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
January 26, 2017

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 10- 27 -2016 OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business
   a. FY 16 FINAL Finance Report (Information) {Att. #2} – 5 minutes
   b. Women's Specific Program, Monore (***Board Action)*** {Att. #3} – 5 minutes
   c. Media Campaign Policy {Att. #4} – (***Board Action***) 5 minutes
   d. OPB Action Request for Strategic Plan (***Board Action)*** {Att. #5}
      a. STRATEGIC PLANNING Follow-Up SWOT Analysis {Att. #6} – 30 minutes

6. New Business
   a. Funding Requests – 30 minutes
      1. WRAP (Washtenaw Recovery Advocacy Project) a Recovery Community Organization (RCO) (***Board Action)*** {Att. #7}
      2. Hegira SBIRT & Case management/peer program at Hope Clinic (***Board Action)*** {Att. #8}
      3. Monroe Women's Specialty enhancement program (***Board Action)*** {Att. #9}
      4. RFP Timeline {Att. #10}

7. Report from Regional Board (Discussion) – 5 minutes
   a. Representation change needed

8. SUD Director Updates (Discussion) –5 minutes
   a. Provider Dashboard
   b. State Grant Application
   c. Livingston Engagement Center Update {Att. #11}

Next meeting: Thursday, February 23, 2017

Parking Lot:

LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
Summary of October 27, 2016 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present:	David Oblak, Kim Comerzan, Sheila Little, Dianne McCormick, Ralph Tillotson, Dave DeLano, William Green, John Lapham, Mark Cochran, Dave O'Dell
Members Absent:	Amy Fullerton, Tom Waldecker, Charles Coleman
Guests:	Passion of Mind staff: Melinda Breeding, Jeremy, Diana
Staff Present:	Stephannie Weary, Marci Scalera, Suzanne Stolz, Joelen Kersten, Zack Shapiro

OPB Chair David Oblak called the meeting to order at 9:30 a.m.

1. Introductions

2. Approval of the agenda

   Motion by M. Cochran, supported by K. Comerzan, to approve the agenda
   Motion carried

3. Approval of September 22, 2016 minutes

   Motion by J. Lapham supported by D. Davidson, to approve the OPB meeting minutes from September 22, 2016
   Motion carried

4. Audience Participation
   - None

5. Passion of Mind Presentation
   - Passion of Mind staff provided an overview of their program, which is based in Monroe County.
   - Passion of Mind partners with Promedica to send their clients there for blood draws.
   - M. Cochran encouraged the agency to reach out to Promedica to coordinate services.
   - D. O'Dell noted that services need to be provided to help prevent relapse.
   - D. Davidson noted that the involvement of the family part of relapse prevention.
   - A strong prevention coalition is needed.

6. Officer Elections

   Motion by J. Lapham, supported by K. Comerzan, to accept the existing slate of officers for another 1-year term
   Motion carried

Chair: David Oblak
Vice-Chair: Amy Fullerton
Secretary: Mark Cochran

7. Old Business
   a. CMHPSM Regional SUD Financial Report
      - S. Stolz reported the Regional SUD financial report.
      - Finance staff is currently in the process of closing FY 16. Final numbers for FY 16 will be available in December.

   b. DYTUR Update
      - K. Postmus provided a DYTUR update.
      - The state will probably incorporate electronic cigarettes, which may initially cause confusion because until now any age has been able to purchase electronic cigarettes.
      - D. Oblak shared info about kratom, a new "drug" being used by kids. It's legal at this point.

8. New Business
   a. Livingston PA2 Website Fund Request

      Motion by R. Tillotson, supported by W. Green, to funding request for $2,400 PA2 Livingston County CMH to develop and maintain a website for the WAKE UP LIVINGSTON! This initiative is the result of implementing Project Lazarus for impacting the Opiate Epidemic in the county
      Motion carried

Board Member	Vote	Board Member	Vote
Cochran	Y	Little	Y
Coleman	Absent	McCormick	Y
Comerzan	Y	Oblak	Y
Fullerton	Absent	O'Dell	Y
DeLano	Y	Tillotson	Y
Green	Y	Waldecker	Absent
Lapham	Y		

   b. Media Campaign Policy
      - M. Scalera and K. Postmus presented the policy.
      - Providers have been consulted regarding the policy. Some provider concerns have involved the lack of definition of what "media campaign" means.
      - K. Comerzan suggested holding off on implementing a policy until the state has clear guidelines that should inform the policy. Also needed: a timeline from the state for when approval can be expected from the state.
      - D. McCormick recommended asking for approval parameters that indicate expectations for how long it will take for state approval, with the understanding that after the stated wait time has wait time has passed approval will be assumed if no response has been received.
      - K. Comerzan requested that M. Scalera ask the state to share any media releases with entities that will be impacted by it before the actual release.

      Motion by D. McCormick, supported by M. Cochran, to table the policy until clarification is received from the state

Motion carried

9. Retreat Follow-Up SWOT Analysis
   - OPB reviewed the notes from the September retreat's SWOT analysis.
   - OPB started to prioritize areas of focus in Strengths, Weaknesses, Opportunities, and Threats that were identified at the retreat.

10. SUD Director Updates
    a. M. Scalera advised of the Regional All Board Meeting that will take place on 11/9/16.
    b. Marci provided an update on the affinity groups going on at the state.

11. Meeting adjournment

Motion by J. Lapham, supported by W. Green, to adjourn the meeting
Motion carried

Meeting adjourned 11:34 a.m.

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
November 2016 FYTD

Summary Of Revenue & Expense	Funding Source					Total Funding Sources
	Medicaid	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	
Revenues						
Funding From MDCH	$ 296,398	$ 574,692	$ 625,451		$ -	$ 1,496,542
PA2/COBO Tax Funding	$ -	$ -	$ -	$ 451,651 *	$ -	$ 451,651
Other	$ -	$ -	$ -	$ -	$ -	$ -
Total Revenues	$ 296,398	$ 574,692	$ 625,451	$ 451,651	$ -	$ 1,948,193
Expenses						
Funding for County SUD Programs						
Lenawee	$ 44,756	$ 89,367	$ 33,559	$ 13,034	$ -	$ 180,716
Livingston	$ 34,258	$ 63,242	$ 161,747	$ 1,648	$ -	$ 260,895
Monroe	$ 34,527	$ 63,258	$ 139,199	$ 25,241	$ -	$ 262,225
Washtenaw	$ 143,760	$ 297,224	$ 341,112	$ 99,021	$ -	$ 881,116
Total SUD Expenses	$ 257,301	$ 513,092	$ 675,617	$ 138,943	$ -	$ 1,584,953
Other Operating Costs						
SUD Use Tax	$ 17,725	$ 34,367	$ -	$ -	$ -	$ 52,092
SUD HICA Claims Tax	$ 2,223	$ 4,310	$ -	$ -	$ -	$ 6,533
Total Operating Costs	$ 19,948	$ 38,677	$ -	$ -	$ -	$ 58,625
Administrative Cost Allocation	$ 11,966	$ 23,864	$ 46,305	$ -	$ -	$ 82,135
Total Expenses	$ 289,215	$ 575,633	$ 721,922	$ 138,943	$ -	$ 1,725,713
Revenues Over/(Under) Expenses	$ 7,184	$ (940)	$ (96,471)	$ 312,708	$ -	$ 222,480

Unallocated PA2	
Lenawee	$ 1,017,138
Livingston	$ 2,393,356
Monroe	$ 243,366
Washtenaw	$ 2,542,374
Total	$ 6,196,234

Attachment #3

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date: January 26, 2017

Action Requested: Recommendation to fund Women's Specific Program budget for Catholic Charities of Southeast Michigan out of Block Grant Funds in the amount of $156,774 during the 2/10/2016 through 9/30/2017.

Background:

Catholic Charities of Southeast Michigan, Monroe was approved by the state DHHS in February 2016 as a designated Women's Specific Program. OPB reviewed the states approval for this expansion in March of 2016. The program was launched in 2016. This action will formally recommend the budget for the program at $78,387 per year.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:

MDHHS request to expand Women's Specific Services in the region.

Recommendation: Recommend CMHPSM Regional Board acceptance of proposed budget total of $156,774 for the Women's Specific program from 2/10/2016 through 9/30/2017.

CMHPSM SUD OVERSIGHT POLICY BOARD
ACTION REQUEST

Board Meeting Date: January 26, 2017

Action Requested: Review updated Media Campaign Policy

Background: Policy was presented at the last OPB meeting. Additional clarification was needed by the state. Policy was reviewed by Larry Scott, current director of OROSC. He suggested adding a definition for social media and approved the policy and attached form.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:
Compliance with state contract

Recommendation: Approval of policy

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Substance Use Disorder (SUD) MEDIA CAMPAIGNS***
Department: Substance Use Disorders **Author: M. Scalera**	**Local Policy Number (if used)**
Regional Operations Committee Approval Date	**Implementation Date**

I. PURPOSE

To ensure that all media campaigns are compatible with MDHHS values; are coordinated with MDHHS campaigns whenever feasible; and associated costs are proportionate to likely outcomes.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION

III. APPLICATION

This policy applies to all contractual organizations receiving any SUD funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who are implementing a media campaign as part of their prevention or treatment service activities.

IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Media Campaign: A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, social and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Social Media: Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration.

Websites and applications dedicated to forums, microblogging, social networking, social bookmarking, social curation, and wikis are among the different types of social media.

V. POLICY

Media campaigns must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. All campaigns must be reviewed by the CMHPSM prior to use of MDHHS-administered funding and submitted to the MDHHS for approval.

VI. STANDARDS

A. All mass media campaigns including, but not limited to billboards, bus panel messages, public service announcements (print, radio or TV); social media messaging; pharmacy bag campaigns; are required to be submitted to the CMHPSM.
B. "Media Campaign Request Form" must be completed and associated materials (PSA Script, Media Message, Pictures, etc.) submitted to CMHPSM no less than four weeks prior to scheduled release.
C. No campaign may be initiated until receipt of approval by MDHHS is obtained.

