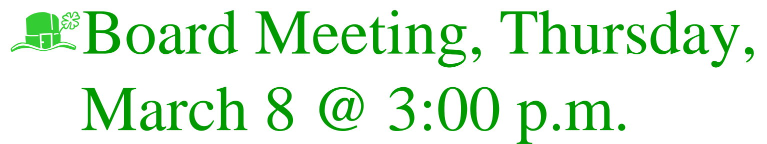
# *Northeast Michigan Community Mental Health Authority*
# *Board Meetings - March 2018*

Happy St. Patrick's Day

All meetings are held at the Board's Main Office Board Room located at 400 Johnson St in Alpena unless otherwise noted.

* Meeting held in the Administrative Conference Room

- Nomination's Committee*, Thursday, March 8 @ 2:30 p.m.



- Board Meeting, Thursday, March 8 @ 3:00 p.m.

  - Annual Board Member Recognition

**Northeast Michigan Community Mental Health Authority**
**Nomination's Committee**
**March 8, 2018 @ 2:30 p.m.**

**A G E N D A**

**I. Slate of Officers Recommendation**

Committee Members:
Pat Przeslawski, Chair
Alan Fischer
Roger Frye
Terry Larson

**NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD**

**BOARD MEETING**

**March 8, 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

**IV.** Appointment of Evaluator

**V.** Information and/or Comments from the Public

**VI.** Approval of Minutes ........................................ (See pages 1-6)

**VII.** Audit Report – Financial & Compliance ........................................ (Straley, Lamp & Kraenzlein PC)
*[Handout at the meeting]*

**VIII.** Board Member Recognition ........................................ (See page 7A)

**IX.** Recess

**X.** Nominations Committee Report ........................................ (Verbal)

**XI.** March Monitoring Reports
1. Treatment of Consumers 01-002 ........................................ (See pages 7-20)
2. Treatment of Staff 01-003 ........................................ (See pages 21-26)
3. Asset Protection 01-007 ........................................ (Included in discussion from Audit Report)

**XII.** Board Policies Review and Self Evaluation
1. Budgeting 01-004 .................... [Review Only] .................... (See page 27)
2. Board Members Code of Conduct 02-008[Review & Evaluate] .................... (See pages 28-29)

**XIII.** Linkage Reports
1. Northern Michigan Regional Entity
   a. Appointment of Board Member to NMRE [Roger Frye's term up 4/1/18]
   b. NMRE Board
      i. Meeting of February 28, 2018 ........................................ (Verbal)
      ii. Meeting of January 24, 2018 ........................................ (See pages 30-33)
2. Board Association
   a. Spring Conference – [May 1 & 2 – Diamond Center, Novi MI] .................... (Verbal)

**XIV.** Operational Report ........................................ (See page 34)

**XV.** Chair's Report
1. CMH PAC – Reminder ........................................ (See page 35)

**XVI.** Director's Report
1. Director's Report ........................................ (See pages 36-40)
2. Annual Submission ........................................ (See pages 41-50)
3. QI Council Update ........................................ (Available at meeting)
4. Closed Session to discuss litigation ........................................ (Verbal)

**XVII.** Information and/or Comments from the Public

**XVIII.** Next Meeting – Thursday, April 12, 2018 at 3:00 p.m.
1. Set April Agenda ........................................ (See page 51)
2. Evaluation of Meeting ........................................ (All)

**XIX.** Adjournment

**MISSION STATEMENT**

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

**Northeast Michigan Community Mental Health Authority Board**

**Board Meeting**

**February 8, 2018**

## I. Call to Order

Chair Gary Nowak called the meeting to order in the Board Room at 3:00 p.m. A sympathy card was circulated for signatures in memory of Steve Dean's daughter who passed away on Wednesday.

## II. Roll Call and Determination of a Quorum

Present: Lester Buza, Bonnie Cornelius, Alan Fischer, Judy Hutchins, Judy Jones, Albert LaFleche, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski

Absent: Steve Dean (excused), Roger Frye (excused)

Staff & Guests: Carolyn Bruning, Lee Ann Bushey, Mary Crittenden, Lynne Fredlund, Laura Gray, Ruth Hewett, Cheryl Jaworowski, Kay Keller, Larry LaCross, Cathy Meske, Nena Sork

## III. Pledge of Allegiance

Attendees recited the Pledge of Allegiance as a group.

## IV. Appointment of Evaluator

Gary Nowak appointed Bonnie Cornelius as evaluator for this meeting.

## V. Information and/or Comments from the Public

There was no information presented.

## VI. Educational Session – Catholic Human Services

Cathy Meske introduced Larry LaCross, Catholic Human Services Clinical Supervisor and NEMROC Board member. Mr. LaCross noted his agency works with those individuals with co-occurring disorders and is working to combat the opioid epidemic. He distributed two handouts; one on Up North Prevention and one on Integrative Partnerships and Community Initiatives around the Opioid Epidemic. Up North Prevention services focus on community education and the links between prescription drugs and the importance of locking up those prescriptions. This initiative is funded through a grant from Blue Cross Blue Shield. Up North Prevention will be working with primary care facilities, county jails, and the community to provide education related to the opioid crisis and providing an understanding of how some of the crisis can be curbed. Mr. LaCross addressed the need to have emergency responders having access to Narcan (naloxone). This medication is an opioid antagonist and can reverse an opioid overdose. Narcan will actually kick the opioid molecules off the brain receptors. This is administered through an injection similar to that of an EpiPen. There is also a nasal spray version of the medication. A tablet form is a long-acting version of this medication as well. Narcan is an immediate method to save a person's life; however, this does not treat the disease. Mr. LaCross stressed the importance in providing integrated services to individuals with a substance use disorder and not providing services in silo setting for best results.

Alcona Health Center received a grant two years ago this May to provide funding for the New Horizons Substance Use Recovery Network. This is a medication assisted treatment (MAT) process. The most effective medication used is Vivitrol (naltrexone), an injectable medication and is administered every 28 days. Suboxone (buprenorphine) is another medication used in MAT and is administered daily.

Judy Jones inquired as to the effects if a person being administered Vivitrol and then takes drugs. Larry LaCross reported MAT does not treat the withdrawal or depletion of drugs. An individual on Vivitrol may not get the "high" from an opioid they may have taken in the past as the opioid receptors have a block. He stressed recovery is best achieved with medication therapy and coaching.

Larry reported the MAT program was successful in that many individuals moved into a maintenance program; however, this taxed their ability to provide the clinical support services within the grant budget.

He noted Catholic Human Services (CHS) has also developed a good relationship with the Thunder Bay Community Health Services and CHS has been able to co-locate some of their substance use treatment clinicians within the offices of Thunder Bay Community Health Services in Rogers City and Atlanta. In addition Ben Martin, Addiction Counselor, is working in Onaway in coordination with Catholic Human Services.

The end goal is to access treatment in an integrated fashion. Thunder Bay Community Health Services is being very active in addressing the role physicians' play in the opioid epidemic. The partnership looks at ways the clinic will support their patients in pain management to reduce the amount of opioids prescribed.

Catholic Human Services received a grant from the Michigan Health Endowment Fund to address integration of services in Alpena and Montmorency counties. The grant project will help the community better integrate services to families involved in the child welfare program where the children also have a caregiver or parent with addiction issues. Referrals began December 1. Meetings of a multi-disciplinary team are held routinely to review referrals. He reported Mary Crittenden is a representative from Northeast participating in this endeavor. The project looks for ways to support the family and support recovery. This assists in keeping children in the community versus placing children out of the area.

Pat Przeslawski inquired about whether there are similar medications that could be used to block receptors craving smoke. Mr. LaCross noted there are some medications to help in curbing cigarette cravings.

Larry LaCross noted over a period of years, doctors were encouraged to treat patients with opioids to keep pain managed and to prescribe. This was based on research and later found most of the research was generated from pharmaceutical companies.

Eric Lawson inquired why some individuals are not susceptible to addiction where other may be. Larry noted there are different risk factors – genetic history, age of first use, and trauma.

Laura Gray inquired as to whether there are new grants available for treatment. Mr. LaCross reported CHS works with those individuals with a mild to moderate diagnosis. He notes the Agency is working with the health centers, who also treat mild to moderate, to provide better integration of services. Ms. Gray noted she has been attending the interagency meetings to stress the importance of community education through such groups as NAMI. Larry LaCross noted most times "tough love" does not work in addiction solutions.

Terry Larson noted it is important for physicians to looks at the MAPS (Michigan Automated Prescription System) to determine the prescriptions individuals receive to ward off abuse. Albert LaFleche noted he believes the use of marijuana is just a stepping stone to opioids.

## VII. Approval of Minutes

***Moved by Judy Hutchins, supported by Eric Lawson, to approve the minutes of the January 11, 2018 minutes as presented.*** Motion carried.

## VIII. Consent Agenda

1. **Contracts/Agreements**
   a. **Quest Software Inc.**

***Moved by Judy Hutchins, supported by Eric Lawson, to approve the Consent Agenda.*** Roll call vote: Ayes: Lester Buza, Bonnie Cornelius, Alan Fischer, Judy Hutchins, Judy Jones,

Albert LaFleche, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski; Nays: None; Absent: Steve Dean, Roger Frye. Motion carried.

## IX. February Monitoring Reports

### 1. Treatment of Consumers 01-002

Pat Przeslawski noted this meeting was postponed from the original date. The quarterly rights activity report for the first quarter of FY17-18 was included in the mailing. Board members had no questions or concerns.

### 2. Budgeting 01-004

Cheryl Jaworowski reviewed the final Statement of Revenue and Expense for FY17. She noted the preliminary numbers were provided to the Board last November. She reviewed the contract settlement funds noting Medicaid funds were over spent and General Funds under spent with $30,561 lapsing back to the state and $40,494 to be carried forward to FY18. This was after the 236 Transfer from AuSable Valley of $100,000. She noted the General Fund line had some late corrections which resulted in the changes. In addition, Healthy Michigan was over spent by $127,991 and Autism was under funded by $435,402. Overall, there was a positive change in net position of $113,581. This will be the statement the auditors will be basing their audit on.

Cheryl Jaworowski reviewed the Statement of Revenue and Expense for month ending December 31, 2017. She reported the shift from general Medicaid to Healthy Michigan is beginning to revert back slightly. For month ending December 31, 2017 there was a positive change in net position of $45,818.

Cheryl Jaworowski reported MMRMA recently notified the Agency they will again be giving a net asset distribution this year which will be larger than last year.

### 3. Financial Condition 01-005

Cheryl Jaworowski reviewed the final Statement of Net Position and Change for FY17. The unrestricted fund balance increased by 9.2% and the Agency has 52 days of operating funds which is where we ended last fiscal year.

Cheryl Jaworowski reviewed the unrestricted fund balance as of December 31, 2017 noting it continues to improve and we now have 56 days of operating funds. In addition to the Agency's quarterly report, the statement from the Community Foundation for the endowment fund was reviewed. She noted the spendable amount from this fund currently is $8,474.24.

### 4. Staff Treatment 01-003

Cathy Meske reported the monitoring report related to staff treatment uses a turnover report for measurement. She noted Kay Keller, HR Assistant, is available for questions. Cathy reviewed the comparison from last year noting turnover "in-house" increased by 2% (from 23% to 25%). Statewide the separation rate was 30.3%. This agency's overall turnover is at 20%. Cathy Meske reported when an agency manages a 24-hour operation turnover is expected. Kay Keller notes some staff go to school and work in the homes for experience which results in turnover once they graduate and move into other full-time jobs.

### 5. Asset Protection 01-007

The monitoring report for Asset Protection is a component of the audit presentation which has been postponed due to late onset of audit.

***Moved by Judy Jones, supported by Bonnie Cornelius, to accept the February monitoring reports as presented.*** Motion carried.

## X. Board Policy Review and Self Evaluation

### 1. Asset Protection 01-007

Board members reviewed this policy and had no recommended changes.

2. **Board Committee Principles 02-005**
   Board members had no comments regarding this policy.

3. **Delegation to the Executive Director 03-002**
   Board members had no comments regarding this policy.

   Eric Lawson commented after serving on the Board a few years now and having policy review monthly he is impressed with the way the policies were written.

## XI. <u>Linkage Reports</u>

1. **CMHAM**
   a. **CMH PAC Campaign**
      Gary Nowak reported the annual campaign for the CMH PAC is underway. Gary Nowak reports the suggested amount is the equivalent of a per diem. Cathy Meske reported she will again match the amount contributed by Board members up to $400.

2. **Northern Michigan Regional Entity (NMRE)**
   a. **Board Meeting January 24, 2018**
      The minutes from the most recent NMRE Board meeting were not yet available. Terry Larson reported there are still some concerns with the SUD services/funding. Cathy Meske reports the mobile crisis response teams for children were discussed. The Behavioral Health Homes are stalled at this point. Eric Kurtz is working with the state to determine how Behavioral Health Home services can be added when there is a waiver in place already.

      Cathy Meske reports the MUNC report was discussed. The pre-screen data was reviewed to reconcile numbers.

3. **Consumer Advisory Council Update**
   Gary Nowak reported he attended this meeting and Council members voiced concerns about re-establishing a NAMI group. Cathy Meske reported several years ago staff at Alpena Regional Medical Center had attempted to institute a local NAMI group; however, that did not materialize. Cathy Meske reports if a group of citizens wanted to work toward establishing this group or a similar type of group, Northeast would be a partner at the table. Laura Gray noted that the NAMI Michigan convention is being held in Traverse City. Cathy Meske reported this might be an opportunity to send a couple individuals to the conference to bring back information for others.

## XII. <u>Chair's Report</u>

1. **Board Member Recognition for March**
   March is the annual Board Member recognition and Judy Jones will be receiving her five-year award. Cake will be served.

## XIII. <u>Director's Report</u>

1. **Director's Report Items**
   A. **Public Hearing 2017 Update**
      Cathy Meske reported the Public Hearing was held last January and the hearing was well attended by the public. Five priorities were identified from the input received. This year a public hearing was not required but we need to update the state on what was done to achieve the goals established on the priority list. This update will be sent to our community partners the survey was sent to last year so they are aware of the progress made toward those priorities.

      Cathy Meske noted we have contracted with Alcona Health Center who has hired a clinician and is working with children in an identified pilot school. Cathy Meske also discussed the 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. Through TRAILS, School Success Workers will be trained to work with children who have anxiety and depression. Services will be provided right at the school and trained CMH staff will work as coaches if needed.

Trauma Informed Community Kick-Off has been held in most counties. Cathy reported we are still working to get one scheduled in Presque Isle. She is working with Julie Waldron from Department of Health and Human Services to get scheduled.

Jail Services training is continued to be coordinated with the county law enforcement agencies. Alpena and Montmorency counties jail staff have received training recently. Scheduling training with Alcona and Presque Isle counties has not been able to be coordinated.

Suicide awareness within the community will be focused on this calendar year. Mary Schalk (Partners in Prevention) and Mary Mingus (NeMCMHA staff) have worked together on the "safeTALK" from Living Works. Community trainings are scheduled for February in Presque Isle and Montmorency counties.

To increase our partnerships with substance abuse providers, the Agency has a staff person participating in the new Family Recovery Care Team which includes Catholic Human Services, Alpena and Montmorency County Department of Health and Human Services, court systems and the Freedom Recovery Center. This group targets families involved with the Child Welfare services having a caregiver identified as having a substance use disorder.

Cathy Meske reports we continue to work with MidMichigan Medical Center to smooth out the Emergency Department processes.

**B. Governor's Proposed Budget**

Cathy Meske reported the Direct Care Wage increase appears to still be in the budget for FY19. More review of the proposed budget will be needed to provide a complete analysis.

**C. Children's Mobile Crisis**

NMRE has requested we develop a plan addressing crisis after hours services for the age group under 21. She notes it was suggested to work cooperatively with AuSable Valley. As the response time requirement is meeting with the individual within two hours of the contact partnering with AuSable Valley would not be an option. This response team will need to be a stand alone on-call service. A Master's Level Clinician along with a support staff will be expected to respond. The peak hours must be covered. She notes we are still in a planning mode. This agency averages about 3 calls per month.

**D. House CARES Task Force**

This report was included in the materials for this meeting. One of the report recommendations were to provide Mental Health First Aid to those in schools. She notes we have been doing this for some time.

**2. Endowment Fund Grant Awards**

Cathy Meske reviewed the endowment fund criteria and reviewed the four grant awards processed in the past six months. She notes future awards will not include rent assistance.

**XIV. Operational Report**

Nena Sork reported the Operational Report is still being tweaked by our report writer. She noted the May date is due to the date our new software was implemented. The unduplicated consumer counts were reviewed by county as well as by program.

The increase in unduplicated services provided is possibly contributed to the loss of prevention service funding. Cathy Meske reported the increase in substance abuse has also increased the prescreens by those individuals seeking pain medications from the Emergency Department.

The Employment Report will be part of the Operational Report and be provided quarterly.

Pat Przeslawski reported many community members still are not aware of community mental health's services or location. Laura Gray reported families are not expecting to have a crisis and it is not until they need the service that they seek help.

***Moved by Gary Nowak, supported by Lester Buza, to authorize the attendance of two individuals to attend the NAMI Conference in Traverse City.*** Roll call vote: Ayes: Lester Buza, Bonnie Cornelius, Alan Fischer, Judy Hutchins, Judy Jones, Albert LaFleche, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski; Nays: None; Absent: Steve Dean, Roger Frye. Motion carried.

## XV. Information and/or Comments from the Public

There was no information or comments provided.

## XVI. Next Meeting

The next regularly scheduled meeting of Northeast Michigan Community Mental Health Authority Board will be held Thursday, March 8, 2018 at 3:00 p.m.

### 1. Set March Agenda

The March agenda items were reviewed.

## XVII. Evaluation of Meeting

Bonnie Cornelius reported the meeting started on time. She believes the educational session was well received by Board members. She really enjoyed learning more about substance use.

Discussion about the new law requiring doctors to check the MAPS system prior to prescribing narcotics ensued with some members noting they don't believe this will easily be enforced.

## XVIII. Adjournment

***Moved by Judy Jones, supported by Pat Przeslawski, to adjourn the meeting.*** Motion carried. This meeting adjourned at 4:40 p.m.

____________________________________

Alan Fischer, Secretary

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Gary Nowak, Chair

Diane Hayka
Recorder

Available at the meeting

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**THANKS TO ALL BOARD MEMBERS FOR THEIR CONTINUTING SERVICE TO THE BOARD**

ROGER FRYE ........................................ 24 YEARS

GARY NOWAK ........................................ 19 YEARS

PATRICIA PRZESLAWSKI ........................................ 18 YEARS

TERRY LARSON ........................................ 17 YEARS

JUDY HUTCHINS ........................................ 14 YEARS

ALAN FISCHER ........................................ 11 YEARS

ALBERT LAFLECHE ........................................ 9 YEARS

LES BUZA ........................................ 8 YEARS

JUDY JONES ........................................ 5 YEARS

ERIC LAWSON ........................................ 3 YEARS

BONNIE CORNELIUS ........................................ 2 3/4 YEARS

STEVE DEAN ........................................ 1 YEAR, 2 MONTHS

## NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

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INTEROFFICE MEMORANDUM

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**TO:** Board Members

**FROM:** Cathy Meske

**SUBJECT:** Monitoring Report – Treatment of Consumers 01-002

**DATE:** February 26, 2018

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The Monitoring Report "Treatment of Consumers" deals with the satisfaction results from various surveys conducted by the State, the Regional Entity and the Agency. Annually the following programs receive a survey from either the State or NMRE: Outpatient Services, ACT Services, Home-Based Services, MI Child and MI Adult Case Management Services, Medical Services and Clubhouse Services. Some excerpts of the FY17 survey are attached. The FY18 Snapshot Satisfaction Survey was conducted by the NMRE for the Outpatient Services, Medical Services, Clubhouse Services and MI Child and MI Adult Case Management Services in February 5 through February 19, 2018. This survey included the ACT program as the State has indicated they will not be providing a survey this fiscal year. The State traditionally surveys the ACT Program and the Home Based Services Program. We have not received any results from the State related to their last survey conducted.

The Customer Satisfaction Committee of this Agency has traditionally conducted a survey of the I/DD population to determine satisfaction. The survey questionnaire is handed out at the time of the Planning Session. Summary results of this survey are provided in the Customer Satisfaction Survey brochure which will be available at the meeting next week.

Attachments

NORTHERN MICHIGAN REGIONAL ENTITY

SNAPSHOT SATISFACTION SURVEY
OCTOBER 31ST – NOVEMBER 10, 2016

The information contained in this portion of the monitoring report is pulled from information compiled by the Northern Michigan Regional Entity upon review of a snapshot satisfaction survey conducted in early FY17. The full report is available by request of Board members if they desire (44-page report).

**Return Rates**

An overall return rate for the NMRE was calculated at 60.62%, a significant decrease compared to FY16 rate of 76.82% and FY15 of 79.63%. This calculation includes all clinicians across all five participating CMHSPs who provided services during the snapshot timeframe. The overall return rates per CMHSP were as follows: AuSable Valley CMH at 74.74% (FY16 75.27%), Centra Wellness Network at 47.96 % (FY16 58.11%), North Country CMH at 79.10% (FY16 89.32%), Northeast Michigan CMH at 40.32% (FY16 62.74%), and Northern Lakes CMH at 56.18% (FY16 84.50%). The return rate per CMHSP will be broken down by program under each program title within this report. Figure 1 illustrates the 2017 return rates for each program surveyed per CMHSP and trendlines for NMRE averages for 2016 and 2017. Figure 2 illustrates how each CMSP compared to the NMRE average for 2016 and 2017.

***Table 1: Return Rates for All Programs Surveyed sorted by CMHSP and Program***

| | ***OUTPATIENT*** | ***ADULT CSM*** | ***YOUTH CSM*** | ***MEDICAL*** | ***CLUBHOUSE*** | ***ACT*** | ***OVERALL*** |
|---|---|---|---|---|---|---|---|
| AuSable Valley CMH | 79.01% | 94.29% | 78.38% | 65.35% | | 40.00% | 74.74% |
| Centra Wellness Network | 31.43% | 56.36% | 46.15% | 61.11% | | 59.09% | 47.96% |
| North Country CMH | 93.06% | 91.89% | 91.67% | 100.00% | 76.83% | 21.82% | 79.10% |
| Northeast Michigan CMH | 52.00% | 30.97% | 44.44% | 45.16% | 90.00% | 21.62% | 40.32% |
| Northern Lakes CMH | 80.82% | 22.14% | 73.33% | 84.29% | 100.00% | 79.10% | 56.18% |
| **NMRE** | **71.95%** | **45.97%** | **65.48%** | **68.42%** | **81.90%** | **36.36%** | **60.62%** |
| NMRE FY16 | 75.27% | 58.11% | 89.32% | 62.74% | 84.50% | n/a | 76.82% |

***Figure 1: FY 17 Snapshot Survey Return Rates by CMHSP and Program***

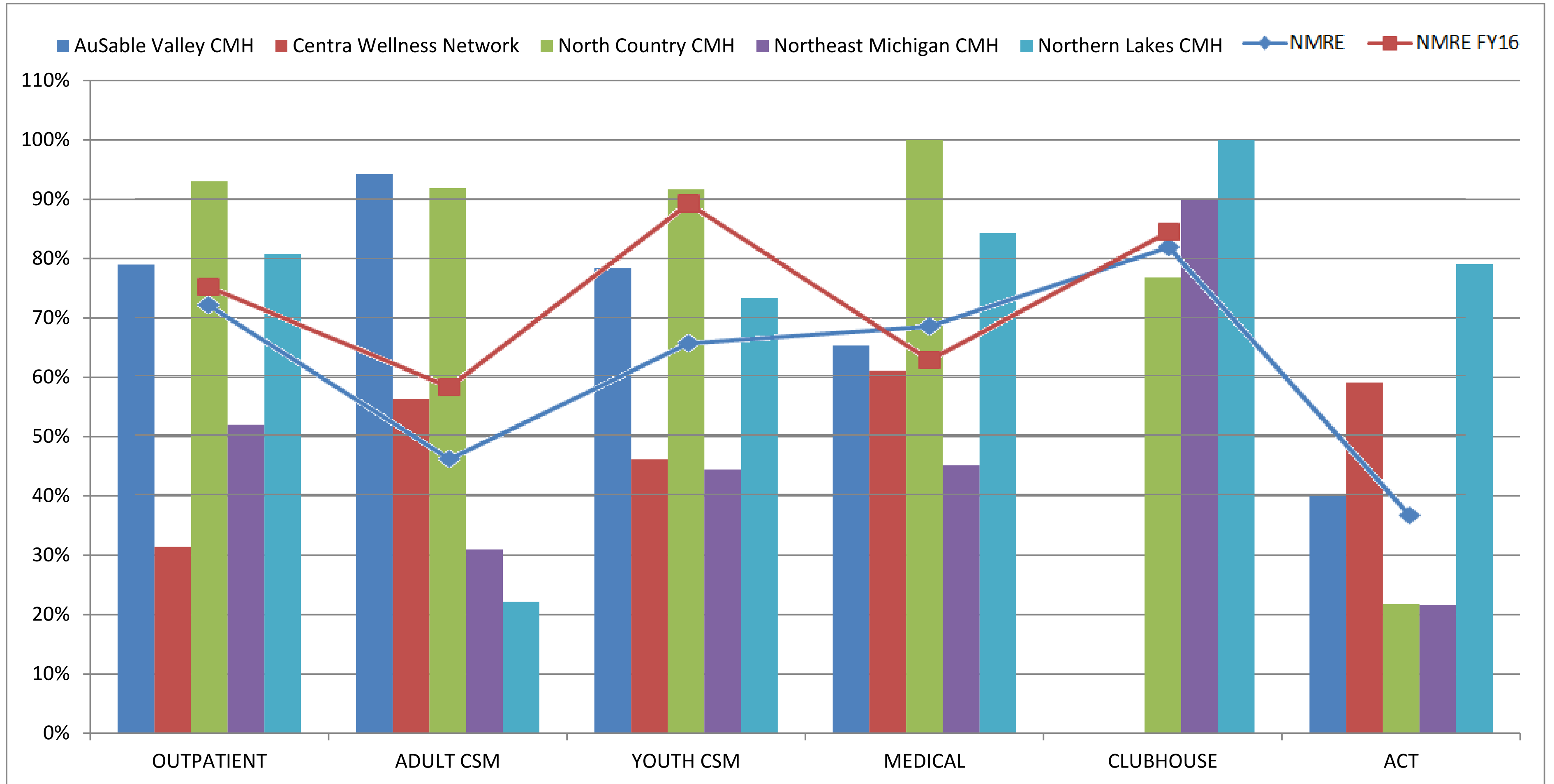
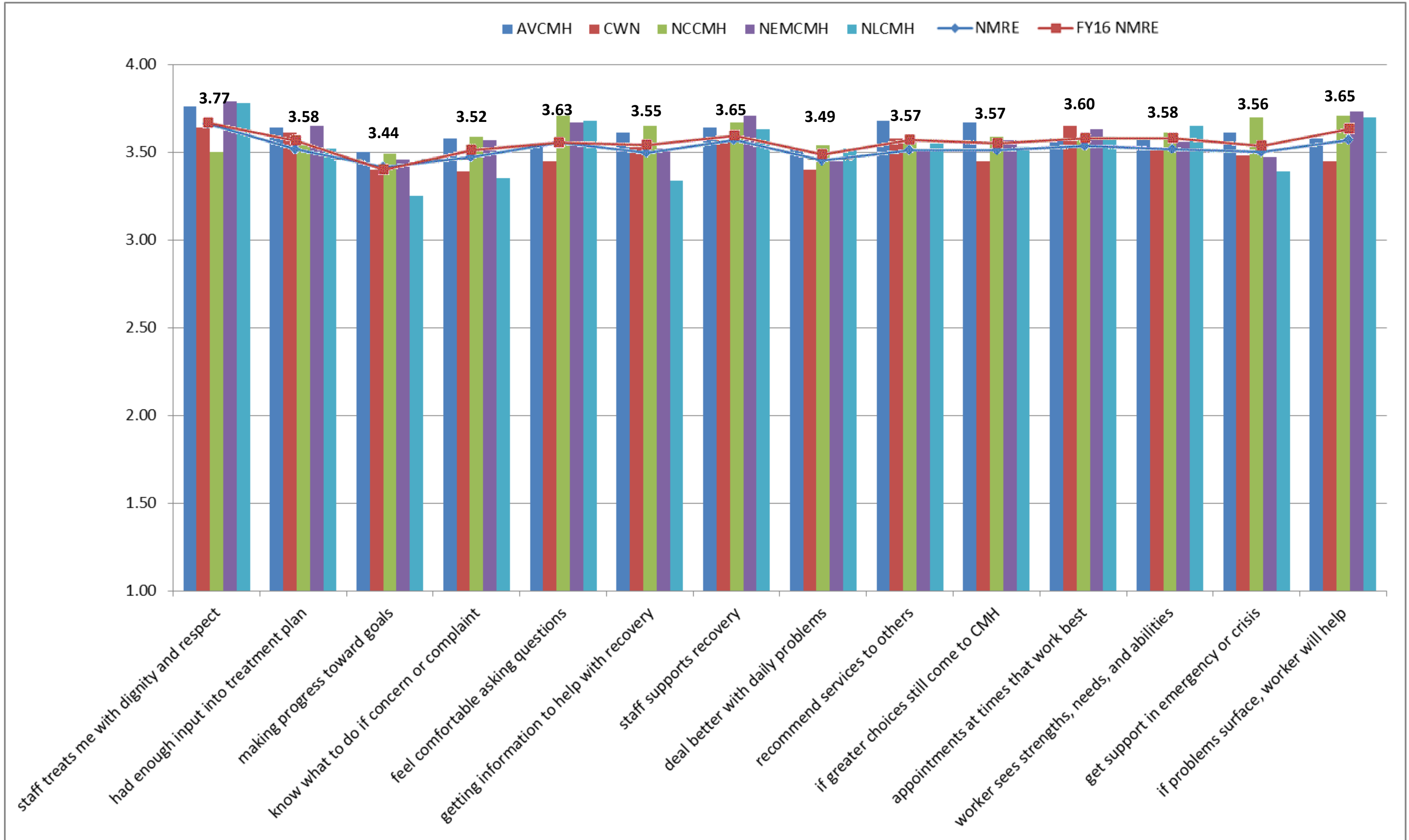


