the First Aid Emergency Kits was suggested to include the milligrams to non-coated aspirin in the kits.

Lynne Fredlund reported the Safety Committee addressed the Site Safety Check List. She noted a small group was formed to take the current form and review to assure MDHHS licensing rules and the NMRE annual review requirements were put into one checklist as well as including any items required in CARF standards. The maintenance department also noted some of the items requested on the checklist were duties of the maintenance department and not appropriate for the home supervisor to be attesting to. This form was presented at the last Safety Committee meeting. Lynne Fredlund questioned where this form should go from here, QI Council or Management Team. The form was not included in the materials for this meeting. It was determined the form will be presented to QI Council at their next meeting and then, if recommended, forwarded to Management Team for final approval.

Cathy Meske stressed the importance of having all materials submitted prior to the Friday preceding the QI Council meeting so this type of delay can be avoided.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Teresa Kowalski

Deadline:
ASAP

Utilization Management

Discussion:
Christine Taylor reported the UM Committee met in March, April and May. She notes at the May meeting introductions were made of the new Compliance Officer, Jen Whyte. Christine Taylor also noted new member, Mark Blandford. Mark's role will be to assist with retrieving the data needed for review as well as providing guidance to supervisors on the pulling of reports from the Majestic system.

Christine Taylor reported she felt it beneficial to develop a Utilization Management Committee Plan to outline the processes/projects the Committee will be working toward over the fiscal year. She noted one focus will be reviewing the Level of Care Benefit Plans as established in Majestic. The Committee will be looking at the original authorization levels and determine based on actual usage if this is on target or whether adjustments will need to be made. Christine also noted forms were developed for Clinical Case Review. This form will eventually be incorporated into Majestic so data will be easily collected. She also notes the CLS Assessment form will also be input into Majestic for staff use. This will eliminate the need to scan in the handwritten form. In addition, several complaints were received related to the POS reviews with difficulty in updating or changing established goals. In order to make the change, an addendum had to be written instead of just an update. This is in the process of revision to make this easier to finalize.

Christine Taylor also reported there will be a Home- and Community-Based Rules compliance section to address residential, non-residential as it relates to community employment support, skill building and choice of individuals.

Monitoring reports will be started soon to review respite care authorizations, case manager respite services monitoring, discharge reasons and progress toward goals, and the Performance Indicator #3, the follow up for services within 14 days. In addition, Jen Whyte noted the ADOS for the Autism Program will also need to be added.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Christine Taylor/Jen Whyte

Deadline:
ASAP

Quality Oversight Committee - NMRE

Discussion:
Lynne Fredlund reported meeting minutes were not yet available; however, the QOC reviewed the Performance Improvement Projects (PIPs).

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Lynne Fredlund

Deadline:
ASAP

Q.I. Member Concerns

Discussion:
There were no concerns raised.

Project Team/Workgroup Update
Old Business

Discussion:
Home- and Community-Based Services Surveys Update
Christine Taylor reported 100% of the survey responses have been sent in to the State. She notes, based on the survey data published in February, there are some homes on heightened scrutiny and some requiring corrective action plans. The NMRE will be working directly with those homes requiring a corrective action plan to address plans. For those locations under heightened scrutiny, homes and supported employment will be scheduled for a site visit from Michigan State University. There are over 800 homes in Michigan on heightened scrutiny. Christine notes the visits will most likely occur before winter. To help the homes under heightened scrutiny, she assisted in developing policy templates to address the various elements. Training was held with home providers and many of the policies have been returned to finalize. For those providers not able to attend the training, packets were sent to them to complete.

Christine Taylor reports case managers have been charged with the task to work with the home providers on their corrective action plans to assure compliance. Case managers are the "boots on the ground" staff best able to assist in this process. If case managers have questions, they are to contact Jen Whyte or herself for assistance.

Clinical Documentation Guidelines

Christine Taylor noted the UM Committee finalized the Clinical Documentation Guidelines. She noted in the 1990s the State put out a Blue Book requiring documentation be completed within 24 hours of service delivery. The Blue Book has gone by the wayside and the Agency needed to develop its own guidelines to meet all the requirements. She noted her original document was several pages longer than the final product. Focus will be on doing documentation accurately, completely and on time. She noted different clinical processes require different timelines for documentation. She noted the committee worked with the various departments to establish acceptable timeframes. The next step will be the UM Committee will need to get reports so monitoring can begin. She notes Mark will be assisting in developing policies to address a monitoring process for timeliness.

Genny Domke noted this may be a segment of the staff training for the fall courses. Christine Taylor noted supervisors received this information at a meeting in February and with the final product sent out February 12. Supervisors were to review this information with their staff and implement. Cathy Meske inquired as to whether staff were required to sign an attestation or signature of attendance at a meeting where this information was disbursed. In addition, this was to be added to the orientation process for new staff.

Site Review Work Group

Lynne Fredlund reported this was briefly discussed under Safety. This will be addressed when the forms are available for Council members to review.

New Business

Discussion:

Clinical Leadership

Lynne Fredlund reported she was informed the Clinical Leadership Team was doing process improvement. The QI Plan includes various committees which report to the QI Council; however, the Clinical Leadership Team was never added to this structure. A revision to the structure is suggested to include Clinical Leadership reporting to a committee. At this point, Management Team receives reports from the Clinical Leadership Team and then Management Team reports information on this group through minutes of their meetings and reports from the QI representative for Management Team, Cathy Meske. Lynne Fredlund reports she will be providing Clinical Leadership Team with a brief training on the process improvement model building off of existing processes.

IPS Review

Lynne Fredlund reported the response has not yet been received from the review conducted on April 24 and 25.

Delegated Functions (PIHP Review)

Christine Taylor reported in late April the PIHP notified us of a need to conduct a delegated functions review in advance of an upcoming Health Services Administration Group (HSAG) audit. This group is under state contract to audit all the PIHPs in Michigan. She reported the requested information had to be provided to them within a short timeframe. Jen Whyte reported she received an e-mail earlier today requesting additional information. Christine Taylor reports overall the review was a good one. She reports the Behavior Support policy needed some updates. In addition, one children's case did not have follow up. Just a couple of minor items to submit a corrective action plan on.

Satisfaction Survey Information received by PIHP

Lynne Fredlund noted the information distributed was just received from the PIHP. This is the charts related to results from the recent snapshot surveys conducted. Lynne requested Council members review the tables. The narrative for this satisfaction survey will be sent to us at a later date. She notes the PIHP really focuses on the return rates. Northeast typically has a lower return rate than other Boards due to the method used in distribution according to initial training. Some Boards will actually have the individual complete the survey while they are still with them at their appointment. The intent was to hand the survey and ask the individual to provide feedback; however, completing the survey is voluntary.

Lynne Fredlund reports it is expected a score of 3.0 or better. Northeast did attain that score in all but one area. The one area was in the snapshot survey for ACT in which we scored a 2.86. The question was whether the individual felt they were making progress toward their goals. There are several factors that could contribute to a lower satisfaction response in this program such as some individuals could be in this program under court order.

Lynne Fredlund noted from an improvement standard we will need to look at the return rate and determine whether all are using the same protocols for distribution and if there has been a change in direction as to how the survey should be distributed.

Lynne Fredlund noted she will be sending the narrative to Council members so discussion can be further at the August meeting.

Lynne Fredlund noted the Annual Report published in May was well laid out and contained great information.

Other

Discussion:

By consensus, this meeting was adjourned at 11:30 a.m.

Next Meeting will be held on June 18, 2018, 10:15 a.m. in the Board Training Room.

AUGUST AGENDA ITEMS

Policy Review

Policy Review & Self-Evaluation
Chairperson's Role 02-004
Board Member Per Diem 02-009
Board Self-Evaluation 02-012

Monitoring Reports
Treatment of Consumers 01-002 (Recipient Rights Complaint Log)
Staff Treatment 01-003 (Turnover Report/Exit)
Budgeting 01-004 (Finance Report)
Financial Condition 01-005 (Quarterly Balance Sheet)

Activity
CEO Evaluation
Strategic Planning Discussion/Ends
Begin Self-Evaluation

Old Business

Ownership Linkage
Public Hearing Program Input – [This is needed every two years and is done in January/February – just before the Annual Submission [should change this on Perpetual Calendar]
Legislative Event

Educational Session
Veteran's Navigator (possibly)

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

MEMORANDUM

DATE: June 18, 2018

TO: Executive Directors of Pre-Paid Inpatient Plans (PIHP's)
Executive Directors of Community Mental Health Service Programs (CMHSP's)
Supervisors of Evidence-based Individual Placement and Support (IPS) Programs

FROM: Lynda Zeller, Deputy Director
Behavioral Health and Developmental Disabilities Administration

SUBJECT: 2017 Individual Placement and Support (IPS) Report

I am pleased to provide a copy of the 2017 Individual Placement and Support (IPS) Report.

An overall highlight of this report shows an individual competitive integrated employment rate of 26% was achieved by individuals with serious mental illness supported through evidence-based IPS services. This is far above the 12.2% reported in a 2014 national report for Michigan when individuals received only general supported employment services. At the time of this most recent report, 1317 individuals received IPS supports across 22 sites within 10 Community Mental Health Services Providers (CMHSPs) representing 18 Michigan counties. Individuals averaged over 26 hours a week and earned an average of $10.10 per hour as people gained greater financial independence. This is remarkable progress.

We applaud the leadership by CMHSPs and contract providers shown below and their ongoing commitment through IPS to achieve high-quality employment outcomes for persons with serious mental illness. We look forward to continued partnerships in supporting individuals to achieve competitive integrated employment as it enhances each person's recovery and leads to far greater independence.

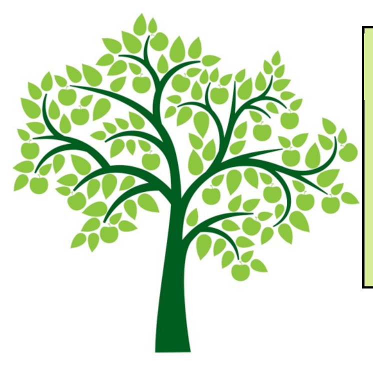
Current IPS programs, supervisor name, and CMHSP are recognized below. Also note, the ** denotes IPS MI-FAST Team Members/Fidelity Reviewers.

- ACCESS, Belal Kadri, Detroit Wayne Mental Health Authority
  - We also recognize and thank Emad and Ghinwah for sharing their success story.
- Central City Integrated Health, Norris Howard, Detroit Wayne Mental Health Authority
- CMH for Central Michigan, Eric Karbowski**, CMH Central Michigan
  - We also recognize and thank Kathy and Amy for sharing their success story.
- Community Care Services, Jill Blackson, Detroit Wayne Mental Health Authority
- Community Network Services, Jeff Segnitz, Oakland Community Health Network
- Development Centers, Marlene Davis, Detroit Wayne Mental Health Authority
- Easter Seals Michigan, Ruth Louwsma, Oakland Community Health Network

- HealthWest, Kris Burgess**, HealthWest
  - We also recognize and thank Mike for sharing his success story.
- Hope Network, Pam McKessy, Lifeways
- Interact of Michigan, Marisela Bobo**, Network 180
- Interact of Michigan, Tami Young**, Kalamazoo CMH & Substance Abuse Services
- Lincoln Behavioral Services, Glynettie Durrah, Detroit Wayne Mental Health Authority
- Northeast Guidance Center, Cynthia Jackson, Detroit Wayne Mental Health Authority
- Northeast Michigan CMH, Mary Mingus, Northeast Michigan CMH
- Riverwood Center, Matt Beilman, Berrien Mental Health Authority
- Services to Enhance Potential, Terey DeLisle, Detroit Wayne Mental Health Authority
- Southwest Counseling Solutions, Barbara Gray, Detroit Wayne Mental Health Authority
  - We also recognize Dominic D'Aguanno** on the MI-FAST team.
- St. Clair County CMH Services, Erika Rice, St. Clair County CMH Services
- Team Wellness Center, Trudy Williams**, Detroit Wayne Mental Health Authority
- The Guidance Center, Karen Harkness, Detroit Wayne Mental Health Authority
- Training and Treatment Innovations, Tanya Waple, Oakland Community Health Network
- Note: Bay-Arenac Behavioral Health Authority, Brenda Rutkowski**, has two emerging IPS sites.

The 2017 IPS report is now available online at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html or at www.improvingmipractices.org under the IPS section once registered. Specific questions may be directed to Joe Longcor at LongcorJ@michigan.gov.

c: Tom Renwick
Jeff Wieferich
Brenda Stoneburner
Joe Longcor



Northern Michigan Regional Entity

Consumer Newsletter

Issue 17 **Spring 2018**

The *Consumer Newsletter* is written for consumers by consumers. If you have something you would like to contribute to the next issue, please contact Member Services at 1.800.834.3393.

Inside this issue:

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Thumbs Up!

Alpena's Light of Hope Clubhouse Members are working to crate a video to welcome new Members. Its message is that everyone should have a place where he or she belongs. Congratulations to them on their great work!

NMRE Responds to Opioid Crisis

Prescription drug and opioid use has reached epidemic proportions in Michigan. Per the Substance Abuse and Mental Health Services Administration (SAMHSA), people with substance use disorders are at high risk for developing other chronic conditions. Data shows that over 40% of individuals with an opioid use disorder also have a mentally illness, namely depression, anxiety, and bipolar disorder.

Individuals with opioid use disorder or opioid use disorder with mental illness are also deeply affected by the social determinants of health (see page 6), particularly related to housing, income, and family and community supports. The availability of treatment and recovery oriented resources are limited and differ vastly based on environment (rural vs. urban), limiting access to care for many in need.

The Michigan Department of Health and Human Services (MDHHS) gathered data on individuals with an opioid use disorder in the past 18 months. As a result of this process, Region 2 PIHP—NMRE was identified as having the highest per person rate of Medicaid recipients diagnosed opioid use disorder in the state.

Of the 21 counties that make up the NMRE region, Grand Traverse County was shown to have the highest occurrence of opioid use disorder diagnoses, followed by Wexford, Alpena, and Otsego. Counties with the highest rate of hospitalizations related to opioid use were Crawford, Montmorency, Alpena, and Roscommon.

The drug Naloxone (Narcan) can reverse the effects of an opioid overdose and save the person's life. There have been 70 reported lives saved in the NMRE region since December 2015. The NMRE has provided law enforcement staff, first responders, and area schools in with life-saving Naloxone. Prevention efforts are focused on the creation of community coalitions and education. Proper disposal of unused or unwanted prescription medication is a key weapon in the fight against misuse.

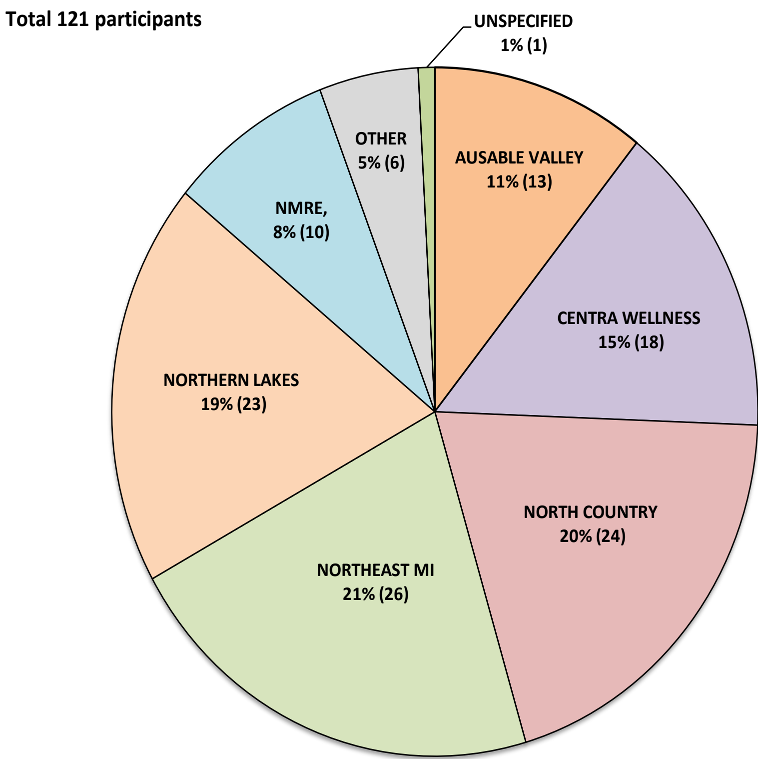
The NMRE is working with MDHHS on a number of creative solutions to the devastating opioid crisis; more information will be made available as they move forward.

Spring Day of Recovery Education

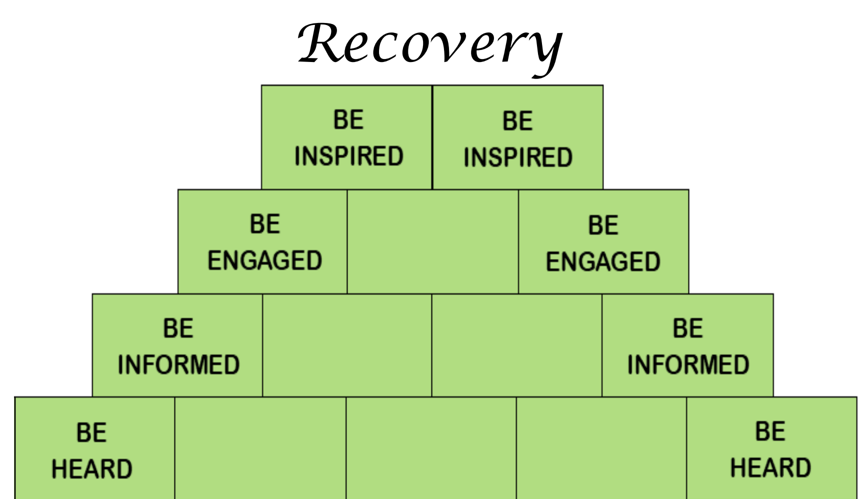
The NMRE hosted the regional Day of Recovery Education on May 11th at Treetops Resort in Gaylord. The theme of the event was "Building Blocks of Recovery" and attendees were encouraged to "Be Heard," "Be Informed," "Be Engaged," and "Be Inspired. The NMRE's Chief Executive Officer, Eric Kurtz welcomed the 121 guests. Speakers included Charlevoix County Probate Judge Valerie Snyder who spoke about guardianship, temporary guardianship, and conservatorship, and Kim Rappleyea, North Country CMH Recipient Rights Officer, who spoke about "enforcing your choice and protecting your health." Afternoon break-out sessions emphasized the theme with Valerie Holloway, North Country CMH Nurse advising individuals on how they can "Be Heard" at their appointments. Mental Health First Aid was presented by Mark Pettinato which gave individuals an opportunity to "Be Informed." Substance Use Disorder Services Recovery Coaches from the NMSAS Recovery Center spoke about the need for individuals to "Be Engaged" in treatment. A panel of mental health services peers gave attendees many reasons to "Be Inspired" by sharing their stories.