VII. EXHIBITS

Media Campaign Request Form

VIII. REFERENCES

MDHHS supports and services contract; Part II (B) SUBSTANCE USE DISORDER (SUD) SERVICES; section 9.0 Media Campaigns

MEDIA CAMPAIGN REQUEST

MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media (i.e., billboards, PSAs, bus panels). Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with Michigan Department of Health and Human Services' (MDHHS) values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. **Prior written approval from MDHHS is required.**

Provider:	Date:
Contact Person, Email, Phone:	
Mass Media Campaign Name:	
Type of Mass Media Mechanism to be Reviewed and Associated Cost:	
Target Message:	
Target Audience:	
Target Community:	
Targeted Outcome:	
Please attach the actual media message, method, PSA script, etc., where applicable.	

Attachment #5

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date: January 26, 2017

Action Requested: Approval of the strategic plan with consideration of planned programming enhancements.

Background: OPB has engaged in a strategic planning process. Goal areas are consistent with the state's request to expand and enhance services. Funding for these enhanced services can be from 1) unallocated Block grant funds; 2) Additional block grant funds that are carry-forward and unallocated at the state level; and 3) PA-2 funds unallocated by the OPB. MDHHS would like to have enhanced programming implemented this fiscal year. Continuation of new programming can be incorporated into the upcoming FY 2018 RFP.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:

The 2016/2017 MDHHS CONTRACT priorities are listed below along with *potential programs* that should be considered by the OPB:

1. **Expand prevention including Synar (tobacco) activities and recovery services in the PIHP region**
    a. Continue to build more prevention programming in identified gap areas across the region
    b. Support additional training opportunities for vendors, clerks and compliance checks
2. **Expand prevention and recovery services in primary care settings**
    a. Screening, Brief Intervention, Referral to Treatment (SBIRT) [1]
    b. Case managers and Peers deployed at primary care sites
    c. Peers in Emergency Departments and Crisis Teams[2]
3. **Implement recovery oriented systems of care guidelines and practices**
    a. Recovery Community Organizations in all counties[3]
    b. Peer services in Drug Courts; Law enforcement/jail partnerships
    c. Support coalitions addressing Opiate epidemic
4. **Expand women's specialty services**

[1] Hegira Request for funding at Hope Clinic includes SBIRT, case manager and peer

[2] Current discussions with UM Psych Emerg Services and ED; WCCMH crisis team and Promedica in Monroe for peers

[3] HNV request to fund WRAP RCO in Washtenaw; discussions with Monroe Recovery group in development

   a. Address Neonatal Abstinence Syndrome through collaboration with OBGYN, NICU, DHHS, Women's Specialty case manager and outreach peer; education program and infant mental health (pending project in Monroe County, explore replication in Washtenaw and Lenawee Counties)[4]
   b. Seek women's specialty services provider in Livingston County.
5. **Expand outreach to high risk adolescents and priority populations in need of substance use disorder services**
   a. Specialized outreach in schools; recreation and community settings; pediatrics; sports medicine clinics;
   b. Peers in Juvenile Court Services
6. **Address service gaps including services gaps for populations experiencing trauma and health disparities.**
   a. Seek new providers or services in all counties where gaps exist[5]
   b. Support funding for Medication Assisted Treatment[6]
   c. Syringe services programs – outreach for early intervention with high risk populations[7]
7. **Workforce development**
   a. Support training in evidence based practices for field
   b. Host peer certification training[8]
   c. ASAM training for clinicians
   d. Prevention Training[9]

Recommendation:

Approve strategic plan

[4] Monroe Catholic Charities & Family Medical to do joint project

[5] Passion of Mind MAT with Methadone

[6] Family Medical Vivitrol services in Monroe and Lenawee; Salvation Army Vivitrol services in Monroe.

[7] Unified to increase outreach services, supported with syringe services and naloxone distribution

[8] Plan to have CCAR peer training in each county; beginning with Lenawee in February

[9] Prevention training series hosted by CMHPSM prevention team

Lenawee
Livingston
Monroe
Washtenaw

SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD

FY17 OPB STRATEGIC PLANNING

OPB Mission

CMHPSM Oversight Policy Board will support The Community Mental Health Partnership of Southeast Michigan Regional Board's ability to make an informed decision of maximum benefit by representing voices of the community, discussing trends and concerns; in order to make recommendations on comprehensive recovery-based Substance Abuse prevention and treatment services.

OPB 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.

Strengths

Significant regional strengths to drive Strategic Planning:

- There are partnerships and collaborations across the region and locally with long history of coming together.
- Access to care occurs throughout the region.
- More minds working together is a great strength.

Weaknesses ****indicates state identified initiative or priority for unallocated funding***		
Priority 1: Address lack of capacity for the demand for services.		
Next Steps	**Category/Department(s) responsible**	**Notes**
▪ Institute Pilot projects across the region with existing unallocated funds for remaining FY 17* ▪ Develop RFP for FY 18 with focus on expanded programming ▪ Utilize data analysis for determining priority areas, capacity gaps, trends	▪ Treatment and Prevention staff ▪ Finance and Contract support	▪ Priority in utilizing block grant funds for expanded services ▪ Supplement programming with PA2 funds where necessary ▪ Respond to the state identified initiatives and priorities
Priority 2: Address limited adolescent treatment capacity.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Conduct analysis of service availability ▪ Convene a SUD adolescent services workgroup to develop strategies ▪ Target allocation or mandates in RFP to increase services and outreach ▪ Expand prevention services where gaps exist*	▪ SUD Treatment staff; ▪ Data Analysist ▪ All providers ▪ CMH Children's Admin Team ▪ Prevention staff	▪ Also, look at interventions using SBIRT model… ▪ Currently receiving request to expand prevention services in washtenaw

▪ Work with children's services at CMHC's for co-occurring services* ▪ Utilize Prevention programs that work with adolescent population for outreach and referrals* ▪ Explore relationships with Juvenile Drug Courts and Services* ▪ Explore relationships with schools and primary care settings*		
Priority 3: Address limited integration with CMH and Primary Care.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Target Funding of peer services in primary care (RFP)* ▪ Increase utilization of SBIRT at primary care settings and deploy case managers or outreach workers/care navigators to enhance services* ▪ Ongoing dialog with CMH in each county to improve partnerships and coordination of care	▪ SUD treatment Staff ▪ CMH leadership and Admin teams	▪ Currently CMH has services in primary care settings… work with CMH on enhancing services in these settings
Priority 4: Address fragmented and inconsistent access to care across the region (i.e. eligibility, diagnosis, medical necessity, etc.).		
Next Steps	**Category/Department(s) Responsible**	**Notes**

▪ Revisit the CORE provider concept to ensure clients are considered "regional" ▪ Ensure ACCESS to services are consistent across all entry points - ▪ Provide ASAM training for all provider access staff* ▪ RFP language to address standardization and protocol for regional services ▪ Explore utilization of ASAM tool for consistency in assessment and placement ▪ Address waitlist issues from a centralization perspective	▪ SUD treatment staff ▪ Providers ▪ Finance and Contract Support	▪ State is certifying all SUD providers on the ASAM level of care. Clinical UM decisions must be aligned with the appropriate level of care. ▪
Priority 5: Address poor communication between providers.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Conduct mandatory provider meetings quarterly ▪ Monitor care coordination practices as part of the annual monitoring process ▪ Engage providers in improving communication process through county specific meetings	▪ Quality improvement support ▪ SUD Treatment staff ▪ Providers	▪ Release provider meeting schedule ▪ Offer technical assistance when necessary

Opportunities ****indicates state identified initiative or priority for unallocated funding***		
Priority 6: Need regional quarterly and annual reports that demonstrate spending by county per person, funds per capita per county, and spending per treatment services per county.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Redesign the funding methodologies to allow for more consistent practices and build into the RFP ▪ Produce and utilize an IBNR report for all fee for service claims ▪ Quarterly finance summary to OPB ▪ Annual report once year is closed to OPB that includes analysis of services, trends and other relevant information.	▪ SUD Treatment and Prevention Staff ▪ Finance Staff ▪ Data Analysist ▪ Quality Improvement Support	▪ Must have an annual posting of monitoring activities or provider report cards. Can incorporate an annual executive summary report or combine with a regional report
Priority 7: Cultivate opportunity to develop partnerships/collaborations and education for primary care, dental services, hospital systems, CMHs and safety net providers.		
Next Steps	**Category/Department(s) Responsible**	**Notes**

▪ Address NAS babies: Expand Women's treatment services to include DHHS, OB/GYN, FQHC's and Neonatal ICUs to Opiate addicted pregnant women and families. * ▪ Work with community coalitions who involve all sectors in identifying and addressing ongoing needs. ▪ Deploy peer supports in ED's or other primary care settings. * ▪	▪ SUD treatment staff ▪ Designated Women's Specialty providers ▪ Finance and Contract support	▪ Pilot program to start in 2017 with Monroe Women's specialty as requested by the state… need to expand to remaining counties. *
Priority 8: Simplify Access process and create procedures for provider communication.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Review current protocols and guidelines ▪ ASAM certification for 100% designated access staff ▪ Have providers enter MOU's and/or business agreements ▪ Use multiple party universal releases* ▪ Use provider meeting to identify and address barriers ▪ use newsletter to broadcast communications	▪ SUD treatment and prevention staff ▪ Quality Improvement support ▪ Contract Support ▪	▪ Build expectations into the RFP ▪ Adjust policies if needed

Priority 9: Look for new best practice models.

Next Steps	Category/Department(s) Responsible	Notes
▪ Expand use of Medication Assisted Treatment * ▪ Support expansion of outreach to opiate/heroin population and implement "syringe services" and harm reduction methods * ▪ Expand use of SBIRT regionally – provide training ▪ Expand Engagement Centers in each county *	▪ SUD treatment staff ▪ Finance and Contract support ▪ Early intervention Services provider ▪ FQHC's	▪ Best practice includes MAT services ▪ Methadone clinics should expand to other forms of MAT * ▪ Engagement centers currently in Washtenaw and Livingston County…Lenawee is in development and Monroe is in consideration. •

Threats

****indicates state identified initiative or priority for unallocated funding***

Priority 10: Strategize for possible state policy changes and political systems that may impact system of care.

