LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD

VISION

"We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life."

AGENDA
October 22, 2015

705 N. Zeeb Road, Ann Arbor
Patrick Barrie Conference Room
9:30 a.m. – 11:30 a.m.

1. Introductions & Welcome – 5 minutes

2. Approval Of Agenda (Board Action) – 2 minutes

3. Approval of October OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business
   a. CMHPSM Regional SUD Financial Report (Discussion) {Att. #2, 2a-e} – 15 minutes
   b. OPB Membership Attendance (Discussion) 10 minutes
   c. OPB Officer Elections (Board Action) – 15 minutes

6. New Business
   a. Prevention Program Briefs (Discussion) {Att. #3} 10 minutes
   b. Washtenaw Communities that Care Contract (Discussion) {Att. #4} – 10 minutes
   c. ROSC Concept Paper Draft (Discussion) {Att. #5} – 20 minutes

7. Report From Regional Board (Discussion) – 5 minutes

8. SUD Director Updates (Discussion) – 10 minutes

   a. Engagement Centers updates
   b. Vivitrol
   c. PIHP Changes
   d. State Updates

Next meeting: Thursday, January 28, 2016
9:30 a.m. – 11:30 a.m.

Parking Lot:
OPB Bylaws
Strategic Planning Retreat

Attachment #1 – December 2015

LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
Summary of October 22, 2015 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present:	David Oblak, Tom Waldecker, Charles Coleman, Kim Comerzan, Sheila Little, Mark Cochran, Dianne McCormick
Members Absent:	Ralph Tillotson, Cheryl Davis, Dave DeLano, Smith, Amy Fullerton, William Green, Laura Rodriguez, Cletus Smith
Guests:	Elijah Wheeler
Staff Present:	Stephannie Weary, Marci Scalera, Marie Irwin, Anne Marshall, Jane Goerge, Katie Postmus, Kristen Ora

OPB Chair D. Oblak called the meeting to order at 9:44 a.m.

1. Introductions

2. Approval of the agenda

   No quorum was present, so no vote was taken to approve the agenda.

3. Approval of September minutes

   No quorum was present, so no vote was taken to approve the minutes.

4. Audience Participation
   - None

5. Old Business
   a. CMHPSM Regional SUD Financial Report
   - M. Irwin presented the report.
   - The trends that we have been seeing are continuing.
   - We received notice that we'll be getting 27K more in Medicaid funding.
   - At the December meet M. Irwin will bring a draft FY 15 year-end report. It won't be finalized until February, after the financial audits.

6. New Business
   a. OPB Officer Elections
      - No quorum was present, so elections did not take place.

   b. RFI, RFP Treatment Services Timeline
      - M. Scalera presented the timeline.
      - M. Scalera proposed a workgroup to draft a concept paper within the next month. The time-limited workgroup that would include staff and board members in some capacity.

- The concept paper would be released for comment, and then be used to write the RFP.
- D. McCormick suggested asking for input and participation from the current provider models that are already out there.
- Per M. Scalera, there are currently gaps in the ROSC model and the challenge will be to determine where our core providers are currently.
- The timeline will include: concept paper, RFI, pilot in Monroe, RFP.
- K. Comerzan would only want to see Monroe do the pilot if all the elements are nailed down and concrete.
- A draft concept paper will be presented at the Dec. 10 OPB meeting.

c. Process for ensuring a quorum
- S. Weary will ask for RSVPs in the packet email. By Monday the week of the meeting, she will contact those who haven't responded, and then advise D. Oblak and M. Scalera of all responses.
- T. Waldecker suggested revising the bylaws to allow attendees by phone to count toward the quorum.
- Board members who are not in compliance with the attendance requirements of the bylaws will need to be contacted.

7. Report from Regional Board
- The new CEO contract was approved. She will start on Dec. 7th.
- The WCHO has dissolved.
- CMH services in Washtenaw reverted to the county: Washtenaw County Community Mental Health. Because their status is provisional as a CMH, the PIHP's contract with them is a 3-month provisional contract.
- In Washtenaw, the mental health board is advisory to the Board of Commissioners.

8. SUD Director Updates

a. Unite to face addition CARA information
- M. Scalera reported on the National Event that occurred in Washington DC. The CARA act proposes changes to funding and services for addictions nationally.

b. State Updates
- Naloxone is ready to go.
- Efforts are underway to redesign what MASACA is. The entity was turned over to the PIHP directors. But now l the consideration is what it can look like as a 503c, and what it can do for the 10 PIHPs.

9. Meeting adjournment

Adjourned at 11:00 a.m.

Community Mental Health Partnership of Southeast Michigan

SUD Financial Highlights

September Preliminary FYTD Report

Statement of Revenues and Expenses

1. Revenue

- Medicaid revenue for the Region for SUD services was ($55,389) less that what was budgeted for FY2015. A TANF adjustment for the 1st and 2nd quarters of FY2015 was received in October and is included in the year to date revenue figure.
- Healthy Michigan revenue was $1,251,655 higher than the year to date budget for September.
- PA2 dollars received for FY2015 were ($292,348) less than what was budgeted for the year. The reduction was anticipated based on communication received earlier in the year. Revenue received was higher than expenses for the year and the balance will be carried forward.

