Northeast Michigan Community Mental Health Authority
Board Meetings - February 2018

Happy Valentine's Day !

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

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

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD
BOARD MEETING
February 08, 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. Educational Session – Catholic Human Services ..... Larry LaCross

VII. Approval of Minutes..... (See pages 1-5)

VIII. Consent Agenda.....(See page 6)
1. **Grants and/or Contracts**
   a. **Quest Software Inc.**

IX. February Monitoring Reports
1. **Treatment of Consumers 01-002..... .....(See pages 7-10)**
2. **Staff Treatment 01-003 ....(See pages 11-12)**
3. **Budgeting 01-004 .... (Available at the Meeting)**
4. **Financial Condition 01-005..... ..... (Available at the Meeting)**
5. **Asset Protection 01-007 ....(Postponed due to late onset of Audit)**

X. Board Policies Review and Self Evaluation
1. **Asset Protection 01-007 ..... [Review] .....(See pages 13-14)**
2. **Board Committee Principles 02-005..... [Review & Self Evaluation]...(See page 15)**
3. **Delegation to the Executive Director 03-002[Review & Self Evaluation]. (See pages 16-17)**

XI. Linkage Reports
1. **CMHAM**
   a. **CMH PAC Campaign..... .....(Available at Meeting)**
2. **Northern Michigan Regional Entity**
   a. **January 24th Board Meeting Report ..... (Verbal Report)**
3. **Consumer Advisory Council .... (Verbal Report)**

XII. Chair's Report
1. **Board Member Recognition in March..... ..... (Verbal Report)**

XIII. Director's Report
1. **Director's Report Summary .... (Verbal Report)**
2. **Endowment Fund Grant Awards..... .....(See page 18)**

XIV. Operational Report ....(Available at Meeting)

XV. Information and/or Comments from the Public

XVI. Next Meeting – Thursday, March 8 at 3:00 p.m.
1. **Set March Agenda..... .....(See page 19)**
2. **Meeting Evaluation .... All**

XVII. Adjournment

MISSION STATEMENT

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

CATHOLIC HUMAN SERVICES, Inc.

Up North Prevention
advancing substance abuse prevention efforts in northern lower Michigan

PREVENTION EFFORTS/COMMUNITY INITATIVES AROUND THE OPIOID EPIDEMIC

- **Blue Cross/Blue Shield Grant: UP North Prevention's Physician and Community Partnership**
  - Implement the Advancing Responsible Opioid Prescribing Program with primary care facilities.
    - Physician Practice Transformation Projects (Altarum)
  - Increase pharmacy takeback sites
  - Expand naloxone usage in county jails
  - Increase understanding of MAT in the medical community
  - Develop county substance abuse data dashboards
    - Increase County coalition/community stakeholder knowledge to efficiently match community resources with strategies to address opioid epidemic

- **Michigan Prevention Initiative: Safer Opioid Prescribing Practices and Data Collection Program**
  - Enhance and increase educational opportunities for the medical profession
    - Increase educational opportunities for medical professionals
    - Identify needs of local providers to reduce opioid misuse
    - Data collection for death overdoses, per capita prescribing for controlled substance, naloxone administration, drug disposal.
    - Host a "Understand Opioid Prescribing/Addiction Symposium

- **Community Education: RX – BE THE SOLUTION**
  - In partnership with Drug-Free Northern Michigan, Up North Prevention provides community awareness presentations, media visibility, letters to the editor, community education on the opioid epidemic and the development and maintenance of permanent drug disposals sites for prescription drugs and over the counter medicine.

- **Naloxone Education/Trainings/Product**
  - County, City and State Police road officers
  - Alcona High School
  - Alpena School buildings and administrative personnel

- County Jail staff trained

- **TALK SOONER CAMPAIGN**
  - TalkSooner serves as a resource for parents to access information about substance use prevention-via a phone app or online

- **Drug and Alcohol Testing Kits for Parents/Guardians (no charge)**
  - Prevention tool for parents

- **Michigan Profile for Healthy Youth**
  - Provide technical assistance to local school districts in administering a health survey through the Michigan Department of Education with a strong focus on substance use to 7th, 9th and 11th graders. Prevention Specialists further assist communities in understanding the data and planning activities & services that meet the needs of our youth

- **BOTVIN LIFESKILLS**
  - An evidence-based, 3 year curriculum provided universally to 7 graders proven to prevent substance abuse. With emphasis on opioids, heroin, alcohol and marijuana.

- **Up North Prevention Website and Facebook page**

CATHOLIC HUMAN SERVICES Inc.

Integrative Partnerships and Community Initiatives around the Opioid Epidemic

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New Horizons Substance Use Recovery Network offers a whole patient approach to treatment, focused on individualized care, and integrated behavioral and physical healthcare services. This initiative is funded through a HRSA/SAMHSA grant and through program generated revenue.

Substance Abuse Counseling individual and group counseling services provided on site at AHC by CHS.
Care Coordination includes skill building, identification of barriers to sobriety and strategies to address those barriers, assistance with coordination of care, and more. Provided on site by CHS.

NEW HORIZONS Substance Use Recovery Network

Medications:
Naltrexone (injectable and tablet)
Buprenorphine (sublingual)

Care Management Services includes medication management, coordination of care with medical providers, support addressing barriers to treatment, and more.
Medication Assisted Treatment provided by Freedom Recovery Center and monitored through our collaborative services.
Physical Health Care Needs through AHC medical services.

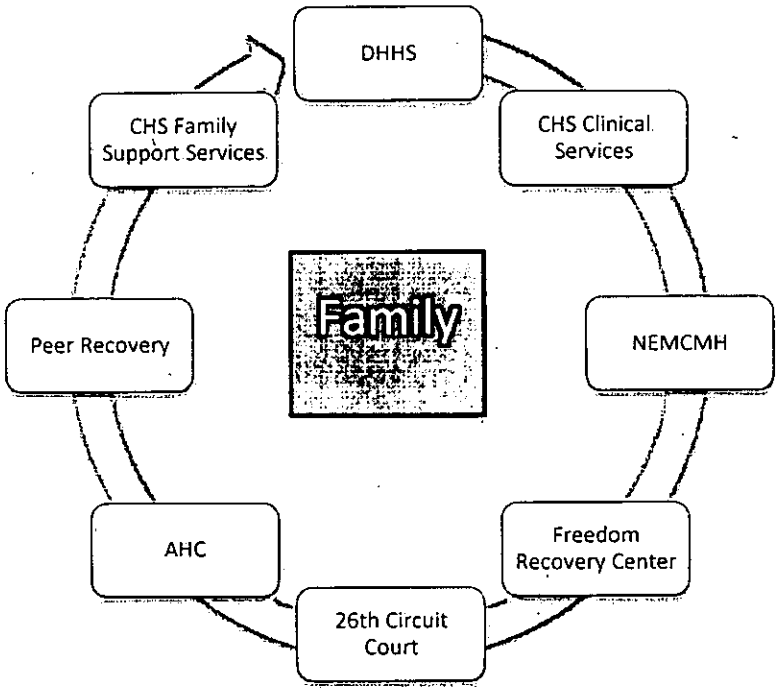
Thunder Bay Community Health Services and Catholic Human Services, INC Integrative Partnership for Substance Use Disorders Treatment

CHS and TBCH have developed and are enhancing integration of Substance Use Disorders treatment within primary care settings in Montmorency and Presque Isle counties to increase access and coordination of care for those with Opioid Use Disorders and other SUD. These initiatives are funded using fee for service funding through NMRE and private insurances (co-located services) and a new HRSA-AIMS grant (integrated services).

Co-Located Services: CHS clinicians provide outpatient Substance Use Disorders treatment on site at TBCH clinics in Rogers City and Atlanta.

Integrated SUD services provided as part of the TBCH treatment team by a full time CHS clinician in the Onaway clinic.

Family Recovery Care Team



Catholic Human Services received a grant from the Michigan Health Endowment fund to develop and implement a process of integration in Alpena and Montmorency Counties. The purpose of this project is to help our community partners better integrate services for families that are involved in the child welfare system that also have a caregiver with a substance use disorder. Goals include improved outcomes for families, especially family reunification and remission of substance use disorders, increased capacity for trauma informed and specific care and increased access to medical and medication assisted treatment.

This project involves the development of a multi-disciplinary team to coordinate services with these families and dedicated care coordinators who implement the process.

Thank you for the great work you do on behalf of our communities!

Please contact me with any ideas or questions.

Larry LaCross, LMSW, CAADC, CCS
Clinical Supervisor, Catholic Human Services
llacross@catholichumanservices.org
989-356-6385

Northeast Michigan Community Mental Health Authority Board

Board Meeting

January 11, 2018

I. Call to Order

Chair Gary Nowak called the meeting to order in the Board Room at 3:00 p.m.

II. Roll Call and Determination of a Quorum

Present: Lester Buza, Bonnie Cornelius, Steve Dean, Alan Fischer, Roger Frye, Judy Hutchins, Judy Jones, Albert LaFleche, Terry Larson, Eric Lawson, Gary Nowak

Absent: Pat Przeslawski (excused)

Staff & Guests: Cheryl Jaworowski, Mary Mingus, Lee Ann Bushey, Cathy Meske, Dennis Bannon, Peggy Yachasz, Lisa Anderson, Ruth Hewett, Lynne Fredlund, Carolyn Bruning

III. Pledge of Allegiance

Attendees recited the Pledge of Allegiance as a group.

IV. Appointment of Evaluator

Gary Nowak appointed Judy Jones as evaluator for this meeting.

V. Information and/or Comments from the Public

Judy Hutchins reported the Bay View Center will be having their fundraising pancake supper next Wednesday, January 17 at the McDonald's on Chisholm Street in Alpena. The cost is $3.00.

VI. Approval of Minutes

Moved by Roger Frye, supported by Lester Buza, to approve the minutes of the December 14, 2017 minutes as presented. Motion carried.

VII. Educational Session – Clubhouse Certification Process

Cathy Meske introduced Mary Mingus, Clubhouse Supervisor, noting she will be presenting Board members with information related to the Clubhouse Certification process. Ms. Mingus reported the Michigan Department of Health and Human Services (MDHHS), in 2016, mandated all Clubhouses in Michigan begin the accreditation process and must be accredited by September 2018 or services provided by the clubhouse will no longer be billable to Medicaid.

Mary reviewed the immediate changes required in the Clubhouse program noting job descriptions have been updated to reflect new titles and the new educational requirements mandating staff attend training in either North Carolina or St. Louis, MO. Mary provided information as to opportunities clubhouse members have in preparing for jobs in the community. These range from various restaurant type positions, clerical positions, maintenance positions, etc. She reports there are also social activities coordinated through the clubhouse and these activities occur outside of the traditional workday.

Mary Mingus reported the mandated training for staff working in the clubhouse includes a 2 -3 week Clubhouse Generalist training at a cost of $4,500-$6,500 not including meals and transportation. She also reviewed the membership costs and the accreditation process. She reported the cost for the site visit for the accreditation process is $3,000 if scheduled before February 12, 2018. If scheduled after that date, it increases to $3,500.

The current active attendance of clubhouse members include about 40 individuals with an actual membership of approximately 70 individuals. Cathy Meske reported there is a transition of members from clubhouse activity to supported employment. She noted concerns of being mandated to be certified by Clubhouse International and this being the only option for this type of service. She noted how our supported employment program has grown and having a Drop-In Center within the community to access other activities related to social and community opportunities would provide some services should the clubhouse be discontinued.

VIII. Consent Agenda

1. **Contracts**
   a. **Blue Horizons Management Agreement**
2. **Grant Applications**
   a. **Community Foundation for Northeast Michigan [Home-Based Services]**
   b. **Federal Block Grant Application for Peer Health Coaches**

Moved by Judy Hutchins, supported by Judy Jones, to approve the Consent Agenda. Motion carried.

IX. January Monitoring Reports

1. **Budgeting 01-004**

   Cheryl Jaworowski reviewed the Statement of Expense and Revenues for month ending November 30, 2017. She discussed the variances identified in this statement. She noted the Employee Relations/Wellness is due to timing as the Wellness screenings are conducted early in the fiscal year. Cheryl Jaworowski reviewed lines 44-46 (Contract settlement items) noting Line 44 – Medicaid Funds should be under spent and Line 45 – General Funds should be over spent.

   Cheryl Jaworowski provided Board members with information discussed last month related to the difference in rate payments between Healthy Michigan and DAB (Disabled, Aged, and Blind) and TANF (Temporary Assistance to Needy Families). She notes there has been a big shift in enrollment. When an individual enrolls in Healthy Michigan, the requirements and paperwork are much less than if they are applying for services as a DAB. She reviewed the Revenue Analysis – Disabled, Aged, Blind results noting the impact of this shift from DAB to Healthy Michigan is $97,597,336.

2. **Emergency Executive Succession 01-006**

   Board members reviewed the Monitoring Report and had no comment or suggestions. Two scenarios were identified in the monitoring report; one for a temporary absence and the second for a more permanent replacement.

   Moved by Eric Lawson, supported by Albert LaFleche, to accept the January monitoring reports as presented. Motion carried.

X. Board Policy Review and Self Evaluation

1. **Emergency Executive Succession 01-006**

   Board members reviewed this policy and had no recommended changes.

2. **Chief Executive Role 03-001**

   Board members had no comments regarding this policy.

XI. Linkage Reports

1. CMHAM

a. Winter Conference (Feb 6 & 7 – Radisson Hotel Kalamazoo)

Board members are not interested in attending this conference. This is a non-voting conference.

2. Northern Michigan Regional Entity (NMRE)

a. Board Meeting December 28, 2017

A copy of the minutes for this meeting is included in the handouts for this meeting. Roger Frye reported there was much discussion about Third Level services and their proposed rate increase. Cathy Meske reported in addition to the rate increase there was also concern about response. She reports this service has almost turned in to a call forwarding service rather than utilizing their clinical staff in providing direct service. The NMRE negotiates this contract on behalf of the member boards. They are intending to issue and RFP for this service and contract with Third Level on a month-to-month basis in the interim.

Cathy Meske reported the NMRE is looking at developing a SUD Health Home. Terry Larson reported at the SUD meeting members were informed there are two law firms soliciting for members to become part of a class action lawsuit related to the opioid epidemic.

Cathy Meske noted the Board expressed an interest is having one of the SUD providers come in to do a presentation to the Board – possibly Sunrise Center, Catholic Human Services or representatives from the Freedom Clinic. She will contact and secure a presenter for the February meeting.

XII. Chair's Report

1. By-Law Review

Cathy Meske noted clarification was sought from Christine Taylor related to a concern of protected rights including "record of arrest without conviction." This is not mandated and the reference will be removed from the by-laws.

Moved by Lester Buza, supported by Steve Dean, to approve revisions to By-Laws as presented. Motion carried.

XIII. Director's Report

1. Director's Report Items

A. Federal Block Grant Application for Peer Health Coaches

Cathy Meske reported the application process for this grant was included on the Consent Agenda approved earlier in this meeting. After much review of this grant and the required use of these services for those individuals using General Funds only not for Medicaid individuals, the decision was made not to pursue this grant.

B. Medical Director Appointment

Cathy Meske reported Dr. Arora has resigned as Medical Director. Dr. Rajasekhar has graciously accepted to fill that role again. Dr. Arora will continue as a contract psychiatrist.

C. RFP for After Hours Crisis Response

Cathy Meske reported NMRE is investigating issuing an RFP to determine options available for After Hours Crisis providers which was briefly discussed in the linkage report earlier in this meeting.

D. Lakeshore Regional PIHP

Cathy Meske provided Board members of an update on Lakeshore Regional PIHP [Allegan CMH, Muskegon CMH, Network180 (Kent County), Ottawa CMH and West MI CMH (Lake, Mason and Oceana counties)]. The PIHP is working closely with the State to address their funding issues and each member board will need to develop a plan to close the deficit gap.

E. Crisis Residential for Children

SafeHouse is a Crisis Residential for children ages 7-17 in Rose City. The provider was onsite today meeting with clinical staff about services they can offer to our agency. She noted the cost for this service is much less than an inpatient setting.

F. Heightened Scrutiny and Home- and Community-Based Services (HCBS) Transition

Cathy Meske reported the HCBS surveys were tabulated and 48% of the residential provider surveys have received their emailing containing the heightened scrutiny survey. Some residents in thirteen homes did not receive any communication related to this and she reported Christine Taylor is in contact with the PIHP to speak with the State regarding the missing communications.

G. Healthy Michigan Plan

Cathy Meske provided information as to the changes in Healthy Michigan. Beginning in February of this year, a letter will be sent to individuals covered by Healthy Michigan which targets those individuals with income over 100% of Federal Poverty Level (FPL). Individuals enrolled in Healthy Michigan must complete a Health Risk Assessment, had to identify a primary care physician and agree to work on a Healthy behavior goal (smoking cessation, controlling blood pressure, weight reduction, etc.) to continue in Healthy Michigan.

She reported an in-service will be provided to staff to let them know letters will be coming to individuals covered by Healthy Michigan and what they can do to assure individuals respond appropriately and work with their doctors to assure they do not lose their coverage. If they have not completed this, the individuals will be transferred to the Marketplace to obtain their insurance coverage. The federal government is trying to assure individuals are using the services.

2. QI Council Update

The minutes from the last meeting were a handout at this meeting. Board members had no questions. Lynne Fredlund reported there are several workgroups working on projects to improve various items. She noted UM is working on Clinical Documentation standards.

XIV. Information and/or Comments from the Public

There was no information or comments provided.

XV. Next Meeting

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

1. Set February Agenda

The February agenda items were reviewed. Steve Dean inquired about the Operations report which will be included in future agendas as per the revisions to the by-laws adopted earlier in this meeting.

XVI. Evaluation of Meeting

Judy Jones reported meeting started on time and all participated. She reported there was a lot of Clubhouse information available and the information related to supported and assisted employment was beneficial. She likes this Board as members have the freedom to ask questions and receive information.

Albert LaFleche inquired about coordinated efforts this agency has with DHHS. Cathy Meske reported the various collaborative efforts this agency has with DHHS.

XVII. Adjournment

Moved by Alan Fischer, supported by Eric Lawson, to adjourn the meeting. Motion carried. This meeting adjourned at 4:05 p.m.

_____
Alan Fischer, Secretary

_____
Gary Nowak, Chair

Diane Hayka
Recorder

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Cathy Meske

SUBJECT: Consent Agenda

DATE: January 30, 2018

1. **Contract Approvals**
   a. **Quest Software, Inc.**
   This is a three-year support agreement totaling $3,050.60. This agreement allows the Agency to use Rapid Recovery software on the server and includes the license. The dollars for this agreement was included in the budget approved by the Board. Due to timing, the agreement was executed on January 26. This agreement and dollar amount are within the guidelines outlined in Policy 01-011. We recommend approval.

Recipient Rights Advisory Committee Minutes
January 24, 2018

The meeting was called to order at 3:15 p.m. in the Administrative Conference Room, NEMCMH, 400 Johnson Street, Alpena, Michigan on January 24, 2018 by Chair Pat Przeslawski.

Present:	Tom Fredlund, Judy Jones, Patricia Przeslawski, Renee Smart-Sheppler, Frank Walter & Lorell Whitscell
Absent:	None.
Staff:	Ruth Hewett
Guests:	None.

I. Old Business. None.

II. New Business.

QUARTERLY RIGHTS ACTIVITY REPORT: The report covered the first quarter of FY 17-18, 10/1/17 – 12/31/17. Complaints totaled 23 of which 20 were opened for investigation, 2 were handled as interventions, and 1 was outside the jurisdiction of the rights office. There were 12 substantiations with one pending. Remedial action was completed on 10 substantiations. Renee moved to review the report, supported by Lorell, motion carried.

JOB DESCRIPTION CHANGE: Ruth informed the committee of her job description proposed change to eliminate responsibilities of facilitating, training, and handling of customer service issues and Medicaid grievance and appeals. With the onset of Majestic, another employee is able to absorb these duties into her job. Therefore, training is being done and before the next meeting the transition should take place.

EDUCATIONAL SESSION: Due to the inclement weather and the need for this meeting to be rescheduled a week later than originally scheduled, no educational session took place.

III. Other Business.

The next meeting will be April 18, 2018 in the Admin Conference Room immediately following the RRAC meeting with Mid-Michigan Health-Alpena-Pointe East which will begin at 3:15 p.m. Renee will be unable to attend this meeting due to a medical appointment.

IV. Adjournment.

Renee moved to adjourn the meeting, supported by Lorell. The meeting adjourned at 3:45 p.m.

_____
Patricia Przeslawski, Chairperson

Ruth Hewett, Recorder

Northeast Michigan Community Mental Health Authority
400 Johnson Street, Alpena, MI 49707
989-358-7847

QUARTERLY RECIPIENT RIGHTS ACTIVITY REPORT

Time Period: October, November & December 2017:

I. COMPLAINT DATA SUMMARY

A. Totals	FY 17-18 1st	2nd	3rd	4th	FY 16-17 1st	2nd	3rd	4th
Complaints Received:	23				22	34	18	26
Investigated:	20				17	27	12	18
Interventions:	02				02	02	03	04
Substantiated:	12 + 1 pdg				08	17	10	12
Outside Jurisdiction:	01				01	01	01	03
No Code Protected Right:	-0-				02	04	02	01

B. Aggregate Summary of Complaints

CATEGORY	Received	Investigation	Intervention	Substantiated
Abuse I	0	0		0
Abuse II	1	1		0
Abuse III	1	1		1
Sexual Abuse	0	0		0
Neglect I	0	0		0
Neglect II	0	0		0
Neglect III	0	0		0
Rights Protection System	0	0	0	0
Admiss/Dischrg-2ND Opinion	0	0	0	0
Civil Rights	0	0	0	0
Family Rights	1	1	0	0
Communication & Visits	0	0	0	0
Confidentiality/Disclosure	3	1	2	2
Treatment Environment	2	2	0	0+1 pend.
Freedom of Movement	0	0	0	0
Financial Rights	0	0	0	0
Personal Property	1	1	0	0
Suitable Services	13	13	0	9
Treatment Planning	0	0	0	0
Photos/Fingerprints/Audio etc	0	0	0	0
Forensic Issues	0	0	0	0
Total	22	20	2	12 + 1 pd

C. Remediation of substantiated rights violations.

Category/Specific Allegation	Specific Provider	Specific Remedial Action
Abuse III	NEMCMH	Resigned prior to action
Confidentiality	NEMCMH	Procedure written/modified
Confidentiality	NEMCMH	Documented Counseling
Suitable Services	Beacon Residential	Terminated
Suitable Services	NEMCMH	Documented Counseling
Suitable Services	NEMCMH	Documented Counseling
Suitable Services	NEMCMH	Pending
Suitable Serv-D & R	NEMCMH	Written Reprimand
Suitable Serv-D & R	NEMCMH	Terminated
Suitable Serv-D & R	NEMCMH	Documented Counseling
Suitable Serv-D & R	NEMCMH	Documented Counseling
Suitable Serv-D & R	Beacon Residential	Pending

D. Summary of Incident Reports: October, November & December 2017

Category Type	1st Qtr		2nd Qtr		3rd Qtr		4th Qtr	
	'18	'17	'18	'17	'18	'17	'18	'17
01.0 Absent without leave (AWOL)	02	01		06		03		01
02.0 Accident – No injury	11	05		03		04		13
02.1 Accident – With injury (Rev 5-17)	24	26		29		47		39
02.2 Accident – Serious injury (Rev 5-17)	-0-	02		01		--		--
03.0 Aggressive Acts – No injury	35	19		23		29		33
03.1 Aggressive Acts – w/ injury (Rev 5-17)	04	04		02		05		05
03.2 Aggressive Acts – Ser inj (Rev 5-17)	-0-	-0-		-0-		--		--
03.3 Aggressive Acts – Property Destruct	02	01		05		03		02
04.0 Death	05	05		06		04		02
05.0 Fall – No injury	06	09		14		21		15
06.0 Medical Problem	29	29		39		56		32
07.0 Medication Delay	10	02		03		08		12
07.1 Medication Error	15	09		19		15		16
07.2 Medication Other	82	52		55		73		80
07.3 Medication Refusal	61	62		87		52		96
08.0 Non-Serious Injury – Unknwn cause	05	05		07		06		06
09.0 Other	35	60		68		57		32
10.0 Self Injurious Acts – No injury	09	05		01		05		03
10.1 Self Injurious Acts – w/inj.(Rev 5-17)	04	04		02		07		09
10.2 Self Injurious Acts – Ser inj (Rev 5-17)	-0-	-0-		-0-		--		--
Challenging Behavior (Rev 5-17)	14					16		29
Fall – with injury (Rev 5-17)	18					05		13
Arrests (Rev 5-17)	15					08		07
Total	386	300		370		424		445

D. Prevention Activity	Quarter	YTD
Hours Used in Training Provided	22.00	22.00
Hours Used in Training Received	4.75	4.75
Hours Used in Site Visits	12.50	12.50

E. Monitoring Activity	Quarter	YTD
Incident Report Received	386	386

F. Source of All Complaints:	Quarter	YTD
Recipient:	05	05
Staff:	12	12
ORR:	05	05
Gdn/Family:	-0-	-0-
Anonymous:	-0-	-0-
Comm/Gen Pub:	01	01
Total	23	23

_____ _____

Ruth M. Hewett, Recipient Rights Officer Date

INTEROFFICE MEMORANDUM

TO: BOARD MEMBERS

FROM: CATHY MESKE

SUBJECT: TURNOVER REPORT

DATE: JANUARY 29, 2018

CC:

Attached is the Turnover Report required by Policy 01-003, Staff Treatment. This report addresses the period January 1, 2017 through December 31, 2017. The report reflects employment activity for the Board's regular employees; substitute and casual employees have not been included as their employment is, by nature, somewhat sporadic and turnover-prone. In the "Turnover by Department" section, we have included internal transfers in the attached report; i.e., a part-time employee accepting a full-time position in a different home would be considered turnover. At the bottom of the report, we have included a statistic showing turnover "Agency-wide," which reflects turnover of employees actually leaving the agency.

Turnover for 2017, including "in-house" turnover, was 25% (versus 23% the prior year); when limited to only those employees that actually left the agency, the rate is 20% (versus 18% the prior year). **For the one-year period January 2016 through December 2016, the US Bureau of Labor Statistics reports a "separation rate" of 30.3% for employees in the classification of "Healthcare and Social Assistance." Therefore, the agency experienced a more stable workforce last year than the healthcare industry in general.