Next Steps	Category/Department(s) Responsible	Notes
▪ Changes to the Affordable Healthcare Act ▪ New grants specific to SUD services (Treatment improvement enhancement grant)	▪ SUD treatment and prevention staff ▪ Executive Director ▪ Finance Support ▪ OPB	▪ Will need to carefully monitor impact of federal and state changes on populations served and financing of services

Priority 11: Plan for working with Department of Corrections, including how to address requirements by state and conflicts of treatment philosophy and service mandates for providers.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Monitor developments in the DOC funding process; ▪ Partner on joint initiatives as they develop	▪ SUD treatment staff	▪ DOC and CMHPSM working with Salvation Army on Vivitrol project for Monroe County residents receiving post release services
Priority 10: Address denial of SUD needs by communities, parents, and schools.		
Next Steps	**Category/Department(s) Responsible**	**Notes**
▪ Needs assessment and analysis ▪ Utilize various indicator data ▪ Provide feedback to communities utilizing community coalitions and workgroups ▪ Utilize media where appropriate ▪ Host SUD informational summits in local communities ▪ Expand support for Recovery Community Organizations who work with recovery community for positive messaging, engagement and support. *	▪ SUD treatment and prevention staff ▪ Community Coalitions	▪ Currently have a request for funding an RCO in Washtenaw County

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date: January 26. 2017

Action Requested: Recommend approval of funding for HOME OF NEW VISION, WASHTENAW RECOVERY ADVOCACY PROJECT (WRAP), a recovery community organization (RCO).

Background: A **recovery community organization** (RCO) is an independent, non-profit **organization** led and governed by representatives of local **communities** of **recovery**. Based on a SAMHSA supported initiative, The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved. MDHHS, Office of Recovery Oriented Systems of Care has requested that PIHP's consider enhancing recovery services as part of the service array funded by the block grant. WRAP was a group that grew out of the Opiate Project workgroup, to focus efforts on bringing persons in recovery together, educate the broader community and work in conjunction with organizations and providers to develop opportunities for peers.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:

Aligns with the MDHHS contract initiatives for enhancing and increasing recovery services.

Recommendation:

Recommend FUNDING IN THE AMOUNT OF $64,620 WASHTENAW PA2 for HNV WRAP. In the event MDHHS Block Grant Funds are available, recommend CMHPSM Board approve funding shift to block grant funds for the WRAP program in the amount of $64,620.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Serving Lenawee, Livingston, Monroe, and Washtenaw Counties

Request for Funds	
Date:	
Contact Person: (Name, email, phone)	Glynis Anderson, LMSW, ACSW, Founder and CEO of Home of New Vision (HNV). Email: ganderson@homeofnewvision.org Phone: (734) 417-7120
Requestor:	Home of New Vision (HNV), a 501(c) 3 non-profit organization/ Washtenaw Recovery Advocacy Project (WRAP).
Amount of Request:	$64,620.00 [see attached budget].
Priority Area: [Change to Treatment, Recovery-Focused Peers]	☐ TREATMENT for Substance Use Disorders (indicate specific populations to be served) ☐ Adolescents ☐ Opiate/Heroin ☐ Adults ☐ Alcohol Specific ☐ Gender specific X☐ Recovery Focused/Peers ☐ Other: _____ ☐ PREVENTION (please check one of the following): ☐ Reduce Childhood and Underage Drinking ☐ Reduce Prescription and Over the Counter Drug Abuse/Misuse ☐ Reduce Youth Access to Tobacco ☐ Reduce Illicit Drug Use ☐ Other: _____
Targeted Community: (Geographic area)	The Washtenaw Recovery Advocacy Project (WRAP) works primarily within Washtenaw County and its residents, however, has collaborated in surrounding areas to promote recovery and reduce stigma. In Washtenaw County alone, WRAP has the potential to impact the 384,240 residents by increasing community awareness of recovery, increasing knowledge of community resources for treatment and intervention, reducing stigma, and forming a coalition of recovering peers and allies of recovery. By including collaboration within the four county region (Monroe, Lenawee and Livingston) the number impacted will be significantly increased.
PREVENTION ONLY Targeted Population: (Institute of Medicine Category)	☐ Universal (general public/whole population group) ☐ Selective (individuals – risk of developing a substance use disorder is significantly higher than average) ☐ Indicated (individuals in high-risk environments, minimal signs/symptoms, biological markers indicating a predisposition for disorder)

Primary Problem/ Consequence(s) Support Data: (Include Data Sources and reason for the request for funding)	National data indicates that there is a 90% addiction treatment gap in the United States. Only one in ten people who need addiction treatment services receive it. This gap largely occurs because of issues a recovery community organization can help address, including: - The portrayal of addictions to alcohol and other drugs as problems for which there are viable and varied recovery solutions, - Providing living role models that illustrate the diversity of recovery solutions, - Enhancing the variety, availability and quality of treatment and recovery support services, - And working to improve environmental barriers to recovery including the promotion of laws and social policies that reduce alcohol and other drug problems and support recovery. The following quotes are from Michigan's Recovery Oriented Systems of Care Initiative: "Specifically, research indicates that sustained recovery is best facilitated when treatment services focus on developing strong therapeutic alliances, incorporate peer and community-based supports, address global health, promote life skills, include families and/or other significant allies, and adopt a chronic- care approach to treatment (Barber et al., 2001; Meier et al., 2006; Klein et al., 1998; McKay, 2005; Isaacson, 1991; White, 2008). "…While recovery can be initiated in a treatment setting, it is maintained and sustained in the natural environment of a person's community (White, 2008). As such, a ROSC goes beyond the individual to help strengthen the surrounding community, by integrating treatment efforts with the services and supports available in a person's natural environment. Within a ROSC, this expanded focus on the promotion of community health and wellness is a critical component of, not only treatment services, but also prevention services. " WRAP and the philosophy of a recovery community organization embody solutions to meeting these needs. Supporting the development of leaders, advocating for meaningful representation and voice for people in recovery and their family members on issues that affect their lives, educating the public, policymakers and service providers about the prevalence and multiple pathways of addiction recovery, and celebrating recovery from addiction through public events that offer living testimony of the transformative power of recovery are effective tools to closing the treatment gap. In October of 2015, the Michigan Prescription Drug And Opioid Abuse Task Force issued their *Report of Findings and Recommendations for Action*. WRAP is uniquely situated to help implement these recommendations. For example, WRAP can be a strategic partner for the distribution of information regarding Rx drug abuse, prevention, and treatment. This includes participation on local DEA Drug Take Back Initiatives and safe storage and disposal education. It also includes activities and public awareness campaigns to reduce the stigma of addiction. Since the group's inception, WRAP has collaborated with REAL Michigan. REAL is a Recovery Community Services-Statewide Network Grantee through SAMHSA. The intent of this program is to further enhance the presence of recovery community organizations as key partners in treatment, recovery, and affiliated health systems. In accordance with SAMHSA's Strategic Initiative on Recovery Support, this program aims to highlight the value of lived experience through the inclusion of addiction as an organized statewide presence. Through this program, it is expected that the infrastructure of recovery community organizations will be strengthened and the delivery of addiction peer recovery services will be more meaningfully supported.

Underlying Root Causes to be Targeted: (Associated Intervening Variables, Risk/ Protective Factors)	Building a strong Recovery Community Organization (RCO) such as WRAP, is a way to break feelings of isolation and shame related to Substance Use Disorders, build strong relationships, and advocate for the solutions that we know work. Grassroots organizations develop recovery leaders, offer opportunities to express a collective voice, and provide a forum for community service. Coming together to build a constituency of consequence means acting together to bring about positive changes on community life through public action (Faces and Voices of Recovery, 2012). This includes reducing the social stigma surrounding Substance Use Disorders through continued community education efforts. The core principles of an RCO are: recovery vision, authenticity of voice, and accountability to the recovering community. Although there are many strategies that RCOs focus on, the Washtenaw Recovery Advocacy Project will focus on three common core strategies: public education and awareness; policy advocacy; and peer-based and other recovery support services and activities in order to increase community stakeholder engagement. Embedded in the RCO philosophy is the idea that there are many different pathways to recovery. This particular outlook is crucial in our community in order to reach the many people that the traditional 12-step approach does not reach. Washtenaw County has made great strides in utilizing the ROSC approach to treating SUD, however, we are still over-utilizing the AA/NA pathways to recovery. This only serves to alienate a significant portion of the recovering community. By having an overwhelming focus on 12-step programs, many are isolated from the greater recovery community and keeps others from seeking treatment. According to Lance Dodes, MD, Harvard Medical Graduate, Addiction Specialist and Author, "Almost all treatment facilities in the United States are 12 step-based" (*Business of Recovery).* Sadly, he goes on to point out that "12-Step Programs only work for 5-10% of the participants. It is better than zero, but should not be thought of as the standard." In addition, members of the traditional AA/NA membership tend to support only those that make it through the doors of their meetings, leaving many other persons without peer supports. Due to the anonymous nature of AA/NA, the success of recovery is not widely known, leaving community members to pathologize and stigmatize addiction, instead of embracing and celebrating recovery. RCOs change the community climate, support recovery, educate the community, change policy, and embrace the many different pathways of recovery. Most importantly, RCOs support those in early recovery, giving them a voice for change. Participation in an RCO ignites additional passion for recovery, teaches participants valuable skills, and provides a sense of accountability to the group. As an offshoot of the Washtenaw Health Initiative's Opioid Work Group, the Community Change Committee created the Washtenaw Recovery Advocacy Project, which has been meeting on a regular basis, one time per week, since its inception. Additional Board of Director's meetings are held once monthly. The Community Change Committee/Recovery Advocacy Committee has set the groundwork to develop and implement an RCO. To build upon the work that has been started, Home of New Vision is proposing to provide the technical support, space, coordination of development, and implementation of Washtenaw County's first Recovery Community Organization. The advent of an RCO brings support and advocacy for recovering persons full circle and supports ongoing efforts to engage both the recovering community and interested stakeholders in supporting the "Recovery is Possible" approach, reduce stigma and shame, and gain a groundswell of support for people seeking recovery. Home of New Vision is seeking $ 64,620.00 to support the RCO formation.