2. Funding For SUD Services

- Lenawee and Livingston Counties have reported projected lapses. This is a combination of treatment and prevention funding.
- Monroe and Washtenaw fee for service claims were higher than what was budgeted in FY2015. The budget for FY2016 was adjusted to more accurately forecast the need for services in these two counties.

Summary of Revenue and Expense by Fund

- Preliminary reporting indicates there will be excess funding for all funding sources. SUD Block Grant funds cannot be carried forward and will be lapsed.
- Utilization is based on preliminary encounter data and it is anticipated there will be changes in the allocation by fund source when final encounters are submitted in late November.
- Final numbers will not be reported until all audits are completed in the second quarter of FY2016.

Attachment #2a - December 2015

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
Preliminary September 2015 FYTD

Summary Of Revenue & Expense	Funding Source						Total Funding Sources
	Medicaid	MIChild	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	
Revenues							
Funding From MDCH	$ 1,444,611	$ 14,031	$ 4,212,097	$ 3,724,460		$ -	$ 9,395,199
PA2/COBO Tax Funding	$ -	$ -	$ -	$ -	$ 3,424,998	$ -	$ 3,424,998
Other	$ -	$ -	$ -	$ -	$ -	$ 6,974	$ 6,974
Total Revenues	$ 1,444,611	$ 14,031	$ 4,212,097	$ 3,724,460	$ 3,424,998	$ 6,974	$ 12,827,171
Expenses							
Funding for County SUD Programs							
Lenawee	$ 115,743	$ -	$ 216,695	$ 527,060	$ 60,189	$ -	$ 919,687
Livingston	$ 188,075	$ 3,219	$ 267,276	$ 581,346	$ 105,137	$ -	$ 1,145,053
Monroe	$ 142,232	$ -	$ 294,663	$ 268,212	$ 628,275	$ -	$ 1,333,382
Washtenaw	$ 695,593	$ -	$ 1,252,231	$ 1,080,565	$ 852,798	$ -	$ 3,881,187
Total SUD Expenses	$ 1,141,643	$ 3,219	$ 2,030,865	$ 2,457,183	$ 1,646,399	$ -	$ 7,279,309
Other Operating Costs							
SUD Use Tax	$ 86,388	$ 839	$ 251,883	$ -	$ -	$ -	$ 339,110
SUD HICA Claims Tax	$ 10,835	$ 105	$ 31,591	$ -	$ -	$ -	$ 42,531
Total Operating Costs	$ 97,223	$ 945	$ 283,474	$ -	$ -	$ -	$ 381,641
Administrative Cost Allocation	$ 84,189	$ 248	$ 149,007	$ 270,022	$ -	$ -	$ 503,466
Total Expenses	$ 1,323,055	$ 4,413	$ 2,463,346	$ 2,727,205	$ 1,646,399	$ -	$ 8,164,416
Revenues Over/(Under) Expenses	$ 121,556	$ 9,618	$ 1,748,751	$ 997,255	$ 1,778,599	$ 6,974	$ 4,662,755

Attachment #2b - December 2015

Community Mental Health Partnership of Southeast Michigan
STATEMENT OF REVENUES, EXPENSES CHANGES IN NET POSITION
For the Twelve Months Ending 9/30/2015

PRELIMINARY

	Original Budget	YTD Actual	YTD Budget	YTD Actual O/(U) Budget	
Operating Revenue					
Medicaid Capitation	$1,500,000	$1,444,611	$1,500,000	$(55,389)	1a.
Healthy Michigan Plan	2,960,442	4,212,097	2,960,442	1,251,655	
MIChild	0	14,031	0	14,031	
SUD Community Grant	3,767,460	3,724,460	3,767,460	(43,000)	
SUD PA2 - Cobo Tax Revenue	3,717,346	3,424,998	3,717,346	(292,348)	1b.
Total Operating Revenue	**$11,945,248**	**$12,820,197**	**$11,945,248**	**$874,949**	
Funding For SUD Services					
Lenawee County	$1,022,761	$919,687	$1,022,761	$(103,074)	
Livingston County	1,309,226	1,145,053	1,309,226	(164,173)	
Monroe County	1,143,346	1,333,382	1,143,346	190,036	
Washtenaw County	3,203,188	3,881,187	3,203,188	677,999	
Total Funding For SUD Service	**$6,678,521**	**$7,279,309**	**$6,678,521**	**$600,788**	1c.
Other Contractual Obligations					
USE and HICA Tax	300,188	381,641	300,188	81,453	
Total Other Costs	**$300,188**	**$381,641**	**$300,188**	**$81,453**	
CMHPSM Administrative Costs					
Salary& Fringe	$410,758	$376,080	$402,631	$(26,551)	
Administrative Contracts	67,589	75,875	88,899	(13,024)	
All Other Costs	44,344	51,511	129,309	(77,798)	
Total Administrative Expense	**$522,691**	**$503,466**	**$620,839**	**$(117,373)**	1d.
Total Operating Expense	**$7,501,400**	**$8,164,416**	**$7,599,548**	**$564,868**	
Operating Income (Loss)	$4,443,848	$4,655,781	$4,345,700	$310,081	
Non-Operating Revenues					
Interest Revenue	$0	$6,974	$0	$6,974	1e.
Change In Net Position	$4,443,848	$4,662,755	$4,345,700	$317,055	