A continental breakfast and delicious lunch was provided (with vegan and vegetarian options available) and everyone delighted in the spirt of fellowship. Members of the Regional Entity Partners (REP) Committee were recognized for their valuable contribution to the NMRE by wearing commemorative t-shirts designed by local artist April Ballentine.

Consumer Relations Specialist, Karan Bingham, organized the event and has already begun planning the next Day of Recovery Education using suggestions provided on the exit evaluation forms. Stay tuned for an announcement of the October date.



More from The Day of Recovery



Percentage of Positive Responses to Satisfaction Questionnaire for Day of Education May 11, 2018

Item	Positive responses
LOCATION: TREETOPS RESORT	94.37%
LUNCH: ROAST BEEF OR VEGETARIAN	88.24%
WELCOME	92.65%
Guardianship, Limited Guardianship,...	92.86%
Building Blocks of Recovery (Karan Bingham)	85.71%
Know Your Rights (Kim Rappleyea)	93.06%
HEALTH CHECKS	84.00%
How to be heard at your appointments	86.67%
Mental Health First Aid training	89.19%
EMOTIONAL SUPPORT ANIMALS - JENNIFER SCHULTZ	84.21%
RECOVERY STORIES	93.75%

Believe in Change

Has it ever been said of you,
"That a leopard can't change its spots?"
Wearing your destructive life,
Like a suit of neon dots.
Well let me tell you my friend,
That statement doesn't hold true,
For I had spots that have changed,
And I'm no different than you.
My spots didn't change all at once,
The process seemed so slow,
But soon they were gone, and in their place,
New ones started to grow.
It took a deep desire,
To live a better way,
My hard worked proved them wrong,
To hell with what they say!
Your spots can change as well,
It's really up to you,
But if you change your spots you'll show
There's nothing this leopard can't do!

By: Robert Newsome

Satisfaction Survey

The NMRE conducted its annual Satisfaction Survey in February to measure individuals' level of satisfaction with the services received from community mental health. Six programs were surveyed (ACT, Adult Case Management, Clubhouse, Medical Services, Outpatient Therapy, and Youth Case Management) for the same two-week timeframe for each of the five CMHSP Boards in the region. Services recipients encouraged to complete surveys and were assured that all responses would remain anonymous.

The return rate was calculated at 68.06%, meaning that 68.06% of individuals who were given a survey to complete did so by by either returning the completed survey to the local CMH office or by mailing it directly to the NMRE. Participation was completely voluntary as individuals were given the option to decline if they did not want to take part. Participants were thanked for their feedback and assured it will be used to guide quality improvement efforts.

Adult Case Management services scored the highest level of favorable responses at **96.70%**, followed by Outpatient Therapy at **95.69%**, Youth Case Management at **95.67%**, Clubhouse at **93.73%**, ACT at **92.17%**, and Medical Services at **92.15%**.

Following are the 11 questions common to all six programs with the percentage of favorable responses shown. A favorable response is a score of 3—Agree or 4—Highly Agree to the survey question.

- Staff treats me with dignity and respect—**94.24%**
- I had enough input into the development of my treatment plan—**88.19%**
- I am making progress toward my treatment goals—**85.42%**
- I know what to do if I have a concern or complaint about my treatment—**88.22%**
- I feel comfortable asking questions about my services, treatment or medication—**89.89%**
- I am getting the information I need to help me with my recovery—**88.40%**
- I think staff supports my recovery—**91.97%**
- I deal better with daily problems because of the services—**85.68%**
- I would recommend these services to a friend or relative—**90.47%**
- If I had other choices, I would still get services from this agency—**89.52%**
- Appointments/contacts are scheduled at times that work best for me—**90.79%**

In addition to these quantitative statements, the survey also asked three open ended qualitative questions to allow individuals to express concerns or voice their experiences, either positive or negative. (continued next page)

More on Satisfaction

thank you for participating in the satisfaction survey!

Question 1: ***What do you like about CMH and think should continue?*** 59.32% of individuals who took the survey responded to this question with positive comments about CMH.

Question 2: ***What do you not like and think should be stopped?*** 45% of individuals who took the survey responded to the question. Of those, 64.98% were responses such as "None," "Nothing," "I don't know," or were in support of the services received ("Keep up the good work!") Only 15.75% were critical of services.

Questions 3: ***Do you have ideas to help the CMH Improve?*** 40.98% of individuals who took the survey responded to the question. Of those, 46.95% were responses such as "None," "Nothing," "I don't know" or were in support of the services ("Keep up the good work!) Only 21.74% were suggestions for improvement.

Number of Survey Responses by Program	
ACT	93
Adult Case Management	234
Clubhouse	115
Outpatient Therapy	445
Medical Services	298
Youth Case Management	135

Manistee Friendship Society June Activity Calendar

Monday	Tuesday	Wednesday	Thursday	Friday
4 Open 9:30-3:00 Community Meeting 11:00	5 Open 9:30-3:00 Rock Painting 11:00-12:00 Depression Group 12:30	6 Open 9:30-3:00 Bible Study 11:00-12:00 Ladies AA 6:30-7:30	7 Open 9:30-3:00 Food Truck Anger Management 11:00-12:00	8 Open 9:30-3:00 Board Member Training Part 2 10:00-2:00
11 Open 9:30-3:00 Mindful Stress Reduction 11:00-12:00 Hearing Voices Support 3:30-4:30	12 Open 9:30-3:00 Rock Painting 11:00-12:00 Gym Day 2:30 Depression Group 12:30-1:30	13 Open 9:30-3:00 Bible Study 11:00-12:00 Talent Show & Lunch 12:30 Ladies AA 6:30-7:00	14 Open 9:30-3:00 Anger Management 11:00-12:00 Gym Day	15 Open 9:30-3:00 Adult Coloring Club 11:00 Bingo 1:00-2:00
18 Open 9:30-3:00 Mindful Stress Reduction 11:00-12:00 Gym Day	19 Open 9:30-3:00 Ars & Crafts 11:00-12:00 Depression Group 12:30-1:30	20 Open 9:30-3:00 Bible Study 11:00-12:00 Ladies AA 6:30-7:30 Gym Day	21 Open 9:30-3:00 Anger Management 11:00-12:00 Free Haircut Day	22 Open 9:30-3:00 Adult Coloring Club 11:00 Recovery Bingo 1:00-2:00 Gym Day
25 Open 9:30-3:00 Mindful Stress Reduction 11:00-12:00 Hearing Voices Support 3:30-4:30	26 Open 9:30-3:00 Arts & Crafts 11:00-12:00 Depression Group 12:30-1:30	27 Open 9:30-3:00 Bible Study 11:00-12:00 Board Meeting 1:00-2:00 Ladies AA 6:30-7:30 Gym Day	28 Open 9:30-3:00 Anger Manage-ment 11:00-12:00 Dinner & Play "You're a Good Man Charlie Brown"	29 Open 9:30-3:00 Adult Coloring Club 11:00 Bingo 1:00-2:00 Gym Day

The Social Determinants of Health

Social determinants of health are the conditions in which people are born, grow, live, and work that shape health. They include things like income, education, neighborhood and physical environment, social support networks, and access to health care. Efforts to improve health have traditionally looked into the healthcare system as the key driver of health and health outcomes. There has been increased recognition, however, that improving health will require broader approaches that address social, economic, and environmental factors that influence health. Research suggests that health behaviors, such as smoking, diet, exercise, and stress reduction are as important to wellness as genetic factors. There is growing recognition that social and economic factors shape individuals' ability to engage in healthy behaviors.

A number of non-health factors affect a person's well being. For example, the availability of public transportation affects access to employment, affordable healthy foods, and health care. Other examples include safe housing, access to job opportunities and training, the quality of schools, the availability of supports in homes, communities and neighborhoods, and the cleanliness of water, food, and air.

A number of tools and strategies are emerging to address the social determinants of health to create social and physical environments that promote good health for everyone.

Social Determinants of Health

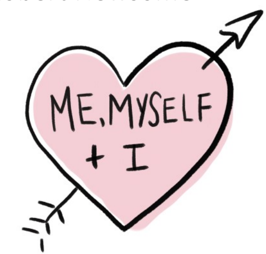
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

I Like Me

I have learned many lessons
Along the path I am on,
I'd like to share one now,
Promise it won't take long.
This lessons about some people,
Whose acceptance you think you need,
They're so powerful in your life,
Their opinions take the lead.
They can dictate your emotions,
With what they have to say,
Pleasing them is your goal,
But they reject you anyway.
Some people that you meet,
You'll truly want to befriend,
Willing to give up all that's you,
For the slightest chance to fit in.
Then there's those in life,
Who share the same bloodline,
That no matter the level of good you do,
You'll always be a waste of time.
This lesion learned from this?
Their thoughts may never be changed,
And thinking that you needs their approval,
I've found is totally deranged!
And the only acceptance that you need,
On this you can rely,
Is give by these three folk,
Me, myself & I.

By: Robert Newsome



June 29, 2018

FRIDAY FACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance Members
Executive Board Members

FROM: Robert Sheehan, Chief Executive Officer
Alan Bolter, Associate Director

RE:

- **Contact information of the CMH Association's Officers:**
- **Work, Accomplishments, and Announcements of CMH Association and its Member Organizations**
  - **Saginaw CMH leader honored for work with LGBTQ+ community**
- **State and National Developments and Resources**
  - **MDHHS, MHEF, and HMA issue papers on crisis services**
  - **CHRT issues papers on Michigan's Medicaid work requirements**
  - **Bill to support for EHR use by mental health systems moving through Congress**
  - **Michigan ACE initiative releases video**
  - **TED Talk: The agony of opioid withdrawal -- and what doctors should tell patients about it**
  - **Ranking of well-being of Michigan's children causes concern**
  - **NAMI Michigan announces "Mental Health Night with the Detroit Tigers"**
- **Resources from association's preferred corporate partners (*A recent addition to the Friday Facts)***
  - **myStrength expands evidence-based behavioral health resources**
- **Legislative Update**
  - **REDISTRICTING PROPOSAL SET TO APPEAR ON BALLOT**
- **National Update**
  - **House Panel Approves FY 19 Health Funding Levels**
- **Michigan clubhouse conference**
- **Ethics Training for Social Work and Substance Abuse Professionals for 2018**
- **Employment First Conference**
- **CMHAM Association committee schedules, membership, minutes, and information**

Contact information of the CMH Association's Officers: The Officers of the CMH Association of Michigan recently proposed, in their commitment to fostering dialogue among the members of the Association with the Association's leaders, that their contact information be shared with the Association membership. While this dialogue will not take the place of the regular dialogue and decision making that occurs during the meetings of the Association's Executive Board, Steering Committee, Provider Alliance, Association Committees, Directors Forum, PIHP CEOs meeting, nor any of the great number of Association-sponsored and supported dialogue venues, the Officers want to ensure that the members of the Association can reach them to discuss issues of interest to the Association's members. The contact information for the officers is provided below:

President: Joe Stone Stonejoe09@gmail.com; (989) 390-2284

First Vice President: Lois Shulman; Loisshulman@comcast.net; (248) 361-0219
Second Vice President: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

WORK, ACCOMPLISHMENTS, AND ANNOUNCEMENTS OF CMH ASSOCIATION AND ITS MEMBER ORGANIZATIONS

Saginaw CMH leader honored for work with LGBTQ+ community

On Tuesday, June 26, 2018, SCCMHA Clinical Director Linda Schneider was awarded the 2018 Great Lakes Bay Pride Business Award for her vision and leadership of Saginaw County Community Mental Health Authority's sexual orientation and gender identity (SOGI) advocacy initiative. For the past two years, SCCMHA has put forth a concerted effort to create a more welcoming environment and to improve services for LGBTQ+ individuals in Saginaw County. Examples of accomplishments include: bringing SOGI topics trainings to more than 200 professionals in the community; creating new partnerships with local LGBT advocacy organizations; and leading preparations for hosting a regional LGBTQ+ conference for mental health program leaders. Congratulations to Linda for this recognition.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

MDHHS, MHEF, and HMA issue papers on crisis services

Below is a recent announcement, by MDHHS, regarding two recent documents issued by the Michigan Health Endowment Fund (MHEF) on mental health crisis services. The development and release of these documents serve to further the dialogue and initiatives designed to address the psychiatric inpatient access issues faced by Michigan residents.

> MDHHS is reaching out to you on behalf of the Michigan Health Endowment Fund (MHEF). The Michigan Health Endowment Fund has been pursuing a range of different initiatives and projects that are related to the workgroup recommendations from the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) initiative. The Michigan Health Endowment Fund recently collaborated with Health Management Associates (HMA) to develop a report that explores different models for behavioral health crisis services. MDHHS is distributing this report and the related supplemental document to MIPAD workgroup members to help inform ongoing discussions about reducing barriers that individuals encounter while attempting to access services during a psychiatric crisis. A full description of the documents is included below.
>
> Over the past year, Health Fund grantees, grant seekers and other partners have identified behavioral health crisis services as a critical piece of the care continuum. As you all are aware, far too many people dealing with behavioral health issues end up in the emergency room. Long waits and noisy environments can exacerbate symptoms, and emergency departments often don't have staff best suited to address complex behavioral health challenges. In order to help us assess how the Health Fund might have the greatest impact in supporting expanded access to crisis services we partnered with Health Management Associates to explore behavioral health response models, and reviews legal, financial, and coordination challenges that can be barriers to meaningful change. We are pleased to share with you the report exploring new models and care configurations, policy and practice recommendations, and how Health Fund grantees are working in this area. This report can be found at: http://www.mihealthfund.org/wp-content/uploads/2018/05/HealthFund_BHcrise_ServicesModels_2018.pdf
>
> The Health Fund also prepared a supplementary piece that outlines our recommendations related to the report, as well as summaries of our grantees' work in this area. This supplementary document can be found at:

http://www.mihealthfund.org/wp-content/uploads/2018/05/HealthFund_BHCrisisServicesReport_RecsAndSummaries.pdf

Please feel free to reach out to Becky Cienki (Becky@mhealthfund.com) with any questions about the reports. Thank you once again for the continued partnership.

Please also note that the department will issue its next quarterly report on the status of implementation for the short-term recommendations in August. MDHHS will distribute a copy of this report to all MIPAD workgroup members (of which the CMH Association and a number of its members are active participants) as soon as the report is published.

CHRT issues papers on Michigan's Medicaid work requirements

The Center for Healthcare Research and Transformation recently released two resources related to Michigan's recently announced Medicaid work requirements:

The first is a consumer guide to these work requirements with a sound discussion of the facts needed for Medicaid enrollees to understand and meet the work requirements that will go into effect on January 2020. This guide can be found at: https://www.chrt.org//wp-content/uploads/2018/06/FINAL-Consumers-Guide-.pdf

The second is a side-by-side comparison of the recently signed bill that defines the work requirements with the original Healthy Michigan Plan statute. This analysis can be found at: https://www.chrt.org//wp-content/uploads/2018/06/FINAL-Comparison-.pdf

Bill to support for EHR use by mental health systems moving through Congress

Below is a recent announcement from the National Council for Behavioral Health on S 1732/HR 3331, a bill that would provide the beginnings of a system of financial support for the expansion of the use of electronic health records (EHR) by the nation's mental health system. This is very good news, has been a long time in coming, and is the result of much advocacy by the National Council and NACBHDD (of which the is Association is a member of both of these national organizations), this Association and its members, in partnership with allies across the country.

> Bipartisan legislation passed by the House last week and Senate last month that would incentivize behavioral health providers to adopt electronic health records (EHRs) is a huge victory for our industry. We have been working for passage of this legislation since 2009, when behavioral health was left out of a law that created financial incentives for providers and hospitals to implement EHR systems to improve patient care. But the real winners are the individuals we serve – people with mental illnesses, addictions and physical health challenges for whom care coordination is sometimes a matter of life and death.
>
> Widespread use of EHRs improves care for individuals and reduces health care costs. The Improving Access to Behavioral Health Information Technology Act (S. 1732/H.R. 3331) would task the Center for Medicare and Medicaid Innovation (CMMI) with creating a demonstration project to incentivize the adoption and use of certified EHR technology by mental health and addiction treatment organizations to "improve the quality and coordination of care through the electronic documentation and exchange of health information systems."
>
> Typically, behavioral health providers have been slow to adopt EHRs because they have been starved for funds. This legislation will test incentive payments to address adoption and the sharing of population health data, to reduce duplicative treatments and provide lifesaving information to providers.
>
> "For decades, behavioral health and substance use treatment providers have received significantly lower levels of funding and reimbursement rates than their primary/acute care counterparts," said Kevin Scalia, executive vice president of Netsmart, a founding member – with the National Council – of the Behavioral Health Information Technology (BHIT) Coalition.
> "The substantial increase in demand for services generated by the opioid crisis has driven this resource issue to new levels. This pilot program would give assistance to some providers and is a step forward to providing whole-

person care to the nearly 70 percent of persons with mental illness and co-occurring physical illness such as heart disease, asthma or diabetes."

Providers and settings that would be included in the CMMI demonstration are clinical psychologists and clinical social workers at psychiatric hospitals, community mental health centers, residential or outpatient mental health treatment facilities and addiction treatment facilities. The House version also includes psychiatric nurse practitioners. The House and Senate versions must now be reconciled before heading to the president's desk for his signature.

The National Council thanks Reps. Lynn Jenkins (R-Kan.) and Doris Matsui (D-Calif.) as well as Sens. Sheldon Whitehouse (D-R.I.) and Rob Portman (R-Ohio) for their work on this important legislation..

And we thank each and every one of you. For nearly a decade, you wrote letters, made phone calls and met with your congressional representatives and senators in person to tell them that we can't improve health care quality and costs and increase patient satisfaction unless behavioral health is an integral part of health care. This win is a victory for all Americans who need and deserve access to comprehensive, coordinated, evidence-based care for mental illnesses and addictions.

Michigan ACE initiative releases video

The Michigan Association of Health Plans Foundation, with funding from the Michigan Health Endowment Fund, created the Michigan ACE Initiative: Building Healthy Communities. This initiative is focused on expanding efforts toward a statewide awareness of Adverse Childhood Experiences (ACEs) and creating a statewide coalition to recommend development of appropriate interventions and state policy; and to provide for the implementation of Medicaid policy for ACEs. The CMH Association of Michigan and a number of other state associations serve on the advisory committee for this ACEs initiative.