***Figure 2: Average Responses per Question for Adult Case Management Program sorted by CMHSP***



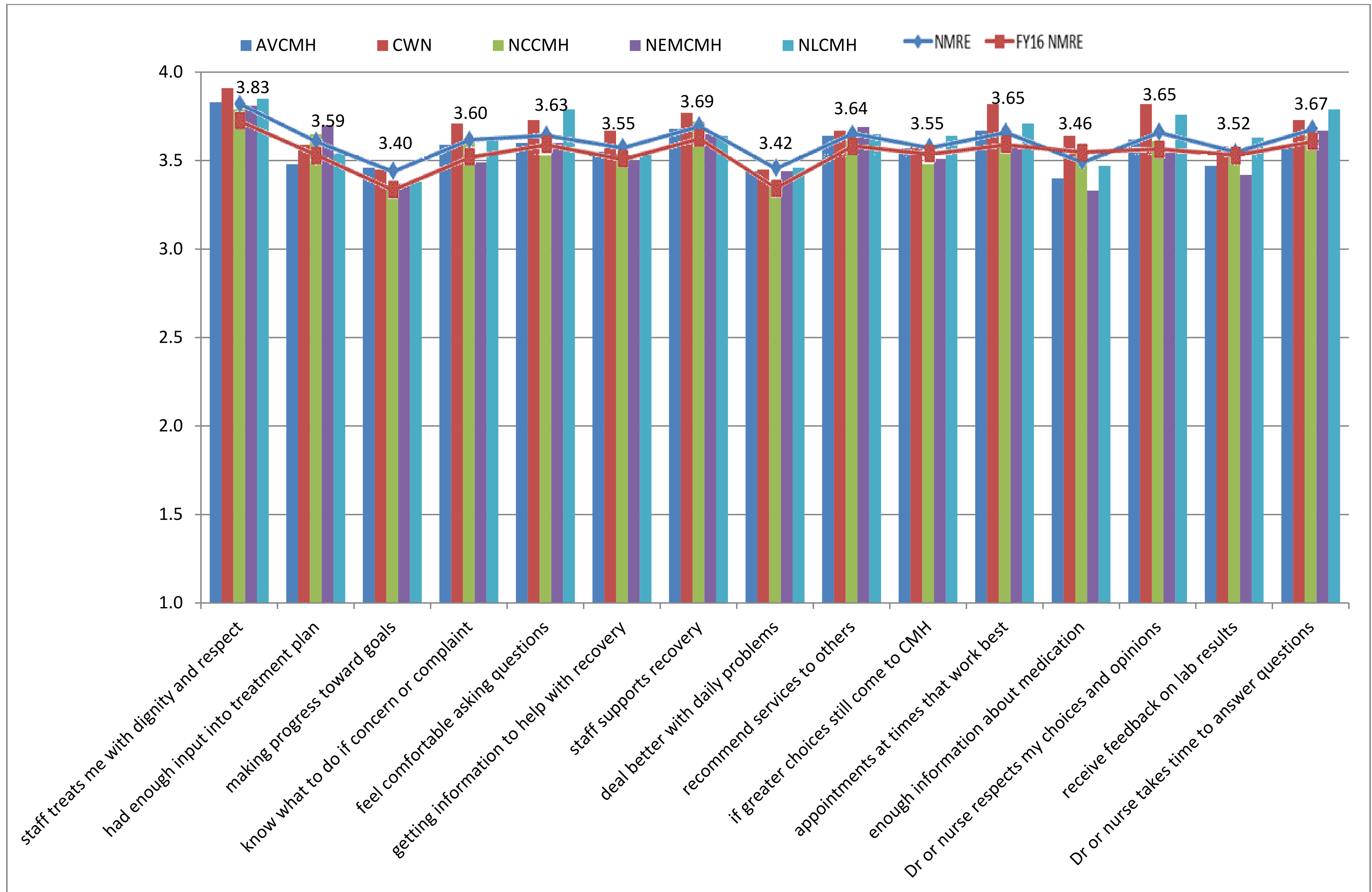

**Adult Case Management**

Adult Case Management services are offered at every CMHSP in the NMRE region. A total of 459 surveys were distributed to recipients of Adult Case Management services during the two-week snapshot timeframe, 211 of which were returned to the NMRE for inclusion in this report. This represents a regional return rate of 45.97%, a decrease compared to 71.62% in FY 16. Completed surveys for two providers from Northeast Michigan CMH and three providers from

Northern Lakes CMH were returned, but a tally sheet was not. The number of surveys requested by and distributed to them was used to calculate the return rate which has caused a lower return rate for their CMHSPs as well as the total for NMRE.

Adult Case Management services scored an overall high level of satisfaction with regional item means ranging from 3.44 to 3.77. The range of favorable responses fell between a low of 85.90% for "I am making progress toward my treatment goals," and a high of 94.13% for "Staff treats me with dignity and respect." Figure 2 details the average scores per question for Adult Case Management services throughout the NMRE region. Trend lines for FY 16 and FY 17 has been included. All averages are above the 3.0 target prescribed by the QOC.

***Figure 3: Average Responses per Question for Medical Services Program sorted by CMHSP***



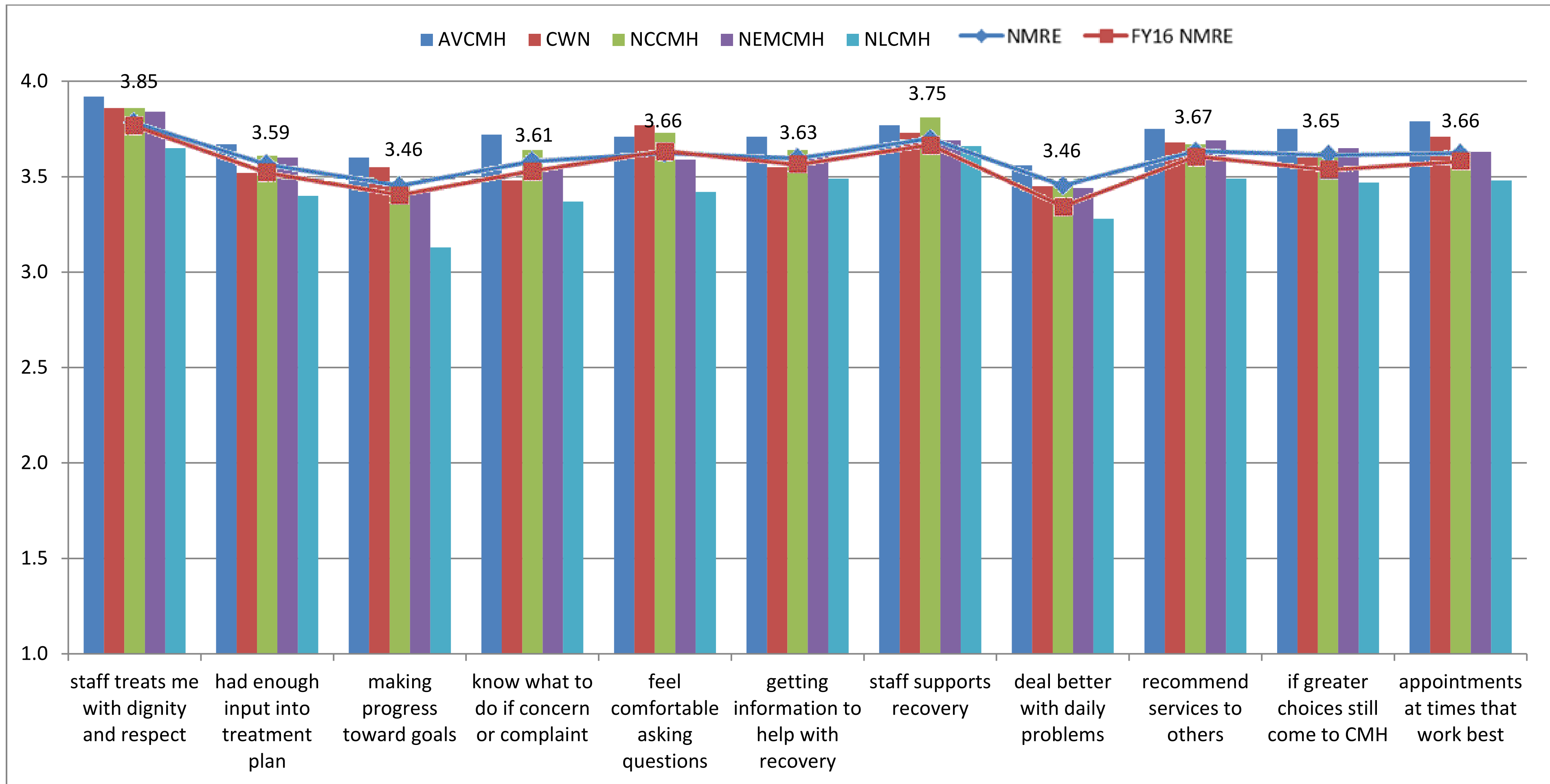

**Medical Services**

Medical Services are offered at every CMHSP in the NMRE Region utilizing the professional services of medical doctors, physician assistants, nurse practitioners, and registered nurses (including telemed/telepsychiatry). A total of 361 surveys were distributed to recipients of Medical services during the two-week snapshot

timeframe, 247 of which were returned to the NMRE for inclusion in this report. This represents a regional return rate of 68.42%, compared to FY16 of 80.81%. One provider from AuSable Valley CMH, Northeast Michigan CMH and Northern Lakes CMH did not return the tally sheet indicating the true number of surveys distributed so the number of surveys initially requested was used in these cases which has caused a lower return rate for their CMHSPs as well as the total NMRE. North Country had the highest return rate in comparison to the other CMHSPs.

Medical Services scored an overall high level of satisfaction with regional item means ranging from 3.4 to 3.83. The range of favorable responses fell between 87.25% for "I deal better with daily problems because of services," and 94.13% for "Staff treats me with dignity and respect." A trend line for FY16 and 17 has been included. All averages are above the 3.0 target prescribed by the QOC.

*Figure 4: Average Responses per Question for Outpatient Therapy Program sorted by CMHSP*

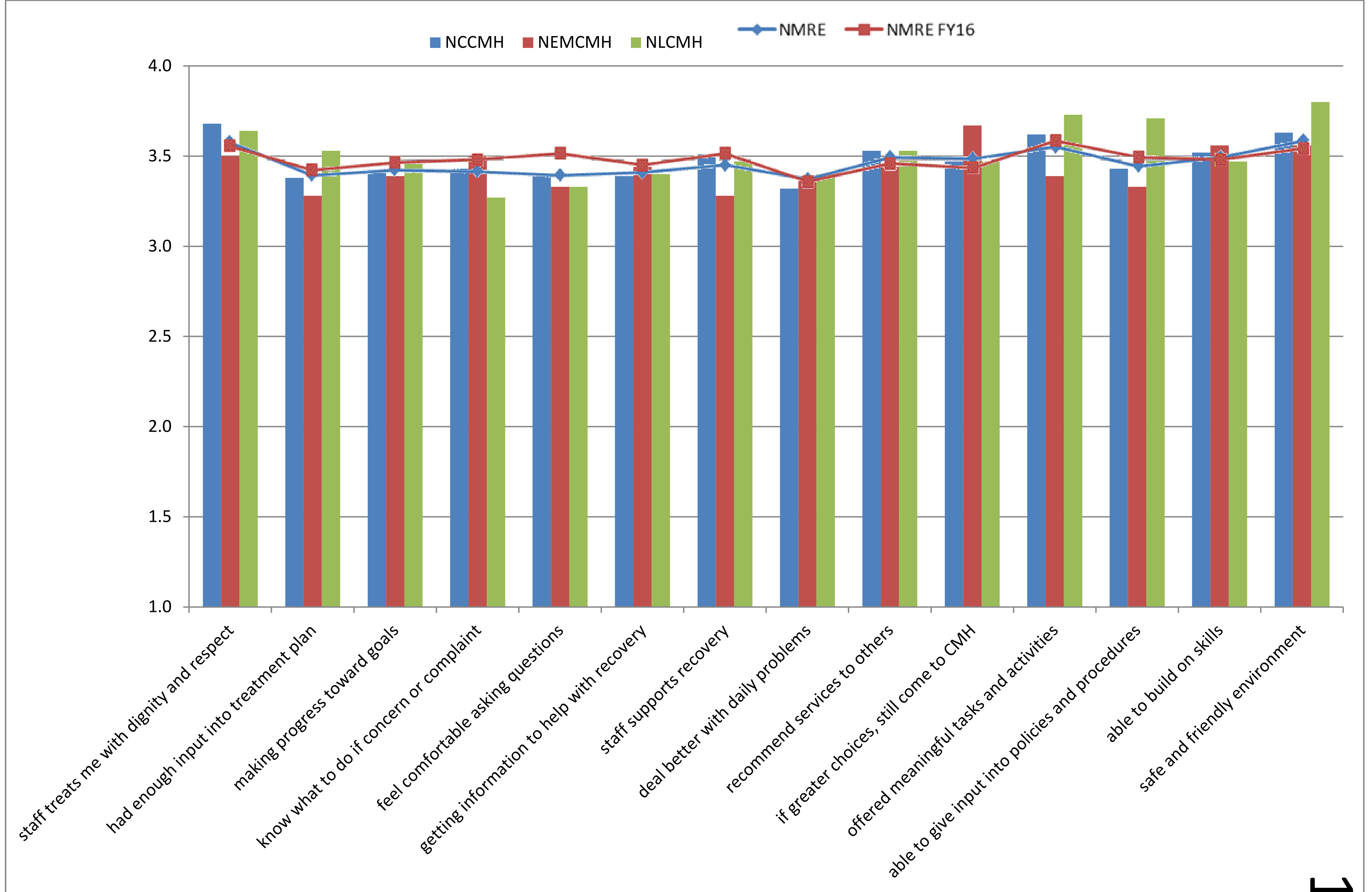



**<u>Outpatient Therapy Program</u>**

Outpatient Therapy Services are offered at every CMHSP in the NMRE region. At total of 549 surveys were distributed to recipients of Outpatient Therapy Services during the two-week snapshot timeframe, 395 of which were returned to the NMRE for inclusion in this report. This represents the largest program surveyed and had a regional return rate of 71.95%, compared to 80.81% for FY16.

Outpatient Therapy Services scored an overall high level of satisfaction with regional item means ranging from 3.46 to 3.85. Figure 4 details the average scores per questions for Outpatient Therapy services throughout the NMRE region. Favorable responses fell between 92.76% for "I deal better with daily problems because of services," and 99.50% for "Staff treats me with dignity and respect." A trend line for FY16 and FY17 has been included. All averages are above the 3.0 target prescribed by the QOC.

*Figure 5: Average Responses per Question for Psychosocial Rehabilitation/Clubhouse Program sorted by CMHSP*

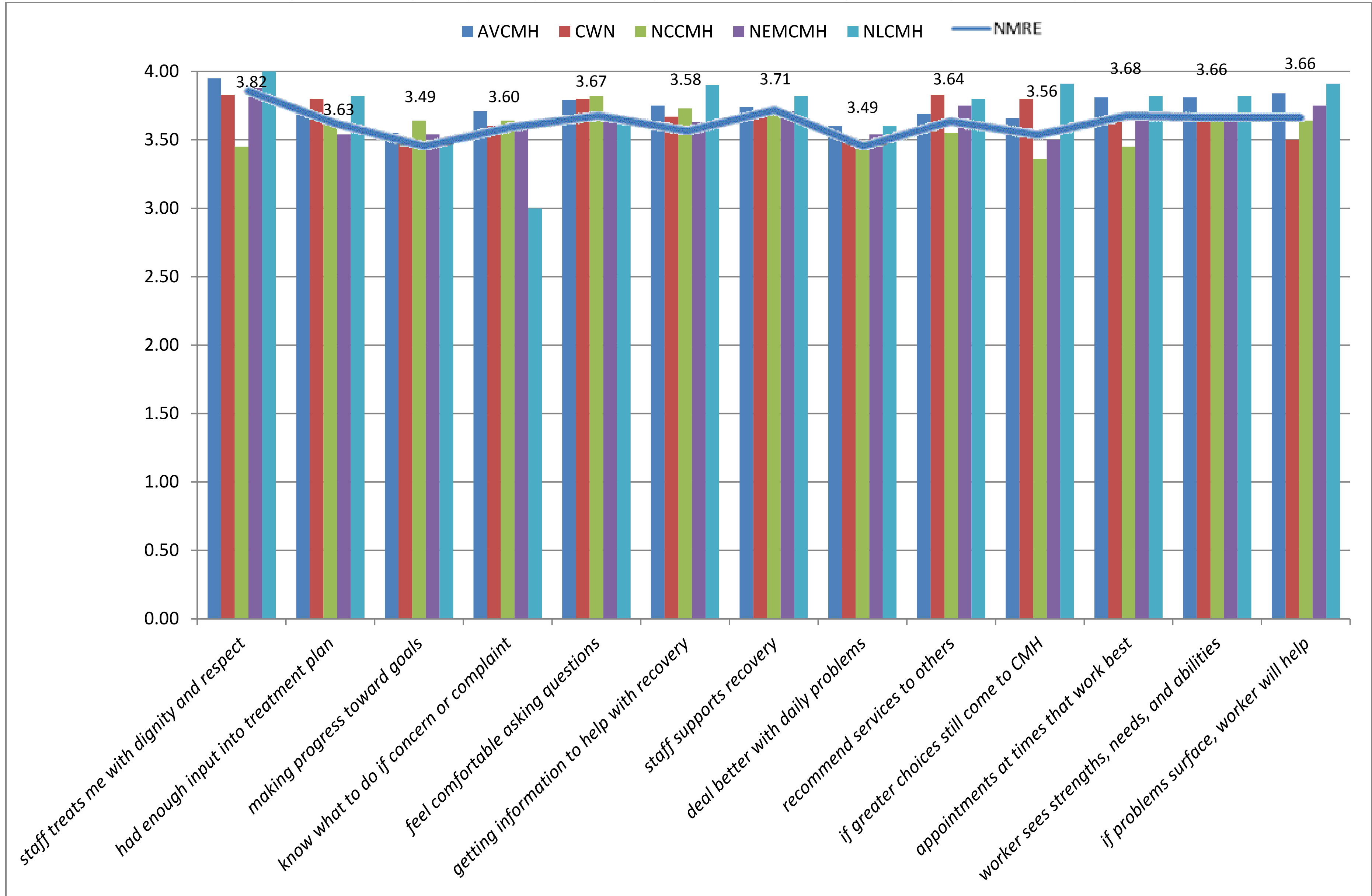


**Psychosocial Rehabilitation/Clubhouse**

Psychosocial Rehabilitation/Clubhouse services are offered by five Clubhouse Programs throughout the region. It should be noted that North Country and Northern Lakes each offer two programs while AuSable Valley CMH and Centra Wellness Network do not offer Psychosocial Rehabilitation/Clubhouse services to consumers. This may become a topic for further discussion if the State continues to push for a consistent service array across the region. No surveys were returned for the Cadillac Club, one of the two programs managed by Northern Lakes, nor was a tally sheet received so a return rate could not be calculated and is not included in any of the calculations. A total of 116 surveys, down from last year's total of 163, were distributed to recipients of Psychosocial Rehabilitation/Clubhouse services during the two-week snapshot timeframe, 95 of which were returned to the NMRE for inclusion in this report. This represents a regional return rate of 81.90%.

Psychosocial Rehabilitation/Clubhouse services scored an overall high level of satisfaction with regional item means ranging from 3.35 to 3.64 (Figure 5). Trend lines have been included to notate the overall ratings for FY16 and FY17. The range of favorable responses fell between a low of 87.23% for both "I had enough input into treatment plan" and "I know what to do if concern or complaint" and a high of 95.79% for "Staff treats me with dignity and respect." All averages are above the 3.0 target prescribed by the QOC.

*Figure 6: Average Responses per Question for Youth Case Management Program sorted by CMHSP*

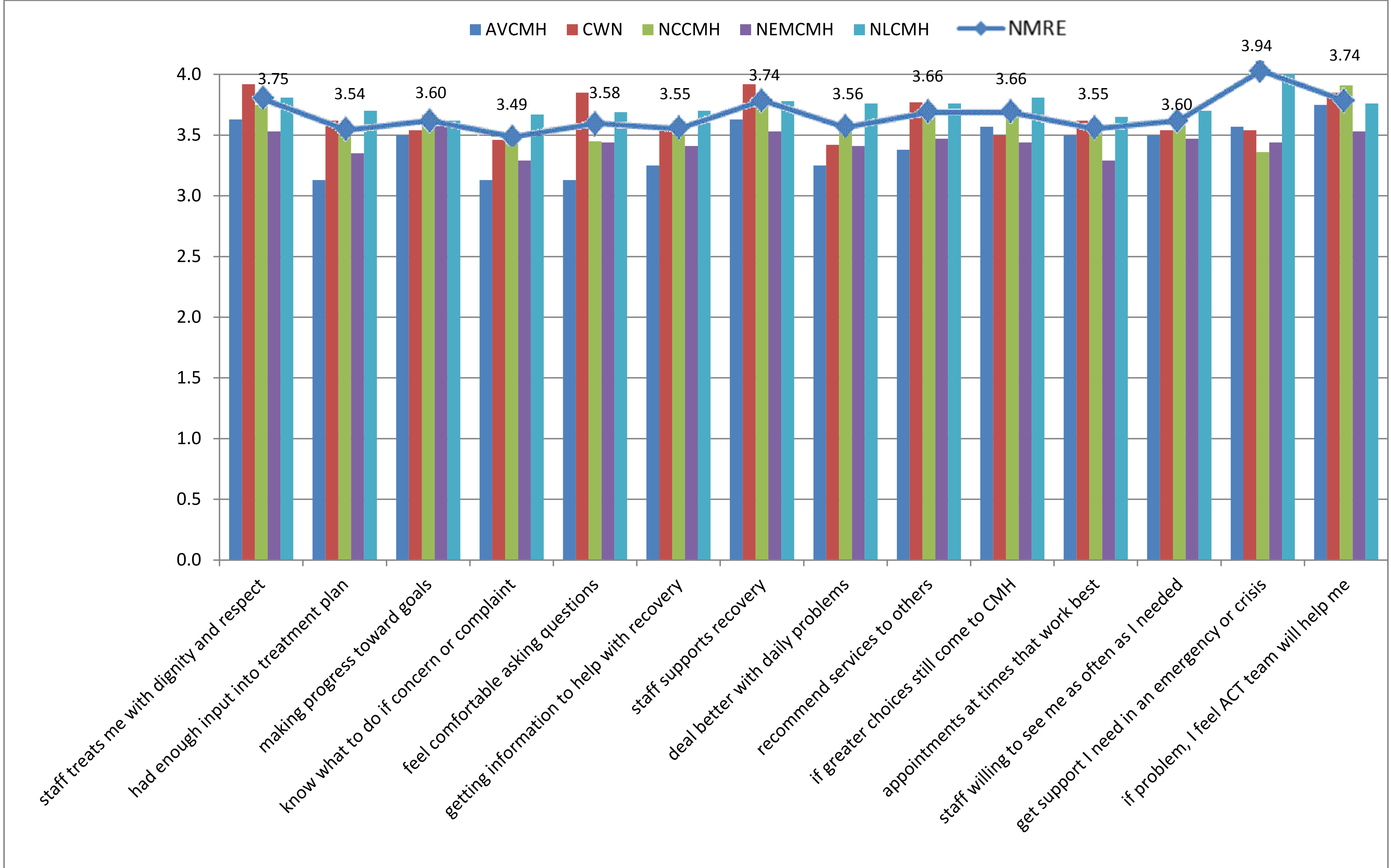



**Youth Case Management Services**

Youth Case Management Services are offered at every CMHSP in the NMRE region to consumers under the age of 18 years. A total of 168 surveys were distributed to recipients of Youth Case Management Services during the two-week snapshot timeframe, 110 of which were returned, but a tally sheet was not. The number of surveys requested by and distributed to them was used to calculate the return rate and likely had impact on their CMH having the lowest return rate.

Youth Case Management Services scored an overall high level of satisfaction with regional item means ranging from 3.55 to 3.88 as documented in Figure 6. The range of average favorable responses for Questions 1 through 10, fell between 95.41% for "If I had greater choices, I would still come to CMH" and 99.08% for "I am making progress toward my treatment goals," "I feel comfortable asking questions" and "Staff supports recovery." It is interesting that this is the only group surveyed in which the average favorable response high was not "Staff treats me with respect and dignity," although this is not of concern since the staff question has a favorable response of 98.18%. All averages are above the 3.0 target prescribed by the QOC.

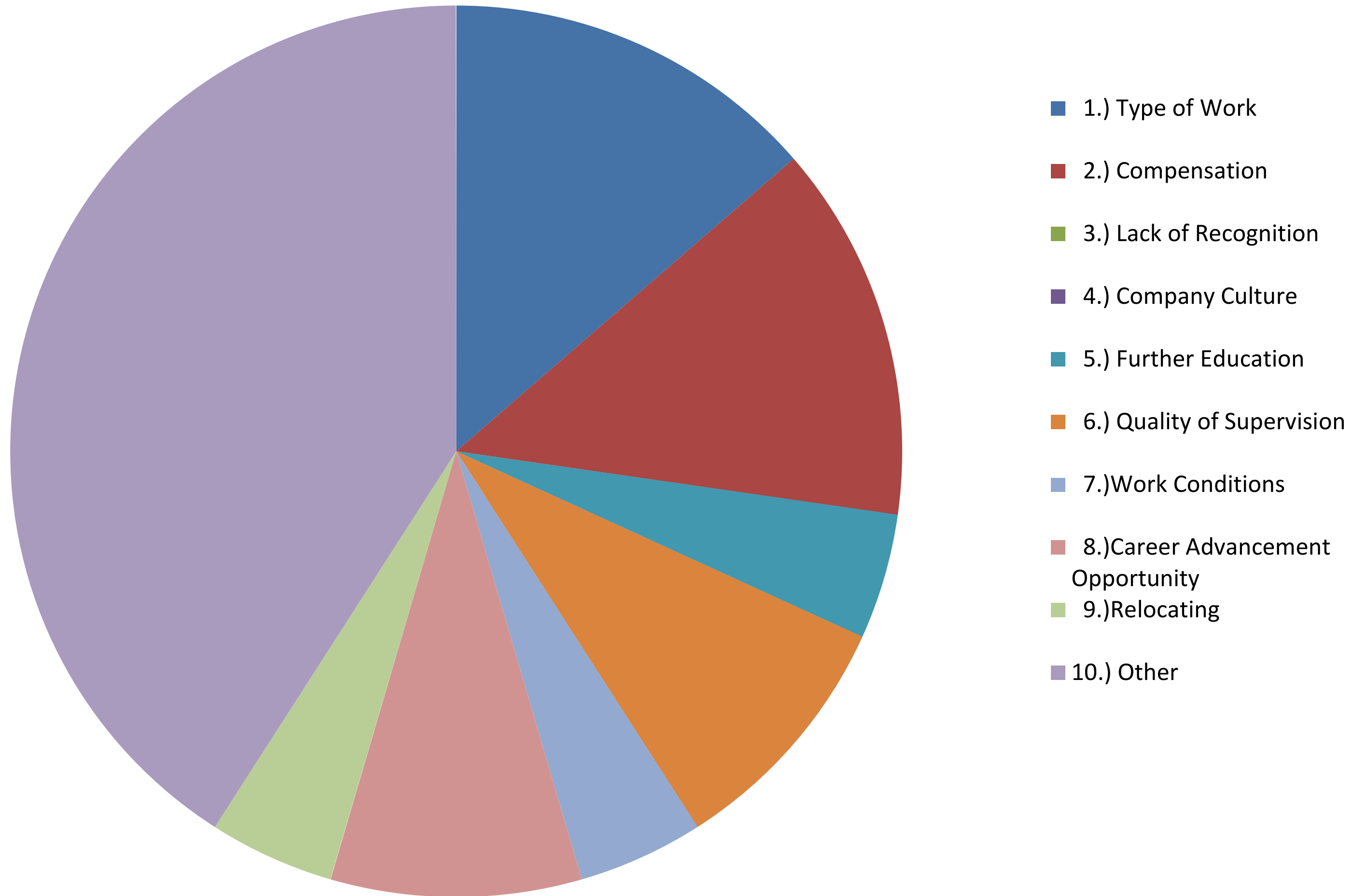
*Figure 7: Average Responses per Question for Assertive Community Treatment Program by CMHSP*