Evidence-based Strategies/Initiatives:	Among the core strategies of an RCO are providing public education about recovery, engaging in policy advocacy, and providing peer-based and other recovery support services (Valentine, White & Taylor, 2007). An important element of public education is reducing the stigma of addiction and building awareness that long-term recovery is possible, and has been achieved by many. Indeed, according to Faces & Voices of Recovery (2012), over 20 million Americans are in recovery from addiction to alcohol and other drugs. In order to build awareness of this in the local community, WRAP will hold an annual Walk for Recovery Awareness. The goal is to have at least 350 participants, including those in recovery as well as allies. This goal will be achieved by distributing flyers to those in the recovery community as well as to local businesses who are allies; by promoting the event through social media; and through word-of-mouth. Speakers who are in long-term recovery will be selected to tell their personal stories and to offer examples of the fact that recovery works. Policy advocacy will be performed by WRAP as well. RCOs engage in advocacy to remove public policy barriers that stop individuals from achieving long-term recovery (Faces & Voices of Recovery, 2012). For example, several WRAP members have recently traveled to Lansing to advocate for the removal of Section 298 of the proposed FY 2017 budget for the state of Michigan. Section 298 would make it nearly impossible for XXXX individuals to receive substance abuse treatment and would also drastically cut funding to treatment providers. Thus, engaging in this advocacy is an important strategy through which WRAP can successfully keep the doors of recovery open to the greatest possible number of people. One of the most common pitfalls for those new in recovery is relapsing after leaving treatment. Thus, an important strategy is to coordinate with these individuals to provide post-treatment support and monitoring. Effective peer-based recovery support services (PBRSS) can be provided by WRAP through telephone support, as outlined by Valentine et al. (2007). A pilot study examining the Connecticut Community for Addiction Recovery telephone PBRSS found that of 1,828 contacts with those who had exited treatment, 1,697, or 92.8%, indicated that they were still in recovery. Of 38 who had relapsed, the CCAR caller was able to help 13 back into recovery (Valentine et al., 2007). Thus, successful PBRSS can be offered by coordinating with local substance abuse treatment centers to enroll clients who desire PBRSS into the services, and then by continuing to follow up with those individuals at intervals such as once per month. Utilizing these strategies and evidence best practices WRAP has accomplished the following: • Researched stigma reduction and community change best practices. • Built community alliances (see “Community Partners” for a complete list). • The first recovery rally was held in March of 2015. This rally introduced the concept of RCOs to 44 recovering persons and allies of recovery whom attended. Rally for the second Recovery Walk brought 52 people from the recovering community and many allies. • Have held five Recovery Messaging trainings (developed by Faces and Voices of Recovery) for RCO supporters. • Successfully became a member of the Association of Recovery Community Organizations (ARCO) Faces and Voices of Recovery.

- Continuously met to develop the **first** annual Recovery Walk that occurred May 30th, 2015, in downtown Ann Arbor that brought 250 people in recovery and treatment as well as our allies. This effort included:
  - Creating an RCO social networking page.
  - Creating five committees for the planning of the recovery walk.
  - Receiving permits from the City of Ann Arbor for the Recovery Walk.
  - Receiving permits from the City of Ann Arbor Parks and Recreation for use of Liberty Plaza as a rally point for the walk.
  - Developing and purchasing recovery t-shirts.
  - Creating flyers.
  - 24 peers designed and made their own signs for the recovery walk.
- **Second** Annual Recovery Walk held on May 21st 2016 with an additional 100 participants from the first year yielding 350 participants.
- Successfully developed a WRAP Board of Directors, which currently has ten board members and meets once per month at the Home of New Vision office.
- Hosted two "Recovery Is …" events at St. Joseph Hospital's auditorium in 2015 and 2016, to bring awareness of the multiple pathways of recovery to our community. The event included a partnership with the Washtenaw County Sheriff's Office, DEA, St. Joseph Mercy Hospital and Recovery Allies.
- WRAP is in the process of completing a PowerPoint presentation to take into schools, in order to educate students about substance use disorder.
- WRAP has been published in a guest editorial on Mlive, in which it was able to broadcast a clear message of recovery and hope to those in the Ann Arbor area and speak out against stigma related to Substance Use Disorders.
  Source: http://www.mlive.com/opinion/ann-arbor/index.ssf/2016/03/communities_need_to_embrace_ad.html
- Three WRAP members (Ashton Marr, Dave Kuhn, and Lindsay Dolan) were featured in the January issue of *The Ann Magazine*, also helping to transmit a message of recovery to the broader community.
  Source: http://www.theannmag.com/facing-up-to-addiction/
- On two separate occasions in 2015, WRAP representatives traveled to the Capitol in Lansing to give testimony, advocating for those with Substance Use Disorders.
- WRAP volunteers collaborated with Mi-Hope naloxone trainings, at Maple Rock and at Ypsilanti High School. Combined, 160 doses of naloxone were given out to our community in 2015.
- WRAP volunteered at Ryan's Hope's Hockey Against Heroin event in Monroe, MI.
- WRAP acting Executive Director, Ashton Marr attended a two day leadership academy designed for recovery community leadership that included training on crafting a recovery message, the importance of engaging youth and families in your RCO, and data collection to support sustainability.

Faces & Voices of Recovery. (2012). By our silence we let others define us: Building the voice of the organized recovery community. Retrieved from http://www.facesandvoicesofrecovery.org/sites/default/files/resources/7.13.15%20FINAL%20Recovery%20Community%20Organization%20Toolkit.pdf
Valentine, P., White, W. & Taylor, P. (2007) The recovery community organization: Toward a definition. Posted at http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf

PREVENTION ONLY Primary Federal Strategies (CSAP)	Check all that apply: ☐ Information Dissemination ☐ Problem Identification & Referral ☐ Education ☐ Community-Based Process ☐ Alternatives ☐ Environmental
Short-term Outcomes (where applicable) : (CDC SMART objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-phased) For each outcome, please include the evaluation method (i.e., survey, questionnaires, etc.)	**Goal 1:** WRAP will use a "network weaving" model of community organization to help build the capacity of organizations within our region (Monroe, Lenawee, Livingston and Washtenaw) supporting recovery services and recovery advocacy efforts, as evidenced by: **Objective 1:** Establish working relationship with consultant from *Recovery Studio*. **Objective 2:** Work with *Recovery Studio* to develop a plan that will include additional counties in the region to be active and build capacity as recovering community organizations and collaborate within the region. **Objective 3:** Develop a Regional Calendar of Recovery Events **Objective 4:** Development of at least one additional RCO within the Community. **Outcome:** To strengthen strategic relationships and the recovery voice within the region. The development of collaboration amongst recovering communities that is focused on utilizing multiple resources, as opposed to relying on local alone. **Goal 2:** WRAP will become a non-profit entity in 2017, as evidenced by: **Objective 1:** Identify potential attorneys that specialize in filing for non-profit status. **Objective 2:** Select and work with a pro bono attorney to complete necessary documentation to achieve 501c (3) status. **Objective 3:** File documentation to achieve non-profit status. **Outcome:** WRAP will be recognized as a registered, free standing, non-profit entity. **Goal 3:** Increase community knowledge about SUD and recovery, through the increase of recovery focused information, as evidenced by: **Objective 1:** Develop a relationship with a local publication printing company. **Objective 2:** Develop an outline for a recovery publication that includes advertising information on treatment resources, recovery-friendly employers, recovery housing options, promotion of the many pathways to recovery, advertising recovery friendly employers, housing options, State and Federal policy changes, and opportunities to give testimony to legislative bodies along with other items of interest for the recovering community.

	Objective 3: Publication will be provided at least two times during 2017, with a plan created for future distribution. **Outcome:** A quarterly publication for individuals in recovery, families, allies and the community at large that allows for the dissemination of education, and an increased knowledge of recovery supportive services and opportunities, as well as Washtenaw County Opioid Project updates. **Goal 4**: Continue to develop a recovery friendly community, as evidenced by: **Objective 1:** WRAP will provide at least five articles, releases or testimonials to local news and radio affiliates. **Objective 2:** WRAP will host at least three community focused events, which will include the Annual Recovery Walk, 'The Recovery Is….' Event and Community Trainings (i.e. Naloxone, Peer Education, Messaging Delivery). **Objective 3:** Will maintain the WRAP Facebook page; increase 'Likes' by 50% **Objective 4:** Increase WRAP membership of both recovering persons and allies by 40 through the objectives above. **Outcome:** WRAP will promote and encourage a diverse coalition of affiliates through a target of media resources, and the facilitation of community friendly events.
Intended Long-term Outcome(s): (Describe how this funding will benefit service delivery and/or the community)	The four county region overseen by the Community Mental Health Partnership of Southeast Michigan (CMHPSM) will have expanded collaboration, resources to utilize and an additional RCO to assist in the development of a recovery supportive region. Individuals in recovery will be increasingly viewed as productive members of the community, as opposed to being defined by the stigma of their substance use disorder. Communities will be able to provide support, guidance and treatment for individuals in active addiction through an enhanced resource base of information and available resources that includes recovery friendly employers, housing options and much more. Individuals in recovery, as well as families, allies and the community at large will utilize WRAP as a way to display their devotion to recovery and building recovery friendly communities, where recovering persons will be welcomed in any environment where people understand the elements of Substance Use Disorder