1a. The Medicaid Revenue line includes yearend accruals and a TANF adjustment was received for the first two quarters.
1b. PA2 dollars were less than what was originally budgeted. There will be surplus rolled forward into FY2016.
1c. Monroe and Washtenaw fee for services were higher than what was budget for FY2015. Lenawee and Livingston are lapsing treatment and prevention dollars.
1d. Administration expenses were incurred below the amended budget.
1e. Operating income of $12,820,197 and non-operating income(interest) of $6,974 tie to the total revenue amount of $12,827,171 on the Summary of Revenue and Expense by Fund report.

Community Mental Health Partnership of Southeast Michigan

SUD Financial Highlights

October FYTD Report

Statement of Revenues and Expenses

1. Revenue

   - Medicaid revenue for the Region for SUD services is $1,781 more than what was budgeted for October.
   - Healthy Michigan revenue is ($42,833) less than the budget for October. The rates established by MDHSS for FY2016 are lower than the rates used for the initial budget. We anticipate having sufficient carry forward from FY2015 to bridge the gap.
   - There was a slight reduction in Community Grant funding for FY2016.
   - PA2 funding for FY2016 is a mixture of current year revenue and carryforward. The revenue being recorded is only current year revenue at this time.

2. Funding For SUD Services

   - All four counties are currently running under budget. Many of the new programs awarded in FY2016 have not been fully implemented at this time.

Summary of Revenue and Expense by Fund

- We are currently showing sufficient revenue for all funding sources. There have not been any adjustments made for utilization at this time.

Attachment #2d - December 2015

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
October 2015 FYTD

Summary Of Revenue & Expense	Funding Source						Total Funding Sources
	Medicaid	MIChild	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	
Revenues							
Funding From MDCH	$ 123,723	$ 1,052	$ 235,042	$ 307,838		$ -	$ 667,655
PA2/COBO Tax Funding	$ -	$ -	$ -	$ -	$ 149,217	$ -	$ 149,217
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Revenues	$ 123,723	$ 1,052	$ 235,042	$ 307,838	$ 149,217	$ -	$ 816,872
Expenses							
Funding for County SUD Programs							
Lenawee	$ 15,391	$ -	$ 28,963	$ 31,515	$ -	$ -	$ 75,869
Livingston	$ 15,380	$ -	$ 28,943	$ 53,960	$ -	$ -	$ 98,283
Monroe	$ 7,161	$ -	$ 9,801	$ 25,582	$ 6,112	$ -	$ 48,656
Washtenaw	$ 36,071	$ -	$ 79,410	$ 70,007	$ 45,975	$ -	$ 231,463
Total SUD Expenses	$ 74,003	$ -	$ 147,117	$ 181,064	$ 52,087	$ -	$ 454,271
Other Operating Costs							
SUD Use Tax	$ 7,399	$ 62	$ 14,056	$ -	$ -	$ -	$ 21,517
SUD HICA Claims Tax	$ 928	$ 8	$ 1,763	$ -	$ -	$ -	$ 2,699
Total Operating Costs	$ 8,327	$ 70	$ 15,819	$ -	$ -	$ -	$ 24,216
Administrative Cost Allocation	$ 6,696	$ -	$ 13,313	$ 23,138	$ -	$ -	$ 43,147
Total Expenses	$ 89,026	$ 70	$ 176,248	$ 204,202	$ 52,087	$ -	$ 521,633
Revenues Over/(Under) Expenses	$ 34,697	$ 982	$ 58,794	$ 103,636	$ 97,130	$ -	$ 295,239

Community Mental Health Partnership of Southeast Michigan
STATEMENT OF REVENUES, EXPENSES CHANGES IN NET POSITION
For the One Month Ending 10/31/2015