For those employees who actually left the agency, the table below shows the circumstances under which those employees left during 2017. Also shown is some detail about the reasons for the terminations.

Reason for Leaving		# of Separations
Retirement		6
Health/Disability		3
Death		1
Layoff		0
Bumped		0
Resigned		46
Termination		14
Attendance	3	
Performance	6	
Rights-related	5	
TOTAL		70

**2017 numbers are not yet released

Attachment

Turnover by Department

Division/Department Name	# at 1/1/2017	Number Hires/Transfers	Total Employees Separated/Trnsfr'd	# at 12/31/2017	Total Turnover Rate
Administration/Support Services	48	3	5	46	10%
MI Programs					
MI Program Management	5		1	4	20%
Psychiatry & Nursing Support	8			8	0%
Geriatric Services	13	1	3	11	23%
MI Adult Outpatient	7	3	1	9	14%
MI Adult Casemanagement	10	3	2	11	20%
MI Integrated Employment	5	2	2	5	40%
MI Adult A.C.T.	7	3	2	8	29%
Home Based Child	8	5	4	9	50%
Clubhouse	3	1	1	3	33%
MI Peer Support Services	3	2	2	3	67%
DD Programs					
DD Program Management	9	1	2	8	22%
DD Casemanagement	12	4	3	13	25%
DD Clinical Support	4	1	1	4	25%
DD App. Behav. Analysis Program	13	3	3	13	23%
DD Integrated Employment	13	5	5	13	38%
DD SIP Residential	47	11	11	47	23%
DD Community Support	30	5	5	30	17%
Blue Horizons	10	2	2	10	20%
Brege	11	9	8	12	73%
Cambridge	12	5	6	11	50%
Harrisville	10	2		12	0%
Mill Creek	11	1	1	11	9%
Pine Park	12	6	6	12	50%
Princeton	11	4	4	11	36%
Thunder Bay Heights	12	2	2	12	17%
Walnut	12	6	6	12	50%
Totals	346	90	88	348	25%

Agency-Wide Turnover

Division/Department Name	# at 1/1/2017	Number Hires	Total Employees Separated	# at 12/31/2017	Total Turnover Rate
All Employees	346	72	70	348	20%

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Twelve Months Ending September 30, 2017
100.0% of year elapsed

		Actual September Year to Date	Budget September Year to Date	Variance September Year to Date	Budget FY17	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 124,396	$ 122,592	$ 1,804	$ 122,592	101.5%
2	Private Contracts	50,714	56,530	(5,815)	56,530	89.7%
3	Grants from Local Units	332,808	270,638	62,170	270,638	123.0%
4	Interest Income	10,409	7,300	3,109	7,300	142.6%
5	Medicaid Revenue	22,654,145	22,723,429	(69,284)	22,723,429	99.7%
6	General Fund Revenue	770,302	841,358	(71,056)	841,358	91.6%
7	Healthy Michigan Revenue	1,271,677	1,182,732	88,945	1,182,732	107.5%
8	3rd Party Revenue	287,740	319,525	(31,785)	319,525	90.1%
9	Autism Revenue	774,135	538,783	235,352	538,783	143.7%
10	SSI/SSA Revenue	529,900	535,078	(5,178)	535,078	99.0%
11	Other Revenue	67,661	59,393	8,268	59,393	113.9%
12	**Total Revenue**	**26,873,887**	**26,657,357**	**216,530**	**26,657,357**	**100.8%**
	Expense					
13	Salaries	11,879,408	11,744,000	(135,408)	11,744,000	101.2%
14	Social Security Tax	526,602	516,000	(10,602)	516,000	102.1%
15	Self Insured Benefits	2,481,843	2,767,000	285,157	2,767,000	89.7%
16	Life and Disability Insurances	202,313	202,000	(313)	202,000	100.2%
17	Pension	949,589	960,000	10,411	960,000	98.9%
18	Unemployment & Workers Comp.	207,849	214,000	6,151	214,000	97.1%
19	Office Supplies & Postage	47,234	42,500	(4,734)	42,500	111.1%
20	Staff Recruiting & Development	133,273	110,000	(23,273)	110,000	121.2%
21	Community Relations/Education	1,693	2,000	307	2,000	84.7%
22	Employee Relations/Wellness	56,327	56,000	(327)	56,000	100.6%
23	Program Supplies	493,809	456,200	(37,609)	456,200	108.2%
24	Contract Inpatient	883,145	940,000	56,855	940,000	94.0%
25	Contract Transportation	127,047	130,000	2,953	130,000	97.7%
26	Contract Residential	4,143,413	4,125,000	(18,413)	4,125,000	100.4%
27	Contract Employees & Services	2,508,019	2,450,000	(58,019)	2,450,000	102.4%
28	Telephone & Connectivity	91,792	80,000	(11,792)	80,000	114.7%
29	Staff Meals & Lodging	34,403	35,000	597	35,000	98.3%
30	Mileage and Gasoline	392,075	395,000	2,925	395,000	99.3%
31	Board Travel/Education	12,431	14,000	1,569	14,000	88.8%
32	Professional Fees	65,542	50,000	(15,542)	50,000	131.1%
33	Property & Liability Insurance	50,254	38,700	(11,554)	38,700	129.9%
34	Utilities	173,538	174,500	962	174,500	99.4%
35	Maintenance	209,968	195,000	(14,968)	195,000	107.7%
36	Rent	258,985	260,000	1,015	260,000	99.6%
37	Food (net of food stamps)	77,882	80,274	2,392	80,274	97.0%
38	Capital Equipment	248,674	96,084	(152,590)	96,084	258.8%
39	Client Equipment	31,645	34,000	2,355	34,000	93.1%
40	Miscellaneous Expense	139,782	130,000	(9,782)	130,000	107.5%
41	Depreciation Expense	331,772	360,099	28,327	360,099	92.1%
42	Budget Adjustment	-	-	-	-	0.0%
43	**Total Expense**	**26,760,306**	**26,657,357**	**(102,949)**	**26,657,357**	**100.4%**
44	**Change in Net Position**	**$ 113,581**	**$ (0)**	**$ 113,581**	**$ (0)**	**0.4%**

Contract settlement items included above:

45	Medicaid Funds Over Spent	(15,043)
46	General Funds Under Spent	71,055
47	Healthy Michigan Funds Over Spent	(127,991)
48	Autism Under funded	(435,402)

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Three Months Ending December 31, 2017
25.0% of year elapsed

		Actual December Year to Date	Budget December Year to Date	Variance December Year to Date	Budget FY18	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 31,904	$ 31,162	$ 743	124,646	25.6%
2	Private Contracts	4,490	14,492	(10,002)	57,967	7.7%
3	Grants from Local Units	68,954	66,659	2,294	266,638	25.9%
4	Interest Income	1,783	1,825	(42)	7,300	24.4%
5	Medicaid Revenue	6,140,032	5,787,182	352,850	23,148,729	26.5%
6	General Fund Revenue	162,643	177,472	(14,829)	709,887	22.9%
7	Healthy Michigan Revenue	389,198	332,584	56,614	1,330,338	29.3%
8	3rd Party Revenue	199,610	57,661	141,949	230,643	86.5%
9	SSI/SSA Revenue	122,184	122,184	-	488,736	25.0%
10	Other Revenue	14,012	14,466	(455)	57,864	24.2%
11	**Total Revenue**	**7,134,810**	**6,605,687**	**529,123**	**26,422,748**	**27.0%**
	Expense					
12	Salaries	3,268,360	3,299,311	30,951	13,197,243	24.8%
13	Social Security Tax	144,864	160,417	15,553	641,669	22.6%
14	Self Insured Benefits	635,294	729,730	94,436	2,918,919	21.8%
15	Life and Disability Insurances	53,732	57,658	3,926	230,633	23.3%
16	Pension	259,787	262,034	2,246	1,048,135	24.8%
17	Unemployment & Workers Comp.	57,242	64,515	7,273	258,058	22.2%
18	Office Supplies & Postage	11,156	14,153	2,997	56,610	19.7%
19	Staff Recruiting & Development	30,259	28,297	(1,961)	113,190	26.7%
20	Community Relations/Education	827	803	(25)	3,210	25.8%
21	Employee Relations/Wellness	31,413	17,505	(13,908)	70,021	44.9%
22	Program Supplies	96,764	123,731	26,967	494,925	19.6%
23	Contract Inpatient	224,218	249,000	24,782	996,000	22.5%
24	Contract Transportation	29,809	26,089	(3,720)	104,356	28.6%
25	Contract Residential	1,165,633	1,195,840	30,208	4,783,361	24.4%
26	Contract Employees & Services	627,987	630,381	2,394	2,521,524	24.9%
27	Telephone & Connectivity	24,590	32,978	8,388	131,912	18.6%
28	Staff Meals & Lodging	4,425	11,464	7,039	45,857	9.6%
29	Mileage and Gasoline	105,953	110,695	4,742	442,780	23.9%
30	Board Travel/Education	5,192	3,654	(1,538)	14,616	35.5%
31	Professional Fees	7,548	13,548	6,001	54,194	13.9%
32	Property & Liability Insurance	26,032	13,391	(12,641)	53,563	48.6%
33	Utilities	41,677	51,274	9,597	205,096	20.3%
34	Maintenance	43,180	62,662	19,482	250,650	17.2%
35	Rent	65,603	65,912	309	263,649	24.9%
36	Food (net of food stamps)	17,184	23,458	6,275	93,834	18.3%
37	Capital Equipment	788	11,900	11,112	47,600	1.7%
38	Client Equipment	18,121	5,244	(12,876)	20,978	86.4%
39	Miscellaneous Expense	18,964	24,268	5,304	97,071	19.5%
40	Depreciation Expense	72,392	68,303	(4,089)	273,212	26.5%
41	Budget Adjustment	-	(752,529)	(752,529)	(3,010,115)	0.0%
42	**Total Expense**	**7,088,992**	**6,605,687**	**(483,305)**	**26,422,748**	**26.8%**
43	**Change in Net Position**	**$ 45,818**	**$ (0)**	**$ 45,818**	**$ (0)**	**0.2%**
	Contract settlement items included above:					
44	Medicaid Funds Under Spent	191,578				
45	General Funds Under Spent	36,251				
46	Healthy Michigan Funds Over Spent	(76,918)				

Northeast Michigan Community Mental Health Authority
Statement of Net Position and Change in Net Position
Proprietary Funds
September 30, 2017

	Total Business-Type Activities Sept. 30, 2017	Total Business-Type Activities Sept. 30, 2016	% Change
Assets			
Current Assets:			
Cash and cash equivalents	$ 3,883,652	$ 3,151,964	23.2%
Restricted cash and cash equivalents	872,575	838,125	4.1%
Investments	750,000	750,000	0.0%
Accounts receivable	1,261,415	1,003,935	25.6%
Inventory	16,518	15,638	5.6%
Prepaid items	448,107	363,835	23.2%
Total current assets	7,232,266	6,123,497	18.1%
Non-current assets:			
Capital assets not being depreciated	90,000	90,000	0.0%
Capital assets being depreciated, net	1,675,571	1,887,245	-11.2%
Total non-current assets	1,765,571	1,977,245	-10.7%
Total assets	8,997,837	8,100,743	11.1%
Liabilities			
Current liabilities:			
Accounts payable	1,820,404	1,196,200	52.2%
Accrued payroll and payroll taxes	647,023	531,710	21.7%
Deferred revenue	6,102	37,049	-83.5%
Current portion of long-term debt (Accrued Leave)	72,685	69,816	4.1%
Total current liabilities	2,546,215	1,834,775	38.8%
Non-current liabilities:			
Long-term debt, net of current portion (Accrued Leave)	799,889	768,309	4.1%
Total liabilities	3,346,104	2,603,085	28.5%
Net Position			
Invested in capital assets, net of related debt	1,765,571	1,977,245	-10.7%
Unrestricted	3,845,668	3,520,413	9.2%
Total net position	5,611,239	$ 5,497,658	2.1%

Net Position Beginning of Year	5,497,658
Revenue	26,873,887
Expense	(26,760,306)
Change in net position	113,581
Net Position September 30, 2017	$ 5,611,239

Unrestricted Net Position as a % of actual annual expense 14.4% or 52 days
Recommended Level 8% - 25%

Northeast Michigan Community Mental Health Authority
Statement of Net Position and Change in Net Position
Proprietary Funds
December 31, 2017

	Total Business-Type Activities Dec. 31, 2017	Total Business-Type Activities Sept. 30, 2017	% Change
Assets			
Current Assets:			
Cash and cash equivalents	$ 3,730,073	$ 3,883,652	-4.0%
Restricted cash and cash equivalents	909,578	872,575	4.2%
Investments	750,000	750,000	0.0%
Accounts receivable	1,846,449	1,261,415	46.4%
Inventory	16,518	16,518	0.0%
Prepaid items	315,995	448,107	-29.5%
Total current assets	7,568,612	7,232,266	4.7%
Non-current assets:			
Capital assets not being depreciated	90,000	90,000	0.0%
Capital assets being depreciated, net	1,505,877	1,675,571	-10.1%
Total non-current assets	1,595,877	1,765,571	-9.6%
Total assets	9,164,489	8,997,837	1.9%
Liabilities			
Current liabilities:			
Accounts payable	1,674,359	1,820,404	-8.0%
Accrued payroll and payroll taxes	869,515	647,023	34.4%
Deferred revenue	13,486	6,102	121.0%
Current portion of long-term debt (Accrued	75,768	72,686	4.2%
Total current liabilities	2,633,128	2,546,215	3.4%
Non-current liabilities:			
Long-term debt, net of current portion	833,810	799,889	4.2%
Total liabilities	3,466,938	3,346,104	3.6%
Net Position			
Invested in capital assets, net of related debt	1,595,877	1,765,571	-9.6%
Unrestricted	4,061,179	3,845,668	5.6%
Total net position	5,657,057	$ 5,611,239	0.8%
Net Position Beginning of Year	5,611,239		
Revenue	7,134,810		
Expense	(7,088,992)		
Change in net position	45,818		
Net Position December 31, 2017	$ 5,657,057		

Unrestricted Net Position as a % of projected annual expense 15.4% or 56 days
Recommended Level 8% - 25%

10/1/17 - 12/31/17

LIABILITY\FUND BALANCE ACTIVITY	YTD
ENDOWMENT	
Beginning Balance	60,416.20
Revenue:	
Contributions	1,008.00
Increase(Decrease)	1,008.00
Ending Balance	61,424.20
RESERVE	
Beginning Balance	15,500.67
Revenue:	
Interest and Dividends	1,103.43
Realized Gain(Loss)	1,631.32
Unrealized Gain(Loss)	622.62
Total Revenue	3,357.37
Expense:	
Transfer To Spendable This FY	3,201.43
Administrative Fees	229.94
Total Expense	3,431.37
Increase(Decrease)	(74.00)
Ending Balance	15,426.67
SPENDABLE	
Beginning Balance	7,772.81
Revenue:	
Transfer From Reserve	3,201.43
Total Revenue	3,201.43
Expense:	
Grants Approved	2,500.00
Total Expense	2,500.00
Increase(Decrease)	701.43
Ending Balance	8,474.24

BALANCE SHEET

	YTD
Assets:	
Investment Pool	85,325.11
Total Assets	85,325.11
Current Liabilities:	
Liability\Fund Balances:	
Endowment	61,424.20
Reserve	15,426.67
Spendable	8,474.24
Total Liability\Fund Balances	85,325.11
Total Liabilities and Equity	85,325.11

EXECUTIVE LIMITATIONS
(Manual Section)

ASSET PROTECTION
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved	June 14, 2007

●1 POLICY:

The CEO may not allow assets to be unprotected, inadequately maintained nor unnecessarily risked.

Accordingly, he or she may not:

1. Fail to insure against theft and casualty losses at:
   - Actual cash value less any reasonable deductible for vehicles;
   - Replacement value less any reasonable deductible for personal and real property; and,
   - Against liability losses to board members, staff or the organization itself in an amount greater than the average for comparable organizations.

2. Allow unbonded personnel access to material amounts of funds.

3. Unnecessarily expose the organization, its board or staff to claims of liability. The CEO's annual monitoring report shall include a risk analysis summary.

4. Make any purchase wherein normally prudent protection has not been given against conflict of interest. Make any purchase of over $500 without having obtained comparative prices and quality. Make any purchase over $5,000 without a stringent method of assuring the balance of long term quality and cost; further, such purchases over $5,000 not included in the Board's capital equipment budget, shall require Board approval. Orders shall not be split to avoid these criteria.

5. Fail to protect intellectual property, information and files from loss or significant damage.

6. Receive, process or disburse funds under controls which are insufficient to meet the board-appointed auditor's standards.

7. Invest or hold operating capital in insecure instruments, including uninsured checking accounts and bonds of less than AA rating, or in non-interest bearing accounts except where necessary to facilitate ease in operational transactions.

8. Endanger the organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission, including changing the name of the organization or substantially altering its identity in the community.

9. Subject facilities and equipment to improper wear and tear or insufficient maintenance.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

BOARD COMMITTEE PRINCIPLES
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision to Policy Approved:	September 14, 2006

●1 POLICY:

Board committees, when used, will be assigned so as to reinforce the wholeness of the board's job and so as never to interfere with delegation from board to CEO. Committees will be used sparingly and ordinarily in an *ad hoc* capacity.

1. Board committees are to help the board do its job, not to help or advise the staff. Committees ordinarily will assist the board by preparing policy alternatives and implications for board deliberation. In keeping with the board's broader focus, board committees will normally not have direct dealings with current staff operations.

2. Board committees may not speak or act for the board except when formally given such authority for specific and time-limited purposes. Expectations and authority will be carefully stated in order not to conflict with authority delegated to the chief executive.

3. Board committees cannot exercise authority over staff. Because the CEO works for the full board, he or she will not be required to obtain approval of a board committee before an executive action.

4. Board committees are to avoid over-identification with organizational parts rather than the whole. Therefore, a board committee which has helped the board create policy on some topic will not be used to monitor organizational performance on that same subject.

5. This policy applies only to committees which are formed by board action, whether or not the committees include non-board members. It does not apply to committees formed under the authority of the CEO.

●2 APPLICATION:
The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

BOARD STAFF RELATIONSHIP
(Manual Section)

DELEGATION TO THE CHIEF EXECUTIVE
(Subject)

Board Approval of Policy	August 8, 2002
Board Approval of Policy Revision:	February 8, 2007

●1 POLICY:

All board authority delegated to staff is delegated through the CEO, so that all authority and accountability of staff—as far as the board is concerned—is considered to be the authority and accountability of the CEO.

1. The board will direct the CEO to achieve specified results, for specified recipients, at a specified worth through the establishment of *Ends* policies. The board will limit the latitude the CEO may exercise in practices, methods, conduct and other "means" to the ends through establishment of *Executive Limitations* policies.

2. As long as the CEO uses *any reasonable interpretation* of the board's *Ends* and *Executive Limitations* policies, the CEO is authorized to establish all further policies, make all decisions, take all actions, establish all practices and develop all activities.

3. The board may change its *Ends* and *Executive Limitations* policies, thereby shifting the boundary between board and CEO domains. By so doing, the board changes the latitude of choice given to the CEO. But so long as any particular delegation is in place, the board and its members will respect and support the CEO's choices. This does not prevent the board from obtaining information in the delegated areas.

4. Only decisions of the board acting as a body are binding upon the CEO.

    A. Decisions or instructions of individual board members, officers, or committees are not binding on the CEO except in rare instances when the board has specifically authorized such exercise of authority.

    B. In the case of board members or committees requesting information or assistance without board authorization, the CEO can refuse such requests that require—in the CEO's judgment—a material amount of staff time or funds or is disruptive.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

January 30, 2018

To: CMH Board Members/Executive Directors (CMH & PIHP)/Management Staff (CMH & PIHP)/Provider Alliance Members

From: PAC Committee

Re: 2018 Annual PAC Campaign

This memorandum is being sent to all CMH boards, PIHPs and Provider Alliance members to announce and solicit participation in this year's CMH-PAC campaign. The CMH-PAC is a political action committee that helps support representatives and senators in leadership positions and those who champion the funding, legislation, and policy initiatives that help support and improve the provision of community-based mental health and substance use disorder services.

Your donations to the CMH PAC help support candidates who are supportive of our efforts at MACMHB. The money that is raised for the CMH PAC helps raise awareness of our issues. While we are not able to match dollar for dollar the contributions of the larger interest groups your efforts go a long way and give MACMHB a "seat at the table".

2018 will be a critical year in the Michigan Legislature. As you know, this is the last year of the Snyder administration and we will be facing a lame duck session where we will push for positive reforms and fight against a continued push for privatization. Additionally, the 2018 election year will have massive turnover in our state's leadership, with a new Governor, Attorney General, Secretary of State, 28 of the 38 state senators will be done, along with another 25-30 House members, so it is critical that we build our fund and invest wisely in the future leaders. With so much uncertainty surrounding the changes at the federal and state levels it is critical we maintain an active presence during this critical time.

Last year's campaign had mixed results from previous years. We raised more money than the previous few years, collecting $14,031 from only fifteen (15) boards and 182 individuals. The number of CMH Boards participating in our PAC campaign has dropped, but the number of people contributing has increased. The PAC Committee continues to encourage and strive for 100% participation in our efforts.

If you have any questions regarding this year's campaign, please contact Robert Sheehan or Alan Bolter at the Board Association offices. Thank you for your participation.

426 S. Walnut St., Lansing MI 48933
(517) 374-6848 ✦ Fax (517) 374-1053 ✦ Email: mvizena@macmhb.org

2018 CMHAM PAC CAMPAIGN
Details and Timeline

The 2018 campaign is designed to encourage more boards and more individuals to participate. Last year only 32% of CMH boards (15 boards) participated in our PAC campaign, the Committee has set a goal of 100% participation.

No specific contribution level is being established as a goal for this year's campaign. Instead, the challenge is to have at least 6 members (50% of the membership of each board) participate in the campaign. Participation by executive staff will be counted towards the participation. Boards that report results of a campaign with at least 6 members participating will qualify for the drawing of the Tiger game box suite tickets.

The campaign is being announced early with the hope that more boards will have time to discuss it merits locally and increase the participation rate. The PAC Committee requests that CMH directors and board chairpersons announce and discuss the campaign over the next three months at their regular monthly meetings. Boards that have conducted successful campaigns have chief executive officer and board member leadership who make this a meeting agenda item and discuss the need for a PAC fund.

As a special incentive for boards and affiliates that meet the challenge target, Muchmore Harrington Smalley and Associates will again donate a Detroit Tigers suite box (12 tickets) for a Tiger ball game. We will have the details on that game later this year.

Boards should forward the results of their campaign and donations to the CMH Association offices by June 22, 2018 in order to be in the drawing for the Tiger tickets if eligible.

Make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please)

Northern Michigan Regional Entity

January 24th Board Meeting Minutes [Available at Meeting]

Consumer Advisory Council

Regular Meeting
02-05-18
5:00 PM to 6:10 PM
Board Room

Meeting called by: Laura Gray

Type of meeting: Regular

Facilitator: **Laura Gray**

Attendees: **Roger Boston, Les Buza, Cindy Craft, Janet Freeman, Laura Gray, Anne Ryan, Eileen Tank**

Absent: **Vicki Bendig (excused), Kim Hoerl, Alan Fischer**

Guests: **Diane Hayka, Gary Nowak, Kathy Wittman**

---------- Agenda Topics ----------

Welcome & Introduction of Visitors
Laura Gray called the meeting to order at 5:00 p.m. and welcomed attendees.

Targeted Agenda Items: *Approval of Minutes*
Discussion:

By consensus, the minutes of the December 11, 2017 was approved.

Roger inquired as to whether there was anyone nominated to fill the REP vacancy. Diane Hayka will check with Cathy Meske to determine if there has been any input from the clinical staff for this position.

Action items:

Person responsible:
Diane Hayka

Deadline:

Targeted Agenda Items: *House CARES Task Force*
Discussion:
The House C.A.R.E.S. Task Force report was included in materials for this meeting. Council members felt this report contained a lot of information. Laura Gray noted this gives council members a route to use to contact our legislative officials in support of recommendations in the report. She noted it is difficult to determine what priority should be focused on first. Roger Boston noted much of the report seems to focus on children services. Council members agreed there were many good recommendations in this report but lacked a means to implement. In addition, the meetings and site visits were all concentrated in southern Michigan with Clare being the northern most location during this process.

Janet Freeman noted teachers in elementary school are seeing children come in without basic manners and respect as they are products of a generation whose parents possibly were affected by substance use or raised in dysfunctional families themselves. Even for those parents in traditional families hands are

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tied sometimes with all the regulations of what can and can't be done regarding disciplining and raising children.

Laura Gray noted last year she attended an event in which there were materials available for group settings targeted at young families. The materials were from a NAMI program. Several council members noted it would be beneficial if there was a local NAMI group giving families a resource for family groups, etc.

Many of the recommendations in the report related to jail services and training for law enforcement officials. Both Laura Gray and Diane Hayka noted the difficulty in getting law enforcement officers time to attend training. In the past, Laura reported she provided training for law enforcement with support of the Michigan Commission on Law Enforcement Standards (MCOLES). Diane reported Amy Pilarski and Stephen Slaght have provided training for Alpena and Montmorency county officers recently but are having difficulty scheduling training for Presque Isle and Alcona county officers.

The report also identifies the difficulties in finding inpatient psychiatric beds for children and adolescents, especially in certain areas of the state. A child needing admission to a psychiatric unit can sometimes be held for a couple of days until a bed is located for placement. The shortage of psychiatric beds also is true for adults.

Eileen provided a brief overview of her traumatic experience with her son, which ultimately ended with his imprisonment. She expressed the dire need for some type of support for her family after the event and the difficulty she had with finding any type of service to provide some guidance for her family. She noted she attended a support group through the church Laura Gray had connected her with. She notes while there may be some supports available for the victims, there should also be some services available for those families of the accused. Both the victim's family and the accused family experience very traumatic events and need guidance to deal with their feelings, etc.

Janet Freeman also voiced her concern when getting services for an adult family member due to their rights; the family is provided limited resources for how to handle situations and what symptoms to look for. Laura Gray reported she has had experiences with several hospitals and each hospital has different methods in providing families with information on how to handle mental health crises.

Council members requested to have a future educational session focusing on available services for families, possibly at the April meeting.

Eileen noted she would be willing to work with a group to get a support group such as NAMI up and going in our area.