The ACEs initiative in Michigan is aimed at benefitting the health and wellness of Michigan's children and will train those who interact with children on a regular basis, including social workers, teachers, community health workers and parents to understand behaviors that exemplify ACEs. This awareness will help children receive assistance from familiar faces within their own community.

The Michigan Association of Health Plans Foundation recently completed a Michigan ACEs video for use in gatherings and meetings in communities across the state. This video can be viewed at:

https://www.youtube.com/watch?v=MtuTmDtvGm0&feature=youtu.be

TED Talk: The agony of opioid withdrawal -- and what doctors should tell patients about it

A recent TED talk (Technology Education and Design) highlighted, in a poignant and very personal way, the experience of opioid withdrawal. The description of this TED talk is provided below as is the link to the TED talk.

The United States accounts for five percent of the world's population but consumes almost 70 percent of the total global opioid supply, creating an epidemic that has resulted in tens of thousands of deaths each year. How did we get here, and what can we do about it? In this personal talk, Travis Rieder recounts the painful, often-hidden struggle of opioid withdrawal and reveals how doctors who are quick to prescribe (and overprescribe) opioids aren't equipped with the tools to eventually get people off the meds.

https://www.ted.com/talks/travis_rieder_the_agony_of_opioid_withdrawal_and_what_doctors_should_tell_patients_about_it?utm_source=newsletter_daily&utm_campaign=daily&utm_medium=email&utm_content=button__2018-06-28

Ranking of well-being of Michigan's children causes concern

Below is an excerpt from a recent Detroit Free Press article that outlines the results of the most recent Kids County study of the well-being of the nation's children. Michigan's ranking on the dimensions captured in this study caused concern among child advocates and policy makers.

> A national report released Wednesday that ranked the well-being of children in all 50 states showed limited improvement in Michigan and placed the state at No. 33, in the bottom half of the nation in every aspect that it measured.
>
> Michigan ranked No. 33, trailing five other Midwest states, which included Illinois, No. 22; Indiana, No. 28.; Ohio, No. 25; Minnesota, No. 4; and Wisconsin, No. 12.
>
> The annual report — "Kids Count Data Book" compiled by the Annie E. Casey Foundation — raised questions about why Michigan is lagging and concerns that the upcoming census in 2020 will undercount the number of impoverished Michiganders.
>
> "It points to a bigger picture," said Alicia Guevara Warren, project director of Kids Count in Michigan at the Michigan League for Public Policy in Lansing. "We can't say that things are going in the wrong direction. Even looking at poverty in Detroit, we know things are getting better
>
> "But," she added, "the speed things are actually happening — when we look at how we fare nationally — things are improving, but in other states, they are improving much faster."
>
> Among the findings: 1 in 5 kids in Michigan lives in poverty.

The full article can be found at: *https://www.freep.com/story/news/local/michigan/2018/06/27/study-michigan-kids-poverty-midwest/732377002/*

More information on the Kids Count in Michigan effort can be found at: http://www.mlpp.org/kids-count
The Annie E. Casey Kids Count site is: http://www.aecf.org/resources/2018-kids-count-data-book/?msclkid=6c54239132911787e39b78a772b61eb3&utm_source=bing&utm_medium=cpc&utm_campaign=Data%20Center&utm_term=kids%20count&utm_content=2018%20Data%20Book

NAMI Michigan announces "Mental Health Night with the Detroit Tigers"

Below is a note from Kevin Fischer, Executive Director of NAMI Michigan:

> As I travel around Michigan, one of my greatest disappointments has been discovering many of our citizens are unaware of available public behavioral health services. The purpose of this message is to invite you to support "Mental Health Night with the Detroit Tigers!" This is our opportunity to connect with up to 41,000 Tigers fans who flock to Comerica Park from every corner of the state. Please see the attached information.
>
> My request is that you attend (if possible),and encourage your community and provider partners to support this event. Collaborating with our Detroit sports teams is our opportunity to increase behavioral health awareness with a broader audience. If all goes well I see this as an opportunity to collaborate with other major and minor sports organizations in Michigan.
>
> For organizations who purchase 100 or more tickets or sponsor the NAMIWalks at Silver Level ($2,500.00) or greater, I'm offering 2 tickets to watch the game from the NAMI Suite.
>
> I look forward to seeing you there.
>
> Mental Health Night with The Tigers
> Join NAMI Michigan & The Detroit Tigers for Mental Health Night
> Detroit Tigers vs. Chicago White Sox

August 25, 2018 @ 6:10 P.M.
Comerica Park | 2100 Woodward Ave, Detroit, MI 48201

Package Rates
Upper Grandstand: $33.00 Upper Box Infield: $43.00
Mezzanine: $37.00 Lower Baseline Box: $56.00
Upper Reserved Infield: $38.00

Each package includes a game ticket, a Detroit Tigers/ National Alliance on Mental Illness (NAMI) t-shirt and a donation to NAMI Michigan.
This Special Theme Event Ticket Package can only be purchased via the Buy Now button at https://www.mlb.com/tigers/tickets/specials/mental-health-awareness and is the only way to receive the exclusive merchandise offered. Individual game ticket purchases are not eligible for this offer. Packages cannot be purchased by phone or at Comerica Park Box Office windows. After you purchase your Special Themed ticket(s) you will receive a confirmation email with further instructions on how and where to receive your premium item. Subject to availability.

For groups of 15 or more, please contact betsy.bouilion@tigers.com.

Questions? Please contact the NAMI Michigan @ 517-485-4049 or call 313-471-2255.

RESOURCES FROM ASSOCIATION'S PREFERRED CORPORATE PARTNERS

myStrength expands evidence-based behavioral health resources

In 2016, 10.05 million U.S. adults identified as LGBTQ+. As a gender and sexual minority group, LGBTQ+ communities face heightened issues related to stigma, lack of cultural sensitivity and discrimination. This amplifies stress that promotes behavioral health disorders and suicide risk. In fact:

- Individuals who identify as LGBTQ+ are 3 times more likely to face mental health issues.
- About 1 in 3 people who are LGBTQ+ faces substance use problems.
- Individuals who are LGBTQ+ are more likely to report a suicide attempt in the last year.
- Only 1 in 2 adults who identify as LGBTQ+ and are in need of behavioral health care will receive treatment.

myStrength Supports LGBTQ+ Communities with:

- Proactive wellness
- Dealing with minority stress
- Building a support system
- Finding equitable care
- Suicide/self-harm prevention
- Addressing problematic substance use

The Community Mental Health Association of Michigan's Preferred Corporate Partner, myStrength, offers interactive activities, inspirations, health trackers and community features offer an inclusive, safe and stigma-free digital support system available 24 hours per day, 7 days per week.

myStrength's self-care resources address prevalent issues among LGBTQ+ communities, including stress, anxiety, depression, insomnia, chronic pain, substance use issues, opioid risk management and much more.

For more information on myStrength (used by many CMH Association members), go to:
https://bh.mystrength.com/

LEGISLATIVE UPDATE

REDISTRICTING PROPOSAL SET TO APPEAR ON BALLOT

Despite opponents' attempts to keep the proposed constitutional amendment seeking to alter how Michigan's districts are formed off of this fall's ballot, the Michigan Board of State Canvassers certified the proposal on Wednesday.

The decision was made on a 3-0 vote, with one member absent, and applauded by more than 200 supporters in attendance. The proposal, brought forth by the group Voters Not Politicians, calls for the state's legislative and congressional districts to be drafted by a 13-member citizen commission, something those in opposition claim violates the Michigan constitution.

Citizen's Protecting Michigan's Constitution, a group opposing the proposal, filed multiple appeals and arguments with the Michigan Court of Appeals and ultimately the Michigan Supreme Court (with that decision still pending).

In seeking to get the proposal approved by the Secretary of State, Voters Not Politicians submitted 425,000 signatures, of which 394,000 were found to be valid, well above the required 315,654. The group noted the proposal is a nonpartisan approach to address gerrymandering in Michigan. The Justices of the Supreme Court are set to make their decision in the coming weeks.

NATIONAL UPDATE

House Panel Approves FY 19 Health Funding Levels

Last Friday, the appropriations subcommittee that covers health care programs approved funding levels for federal health spending for FY 2019. Earlier this year, Congress set federal spending levels for FY 2019, boosting both defense and non-defense spending by a combined $300 billion. As currently written, the Labor, Health and Human Services, Education and Related Agencies (Labor-HHS) appropriations bill would prioritize efforts to address the opioid crisis and increase medical research.

The legislation would set Health and Human Services' (HHS) budget overall at $89.2 billion, or $2.4 billion more than was requested by President Trump in his budget proposal. To address the opioid addiction crisis, the bill contains funding increases for SAMHSA as well as the National Institutes of Health or NIH. The additional dollars would support efforts to expand opioid addiction treatment and research related to opioids and pain management.

Topline subcommittee funding levels include:

Program	FY 2019 Funding	FY 2019 vs FY 2018
Substance Abuse and Mental Health Services Administration (SAMHSA)	$5.6 billion	*+$448 million*
National Institutes of Health (NIH) *Overall funding*	$38.3 billion	*+$1.2 billion*
NIH: National Institute on Mental Health (NIMH)	$1.8 billion	*+$200 million*
NIH: National Institute on Drug Abuse (NIDA)	$1.4 billion	*+$300 million*
NIH: National Institute on Alcohol Abuse and Alcoholism (NIAAA)	$516 million	*+$33 million*
Centers for Medicare and Medicaid Services (CMS)	$2.5 billion	*-$168 million*
Centers for Disease Control and Prevention (CDC)	$7.6 billion	*-$663 million*

WHAT'S NEXT?

This subcommittee vote is the first step in the long process of funding the federal government. This funding measure now heads to the full House Appropriations Committee for its consideration and approval next week. Currently, the Senate's topline spending levels are $2 billion more than the House's, meaning the spending levels in the bill are likely to change.

TRAININGS:

MICHIGAN CLUBHOUSE CONFERENCE

"Opening New Doors" Conference will be held on July 15 – 18, 2018 at the Grand Traverse Resort in Traverse City.

CONFERENCE REGISTRATION: Conference Registration Fee: $75 per person
Fee includes opening reception, 3 breakfasts, 2 luncheons, 1 dinner and reception with entertainment.

HOTEL DETAILS & RESERVATIONS: Room Rates:
Hotel Room: $75 plus $16.95 resort fee and taxes
Tower Room: $209 plus $16.95 resort fee and taxes
Two Bedroom Condos: $279 plus $16.95 resort fee and taxes per room

Deadline for These Rates: Friday, June 15, 2018

Reservations: Call 800-968-7352 and use code: CLUBHOUSE CONF 2018

To Register for the Clubhouse Conference, Click Here:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5160&AppCode=REG&CC=118060403651&RegType=MCCTC

ETHICS FOR SOCIAL WORK & SUBSTANCE USE DISORDER PROFESSIONALS TRAININGS FOR 2018

Community Mental Health Association of Michigan is pleased to offer 6 Ethics for Social Work & Substance Use Disorder Professionals Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This training fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for ethics. This training fulfills the MCBAP approved treatment ethics code education – specific.

Trainings offered on the following dates.

- June 27 –Kalamazoo
- July 11 - Troy
- August 22 – Lansing

Training Fees: (fee includes training material, coffee, lunch and refreshments.
$115 CMHAM Members
$138 Non-Members

To register: https://cmham.ungerboeck.com/prod/emc00/PublicSignIn.aspx?&SessionID=fa7fe5ej2fe8fc5&Lang=*

REGISTER NOW! EMPLOYMENT FIRST CONFERENCE

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

July 11 & 12, 2018
Kellogg Hotel & Conference Center, East Lansing, Michigan

Registration Fee: $50

Who Should Attend: Staff who's involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership
- CRO Leadership

Workshop Tracks:

- Leadership
- Provider Transformation
- HCBS Implementation

Sponsored By: The Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Additional conference details and registration, click here: CLICK HERE!

CMH ASSOCIATION COMMITTEE SCHEDULES, MEMBERSHIP, MINUTES, AND INFORMATION: go to our website at https://www.macmhb.org/committees

June 22, 2018

FRIDAY FACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance Members
Executive Board Members

FROM: Robert Sheehan, Chief Executive Officer
Alan Bolter, Associate Director

RE:

- **Contact information of the CMH Association's Officers:**
- **Work, Accomplishments, and Announcements of CMH Association and its Member Organizations**
  - **Network 180 leadership changes**
- **State and National Developments and Resources**
  - **SAMHSA publishes Spanish language version of "Finding Quality Treatment For Substance Use Disorders"**
  - **Michigan announces PCMH-like effort in areas outside of SIM regions**
  - **Two long-sought healthcare resolutions to be proposed at summer NACo conference**
  - **Media story underscores rural mental health shortage**
  - **The Hill editorial: Medicaid exclusion remains a barrier to treatment**
  - **SAMHSA announces CJ and SMI webinar**
  - **CHCS issues brief: Building Community-Based Behavioral Health and Long-Term Care Provider Readiness for Payment Reform**
- **Resources from association's preferred corporate partners (*A recent addition to the Friday Facts)***
  - **Relias webinar: Everything You Need to Know about CCBHCs**
  - **Relias provides HR tool kit – white papers and webinars**
  - **MyStrength explains digital dashboard**
- **Legislative Update**
  - **FY19 & FY18 Supplemental Budgets Head to the Governor**
  - **Medicaid Work Requirements Head to the Governor**
- **National Update**
  - **House Passes First Wave of Opioid Bills**
  - **House Passes Behavioral Health Information Technology Bill**
- **Michigan clubhouse conference**
- **Ethics Training for Social Work and Substance Abuse Professionals for 2018**
- **Employment First Conference**
- **CMHAM Association committee schedules, membership, minutes, and information**

Contact information of the CMH Association's Officers: The Officers of the CMH Association of Michigan recently proposed that their contact information be shared with the Association membership to foster dialogue. While this dialogue will not take the place of the regular dialogue and decision making that occurs during the meetings of the Association's Executive Board, Steering Committee, Provider Alliance, Association Committees, nor any of the great number of Association-

sponsored and supported dialogue venues, the Officers want to ensure that the members of the Association can reach them to discuss issues of interest to the Association's members. The contact information for the officers is provided below:

President: Joe Stone Stonejoe09@gmail.com; (989) 390-2284
First Vice President: Lois Shulman; Loisshulman@comcast.net; (248) 361-0219
Second Vice President: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

WORK, ACCOMPLISHMENTS, AND ANNOUNCEMENTS OF CMH ASSOCIATION AND ITS MEMBER ORGANIZATIONS

Network 180 leadership changes

Below are excerpts from a recent MLive article on changes in the leadership of Network 180.

> The head of Kent County's community mental health authority has resigned. It was announced this week Network 180 CEO Scott Gilman would not seek a contract renewal.
>
> Network 180's Chief Operating Officer Bill Riley was chosen as transition manager.
>
> Further cuts to staff and services, Riley said, don't appear to be on the horizon.
>
> "Our choice is to look forward at the opportunities that we're going to be working," he said. "We don't anticipate any major hiring or any additional losses at this point."
>
> Although Gilman couldn't be reached for comment, he did give a statement within a Network 180 press release on his departure.
>
> "My goal was to leave Network 180 in a stronger place," he said in the statement. "I take pride in my contributions of serving this community and an incredible team of employees and partners, while guiding us with grassroots advocacy and through one of the largest challenges in the organization's recent history."
>
> During his tenure, Gilman helped oversee the formation of Lakeshore Regional Entity in 2014, established an "innovative" Behavioral Health Home and started "the community process of addressing the need to develop a better community response to mental health crisis situations," Mast (Kent County commissioner and chairman of the Network 180 Board of Directors) said.
>
> Within the next month, Mast said the authority hopes to institute an interim CEO. Five to six months later, a permanent CEO is expected to be picked.
>
> "I think he decided to move on," said Harold Mast, "It was contract renewal time and he thought it was a good time."

The full article can be found at:
https://www.mlive.com/news/grand-rapids/index.ssf/2018/06/kent_county_mental_health_ceo.html

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

SAMHSA publishes Spanish language version of "Finding Quality Treatment For Substance Use Disorders"

SAMHSA's popular fact sheet, ***Finding Quality Treatment For Substance Use Disorders***, has been published in Spanish. It outlines the steps to using a treatment center, lists signs of a quality treatment center and more. Download the fact sheet here. https://store.samhsa.gov/product/PEP18-TREATMENT-LOCS

Michigan announces PCMH-like effort in areas outside of SIM regions

The Care Delivery component of the State Innovation Model (SIM) is designed to support the spread of Advanced Alternative Payment Methods (APM) across the state. The Michigan Department of Health and Human Services (MDHHS) continues to work with Medicaid Health Plans to support the expansion of current APMs and the development of new APMs. Through this work, the Department is supporting Medicaid Health Plans in pursuing a care delivery model, similar to the SIM Patient Centered Medical Home (PCMH) Initiative as a mechanism to continue the valued work of primary care transformation across Michigan.

This program will provide an opportunity for eligible practices and providers across the state (both those within and outside the SIM test regions) that are not currently participating in the SIM PCMH Initiative to engage in a similar care delivery model as that used in the SIM PCMH Initiative by working closely with the Medicaid Health Plans participating in this APM. While administered directly by each individual Medicaid Health Plan (not all Medicaid Health Plans will participate in calendar year 2019), participant eligibility for this program will mirror that of the MDHHS led SIM PCMH Initiative. Therefore, this program will require an application for all interested in participating. MDHHS will be facilitating an application process to support the participating Medicaid Health Plans as they execute this program.

The application is now open and submissions will be accepted through 11:59 PM EST on July 13, 2018. The application can be found at: https://umich.qualtrics.com/jfe/form/SV_eKF8K0s1gL6whOR

A live webinar on the application process will be held on June 26, 2018 1:00 PM - 2:00 PM EDT. To register for this informational session, register at:. https://register.gotowebinar.com/register/6176884092634235395

For more information, visit www.michigan.gov/SIM
Questions or comments may be sent to: MDHHS-SIM@michigan.gov

Two long sought healthcare resolutions to be proposed at summer NACo conference

Below are two resolutions, related to the work of the members and stakeholders of the CMH Association, that will be introduced in this summer's National Association of Counties (NACo) Board meetings, via the NACo Health Committee.