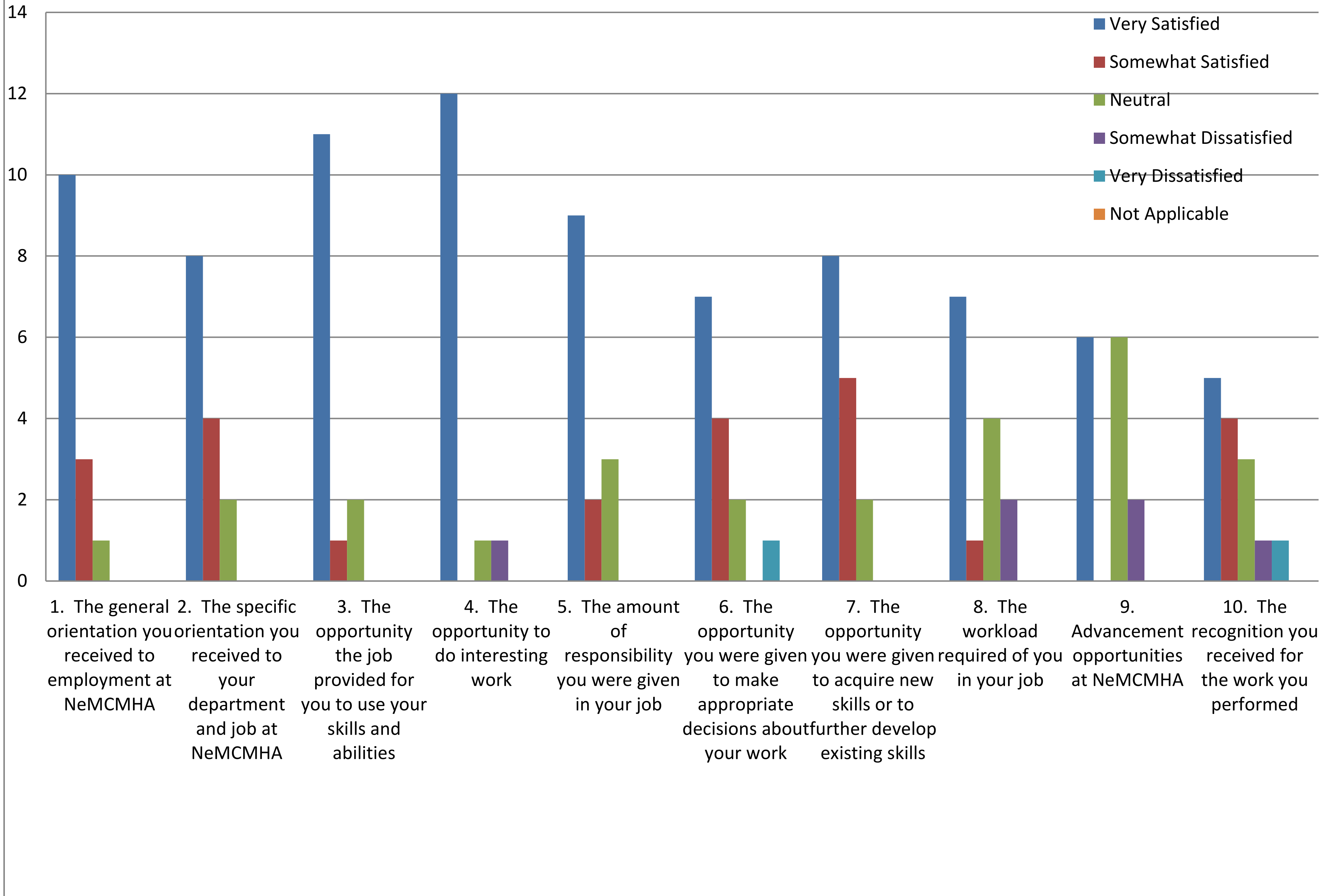


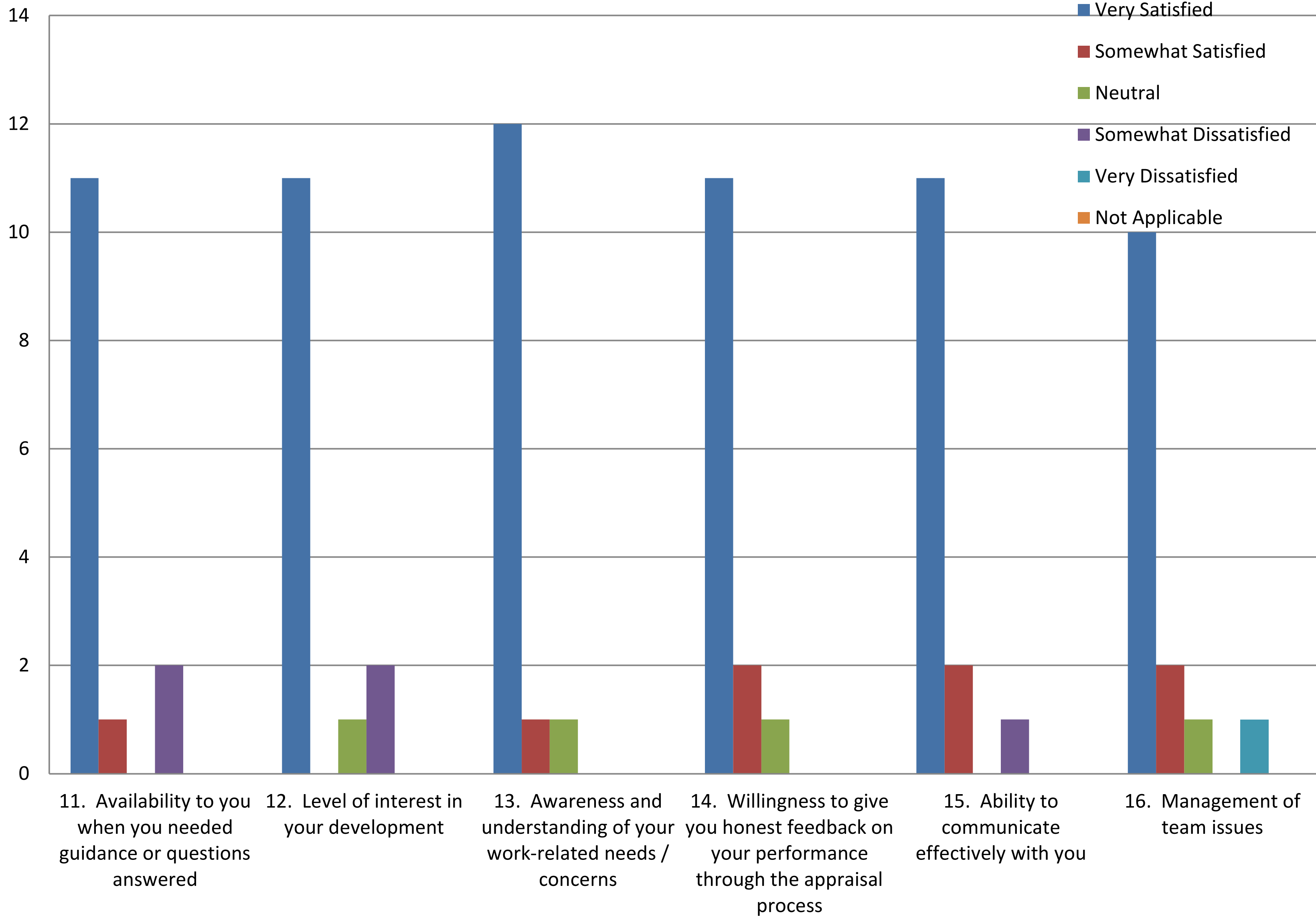
## Assertive Community Treatment (ACT)

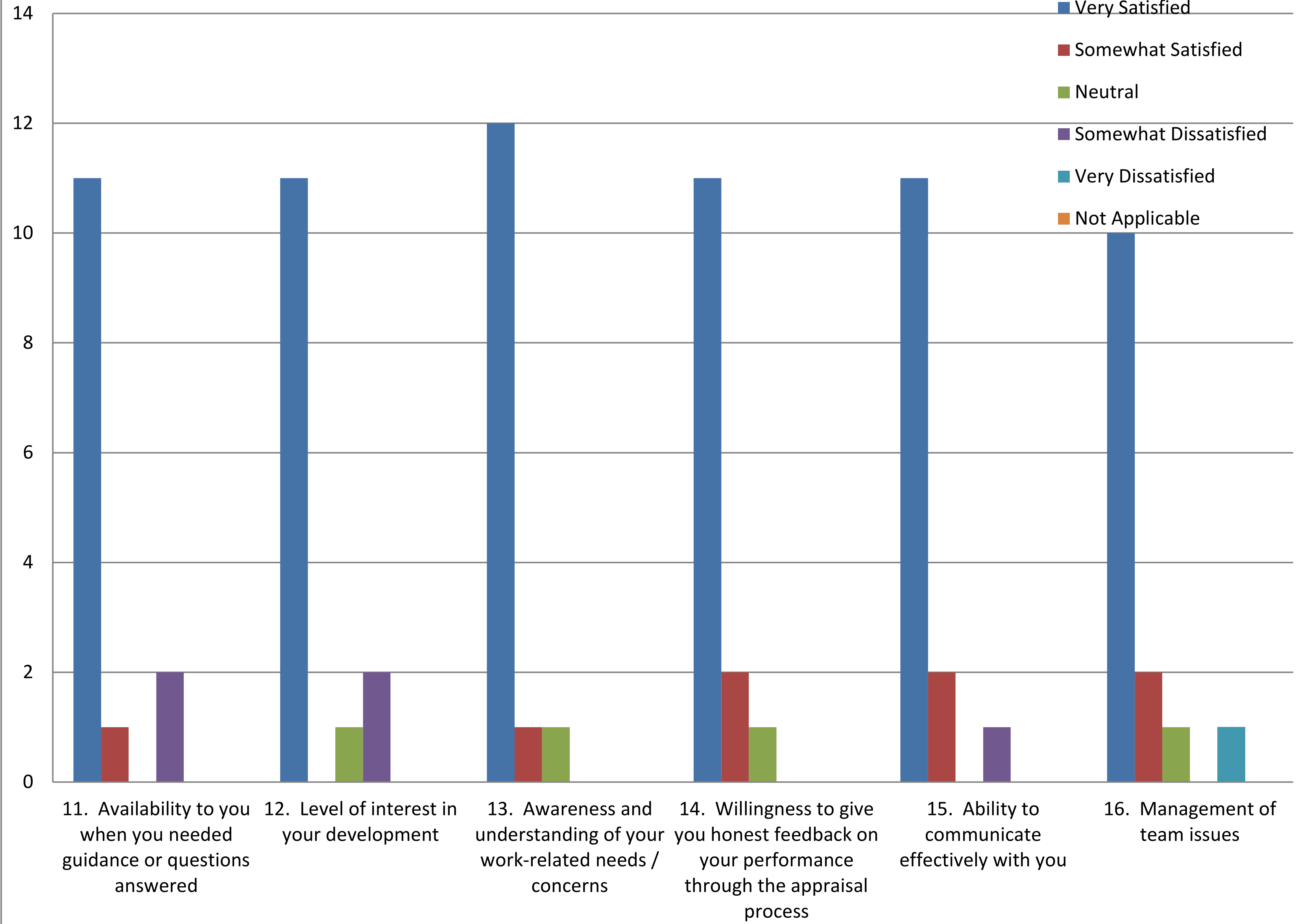
ACT services are offered at every CMHSP in the NMRE region. A total of 231 surveys were distributed to recipients of Assertive Community Treatment services during the two-week snapshot timeframe, 84 of which were returned to the NMRE for inclusion in this report. This represents a regional return rate of 36.36%, the lowest percentage compared to other programs surveyed this year. Completed surveys for fiver providers from Northeast Michigan CMH and one provider from North Country were returned, but a tally sheet was not, which certainly affected the return rates for those CMHs but also the total NMRE rate.

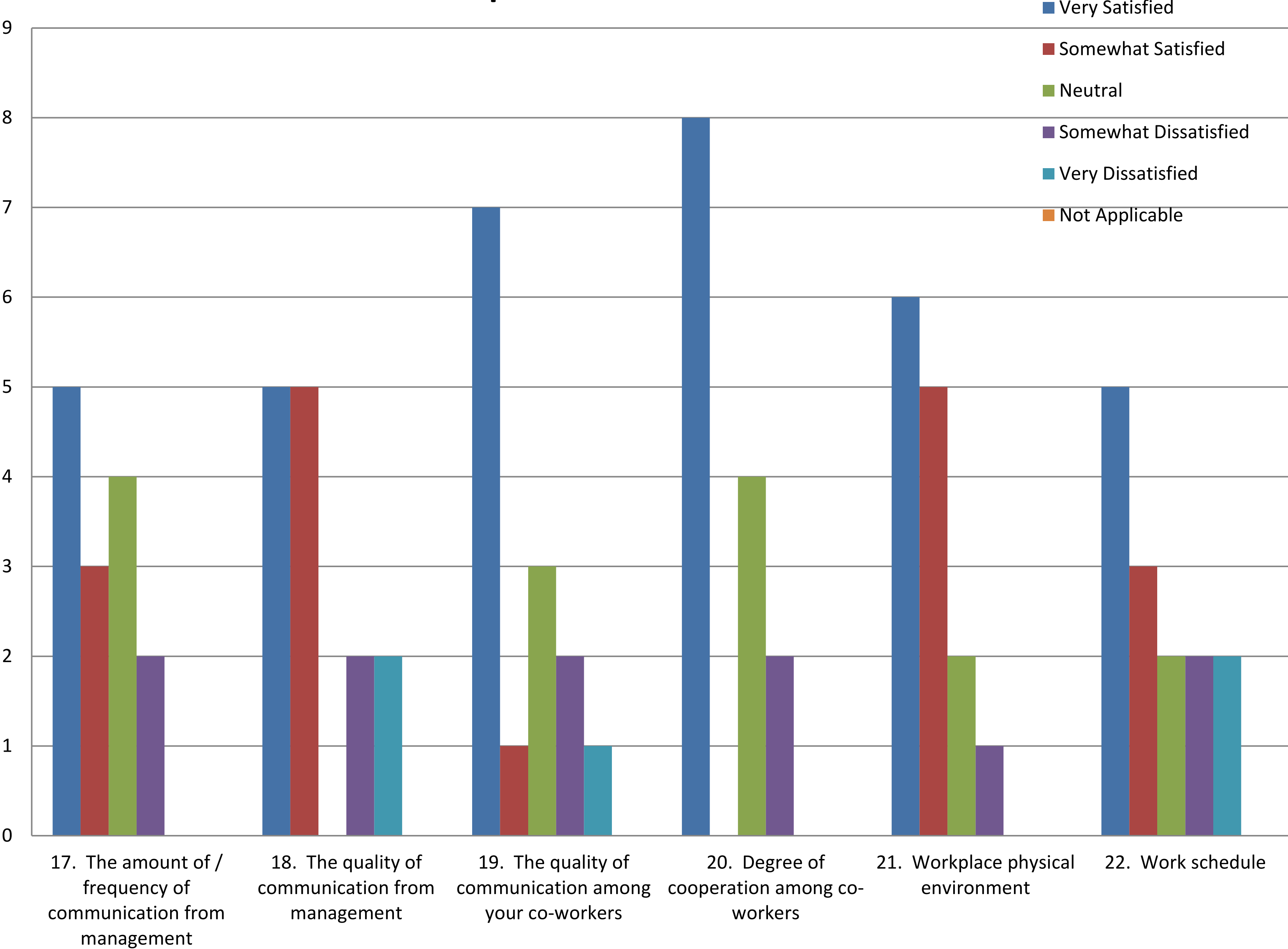
ACT services scored an overall high level of satisfaction with regional item means ranging from 3.54 to 3.75. The range of favorable responses fell between 87.21% for “I know what to do if I have a concern or complaint” and 93.68% for “Staff treats me with dignity and respect.” Figure 7 details the average scores per question for Adult Case Management services throughout the NMRE region. All averages are above the 3.0 target prescribed by the QOC.


What prompted you to seek alternative employment?
1.) Type of Work
2.) Compensation
3.) Lack of Recognition
4.) Company Culture
5.) Further Education
6.) Quality of Supervision
7.)Work Conditions
8.)Career Advancement Opportunity
9.)Relocating
10.) Other

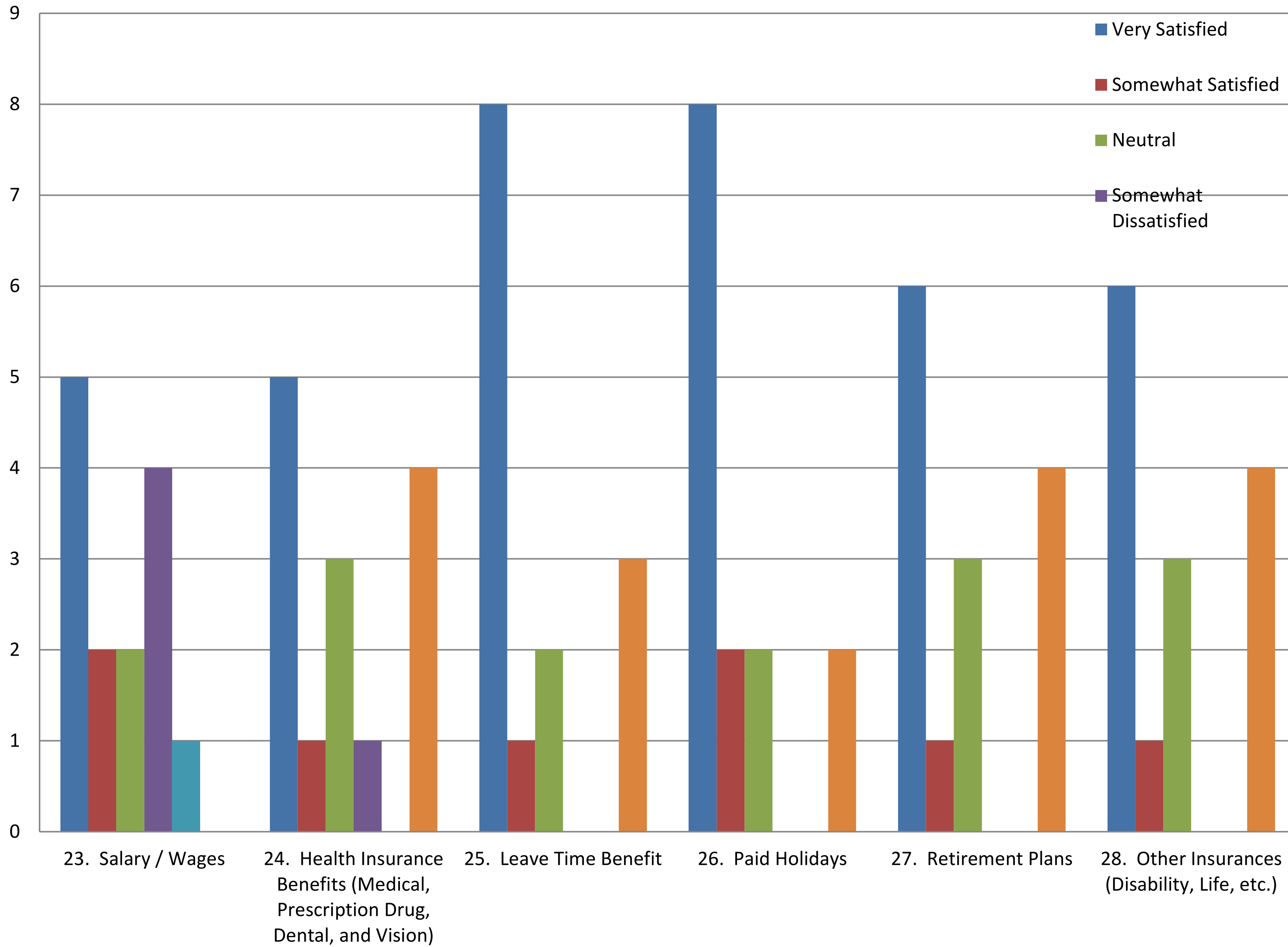

The Job
14
12
10
8
6
4
2
0
Very Satisfied
Somewhat Satisfied
Neutral
Somewhat Dissatisfied
Very Dissatisfied
Not Applicable
1. The general orientation you received to employment at NeMCMHA
2. The specific orientation you received to your department and job at NeMCMHA
3. The opportunity the job provided for you to use your skills and abilities
4. The opportunity to do interesting work
5. The amount of responsibility you were given in your job
6. The opportunity you were given to make appropriate decisions about your work
7. The opportunity you were given to acquire new skills or to further develop existing skills
8. The workload required of you in your job
9. Advancement opportunities at NeMCMHA
10. The recognition you received for the work you performed


Your Supervisor Questions
14
12
10
8
6
4
2
0
Very Satisfied
Somewhat Satisfied
Neutral
Somewhat Dissatisfied
Very Dissatisfied
Not Applicable
11. Availability to you when you needed guidance or questions answered
12. Level of interest in your development
13. Awareness and understanding of your work-related needs / concerns
14. Willingness to give you honest feedback on your performance through the appraisal process
15. Ability to communicate effectively with you
16. Management of team issues


Your Supervisor Questions
14
12
10
8
6
4
2
0
Very Satisfied
Somewhat Satisfied
Neutral
Somewhat Dissatisfied
Very Dissatisfied
Not Applicable
11. Availability to you when you needed guidance or questions answered
12. Level of interest in your development
13. Awareness and understanding of your work-related needs / concerns
14. Willingness to give you honest feedback on your performance through the appraisal process
15. Ability to communicate effectively with you
16. Management of team issues



Workplace Climate and Culture
Very Satisfied
Somewhat Satisfied
Neutral
Somewhat Dissatisfied
Very Dissatisfied
Not Applicable
9
8
7
6
5
4
3
2
1
0
17. The amount of / frequency of communication from management
18. The quality of communication from management
19. The quality of communication among your co-workers
20. Degree of cooperation among co-workers
21. Workplace physical environment
22. Work schedule



Wage and Benefit Package
9
8
7
6
5
4
3
2
1
0
Very Satisfied
Somewhat Satisfied
Neutral
Somewhat Dissatisfied
23. Salary / Wages
24. Health Insurance Benefits (Medical, Prescription Drug, Dental, and Vision)
25. Leave Time Benefit
26. Paid Holidays
27. Retirement Plans
28. Other Insurances (Disability, Life, etc.)

EXECUTIVE LIMITATIONS
(Manual Section)

**BUDGETING**
(Subject)

| | |
|---|---|
| Board Approval of Policy | April 8, 2004 |
| Last Revision of Policy Approved | June 8, 2006 |

## ●1 POLICY:

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate materially from board *Ends* priorities, risk fiscal jeopardy, or fail to be derived from a multi-year plan.

Accordingly, he or she may not cause or allow budgeting which:

1. Contains too little information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.

2. Plans the expenditure in any fiscal year of more funds than are conservatively projected to be received in that period.

3. Provides less than is sufficient for board prerogatives, such as costs of fiscal audit, board development, board and committee meetings, and board legal fees.

4. Reduce the current assets at any time to less than twice current liabilities (or allow cash and cash equivalents to drop below a safety reserve of less than $2,500,000 at any time.)

5. Endangers the fiscal soundness of future years or ignores the building of organizational capability sufficient to achieve ends in future years.

## ●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

## ●3 DEFINITIONS:

## ●4 REFERENCES:

## ●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

**BOARD MEMBERS CODE OF CONDUCT**
(Subject)

Board Approval of Policy August 8, 2002
Board Approval of Policy Revision: October 8, 2015

## ●1 POLICY:

The board commits itself and its members to ethical and businesslike conduct. This includes proper use of authority and appropriate decorum when acting as board members.

1. Members must represent unconflicted loyalty to the interests of the people of Alcona, Alpena, Montmorency and Presque Isle counties. This accountability supersedes any conflicting loyalty such as that to advocacy or interest groups and membership on other boards or staffs. It also supersedes the personal interest of any board member acting as a consumer of the organization's services.

2. Members must avoid conflict of interest with respect to their fiduciary responsibility.

   A. There must be no self-dealing or any conduct of private business or personal services between any board member and the organization except as procedurally controlled to assure openness, competitive opportunity and equal access to "inside" information.

   B. When the board is to decide upon an issue, about which a member has an unavoidable conflict of interest, that member shall absent herself or himself without comment from not only the vote, but also from the deliberation.

   C. Board members must not use their positions to obtain employment in the organization for themselves, family members or close associates. Should a member desire employment, he or she must first resign.

   D. Members will disclose their involvements with other organizations, with vendors, or any other associations which might produce a conflict.

3. Board members may not attempt to exercise individual authority over the organization except as explicitly set forth in board policies.

   A. Members' interaction with the chief executive or with staff must recognize the lack of authority vested in individuals except when explicitly board-authorized.

   B. Members' interaction with public, press or other entities must recognize the same limitation and the inability of any board member to speak for the board.

   C. Members will give no consequence or voice to individual judgments of CEO or staff performance.

4. Members will respect the confidentiality appropriate to issues of a sensitive nature.

5. Members will be properly prepared for board deliberation.

6. All special gifts, donations, and bequests to the Board and its members shall be reported to the Board. Board members shall not accept gifts, gratuities, entertainment or other favors from any party under contract with, seeking to do business with or receiving services from Northeast Michigan Community Mental Health Authority.

   A. If fixed property or equipment is donated to the Board, the Board shall determine the fair market value of that property at the time of transfer. If only the use of the property is donated and such usage shall be for matching any other funds, the amount allowed to be matching shall be determined by the fair market value upon the evaluation of an independent appraiser.

**●2 APPLICATION:**

The Northeast Michigan Community Mental Health Authority Board

**●3 DEFINITIONS:**

**●4 REFERENCES:**

**●5 FORMS AND EXHIBITS:**

_______________________________ _______________________
Signature Date

_______________________________
Printed Name

**NORTHERN MICHIGAN REGIONAL ENTITY**
**BOARD MEETING**
**10:00AM, JANUARY 24, 2018**
**CROSS STREET CONFERENCE ROOM, GAYLORD**

| | |
|---|---|
| **BOARD MEMBERS IN ATTENDANCE:** | **Roger Frye, Ed Ginop, Annie Hooghart, Gary Klacking, Terry Larson, Jay O'Farrell, Dennis Priess, Richard Schmidt, Karla Sherman, Joe Stone, Don Tanner, Nina Zamora** |
| **BOARD MEMBERS ABSENT:** | **Carol Crawford, Randy Kamps, Gary Nowak** |
| **STAFF IN ATTENDANCE:** | **Richard Carpenter, Christine Gebhard, Chip Johnston, Karl Kovacs, Eric Kurtz, Mary Marlatt-Dumas, Brian Martinus, Cathy Meske, Christine Pudvan, Paul Rebandt, Dee Whittaker, Deanna Yockey, Carol Balousek** |
| **PUBLIC IN ATTENDANCE:** | **Chip Cieslinski, Sue Winter** |

CALL TO ORDER
Let the record show that, in the absence of Chairman Kamps, Vice-Chairman Roger Frye called the meeting to order at 10:03AM.

ROLL CALL
Let the record show that Carol Crawford, Randy Kamps, and Gary Nowak were absent with notice for the meeting on this date. All other Board Members were present.

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 November meeting of the Northern Michigan Regional Entity Governing Board were included in the materials for the meeting on this date.
**MOTION MADE BY RICHARD SCHMIDT TO APPROVE THE MINUTES OF THE DECEMBER 27, 2017 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, SECOND BY ANNIE HOOGHART. MOTION CARRIED.**

APPROVAL OF AGENDA
No additions or changes were proposed to the agenda for the meeting on this date.
**MOTION MADE BY DENNIS PRIESS TO APPROVE THE AGENDA FOR THE JANUARY 24, 2018 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, SECOND BY DON TANNER. MOTION CARRIED.**

CORRESPONDENCE
- THE PIHP Revenue Analysis for DAB population from Rehman dated December 2017.
- A letter to Eric Kurtz from Jeff Wieferich, Director of Quality Management and Planning Division, Bureau of Community Based Services at MDHHS, dated December 28, 2017 requesting additional data

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on Assertive Community Treatment, Intensive Crisis Stabilization, Crisis Residential, Crisis Intervention. Pre-Admission Screening, and Partial Hospitalization services offered throughout the region.

- Proposed Policy Draft from MDHHS and MSA on the MI Marketplace Option benefit plan and Healthy Michigan Plan program updates (effective date April 1, 2018).
- An email from Robert Sheehan at CMHAM discussing the Association's activity relative to Section 298 Pilot RFI.
- Recommended principles and design elements of the system redesign and refinement effort (related to Section 298 Pilots) from CMHAM listing eight essential core elements.
- Several documents from the Michigan Consortium for Healthcare Excellence (MCHE). (Further discussion under "New Business.")
- The CMHAM Director's Report for January 2018.
- Enrolled Senate Bill No. 649, dated December 19, 2017 (effective March 20, 2018) to release 298 pilots from the Act.
- MDHHS/BHDDA Veteran and Military Service Members Three-Year Strategic Plan Supplement, updated December 2017.
- House CARES Task Force Final Report, Michigan House of Representatives, issued January 17, 2018.

Regarding the DAB issue, Karla Sherman asked whether the Rehman report was widely distributed. Mr. Kurtz responded, it was, but there are two sides to the information. From the standpoint of MDHHS, it reflects the changes in enrollment , and from the standpoint of CMHAM and its partner CMHSPs (and PIHPs), it's a real loss in revenue.

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 then public during the meeting on this date.

REPORTS

**Board Chair/Executive Committee Report**

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

**CEO Report**

The CEO Report for January 2018 was included in the materials for the meeting on this date. Mr. Kurtz mentioned that the meeting with War Memorial, on January 22nd, was turned into a conference call due to the ice storm. Mr. Kurtz attended the Centra Wellness Network Board retreat on the 19th; Don Tanner thanked him for being present.

**SUD Board Report**

The minutes of Northern Michigan Regional SUD Oversight Board meeting for January 8, 2018 were included in the materials for the meeting on this date. Jay O'Farrell informed the Board that a law firm out of Traverse City has been contacting various Boards of Commissioners regarding filing lawsuits pertaining to the opioid crisis. The intent is to take civil action against drug companies and potentially insurance companies. NMRE SUD Oversight Board Member, Chuck Welsh, stated, in the January 8th meeting, that Grand Traverse, Chippewa, and Leelanau Counties had already engaged with the law firm. Chip Johnston added that Manistee and Benzie Counties are also involved, and the number of counties is growing. It was noted that another firm from Grand Rapids is involved.