Laura reiterated the importance to contact our legislative representatives and push to get some of the recommendations listed in this report enacted.

Late introductions of Council members were made. At this point, we have a full membership with each county represented.

Kathy Wittman, working through the self-determination program, voiced concern related to the focus on inclusion but when out in the community individuals are to be introduced without names. True inclusion would be to say "I would like you to meet my friend, Cindy."

Action items:

Person responsible:

Deadline:

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Targeted Agenda Items: *NMRE Updates*

Discussion:

REP/Recovery Council Meetings

The minutes of the December 14, 2017 Regional Entity Partners (REP) meeting were included in the packet. The minutes of the January 18, 2018 REP meeting was a handout at this meeting. Roger Boston noted there is a new member to the REP group representing North County CMH. Roger reported the Recovery Council will be separated out from the REP and the groups will meet independently. Roger Boston indicated a willingness to serve on both; however, it was his understanding an individual could only serve on one. The Day of Recovery will be held on May 11th and a judge was secured to discuss guardianship, limited-guardianship and conservatorship. The theme of the event will be called "Be Heard, Be Informed, Be Engaged, Be Inspired." T-Shirts will be obtained for the REP members.

Roger noted he updated the REP group about the McDonald pancake fundraiser held recently for the Bay View Center in Alpena.

NMRE Board Meetings

The minutes of the December 27, 2017 NMRE Board meeting was included in the material mailed with this packet. The NMRE Board also met on January 24, 2018 and those minutes are not yet available. Gary Nowak reported Eric Kurtz is a good leader. He also reported a lease was signed with North Country to continue office space for the NMRE.

Council members requested some history of the regional entity and questioned some of the acronyms used during meetings. Diane Hayka will pull some materials together as an orientation packet for members.

Action items:

Person responsible:

Deadline:

DRAFT

Targeted Agenda Items: *Public Hearing Program Input 2017 Update*

Discussion:

Diane Hayka reported the Annual Submission requirements were received from the Michigan Department of Health and Human Services (MDHHS). As the Agency held a public hearing last year to receive public input, this year the requirement is to update the Department as to progress made toward our priority issues identified last year. The report was distributed to Council members. Diane Hayka reported this information will be sent out to all those invited to last year's public hearing as a status update.

Action items:

Person responsible:

Deadline:

Targeted Agenda Items: *Board Agenda Review*

Discussion:

Council members reviewed the Board Agenda for February 8. Diane Hayka reported the Educational Session will be provided by Larry LaCross from Catholic Human Services. The Director will review with

the Board the Public Hearing Program Input 2017 report this council reviewed. Council members noted the Consumer Advisory Council update is on the agenda as well. Diane Hayka reported Lester Buza, Gary Nowak and Alan Fischer are all Board members and can provide the update. She will have a draft of this meeting's minutes available for the Board to review as well.

Action items:

Person responsible:

Deadline:

Targeted Agenda Items: *Other*

Discussion:

Gary Nowak reported he will bring the NAMI concern to the Board to let them know the difficulty in getting this organization off the ground again.

Action items:

Person responsible:

Deadline:

Next Regular Meeting Date:

The next regular meeting is scheduled for April 9, 2018 @ 5:00 p.m. in the Board Training Room. This meeting adjourned at 6:10 p.m.

DRAFT

Community Access Resources Education Safety

House C.A.R.E.S. Task Force

FINAL REPORT

MICHIGAN HOUSE OF REPRESENTATIVES

House **C.A.R.E.S.** Task Force

Community Access Resources Education Safety

FINAL REPORT

MESSAGE FROM THE SPEAKER

When I was first elected Speaker of the House, I immediately set my priorities for the coming legislative term. Reforming our broken mental health system was at the top of that list. That is why this report exists today.

Throughout my career, I have seen firsthand the failings of our current mental health system and the consequences those failures have had on Michigan families. As a prosecutor in Genesee County, I witnessed broken families coping with the fallout of untreated issues at both crime scenes and court hearings. I watched people who knew they were troubled trying to seek help only to be turned away. And I have seen the immense burden put on every one of us in Michigan by a misdirected focus on our budget and state programs on treatment after the fact in our criminal justice system rather than on prevention and rehabilitation. This report and the legislation that will follow is our opportunity to begin realigning these priorities.

Every step in the current process can be improved, from our local delivery of services, to our understanding of developmental disabilities, to how we understand, treat and combat substance use disorders. Michiganders who are impacted by these challenges, including parents, crime victims, veterans and many others, deserve new options and smarter programs. They expect us to deliver them.

That is why I created the bipartisan House C.A.R.E.S. Task Force, focusing on Community, Access, Resources, Education, and Safety. This Task Force was committed to reviewing every single place in our local communities where vulnerable residents lacked care or resources. After five months of work, including meetings all over the state and public feedback over the web, the Task Force has proposed strong recommendations I believe will deliver real, tangible results for families in need.

Our goal, as policymakers, must be to create a state where every person feels safe, where opportunity exists for everyone, and where those struggling to cope with mental illness can get the treatment that will enable them to heal and thrive as productive members of their community. I look forward to putting the recommendations presented in this report into action so we can begin the long overdue conversation on how to best deliver help to our most vulnerable citizens.

Sincerely,

State Representative Tom Leonard
Speaker of the Michigan House of Representatives

LETTER FROM THE CO-CHAIRS

Dear Michigan Residents:

We submit this report to serve as our recommendations and the conclusion of our findings through our work as co-chairs of the House C.A.R.E.S. Task Force. In developing these recommendations the Task Force members had the distinct honor to listen to people and stakeholders across communities in Michigan. From July to October, we held meetings and site visits across Michigan to learn how we can deliver meaningful solutions to change policy and eliminate barriers to address mental health in our state.

Our goal now is to craft these solutions that cross issue areas and address the many concerns we have heard these last few months. We believe this report serves as a strong foundation to start working toward supporting a better place for our citizens to live happier and healthier lives. Over the next several months it is our hope that we will continue to identify solutions that fit into the framework of this report, and we will work with the citizens of our state to provide resolution to barriers to access mental health care, enhance current services, and improve our current programs.

Whether through legislative means or policy changes, and with the help of the Task Force members and all of our legislative colleagues, it is our plan to work through each one of these recommendations. It is clear to the Task Force that there is a lot of work to be done, and it is our privilege to be in a position to help coordinate these efforts to make Michigan a place where any citizen can receive the best care and services they need to live full and normal lives.

It has been a pleasure to serve the citizens of Michigan as co-chairs of the House C.A.R.E.S. Task Force. It is our hope this bipartisan effort will produce significant results to make a difference for many generations to come. We know with the support of the Legislature and the people of Michigan, this is a possible achievement.

Finally, we want to thank Speaker Tom Leonard for his support and direction with our work, and we want to thank the members of the Task Force who have spent time gathering the quality information that it took to develop these recommendations. We also want to thank the many residents and participants who joined our meetings to educate us on how we can better serve our state's most vulnerable populations.

Respectfully yours,

Representative Klint Kesto
Co-Chair of House C.A.R.E.S. Task Force

Representative Hank Vaupel
Co-Chair of House C.A.R.E.S. Task Force

TASK FORCE MEETINGS

The House C.A.R.E.S. Task Force was announced by Speaker Leonard on July 12, 2017. The bipartisan Task Force included the following members:

Representative Klint Kesto (co-chair)

Representative Hank Vaupel (co-chair)

Representative Edward Canfield

Representative Fred Durhal III

Representative Vanessa Guerra

Representative Abdullah Hammoud

Representative Robert Kosowski

Representative David LaGrand

Representative Dave Pagel

Representative Daire Rendon

Representative Sylvia Santana

Representative Jason Wentworth

Representative Mary Whiteford

Representative Robert Wittenberg

The Task Force held a series of meetings over several months where people from the local communities were able to share their experiences. The Task Force also collected numerous written comments at each of its meetings, and many more comments were submitted through the Task Force website. The summaries of these meetings can be found at www.house.mi.gov/CARES/. The meetings were held at the following locations:

- *Livingston County's EMS Building in Howell on July 31*
- *Hope Network in Grand Rapids on August 17*
- *Oakland Community Health Network in Auburn Hills on August 29*
- *House Appropriations Room Capitol Building in Lansing on September 7*
- *Team Wellness Center in Detroit on September 11*
- *Mid-Michigan Community College in Clare on September 29*

Finally, members of the Task Force went on several site-visit tours to view services and programs firsthand. The tours included all of the following locations:

- *The Livingston County Jail in Howell*
- *St. Mary's Mercy Health Hospital in Grand Rapids*
- *The Michigan Center for Forensic Psychiatry in Saline*
- *Michigan Hawthorn Center in Northville*
- *University of Michigan Medical Center for Children and Adolescents in Ann Arbor*
- *Michigan Department of Corrections Vocational Village in Ionia*

TASK FORCE MEETINGS

The Task Force's priorities were centered on improving mental health services, ensuring public safety, smarter expenditure of resources, satisfying the needs of crime victims and other vulnerable populations, preparing those who are incarcerated to safely and productively re-enter society, breaking the cycle of crime, building our workforce, and encouraging coordination of state services. Furthermore, the Task Force focused on where coordination between community programs and other state governmental programs can be improved to enhance overall care to residents while reducing duplication of services. In other words, the Task Force explored ways to tap into our existing infrastructure and encourage services to assist in breaking down barriers to consistent care.

Through the course of the meetings, tours, and written comments, a number of issues repeatedly were identified. Many of these issues have also been identified by recent commissions and committees, and in those cases, we now echo their findings and add to the Legislature's support of addressing the issues. The issues are summarized below and are taken from multiple sources, but must not be considered an exhaustive list as we will continue to work toward identifying solutions.

A bipartisan group of House legislators comes together for a CARES Task Force meeting.

PROBLEMS IDENTIFIED AND RECOMMENDED SOLUTIONS

Community Access Resources Education Safety

OPPORTUNITIES TO IMPROVE CARE

CHILDREN

Give CMH Priority to Foster Children

Children entering the foster care system are highly vulnerable to traumatic events, increasing their likelihood to develop behavioral health issues. In order to curb long-term effects as much as possible, children assigned to foster care should be given a priority in the Community Mental Health (CMH) system. A psychological evaluation for each child entering the foster care system is a useful tool for determining the best treatment and services for the child. We should also encourage more complete reporting of the child's history.

Explore a Pilot for the Sobriety Treatment and Recovery Team for Parents (START) Program

START is a child protective services program found in other states for families with substance use and child maltreatment issues. START pairs child protective services (CPS) workers trained in family engagement with family mentors using a system-of-care and team decision-making approach with families, treatment providers, and the courts. We identify the START program as a useful program to help children and families and encourage its implementation.

Provide Mental Health Training to Teachers and Counselors

Teachers and counselors should be equipped to identify and address a mental health crisis that a child might be experiencing. While it is helpful to have social workers and psychological professionals in a school, for areas that cannot afford these professionals, mental health crisis and mental health first aid training for teachers and other school staff will better serve these students. We should explore offering such training to teachers and other school staff throughout the state.

Dr. Laura Hirshbein, University of Michigan professor of psychiatry and medical director of adult psychiatric impatient unit, shares her experience and recommendations during a Task Force meeting held at the Capitol.

Increase Number of Psychiatric Beds for Children

It is important that we identify and address mental illnesses in the earlier stages of life. We need to find ways to increase the availability of psychiatric beds in hospitals and facilities in certain areas of the state to address the shortage and waiting lists for individuals that need services, especially children.

Rep. Jason Wentworth speaks with stakeholders at a Task Force meeting at Hope Network in Grand Rapids.

VETERANS

Increase Support for Michigan Veterans

The Michigan Veterans Affairs Agency (MVAA) is piloting a Veterans Reentry Search Service, which looks to identify veterans in prison, jails, and courts. Once a veteran is identified, the MVAA can work with the veteran to maximize available VA services. This pilot program should be continued and expanded in order to make sure our veterans found in these vulnerable situations are given the chance to maximize the services available to them.

The MVAA is also actively working to reach veterans who are suffering from mental illness. We should provide support for the anonymous mental health screening tool and increase awareness of the tool to help veterans in need of mental health services.

Finally, we need to find ways to support our veterans at the county level when they are seeking benefits and services. Supporting local County Veteran Affairs offices to provide referrals to veterans with mental health illnesses at this first step will connect them with treatment earlier.

Encourage Opportunities to Connect Veterans to Providers

We should continue to support our current programs in Michigan that aim to connect veterans with mental health care that is provided at a reduced or free cost from a network of volunteer professionals. We should also seek new opportunities and collaborations between the state and non-profits that might enhance mental health treatment to veterans and their families.

CRIME VICTIMS

Improve Services for Victims

Many times victims of crime are lost in the system and do not receive the support, services, or resources they need to take back control of their lives and begin the process of healing. We need to increase efforts to enforce the constitutional rights of crime victims and pursue ways to better serve these individuals and give them the treatment they deserve.

Encourage the Use of Crime Victim Advocates

Crime Victim Advocates provide an invaluable service in many prosecuting attorney offices throughout the state. They respond to the emotional and physical needs of crime victims, assist primary and secondary victims of crime to stabilize their lives after victimization, assist victims to understand and participate in the criminal justice system, and provide victims of crime with a measure of safety and security. We need to ensure that professionals like Victim Advocates receive the resources, training, and funding they need to continue serving crime victims in this state.

Support Canine Advocates for Victims

Michigan needs to think about new and improved methods to protect victims' rights. The criminal justice system can be extremely overwhelming, stressful, and terrifying for victims, especially when having to testify in court against a defendant who has caused them physical or emotional harm. More and more prosecutors' offices across the state are using Canine Advocates as an additional comfort for the most vulnerable crime victims, such as child sexual/physical abuse victims. Canine Advocates provide support to crime victims by being present at interviews and court proceedings.

SERVICES

Expand the Use of "Telehealth"

"Telehealth" or "telemedicine" refers to the use of electronic information and communications technologies to link patients with health care professionals in other locations. We should expand the use of telehealth services to include services for pre-screening on inpatient units, psychiatric inpatient screening, assessments by a non-physician, and ongoing psychiatric care.

Make Services More Efficient for Patients with Mild or Moderate Mental Health Needs

Persons suffering from mild to moderate mental illness are often the ones with the least amount of resources for help. One way to help expand services for this population is to exempt CMH systems from certain legal requirements in these cases. Such requirements include extensive data collection and reporting, full psycho-social assessments, and a full person centered plan. While these requirements may be appropriate for long-term intensive services, they are not necessarily appropriate for brief, focused, office-based psychotherapy. Fulfilling these requirements artificially increases the cost and time spent to serve those with mild to moderate mental illness. Reducing these requirements would allow the CMH further use of funds and flexibility to expand its services.

Rep. Klint Kesto, Task Force co-chair, speaks with meeting attendees at a CARES meeting.

Capture More Funds for Substance Abuse Services and Programs

Many individuals who need services for substance use disorders (SUD) seek help at local CMH systems. With the growing opioid problem in our state, we need to ensure that CMHs have strong financial support from the state to provide more outpatient services. Providing such services to addicts early can potentially get their addiction under control and keep them out of the corrections system.

Simplify Dispute Resolutions for Consumers and Families by Adding Mediation

Currently, the Mental Health Code prevents the use of mediation to resolve disputes involving mental health consumers until after an investigative report is completed. The Mental Health Code should be amended to allow the use of mediation as a first step in dispute resolution.

Require CMHs to Prioritize

Each CMH system should determine what constitutes the most severe forms of mental illness and emotional disorder, and based upon those determinations, the CMHs should have an established priority of services for individuals presenting with mental illnesses.

FIRST RESPONDERS

Provide Crisis Intervention Training and Resources to Law Enforcement

We should increase access for law enforcement officers to participate in crisis intervention training (CIT), especially in service training for sheriff departments and local police departments. This can be through additional funding for the Michigan Commission on Law Enforcement Standards (MCOLES) to provide grants, or through mandating the training at the state level. At a minimum, CIT training should include information on signs and symptoms of mental illnesses, mental health treatment, co-occurring substance use disorders, and de-escalation techniques.

In addition to increasing safety in police encounters and diverting appropriate people with mental illness from the criminal justice system to mental health treatment, we need to provide the proper resources to adequately address these situations. Law enforcement professionals often spend significant time transporting or processing these cases. This added capacity pulls them off the road and away from addressing other public safety concerns. Expanded use of telehealth may also help alleviate this burden.

West Bloomfield Police Chief Michael Patton speaks to the Task Force during its Lansing meeting in the Capitol.

Encourage EMT Training to Identify and Respond to Signs and Symptoms of Mental Illness

Much like crisis intervention training, emergency medical technicians (EMT) and paramedics should have training to identify and respond appropriately to a person dealing with a mental illness. We need to find ways to encourage training for these professionals across the state.

Continue to Fund 911 Registration Programs

We should continue to support voluntary programs to allow local residents to pre-notify the police when there is a person in the residence with a special need. This allows law enforcement to be aware that there may be a person with a mental health disability on the premises when the officers respond to a call for help.

PROVIDERS OF SERVICES

Address the Shortage of Case Managers and Social Workers

We need to find ways to address the shortage of case managers and social workers in our state. If we can increase the number of these providers, we can get more services in places where there is a need, such as schools and jails.

Provide Incentives for Mental Health Professionals to Work in Michigan

There is a limited number of mental health professionals in Michigan. Increasing the number of residencies in our state for these professionals will subsequently increase the number of providers. We should encourage GME programs in our hospitals, especially in communities where there is a shortage of providers. Additionally, we can provide incentives, such as student loan repayment programs, to mental health professionals who work in underserved areas.

In addition, civil service rules for hiring psychiatrists in state facilities have limited the Department of Health and Human Services' ability to hire and retain psychiatrists. We should revise these rules to give DHHS more latitude in recruiting and retaining these needed professionals.

Rep. Klint Kesto thanks Detroit police officers for addressing the Task Force at the Team Wellness Center in Detroit.

Implement Universal Credentialing

In Michigan, physicians must be credentialed with each Medicaid Health Plan. We have heard that implementing universal credentialing at the state level for all the health plans will ease the process for providers and make it easier for them to accept Medicaid patients throughout the state.

Streamline Recipient Rights Officers

Mental health services providers are required to have a "recipient rights officer" to ensure that patients' rights are not violated. Yet it is often inefficient and unnecessary to have a recipient rights officer at every single provider. By streamlining these officers into a regional system, we could save money without cutting into services.

LOCATION OF SERVICES

Provide Wrap-Around Services and Peer Support

We have repeatedly heard about the need for continuity of care. It is not enough to solely provide treatment or care. An individual suffering from a mental illness or SUD can hardly focus on staying healthy if they do not have proper transportation, housing, or employment. We need to remove barriers in all instances where these wrap-around services are not available, and provide affordable options for these vulnerable populations.

Additionally, we should explore other opportunities such as support services for people seeking SUD treatment. Peer recovery coaches and activity engagement can lead a person suffering with addiction toward a successful sober life. It is important that we look for ways to increase community service options, not just psychiatric beds or institutional care.

Offer More Options for Mental Health or Regional Crisis Stabilization Units

Feedback from multiple parties – including law enforcement, patients and caretakers – expressed frustration with the lack of options for persons presenting with a mental health episode, but who have not committed a crime and are ineligible for hospitalization. Mental health stabilization units or regional crisis stabilization units should be supported to provide more options for crisis intervention and stabilization for persons suffering from a mental health episode.

Rep. Hank Vaupel shakes hands with a concerned individual after a Task Force meeting in Oakland County.

Seek Collaborative Efforts to Increase Access

We should explore opportunities and collaborative efforts to develop psychiatric wards or crisis centers to house mentally ill populations in underserved areas.

Encourage Providers to Have Additional Beds for Mental Health

There is near unanimous agreement among key stakeholders about the shortage of psychiatric beds across the state (previously noted). In order to address this shortage, we need to find ways to incentivize and encourage providers to create or expand psychiatric wards. This includes the statewide need for acute care beds for psychiatric emergencies. The absence of beds increases the probability of police officers using jails as substitute mental health facilities.

Create a Database for Available Mental Health Services

Many times, when an individual has a mental health crisis or is brought to the hospital by law enforcement, there are not enough psychiatric beds available to place the individual. We should work toward developing a state database that contains information about the number and locations of available beds, and make this database accessible to facilities, providers, and law enforcement.

Create the Michigan CARES Hotline

In addition to fulfilling the need for a database, the state should have a crisis hotline for individuals who do not know where to turn for help. This hotline can refer the individual to local services or a health facility that has available providers to address their concerns.

Create Opportunities for Intermediate and Long-Term Care

Creating more opportunities for intermediate or long-term care will ensure individuals are getting the services they need. Residential options that offer treatment short of full hospitalization should be explored. Currently, many facilities that provide adult psychiatric residential services are licensed individually as adult foster care homes. The license does not fully recognize the services received by residents and limits the opportunity for private insurance coverage.

COURTS AND DIVERSION PROGRAMS

Support and Expand Michigan's Problem-Solving Courts

Michigan's problem-solving courts have been extremely successful in helping offenders get access to treatment and other support needed to address substance abuse or mental health issues. According to the State Court Administrative Office, graduates of the state's 185 drug, sobriety, mental health, and veterans courts are 2-3 times less likely to reoffend, and such programs have reduced participant unemployment by 74 percent.

We need to make sure that as many courts and judges as possible have the necessary resources and funding to ensure continued success with specialty courts. The Legislature recently passed legislation expanding the eligibility for such courts and allowing a case to be transferred to another county's court to allow for a defendant's participation in a state-certified treatment court if certain criteria are met. However, the state should continue efforts to expand participant eligibility and consider providing additional funding to counties that create new mental health, veterans, or drug specialty courts.

Seema Sadanandan shares her experience as managing director of state campaigns for Alliance for Safety and Justice during the Task Force's Oakland County meeting.

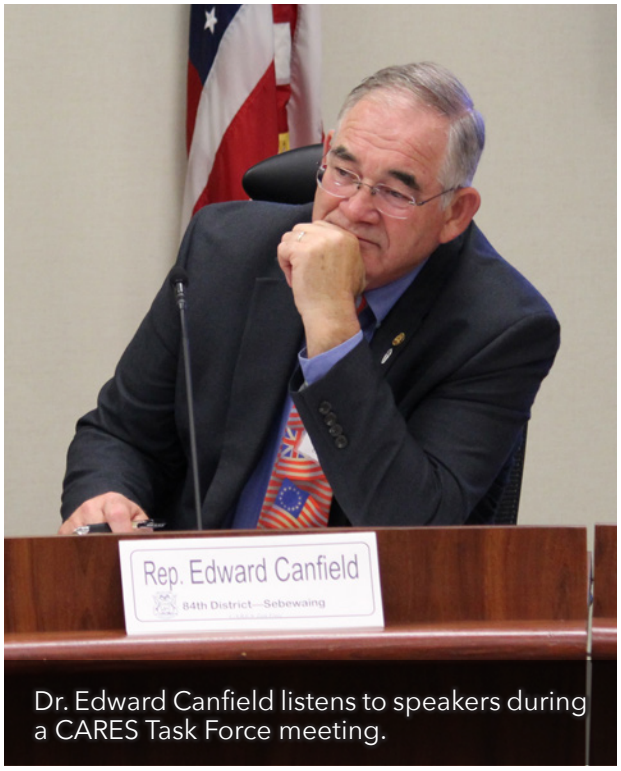
Expand Diversion and Deferral Programs for Veterans and Individuals with Mental Health or Substance Abuse Issues

Michigan already has problem-solving courts and diversion/deferral programs that address substance and alcohol abuse, domestic violence issues, and veterans' issues. It is essential, however, that we continue to support these options, expand defendant eligibility, encourage the development of new programs and expand program authorization. This is the best method to ensure individuals get the treatment they need while they are navigating the court systems.

Authorize Prosecutorial "Restitution and Diversion" Programs

If the interest of justice can be served outside formal court proceedings, individuals should be allowed to be successfully rehabilitated through a diversion program. Several prosecuting attorneys' offices offer diversion programs that allow offenders to bypass the usual criminal process and avoid a conviction if they abide by a set of conditions, which often includes restitution and some type of treatment. These programs increase the efficiency of the criminal justice system by reducing court caseloads, reducing jail overcrowding and by increasing the potential for collection of restitution to victims by offering offenders the opportunity to avoid a criminal record.

The Legislature should authorize and encourage these "Restitution and Diversion" programs. This will allow prosecuting attorneys to seek an alternative resolution working with victims, community corrections, parole and probation officers, community based mental health and substance abuse treatment providers and the courts to produce a disposition outside the jail or prison.



Dr. Edward Canfield listens to speakers during a CARES Task Force meeting.

PRE-TRIAL AND TRIAL PRACTICES

Reduce Pre-Trial Incarceration of Low-Risk Individuals with Substance Abuse and Mental Health Issues

In order to reform our pre-trial system to reduce pre-trial incarceration of low-risk individuals who suffer from either substance use disorders or mental illnesses, we should encourage the use of an evidence-based risk assessment tool to assess defendants and the risk of pre-trial release. This should also assess defendants to determine whether the person has a serious mental illness, co-occurring substance use disorder, or a developmental disability, and would therefore benefit from a problem-solving court, mental health services, and/or additional support in accordance with local jail diversion agreements.

Address the Backlog of Cases at State Forensic Center

Currently, there is a huge backlog of cases at the state forensic center, due in part to a shortage of available forensic staff to provide evaluations and/or treatment. Clearly, we need to adopt policies to reduce employee turnover, and hire and retain qualified staff. These efforts will ensure that those in the system are being evaluated on a timely basis, and therefore will receive the services and treatment they need.