	Original Budget	YTD Actual	YTD Budget	YTD Actual O/(U) Budget	
Operating Revenue					
Medicaid Capitation	$1,463,301	$123,723	$121,942	$1,781	
Healthy Michigan Plan	3,334,500	235,042	277,875	(42,833)	
MIChild	0	1,052	0	1,052	
SUD Community Grant	3,767,460	307,838	313,955	(6,117)	
SUD PA2 - Cobo Tax Revenue	2,105,798	149,217	175,483	(26,266)	
Total Operating Revenue	**$10,671,059**	**$816,872**	**$889,255**	**$(72,383)**	1a.
Funding For SUD Services					
Lenawee County	$1,278,823	$75,869	$106,569	($30,700)	
Livingston County	1,614,420	98,283	134,535	(36,252)	
Monroe County	1,506,177	48,656	125,515	(76,859)	
Washtenaw County	4,026,893	231,463	335,574	(104,111)	
Total Funding For SUD Servic	**$8,426,313**	**$454,271**	**$702,193**	**$(247,922)**	1b.
Other Contractual Obligations					
USE and HICA Tax	322,891	24,216	26,908	(2,692)	
Total Other Costs	**$322,891**	**$24,216**	**$26,908**	**$(2,692)**	
CMHPSM Administrative Costs					
Salary& Fringe	$433,670	$33,782	$36,139	($2,357)	
Administrative Contracts	82,064	5,399	6,839	(1,440)	
All Other Costs	64,482	3,965	11,901	(7,936)	
Total Administrative Expense	**$580,216**	**$43,146**	**$54,879**	**$(11,733)**	1c.
Total Operating Expense	**$9,329,420**	**$521,633**	**$783,980**	**$(262,347)**	
Operating Income (Loss)	$1,341,639	$295,239	$105,275	$189,964	
Non-Operating Revenues					
Interest Revenue	$0	$0	$0	$0	
Change In Net Position	$1,341,639	$295,239	$105,275	$189,964	

1a. Healthy Michigan paid rates are lower than what was projected for budget. There was a slight reduction in the State Community Grant allocation.

1b. There were many new programs awarded in FY2016 and they have not achieved full implementation at this point in time.

1c. Administrative expense are being incurred under budget.

Lenawee
Livingston
Monroe
Washtenaw

SUBSTANCE ABUSE PREVENTION SERVICES

PROGRAM BRIEFS

As the Community Mental Health Partnership of Southeast Michigan (CMHPSM) continues to emphasize the use of an effective, data-driven, outcome-based approach to substance abuse prevention, various methods are utilized to promote the applicability of this system. For instance, as part of the overall reporting process, prevention providers develop year-end ***Program Briefs*** to:

- Highlight program results and spotlight specific interventions/initiatives.
- Share program information in a creative and informative way.
- Educate and inform decision-making bodies and others about prevention efforts in the CMHPSM region.
- Promote the effectiveness of substance abuse prevention.
- Utilize a reporting mechanism that is beneficial to both the agency and the CMHPSM.

While the CMHPSM provides a 'checklist' for potential inclusions, agencies are free to select the means for demonstrating program results (i.e., graphs, charts, anecdotal statements, trends, etc.). CMHPSM began using this informational sharing method at the end of 2013-2014 fiscal year and plans to gauge the usefulness of this approach.

For more information, visit the CMHPSM website at www.cmhpsm.org/sudprevention.

Attachment #4 – December, 2015

Oversight Policy Board – Contract Change Notice

Board Meeting Date: December 10, 2015

Background: Due to staffing changes at Karen Bergbower and Associates, the agency is no longer able to fulfill the Communities That Care (CTC) program in Washtenaw County, for which it was awarded $50,000 in SUD prevention funds for FY16. Karen Bergbower and Associates will have their FY16 contract amended to remove all remaining CTC funding.

Eastern Michigan University has the capacity, willingness, and experience with the CTC program, and the CMHPSM SUD Prevention Team has recommended that EMU assume the contract and programing responsibilities of CTC for the remainder of FY16. Not only will this contract with EMU maintain the community momentum and progress garnered by the CTC program, but it also provides CMHPSM the opportunity to partner with EMU, which is a pillar in the Ypsilanti community, to cultivate future prevention programming opportunities.

EMU is requesting $57,433.00 to assume the CTC contract; the additional funding will be managed within the SUD Prevention budget. The additional funding includes expanded outcomes for the contract. The proposed contract term with Eastern Michigan University will be 12/1/2015 – 9/30/2016.

Action required by Oversight Policy Board

No action required of the OPB. The proposed funding allocation change will go to the Regional Board for approval on 12/9/15.

Concepts for Recovery Oriented Systems of Care for Lenawee, Livingston, Monroe, and Washtenaw Counties

Themes

1. Core Provider Model with consistency across the region
2. Recovery focused
3. Non-traditional treatment in non-traditional settings
4. Integration with mental health and primary care
5. Services to support pre and post engagement
6. Co-occurring services including psychiatry to support MH needs for mild to moderate population
7. Improved adolescent services
8. Community integration and participation
   a. Initiatives in the community such as human services collaborative coalitions
   b. Prevention integration
9. More delegated administrative functions:
   a. Access to care - screening and assessment that works within a no wrong door format
   b. Utilization management - ensuring right amount of care in the right setting
   c. Monitoring of finances and expenditures - IBNR, data, cost containment, risk assessment, rate setting
   d. Quality assurance through outcome indicators
   e. Contracting capabilities
   f. Claims Processing
   g. Data management and infrastructure

Concepts for Recovery Oriented Systems of Care for Lenawee, Livingston, Monroe, and Washtenaw Counties