Key People/Coalition:	) ***Glynis Anderson***, LMSW, ACSW, is the Founder and CEO of Home of New Vision (HNV), a nonprofit drug and alcohol treatment facility in Ann Arbor, MI. She also serves on the Board of Directors for the Washtenaw Recovery Advocacy Project. Glynis participates in statewide forums that focus behavioral services, ROSC and the implementation of Recovery Community Organization's (RCO) in the State of Michigan as a founding member of two RCO'S. Glynis' experience includes conducting outreach case management services as part of a federally funded SSI managed care project, work with court-ordered and criminal justice-involved clients; providing individual and group therapy; conducting interventions both locally and as part of a national program. She has provided training for the State of Michigan on implementing ROSC statewide. As a former adjunct professor at both EMU and UM she has taught Community Organizing, Practice issues for Women and Grant Writing. In 2012, she was awarded recognition from the State of Michigan Office of Community Health, Substance Abuse Services, for her work in the statewide ROSC transformation.) ***Ashton Marr***, President of the Washtenaw Recovery Advocacy Project Board of Directors (since October, 2015), is a person in long-term recovery. She is in the process of completing her Bachelor's degree in Social Work from Eastern Michigan University. Additionally, she is an outreach worker for the Washtenaw County Sheriff's Office, helping to reduce recidivism by connecting under-served populations with community resources. Ashton has been instrumental in bringing more publicity to WRAP and was the subject of an article in the January issue of *The Ann Magazine.* She has also helped to form an ongoing partnership between WRAP and the Washtenaw County Sheriff's Office.) ***Chris O'Droski***, MA, CCAR, has a Bachelor's and Master's degrees in Communications from Eastern Michigan University. He is CCAR-trained and sits on a number of local and state boards for recovery advocacy and peer training initiatives, including: Past interim Chair of Behavior Health Advisory Council of Michigan (2014), current Chair of Michigan Recovery Voices, Co-founder of Ann Arbor Soberfest (2012 – present), Vice President of the Washtenaw Recovery Advocacy Project's Board of Directors, Washtenaw County Ambassador for REAL Michigan in 2015, Member of Michigan Peer Conference Council (2014 – present), KNOPF Training Facilitator ("The Use of Recovery Coaches and Peer Supports," since July 2013).) ***Debra Wright***, LMSW, CAADC, is a person in long-term recovery. Currently, she is the Program Director at Home of New Vision's Engagement Center and has been in that position for seven years. Prior to that, Debra worked at Michigan Advocates Exchange, Inc., a legal services agency serving people with HIV in the State of Michigan. Debra has also had almost five years of experience working in HIV HOPWA Program in a six-region area including Wayne County, Michigan. Ms. Wright is currently Secretary on the Board of Directors of the Washtenaw Recovery Advocacy Project. She is also on the Steering Team for Nation Outside, a group of

	formerly incarcerated people who are advocating for change in Michigan, and is a member of the Collaboration to End Mass Incarceration in Michigan. ❯ ***Suzie Antonow***, LMSW, sits on the Washtenaw Recovery Advocacy Project Board of Directors and is a manager at the St. Joseph Mercy Health System. ❯ ***Dave Kuhn*** is a person in long-term recovery and works for the Hamilton House Engagement Center. He, too, was featured in *The Ann Magazine* and sits on the WRAP Board of Directors. Starting in April, 2016, Mr. Kuhn will be representing WRAP at the WHI Opioid Work Group monthly meetings. ❯ ***Deborah Garrett. Owner of Recovery Studio*** Deborah is a Certified Prevention Specialist, Certified Peer recovery mentor, and holds a Bachelor's Degree in Psychology. She brings her experience as a community organizer in the prevention field, as well as her advocacy skills to the project. Deborah has organized numerous educational opportunities and awareness raising events since her entry into the recovery advocacy field in 2005. She has presented at MI State Substance Use Conferences and MAADAC Annual Conferences on advocacy and role clarity for recovery coaches. Her expertise in network development and event management will be valuable to the project. ❯ ***RCO Coordinator:*** 40 hours per week to provide support for activities related to all aspects of the RCO. The person selected will possess exceptional organizational skills, will have experience in community organization, and have knowledge related to Substance Use Disorders and recovery.
Community Partners:	❯ UM School of Nursing ❯ Brighton Center for Recovery ❯ Washtenaw County Sheriff's Office (WCSO) ❯ Saint Joseph Mercy Hospital - Greenbrook ❯ Metropolitan Memorial Baptist Church ❯ Second Baptist Church ❯ Saint John Missionary Baptist Church ❯ Cooley Law School ❯ Families Against Narcotics ❯ Mi-Hope ❯ Ryan's Hope (and other family-generated grassroots organizations) ❯ Washtenaw Health Initiative's Opioid Work Group ❯ Ann Arbor Women's Group (A2WG) ❯ Maple Rock ❯ Michigan Recovery Voices (MRV) ❯ Unite to Face Addiction Michigan (UFAM) ❯ REAL Michigan

Please note:
All programming must be consistent with the implementation of Recovery-Oriented Systems of Care (ROSC).

Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems (Center for Substance Abuse Treatment, 2005).

CMHPSM Office Use Only

Amount Recommended & Comments:	

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date: January 26, 2017

Action Requested: Recommend approval of funding for Hegira Programs, Inc. (HPI) for Screening, Brief Intervention, Referral to Treatment (SBIRT) programming, Case Manager and Peer Recovery Coach for HOPE Clinic, Ypsilanti; Washtenaw County

Background: HPI currently provider substance services for our region as part of the network panel. HOPE clinic provider medical and social support services for low income and Medicaid recipients in Washtenaw county but also has been a safety net clinic for over 30 years. HPI partnered with HOPE Clinic to provide SBIRT, case management and SUD peer services initially through a Flynn Foundation Grant. Given this service is aligned with the MDHHS priorities, the continuation of this program will enhance services to individuals with SUD needs in an integrated setting.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:

Aligns with the funding priorities identified by the state.

Recommendation:

Recommend FUNDING IN THE AMOUNT OF $100,000 WASHTENAW PA2 for HPI. In the event MDHHS Block Grant Funds are available, recommend CMHPSM Board approve funding shift to block grant funds for the HPI program in the amount of $100,000.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Serving Lenawee, Livingston, Monroe, and Washtenaw Counties

Request for Funds	
Date:	December 13, 2016
Contact Person: (Name, email, phone)	Melissa Tolstyka mtolstyka@hegira.net 734-458-4601 ext. 210
Requestor:	Hegira Programs, Inc.
Amount of Request:	$100,000
Priority Area:	✓ TREATMENT for Substance Use Disorders (indicate specific populations to be served) ☐ Adolescents ✓ Opiate/Heroin ✓ Adults ✓ Alcohol Specific ☐ Gender specific ✓ Recovery Focused/Peers ✓ Other: ___COD_____ ☐ PREVENTION (please check one of the following): ☐ Reduce Childhood and Underage Drinking ☐ Reduce Prescription and Over the Counter Drug Abuse/Misuse ☐ Reduce Youth Access to Tobacco ☐ Reduce Illicit Drug Use ☐ Other: _____
Targeted Community: (Geographic area)	Uninsured Adult patients residing in Washtenaw County receiving services at Hope Clinic.
PREVENTION ONLY Targeted Population: (Institute of Medicine Category)	☐ Universal (general public/whole population group) ☐ Selective (individuals – risk of developing a substance use disorder is significantly higher than average) ☐ Indicated (individuals in high-risk environments, minimal signs/symptoms, biological markers indicating a predisposition for disorder)
Primary Problem/ Consequence(s) Support Data: (Include Data Sources and reason for the request for funding)	Studies show that individuals who have a mental health condition are dying on average 25 years earlier than the general population. Individuals with co-occurring disorders are dying, on average, 32 years earlier than the general population (Bazelon Center, 2004). The World Health Organization's (2000) research showed that up to 60% of people contemplating suicide sought medical attention for health problems in the weeks before their death. Yet, there is a

staggering gap in the amount of individuals who reach out for psychiatric help. Reasons for this vary, but the overall coordination of treatment between primary care and behavioral health care has, traditionally, been limited. The primary solution to address this issue is to improve access to services and to integrate behavioral health care within primary health care services (Bazelon Center, 2004). Improved detection, referrals and continuation of assistance for individuals with psychiatric disorders in a primary care setting is crucial to prevent these issues (WHO, 2000). The US Preventive Services Task Force and other authorities recommend screening and intervention for tobacco, alcohol, drugs, depression, and obesity, but few healthcare settings deliver these services in an evidence-based manner (SAMHSA, 2012).

Identification of behavioral health problems has been rising, but in primary care settings they are still being under acknowledged. When these problems are identified there is a lack of referrals to appropriate services. Many physicians lack the time and training to take care of these problems. That, along with poor reimbursement rates, makes it very challenging to receive comprehensive care. (DiMatteo, Lepper & Croghan, 2000). Consequently, individuals with depression are less likely to follow through with their medical treatment plans. (DiMatteo, Lepper & Croghan, 2000). Research suggests that implementing behavioral health into primary care can lead to a reduction in self-reported levels of depression and the rate of high cost medical visits. In addition to lower rates of treatment adherence, there is an association between treating depression and prevention of heart attack and strokes (Stewart, Perkins & Callahan, 2014).

Frequently, research focuses on depression as an association between psychiatric illnesses and chronic medical conditions. While less often studied, there is strong evidence suggesting anxiety plays an equal role in affecting self-care for medical conditions and increasing the risk for premature deaths, medical treatment complications and increasing the rate of emergency medical problems. Anxiety plays an epidemiological role in the presence of several health conditions including Irritable Bowel Disease, Cardiovascular Disease and chronic pain (Roy-Byrne, et al., 2008). This association is further complicated by the association of anxiety and the use of tobacco products. The use of tobacco has been identified as a major modifiable risk factor for many health diseases including cardiovascular disease, stroke, various forms of cancer, pulmonary diseases and many more (The US Department of Health and Human Services, 2006). Furthermore, individuals who experience anxiety and depression were found to "smoke with higher intensity and frequency, have more dependence, and have lower success at quitting." Implications from the same study suggest a need to address an individual's mental health needs when addressing nicotine dependence. (Trosclair & Dube, 2010).