Increase Judicial Discretion in Sentencing for Veterans

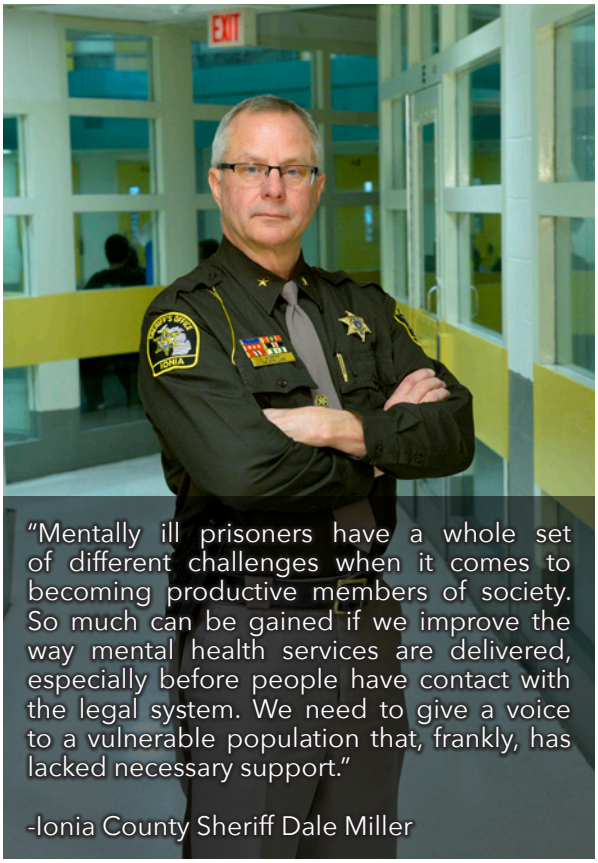
Post-Traumatic Stress Disorder (PTSD) affects many of our veterans and their daily lives. Courts should have the ability to take a veteran's PTSD into consideration while sentencing in all cases. Additionally, the use of veteran specialty courts should be expanded in our state.

Promote Early Intervention in Our Mental Health System

Considering the shortage of psychiatric beds in hospitals and facilities across our state, increased efforts need to be made to promote early intervention in our mental health system. For far too many, our mental health system is outdated and ineffective. Untreated mental illness often results in homelessness, incarceration, and poverty. Taking care of mental illness early could save money, reduce hospitalization costs, and reduce incarceration costs.

Assisted Outpatient Treatment (AOT) refers to community services provided under court order for adults with severe mental illness who need ongoing psychiatric treatment to prevent relapse, incarceration, re-hospitalization, homelessness, or dangerous behavior. AOT is an early intervention strategy that has been effective in promoting recovery, increasing medication adherence, and reducing inpatient hospitalization and incarceration.

Michigan's AOT law, "Kevin's Law," has been in existence since 2005. While the Legislature recently expanded the use of AOT, additional changes are necessary to simplify the AOT court process and to promote greater use of outpatient treatment. For example, two witnesses are required to testify with an AOT petition. This requirement can be difficult to satisfy, especially in rural counties. The law should be amended to require only one licensed psychiatrist or psychologist to testify when a clinical certificate is provided for AOT only. We should also revise current law to allow guardians to consent to mental health treatment, which will allow for early intervention and outpatient treatment before a serious mental health crisis occurs.



"Mentally ill prisoners have a whole set of different challenges when it comes to becoming productive members of society. So much can be gained if we improve the way mental health services are delivered, especially before people have contact with the legal system. We need to give a voice to a vulnerable population that, frankly, has lacked necessary support."

-Ionia County Sheriff Dale Miller

INCARCERATION PRACTICES

Ask Congress to Allow Medicaid Coverage During Incarceration

Numerous local county jails reported the difficulties that arise when Medicaid services are cut off for those in jail. This includes lack of resources for care, delay of care upon release from jail, and inconsistencies between care given in jail and upon release. We should call upon Congress to change current law to allow Medicaid services during incarceration or to allow states to seek a federal waiver to the law.

Require the Use of a Mental Health Screening in All Jails at Intake

Although all jails provide some level of observational and question-based screening for mental health problems by jail staff, the process varies from county to county. An empirically validated mental health screening measure should be utilized during the booking process to detect serious mental health issues. We should also consider an increased emphasis on identifying substance use disorders, as individuals with serious mental illness and co-occurring substance use disorders are more likely to go to jail and return multiple times.

Expand Custody Options for Prisoners with Severe Mental Illness and Increase Options of Care for Parolees who Suffer from Mental Illness

Prisoners who suffer from mental illness and developmental disabilities receive a myriad of care while incarcerated, from short-term mild care to long-term serious and intense long-term care. Unfortunately, prisoners suffering from severe and irreversible conditions, such as dementia, require heightened care and are at an increased vulnerability for abuse among the prison population. Options should be explored to house these prisoners in a more effective and safe environment.

For parolees suffering from mental illness, greater options are needed to transfer them to long-term care living arrangements. It is common for a prisoner who has reached parole to remain in prison for up to two years while waiting for a proper treatment setting to become available. In these cases, prison can be the least effective and safe place for mental health treatment.

State Rep. Mary Whiteford listens to feedback from a Task Force attendee.

Similarly, prisoners who suffer from severe and irreversible physical illness are a major drain on the corrections system. These prisoners would receive better and more cost-effective care if they are released to a supervised health care facility.

Megan Noland, director of government affairs for the Oakland County Sheriff's Office, speaks to the Task Force during a meeting at the Oakland Community Health Network in Auburn Hills.

Increase Meaningful Rehabilitation Efforts in Prison

Increasingly, prisons are focusing on training and activities that increase a prisoner's educational opportunities and vocational training. The goal is to increase the chances that prisoners will successfully reintegrate into society after release, and decrease the chances that they will end up back in prison. In light of this trend, we should incentivize prisoners who are eligible for parole to complete educational courses, vocational training, and counseling activities.

Expand the Vivitrol Program

In order to provide proper treatment to parolees with substance use disorders, we should continue to support and expand the vivitrol pilot program that is currently offered through the Department of Corrections, and add support services for parolees who participate in the program.

POST-INCARCERATION

Increase Continuity from Incarceration to the Community

One of the most vulnerable times for a new parolee are the first few days and weeks of re-entry. This is especially so for those who suffer from a mental illness where it is critical to avoid any lapse in treatment. Programs should be supported and expanded to help get a parolee connected with a federally qualified health center (FQHC) or other providers. Opportunities should also be explored to increase the access of prescription medicine upon his or her release. Most parolees are given about a two weeks supply of their needed prescription drugs as they leave. Unfortunately, many parolees – especially parolees suffering from mental illness – do not take the steps necessary to receive additional medication after this supply runs out. Often, this is because navigating the Medicaid system and finding a new provider can be difficult for a parolee readjusting to society.

Eliminate Barriers to Work

Successfully getting and keeping a job is key to ensuring a person does not end up back in the criminal justice system. While prohibiting persons with criminal records from obtaining certain jobs can protect potential victims, often these prohibitions exceed their intended scope and prevent rehabilitated persons from gaining employment.

Therefore, the law should be amended to eliminate certain employment restrictions for people with a criminal record, decriminalize minor offenses that create long-term employment repercussions, and expand expunction eligibility for those with diagnosed mental illness and for veterans who go through veterans treatment court. This also includes eliminating automatic suspension of driver's licenses for drug offenses.

State Rep. Edward Canfield, D.O. (right) speaks with Cara Poland, M.D., addiction medicine specialist at Spectrum Health (left) and Phil Weaver, CEO of Hope Network where the Grand Rapids Task Force meeting was held.

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House C.A.R.E.S. Task Force

FINAL REPORT

MICHIGAN HOUSE OF REPRESENTATIVES

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 - 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) 2. Increase CMH presence in schools to include increased outpatient access in schools by CMH contractors 3. Complete Trauma assessments on children/adults referred by local DHHS Children's Services through partnership Children's Trauma Assessment Center (CTAC) 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. 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. 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. 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. 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. 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. - Community members lacking knowledge of mental health treatment options. What to do when spouse is experiencing confusion (dementia vs. mental health disorder). - 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 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. 2. NeMCMHA continues to contract with Partners in Prevention to provide Youth and Mental Health First Aid to our communities: • 51 community members participated in Mental Health First Aide in FY17, and • 35 community members completed Youth Mental Health First Aid; • 422 community members (school staff, agency and community members at large) completed 'Building Trauma Awareness' training. • 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. 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. - Synthetic drug abuse, lack of community knowledge - 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 2. Participate in community presentations regarding substance use disorders and synthetic drug abuse 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. Northeast staff are members of the Substance Use Coalition and Northeast staff is scheduled to participate in training specific to adolescent substance use.

Northeast Michigan Community Mental Health Authority

To: Board Members

From: Cathy Meske

Date: January 31, 2017

Subject: Endowment Fund Grant Awards

In continuing in providing notification to the Board for usage of the spendable dollars available in the Endowment Fund created through The Community foundation of Northeast Michigan, this memo serves as an update of the grant awards since 8-16.

1. $500-Laptop, graphic drawing tablet and supplies for college
2. $305-Household items for independent living
3. $500-Security deposit and household items
4. $500-Security deposit
5. $449-Digital camera for college class and portfolio items
6. $500-Security deposit/rent

Total award for past six months: $2,754.00

	Program	Consumers served January 2018	Consumers served since May 2017
1	**Access / Crisis / Prescreens**	65 - Routine 90 Crisis 28 Prescreens	529 Routine 1 Emergent 3 Urgent 665 Crisis 341 Prescreens
2	**Doctors' Services**	1184	1449
3	**Case Management**		
	Older Adult (OBRA)	142	162
	MI Adult	251	333
	MI ACT	35	44
	Home Based Children	125	187
	DD	337	368
4	**Outpatient Counseling**	196(34/162)	448
5	**Hospital Prescreens**	28	341
6	**Private Hospital Admissions**	21	196
7	**State Hospital Admissions**	0	4
8	**Employment Services**		
	DD	105	109
	MI	60	124
	PSR Clubhouse	68	97
9	**Peer Support**	66	74
10	**Community Living Support Services**		
	DD	152	154
	MI	198	230
11	**CMH Operated Residential Services**		
	DD Only	59	61
12	**Other Contracted Resid. Services**		
	DD	23	23
	MI	12	12
13	**Total Unduplicated Served**	1133	2117

	Unduplicated Consumers Served Since May 2017
Alcona	224
Alpena	1364
Montmorency	202
Presque Isle	252
Other	61

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

DIVISION/DEPARTMENT NAME

Administration/Support Services	61
Vacancies	5

PROGRAMS

Psychiatry & Nursing Support	9
MI Adult Outpatient (ACCESS-CRS-ESU)	8
DD Clinical Support	5
Vacancies	0
DD Integrated Employment	16
MI Integrated Employment	4
Clubhouse	5
Vacancies	0
DD Case Management	14
MI Adult Case Management	12
MI Adult A.C.T.	8
Geriatric Services	13
Home-Based Child	10
DD ABA Program	14
Vacancies	5
Peer Support Services & MNA	7
DD SIP Residential	51
DD Community Support	31
Blue Horizons	10
Brege	12
Cambridge	12
Harrisville	12
Mill Creek	12
Pine Park	12
Princeton	12
Thunder Bay Heights	12
Walnut	12
Vacancies	11

TOTAL: **373**

ADMINISTRATION/SUPPORT SERVICES

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

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

Services Reporting To:

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

PSYCHIATRIC NURSING SERVICES

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

MI ADULT OUTPATIENT

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

DD CLINICAL SUPPORT

Ross, Bailey	Psychologist
Witkowski, Katherine	Psychologist
Anderson, Carolyn	Registered Nurse
Hardies, Mary	Registered Nurse/Infection Control Nurse
Schimmel, Joan	Registered Nurse

Services Reporting To:

Team Lead-Mingus, Mary — Community Employment Coordinator

MI INTEGRATED EMPLOYMENT

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

CLUBHOUSE

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

DD INTEGRATED EMPLOYMENT

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

Services Reporting To:

Team Lead-Murphy, Linda — OAS/OBRA Coordinator

GERIATRIC SERVICES

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

MI ADULT CASEMANAGEMENT & SELF DETERMINATION

Vacancy	SM/SC Supervisor
Dehring, Donald	Case Manager
Edgar-Travis, Alisha	Case Manager
Harbson, Jessica	Case Manager
Herbek, Chelsea (Split)	Case Manager
Ross, Nancy	Case Manager
Stepanski, Ingrid	Case Manager
Stephan, Melissa	Case Manager
Dziesinski, Nancy	MI Community Support Worker
Paad, Renee	MI Community Support Worker
Murphy, Katie (PT)	MI Community Support Worker
Watson, Dylan (PT)	MI Community Support Worker

HOME-BASED CHILD

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

DD CASEMANAGEMENT

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

APPLIED BEHAVIORAL ANALYSIS PROGRAM (6 FT, 8 PT)

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

MI ADULT A.C.T.

Konczak-Miltz, Vicki	*ACT Clinical Services Supervisor*
Baughman, Morgan	ACT Social Worker
Corpe, Sarah	ACT Registered Nurse
Jackson, Amy	ACT Registered Nurse
VanTrump, Olivia	ACT Registered Nurse
Misel, Joann	ACT Clerical Support Staff
Gersewski, Marlene	MI Community Support Worker
Wilson, Karen (PT)	MI Community Support Worker

Services Reporting To:

Team Lead-Yachasz, Peggy — SIP Coordinator

PEER SUPPORT SERVICES & MONDAY NIGHT ACTIVITIES

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

DD SIP RESIDENTIAL

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

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

DD COMMUNITY SUPPORT

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

DD GROUP HOMES

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

BLUE HORIZONS (5 FT/5 PT)

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

BREGE (7 FT/5 PT)

Smith, Ann – Supervisor	
Bailey, Dottie	Residential Training Worker
Colorite, Julie	Residential Training Worker
Petit, Danielle	Residential Training Worker
Schultz, Courtney	Residential Training Worker
Sorrells, Lori	Residential Training Worker
Wirgau, Randy	Residential Training Worker
Vacancy (PT)	Residential Training Worker
Kortman, Kaitlin (PT)	Residential Training Worker
Kruczynski, Linda (PT)	Residential Training Worker
Marx, Dawn (PT)	Residential Training Worker
Vacancy (PT)	Residential Training Worker

CAMBRIDGE (7 FT/5 PT)

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

HARRISVILLE (7 FT/5 PT)

Reynolds, Bob	*Home Supervisor*
Anderson, Geraldine	Residential Training Worker
Duterte, Ma-Gina	Residential Training Worker
Lancaster, Kim	Residential Training Worker
Mahalak, Elke	Residential Training Worker
Nelson, Sam	Residential Training Worker
Witek, Jamie	Residential Training Worker
Burns, Sandy (PT)	Residential Training Worker
Cummins, Duane (PT)	Residential Training Worker
Moldenhauer, Brooke (PT)	Residential Training Worker
Newland, Lori (PT)	Residential Training Worker
Windsor, Natalie (PT)	Residential Training Worker

MILL CREEK (7 FT/5 PT)

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

PINE PARK (7 FT/5 PT)

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

PRINCETON (8 FT/4 PT)

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

THUNDER BAY HEIGHTS (7 FT/5 PT)

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

WALNUT (8 FT/4 PT)

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

MARCH AGENDA ITEMS

Policy Review
Budgeting 01-004

Policy Review & Self-Evaluation
Governance Commitment 02-001
Code of Conduct 02-008

Monitoring Reports
Treatment of Consumers 01-002 (Satisfaction Surveys)
Staff Treatment 01-003 (Employee Surveys)
Budgeting 01-004 (Finance Report)

Activity
Board Member Recognition

Ownership Linkage

Educational Session
Audit Reports – Financial and Compliance??

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

February 2, 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**
  - **Employment First Provider Transformation participating organizations named**
- **State and National Developments and Resources**
  - **Mental health service reductions in west Michigan covered by media reports**
  - **Michigan PIHPs announce consensus statement of MAT**
  - **Mental Health Coalition announces first in a series of public forums**
  - **CMH Association and other stakeholders express concerns over answers in 298 RFI Q&A**
  - **MDOE, MRS, BSBP, and DDC announce technical assistance grant to support school to work transition initiatives**
  - **Michigan's SIM effort to receive continued federal support**
  - **CMH Association joins coalition in expressing concern over weakening of federal Office of Drug Control Policy**
  - **MDHHS improves assistance application**
  - **MPCC and MiHIN announce Coordinating the Care Coordinators Workshop**
  - **CHCS offers webinar on social determinants and Medicaid ACOs**
  - **New US HHS Secretary sworn in**
  - **Final opportunity for 2018 Governor's Service Awards nominations**
  - **Recent announcement of healthcare initiative by Amazon, Berkshire Hathaway and JPMorgan stirs range of views**
- **Legislative Update**
  - **SUD Funding Bill Passed House Committee**
- **National Update**
  - **Legislation of Potential Import to NACBHDD**
- **CMHAM Winter Conference**
- **Gambling Symposium – March 2, 2018**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Webinar: Business or Exploitation?" Exposure of the Tobacco Industry's Exploitation of Individuals with Mental Health Conditions**

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**.

WORK AND ACCOMPLISHMENTS OF CMH ASSOCATION MEMBER ORGANIZATIONS

Employment First Provider Transformation participating organizations named

The Employment First Provider Transformation initiative is a partnership between the Michigan Developmental Disabilities Council, the Community Mental Health Association of Michigan, and MARO. The State of Michigan FY 18 budget appropriated funding for this initiative to support the objectives stated in Executive Order No. 2015-15 – by providing the service provider community and technical assistance in the process of provider transformation, and to promote increased competitive integrated employment outcomes for people with disabilities throughout our state. Ten Michigan organizations have been identified, and each will work with a Subject Matter Expert (SME) to review current business practices, assess strengths and areas in need of improvement, and develop a corresponding plan of action.

Transformation occurs in the culture of participating organizations, and the competitive integrated employment outcomes persons receiving services are achieving. Short and long term transformation goals will be established; projected outcomes defined to establish benchmarks and a quality measurement framework, and competitive integrated employment woven into organizational strategic plans. External focus on customers – job seekers with disabilities and businesses looking to recruit and retain a talented workforce – will be aligned with internal focus on operations and service delivery model, to obtain greater buy-in from stakeholders, and help secure support from funding sources as well.

The programming offered through this initiative compliments and enhances previous work in Michigan funded through the US Department of Labor's Office of Disability Employment Policy. In calendar year 2016, 352 individuals with disabilities transitioned into competitive integrated employment because of this transformation process.

Nationally recognized disability employment subject matter experts will begin the process of providing technical assistance in Michigan in February; participating organizations will also engage with a Capacity Building Initiative, promoting a skilled community of employment service practitioners across the entire state.

The ten organizations participating in the Provider Transformation initiative (many of whom are CMH Association members) are:

The Arnold Center in Midland
The Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
Goodwill Industries of Northern Wisconsin and Upper Michigan in Marquette
HealthWest in Muskegon
Hope Network in Grand Rapids
Key Opportunities in Hillsdale
Lapeer TeamWork in Lapeer
New Horizons Rehabilitation Services in Auburn Hills
Services to Enhance Potential in Wayne County
Vocational Independence Program in Flint

Congratulations to these organizations and best of luck as they take one these leadership roles in the Employment First Initiative.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Mental health service reductions in West Michigan covered by media reports

Below is an excerpt from a recent MLive report on the reductions in mental health services, in several west Michigan communities, resulting from dramatic Medicaid revenue reductions to the PIHP and CMHSPs in that region. This Association is working with these Association members, MDHHS, and members of the State Legislature to close this revenue gap and stem these service cuts.

> Mental health services are being scaled back in West Michigan as a regional board grapples with a multimillion-dollar budget deficit.
>
> Through there are disagreements on both the cause and scale of the problem, most agree a statewide revenue shift has occurred that could affect services for some of Michigan's most vulnerable residents.
>
> Network180, Kent County's community mental health authority, recently eliminated 17 employees, froze hiring for another 15 positions and cut another $778,000 in services. That only solved a small portion of the more than $10 million problem Network 180 faces in its 2016-17 fiscal year, the local share of a #21-$23 million shortfall estimated at the regional level.
>
> Though it manifested locally, the root problem threatens both providers and recipients of mental health services statewide. Network 180 Executive Director Scott Gilman recently told a packed room of concerned citizens.
>
> "In many ways we're the canary in the coal mine," Gilman said.

The full article can be found at:

http://www.mlive.com/news/grand-rapids/index.ssf/2018/01/eroding_funding_threatens_ment.html

Michigan PIHPs announce consensus statement on MAT

Below is a recent announcement from Michigan's public Prepaid Inpatient Health Plans (PIHP) on the release of the PIHP's consensus statement on Medication Assisted Treatment (MAT). The statement provides a clear philosophic and policy framework for the public funding and organization of MAT treatment across the state – funding that is managed by these PIHPs. This statement is a core dimension in the effort, by the public substance use disorder and mental health treatment system, to combat this state's opioid crisis.

> The Substance Abuse Treatment and Prevention (SAPT) Directors group of the ten (10) Michigan PIHPs have reached consensus on the following treatment philosophy regarding Medication Assisted Treatment (MAT). The Chief Executives of the PIHPs have approved and adopt the following:
>
> Purpose: Medication-Assisted Treatment (MAT) is a standard of care that is broadly recognized as an essential pillar in any comprehensive approach to the national opioid addiction and overdose epidemic. We seek therefore to ensure that no consumer is denied access to or pressured to reject the full service array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that consumer.
>
> SAPT Directors' Treatment Philosophy & Recommendations: Disparaging evidence-based practices is inappropriate and dangerous. It is important to follow the recommendations by:
>
> - Substance Abuse and Mental Health Services Administration (SAMHSA)
> - Centers for Disease Control and Prevention (CDC)
> - American Society for Addiction Medicine (ASAM)
> - National Institute for Drug Abuse (NIDA)
> - Michigan Department of Health and Human Services (MDHHS)'s Office of Recovery Oriented Systems of Care (OROSC)
>
> SAPT Directors recognize MAT as a best practice consistent with current research for an Opioid Use Disorder (OUD). In the interest of offering consumer choice, within a Recovery-Oriented System of Care (ROSC), the SAPT Directors expect the people we serve to be supported and respected in leading self-directed lives where multiple recovery pathways are viable.
>
> Treatment options should be discussed in an objective way so each consumer can make an informed decision based on research and outcome data. The SAPT Directors of Michigan's ten (10) PHIPs expect that PIHP-contracted SUD treatment providers will do the following:
>
> 1) Adopt a MAT-inclusive treatment philosophy that recognizes multiple pathways to recovery,
> 2) Reject pressuring MAT clients to adopt an accelerated tapering schedule and/or a mandated period of abstinence
> 3) Develop and/or strengthen policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients orin the public domain
> 4) When a consumer on MAT (or considering MAT) is seeking treatment services at the point of access, access staff will respect MAT as a choice without judgment, stigma, or pressure to change recovery pathways.
>
> If a provider does not have capacity to work with a person receiving MAT, the provider will work with the consumer and with local PIHP or CMH Access Departments to facilitate a warm handoff/transfer to another provider, who can provide ancillary services (counseling, case management, recovery supports, recovery housing) while the client pursues his or her chosen recovery pathway.

References:

1. SAMHSA Treatment Improvement Protocol #43 – MAT for Opioid Addiction in Opioid Treatment Programs
2. U.S. Surgeon General – Treatment Options
3. National Institute on Drug Abuse Effective Treatment for Opioid Addiction
4. The Center for Disease Control "Vital Signs" – Today's Heroin Epidemic
5. White House Commission on Combating Drug Addiction and the Opioid Crisis – White House Commission on Combating DrugAddiction and the Opioid Crisis – Letter to the President
6. The ASAM National Practice Guideline
7. MDHHS MAT Guidelines for Opioid Use Disorders

Mental Health Coalition announces first in a series of public forums

Below is a recent announcement, from a coalition of mental health advocates, providers, and payers, on an upcoming public forum on mental health issues. Additional forums of this type are being planned for other communities across Michigan. The association is one of the co-sponsors of this forum.

These forums were key to the discussion of the 298 privatization proposals over the last several years, providing a venue for the voices of persons served, families, advocates, and the community at large to express their concerns and hopes relative to the public mental health system.

Mental Health Peace of Mind
Community Collaboration Public Forum
Thursday, March 1, 2018
7:00 PM (Opens at 6:30 pm)
Macomb Intermediate School District
44001 Garfield, Clinton Township, MI 48038
West side of Garfield, South of M-59

This will be an open forum for discussion of potential changes in the Michigan public mental health system with a focus on Macomb County.

Agenda:

- Advocates will introduce issues and objectives
- Legislators and local public officials will discuss their positions on mental health system reform.
- Concerned citizens will have an opportunity to comment on the needs for change and the ideas presented by community leaders and advocates.

Individual comments will be limited to 3 minutes each to enable many people to express their concerns. You may email more extensive comments to fred.a.cummins@gmail.com , President, Alliance for the Mentally Ill of Oakland County, to be shared with legislators.

Background material:
CARES Report: https://house.mi.gov/PDFs/HouseCARESTaskForceReport.pdf
Key Objectives for Change http://www.amioakland.org/18-01-21KeyObjectivesChange.docx

Everybody is welcome.

Sponsors

- Alliance for the Mentally Ill of Oakland County
- Mental Health Association in Michigan
-UAW Region 1
- UAW Region 1A
- UAW Region 1a, Retire Chapter
- MICHUHCAN
- Parents Alliance of Metro Detroit
-ARC of Michigan

- Michigan Protection and Advocacy Service
- Michigan Disability Rights Coalition
- Michigan Alliance to Strengthen Social Security and Medicare
- Community Mental Health Association of Michigan
- Mich. AFSCME Council 25
- Michigan State AFL-CIO
- Local 412 UAW
- Michigan Alliance for Retired Americans
- South East Michigan Jobs With Justice
- Alliance for Retired Americans
- Detroit-Wayne Mental Health Authority
- Oakland Community Health Network
- Macomb County Community Mental Health
- Michigan Nurses Association

Labor donated

For more information, call 248-203-1998.

CMH Association and other stakeholders express concerns over answer in 298 RFI Q&A

MDHHS recently issued a Q&A document, responding to questions that the public, this Association, and its members posed to MDHHS relative to the Section 298 RFI. That Q&A, highlighted in a recent edition of this Association's Friday Facts, can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_76181-458391--,00.html

Two of the responses in that Q&A document stood out, in the eyes of this Association, its members, and the advocacy community, as fundamental flaws in the 298 RFI contents and process. Below is the communication sent by this Association to MDHHS outlining the Association's concerns around these two issues. Advocates from across the state are making the same points. As the discussions with MDHHS on this front progress, we will keep you informed.

CMH Association communication to MDHHS:

The recent Q&A document, released by MDHHS contained much useful guidance and clarification for those CMHs considering a submission of a response to the Section 298 Pilot RFI.

However, two of the fundamental components of the RFI, raised by our association via the Q&A process, remain to be addressed. These two issues, in **unaddressed, are contrary to the intent of the boilerplate.** These RFI components, if unchanged, **hinder health care integration and erect barriers to the submission of RFI responses by the state's CMHs.**

The MDHHS response contained in the recently issued Q&A, related to these two issues, is outlined below, followed by this association's concerns and recommendation relative to these issues.

