OVERSIGHT POLICY BOARD

Regular Board Meeting

Patrick Barrie Conference Room
3005 Boardwalk Drive, Suite 200
Ann Arbor, MI
Thursday, April 28, 2022
9:30 a.m. – 11:30 a.m.

To Join by Phone:
1-312-626-6799; 1-646-876-9923; or
1-346-248-7799
Meeting ID: 133 461 219

To Join by Computer:
https://us02web.zoom.us/j/133461219
Passcode: 513544

Agenda

1. Introductions, Welcome Board Members & Review Open Meetings Act Procedures– 10 minutes
2. Approval of Agenda **(Board Action)** – 2 minutes
3. Approval of February 24, 2022 OPB Minutes {Att. #1} **(Board Action)** – 5 minutes
4. Audience Participation – 3 minutes per person
5. Old Business
   a. Finance Report {Att. #2} (Discussion) – 10 minutes
   b. FY22 American Rescue Plan Act Funding Update {Att. #3} (Discussion) – 15 minutes
   c. PA2/Block Grant Spending Plan FY23 (Discussion) – 15 minutes
6. New Business
   a. Strategic Initiatives Mid-Year Update {Att. #4} (Discussion) – 10 minutes
   b. SUD and CMHPSM Strategic Plan Updates {Att. #5a, 5b} (Discussion) – 15 minutes
   c. Request for PA2 Funds for Livingston {Att. #6} (**Board Approval**) – 10 minutes
   d. Opioid Settlement Funds (Discussion) – 15 minutes
   e. Mini Grant Request {Att. #7} (Discussion) – 5 minutes
7. Report from Regional Board (Discussion) {Att. #8} – 5 minutes
8. SUD Director Updates (Discussion) – 10 minutes
   a. CEO Update {Att. #9}
   b. Staffing Update
   c. SOR I Report {Att. #10}
   d. Back to office plans
9. Adjournment **(Board Action)**

***Next meeting: Thursday, May 26, 2022**
Location: 3005 Boardwalk, Suite 200; Patrick Barrie Room

Oversight Policy Board Minutes
February 24, 2022
Meeting held electronically via Zoom software

Members Present:	Mark Cochran, Kim Comerzan, James Goetz, Ricky Jefferson (remote), Molly Welch Marahar, Dianne McCormick, Frank Nagle (remote), Dave Oblak, Carol Reader, Ralph Tillotson, Monique Uzelac, Tom Waldecker
Members Absent:	Amy Fullerton, Susan Longsworth, Dave O'Dell
Guests:	
Staff Present:	Stephannie Weary, James Colaianne, Nicole Adelman, Matt Berg, CJ Witherow, Alyssa Tumolo, Rebecca DuBois, Danielle Brunk, Jessica Sahutoglu, Joelen Kersten, Kate Hendricks

Board Chair M. Cochran called the meeting to order at 9:35 a.m.

1. Introductions
   An in-person quorum of board members present was confirmed.

2. Approval of the Agenda
   Motion by R. Tillotson, supported by M. Welch Marahar, to approve the agenda
   Motion carried

3. Approval of the October 28, 2021 Oversight Policy Board minutes
   Motion by T. Waldecker, supported by K. Comerzan, to approve the October 28, 2021 OPB minutes
   Motion carried

4. Audience Participation
   - OPB would like other meeting location options for social distancing purposes.
   - R. Jefferson suggested the LRC as an OPB meeting location going forward.

5. Old Business
   a. Finance Report
      - M. Berg presented.
   b. FY22 American Rescue Plan Act Funding Update
      - OPB reviewed plan for funding allocations.
   c. PA2/Block Grant Spending Plan FY23
      - Staff requested input and ideas from OPB regarding FY23 PA2 and block grant spending.
      - N. Adelman recommended to continue existing programs for the coming year, rather than awarding additional funding that may or may not be available going forward. OPB agreed with this approach.

6. New Business
   a. Core Provider Service Model Review
      - The fee for service model will start in October 2022 for Washtenaw's former core providers, Home of New Vision and Dawn Farm instead of the original plan of April 1, 2022, if approved by Regional Board.

- M. Welch Marahar expressed concern for the continued availability of publicly-funded treatment beds, and how the PIHP will ensure that availability now that the access has been streamlined.
- Nicole agreed that this is a concern, which is one reason for a 10/1/22 start date to provide time and dialogue with the former core providers to ensure availability.
- This item will remain as a standing agenda item for OPB for now.

b. Request for PA2 Funds for Livingston Women's Specialty Service
- A missing FY18 payment was discovered during a Livingston County CMH audit.
- PIHP has no record of submission, but CMH is sure they submitted.

Motion by R. Tillotson, supported by J. Goetz, to approve $11,058.50 in FY22 PA2 funds to Livingston County Community Mental Health Authority for the Livingston Women's Specialty Services (WSS) Program for an outstanding FY18 invoice
Motion carried

c. SUD Dashboard
- J. Sahutoglu presented.
- Staff will bring the dashboard to the quarterly provider meetings going forward.
- OPB would also like to review the dashboard on a quarterly basis.

d. Naloxone Distribution and Regional Reports
- A. Tumolo and R. DuBois presented.
- This data will be presented to OPB on a quarterly basis.

e. Naloxone Policy
HBV HCV, page 15 of packet: K. Comerzan advised that both Hepatitis B and Hepatitis C should be included.

Motion by T. Waldecker, supported by D. McCormick, to approve the revised Naloxone policy, including K. Comerzan's recommendation, noted above
Motion carried

f. SUD Media Campaign Policy

Motion by T. Waldecker, supported by R. Tillotson, to approve the revised SUD Media Campaign
Motion carried

7. Report from Regional Board
- No official meeting, no quorum.

8. SUD Director Updates
a. CEO Update
- The Shirkey bill has momentum, will likely make it to the senate floor. If it passes in the Senate, the next step would be a move to the House.
- The current plan is for staff to begin returning to the office in March.

b. Opioid Health Homes
- Packard is the current OHH.

- Next month, Passion of Mind will be submitted to regional board for approval as an OHH, and Family Medical Center the following month.

c. Military Cultural Competency Training
   - Veteran Navigator staff will be providing military cultural competency training across the region.

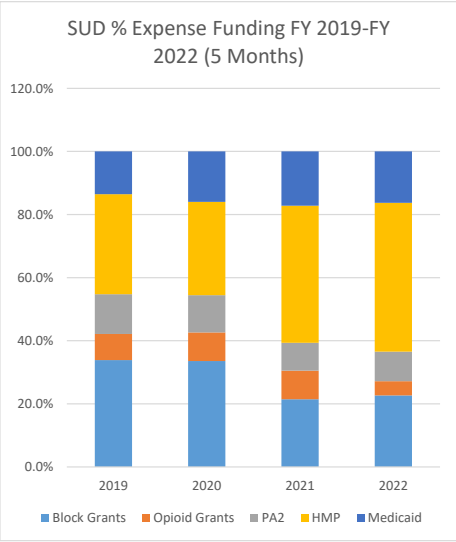
9. Adjournment
   Motion by R. Tillotson, supported by K. Comerzan, to adjourn the meeting
   Motion carried

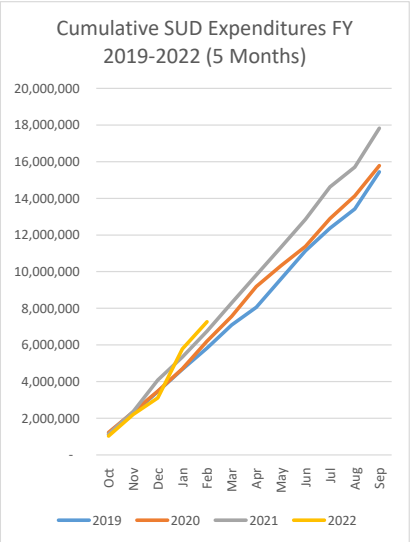
   - Meeting adjourned at 11:15 a.m.

***Next meeting: Thursday, March 24, 2022**
Location 3005 Boardwalk, Suite 200; Patrick Barrie Room

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
February 2022 FYTD

Summary Of Revenue & Expense	Funding Source							Total Funding Sources	FY21 YTD
	Medicaid	Healthy Michigan	Block Grants/OHH	OHH	Opioid Grants	Gambling Prev	SUD-PA2		
Revenues									
Funding From MDHHS	1,497,284	4,338,403	2,086,589	50,662.72	411,393	24,899		**$ 8,409,232**	$ 7,469,188
PA2/COBO Tax Funding Current Year							449,832	**$ 449,832**	$ 553,230
PA2/COBO Reserve Utilization							416,825	**$ 416,825**	$ 304,899
Other (transfer to ISF)			-		-	-	-	**$ -**	
Total Revenues	**$ 1,497,284**	**$ 4,338,403**	**$ 2,086,589**	**$ 50,663**	**$ 411,393**	**$ 24,899**	**$ 866,656**	**$ 9,275,888**	$ 8,327,317
Expenses									
Funding for County SUD Programs									
CMHPSM			$ 43,840	$ 25,367	$ 411,393	$ 24,899		**505,499**	695,796
Lenawee	163,025	427,950	254,833				$ 66,554	**912,362**	915,528
Livingston	91,615	308,605	315,167				168,010	**883,397**	863,758
Monroe	206,778	443,542	596,311				193,652	**1,440,283**	1,201,767
Washtenaw	390,876	1,371,925	735,129				438,440	**2,936,370**	2,572,952
Total SUD Expenses	$ 852,294	$ 2,552,022	$ 1,945,280	$ 25,367	$ 411,393	$ 24,899	$ 866,656	**$ 6,677,912**	$ 6,249,801
Administrative Cost Allocation	124,474	321,174	141,309	10,133			-	**$ 586,957**	$ 493,238
Total Expenses	**976,768**	**2,873,196**	**$ 2,086,589**	**$ 35,500**	**$ 411,393**	**$ 24,899**	**$ 866,656**	**$ 7,264,869**	$ 6,743,039
Revenues Over/(Under) Expenses	**520,515.90**	**1,465,207**	**0**	**15,163**	**$ 0**	**$ 0**	**-**	**$ 2,011,019**	$ 1,584,278





FY 2022 PA2 Current Expenses and Budget

	Revenues	Expenditures	Revenues Over/(Under) Expenses
PA2 by County			
Lenawee	38,534	66,554	(28,020)
Livingston	117,757	168,010	(50,253)
Monroe	86,813	193,652	(106,839)
Washtenaw	206,727	438,440	(231,713)
Totals	$ 449,832	$ 866,656	$ (416,824)

Unallocated PA2	FY 22 Beginning Balance (Prelim)	FY22 Budgeted Utilization	FY22 Projected Ending Balance	FY 21 YE Over/(Under) Expenses
Lenawee	524,050	(347,226)	176,824	(199,668)
Livingston	3,741,037	(198,708)	3,542,328	93,773
Monroe	303,906	(69,131)	234,775	(125,039)
Washtenaw	1,621,374	(599,327)	1,022,048	(418,078)
Total	$ 6,190,367	$ (1,214,391)	$ 4,975,976	$ (649,012)

SABG Supplemental – ARPA from OROSC

CMHPSM Region 6 Allocation

Prevention, Treatment, Recovery	Activity	Available per PIHP/year	Amount Requested	Amount Allocated	Project Ideas	County/Amt
Prevention	Student Assistance Programming- Alternatives to suspension for substance use (PFL 420, Teen Intervene etc.)	$100,000	$100,000	$50,000	Monroe County ISD $2,485 Jefferson School District $47,515 **CONFIRMED**	Monroe $50k
Prevention	Evidence-Based Program/Practice for diverse priority areas and populations determined by community needs assessment	$119,060	$119,060 FY 1- 49,434 FY 2- 114,000	$119,060	St. Joe Project SUCCESS in Dexter and Chelsea $67,800 **CONFIRMED**	Washtenaw $119,060 total allocation; not likely to spend total award in year 1 due to May start
Treatment	Staffing support: same day appointments for OTP, WM, Residential	$50,000	$50,000	$50,000	TBD	TBD
	SUD Health Home maintenance	$10,000	$10,000	$0	State deferred because we are not currently implementing SUD Health Home	
Treatment	Accessing Behavioral Health for African American and other disparate populations – utilizing anchor	$100,000/community – **10 communities in total for duration of grant*	$100,000	$100,000; $25k/one per county	Mexicenses en Michigan $25k Supreme Felons $25k **CONFIRMED**	Washtenaw $50k

Prevention, Treatment, Recovery	Activity	Available per PIHP/year	Amount Requested	Amount Allocated	Project Ideas	County/Amt
	institutions for connections to provider services.				Monroe Co. Opportunity Program $25k **CONFIRMED**	Monroe $25k
Treatment	Telehealth Technology – provider updates to make telehealth more accessible – year 1 only	$75,000	$75,000	$75,000	Workit Health $75,000 **CONFIRMED**	$75,000 Regional
Treatment	Telehealth Hubs in the community – allow individuals without reliable access a community space to participate in telehealth sessions.	$50,000	$50,000	$50,000	**TBD**	TBD
Recovery	Prosocial Activities for youth in recovery or misusing substances	$7,500	$7,500	$7,500	Ozone House $2,500 **CONFIRMED**	Washtenaw $2,500
					Liv - Youth Connect $2,500 **CONFIRMED**	Livingston $2,500
					Boys and Girls Club of Lenawee $2,500 **CONFIRMED**	Lenawee $2,500
Recovery	Youth Community Centers – 2 each yr; 1 yr only with carry forward and possible additional years if other regions don't want it.	$350,000	$350,000	$350,000	Monroe County Opportunity Program $350,000 **CONFIRMED**	Monroe $350k
Recovery	Individualized Placement and Support	$25,000 – if every region were interested	$25,000	$25,000	Eisenhower Center	Washtenaw $25k