A discussion of the potential that the PIHPs may have some damages to recoup followed. A significant amount of resources is being spent to combat the opioid/heroin epidemic. At this point, there is a question



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of whether the PIHPs would have standing in court; it's clear that counties would. The law firm has stressed it is not a class action law suit. Funds returning to counties are not necessarily earmarked to address the crisis. Mr. Stone commented that steering funds toward prevention and treatment makes the most sense. Cathy Meske noted that tobacco tax launched respite care and some current b3 services. Mr. O'Farrell added that he believes there was a stipulation with the tobacco tax to direct funds to CMHSPs, noting it took about 10 years to do so.

**Finance Report**
The NMRE Monthly Financial Report for November 2017 was included in the materials for the meeting on this date. Richard Carpenter reported first couple of pages show that DAB enrollees are below last year at this time, but close to the end of FY17. The hope is that this remains flat. Mr. Carpenter noted TANF is also staying flat, though HMP has increased. Revenue is above FY17 due to rate adjustment, much of which has already been spoken for (direct care wage increase, autism revenue backed into DAB/TANF). HAB waiver decline is likely due to a payment issue at the State that has been experienced by additional PIHPs. NMRE received twenty-three additional slots in FY17, and five or six more recently. Packets are kept on standby at the NMRE.

Traditional Medicaid shows a surplus of $1.5M. The CMHSPs have estimated direct care wage (DCW) increase in costs, which may fluctuate as actual payments go out. A small deficit is shown for HMP of $13K; Medicaid may be used to offset. Mr. Carpenter cautioned that we are still in audit prep for FY17; numbers could change a bit as accruals are booked. Mr. Stone asked about using Medicaid to pay for HMP shortfall. If the State is shorting HMP, using Medicaid to subsidize isn't a long-term solution. Mr. Carpenter agreed. A discussion of the impact of the HMP shortage and the impact on DAB rates followed.

<u>NEW BUSINES</u>
**SUD Liquor Tax Requests**
A summary of the liquor tax requests recommended by the NMRE SUD Oversight Board were included in the materials for the meeting on this date. Richard Schmidt expressed that the summary is inconsistent with the full requests reviewed by the SUD Board; he stressed the need for that the information be the presented in the same manner. The second request was for Crawford County in the amount of $59K, 66.5% of its $90K balance. Representatives from Crawford County were in attendance and supported the expense.
**MOTION MADE BY JOE STONE TO APPROVE THE LIQUOR TAX REQUESTS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON JANUARY 8, 2018, SECOND BY NINA ZAMORA. MOTION CARRIED.**

**MOTION MADE BY JOE STONE TO INCLUDE LIQUOR TAX BALANCE AMOUNTS, ALONG WITH AMOUNTS REQUESTED FOR TARGETED SPENDING, WHEN SEEKING APPROVAL OF THE NORTHERN MICHIGAN REGIONAL ENTITY GOVERNING BOARD FOR LIQUOR TAX FUNDS, SECOND BY KARLA SHERMAN. MOTION CARRIED.**

**NMRE Board Meeting Schedule**
The fiscal year 2018 Board meeting schedule was included in the materials packet for the meeting on this date.
**MOTION MADE BY DENNIS PRIESS TO ADOPT THE NORTHERN MICHIGAN REGIONAL ENTITY GOVERNING BOARD SCHEDULE AS PRESENTED, SECOND BY ED GINOP. MOTION CARRIED.**

**NMRE Policy/Procedure Review & Revamp**
Mr. Kurtz stated he has reviewed the NMRE's Bylaws and the Policies and Procedures submitted to the state in the Application for Participation (AFP) to form the Regional Entity. He reported NMRE staff

members are in the process of reviewing policies to reflect current business practices and adherence to Managed Care Rules. He asked what role the Board wanted to play in the process of approving policies, noting there will be many coming through in the coming months. Mr. Tanner recommended that the Board Policy Committee be reconvened. Mr. Larson suggested that the full Board review a few policies each Board meeting after they have been recommended by the Policy Committee. Policies will be reviewed by the Operations Committee as needed.

**Michigan Consortium for Healthcare Excellence (MCHE)**

When it transitioned from the Michigan Association of Substance Abuse Coordinating Agencies (MASACA), the MCHE was formed as a new non-for profit. When Mr. Kurtz joined the NMRE last year, he was appointed to its Board (replacing the previous CEO). The Board meets every other month. Current financial reports show a balance of $2,050 in the account. Mr. Kurtz discussed the group's activities. The NMRE Board previously indicated that, if dues are charged for membership, it no longer wishes to participate. Clarification was made that this still holds true, but a new board vote would be requested, or if other factors leading toward its continuation arise.

OLD BUSINESS

**SUD Health Home Update**

Mr. Kurtz indicated that progress is moving rapidly. The State is looking at an October 2018 kickoff. There is not anticipated problems from CMS. Licensing revenue from marijuana facilities is coming through as expected. The State is scheduling a visit to the region in February. The Budget Office is on board, Medicaid is at the table, and everything seems to be coming into place. Mr. Kurtz will update as progress is made.

PRESENTATION

**PIHP Regional Environmental Update**

Mr. Kurtz distributed a handout to attendees on this date. He discussed the current external environment, which he felt was important prior to the upcoming Board Association Conference. Mr. Kurtz emphasized that the Regional Entities were formed "pursuant to the authority granted under the Mental Health Code." Mr. Kurtz reiterated the powers granted to a regional entity. He discussed his view of the NMRE as a "provider sponsored" health plan. Mr. Kurtz continued, "the NMRE is here to serve the regional partners as an administrative support system." The NMRE's draft Strategic Plan will come to the Board for discussion in February.

COMMENTS

**Board**

Mr. Stone announced the CMHAM Spring Conference will be held in Novi. Discussions of eliminating the Winter Conference are stalled but will be addressed in February.

**Staff/CEOs**

It was noted that Roger Frye and Dennis Priess will both be in Florida for the February Board meeting. Attempts will be made for them to attend via Skype.

NEXT MEETING

The next meeting of the Northern Michigan Regional Entity Governing Board is scheduled for 10:00AM on February 28, 2018 in the Cross Street Conference Room in Gaylord.

ADJOURN

**MOTION MADE BY JOE STONE TO ADJOURN THE MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY GOVERNING BOARD FOR JANUARY 27, 2018, SECOND BY ED GINOP. MOTION CARRIED.**

Let the record show that Mr. Frye adjourned the meeting at 11:43AM.

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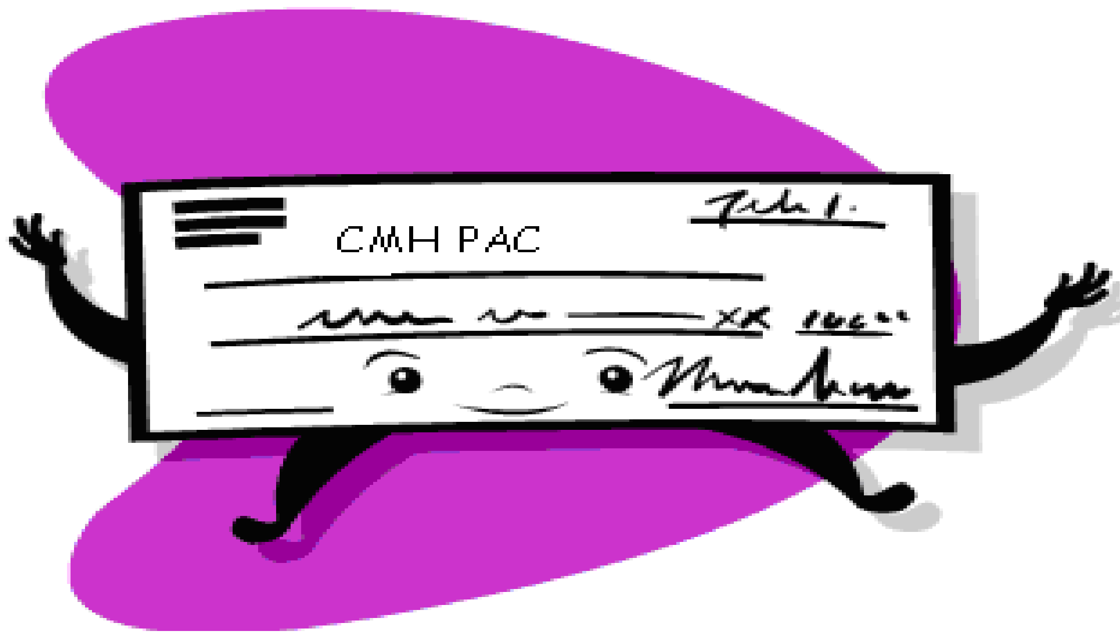
| | Program | Consumers served January 2018 | Consumers served since May 2017 |
|---|---|---|---|
| 1 | **Access / Crisis / Prescreens** | 66 - Routine<br>91 Crisis<br>37 Prescreens | 579 Routine<br>1 Emergent<br>3 Urgent<br>738 Crisis<br>378 Prescreens |
| 2 | **Doctors' Services** | 1184 | 1493 |
| 3 | **Case Management** | | |
| | Older Adult (OBRA) | 142 | 166 |
| | MI Adult | 259 | 348 |
| | MI ACT | 35 | 44 |
| | Home Based Children | 5 | 11 |
| | DD | 337 | 368 |
| 4 | **Outpatient Counseling** | 196(27/169) | 459 |
| 5 | **Hospital Prescreens** | 37 | 378 |
| 6 | **Private Hospital Admissions** | 21 | 212 |
| 7 | **State Hospital Admissions** | 0 | 4 |
| 8 | **Employment Services** | | |
| | DD | 105 | 111 |
| | MI | 57 | 79 |
| | PSR Clubhouse | 65 | 71 |
| 9 | **Peer Support** | 66 | 74 |
| 10 | **Community Living Support Services** | | |
| | DD | 152 | 154 |
| | MI | 198 | 233 |
| 11 | **CMH Operated Residential Services** | | |
| | DD Only | 59 | 62 |
| 12 | **Other Contracted Resid. Services** | | |
| | DD | 37 | 37 |
| | MI | 29 | 31 |
| 13 | **Total Unduplicated Served** | 1547 | 1937 |

| | Unduplicated Consumers Served Since May 2017 |
|---|---|
| **Alcona** | 232 |
| **Alpena** | 1393 |
| **Montmorency** | 217 |
| **Presque Isle** | 261 |
| **Other** | 67 |




TO: Board Members

FROM: Gary Nowak, Chair

SUBJECT: CMH PAC

Please remember last month we discussed our support of the CMH PAC. Please consider a donation. The Board Association's recommendation is the equivalent of one monthly per diem but anything you are comfortable in donating would certainly be appreciated and Cathy has indicated that she would match up to $400 ***so let's make her pay!***

If you wish to pay by check, it must be a personal check made out to "CMH PAC." Business checks are not accepted. Diane will collect any donations and send them as a group to the Board Association.

INTEROFFICE MEMORANDUM

**TO:** Board Members

**FROM:** Cathy Meske

**SUBJECT:** Director's Report

**DATE:** February 27, 2018

---

**Home and Community-Based Services (HCBS) Rule Update**

Currently we have four residential providers on the heightened scrutiny survey list and five participants who have not responded to the survey. Our staff are working with consumers and providers to develop corrective action plans as needed.

**Application for the Michigan Employment First Initiative Rate Restructuring Technical Assistance**

Northeast has applied for the MDHHS sponsored technical assistance last week. This technical assistance will focus on those 25 individuals currently employed by NEMROC and are part of an enclave/Mobile crew in developing independent supportive employment. As you are aware, the HCBS Rule currently supports competitive employment where an employee is able to work alongside of a person without a disability. Enclaves/Mobile Crews are not in compliance with this rule. With the added support, we are hoping to develop additional employment opportunities for those specific individuals.

**CMHAM request for legal opinion regarding fiscal liability of CMHs, PIHPs and MDHHS**

CMHAM requested a legal opinion from the Cohl, Stoker & Toskey, P.C law firm regarding the "fiscal responsibility/liability of the PIHP and CMHs within a PIHP's region as well as the State's responsibility to fund the obligations of the PIHP when a PIHP cannot do so, as outlined in statute, the state constitution and supported by the Attorney General's opinions." The opinion states, "the PIHP and only the PIHP, that has financial liability to MDHHS under the Master Contract. The constituent CMHSPs whether as subcontractor or otherwise, have no contractual liability for the PIHP's financial obligations under the Master Contract. If the PIHP fails to meet is obligations, the MDHHS should cover the shortfall, as it is the State that is ultimately responsible to provide mental health services to the residents of the State." [See attached opinion.]

**Personnel Policy Review**

As you are aware, Northeast has a substantial personnel manual, from employment recruitment, employment agreements and contracts, client services and Administrative policies. Many of the original policies have been in place for 30+ years and were written with the assistance of an attorney. Although all of the policies are reviewed and updated regularly (using a perpetual calendar of reviews), we have not had an attorney look at them except when we had a legal question specific to an identified policy. Lisa Anderson and I have met with four law firms that came from recommendations of other CMHSP Directors and HR coordinators. All had experience with employment law, trial law, contracts and two were familiar with the Mental

Health Code and the MDHHS contracts and the boilerplate language associated with those contracts and one attorney was familiar with the Mental Health Code, MDHHS contracts and Medicaid Fair Hearings. As you can imagine the hourly rate from those different firms varied as well; ranging from $340.00 per hour to $150.00 per hour. Currently Northeast pays an attorney $250.00 per hour. I do believe it is time to have our employment policies and contracts reviewed by an attorney. There are two attorneys who I believe would address this project: Chris Cooke from the Neuman Law Group in Traverse City for matters specific to client services and state contractual obligations and Liz Peters from MASUD Labor Law Group in Saginaw for employment matters. Mr. Cooke's hourly rate is $150.00 per hour and Ms. Peter's hourly rate is $190.00 per hour.

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February 22, 2018

***Attorney-Client Privileged***

Robert Sheehan, CEO
Community Mental Health Association of Michigan
426 South Walnut Street
Lansing, MI 48933

Re: Non-liability of CMHSP's for PIHP's Risk under MDHHS Master Contract

Dear Mr. Sheehan:

This is in response to your question regarding whether the constituent Community Mental Health Service Programs (CMHSP's) of a Regional Entity Pre-Paid Inpatient Health Program (PIHP) may be held liable for the PIHP's contractual financial obligations to the Michigan Department of Health and Human Services (MDHHS), specifically, for expenses incurred by the PIHP in excess of the revenues and reserves possessed by the PIHP.

We have reviewed the standard MDHHS/PIHP Master Agreement for Medicaid Funds for FY 2018 (Master Contract). This Master Contract is a cost reimbursement contract, with MDHHS funding obligated through Medicaid capitation payments, contingent on the annual Appropriation Act.

The Master Contract is between MDHHS and the PIHP only. The CMHSP's in the PIHP's region are not a party to the Master Contract, and therefore cannot be held financially liable for the contractual obligations of the PIHP or MDHHS, unless they separately agreed to do so by contract with the PIHP. There is no indication in the Master Contract that any person or entity other than the PIHP could be held liable.

For example, Part I, Sec. 38 of the Master Contract specifies that the PIHP shall be held "solely and fully responsible" to execute all provisions of the Contract, whether or not those provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor. Section 38 also expressly states that MDHHS is not a party to any of the PIHP's

subcontracts, and not a party to any employer/employee relationship with the subcontractor of the PIHP.

Further, in Part II, Sec. 1.3, the PIHP "shall be responsible for payment for services that the PIHP authorizes." Under Part II, Sec. 7, the PIHP "remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its provider networks."

Additional provisions in the Master Contract indicate that the PIHP is solely liable. In developing an overall financial plan under the Master Contract, the PIHP is required in Part II, Sec. 8.6 to consider (a) the parameters of the MDHHS/PIHP shared-risk corridor, (b) the reinvestment of savings, and (c) the strategic approach in the management of risk.

The assumption of a shared-risk arrangement between the PIHP and the MDHHS does not permit the PIHP to overspend its total operating budget for any fiscal year. The PIHP's financial responsibility for liabilities for costs between 100% and 110% must first be paid from the PIHP's Internal Service Fund (ISF) for risk funding, or from insurance for cost over-runs. If the PIHP's liability exceeds the amount available from ISF and insurance, other funding available to the PIHP may be utilized in accordance with the terms of the PIHP's Risk Management Strategy. (Part II, Sec. 8.6.1) The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by the PIHP to assure that its risk commitment is met.

The PIHP shall also develop and implement a reinvestment strategy for all Medicaid savings realized. In this regard, only a PIHP may earn and retain Medicaid savings. CMHSPs may not earn or retain Medicaid savings. (Part II, Sec. 8.6.2)

The Master Contract in Part II, Sec. 8.6.4 states that the PIHP must provide to MDHHS, upon request, documentation that demonstrates financial risk protections sufficient to cover the PIHP's determination of risk. The PIHP must update this documentation any time there is a change in the information. The PIHP may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF.

The relevant provisions from the Master Contract set forth above indicate that it is the PIHP, and only the PIHP, that has financial liability to MDHHS under the Master Contract. The constituent CMHSP's, whether as subcontractor or otherwise, have no contractual liability for the PIHP's financial obligations under the Master Contract.

If the PIHP fails to meet its obligations, the MDHHS should cover the shortfall, as it is the State that is ultimately responsible to provide mental health services to the residents of the State. See, e.g., Const 1963, art. 4, §51, art. 8, §8; MCL 330.1116. In OAG, 1979-1980, No. 5665 (February 22, 1980), the Attorney General opined that, under MCL 330.1116, the Department has the duty "to ensure that mental health services are available to all citizens of the State." Other provisions of the Mental Health Code reflect a legislative intent that the State has financial responsibility for the provision of mental health services. See, e.g., MCL

330.1202(1), which requires that the State financially support community mental health services administered under the Mental Health Code, MCL 330.1240 (all expenditures by a community mental health services program necessary to execute the program shall be eligible for state financial support), and MCL 330.1308(1)(subject to actual appropriations, State shall pay 90% of annual net cost of community mental health service programs).

If this issue leads to a dispute, Part II, Sec. 19 of the Master Contract allows for such disputes to be resolved through the dispute resolution process, which involves the PIHP making a written request for a meeting between agents of the PIHP and the MDHHS.

If you have any questions, do not hesitate to contact me.

Very Truly Yours,

COHL, STOKER & TOSKEY, P.C.

Timothy M. Perrone

TMP/gmk

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ESTIMATED FTE EQUIVALENTS

CMHSP: Northeast Michigan Community Mental Health
Contact name/e-mail: Cathy Meske/csmeske@nemcmh.org

## TABLE 1 - Total Workforce in Specialized Residential Settings

| | FTEs and Est DCW Cost | Actual Filled as of 9/30/17 | Approved Vacancies | Total Actual and Approved |
|---|---|---|---|---|
| | **Workforce in Specialized Residential Settings** | | | |
| 1 | **Specialized Residential Settings** | | | |
| 2 | a. CMHSP Employees | 94.4 | 0 | 94.4 |
| 3 | b. Contract Agency Staff | 60.8 | 0 | 60.8 |
| | | | | |
| 4 | Total | 155.2 | 0 | 155.2 |

## TABLE 2 - Total Workforce in Other Settings

| | Total Workforce FTEs | Actual Filled as of 9/30/17 | Approved Vacancies | Total Actual and Approved |
|---|---|---|---|---|
| 5 | CMHSP Employees | 91.5 | 0 | 91.5 |
| 6 | Contract Agency Staff | 54.5 | 0 | 54.5 |
| 7 | Total | 146 | 0 | 146 |

**Expected FY 18 Workforce Changes**

Provide a brief description (1-2 paragraphs) of expected FY 18 workforce changes

The CMHSP FTE Information is centrally maintained. Contract Agency Staff estimate based upon pro rata projection of directly operated specialized residential sites FTE's onto contractual costs assuming the same staff to client ratios exist. Again this year we are expecting recruting difficulites for direct care workers and Master Level Social Workers. However we have changed our recrutiment strategies to an on-line advertising approach which has improved applicant flow. We have also increased wages for direct support staff which has also improved applicant flow and helped us complete with local corporate retailers.

Also, please provide a brief description of the source of the FTE information (e.g. centrally maintained, surveyed providers, etc.)

CMHSP: Northeast Michigan Community Mental
Period: October 1, 2016 to September 30, 2017 Contact person and e mail: Cathy Meske [csmeske@nemcmh.org]

**Report on the Requests for Services and Disposition of Requests**

| | **CMHSP Point of Entry-Screening** | **DD All Ages** | **Adults with MI** | **Children with SED** | **Unknown and All Others** | **Total** |
|---|---|---|---|---|---|---|
| 1 | Total # of people who telephoned or walked in | 46 | 879 | 250 | 358 | 1533 |
| 2 | Is Info on row 1 an unduplicated count? (yes/no) | No | No | No | No | No |
| 3 | # referred out due to non MH needs (of row 1) | 3 | 39 | 4 | 136 | 182 |
| 4 | Total # who requested services the CMHSP provides (of row1) | 41 | 790 | 237 | 197 | 1265 |
| 5 | Of the # in Row 4 - How many people did not meet eligibility through phone or other screen | 2 | 129 | 23 | 39 | 193 |
| 6 | Of the # in Row 4 - How many people were scheduled for assessment | 28 | 406 | 173 | 83 | 690 |
| 7 | other--describe | 2 | 50 | 9 | 25 | 86 |

| | **CMHSP ASSESSMENT** | | | | | |
|---|---|---|---|---|---|---|
| 8 | Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.) | 3 | 71 | 26 | 49 | 149 |
| 9 | Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan) | 0 | 0 | 0 | 0 | 0 |
| 10 | Of the # in Row 6 - how many were not served because they were MA HP enrolled and referred out to MA health plan | 0 | 0 | 0 | 0 | 0 |
| 11 | Of the # in Row 6 - how many otherwise did not meet cmhsp non-entitlement eligibility criteria | 2 | 36 | 9 | 8 | 55 |
| 11a | Of the # in row 11 - How many were referred out to other mental health providers | 0 | 28 | 6 | 2 | 36 |
| 11b | Of the # in row 11 - How many were not referred out to other mental health providers | 2 | 8 | 3 | 6 | 19 |
| 12 | Of the # in Row 6 - How many people met the cmhsp eligibility criteria | 20 | 295 | 122 | 0 | 437 |
| 13 | Of the # in Row 12 - How many met emergency/urgent conditions criteria | 0 | 69 | 20 | 0 | 89 |
| 14 | Of the # in Row 12 - How many met immediate admission criteria | 20 | 226 | 102 | 0 | 348 |
| 15 | Of the # in Row 12 - How many were put on a waiting list | 0 | 2 | 2 | 0 | 4 |
| 15a | Of the # in row 15 - How many received some cmhsp services, but wait listed for other services | 0 | 0 | 0 | 0 | 0 |
| 15b | Of the # in row 15 - How many were wait listed for all cmhsp services | 0 | 2 | 2 | 0 | 4 |
| 16 | Other - explain | 0 | 0 | 0 | 0 | 0 |

## Waiting List Information

**CMHSP:** Mental Health Authority
**Contact name and phone** Cathy Meske (989) 356-2161
**As of (Date)** 2/14/2018
**Time period covered for Added/Removed** 5/1/17 - 2/13/18

| | MI Adult | DD | SED | Total |
|---|---|---|---|---|
| **Targeted CSM/Supports Coordination** | | | | |
| **Specify HCPCS and CPT Codes included in this category** | | | | |
| Number on waiting list as of date above | 0 | 0 | 0 | 0 |
| Added during the time period covered | 2 | 0 | 0 | 2 |
| Removed during the time period covered- service provided | 1 | 0 | 0 | 1 |
| Removed during time period covered - all other reasons | 1 | 0 | 0 | 1 |
| Number left at the end of the time period covered | 0 | 0 | 0 | 0 |
| | | | | |
| **Intensive Interventions/Intensive Community Services** | | | | |
| **Specify HCPCS and CPT Codes included in this category** | | | | |
| Number on waiting list as of date above | 0 | 0 | 0 | 0 |
| Added during the time period covered | 0 | 0 | 0 | 0 |
| Removed during the time period covered- service provided | 0 | 0 | 0 | 0 |
| Removed during time period covered - all other reasons | 0 | 0 | 0 | 0 |
| Number left at the end of the time period covered | 0 | 0 | 0 | 0 |
| | | | | |
| **Clinic Services** | | | | |
| **Specify HCPCS and CPT Codes included in this category** | 90792 | | | |
| Number on waiting list as of date above | 0 | 0 | 0 | 0 |
| Added during the time period covered | 16 | 0 | 2 | 18 |
| Removed during the time period covered- service provided | 12 | 0 | 0 | 12 |
| Removed during time period covered - all other reasons | 4 | 0 | 2 | 6 |
| Number left at the end of the time period covered | 0 | 0 | 0 | 0 |
| | | | | |
| **Supports for Residential Living** | | | | |
| **Specify HCPCS and CPT Codes included in this category** | | | | |
| Number on waiting list as of date above | 0 | 0 | 0 | 0 |
| Added during the time period covered | 0 | 0 | 0 | 0 |
| Removed during the time period covered- service provided | 0 | 0 | 0 | 0 |
| Removed during time period covered - all other reasons | 0 | 0 | 0 | 0 |
| Number left at the end of the time period covered | 0 | 0 | 0 | 0 |
| | | | | |
| **Supports for Community Living** | | | | |
| **Specify HCPCS and CPT Codes included in this category** | H2015 | | | |
| Number on waiting list as of date above | 0 | 0 | 0 | 0 |
| Added during the time period covered | 0 | 1 | 0 | 1 |
| Removed during the time period covered- service provided | 0 | 0 | 0 | 0 |
| Removed during time period covered - all other reasons | 0 | 1 | 0 | 1 |
| Number left at the end of the time period covered | 0 | 0 | 0 | 0 |
| | | | | |
| **Narrative:** | | | | |

How do you assure that service needs are met at an individual level as well as from a program capacity level?

NeMCMHA has a process which includes all persons placed on a waiting list be reviewed on a weekly basis to determine the need for services, the severity of symptoms, length of time places on waiting list, and change in Medicaid status. Priority is given to those based on highest need and severity. All on waiting list are encouraged to come into crisis walk-in if they are experiencing an increase in symptoms.