1. **Movement of the Medicaid enrollees not enrolled with a Medicaid Health Plan from the management of the PIHP to that of private ASO or MBHO:**

   MDHHS answer in 298 pilot Q&A: "It is the intent of the MDHHS that the payment for individuals within a pilot region, but not enrolled in an MHP, will go to a contracted ASO or MBHO. The contracted entity will act on behalf of the state to ensure services are delivered in an appropriate manner."

   CMH Association concern and recommendation: This association is reiterating, here, our concerns over the RFI's planned movement of the management of the behavioral healthcare benefit for persons not enrolled in a Medicaid Health Plan, from the PIHP, where they currently have their care managed, to a Managed Behavioral Health Organization (MBHO) or an Administrative Service Organization (ASO).

   This movement:
   - **does nothing to better integrate care**
   - unnecessarily **disrupts the care for these persons**

- **adds one more managed care entity** to the already chaotic environment that will be experienced in the pilot communities when a single payer, the current PIHP, is replaced by a number of Medicaid Health Plans and, if the addition of a MBHO or ASO, one more payer
- **inflicts considerable and unnecessary fiscal harm to the PIHP** serving the pilot community
- **adds another extraneous variable** to the pilot

This association recommends that those Medicaid enrollees not enrolled with a Medicaid Health Plan continue to have their behavioral healthcare and intellectual/developmental disability services managed by their current PIHP.

2. **Requirements that CMHs responding to the RFI obtain MOUs/MOSs from half of the Health Plans in their community:**

   MDHHS answer in 298 pilot Q&A: "However, it is essential that at least 50% of MHPs within the pilot region have been involved in the development of the application. This Memorandum of Support is NOT a binding agreement on the part of the MHP. For access to the referenced document, please visit www.michigan.gov/stakeholder298."

   CMH Association concerns and recommendations: This association is reiterating, here, our concerns over the RFI's requirement that CMHs responding to the RFI obtain MOUs/MOSs from half of the Health Plans in their community.

   Requiring the support of at least 50% of the MHPs in the pilot community is impractical given the timeframe for the RFI response and the time consuming and complex nature of the discussions/negotiations that would be required, with a number of MHPs, within the applicant pilot community, all with diverse interests and modes of operations.

   The CMH, interested in being a 298 pilot site, should not have to court seek the support, even if not via a binding contract, of the Medicaid Health Plans in a community in order to be selected as a pilot site.

   Given that **MDHHS will be mandating the involvement, in the pilot, of all of the MHPs** in the selected pilot community, **requiring the CMH to obtain the written support of half of the MHPs simply places a barrier in the way of CMHs that wish to be involved in the 298 pilot.**

   This association recommends that the RFI require that a CMH's RFI response contain the written support of one MHP in the pilot community, recognizing that the involvement of the other MHPs in the community, a requirement of the boilerplate, be developed once the pilot communities are selected.

MDOE, MRS, BSBP, and DDC announce technical assistance grant to support school to work transition initiatives

Below is a recent announcement of an opportunity for organizations to receive technical assistance on efforts to support school to work transitions for persons with disabilities.

> Invitation to Apply – Technical Assistance
> Seamless Transition – Employment First
>
> The School-to-Work Employment First Workgroup is pleased to announce an opportunity for your local transition community to receive technical assistance and training to implement the Seamless Transition Model for students with intellectual/developmental disabilities enrolled in secondary education.

The FY18 State of Michigan budget has allocated funds to support objectives stated in Executive Order No. 2015-15. This project opportunity falls under an umbrella of work that is supported by these funds. This project is a collaboration between the Michigan Department of Education/Office of Special Education, Michigan Rehabilitation Services, Bureau of Services for Blind Persons, the Developmental Disability Council and other stakeholders.

Please review the project material and application by going to: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4897-306627--,00.html
and scrolling to the bottom of the page to find the 2018 Seamless Transition Pilot documents

Participation is limited to 4 teams. Applications must be received by Friday, February 16, 2017.

Please address questions to:
Janet Timbs timbsj@michigan.gov from Michigan Department of Education, Office of Special Education
Cynthia Wright wrightc1@michigan.gov from Michigan Rehabilitation Services
Shannon McVoy mcvoys@michigan.gov from the Bureau of Services for Blind Persons

Michigan's SIM effort to receive continued federal support

Below is a recent press release from MDHHS regarding the federal extension of Michigan's State Innovation Model (SIM) effort.

Michigan receives approval for continuation of State Innovation Model; continues effort to reinvent state's health care system

The Michigan Department of Health and Human Services (MDHHS) is continuing its quest to provide Michiganders with a better quality, lower cost health care system thanks to the continuation of Centers for Medicaid and Medicare Services (CMS) funding for its State Innovation Model (SIM).

In 2015, CMS awarded MDHHS nearly $70 million over four years to test and implement a model for delivering and paying for health care in the state. The award was based on Gov. Rick Snyder's Blueprint for Health Innovation, in which he envisioned an efficient, effective and accountable government that collaborates on a large scale to provide quality service. CMS recently approved MDHHS's Operational Plan for year three of the project which began today.
"Reinventing Michigan's health care system is one of the state's top priorities," said Nancy Vreibel, MDHHS chief deputy director. "Michigan's model recognizes that better health requires a comprehensive approach involving safe and healthy communities, workplaces, homes and lifestyles."

The state has organized its SIM initiative into three categories: population health, care delivery and technology. Each category also focuses on improving outcomes for three priority populations: individuals at risk of high emergency department utilization, pregnant women and babies and individuals with multiple chronic conditions.

Implementing the population health component of the initiative are Community Health Innovation Regions (CHIRs). These broad partnerships of community organizations, local government agencies, business entities, health care providers, payers and community members work together to identify and implement strategies that address social determinants of health. CHIRs are being piloted in fiver areas of the state: Jackson, Muskegon and Genesee counties, the Northern Region and the Livingston-Washtenaw county areas.

A strong correlation between housing issues and homelessness and high emergency department utilization and poor health was observed across all CHIRs. Year 3 activities will focus on developing programs to help communities identify individuals in need of housing assistance, developing a sustained model for housing coordination funding and addressing housing shortages.

The care delivery component revolves around a Patient-Centered Medical Home (PCMH) initiative and the promotion of alternative payment models. PCMHs coordinate patient treatment through partnerships between patients and their primary care physicians to ensure they receive the necessary care when and where they need it, in a manner they can understand.

PCMH Year 3 activities will continue development, refinement and sustainability of clinical-community linkages, which will support patient linkage and coordination between clinical care and community-based social services.

On the technology front, the state is leveraging new and existing statewide infrastructure and related health information exchange initiatives including the Relationship and Attribution Management Platform (RAMP). RAMP supports several aspects of care management and coordination, including a health provider directory, a system for tracking active care relationships between patients and health care providers, the exchange of quality-related data and performance results and the transmission of admission, discharge and transfer notifications.

Year 3 will expand RAMP to allow it to be used in support of broader statewide health initiatives; establish a roadmap for increasing quality and detail of patient-level attribution data within Medicaid; and develop a use case for the collection and reporting of social determinants of health data.

For more information about Michigan's State Innovation Model, visit Michigan.gov/SIM

CMH Association joins coalition in expressing concern over weakening of federal Office of Drug Control Policy

Below is a letter, signed by dozens of substance use disorder advocacy, prevention, and treatment organizations from across the country, including this association, expressing concern over proposals, recently made by the federal Office of Management and Budget, that would weaken the policy impact of the National Drug Control Policy (ONDCP).

RE: OMB proposed shrinking of ONDCP

We the undersigned represent the major groups across all disciplines working on a comprehensive response to the drug crisis facing our nation, to include prevention, treatment, recovery supports, medicine, overdose reversal, law enforcement, and criminal justice reform.

As you know, the White House Office of National Drug Control Policy (ONDCP) oversees and manages the Drug Free Communities (DFC) and the High Intensity Drug Trafficking Area (HIDTA) programs. DFCs provide critical drug prevention funding directly to community coalitions capable of reducing youth drug use, while the mission of the HIDTA program is to disrupt the market for illegal drugs by dismantling or disrupting drug trafficking organizations through the coordinated efforts of federal, state, and local law enforcement.

According to a recent report, the White House Office of Management and Budget (OMB) is considering moving these vital programs out of the ONDCP to other federal agencies. **We strongly oppose any attempt to move either the DFC or HIDTA programs out of ONDCP.**

The DFC program is the only federal drug prevention program that goes directly to communities to deal with all of their most pressing local drug issues. It is unique, in that it requires participation of all community sectors, across the supply – demand reduction split to plan, implement and evaluate locally tailored comprehensive strategies capable of dealing with the full range of drug issues and trends. The program requires a local match in order to leverage all available resources. The DFC program has consistently reduced youth drug use in funded communities to levels lower than national averages through its data driven, comprehensive, multi-sector approach. Moving the DFC program out of ONDCP would markedly reduce its

effectiveness by limiting the full range of essential partners and strategies, to include local law enforcement, needed to achieve population level reductions in youth drug use rates.

The HIDTA program is an essential component of the National Drug Control Strategy. It is clear that federal, state, local, and tribal law enforcement plays an integral role in a balance strategy to reduce drug abuse and its harmful consequences. The HIDTA program enhances and coordinates federal, state, local, and tribal anti-drug abuse efforts from a local, regional, and national perspective, leveraging resources at all levels in a true partnership. The HIDTA program gives federal, state, local and tribal criminal justice leaders a balanced and equal voice in identifying the regional threat, develop a strategy, investing in the strategy, and assessing performance. This unique feature of the HIDTA program creates the ability for each HIDTA to quickly, effectively, and efficiently adapt to emerging threats that may be unique to a given region providing for the greatest level of impact. Moving the HIDTA program out of ONDCP would all but eliminate the balanced voice found in the long-standing law enforcement partnerships, and the many other innovative approaches that are essential components of an effective drug policy.

Not only would such a move drastically weaken these vitally important programs, and force them to compete for priority, direction, and funding in larger agencies with competing and higher priorities, but it would significantly impact ONDCP's ability to effectively carry out its mission. ONDCP oversees federal efforts to combat every drug problem facing our nation, to include the opioid overdose epidemic, methamphetamines, synthetic drugs, cocaine, marijuana, etc., by coordinating all federal agencies responsible for reducing drug trafficking and use, and ensuring their adherence to the President's priorities. No other agency has this unique responsibility to coordinate efforts across the federal government to execute one shared drug strategy. This oversight is instrumental in eliminating waste and fraud by preventing duplicative programs and strategies among the various federal agencies. Cutting ONCDP's budget would significantly harm the effectiveness of this unique mission.

According to the Centers for Disease Control, more than 63,000 Americans died of a drug overdose in 2016, a staggering 21 percent increase from 2015. With 174 people dying from drug overdose each day there is no doubt the opioid epidemic is an urgent and serious problem impacting families across our nation. This reported budget proposal would create an unnecessary distraction from efforts to save lives. We urge you to continue to allow the ONDCP to use its expertise to administer these programs with its full funding intact.

MDHHS improves assistance application

Below is a recent press release from MDHHS regarding improvement to the public assistance application – improvements designed to make it easier for applicants to complete and submit.

MDHSS reforms assistance application to be more user friendly
New document is less than half the size of previous version

Michigan has debuted a more user friendly application for public assistance that is more comprehensive and less than half the size of the previous form.

The streamlined application for food assistance, Medicaid and other benefits now has 18 pages – down from 42 pages in the previous application that was the was the lengthiest in the United States. It has 80 percent fewer words – with 3,904 – and 80 percent fewer questions – with 213.

The Michigan Department of Health and Human Services Project Re:form resulted in the improved application, which is easier to navigate due to an updated design that includes the use of colors and improved headings

and organization. The Detroit design studio Civilla worked with MDHHS and based the improvements on input from MDHHS clients and staff who tested and led the application redesign effort.

"As our staff experience significant reductions in time spent reviewing and correcting application forms that had become too complicated, they will be able to better assist our clients in removing barriers to self-sufficiency and finding jobs to support their families," said MDHHS Director Nick Lyon. "Clients will find it is easier to receive the help that they need."

MDHHS piloted the new application in 2017 in its Hamtramck office in Wayne County and in its office in Eaton County. Civilla monitored the pilot and engaged nearly 400 clients and numerous staff members in conversations about how to improve the form.

As a result, clients in the pilot counties spent an average of 20 minutes completing the application, compared to 45 minutes for the previous application. Staff spent 20 minutes less time reviewing each application, seeking additional information and making corrections.

MDHHS began using the new application statewide Jan. 22. It combines into a single form application for food assistance. Medicaid, cash assistance, State Emergency Relief and child care assistance.

MDHHS has been working with Civilla on the improved application for more than two years. In addition to the design work and engaging clients who use the form, Civilla was involved in staff training, analysis of data that showed improved outcomes from use of the new form and months of meetings with MDHHS staff, stakeholders and community partners to introduce the new application and seek feedback.

The new application reflects client needs rather than program needs – a main concept behind the creation of MDHHS in 2015.

Lessons the department learned from Project Re:form will be incorporated into the online MI Bridges public assistance application process in the coming months.

The new Assistance Application form can be found on the MDHHS website. It is available to applicants for public assistance benefits at local MDHHS offices. Michigan residents also can apply for assistance online at www.michigan.gov/mibridges.

MPCC and MiHIN announce Coordinating the Care Coordinators Workshop

2018 Coordinating the Care Coordinators Workshop #1
Sponsored by the Michigan Health Information Network (MiHIN) Shared Services and the Michigan Primary Care Consortium

DATE AND TIME
Tue, February 20, 2018
12:00 PM – 4:00 PM EST

LOCATION
The Cadillac Room
1115 South Washington Avenue
Lansing, MI 48910

DESCRIPTION
Workshop #1

Objectives:

1. Develop a care coordinator registration process for a statewide directory
2. Establish types of care coordinators to be included in the statewide directory

Outcomes:
1. Reduce the burden of maintaining contact information for care coordinators connected to a person
2. Help care coordinators recognize other types of care coordinators working with a person

Register at: https://www.eventbrite.com/e/2018-coordinating-the-care-coordinators-workshop-1-tickets-42498694740

CHCS offers webinar on social determinants and Medicaid ACOs

The Center for Health Care Strategies recently announced (announcement is provided below) an upcoming webinar on the impact that Medicaid Accountable Care Organizations (ACOs) are having on the social determinants of persons served through these ACOs.

> Addressing Social Determinants of Health through Medicaid Accountable Care Organizations: Early State Efforts
> Date: February 14, 2018, 11:30 am – 1:00 pm ET
>
> Accountable care organizations (ACOs) have become increasingly prevalent in state Medicaid programs as a way to improve health care quality and control costs. Some states are beginning to use their ACO programs to address social determinants of health(SDOH) – such as living environment and access to healthy food – that ultimately affect health outcomes. Expanding the services covered by Medicaid ACOs may be critical to their success, given that many of the highest-need, highest-cost Medicaid patients have complex social needs that are often not addressed in the current fragmented health care system.
>
> This webinar, made by possible by The Commonwealth Fund, will explore early efforts to address SDOH through Medicaid ACO programs – such as partnership requirements and social needs screening. It will feature innovations from two state Medicaid ACO programs: Minnesota's Integrated Health Partnerships and Rhode Island's Accountable Entities.
>
> State officials, policymakers, and other interested stakeholders can join this 90-minute webinar to gain a better understanding of how ACO programs may serve as a vehicle to help states better address the social determinants among Medicaid beneficiaries.
>
> Register for this webinar at:
>
> https://www.chcs.org/resource/addressing-social-determinants-health-medicaid-accountable-care-organizations-early-state-efforts/?utm_source=CHCS+Email+Updates&utm_campaign=2768f6ec22-EMAIL_CAMPAIGN_2018_01_29&utm_medium=email&utm_term=0_bbced451bf-2768f6ec22-152144421

New US HHS Secretary sworn in

Below is a recent Associated Press announcement of the appointment of the new Secretary of the US Department of Health and Human Services.

> Alex Azar (AY'-zahr) has been sworn in as President Donald Trump's second health secretary.
>
> The former drug company executive and official in George W. Bush's administration succeeds former Republican Georgia congressman Tom Price, who resigned last fall following an outcry over his use of costly private charter aircraft for official travel.

Azar's nomination as secretary of Health and Human Services was approved by the Senate last week, largely along party lines.

Azar has said his priorities include curbing the cost of prescription drugs, making health insurance more affordable and available, and confronting the opioid addiction epidemic.

President Trump says, "He's going to get those prescription drug prices way down."

Azar spent a decade at Indianapolis-based drugmaker Eli Lilly and Co.

Final opportunity for 2018 Governor's Service Awards nominations

The Michigan Community Service Commission is seeking nominations for the 2018 Governor's Service Awards. The Governor's Service Awards are given annually by the governor to individuals, organizations and businesses to acknowledge their commitment to serving their communities through volunteerism. This event is hosted by the Michigan Community Service Commission. The awards celebration will be held June 5 in East Lansing.

The 2018 Governor's Service Awards nomination is an online application available at www.michigan.gov/governorsserviceawards. Because of numerous request following the holidays, the nomination deadline has been extended to Feb. 16.

"These awards serve as a unique opportunity to highlight Michiganders helping Michiganders," Gov. Rick Snyder said.

"We want to hold up Michigan's best volunteers and show them off as role models for others. I hope you will help recognize the outstanding individuals, organizations and businesses in Michigan by nominating them for the Governor's Service Awards."

In 2018, awards will be presented in 10 categories which reflect the diverse nature of volunteers throughout the state. The categories are:

- **Governor George Romney Lifetime Achievement Award:** honors an individual who has shown a lifelong commitment to community involvement and volunteerism.
- **Lifetime Humanitarian Award:** honors individuals or families that have demonstrated a lifetime of outstanding civic and charitable responsibility to a community or organization.
- **Senior Volunteer of the Year Award:** honors individuals age 65 and older who have taken action to make their community a better place to live through service.
- **Volunteer of the Year Award:** honors an individual who strives to improve the lives of neighbors, friends, community or congregation through volunteerism.
- **Youth Volunteer of the Year Award:** honors individuals who are age 25 or younger who have already begun making a significant difference in their community through service.
- **Mentor of the Year Award:** honors an individual who provides youth (25 and under) with the confidence and assets to be successful.
- **Outstanding Volunteer Organization Award:** honors service clubs, nonprofit, faith-based, veteran, disaster preparedness and other organizations that make a demonstrated difference in their community.
- **Education Service Leader Award:** honors schools, colleges, universities and other organizations that support youth making a difference in their communities.
- **Outstanding National Service Program Award:** honors organizations that provide a high-quality national service program that yields a significant impact in a Michigan community.
- **Corporate and Small Business Community Leader Award:** honors corporations and businesses that excel in community involvement and demonstrate excellent corporate citizenship by giving back to their community in a variety of ways.

This will be Gov. Snyder's eight year of involvement in the Governor's Service Awards, which were launched by Gov. John Engler in 1992 and maintained by Gov. Jennifer M. Granholm during her terms in office.

For additional information or questions, please contact the MCSC at 517-335-4295 or gsa@michigan.gov.

Recent announcement of healthcare initiative by Amazon, Berkshire Hathaway and JPMorgan stirs range of views

Below are three articles discussing the potential impact of the initiative, recently announced by Amazon, Berkshire Hathaway and JPMorgan, to join forces to impact the cost and quality of healthcare. The range of reactions and projections of the impact of this joint effort are represented in the three articles provided below.

New York Times: Amazon, Berkshire Hathaway and JPMorgan ?Team Up to Try to Disrupt Health Care
Nick Wingfield, Katie Thomas and Reed Abelson

Excerpt of article:

Three corporate behemoths – Amazon, Berkshire Hathaway and JPMorgan Chase – announced on Tuesday that they would form an independent health care company for their employees in the United States. The alliance was a sign of just how frustrated American businesses are with the state of the nation's health care system and the rapidly spiraling cost of medical treatment. It also caused further turmoil in an industry reeling from attempts by new players to attack a notoriously inefficient, intractable web of doctors, hospitals, insurers and pharmaceutical companies.
It was unclear how extensively the three partners would overhaul their employees' existing health coverage – whether they would simply help workers find a local doctor, steering employees to online medical advice or use their muscle to negotiate lower prices for drugs and procedures. While the alliance will apply only to their employees, these corporations are so closely watched that whatever successes they have could become models for other businesses.

Full article:
https://www.nytimes.com/2018/01/30/technology/amazon-berkshire-hathaway-jpmorgan-health-care.html

Bloomberg View: Can Amazon Transform Health Care? It's Not a Crazy Idea
Megan McArdle, Bloomberg View

Excerpt of article:

But as customers with a combined employment base of over a million people, Amazon and JPMorgan and Berkshire Hathaway may have the incentives, and the expertise, to do it right.

That said, there are other companies in the industry, with an incentive to get technology right, and so far, few of them have managed to overcome all of the obstacles that the system puts in their way. The dysfunctional incentives of third-party payer, where the people making the decisions seldom have any reason to reward efficiency… the incredible fragmentation of the market, which makes it hard to come up with big, unified solutions… the fierce resistance of providers to adopting new ways of doing things… and if you somehow manage to surmount all of those obstacles, and actually start rationalizing things, the tendency of legislators and regulators to come steaming in with some new law or regulations that renders your idea illegal.

Most importantly, you are dealing with human beings at their most stubborn and vulnerable. Your regime of evidence-based medicine will founder on the fact that human bodies are not very well standardized, and go wrong in all sorts of perplexing ways that will resist any attempt to neatly categorize them. Your behavioral modifications will run up against the fact that human behavior is awfully hard to change. And your attempts to beat down costs will run aground when you discover that many market participants enjoy being the only game in town – like rural hospitals and pharmaceutical manufacturers – and that you cannot avoid dealing with them unless you want some combination of legal trouble or employee revolt.

So while there are some reasons to think this company might succeed, there are also plenty of reason to think that it will fail. The one thing we can say, however, is that if it succeeds, its success may help usher in an era of even tighter employer control over employees' lives.

Right now, even when our employer is functionally purchasing health-care services for us, that transaction is arms-length: We decide on the services, and the intermediary actually pays the bill.

There are probably considerable savings to be had if employers use their power to guide employees toward better decisions about everything from ER use to smoking.

But one big reason that our health care system is such an expensive mess is that Americans hate being told what to do. They demand maximal, expensive, freedom of choice about their health care. They rebel if they can't get it. Worse still, if they are denied it, they call their legislators, who do things like telling insurers to stop denying so many claims for experimental treatments of dubious worth.

Full article:
https://www.bloomberg.com/view/articles/2018-01-30/can-amazon-transform-health-care-it-s-not-a-crazy-idea

Washington Post: Amazon already has huge amounts of our data. What happens when you add health care to the mix?
Abha Bhattarai, Washington Post

Excerpt of article:
"Amazon already has huge amounts of our data – we give it to them in exchange for two-day shipping," said 1. Glenn Cohen, a Harvard Law School professor who specializes in health law policy. "But what happens when you add in actual health care data? Many people are already concerned about who has access to that information, and this exacerbates those concerns."

Amazon declined to comment for this story. Its announcement comes a week after the company opened its cashier-less supermarket, Amazon Go, to the public. In place of cash registers, the store has a network of cameras, scanners and infrared sensors that allow the store to automatically charge customers for items they place into their bags.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits health insurance companies and other entities from sharing personally identifiable medical data. There are also federal restrictions on using medical data for marketing purposes or to make lending decisions by banks. But, even if the new joint venture is subject to HIPAA rules, experts said there are exceptions to exactly what is covered.

"The law covers traditional health insurance and provider health care, but it doesn't cover many of the other sources of health-related data that today's technology generates," said Peter Swire, a professor of law at Georgia Tech and White House coordinator for HIPAA under President Clinton. "It doesn't cover, for example, the books you buy about health care or the many fitness and health care apps you may have on your phone."

He and others added that even if companies aren't collecting – or sharing – medical records, there are a number of other ways a patient's habits and history could be used to glean important information about their health. (There are also signs that Amazon is considering possible privacy concerns: it recently posted a job opening on its site for a HIPAA expert who can "own and operate the security and compliance elements of a new initiative.")

"You could say, 'This patient uses our system to book doctors' appointments six times a year,' and compare that with that person's purchase history to make certain connections," said Cohen of Harvard. "Non-healthcare data can often be a rich source of information."

Companies could also market cold and flu medicines to someone who always books doctor's appointments at the beginning of flu season, he said, or recommend obstetricians to a shopper who recently ordered pregnancy tests or prenatal vitamins.

Research shows that increased access to patients' medical records and history reduces the cost of health care. But it also raises privacy concerns, particularly as companies use predictive technology to guess which patients may end up with a certain illnesses or chronic disease, said Idris Adjerid, a professor who specializes in health technology and privacy at the University of Notre Dame's Mendoza College of Business.

"Amazon is a data-centric company that's good at artificial intelligence and machine learning, so it doesn't take much to see that that's what they'll bring to the health care industry," he said. "It's all very tantalizing but there is also a constant tension between the pros of predictive health care data and the challenges."

Full article:
https://www.washingtonpost.com/news/business/wp/2018/01/30/amazon-already-has-huge-amounts-of-our-data-what-happens-when-you-add-healthcare-to-the-mix/?utm_term=.ed7302ee6479

LEGISLATIVE UPDATE

SUD Funding Bill Passed House Committee

This week, HB 5085 introduced by State Rep. Steve Marino (Harrison Township), which would increase funding for substance use disorder services passed unanimously out of the House Health Policy Committee this week.

HB 5085 would dedicate 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.

"Substance abuse is a major problem in Michigan," Marino said. "This bill will deliver more resources to agencies on the front lines of this fight."

Last month, the final report was released of the House of Representatives' CARE (Community, Access, Resources, Education and Safety) Task Force, which convened last summer to explore Michigan's mental health system. Increasing funding for substance use disorder services was one of the 50 recommendations in that final report.

HB 5085 was referred to the House floor for consideration.

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 of 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.]

CMHAM WINTER CONFERENCE – HOPE TO SEE YOU THERE!

The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & 7, 2018 at the Radisson Plaza Hotel & Suites, Kalamazoo. The conference will feature 4 powerful keynote addresses, a wide variety of workshops, as well as pre-conference institute on Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments.