1. Integration of Mental Health and Addiction Care to Address the Opioid Crisis

Issue: Although opioid addiction very frequently follows the onset of depression, and opioid addiction frequently triggers depression within as few as 30 days, our patterns of care organization and funding do not make provision for a necessary linkage between mental health and substance use care.
Proposed Policy: NACo urges the federal government, specifically, SAMHSA, HRSA, CDC, and CMS, to modify grant, technical assistance, and service funding programs that support the development and operation of integrated care to include provision for the integration of mental health and addiction care, including care for depression and opioid addiction.
Background: County behavioral health programs currently are moving toward integration of mental health and primary care because many persons served in the public mental health system also suffer from chronic physical diseases, such as heart disease and diabetes. These efforts are supported by long-standing federal policy, grant, and service funding programs from SAMHSA, HRSA, CDC, and CMS. Within this environment, a subsequent step for counties is the integration of addiction care into this service framework. Because of the national opioid crisis, it is expected that new federal resources will become available for the improvement and implementation of this feature of addition care. Depression screening and treatment are key steps required to prevent opioid addition, as well as to treat it.

Fiscal/Urban/Rural Impact: This effort would provide new federal funds to counties and community-based organizations. It would not require new county resources, but rather require the linkage of current clinicians and clinical practice from the two fields.
Sponsor: Ron Manderscheid, Executive Director, National Association of County Behavioral Health and Developmental Disability Directors and National Association for Rural Mental Health.

2. Proposed Resolution to Prohibit Insurers from Denying Health Benefits to Preadjudicated Persons

Issue: Private insurance companies' "inmate exclusion" shifts health care costs from preadjudicated inmates to counties.

Proposed Policy: The National Association of Counties (NACo) urges the Department of Health and Human Services (HHS) to prohibit insurers from denying reimbursement under health benefit plans for covered services provided to preadjudicated persons in the custody of local supervisory authorities.

Background: Local governments are obligated to provide medical care to the people they incarcerate. Counties hire nurses, doctors, dentists, and mental health staff who have the same experience, credentials, and ability to improve care as in our county clinics or our hospitals.

As a result, counties throughout the United States are shouldering a tremendous cost for inmate health care. According to the Urban Institute, "Typically 9 to 30 percent of corrections costs go to inmate health care.

This amounts to hundreds of millions of dollars annually, and is an aspect of corrections of which the public and many decision makers are largely unaware. Inmate care costs are high in both prisons and jails."

According to the State of Oregon Legislative Counsel, "The Affordable Care Act requires all nonexempt individuals to have health insurance. Preadjudicated inmates are inmates who have not been convicted and who are being held pending disposition of charges. Such inmates are not excused from the requirement to have insurance until after they have been convicted and are incarcerated as a result of a conviction."

Legislative Counsel continues by explaining, "Insurance companies are required to provide health insurance to anyone who applies for insurance. An inmate may enroll in insurance that is offered in the private market outside of the exchange. Prior to conviction, an eligible inmate also may enroll in insurance through the health insurance exchange. Therefore, an insurance company must provide insurance to preadjudicated inmates and may not deny coverage for any service that is an essential health benefit."

Though some preadjudicated people who enter jails have private insurance, most insurers have an "inmate exclusion" and do not pay for health care services provided to their insured while they are in county jails. For those inmates pending disposition of charges, counties are paying their health costs despite the fact that their private insurer is collecting a premium. As a result, taxpayers bear the cost that otherwise would be paid by insurance companies.

An example of this issue is illustrated in Oregon. A recent survey of counties found an average of eight percent of inmates have private health insurance and 61 percent of inmates in jail are pre-adjudicated. Multnomah County, Oregon, estimates that they could save up to $1 million annually by billing private insurers for preadjudicated inmate health costs. Requiring counties to pay for health care for inmates who have private health care coverage is neither a good use of taxpayer dollars nor good public policy.

Fiscal/Urban/Rural Impact: If counties were able to bill private insurers for the health costs of their preadjudicated, insured clients, counties could shift the burden from taxpayers. Counties can use these funds for other critical services, including public safety.

Sponsor(s): Loretta Smith, Commissioner, Multnomah County, Ore.

Media story underscores rural mental health shortage

A recent Google News article, “Rural Areas Have The Highest Suicide Rates And Fewest Mental Health Workers” provides a clear picture of the mental health workforce shortage facing America’s rural communities. Excerpts of that article are provided below.

> There isn’t a single psychiatrist in 65 percent of nonmetropolitan counties, and there’s no psychologist in almost half of them
> In the days and weeks following the suicides of celebrity chef Anthony Bourdain and handbag designer Kate Spade, a chorus of social media users urged people with depression to not be “afraid” to ask for help.
>
> But for most Americans, fear isn’t the thing that stands in the way of therapy. It’s having no one to turn to.
> This was the case for Sue, 57, who spent over 30 years trying to get effective treatment for bipolar disorder, depression, anxiety and a personality disorder.
>
> For years, whenever Sue felt a major anxiety attack coming on, she’d panic. She would grab her keys, bolt out the door and frantically search for help. In rural Nebraska, that often meant walking up to two miles to the nearest neighbor’s house or emergency room, sometimes in the middle of the night.
>
> Sue estimates that she’s been to the emergency room in crisis about 30 times. Staff members at the local hospitals she visited weren’t usually equipped to treat her and would typically send her home in a matter of hours.
>
> Still, just having someone tell her she would be all right was enough of an incentive for Sue to return to the ER when her anxiety became too much to bear. “I ended up being released and going right back to the condition I was in,” she said. “I would do it again about a month later.”
>
> There is a severe shortage of mental health workers across the U.S., but the problem is most pronounced in rural areas.
>
> There isn’t a single psychiatrist in 65 percent of nonmetropolitan counties, and almost half of those counties don’t have a psychologist, according to a report from the American Journal of Preventive Medicine released this month. Patients like Sue, who are desperate for care, will often turn to overburdened emergency rooms, which often don’t have the systems in place to help people with mental health issues.
>
> “People with mental illness will present in the ER because they don’t know what else to do,” said Stephanie Knight, a licensed independent mental health practitioner and the administrative director at Fillmore County Hospital in Geneva, Nebraska.
>
> But even when a rural area does have some mental health workers, they alone usually can’t address the entire population’s needs. Many residents are uninsured or underinsured, and can’t afford regular treatment. Residents may have to travel dozens of miles to get to the nearest town where a therapist works, and may not have access to transportation. Some therapists have irregular office hours and may only visit town a few days a month. The inconsistency can be a deterrent to patients.
>
> Such was the case with Ann, 72, who lives in Crete, Nebraska. She has major depressive disorder and attempted suicide seven years ago. She enjoyed seeing a local therapist, but the therapist only came to her town once a month.
> “It was so infrequent,” Ann said. “After a couple of weeks, I’d think: ‘Why go back?’ There was no momentum.”
>
> Rural areas have the highest suicide rates, according to the Centers for Disease Control and Prevention, as well as a high concentration of veterans, who experience higher rates of suicide than nonveterans. Rates of drug overdoses in rural areas have surpassed those in metropolitan areas. There are also more elderly people, who are often socially isolated and at risk for depression, said Ron Manderscheid, executive director of the National Association for Rural Mental Health.

"If I went and looked at all those local communities, I will find a lot of socially isolated people. That is almost as deadly upon you as smoking," said Manderscheid. "When you put that all together, rural areas are a pretty risky place for being at risk for suicide."

Not enough people are going into the mental health field, and those in the field are aging, Manderscheid said. The average psychiatrist is in their mid-50s. Other specialists and primary care physicians are, on average, in their mid-40s. Those who do pursue careers in mental health typically find jobs in major cities.

"Historically, mental health has been an urban discipline," Manderscheid added. "If you're in New York, Chicago, San Francisco, Houston — any of our big areas — you will get the best mental health services we have to offer. If you're in some of these rural areas, you won't. It's just as simple as that."

While some government incentive programs help repay the student loans of therapists who work in underserved areas, many professionals don't stick around once they've paid off their debts, Knight said.
Manderscheid said improving telehealth programs, which allow patients to call or video chat with therapists in cities, is one potential solution. Encouraging young people from rural areas to go into the mental health field could also help.

"We need to start recruiting some of our providers from these rural areas, and work with people in high schools and colleges," he said. "They are most likely to go back. They have an appreciation for rurality and living in rural communities."

The Hill editorial: Medicaid exclusion remains a barrier to treatment

Below is a recent guest editorial rrom former Rep. Patrick Kennedy (D-R.I.), founder of The Kennedy Forum, former member of the President's Commission on Combatting Drug Addiction and the Opioid Crisis, co-founder of One Mind; and Mark Covall, president and CEO of the National Association for Behavioral Healthcare

We appreciate the experience that Michael Botticelli and Richard Frank call upon as they work to address our nation's deadly opioid crisis ("Congress needs a broader approach to address opioid epidemic," June 10). And we support their view that effective treatment for opioid use disorder "can involve a broad continuum of services that range from institutional care to pharmacotherapies to psychosocial and rehabilitation services." But we disagree with the authors about the effects of repealing Medicaid's Institutions for Mental Diseases (IMD) exclusion. Simply put, the IMD exclusion is a barrier to care. Since 1965, the IMD exclusion has prevented Medicaid beneficiaries between the ages of 21-64 from accessing behavioral health care in psychiatric hospitals and residential treatment facilities with more than 16 beds. The American Society of Addiction Medicine identifies adolescents, expectant mothers, people with unstable housing arrangements, or those with co-occurring substance use disorders as patients who typically require residential or hospital care. Many of these patients are also Medicaid beneficiaries, and the IMD exclusion prohibits them from accessing the care they need.

Proof that the IMD exclusion is not working: Our nation's prisons have become a de facto mental health and addiction treatment system. Tens of thousands of people with severe mental illness and substance use disorder are currently incarcerated because they could not secure a bed in a treatment facility. Providing appropriate services along the behavioral health care continuum will help to prevent this, thereby greatly reducing costs in the prison system.

Repealing the IMD exclusion and, consequently, opening access to inpatient treatment does not close access to outpatient treatment. At a time when the opioid crisis is still a public health emergency, we should all advocate that both inpatient and outpatient services be widely available so patients have access to the right care, in the right setting, at the right time.

Most important, we cannot have a comprehensive behavioral health care continuum without adequate access to one vital piece of that continuum: inpatient care. Dozens of opioid-related bills are currently circulating in both chambers of Congress, and most of those bills center on outpatient treatment. We applaud Rep. Mimi Walters (R-

Calif.) and Congress for recognizing the need for wider access to inpatient care. As Congress responds to America's opioid crisis, we urge it to remember that repealing the IMD exclusion is critical to developing our nation's behavioral healthcare system.

Lives depend on it.

SAMHSA announces CJ and SMI webinar

A SAMHSA (Substance Abuse and Mental Health Services Administration) sponsored webinar**,** "Criminal Justice and Serious Mental Illness: Moving to Patient Centered Care", developed under contract by the National Council for Behavioral Health, will take place Thursday, June 28 from 12:30-2:00 p.m. ET**.**

Please register here: https://nasmhpd.adobeconnect.com/patientcenteredcare_reg/event/event_info.html

Description: A 2010 report from the Treatment Advocacy Center found that jails and prisons have more than three times the individuals living with serious mental illness than hospitals. Labeled as the "new mental hospitals or asylums," at least 16 percent of inmates currently in jails and prisons have a serious mental illness compared to 6.4 percent in 1983. Unless gaps in care for these individuals are identified and effective patient-centered interventions are implemented, this problem will persist and potentially worsen.

Attendees of this webinar will learn about the factors contributing to the current situation, gaps in the systems, how to improve access to care in the community and the role of diversion programs such as Mental Health Courts and Drug Courts in decreasing criminalization of serious mental illness and substance use disorders.

Presenter: Angeline Stanislaus, MD, Chief Medical Director of Adult Services for the Missouri Department of Mental Health

CHCS issues brief: Building Community-Based Behavioral Health and Long-Term Care Provider Readiness for Payment Reform

Payment and delivery system reforms are critical to achieve the Triple Aim of improved health, improved patient experience and quality, and reduced cost. While involvement in payment reform grows, participation remains challenging for many community-based behavioral health and long-term services and supports (LTSS) providers.

This new CHCS brief examines the competencies necessary for community-based behavioral health and LTSS providers to successfully participate in alternative payment models, discusses the barriers they face, and explores how states, the federal government, and private organizations can increase community-based providers' readiness to participate in payment reform activities.

Two companion case studies highlight examples where public and private organizations successfully partnered to increase community-based behavioral health and LTSS provider readiness for payment reform.

A copy of this brief can be found at:
https://www.chcs.org/resource/building-community-based-behavioral-health-and-long-term-care-provider-readiness-for-payment-reform/

RESOURCES FROM ASSOCIATION'S PREFERRED CORPORATE PARTNERS

Relias webinar: Everything You Need to Know about CCBHCs

Are you applying for a CCBHC Expansion Grant? Don't miss our upcoming webinar for essential information and advice on preparation.

Webinar Details

Title: CCBHCs: What You Need to Know & How Relias Can Help

Date: Thursday, June 28

Time: 3:00 p.m. - 4:00 p.m. ET

The next wave of CCBHC opportunity is focused on readiness for delivering value-based care under a case rate model. This webinar will review the key principles behind the CCBHC model and discuss the grant requirements and objectives for participants. In addition, we'll discuss how Relias can help you prepare, implement and manage the CCBHC model of delivery.

Register at:
http://go.reliaslearning.com/WBN2018-06-28CCBHCExpansion_Registration.html?utm_source=marketo&utm_medium=email&utm_campaign=wbn_2018-06-28_ccbhc-expansion_population-health-management&mkt_tok=eyJpljoiTlRNeE5EbGlOVEJsTjJFMSIsInQiOiJ2ODUzS3Q0eDNUQ0VjU0FFVmhBSTVUM3FESzVxNlwvSjNkTWc5S0FJaytlYnZiRE9NNlRFUE1DM09tc2pjUXEyWUlzV0xvbzNPekhySWpDRVpjOEo0Sjk4dFBTY05Yc0FPY0tPVGd4QkJ0bHhFSGluNCt5SVFlbWRMMktNbnN0XC8zIn0%3D

Relias provides HR tool kit – white papers and webinars

White Papers:

Overcoming Hiring Conundrums: Hunting Unicorns or Chasing Cats (https://www.relias.com/resource/overcoming-hiring-conundrums?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper explains the purpose, capability and function of assessments in making data-informed hiring decisions in healthcare.

Shining a Light on Employee Engagement (https://www.relias.com/resource/shining-light-on-employee-engagement?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper discusses how to cultivate high levels of employee engagement as one key to combatting turnover and improving performance in healthcare.

Nurse Turnover: Do Generational Differences Impact Turnover? (https://www.relias.com/resource/generational-differences-impact-nurse-turnover?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper explores the reasons why nurses decide to leave and whether generation plays a role in that decision.

Rewards and Recognition: A Key Player in Your Retention Strategy (https://www.relias.com/resource/reward-and-recognition-retention-strategy?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper discusses the importance of a rewards and recognition program, especially in assisted living and senior care facilities, and how to implement a successful program.

Webinar Series:

Staff shortages, burnout and *challenging work environments contribute to the increasing turnover rates across the healthcare continuum. High turnover negatively impacts the quality of care and results in adverse clinical and financial outcomes.*

Join us for a 3-part webinar series to learn how to improve hiring and onboarding programs, evaluate and enhance competency, and develop the next generation of leaders— all to build and retain the best workforce.

1. Hiring in Healthcare – How to Find Your Unicorns (http://go.reliaslearning.com/WBN2018-06-28HireRetainLaunchPart1_Registration.html?utm_source=partner_silver&utm_medium=referral&utm_campaign=wbn_2018-06-28_hire-retain-launch-1_hiring-and-retaining)

- **Date:** June 28, 2018 at 2 p.m. ET
- **Presenters:** Leslie Jefferies, MSN, BSN, RN, Director of Clinical Solutions & Justin Hess, M.S., Product Manager, Assessments
- **Description:** This webinar will discuss two personnel challenges that all healthcare organizations face: staff shortages and high turnover. We will then explore using validated assessments as a pre-hire tool to help organizations choose and retain the best talent for their organization.

2. How to Go From Good to Great: Cultivate Your Leaders (http://go.reliaslearning.com/WBN2018-07-12HireRetainLaunchPart2_Registration.html?utm_source=partner_silver&utm_medium=referral&utm_campaign=wbn_2018-07-12_hire-retain-launch-2_hiring-and-retaining)

- **Date:** July 12, 2018 at 2 p.m. ET
- **Presenters:** John McGinn, Healthcare Industry Principal, Skillsoft®
- **Description:** This webinar will explore how leadership development is key to creating a culture of engaged employees. High-performing organizations are leading the industry through talent development, which positively impacts turnover and patient outcomes.

3. Retention Battle Cry: Onboarding & Development (http://go.reliaslearning.com/WBN2018-07-26HireRetainLaunchPart3_Registration.html?utm_source=partner_silver&utm_medium=referral&utm_campaign=wbn_2018-07-26_hire-retain-launch-3_hiring-and-retaining)

- **Date:** July 26, 2018 at 2 p.m. ET
- **Presenters:** Felicia Sadler, MJ, BSN, RN, CPHQ, Clinical Effectiveness Consultant & Justin Hess, M.S., Product Manager, Assessments
- **Description:** This webinar will focus how to address industry challenges such as outcomes, patient satisfaction, and turnover, through onboarding and staff development. We will discuss best practices for creating and maintaining effective onboarding programs, as well as how to engage and build future leaders by developing their skill sets.

MyStrength explains digital dashboard

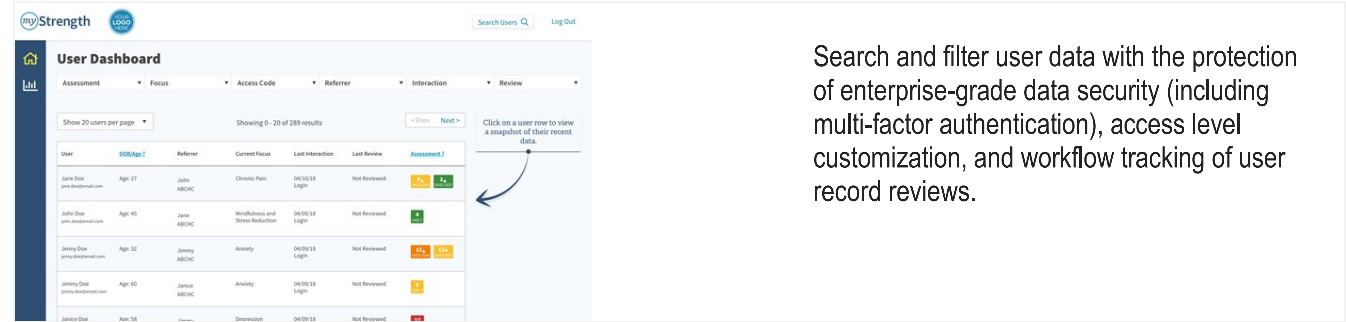
Mitigating Clinical and Financial Risk with Behavioral Health Transparency

Between 1999 and 2016, suicide rates increased across 49 states, with most states experiencing an increase of more than 30%. With several prominent figures tragically ending their own lives recently, suicide is gaining attention as a national health issue.

myStrength's digital platform arose from a deep passion to help those challenged with behavioral health disorders, with the hope of preventing tragedies like suicide. In an effort to increase transparency into often "invisible" mental health challenges, myStrength is proud to announce the User Dashboard.