**Northeast MI Community Mental Health Authority**
**Priority Needs and Planned Actions: Update of Progress January 31, 2018**

Based on feedback received from stakeholder groups and data collected during the Public Hearing in 2017, Northeast Michigan Community Mental Health developed a priority needs assessment and a plan of action to begin addressing those needs during this past year. The table below provides a format for identifying the top issues along with a status update. This plan continues to evolve as goals are reached and new resources are developed to further support our efforts. With the help of our community partners and the services they provide we have been able to address the priority issues identified

| Priority Issue | Reasons For Priority | CMHSP Plan | 2018 Update to Planned Actions |
|---|---|---|---|
| 1. Develop a Trauma Informed Community | -Effects on Children/Family Children K-3 exhibiting serious signs of emotional disturbance in Classroom. – Children acting out aggressively without little/if any regard for law enforcement<br>- Law Enforcement noting increased acting out behaviors of children in this age range. Requesting additional inservice opportunities. | 1. NeMCMHA will Complete education of Bus Drivers and Aides in Alpena Public Schools on the effects of trauma on children/adults (teachers completed FY 16-17)<br>2. Increase CMH presence in schools to include increased outpatient access in schools by CMH contractors<br>3. Complete Trauma assessments on children/adults referred by local DHHS Children's Services through partnership Children's Trauma Assessment Center (CTAC)<br>4. Community Wide Trauma informed community kick off to occur May 17, 2017 with Drs. Henry and Sloan from CTAC | 1. One of NeMCMHA contract providers, Partners in Prevention, completed training for Alpena Public Schools transportation, instructional aides and food service staff on the effects of trauma on children/adults in August 2017. Partners in Prevention will work with Alcona County on the effects of trauma on children/adults in 2018.<br>2. NeMCMHA contracted with Alcona Health Center (AHC) to provide additional outpatient counseling services at the identified pilot school up to 2 days per week. NeMCMHA will reimburse AHC for providing services to children who are experiencing a serious emotional disturbance. Students who do not have a serious emotional disturbance and in need of counseling may also be offered counseling through AHC at the school.<br>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. |

| Priority Issue | Reasons For Priority | CMHSP Plan | 2018 Update to Planned Actions |
|---|---|---|---|
| Develop a Trauma Informed Community (continued) | | 5. Identify Pilot school to focus on increased CMH and/or contractor presence/Trauma services. Increase educational opportunities from CTAC for teachers in dealing with children experiencing aggressive behaviors | 3. NeMCMHA worked with the NEMSCA School Success staff, local DHHS staff and the Children's Trauma Assessment Center (CTAC) in developing a protocol to screen children for trauma. Those children who may need further assessment are referred to NeMCMHA for assessment and services as appropriate.<br>4. The Trauma Informed Community Kick-Off for Alpena occurred May 17, 2017.The Trauma Informed Community Kick-Off for Alcona County was June 29, 2017.<br>5. The Pilot school was identified; additional counseling services are currently in place and NeMCMHA Children's Services staff also making school visits to the children we serve.<br>6. NeMCMHA staff have participated in training specific to Secondary Trauma: |
| 2. Improve Emergency Response, Jail Services, and Assisted Outpatient Treatment | - Noted challenging wait times by law enforcement in emergency rooms awaiting mental health screen.<br>- Community members lacking knowledge of mental health treatment options. What to do when spouse is experiencing confusion (dementia vs. mental health disorder).<br>- Courts noting need for AOT vs. ATO. Focus on earlier intervention | 1. CMH will continue to meet with local hospitals in an attempt of developing a standard protocol to decrease wait times of law-enforcement individuals in Emergency Departments when bringing in citizens on mental health petitions<br>2. Provide Community Education opportunities (churches, senior centers, service organizations and others) about community resources for persons experiencing mental health concerns to include court processes | 1. NeMCMHA has attempted to reach out to the MidMichigan Emergency Department Physician Group to address Behavioral Health Services. We will continue our efforts to meet with hospitals.<br>2. NeMCMHA continues to contract with Partners in Prevention to provide Youth and Mental Health First Aid to our communities:<br>• 51 community members participated in Mental Health First Aide in FY17, and<br>• 35 community members completed Youth Mental Health First Aid;<br>• 422 community members (school staff, agency and community members at large) completed 'Building Trauma Awareness' training.<br>• NeMCMHA staff has provided mental health training for two of our local jail staff (Montmorency and Alpena). NeMCMHA jail diversion staff available to provide mental health training Presque Isle and Alcona jail staff |

| Priority Issue | Reasons For Priority | CMHSP Plan | 2018 Update to Planned Actions |
|---|---|---|---|
| Improve Emergency Response, Jail Services, and Assisted Outpatient Treatment (continued) | -Correction Officers, court personnel and Law enforcement requesting inservice on symptoms of mental health disorders. | 3. Increase knowledge of CMH staff about the process of probate court forms for persons requiring court ordered treatment and/or guardianship | • NeMCMHA staff and Alpena Sheriff Department staff attended jail diversion training in September.<br>3. All NeMCMHA supervisors were trained in the completion of probate court treatment orders and processes. |
| 3. ABA Service Increase | Expanded population eligible for ABA services | Increase contract opportunities for expanded population. Recruit additional staff for 18 mos-6 year olds eligible for Behavioral Treatment Services | NeMCMHA continues its efforts to recruit additional contract opportunities for the expanded population requiring Behavioral Treatment services. |
| 4. Increased suicide prevention for youth and vets | Lack of community presentations on suicide prevention | PSA on suicide prevention. Coordinate community partnerships in suicide prevention. Work with the schools, VA, community members and Behavioral Health providers to coordinate suicide prevention and protocol | NeMCMHA, Partners in Prevention and other community partners will provide community wide suicide awareness/prevention training scheduled to begin in May 2018. NeMCMHA has partnered with Presque Isle Suicide Prevention Task Force to increase suicide awareness and prevention. Community Trainings using 'safeTALK' from Living Works are scheduled for February 2018 in Presque Isle and Montmorency Counties. |
| 5. Increased Substance Abuse Services | -Notable increase in opioid use, limited community resources; folks have to travel to Gaylord for Methadone therapy.<br>- Synthetic drug abuse, lack of community knowledge<br>- Substance use disorders that co-occur with mental health disorders | 1. Partner with local substance use disorder providers to investigate options for increasing SUD providers<br>2. Participate in community presentations regarding substance use disorders and synthetic drug abuse<br>3. Increase CMH provided substance use treatment that affects the people served by CMH | 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.<br>Northeast staff are members of the Substance Use Coalition and Northeast staff is scheduled to participate in training specific to adolescent substance use. |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Community Needs Assessment** | | | | | | | | | | | |
| | **Community Data Sets** | | | | | | | | | | | |
| | **CMHSP name:** | Northeast Michigan Community Mental Health Authority | | | | | | | | | | |
| | **Contact person/e mail address:** | Cathy Meske / csmeske@nemcmh.org | | | | | | | | | | |
| 1 | **Population (Census)-- As of September -- by county** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | |
| County 1 | **Alcona** | **11299** | **11091** | **10942** | **10787** | **10635** | **10578** | **10454** | **10349** | **10461** | | |
| County 2 | **Alpena** | **29600** | **292289** | **29598** | **29352** | **29234** | **29091** | **28988** | **28803** | **28929** | | |
| County 3 | **Montmorency** | **10185** | **10094** | **9765** | **9590** | **9476** | **9350** | **9300** | **9259** | **9317** | | |
| County 4 | **Presque Isle** | **13574** | **13436** | **13376** | **13198** | **13129** | **13062** | **13004** | **12841** | **12955** | | |
| County 5 | | | | | | | | | | | | |
| County 6 | | | | | | | | | | | | |
| | **Total CMHSP Population** | 64658 | 326910 | 63681 | 62927 | 62474 | 62081 | 61746 | 61252 | 61662 | 0 | |
| | Change from Prior Year | | 262252 | -263229 | -754 | -453 | -393 | -335 | -494 | 410 | -61662 | |
| | % change from Prior Year | | 405.60% | -80.52% | -1.18% | -0.72% | -0.63% | -0.005396 | -0.008001 | 0.0066937 | -1 | |
| | Cumulative Change since 2008 | | 262252 | -977 | -1731 | -2184 | -2577 | -2912 | -3406 | -2996 | -64658 | |
| | % cumulative change since 2008 | | 405.60% | -1.51% | -2.68% | -3.38% | -3.99% | -0.045037 | -0.052677 | -0.046336 | -1 | |
| | Source: | State of Michigan Census Estimates | | | | | | | | | | |
| | 2000-2009 | http://www.michigan.gov/documents/cgi/cgi_census_county0009_329372_7.xls | | | | | | | | | | |
| | 2010-2012 | http://www.michigan.gov/documents/cgi/cgi_census_CVTR1012_422152_7.xls | | | | | | | | | | |
| | 2013 | http://www.census.gov/popest/data/cities/totals/2013/SUB-EST2013-3.html | | | | | | | | | | |
| | 2013-2015 | http://www.census.gov/popest/data/state/totals/2015/index.html | | | | | | | | | | |
| 2 | **Medicaid Enrollment - Average Enrollment for September:** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | |
| County 1 | **Alcona** | 1726 | 1875 | 1947 | 1906 | 1892 | 1921 | 2307 | 1624 | 1715 | 1792 | |
| County 2 | Alpena | 6123 | 6787 | 6869 | 6786 | 6628 | 6778 | 7626 | 5323 | 5660 | 6075 | |
| County 3 | Montmorency | 2116 | 2364 | 2395 | 2331 | 2215 | 2148 | 2536 | 1625 | 1616 | 1787 | |
| County 4 | Presque Isle | 2005 | 2232 | 2285 | 2397 | 2353 | 2387 | 2829 | 2038 | 2122 | 2201 | |
| County 5 | | | | | | | | | | | | |
| County 6 | | | | | | | | | | | | |
| | **Total CMHSP Medicaid Enrollment** | 11970 | 13258 | 13496 | 13420 | 13088 | 13234 | 15298 | 10610 | 11113 | 11855 | |
| | Change from Prior Year | | 1288 | 238 | -76 | -332 | 146 | 2064 | -4688 | 503 | 742 | |
| | % change from Prior Year | | 0.1076023 | 0.0179514 | -0.005631 | -0.024739 | 0.0111553 | 0.1559619 | -0.306445 | 0.0474081 | 0.0667686 | |
| | Cumulative Change since 2008 | | 1288 | 1526 | 1450 | 1118 | 1264 | 3328 | -1360 | -857 | -115 | |
| | % cumulative change since 2008 | | 0.1076023 | 0.1274854 | 0.1211362 | 0.0934002 | 0.1055973 | 0.2780284 | -0.113617 | -0.071596 | -0.009607 | |
| | Source: | MDCH to provide data to CMHSP | | | | | | | | | | |
| 3 | **Number of Children in Foster Care** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | | |
| | Children Ages 0-17 in Out of Home Care-Abuse or Neglect (Number) | 38 | 63 | 75 | 73 | 80 | **93** | **102** | **75** | | | |
| | Children Ages 10-16 in Out of Home Care-Delinquency (DHS Placement) | 14 | 12 | 9 | 15 | n/a | **n/a** | **n/a** | | | | |
| | Children Ages 0-5 in Foster Care (Number) | 17 | 30 | 35 | 44 | 37 | **n/a** | **63** | | | | |
| | Source: http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI | | | | | | | | | | | |
| | ****Some information may not be available for every year.** | | | | | | | | | | | |
| | **Total CMHSP** | 69 | 105 | 119 | 132 | 117 | 93 | 165 | 75 | 0 | | |
| | Change from Prior Year | | 36 | 14 | 13 | -15 | -24 | 72 | -90 | -75 | | |
| | % change from Prior Year | | 52.17% | 13.33% | 10.92% | -11.36% | -20.51% | 0.7741935 | -0.545455 | -1 | | |
| | Cumulative Change since 2008 | | 36 | 50 | 63 | 48 | 24 | 96 | 6 | -69 | | |
| | % cumulative change since 2008 | | 52.17% | 72.46% | 91.30% | 69.57% | 34.78% | 1.3913043 | 0.0869565 | -1 | | |
| 4 | **Number of Licensed Foster Care Beds in Catchment Area** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | | | | | |
| | **Adults - Eneter the Total Number of Bed Capacity** | | | | | | | | | | | |
| | http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717-82231--,00.html | | | | | | | | | | | |
| | **Kids - Enter the Total Number of Licensed Facilities** | | | | | | | | | | | |
| | http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27719-82293--,00.html | | | | | | | | | | | |
| | ***This data is also provided by MDCH on the website under "Provided Information".** | | | | | | | | | | | |
| 5 | **Prevalence Proxy Data** | | | | | | | | | | | |
| | | **1990** | **2008** | **Change** | ***or most recent projection** | | | | | | | |
| 5-A | **Adults with Serious Mental Illness (Kessler Methodology)** | | | | | | | | | | | |
| | Trend - Kessler Prevalance Data | | | | | | | | | | | |
| | *Provided by MDCH in 2012 | | | | | | | | | | | |
| | | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | | | | |
| 5-B | **Children at risk for Serious Emotional Disturbance 100% below poverty** | 2622 | n/a | n/a | n/a | n/a | n/a | | | | | |

| | Commuity Needs Assessment | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Community Data Sets | | | | | | | | | | | |
| | CMHSP name: | Northeast Michigan Community Mental Health Authority | | | | | | | | | | |
| | Contact person/e mail address: | Cathy Meske / csmeske@nemcmh.org | | | | | | | | | | |
| | | | | | | | | | | | | |
| | http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t | | | | | | | | | | | |
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | |
| 5-C | Persons with Developmental Disabilities -.005% of census | 323 | 319 | 318 | 314 | 312 | 310 | 307 | 306 | 308 | | |
| | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Community Needs Assessment** | | | | | | | | | | | |
| | **Community Data Sets** | | | | | | | | | | | |
| | **CMHSP name:** | Northeast Michigan Community Mental Health Authority | | | | | | | | | | |
| | **Contact person/e mail address:** | Cathy Meske / csmeske@nemcmh.org | | | | | | | | | | |
| **6** | **Community Homelessness- catchment area** | **2009** | **2011** | **2013** | **2015** | **2017** | | | | | | |
| **6-A** | **Local Continuum of Care Bi-ennial Homeless Count** | | | | | | | | | | | |
| | Change from Prior Time Period | | 0 | 0 | 0 | 0 | | | | | | |
| **6-B** | **# served from CMHSP data- of persons that are homeless** | | | | | | | | | | | |
| | Change from Prior Time Period | | 0 | 0 | 0 | 0 | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| **6-C** | **Community Employment** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | |
| County 1 | **Alcona** | **3920** | **3376** | **3327** | **3424** | **3438** | **3436** | **3577** | **3659** | **3492** | **3683** | |
| County 2 | **Alpena** | **13704** | **12649** | **12234** | **12312** | **12299** | **12266** | **12373** | **13090** | **13149** | **12970** | |
| County 3 | **Montmorency** | **3522** | **3204** | **3129** | **3117** | **3046** | **3050** | **3165** | **2942** | **2701** | **2869** | |
| County 4 | **Presque Isle** | **5505** | **5025** | **4908** | **4949** | **5053** | **5132** | **5045** | **4966** | **4682** | **4984** | |
| County 5 | | | | | | | | | | | | |
| County 6 | | | | | | | | | | | | |
| | **Total CMHSP** | 26651 | 24254 | 23598 | 23802 | 23836 | 23884 | 24160 | 24657 | 24024 | 24506 | |
| | Change from Prior Year | | -2397 | -656 | 204 | 34 | 48 | 276 | 497 | -633 | 482 | |
| | % change from Prior Year | | -8.99% | -2.70% | 0.86% | 0.14% | 0.20% | 0.0115559 | 0.0205712 | -0.025672 | 0.0200633 | |
| | Cumulative Change since 2008 | | -2397 | -3053 | -2849 | -2815 | -2767 | -2491 | -1994 | -2627 | -2145 | |
| | % cumulative change since 2008 | | -8.99% | -11.46% | -10.69% | -10.56% | -10.38% | -0.093467 | -0.074819 | -0.09857 | -0.080485 | |
| | | | | | | | | | | | | |
| | Source: | State of Michigan Labor Market Information | | | | | | | | | | |
| | | www.milmi.org/cgi/dataanalysis/AreaSelection.asp?tablename=Labforce | | | | | | | | | | |
| | | | | | | | | | | | | |
| **7** | **Justice System** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | |
| **7-A** | **Jail diversions** | | | | | **3** | **4** | **5** | **2** | **4** | | |
| | **(describe data source)** | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | | | | | |
| **7-B** | **Prison discharges-number of people expected to meet SMI Criteria** | **3** | **4** | **5** | **3** | **8** | | | | | | |
| | **(describe data source)** | | | | | | | | | | | |
| | | | | | | | | | | | | |
| **8** | **Education System** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | | | |
| **8-A** | **Number of students aging out or graduating special education** | | | | **7** | **7** | **5** | **4** | | | | |
| | | | | | | | | | | | | |
| **9** | **Graduation and Dropout Rate** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** |
| County 1 | **Alcona** | **10** | **17** | **17** | **8** | **4** | **3** | **4** | **1** | **0** | **0** | |
| County 2 | **Alpena** | **57** | **51** | **41** | **24** | **38** | **34** | **34** | **35** | **27** | **27** | |
| County 3 | Montmorency | 13 | **10** | **9** | **4** | **11** | **6** | **5** | **7** | **4** | **6** | |
| County 4 | Presque Isle | 16 | **21** | **12** | **6** | **17** | **16** | **12** | **17** | **10** | **15** | |
| County 5 | | | | | | | | | | | | |
| County 6 | | | | | | | | | | | | |
| | **CMHSP Total:** | 96 | 99 | 79 | 42 | 70 | **59** | **55** | **60** | **41** | **48** | **0** |
| | Source - http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI | | | | | | | | | | | |
| **9-A** | % graduated | 78.325 | **77** | **72.85** | **82.725** | **76.025** | **78.25** | **84.125** | **89.1** | | | |
| **9-B** | % dropped out | 11.325 | 12.85 | 12.55 | 4.925 | 8.575 | 9.53 | 15.875 | 10.9 | | | |
| | Source - http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI | | | | | | | | | | | |

| | Commuity Needs Assessment | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Community Data Sets** | | | | | | | | | | | |
| | **CMHSP name:** | Northeast Michigan Community Mental Health Authority | | | | | | | | | | |
| | **Contact person/e mail address:** | Cathy Meske / csmeske@nemcmh.org | | | | | | | | | | |
| | **For primary health items, identify point in time being reported** | | | | | | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** |
| **10** | **Primary Health** | | | | | | | | | | | |
| **10-A** | % of CMHSP consumers with an identified Primary Care Physican | | | | | | 0.76 | 0.85 | 0.8341 | 0.8998 | 0.8043 | 0.8392 |
| | | | | | | | | | | | | |
| **10-B** | CMHSP Medicaid recipients with primary care service/encounter | | | | | | 198 | | | 540 | n/a | |
| **10-C** | # with primary care plus emergency room | | | | | | 92 | | | 259 | n/a | |
| **10-D** | # with emergency room no primary care | | | | | | 10 | | | 10 | n/a | |
| | **DCH to supply data for 10B, 10C, and 10D** | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | **Number of CMHSP consumers with:** | | | | | | | | | | | |
| **10-E** | **Pneumonia** | | | | | | | | | | | |
| | History of Pneumonia within the past 12 months | | | | | | 376 | 381 | 91 | 76 | 89 | 46 |
| **10-F** | **Diabetes** | | | | | | | | | | | |
| | History of Diabetes but not treated for Diabetes within the past 12 months | | | | | | 39 | 34 | 30 | 36 | 41 | 36 |
| | Treated for Diabetes within the past 12 months | | | | | | 237 | 197 | 172 | 169 | 159 | 116 |
| **10-G** | **Asthma** | | | | | | | | | | | |
| | History of Asthma but not treated for Asthma within the past 12 months | | | | | | 195 | 174 | 147 | 125 | 124 | 83 |
| | Treated for Asthma within the past 12 months | | | | | | 289 | 272 | 217 | 232 | 213 | 141 |
| **10-H** | **Hypertension** | | | | | | | | | | | |
| | History of Hypertension but not treated for Hypertension within the past 12 months | | | | | | 119 | 89 | 78 | 86 | 84 | 68 |
| | Treated for Hypertension within the past 12 months and blood pressure is stable | | | | | | 392 | 295 | 230 | 229 | 250 | 182 |
| **10-I** | **Obesity** | | | | | | | | | | | |
| | Have medical diagnosis of Obseity present or BMI > 30 | | | | | | 542 | 466 | 410 | 343 | 417 | 275 |
| | | | | | | | | | | | | |
| **11** | **Optional** | **2011** | **2012** | **2013** | **2014** | **2015** | **2017** | | | | | |
| | **Private Providers and Public SA Providers** | | | | | | | | | | | |
| **11-A** | Number of Existing Private Providers in Community | | | | | | | | | | | |
| **11-B** | Number of providers that utilize a sliding fee scale | | | | | | | | | | | |
| **11-C** | Number of providers that are accepting new clients | | | | | | | | | | | |

Available at the meeting

## APRIL AGENDA ITEMS

**Policy Review**
Financial Condition 01-005
Communication & Counsel 01-009

**Policy Review & Self-Evaluation**
Governing Style 02-002
Cost of Governance 02-013

**Monitoring Reports**
Budgeting 01-004
Communication & Counsel 01-009

**Activity**
Election of Officers
Orientation of New Members
Set Calendar and Committee Appointments [Organizational Meeting]

**Ownership Linkage**

**Educational Session**

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

February 23, 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:

- New e-mail addresses for Association staff
- Association soon to announce new membership opportunities
- Friday Facts to become a members-only electronic newsletter
- Work and Accomplishments of CMH Association Member Organizations
  - CEI publishes comprehensive "Culture of Health" plan
  - St. Clair CMH announces Run for Recovery
- State and National Developments and Resources
  - CMH Association publishes special edition newsletter on gun violence and mental health
  - Okay2Say issues reminder on combating threats of violence
  - Michigan accepts bids for 298 pilots
  - CHCS publishes interview with Michigan healthcare thought leader
  - NACBHDD announces Congressional policy briefing
  - CMS Office of the Actuary releases 2017-2026 Projections of National Health Expenditures and related trends
- Legislative Update
  - Upcoming DHHS Committee Meetings
  - House CARES Update
- National Update
  - Mental Health and Addiction Groups Call on Congress to Prioritize High-Impact SUD Programs
- CMHAM Spring Conference – Change of Dates and Location
- Gambling Symposium – March 2, 2018
- Social Work Ethics, Addiction & Pain Management Trainings for 2018
- 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 soon 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 will soon be announcing 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**.

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## WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

### CEI publishes comprehensive "Culture of Health" plan

Below is a recent announcement, by the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI), of the recent completion of its comprehensive behavioral health prevention and wellness plan. Excerpts from that announcement are provided below:

> The CMHA-CEI Behavioral Health Prevention and Wellness Promotion Committee consisting of broad representation across the organization worked throughout FY17 on defining what constitutes Behavioral Health Prevention and Wellness for CMHA-CEI resulting in a comprehensive plan titled "Creating a Culture of Health"
>
> Behavioral Health Prevention & Wellness Promotion Plan Publication
> CMHA-CEI's Behavioral Health Prevention and Wellness Promotion Committee is proud to present the new publication titled "Creating a Culture of Health: Changing the landscape to improve behavioral health and wellness for those we serve, our staff, and our communities".
>
> This multi-year plan highlights our target population, the purpose behind this effort, and the CMHA-CEI Behavioral Health Prevention and Wellness Promotion Committee who were instrumental in its development. The plan also provides the underlying research, rationale, relevant national models, goals, objectives, and

strategies as well as existing examples of what we have already achieved towards this end. The identified Goal Areas are:

1. Create a Culture of Health and Wellness,
2. Expand upon Behavioral Health Prevention, Promotion, Public Relations, and Community Outreach Opportunities,
3. Initiate and Promote Early Intervention Programming,
4. Expand the Behavioral Health Education and Training Opportunities offered to area professionals,
5. Enhance Behavioral Health System Alignment Efforts, Access to Additional Funding Streams, and Integrated Care Opportunities, and
6. Compile Data and Prioritize Data Indicators and At-Risk Populations.

The plan and its executive summary can be found at:
http://ceicmh.org/component/docman/doc_details/770-2017-culture-of-health-plan?Itemid=458

### St. Clair CMH announces Run for Recovery

Below are excerpts from a press release recently release by St. Clair County Community Mental Health regarding its annual Run for Recovery:

> St. Clair County Community Mental Health is holding their 10th Annual Healthy Minds, Healthy Bodies Run for Recovery on Saturday, May 12, 2018 at their 3111 Electric Avenue location. Individuals can participate in a 5K USTAF Certified run, 1 Mile Fun Walk, or 1 Mile timed run (for ages 12 and under). The 1 Mile Walk and 1 Mile Timed Run both begin at 8:30am, and the 5K run begins at 9am. The early registration fee is $25 before April 13th and includes an event t-shirt. Registration on or after April 14th is $30 and t-shirts are provided only while supplies last.
>
> The Run for Recovery event proceeds will be shared between the St. Clair County Community Mental Health Lifeline Fund, the St. Clair County Community Mental Health Endowment Fund, the Peoples' Clinic for Better Health, and Mid-City Nutrition.
>
> The Governor's Council on Physical Fitness, Health and Sports and the Michigan Fitness Foundation has endorsed the Healthy Minds, Healthy Bodies Run for Recovery as a quality physical activity event through the Pure Michigan FITness Series endorsement program. The Pure Michigan FITness Series program endorses local, regional and statewide events that are consistent with the Governor's Council and the Michigan Fitness Foundation mission to promote healthy choices while offering a physical activity event that is open to all participants, regardless of skill level or age. The Healthy Minds, Healthy Bodies Run for Recovery leads by example by providing a safe, healthy physical activity event for Michigan residents. With this endorsement, participants age 18 and above are eligible to register for the 2018 lottery for a chance to be one of only 400 runners to run over the Mackinaw Bridge on Labor Day.
>
> Awards will be given to 1st through 5th place finishers of the 5K run and 1 Mile Timed Run for ages 12 and under by gender and age group. Awards will also be given to the overall top male and female finishers.
>
> Online registration is available at https://run4recovery.enmotive.com/ or the registration form may be downloaded at www.scccmh.org. Cash, check and credit card registrations are also accepted in-person at the SCCCMH Port Huron office, 3111 Electric Avenue between 8:30am and 5pm Monday through Friday.
>
> Pre-registered participants may pick up their event packet on Thursday or Friday, May 10th or 11th, between 8:30am and 5pm. Participants who do so will have their names entered in a drawing to win "Beat the Rush" prizes.
>
> For more information, visit the SCCCMH web site at www.scccmh.org or call St. Clair County Community Mental Health at 810-985-8900.

## STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

### CMH Association publishes special edition newsletter on gun violence and mental health

With the recent school shooting in Parkland, Florida, communities across the country, policy makers, high school students, families, members of the law enforcement and mental health communities are expressing their grief, often accompanied by outrage, and their commitment to addressing the causes of gun violence in this country.

In an effort to foster a fact and research based approach to addressing gun violence, this association published, earlier this week, a Special Edition of the Friday Facts, focused solely on gun violence and mental health. This edition compiled some of the best thinking on this issue.

Note, that this Association is not advocating any specific approach to reducing gun violence. Our hope is that some of the myths that drive this debate can be replaced with facts and that the information and views contained in this special edition will support clear-headed thinking and concrete action to halt gun violence in America.

This special edition of Friday Facts can be found at:

https://www.macmhb.org/sites/default/files/attachments/files/special%20edition%20-%20gun%20violence%20and%20mental%20health%20022118.pdf

### Okay2Say issues reminder on combating threats of violence

Below is a recent announcement, from Michigan's Okay2Say program, reminding Michiganders of the resources available through the Okay2Say program:

> In the wake of the school tragedy in Florida, many people are wondering how they can keep their schools safe. Others in Michigan, have been contacting our office for more information, resources (banners, posters, etc.) and to inquire how to schedule a free OK2SAY presentation.
>
> https://www.michigan.gov/ag/0,4534,7-359-82918_80840_80842_80843---,00.html
>
> For those who may not be aware, in 2014 the Michigan Attorney General's office implemented a student safety initiative called OK2SAY. OK2SAY is a program that ensures every student, parent, teacher, and community member has access to a safe and confidential way to report any concerns about their safety or the safety of others. OK2SAY operates as an early warning system in our schools to help stop tragedies before they start.
> Remind your students that they have a confidential way to report a safety threat. OK2SAY is operational 24/7: Submit a tip using email, mobile app, telephone, text message, or through the OK2SAY website.
> http://www.michigan.gov/ok2say
>
> When students make the courageous decision to break the code of silence and speak out against harmful behavior, they equip authorities with the information needed to respond to threats and avert tragedy. And that's a good thing for Michigan schools, communities, and families.

### Michigan accepts bids for 298 pilots

Below are excerpts from a recent Crain's Detroit Business article on the Section 298 pilot initiatives.

Michigan has received bids from community health agencies to participate in up to three regional pilot projects to test combining behavioral health and physical health services in the Medicaid system.

Under what is known as Section 298, named after a budget section the Legislature approved last year, Michigan will test the pilot projects over the next several years to determine if costs can be reduced, quality improved and services expanded using a managed care approach.

Originally, Medicaid health plans lobbied legislators in 2016 to have them manage the state's $2.6 billion Medicaid behavioral health system. The managed care organizations, some of which are for-profit companies, already manage a nearly $9 billion Medicaid physical health system.
But state officials only allowed the quasi-public community mental health agencies, which currently manage Medicaid behavioral health services, to submit proposals. However, several Medicaid health plans will participate in the pilots in ways the state has yet to specify.

The Michigan Department of Health and Human Services plans to hear oral presentations of the proposals March 1-2; announce pilot decisions March 9; complete contracts and other details by July 1; and have the pilots fully implemented by Oct. 1.

Last year, the Legislature allowed for a fourth pilot to be allowed in Kent County, but the local mental health agency, Network 180 in Grand Rapids, was unable to find a Medicaid health plan to participate.
In a statement, the Community Mental Health Association of Michigan said it supports the range of innovative submissions delivered by state community mental health organizations.

"We commend the community mental health organizations and leaders across the entire state," CEO Robert Sheehan of CMHAM said in a statement. "The system's value lies in our ability to develop innovative integrated health care practices in communities of all types and sizes, and we must continue to work together for the state's mental health safety net, as well as serving some of Michigan's most vulnerable public citizens."

CMHAM said themes represented in the submitted applications included:

- public and private partnerships
- advanced integrated models of behavioral and physical health care using traditional and nontraditional (housing and employment) services
- fostering person-centered care through collaboration

While only community mental health agencies were considered "qualified applicants" by the state, the Michigan Association of Health Plans submitted its own pilot proposal for discussion purposes, said Dominick Pallone, the association's executive director.

Pallone said that proposal is what the Medicaid HMOs believe should be the model for integrating behavioral and physical health care.

"Our approach would allow the health plan to contract with the community mental health (agency) and also with direct care service providers to enhance the network of credentialed behavioral health providers," Pallone said in an email to *Crain's*.

"This approach would promote individual consumer choice of provider networks and would eliminate county geographic restrictions that exist today," he said.

Under the proposal, care management and care coordination would be aligned between the health plan, community mental health agency, the provider, enrollee and family. The system would follow an "integrated care team" approach, which would be patient-centered, he said.

Medicaid health plan involvement in pilots: When devising the pilot standards, state officials concluded that enabling regulations prevented allowing Medicaid HMOs to be lead applicants for the pilots, Pallone said.

"We disagreed and suggested that the Legislature could remove any perceived statutory barrier similar to the way they acted to amend the Social Welfare Act to allow health plans to hold the contract for the purposes of the pilot," Pallone said.

However, state officials decided only community mental health agencies could apply for the pilots, but the "HMO would ultimately hold the contract."

State officials did not release the number or whereabouts of pilot proposals.

However, Pallone said he believes some of the pilot proposals have been submitted in Muskegon, Saginaw County, Ludington and Genesee County.

The four pilot proposals with which Pallone said he is familiar promote programs the agencies are already doing; they propose to give state mental health Medicaid funds to the health plans, which will reimburse the mental health agencies for services so they can pay providers.

"All propose managing their own providers (and performing) care management," he said. "All would increase co-location or reference the co-location of clinical services they are already doing, and all would suggest that they would assume the responsibility for the mild to moderate population that is currently the responsibility of the health plan.

Pallone said the Medicaid health plans have been promised by MDHHS that if the final plans for integration fail to show meaningful progress in financial, clinical and operation integration "then it's not likely the pilots actually get off the ground even if the department selects them from the RFI process. "

Section 298 has undergone several revisions over the past year, the last being Feb. 9 when the state updated its timeline for the request for information and amended its financing model.

**CHCS publishes interview with Michigan healthcare thought leader**

Below is the announcement, by the Center for Health Care Strategies (CHCS) of the publishing of a recent interview with Michigan's former Medicaid Director and current principal at Health Management Associates, Steve Fitton:

Building a Medicaid Framework to Promote Healthy Behaviors: An Interview with Steve Fitton: Medicaid programs are increasingly interested in strategies for engaging consumers — including the use of financial incentives to promote healthy behaviors. Steve Fitton, former Medicaid director from Michigan and current Principal at Health Management Associates, ushered in Michigan's Medicaid expansion, Healthy Michigan, along with a financial incentive program to encourage such behaviors. Michigan is one of a few states that provides reduced co-payments and premiums, as well as incentives such as gift cards, to Medicaid enrollees in the expansion population who complete a health risk assessment and commit to healthy behaviors such as losing weight and smoking cessation.