Keynote Addresses:

Current Efforts toward Behavioral Health and Justice Collaborations for Better Outcomes
- *Debra A. Pinals. MD, Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services*

I Have Been Running my Entire Life – I am Finally Free
- *Dominic Carter, Veterans Newsman, Mental Health Advocate, Author, and Speaker*

What's Hot in Behavioral Health – A National Update
- *Charles Ingoglia – Senior Vice President, Public Policy and Practice Improvement, National Council for Behavioral Healthcare*

The Life, the Game, the Pain and the Transition
- *Adrian Muldrow, Founder, We Can Achieve Youth Advocacy Project*

Pre-Conference Institute:

February 5, 2018 from 1:00pm – 4:00pm

Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments
- *David Michael Mank, Ph.D., Professor Emeritus, Indiana University*

For a detailed conference brochure, click here: https://macmhb.org/education

To Register for the Full Conference, click here: https://goo.gl/ATd6pb

To Register for the Pre-Conference Institute, click here: https://goo.gl/3UeQDc

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

WEBINAR: BUSINESS OR EXPLOITATION?" EXPOSURE OF THE TOBACCO INDUSTRY'S EXPLOITATION OF INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

The Smoking Cessation Leadership Center (SCLC) is excited to be hosting our **75th webinar** with our partners, the National Behavioral Health Network for Tobacco and Cancer Control (NBHN), and the Truth Initiative®. We invite you to register for this **One-Hour Power Break** webinar: ***"Business or Exploitation?" Exposure of the tobacco industry's exploitation of individuals with mental health conditions*** on **Thursday, January 18, 2018, at 1:00pm EST** (60 minutes).

We are honored to have the following speakers presenting on this topic for us:

- **Margaret Jaco Manecke, MSSW,** Project Manager, Practice Improvement, National Council for Behavioral Health
- **Ashley Persie,** Senior Brand Marketing Associate, Truth Initiative®
- **Judith (Jodi) Prochaska, PhD, MPH,** Associate Professor of Medicine, Stanford University

Webinar Objectives:

1. Explain why people with mental health conditions (depression and ADHD, for example) and substance use disorders have been historically targeted by the tobacco industry.
2. State whether adults with mental health conditions and substance use disorders smoke more than adults without those conditions.
3. Describe the morbidity rates of people with mental health conditions and name specific causes of death that can be attributed to tobacco use.
4. Explain the impact of the **truth®** campaign among its target audience.

5. Describe evidence-based approaches for treating tobacco use and tobacco addiction in persons with co-occurring mental illness.
6. Describe how you can leverage the National Behavioral Health Network for Tobacco & Cancer Control's tools, resources, and network to combat tobacco use & cancer disparities among individuals with mental illnesses and addictions and network members.

REGISTER HERE: https://cc.readytalk.com/r/eyjfkcfgqogs&eom

CME/CEUs will be available for participants who join the **LIVE** session, on **January 18, 2018**. You will receive instructions on how to claim credit via the post webinar email.

Have a Great Weekend!

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

January 26, 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**
- **State and National Developments and Resources**
  - **MDHHS publishes answers to questions on 298 pilots**
  - **LARA calls together group to examine SUD licensing redesign**
  - **Webinar on 1332 waivers announced**
  - **CIHS announces integrated care workforce resource**
  - **CHCS blog to provide latest on Medicaid ACOs**
  - **Link of poverty to health status of Michigan residents' health status underscored in recent report**
- **Legislative Update**
  - **State of the State**
- **National Update**
  - **Congress Approves Six Year CHIP Authorization, Re-opens Government for Three Weeks**
- **CMHAM Winter – Last Day for Early Bird Discount**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Webinar: Business or Exploitation?" Exposure of the Tobacco Industry's Exploitation of Individuals with Mental Health Conditions**

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**.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

MDHHS publishes answers to questions on 298 pilots

MDHHS recently published the answers to questions posed by the public relative to the content of the Section 298 pilot project Request for Information (RFI). The announcement of the release of these answers and the link to the answers are provided below.

> The Michigan Department of Health and Human Services (MDHHS) is providing another update on the Section 298 Initiative today. The Section 298 Initiative is a statewide effort to improve the coordination of physical health services and behavioral health services in Michigan. This initiative is based upon Section 298 in the Public Act 268 of 2016. The Michigan legislature approved a revised version of Section 298 as part of Public Act 107 of 2017.
>
> Under the revised Section 298, the Michigan Legislature directed MDHHS to implement up to three pilot projects to test the integration of publicly-funded physical and behavioral health services. The department posted a Request of Information (RFI) to select the pilot sites on December 20th, 2017.
>
> As part of the RFI process, MDHHS collected questions for interested applicants and other stakeholders on the content within the RFI. MDHHS has developed responses to each of these questions, and these responses have been posted on the State of Michigan's procurement website. The department also posted a PDF version of the responses on the project website, which can be accessed through the following link:

www.michigan.gov/stakeholder298

Interested applicants must submit their applications through the website by February 13, 2018. MDHHS will evaluate each informational response that meets all of the minimum mandatory requirements utilizing an evaluation process. MDHHS will use the results of the evaluation process to select up to three pilot projects in compliance with Section 298 of Public Act 107 of 2017. The anticipated notice of the pilot decision is February 28, 2018. The department is aiming to implement the pilots and demonstration model by July 1, 2018.

For more background on the Section 298 Initiative and the RFI for the pilots, visit www.michigan.gov/stakeholder298.

The link to the Q&A document can be found at:
http://www.michigan.gov/documents/mdhhs/QA_Document_on_the_298_Pilot_RFI_-_Final_Version_612027_7.pdf

LARA calls together group to examine SUD licensing redesign

The Michigan Department of Licensing and Regulatory Affairs (LARA) has recently called together a group of substance use disorder (SUD) payers (primarily PIHPs) and providers, and state associations, including this Association, to discuss the potential of refocusing Michigan's SUD licensing rules and practices. Recognizing that the SUD and health care world have changed dramatically since the 1980s, when the bulk of the state's SUD licensing rules and practices were developed, LARA is examining how it can better focus its efforts. As this workgroup progresses, this Association will keep its members informed.

Webinar on 1332 waivers announced

Health Management Associates (HMA) has recently announced an upcoming webinar on the lasts developments related to the federal Section 1332 waivers. These waivers, which allow states to waive components of the Affordable Care Act (ACA), are gaining momentum across the country with Michigan considering the development of such a waiver request.

New Life for 1332 Waivers: Next Steps in State Health Insurance Exchange Market Innovation
Wednesday, February 7, 2018
1 to 2 p.m. EST

With the current administration aiming to provide increased state flexibility in the use of federal healthcare funds, ACA Section 1332 State Innovation Waivers may attract renewed interest. Section 1332 waivers allow states to modify certain aspects of their health insurance Exchange markets and operating rules, for example easing regulations on benefit levels, allowing flexibility in how subsidies are spent, and developing reinsurance programs to promote the stability of individual markets. While only a handful of states have applied to date, Section 1332 waivers remain an important policy lever to watch.

During this webinar, HMA experts will provide an update on the status of Section 1332 waivers, address the types of modifications states are applying for, and assess the potential impact on health plans, providers, regulators, and consumers.

Who Should Attend: State officials and staff; executives of Medicaid managed care plans; clinical and administrative leadership of health systems, behavioral health providers, FQHCs, and other provider organizations.

Register at:

https://hlthmgtevents.webex.com/mw3200/mywebex/default.do?nomenu=true&siteurl=hlthmgtevents&service=6&rnd=0.28311050070122323&main_url=https%3A%2F%2Fhlthmgtevents.webex.com%2Fec3200%2Feventcenter%2Fevent%2FeventAction.do%3FtheAction%3Ddetail%26%26%26EMK%3D4832534b00000004013b59b1ec0af2cc768aaea3671e1c4ea79219a9962aaed4bac7872e8e8ee572%26siteurl%3Dhlthmgtevents%26confViewID%3D84512485196988290%26encryptTicket%3DSDJTSwAAAARJAiS-Ft1ctapqgiuGhsni5EGQmh-kSaenmoHGPPDGKw2%26

CIHS announces integrated care workforce resource

The SAMHSA/HRSA Center for Integrated Health Solutions recently announced a publication designed to provide resources on recruiting, retaining, and developing the workforce needed for the growing integrated care systems within our communities:

> Sustaining Integrated Behavioral Health Services: Strategies and Tools for Recruitment, Retention, and Workforce Development
>
> Check out the Integration Edge today for Sustaining Integrated Behavioral Health Services: Strategies and Tools for Recruitment, Retention, and Workforce Development.
> Integrated care teams currently serve more than 25 million patients in the U.S. The key to successful integrated care is high-functioning multidisciplinary teams. Teams should be comprised of well-trained staff with the core professional competencies and personal qualities needed to deliver services in integrated care settings.
>
> To achieve this, organizations should develop strategies and utilize best practices to recruit, hire, train, and retain competent care providers who function well in a team environment. Integrated care is unique in that, although a clinician may have been effective as an independent provider, he or she may not necessarily function well and appreciate working in an integrated setting.
>
> This brief guide provides managers with the necessary framework for building integrated teams. Building on the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) resource on Core Competencies for Integrated Care which can be found at:
> https://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf
>
> This document offers HRSA-funded safety-net providers recruitment resources and interview questions to help develop an integrated care staff. Included are techniques to identify behavioral health clinicians with the right skills and qualities to work in integrated care settings, as well as training resources to continue strengthening an integrated care team. Additional resources are provided to support creating teams appropriate to the specific clinical environment.

Integration Edge can be found at: >https://integrationedge.readz.com/sustaining-integrated-behavioral-health-services-p

CHCS blog to provide latest on Medicaid ACOs

The Center for Health Care Strategies (CHCS) recently announced a blog post that focuses on the progress of Medicaid ACO development in Minnesota and Colorado. Given that much of the work of this Association's members revolves around ACO-like structures, this blog is a useful resource in these efforts.

> Medicaid Accountable Care Organizations Version 2.0 Underway in Minnesota and Colorado: In several states across the country, Medicaid accountable care organization (ACO) programs have been operating for more than five years now. Lessons from those early adopters are being used to enhance existing state programs as well as inform states that are newly pursuing ACO programs. Two early innovating states with successful Medicaid ACO programs – Vermont and Oregon – have already introduced new ACO "2.0 versions."

> This new CHCS blog post looks at how Minnesota and Colorado are building on initial ACO successes and rolling out enhanced 2.0 models. In the first versions of their ACO programs, these two states achieved both improvements in quality of care and cost savings. Minnesota's Integrated Health Partnerships program saved the state nearly $156 million in its first three years, reducing inpatient admissions by 14 percent and emergency department visits by seven percent. Similarly, Colorado's Accountable Care Collaborative demonstrated reductions in costs and utilization as well as growth in enrollment.

The blog can be found at:
https://www.chcs.org/medicaid-accountable-care-organizations-version-2-0-underway-minnesota-colorado/?utm_source=CHCS+Email+Updates&utm_campaign=6ea4499c66-EMAIL_CAMPAIGN_2018_01_18&utm_medium=email&utm_term=0_bbced451bf-6ea4499c66-152144421

Link of poverty to health status of Michigan residents' health status underscored in recent report

Bridge magazine recently highlighted the results, for Michigan, of a study of the health status of all fifty states, conducted by the United Health Foundation. The study found that, not surprisingly, health status is closely linked to poverty and racial disparities. A short excerpt from the Bridge article and the full article are provided below.

> If Michigan's nearly 10 million residents received a collective physical exam, the result would be a mixed bag – and likely a frown from the doctor.
>
> Michigan ranked 35th best among states in 2017 for a range of health metrics that include obesity, diabetes, cancer, and other health factors. The United Health Foundation, which compiles the annual rankings, considered Michigan the 28th healthiest state as recently as 2010.
>
> In many cases, adverse health outcomes are tied to the broader social disease of poverty. Troubling health signs show up in everything from higher infant mortality to exposure to air pollution to the poisoning of Flint's drinking water.

The full Bridge article can be found at:

http://www.bridgemi.com/special-report/michigans-adverse-health-trends-track-along-racal-poverty-lines

LEGISLATIVE UPDATE

State of the State

This week, Governor Rick Snyder presented his eighth and final State of the State Address to the Legislature and citizens of Michigan. As is typical, particularly in a final speech, the Governor reflected on the last seven years of his tenure. Governor Snyder highlighted consistent economic growth, significant tax reforms, a tangible commitment to paying down the state's long-term debt, and shepherding the City of Detroit through the country's largest municipal bankruptcy.

Below is a list of a few items the Governor highlighted during his speech:

- Preserving and building upon fiscally responsible budgeting/saving practices
- Investment in infrastructure with a likely acceleration of dedicated resources
- The need for an A-F grading system for public schools
- Additional resources dedicated to combating the statewide opioid crisis
- Talent, talent, talent. The Governor broadly outlined the "Marshall Plan", an enterprise wide transformation in talent creation and delivery
- The need to maintain and champion civility in government

- New initiatives in broadband access, recycling, clean water infrastructure, and combating PFAS and Asian carp

NATIONAL UPDATE

Congress Approves Six Year CHIP Authorization, Re-opens Government for Three Weeks

After a three-day government shutdown, the House and Senate passed a stopgap spending bill Monday to keep the government running through Feb. 8. The deal also provided a six-year extension of the Children's Health Insurance Program (CHIP) and delayed certain Affordable Care Act (ACA) taxes. With a new Feb. 8 funding deadline, lawmakers will once again start negotiating on a long-term FY 2018 budget deal and a potential immigration package, among some remaining health care measures that have been logjammed in the government funding process.

GOVERNMENT SHUTDOWN

Last Friday, the federal government shutdown after a short-term spending patch, known as a continuing resolution or CR, failed to pass both chambers of Congress before an all-important funding deadline. The original four-week CR, written by House Republicans, passed through the House but stalled in the Senate. Conflicts between Republicans and Democrats on appropriate levels of funding levels for defense and non-defense priorities as well as Democrats' commitment seeing an immigration debate ultimately resulted in the Senate's inability to pass the bill. However, the shutdown came to a close quickly the following Monday when Senate Majority Leader Mitch McConnell (R-KY) agreed to hold a debate on immigration in the coming weeks and the CR was shortened by one week.

Importantly, in spite of the Senate's "gentleman's agreement" and the shutdown drama, it appears that House Republicans and President Trump are resolutely against pairing the Senate's bipartisan immigration deal with any broader spending bill. That dynamic will be the one to watch as Congress tries to negotiate on a more permanent way forward.

HEALTH CARE MEASURES

The spending deal reauthorized CHIP for six years, ending a nearly four-month lapse in the program's long-term federal funding. The CR delays the ACA's medical device tax and the "Cadillac tax" on high-cost workplace health plans for two years and its health insurance tax for one year.

Notably, the bill does not contain a funding extension for community health centers or renewal of so-called Medicare "extenders." Many advocates expressed alarm that these measures are now separated from the more politically-expeditious CHIP program and ACA taxes – both of which were signed into law by President Trump as part of Monday's CR. Historically, these smaller health care measures have been assured regular extensions by being tied to CHIP – a bipartisan, priority health insurance program covering 9 million low-income children and families. Despite a number of promises from lawmakers on which issues will be addressed in February's funding decision, it remains unclear what will ultimately be included in the next government funding package.

CHAM WINTER CONFERENCE – LAST DAY FOR EARLYBIRD DISCOUNT!

The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & 7, 2018 at the Radisson Plaza Hotel & Suites, Kalamazoo. The conference will feature 4 powerful keynote addresses, a wide variety of workshops, as well as a pre-conference institute on Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments.

Keynote Addresses:

Current Efforts toward Behavioral Health and Justice Collaborations for Better Outcomes

- *Debra A. Pinals. MD, Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services*

I Have Been Running my Entire Life – I am Finally Free

- *Dominic Carter, Veterans Newsman, Mental Health Advocate, Author, and Speaker*

What's Hot in Behavioral Health – A National Update

- *Charles Ingoglia – Senior Vice President, Public Policy and Practice Improvement, National Council for Behavioral Healthcare*

The Life, the Game, the Pain and the Transition

- *Adrian Muldrow, Founder, We Can Achieve Youth Advocacy Project*

Pre-Conference Institute:

February 5, 2018 from 1:00pm – 4:00pm

Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments

- *David Michael Mank, Ph.D., Professor Emeritus, Indiana University*

For a detailed conference brochure, click here: https://macmhb.org/education

To Register for the Full Conference, click here: https://goo.gl/ATd6pb

To Register for the Pre-Conference Institute, click here: https://goo.gl/3UeQDc

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

WEBINAR: BUSINESS OR EXPLOITATION?" EXPOSURE OF THE TOBACCO INDUSTRY'S EXPLOITATION OF INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

The Smoking Cessation Leadership Center (SCLC) is excited to be hosting our **75th webinar** with our partners, the National Behavioral Health Network for Tobacco and Cancer Control (NBHN), and the Truth Initiative®. We invite you to register for this **One-Hour Power Break** webinar: "***Business or Exploitation?" Exposure of the tobacco industry's exploitation of individuals with mental health conditions*** on **Thursday, January 18, 2018, at 1:00pm EST** (60 minutes).

We are honored to have the following speakers presenting on this topic for us:

- **Margaret Jaco Manecke, MSSW**, Project Manager, Practice Improvement, National Council for Behavioral Health
- **Ashley Persie,** Senior Brand Marketing Associate, Truth Initiative®
- **Judith (Jodi) Prochaska, PhD, MPH,** Associate Professor of Medicine, Stanford University

Webinar Objectives:

1. Explain why people with mental health conditions (depression and ADHD, for example) and substance use disorders have been historically targeted by the tobacco industry.
2. State whether adults with mental health conditions and substance use disorder smoke more than adults without those conditions.
3. Describe the morbidity rates of people with mental health conditions and name specific causes of death that can be attributed to tobacco use.

4. Explain the impact of the **truth®** campaign among its target audience.
5. Describe evidence-based approaches for treating tobacco use and tobacco addiction in persons with co-occurring mental illness.
6. Describe how you can leverage the National Behavioral Health Network for Tobacco & Cancer Control's tool, resources, and network to combat tobacco use & cancer disparities among individuals with mental illnesses and addictions and network members.

REGISTER HERE: https://cc.readytalk.com/r/eyjfkcfgqogs&eom

CME/CEUs will be available for participants who join the **LIVE** session, on **January 18, 2018.** You will receive instructions on how to claim credit via the post webinar email.

Have a Great Weekend!

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

January 19, 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**
  - **Newaygo CMH Board member named to Michigan DD Council**
  - **DWMHA announces new CEO**
- **State and National Developments and Resources**
  - **MDHHS reiterates 298 pilot RFI response process**
  - **MDHHS issues summary of HCBS heightened scrutiny process**
  - **MDHHS issues final bulletin on reenrollment of Medicaid providers in CHAMPS**
  - **SAMHSA Finalizes 42 CFR Part 2 changes**
  - **National Council joins others in expressing concern over Medicaid work requirements**
  - **Assistant Secretary for MH and SUD announces federal EBP registry**
  - **SAMHSA offers webinar on the value of peer supports in supportive housing**
  - **CHCS announces results of study of cross-sector service use among high health care utilizers after Medicaid expansion**
  - **CHCS announces blog on VSP**
  - **A&E offers series on young adult mental health and substance use**
- **Legislative Update**
  - **House CARES Task Force Report Released**
  - **First Medicaid Work Requirement Bill Rolled Out**
- **National Update**
  - **CMS Issues Guidance Allowing Medicaid Work Requirements**
- **CMHAM Winter – Registration Open Next Week**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Webinar: Business or Exploitation? Exposure of the Tobacco Industry's Exploitation of Individuals with Mental Health Conditions**

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**.

WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

Newaygo CMH Board member names to Michigan DD Council

Below is a recent press release on the appointment of Todd Koopmans, a member of the Board of Director of Newaygo County Mental Health to the Michigan Developmental Disabilities Council. Congratulations to Todd.

> Gov. Rick Snyder today announced the appointments of Karsten Bekemeir of East Lansing and Todd Koopmans of Fremont to the Developmental Disabilities Council.
>
> Housed within the Michigan Department of Health and Human Services, the 21-member council advocates for people with disabilities on a statewide level.
>
> "I thank Karsten and Todd for serving and I am confident they will be great advocates for Michiganders with disabilities," Snyder said.
>
> Bekemeier is a policy consultant of the Michigan Vocational Rehabilitation Program within the Michigan Department of Health and Human Services. He holds a bachelor's degree in psychology from Eastern Michigan University and both a master's degree in rehabilitation counseling and a doctorate in rehabilitation counseling education from Michigan State University. He will represent an individual from the state agency that administers funds provided under the Rehabilitation Act of 1973.

Koopmans works at Fremont Cinema as a ticket taker and maintenance worker and previously spent 13 years as a greeter at Walmart. He will represent individuals with a developmental disability and a member of the Self-Advocates of Michigan. He fills the vacancy created by the resignation of Katie Miller.

Bekemeir will serve a four-year term to expire Sept. 30, 2021. Koopmans will serve the remainder of a four-year term to expire Sept. 30, 2020.

DWMHA announces new CEO

Below is an excerpt from a recent announcement, from the Detroit Wayne Mental Health Authority (DWMHA), on the hiring of Willie Brooks as the Authority's new CEO. We wish Willie and DWMHA the best.

The CEO Search Committee of the Board of Directors for the Detroit Wayne Mental Health Authority (DWMHA) began a national search in May 2017 through the firm B.E. Smith for a qualified and capable President and CEO to lead our organization. After a thorough search that yielded over 100 candidates, interviews with the top five candidates were conducted over the last five weeks. Panelists included members of our community stakeholders, provider network, advocacy groups, consumers and staff.

The DWMHA Board of Directors voted to unanimously accept the CEO Search Committee's recommendation of Willie Brooks as its next President and CEO.

"I am looking forward to working with Mr. Brooks and the experience he brings to our system of care, DWMHA and the role of President and CEO. During this time of transition in community mental health, the strength of Wayne County is vital to the success of Michigan's Community Mental Health System", according to Dr. Herbert C. Smitherman, Jr., DWMHA Board Chairman

Mr. Brooks comes to CWMHA with extensive knowledge of the Community Mental Health System, strong relationships among local leaders and is well-respected within the provider and advocate community. We are confident that with his experience he will be able to lead our organization as we provide the quality behavioral healthcare that is expected throughout Wayne County.

Willie Brooks has served as both Chief Executive Officer and Chief Financial Officer at Oakland County Health Network, He brings strong leadership skills and knowledge of the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health System Program (CMHSP).

STATE AND NATIONAL DEVELOPMENT AND RESOURCES

MDHHS reiterates 298 pilot RFI response process

Below is an excerpt from a recent announcement, that was sent to the state's CMHs, on the methods for interested CMHs to respond to the Section 298 pilot Request for Information (RFI).

Dear CMHSP Directors,

On December 20th, 2017, the Michigan Department of Health and Human Services (MDHHS) issued a Request for Information (RFI) in order to select the pilot sites for the Section 298 Initiative. MDHHS issued the RFI through the SIGMA Vendor Self Services system. MDHHS has received a number of questions about the process for accessing the RFI and submitting responses through the SIGMA VSS system. MDHHS would like to provide the following guidance on this issue:

- ACCESSING THE RFI – Lance Kingsbury, the buyer specialist for the RFI, has offered to provide assistance to CMHSPs who are attempting to access the RFI through the SIGMA VSS system. Lance can be contacted by phone (517-335-8170) or by email (kingsburyl@michigan.gov).

Please note that the responses to the RFI are due no later than 1:59 PM EST on February 13th, 2018. If you have additional questions about the RFI or the response process, please reach out to Lance.

MDHHS issues summary of HCBS heightened scrutiny process

Below is a recently issued summary of the heightened scrutiny process that MDHHS will use as part of the state's transformation plan to meet the requirements of the federal Home and Community Based Services (HCBS) rules. This document is intended to assist a wide audience, with a focus on persons served and their families, in gaining a better understanding of the heightened scrutiny process.

Heightened Scrutiny

What is the Home and Community Based Services (HCBS) Rule?

In January 2014 the Centers for Medicare and Medicaid Services (CMS) announced a Final Rule on HCBS. HCBS are Medicaid services for people with disabilities. The Home and Community Based Services rule (HCBS) requires that individuals have equal access to the community, the opportunity for independence in making the decisions, and ensures that their rights are respected.

What is Heightened Scrutiny?

Heightened Scrutiny (HS) is a review process required by CMS for services that *may not* be Home and Community Based (HCB). The purpose of this review is to find out if the services can become HCB.

Why is the Heightened Scrutiny needed?

If a service is on Heightened Scrutiny (HS), the provider will need to change how it provides service in your home or community. Services must be Home and Community Based (HCB). The Michigan Department of Health and Human Services (MDHHS) is collecting information about Michigan's services of HS. MDHHS will give this information to the Centers for Medicare and Medicaid Services (CMS). CMS will decide if a services is HCB.

What does Heightened Scrutiny mean to my services?

You can make decisions about your services and who provides them at any time. During Heightened Scrutiny (HS), providers will work to make the changes on how a service is provided. You will continue to receive services from your current provider if that is your choice. If you provider is not able to deliver HCB then the service provider will need to change. Some HS providers may not be able to become HCB. If you are receiving services from a provider that *cannot* become HCB, you will get help from your Community Mental Health (CMH). The CMH will help you find providers delivering HCB services and help you transition to the HCB services.

What will happen next?

Your support coordinator will ask if you want to keep receiving services from the provider who is on Heightened Scrutiny. If you say **yes**, the provider will make changes so the provider can keep providing your services. If you say **no**, then your supports coordinator will work with you to find services that are Home and Community Based.

What do I need to do?

Your support coordinator will help you answer the Heightened Scrutiny survey. Your survey answers will tell the Michigan Department of Health and Human Services (MDHHS) what you want to do. You can have a

person centered planning at any time to talk about your services and make changes if you want. If you have questions or concerns, talk with your supports coordinator who can answer questions and provide more information.

FOR MORE INFORMATION
Michigan Department of Health and Human Services, Home and Community Based Services Program Transition: http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html

Michigan Developmental Disabilities Institute, Wayne State University – Michigan Home and Community Based Services Transition Project: http://ddi.wayne.edu/hcbs

MDHHS issues final bulletin on reenrollment of Medicaid providers in CHAMPS

Below is a recent bulletin, from MDHHS, on the requirements related to enrollment, into the State's CHAMPS system, of various types of providers receiving Medicaid funds and serving Medicaid enrollees.