What is the myStrength User Dashboard?

Gain unparalleled transparency into consumer behavioral health and well-being data. myStrength can also facilitate this same visibility through direct integration with EHR systems.



Sample Use Cases:

- Identify high-risk users based on health assessment scores, then provide proactive interventions
- Review a user's record prior to/after an appointment
- Monitor adherence to assigned/recommended myStrength interventions
- Maximize utilization by incentivizing staff to refer consumers to myStrength

myStrength's digital behavioral health platform offers support that is affordable, accessible and free from stigma. myStrength includes self-care tools for depression, anxiety, stress, substance use, chronic pain, insomnia and more.

Learn more at: https://bh.mystrength.com/

LEGISLATIVE UPDATE

FY19 & FY18 Supplemental Budgets Head to the Governor

On Tuesday the legislature passed SB 848, which is the FY19 omnibus budget for all non-educational departments and a FY18 supplemental budget. There were no changes from what I reported late last week related to the FY19 DHHS budget items.

Below is a link to the House Fiscal summary of the FY19 budgets and the FY18 supplemental (starts on page 107). Items of note included in FY18 supplemental:

http://www.house.mi.gov/hfa/PDF/Summaries/18s848h1cr1_General_Omnibus_Conference_Report_Summary.pdf

PIHP rate adjustment – provides $59.8 million gross ($17.1 million GF) to support a one-time rate adjustment paid to the PIHPs based on a review of previous fiscal year data indicating the rate trends assumed for the cost of behavioral health services were too low. (page 111)

Statewide PIHP Reimbursement Audit – Adds $1.5 million GF to perform a statewide reimbursement audit of the PIHPs to identify any reimbursement outliers. (page 111)

Lakeshore Regional Entity PIHP Risk Sharing – Provides $6.974 million GF to LRE for the state's share of the PIHP's FY17 liability. In total, the LRE FY17 liability totaled 10.25% (page 111)

Macomb County Community Mental Health – included in a long list of Michigan Enhancement Grants was $1 million GF for Macomb County Community Mental Health. (page 117)

Medicaid Work Requirements Head to the Governor

A compromised Medicaid work requirement bill passed the House last week and is headed to the Governor's desk for his signature. The Medicaid work requirement bill was changed in a House committee to impact only able-bodied Healthy Michigan recipients who are between 19 and 62 years of age. Below are the notable changes:

- The bill only applies to Healthy Michigan (not traditional Medicaid)
- Work requirement reduced to 20 hours per week (changed from 29)
- Work requirements only apply to individuals up to 62 years old (changed from 64)
- "Grace period" for non-working recipients is now a total of three months out of each year (as opposed to disqualification after one month)
- Failure to meet the work requirement only disqualifies an individual for one month and requires them to meet the requirement to be reinstated (as opposed to disqualification for an entire year--the penalty for intentional fraud in reporting is still a one-year disqualification)
- Removal of the county unemployment rate exemption, with the addition of allowing community service for three months out of a year
- Implementation date has been pushed back to 2020 (changed from 2019)

The Department of Health and Human Services would receive an extra $5 million under the bill for the additional personal auditors needed to track these recipients. Lastly, there has been a change to the bill that requires that after a recipient has received HMP coverage for 48 months, they must complete a health behavior assessment tailored towards stricter healthy behavior requirements. Additionally, these individuals would also have to pay a premium for HMP coverage equal to 5% of their income. This provision requires an additional waiver from CMS to implement and the bill will ultimately terminate HMP entirely if DHHS cannot obtain the waiver.

Once signed by the Governor the federal government must approve a waiver for the changes to go into effect.

NATIONAL UPDATE

House Passes First Wave of Opioid Bills

This week, the House of Representatives kicked off a two-week focus on legislation to address the nation's opioid crisis. The House passed dozens of measures this week and is slated to vote on more opioid legislation next week with the hopes of advancing a comprehensive package to the Senate. Bills that advanced this week included efforts to expand: telemedicine prescribing for medication-assisted treatment, student loan forgiveness for addiction treatment professionals, the use of electronic health records by behavioral health providers and recovery housing best practices.

All of the bills advanced with bipartisan support, and included many National Council priorities, such as:

- The Special Registration for Telemedicine Clarification Act (H.R. 5483): This bill would require the Drug Enforcement Agency (DEA) to establish a special registration process for certain providers that wish to prescribe controlled substances via telemedicine. This would remove barriers to accessing medication-assisted treatment for opioid use disorders in rural and frontier areas, and is a direct result of National Council advocacy efforts.

- The Substance Use Disorder Workforce Loan Repayment Act (H.R. 5102): This bill would create a program to help addiction treatment professionals repay student loans, adding incentives for students to pursue these professions and ultimately increasing timely access to treatment for individuals living with addiction. This legislation was introduced as a result of education and advocacy by the National Council and the Association for Behavioral Health in Massachusetts.

- Improving Access to Behavioral Health Information Technology Act (H.R. 3331): A longtime National Council priority, this bill would incentivize behavioral health providers to adopt electronic health records (EHRs). Behavioral health providers have adopted EHRs more slowly than physical health providers as they have traditionally not had the resources needed to implement the technology. A companion bill passed the Senate in May. Find our full analysis of this bill here [LINK NEEDED].

- Ensuring Access to Quality Sober Living Act (H.R.4684): The bill would require the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify and disseminate recovery housing best practices, such as the

National Alliance for Recovery Residence's (NARR) quality standards, to the states and provide them with technical assistance to adopt the standards. The bill aligns closely with the recommendations of the National Council's State Policy Guide for Supporting Recovery Housing.

- The National Council applauds the continued advocacy of its members, many of whom played a key role in the introduction and advancement of these bills. For more detail on opioid bills that passed the House this week, see the following House Energy and Commerce Committee press release.

WHAT'S NEXT?

House leaders will hold votes on a second round of opioid legislation next week. More controversial measures are expected to be included in next week's roundup, including efforts to loosen the IMD rule for residential addiction treatment and 42 CFR Part 2, the federal regulation governing the privacy of addiction treatment records. A full list of bills to be considered next week will be posted here as they become available.

House Passes Behavioral Health Information Technology Bill

A bipartisan bill that would incentivize behavioral health providers to adopt electronic health records (EHRs) passed the House on Tuesday, following passage of a similar bill by the Senate last month. The Improving Access to Behavioral Health Information Technology Act (H.R. 3331), a long-standing National Council priority, would incentivize behavioral health providers to incorporate electronic health records (EHRs) into their practices. The House and Senate versions of the bill must now be reconciled before moving to the President's desk for his signature.

EHRs provide a digital record of a patient's chart, and can be more easily shared among all clinicians involved in that patient's care. Behavioral health providers have adopted EHRs more slowly than physical health providers as they have traditionally not had the resources needed to implement the technology. Since 2009, the National Council has fought for a solution to this problem by shepherding the introduction and advancement of legislation (including the Improving Access to Behavioral Health Information Technology Act) that would give mental health and addiction treatment providers the necessary resources to adopt EHRs. Further, the National Council led the formation of the Behavioral Health Information Technology (BH IT) Coalition, a group that has played a key role in raising the issue's profile on Capitol Hill. The House and Senate's passage of behavioral health information technology legislation represents a huge victory for the National Council and its members.

On the House floor, Representative Lynn Jenkins (R-KS) explained why this measure has become increasingly important. "Our nation finds itself in a mental health and opioid crisis, and Congress must do all it can to ensure providers have the tools they need to effectively treat their patients," she said. "By utilizing electronic health records, they can better coordinate care, support delivery of treatment, and help to fully integrate recovery and prevention services for all Americans."

The Improving Access to Behavioral Health Information Technology Act would help to improve the coordination of care and behavioral health integration into physical health settings by tasking the Center for Medicare and Medicaid Innovation (CMMI) with creating a demonstration project to incentivize the use of EHR systems in mental health and addiction treatment settings. Providers and settings that would be included in these incentives are: clinical psychologists and clinical social workers at psychiatric hospitals, community mental health centers, residential or outpatient mental health treatment facilities and addiction treatment facilities. The major difference between two versions of the bill is that the House version was amended to add psychiatric nurse practitioners to the list of eligible providers that would qualify for the demonstration.

TRAININGS:

MICHIGAN CLUBHOUSE CONFERENCE

"Opening New Doors" Conference will be held on July 15 – 18, 2018 at the Grand Traverse Resort in Traverse City.

CONFERENCE REGISTRATION: Conference Registration Fee: $75 per person
Fee includes opening reception, 3 breakfasts, 2 luncheons, 1 dinner and reception with entertainment.

HOTEL DETAILS & RESERVATIONS: Room Rates:
Hotel Room: $75 plus $16.95 resort fee and taxes
Tower Room: $209 plus $16.95 resort fee and taxes
Two Bedroom Condos: $279 plus $16.95 resort fee and taxes per room

Deadline for These Rates: Friday, June 15, 2018

Reservations: Call 800-968-7352 and use code: CLUBHOUSE CONF 2018

To Register for the Clubhouse Conference, Click Here:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5160&AppCode=REG&CC=118060403651&RegType=MCCTC

ETHICS FOR SOCIAL WORK & SUBSTANCE USE DISORDER PROFESSIONALS TRAININGS FOR 2018

Community Mental Health Association of Michigan is pleased to offer 6 Ethics for Social Work & Substance Use Disorder Professionals Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This training fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for ethics.
This training fulfills the MCBAP approved treatment ethics code education – specific.

Trainings offered on the following dates.

- June 27 –Kalamazoo
- July 11 - Troy
- August 22 – Lansing

Training Fees: (fee includes training material, coffee, lunch and refreshments.
$115 CMHAM Members
$138 Non-Members

To register: https://cmham.ungerboeck.com/prod/emc00/PublicSignIn.aspx?&SessionID=fa7fe5ej2fe8fc5&Lang=*

REGISTER NOW! EMPLOYMENT FIRST CONFERENCE

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

July 11 & 12, 2018
Kellogg Hotel & Conference Center, East Lansing, Michigan

Registration Fee: $50

Who Should Attend: Staff who's involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership

- CRO Leadership

Workshop Tracks:

- Leadership
- Provider Transformation
- HCBS Implementation

Sponsored By: The Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Additional conference details and registration, click here: CLICK HERE!

CMH ASSOCIATION COMMITTEE SCHEDULES, MEMBERSHIP, MINUTES, AND INFORMATION: go to our website at https://www.macmhb.org/committees

Michigan Association of Community Mental Health Boards is now
Community Mental Health Association of Michigan.

June 15, 2018

<u>FRIDAYFACTS</u>

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance Members
Executive Board Members

FROM: Robert Sheehan, Executive Director
Alan Bolter, Associate Director

RE:

- New e-mail addresses for Association staff
- Association to announce new membership opportunities
- Friday Facts to become a members-only electronic newsletter
- Work, Accomplishments, and Announcements of CMH Association and its Member Organizations
  - DWMHA receives 3-year national accreditation for quality management
  - Detroit Wayne Mental Health Authority moves to bring services in-house
  - CMH Association named as recipient to RWJF funded grant to strengthen healthcare safety nets
  - CMH Association working with University of Wisconsin in seeking SAMHSA designation as technical assistance centers
- Resources from association's preferred corporate partners
  - Relias Webinar: Integrated Care in Value Based World
- State and National Developments and Resources
  - Provision in Medicaid work bill could end Healthy Michigan program
  - SAMHSA Announces Grant Opportunity for Medication-Assisted Treatment
  - Taking on behavioral health workforce crisis
  - Suicide rates rise sharply across the United States, new report shows
  - NIH Unveils New Opioid Research Plans
  - SAMHSA-HRSA Center for Integrated Health Solutions offers medication adherence webinar
  - Congress needs a broader approach to address opioid epidemic
  - New Director of SAMHSA Center for Substance Abuse Treatment announced
  - Encouraging Substance Use Disorder Treatment in Primary Care through Value-Based Payment Strategies
  - CMS Issues, Improving the Balance: The Evolution of Long Term Services and Supports, FY 1981-2014
- Legislative Update
  - FY19 & FY18 Supplemental Budgets Head to the Governor
  - Medicaid Work Requirements Head to the Governor
- National Update
  - House Passes First Wave of Opioid Bills
  - House Passes Behavioral Health Information Technology Bill
- Co-occurring college: selected workshops for Implementation & sustainability
- Michigan clubhouse conference

- **Ethics Training for Social Work and Substance Abuse Professionals for 2018**
- **Employment First Conference**
- **CMHAM Association committee schedules, membership, minutes, and information**

New e-mail addresses for Association staff: The Michigan Association of CMH Boards is now the COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN.

Please update your email address for CMHAM staff:

Alan Bolter, Associate Director: abolter@cmham.org
Chris Ward, Administrative Executive: cward@cmham.org
Dana Owens, Accounting Clerk: dowens@cmham.org
Michelle Dee, Accounting Assistant: acctassistant@cmham.org
Monique Francis, Executive Board/Committee Clerk: mfrancis@cmham.org
Annette Pepper, Training and Meeting Planner: apepper@cmham.org
Anne Wilson, Training and Meeting Planner: awilson@cmham.org
Carly Palmer, Training and Meeting Planner: cpalmer@cmham.org
Chris Lincoln, Training and Meeting Planner: clincoln@cmham.org
Nakia Payton, Receptionist: npayton@cmham.org
Robert Sheehan, CEO: rsheehan@cmham.org

Association to announce new membership opportunities: In response to requests for a broader range of membership options and a fuller list of benefits of each membership type, the CMH Association of Michigan is developing several new membership opportunities for organizations and individuals. Look for the revised Association membership brochure to be available in November.

Friday Facts to become a members-only electronic newsletter: Note that the receipt of this electronic newsletter will become a members-only benefit sometime in the next few months. While there will be another electronic newsletter for a wider range of non-members, it will not contain the depth or breadth of information contained in this newsletter. **So, if you find the information in this newsletter useful and are not an Association member, consider becoming a member when the new membership opportunities are announced**.

WORK, ACCOMPLISHMENTS, AND ANNOUNCEMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

DWMHA receives 3-year national accreditation for quality management

Detroit Wayne Mental Health Authority (DWMHA) has met the qualifications required to be awarded Full Accreditation as a Managed Behavioral Healthcare Organization (MBHO) by the National Committee on Quality Assurance (NCQA). This accreditation is awarded for three years.

"This confirms what our board of directors, leadership and staff already know," said Willie Brooks, President and CEO of Detroit Wayne Mental Health Authority. "We are committed to quality care to our members throughout Wayne County."

NCQA administers the most comprehensive evaluation in the industry and is the only assessment that bases results of clinical performance and consumer experience. DWMHA participated in a rigorous review process, analyzing several years of documentation along with interviews of key personnel.

"DWMHA's MBHO Accreditation is proof that it's an organization which works hard to coordinate care, provide access and good customer support for members," said Margaret E. O'Kane, NCQA President, "It's a sign that CWMHA is focused on improving the behavioral health of its members."

NCQA MBHO Accreditation evaluates how well a behavioral health plan manages all parts of its delivery system – physicians, hospitals, other providers and administrative services – in order to continuously improve behavioral health care services throughout Wayne County.

"This accomplishment reflects the hard work of DWMHA staff who maintain the highest quality standards and practices," said Brooks. "We have a dedicated staff that is focused on effective and efficient planning and implementation for our network and the people we are committed to serving."

Detroit Wayne Mental Health Authority moves to bring services in-house

Below is an excerpt from a recent article in Crain's Detroit Business on an effort being undertaken by the Detroit-Wayne Mental Health Authority.

> The Detroit Wayne Mental Health Authority is moving to phase out or substantially downsize relationships with four managed care provider networks with which it contracts for behavioral health services and bring the majority of services in-house.
> In a resolution Wednesday, the DWMHA board unanimously approved a yearlong plan to assume direct responsibility for behavioral health services for its 80,000 clients. By Oct. 1, 2019, the authority also plans to contract with at least one Medicaid health plan on a pilot basis to integrate behavioral and physical health services at the provider level, said Willie Brooks, DWMHA's CEO.
>
> In the resolution, the board said it agrees with the authority's plan for system transformation, the elimination of the current MCPN structure and "DWMHA assuming full management of all services and supports thereby taking over the responsibility for delegated services and responsibilities."
>
> DWMHA contracts with MCPNs' Integrated Care Alliance Inc., Community Living Services Inc., CareLink Network and CommunityLink Network for behavioral health provider services, according to its website.
>
> "We are not renewing the contracts and are in negotiations now" with the MCPNs and will assume most of the administrative duties of the managed care provider networks, Brooks said.
>
> Over the next several weeks, Brooks said DWMHA expects to first absorb 20-25 employees from Integrated Care Alliance, the smallest MCPN. He said the authority also expects to soon reach agreement with Community Living to absorb some of its employees, but allow the organization to continue to manage some direct behavioral services.

The full article can be found at: http://www.crainsdetroit.com/article/20180614/news/663646/detroit-wayne-mental-health-authority-moves-to-bring-services-in-house

CMH Association named as recipient of RWJF funded grant to strengthen healthcare safety nets

Recently, the CMH Association of Michigan was named as one of ten participants in the State Learning and Action Collaborative initiative of the Delta Center for A Thriving Safety Net. This initiative, funded by the Robert Wood Johnson Foundation, involves primary care associations (PCAs) and behavioral health state associations (BHSAs), drawn from across the country, to expand and elevate their existing work around: healthcare transformation and integration, payment reform, and the development of sustainable learning communities. This initiative will provide technical assistance to the CMH Association and a team of trainers/coaches (to be identified) to provide, in concert with nationally renowned experts, training, coaching, shadowing, via both learning community and broad distribution approaches as well as working to change state policy, statute, and practices to support a range of healthcare transformation initiatives.