Prevention, Treatment, Recovery	Activity	Available per PIHP/year	Amount Requested	Amount Allocated	Project Ideas	County/Amt
					CONFIRMED	
Recovery	Collegiate Recovery Programs – support for peer recovery services, training, development of additional programs (up to 10 programs in total)	$25,000/CRP	$100,000	$25,000 *this is intended for one CRP	Adrian College (Sienna Heights partnership) **CONFIRMED**	Lenawee $25k
	Recovery Community Organization development	Up to 4 organizations/year - $150,000	$150,000	$0	State deferred our request since we already have some RCOs.	
Recovery	Recovery Support Services to special populations: older adults, WSS, youth, incarcerated	$75,000	$368,971	$75,000	CCSEM $75,000 **CONFIRMED**	Monroe $75,000
Recovery	Recovery Housing	$100,000	$100,000	$100,000	Ty's House **CONFIRMED**	Monroe $30,000
					Dawn Farm, Paula's House TBD	TBD

Program	FY22 Mid-Year Outcomes
Avalon Housing (Integrated Health Care)	Utilizing an integrated care model to serve 202 individuals with a goal of 300. Distributing 2,792 harm reduction and Narcan kits with a goal of 2,000.
Catholic Charities SEM (Recovery Supports)	Number of clients who met with a recovery coach or case manager 77 with a goal of 100. Number of clients who received assistance with employment, disability and/or unemployment 47 with a goal of 100.
Dawn Farm (Recovery Court)	Increase participation in Recovery Court- 21 individuals with a goal of 45. Engagement in Recovery Support Services- 21 with a goal of 20. A total of 5 individuals have graduated.
Growth Works (Educational Groups)	Gaining contact potentials 4 meetings, 9 contacts, with a goal of 2 per month. Providing educational program or group discussions to youth 1 meeting, with a goal of 1 per month.
Home of New Vision (Engagement Center)	100% of clients have prepared a recovery plan for discharge, with a goal of 95%. 81% of individuals were more likely to use the engagement center instead of the Emergency room in the future, with a goal of 80%.
Home of New Vision (ROOT)	ROOT continues to assist individuals who had recently experienced an overdose, providing support, linkage to services, and utilization of harm reduction techniques and services. Root distributed 360 Naloxone Kits
Home of New Vision (Recovery Supports)	38 unique individuals have received Case Management Services with a goal of 230. A total of 119.32 hours of Recovery Coach Services has been provided with a goal of 1000 hrs.
Home of New Vision (WRAP)	Narcan Training and Distribution of 686 with a goal of 200. Community education/training to 327 individuals with a goal of 150. Increased inclusivity of family and friends who have been affected by SUD was 224 with a goal of 50.
Lenawee County CMH (Drug Court)	Number of graduates 5 with a goal of 8. Number of participants who engage with a peer recovery coach 10 with a goal of 22.
Lenawee Pathways (Engagement Center)	92 participants in the program to date with a goal of 174. Number of recovery groups offered per week 18 with a goal of 18. 12 individuals referred by law enforcement, corrections, or probation with a goal of 20.
Lenawee/Parkside (Probate Ct. Treatment)	Placement in community with probate court is 100% with a goal of 65%. Family cohesion increased by 3.71 with a goal of increase at 4. Efforts for this program continue however, many struggles have occurred due to COVID. Quarter 2 report has not been received.
Livingston CMH (Engagement Center)	Access to Engagement Center by 474 individuals with a goal of 1,400. Onsite and telehealth recovery support groups 43 with a goal of 500. Onsite and telehealth sober social activities and recovery speakers 96 with a goal of 250.
Ozone House (Engagement Program)	Youth engaged 984 with a goal of 1,700. Smart Recovery Program is used as a 10-week program and consists of 7 to 8 individuals attending sessions. Quarter 2 report has been given an extension.

Parkside Family Counseling (Education Groups)	Reduction in AOD/Vaping Behaviors scoring at 89% during classes for youth with a goal of 65%. Reduction in AOD/Vaping behaviors scoring 80% during group for teens with parents with a goal of 75%. Quarter 2 report has not been received.
RAIL (Recovery Housing)	Number of participants 26 with a goal of 15-18. 88% of the women living in the sober living recovery house have increased their length of sobriety and quality of life by the end of the program with a goal of 85%.
RAIL (Recovery Community Organization)	A recovery focused resource website accessible to people in recovery in Livingston County had 339 site visits and 255 new visitors, with a goal of 100 site visits. Recovery Support Services had 214 contacts with people in recovery in Livingston County, with a goal of 25 participants per quarter. A total of 339 participants have attended recovery support services.
Ty's House (Recovery Housing)	96% of individuals have health insurance with a goal of 100%. 89% of individuals have obtained full time employment within 30 days (unless in OP/IOP) with a goal of 80%.
Unified HIV and Beyond (Outreach)	SSP Syringes Distributed 42,747 with a goal of 40,000. Safer Smoking Crack Kits 378 with a goal of 200. Naloxone Distributed 739 with a goal of 2,000.
Paula's House (Recovery Housing)	Number or pregnant women housed to date 2 with a goal of 2. Number of women reunifying with their children each month 7 with a goal of 3.
Washtenaw CMH (Crisis Access)	Total of 585 contacts with the Mental Health Professional, with a goal of 75. Total of 27 unduplicated individuals receiving case management from the Mental Health professional, with a goal of 20. With Washtenaw County CMH taking on the Access Department for the county, they will no longer receive the grant for Strategic Initiatives.

FY2021-23 CMHPSM Strategic Plan Metrics / Milestones

The CMHPSM will report to the CMHPSM Board on a semi-annual basis on strategic plan metrics and milestones.

Report #3:

3/31/2022

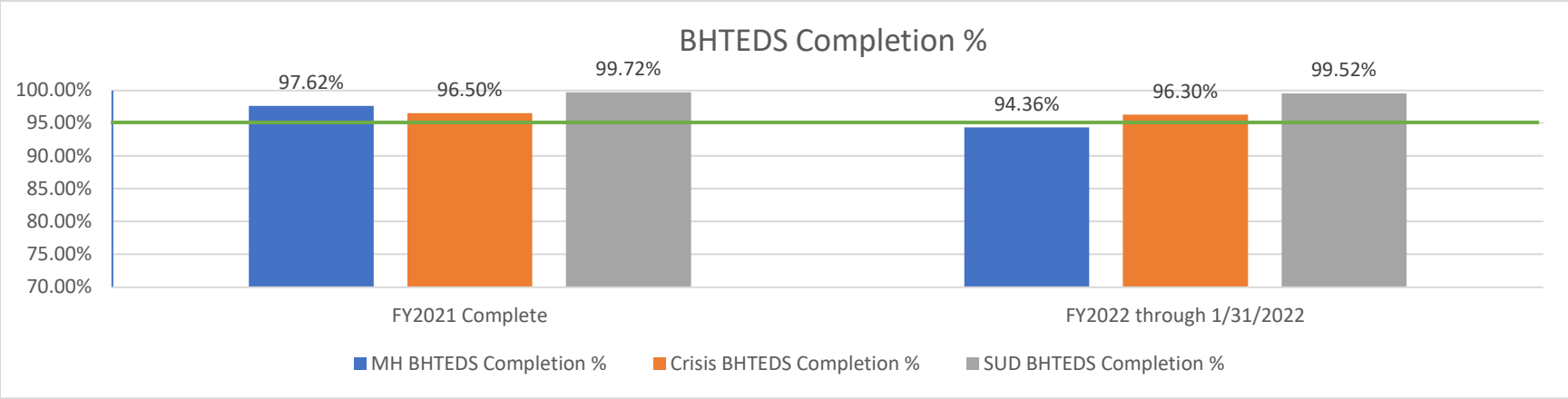
Summary:

Goal	Report 1: 3/31/2021	Report 2: 9/30/2021	Report 3: 3/31/2022	Report 4: 9/30/2022	Report 5: 3/31/2023	Report 6: 9/30/2023
#1	N/A	Partially Met	Partially Met			
#2	N/A	N/A	Fully Met			
#3	Fully Met	Fully Met	Fully Met			
#4	N/A	Not Met	Fully Met			
#5	N/A	Partially Met	Partially Met			
#6	N/A	Fully Met	Fully Met			
#7	Fully Met	Fully Met	Fully Met			
#8	Fully Met	Fully Met	Fully Met			
#9	Fully Met	Fully Met	Fully Met			
#10	Fully Met	Fully Met	Fully Met			
#11	Fully Met	Fully Met	Fully Met			

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: #1: Partially Met
#1. Improve working relationships and financial expertise within our system, which includes the CMHPSM, regional CMHSPs and external service providers. (Lead Finance)	Conduct an in-depth analysis of the top 1-5 CPT service codes that account for the most service cost by Q4 of FY2021.	Conduct an in-depth analysis of the top 6-10 CPT service codes that account for the most service cost by Q4 of FY2022.	Conduct an in-depth analysis of the top 11-15 CPT service codes that account for the most service cost by Q4 of FY2023.	#1: The ECC workgroup continues to meet and the group transitioned our focus to the many service coding changes that are to be implemented in this current fiscal year or FY2023. Current work centers around our skill building services (H2014) and a survey was recently released around this potential code and modifier reimbursement model revision. To some extent this goal has been altered by MDHHS mandated changes which are pre-empting internal analyses as originally planned.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#2. Increase the contribution amount to the CMHPSM Internal Service Fund (ISF) each year until the ISF is fully funded. (Lead Finance)	Increase contribution amount level over FY2020.	Increase contribution amount level over FY2021.	Increase contribution amount level over FY2022.	#2: The CMHPSM closed out FY2021 with a significant ISF contribution. The CMHPSM also recently revised FSRs for FY2018, FY2019 and FY2019 to reflect a negative balance in the ISF and thus ISF contributions for that period are: FY2018: -$11,352,411 contribution bringing the year end ISF balance to -$4,286,744. FY2019: -$10,622,497 contribution bringing the year end ISF balance to -$14,909,241. FY2020: $11,054,816 contribution bringing the year end ISF balance to -$3,854,425. FY2021: $18,880,568 contribution bringing the year-end ISF balance to the FY2021 maximum of $15,026,143. With the revised reporting status, the CMHPSM region currently has a fully funded ISD of over $15 million. This reporting status also reflects the full repayment of PIHP risk corridor amounts and is pending MDHHS review.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#3. Improve the comprehensiveness and validity of the health data within our regional electronic health record: CRCT. (Lead IM)	Maintain overall BHTEDS completion rates to state 95% standard during FY2021. Improve crisis encounter BHTEDs completion to 80% during FY2021.	Maintain overall BHTEDS completion rates to state 95% standard during FY2022. Improve crisis encounter BHTEDs completion to 85% during FY2022.	Maintain overall BHTEDS completion rates to state 95% standard during FY2023. Improve crisis encounter BHTEDs completion to 95% during FY2023.	#3: The CMHPSM and the partner CMHSPs have maintained overall BHTEDS completion rates above the 95% standard for both mental health and SUD encounters through FY2021. Preliminary levels for FY2022 include some cleanup on the MH BHTEDS which we expect to have completed prior to year end. Our crisis encounter BHTEDs are above our FY2022 and FY2023 metric goals, therefore our goal metric will be revised upwards to maintain 95% on all measures through FY2022-2023.



Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#4. Improve the user experience for all users of our regional electronic health record: CRCT. (Lead: IM)	Create and release a CRCT user survey by Q3 of FY2021 to establish a user satisfaction baseline.	Re-issue a CRCT user survey by Q3 of FY2022 and maintain or increase user satisfaction scores over FY2021.	Re-issue a CRCT user survey by Q3 of FY2023 and maintain or increase user satisfaction scores over FY2022.	#4: The CRCT user survey was released in November 2021, and results of the survey have been discussed at subsequent EHR Operations Committee meetings. This survey will act as the baseline satisfaction level with CRCT. A user survey had not been conducted since 2015. Moving forward we will utilize the information obtained through this process to continually improve our electronic health record CRCT.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: #5: Partially Met
#5. Improve the financial stability and service capacity of our regional provider network. (Lead: Operations/Finance)	Conduct an in-depth analysis of the top 1-5 CPT service codes that account for the most service cost by Q4 of FY2021.	Conduct an in-depth analysis of the top 6-10 CPT service codes that account for the most service cost by Q4 of FY2022.	Conduct an in-depth analysis of the top 11-15 CPT service codes that account for the most service cost by Q4 of FY2023.	#5: The CMHPSM region has introduced provider financial stability programs, improved staff training capabilities and adopted revised accreditation standards for certain providers. The CMHPSM also passed through 98.3% of direct care worker premium pay to the tune of nearly $15 million. Providers continue to struggle with staffing supply and the CMHPSM plans to continue advocacy around at minimum the continuation of premium pay, with the hope for additional resources to stabilize provider staffing concerns.