CHCS recently spoke with Mr. Fitton, a former Fellow of CHCS' *Medicaid Leadership Institute*, about his experience developing this program.

The interview can be found at:
https://www.chcs.org/building-medicaid-framework-promote-healthy-behaviors-interview-steve-fitton/?utm_source=CHCS+Email+Updates&utm_campaign=597a62d861-EMAIL_CAMPAIGN_2018_02_14&utm_medium=email&utm_term=0_bbced451bf-597a62d861-152144421

**NACBHDD announces Congressional policy briefing**

(While this event is taking place in Washington, DC, - and unlikely to attract many readers of the Friday Facts, this association wants to ensure that its Friday Facts readers are aware of the advocacy and policy work of the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD), of which this Association is a member and officer, regarding full inclusion of persons with intellectual an developmental disabilities.)

> The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) and the National Association for Rural Mental Health (NARMH) invite you to a Congressional policy briefing:
>
> *WHEN A GOOD LIFE IS DEPENDENT ON FEDERAL POLICY*
> *FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES(I/DD)*
>
> *Tuesday, March 6, 2018*
> *2:00 to 3:00 PM*
> *Room SV209, US Capitol Visitors Center*
> *OPEN to Hill Staff and The Public*
>
> *Hear from a parent and experts in the I/DD field about the importance of personal independence and the key role of Medicaid funding for services, the need for a strong workforce supporting individuals, and the essential role employment plays for individuals with disabilities.*
> *SPEAKERS:*
>
> - Cheryl Dougan – Advocate, parent and National Alliance for Direct Support Professionals (NADSP) Director at Large, Board of Directors
> - Mary Lee Fay - Executive Director, National Association of State Directors of Developmental Disabilities Services (NASDDDS)
> - John Butterworth, Ph. D – Director of Employment System Change and Evaluation, Institute for Community Inclusion, University of Massachusetts, Boston
> - Moderator: Les Wagner – NACBHDD Board Member and Executive Director, Missouri Association of County Developmental Disabilities Services
>
> Sponsors: Optum, ANCOR, National Alliance for Direct Support Workers, NACo, NACBHDD, and NARMH

**CMS Office of the Actuary releases 2017-2026 Projections of National Health Expenditures and related trends**

Below is a recent press release from the federal Centers for Medicare and Medicaid Services (CMS) regarding the growth in the nation's health care costs:

> Today the independent CMS Office of the Actuary released the projected national health expenditures for 2017-2026.
> National health expenditure growth is expected to average 5.5 percent annually over 2017-2026, according to a report published today as an "Ahead Of Print" by Health Affairs and authored by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS).
>
> Growth in national health spending is projected to be faster than projected growth in Gross Domestic Product (GDP) by 1.0 percentage point over 2017-2026. As a result, the report projects the health share of GDP to rise from 17.9 percent in 2016 to 19.7 percent by 2026.
>
> The outlook for national health spending and enrollment over the next decade is expected to be driven primarily by fundamental economic and demographic factors: trends in disposable personal income, increases in prices for medical goods and services, and shifts in enrollment from private health insurance to Medicare that result from the continued aging of the baby-boom generation into Medicare eligibility.

“Personal healthcare spending” measures spending for medical goods and services provided directly to patients. Over the projection period, growth in personal healthcare prices and growth in the use and intensity of care provided collectively explain about three quarters of the growth in personal healthcare spending. The report also found that by 2026, federal, state and local governments are projected to finance 47 percent of national health spending, up from 45 percent in 2016.

“Today’s report from the independent CMS Office of the Actuary shows that healthcare spending is expected to continue growing more quickly than the rest of the economy,” said CMS Administrator Seema Verma. “This is yet another call to action for CMS to increase market competition and consumer choice within our programs to help control costs and ensure that our programs are available for future generations.”

These projections are constructed using a current-law framework and include major health provisions from the Tax Cut and Jobs Act and funding throughout the projection period for the Children’s Health Insurance Program. These projections do not reflect other health provisions from the Bipartisan Budget Act of 2018.

Additional findings from the report:

- **Total national health spending growth:** Growth is projected to have been 4.6 percent in 2017, up slightly from 4.3 percent growth in 2016, as a result of i) accelerating growth in Medicare spending, ii) slightly faster growth in prices for healthcare goods and services, and iii) increases in premiums for insurance purchased through the Marketplaces. In 2018, total health spending is projected to grow by 5.3 percent, driven partly by growth in personal healthcare prices. Growth in personal healthcare prices is projected to rise to 2.2 percent in 2018 from 1.4 percent in 2017, reflecting, in part, faster projected prescription drug price growth as the dollar value of drugs losing patents in 2018 is smaller than in prior years. National health expenditure growth is projected to average 5.5 percent for 2019-2020 largely due to expected faster average growth in Medicare partially offset by slower average growth in private health insurance spending. For 2021-2026, average national health spending growth is projected to increase by an average of 5.7 percent, or 0.2 percentage point faster compared to average growth in 2019-2020. During this timeframe, Medicare spending growth is projected to continue to outpace growth in private health insurance spending, mostly due to enrollment growth (as baby boomers continue to age out of private insurance and into the Medicare program).
- **Medicare:** Among the major payers for healthcare over the 2017-2026 period, Medicare is projected to experience the most rapid annual growth at 7.4 percent, largely driven by enrollment growth and faster growth in utilization from recent near-historically low rates.
- **Private health insurance:** Private health insurance spending is projected to average 4.7 percent over 2017-2026, the slowest of the major payers, reflecting low enrollment growth and downward pressure on utilization growth influenced by: i) lagged impact of slowing growth in income in 2016 and 2017, ii) increasing prevalence of high-deductible health plans, and iii) to a lesser extent, repeal of the penalty associated with individual mandate.
- **Medicaid:** Medicaid is projected to average 5.8 percent annual growth over 2017-2026, which is slower than the average observed for 2014-2016 of 8.3 percent, when the major impacts from the Affordable Care Act’s expansion took place.
- **Personal healthcare spending:** Over 2017-2026, growth in personal healthcare spending is projected to average 5.5 percent. Among the factors, personal healthcare price growth is anticipated to be the largest factor at 2.5 percentage points, growth in the use and intensity of goods and services is expected to contribute 1.7 percentage points of total growth, and population growth (0.9 percentage point) and changing demographics (0.5 percentage point) account for the remaining growth.
- **Prescription drug spending:** Among the major sectors of healthcare, spending growth is projected to be fastest for prescription drugs, averaging 6.3 percent for 2017-2026. This is due in part to faster projected drug price growth, particularly by the end of the period, influenced by trends in relatively costlier specialty drugs.

- **Insured share of the population:** The proportion of the population with health insurance is projected to decrease from 91.1 percent in 2016 to 89.3 percent in 2026, due in part to the elimination of the penalty payments associated with the individual mandate and also to a continuation of a downward trend in the offering and take-up of employer-sponsored health insurance.

The Office of the Actuary's report will appear at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

An article about the study is also being published by Health Affairs and is available here: http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1655

## LEGISLATIVE UPDATE

## Upcoming DHHS Committee Meetings

### House DHHS Budget Committees

DATE: Wednesday, February 28, 2018

TIME: 12:00 PM

PLACE: Room 352, House Appropriations, State Capitol Building, Lansing, MI

AGENDA:
Public Health, Health Policy, Aging and Adult Services -Department Presentation on FY 2018-19 Executive Budget Recommendation -Public Testimony

DATE: Thursday, March 1, 2018

TIME: 1:30 PM or after committees are given leave by the House to meet, whichever time is later.

PLACE: Room 352, House Appropriations, State Capitol Building, Lansing, MI

AGENDA:
Medicaid and Healthy Michigan Plan
-Department Presentation on FY 2018-19 Executive Budget Recommendation -Public Testimony

### Senate DHHS Budget Committee

Committee: Senate Health and Human Services Appropriations Subcommittee

Location: Room 1100, Binsfeld Senate Bldg, 201 Townsend Street, Lansing MI

Date: Tuesday, February 27, 2018

Time: 1:00 – 2:30PM

Agenda 1. Population Health, Health Policy Aging and Adult Services

2. Public Testimony

## House CARES Update

Over the past couple of weeks a number of bills have been introduced from the House of Representatives' CARES (Community, Access, Resources, Education and Safety) Task Force, which convened last summer to explore Michigan's mental health system. Below is a list of the bills that have had at least a committee hearing in the past month and a link to the full task force report.

https://house.mi.gov/PDFs/HouseCARESTaskForceReport.pdf

**HB 5085** – dedicates 4% of the unmarked money raised through Michigan's liquor sales and fees and earmark it specifically for substance use disorder treatment and prevention services. HB 5085 could provide more than $17 million a year to combat alcohol-related disorders, opiate addiction and other substance use disorders.

**HB 5439** – requires the DHHS to establish and administer an electronic inpatient psychiatric bed registry, with beds categorized by patient gender, acuity, age, and diagnosis that is accessible through the DHHS website.

**HB 5460** – require that programs and curricula for paramedics or medical first responders include training in treating drug overdose patients that is equivalent to training provided by the American Heart Association Basic Life Support (BLS) for Health Care Providers.

**HB 5461** – Current law allows peace officers to possess and administer an opioid antagonist if they have been trained in its proper administration and have reason to believe that the recipient is experiencing an opioid-related overdose. The bill would stipulate that the training required before administration of an opioid antagonist must meet the requirements set out in HB 5460.

**HB 5524** – requires that the Department of Education (MDE), in conjunction with the DHHS to develop or adopt a professional development course for teachers in mental health first aid.

**HB 5487** – establishes a uniform credentialing requirement for individuals who provide medical services through a contract health plan.

**HBs 5450-5452** – allows those once convicted of some minor felonies and misdemeanors would be allowed to work in some mental health care jobs (nursing homes, psychiatric facilities, & adult foster care homes)

## NATIONAL UPDATE

## Mental Health and Addiction Groups Call on Congress to Prioritize High-Impact SUD Programs

Alongside the most recent budget deal, Congress allocated $6 billion over the next two years to address the nation's opioid epidemic. In response, 27 mental health and addiction groups, including the National Council, called on Congress to direct the money into nationally-recognized, evidence-based programs and practices. These programs and practices include: mental health and substance use block grants, the Certified Community Behavioral Health Clinic program, the Opioid State Target Response grants and SAMHSA.

As it stands, the funding package is set to provide states with grants to fight drug use, and expand substance use and mental health treatment. States that have been particularly hard-hit by opioid overdose deaths will see additional

assistance. In their letter to key Congressional leaders, the 27 leading behavioral health organizations voiced support for and recommended action on the following programs:

- Substance Abuse Prevention and Treatment (SAPT) Block Grant: The SAPT block grant supports about 2 million individuals receiving treatment for substance use disorders (SUD) each year and accounts for almost a third of public funds expended for SUD prevention and treatment. The President suggested adding $13 million to the block grant in his Fiscal Year 2019 budget proposal. Advocates say this proposal will not be enough to overcome years of insufficient funding, and therefore are asking for some of the $6 billion to help bolster this important program.

- Opioid State Targeted Response (Opioid STR) Grants: These grants were created under the 21st Century Cures Act, and are meant to support states based on their identified unmet need for opioid use disorder treatment and prevention of drug overdose deaths. Advocates are calling on Congress to continue funding for these grants beyond their current expiration in 2018.

- Excellence in Mental Health and Addiction Treatment Act: This two-year, eight-state demonstration program expands Americans' access to mental health and addiction care through the establishment of federally-recognized Certified Community Behavioral Health Clinics (CCBHCs). In the first year of the demonstration, the participating states have shown increased treatment capacity, the ability to offer more evidence-based treatments, and better collaboration with other community stakeholders. Advocates are urging Congress to allocate funding to expand the demonstration to more states and for more years.

- SAMHSA's Centers for Substance Abuse Prevention and Substance Abuse Treatment: These two offices in the Substance Abuse and Mental Health Services Administration (SAMHSA) support regional and national programs to improve the adoption of evidence-based addiction care, bolster prevention activities, and ensure the availability of recovery supports. Funding for these offices has also stagnated in recent years, therefore advocates have suggested providing funding increases for these critical offices.

## CMHAM ANNUAL SPRING CONFERENCE: NEW DATE/LOCATION & CALL FOR PRESENTATIONS

Update your calendars! The CMHAM Annual Spring Conference will now be held on:

Monday, April 30, 2018 – Pre-Conference Institutes
Tuesday, May 1 and Wednesday, May 2, 2018 – Full Conference
Diamond Center at Suburban Collection Showplace in Novi, Michigan

Click here for Call for Presentations: https://macmhb.org/annual-conferences
Deadline Friday, March 2, 2018

## TENTH ANNUAL GAMBLING DISORDER SYMPOSIUM

MDHHS & CMHAM Present: Michigan's Tenth Annual Gambling Disorder Symposium, ""A Holistic Approach to Gambling Disorder Treatment…Mind, Body & Spirit." The Symposium will be held on Friday, March 2, 2018 at the Diamond Center at Suburban Collection Showplace in Novi, Michigan.

Registration Fee: $35 per person and includes all materials, continental breakfast, lunch and refreshments.
To Register Click Here!

Symposium Highlights:
- Assessment and Treatment of Gambling Disorder with an Emphasis on High Risk Populations
- Problem Gambling: A Growing Epidemic Among Youth & Using Adverse Childhood Experiences (ACE) in Treatment
- Neurobiology of Gambling and Other Addictions

- Prevention: An Open Panel Discussion
- Treating Gambling Disorder with Mindfulness and Spirituality
- The Problem Gambler and the Criminal Justice System
- Insider's View of Gamblers Anonymous: Open Meeting
- Gambling Behavior - it's Functional

**SOCIAL WORK ETHICS, ADDICTION & PAIN MANAGEMENT TRAININGS FOR 2018**
Community Mental Health Association of Michigan is pleased to offer 6 Social Work Ethics, Addiction and Pain Management Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC, on the following dates. Registration will open on February 26th.

- March 21 - Lansing
- April 25 - Lansing
- May 30 - Lansing
- June 27 – Battle Creek/Kalamazoo Area
- July 11 - Novi/Detroit area
- August 22 - Lansing

**CMH Association committee schedules, membership, minutes, and information go to our website at** https://www.macmhb.org/committees

**EMDR Training**
Trauma Recovery/EMDR Humanitarian Assistance Programs presents Eye Movement Desensitization and Reprocessing (EMDR). EMDR Basic Training consists of Weekend I (April 11-13, 2018) and Weekend II Training. Each training event is three days of didactic and supervised practice. To complete Trauma Recovery/HAP's EMDR Training, each participant is required to complete 10 hours of consultation. Each participant/agency must arrange for consultation hours on their own, through the HAP Consultant Directory. If you have staff interested, please email awilson@cmham.org for more information.

***Have a Great Weekend!***

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

February 21, 2018

**FRIDAYFACTS**

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

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

RE: **Special Edition: gun violence and mental health**

- **Connecting mental illness and mass shooting misses the point, experts say (Phil McCausland, NBC News)**
- **Mass Shootings and Mental Illness (James L. Knoll IV, M.D.; George D. Annas, M.D., M.P.H.; American Psychiatric Association)**
- **How to reduce shootings (Nicholas Kristof; New York Times)**
- **How to Reduce Mass Shooting Deaths? Experts Rank Gun Laws (Margot Sanger-Katz; Quoctrung /Bui, New York Times)**
- **Need to boldly face the causes of gun violence rather than scapegoating those with mental illness (Robert Sheehan, Community Mental Health Association of Michigan)**

With last week's school shooting in Parkland, Florida, communities across the country, policy makers, high school students, families, members of the law enforcement and mental health communities are expressing their grief, often accompanied by outrage, and their commitment to addressing the causes of gun violence in this country.

In an effort to foster a fact and research based approach to addressing gun violence, this association is publishing this Special Edition of the Friday Facts. This edition compiles some of the best thinking on this issue.

Note, that this Association is not advocating any specific approach to reducing gun violence. Our hope is that some of the myths that drive this debate can be replaced with facts and that the information and views contained in this special edition will support clear-headed thinking and concrete action to halt gun violence in America.

**Connecting mental illness and mass shooting misses the point, experts say (Phil McCausland, NBC News)**

Below are excerpts from a recent NBC News article on the views of a range of experts on gun violence and mental health:

> In the wake of the tragedy in Parkland, Florida, where a gunman killed 17 students and staff, the Trump administration and many Republicans have said that the best way to end the seemingly constant stream of mass shootings is by combating mental illness.
>
> And while some think it a reasonable idea, mental health and mass shooting experts aren't so sure. Dr. James Alan Fox, a criminologist with Northeastern University and author of "Extreme Killing: Under standing Serial and Mass Murder," said it's dangerous to assume that the mentally ill tend to commit these shootings.

"There's not really a correlation," said Fox, who maintains a database on mass shootings. "We like to think that these people are different from the rest of us. We want a simple explanation and if we just say they're mentally ill, case closed. Because of how fearful dangerous and deadly their actions are, we really want to distance ourselves from it and relegate it to illness."

---

Experts say that the public has to be careful with how it thinks about gun violence and mental illness, otherwise it could stigmatize those who suffer from mental health issues.
And considering that suicide by firearm killed 313,641 people between 1999 and 2015, according to the National Center for Injury Prevention, it appears much more likely that the mentally ill will hurt themselves than others.
Dr. Jonathan Metzl, director of the Center for Medicine, Health and Society at Vanderbilt University, said that these mass shooting highlight Americans' desire to reaffirm a stigmatization of the mentally ill as "ticking time bombs" to avoid more difficult conversations about gun violence.

"Mass shootings are horrific and terrifying," he said. "But if we really want to stop gun violence in this country, everyday gun violence is predictable and could be stopped. Ending everyday gun violence would help end mass shootings as well."

According to a 2016 report published by the American Psychiatric Association (APA) (**that report is cited with its link below**), just ensuring weapons don't enter the hands of the mentally ill isn't enough to prevent mass shootings from occurring regularly. Instead, the report suggests that public health and education campaigns are needed to teach people how to report concerning behavior to authorities and how to learn coping skills for anger and conflict resolution.

The report also proposes that policies and laws be focused on dangerous behavior that shows risk for committing gun violence, rather than a blanket category for the mentally ill, and recommends that institutions and communities develop threat assessment teams that can evaluate reports of potential danger.

As Fox asserts, the belief that the mentally ill are more likely to take part in a mass shooting appears to be a misleading. There were 198,760 homicides committed by a firearm in the United States between 1999 and 2015, according to the National Center for Health Statistic. Despite the high number, the APA report from 2016 says that fewer than 1 percent of firearm homicides are committed by a person diagnosed with a mental illness.

The full article can be found at:
https://www.nbcnews.com/news/us-news/connecting-mental-illness-gun-violence-misses-point-experts-say-n821696

**Mass Shootings and Mental Illness (James L. Knoll IV, M.D.; George D. Annas, M.D., M.P.H.; American Psychiatric Association)**

Below are excerpts from a study, conducted and published by the American Psychiatric Association, on gun violence and mental health:

Common Misperceptions

- Mass shootings by people with serious mental illness represent the most significant relationship between gun violence and mental illness.
- People with serious mental illness should be considered dangerous.
- Gun laws focusing on people with mental illness or with a psychiatric diagnosis can effectively prevent mass shootings.
- Gun laws focusing on people with mental illness or a psychiatric diagnosis are reasonable, even if they add to the stigma already associated with mental illness.

Evidence-Based Facts

- Mass shootings by people with serious mental illness represent less than 1% of all yearly gun-related homicides. In contrast, deaths by suicide using firearms account for the majority of yearly gun-related deaths.
- The overall contribution of people with serious mental illness to violent crimes is only about 3%. When these crimes are examined in detail, an even smaller percentage of them are found to involve firearms.
- Laws intended to reduce gun violence that focus on a population representing less than 3% of all gun violence will be extremely low yield, ineffective, and wasteful of scarce resources. Perpetrators of mass shootings are unlikely to have a history of involuntary psychiatric hospitalization. Thus, databases intended to restrict access to guns and established by guns laws that broadly target people with mental illness will not capture this group of individuals.
- Gun restriction laws focusing on people with mental illness perpetuate the myth that mental illness leads to violence, as well as the misperception that gun violence and mental illness are strongly linked. Stigma represents a major barrier to access and treatment of mental illness, which in turn increases the public burden

The full report can be found at:
https://psychiatryonline.org.psychiatryonline.org/doi/pdf/10.5555/appi.books.9781615371099

**How to reduce shootings (Nicholas Kristof; New York Times)**

Below are excerpts from a recent New York Times editorial (printed originally in the aftermath of a mass shooting in Texas) that provides a rich source of facts related to gun violence and a comparison of the impact of public policy initiatives to combat it.:

> Inevitably, predictably, fatefully, another mass shooting breaks our hearts. This time, it was a school shooting in Florida on Wednesday that left at least 17 dead at the hands of 19-year-old gunman and his AR-15 semiautomatic rifle.
> But what is perhaps most heartbreaking of all is that they shouldn't be shocking. People all over the world become furious and try to harm others, but only in the United States do we suffer such mass shootings so regularly; only in the United States do we lose one person every 15 minutes to gun violence.
>
> So let's not just mourn the dead, let's not just lower flags and make somber speeches. Let's also learn lessons from these tragedies, so that there can be fewer of them. In particular, I suggest that we try a new approach to reducing gun violence — a public health strategy

The full editorial can be found at:
https://www.nytimes.com/interactive/2017/11/06/opinion/how-to-reduce-shootings.html

**How to Reduce Mass Shooting Deaths? Experts Rank Gun Laws ( Margot Sanger-Katz; Quoctrung Bui, New York Times)**

Below are excerpts from a recent New York Times editorial (printed originally in the fall of 2017) that provides a rich source of facts related to gun violence and a comparison of the impact of public policy initiatives to combat it.:

> Whenever a mass shooting shocks America, people ask if tighter gun-control measures could have prevented the slaughter.
>
> Gun violence researchers say that no law can eliminate the risk of mass shootings, which are unpredictable and represent a small minority of gun homicides over all. But there are a handful of policies that could reduce

the likelihood of such events, or reduce the number of people killed when such shootings do occur. And several of them have strong public support.

These are findings from surveys we conducted a year ago about the recurring problem of gun violence in the United States. We asked dozens of researchers in criminology, law and public health to assess a range of policies often proposed to prevent gun deaths. We also conducted a national poll to measure public support for the same set of measures.

The full article can be found at:
https://www.nytimes.com/interactive/2017/10/05/upshot/how-to-reduce-mass-shooting-deaths-experts-say-these-gun-laws-could-help.html?smid=fb-share

**Need to boldly face the causes of gun violence rather than scapegoating those with mental illness (Robert Sheehan, Community Mental Health Association of Michigan)**

Below is a recent editorial issued by this association in response to the mass shooting in Parkland Florida.

The recent mass shooting in Florida is a tragedy, especially when preceded by the shooting in Sutherland Springs, Texas, only a few months ago. The continual, devastating tragedies call us to examine and take action on the real causes of gun violence in America, as these tragedies continue to arise. Together, we must bravely discuss the real actions needed to dramatically reduce gun-related violence in our country.

To be clear, my call for such a clear-eyed examination is not an argument for or against gun control. That is a different topic for a different day. In the wake of the Florida school shooting, I am calling, as are many others in the mental health and public safety arenas across the country, that we stop derailing this difficult but sorely needed examination by scapegoating, in the wake of tragic mass shootings, those with mental illness, while doing nothing to address this nation's gun violence nor its mental health needs.

Attempts to connect every violent act to mental illness represent an inaccurate and simplistic analysis to a complex problem. Study after study has shown that ***persons with mental illness are more likely to be victims of violence than perpetrators***. A comprehensive study of gun violence in America found that only 4% of American gun deaths are related to mental illness. The bulk of these are suicides and do not involved violence to others.[1]

Additionally, if mental illness were truly the cause of gun violence, then other developed countries with comparable mental health spending, and mental health practitioners per capita would have similar levels of gun violence. None of them do.

While there are 33 gun deaths in the U.S. per year, per million people, there were only 5 per year, per million in Canada and 0.7 per million in Britain.[2]

Ironically, while repeatedly calling, after nearly every mass shooting, for the examination of a person's mental stability as part of gun purchase, Congress passed and President Donald Trump recently signed a bill eliminating rules, which would limit gun access for those with mental illness. While these prohibitions are controversial, given the delicate balance between civil liberties and public safety, eliminating this rule instead of refining it was a missed opportunity and sadly ironic.

Equally ironic is the contrast of the call, in the wake of a mass shooting, for improved access, by all Americans, to mental health services, while those sounding that call are also working to cut Medicaid and Affordable Healthcare Act (ACA)-supported health insurance which are among the chief tools for ensuring such access to mental health and substance use disorder treatment.

I mourn the victims of this senseless violence in Florida, as we have mourned for the victims so many high-profile killings, and those that do not make the press, over the past several years. I grieve for the families who have lost loved ones.

I, along with many across the country, want to ignite a conversation. A conversation around the real causes of gun violence and around the need to stop scapegoating those working so hard to live with and recover from mental illness.


Sources:

[1] Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of epidemiology*, *25*(5), 366-376.

[2] Zimring, F. E., & Hawkins, G. (1999). *Crime is not the problem: Lethal violence in America*. Oxford University Press.

February 16, 2018

**FRIDAYFACTS**

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

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

RE:

- **New e-mail addresses for Association staff**
- **Association soon to announce new membership opportunities**
- **Friday Facts to become a members-only electronic newsletter**
- **Work and Accomplishments of CMH Association Member Organizations**
  - **Northeast Guidance Center announces Anti-Stigma Forum**
- **State and National Developments and Resources**
  - **CMH Association issues editorial: Need to boldly face the causes of gun violence rather than scapegoating those with mental illness**
  - **Clear-eyed research-based response to recent school shootings**
  - **MDHHS releases recommendations to improve access to inpatient psychiatric services**
  - **How Medicaid work requirements will harm people with addictions**
  - **Center for Bioethics announces blog on Medicaid and health policy**
  - **National Council offers webinar: Get Upstream to Reduce the Opioid Epidemic**
  - **CDC funded program announces suicide prevention initiative aimed at men**
  - **National Council announces NatCon 2018**
  - **2018 Michigan Rural Health Conference**
  - **National Council offers webinar on support for persons with schizophrenia**
- **Legislative Update**
  - **Upcoming DHHS Committee Meetings**
  - **House CARES Update**
- **National Update**
  - **Trump Releases Budget Proposal, Seeks Medicaid Cuts and Opioid Funding**
- **CMHAM Spring Conference – Change of Dates and Location**
- **Gambling Symposium – March 2, 2018**
- **Social Work Ethics, Addiction & Pain Management Trainings for 2018**
- **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 soon 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 will soon be announcing 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**.

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## WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

### Northeast Guidance Center announces Anti-Stigma Forum

Northeast Guidance Center's (NEGC) annual Anti-Stigma Forum is slated for:

Thursday, May 3rd
5pm-7:30pm
The Salvation Army
3000 Conner
Detroit.

This event is free to attend and focuses on the impact of the opioid epidemic on children and adolescents (see details above). Speakers will share personal experiences, bring awareness to the national epidemic and discuss ways Michigan is working to reduce overdoses, addiction and deaths. The

Anti-Stigma Forum is held during Mental Health Awareness Month and focuses on issues of mental health and the associated stigma.

Speakers include:

Ken Daniels, a play-by-play announcer for the Detroit Red Wings who lost his 23-year-old son to an opioid overdose. Daniels presents a strong and powerful message to the community, especially student athletes and parents, about the ever growing opioid crisis.

Jacque Liebner and Corey Warren are a mother and son duo who founded WAI-IAM, a Lansing-based non-profit that focuses on prevention, awareness and post-treatment services for substance abuse. Their presentation, Straight Talk, focuses on Corey's experience as a former heroin addict and how Jacque dealt with the many trials and tribulations of Corey's journey to sobriety.

Community Network Services (CNS) has a unique Anti-Stigma Program, which combines educational information with poetry and music into a presentation that spreads the message that hope and recovery with a mental illness is possible.

Audiences invited to attend this free event include parents, grandparents, educators, social workers, high school students, youth groups, church members, pastors, law enforcement, first responders and others who need to know about opioids and why the epidemic is spreading so rapidly in SE Michigan.

RSVP by April 30th to scommon@neguidance.org, call 313-308-1416 or go to https://www.neguidance.org/event/anti-stigma-forum/ and click on the RSVP button.

## STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

### CMH Association issues editorial: Need to boldly face the causes of gun violence rather than scapegoating those with mental illness

The recent mass shooting in Florida is a tragedy, especially when preceded by the shooting in Sutherland Springs, Texas, only a few months ago. The continual, devastating tragedies call us to examine and take action on the real causes of gun violence in America, as these tragedies continue to arise. Together, we must bravely discuss the real actions needed to dramatically reduce gun-related violence in our country.

To be clear, my call for such a clear-eyed examination is not an argument for or against gun control. That is a different topic for a different day. In the wake of the Florida school shooting, I am calling, as are many others in the mental health and public safety arenas across the country, that we stop derailing this difficult but sorely needed examination by scapegoating, in the wake of tragic mass shootings, those with mental illness, while doing nothing to address this nation's gun violence nor its mental health needs.

Attempts to connect every violent act to mental illness represent an inaccurate and simplistic analysis to a complex problem. Study after study has shown that ***persons with mental illness are more likely to be victims of violence than perpetrators***. A comprehensive study of gun violence in America found that only 4% of American gun deaths are related to mental illness. The bulk of these are suicides and do not involved violence to others.[1]

Additionally, if mental illness were truly the cause of gun violence, then other developed countries with comparable mental health spending, and mental health practitioners per capita would have similar levels of gun violence. None of them do.