The goal is to enhance state associations' capacity to support the shift to value-based care and payment and to sustain this shift by cultivating the practices of learning organizations. The three major activities include:

- State Learning & Action Collaborative: The CMH Association will participate in a national learning and action collaborative focused on supporting state associations' understanding of and movement towards value-based payment and care. The collaborative will also seek to bolster partnerships between primary care and behavioral

health state associations, with the CMH Association inviting the Michigan Primary Care Association to join them in this effort.

- Engaging with Local Members: The CMH Association will use what the Association learns from our participation in the State Learning & Action Collaborative to support primary care and behavioral health providers across both urban and rural areas in Michigan as they transition to value-based care and payment.

- Advancing Policy: The CMH Association will engage with Association members and policy stakeholders in Michigan states to explore and advance payment transformation that can support and sustain care transformations aimed at improving health outcomes, care experiences and staff experiences, as well as reducing health disparities, and total costs of care.

CMH Association working with University of Wisconsin in seeking SAMHSA designation as technical assistance centers

Substance Abuse and Mental Health Services Administration (SAMHSA) Technology Transfer Center: The University of Wisconsin, which operates the Great Lakes Addiction Technology Transfer Center (funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is applying to build on this work by taking on the role of the regional Mental Health Technology Transfer Center (MHTTC), under the funding opportunity announcement (FOA) recently issued by SAMHSA.

As part of this application, the University of Wisconsin has approached the CMH Association of Michigan, inviting the Association to serve as the Technology Transfer Center for the state of Michigan.

The purpose of this program is to establish one MHTCC National Coordinating Center and ten (10) MHTTC Regional Centers (of which the University of Wisconsin would be one to develop and maintain a collaborative network to support resource development and dissemination, training and technical assistance, and workforce development to the field. It is expected that MHTTCs will work to ensure that high-quality, effective mental health disorder treatment and recovery support services, and evidence-based practices are available for all individuals with mental disorders including, in particular, those with serious mental illness.

The University of Wisconsin and the CMH Association of Michigan hope to hear about the outcome of this proposal later this summer.

<u>RESOURCES FROM ASSOCIATION'S PREFERRED CORPORATE PARTNERS</u>

Join us next Tuesday for a discussion of how a rich performance management analytics solution can bolster your existing clinical initiatives, targeting high-risk populations to deliver better care, all while keeping costs in check.

Designed for organizational and clinical leaders at behavioral health, managed care, and payer organizations, the webinar will provide an up-close look at how the Relias Analytics platform sorts through all your data and applies complex algorithms so that organizational leadership and clinicians can:

- Get a longitudinal view of individual members

- Identify high-risk probability and rising risk members
- Measure the impact of integrated care initiatives
- Identify opportunities for providers to standardize to evidence-based practice
- Focus on proactive, tiered interventions to deliver better, less costly outcomes

Details and registration at: http://go.reliaslearning.com/WBN2018-06-19IntegratedCareinaVBWorld_Registration.html?utm_source=partner_silver&utm_medium=email&utm_campaign=eb_2018-06-19_integrated-care-in-a-vb-world_integrated-care&mkt_tok=eyJpIjoiTkdNME5XTXlOR1ExTnpjeiIsInQiOiJWSVhzZWNHZzNnMUNUSzlnTFVpUEhxWkUxbTRVVWdlbytzblNETDFCNnMwaUFJMVRGZmFIeWhKd0wwdEpXTm00WDdaS1pnXC9HZW80RVZ4Sk9yK0ljSFh3RzlpWEtwUUdrTnVMU1poY2RnbUN2c3lmTElUUDNuQUZMeWZXNXc5dGsifQ%3D%3D

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Provision in Medicaid work bull could end Healthy Michigan program

Below is an excerpt from a recent article in the Detroit Free Press highlighting a provision in the recently passed Healthy Michigan bill.

> Tucked into the bill that requires able-bodied Medicaid recipients to work at least 80 hours a month is a provision that could kill the state's Healthy Michigan plan altogether.
>
> The poison pill would end the Medicaid expansion that was approved by the Legislature in 2013, which covers 680,000 Michiganders with health care, if the federal government fails to approve a waiver within 12 months.
>
> If the state's Medicaid expansion plan deviates from previous practices, it has to apply for a waiver from the federal government to implement those changes. In Michigan's case, it will have to apply for a waiver on a provision that would limit benefits for recipients to 48 months and if they exceed that time, they'll have to start paying 5 percent of their income into their health care and prove that they are practicing healthy behaviors, such as quitting smoking or losing weight.
>
> If the Trump administration, which has wanted to repeal Obamacare since taking office in 2017, wants to end the Medicaid expansion in Michigan, the 12-month trigger could give it the excuse to do that.
>
> It was that provision that had Democrats especially worried and opposed to the bill, which requires that an estimated 350,000 people who are receiving Medicaid benefits work or lose their coverage.
>
> "The goal is to kick people off health care. In the bill, it says if they don't get the waiver, Healthy Michigan ends," said Senate Minority Leader Jim Ananich, D-Flint. "That's 680,000 people losing health care. That's what it's about." Sen. Mike Shirkey, R-Clarklake, the sponsor of the bill, said he expects the waiver to be granted, but that recipients would have some time before the program ended if the federal government denies the waiver request.
>
> The state "would have to give notice to enrollees and the program stops in four months," he said.
>
> The movement toward requiring work for Medicaid coverage is growing across the nation with three states already requiring work for benefits and the administration of President Donald Trump reviewing requests from seven other states. The administration told Medicaid administrators earlier this year that it would support such requests and Trump signed an executive order last week asking for work requirements for recipients of federal benefits, such as food stamps and Medicaid.
>
> The bill, which received final passage Thursday in the Senate, is a compromise from what was initially proposed, which included a 29-hour workweek requirement and a controversial provision that would allow counties that had unemployment rates of 8.5% or more to be exempt from the work requirements. That would primarily benefit rural counties, but not urban cities such as Detroit, Flint and Saginaw that are in counties that have lower overall unemployment rates.

That provision was stripped out of the bill, in part, because it would cost the state Department of Health and Human Services too much to administer. But it also would have affected minority communities much harder than the rest of the population.

People who are exempt from the work requirements include pregnant women; people receiving disability benefits; full-time students; the medically frail; caretakers of a family member under age 6 or a dependent with a disability; a recipient who met a good cause temporary exemption; a recipient with a medical condition that resulted in a work limitation; a recipient who had been incarcerated within the last six months; a recipient of unemployment benefits, or a recipient under 21 who had previously been in foster care.

Shirkey estimated that about 350,000 of the 680,000 Health Michigan program recipients would be required to work under the bill.

Michigan has about 2.4 million people who get health care coverage through Medicaid. A majority are elderly, disabled or children, but in 2013, the Legislature passed the Healthy Michigan law to expand Medicaid to low-income Michiganders and 680,000 people signed up.

SAMHSA Announces Grant Opportunities for Medication-Assisted Treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a funding opportunity for nonprofit organizations, including community mental health and addiction treatment providers, in certain states and tribal communities to improve access to medication-assisted treatment (MAT), a highly effective, evidence-based treatment for opioid use disorder (OUD). Eligible organizations wishing to compete for up to almost $525,000 per year must submit their applications by July 9th. Read more at: https://www.samhsa.gov/grants/grant-announcements/ti-18-009

Taking on behavioral health workforce crisis

Below is an introduction and excerpt from recent edition of .Behavioral Healthcare Executive, by Ron Manderscheid, PhD, Executive Director of NACBHDD and NARMH, on the behavioral healthcare workforce shortage.

> I am delighted to announce that the American Journal of Preventive Medicine has released a Special Supplement on workforce developments in behavioral healthcare. You can access this entire document gratis.
>
> Articles in this special issue cover a broad range of topics. Specifically, they address research on workforce planning, service delivery and practice, and workforce preparation. They also advocate for intelligent allocation of resources to ensure all clients have access to behavioral healthcare.
>
> No more important topic surrounds our field than the current and growing crisis in the availability of well-trained providers. Our baby boomers are retiring, and too few millennials are joining us. Thus, this Special Supplement could not come at a more opportune time. It focuses a spotlight on our human resource issues and provides an important glimpse into new developments that can allay this problem.
>
> On several prior occasions, I have argued that our human resource crisis is far, far too important to be ignored or left to chance. Here is one simple example of the growing magnitude of this crisis: By 2060, almost 100 million Americans will be age 65 or older. Of this total, it is reasonable to estimate that about 20 million persons will require behavioral healthcare services. This latter group would represent an approximate doubling of the number who currently receive behavioral healthcare services today. Clearly, such growth simply will not be achievable unless we have a dramatic change in direction.
> What are some of our options?

Read more at: https://www.behavioral.net/blogs/ran-manderscheid/taking-our-workforce-crisis

Suicide rates rise sharply across the United States, new report shows

Below is an excerpt from a recent Washington Post article underscoring the findings of a recent CDC study on rising suicide rates.

> Suicide rates increased in 49 states between 1999 and 2016, according to a report released Thursday by the Center for Disease Control and Prevention. The increases were seen across sex, age, race and ethnicity. In half of all states, the increase was 30 percent or more.
>
> In 2016, there were almost 45,000 suicides in the United States – more than twice the number of homicides. Suicide is now the 10th leading cause of death overall in America, and the second leading cause of death for people between the ages of 10 and 34.
>
> Anne Schuchat, the CDC's principal deputy director, called the data "disturbing" and said, "the widespread nature of the increase, in every state but one, really suggests that this is a national problem hitting most communities."

The full article can be found at:
https://www.washingtonpost.com/news/to-your-health/wp/2018/06/07/u-s-suicide-rates-rise-sharply-across-the-country-new-report-shows/?utm_term=.2cdd0a5acbb1

NIH Unveils New Opioid Research Plans

The National Institutes of Health outlined its new HEAL initiative to combat opioid addiction and improve pain management in *JAMA* Tuesday.

In an editorial, NIH Director Francis Collins, MD, PhD – along with Walter Koroshetz, MD, director of the National Institute of Neurological Disorders and Stroke, and Nora Volkow, MD, director of the National Institute on Drug Abuse – discussed the role of the new NIH research program in the national opioid problem.

An in-depth discussion of this initiative can be found at: https://www.medpagetoday.com/primarycare/opioids/73439

SAMHSA-HRSA Center for Integrated Health Solutions offers medication adherence webinar

Webinar: Clinical Strategies to Promote Medication Adherence

June 19, 2018
2:00 – 3:30 PM ET

Presenter: Joe Parks, MD, Medical Director, National Council for Behavioral Health

Register for free here: https://goto.webcasts.com/starthere.jsp?ei=1194137&tp_key=10d9acb6df

The use of medications to treat mental illness and opioid and alcohol use disorders can produce life changing benefits. However, these medications also have significant side effects. Non-adherence to medications is generally more common among persons with mental disorders than individuals with physical health conditions and can negatively impact health outcomes and increase costs.

Interdisciplinary teams in integrated care settings have the opportunity to improve medication adherence among patients by incorporating shared decision making into the provider-patient relationship, using motivational interviewing to promote adherence, establishing pharmacies onsite to reduce barriers to accessing medications, and engaging family members in the treatment plan.

Join the SAMHSA-HRSA Center for Integrated Health Solutions for this webinar to review the importance of medication adherence and key recommendations for organizations to promote medication adherence.

After this webinar, participants will:

- Better understand the impact of medication non-adherence on the individual, family, and community
- Better understand consumers' perspectives and concerns related to medication
- Learn about several key recommendations to improve medication adherence
- Hear about how one integrated care setting is successful in promoting medication adherence
- Identify tools and resources to promote medication adherence

Please note the following:

Registration is free and closed captioning is available upon request.

The SAMHSA-HRSA Center for Integrated Health Solutions does not provide certificates of attendance or continuing education credits for webinar attendance.

Congress needs a broader approach to address opioid epidemic

Below is an excerpt from a recent editorial carried in the Hill, by Michael Botticelli and Richard Frank, on the need for a broader approach to the nation's opioid crisis.

> When it comes to addressing the opioid crisis, the United States is falling far short. Only 10 to 26 percent of those with an opioid use disorder are getting care. And among that group, only a bit more than a third are getting the most effective care, with one of the three FDA-approved medications – buprenorphine, methadone and naltrexone, known collectively as Medication Assisted Treatment, or MAT.
>
> But while policymakers are justifiably focused on the opioid crisis, a bill that the House will consider this week won't direct new federal resources where they're most effective. In fact, it might undermine efforts to improve the full continuum of care for people with substance use disorders (SUDs).
>
> That's because the bill would expand opioid disorder treatment in an unbalanced and potentially counter-productive way by simply letting Medicaid pay for that treatment in specialty residential and inpatient facilities. That is, it would scale back the prohibition – known as the Institutions of Mental Disease (IMD) exclusion – on using federal matching funds in Medicaid to pay for care in facilities with more than 16 beds that treat mental diseases.
>
> Opioid use disorder is a chronic recurring condition. However, effective treatment can involve a broad continuum of services that range from institutional care to pharmaco-therapies to psychosocial and rehabilitation services.
>
> That's why, under both Presidents Obama and Trump, the federal Centers for Medicare & Medicaid Services (CMS) has given states waivers from the IMD exclusion if they improved their community-based services Eleven states already have waivers, while 12 others have proposals pending for them.
>
> CMS' guidance to the states in 2015, for instance, conditioned such waivers on states "developing comprehensive strategies to ensure a full continuum of services, focusing greater attention to integration efforts with primary care and mental health treatment, and working to deliver services that are considered promising practices or have fidelity to evidence-based models consistent with industry standards."
>
> The House bill, by contrast, doesn't tie federal funds to IMD care to improvements in community-based services. Thus, it would weaken states' incentives to pursue these needed improvements. And without incentives to improve access to treatment more broadly, narrowing the IMD exclusion through legislation may simply encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option.
>
> Access to treatment is particularly limited in rural areas, and waiving the IMD exclusion will do little to address that problem. Forty percent of rural counties lack a SUD treatment facility that provides outpatient care and accepts Medicaid. Rural counties are much likelier to lack access to outpatient SUD facilities that accept Medicaid, particularly in Southern and Midwestern states.

While some people certainly need inpatient or residential services, increasing bed capacity in in those facilities will sometimes mean expanding the wrong services. That's especially true because many of the facilities providing residential and inpatient care for opioid use disorder don't offer any form of medications for addiction treatment (MAT), the gold standard for treating opioid use disorder.

Most of these facilities provide detoxification services, but detoxification is only the first stage of addiction treatment, according to the National Institute of Drug Abuse's Principles of Effective Treatment. By itself does little to facilitate long-term recovery.

Indeed, it may increase the potential for overdose if patients do not remain in treatment since, with detoxification, their tolerance for opioids is significantly reduced. In fact, recent data suggest that inpatient detoxification is an important predictor of overdose, largely because many who receive inpatient care aren't then connected to community-based treatment programs or put on a medication, leaving them extremely vulnerable to relapse and overdose.

The House bill is troubling in other ways. White it focuses exclusively on opioid treatment, an estimated 64 percent of people seeking care for an SUD use multiple substances.

For those with an opioid use disorder, 41 percent had an alcohol use disorder and 43 percent had another drug use disorder. About 30 percent suffer from depression. Some 90 percent of people with these illnesses are treated in an outpatient setting.
All in all, the House bill could do more harm than good. Focusing the IMD policy narrowly on opioid use disorder fails to recognize the basic truth that most people with an SUD misuse multiple substances.

In fact, the House bill will likely result in an increase in the reported prevalence of opioid use disorder as a result of efforts to give people who don't fit the narrow policy access to needed care.

We strongly suggest that if Congress wants to change Medicaid IMD exclusion, it should do so in a way that promotes a greater state capacity to provide the full continuum of care, thus working in concert with CMS's guidance.

Michael Botticelli is director of the Grayken Center for Addiction Medicine at Boston Medical Center and was previously the Director of National Drug Control Policy. Richard G. Frank is the Margaret T. Morris Professor of Health Economics at Harvard University.

New Director of SAMHSA Center for Substance Abuse Treatment announced

I am very pleased to announce that CAPT Chideha Ohuoha, MD, MPH, will be joining SAMHSA as the new Director of the Center for Substance Abuse Treatment. Most recently, CAPT Ohuoha has been stationed at Fort Belvoir as an officer of the U.S. Public Health Service since 2008. He has served as the Director of Addiction Medicine there since 2015. Prior to assuming that position at Ft. Belvoir he was the Deputy Director of Addiction Medicine, Director Addiction Medicine Research, and the chief psychiatrist for the Wounded Warrior Transition Brigade. CAPT Ohuoha was responsible for implementing the Co-Occurring Partial Hospital program at Fort Belvoir. Dr. Ohuoha has many honors to his credit. Most recently he was awarded the Meritorius Service Medal (PHS) in 2016. Fort Belvoir Community Hospital ACE Awards, in 2014 and 2015, and in 2012 received the Army Commendation Medal as well as the Outstanding Service Medal (PHS).

CAPT Ohuoha completed his psychiatry residency at St Elizabeth's Hospital in Washington, DC and completed a three year addiction psychiatry fellowship at NIMH. He was awarded his MPH from Harvard University. CAPT Ohuoha's experience in addiction psychiatry will be a great asset to SAMHSA and CSAT. His official start date here at SAMHSA will be June 11.

In addition to welcoming CAPT Ohuoha, I would like to thank Acting Director Kathryn Power for stepping in to provide leadership and stability to CSAT during the past few months. I have been very gratified to have the opportunity to work with Ms. Power and to benefit from her extensive knowledge of federal government as well as her steady leadership of CSAT.

I hope you all will join me in welcoming CAPT Ohuoha to SAMHSA.

Thank you: Elinore F. McCance-Katz, MD, PhD.
Assistant Secretary for Mental Health and Substance Use Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services

Encouraging Substance Use Disorder Treatment in Primary Care through Value-Based Payment Strategies

Across the US, it is nearly impossible to open a newspaper and not find an article about the opioid epidemic. Its impact is ubiquitous - families, communities, and states all feel its effect. Opioids, however, are not the only addictive substance impacting Americans. While the rate of overdose deaths related to opioid pain relievers and heroin increased by 200 percent from 2000-2014, excessive alcohol use continues to be a leading cause of preventable death. A clear gap in treatment remains for people with ***any*** substance use disorder (SUD) – drug or alcohol – with only one in 10 ever receiving specialty treatment.