Bulletin Number: MSA 17-48
Distribution: All Providers
Issued: November 27, 2017
Subject: Managed Care Network Provider Enrollment in the Community Health Automated Medicaid Processing System (CHAMPS)
Effective: January 1, 2018
Programs Affected: Medicaid, Health Michigan Plan (including dental), Children's Special Health Care Services, MI Health Link

The purpose of this bulletin is to update and clarify Medicaid managed care network provider enrollment requirements to comply with 42 CFR 438.602(b) and Section 5005(b)(2) of the 21st Century Cures Act.

Effective January 1, 2018, any individual or entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the State Plan participating in a managed care organization's provider network are required to be screened and enrolled in the Michigan Medicaid Program, Managed Care Organization (MCO) providers furnishing services to Medicaid beneficiaries must enroll in CHAMPS.

Medicaid rules prohibit payment to providers not appropriately screened and enrolled. Beginning March 1, 2018, MDHHS will prohibit MCOs from making payments to all typical rendering referring, ordering and attending providers not enrolled in CHAMPS. Effective for dates of service on and after May 1, 2018, MDHHS will prohibit payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Fee-for-Service Medicaid beneficiaries. Enrollment in CHAMPS is solely used for the purpose of screening providers participating in Medicaid.

Providers enrolling in CHAMPS are divided into two categories: (1) typical and (2) atypical. Typical providers are professional health care providers that provide health care services to beneficiaries. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to: physicians, physician assistants, certified nurse practitioners, dentists and chiropractors, Providers should refer to the Michigan Medicaid Provider Manual and any applicable State policy or law for educational and professional licensure requirements.

Atypical providers provide support services for beneficiaries. These providers generally do not have professional licensure requirements, and may not have an NPI.

If a provider type is currently unbailable as an option in CHAMPS, it does not mean the provider is not required to enroll, only that the provider type is not currently being accepted for enrollment in CHAMPS. CHAMPS continues to be updated to accept additional provider types for enrollment. The Michigan Department of Health and Human Services (MDHHS) will release future updates as additional provider types become available in CHAMPS.

Providers requiring additional information or assistance enrolling in CHAMPS may call the Provider Support Help Line or visit any of the MDHHS provider websites listed below under the Resources section of this bulletin.

Resources:
Provider Support Help Line
•Typical Providers: 1-800-292-2550
•Atypical Providers: 1-800-979-4662

Provider General Information: www.michigan.gov/medicaidproviders

Provider Enrollment General Information: www.michigan.gov/medicaidproviders>>Provider Enrollment
CHAMPS Provider Enrollment: https://milogintp.michigan.gov

Medicaid Provider Manual: www.michigan.gov/medicaidproviders>>Policy, Letters & Forms

Public Comment: The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the changed noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Sharene Johnson
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: JohnsonS14@michigan.gov

If responding by e-mail, please include "Managed Care Network Provider Enrollment" in the subject line. Comments received will be considered for revisions to the change implemented by this bulletin.

SAMHSA Finalizes 42 CFR Part 2 changes

On Tuesday, January 2, SAMHSA announced the finalization of proposed changes to 42 CFR Part 2, the Confidentiality of Substance Use Disorder Patient Records regulation. Major provision sin the rule include:

- Permitting additional disclosures of patient identifying information, with patient consent, to facilitate payment and health care operations such as claims management, quality assessment and patient safety activities.
- Permitting additional disclosures of patient identifying information to certain contractors, subcontractors, and legal representatives for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation.
- Assisting users of electronic health records (EHRs) by permitting use of an abbreviated notice of prohibition on re-disclosure more easily accommodated in EHR test fields.

The full rule and accompanying press release can be found on SAMHSA's website: https://www.samhsa.gov/newsroom/press-announcements/201801021100. A listening session for concerned parties to provide input on the potential impact of the rule changes will be held on Wednesday, January 31, 2018 from 8:30 a.m. to 1 p.m. ET. Information on that listening session can be found at: https://www.eventbrite.com/e/samhsa-listening-session-42-cfr-part-2-tickets-41087357392

National Council joins other in expressing concern over Medicaid work requirements

Below is a recent press release from the National Council for Behavioral Health (of which this Association and its members are long-time members) on the National Council's view on the recent support, by the federal Centers for Medicare and Medicaid Services (CMS) of work requirements for Medicaid enrollees.

> Medicaid Work Requirements: A Bad Solution in Search of a Problem
>
> WASHINGTON, D.C. (Jan. 15, 2018) – The National Council for Behavioral Health opposes the restrictions to Medicaid that the Centers for Medicare & Medicaid Services (CMS) announced last week. These restrictions make it harder for people with substance use disorders or mental illness to receive the care they need. In addition, the restrictions are expensive and complicated for states to administer, are burdensome for recipients to understand and comply with and almost always result in people losing access to the care they need – all because of needless red tape.
>
> Medicaid's core mission is to provide comprehensive health coverage to low-income people so they can get needed health services. Section 1115 of the Social Security Act allows states to deviate from certain federal Medicaid requirements, but only when necessary to implement demonstration projects that promote Medicaid's objectives. These restrictions take us far away from the core mission.
>
> It's important to note that most Medicaid beneficiaries who can work are *already working* – nearly eight in 10 non-disabled adults with Medicaid coverage live in working families, and most are working themselves. The majority of those who are not working have health conditions that prevent them from working, are caring for children or other family members who are ill or have a disability or are in school.
>
> In addition, a substantial number of individuals with substance use disorders or mental illness also have a criminal history that is directly related to their untreated illness. The CMS guidance completely fails to recognize the discrimination and related legal and policy barriers to employment confronting these individuals. Imposing work requirements compound the obstacles they already face when trying to secure employment, while denying needed health care.
>
> Studies of adults who gained coverage in Ohio and Michigan under the Affordable Care Act's Medicaid expansion, found that gaining health coverage helped a majority look for work or remain employed. Losing coverage – and, with it, access to treatment of substance use disorders such as opioid addiction and mental illness – will have the reverse result of impeding future employment.
>
> Work requirements are a political response to the stereotype of Medicaid recipients as lazy, living high on the hog rather than the reality of the sick, the disabled, the elderly and struggling working parents.

Assistant Secretary for MH and SUD announces federal EBP registry

Elinore F. McCance-Katz, the Assistance Secretary for Mental Health and Substance Use, within the US Department of Health and Human Services, recently announced the National Registry of Evidence-based Programs and Practices and SAMHSA's new approach to implementation of evidence-based practices (EBPs). Excerpts from that announcement are provided below.

> SAMHSA and HHS are committed to advancing the use of science, in the form of data and evidence-based policies, programs and practices, to improve the lives of Americans living with substance use disorders and mental illness and of their families.
>
> People throughout the United States are dying every day from substance use disorders and from serious mental illnesses. The situation regarding opioid addiction and serious mental illness is urgent, and we must

attend to the needs of the American people. SAMHSA remains committed to promoting effective treatment options for the people we serve, because we know people can recover when they receive appropriate services.

SAMHSA has used the National Registry of Evidence-based Programs and Practices (NREPP) since 1997. For the majority of its existence, NREPP vetted practices and programs submitted by outside developers – resulting in a skewed presentation of evidence-based interventions, which did not address the spectrum of needs of those living with serious mental illness and substance use disorders. These needs include screening, evaluation, diagnosis, treatment, psychotherapies, psychosocial supports and recovery services in the community.

The program as currently configured often produces few to no results, when such common search terms as "medication-assisted treatment" or illnesses such as "schizophrenia" are entered. There is a complete lack of a linkage between all of the EBPs that are necessary to provide effective care and treatment to those living with mental and substance use disorders as well. If someone with limited knowledge about various mental and substance use disorders were to go to the NREPP website, the could come away thinking that there are virtually no EBPs for opioid use disorder and other major mental disorders – which is completely untrue.

They would have to try to discern which of the listed practices might be useful, but could not rely on the grading for the listed interventions; neither would there be any way for them to know which interventions were more effective than others.

We at SAMHSA should not be encouraging providers to use NREPP to obtain EBPs, given the flawed nature of this system. From my limited review – I have not looked at every listed program or practice – I see EBPs that are entirely irrelevant to some disorders, "evidence" based on review of as few as a single publication that might be quite old and, too often, evidence review from someone's dissertation.

This is a poor approach to the determination of EBPs. As I mentioned, NREPP has mainly reviewed submissions from "developers" in the field. By definition, these are not EBPs because they are limited to the work of a single person or group. This is a biased, self-selected series of interventions further hampered by a poor search-term system. Americans living with these serious illnesses deserve better, and SAMHSA can now provide that necessary guidance to communities.

We are now moving to EBP implementation efforts through targeted technical assistance and training that makes use of local and national experts and will that assist programs with actually implementing services that will be essential to getting Americans living with these disorders the care and treatment and recovery services that they need.

These services are designed to provide EBPs appropriate to the communities seeking assistance, and the services will cover the spectrum of individual and community needs including prevention interventions, treatment and community recovery services.

We must do this now. We must not waste time continuing a program that has had since 1997 to show its effectiveness.
But yet we know that the majority of behavioral health programs still do not use EBPs: one indicator being the lack of medication-assisted treatment, the accepted, life-saving standard of care for opioid use disorder, in specialty substance use disorder programs nationwide.

SAMHSA will use its technical assistance and training resources, its expert resources, the resources of our sister agencies at the Department of Health and Human Services, and national stakeholders who are consulted for EBPs to inform American communities and to get Americans living with these disorders the resources that they deserve.

For more information, contact the SAMHSA Press Office at 240-276-2130.

SAMHSA offers webinar on the value of peer supports in supportive housing

A SAMHSA sponsored webinar developed under contract by the National Council for Behavioral Health, will take place Friday, January 26th at 2pm ET called **"Peer Support: A Critical Component in Supported Housing"**.

Evidence shows that individuals living with a substance use disorder and serious mental illness can achieve and sustain long-term recovery. To help these individuals, there are services and supports behavioral health providers and community leaders could develop and implement. Join the National Council to explore how peer support and housing strategies increase the likelihood of successful recovery.

Presenters:

- Tom Hill, Vice President of Practice Improvement, National Council for Behavioral Health
- Lyn Legere, Lyn Legere Consulting

Register at: https://events-na3.adobeconnect.com/content/connect/c1/986655080/en/events/event/shared/1700946820/event_landing.html?sco-id=2051220064&_charset_=utf-8

CHCS announces results of study of cross-sector service use among high health care utilizers after Medicaid expansion

The expansion of Medicaid coverage through the Affordable Care Act improved coverage for millions of low-income Americans. This population is known to have high rates of substance use disorders, mental illness, criminal justice involvement, and homelessness – which are associated with high emergency department and hospital services use, as well as involvement in other public sectors such as supportive housing.

Interventions aimed at reducing acute health care use among these high-need, high-cost individuals often focus on the integration of social and behavioral support within traditional medical care. Yet, planning and evaluation of integrated care models requires data on cross-sector service use and costs – data that are often difficult to merge across sectors.

A new article, in the January 2018 issue of ***Health Affairs,*** explores the results of a novel cross-sector data analysis – including health care, criminal justice, housing, and human services sectors – that looked at service use and costs of Medicaid expansion enrollees in Hennepin County, Minnesota. The article shares key findings from the **full study,** which was made possible through CHCS' *Complex Care Innovation Lab.* The findings suggest that there are opportunities for cross-sector collaboration that may result in health improvements and cost savings across sectors. Hennepin County's experience may help policymakers and local leaders in developing new and integrated service delivery models for the most vulnerable members of society.

The article can be found at:

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0091?utm_source=CHCS+Email+Updates&utm_campaign=fb82afc53a-EMAIL_CAMPAIGN_2018_01_08&utm_medium=email&utm_term=0_bbced451bf-fb82afc53a-152144421&

CHCS announces blog on VBP

The Center for Health Care Strategies (CHCS) recently announced a blog that will focus the use of Value Based Purchasing (VBP) in Medicaid managed care programs. The announcement is provided below:

> Using Pay for Success in Medicaid Managed Care and Value-Based Purchasing Initiatives
>
> In discussing Medicaid, we often use jargon, acronyms, and maxims. Pay for value, not volume. Address social determinants of health (SDOH).

Now, we have a new maxim: Pay for Success (PFS). Over the past few years, states and localities have used PFS principles to fund supports for at-risk moms, in-home asthma assessments, and supportive housing. PFS projects typically address SDOH, while maintaining an aggressive focus on outcomes. But until recently, only one state. South Carolina, has used PFS in its Medicaid program.

What Matters: Investing in Results to Build Strong, Vibrant Communities, (which can be found at: http://investinresults.org/book?utm_source=CHCS+Email+Updates&utm_campaign=8a1200d041-EMAIL_CAMPAIGN_2018_01_08&utm_medium=email&utm_term=0_bbced451bf-8a1200d041-152144421a) recent book published by the Federal Reserve Bank of San Francisco and Nonprofit Finance Fund, discusses the potential impact of PFS on public sector programs. In one chapter, CHCS' Allison Hamblin outlines how PFS could gain traction in Medicaid.

This blog post explores what PFS can bring to Medicaid. It also discusses how PFS can be integrated into Medicaid managed care programs and value-based purchasing initiatives, including Medicaid accountable care organization programs, and support partnerships with community-based organizations.

The link to the blog is:
https://www.chcs.org/using-pay-success-medicaid-managed-care-value-based-purchasing-initiatives/?utm_source=CHCS+Email+Updates&utm_campaign=8a1200d041-EMAIL_CAMPAIGN_2018_01_08&utm_medium=email&utm_term=0_bbced451BF-8A1200D041-152144421

A&E offers series on young adult mental health and substance use

The A&E television network has recently announced a series dealing with late adolescent and young adult mental health and substance use issues. Below is a description of the series:

Undercover High follows seven young adults, ranging in age from 21 to 26, who embed themselves for a semester in Topeka, Kansas' Highland Park High School. The participants pose as typical students – attending classes, making friends and participating in school clubs and activities – to help enact positive change, the participants, unaware of each other, arrive on campus where only the school administrators and select members of the community know their true identities and the reason for their semester-long stay. From bullying and the pervasiveness of social media to the struggle to excel in the classroom and navigate evolving social standards, participants discover the challenges and complexities, both new and familiar, facing today's teens.

Digging into their past, participants bring to the program a variety of cultures and experiences. The young adults include a former bully, victims of bullying, a teen mom, a youth motivational speaker, a set of siblings and a teen minister. Following through background checks, extensive training and ongoing meetings with psychologists and school counselors, these participants called Highland Park High School their new home for the Spring 2017 semester, befriending students and striving to implement positive changes to their lives and the school community.

DISCUSSION GUIDE
Find resources and discussion tools related to Undercover High. Download the guide at:
http://cdn.watch.aetnd.com/prod.cdn.watch.aetnd.com.s3.amazonaws.com/sites/4/2018/01/undercover-high-disc-guide.pdf

SCHOOL TOOLKIT
Download a Crisis Text Line school toolkit with great resources for your school at:
https://www.crisistextline.org/schooltoolkit

More information on the series can be found at:
http://www.aetv.com/shows/undercover-high

LEGISLATIVE UPDATE

House CARES Task Force Report Released

This week, Speaker Tom Leonard rolled out the final report of the House of Representatives' CARES (Community, Access, Resources, Education and Safety) Task Force, which convened last summer to explore Michigan's mental health system. Legislation to address some of the issues addressed in the report is expected in the near future, and this 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. We will keep you informed as bills are introduced and the committee defines its schedule on this topic.

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."

Among the areas needing improvement, according to the report, are:

- Increasing access to mental health services and mental health personnel.

- Providing crisis intervention training for law enforcement.

- Crisis intervention training for emergency medical technicians.

- Addressing the shortage of case managers and social workers.

- Providing incentives for mental health professionals to work in Michigan.

- Encouraging providers to have more beds for mental health patients.

- Creation of a database of available mental health services.

- Increasing judicial discretion for sentencing veterans.

- Promoting early intervention.

- Using electronic, communications to link patients with mental health professionals in other locations.

- Expanding diversion programs.

- Eliminating barriers to work for mental health patients.

- Requiring use of mental health screening in jails at intake.

A link to the full report can be found below:

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

First Medicaid Work Requirement Bill Rolled Out

Able-bodied Medicaid recipients should be working, going through job training or performing community service in order to keep their benefits under legislation Rep. Gary Glenn (R-Williams Twp.) rolled out this morning. The legislation comes after the federal government approved a Kentucky move along these lines. It's a policy made possible by the U.S. Department of Health and Human Services

Glenn is also proposing an enrollment freeze to Michigan's Medicaid expansion plan as a way to "limit damage to the state budget," which is required to pick up 5 percent of expansion costs in the coming fiscal year.

Rep. Gary Howell (R-North Branch) co-sponsored the Medicaid work requirement bill, HB 5317 and the Healthy Michigan freeze. HB 4598, with Rep. Glenn.

NATIONAL UPDATE

CMS Issues Guidance Allowing Medicaid Work Requirements

On Thursday, the Trump Administration released guidelines for states to create the first-ever work requirements for Medicaid recipients. The guidance targets "able-bodied adults" with some exemptions. While details are still emerging, the National Council has grave concerns that the policy's exemptions will not be broad enough to protect all individuals with mental health and substance use disorders. Ten states have asked the federal government for approval to institute Medicaid work requirements. With this new guidance, the Administration is expected to begin approving these requests.

Despite numerous attempts, work requirements have never been permitted in Medicaid's 52-year history. However, CMS Administrator Seema Verma recently proclaimed that Trump Administration will approve such proposals. In a letter to State Medicaid Directors. CMS outline policy guidance for implementing Medicaid work requirements.

The guidance exempts Medicaid enrollees with disabilities, the elderly, pregnant women and children from job requirements. States must also exempt individuals who are considered "medically frail," which includes individuals with mental illness and addiction per a 2013 federal regulation. Specifically, that rule requires states to include people with "disabling mental disorders" and "chronic substance abuse disorders" in their definition of medically frail. The guidance also notes that people with substance use disorders must be afforded "reasonable modifications." These modifications can include counting time spent in treatment towards the work requirements or exempting individuals in participating in intensive addiction treatment from work requirements.

States that choose to pursue work requirements are given a great deal of flexibility from CMS' guidance. States can determine how "able-bodied adults" will be defined and what activities will count as work. The letter says that work activities "include, but are not limited to, community service, caregiving, education, job training, and substance use disorder treatment."

States are encouraged to help Medicaid enrollees successfully complete the work requirement through job training, child care, and other supports, but are prohibited from using Medicaid funds to do so. For enrollees that already have jobs, are in school or are caregivers, they will need to regularly document with the state's Medicaid agency that they are in compliance or risk losing Medicaid benefits.

The National Council opposes making employment a condition for health care coverage as mental health and substance use conditions can result in impairments that preclude individuals from consistent, full-time employment.

With this new guidance, reports indicate that federal officials will quickly act to approve Kentucky and Indiana's proposed work requirements. Any work requirement approval is likely to be challenged in the courts by a number of health care and legal advocacy groups. Other states that have requested work requirements through Medicaid waivers include: Arizona, Arkansas, Kansas, Maine, Mississippi, New Hampshire, Utah and Wisconsin.

CMHAM WINTER CONFERENCE – REGISTARTION OPENS

The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & 7, 2018 at the Radisson Plaza Hotel & Suites, Kalamazoo. The conference will feature 4 powerful keynote addresses, a wide variety of workshops, as well as a pre-conference institute on Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments.

Keynote Addresses:

Current Efforts toward Behavioral Health and Justice Collaborations for Better Outcomes

- *Debra A. Pinals. MD, Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services*

I Have Been Running my Entire Life – I am Finally Free

- *Dominic Carter, Veterans Newsman, Mental Health Advocate, Author, and Speaker*

What's Hot in Behavioral Health – A National Update

- *Charles Ingoglia – Senior Vice President, Public Policy and Practice Improvement, National Council for Behavioral Healthcare*

The Life, the Game, the Pain and the Transition

- *Adrian Muldrow, Founder, We Can Achieve Youth Advocacy Project*

Pre-Conference Institute:

February 5, 2018 from 1:00pm – 4:00pm

Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments

- *David Michael Mank, Ph.D., Professor Emeritus, Indiana University*

For a detailed conference brochure, click here: https://macmhb.org/education

To Register for the Full Conference, click here: https://goo.gl/ATd6pb

To Register for the Pre-Conference Institute, click here: https://goo.gl/3UeQDc

WEBINAR: BUSINESS OR EXPLOITATION?" EXPOSURE OF THE TOBACCO INDUSTRY'S EXPLOITATION OF INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

The Smoking Cessation Leadership Center (SCLC) is excited to be hosting our **75th webinar** with our partners, the National Behavioral Health Network for Tobacco and Cancer Control (NBHN), and the Truth Initiative®. We invite you to register for this **One-Hour Power Break** webinar: "***Business or Exploitation?" Exposure of the tobacco industry's exploitation of individuals with mental health conditions*** on **Thursday, January 18, 2018, at 1:00pm EST** (60 minutes).

We are honored to have the following speakers presenting on this topic for us:

- **Margaret Jaco Manecke, MSSW**, Project Manager, Practice Improvement, National Council for Behavioral Health
- **Ashley Persie,** Senior Brand Marketing Associate, Truth Initiative®
- **Judith (Jodi) Prochaska, PhD, MPH,** Associate Professor of Medicine, Stanford University

Webinar Objectives:

1. Explain why people with mental health conditions (depression and ADHD, for example) and substance use disorders have been historically targeted by the tobacco industry.
2. State whether adults with mental health conditions and substance use disorder smoke more than adults without those conditions.
3. Describe the morbidity rates of people with mental health conditions and name specific causes of death that can be attributed to tobacco use.
4. Explain the impact of the **truth®** campaign among its target audience.
5. Describe evidence-based approaches for treating tobacco use and tobacco addiction in persons with co-occurring mental illness.
6. Describe how you can leverage the National Behavioral Health Network for Tobacco & Cancer Control's tool, resources, and network to combat tobacco use & cancer disparities among individuals with mental illnesses and addictions and network members.

REGISTER HERE: https://cc.readytalk.com/r/eyjfkcfgqogs&eom

CME/CEUs will be available for participants who join the **LIVE** session, on **January 18, 2018.** You will receive instructions on how to claim credit via the post webinar email.

Have a Great Weekend!

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

January 12, 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**
  - **CMH Services of Livingston County receives Goal Seal JCAHO approval**
  - **Tuscola Behavioral Health Systems receives CARF Three-Year Accreditation**
  - **Central Michigan CMH Medical Director named to The National Council's Medical Director Institute**
  - **Leadership changes at Lapeer County CMH**
- **State and National Developments and Resources**
  - **Michigan's Employment First draft mission statement**
  - **NPR announces "Abused and Betrayed" Series**
  - **Pscholka Leaving Budget Office**
  - **MATCP announces conference on justice and mental health**
  - **National Action Alliance for Suicide Prevention announces webinar**
  - **Arizona Legislator To Propose Medicaid Buy-In Option**
  - **Opinions: Medicaid Work Requirements Are About Eliminating Coverage for Low-Income People**
  - **CBO cost estimate finds that CHIP saves money**
  - **Health Affairs discusses recent CHCS study on the impact of cross-sector initiatives on health status**
  - **Michigan Federal announces conference**
- **Legislative Update**
  - **January Consensus Revenue Estimating Conference**
  - **Opioid Bills Signed into Law**
- **National Update**
  - **CMS Issues Guidance Allowing Medicaid Work Requirements**
- **CMHAM Winter – Registration Open Next Week**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Webinar: Business or Exploitation?" Exposure of the Tobacco Industry's Exploitation of Individuals with Mental Health Conditions**

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**.

WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

CMH Services of Livingston County receives Gold Seal JCAHO approval

Below is an excerpt from a recent announcement of the receipt, by the Community Mental Health Services of Livingston County of their receipt of the CAHO Gold Seal of Approval. Congratulations to CMH Services of Livingston County.

> Community Mental Health Services of Livingston County today announced it has earned The Joint Commission's Gold Seal of Approval® for Behavioral Health Care Accreditation by demonstrating continuous compliance with its performance standards. The Gold Seal of Approval® is a symbol of quality that reflects an organization's commitment to providing safe and effective care.
>
> Community Mental Health Services of Livingston County underwent a rigorous onsite survey on October 4 – 6, 2017. During the review, compliance with behavioral health care standards related to several areas, including care, treatment, and services; environment of care; leadership; and screening procedures for the early detection of imminent harm was evaluated. Onsite observations and interviews also were conducted.
>
> "Joint Commission accreditation provides behavioral health care organizations with the processes needed to improve in a variety of areas related to the care of individuals and their families," said Julia Finken, RN, BSN, MBA, CSSBB, CPHQ, executive director, Behavioral Health Care Accreditation Program, The Joint Commission. "We commend Community Mental Health Services of Livingston County for its efforts to elevate the standard of care it provides and to instill confidence in the community it serves."

"Community Mental Health Services of Livingston County is pleased to receive Behavioral Health Care Accreditation from The Joint Commission, the premier health care quality improvement and accrediting body in the nation," added Constance Conklin, Executive Director of Community Mental Health Services of Livingston County. "Staff from across the organization continue to work together to develop and implement approaches and strategies that have the potential to improve care for those in our community."

The Joint Commission's behavioral health care standards are developed in consultation with health care experts and providers, quality improvement measurement experts, and individuals and their families. The standards are informed by scientific literature and expert consensus to help organizations measure, assess and improve performance.

Tuscola Behavioral Health Systems receives CARF Three-Year Accreditation

Below is an excerpt from a recent announcement of the receipt, by Tuscola Behavioral Health Systems of full CARF accreditation. Congratulations to Tuscola Behavioral Health Systems.

Tuscola Behavioral Health Systems (TBHS) Board of Directors are pleased to report to the residents of Tuscola County that TBHS has been accredited for a period of three years for the following programs:

Assertive Community Treatment: Mental Health-Adults; Case Management/Services Coordination Mental Health-Adults; Children and Adolescents; Integrated DD/Mental Health-Adults; Crisis Intervention-Mental Health-Adults; Community Employment Services; Employment Supports and Job Development; Community Integration; Intensive Family-Based Services-Family Services-Children and Adolescents; Outpatient Treatment Mental Health-Adults, Children and Adolescents program.