While there are 33 gun deaths in the U.S. per year, per million people, there were only 5 per year, per million in Canada and 0.7 per million in Britain.[2]

Ironically, while repeatedly calling, after nearly every mass shooting, for the examination of a person's mental stability as part of gun purchase, Congress passed and President Donald Trump recently signed a bill eliminating rules, which would limit gun access for those with mental illness. While these prohibitions are controversial, given the delicate balance between civil liberties and public safety, eliminating this rule instead of refining it was a missed opportunity and sadly ironic.

Equally ironic is the contrast of the call, in the wake of a mass shooting, for improved access, by all Americans, to mental health services, while those sounding that call are also working to cut Medicaid and Affordable Healthcare Act (ACA)-supported health insurance which are among the chief tools for ensuring such access to mental health and substance use disorder treatment.

I mourn the victims of this senseless violence in Florida, as we have mourned for the victims so many high-profile killings, and those that do not make the press, over the past several years. I grieve for the families who have lost loved ones.

I, along with many across the country, want to ignite a conversation. A conversation around the real causes of gun violence and around the need to stop scapegoating those working so hard to live with and recover from mental illness.

*Robert Sheehan is the chief executive officer of the Community Mental Health Association of Michigan (formerly, the Michigan Association of Community Mental Health Boards).*

# # #

Sources:

[1]Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of epidemiology*, *25*(5), 366-376.

[2]Zimring, F. E., & Hawkins, G. (1999). *Crime is not the problem: Lethal violence in America*. Oxford University Press.

**Clear-eyed research-based response to recent school shootings**

In the wake of the school shootings in Parkland Florida, Brian Van Brunt, the Executive Director of the National Behavioral Intervention Team Association, was recently interviewed on National Public Radio (NPR) and provided one of the more fact-based description of the causes of gun violence. Dr. Van Brunt went on to outline a set of level headed and research-based approaches to preventing mass shootings.

The interview can be heard at:
https://www.npr.org/2018/02/16/586315515/intervening-early-to-stop-killers

Learn more about the National Behavioral Intervention Team Association at: https://nabita.org/

**MDHHS releases recommendations to improve access to inpatient psychiatric services**

Below is a recent press release, from MDHHS, on the recent release, by the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) workgroup, of the report containing a series of recommendations to improve access to inpatient psychiatric care.

> The Michigan Department of Health and Human Services (MDHHS) is taking action to improve access to inpatient psychiatric services for Michigan residents by implementing recommendations that address staffing, expanded treatment options, health information sharing and financing and reimbursement.
>
> In July 2017, MDHHS launched the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) initiative to investigate ongoing barriers to accessing inpatient psychiatric services in the state. A workgroup composed primarily of providers and payers analyzed the issue and produced a report of its recommendations in October 2017. MDHHS analyzed statutory, regulatory and fiscal impacts of implementing MIPAD's recommendations. Based upon this analysis, MDHHS has identified 19 of these recommendations for short-term action in 2018.
>
> "Over the last several decades, the number of inpatient psychiatric beds has decreased, and health care providers have increasingly struggled to secure inpatient services for individuals who are in psychiatric crisis," said Lynda Zeller, MDHHS's Director of Behavioral Health and Developmental Disabilities Administration. "Taking immediate action on these recommendations will help Michigan residents get the psychiatric services they need."

In 1993, community hospitals in Michigan had 3,041 adult psychiatric beds and 729 child/adolescent psychiatric beds. In 2017, that number dropped to 2,197 adult beds and 276 child/adolescent beds. The lack of psychiatric beds has escalated the pressure on hospital emergency departments, which are called to serve individuals on voluntary and involuntary psychiatric holds while awaiting transfers to psychiatric facilities. For example, Michigan emergency departments experienced 52,671 visits from 34,517 Medicaid beneficiaries who had a principal mental health diagnosis in 2016.

MDHHS will continue to engage stakeholders throughout the implementation process. In addition, the department will explore opportunities to partner with the House C.A.R.E.S. Task Force on improving access to inpatient psychiatric services. Grant funding from the Michigan Health Endowment Fund will be used to jumpstart the implementation process.

The workgroup's full report is available online at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_85156---,00.html

**How Medicaid work requirements will harm people with addictions**

The Center on Budget and Policy Priorities recently released a report outlining how new Medicaid work requirements, such as those approved in Kentucky and Indiana, threaten recent gains in health coverage and treatment access for individuals with addiction. The report points out that despite certain designated exemptions, many people with substance use disorders (SUDs) will not be exempt from work requirements. Even those who are eligible for exemption will likely have trouble proving it due to bureaucratic obstacles and concerns with revealing a SUD to a public Medicaid agency. Further, many people with SUDs face significant employment barriers, making it unlikely they will be able to meet these new requirements. Read the report here. https://www.cbpp.org/research/health/how-medicaid-work-requirements-will-harm-people-with-substance-use-disorders

**Center for Bioethics announces blog on Medicaid and health policy**

The Michigan State University's Center for Ethics and Humanities and Life Sciences recently announced a blog, "At a Crossroads: Medicaid ad Health Policy in the U.S." The blog, led by Dr. Hannah Giunta,can be found at: https://msubioethics.com/2018/01/30/at-a-crossroads-medicaid-and-health-policy/

**National Council offers webinar: Get Upstream to Reduce the Opioid Epidemic**

Join Dr. Karl Haake, Pain Management Consultant for the Missouri Primary Care Association, and Dr. Leigh Steiner, Senior Analyst of Clinical Analytics and Applications at Relias, for a discussion on rethinking the healthcare response to pain before dependency starts.

The discussion will include leveraging behavioral health clinician expertise in assessing for behavioral health concerns that may exacerbate the pain condition and utilize behavioral health expertise in assisting persons with pain management behavioral techniques.

The webinar will be held on:

Date: February 22, 2018
Time: 2:00 p.m. ET
Duration: 1 hour

Register at:

http://go.reliaslearning.com/WBN2018-02-22OpioidCrisis_Registration.html?utm_source=marketo&utm_medium=email&utm_campaign=wbn_2018-02-22_opioid_crisis_hhs_pay&mkt_tok=eyJpIjoiWTJabE5ETTNOMlk0WlROaCIsInQiOiIyK1hhaXBWNENPRjdZYzBjWUh0Ymhjd01EZ2VxU2N2d0dXK1pGeVpHRFpaWTJsZERzY2hhWmNBMXZKdXRUd0Rha3NCTWdXNzZlK2lUdFhTcHN0Zk1IeXpscE5hdStMTXoxYVwvRXA0c1hlM2V0RndJQ3hZcHlYZVhmM056K3pzek8ifQ%3D%3D

**CDC funded program announces suicide prevention initiative aimed at men**

Below is a recent announcement of the work of the Healthy Men Michigan initiative in the area of suicide prevention. This effort, funded by the federal Centers for Disease Control (CDC) provides a number of tools for communities to use to prevent suicide among men.

Suicide is the leading cause of injury death among men in Michigan

Luckily, there is a new resource to help men deal with their mental and emotional health.

> What is Healthy Men Michigan? The HealthyMenMichigan.org campaign is a statewide initiative designed to promote mental health and wellbeing among working-aged men. The website offers free online screening and referral resources for several mental health issues, including suicide, and access to local, quality treatment options. Based on anonymous screening results, some men will be invited to participate in a voluntary, paid research study testing the effectiveness of a new male-focused online program.
>
> Visit HealthyMenMichigan.org to take a screening and to learn more:. http://healthymenmichigan.org/
>
> Dr. Jodi Jacobson Frey is PI for a voluntary research study connected to the campaign. To learn more about the research, please visit http://www.ssw.umaryland.edu/healthymenmichigan/.
>
> We are currently seeking organizational and community partners throughout Michigan to help promote the HealthyMenMichigan.org Campaign.
>
> How do I get involved? Follow these three easy steps to become a promotional partner and support this CDC-funded statewide initiative:
>
> 1 Join the Healthy Men Michigan e-newsletter mailing list by emailing us at healthymenmichigan@mentalhealthscreening.org
>
> 2. Get your free Healthy Men Michigan promotional materials to share in your community
>
> - Visit the Healthy Men Michigan Downloadable Resource Center (DRC) at HealthyMenMichigan.org/toolkit https://mentalhealthscreening.org/materials/healthy-men-michigan-downloadable-resource-center/sMhhmm2016
> - to access flyers, posters, social media posts, graphics and PSA scripts.
> - Order promotional materials like posters, coasters and other hand-outs that will be shipped
> - to you at no cost from https://shop.mentalhealthscreening.org/collections/healthy-men-michigan.
>
> 3 Take the Take 5 Pledge to help spread the word about Healthy Men Michigan
>
> - Add a link to www.HealthyMenMichigan.org on your company's website
> - Add a link to www.HealthyMenMichigan.org in your company's newsletter
> - Send promotional emails and social media posts to community members
> - Bring promotional materials to local venues
> - Share promotional materials at men-specific locations and events

> If you have any questions about Healthy Men Michigan, or would like to become a promotional partner, email us at HealthyMenMichigan@mentalhealthscreening.org.

**National Council announces NatCon 2018**

The National Council for Behavioral Health, of which this Association, and all of its members, are members, is holding its 2018 annual conference, NatCon. NatCon is the annual conference of the National Council for Behavioral Health, of which all of the members of the CMH Association of Michigan are members and receive discounts on the registration of the CMH Association's staff and Board members, to NatCon. NatCon 2018 takes place in Washington DC from April 23 through 25, 2018

Be Present
Join more than 5,000 leaders – like you – and explore health care's greatest innovations in practice improvement, financing, integrated health care, technology, policy and advocacy and professional development at the National Council Conference, NatCon18.

Be Supported
NatCon18 is hosted by the National Council for Behavioral Health, the unifying voice of America's mental health and addictions treatment organizations.

Be Informed
At NatCon18, you'll get the information and the tools you need to improve your practice and bottom line as you learn what the future looks like and how to prepare to compete in the new health care world.

Be Active
Exercise your right to meet your representatives on Capitol Hill. Join the National Council's Hill Day, happening right after NatCon18.

Be Heard
NatCon18 is the single biggest event for behavioral health – a powerful gathering of leaders in health care. We invite you to join your community. Bring your passion. Share your experience. Lend your voice.

NatCon 18 will be hosting some of the biggest names in our space, including Brené Brown, former Surgeon General Vivek Murthy, Elisabeth Rosenthal, Meet the Press Moderator Chuck Todd, Elinor McCance-Katz and many more.

You can learn more about NatCon 18 and its offerings at: https://natcon18.thenationalcouncil.org/

**2018 Michigan Rural Health Conference**

The Michigan Center for Rural Health recently announced the 2018 Michigan. Rural Health Conference. Below is that announcement:

> Please join us for the 2018 Michigan Rural Health Conference May 3-4, 2018 at the Soaring Eagle Casino & Resort in Mt. Pleasant, Michigan.
>
> The theme of this year's conference is, "Innovations in Rural Health." Participants will gain new knowledge of timely and effective methods to enhance their organization. Whether it's concentrating on improving clinical quality, leadership, managing staff, or focusing on patient satisfaction, participants will have the opportunity to learn from subject matter experts and rural health peers. The conference sessions will feature a variety of informative topics such as a Federal Update on Rural Health Issues, MACRA: Using Data to Capture Quality, The Quality Payment Program: 2018 Rule Updates and Strategies for Successful Participation, Cyber

Security, Benefits of Care Management, Behavior Health, and Opioid Disscussion Panel, as well as several other valuable presentations.

Who Should Attend?
This conference is designed to be of interest to a wide range of rural health advocates including community leaders, clinicians, administrators, board members, public health officials, rural health clinics, federally qualified health centers, local health departments and others interested in the development of healthcare in their community.

Speaker Presentations
Speaker presentations will be available one to two days prior to the conference. Visit the Michigan Rural Health Conference section on our website to get the presentations. *Please note paper copies will not be available at the conference.*

*Information about the conference can be found at:*
*http://events.r20.constantcontact.com/register/event?llr=9gwxeymab&oeidk=a07eevkh9kl85e9c29c*

Register at:
https://events.r20.constantcontact.com/register/eventReg?oeidk=a07eevkh9kl85e9c29c&oseq=&c=&ch=

**National Council offers webinar on support for persons with schizophrenia**

Below is a recent announcement from the National Council for Behavioral Health on the "Importance of Transitions of Care in the Management of Schizophrenia"

*Managed care organizations face many challenges regarding transitions of care for their members with schizophrenia, from medication adherence to follow up after hospitalization. Join Alkermes and the National Council for a one hour webinar featuring real-world examples of payer and provider-led programs focused on transitions of care for individuals with schizophrenia.*

*A Montefiore Medical Center representative will share their experiences and observations with implementing care models focused on enhancing transitions of care for individuals with schizophrenia.*

February 20th, 2:00 to 3:00 p.m. ET

Register here: https://attendee.gotowebinar.com/register/1327681569103442435

Presenters:
Chuck Ingoglia, MSW, Sr. Vice President, Public Policy and Practice Improvement, National Council for Behavioral Health
With more than fifteen years experience in behavioral health care, Chuck Ingoglia has worked as a provider, an advocate and an educator for government and public sector organizations at the national and local levels. In his current role, Mr. Ingoglia directs the federal affairs function of the nonprofit trade association as well as its policy and technical assistance outreach to more than 2,900 member organizations across the nation. Most recently, his efforts have centered on key issues such as Medicare Part D, the service implications of the federal Deficit Reduction Act, provider/physician reimbursement, the emergence of electronic health records and the coordination of behavioral health and primary health care.

Scott Wetzler, PhD, CEO, University Behavioral Health Associates; Vice Chairman, Department of Psychiatry, Montefiore Medical Center/ Albert Einstein College of Medicine
A national leader in population health approaches for the behavioral health population, Dr. Wetzler oversees the behavioral health component for Montefiore Medical Center's Accountable Care Organization.

## LEGISLATIVE UPDATE

### FY19 Executive Budget Proposal

### Upcoming DHHS Committee Meetings

### Senate DHHS Budget Committee

Committee: Senate Health and Human Services Appropriations Subcommittee

Location: Room 1100, Binsfeld Senate Bldg, 201 Townsend Street, Lansing MI

Date: Tuesday, February 20, 2018

Time: 1:00 – 2:30PM

Agenda 1. Child Welfare Services Public Assistance and Field Operation

2. Public Testimony

### House DHHS Budget Committee

Committee: House Health and Human Services Appropriations Subcommittee

Location: Room 352, House Appropriations, State Capitol Building, Lansing, MI

Date: Wednesday, February 21, 2018

Time: Noon – 1:30PM

Agenda 1.Behavioral Health & Developmental Disabilities Administration presentation

2. Public Testimony

### House CARES Update

Over the past couple of weeks a number of bills have been introduced from the House of Representatives' CARES (Community, Access, Resources, Education and Safety) Task Force, which convened last summer to explore Michigan's mental health system. Below is a list of the bills that have had at least a committee hearing in the past month and a link to the full task force report.

https://house.mi.gov/PDFs/HouseCARESTaskForceReport.pdf

**HB 5085** – dedicates 4% of the unmarked money raised through Michigan's liquor sales and fees and earmark it specifically for substance use disorder treatment and prevention services. HB 5085 could provide more than $17 million a year to combat alcohol-related disorders, opiate addiction and other substance use disorders.

**HB 5439** – requires the DHHS to establish and administer an electronic inpatient psychiatric bed registry, with beds categorized by patient gender, acuity, age, and diagnosis that is accessible through the DHHS website.

**HB 5460** – require that programs and curricula for paramedics or medical first responders include training in treating drug overdose patients that is equivalent to training provided by the American Heart Association Basic Life Support (BLS) for Health Care Providers.

**HB 5461** – Current law allows peace officers to possess and administer an opioid antagonist if they have been trained in its proper administration and have reason to believe that the recipient is experiencing an opioid-related overdose. The bill would stipulate that the training required before administration of an opioid antagonist must meet the requirements set out in HB 5460.

**HB 5524** – requires that the Department of Education (MDE), in conjunction with the DHHS to develop or adopt a professional development course for teachers in mental health first aid.

**HB 5487** – establishes a uniform credentialing requirement for individuals who provide medical services through a contract health plan.

**HBs 5450-5452** – allows those once convicted of some minor felonies and misdemeanors would be allowed to work in some mental health care jobs (nursing homes, psychiatric facilities, & adult foster care homes)

## NATIONAL UPDATE

### Trump Releases Budget Proposal, Seeks Medicaid Cuts and Opioid Funding

On Monday, President Trump unveiled his Fiscal Year (FY) 2019 budget request — detailing his Administration's legislative and regulatory priorities for next year. The document revives last year's failed attempts to block grant Medicaid, boosts spending to combat opioid addiction, and outlines other major health care priorities. As with most presidential budgets, this proposal stands little chance of being enacted into law as written. Instead, the President's budget proposal will act more as a messaging tool to Congress, which just passed a major budget deal boosting defense and non-defense discretionary spending limits last week.

It is important to note that it is the role of Congress, not the President, to design and pass the federal budget. Last week, Congress passed a bill establishing topline spending numbers for various federal policy priorities for the remainder of the current fiscal year (FY 2018) and FY 2019. Now Congress has until March 23rd to appropriate those funds to specific agencies and programs for FY 2018. At the same time, the President has released his budget plan for FY 2019, which starts Oct. 1, 2018, yet it remains to be seen if any of the President's recommendations (detailed below) will be taken up by Congressional appropriators as they move through the budget process.

Among the highlights of the President's budget request for the Health and Human Services Department (HHS) for FY 2019:

Medicaid and ACA Repeal: The White House's budget proposal endorses the Graham-Cassidy health care bill, which would end the Affordable Care Act's (ACA) Medicaid expansion and convert federal Medicaid funding into block grants to the states. Both measures would result in tremendous cuts to the Medicaid program, however, there appears to be little political willpower to pass these proposals now after multiple ACA "repeal and replace" attempts failed last year. The National Council strongly opposes any attempt to cut or cap Medicaid as these provisions would seriously harm individuals with mental illness and addiction who rely upon Medicaid coverage for life-saving care.

Beyond that, the budget also proposes making it easier for states to charge patients higher co-pays for emergency room visits and bolster requirements that Medicaid recipients show immigration status before enrolling. Many of these changes have already been endorsed and encouraged by the Centers for Medicare and Medicaid (CMS) as part of state Medicaid waivers.

Opioid and Mental Health Funding: The budget proposal includes $10 billion in discretionary funding for HHS to fight the opioid crisis and outlines a number of policy changes in Medicare and Medicaid aimed at curbing drug abuse — part of a larger investment across government agencies to prevent and treat drug abuse. The proposal recommends some of these funds support an expansion of Certified Community Behavioral Health Clinics (CCBHCs) to care for people with serious mental illness and addiction. The budget also includes proposes allowing Medicare to provide comprehensive coverage for substance abuse treatment and requiring Medicaid to cover all three FDA-approved medication-assisted treatment (MAT) options including methadone, buprenorphine and extended-release naltrexone.

Importantly, mental health and addiction advocates should understand that the $10 billion fund is likely not entirely new funding. Although details of the President's budget are still emerging, some of the $10 billion appears to be offset by proposed cuts to other health care agencies, including a $668 million cut to the Substance Abuse and Mental Health Services Administration (SAMHSA) in FY 2019.

Late last week, the House and Senate passed a budget agreement to lift the budget caps and authorize an additional $6 billion to help address the opioid epidemic over FY 2018 and FY 2019. Over the next two fiscal years, the $6 billion will be allotted for various efforts to address opioid diversion and opioid addiction prevention and treatment. Funding will be distributed via state grants, taking into account each state's opioid mortality rates. It is also not yet clear how this additional spending authority impacts the President's FY 2019 budget proposal.
Further, the budget calls for all-but-eliminating the White House Office of National Drug Control Policy (ONDCP) and shifting its key grant programs to different agencies. The proposal requests $17 million for the drug office, down from $368.6 million last year. Most of that drop would come from moving the High Intensity Drug Trafficking Areas grant to the Justice Department, and the Drug Free Communities Act to HHS.

Prescription Drugs: With respect to enforcement, the budget proposes to establish HHS reciprocity with the Drug Enforcement Administration (DEA) to terminate provider prescribing authority for doctors who improperly prescribe addictive painkillers. The budget calls for cracking down on high opioid prescribers and utilizers in Medicaid and would also require plans to participate in a program to prevent prescription drug abuse in Medicare Part D.

NIH and Research Funding: The National Institutes of Health (NIH) would get $35.5 billion, or a $1.4 billion increase over fiscal 2018 funding levels. This includes $750 million from a broader $10 billion investment throughout HHS to fight the opioid crisis and address serious mental illness.

**CMHAM ANNUAL SPRING CONFERENCE: NEW DATE/LOCATION & CALL FOR PRESENTATIONS**

Update your calendars! The CMHAM Annual Spring Conference will now be held on:

Monday, April 30, 2018 – Pre-Conference Institutes
Tuesday, May 1 and Wednesday, May 2, 2018 – Full Conference
Diamond Center at Suburban Collection Showplace in Novi, Michigan

Click here for Call for Presentations: https://macmhb.org/annual-conferences
Deadline Friday, March 2, 2018

**TENTH ANNUAL GAMBLING DISORDER SYMPOSIUM**

MDHHS & CMHAM Present: Michigan's Tenth Annual Gambling Disorder Symposium, ""A Holistic Approach to Gambling Disorder Treatment…Mind, Body & Spirit." The Symposium will be held on Friday, March 2, 2018 at the Diamond Center at Suburban Collection Showplace in Novi, Michigan.

Registration Fee: $35 per person and includes all materials, continental breakfast, lunch and refreshments.
To Register Click Here!

Symposium Highlights:

- Assessment and Treatment of Gambling Disorder with an Emphasis on High Risk Populations
- Problem Gambling: A Growing Epidemic Among Youth & Using Adverse Childhood Experiences (ACE) in Treatment
- Neurobiology of Gambling and Other Addictions
- Prevention: An Open Panel Discussion
- Treating Gambling Disorder with Mindfulness and Spirituality
- The Problem Gambler and the Criminal Justice System
- Insider's View of Gamblers Anonymous: Open Meeting
- Gambling Behavior - it's Functional

**SOCIAL WORK ETHICS, ADDICTION & PAIN MANAGEMENT TRAININGS FOR 2018**

Community Mental Health Association of Michigan is pleased to offer 6 Social Work Ethics, Addiction and Pain Management Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC, on the following dates. Registration will open on February 26th.

- March 21 - Lansing
- April 25 - Lansing
- May 30 - Lansing
- June 27 – Battle Creek/Kalamazoo Area
- July 11 - Novi/Detroit area
- August 22 - Lansing

**CMH Association committee schedules, membership, minutes, and information go to our website at** https://www.macmhb.org/committees

**EMDR Training**

Trauma Recovery/EMDR Humanitarian Assistance Programs presents Eye Movement Desensitization and Reprocessing (EMDR). EMDR Basic Training consists of Weekend I (April 11-13, 2018) and Weekend II Training. Each training event is three days of didactic and supervised practice. To complete Trauma Recovery/HAP's EMDR Training, each participant is required to complete 10 hours of consultation. Each participant/agency must arrange for consultation hours on their own, through the HAP Consultant Directory. If you have staff interested, please email awilson@cmham.org for more information. .

***Have a Great Weekend!***

February 9, 2016

**FRIDAYFACTS**

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

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

RE:

- **New e-mail addresses for Association staff**
- **Association soon to announce new membership opportunities**
- **Friday Facts to become a members-only electronic newsletter**
- **Work and Accomplishments of CMH Association Member Organizations**
  - **SWMBH, CMHs in southwest Michigan and partners received federal grant**
- **State and National Developments and Resources**
  - **Can new bipartisan group break through divisions and build reform consensus?**
  - **SAMHSA/HRSA CIHS issues healthcare integration sustainability guide**
  - **MI Bridges issues latest Community Partner Bulleting**
  - **Numerous Flaws Found in Flint Area Community Health and Environment Partnership Journal Articles**
  - **Michigan Association for Suicide Prevention announces spring conference**
  - **NASW-Michigan and MCCD offer at-risk youth workshop**
  - **HIPAA updates from Abilita and Enhanced Computing Solutions**
- **Legislative Update**
  - **FY19 Executive Budget Proposal**
  - **More Mental Health Task Force Bills Introduced**
- **National Update**
  - **Legislation of Potential Import to NACBHDD**
- **Gambling Symposium – March 2, 2018**
- **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 soon 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 will soon be announcing 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**.

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## WORK AND ACCOMPLISHMENTS OF CMH ASSOCATION MEMBER ORGANIZATIONS

**SWMBH, CMHs in southwest Michigan and partners received federal grant**

Below is an excerpt from a recent article in the WMU News highlighting the receipt of a federal grant to address the state's mental health workforce needs. As the article underscores, Southwest Michigan Behavioral Health (SWMBH) and the CMHs in the SWMBH region, all members of this association , are key partners in this effort.

> OT, social work faculty earn $1.8 million behavioral health grant: A four-year, $1.8 million grant for behavioral health workforce education and training will support a Western Michigan University project that aims to increase the number of thoroughly trained treatment providers who work with the region's underserved and vulnerable community members.
>
> Dr. Ann Chapleau, associate professor of occupational therapy, and Dr. Jennifer Harrison, assistant professor of social work, received the grant from the U.S. Health Resources and Services Administration. The funding will support WMU's Interprofessional Peer Education and Evidence for Recovery project, IPEER, a joint initiative of the Department of Occupational Therapy and School of Social Work.
>
> Chapleau and Harrison created IPEER to enhance interdisciplinary education for social workers, occupational therapists and peer specialists, and to expand the number of these professionals who are available to serve rural and medically underserved communities in southwest Michigan.

The IPEER project connects the educational training and direct service provided through WMU;s College of Health and Human Services with numerous off-campus partner organizations where students complete their required fieldwork.
Organizations where that collective training takes place include the Kalamazoo Psychiatric Hospital, **Southwest Michigan Behavioral Health and the Recovery Institute of Southwest Michigan,** as well as community mental health programs and their providers **in Allegan, Barry, Berrien, Branch, Cass, Calhoun, Kalamazoo, Ottawa, ST. Joseph and Van Buren counties.**

Harrison says the new grant funding will boost the ability of WMU and its partners to prepare students for interprofessional behavioral health practices as well as to provide innovative training that will strengthen the behavioral health workforce in southwest Michigan.

"The majority of the funding will be used to provide stipends to occupational therapy and social work master's students in their final-year field placements at our partner organizations," Harrison says. "Twenty-eight students will be eligible for $10,000 stipends each year. This will remove a significant financial burden from both the University and our students and allow the students to focus on their research and to make the most of their final-year clinical experiences."

The full article can be found at:
https://www.wmich.edu/news/2018/02/45083

## STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

### Can new bipartisan group break through divisions and build reform consensus?

Below is an excerpt from a recent Modern Healthcare article on the formation of a non-profit group, headed up by former CMS Director, Andy Slavit.

American health policy is stuck in a deep political rut. Now a bipartisan group of prominent healthcare, political and not-for-profit leaders have come together to try to build a public consensus for how to reform the system.

The new not-for-profit group launched on Tuesday is called United States of Care ( https://unitedstatesofcare.org/about-us/ ) and promises to move beyond partisan politics and find politically sustainable ideas to ensure that every American has a regular source of affordable care, no one faces financial devastation due to an illness or injury, and that any solutions are economically responsible and have broad political support.

You are forgiven for your initial skepticism. But what are the alternatives if not finding consensus and compromise?

"It's very hard to negotiate things that are acceptable to both sides of the political spectrum, particularly if you consider the left fringe of the Democratic Party and the right fringe of the Republican Party," said Dr. David Blumenthal, president of the Commonwealth Fund and a historian of health policy. "But American politics has gone through many changes over the centuries. It's not impossible to imagine another political or policy window opening."

Starting this month, United States of Care plans to hold public listening events in Minnesota, North Caroling and Utah bringing together residents, elected officials of both major parties, healthcare leaders, academic experts and patient advocates to discuss what they want to see from the healthcare system.

Andy Slavitt, founder and chairman of United State of Care and former acting CMS administrator during the Obama administration, said he and former GOP Sen. David Durenberger will lead the listening tour in their

home state of Minnesota. Dr. Mark McClellan, a Republican who headed the CMS and the U.S. Food and Drug Administration, will lead the tour in North Carolina, while Mike Leavitt, Utah's former Republican governor and former HHS secretary, will head up the Utah sessions.

The full article can be found at:

http://www.modernhealthcare.com/article/20180206/BLOG/180209937

**SAMHSA/HRSA CIHS issues healthcare integration sustainability guide**

The federal SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) recently issued a guide book that addresses a question often asked by the members of this association who are engaged in healthcare integration efforts: Sustaining Integrated Behavioral Health and Primary Care: A Step-by-Step Guide. The details of the guide are described below:

> Clients, health care teams, and researchers agree that integrating care promotes a whole-person approach to health with immediate and lasting benefits. Whether just starting to integrate behavioral health services or working to enhance services already in place, the SAMHSA-HRSA Center for Integrated Health Solutions has created a step-by-step guide presenting four steps for safety net and other primary care providers to integrate behavioral health services and achieve sustainable integrated care models.
>
> - Step 1 – Operational and Administrative Readiness
> - Step 2 – Workforce Development
> - Step 3 – Clinical Practice Tools
> - Step 4 – Sustainability and Continuous Improvement

The Guide can be found at: https://integrationedge.readz.com/overview-and-step-1--operational-and-administrativ

Did you miss Part 1 of this email series. Sustaining Integrated Behavioral Health Services: Strategies and Tools for Workforce Development? Find it on the *Integration Edge.* https://integrationedge.readz.com/home

**Numerous Flaws Found in Flint Area Community Health and Environment Partnership Journal Articles**

Below is a recent press release, issued by MDHHS, that outlines some of the flaws in the journal articles describing the Flint water crisis.