To address this treatment gap, a comprehensive approach including primary care is needed. As the foundation of the health care system, primary care plays an important role in screening and treating SUDs. Furthermore, primary care is uniquely positioned to address comorbidities (e.g., lung disease, hepatitis C, and cardiovascular disease) that are common among people with SUDs. While SUD and physical health services have historically been sliced, recent efforts are creating opportunities to integrate care.

This CHCS blog post – drawing from a new brief, *Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care,* developed by CHCS and the Technical Assistance Collaborative and supported by the Melville Charitable Trust – explores how states and health plans can use value-based payment levers to encourage substance use disorder treatment in primary care.

https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/

CMS issues, improving the Balance: The Evolution of Long Term Services and Supports, FY 1981-2014

This historical expenditures report and corresponding state-by-state data tables document three decades Medicaid Long Term Services and Supports (LTSS) systems transformation from primarily institutional services to the present, where home and community-based services (HCBS) are a majority of LTSS spending. These reports include Medicaid expenditures for all LTSS, including institutional services and HCBS, by service category and state. The data comes primarily from the Centers for Medicare & Medicaid Services (CMS)-64 reports.

The report can be found at: https://www.medicaid.gov/medicaid/ltss/reports-and-evaluations/index.html

LEGISLATIVE UPDATE

FY19 & FY18 Supplemental Budgets Head to the Governor

On Tuesday the legislature passed SB 848, which is the FY 19 omnibus budget for all non-educational departments and a FY 18 supplemental budget. There were no changes from what I reported late last week related to the FY19 DHHS budget items.

Below is a link to the House Fiscal summary of the FY19 budgets and the FY18 supplemental (starts on page 107). Items of note included in FY18 supplemental:

http://www.house.mi.gov/hfa/PDF/Summaries/18s848h1cr1_General_Omnibus_Conference_Report_Summary.pdf

PIHP rate adjustment – provides $59.8 million gross ($17.1 million GF) to support a one-time rate adjustment paid to the PIHPs based on a review of previous fiscal year data indicating the rate trends assumed for the cost of behavioral health services were too low. (page 111)

Statewide PIHP Reimbursement Audit – Adds $1.5 million GF to perform a statewide reimbursement audit of the PIHPs to identify any reimbursement outliers. (page 111)

Lakeshore Regional Entity PIHP Risk Sharing – Provide $6.974 million GF to LRE to the state's share of the PIHP's FT17 liability, in total, the LRE FY17 liability totaled 10.25% (page 111)

Macomb County Community Mental Health – included in a long list of Michigan Enhancement Grants was $1 million GF for Macomb County Community Mental Health. (page 117)

Medicaid Work Requirements Head to the Governor

A compromised Medicaid work requirement bill passed the House last week and is headed to the Governor's desk for his signature. The Medicaid work requirement bill was changed in a House committee to impact only able-bodied Healthy Michigan recipients who are between 19 and 62 years of age. Below are the notable changes:

- The bill only applies to Healthy Michigan (not traditional Medicaid)
- Work requirement reduced to 20 hours per week (changed from 29)
- Work requirements only apply to individuals up to62 years old (changed from 64)
- "Grace period" for non-working recipients is now a total of three months out of each year (as opposed to disqualification after one month)
- Failure to meet the work requirement only disqualifies an individual for one month and requires them to meet the requirement to be reinstated (as opposed to disqualification for an entire year—the penalty for intentional fraud in reporting is still a one-year disqualification)
- Removal of the county unemployment rate exemption, with the addition of allowing community service for three months out of a year
- Implementation date has been pushed back to 2020 (changed from 2019)

The Department of Health and Human Services would receive an extra $5 million under the bill for the additional personal auditors needed to track these recipients. Lastly, there has been a change to the bill that requires that after a recipient has received HMP coverage for 48 months, they must complete a health behavior assessment tailored towards stricter healthy behavior requirements. Additionally, these individuals would also have to pay a premium for HMP coverage equal to 5% of their income. This provision requires an additional waiver from CMS to implement and the bill will ultimately terminate HMP entirely if DHHS cannot obtain the waiver.

Once signed by the Governor the federal government must approve a waiver for the changes to go into effect.

NATIONAL UPDATE

House Passes First Wave of Opioid Bills

This week, the House of Representatives kicked off a two-week focus on legislation to address the nation's opioid crisis. The House passed dozens of measures this week and is slated to vote on more opioid legislation next week with the hopes of advancing a comprehensive package to the Senate. Bills that advanced this week included efforts to expand: telemedicine prescribing for medication-assisted treatment, student loan forgiveness for addiction treatment professionals, the use of electronic health records by behavioral health providers and recovery housing best practices.

All of the bills advanced with bipartisan support, and included many National Council priorities, such as:

- The Special Registration for Telemedicine Clarification Act (H.R. 5483): This bill would require the Drug Enforcement Agency (DEA) to establish a special registration process for certain providers that wish to prescribe controlled substances via telemedicine. This would remove barriers to accessing medication-assisted treatment for opioid use disorders in rural and frontier areas, and is a direct result of National Council advocacy efforts.

- The Substance Use Disorder Workforce Loan Repayment Act (H.R. 5102): This bill would create a program to help addiction treatment professionals repay student loans, adding incentives for students to pursue these professions and ultimately increasing timely access to treatment for individuals living with addiction. This legislation was introduced as a result of education and advocacy by the National Council and the Association for Behavioral Health in Massachusetts.

- Improving Access to Behavioral Health Information Technology Act (H.R. 3331): A longtime National Council priority, this bill would incentivize behavioral health providers to adopt electronic health records (EHRs). Behavioral health providers have adopted EHRs more slowly than physical health providers as they have traditionally not had the resources needed to implement the technology. A companion bill passed the Senate in May. Find our full analysis of this bill here [LINK NEEDED].

- Ensuring Access to Quality Sober Living Act (H.R.4684): The bill would require the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify and disseminate recovery housing best practices, such as the National Alliance for Recovery Residence's (NARR) quality standards, to the states and provide them with technical assistance to adopt the standards. The bill aligns closely with the recommendations of the National Council's State Policy Guide for Supporting Recovery Housing.

- The National Council applauds the continued advocacy of its members, many of whom played a key role in the introduction and advancement of these bills. For more detail on opioid bills that passed the House this week, see the following House Energy and Commerce Committee press release.

WHAT'S NEXT?

House leaders will hold votes on the second round of opioid legislation next week. More controversial measures are expected to be included in next week's roundup, including efforts to loosen the IMD rule for residential addiction treatment and 42 CFR Part 2, the federal regulation governing the privacy of addiction treatment records. A full list of bills to be considered next week will be posted here as they become available.

Houses Passes Behavioral Health Information Technology Bill

A bipartisan bill that would incentivize behavioral health providers to adopt electronic health records (EHRs) passed the House on Tuesday, following passage of a similar bill by the Senate last month. The Improving Access to Behavioral Health Information Technology Act (H.R. 3331), a long-standing National Council priority, would incentivize behavioral health providers to incorporate electronic health records (EHRs) into their practices. The House and Senate versions of the bill must now be reconciled before moving to the President's desk for his signature.

EHRs provide a digital record of a patient's chart, and can be more easily shared among all clinicians involved in that patient's care. Behavioral health providers have adopted EHRs more slowly than physical health providers as they have traditionally not had the resources needed to implement the technology. Since 2009, the National Council has fought for a solution to this problem by shepherding the introduction and advancement of legislation (including the Improving Access to Behavioral Health Information Technology Act) that would give mental health and addiction treatment providers the necessary resources to adopt EHRs. Further, the National Council led the formation of the Behavioral Health Information Technology (BH IT) Coalition, a group that has played a key role in raising the issue's profile on Capitol Hill. The House and

Senate's passage of behavioral health information technology legislation represents a huge victory for the National Council and its members.

On the House floor, Representative Lynn Jenkins (R-KS) explained why this measure has become increasingly important. "Our nation finds itself in a mental health and opioid crisis, and Congress must do all it can to ensure providers have the tools they need to effectively treat their patients," she said. "By utilizing electronic health records, they can better coordinate care, support delivery of treatment, and help to fully integrate recovery and prevention services for all Americans."

The Improving Access to Behavioral Health Information Technology Act would help to improve the coordination of care and behavioral health integration into physical health settings by tasking the Center for Medicare and Medicaid Innovation (CMMI) with creating a demonstration project to incentivize the use of EHR systems in mental health and addiction treatment settings. Providers and settings that would be included in these incentives are: clinical psychologists and clinical social workers in psychiatric hospitals, community mental health centers, residential or outpatient mental health treatment facilities and addiction treatment facilities. The major difference between two versions of the bill is that the House version was amended to add psychiatric nurse practitioners to the list of eligible providers that would qualify for the demonstration.

TRAININGS:

CO-OCCURRING COLLEGE: SELECTED WORKSHOPS FOR IMPLEMENTATION & SUSTAINABILITY

June 25-26, 2018
Kellogg Hotel and Conference Center
East Lansing, Michigan

WHO SHOULD ATTEND: Clinical directors, case workers, support coordinators, children's supervisors and other practitioners who must be able to address comorbid mental health and substance use disorders at all levels of practice (beginning, intermediate and/or advanced).

COST: $140 for two-day training, including breakfast, lunch and parking

LOCATION: Kellogg Center Hotel: 219 S. Harrison Rd., E. Lansing, MI 48824; Phone: 517-432-4000

TO REGISTER FOR CO-OCCURING COLLEGE:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5156&AppCode=REG&CC=118053182060&RegType=2005-42

MICHIGAN CLUBHOUSE CONFERENCE

"Opening New Doors" Conference will be held on July 15 – 18, 2018 at the Grand Traverse Resort in Traverse City.

CONFERENCE REGISTRATION: Conference Registration Fee: $75 per person
Fee includes opening reception, 3 breakfasts, 2 luncheons, 1 dinner and reception with entertainment.

HOTEL DETAILS & RESERVATIONS: Room Rates:
Hotel Room: $75 plus $16.95 resort fee and taxes
Tower Room: $209 plus $16.95 resort fee and taxes
Two Bedroom Condos: $279 plus $16.95 resort fee and taxes per room

Deadline for These Rates: Friday, June 15, 2018

Reservations: Call 800-968-7352 and use code: CLUBHOUSE CONF 2018

To Register for the Clubhouse Conference, Click Here:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5160&AppCode=REG&CC=118060403651&RegType=MCCTC

ETHICS FOR SOCIAL WORK & SUBSTANCE USE DISORDER PROFESSIONALS TRAINING FOR 2018

Community Mental Health Association of Michigan is pleased to offer 6 Ethics for Social Work & Substance Use Disorder Professionals Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This training fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for ethics.
This training fulfills the MCBAP approved treatment ethics code education – specific.

Trainings offered on the following dates.

- June 27 – Kalamazoo
- July 11 – Troy
- August 22 – Lansing

Training Fees: (fee includes training material, coffee, lunch and refreshments.

$115 CMHAM Members
$138 Non-Members

To register: https://cmham.ungerboeck.com/prod/emc00/PublicSignin.aspx?SessionID=fa7fe5ej2fe8fc5&Lang=*

REGISTER NOW! EMPLOYMENT FIRST CONFERENCE

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

July 11 & 12, 2018
Kellogg Hotel & Conference Center
East Lansing, Michigan

Registration Fee: $50

Who Should Attend: Staff who's involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership
- CRO Leadership

Workshop Tracks:

- Leadership
- Provider Transformation
- HCBS Implementation

Sponsored By: The Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Additional conference details and registration, click here: CLICK HERE!

CMH ASSOCIATION COMMITTEE SCHEDULES, MEMBERSHIP, MINUTES, AND INFORMATION: go to our website at https://www.macmhb.org/committees

Michigan Association of Community Mental Health Boards is now
Community Mental Health Association of Michigan.

June 8, 2018

FRIDAYFACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance Members
Executive Board Members

FROM: Robert Sheehan, Executive Director
Alan Bolter, Associate Director

RE:

- New e-mail addresses for Association staff
- Association to announce new membership opportunities
- Friday Facts to become a members-only electronic newsletter
- Work, Accomplishments, and Announcements of CMH Association Member Organizations
  - Lenawee CMH announces two significant accomplishments: 3-year Certification from Joint Commission; Successful E-Race the Stigma 5K Run, Walk & Kids Dash
- State and National Developments and Resources
  - MDHHS invites public comment on Title V Block grant application
  - SAMHSA announces availability of opioid treatment dollars
  - Mental health care cited as key to health of cancer survivors
  - Health inequities highlighted in recent issue of national journal
  - New Medicaid-Public Health Resource Center for Implementing CDC's 6|18 Initiative
  - NACBHDD and NARMH joint press release on behavioral health workforce issues
  - 2016 Medicaid Expenditures for Long-Term Services and Supports Report
- Legislative Update
  - FY19 DHHS Conference Committee Report
  - HICA Reform headed to the Governor
  - Marijuana Initiative Headed to the Ballot
- National Update
  - SAMHSA Announces Funding Opportunity for CCBHC Expansion
- Co-occurring college: selected workshops for implementation & sustainability
- Michigan clubhouse conference
- Ethics Training for Social Work and Substance Abuse Professionals for 2018
- Registration Open: Employment First Conference
- CMHAM Association committee schedules, membership, minutes, and information

New e-mail addresses for Association staff: The Michigan Association of CMH Boards is now the COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN.

Please update your email address for CMHAM staff:

Alan Bolter, Associate Director: abolter@cmham.org
Chris Ward, Administrative Executive: cward@cmham.org
Dana Owens, Accounting Clerk: dowens@cmham.org
Michelle Dee, Accounting Assistant: acctassistant@cmham.org
Monique Francis, Executive Board/Committee Clerk: mfrancis@cmham.org
Annette Pepper, Training and Meeting Planner: apepper@cmham.org
Anne Wilson, Training and Meeting Planner: awilson@cmham.org
Carly Palmer, Training and Meeting Planner: cpalmer@cmham.org
Chris Lincoln, Training and Meeting Planner: clincoln@cmham.org
Nakia Payton, Receptionist: npayton@cmham.org
Robert Sheehan, CEO: rsheehan@cmham.org

Association to announce new membership opportunities: In response to requests for a broader range of membership options and a fuller list of benefits of each membership type, the CMH Association of Michigan is developing several new membership opportunities for organizations and individuals. Look for the revised Association membership brochure to be available in November.

Friday Facts to become a members-only electronic newsletter: Note that the receipt of this electronic newsletter will become a members-only benefit sometime in the next few months. While there will be another electronic newsletter for a wider range of non-members, it will not contain the depth or breadth of information contained in this newsletter. **So, if you find the information in this newsletter useful and are not an Association member, consider becoming a member when the new membership opportunities are announced**.

WORK, ACCOMPLISHMENTS, AND ANNOUNCEMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

Lenawee CMH announces two significant accomplishments

Below is a recent announcement by the Lenawee Community Mental Health Authority regarding the receipt of its three-year JCAHO accreditation and its recently completed E-Race the Stigma 5K Run. Congratulations to Lenawee CMH on both counts.

> Lenawee Community Mental Health Authority is proud to report that they have been awarded their three year certification from The Joint Commission. We have also just had our biggest ever, most successful, E-Race the Stigma 5K Run, Walk & Kids Dash – with over 750 runners and walkers participating in the event on May 20th downtown Adrian. Thanks to organizer Greg Adams (who is also Vice Chair of the board) every year this race has gained in popularity. People are coming back year after year, bringing their family and friends. Many different groups participate – county government had a team of over 70 including the county administrator, the sheriff, judges, etc. Businesses like Adrian Steel and Old National, organizations like Goodwill and CMH, schools all brought teams – many wearing their own team shirts – ran, walked, jogged, pushed strollers, to bring awareness to the stigma of mental illness and substance use disorders. Everyone receives a medal and a T-shirt, prize money is awarded to the top finishers male and female. Dollars raised will go back to the community for health and wellness initiatives.
>
> "The first year we only had about 250 participants, it is amazing to be a part of something that has become the number one race and family friendly event in Lenawee County" reported Greg Adams.

The article below was featured in the local media (Daily Telegram: Lenconnect.com)
http://www.lenconnect.com/news/20180524/lenawee-county-e-race-marks-record-turnout

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

MDHHS invites public comment on Title V Block Grant application

The Michigan Department of Health and Human Services (MDHHS) invites the public to comment on the Title V Maternal and Child Health (MCH) Services Block Grant application. Title V of the Social Security Act of 1935 provides funding to states to improve the health of mothers, infants and children, including children with special health care needs.

Per federal requirements, a five-year needs assessment was completed in 2015 and a summary is included in the application. Based on the needs assessment, the seven priorities for the state for 2016-2020 are aimed at improving the health of the MCH population by:

- Reducing barriers, improving access and increasing availability of health services for all populations.
- Supporting coordination and linkage across the perinatal to pediatric continuum of care.
- Investing in prevention and early intervention strategies.
- Increasing family and provider support and education for children with special health care needs.
- Increasing access to and utilization of evidence-based oral health practices and services.
- Fostering safer homes, schools and environments with a focus on prevention.
- Promoting social and emotional well-being through the provision of behavioral health services.

These priorities are linked to state and national performance measures across five federally-identified population domains, women/maternal health, perinatal/infant health, child health, adolescent health and children with special health care needs. Michigan's Title V application is for services from Oct. 1, 2018 to Sept. 30, 2019, and also includes a report on activities and services provided in FY 2017.

The Title V draft application and annual report are available online. MDHHS welcomes comments on the application, which must be received by June 15 by 5 p.m., and can be submitted to daviss11@michigan.gov.

SAMHSA announces availability of opioid treatment dollars

Application Due Date: Monday, July 9, 2018

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for fiscal year (FY) 2018 Targeted Capacity Expansion: Medication Assisted Treatment – Prescription Drug and Opioid Addiction (Short Title: MAT-PDOA) grants. The purpose of this program is to expand/enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder (OUD) seeking or receiving MAT. This program's focus is on funding organizations and tribes/tribal organizations within states identified as having the highest rates of primary treatment admissions for heroin and opioids per capita and includes those states with the most dramatic increases for heroin and opioids, based on SAMHSA's 2015 Treatment Episode Data Set (TEDS). The desired outcomes include: 1) an increase in the number of individuals with OUD receiving MAT 3) a decrease in illicit opioid drug use and prescription opioid misuse at six-month follow-up.

MAT using one of the FDA-approved medications for the maintenance treatment of opioid use disorder (methadone, buprenorphine/naloxone products/buprenorphine products including sublingual tablets/film, buccal film, and extended release, long-acting injectable buprenorphine formulations and injectable naltrexone) is a required activity of the program. MAT is to be provided in combination with comprehensive OUD psychosocial services, including, but not limited to: counseling, behavioral therapies, Recovery Support Services (RSS), and other clinically appropriate services required for individuals to achieve and maintain abstinence from opioids.