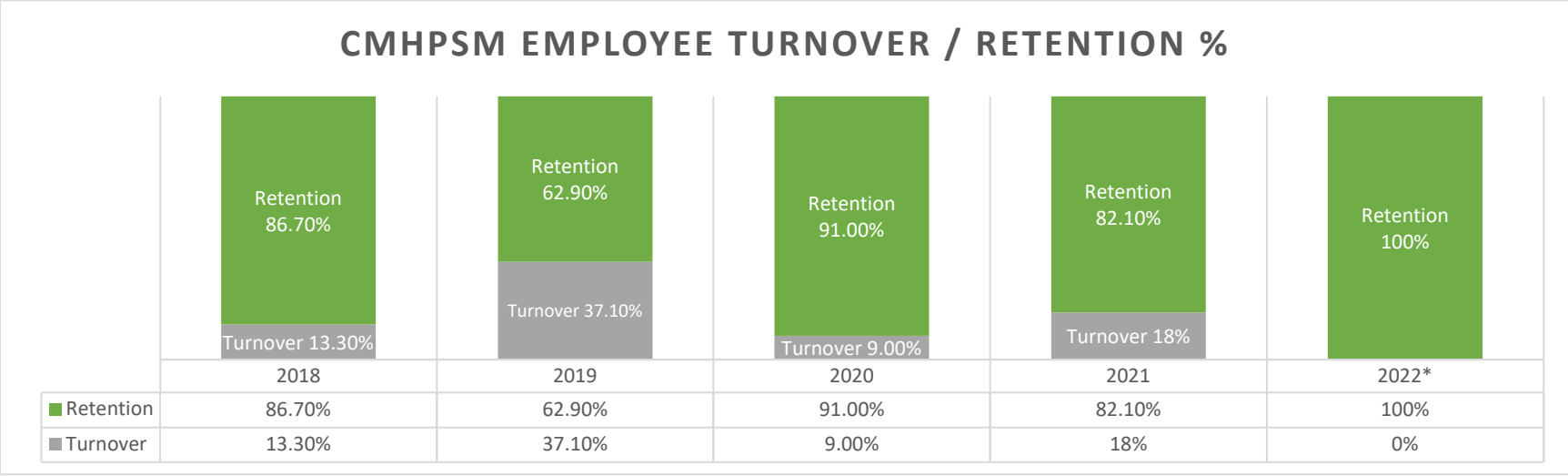
Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#6. Improve documentation for all critically important CMHPSM functions. (Lead: Operations)	Review and approve process and procedure documentation for 100% of critically important functions by Q3 of FY2021.	Assess 100% of critically important process and procedure documentation for needed updates by Q3 of FY2022.	Assess 100% of critically important process and procedure documentation for needed updates by Q3 of FY2023.	#6: All CMHPSM staff persons have been working on process and procedure documents related to critical functions. The CMHPSM leadership team is continuing to review and approve the processes and procedures that are developed. Existing processes and procedures are continually updated as needed.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#7. Improve regional compliance reviews to support components of the quadruple aim. (Lead: Operations)	Revise all compliance monitoring tools by end of Q1 of FY2021.	Revise all compliance monitoring tools by end of Q1 of FY2022. Create and issue provider survey for entities that are audited by the CMHPSM by Q4 of FY2022	Revise all compliance monitoring tools by end of Q1 of FY2023. Assess provider survey results for entities that are audited by the CMHPSM for areas of improvement to revise FY24 monitoring tools and processes.	#7: The CMHPSM operations department led by CJ Witherow revised all monitoring tools to maintain compliance while increasing the efficiency and effectiveness of the reviews. CJ Witherow worked with the compliance committee, network management committee and key PIHP/CMHSP staff on these revisions wherever appropriate. A survey is planned for later this fiscal year related to compliance and other PIHP function oversight.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#8. Improve the capacity, effectiveness, and quality of SUD services. (Lead: SUD)	Assess regional SUD access across core providers.	Issue RFP for delegated core provider functions by Q2 FY2022. Develop timeline for procuring additional core provider functions during FY2022.	Continue the re-design and procurement of the SUD core provider system.	#8: On 1/1/2022 the CMHPSM transitioned to align Washtenaw core provider access with Lenawee, Livingston and Monroe counties after assessing options in Washtenaw. On 10/1/2022 the two Washtenaw core providers will transition to fee-for-service providers and join the rest of the provider network as that type of provider.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#9. Ensure that the Regional SUD Strategic Plan is effectively implemented, and associated outcomes are monitored and reported to the OPB and Regional Boards. (Lead SUD)	Develop charge for SUD Operations Committee by Q1FY2021. Assess 100% of strategic initiative programming delivered semi-annually during FY2021.	Assess 100% of strategic initiative programming delivered semi-annually during FY2022.	Assess 100% of strategic initiative programming delivered semi-annually during FY2023.	#9: The CMHPSM SUD Director has continued to join the first Regional Operations Committee meeting of each month and ROC would focus on SUD services at that meeting. The SUD team continues to assess all SUD strategic initiative programming and did so throughout FY2022. The SUD Oversight Policy Board reviews these reports in detail.

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#10. Assess CMHPSM internal human resources and related activities in conjunction with current and future potential PIHP functions. (Lead: CEO)	Develop process for employee development requests during Q1 FY2021.	Measure employee retention after implementation of employee engagement committee recommendations.	Improve or maintain employee retention percentage during FY2023.	#10: The CMHPSM has implemented multiple suggestions from the employee engagement committee and is tracking employee retention and turnover percentages. Comments from employee exits interviews, employee engagement survey results and day-to-day feedback are all utilized by leadership to improve employee retention wherever possible. We continue to offer employee training and developmental opportunities to staff as well.



*FY2022 1/1/2022-3/31/2022

Strategic Plan Goal(s)	FY2021 Metric	FY2022 Metric	FY2023 Metric	Current Status Report #3 3/31/2022: Fully Met
#11. Implement engagement committee recommendations related to CMHPSM employee morale. (Lead: CEO)	Continue CEO updates and update employee handbook. Conduct employee satisfaction survey in February 2021. Conduct salary study for salary tiers by March 2021.	Continue CEO updates and update employee handbook during FY2022. Conduct employee satisfaction survey in August 2022. Develop formal staff on boarding process and procedure during Q1 FY2022.	Continue CEO updates and update employee handbook during FY2023.	#11: The CMHPSM CEO has continued CEO updates through Q2 of FY2022. Preparations for a re-release of the employee satisfaction survey are underway for July, survey results to the Board in August 2022. Onboarding process was documented and completed.

ATTACHMENT B: IMPLEMENTATION PLAN AND TIMELINE FY22 Mid-Year Update

SERVICE NEEDED	TYPE OF SERVICE	RESPONSIBLE PARTY	COMPLETION DATES	Mid-Year FY22 Update
Promote and Expand Availability of Programming to Specific Populations Specific populations of focus include: • Adolescents • Older Adults • African Americans • Latinx Services should be recovery focused and culturally specific, with the inclusion of peers. Could be provided through tra ditional treatment services, prevention efforts, innovative local models, outreach components, and diver se population focused.	Prevention Treatment Recovery	CMHPSM and Regional SUD Operations Committee	• Establishment of a regional SUD Operations Committee during Q1 FY 2021 • Develop a plan on how to address gaps in services to specific populations by Q3 FY2021 • Ensure existing services are promoted across the region, and ensure available funding focuses on implementation of programming for identified special populations in FY 2021, FY2022 and FY2023.	This establishment of a regional SUD Operations Committee was replaced by the process of the SUD Director discussing issues with the SUD Team, bringing items to the Leadership Team as needed, to All Things SUD monthly, and to the Regional Operations Committee monthly. Addressing the expansion of programming available to special populations was delayed due to COVID. ARPA funds are allowing us to now address expansion of programs into African American and Latinx communities through Anchor Institutions, Prevention EBIs, a Youth Community Center and Sober Youth Activities. Also, while dialogue of availability of programs for youth is ongoing, and funded in part by programs through Strategic Initiatives, CMHPSM is hosting what we hope is the first regional SUD Youth Program/Services Forums in Washtenaw County in partnership with the WISD in May 2022.

ATTACHMENT B: IMPLEMENTATION PLAN AND TIMELINE FY22 Mid-Year Update

SERVICE NEEDED	TYPE OF SERVICE	RESPONSIBLE PARTY	COMPLETION DATES	Mid-Year FY22 Update
Address capacity gaps for higher levels of care in treatment across the region. Focus on Livingston and Lenawee counties.	Treatment	CMHPSM staff and Regional SUD Operations Committee	• Capacity review by Q2 FY2021, incorporate utilization data, resource availability; workforce capacity and special service needs such as psychiatry/other medical services. • Complete plan by Q3 FY2021 • Address through RFP process during FY2022 and FY2023	While gaps in higher levels of care still need to be analyzed with Livingston and Lenawee counties, COVID has caused a delay in ability for programs to expand due to staffing shortages. This will be re-examined as soon as possible. Livingston County currently contracts with a total of six residential providers. One new provider was added a month ago and another is expected to be added next quarter to bring the total up to seven. Lenawee County CMH currently contracts with a total of six residential providers.

ATTACHMENT B: IMPLEMENTATION PLAN AND TIMELINE FY22 Mid-Year Update

SERVICE NEEDED	TYPE OF SERVICE	RESPONSIBLE PARTY	COMPLETION DATES	Mid-Year FY22 Update
Expansion of recovery housing to include special populations Recovery housing should be capable of assisting consumers with special needs, such as MOUD; unemployed due to lack of available jobs; lack of transportation; women's specialty with small children; old er adults; LGBTQ, etc. Recovery housing is needed across the region.	Recovery Treatment	CMHPSM staff Core Providers Local Housing and Local coalitions to advocate and support recovery housing in their communities.	• Establishment of a regional SUD Operations Committee during Q1 FY 2021 • Regional SUD Operations Committee to recommend workgroup to perform a specific needs assessment, policy review and exploration of funding mechanisms by Q3 FY-2021 and annually.	See above for SUD Operations Committee. Recovery housing has been expanded to include MAT houses for women and men through Home of New Vision; funding is being provided to support those unable to pay due to unemployment and lack of transportation. Livingston County now has two Recovery Housing providers- RAIL and HNV. Dawn Farm and Paula's House are able to provider recovery housing for women with small children. All recovery houses are expected to welcome those who identify as LGBTQ, older adults, etc.

ATTACHMENT B: IMPLEMENTATION PLAN AND TIMELINE FY22 Mid-Year Update

SERVICE NEEDED	TYPE OF SERVICE	RESPONSIBLE PARTY	COMPLETION DATES	Mid-Year FY22 Update
Build Workforce for Recovery Coaches, Prevention and Treatment through training Provide opportunities to educate the community on specific SUD topics including: • CCAR, MCBAP and MDHHS Peer Certification • Prevention Ethics • Infographics • ACEs • Gambling Addiction Certification • Adolescent treatment strategies • LGBTQ treatment strategies	Prevention Treatment Recovery	Regional SUD Operations Committee CMHPSM Staff	• Establishment of a regional SUD Operations Committee during Q1 FY 2021 • Regional SUD Operations Committee to create workgroup to address cross discipline training needs by Q2 2021 • Set aside local funds to support training regionally by Q3 2021 • Host regional trainings annually with topics determined through professional workforce and community survey responses.	See above for SUD Operations Committee. A workgroup has not been identified, but the SUD Team has discussed trainings to offer across the region. To date, trainings have been offered on Stacked Deck; Gambling NODS Screening; Ecosytem of Gambling and Youth; Gambling Disorder-Understanding the Hidden Addiction; Self Care and Trauma Informed and Resilience Oriented Work Force, Stage Specific Interventions (Stages of Change), and Naloxone Training and Train the Trainer (ongoing). There are also plans to support a speaker either for the Washtenaw County Opioid Summit or a related speaker before the end of the FY. All trainings are open across the region.

ATTACHMENT B: IMPLEMENTATION PLAN AND TIMELINE FY22 Mid-Year Update

SERVICE NEEDED	TYPE OF SERVICE	RESPONSIBLE PARTY	COMPLETION DATES	Mid-Year FY22 Update
Continue to assess and improve Recovery Focused Services (ROSC) through Recovery Self-Assessment Survey (RSA)	Treatment Recovery	COD workgroup (SUD/MH) Engage student interns if possible	• Initiate in March 2021, 2022, 2023 • Analysis complete by August 2021,2022, and 2023	The Recovery Self Assessment (RSA) is implemented and analyzed annually in the fourth quarter. During Q1, each county is expected to create a workplan addressing any issues identified in the RSA specific to their county.
Implement community feedback surveys	Prevention Treatment Recovery	CMHPSM Staff	• Annually by end of Q4 September FY2021, FY2022, FY-2023	The SUD Community Survey was implemented in Q4 of FY21. The results were analyzed but the sample size was very small and it was agreed changes to programming could not be identified as a result of such a small response. During FY22, a much greater effort will occur to get a larger survey response.

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

FY22 PA2 Request for Livingston County WSS Payment

Board Meeting Date: April 28, 2022

Action Requested: Review and approve $10,766 in FY22 PA2 funds to Livingston County Community Mental Health Authority for the Livingston Women's Specialty Services (WSS) Program for an outstanding FY21 invoice.

Background:

Funding for WSS is provided annually from MDHHS through CMHPSM to Livingston County Community Mental Health Authority. This is paid through a financial status report (FSR) typically sent monthly to CMHPSM from LCCMHA. This was a billing for the last month of FY21 that was somehow not paid. It was recently discovered and payment is being requested through Livingston County PA2 funds.

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

Ensures continuation funding for existing FY22 program.