Fiscal Year 2016

I. INTRODUCTION:

In 2009, the Washtenaw Community Health Organization embarked upon a transformational change that launched the existing Substance Use Disorders Treatment system of care into a new way of providing for and funding treatment services, with the goal to "embrace the philosophy that individuals (adolescents and adults) with substance use/addiction disorders can recover". The initiative focused on the primary principles and elements of recovery and wellness while ensuring that the individual is offered a level of service that is based on his or her readiness for change. This system moved services from an acute care model to one in which sustained engagement to address the chronic nature of substance use disorders. Community input was obtained, in order to best design the system of care in each local county that could accomplish the goals of ROSC in a way that worked best for their unique communities. The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is now interested in continuing to improve the service delivery system to incorporate significant changes that have occurred locally, statewide and nationally since this ROSC system transformation was implemented. The CMHPSM seeks to expand and refine the original vision of the Recovery Oriented System of Care in order to meet these new challenges and ensure the individuals seeking services receive the best possible outcomes.

II. VISION:

The Community Mental Health Partnership of Southeast Michigan envisions the service delivery system for the four county region will embrace a recovery focused infrastructure that addresses the complete

continuum of care for all individuals seeking services. The provision of care will incorporate cross system mechanisms that bridge mental health and physical health needs to ensure a holistic approach to care.

The CMHPSM considers readiness for change to be a key factor in designing the range of activities and or services (i.e. peer involvement, community groups, didactic/educational groups) that are available to individuals. Traditional treatment availability is the mainstay of the expected services that can be provided across the region. However, many individuals would benefit from something other than traditional treatment. The availability of community-based supports may be more effective in facilitating movement along their recovery path. Additionally, changes in benefits available offer new challenges and opportunities to the system of care. Providers must consider alternative settings, new and innovative treatments that include medication assisted treatment; screening, brief intervention, and brief treatment; prevention and early intervention modalities; integration with primary care and mental health services. As noted in the original concept for ROSC transformation, the following still holds true. *"Individuals with substance use/addictive disorders, who require more supports, may benefit from treatment services designed to maximize their current stage of readiness. For some, traditional treatment (i.e. Outpatient, Intensive Outpatient, Residential etc.) might be an appropriate step in recovery. However, an array of recovery support services should include pre and post engagement supports. This is necessary to address the chronic nature of substance use/addictive disorders and the importance of developing lasting relationships within the recovery community, as well as, maintaining consistent connections to caring individuals."*

Collaboration within the community is also a hallmark of ROSC. Available human services and resources within ones "healthy" community can serve to support an individual's path toward self-sustainable living situations. This would include supported recovery housing opportunities, employment, education, community and recreational activities. A ROSC provider should be involved in activities that shape the communities in which the individuals being served reside in. Assisting these individuals in engaging in their communities builds strength and supports hope, which lays a foundation for future reinvestment and "giving back".

An the future in healthcare moves toward an increased shift to value-based services (in which reimbursement is tied to effective outcomes) rather than volume-based services (in which payment is tied to the delivery of service units), the CMHPSM should look for providers to develop the capacity, technology, and ability to measure and report outcomes that demonstrate quality and effectiveness.

Additionally, in a system where providers take on increasing delegated functions, there must be greater attention to provider accountability.

III. CORE PROVIDER:

Ideally, the CMHPSM will continue to fund services through a *CORE PROVIDER* model. A CORE provider is defined as, "a provider that will provide, or arrange for the provision of the **entire** array of services -- the Pre-recovery/ Post-engagement continuum." The concept of the "core provider" role is to ensure a comprehensive delivery system either through the direct provision of, or a contracted arrangement for, services to individuals who are assessed as having a substance use or co-occurring disorder. The core provider will be responsible for the management of various delegated functions, such as access to quality care from assessment through placement and discharge; utilization management; fiscal management; monitoring of services; coordination of care; etc.

The extent to which the PIHP will delegate functions will be the subject of this concept paper, as the capacity to perform the functions may not be adequate at this time, warranting a development phase to prepare a core provider network in acquisition of technological skills, capabilities and infrastructure.

Currently, the core provider is responsible for the system of care within their defined population range, regardless of funding stream and age of individual seeking services. The core provider must abide by all regulatory and statutory requirements and uphold standards of care through licensing and accreditation. Staff providing services must have the appropriate training and credentials to carry out the service delivery. The core provider must have adequate infrastructure and capacity for both administrative and clinical functions.