The latest accreditation is the ***fourth consecutive*** Three-Year Accreditation that the international accrediting body, CARF, has awarded to Tuscola Behavioral Health Systems. Prior to 2008 TBHS was accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (JCAHO).

By pursuing and achieving accreditation TBHS has demonstrated that it meets international standards for quality and is committed to pursuing excellence. TBHS has established a history of using the CARF standards to guide administrative policies and program practices and consistently uses the CARF standards as a framework for quality improvement.

The survey report highlighted a number of items that CARF determined to be strengths of TBHS such as:

- Stakeholders reported satisfaction in working with the TBHS programs and staff. Individuals served reported they were treated as a member of the team and they were comfortable in seeking help and stating concerns to the TBHS staff all the way up to the CEO. TBHS's facilities are attractive and spacious, providing a welcoming environment for the consumers and comfortable work setting for the employees.

- In the programs that were surveyed, the interdisciplinary staff members work together and are motivated by excellence in providing quality services to the consumers. The staff members are mission oriented and apply their skills with a commitment to the wellness and recovery of their persons served while also nurturing a supportive work and employment culture.

- TBHS staff members, including senior leadership and frontline staff, are active in Tuscola County by sitting on various boards such as: Tuscola County Child Advocacy Center, Tuscola County Recovery/Prevention Coalition, Tuscola County Suicide Prevention Council and the Michigan School Readiness Council and provides Mental Health First Aid curriculum free of charge to community members. TBHS's CEO is engaged and committed to working with the organizations community partners. The CEO/Senior Leadership and all staff are recognized as a vital part of mental healthcare in Tuscola County by referral agencies and other stakeholders.

- The vocational staff members (Skill Building and Community Supports) have been positive and motivated to make the move into the Community Bound program successful. This has required the staff to develop new skills and to be able to use the skills in new community settings. The case management members are also recognized for their important role in making this transition happen.

Sharon Beals, TBHS Chief Executive Officer, stated "the survey results are confirmation of the staff member's commitment of providing consistent delivery of quality services and commitment to individuals during their recovery process."

This accreditation decision represents the highest level of accreditation that can be awarded to an organization and shows our organization's substantial conformance to the CARF standards. An organization receiving a Three-Year Accreditation has put itself through a rigorous peer review process. It has demonstrated to a team of surveyors during an on-site visit in October 2017, its commitment to offering programs and services that are measurable, accountable, and of the highest quality.

Central Michigan CMH Medical Director named to The National Council's Medical Director Institute

Angela Pinheiro, the Medical Director of Community Mental Health for Central Michigan has recently been named to the The National Council for Behavioral Health's Medical Director Institute.

The Medical Directors' Institute:

- Informs National Council staff and board members on rapidly evolving policy and public relations questions heavily related to clinical practice and provide a menu of options for responding to the particular situation;

- Provides longer-term strategic guidance on policy issues heavily related to clinical practice through developing technical reports. The technical reports would consist of background information, analysis, and a menu of possible options for subsequent action;

- Provides National Council members with resources to better recruit and utilize clinicians;

- Provides National Council staff with an in-depth bench of immediate clinical policy consultation; and

Congratulations to Dr. Pinheiro.

Leadership changes at Lapeer County CMH

Below is an excerpt from a recent announcement from Lapeer Community Mental Health regarding its change in leadership.

This communication is to advise you of changes in the administrative personnel at Lapeer County CMH. The changes are as follows:

- Dr. Robert Sprague resigned as CEO effective December 15, 2017
- Lauren Emmons, LMSW, ACSW is the Interim CEO and COO
- Effective January 8m, 2018, Dr. Christine Cucchi, DO, will assume the position of Medical Director

Best of luck to Bob Sprague in his future endeavors. Congratulations to Lauren Emmons and Dr. Christine Cucchi.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Michigan's Employment First draft mission statement

For the past several years, the State of Michigan and a number of employment services providers have been involved in the Employment First Initiative. In support of this initiative, the Governor and Lieutenant Governor issued Executive Order No. 2015-15. This EO can be found at: http://files.constantcontact.com/f53f497b001/37dbbb47-5d9f-4e45-bde3-3c51e26f8a87.pdf

This Association is involved in this effort, in partnership with the Michigan Developmental Disabilities Council, MDHHS, and MARO. Many of the readers of this Friday Facts (CEOs of CMHs, PIHPs, and Provider Alliance members) may remember the announcement of the grant and technical assistance opportunities related to the Provider Transformation and Rate Restructuring initiatives, within the Employment First effort.

The context for these efforts is best found within the draft mission statement for Michigan's Employment First effort below:

> Employment First in Michigan
>
> The State of Michigan has established Employment First as a policy priority. This document outlines the vision, mission, values and key objectives of this policy.
>
> Vision Statement: All persons with disabilities in Michigan will realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.
>
> Mission Statement: The purpose of Employment First is to maximize opportunities for persons with disabilities to achieve independence and economic self-sufficiency, promoting individual competitive integrated employment through a collaborative, seamless service model.
>
> Values: Employment First partners believe that employment:
>
> - Results in independence and economic self-sufficiency;
> - Enhances purpose, dignity, self-esteem, a sense of accomplishment and pride;
> - Creates inclusion in other community activities; and,
> - Enriches local communities through a diverse workforce and promotes economic development
>
> Objectives: The objectives of Employment First are:
>
> - To build collaborative capacity among public and private sector services providers through intentional resource director and program design;
> - To create a strategic and measurable approach to accelerate the pace of systems transformation, including provider transformation and rate restructuring to increase competitive integrated employment outcomes;
> - To clarify state and local agency roles and strengthen collaboration in order to braid and sequence resources, resulting in accessible, seamless, and non-duplicative services;
> - To sustain and expand investments by state agencies, the business community, and additional stakeholders, by joint efforts and coordinated services, to increase competitive integrated employment for people with disabilities, including youth with disabilities through seamless transition from school to work;
> - To promote and enhance the capabilities of support networks to assist individuals in their career journey and engage the business community to effectively assess their talent management and labor market needs;
> - To establish a common space for business community resources to highlight additional available assistance and streamline the process for the business community to find the resources they want and need to better recruit, employ, and retain individuals with disabilities;
> - To develop and utilize a shared communication strategy for all stakeholders inclusive of persons receiving employment services and their families so that individuals are aware of

the benefits coordination and planning options available to enable competitive integrated employment as well as the full array of competitive integrated employment options;
    - To foster innovation in program design and service delivery across agencies utilizing research-based practices;
    - To further leverage innovation at the local level, with an eye toward scalability and sustainability;
    - To collect service and outcome data in consistent and useful manner among all stakeholders; and,
- To develop action items through collaborative workgroups that will advance implementation of Employment First.

NPR announces "Abused and Betrayed" Series

At a moment of reckoning in the United States about sexual harassment and sexual assault, a yearlong NPR investigation finds that there's little recognition of a group of Americans that is one of the most at risk: adults with intellectual disabilities. The series starts on Monday, January 8th and runs through Thursday, January 18th. There will be print stories (with photos and art) on-line at www.npr.org. And the radio stories can be heard there.

Schedule:

Jan 8: Morning Edition: Correspondent Joe Shapiro talks about the series with host Steve Inskeep.

Jan 8: All Things Considered: The epidemic of sexual abuse of people with intellectual disabilities. Number obtained by NPR show they are sexually assaulted at rates more than 7 times those for all adults without disabilities.

Jan 9: Morning Edition: A visit to a Sex Ed class for people with intellectual disabilities. They talk about how they want relationships, but how the sexual violence of their past often gets in the way.

Jan 10: All Things Considered: On cases that go unnoticed when people have difficulty communicating.

Jan 16: All Things Considered: Police and prosecutors are often reluctant to take these cases, NPR goes back to Essex County, New Jersey, where the first case to get widespread attention—in Glen Ridge, New Jersey, 25 years ago—was prosecuted. And look at what prosecutors have learned since.

Jan 18: Morning Edition: therapists Nora Baladerian and Karyn Harvey talk about the stunning violence in the lives of their clients.

Jan 18: All Things Considered: Self-advocates speak—thoughtfully—of the effects of sexual violence. This piece is entirely in the voices of people with intellectual disabilities (plus Joe Shapiro).

The episodes of this series can be found at: https://www.npr.org/series/575502633/abused-and-betrayed

Pscholka Leaving Budget Office

State Budget Director Al Pscholka is resigning from his role effective Feb. 28, Gov. Rick Snyder announced today, clearing the way for Pscholka for a presumed run for the 21st Senate District that's coming open.

Pscholka was named the state's budget director in 2017 after terming out of the House. He'll be leaving soon after the finishing touches are put on the proposal of the Fiscal Year 2018 budget, the Governor's office announced today.

The 21st Senate District is currently held by Sen. John Proos (R-St. Joseph), who is term-limited.

"After seven year, more than 320,000 miles driven, and having worked on eight balanced budgets with surpluses, it's

time for me to return home full-time to spend more time with family and friends," he said.

Meanwhile, Snyder named John Walsh, the former lawmaker and Governor's director of strategy, to be Pscholka's replacement as budget director.

That means a promotion for Angela Ayers, who will become the director of strategy after serving as the deputy director in the strategic policy office and as deputy director of the Office of the Great Lakes.

MATCP announces conference on justice and mental health

The Michigan Association of Treatment Court Professionals (MATCP) recently announced its upcoming annual conference. MATCP's two day conference is designed to meet the educational needs of anyone who works within the justice system and deals with defendants and clients engaged in drug and alcohol abuse, dealing with mental health issues, trauma, and family matters. Whether or not your jurisdiction has a drug treatment court, veterans treatment court, or mental health court, this conference will enhance your skills in dealing with the needs of your defendants and clients. The conference will be held in Grand Rapids on March 13 and 14, 2018. More information on the conference can be found at: https://www.matcp.org/conference-2018.html

The registration fee ($305.00) includes a one-year complimentary MATCP membership, continental breakfast, and snacks both days of the conference. All other expenses (including lunch, dinners, lodging, gratuities, phone calls, mileage, etc.) are the responsibility of the attendee.

Deadline to register is Thursday, March 1, 2018. Payment may be made with your registration online or by check before Thursday, March 1, 2018.

Cancellations before Friday, February 16, 2018 will receive a 50% refund. Cancellations after Friday, February 16, 2018, may result in, at the discretion of MATCP, forfeiture of the full registration fee. Register for the conference at": https://www.regonline.com/registration/Checkin.aspx?EventId=2122927

National Action Alliance for Suicide Prevention announces webinar

In 2016, the National Action Alliance for Suicide Prevention published "Crisis Now: Transforming Care is Within Our Reach." Alignment with these practices cuts cost of care substantially, reduces the need for psychiatric hospital bed usage, ED visits and law enforcement overuse; resulting in better health and declines in suicide rate, justice system involvement/incarcerations and psychiatric boarding. These challenges are simply greater than previously acknowledged, but the Washington State supreme court ruling on the unconstitutionality of boarding, the suicide death of Virginia State Senator Deeds' son, the insistence of hospitals nationwide about the costs and safety and the series of violent incidents from Columbine forward are changing the expectations.

These issues will be the subject of the upcoming webinar, Crisis Now: What are We Learning?: to be held at 3:30 pm on January 24, 2018. Register for the webinar at: https://attendee.gotowebinar.com/register/7703251419849927171

Arizona Legislator To Propose Medicaid Buy-In Option.

The Arizona Republic recently reported that Arizona state Rep. Kelli Butler (D) of Phoenix plans to introduce a law this legislative session that would permit uninsured Arizonans to purchase Medicaid coverage. Butler "said the Medicaid buy-in option would provide a practical insurance option for residents who don't qualify for subsidized plans through the Affordable Care Act marketplace." Other states, including Nevada and Minnesota, have considered similar plans, but they have faced "an uphill battle." Butler said, "I can't imagine why everyone wouldn't support this. It is solving a problem in a real way."

Opinions: Medicaid Work Requirements Are About Eliminating Coverage For Low-Income People.

With the recent announcement, by the federal Centers for Medicare and Medicaid Services (CMS) of the willingness of CMS to consider the addition of work requirements on Medicaid enrollees, if requested by states through Medicaid waivers (see the article in the National Update section of this edition of Friday Facts, "CMS Issues Guidance Allowing Medicaid Work Requirements") a number of policy centers, advocates, healthcare professionals, and elected officials have expressed concern over this change in longstanding federal support for access to Medicaid. Some of those voices are referenced below:

Judy Solomon, vice president for health policy at the Center on Budget and Policy Priorities, writes for CNN on its website that the Administration's policy to "tie low-income people's eligibility for Medicaid to work" is not aimed at "promoting work." Rather, "It's the first of several expected steps to shrink and weaken the Affordable Care Act's Medicaid expansion that provided coverage for 11 million low-income adults." Solomon argues that "the main impact of work requirements will be to eliminate health coverage for large numbers of low-income people, most of whom gained coverage through the Medicaid expansion – including people who are already working but don't meet state paperwork requirements and those who can't work due to illness or disability."

The Boston Globe reports Massachusetts Governor Charlie Baker (R) "is rejecting the Trump administration's new effort to allow states to force some poor people to work in order to get government-funded Medicaid health insurance." Baker "said he does not back such a move for Massachusetts' Medicaid program, which covers 1.85 million poor and disabled Massachusetts residents and is known as MassHealth."

The Boston Herald reports that Massachusetts Health and Human Services Secretary Marylou Sudders also "said such a requirement has 'not been something we've been pursuing,' and indicated she likely won't seek to add it amid other efforts to reshape the state's Medicaid program, known as MassHealth."

The Connecticut Mirror reports Connecticut does not intend to impose a work requirement on "Medicaid recipients, Gov. Dannel P. Malloy said, even as the Trump administration moved Thursday to allow states to do so." Malloy, a Democrat, stated "Connecticut remains committed to providing Medicaid for all those who qualify, because it's the right thing to do. … The fact remains that the majority of individuals on Medicaid are working people, or those that cannot work, such as seniors and people with disabilities."

CBO cost estimate finds that CHIP saves money

Vox reports the CBO's new estimate that extending CHIP for 10 years would save the federal government $6 billion was issued in a letter to Rep. Frank Pallone (D-NJ). The CBO wrote, "Extending funding for CHIP for 10 years yields net savings to the federal government because the federal costs of the alternatives to providing coverage through CHIP (primarily Medicaid, subsidized coverage in the marketplaces, and employment-based insurance) are larger than the costs of providing coverage through CHIP during that period."

The Washington Examiner reports that the new projections released Thursday found that "a 10-year extension would increase the deficit from 2018 to 2020 but reduce it each year after that through 2027." The Examiner adds, "Lawmakers say it is increasingly likely that CHIP will be addressed in the next continuing resolution to fund the government."

The Washington Examiner, in a separate article, reports that as a result of the CBO score, some congressional Democrats "are pushing for a permanent reauthorization" of CHIP. Sen. Wyden said, "I would like this to be as long as possible," adding that "he hasn't heard of any Democrats that would vote against a much longer or permanent reauthorization," according to the article. Wyden added, "Even I didn't think it would be this eye-popping development where you could have permanent reauthorizations." Sen. Chris Murphy (D-CT) agreed, but said, "It would be smarter to do a permanent deal, but I think we need to be realistic on what we can get done in the next couple of weeks."

As noted in a recent edition of The Hill, House Energy and Commerce Committee Chairman Greg Walden (R-OR) said that "he is aiming to bring a six-year reauthorization of the Children's Health Insurance Program (CHIP) to the floor next week." Walden referred to the new CBO analysis and told reporters, "If we go to six years, it may have no cost. … The

good news is you can do six years and it costs you nothing." Walden added that the bill would probably only include CHIP and would not attach funding for community health centers or Medicare "extenders."

Congressional Quarterly reports that Rep. Fred Upton (R-MI) confirmed that CHIP may be included in a vote on the continuing resolution, saying, "There's a pretty solid group of folks that will not vote for a CR unless CHIP is part of it, and I feel pretty good that it'll be there."

Health Affairs discusses recent CHCS study on the impact of cross-sector initiatives on health status

The expansion of Medicaid coverage through the Affordable Care Act improved coverage for millions of low-income Americans. This population is known to have high rates of substance use disorder, mental illness, criminal justice involvement, and homelessness – which are associated with high emergency department and hospital services use, as well as involvement in other public sectors such as supportive housing.

Interventions aimed at reducing acute health care use among these high-need, high-cost individuals often focus on the integration of social and behavioral support within traditional medical care. Yet, planning and evaluation of integrated care models requires data on cross-sector service use and costs – data that are often difficult to merge across sectors.

A new article, in the January 2018 issue of Health Affairs, explores the results of a novel cross-sector data analysis – including health care, criminal justice, housing, and human services sectors – that looked at service use and costs of Medicaid expansion enrollees in Hennepin County, Minnesota. The article shares key finding from the **full study.** (found at: https://www.chcs.org/resource/cross-sector-service-use-costs-among-medicaid-expansion-enrollees-minnesotas-hennepin-county/?utm_source=CHCS+Email+Updates&utm_campaign=fb82afc53a-EMAIL_CAMPAIGN_2018_01_08&utm_medium=email&utm_term=0_bbced451bf-fb82afc53a-152144421) which was made possible through Center for Health Care Studies' (CHCS) *Complex Care Innovation Lab.* The findings suggest that there are opportunities for cross-sector collaboration that may result in health improvements and cost savings across sectors. Hennepin County's experience may help policymakers and local leaders in developing new and integrated service delivery models for the most vulnerable members of society. The Health Affairs article can be found at:
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0991?utm_source=CHCS+Email+Updates&utm_campaign=fb82afc53a-EMAIL_CAMPAIGN_2018_01_08&utm_medium=email&utm_term=0_bbced451bf-fb82afc53a-152144421&

Michigan Federal announces conference

The Michigan Federation for Children and Families recently announced the Sixth Annual Residential Treatment Conference Transforming Lives Through Innovative Residential Treatment Featuring national and state expertise in the areas of:

- Residential transformation efforts across the U.S.
- Aligning residential practices with desired outcomes
- Incorporating youth-guided family-driven principles of care
- Working through adolescent trauma
- Engaging and supporting families with complex challenges

The conference will be held of Monday, February 26, 2018 at The MTG Space in Lansing, Michigan
Register today to lock in low prices! Group registrations are encouraged: lock in low price now, submit names later. Prices increase after January 31, 2018. Register at:
http://michfed.org/story/registration_open_michigan_federation_children_and_families%C2%A06th_annual_residential_treatment

LEGISLATIVE UPDATE

January Consensus Revenue Estimating Conference

On Thursday, the Consensus Revenue Estimating Conference convened their biannual economic forecasting that state officials use to figure out how much money they have to spend. State economist projected the state's $10 billion General fund probably won't keep up with inflation over the next three years and the School Aid Fund (SAF) – when adjusted for inflation – should remain smaller than it was 10 years ago.

This means, once again, that the Governor and lawmakers shouldn't think about huge tax cuts, a wild spending spree or start hauling out their budget-cutting knives as they embark on the Fiscal Year (FY) 2019 budget-building project.

As a result of the meeting the heads of the Senate Fiscal Agency (SFA), House Fiscal Agency (HFA) and Department of Treasury agreed to reduce its revenue projections for this year's General Fund $100.9 million, but increase its projections for the SAF $114 million for a slender net nudge of $13.1 million.

For the FY19 budget Gov Snyder will propose next month, General Fund projections are down $149.9 million, but SAF is expected to go up $133.5 million for a slight dip of $16.4 million. Meanwhile, next year's 2019 budget will be spending $350 million in new money for Michigan's roads according to the bill passed a couple of years ago, with that moving to $800 million in 2021. Then there's the Personal Property Tax (PPT) elimination, the scheduled increase in the personal exemption as part of the road package and the already-scheduled elimination of the driver responsibility fees – all of this will have a negative impact of general fund revenues in the coming years.

In other news, State Budget Director Al Pscholka acknowledged $280 million in lapsed money from FY 2017, which he wants to add to the $800 million Rainy Day Fund so it can rise to $1 billion. Pscholka also noted that the House and Senate fiscal agencies are projecting $1 billion in lapsed money from 2017, but the Budget Director said about two-thirds of that money is already accounted for.

Opioid Bills Signed into Law

Over the holiday break, Lt. Governor Calley signed the package of bills addressing the opioid epidemic into law.

The package of bills included Senate Bills: 47, 166, 167, 270, 273, & 274 and House Bills; 4403, 4406, 4407, & 4408. The cornerstone bills of the package SBs 166 and 167 would require doctors to check on the Michigan automated prescription system (MAPS) for the history of new patients before prescribing schedule II-V drugs, and provides sanctions if doctors fail to check MAPS. Many believe by using MAPS, doctors will be able to tell if new patients have been getting too many prescriptions for opioids. Critics argued it is another step in the process for doctors treating a patient.

Other bills in the package required a doctor have a bona fide prescriber-patient relationship before a doctor can prescribe drugs, requires the doctor provide treatment service information to patients who have suffered an overdose, requires the consent of parents before minors are prescribed opioids, and a bill that requires education on opioids in schools.

NATIONAL UPDATE

CMS Issues Guidance Allowing Medicaid Work Requirements

On Thursday, the Trump Administration released guidelines for states to create the first-ever work requirements for Medicaid recipients. The guidance targets "able-bodied adults" with some exemptions. While details are still emerging, the National Council has grave concerns that the policy's exemptions will not be broad enough to protect all individuals

with mental health and substance use disorders. Ten states have asked the federal government for approval to institute Medicaid work requirements. With this new guidance, the Administration is expected to begin approving these requests.

Despite numerous attempts, work requirements have never been permitted in Medicaid's 52-year history. However, CMS Administrator Seema Verma recently proclaimed that Trump Administration will approve such proposals. In a letter to State Medicaid Directors, CMS outlined policy guidance for implementing Medicaid work requirements.

The guidance exempts Medicaid enrollees with disabilities, the elderly, pregnant women and children from job requirements. States must also exempt individuals who are considered "medically frail," which includes individuals with mental illness and addiction per a 2013 federal regulation. Specifically, that rule requires states to include people with "disabling mental disorders" and "chronic substance abuse disorders" in their definition of medically frail. The guidance also notes that people with substance use disorders must be afforded "reasonable modifications." These modifications can include counting time spent in treatment towards the work requirements or exempting individuals in participating in intensive addiction treatment from work requirements.

States that choose to pursue work requirements are given a great deal of flexibility from CMS' guidance. States can determine how "able-bodied adults" will be defined and what activities will count as work. The letter says that work activities "include, but are not limited to, community service, caregiving, education, job training, and substance use disorder treatment."

States are encouraged to help Medicaid enrollees successfully complete the work requirement through job training, child care, and other supports, but are prohibited from using Medicaid funds to do so. For enrollees that already have jobs, are in school or are caregivers, they will need to regularly document with the state's Medicaid agency that they are in compliance or risk losing Medicaid benefits.

The National Council opposes making employment a condition for health care coverage as mental health and substance use conditions can result in impairments that preclude individuals from consistent, full-time employment.

With this new guidance, reports indicate that federal officials will quickly act to approve Kentucky and Indiana's proposed work requirements. Any work requirement approval is likely to be challenged in the courts by a number of health care and legal advocacy groups. Other states that have requested work requirements through Medicaid waivers include: Arizona, Arkansas, Kansas, Maine, Mississippi, New Hampshire, Utah and Wisconsin.

CMHAM WINTER CONFERENCE – REGISTRATION OPEN

The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & 7, 2018 at the Radisson Plaza Hotel & Suites, Kalamazoo. The conference will feature 4 powerful keynoted addresses, a wide variety of workshops, as well as a pre-conference institute on Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments.

Keynote Addresses:

Current Efforts toward Behavioral Health and Justice Collaborations for Better Outcomes

- *Debra A. Pinals. MD, Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services*

I Have Been Running my Entire Life – I am Finally Free

- *Dominic Carter, Veterans Newsman, Mental Health Advocate, Author, and Speaker*

What's Hot in Behavioral Health – A National Update

- *Charles Ingoglia – Senior Vice President, Public Policy and Practice Improvement, National Council for Behavioral Healthcare*

The Life, the Game, the Pain and the Transition

- *Adrian Muldrow, Founder, We Can Achieve Youth Advocacy Project*

Pre-Conference Institute:
February 5, 2018 from 1:00pm – 4:00pm
Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments

- *David Michael Mank, Ph.D., Professor Emeritus, Indiana University*

For a detailed conference brochure, click here: https://macmhb.org/education

To Register for the Full Conference, click here: https://goo.gl/ATd6pb

To Register for the Pre-Conference Institute, click here: https://goo.gl/3UeQDc

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

WEBINAR: BUSINESS OR EXPLOITATION?" EXPOSURE OF THE TOBACCO INDUSTRY'S EXPLOITATION OF INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

The Smoking Cessation Leadership Center (SCLC) is excited to be hosting our **75th webinar** with our partners, the National Behavioral Health Network for Tobacco and Cancer Control (NBHN), and the Truth Initiative®. We invite you to register for this **One-Hour Power Break** webinar: "***Business or Exploitation?" Exposure of the tobacco industry's exploitation of individuals with mental health conditions*** on **Thursday, January 18, 2018, at 1:00pm EST** (60 minutes).

We are honored to have the following speakers presenting on this topic for us:

- **Margaret Jaco Manecke, MSSW**, Project Manager, Practice Improvement, National Council for Behavioral Health
- **Ashley Persie,** Senior Brand Marketing Associate, Truth Initiative®
- **Judith (Jodi) Prochaska, PhD, MPH,** Associate Professor of Medicine, Stanford University

Webinar Objectives:

1. Explain why people with mental health conditions (depression and ADHD, for example) and substance use disorders have been historically targeted by the tobacco industry.
2. State whether adults with mental health conditions and substance use disorder smoke more than adults without those conditions.
3. Describe the morbidity rates of people with mental health conditions and name specific causes of death that can be attributed to tobacco use.
4. Explain the impact of the **truth®** campaign among its target audience.
5. Describe evidence-based approaches for treating tobacco use and tobacco addiction in persons with co-occurring mental illness.
6. Describe how you can leverage the National Behavioral Health Network for Tobacco & Cancer Control's tool, resources, and network to combat tobacco use & cancer disparities among individuals with mental illnesses and addictions and network members.

REGISTER HERE: https://cc.readytalk.com/r/eyjfkcfgqogs&eom

CME/CEUs will be available for participants who join the **LIVE** session, on **January 18, 2018.** You will receive instructions on how to claim credit via the post webinar email.

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Have a Great Weekend!