Recommendation: Approve the use of FY22 PA2 funds in the amounts of $10,766 to Livingston County Community Mental Health authority for the Livingston County Women's Specialty Services Program from FY21.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Serving Lenawee, Livingston, Monroe, and Washtenaw Counties

Request for MINI GRANT Funds	
Mini-Grants: A specific amount of funds per county set aside annually for small initiatives that arise during the fiscal year in the amount not to exceed $1000. ***There is a limit of $5000 per county each fiscal year.*** *Mini-Grants may only be awarded for special activities or initiatives related to substance use disorders education, awareness, community activities and events, etc., and not be used for staffing purposes. The applicant must identify a source of other matching funds or in-kind effort to receive the grant. Once an award is made, the applicant will not be eligible to receive other mini-grant funding for any additional project during the fiscal year.*	
Date:	Apr 18, 2022
Contact Person: (Name, email, phone)	Desireè Underwood dunderwood@miunified.org 313-316-5109
Requestor:	Unified HIV Health & Beyond
Amount of Request:	$1000.00
Type of Request:	☐Community event X☐ Other: _supplies _____ ☐Staff Training ☐Coalition Support Attach information as needed.
Describe Program Request:	UHHB SSP will be able to support other community partners with overdose prevention in providing supplies that would assist PWUD with testing illicit drug poisoning agents such as fentanyl.
Targeted Community:	(Geographic area) Region 6 (Lenawee, Livingston, Monroe, and Washtenaw Counties)
Describe how and where matching funds will be applied. If in-kind, describe:	Due to increasing illicit drug poisoning deaths among PWUD in the State of Michigan and within Washtenaw County, the overall goal of our program is to decrease the number of illicit drug poisoning fatalities occurring in Washtenaw County due to fentanyl overdose and provide fentanyl testing strips to consumers/PWUD. UHHB will purchase 600/100 per box of fentanyl strips to distribute to community partners and consumers, in addition to what the UHHB harm reduction program already distribute.
Identify Key People, Coalitions, and/or Community Partners involved in program:	UHHB will support other community partners within Region 6 (Lenawee, Livingston, Monroe, and Washtenaw Counties)
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:	Approved  4.19.2022

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
April 13, 2022

Members Present: Judy Ackley, Susan Fortney, Roxanne Garber, Sandra Libstorff, Bob King (remote), Molly Welch Marahar, Randy Richardville (remote), Mary Serio, Sharon Slaton, Holly Terrill, Ralph Tillotson (remote)

Members Absent: Katie Scott

Staff Present: Kathryn Szewczuk, Stephannie Weary, James Colaianne, CJ Witherow, Matt Berg, Lisa Jennings, Trish Cortes, Nicole Adelman, Connie Conklin

Guests Present:

I. Call to Order
Meeting called to order at 6:00 p.m. by Board Chair S. Slaton.

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by R. Garber, supported by S. Fortney, to approve the agenda
Motion carried

IV. Consideration to Approve the Minutes of the 3-9-2022 Regular Meeting and Waive the Reading Thereof
Motion by R. Garber, supported by J. Ackley, to approve the minutes of the 3-9-2022 regular meeting and waive the reading thereof
Motion carried

V. Audience Participation
None

VI. Old Business
a. Board Review – March Finance Report – FY2022 as of February 28th
   - M. Berg presented. Discussion followed.
   - Staff will provide an update on the prior years' deficits in next month's Finance Report to the Board.

b. CEO Evaluation Update
   - CEO Evaluation Committee Chair M. Serio advised that the committee will recommend a change in terms with the next CEO contract, from 3 years to 5 years.
   - 7 evaluation responses have been received so far.
   - Final CEO Evaluation report to be presented in May.

VII. New Business
a. Board Action: Financial Stability and Risk Reserve Management Board Governance Policy

Motion by R. Garber, supported by M Welch Marahar, to approve the Financial Stability and Risk Reserve Management Board Governance Policy as presented
Motion carried

b. Board Action: Review Regional Board Bylaws and Board Governance Policies

Motion by R. Garber, supported by M. Welch Marahar, to table the review of the Regional Board Bylaws and Board Governance Policies pending further review
Motion carried
Roll Call Vote
Yes: Ackley, Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill
No:
Non-voting: King, Richardville, Tillotson
Absent: Scott

- The Board decided to table this agenda item pending further discussion on attendance and participation.
- Board agreed that board members attending remotely will be permitted to participate in meeting discussions. Voting remotely isn't allowed, per law.
- S. Slaton appointed a subcommittee to review the policies and attendance language.
  - ❖ M. Welch Marahar (lead)
  - ❖ S. Fortney
  - ❖ R. Richardville

c. Board Action: SUD Utilization and Treatment Specialist

Motion by R. Garber, supported by J. Ackley, to approve the addition of one full-time SUD Utilization and Treatment Specialist (UTS) position at the CMHPSM
Motion carried
Roll Call Vote
Yes: Ackley, Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill
No:
Non-voting: King, Richardville, Tillotson
Absent: Scott

d. Board Action: Contracts

Motion by M. Welch Marahar, supported by R. Garber, to authorize the CEO to execute the contracts/amendments as presented
Motion carried
Roll Call Vote
Yes: Ackley, Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill
No:
Non-voting: King, Richardville, Tillotson
Absent: Scott

e. Board Action: Dana Darrow 5-Year Anniversary Recognition

Motion by R. Gerber, supported by S. Fortney, to authorize the CMHPSM Board Chair to sign the formal proclamation acknowledging the five years of service by Dana Darrow to the PIHP region as a CMHPSM employee.

Motion carried

f. Board Action: Randy Salow 5-Year Anniversary Recognition

Motion by M. Welch Marahar, supported by M. Serio, to authorize the CMHPSM Board Chair to sign the formal proclamation acknowledging the five years of service by Randy Salow to the PIHP region as a CMHPSM employee
Motion carried

g. Board Action: Jessica Sahutoglu 6-Year Anniversary Recognition

Motion by J. Ackley, supported by M. Welch Marahar, to authorize the CMHPSM Board Chair to sign the formal proclamation acknowledging the six years of service by Jessica Sahutoglu to the PIHP region as a CMHPSM employee
Motion carried

h. Board Information: Strategic Plan Metrics Report #3
- The Board reviewed the current status of the Strategic Plan goals.
- J. Colaianne offered to bring back some suggestions on modified/updated metrics based on the changing requirements of the state, for which the not fully met goals are no longer relevant (#'s 1 and 5). The Board agreed with this approach.
- J. Colaianne and N. Adelman will work on some new proposed metrics for the SUD goals.

i. Board Information: CEO Authority Action Update
- A contract for Behavioral Health Home (BHH) Director was approved by the Board last month. Upon further consideration, J. Colaianne determined that this position should be a temporary, part-time hire, not a contract. This change was made within the CEO's authority. The position is funded by BHH grant.

VIII. Reports to the CMHPSM Board

a. OPB Meeting Update
- The OPB did not meet last month.

b. CEO Report
- All staff received the 2% COLA increase as of April 4.
- Staff have returned to office in reduced capacity.
- The Board would like to receive the audit report in person next month, in addition to paper copies.

IX. Adjournment

Motion by M. Welch Marahar, supported by R. Garber, to adjourn the meeting
Motion carried

Meeting adjourned at 7:23 p.m.

_____
Sandra Libstorff, CMHPSM Board Secretary

CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors

April 6, 2022 for the April 13, 2022 Meeting

CMHPSM Update

- The CMHPSM had an all staff meeting on March 14, 2022. The March 28, 2022 all staff meeting was cancelled due to the lack of agenda items. We are scheduled to meet on April 11, 2022 and April 25, 2022.
- The CMHPSM leadership team is continuing to meet on a weekly basis while we are working remotely.
- Multiple year-end financial reports have been submitted and work is nearly completed on our FY2021 financial audit.
- As approved in our FY2022 budget by the Regional Board, a 2% cost of living increase was implemented for all staff that are on the salary tiers. This increase took effect with hours worked beginning Monday April 4, 2022.

COVID-19 Update

- The CMHPSM office continues to be closed to the public outside of public Board meetings. We implemented a March 28, 2022 return to the yellow reduced capacity phase. The most recent version of the re-opening plan is continually shared with staff as it is updated. The leadership team is continuing to review statewide and county guidance related to best practices.
- We will continue to monitor recommendations around the projected return to full office capacity in the future.

Re-Opening Plan Phases as of April 6, 2022

Phase:	**Essential Only Capacity**	**Limited Capacity**	**Reduced Capacity**	**Full Capacity**
Office:	**Office Closed**	**Limited Office Attendance and Office Closed to Public (Except for Board Meetings)**	**50% Capacity – 75% Capacity and Office Closed to Public (Except for Board Meetings)**	**100% Capacity – Office Open to Public**
Projected Date Range for Phase:			3/28/2022 – 5/29/2022	5/30/2022
Current Phase:			**X**	

CMHPSM Staffing Update

- The CMHPSM currently has two open positions that we are actively interviewing candidates to fill: SIS Assessor and Operations Specialist.
  - We have requested the approval of one additional position, funding for this position was included in the budget revision which was approved last month.
  - More information and links to job descriptions and application information can be found here: https://www.cmhpsm.org/interested-in-employment

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Regional Update

- The CMHPSM continues to update our general COVID-19 resources and information on our website: https://www.cmhpsm.org/covid19
- We have also established a webpage for provider information related to service delivery changes during this pandemic: https://www.cmhpsm.org/covid19provider
- Individuals receiving Behavioral Health and/or substance use disorder services can access targeted information at the following webpage: https://www.cmhpsm.org/covid19consumers
- Our regional committees continue to meet using remote meeting technology, the Regional Operations Committee will work with our committees to determine best practices moving forward related to in-person versus remote regional committee meetings.
- The Regional Operations Committee continues to meet on at least a weekly basis. The remote meetings are allowing our region to share best practices while obtaining a regional picture of our COVID-19 pandemic response.

Statewide Update

- The PIHP has been represented at meetings with BHDDA related to COVID-19 pandemic responses that began in mid-March 2020. These meetings have been helpful in ascertaining the MDHHS response to COVID-19 and to provide our region's input to BHDDA. Beginning in July 2021 the meetings have transitioned to a bi-weekly schedule, more recently we have been meeting on a monthly basis.
- PIHP CEO meetings are being held remotely on a monthly basis. The PIHP CEOs last met on April 6, 2022. Discussions around the BHDDA reorganization occurred with representatives from the new MDHHS department.
- The PIHP CEO / MDHHS operations meeting with BHDDA leadership staff was cancelled in March. We are scheduled to meet Thursday April 7, 2022 with

the re-organized MDHHS staff. Included in the meetings are updates on the various emergency waivers and MDHHS COVID funding that impact our service delivery systems, funding, and requirements. I provide a summary of those meetings to our regional directors at our Regional Operations Committee meetings each month.

- Latest information on Michigan legislation will be shared at our Board meeting.

Future Update

- Our financial auditors will present our regions financial audit to the Board at our May meeting. The auditors are willing to make their presentation in-person or virtually at the preference of the Board.
- Rates are expected to be revised in May 2022 to compensate for the $2.35/hr premium pay which was authorized by the legislature in October. The premium pay funding that is built into our current rates covers $2.00/hr premium pay rates.
- We're contemplating a pro-active cancellation of the June Board meeting unless additional items present themselves prior to that meeting date.

Respectfully Submitted,

James Colaianne, MPA

STATE OPIOID RESPONSE GRANT

Grant Program Summary

September 30, 2018 – September 29, 2021

WAYNE STATE
School of Social Work

MDHHS
Michigan Department of Health & Human Services

Table of Contents

Overview

In recent decades, the State of Michigan has experienced a dramatic increase in opioid-involved overdose and death. One figure has determined that between 1999 and 2017, overdoses caused by opioid use increased by 17 times the initial rate (Drug Overdose Deaths in Michigan, 2020). Of the over 2,500 individuals who died from drug overdose in Michigan in 2018, opioids were involved in 78% of those events (n=2,038). Furthermore, drug use trends have shown an increased presence in synthetic opioids (e.g., fentanyl and its analogues, tramadol), with a nearly 11% increase between 2017 and 2018 alone. All indications show that this trend has continued to the current year (data unavailable), making the probability of an overdose occurring several times more likely.

The Michigan Department of Health and Human Services (MDHHS), seeking to address this opioid epidemic, applied for the State Opioid Response (SOR) grant released by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018. The goals set forward in the application were listed as follows: (1) to increase access to Medication-Assisted Treatment (MAT) for the three medications approved by the United States Food and Drug Administration (FDA); (2) reduce unmet treatment need; (3) and reduce opioid overdose-related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorders (OUD). On September 19, 2018, SAMHSA awarded MDHHS the SOR grant for $27,914,639 per grant year. Funding began on October 1, 2018, with an additional 16-month award for a one-time SOR supplement on June 1, 2019, in the amount of $14,571,442. After the initial two-year grant period, Michigan applied for and received a one-year No Cost Extension (NCE) for SOR Prime and SOR Supplemental on September 21, 2020. The final amounts were $18,972,985 for SOR Prime and $8,960,077 for SOR Supplemental, for a total of $27,933,062. The NCE was completed on September 29, 2021.

MDHHS allocated SOR funds to the 10 Prepaid Inpatient Health Plans (PIHP) to implement opioid-focused initiatives strategic to their respective geographic regions. The PIHP network operates as regional managed care organizations for Michigan's 83 counties, distributing discretionary public funding to local community providers. Prevention initiatives implemented through the PIHPs include Opioid Education and Naloxone Distribution (OEND) and Youth & Family Evidence-Based Prevention programming. Treatment and recovery initiatives include placing peer recovery coaches in Federally Qualified Health Centers (FQHCs), expanding jail-based MAT services, securing mobile care units to deliver OUD services to individuals lacking transportation and underserved areas, the implementation of the Opioid Health Home model, expanding availability of and stay in recovery housing, providing employment support for those in recovery from OUD, and funding the cost of OUD treatment and OUD recovery services for uninsured and underinsured individuals.