The CMHPSM, under contract with the Michigan Department of Health and Human Services, is committed to serve residents better by providing services that are integrated and coordinated. To ensure that community collaboration and a high level of service delivery is given to clients, all contracted providers should have these elements:

- Person-Centered
- Services proportional to the level of readiness of change of the individual
- Continuity of care
- Strength-based

- Mechanisms for sustained engagement
- Commitment to peer recovery support services
- Integrated Services
- Workforce Training and Education to support retention
- Ongoing Monitoring of outcomes to ensure maximum impact and resource utilization

IV. SERVICE ARRAY:

The CMHPSM believes that offering a full range of services is a vital part of ROSC. Some examples of the services that make the ROSC effective are:

- **Co-Occurring Services:** Services for Individuals who have an established diagnosis in one domain and exhibits signs or symptoms of an evolving disorder in the other; and/or Individuals who display one or both of their substance-related or mental disorders may have acute signs and/or symptoms of a co-occurring condition who present for services. Providers need to have the clinical and resource capacity to serve this population in the most efficient/expeditious manner, ideally through clinical staff who have the training and capacity to manage the client's needs simultaneously, as well as psychiatric support/oversight. Provider must ensure that any clients with dual-need receive appropriate ongoing psychiatric and mental health services. Providers will need to demonstrate how they determine whether they have the capacity to serve the co-occurring client and whether they have enough psychiatric time and clinician resources to address the mental health needs of the individuals served.
- **Collaboration:** a more formal process of sharing responsibility for treating a person with SUD or COD service needs in different settings, involving regular and planned communication, sharing of progress reports through case coordination. This would require entry into a qualified service agreement or memorandum of understanding that defines the operational efforts in coordinating care. Additional protections under confidentiality laws shall apply and appropriate releases must be obtained.
- **Recovery Coaching:** Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent

relapse and promote recovery. Peer services may be paid or volunteer. Employed peers must have adequate training and certification to meet reimbursement criteria.

- **Peer Supports:** Individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another in a treatment setting. Both peers and recovery coaches should work collaboratively and in conjunction with professional staff in the delivery of comprehensive services.
- **Community and Recovery Groups:** Services provided by other community agencies and or volunteer groups such as AA, NA, DRA that may be more applicable for addressing the individual's recovery. Providers must offer connections to these groups for persons in services.
- **Women's Specialty Programs:** SUD treatment services that are gender specific with connections to primary medical care for women including 1) referral for prenatal care, and while women are receiving such services, child care; 2) primary pediatric care, including immunization for children; 3) gender specific substance abuse treatment and other therapeutic interventions for women which address issues of relationships, sexual/physical abuse and parenting and child care while women are receiving these services; 4) therapeutic intervention for children in custody of women in treatment which may address their developmental needs, issues of sexual and physical abuse and neglect and; 5) sufficient case management and transportation to ensure that women and their children have access to services listed above.
- **Residential Services (Short/Long Term)**
  - **Short Term:** professionally supervised alcohol and/or drug treatment services, non-medical, non-acute program that includes planned individual and/or group therapeutic and rehabilitative counseling, didactics, peer therapy and rehabilitative care provided in a residential setting including an overnight stay. Short-term residential is less than 30 days.
  - **Long Term:** alcohol and/or drug treatment services that include planned individual and/or group therapeutic and rehabilitative counseling and didactics that are provided as an intense, organized daily treatment regime in a residential setting which includes an overnight stay. These programs have trained treatment staff that is supervised by a professional responsible for the overall quality of clinical care. Long-term residential is 30 days or more in a non-hospital residential treatment program.

- **Outpatient – Individual, Family and Group:** Therapy using accepted individual and group treatment modalities focusing on recovery based issues that include but not limited to Didactics, Gender specific and Co-occurring issues. Providers utilize various evidence based practices to assist individuals with treatment needs.
- **Medication Assisted Treatment:** As we have seen locally, statewide and nationally, the opioid/heroin addiction, dependency and overdose death rates has risen to epidemic proportions. To increase client choice and availability of treatment options, the CMHPSM is committed to funding the cost of buprenorphine/naloxone (Suboxone®) or Vivitrol® medication as adjunct therapy for opioid addiction treatment services. Opioid Treatment Programs (OTP's) must conform to the Federal opioid treatment standards set forth under 42 C.F.R. Part 8, including off-site dosing.

  The CMHPSM believes that Medication Assisted Treatment is a necessary service that should be offered to clients seeking services within ROSC. Partnership with primary care in the delivery of comprehensive treatment services for persons prescribed MAT will be an expected role for the provider network.

- **Outreach:** Services that occur in the community where individuals who need assistance may be located. This can include home based, shelter based, street, jail, church or a number of other settings that the provider can engage with the individual of need. The goal of outreach is to meet the client where they are "at", literally. Often outreach services are paired/performed by case managers or peers.
- **Case Management:** Services provided to link individuals to, or to assist and support clients in gaining access to or developing their skills for accessing/obtaining needed medical, social, educational and other services essential to meeting basic human needs, as appropriate; to train the individual in the use of basic community services; and to monitor treatment progress and overall service delivery.

- **Integration with Faith-Based community:** According to 45 CFR part 96, which applies to both prevention and treatment providers/programs, faith-based organizations are eligible to participate as providers. This will create a level playing field with regard to participation in the PIHP provider panel. Regardless of service provider, enabling the individual to access spiritual services is encouraged. Partnering with the faith based organizations in the community are encouraged. In

the event the faith based provider is also the service provider, the agency must uphold the charitable choice requirement to provide notice of choice.