The Michigan Department of Health and Human Services (MDHHS) recently learned that Wayne State University, the University of Michigan and Colorado State University will publish two journal articles based on data from the Flint Area Community Health and Environment Partnership (FACHEP) project.

Previously, FACHEP provided MDHHS with a draft of these journal articles which claim to explore the statistical relationship between the change in water source and the incidence of Legionnaire's Disease in Flint and other Southeast Michigan counties and the prevalence of various strains of legionella found in the cities of Flint and Detroit. MDHHS reviewed the draft articles as did an external, independent third party, KWR Watercycle Research Institute (KWR). KWR was asked to review the FACHEP project on behalf of the Michigan Department of Management and Budget. Both MDHHS and KWR found numerous flaws in the articles which were brought to FACHEP's attention and appear to remain unaddressed. By publishing these inaccurate, incomplete studies at this point, FACHEP has done nothing to help the citizens of Flint and has only added to the public confusion on this issue.

The researchers not only failed to accurately describe conversations with MDHHS, but utilized variables in their dataset that inaccurately reflect the timing associated with cases of Legionnaires in Flint. Researchers also overestimate the risk to public health by focusing on a strain of the bacteria, serogroup 6, that is not typically associated with Legionnaires' disease. FACHEP acknowledges that 16/18 of the environmental isolates that it found were serotype 6. Not a single case of serogroup 6 Legionnaire's Disease was identified in Genesee county, despite widespread use of

legionella cultures. As even FACHEP recognizes, more research is needed to evaluate the risk of this strain. Publishing this report now, however, implies that a public health risk exists when there may not be one.

In addition KWR noted that the report focusing on the link between the switch in the Flint water and increase in Legionnaires' disease" … raises a number of serious critical questions with regard to the applied methodology, and gives little insight in the actual crude numbers in the various analyses." KWR added that "[t]he paper is difficult to follow in places and does not provide insight into the crude data with which the statistical analyses were performed. The authors claim that their analyses reveal causal relations, but failed to distinguish between the demonstration of a statistical association, and its interpretation as a causal relation."

Based upon concerns over FACHEP's methodology, the State of Michigan informed FACHEP that it was only willing to continue the partnership under the independent review and oversight of KWR. FACHEP rejected the State's offer to continue under these conditions.

Additional detail regarding the scientific concerns MDHHS has to these two journal articles can be found in "MDHHS Response to FACHEP Proceedings of the National Academy of Sciences Article" and "MDHHS Response to FACHEP American Society of Microbiology mBio Article" attachments.

Additional, related resources on this topic can be found at:

- MDHHS+Response+to+FACHEP+Proceedings+of+the+National+Academy+of+Sciences+Article+FINAL.pdf: https://content.govdelivery.com/attachments/MIDHHS/2018/02/05/file_attachments/953946/MDHHS%2BResponse%2Bto%2BFACHEP%2BProceedings%2Bof%2Bthe%2BNational%2BAcademy%2Bof%2BSciences%2BArticle%2BFINAL.pdf)

- MDHHS+Response+to+FACHEP+American+Society+for+Microbiology+mBil+Article+FINAL.pdf (https://content.govdelivery.com/attachments/MIDHHS/2018/02/05/file_attachments/953945/MDHHS%2BResponse%2Bto%2BFACHEP%2BAmerican%2BSociety%2Bfor%2BMicrobiology%2BmBio%2BArticle%2BFINAL.pdf)

- 171108+KWR+2017.081+final+report+scoping+mission+DEF.PDF (https://content.govdelivery.com/attachments/MIDHHS/2018/02/05/file_attachments/953949/171108%2BKWR%2B2017.081%2Bfinal%2Breport%2Bscoping%2Bmission%2BDEF.PDF )

**MI Bridges issues latest Community Partner Bulletin**

Below is the announcement of the most recent issue of the MI Bridges Community Partner Bulletin. This association, a member of the MI Bridges Advisory Group, urges its members to become subscribers to this bulletin, a key tool in their work with persons in need of a range of health and human services and supports.

We are excited to share with you the January issue of the MI Bridges Community Partner Bulletin!

As part of the MDHHS's Integrated Service Delivery effort, MI Bridges and the Assistance Application are undergoing transformative changes. These changes have been made in close collaboration with clients, community partners, and MDHHS caseworkers, who have provided input and feedback throughout the process. The new MI Bridges will enable residents to identify their needs and connect to community resources that meet those needs to improve stability over time. These resources include community programs and organizations through a partnership with Michigan 2-1-1.
We hope you find the bulletin useful as it contains information specifically designed for community partners, such as upcoming events, key MI Bridges updates, a timeline of key dates, and frequently asked questions.

Included in this issue:

- MI Bridges Soft Launch
- New Assistance Application

- MI Bridges Training for Community Partners
- MI Bridges Statewide Rollout Dates

The January Bulleting can be found at:
https://content.govdelivery.com/attachments/MIDHHS/2018/02/02/file_attachments/953121/Jan-MIBridgesBulletin-Community%2BPartner_Final.pdf

If you would like more information about the new MI Bridges, please visit our MI Bridges Partner website at www.michigan.gov/mibridgespartners.

If you have any questions or for more information, please contact us at MDHHScommunitypartners@michigan.gov.

**Michigan Association for Suicide Prevention announces spring conference**

Michigan Association for Suicide Prevention Conference
March 6 & 7, 2018
Comfort Suites, Mount Pleasant, Michigan

Educational Topics include:

- Adult and youth mental health first aid training
- Crisis intervention
- Teams and trauma training
- Suicide prevention

$75 Registration Fee through February 16, 2018

To Register Visit: https://www.mymasp.org/

**NASW-Michigan and MCCD offer at-risk youth workshop**

Working with Transgender and Gender Nonconforming At-Risk Youth
A Training for Psychologists, Social Workers, Mental Health Providers and Juvenile Justice Professionals

Friday, April 6th, 2018 from 9:00am-4:00pm
Saturday, April 7th, 2018 from 9:00am-4:00pm

Held at the Michigan Council on Crime and Delinquency
1679 Broadway Street Ann Arbor, Michigan 48105

Hosted by the National Association of Social Workers (NASW) and the Michigan Council on Crime and Delinquency (MCCD)

A 2-day, in depth training for practitioners who want to learn how to work more effectively with transgender/gender non-conforming at-risk youth. We will explore barriers and challenges, discuss successful strategies for engagement, hear directly for impacted people, and provide participants with an opportunity to learn from, and problem-solve with, local and statewide experts.

Registration:
Regular Price: $325
Student Price: $210
Discounted Price for NASW Members: $295
Discounted Price for NASW Student and Transitional Members: $150

Lunch will be provided and 12 CEs will be available for licensed social workers

Please register at http://www.nasw-michigan.org/events

**HIPAA updates from Abilita and Enhanced Computing Solutions**

Two corporate partners of this association, Abilita and Enhanced Computing Solutions periodically provide useful guidance, to the Association's members, on a range of healthcare information technology issues. Below is the most recent set of updates in this series.

- Misconception of HIPAA and the Opioid Crisis
  A common misconception of a HIPAA regulation is causing doctors to not notify families in the event of an overdose. HIPAA regulations tell us we cannot share patient health information without their consent. But what if the patient is unconscious and it is imperative to get information from the family?

- Sharing health information with family and close friends who are involved in the care of the patient if the provider determines that doing so is in the best interests of an incapacitated or unconscious patient is allowed. Also, informing persons in a position to prevent or lessen a serious and imminent threat to a patient's health or safety is allowed. It's important to note that whenever a state law conflicts with HIPAA, the more restrictive law is the winner. https://www.hhs.gov/about/news/2017/10/27/hhs-office-civil-rights-issues-guidance-how-hipaa-allows-info-sharing-address-opioid-crisis.html. We welcome you to join us at our CMHA pre-conference seminar to learn more.

- Why end user security awareness training is so important
  HIPAA training is required for compliance, but are you providing security awareness training? You may be asking; what does that have to do with HIPAA? A large percentage of patient data breaches are caused by phishing. The Office for Civil Rights has just released a newsletter regarding cyber extortion as well as a fact sheet and checklist. https://www.hhs.gov/sites/default/files/cybersecurity-newsletter-january-2018.pdf. Many of these attacks could have been prevented with continuous security awareness training.

- Whether its compromised email credentials, computer system credentials, or ransomware, it's critical for all end users with access to ePHI to know how to identify these emails to avoid becoming a victim. Compromised credentials to a system containing ePHI could mean a reportable breach for your organization. We welcome you to join us at our CMHA pre-conference seminar to learn more.

- What are the hot topics in HIPAA for 2018?
  In a study conducted by HIMSS Analytics, 78% of healthcare providers interviewed had experienced some form of cyber-attack with the past 12 months. According to a study by Bitglass, hacking and IT incidents pose the greatest risk to compliance. The volume of records that leak as a result of hacking is greater than all other breach events combined. AS new technologies emerge, they also bring new challenges in protecting your network.

- The first breach settlements of 2018 are here and they're related to not having a proper risk analysis or risk management plan. https://www.hhs.gov/about/news/2018/02/01/five-breaches-add-millions-settlement-costs-entity-failed-heed-hipaa-s-risk-analysis-and-risk.html. Completing a risk analysis each year will help you stay on top of your constantly changing network environment and the security risks that come with it. No network is 100% secure, which is why having a risk management plan drafted each year can help continuously fill the gaps in security. We welcome you to join us at our CMHA pre-conference seminar to learn more.

- HIPAA Enforcement Rule
  Most of us have heard of the 1.5 million dollar maximum penalty for a HIPAA violation, but there is more to it. The 1.5 million dollar max per year is per identical provision. Meaning that the maximum per year can be

much more than you think. The highest HIPAA penalty to date was for $5.5 million and was related to one stolen laptop. https://www.storagecraft.com/blog/most-costly-hipaa-fines-in-history/. The reason the penalty was so high? They were found to not have a risk analysis or have implemented basic security principals.

- Penalties are broken down into a few categories. Did not know, reasonable cause, willful neglect – corrected, and willful neglect – not corrected. In short, if you have a breach but were completing your annual risk analysis, providing end user HIPAA training, and were updating your HIPAA policies and procedures but a human error or cyber incident occurs, then the fine would be much less than if you were not completing these tasks. We welcome you to join us at our CMHA pre-conference seminar to learn more.

## LEGISLATIVE UPDATE

### FY19 Executive Budget Proposal

**Specific Mental Health/Substance Abuse Services Line items**

| | FY '17 (final) | FY '18 (final) | FY '19 (Exec Rec) |
|---|---|---|---|
| -CMH Non-Medicaid services | $120,050,400 | $120,050,400 | $120,050,400 |
| -Medicaid Mental Health Services | $2,336,960,100 | $2,315,608,800 | $2,364,039,500 |
| -Medicaid Substance Abuse services | $53,392,400 | $52,408,500 | $68,441,000 |
| -State disability assistance program | $2,018,800 | $2,018,800 | $2,018,800 |
| -Community substance abuse (Prevention, education, and treatment programs) | $73,811,800 | $77,380,000 | $76,456,200 |
| -Children's Waiver Home Care Program | $20,000,000 | $20,241,100 | $20,241,100 |
| -Autism Services | $61,168,400 | $105,097,300 | $199,841,400 |
| -Healthy MI Plan (Behavioral Health) | $247,822,900 | $288,655,200 | $292,962,900 |

**Other Highlights of the FY19 Executive Budget**

### Direct Care Staff Wages

The governor's FY19 budget continues the .50 cent wage increase to support direct care workers who provide critical hands-on supports and services (e.g., personal care services, mobility support) to residents served through Michigan's community mental health system. The funding is reflected in the budget within the Medicaid and HMP behavioral health line items to maintain the $0.50 wage increase for direct care workers. Boilerplate from FY18 requiring the $.50 increase is no longer in the budget because the increase is in place, however, there is still a reporting requirement in section 1009 for PIHPs to report on wages paid to these workers.

### Medicaid pharmaceutical savings

The governor's FY19 budget assumes $14 million Gross/$5 million GF savings in Medicaid pharmaceutical line item through implementing/refining a preferred drug list, enhanced rebates and other efficiencies. This reduction is not related to prior authorization and will not reduce overall services.

### Boilerplate Sections

**Section 298** – The FY19 executive budget continues the language from the final FY18 budget:

**Sec. 298.** (1) The department shall continue to pursue the implementation of the demonstration model as specified under subsection (2) of Section 298 of Article X of PA 107 or 2017. The department shall ensure that the demonstration model described in this subsection is implemented in a manner that ensures at least all of the following:

(a) That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot project described in this subsection must only be in effect for the duration of the pilot project described in this subsection.

(b) That the project is consistent with the stated core values as identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268.

(c) That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(2) The department shall continue to pursue the implementation of up to 3 pilot projects as specified under subsection (3) of Section 298 of Article X of PA 107 of 2017. The department shall ensure that the pilot projects described in this subsection are implemented in a manner that ensures at least all of the following:

(a) That allows the CMHSP in the geographic area of the pilot project to be a provider of behavioral health supports and services.

(b) That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot projects described in this subsection must only be in effect for the duration of the pilot projects described in this subsection.

(c) That the project is consistent with the stated core values as identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268.

(d) That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(3) For the duration of any pilot projects and demonstration models, the department shall require that contracts between CMHSPs and the Medicaid health plans within their pilot region mandate that any and all realized benefits and cost savings of integrating the physical health and the behavioral health systems shall be reinvested in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder. Any and all realized benefits and cost savings shall be specifically reinvested in the counties where the savings occurred in accordance with the Medicaid state plan and any applicable Medicaid waivers.

(4) The department shall continue to partner with 1 of the state's research universities to evaluate any pilot project(s) and demonstration model that are authorized under this section.

(a) The evaluation shall include information on the pilot project's or demonstration model's success in meeting the performance metrics developed in this subsection and information on whether the pilot project could be replicated into other geographic areas with similar performance metric outcomes.

(b) The evaluation shall include the performance metrics, at a minimum, from each of the following categories:

(i) Improvement of the coordination between behavioral health and physical health.

(ii) Improvement of services available to individuals with mental illness, intellectual or developmental disabilities, or substance use disorders.

(iii) Benefits associated with full access to community-based services and supports.

(iv) Customer health status.

(v) Customer satisfaction.

(vi) Provider network stability.

(vii) Treatment and service efficacies before and after the pilot projects and demonstration models.

(viii) Use of best practices.

(ix) Financial efficiencies.

(x) Any other relevant categories

(c) The evaluation shall be completed within 6 months of the end of the pilot project or demonstration model and shall be provided to the department, the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office.

(5) Upon completion of any pilot projects or demonstration models advanced under this section, the managing entity of the pilot project or demonstration model shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office within 30 days of completion of that pilot project or demonstration model detailing their experience, lessons learned, efficiencies and savings revealed, increases in investment on behavioral health services, and recommendations for extending pilot projects to full implementation or discontinuation.

**Section 909** – Language directing the use of revenue from the marihuana regulator funds be used to improve physical health, expand access to substance use disorder prevention and treatment services; and strengthen existing prevention, treatment, and recovery systems. (Same as FY18)

**Section 920** – Requires that the Medicaid rate-setting process for PIHPs include any state minimum wage increases; also states legislative intent that any Medicaid rate increase due to minimum wage increase be also distributed to direct care employees. (Same as FY18)

**Section 928** – Local match draw down. Section 928 – Local match draw down, includes subsection (2) stating legislative intent that any lapse funds for Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds. (Same as FY18)

**Section 940** – Transferring and Withdrawing CMHSP Allocations – Requires DHHS to review CMHSP expenditures to identify projected lapses and surpluses and to encourage the board of the CMHSP with a projected lapse to concur with the recommendation to reallocate the lapse to other CMHSPs and requires DHHS to withdraw funds from a CMHSP if those funds were not expended in a manner approved by DHHS, including for services and programs provided to individuals residing outside of the CMHSP's geographic region. (Same as FY18)

**Section 1009** – Each PIHP shall report to the department by February 1 of the current fiscal year the range of wages paid to direct care workers, including information on the number of workers at each wage level.

(2) The department shall report the information required to be reported according to subsection (1) to the senate and house appropriations subcommittee on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office by March 1 of the current fiscal year.

**Section 1010** – From the funds appropriated in part 1 for behavioral health program administration, up to $2,000,000.00 shall be allocated to address the implementation of court-ordered assisted outpatient treatment as provided under chapter 4 of the mental health code, 1974 PA 258, MCL 330.1400 to 330.1491. (Same as FY18)

**Section 1860** – Language requiring the Department to report by March 1 on the number of HMP participants who haven't paid their co-pays, the total amount of uncollected co-pays, and the steps taken by the Department and health plans to ensure greater collection of co-pays.

**Section 1867** – The department shall continue a workgroup that includes psychiatrists, other relevant prescribers, and pharmacists to identify best practices and to develop a protocol for psychotropic medications. Any changes proposed by the workgroup shall protect a Medicaid beneficiary's current psychotropic pharmaceutical treatment regimen by not requiring a physician currently prescribing any treatment to alter or adjust that treatment.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office.

**More Mental Health Task Force Bills Introduced**

This week more CARES task force recommendations were released, including HBs 5450-5452, which allows those once convicted of some minor felonies and misdemeanors would be allowed to work in some mental health care jobs.

Additionally, first responders would be required to get opioid overdoes training according to HB 5460 and HB 5461 and a database of open psychiatric beds would be created under HB 5439.

Legislation to address the CARES task force report will be an immediate focus on the House Health Policy Committee. In total the report includes roughly 50 recommendations, our association submitted 13, many of them were included.

House Health Policy Chair Hank Vaupel (R-Fowlerville) said this is not going to be a short-term plan. "This is not going to be a one-year fix. This is going to take many years to come up with solutions. In fact, it is going to be ongoing forever. Things change and we have to change."

A link to the full report can be found below:

https://house.mi.gov/PDFs/HouseCARESTaskForceReport.pdf

**NATIONAL UPDATE**

**Legislation of Potential Import to NACBHDD**

Behavioral Health Services

- **Behavioral Health Coverage Transparency Act (S. 2647; HR 4276).** Introduced by Senator Elizabeth Warren (D-MA) and Rep. Joe Kennedy III (D-MA) and originally cosponsored by 12 Senators and 8 Representatives, all

Democrats. *Measure would hold insurers accountable for providing adequate mental health benefits (parity) and increase transparency for consumers seeking coverage for mental and substance use disorders.*

- **Medicare for All Act 2017 (S. 1804).** Introduced by Senator Bernie Sanders (I-VT). *Measure would establish a universal Medicare program, including transitional Medicare buy-in option and transitional public option. Premium assistance/cost-sharing subsidies would be available. Establishes a Universal Medicare Trust Fund using funds from Medicare, Medicaid, FEHBP and TRICARE. Individuals must be covered without regard to pre-existing condition or nature of medical issue (e.g., parity for behavioral health) Coverage includes, among other provisions, preventive care and all necessary inpatient and outpatient care to prevent, diagnose, treat and maintain recovery from behavioral disorders.*
- **Mental Health and Substance Abuse Treatment Act of 2017 (HR 1253).** Introduced by Rep. Derek Kilmer (D-WA). *The measure would allow HHS to make loans/loan guarantees for construction or renovation of psychiatric or substance abuse treatment facilities, and to refinance such loans and loan guarantees. Revenues from the loans/loan guarantees in excess of program costs would be place in a Mental Health and Substance Use Treatment Trust Fund and be made available for block grants for community mental health services.*
- **Trauma-informed Care for Children and Families Act of 2017 (S. 774).** Introduced by Senator Heidi Heitkamp (D-ND) *Measure promotes development, testing, dissemination, and application of best practices in trauma-informed identification, referral, care and support for trauma-exposed children and families through a task force, funding through the NCTSI, and specific responsibility for dissemination of identified best practices by a range of HHS agencies and offices.*
- **CHIP Mental Health Parity Act (S. 22532; HR 3192).** Introduced by Senator Debbie Stabenow (D-MI) and Rep. Joseph P. Kennedy III (D-MA). *Measure would ensure access to mental health services under the Child Health Insurance Program, including all services "necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders."*
- **ACE Kids Act of 2017 (S. *1016;* HR 2556).** Introduced by Senator Chuck Grassley (R-IA) and Rep. Joe Barton (R-TX). *The measure amends Medicaid to enable, but not require, States to provide coordinated care to children with complex medical conditions through enhanced pediatric health homes using, as necessary, alternative payment mechanisms. Two MACPAC reports to Congress are to be developed—one (within 2 years) making recommendations on the program, the second (in 5 years) on the program's conduct recommendations for the future, and potential expansion.*
- **CONNECT for Health Act of 2017 (S. 1016; HR 2556).** Introduced by Senator Brian Schatz (D-HI) and Rep. Diane Black (R-TN). *Measure would amend Medicare to Allow ACOs, FQHCs, Native American health service facilities, and rural clinics to engage in and be reimbursed for telehealth services, including for stroke, patient monitoring, and expanded mental health care.*
- **Medicaid Bump Act of 2017 (HR 324).** Introduced by Rep. Joseph Kennedy III (D-MA). *Measure would provide a higher federal matching rate for increased expenditures under Medicaid for mental and behavioral health services, and require the Medicaid and Chip Payment and Access Commission to report to Congress annually on Medicaid mental and behavioral health services payment rates and service utilization.*
- **Road to Recovery Act (HR 2938).** Introduced by Rep. Brian Fitzpatrick (R-PA). *Measure would remove barriers to residential substance disorder treatment services provided in specialty substance use treatment facilities under Medicaid and CHIP for individuals under the age of 65.*
- **Family-based Care Services Act (S. 1357, HR 2290).** Introduced by Senator Tammy Baldwin (D-WI) and Rep. Rosa DeLauro (D-CT). *Measure would amend Medicaid to provide a standard definition of therapeutic family care services,* to wit: services for children under 21 who, due to mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, need the level of care provided in an institution (including a psychiatric residential treatment facility) or nursing facility, the cost of which could be reimbursed under the State plan but who can be cared for or maintained in a community placement, through a qualified therapeutic family care program.
- **National Suicide Hotline Improvement Act of 2017 (S. 1015, HR 2345).** Introduced by Senator Orrin Hatch (R-UT) and Rep. Chris Stewart (R-UT). *Measure would require the FCC to coordinate with SAMHSA and the VA to examine: (1) designating a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system; and (2) the effectiveness of the National Suicide Prevention Lifeline (1-800-273-TALK), including how well it addresses the needs of veterans.* [NOTE: Passed Senate, Nov. &, 2017.].

**OPIATE-SPECIFIC**

- **Opioid Addiction Prevention Act of 2017 (S. 892; HR 4408).** Introduced by Senator Kirsten Gillibrand (D-NY) and Rep. John Katko (R-NY). *Measure would require clinicians to restrict initial prescribing of opiates for acute pain to 7 days as a condition of registration under the Controlled Substances Act.* [A similar bill, with a 10-day limit, HR 3964, was introduced by Rep. Phil Roe (R-TN)].
- **Youth Opioid Use Treatment Help Act of 2017 (YOUTH Act) (HR 3382).** Introduced by Rep. Katherine Clark (D-MA). *Measure would amend the PHS Act substance abuse program provisions to include* ***young adults*** *as well as children and adolescents, including access to prevention and treatment programs, including MAT.*
- **Safer Prescribing of Controlled Substances Act (S. 1554).** Introduced by Senator Edward Markey (D-MA). *Measure would require health care professionals who want to receive or renew registration for prescribing opiates to complete training regarding best practices for pain management, including alternatives to prescribing controlled substances and other alternative therapies to decrease the use of opioids; responsible prescribing of pain medications; ways to diagnose, treat and manage a substance use disorder, including medications and evidence-based non-pharmacologic therapists; linking patients to evidence-based treatment for substance use disorders; and tools to manage adherence and diversion of controlled substances.*
- **Medicare Beneficiary Opioid Addiction Treatment Act (HR 4097).** Introduced by Rep. Richard Neal (D-MA). *Measure would make methadone available under Medicare Part B.*

JUSTICE-RELATED ISSUES

- **Law Enforcement Mental Health and Wellness Act of 2017 (S. 867, HR 2228).** Introduced by Senator Joe Donnelly (D-IN) and Rep. Susan Brooks (R-IN) **THIS HAS BEEN SIGNED INTO LAW (PL 115-113).** *Under the new law, grants available under the Community Oriented Policing Services program can be used to establish peer mentoring mental health and wellness pilot programs at the state, local and tribal levels. The Department of Justice (DoJ) will (1) review existing crisis hotlines, recommending improvements; examine the behavioral health needs of federal officers; and assure privacy is maintained; (2) working with HHS, develop materials for mental health providers to educate about the culture of law enforcement and relevant therapies for common problems; and (3) report of DoD and VA mental health practices and services that could be adopted by law enforcement agencies, and on programs to address the mental health and wellbeing of law-enforcement officers.*
- **Veterans Treatment Court Improvement Act of 2017 (S. 946, HR 2147).** Introduced by Senator Jeff Flake (R-AZ) and Rep Mike Coffman (R-CO). *Measure would require the VA to hire at least 50 Veterans Justice Outreach Specialists to serve at an eligible VA medical center to serve as part of a veterans treatment court justice team or other veteran-focused court. The individuals would work with veterans with active, ongoing, or recent contact with some component of local criminal justice system.*
- **Keeping Communities Safe through Treatment Act of 2017 (HR 1763).** Introduced by Rep. Sean Maloney (D-NY). *Measure would require the Department of Justice to conduct a pilot program to provide grants to eligible entities to divert individuals with low-level drug offenses to pre-booking diversion programs.*

SERVICE PROVIDERS

- **Mental Health Access Improvement Act of 2017 (HR 3032).** Introduced by Rep. John Katko (R-NY). *Measure would provide Medicare coverage for services of mental health counselors and marriage and family therapists within their scopes of practice.*
- **Medicare Mental Health Access Act (S.448).** Introduced by Senator Sherrod Brown (D-OH). *Measure would expand Medicare's definition of 'physician' to include state licensed, clinical psychologists for the purpose of providing services within a psychologist's scope of licensure.*
- **Prescriber Support Act of 2017 (HR 1375).** Introduced by Rep. Katherine Clark (D-MA). *Measure would establish a grant program to states or groups of states through HHS to establish, expand or maintain a comprehensive regional, State, or municipal system to provide training, education, consultation, and other resources to prescribers relating to patient pain, substance misuse, and substance abuse disorders.*
- **Strengthening the Addiction Treatment Workforce Act (S. 1453).** Introduced by Sen. Joe Donnelly (D-IN). *The measures makes certain substance abuse treatment facilities, both inpatient and outpatient that meet specified criteria*

*(e.g., use of MAT, counseling or other evidence-based services) eligible for National Health Services Corps (NHSC) service.*

- **Addiction Treatment Access Improvement Act of 2017 (HR 3692).** Introduced by Rep. Paul Tonko (D-NY). *Measure would amend the Controlled Substances Act to provide greater flexibility in the use of MAT for opioid use disorders by eliminating any time limitations for nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, and physician assistants to become qualifying MAT practitioners*
- **Ensuring Children's Access to Specialty Care Act of 2017 (S. 989).** Introduced by Senator Roy Blunt [R-MO]. *Measure would add pediatric subspecialties (including child psychiatrists) to the roster of physicians eligible to participate in the NHSC, with relevant loan forgiveness.*

VETERANS' ISSUES

- **Mental Health Care Provider Retention Act of 2017 (HR 1064).** Introduced by Rep. Beto O'Rourke (D-TX). *Measure would ensure that an individual transitioning from treatment through DoD to VA to continue receiving treatment from the DoD mental health care provider.*
- **Community Care Core Competency Act of 2017 (S. 1319).** Introduced by Senator Sherrod Brown (D-OH). *Measure directs the VA to establish a 5-year, no-cost online program of continuing medical education for non-VA medical professionals designed to (1) increase knowledge and recognition of medical conditions common to veterans, and (2) improve outreach to veterans and family members, CME topics include working with veterans and their family members; identifying and treating their common mental and physical conditions; and the VA health care system.*
- **Honor Our Commitment Act of 2017 (S. 699).** Introduced by Senator Christopher Murphy [D-CT]. *Measure would require the VA to provide behavioral health services to individuals discharged/released from active service under other than honorable conditions.*
- **Veteran Urgent Access to Mental Healthcare Act (HR 918).** Introduced by Rep. Mike Coffman (R-CO), *Measure would require the VA to give former members of the Armed Forces an initial mental health assessment and mental health services to treat a member's urgent mental health care needs, including risk of suicide or harming others. Such mental health services can be provided at a non-VA facility if VA care is clinically inadvisable or geographically untenable.* [NOTE: Passed House Nov 7, 2017.]

**TENTH ANNUAL GAMBLING DISORDER SYMPOSIUM**

MDHHS & CMHAM Present: Michigan's Tenth Annual Gambling Disorder Symposium, "A Holistic Approach to Gambling Disorder Treatment… Mind, Body & Spirit." The Symposium will be held on Friday, March 2, 2018 at the Diamond Center at Suburban Collection Showplace in Novi, Michigan.

Registration Fee: $35 per person and includes all materials, continental breakfast, lunch and refreshments.
To Register Click Here!

Symposium Highlights:
- Assessment and Treatment of Gambling Disorder with an Emphasis on High Risk Populations
- Problem Gambling: A Growing Epidemic Among Youth & Using Adverse Childhood Experiences (ACE) in Treatment
- Neurobiology of Gambling and Other Addictions
- Prevention: An Open Panel Discussion
- Treating Gambling Disorder with Mindfulness and Spirituality
- The Problem Gambler and the Criminal Justice System
- Insider's View of Gamblers Anonymous: Open Meeting
- Gambling Behavior - it's Functional

**CMH Association committee schedules, membership, minutes, and information go to our website at**
https://www.macmhb.org/committees

***Have a Great Weekend!***