In addition to regional efforts, MDHHS also partnered with a wide array of stakeholders to fund statewide initiatives across the prevention, treatment, and recovery continuum for individuals who use opioids. Stakeholders included university partners, state offices both within and outside of MDHHS, philanthropic foundations, community organizations, and a national pharmaceutical manufacturer. A full list of these grant partners are as follows:

Inter-Tribal Council of Michigan
Michigan Collaborative Addiction Resources and Education System
Michigan State University Extension
Michigan Opioid Collaborative
Michigan Opioid Prescriber Engagement Network
Michigan Opioid Partnership
Michigan Association of Recovery Residences
Michigan State Police
Michigan Department of Corrections
Michigan Department of Licensing and Regulatory Affairs
MDHHS Office of Communications
MDHHS Public Health Administration
Community Mental Health Association of Michigan

Michigan Primary Care Association
Emergent BioSolutions
Wayne State University Center for Behavioral Health and Justice

During project year one (October 2018 to September 2019), SOR grantees began implementing their respective projects to varied degrees of success and expediency. While select initiatives, such as support for costs related to the treatment of OUD, were built on already established infrastructure, many of the other initiatives began from their foundation. Among the initiatives that required a period of infrastructure building: PIHP network providers built on their relationships with local hospitals and FQHCs to install peer recovery coaches into their service delivery models; mobile care units were purchased and retrofitted to state and national standards for OUD treatment; and the Michigan Collaborative Addiction Resources and Education System (MI-CARES) project began developing a curriculum to be used to increase the number of certified addiction medicine and addiction psychiatry specialists in the state. There were also certain administrative barriers which delayed project implementation, such as the MDHHS electronic grant administration system and the inability to quickly train provider staff in prevention and treatment modalities. Another barrier was a perceived unwillingness from certain systems to implement OUD services, possibly due to systemic professional bias or stigma.

Project year two (October 2019 to September 2020) built on the progress made in year one, as well as the addition of new grantee projects, such as the Michigan Opioid Partnership (MOP) to implement Buprenorphine induction and referral to treatment within jails statewide. Also notable is the MDHHS partnership with Emergent BioSolutions to introduce a State-funded Naloxone Portal. This Portal, established in January of 2020, provided over 160,000 intra-nasal Naloxone kits to law enforcement, correctional facilities, and community stakeholders through support from the SOR grant. This year was not without challenges, however, the most disruptive being the COVID-19 pandemic which began in March of 2020. Among those barriers: all initiatives working with jails and prisons were temporarily halted given the severity of COVID-19 breakouts in those facilities and subsequently significantly reduced due to ongoing health concerns; the implementation of syringe service programs was delayed as local health departments reprioritized staff time and funding to pandemic response; and mobile care units managed by PIHP paneled providers were idled as telehealth was implemented statewide and providers were forced to redirect attention to more urgent client needs (COVID-19 testing, masks, etc.).

In Federal Fiscal Year 2021 (October 2020 to September 2021), MDHHS received approval for a No Cost Extension year for the SOR grant to complete grant supported projects. This additional year to expend remaining funding allowed MDHHS and SOR grant partners the ability to meet any unaccomplished objectives established in the initial applications. This year also brought new State-funded projects such as the inclusion of MAT program pilots in four state correctional facilities, led by the Michigan Department of Corrections. While the COVID-19 pandemic continued to provide significant program barriers, SOR grantees were largely able to innovate in finding ways to meet the needs presented in the opioid epidemic despite those challenges.

This final report will provide overall programmatic narratives, outcomes, financial data, and highlights of programming throughout the entirety of the SOR grant.

Highlights

Throughout all three years of SOR and across all programs, Michigan saw major growth in OUD prevention, treatment, and recovery services. With SOR funding, the following were accomplished:

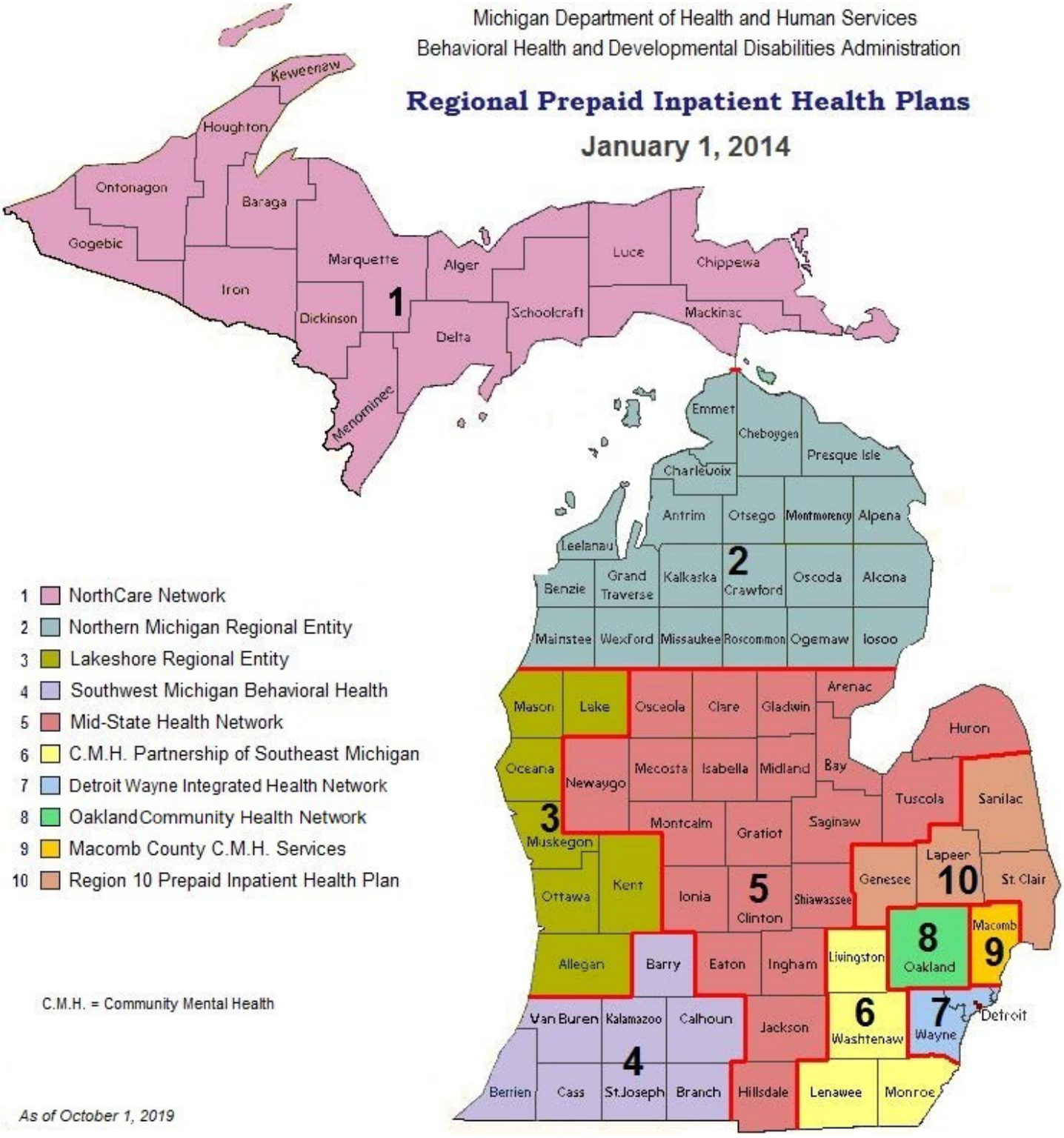
- Over 7,000 youth and families engaged in substance abuse prevention programming.
- Over 215,000 Naloxone kits distributed.
- At least 1,275 lives saved with Naloxone.
- Six-thousand three-hundred and seven clients received OUD treatment services including MAT, case management, and transportation.
- Collaborations with 48 different correctional facilities to provide OUD services.
- One-hundred and twenty-seven new clients received telehealth services.
- Twelve-thousand five-hundred and twenty-eight individuals contacted through peer recovery coach outreach efforts.
- Collaboration with more than 30 recovery homes.

Our SOR GPRA indicated improvements for clients in the following areas.

- Increase in housing stability
- Increase in social connectedness
- Increase in employment and education attainment
- Increase in abstinence from drugs and alcohol
- Decrease in anxiety
- Decrease in depression
- Decrease in hallucinations
- Decrease in trouble understanding, concentration, or remembering
- Decrease in trouble controlling violent behavior

Prepaid Inpatient Health Plans across Michigan

The following map presents the 10 PIHP regions across Michigan.



Prevention Activities

Youth and Family Oriented Prevention Evidence-Based Practices (EBP)

Each PIHP utilized SOR funding to implement youth and family-oriented evidence-based or promising practice substance abuse prevention programs. Many PIHP partnered with location schools and youth and family serving organizations to recruit participants for their EBPs. Due to the COVID-19 pandemic, schools in Michigan ceased offering in-person learning in March 2020. Prevention providers swiftly adapted to online methods of facilitating the EBPs. Northern Michigan and other geographically rural sections of the state found an increase in attendance and retention with the switch to online programming. By the end of the NCE year, school-based and in-person programming were beginning to resume statewide.

Guiding Good Choices (GGC)

GGC is a family competency training program for parents of youth in middle school that gives parents the skills needed to reduce their children's risk for using alcohol and other drugs. The program consists of five two-hour sessions. Youth attend one of the five sessions with their parents or caregivers. GGC has demonstrated outcomes in delaying the onset of substance use in the children of participants. Regions 1, 4, 6, 8, and 10 implemented GGC. Across these regions and throughout the entire grant, 396 families participated in GGC.

Project Towards No Drug Abuse (PTNDA)

PTNDA is a prevention program for individuals aged 14 to 19 years. The curriculum is comprised of 12 classroom-based sessions between 40 and 50 minutes in length that are delivered over a four-week period. Participants complete pre- and post-tests, and instructors complete fidelity observation checklists. Regions 4 and 7 implemented PTNDA. Across these regions and throughout the entire grant, 1,483 individuals participated in PTNDA training.

Botvin LifeSkills Training (LST)

LST is an interactive evidence-based substance abuse and violence prevention program. LST has curricula designed for middle school, high school, and transition aged students. LST also has a specific prescription drug abuse prevention module that many facilitators have incorporated into their training. The instructor or an observer can complete fidelity checklists for each module. Regions 2, 3, 5, and 7 implemented LST. Across these regions and throughout the entire grant, 4,223 students participated in LST.

Prime For Life (PFL)

PFL is an evidence-based prevention and intervention program for universal, selective, and indicated audiences. It provides participants a way of understanding how alcohol and drug-related problems develop, what they can do to prevent them, and why they sometimes need help. PFL has been used for youth and adults aged 13 to 20 years old. PFL also includes a tool for assessing instructors' delivery and ensuring program fidelity called the Moving ForWarD Rating Scale. Regions 3, 5, 6, and 9 implemented PFL trainings. Across these regions and throughout the entire grant, 1,106 individuals participated in PFL.

Youth and Family Oriented Prevention Evidence-Based Practices				
Program	**Year 1**	**Year 2**	**NCE**	**Total**
Guiding Good Choices	98	159	139	396
Project Towards No Drug Abuse	400	960	223	1,483
Botvin LifeSkills Training	1,300	967	1,956	4,223
Prime For Life	183	508	415	1,106

Overdose Education and Naloxone Distribution (OEND) with Harm Reduction

The SOR grant awarded each PIHP, the Inter-Tribal Council (ITC), Syringe Service Programs, and Hope Not Handcuffs funds for naloxone purchasing and training opportunities that include harm reduction activities. Naloxone (Narcan®) is an opioid antagonist medication approved by the FDA to reverse an opioid overdose. The medication blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. Due to the COVID-19 pandemic, prevention providers moved their training curricula online and began offering virtual OEND trainings in April 2020. Towards the end of the NCE year, in-person OEND trainings resumed. Throughout this grant, grantees distributed 59,737 naloxone kits and trained over 25,330 individuals. Not all naloxone usage and saves are reported to the state; however, grantees reported 2,372 opioid overdose reversals. PIHP regions also used funding to support local harm reduction and prevention coalitions which distributed medication lock boxes, drug disposal bags, and poke resistant gloves to law enforcement and community members.

Overdose Education and Naloxone Distribution across Grantees				
	Year 1	Year 2	NCE	Total
Kits distributed	9,435	39,002	11,300	59,737
Individuals trained	7,661	14,831	3,763	25,330
Saves	74	1,533	776	2,372

In January 2020 MDHHS launched the statewide online Naloxone Portal which allows community organizations, law enforcement, SUD service providers, and other agencies to request Narcan nasal spray at no charge to their organization. MDHHS rolled out the portal in stages and first opened it to law enforcement and treatment courts in February and March 2020. Through September 2020, this was expanded to include local health departments, prisons/jails, academic institutions (i.e., universities and local school districts), hospitals/medical clinics, emergency services (i.e., fire departments and EMS), pharmacies, libraries, and faith-based institutions. The Naloxone Portal received requests for **150,240** double dose kits from over 800 different agencies. A centralized option for agencies to request and receive free naloxone is a hugely important resource for reducing overdose deaths.