- **Primary Care Coordination:**

The CMHPSM believes that for a complete continuum of care under ROSC, that primary care coordination with substance use disorder treatment services are crucial to the overall health of the individual. The CMHPSM will work to ensure that our providers maintain a consistent level of coordination with primary care providers. It should be noted that "care coordination agreements or joint referral agreements by themselves are not sufficient enough to show that all appropriate steps have been taken to optimize client outcomes. Core providers will need to be able to show how coordination of care has been achieved through evidence of client case file documentation. Additional service coordination, such as co-location of clinical services, case consultation, and creative partnerships are encouraged.

The CMHPSM recognizes that limitations in funding OR service capacity may impede the creation and array of services that an agency may be able to offer. However, it is our belief that systems can be and are in place that utilizes collaboration of agencies to provide a larger array of services for clients. This in turn will increase engagement of clients and families, increase retention rates, and reduce clients cycling in and out of treatment services.

V. ADMINISTRATIVE FUNCTIONS:

- **Requirements of Licensure:**

According to the MDHHS PIHP 2016 Contract: "The PIHP shall enter into agreements for substance use disorder prevention, treatment, and recovery services only with providers appropriately licensed for the service provided as required by Section 6234 of P.A. 501 of 2012, as amended. The CMHPSM will work to ensure that all providers are appropriately licensed. A core provider must only contract with service providers who meet these standards.

- **Accreditation of Subcontractors:**

According to the MDHHS PIHP 2016 Contract: "The PIHP shall enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the

American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The PIHP must determine compliance through review of original correspondence from accreditation bodies to providers.

Accreditation is not needed in order to provide access management (AMS) services which is a function of the core provider. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

The overall goal of the CMHPSM is to ensure that contracted providers have the required credentials to practice and provide services to clients within the ROSC environment.

- **Credentialing Responsibility:**

  To maintain a high level of service to our clients, the CMHPSM must ensure that all providers maintain the correct licensure and credentialing for their own staff appropriately. The MDHHS PIHP Contract (2016) affirms that "primary responsibility for assurance that staff qualification requirements are met rests with the individual and the provider agency that directly employs or contracts with the individual to provide prevention or treatment services."

  To ensure that these obligations have been met, the CMHPSM will be responsible for monitoring the provider agency performance to ensure that the above obligations have been met.

- **Prevention Integration/Coordination:**

  The CMHPSM also believes that integration and participation between treatment and prevention service providers is an integral component to developing a successful ROSC network and continuum of care. Community involvement from core providers and prevention providers is needed; examples of such functions being community coalition meetings, collaborative events, and prevention events such as prescription take-back days.

  Core Treatment Providers and Prevention providers should inform each other on changing trends in the client population, treatment modalities, etc. Data sharing is also a vital component of the unified philosophy in the ROSC which will also inform practice and assess community needs.

Connection of resources and referrals between Core Treatment Providers and Prevention Providers is also imperative to ensure the continuity of care and a "warm hand-off" for the consumer.

- **Quality Improvement & Outcomes:**

  To maintain a successful ROSC in the four-county region, service providers must be able to continuously evaluate and improve services and identify strengths and weaknesses within their system. The CMHPSM will have a standard metric to use (qualitative and quantitative) to evaluate and measure both client outcomes and program outcomes. The PIHP will review and measure the outcomes of the provider agencies and their progress towards a complete ROSC.

- **Electronic Health Record and Information Technology:**
  Providers must meet all requirements related to health information technologies and protected health information standards.
- **Access to Care, Screening and Assessment:**

  Core providers will be performing access services in which screening, assessment and eligibility determinations for level of care is managed. Under full delegation of these services, utilization management and continued stay reviews and authorizations are performed. Use of standardized assessment tools and protocols will be necessary to provide regional consistency in level of care placement determinations. Staff making these determinations must have the clinical capacity through training and experience and appropriate qualifications or certifications.

VI. FUNDING MECHANISMS:

Funding for the regional SUD Service delivery system must be aligned with financing principles established by the state and federal regulations and laws. The CMHPSM receives Medicaid, Healthy Michigan and Community Grant funds for treatment services. Rates must be consistent across funding streams and services, and must be determined through utilization and demonstrated rate to cost ratios.

Funding core providers may be on an allocation basis with performance expectations established; fee for services with defined rates; case rate basis that bundles a series of services into a monthly

rate, or finally, a staffing grant, assuring that staffing is provided to perform a service or set of services across a period of time, usually annually.

Funding initiatives covered by local resources, PA2 liquor tax dollars, are flexible and allocated through the Oversight Policy Board. These funds can supplement treatment and prevention initiatives, but typically are used for innovative programming not allowable by traditional means. The CMHPSM is committed to utilizing state and federal funds for all services covered under the allowable benefit and designations, thereby reserving the PA2 funds for supplemental programming and risk management where necessary.