There is a strong association between both mental health and substance use disorders diagnoses and tobacco use. Individuals with mental illness or substance use disorder have been found to smoke more frequently and more heavily than individuals who are spared these issues (Weir, 2013). Specifically,

	individuals with behavioral health needs are smoking 40% of all cigarettes smoked (Substance Abuse and Mental Health Services Administration 2013). Smoking is the leading cause of preventable death resulting in more than 480,000 each year. The effects of clinical intervention can contribute to the decrease of smoking by up 10 percent (Centers for Disease Control and Prevention, 2012). Another behavioral health concern for patients in primary care settings is risky alcohol intake and drug use. In a survey conducted by the National Center on Addiction and Substance Abuse, of primary care patients surveyed, over 50% stated that their primary care physician did not discuss substance abuse (Madras, Compton, Avula, Stegbauer, Stein & Clark 2010). NIAAA guidelines suggest that males who drink more than 14 standard drinks per week or 4 drinks per day and woman who drink more than 7 standard drinks per week or 3 drinks per day are at risk for alcohol related problems (Research Into Action, 2008). These problems include medical issues, mental health conditions, a myriad of environmental issues and over utilization of health care services (Cornah, 2006). The implementation of BSI (Brief Screening and Intervention) program has been shown to statistically and significantly decreases the amount of use for marijuana, cocaine, methamphetamines, heroin and alcohol (Madras et al., 2010). Behavioral risks and disorders are responsible for 40 percent of deaths, $300 billion in healthcare costs, and $600 billion in additional expenditures yearly in the United States (Beasley et al., 2004). Furthermore, primary care physicians do not have time to focus on behavioral health care issues. Altschuler (2004) and Beasley (2004) show that if a primary care physician addressed behavioral health issues along with health related issue; the visit would require 130 minutes. Hope Clinic, located in Washtenaw County, Michigan, is a free primary and dental care clinic and food distribution center for patients who are uninsured. The majority of staff, including physicians, are volunteers. Hope Clinic does provide social resources assistance to patients such as applying for Healthy Michigan/Medicaid insurance, assisting with vouchers for clothes and helping with food distribution. However, patients were not screened and offered immediate interventions for behavioral health issues. In 2014, Hegira Programs, Inc. offered Screening, Brief Intervention and Referral to Treatment (S-BIRT) services to Hope Clinic, and based on the need for behavioral health services for the patient population, Hope agreed to the partnership. Hegira, a behavioral health care organization in out-Wayne County, obtained a two-year grant from the Flinn Foundation to implement Project INSPIRE (Integration, Screening, Prevention, Intervention, Referral and Evaluation). The Project INSPIRE team consists of a full time bachelor's level Case Manager and a part time Certified Peer Support Specialist/Recovery Coach. Staff provides universal screenings for alcohol, drug and tobacco use, as well as depression in both the medical and dental clinics. Universal screens are delivered face-to-face rather than having the patients use paper-and-pencil. Based on the screening scores,

patients will receive a Brief Intervention, Brief Treatment and/or a Referral to Treatment. The Peer will follow up with the patient for coordination of care, support in the community and assists with barriers to treatment while the Case Manager periodically follows up with the patient to retrieve outcome data. All documentation is electronic.

To date, Project INSPIRE has screened over 1,300 patients for substance use, tobacco use and depression. Out of those patients, over 100 referrals to treatment have been made and 150 patients have been monitored for depression using the Patient Health Questionnaire-9 (PHQ-9). Prior to the Project INSPIRE implementation at Hope Clinic, individuals such as the ones screened and given brief intervention, treatments, or referrals may had their behavior health needs overlooked. This is especially salient as several individuals throughout the screening process reported having suicidal ideation and were able to be screened for intensity and severity of suicidal ideation. Individuals such as this were given emergency resources and connections including mobile crisis who went to Hope Clinic and assessed patient needs during the crisis. Throughout the implementation process and establishment of the program, new needs were identified including an increase in patients with unaddressed anxiety issues and individuals requesting food assistance outside of the medical and dental clinics and therefore not being screened for behavioral health services.

Incorporating the Generalized Anxiety Disorder – 7 screening tool into the Project INSPIRE repertoire can reach more patients. This tool has been proven to be effective in quickly assessing medical patients for anxiety disorders and will therefore be effective in screening Hope Clinic's patient base. With this expansion Project INSPIRE will have objective and quantitative data to guide interventions and referrals for individuals with anxiety and to assist in providing follow up contact/goal planning with our patients as has been done in previous studies using SBIRT. Additionally, SAMHSA has begun to explore the potential of using SBIRT for anxiety. Based on the available research, which is still emerging, indicates SBIRT is effective in screening for anxiety and providing referrals for anxiety disorders in the healthcare setting. Furthermore, the brief intervention component of SBIRT for anxiety in the healthcare setting has been shown to have "promising results" (SAMHSA, 2011).

The food distribution center sees unique individuals who are not seen at either the medical or the dental clinics. Research has found an association between depression and food insecurity. This association can be causal in either direction which indicates a need to assist individuals who are experiencing food insecurity and therefore are at a potential to be experiencing depression (Hamelin, Habicht, & Beaudry, 1999). Furthermore, Project INSPIRE has not been implemented in a food pantry and yet research indicates that individuals with social needs experience depression and anxiety at greater rates and potentially at greater severities than other populations. One research study found "the prevalence of depressed mood or anxiety was 2.49 times higher" in individuals

	with low socio-economic status compared to individuals with higher SES (Lorant, et al., 2003). The project goal is to continue to provide mental health and substance use disorder services to uninsured adults in Washtenaw County, 18 years or older, who are coming in for primary care treatment, dental services, and/or to obtain food from the food distribution center. Currently, ten percent of Washtenaw's current population are uninsured (http://www.countyhealthrankings.org) and 43,000 adults do not have dental insurance (http://www.ewashtenaw.org/government/departments/public_health/health-promotion/hip/cha-chip-landing-page/cha-access). Last fiscal year, Hope Ypsilanti provided services for 1,380 adults in the medical clinic, 1, 068 in the dental clinic and had 8,608 requests for assistance for food supplies. Hegira Programs, Inc. is requesting $100,000 to expand the current services to include a Full Time and Part Time Health Manager and a Full Time Peer Recovery Coach. The following will be accomplished: 1. To offer behavioral health pre-screenings for substances, tobacco, depression and anxiety to all individuals seeking treatment or food at Hope Clinic. 2. To complete a full screen with all individuals who pre-screen scores indicate behavioral health risk. 3. To provide Brief Interventions to all individuals with an identified behavioral health risk. 4. To provide Brief Treatment to individuals who screened positive but are deferring behavioral health treatment. 5. To provide treatment referrals to all individuals with a severe behavioral health risk. 6. To facilitate smoking cessation activities and resources for individuals who use tobacco products.
Underlying Root Causes to be Targeted: (Associated Intervening Variables, Risk/ Protective Factors)	One of the underlying root causes of the issues Project INSPIRE seeks to address is resource scarcity. While recent statistics performed on Washtenaw County show a 10% rate of individuals who are uninsured which is under the national average, this only illustrates the need for resources for the 10% of individuals who are experiencing this scarcity. Hope Clinic's patient base is 100% uninsured and often-times have a difficult time with multiple issues as a result. Research oftentimes finds that individuals who are in a lower socio-economic class and specifically who are uninsured experience higher mortality rates. Reasons for this vary, but traditionally it is from overlooked mental and physical health conditions as they are not able to receive prevention and treatment resources (Hadley, 2003). The INSPIRE staff will seek to provide continuous and universal assessments for tobacco use, alcohol, recreational drugs, depression, and with

	the expansion of services anxiety. In this way Project INSPIRE will attempt to correct the deficit in the amount of prevention attempts and subsequent referrals to low-cost or free behavioral health treatment referrals made to individuals who are uninsured. Furthermore, Hope Clinic provides many of the opportunities for individuals to receive the resources to make up for the scarcity they are experiencing. There are patients, however, who require encouragement to take advantage of these resource opportunities which Project INSPIRE provides during the screening and intervention phase when individuals discuss their needs with INSPIRE staff. Staff are also trained in providing referrals for resource management as well, not just for behavioral health needs. Another root cause is a lack of social supports. Research shows that higher rates of perceived social supports are associated with lower rates of mental and physical health disorders. This includes not only depression and anxiety but also increased rates of substance abuse. This particular research suggests that perceiving adequate social support can act as a buffer against the stress caused by resource scarcity, especially for individuals who are uninsured. The same research indicates that having positive social supports was also associated with lower rates of smoking but that both of these can increase the health, both physical and mental, of the patient (Cadzow & Servoss, 2009). Project INSPIRE seeks to provide social support in several ways. The first way is by connecting personally with the patient through the Case Manager and Peer Recovery/Support coach. These individuals connect with patients at the first contact and will provide follow up with individuals to continue to provide encouragement and resource management with the patient. The second form of support that Project INSPIRE will provide is through referral connections. Case Managers and Peers will assist with finding resources that can continue to provide social supports to the patient. Some of the many examples that could be listed include connections to Hope Clinic's social work department who can further help with applying for insurance or other benefits, connections to therapy, and connections to support groups. Additionally, the Peer Recovery Coach can follow the patients into the community to further the perception of social supports should they desire this. In 2013, when the partnership between Hope Clinic and Hegira Programs was first being explored Hope Clinic saw 3,589 patients between the medical and dental clinics in the Washtenaw County clinic. The following year Hope saw 3,127 patients. During this time INSPIRE staff screened over 1,300 patients and tracked 150 for depression. Of these individuals 70% were a moderate or lower risk for depression based on their PHQ – 9 scores. Thirty percent of individuals were at a severe risk for depression. Twenty eight percent of the total number of patients followed showed reductions in their depressive symptoms throughout the course of follow up from INSPIRE team staff. Prior to Hegira and Hope's partnership other teams at other sites were screening and providing S-BIRT services only for substance use. As SAMHSA indicates research showed that providing S-BIRT services for depression was promising. Currently, SAMHSA shows the same to be true of anxiety indicating that perhaps this pattern of

	effectiveness is the same and that Hope Clinic patients could benefit from the same prevention and/or treatment procedures that they would likely not receive anywhere else (SAMHSA, 2011).
Evidence-based Strategies/Initiatives:	There will be two Evidence-Based Practices (EBP) that will be utilized in our services. The first EBP is S-BIRT. In the SAMHSA whitepaper "Screening, Brief Intervention and Referral to Treatment (S-BIRT) in Behavioral Healthcare," SAMHSA reported that, "in general only a small percentage of patients in primary care settings screened positive for some level of substance misuse, abuse or dependency. This is usually 5-20% but may be as high as 40% in some clinical settings" (SAMHSA, 2011). S-BIRT is also recommended as an EBP by the National Institute of Health and the U.S. Preventative Taskforce (Bernstein et al., 2009). Research shows that S-BIRT opens up conversations about substance use. In a primary care setting, this can make the topic less stigmatizing and more productive (Office of National Drug Control, 2011). The second EPB will be the IMPACT model. IMPACT is a stepped care disease management for depression in primary care offered for up to 12 months. A Case Manager is embedded in the primary care location and is responsible for screening patients for depression, providing treatment, or referring to treatment based on the level of depression, working with the medical treatment team and tracking outcomes. The President's New Freedom Commission of Mental Health recommends collaborative care and sites IMPACT as an EBP that help bridge gaps between mental health treatment and primary care (Unutzer, Schoenbaum, Druss & Katon, 2006). The Project INSPIRE Case Manager will meet with patients upon appointment check in at Hope Clinic and complete a screening for depression and anxiety, substance use, and smoking. The screening will consist of the first two questions of the PHQ-9, GAD-7, the Drug Abuse Screening Test (DAST-10) and the first three questions of the Alcohol Use Disorders Identification Test (AUDIT). Screenings will be completed by the Case Manager with the patient face-to-face. These questions will help determine if the patient requires a full screening of those tools. The Case Manager will establish a baseline for each patient receiving interventions and will continue to measure depression, anxiety, substance use and/or smoking, every 3 months following treatment initiation. If the patient score is higher than 5 but less than 15 on the PHQ-9, the Case Manager will complete a brief intervention and assess for risk. If the patient scores higher than a 15, brief treatment or a referral to treatment will be utilized. If a patient score is under 7 in the GAD-7, brief intervention will commence. If the score is over a 7, brief treatment or referral to treatment will be utilized. If the patient score on the AUDIT-C indicates risky drinking levels and/or illegal drug use, a full AUDIT, and/or DAST-10 will be completed. If necessary, the Case Manager will ensure the patient is provided with education, resources and treatment.