Naloxone Portal Distribution		
Type of Organization	Number of Orders Processed	Number of Kits Shipped
Community Organizations and Nonprofits	212	81,072
Pharmacies	101	6,636
Law Enforcement (i.e., MSP, DNR, City, County, Township)	135	10,800
Treatment/Recovery Centers	94	18,216
Correctional Facilities/Jails/Prisons	56	3,984
District/Regional/Drug Courts	48	1,344
Local Health Departments	33	8,784
Hospitals and Medical Clinics	57	6,336

Naloxone Portal Distribution		
Behavioral Health Services	21	1,944
Academic Institutions (i.e., colleges, universities, school districts)	26	1,992
Regional Prepaid Inpatients Health Plans (PIHPs)	11	7,896
Emergency Services (i.e., Fire Departments, EMS)	9	900
Faith-Based Institutions	3	36
Other	9	300

Michigan Collaborative Addiction Resources & Education System (MI CARES)

The mission of the MI CARES program is to address the lack of addiction medicine and addiction psychiatry specialists in Michigan. MI CARES' goal is to create a curriculum to train physicians to attain accreditation in Addiction Medicine (AM) via the American Board of Preventive Medicine (ABPM) practice pathway. This practice pathway enables physicians to use a combination of experiential hours coupled with passing a board examination to become a board-certified AM provider. The curriculum closely follows the ABPM blueprint for the subspecialty certification exam.

Curriculum

MI CARES hosted the 13 modules of curriculum on the Michigan State University (MSU) learning management system, Desire2Learn (D2L). Special topics including Veterans, Infectious Disease, Behavioral Addictions, and Toxicology were finalized and released late in the No Cost Extension year. The modules and number of visitors for each module are listed in the table.

MI CARES Curriculum Modules	
Module	**Number of Visitors**
Practice Pathway	224
Opioids	107
Alcohol	79
Stimulants	68
Cannabis	56
Nicotine	53
Sedatives	49
Neurobiology	44
Club Drugs	42
Toxicology	15
Behavioral Addictions	12
Veterans	10
Infectious Disease	8

Physician Recruitment

MI CARES' team recruits physicians through the MSU website, through medical school listservs, and at conferences. The MI CARES team has enrolled 420 physicians into the program. Over half (54%) of the physician specialties were family or internal medicine. Other physician specialties included addiction medicine, anesthesiology, diagnostic radiology, emergency medicine, maternal/fetal, OB/GYN, pediatrics, physical medicine rehabilitation, prevention and public health, psychiatry, and surgery. Fifty-one participants received board certification in 2020. Twenty-two participants applied to sit for the 2021 ABPM certification examination and are still awaiting full results. The MI CARES curriculum continues to help bridge the gap between individuals needing SUD treatment and SUD treatment providers.

Older Adult Prevention Evidence Based Practices (EBP)

Michigan State University's Extension office (MSUE) was funded to offer evidence-based prevention programming for older adults across Michigan through the Chronic Pain and Chronic Disease Self-Management Programs (CPSMP, CDSMP), Stress Less with Mindfulness (SLM), and the Wellness Initiative for Senior Education (WISE), all with the goal of reducing the need for narcotic medications.

MSUE sites are embedded in all 83 counties in Michigan and have strong community ties. Throughout the duration of the SOR grant, MSUE educated a total of 3,004 unduplicated older adults.

Stress Less with Mindfulness (SLM)

SLM is a research-based and practice-tested program that is an introduction to a variety of mindfulness techniques taught in a series of five weekly one-hour lessons. The goals of SLM include increased personal self-awareness of stress symptoms and use of mindful breathing and mindful movement to calm the body and mind. MSUE utilized supplemental funding to implement single session mindfulness trainings. Throughout the duration of the SOR grant 2,086 unduplicated older adults attended mindfulness classes.

MSUE received feedback from multiple participants that the mindfulness strategies were particularly useful in coping with COVID-19 related stress. SLM was successfully transitioned to virtual implementation and had greater reach into the Upper Peninsula of Michigan, including participants from Gogebic and Chippewa counties. MSUE utilized evaluation data to compare the pre-intervention use of mindfulness techniques composite scores and post-intervention use of mindfulness techniques composite score. There was a significant increase in the scores for pre-survey mindfulness techniques scores (M=6.45, SD=2.08) and post-survey mindfulness techniques scores (M=9.28, SD=1.33).

Chronic Pain and Chronic Disease Self-Management Programs

CPSMP is an EBP with goals to reduce pain and fatigue, increase medication adherence, quality of life, and sleep, and reduce health distress and improve communication with doctors. CPSMP consists of two and a half hour sessions taught weekly over six weeks. The CPSMP curriculum includes light physical exercise. CDSMP is also a six-week self-management workshop that is designed to help participants take an active role in managing their chronic disease(s). Adults of all ages interested in managing their chronic diseases were welcome to attend, as well as their family members and caregivers. CPSMP and CDSMP have been integrated into MSUE's Personal Action Toward Health (PATH) programming along with diabetes management.

MSUE delivered these evidence-based self-management classes to 918 unduplicated older adults. MSUE hosted five single sessions of CDSMP and seven single sessions of CPSMP. The single sessions provide an overview of the curriculum without the need for a multi-week commitment from participants. MSUE facilitators successfully moved CPSMP and CDSMP to online implementation after March 2020. MSUE trained 12 new CPSMP trainers in project year two. Evaluation data compared the pre-intervention chronic disease/pain self-management composite scores and post-intervention chronic disease/pain self-management composite score. There was a significant increase in the scores for pre-survey chronic disease/pain self-management scores (M=6.89, SD=2.00) and post-survey chronic disease/pain self-management scores (M=7.49, SD=1.53).

Wellness Initiative for Senior Education (WISE)

The WISE curriculum includes information on healthy aging, alcohol and drug use, stress management, and medication management. MSUE completed 11 WISE programs for over 50 individuals. MSUE held four single sessions of WISE for 86 individuals.

Michigan Opioid Prescribing Engagement Network (MI OPEN)

The SOR grant funded the University of Michigan's Michigan Opioid Prescribing Engagement Network (MI OPEN) to facilitate the Optimizing Pain Management and Opioid Prescribing During Procedural Care project. This initiative is making advances in opioid prescribing practices after surgery by developing perioperative care pathways, refining and implementing prescribing recommendations through Collaborative Quality Initiatives

(CQIs), and coordinating an interprofessional network focused on improving opioid stewardship and coordinated care.

Emergency Department Naloxone Distribution

MI OPEN utilized SOR funding to distribute naloxone to emergency departments to give to patients with an SUD through collaboration with the Michigan Emergency Department Improvement Collaborative (MEDIC). MI OPEN and MEDIC hosted two interdisciplinary summits on ED treatment of post-overdose patients. They also created an Emergency Department Naloxone Implementation Guide to distribute to their hospital partners. All 10 hospital sites received train-the-trainer naloxone administration training. MI OPEN distributed over 4,540 naloxone kits to the following hospitals:

- Munson Medical Center
- Spectrum Health Butterworth Hospital
- Sparrow Hospital
- Hurley Medical Center
- Ascension St. John Hospital
- Detroit Medical Center Receiving
- Detroit Medical Center Sinai-Grace
- Henry Ford Hospital
- St. Joseph Mercy Hospital
- University of Michigan Hospital

Transitions of Care (TOC)

MI OPEN's TOC project seeks to optimize transitions of care for surgical patients currently using opioids, who have an OUD, or who may be at risk of new persistent opioid use. MI OPEN developed and pilot tested a tool to screen patients preoperatively into categories of risk for poor opioid-related outcomes. Over 10 team members were trained in the pathway program and conducted over 450 patient screening surveys via telephone. To understand how physicians utilized the TOC screening tool and identify improvements to be made, MI OPEN conducted semi-structured interviews with anesthesia providers, primary care physicians, and surgical providers who used the tool. This pilot was completed and further work on the tool will continue with SOR 2 funding.

Massive Open Online Course (MOOC)

In October 2019, MI OPEN launched a MOOC. The MOOC, called Impacting the Opioid Crisis: Prevention, Education, And Practice for Non-Prescribing Providers, consists of six modules on the epidemiology of the opioid crisis, understanding pain and drug targeting, prevention, clinical care and population health, and addiction treatment. Course participants have the opportunity to obtain continuing education hours. The modules are non-sequential and self-paced and are provided through Coursera and EdX. Throughout the grant, there were over 5,800 participants.

Dental Prescribing

MI OPEN conducted a nationwide survey of US Dental Schools to inform opioid-related curriculum. Through their research they found 60% of dental schools offer novel procedure-specific opioid prescribing limits to faculty and students and less than 50% dental schools require students to educate patients about safe opioid

storage, disposal, and tapering methods. MI OPEN also created and launched a continuing education course for dental prescribing. Over 100 individuals completed the dentistry course. Following the course there was a 54% increase in knowledge that ibuprofen and acetaminophen are more effective at pain management compared to opioids.

Collaborative Quality Initiatives (CQIs)

Much of the work collaborating with CQIs was put on hold due to COVID-19. However, the Obstetrics Initiative (OBI) was able to move forward with planning a hospital training program for both prescribers and non-prescribing healthcare professionals on alternatives to opioids during and after childbirth. The OBI selected four labor support skill development programs and one doula program to educate over 400 staff members at 16 hospitals.

Statewide Media Campaign

MDHHS Office of Communications contracted with Brogan & Partners to create an opioid anti-stigma media campaign. The objective of the media campaign was to start a conversation that reworks the narrative, helps end the stigma of OUD, and leads to healing. The primary target audience for the campaign was individuals aged 25 to 44 who misuse opioids, and their peers and family. The campaign was a statewide effort with emphasis on Genesee, Lapeer, Macomb, Sanilac, St. Clair, and Wayne counties. More information about the campaign can be found at Michigan.gov/Opioids.

The End the Stigma campaign included advertisements on radio, cable television, billboards, transit, Google search, Facebook, Instagram, YouTube, and Michigan Chronicle. The advertisements ran from November 2019 through April 2020. During this time, the digital campaign received 89,559,342 impressions, 5,913,846 video views on YouTube and cable television, and 57,908,457 impressions outdoors or on transit. Across all media forms, there were 153,804,944 impressions.

The End the Stigma campaign website encourages individuals to share the messages, images, and videos on their social media networks. The website includes images like the one below and sample social media posts such as, “Conversations don’t come with autocorrect, so when you talk about opioid use disorder, it’s important to be aware of what you say, and how it impacts those affected. Learn how you can start a conversation that leads to healing at Michigan.gov/Opioids.”

The End the Stigma campaign website also includes information about stigmatizing language and preferred language when discussing OUD, concrete suggestions for reducing stigma, and tips for talking to a loved one with SUD.

A second media campaign was initiated to target individuals who were actively using and provides resources for harm reduction such as syringe service programs, HIV and Hep A/B/C testing, and Naloxone. The “Change, At Your Own Pace” campaign began during the NCE. The campaign sought to reduce health disparities in harm reduction services with the ads and is focused on Southeast Michigan and Northern Michigan. The campaign includes images to post on Facebook, Instagram, and other digital platforms. In addition, a portion of

the Michigan.gov website has been devoted to the campaign and resources for treatment, recovery supports, and harm reduction. A sample of the ads are below. Filming and digital ads were completed in November 2020, and the campaign was formally rolled out on March 1, 2021. From March 2021 through September 2021, the digital campaign received 75,760,123 impressions, 132,789 clicks, and 12,821,781 video views, with a 76% completion rate. The Change, At Your Own Pace campaign received the Social Justice Campaign Award from PR Daily. Judges commented, “The Michigan statewide campaign removed stigma, shame, and stereotypes around drug use and promoted avenues for assistance.”

Syringe Service Programs (SSP)

Syringe Service Programs (SSP) are an essential harm reduction approach to reduce the risk of using substances to both the individual and the community. SSPs connect marginalized individuals to their communities and empower them to make positive changes. These programs focus on building relationships and linking individuals to services like SUD treatment. SSPs offer a variety of other services including naloxone distribution, human immunodeficiency virus (HIV) and hepatitis C (HCV) testing; hepatitis A (HAV) and B (HBV) vaccinations, as well as various trainings. SSPs also provides items like needle disposal boxes, gloves, alcohol wipes, and personal hygiene kits.

In project year two of the SOR grant, beginning in April 2020, SOR Prime and SOR Supplemental funds were dispersed across 17 SSPs embedded in health departments and social service organizations. SSPs conducted outreach and provided trainings on stigma reduction with SOR funds. SSPs also utilized funds to provide referrals to SUD treatment and distribute naloxone, as shown in the table below. SOR funds supported HIV and HCV testing.

Overall, SSPs had 11,529 encounters and referred 166 individuals to SUD treatment. Over 26,000 naloxone kits were distributed and over 750 overdoses were reversed by these kits. Additionally, over 300 HIV and HCV tests were conducted.

Local Health Department Access to Overdose Data

The System for Opioid Surveillance (SOS) was created through a partnership between the University of Michigan Injury Prevention Center and the Michigan High Intensity Drug Trafficking Areas. The SOS provides close to real-time mapping of fatal and non-fatal overdoses. The public can access county-level data, while authorized public health and safety officials can access more detailed data and demographic information. The SOS is a data-driven tool to inform prevention efforts and reduce overdose injuries and fatalities.

Funds were utilized to develop statements of work for local health departments and guide local health departments in developing an evaluation process. The MDHHS technical assistance team worked with local health departments to use the SOS to determine high risk areas and identify naloxone distribution sites. This

information was used to inform statements of work. COVID-19, however, redirected the focus of local health departments and transitioned staff to address the pandemic. This delayed the development of statements of work and corresponding evaluation processes. At the end of the NCE, the Kent County Health Department was able to establish a process for sharing surveillance updates with 52 community organizations, and the Detroit Health Department (Wayne County) used the system to identify local organizations and community members who may benefit from receiving naloxone training. The Muskegon Health Department plans to use the system in partnership with local EMS to conduct in-person follow-up and resource linkage for persons who experienced an overdose.