Eligibility

Eligibility is limited to the domestic states, political subdivisions within states, and public and private nonprofit organizations in states with the highest rates of primary treatment admissions for heroin and opioids per capita and includes those with the most dramatic increases for heroin and opioids, as identified by SAMHSA's 2015 Treatment Episode Data Set (TEDS). Tribes/tribal organizations across the United States are also eligible to receive funding.

Award Information
Funding Mechanism: Grant
Anticipated Total Available Funding: $65,583,803 (At least $5 million will be awarded to federally recognized American Indian/Alaska Native (AI/AN) tribes/tribal organizations)
Anticipated Number of Awards: Up to 125 awards
Anticipated Award Amount: Up to $524,670 per year
Length of Project: Up to three years
Cost Sharing/Match Required?: No

Proposed budgets cannot exceed $524,670 in total costs (direct and indirect) in any year of the proposed project. Funding estimates for this announcement are based on the Consolidated Appropriations Act, 2018. Annual continuation awards will depend on the availability of funds, recipient progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

In addition to tribes/tribal organizations across the country, eligibility for these grants is limited to a number of states, including Michigan, or political subdivisions or nonprofit organizations within the states, including Michigan, identified with the highest rates of primary treatment admissions for heroin and opioids per capita and includes those with the most dramatic increases for heroin and opioids, as identified by 2015 SAMHSA's Treatment Episode Data Set (TEDS).

Mental health care cited as key to health of cancer survivors

Below is a recent press release, from MDHHS, underscoring the fact that addressing physical and mental health is key to improving quality of life for Michigan cancer survivors, as part of the recent celebration of *National Cancer Survivors Day.*

Battling cancer can have a significant impact on families, and as part of National Cancer Survivors Day the Michigan Department of Health and Human Services (MDHHS) is sharing physical and mental health strategies to improve survivors' quality of life.

A person is a cancer survivor from the time of diagnosis through the remainder of their life. There are currently more than 15.5 million cancer survivors in the United States and this number is expected to grow to 20.3 million by 2026. In Michigan, it is estimated that there are 526,100 cancer survivors.

"Due to advances in screening and early detection, as well as treatment, many people are living longer after a cancer diagnosis," said Dr. Eden Wells, MDHHS chief medical executive. "Having support during treatment and living as healthy as you can during and after treatment are vital to survivorship."

With many different types of cancer and cancer treatments, cancer survivorship is different for each survivor. While many survivors are living longer, they may still experience effects of their cancer and its treatment for years to come. This can include physical, emotional and financial impacts on survivors and their families.

Quality of life is important in survivorship for those who are free of cancer, continue to live with a manageable cancer or face end of life issues. Survivorship care means looking after peoples' mental and physical health. Cancer survivors can address their quality of life by working with their health care providers to manage side effects or long-term effects they experience.

Making healthy choices can improve quality of life and reduce the chance of a cancer recurrence or developing second cancer type. Healthy choices can include increased physical activity, good nutrition, limited alcohol intake and tobacco cessation. Mental health can be addressed through participation in a cancer support group or speaking with a counselor. To improve health, survival and quality of life after a cancer diagnosis:

- Quit tobacco. Smoking and other tobacco products increase your risk for cancer recurrence and additional cancers.

- Be active and strive to maintain a healthy diet and weight.
- Discuss a follow-up car plan with your health care provider.
- Get help for depression or anxiety related to cancer or its treatment.

For resources about survivorship and life after cancer treatment, visit the American Cancer Society website (https://www.cancer.org/health-care-professionals/national-cancer-survivorship-resource-center/tools-for-cancer-survivors-and-caregivers.html) or call 800-227-2345.

Health inequities highlighted in recent issue of national journal

The May issue of the Journal of Health Care for the Poor and Underserved (Volume 29, Number 2, May 2018) centers on a range of health equity issues including:

- health inequities
- promising ways to combat them clinically
- policies that affect them
- reflections on the relationship between structural, sociopolitical facts of life and the well-being of all people

Whole issue: http://muse.jhu.edu/issue/38537

Open Access Pre-Print site (selected articles only): https://preprint.press.jhu.edu/jhcpu/

New Medicaid-Public Health Resource Center for Implementing CDC's 6|18 Initiative

Across the country, states and counties are seeking to improve health care quality and stem rising health care costs by investing in prevention strategies and value-based payment models. CDC's ***6/18 Initiative*** aligns evidence-based preventive practices with emerging payment and delivery models by offering proven interventions that payers can adopt to help prevent or control six prevalent, high-burden conditions – potentially improving health outcomes and controlling costs.

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies has developed a new online resource center to help Medicaid agencies and managed care plans collaborate with state and local public health departments to launch 6|18 interventions. It offers practical how-to resources, including:

- *What is CDC's 6|18 Initiative?* – (http://www.618resources.chcs.org/what-is-the-cdcs-618-initiative/) Background and frequently asked questions about this set of evidence-based approaches for improving population health and controlling costs.

- *CDC's 6|18 Initiative in Action* – (http://www.618resources.chcs.org/618-initiative-in-action/) Interactive map of prevention-focused 6|18 activities from across the country and profiles of select state activities.

- *Implementation Tools* – (http://www.618resources.chcs.org/general-implementation-tools/) Resources to help stakeholders plan and implement 6|18 interventions – including ***Getting Started: CDC's 6|18 Initiative***, a how-to guide developed by ASTHO for Medicaid and public health agencies.

- ***Priority Condition Resources*** – (http://www.618resources.chcs.org/priority-conditions/) An array of health condition-specific resources to guide the implementation of CDC's 6|18 Initiative strategies.

NACBHDD and NARMH joint press release on behavioral health workforce issues

Special Supplement on "The Behavioral Health Workforce: Planning, Practice, and Preparation" Released Today by the American Journal of Preventive Medicine

NACBHDD and NARMH are delighted to announce the release of a Special Supplement to the *American Journal of Preventive Medicine* in which experts focus on the key issue of behavioral health human resources. Articles in this special issue cover research on workforce planning, service delivery and practice, and workforce preparation, and advocate for intelligent allocation of resources to ensure all clients have access to behavioral healthcare.

A 2016 report by the Health Resources and Services Administration (HRSA) on the projected supply and demand for behavioral health practitioners through 2025 indicated significant shortages of psychiatrists, psychologists, social workers, mental health counselors, and marriage and family therapists. The magnitude of provider shortages, however, is not the only issue when considering access to behavioral health services. Another major concern is maldistribution since parts of the US have few or no behavioral health providers available, and access to mental health services is especially critical in areas of poverty.

More than 44 million American adults have a diagnosable mental health condition, and rates of severe depression are worsening among young people. Mental health and disability are well-established drivers of substance use, and drug overdose deaths fueled by opioid misuse have more than tripled from 1999 to 2016.

"There is no more important topic surrounding behavioral healthcare than the current and growing crisis in the availability of well-trained providers," indicated Ron Manderscheid, Executive Director of NACBHDD and NARMH, and Co- Editor of the Special Supplement. "Our Baby Boomers are retiring, and too few Millennials are joining us. This Special Supplement could not come at a more opportune time. It will focus a spotlight on our human resource issues and provide an important glimpse into new developments that can allay this problem."

"The barriers to strengthening behavioral health workforce capacity and improving service delivery will not be easily overcome," caution the Guest Editors, Angela J. Beck, PhD, MPH, Ronald W. Manderscheid, PhD, The National Association of County Behavioral Health and Developmental Disability Directors, Washington, DC, USA, and Peter Buerhaus, PhD, RN, Center of Interdisciplinary Health Workforce Studies, Montana State University, Bozeman, MT, USA. "But with challenge comes opportunity. The increased national and state focus on mental health and addiction services has mobilized the field. The portfolio of efforts highlighted throughout this publication are strong evidence of this energy and enthusiasm. The vision for the future of the behavioral health workforce is one of real hope!"

These articles appear in the *American Journal of Preventive Medicine,* volume 54, issue 6, supplement 3 (June 2018), published by Elsevier. It will be openly available at http://www.ajpmonline.org/issue/S0749-3797(18)X0003-8. Please visit this site to view the table of contents and access full text of the contributions.

2016 Medicaid Expenditures for Long-Term Services and Supports Report

Recently, the Centers for Medicare & Medicaid Services (CMS) announced that the report on Medicaid Expenditures for Long-Term Services and Supports (LTSS) in federal fiscal year (FY) 2016 is now available. Federal and state spending on Medicaid LTSS totaled approximately $167 billion in FY 2016, a 4.5 percent increase from $159 billion in FY 2015.

Home and community-based services (HCBS) have accounted for almost all Medicaid LTSS growth in recent years, while institutional expenditures have remained close to the FY 2010 amount. HCBS spending increased 10 percent in FY 2016, greater than the five percent average annual growth from FY 2011 through 2015. Institutional service spending decreased two percent in FY 2016 following an average annual increase of 0.3 percent over the previous five years. LTSS provided through managed care continued to grow as states have expanded the use of managed LTSS delivery systems. Managed LTSS expenditures were $39 billion in FY 2016, a 24 percent increase from $32 billion in FY 2015.

For the full report visit: https://www.medicaid.gov/medicaid/ltss/reports-and-evaluations/index.html

LEGISLATIVE UPDATE

FY19 DHHS Conference Committee Report

Specific Mental Health/Substance Abuse Services Line items

	FY'18 (final)	FY'19 (Exec Rec)	FY'19 (Conference Report)
-CMH Non-Medicaid services	$120,050,400	$120,050,400	$125,578,200
-Medicaid Mental Health Services	$2,315,608,800	$2,364,039,500	$67,640,500
-Medicaid Substance Abuse Services	$52,408,500	$68441,000	$67,640,500
-State disability assistance program	$2,018,800	$2,018,800	$2,108,800
-Community substance abuse (Prevention, education, and treatment programs)	$76,530,000	$76,456,200	$76,956,200
- Children's Waiver Home Care Program	$20,241,100	$20,241,100	$20,241,100
-Autism services	$105,097,300	$199,841,400	$192,890,700
- Healthy MI Plan (Behavioral health)	$288,655,200	$292,962,900	$299,439,000

Highlights of the FY19 Conference Committee Report:

- Conference Committee REMOVES 298 (e) language from the bill.
- Conference Committee modified autism line and adds boilerplate language to require the establishment of a fee schedule for autism services by October 1, and reduced behavioral technician rates by 10%.
- Conference Committee concurred with the House's recommendation to add $5.5 million GF for non-Medicaid mental health services to hold harmless CMHs that may be negatively impacted by the new FY19 GF funding formula.
- Conference Committee concurs with House recommendation to reduce $9 million Gross ($5.7 million GF) to the Mental Health and Wellness Commission recommendations.

Boilerplate Sections

Section 298 – removes € language from the budget

Section 924 – Autism Reimbursement Limit – for the purposes of actuarially sound rate certification and approval for Medicaid behavioral health managed care programs, the department shall establish and implement a fee schedule for autism services reimbursement rates for direct services by October 1 of the current fiscal year. Expenditures used for rate setting shall not exceed those identified in the fee schedule. The rates for behavioral technicians shall be reduced by 10% of the 2017 autism fee schedule, but shall not be less than $50 per hour.

Section 925 – Non-Medicaid Dollars – From the funds appropriated in part 1 for community mental health non-Medicaid services, each CMHSP is allocated not less than the amount allocated to that CMHSP during the previous fiscal year.

Section 950 – Court Appointed Guardians – Directs the department to not allocate more than $1.5 million to reimburse counties for 50% of the cost incurred by the county to reimburse court-appointed public guardians and conservators for recipients who also receive CMHSP services.

Section 959 – Medicaid Autism Benefit Cost Containment – The department shall establish a workgroup in collaboration with the chairs of the house and senate appropriations subcommittees on the DHHS budget or their designees, CMHSP members, autism service provider clinical and administrative staff, community members, Medicaid autism services clients, and family members to make recommendations to ensure appropriate cost and service provision, including but not limited to, the following:

a. Ways to prevent fraud and overdiagnosis.
b. Comparison of Medicaid rates for autism services to commercial insurance rates.
c. Comparison of diagnosis process between Medicaid, Tricare, and commercial insurance.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house DHHS subcommittee, the house and senate fiscal agencies, and the state budget office.

Section 1009 – Direct Care Worker Wage Increase. Conference Committee includes Senate revised language to clarify what expenses can be covered.

"Funds provided in this section must be utilized by a PIHP for increasing direct care worker wages, for the employer's share of federal insurance contributions act costs, purchasing worker's compensation insurance, or the employer's share of unemployment costs."

Section 1696 NEW Language – Traditional Medicaid to HMP Migration Restriction- It is the intent of the legislature that, beginning in the fiscal year beginning October 1, 2019, if an applicant for Medicaid coverage through the Healthy Michigan Plan received medical coverage in the previous fiscal year through traditional Medicaid, and is still eligible for coverage through traditional Medicaid, the applicant is not eligible to receive coverage through the Healthy Michigan Plan.

Section 1867 – Requires DHHS to convene a workgroup to identify best practices and to develop protocols for prescribing psychotropic medications and requires a report by March1.

Section 1875 – Conference committee retains previous years' language regarding prior authorization – Applies prior authorization prohibition to DHHS and its contractual agents for psychotropic medications and drugs for the treatment of epilepsy/seizure disorder or organ transplant therapy, if those drugs were either carved out or not subject to prior authorization procedures as of May 9, 2016, defines "prior authorization".

HICA Reform Headed to The Governor

Last week, House members passed a three-bill Senate package outlining reforms for the states highly contentious Health Insurance Claims Assessment (HICA) Tax. Senate Bills 992-994 all passed via 107-1 votes without debate or changes, meaning they are now headed to Governor Rick Snyder for signature.

Under the bills, the HICA Tax will be repealed and replaced with the Insurance Provider Assessment (IPA) Tax. The IPA Tax will be multi-tiered and could apply at varying rates to non-Medicaid health insurers, prepaid inpatient health plans (PIHPS), and Medicaid physical health managed care services. Along with the creation of the IPA, an Insurance Provider Fund will be created to collect revenue from the new tax system, with estimates at $601.6 million in the 2018-19 Fiscal Year (SB 992). For the new tax to be allowed to be in effect for at least five years, the Michigan Department of Health and Human Services (DHHS) would be required to file a request for a waiver from the federal Centers for Medicare and Medicaid (SB992). Then, once that waiver is granted (or on October 1 of this year, whichever occurs first) the repeal of HICA would be allowed (SB

993). The current Use Tax Act would also be amended by eliminating language that would reinstate the Medicaid managed care use tax if the HICA Act is repealed or HICA's rate drops to zero percent (SB 994).

Of the expected $601.6 million in revenue for the coming Fiscal Year, $315 will offset HICA revenues, $155 million will ensure the plan's "actuarial soundness", $17 million will be used for physical health capitation rate increased and administration costs, and $114.6 million will be placed in the new Insurance Provider Fund. Michigan now joins the rest of the states in eliminating the HICA Tax.

<u>Marijuana Initiative Headed to the Ballot</u>

A citizen's initiative to legalize the recreational use of marijuana is headed to the November ballot, as lawmakers declined to adopt legislatively the proposal put forward by Coalition to Regulate Marijuana Like Alcohol (CRMLA).

Tuesday was the final day of the Legislature could take action before the citizens' initiative automatically moves to the ballot, House leadership announced they will not be voting on the issue. The 55 House votes were not being there to legalize pot without a public vote despite the votes allegedly being there in the Senate if the House had acted.

The House was always the challenge for legislative adoption, with House Speaker Tom Leonard (R-DeWitt) consistently being against the measure and publicly questioning whether there were not enough votes in the Republican caucus to adopt the initiative. Also, House Democrats were leery of taking action, consistently wanting the citizens to vote on the measure.

Much of the argument in favor of adopting the initiative legislatively was that it could be amended with a simple majority vote with regulations that exactly mirror those of medical marijuana. If the people adopt it, the Legislature could only change it with a three-quarters majority vote.

<u>NATIONAL UPDATE</u>

<u>SAMHSA Announces Funding Opportunity for CCBHC Expansion</u>

This week, SAMHSA released a funding opportunity for FY 2018 Certified Community Behavioral Health Clinics (CCBHCs) Expansion Grants. SAMHSA anticipates awarding 25 eligible providers up to $2 million annually to increase access to and improve the quality of community behavioral health services through the expansion of CCBHCs. CCBHCs and community behavioral health providers in the eight CCBHC demonstration states (MN, MO, MV, MJ, MY, OK, OR, PA) **<u>and</u>** the planning grant states (AK, CA, CO, Christine Taylor, IA, IL, IN, KY, MA, MD, MI, NC, RI, TX and VA) are eligible to apply.

Applications are due July 9, 2018. For a program description and details on eligibility click here: https://www.samhsa.gov/grants/grant-announcements/sm-18-019

<u>TRAININGS:</u>

<u>CO-OCCURRING COLLEGE: SELECTED WORKSHOPS FOR IMPLEMENTATION & SUSTAINABILITY</u>

June 25-26, 2018
Kellogg Hotel and Conference Center
East Lansing, Michigan

WHO SHOULD ATTEND: Clinical directors, case workers, support coordinators, children's supervisors and other practitioners who must be able to address comorbid mental health and substance use disorders at all levels of practice (beginning, intermediate and/or advanced).

COST: $140 for two-day training, including breakfast, lunch and parking

LOCATION: Kellogg Center Hotel: 219 S. Harrison Rd., E. Lansing, MI 48824; Phone: 517-432-4000

OVERNIGHT ROOMS: Hotel rooms are $75 per night
To make your reservation call 517-432-4000 and request Group Code 1806COOCCU to receive your discounted rates.
Deadline for discounted rates: June 7, 2018

TO REGISTER FOR CO-OCCURING COLLEGE:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5156&AppCode=REG&CC=118053182060&RegType=2005-42

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REGISTER NOW! EMPLOYMENT FIRST CONFERENCE

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

July 11 & 12, 2018
Kellogg Hotel & Conference Center
East Lansing, Michigan

Registration Fee: $50

Who Should Attend: Staff who's involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership
- CRO Leadership

Workshop Tracks:

- Leadership
- Provider Transformation
- HCBS Implementation

Sponsored By: The Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Additional conference details and registration, click here: CLICK HERE!

CMH ASSOCIATION COMMITTEE SCHEDULES, MEMBERSHIP, MINUTES, AND INFORMATION: go to our website at https://www.macmhb.org/committees