	Staff will continue to use S-BIRT which includes techniques such as a Brief Negotiated Interview and Motivational Interviewing. A Brief Negotiated Interview is a technique that assists with building rapport, assessing the pros and cons of a behavior, provides feedback and factual information about the behavior, uses the Readiness Ruler to assess stage of change and creates goals with the patient. The goals could be anything the patient identifies as being risky. Using this technique will aid the Case Manager in receiving a comprehensive view of the individuals' behavioral health problems, their substance use habits, and/or tobacco use and identified goals. If a patient requires and agrees to Brief Treatment, Motivational Enhancement Therapy (MET) will commence. Motivational Enhancement Therapy is brief therapy that is based on motivational principles to produce a rapid change (Miller, Rollnick, & Conforti, 2002). MET delivers effective outpatient treatment in short time frame (Miller, Zweben, Diclemente, & Rychtarik, 1999). If a patient self-reports tobacco use the Case Manager will complete a Brief Intervention. This brief intervention will be similar to S-BIRT but will use the "5 A's" from the University of Colorado Denver. These 5 A's are an evidence based practice to assist an individual in risk-reduction for smoking. They are widely used in medical and behavioral health settings and these procedures have been shown to be effective and considered a "best practice" for tobacco cessation (SCORE, 2010). The Case Manager will ask the patient at every visit about the patient's tobacco use and will ascertain the frequency of use. The Case Manager will advise the patient on their tobacco use and will provide educational materials in a personal way connecting the physical health condition to the tobacco use. The patient will then be referred to a Freedom from Smoking group and Peer Support Specialist services as well as national, state, and county-level tobacco recovery sources including but not limited to Nicotine Anonymous, 1-800 Quit assistance phone services, and free talk therapy for individuals through local colleges. Individuals who are interested in accepting these referrals and/or are willing to receive follow up will be called to ascertain where their motivation to change is at and if they are experiencing any barriers to connecting with referral sources. The Peer Support Specialist plays an integral role in the recovery process. When a patient is considered to be at a higher risk for depression and/or anxiety or for unhealthy drinking or drug use, the Peer Support Specialist will meet with the patient and the Health Manager and assist with the development of establishing health goals. The Peer Support Specialist will also assist the patient with the navigation of community referrals, ensure follow-up with behavioral health treatment, and provide the patient with resources and education needed during the recovery process.
PREVENTION ONLY	Check all that apply: ☐ Information Dissemination ☐ Problem Identification & Referral

Primary Federal Strategies (CSAP)	☐ Education ☐ Community-Based Process ☐ Alternatives ☐ Environmental
Short-term Outcomes (where applicable) : (CDC SMART objectives – Specific, Measurable, Achievable, Realistic, and Time-phased) For each outcome, please include the evaluation method (i.e., survey, questionnaires, etc.)	The outcomes of this project include: 1. Identified patients will experience 50% or greater reduction in their depression scores over a one-year period. Evaluation Method: The Patient Health Questionnaire-9 will be given at intake, and again at 12 weeks. If there is not a 50% reduction in the patient's score, the treatment recommendations will be reviewed with the physician which will warrant a change in the patient's treatment. 2. Identified patients will self-report an improvement in their overall health issues. Evaluation Method: A survey will be given to the patient to complete. 3. Identified patients will experience a 40 % reduction in their drinking and/or drug use. Evaluation Method: Patients will be given the AUDIT and/or DAST-10 at intake. Once Brief Intervention/Negotiation and/or Brief Treatment or Referral to Treatment has been completed, patients will be asked at 1 month, 3 month and 6 months if they have drunk and/or used drugs in the last 7 days, and, if so, how much was consumed. 2. Identified patients will report a 25% reduction in tobacco use and 5% will quit completely in a one-year period. Evaluation Method: Patients will be given a Tobacco Use Assessment at intake. Outcomes will be captured at 1 month, 3 month, 6 months and annually after the screening and intervention was completed. 3. Identified patients will experience a 50% or greater reduction in their anxiety scores over a one-year period. Evaluation Method: Patients will complete a GAD – 7 at intake and will be re-assessed using the GAD – 7 at 12 weeks to identify change in score.
Intended Long-term Outcome(s): (Describe how this funding will benefit service delivery and/or the community)	Hope Clinic serves a unique population for Washtenaw County. The population that is served may experience a lack of medical, dental, and nutrition resources were it not for Hope Clinic. The Project INSPIRE seeks to add access to behavioral healthcare prevention and treatment or referral connections to this same population that may otherwise experience scarcity in regards to their behavioral health needs. One of the long-term goals for this project is to continue increasing Hope Clinic knowledge of Project INSPIRE goals for the community as well as to continue Hope Clinic utilization of Project INSPIRE services.

	Project INSPIRE staff will become more interconnected with the procedures and programs of Hope Clinic to benefit service delivery to patients of Hope Clinic in the following ways: 1. Project INSPIRE staff will train Hope Clinic Social Work staff on S-BIRT procedures. 2. As Hope Clinic develops its interconnectedness between programs and structural and workflow changes are made within Hope, Project INSPIRE staff will work with Hope Clinic's administration staff to determine how to screen additional patients. 3. As Hope Clinic providers are primarily volunteers and rotate at sometimes infrequent intervals Project INSPIRE staff will meet with providers on a monthly basis. They will do this on a different day of the week to remind volunteers what Project INSPIRE does and provide outcomes to continue, enhance, and increase provider utilization of Project INSPIRE staff. Hegira staff will work with Hope Clinic Social Work department on providing at least two educational presentations to the community at Hope Clinic in 2017 on a topic related to substance abuse, tobacco cessation, depression, or anxiety.
Key People/Coalition:	Project Lead: Greg Seedott, MA Responsible for: - Overall implementation of the project - Supervision of HPI staff - Internal and external reporting - Electronic Health Record documentation and communication pathways development - Facility safety monitoring Health Manager: Katoya Campbell Responsible for: - Following EBP models with respect to screening, interventions, referrals and follow-up visits - Facilitate smoking cessation groups - Coordination of patient care with Hope Clinic staff - Participate in Hope Clinic team meetings Peer Support Specialist: To be determined Responsible for: - Assisting the patient with navigation of community resources

	) Providing on-going support for identified risk) Assisting the Health Manager with screening) Participating in primary care team meetings
Community Partners:	HPI's partner in this project is Hope Clinic. Hope Clinic was founded over 30 years ago to assist patients without medical insurance. What began as a small endeavor, expanded into a large organization that assists over 8,000 persons annually, across two counties by providing medical treatment, dental services and social services. While Hope Clinic continues to provide excellent medical and dental treatment to patients, the behavioral health component can be improved upon. Aside from the current Project INSPIRE staff behavioral health prevention and/or treatment are very limited. The Health Manager and the Peer Support Specialist will be located at Hope Clinic and will be part of the treatment team following the highly regarded co-located model of integrated care. Because Hope Clinic services fewer patients than an Emergency Department or an FQHC, more time will be spent with the medical staff to engage the patient and to ensure follow-up for all treatment areas.
Please note: All programming must be consistent with the implementation of Recovery-Oriented Systems of Care (ROSC). *Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems* (Center for Substance Abuse Treatment, 2005).	
CMHPSM Office Use Only	
Amount Recommended & Comments:	RECOMMEND FUNDING

CMHPSM SUD OVERSIGHT POLICY BOARD
ACTION REQUEST

Board Meeting Date: January 26, 2017

Action Requested: Recommend CMHPSM Board Approve funding for MDHHS "Enhancing Treatment Services to Pregnant Women", for Monroe County, Catholic Charities of Southeast Michigan (CCSEM)

Background: MDHHS released an RFI for **Enhancing Treatment Services to Pregnant Women,** seeking plans to implement innovative treatment and support strategies to improve outcomes for families affected by NAS/NOW, impacting persons in treatment for opioid dependence. CMHPSM SUD staff coordinated with CCSEM, DHHS, Family Medical Center to submit a proposal to the state. The state has indicated that they would accept this proposal and encourage PIHP's to begin planning for implementation for this year. CCSEM submitted a program plan and budget for outreach case management and peer services, that would function as a community based team to work with High Risk pregnant women and support the OBGYN team; NICU team, DHHS and other supportive community based services, in addition to the women's specialty services currently provided. Staff recommend a maximum funding amount of **$123,250** which includes salary and fringes, operating and material expenses and indirect costs.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:
Response to the MDHHS Office of Recovery Oriented Systems of Care (OROSC) RFI; provision of integrated services (primary care and SUD) and addressing the Opioid Epidemic.

Recommendation:

Recommend CMHPSM regional board approve funding of this program out of MDHHS SUD block grant funds in the maximum amount of $123,250

Innovative Strategies for Enhancing Treatment Services to Pregnant Women Consistent with the Requirements of the Substance Abuse Prevention and Treatment Block Grant

Monroe County Women Specific Services: Catholic Charities of Southeast Michigan currently collaborates with several agencies within the community to ensure pregnant women and women with dependent children are a priority for treatment.