LARA Michigan Automated Prescription System (MAPS)

The Licensing and Regulatory Affairs Michigan Automated Prescription System (MAPS) is Michigan's Prescription Drug Monitoring Program. Prescribers and pharmacists utilize MAPS to determine if patients are receiving controlled substances from other providers and to assist in the prevention of prescription drug misuse and abuse. SOR funds were used to cover the cost of integrating MAPS into existing electronic medical records and pharmacy dispensation systems. MAPS provides MDHHS with data that includes the numbers of health systems, hospitals, physician's offices, and pharmacies that are integrated with MAPS and the number of each that are pending integration with MAPS. Data also includes the number of registered MAPS users by prescribers, pharmacists, as well as the number of users that are utilizing MAPS.

During project year two, 395 health systems, hospitals, pharmacies, and physician's offices integrated with MAPS. Physician's offices utilized MAPS most frequently, followed by pharmacies, health systems, and hospitals. There was a total of 83,741 online registered MAPS users, which are most frequently prescribers, followed by delegates and pharmacists.

Treatment Activities

Peers in Federally Qualified Health Centers, Urgent Care, and Other Outpatient Settings

Nine PIHP regions received SOR Prime and SOR Supplemental funding to support peer support specialists in outpatient settings such as Urgent Care or Federally Qualified Health Centers (FQHC). These peers are individuals with lived experience of SUD recovery who can connect with individuals currently struggling in a meaningful, empowering way. Peers uniquely well suited to meet individuals struggling with SUD whenever they are on their pathway to recovery since they are not tied to a specific treatment service. Agencies placed peers placed in outpatient treatment settings to conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) for individuals at risk of OUD. Peers work with clinicians collaboratively and are essential to support and enhance the work of fully integrated behavioral health delivery systems.

Throughout the SOR grant, peer support specialists from nine regions made 6,477 initial contacts with individuals at risk of OUD, and 12,602 follow-up contacts with the same individuals. Peer programming was implemented in over 23 different locations across Michigan. While COVID-19 limited the ability of peers to engage new clients and expand programming to new locations, many were able to connect with clients virtually.

Peers in FQHCs, Urgent Care, and Other Outpatient Settings				
	Year 1	Year 2	NCE	Total
Initial Contacts	1,858	2,821	1,798	6,477
Follow-Up Contracts	4,012	5,540	3,050	12,602

Mobile Care Units

Mobile care units (MCU) are retrofitted RVs and health vans that provide SUD screening, referral to treatment, SUD counseling, peer supports, overdose education, naloxone distribution, drug screening, and basic primary care supports. Transportation is consistently a barrier for individuals seeking resources and health care services for OUD. MCU help address this barrier by bringing prevention, treatment, and recovery support services directly to the individuals that require them. Providers utilize MCU strategically throughout the community to reach individuals in rural areas and underserved populations. Through community partnerships, MCU are also able to offer ancillary services such as referrals to housing, clothing, and food support. PIHP Regions 5, 7, and 10 were able to implement MCU. The Michigan Primary Care Association worked with Great Lakes Bay Health Centers to support an existing MCU for MAT service delivery and established community partners for future implementation.

Region 5 served clients in Arenac, Bay, Eaton, Gladwin, Isabella, Midland and Saginaw counties. The MCU operated five days a week throughout the region. Region 7 supported two existing MCU in Detroit and throughout Wayne County. Region 10 contracted with an existing MCU provider agency and delivered services once a week in Flint. Due to COVID-19, MCUs adapted services to include basic needs for the community like hygiene and personal protective equipment. Throughout the grant, the MCU provided services to over 6,000 individuals statewide.

Mobile Care Unit Services				
Type of Service	**Year 1**	**Year 2**	**NCE**	**Total**
SUD Screening	797	1,902	1,318	4,017
Peer Supports	230	926	1,151	2,307
Drug Screening	307	620	248	1,175
Referral to SUD Treatment	662	1,714	288	2,664
Case Management	142	232	23	397
OEND and Harm Reduction	165	233	759	1,157
SUD Counseling	504	1,161	673	2,338
Basic Primary Care Supports	233	462	302	997
Individuals Served	1,000	3,125	1,962	6,051

Jail-Based Medication Assisted Treatment (MAT) Expansion

Medication assisted treatment (MAT) is the use of U.S. Food and Drug Administration-approved medications, in combination with counseling, to treat alcohol, opioid, or tobacco use disorders. For addressing OUD, medications bind or block opioid receptors in the brain to address craving and withdrawal symptoms. This helps manage symptoms and allows brain chemistry to fight the opioid addiction. Research shows MAT can successfully treat OUD and help maintain recovery by decreasing opioid use and overdose deaths, while increasing treatment retention. There are three types of medications specific to OUD: buprenorphine, methadone, and naltrexone.

- Buprenorphine (Suboxone ®, Sublocade ®) is a partial opioid agonist that binds with brain receptors to limit the euphoric effects of other opioids, which reduces craving and withdrawal symptoms. Only authorized prescribers with special training can provide buprenorphine. It can be dispensed daily in a dissolving tablet or cheek film, monthly injection, or a six-month implant under the skin. In April 2021, policy updates allow prescribers to dispense buprenorphine for up to 30 clients without being a specially trained prescriber.

- Methadone is a full opioid agonist that binds with brain receptors to limit the euphoric effects of other opioids, which reduces craving and withdrawal symptoms. Only specially licensed clinics can provide methadone, and it is dispensed daily in liquid form.

- Naltrexone (Vivitrol ®) is an opioid antagonist that blocks opioid receptors to eliminate the euphoric effects of opioids, but it does not address craving or withdrawal symptoms. Any health professional who is licensed to prescribe medication can prescribe naltrexone, and it is taken through a daily pill or monthly injection.

Throughout the three project years, nine regions either continued existing jail-based MAT programming or expanded programming to new jails. Twenty-nine facilities across Michigan implemented jail-based MAT

through SOR Prime and Supplemental funds, and an additional nine facilities met with PIHPs to discuss implementing jail-based MAT, as shown in the table below.

Facilities Implementing Jail-Based OUD Services	
Alcona County Jail	Manistee County Jail
Alpena County Jail	Missaukee County Jail
Antrim County Jail	Monroe County Jail
Benzie County Jail	Montmorency County Jail
Eaton County Jail	Muskegon County Jail
Grand Traverse County Jail	Newaygo Country Jail
Ingham County Jail	Oakland County Jail
Iosco County Jail	Otsego County Jail
Jackson County Jail	Ottawa County Jail
Kalamazoo County Jail	Roscommon County Jail
Kalkaska County Jail	Schoolcraft County Jail
Kent County Jail	St. Clair County Intervention Center
Lake County Jail	Wexford County Jail
Leelanau County Jail	William Dickerson Detention Facility
Macomb County Jail	
Facilities in Talks to Implement Jail-Based MAT	
Calhoun County Jail	Newaygo Country Jail
Chippewa County Jail	Ogemaw County Jail
Livingston County Jail	Washtenaw County Jail
Marquette County Jail	Wexford County Jail
Mason County Jail	

Overall, more than 2,200 individuals received jail-based MAT programming. Staff provided over 800 doses of medication along with other services such as counseling, referrals to treatment, peer services, and post-release follow-up contact. The table below presents the number of people served by medication type.

Jail-Based MAT Medications				
Medication	**Year 1**	**Year 2**	**NCE**	**Total**
Buprenorphine (Suboxone ®)	62	184	199	445
Methadone	40	95	105	240
Naltrexone (Vivitrol ®)	9	58	93	160

COVID-19 had a major impact on jail-based services. In March 2020, an executive order (2020-29) was issued that limited access to correctional facilities and most regions had to temporarily suspend programming. Through the order, county jails were also encouraged to consider early release for certain individuals to try to reduce the risk of spreading COVID-19. This included, “Anyone with behavioral health problems who can safely be diverted for treatment.” As such, many individuals eligible for jail-based MAT were diverted to community-based programming. By the end of the NCE project period many jail-based MAT programs had returned to providing services.

Michigan Department of Corrections (MDOC) MAT Expansion

During the SOR NCE, MDOC was granted funds to pilot MAT programs at Carson City Correctional Facility, Central Michigan Correction Facility, Charles Egeler Reception and Guidance Center, Women's Huron Valley Correctional Facility, and Marquette Branch Prison. MDOC contracted with Corizon Correction Healthcare to provide medical services. At the onset of the pilot program, they identified MAT champions at each site to act as guides and assist other providers in initiating or providing MAT to inmates. MAT champions and other facility staff attended regular support and coaching calls convened by the MAT Steering Committee.

Carson City Correctional Facility and Central Michigan Correction Facility adopted a screening and assessment protocol for inmates and proceeded with MAT inductions for eligible individuals. During the NCE year there were 345 total inductions.

Charles Egeler Reception and Guidance Center and Women's Huron Valley Correctional Facility opted to continue providing MAT for inmates who arrived already on MOUD or in acute opioid withdrawal.
All facilities experienced challenges due to COVID-19 outbreaks. During COVID-19 outbreak statuses inmate movement was restricted. During these times, mental health clinicians were unable meet with inmates and complete screening and assessments for MAT treatment, and healthcare staff were unable to provide MAT. Shortage of nursing staff to provide care was a barrier throughout the NCE.

Opioid Use Disorder (OUD) Treatment Costs

PIHPs provided agencies with SOR Prime and SOR Supplemental funding to cover the costs of OUD treatment services for clients who are uninsured or under-insured. Agencies also used these funds to cover the salary and wages of essential staff who provide treatment services. Covered services include case management, drug testing supplies and lab costs, medication for treatment (buprenorphine, methadone, naltrexone), transportation, or web-based treatment services. Seven regions used funds to cover treatment costs for OUD. Additionally, PIHP Region 1 partnered with a provider to support the implementation of an Opioid Treatment Program (OTP) in the Upper Peninsula, a large 13-county area of the state with no OTP in operation. During the NCE, a building was secured, a physician and peer were hired, and MOUs were made with a local provider agency for clinical time. Licensing is underway with anticipated opening in late 2021. The table presents the different types and number of services. The table presents the different types and number of services. Overall, the seven regions provided over 4,400 OUD treatment services to more than 3,600 clients.

OUD Treatment Services				
Type of Service	**Year 1**	**Year 2**	**NCE**	**Total**
Case Management	350	542	1,120	2,012
Transportation to Treatment	0	447	39	486
Web-Based/Telehealth Treatment	150	324	386	860
Drug Testing Supplies & Lab Costs	150	311	300	761

Buprenorphine (Suboxone ®)	25	114	179	318
Methadone	0	0	2	2
Naltrexone (Vivitrol ®)	0	0	50	50
Individuals Served	825	1,100	1,749	3,674

Telehealth to Support Rural Communities

Rural areas of Michigan have limited access to MAT for OUD. Initially, few physicians in rural areas have the necessary training to prescribe MAT. The physicians who are trained often lack resources and ongoing professional support to successfully deliver telehealth services and MAT.

The Michigan Opioid Collaborative (MOC) of the University of Michigan received funds to address this problem by studying the efficacy of telehealth supports for patients receiving MAT, as well as providers offering MAT. Through MOC, physicians who prescribe MAT can receive a same-day consultation with an addiction psychiatrist or local Behavioral Health Consultant (BHC) on case consultations, clinic practices, or general OUD treatment and MAT information. Additionally, patients experiencing transportation barriers can participate in telehealth-based therapy with their MAT provider to eliminate this barrier to treatment.

Throughout the SOR grant, MOC implemented telehealth counseling services with 50 patients. Providers first completed an orientation process with MOC to provide eight-week MI-teleCONNECT intervention to their patients. Throughout the grant, MOC provided 298 sessions.

While telehealth counseling focuses on providing MAT to patients, telementoring supports MAT providers by including University of Michigan addiction specialists in patient appointments (alongside their provider) to support the provider in assessment and treatment planning for patients with OUD, via videoconference. MOC enrolled 17 providers throughout Michigan and provided over 50 provider/patient consultations including email, meeting, and call support. These 17 providers are now able to support and treat patients with medications for opioid use disorder. Additionally, MOC has been able to connect providers with the resources (i.e., other providers, guides, etc.) to improve their clinic flow and patient load. Throughout the grant, MOC identified ways to improve their products and support. Through collaborative processes, MOC providers were able to create several tools and presentations/webinars that assist providers with treating patients with MAT.

MOC also conducted a Sequential Multiple Assignment Random Trial (SMART) to reach out to providers who are Drug Addiction Treatment Act (DATA) 2000 waivered, but have not been providing buprenorphine. MOC sent out 698 letters to waivered providers. Providers either received a “standard” or a “commitment” letter. The “standard” letter encouraged them to prescribe MAT when appropriate. These letters contained provider-specific data, information on MOC and the services available to them, as well as an MOC-branded pen and pad of paper. The “commitment” letter also encouraged them to prescribe MAT when appropriate and included all the information from the “standard” letter. An additional paragraph in this letter was included on making a commitment to prescribe buprenorphine along with a business reply mail envelope and a signable form indicating their commitment to making buprenorphine available to their patients. Providers were given three ways to respond to the letter— (1) fill out the form by hand and mail it back to MOC at no cost, (2) email MOC a picture of the signed form, or (3) fill out an online form. Twenty-five providers from the standard letter group and 56 providers of the commitment letter group responded to the letter. Providers who did not respond to the letter were then contacted via phone or email from either a BHC or a peer physician. This yielded 187 successful follow-ups with providers.