VII. SYSTEM CHANGES AND OPPORTUNITIES:

The following table represents opportunities to review the current ROSC system and discuss potential changes for the future. Change is necessary to align the region, ensure the elements discussed above are implemented in a timely and value added fashion. Moving toward better integration of services across disciplines and systems of care requires a transformational approach. As in the original transformation from traditional treatment and prevention services to the ROSC concept in 2009, the process must include input from various stakeholders – internal and external, in order to obtain differing perspectives on impact and feasibility.

CMHPSM CURRENT SYSTEM	CMHPSM FUTURE SYSTEM (with alternatives)	OPERATIONAL DIFFERENCES AND ASSUMPTIONS
Contracts: Core Providers are used in Washtenaw, Livingston and Lenawee Counties. Fee for services contracted directly with providers in Monroe	**Choice A:** Contracts will be with ONE Core Provider for each county **Choice B:** Contracts will be central to the CMHPSM	**A:** Core provider will perform delegated functions of access and contract with SUD provider network for services **B:** CMHPSM will contract with providers and can integrate ACCESS SERVICES with CMHSP's
ACCESS: Services are handled differently in each county: **Lenawee** – CMH is the core provider, Access provides screening and authorization for fee for services. May be in or outside the county. **Livingston –** CMH is the core provider, Access provides screening and authorization for services…some services are case rate, some are fee for service. May be in or outside the county. **Monroe –** CMHPSM hires Access Staff and co-locates within Monroe CMH Access; Authorization for all Services go through CMHPSM staff. Contracts can be in and outside the county. **Washtenaw –** Two core providers, access screening is delegated for services provided by each core provider. CMHPSM Contracts with external providers which may be located within or outside the county. Core provider will screen on behalf of the CMHPSM for services at external providers. Coordination is essential but sometimes difficult to manage	**ACCESS: Goal is for consistency across the region** **Choice A**: Access Services can be delegated to the Core Provider with a standardized array of services that enables the ability to have case rates for some of the services, and still have services authorized though the core provider. Core provider would be responsible for the authorization of services provided by them as well as have a sub contractual relationship with external providers. This will ensure ongoing coordination of care amongst service providers. **Choice B:** Access services can be pulled out of the core provider function and integrated into the CMHSP Access in each county to provide for consistency in authorizing services and promoting integration with CMH services. **Choice C:** Maintain some external contracts at the CMHPSM for all core providers to use.	**A.** Financing can continue to be on a performance based allocation which is managed by the core provider. Performance standards and incentives should be considered **B.** Financing structure will have to be modified and managed by the CMHPSM AND the CMHSP Access. Strong collaborative care will be necessary between all service providers, especially where co-occurring services are needed **C.** Maintain clinical oversight and UM for external contracts. Work with core providers to improve utilization and coordination of care

FINANCIAL /ADMINISTRATIVE CAPACITY: This involves the ability to act as a fiduciary, manage contracts, monitor performance standards, meet quality measures, process claims, and data reporting, etc. Many of these functions are delegated to the CMHSP's by the PIHP, but not necessarily to all SUD core providers. Currently Livingston and Lenawee CMH's perform these functions in their respective counties. The CMHPSM manages these functions for Monroe and Washtenaw Counties.	**Choice A:** To ensure the Core provider would have the capability to perform various Administrative Functions, the PIHP would need to delegate and the core provider would need to take on new functions as necessary. This may require financial investments that are not readily available. Additionally, this is time consuming and should be given the opportunity to build this capacity over a 1 year period. **Choice B:** maintain current system with limited delegated functions performed by core providers. Pilot partnerships within Monroe County to establish a core provider relationship between CMH and SUD providers similar to the other counties in the region. Goal to implement by FY 2017	**A.** Would need to invest in the core provider system to build the capacity for managing the administrative functions **B.** Could foster/create a partnerships within each county for performing these functions within the existing systems…may create new alliances between CMH and SUD core providers/non-core providers
INFORMATION INFRASTRUCTURE: SUD providers currently use the E2 information management system to access client information, report encounters, minimal qualitative data, and claims submission. The system is not an electronic health record for core or non-core SUD providers. SUD providers hold their own records, many have invested independently in their own EHR.	PHIP must ensure the data integrity in the system is accurate, timely and protected.	There is no need to change the system at this time, providing that core providers and non-core providers meet standards set for health records, billing capacity and privacy protections.
SERVICE PROVISION: Services are provided either directly by the core provider or by contract. Not all counties have the same service capacity. Livingston and Lenawee Counties do not have residential services within their county borders. Lenawee County does not have Opiate Replacement Therapy (methadone) services within the county. Adolescent services is limited across all counties as is co-occurring psychiatric services outside of the CMH system	Goal is to ensure all essential service levels are available within each county. Creative partnerships must be developed by the core provider with assistance from the CMHPSM staff. All levels of care should be sought after within the county if possible. Medicaid distance standards must be upheld and alternatives identified.	RFP's could be utilized to stimulate new programming within each county to cover gaps in services. Additionally, alternatives to traditional programming could be sought after that could be utilized to support the traditional service array. An example of this are ambulatory detox, engagement centers, recovery housing, recovery community organizations which are consumer run, etc.