Services Narrative: Women who are pregnant and addressing addiction are seen within 24 hours of being screened for services. Women are offered clinical counseling, Recovery Peer Support services, clinical case management through our Women's Specialty program in addition to our Empowering Women Recovery Group and Hope for Healthy Babies. Women's Specialty Services provides women the opportunity to further remove barriers and connect with resources. Women are offered assistance with transportation, daycare for children during appointments or job searching, FASD screening, FASD education, document replacement to include birth certificates, state id, and driver license, housing resources, medical referrals to include OB doctors, and support and advocacy with open DHHS cases. The Clinical Case Manager works offsite at several community agencies in addition to being onsite at CCSEM. Empowering Women Recovery Group is a 1 ½ hour women specific recovery group which places focus on the underlying issues that can contribute to addiction in women. There are 15 group topics which include: Coping with Anxiety and the Pressures of Women; Building Support in Recovery; The Deadly D's: Denial, Delay, Detour, Deception, and Death; Feelings of Self-Worth, Strengths, Role as Women; Effect of Addiction on Children and Adult Children; Grief and Loss; Managing Stress and Being Mindful; Examining Our Relationships with Money; Learning to Communicate Our Needs in Recovery; Choosing the Right Partner; Developing An Emotional Awareness; Parenting and Substance Use; Meeting Our Personal Needs; Nutrition and Healthy Living; and Healing After Trauma. **Hope for Healthy Babies** is a six-week group that provides women who are pregnant and struggling with addiction the opportunity to receive education and resources within the community to reduce harm to mother and infant. Hope for Healthy Babies was developed through a collaboration of partners which includes: CCSEM, ProMedica, Monroe County Health Department, and The Great Start Collaborative. Each partner shares resources and education during group sessions to better educate the group members about addiction and the impact on the fetus during pregnancy. Addiction and the brain; addiction and the fetus; labor, delivery and withdrawal possibilities for mom and/or infant; Health Department resources; Great Start Collaborative resources; CCSEM Services; ProMedica Regional Hospital Services; and Possible DHHS Involvement are all topics that are discussed throughout the group process. Women are encouraged to engage in additional services to better manage their addiction and enhance their opportunity for recovery.

MEDICAL Collaborations: Family Medical Center OB/GYN, Dr. Laura Katz, ProMedica Hospital, ProMedica Family Residency Center.

DHHS Contracts and Services provided through CCSEM: Supervised Visitation, Parenting Education, Substance Abuse Evaluations, Substance / Mental Health Counseling, Women's Specialty Services.
Other Collaborations: Monroe County Health Department, Michigan Works, Monroe County Great Start Collaborative, Speckled Frog Child Care Center, Monroe Community Mental Health, Salvation Army Harbor Light, Paula's House I and II, Monroe County Probation and Parole.

Lenawee
Livingston
Monroe
Washtenaw

SUD PREVENTION & TREATMENT SERVICES

SUD RFP TIMELINE 2017

CMHPSM SUD TREATMENT RFP#_____

CMHPSM SUD PREVENTION RFP#_____

RFP in Oversight Policy Board packet	March 16, 2017
RFP to Oversight Policy Board for approval	March 23, 2017
RFP in CMHPSM Regional Board packet	April 5, 2017
RFP to CMHPSM Regional Board – summary approval	April 12, 2017
RFP available on MITN website	April 13, 2017
Mandatory Bidders Conference	April 21, 2017
Bidders Conference Q & A posted on MITN	April 28, 2017
Bid submission deadline	**May 22, 2017 3:00 P.M.**
Bid review begins	May 23, 2017
Award recommendations in Oversight Policy Board packet	June 15, 2017
Award recommendations to Oversight Policy Board	June 22, 2017
Contracts/Awards in CMHPSM Regional Board packet	July 5, 2017
Contracts/Awards to CMHPSM Regional Board	July 12, 2017
Award notices	July 17, 2017
Contracts issued to awarded organizations	Prior to October 1, 2017

Livingston County CMH Authority
Engagement Center grant
Final grant report for FY16

Engagement Center

Collaboration and Engagement

- Extensive collaboration and integration with community partners has ignited excitement and dialogue around community needs. Engagement Center (EC) staff has accepted invitations and collaboration with community partners to bridge gaps in our ROSC services continuum. Additional collaborative partnership opportunities and networking achieved through SUD Workgroup attendance and participation including DHHS, Karen Bergbower and Associates, United Way, Brighton Recovery Center, Human Services Collaborative Body, Livingston County Community Alliance. EC staff has also worked with Dual Recovery Anonymous locally. These partnerships linked EC staff with recovery community and core providers in efforts to explore, learn and review assessments, policies and procedures. This information provided helpful feedback in creation of EC screening and intake assessments.
- Extensive collaboration has occurred with St. Joseph Mercy Livingston Hospital system that has provided $50,000 in funding toward our building renovations. Additional partnerships with local law enforcement, probation/parole, prosecutors, jail and jail diversion teams create opportunities to develop our collaborative effort and referral sources.
- It is our goal to continue to seek collaboration with local police and sheriff departments, St. Joseph Mercy and EMS. Upon completion of programming, our hope is to train each of these partners, have a Q & A meeting and an open house.
- Focus groups conducted at CMH, Key Development and Catholic Charities yielded valuable information regarding consumer and staff needs/wants /desires for EC and programming. Consumers provided name possibilities, desired activities, group content/types and food preferences.

Site Preparation

- Extensive time, research and effort have been given to site preparation. The former First Impressions building at 2020 E. Grand River, Ste. 102 in Howell provides an exceptional space fo the program. It is located in a business district on a main road with easy access to the local hospital emergency room and to local law enforcement support.
- St. Joseph Mercy Livingston Hospital provided $50,000 in renovation costs for the site.
- The physical space was carefully designed to be welcoming and meet the criteria of a living room model. All considerations for electrical, color and furnishing are carefully designed to exhibit a warm, welcoming and positive sensory experience. Furnishings, appliances, etc. have been purchased.

- Peer staff have visited the site and approved of the atmosphere.
- Livingston CMH Health and Medications Supervisor researched and purchased health and safety equipment (AED, First aid kit/supplies etc.) in accordance with TJC requirements.
- Contracts are in place or receiving CMH Board approval in November for phone, internet service, etc. Equipment for IT has been identified and purchased.

Program Development

- We have developed screening, assessment and paperwork flow for service provision. The screening and assessment tools cover all fundamental areas for assessment of needs. Specific health and safety assessment tools will determine program admission or referral. Evidence-based screening tools are attached to the assessment for trauma, TBI, specific substances, etc.
- All data elements required by the PIHP for engagement centers have been embedded in the documentation flow. Additional data elements are under consideration as well.
- All consumers will complete and leave with a recovery plan from their EC visit.
- All documentation is in accordance with The Joint Commission requirements for accreditation.
- Community needs assessment data and themes were used to drive planning and program development of Engagement Center. Current community issues related to persons with Substance Use Disorders include but are not limited to lack of programming off hours/weekends. Activities and programming under development which will be housed at the Engagement Center potentially include DRA/AA/NA/Alanon meetings; Family Psychoeducation groups; recovery-based groups; stage-wise interventions; self-care, brief therapy skills/tools.
- EC staff had the opportunity to conduct site visits to explore, learn and review applicable policies, procedures and training materials. The opportunity yielded valuable information to visit contracted/non-contracted SUD referrals sources with a wide variety of populations and needs. These included Brighton Center for Recovery, Sacred Heart, Washtenaw Engagement Center, Salvation Army- Harbor Light, Oakdale Recovery, Dawn Farm and Spera. Resources, networking and training materials obtained at conferences and seminars including Strengthening Families, Faith Based Initiatives Conference, community opioid forums (Fowlerville/Pinckney) and St. John/Brighton Recovery Center Addictions Treatment Conference.
- All staff will be trained to complete Medicaid applications. Program Coordinator has developed up-to-date resource list for referrals related to housing, mental health and community providers (according to fee schedule and insurance options) and daily/times and locations for recovery community meetings . The program will provide a clearinghouse of information on immediate needs including but not limited to transportation, car repairs, utility assistance, food and clothing.

Policy and Procedures

- Policy and procedures continue to be developed for the program. Additions to the personnel manual for 24-hour programs have been submitted to the CMH Board for November. Specific policies and protocols for medical clearance, medications and medical competencies remain in final development.

- All staff will follow the same requirements as other Livingston CMH programs for additional agency policies, trainings, etc.
- Collaborative work with CMH nursing staff has included safety protocols, first aid kits, supplies, AED, sharps containers and naloxone training. Each staff will be required to complete core CMH trainings and site specific trainings upon hire.

Staffing

- Jobs have been posted for EC positions. Multiple positions have been hired or are in the hiring phase with a goal for opening in December.
- All staff have appropriate state licensure and MCBAP certification (or development plan).
- Staff will be trained together as a team prior to opening the center.
- Program coordinator has completed naloxone training which will be on site for use if needed. Additional staff will be trained as part of the orientation process.
- Staff will receive all required CMH trainings, substance licensed required trainings (eg. Level 1 communicable diseases) and specific policy/protocol trainings (eg. breathalyzer competencies, health and safety assessment for consumers, etc.). The training plan is being finalized to prepare staff.
- Staff schedules have been developed to align with similar agency 24-hour programs like PERS. Staffing will run from 5 pm to 9 am on weekdays and 24/7 on weekends. Currently EC staff will work eight-hour shifts with two staff working at a time. EC positions include: FT therapist, FT case manager, 2 FT peer specialists, 2 occasional PT peer specialists, 3-4 occasional PT mental health assistants and program coordinator. All staff are part of the regular hours to cover program needs. In order to provide absence coverage, the program requires support by program coordinator, occasional peers and occasional mental health assistants.
- We recognize a need to increase the occasional staffing in the budget to ensure all shift coverage weekly and to allow absence coverage. These would be occasional staff with variable hours to allow flexibility for coverage. We are concerned about the need for an occasional part-time case manager as well for assessments and backup of clinical positions. We do not know enough about how the center will operate in terms of flow and busy times to determine staffing needs permanently. We expect to need to adjust the staffing pattern over time when we have more information. Our current budget has room to adjust staffing costs.

Unanticipated Challenges

- New site location secured with financial support of St. Joseph Mercy Livingston Hospital after program was not able to exist on hospital campus.
- Scheduling has been a challenge in order to project occupancy and acuity. We have consulted with a program coordinator at CMH who supervises a 24 hour program. She was able to provide insight and possible solutions to our scheduling gaps.

- We know that we will need to be clear with the community about our mission and avoid community pressure to fill other gaps (eg. homeless shelter, jail release at midnight issues, etc.). We have been having clear discussions with community partners about our mission, will train EC staff accordingly and will continue to keep the word out there over time.