MISSION Michigan Reentry Program (MI-REP) Expansion

The Wayne State University Center for Behavioral Health and Justice (CBHJ) in partnership with the Michigan Department of Corrections (MDOC) and Regions 3, 6, 7, 8, and 9 implemented the evidence-based, integrated behavioral health intervention Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking-Criminal Justice (MISSION). Developed by the University of Massachusetts Medical School, MISSION was designed to meet the unique needs of individuals with co-occurring substance use and mental health disorders. Michigan adapted MISSION specifically for individuals released from prison and reentering the community with OUD and mental health disorders. The MI-REP team works with corrections department staff to receive referrals for programming, conduct screenings and enroll clients meeting eligibility criteria. Once enrolled, staff assign clients a peer recovery coach and case manager team for up to three months pre-release and up to nine months post-release. This team works with clients to ensure they have the services needed to support their recovery in the community. Clients receive an initial dose of Vivitrol ® while they are incarcerated. Upon release, they are linked to community MAT providers, as well as to other recovery resources through their CMH or PIHP.

MI-REP utilized SOR Prime funds for to provide programming in Wayne, Macomb, Oakland, Kent, and Monroe counties. During an extended length of time, the ability to offer services was limited due to COVID-19 and its impact on access to correctional facilities. Staff-turnover within the facilities and county provider teams was an ongoing challenge. Wayne, Macomb, and Oakland country programming were halted due to a need for case managers and peers. The table below presents the number of referrals, screenings, enrollments, and graduates for Wayne, Macomb, Oakland, Kent, and Monroe throughout all three years of the SOR grant. Altogether, the counties received over 700 referrals and completed over 200 screenings.

Implementation & Enrollment				
County	**Referrals**	**Screenings**	**Enrollments**	**Graduates**
Wayne County	161	70	71	26
Macomb County	50	27	32	16
Oakland County	47	24	27	12
Kent County	539	173	109	20
Monroe County	226	76	67	21

Direct Provider Support for Medication Assisted Treatment (MAT)

The Michigan Opioid Partnership (MOP) is a unique public-private funding collaborative aimed at decreasing opioid overdoses and deaths in Michigan through prevention, treatment, harm reduction, and recovery services. MOP includes The Community Foundation for Southeast Michigan, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Michigan Foundation, Ethel and James Flinn Foundation, The Jewish Fund, MDHHS, Michigan Health Endowment Fund, and the Superior Health Foundation.

Through SOR Prime and Supplemental funding, MOP implemented culture-changing initiatives in ED and initiation of MAT. Traditionally when an individual presents to the emergency department with symptoms of an overdose or withdrawal, staff stabilize and discharge them. MOP granted funding to hospital facilities that ensure any individual who presents at their ED with symptoms of an opioid overdose or withdrawal symptoms receives an initial dose of buprenorphine and a warm handoff to an outpatient treatment provider for treatment of OUD.

MOP implemented programming at Munson Medical Center, Royal Oak Beaumont, St. Joseph Mercy Ann Arbor, Sparrow Hospital, War Memorial, Henry Ford Hospital, Henry Ford Wyandotte, Beaumont Wayne, Beaumont Troy, and Spectrum Butterworth Hospital.

Together all 10 hospitals inducted over 450 individuals in MAT, provided over 500 referrals to outpatient treatment, and provided over 250 prescriptions upon discharge. COVID-19 had a significant impact on programming, the ability to access emergency departments, and furloughed staff who were unable to provide services. However, toward the end of the NCE project year much of the hospital programming had resumed. The table below presents the number of inductions, referrals to outpatient treatment, and MAT prescriptions provided throughout all three years of the SOR grant.

Implementation of MAT in Emergency Departments			
Emergency Department	**Inducted in MAT in ED**	**Referrals to Outpatient Treatment**	**Prescriptions Provided on Discharge**
Munson Medical Center	30	36	20
Royal Oak Beaumont	100	51	35
St. Joseph Mercy Ann Arbor	49	37	31
Sparrow Hospital	6	8	8
War Memorial	13	81	13
Henry Ford Hospital	134	67	43
Henry Ford Wyandotte	48	107	51
Beaumont Wayne	10	1	5
Beaumont Troy	22	125	16
Spectrum Butterworth Hospital	64	39	63

The MOP also distributed SOR Prime and Supplemental funds to treatment agencies working in Michigan's county correctional systems to expand access to medication for OUD in Muskegon County Jail, Jackson County Jail, Washtenaw County Jail, and Schoolcraft County Jail. Staff in the Schoolcraft County Jail provided weekly SUD therapy sessions for inmates and were working to get MAT started at the time of grant end. Through these efforts, over 120 individuals were started on MAT. The table below presents the number of bookings, OUD screenings, positive OUD screens, and number of individuals started on MAT throughout all three project years of the SOR grant.

Implementation of MAT in Jails				
Correctional Facility	**# of bookings**	**# OUD screenings**	**# positive OUD screens**	**total # of individuals started on MAT**
Muskegon County Jail	2,261	1,183	109	48
Jackson County Jail	1,909	1,160	157	46

Implementation of MAT in Jails				
Washtenaw County Jail	2,304	1,585	127	28

Hope Not Handcuffs (HNH) Expansion

Families Against Narcotics (FAN) started the HNH initiative, which brings together local police departments, volunteers, and community organizations to help people access treatment for OUD/SUD. Partnering police departments allow people to voluntarily enter a police department and ask for help without fear of arrest. Once enrolled, clients are assigned a volunteer "angel" that conducts an intake and facilitates their connection to treatment. The volunteer angel also guides them through paperwork and provides support until they enter treatment.

Throughout the grant, FAN recruited 15 additional police stations to become HNH sites and launched two new chapters. HNH trained over 300 new angel volunteers. Over 950 family members and friends of individuals at risk for overdose and police officers were trained in naloxone administration and responding to overdoses.

New HNH Sites	
County	**Site**
Antrim	Elk Rapids Police Department
Crawford	Grayling Police Department
	Crawford County Sheriff
Genesee	Burton Police Department
	Metro Policy Authority
	Montrose Police Department
Macomb	41B District Court
Oakland	Berkley Police Department
	Oak Park Police Department
Otsego	Otsego County Sheriff
	Gaylord Police Department
St. Clair	Yale Police Department
Wayne	Grosse Ile Police Department
	Garden City Police Department
	Wayne Police Department

Despite issues related to COVID-19 and access to police departments, HNH utilized their toll-free number and online referral process to continue engaging potential participants, as well as their family and friends. Over 4,000 calls were received throughout the grant period. HNH assisted in placing over 1,100 individuals in treatment and conducted over 1,000 successful follow-up contacts to continue engagement in treatment.

Angel Program

The Michigan State Police (MSP) Angel Program aims to connect people to treatment services to combat opioid overdoses and death. The program allows an individual struggling with an OUD/SUD to walk into any of MSP's 30 posts during regular business hours and ask for assistance, without fear of being charged for possession of substances or paraphernalia. The program coordinator continually updated a list of treatment agencies by PIHP region. The coordinator also developed and implemented five statewide *Angel Program Refresher Training* opportunities and three new provider trainings. Throughout the SOR grant, the Angel Program assisted in placing 582 individuals into treatment. The Angel Program also increased MSP's ability to respond to overdose emergencies and administer life-saving naloxone by distributing over 900 naloxone kits to MSP posts statewide.

Opioid Health Homes

The Opioid Health Home (OHH) exists under Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). The Health Home service model is meant to help chronically ill Medicaid and Healthy Michigan Plan beneficiaries manage their conditions through an intensive level of care management and coordination. Potential beneficiaries must have full Medicaid coverage, have an OUD diagnosis, and reside within specific counties in Michigan. The OHH is centered on whole-person, team-based care, with peer recovery coaches at the center of care. The overarching goals for the OHH program include improving care management of beneficiaries with OUD; improving care coordination between physical and behavioral health care services; and improving care transitions between primary, specialty, and inpatient settings of care. Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary.

Region 1, as the LE worked with Great Lakes Recovery, Upper Great Lakes Family Health, and UP Health System Marquette Family Medicine, HHPs, on implementing an OHH model with SOR Prime funding. Region 1 and its HHPs completed a two-day virtual kick-off training with sessions consisting of MAT best practices, interplay between partners, health home care model deliveries, and billing and payment procedures. Additional trainings such as the waivers support application identified and detailed the accountability of each LE and HHP, and the need to register OHH potential beneficiaries into services. Region 1 implemented a regional media campaign designed to target potential OHH beneficiaries with radio advertisements, billboards, and social media.

Regions 4 and 9 utilized SOR Supplemental funding to plan OHHs in their regions and media campaigns aimed at increasing awareness of OHH services. Region 4 executed contracts with Summit Pointe and Victory Clinic Services and hired a regional OHH coordinator. Region 9 executed contracts with Gammons Medical, MyCare Health Center, Quality Behavioral Health, and Sacred Heart Rehabilitation Center.

At the end of project year two, the Medicaid State Plan Amendment was approved to include OHH services in Regions 1, 4, and 9, allowing for sustained care coordination beyond the life of the SOR Prime and SOR Supplemental grants. Region 1 was able to identify a list of more than 1,700 potential beneficiaries that will qualify for OHH services.

Recovery Activities

Recovery Housing

Recovery housing provides safe and substance free living environments and offer supports for individuals as a part of their treatment and recovery plan. Housing often consists of a structured environment with case management services, life skills training, consistent peer supports, and connections to other recovery supports like medical consultations and counseling services. This type of housing has proven effective for reducing substance use and promoting long term recovery.

Nine PIHPs distributed SOR Prime and Supplemental grant funds to over 30 recovery homes statewide to pay the wages of essential personnel and costs associated with housing residents with OUD. Recovery homes also used funds for necessary home repairs and purchases essential to making the home a livable space, such as beds and mattresses, furnace repairs, hot water heaters, roof repairs, or window installation. Finally, recovery homes utilized SOR funds to obtain the Michigan Association of Recovery Residents (MARR) certification. MARR is the Michigan statewide affiliate of the National Alliance for Recovery Residences, Inc. (NARR). MARR and NARR certification requires recovery homes to meet 31 standards across four domains including administrative operations, physical environment, recovery support, and good neighbor principles.

Individualized Placement and Support (IPS)

IPS is an evidence-based model of supported employment for individuals with a mental health disorder. IPS assists clients with the eight domains shown below.

SOR Prime funds in Michigan were used to pilot this program with clients aged 18 – 25 years of age who had co-occurring mental health disorders and OUD. PIHP Regions 1, 7, and 8 were identified because of the number of individuals in the identified age range that were entering behavioral health treatment without employment. Region 8 employed two employment specialists throughout the grant and received 311 referrals to the program. During project year one, the eligibility pool was expanded to include adults over the age of 25. This expansion of age range allowed for more individuals to participate in IPS. Since inception, the IPS program in Region 8 assisted 30 individuals in getting 52 jobs. Eleven of the participants at grant end were currently working.

Region 7 struggled to retain an employment specialist to operate the IPS program throughout the grant. During the NCE project year, Region 7 contracted with Team Wellness to employ an employment specialist. Twelve employers were recruited as sites for the IPS program; however, Region 7 was unable to recruit any program participants during this time period.

Region 1 enrolled 13 individuals into their IPS program. Their employment specialist recruited individuals from Great Lakes Recovery Centers outpatient and residential locations in Sault Ste. Marie.
Across all regions, a major difficulty with implementing IPS was recruiting employment sites. Many employers had policies against hiring individuals with criminal backgrounds and/or previous substance use issues. This ongoing stigma towards individuals in recovery remains a barrier to employment.

Opioid Use Disorder (OUD) Recovery Services Costs

PIHPs provided agencies with SOR Prime and SOR Supplemental funding to cover the costs of OUD recovery services for uninsured or under-insured patients, as well as to cover the salary and wages of essential positions like peer recovery coaches (PRC) and peer support specialists (PSS) who provide recovery services. The types of services that were covered included case management, intake assessments, outreach, skill-based groups, support groups, and transportation.

Seven regions utilized funds for OUD recovery service costs. Six regions used funds to cover salary and wages for various positions including community navigators, house managers, PRC, therapists, and program coordinators. Almost 200 positions were funded with the SOR Prime and Supplemental grants. Six regions used funds to cover recovery services for over 6,420 clients throughout all three project years of the SOR Prime grant. Most often these services included transportation support to access services, mental health services, case management, sober social activities, recovery meetings, skills training like problem solving and conflict resolution, as well as basic needs such as housing and food.

In Jackson County, Region 5, Home of New Vision (HNV) was able to renovate a physical space, hire staff, and develop procedures for an engagement center. HNV hired and trained 14 staff on screening process, medication monitoring, vitals' protocol, admissions, de-escalation, confidentiality, recipient rights, documentation, health, and safety. The engagement center opened in March 2021 to serve individuals 18 years of age and older. Typical stays at the engagement center are between 24 and 48 hours. During their stay, clients participate in their own recovery planning and are linked to available resources. Since opening, they have admitted 157 individuals.

Peer Recovery Support in Tribal Communities

The Inter-Tribal Council of Michigan (ITC), Anishnaabek Healing Circle utilizes a culturally tailored and evidence-based model of peer recovery support for clients with co-occurring mental health and SUD. This model integrates peer recovery support services with culturally responsive and trauma informed treatment, as well as naloxone distribution.

Throughout the SOR grant period, Keweenaw Bay Indian Community, Lac Vieux Desert Band of Lake Superior Chippewa Indian, Bay Mills Indian Community, Grand Traverse Band of Ottawa and Chippewa Indians, Hannahville Indian Community, and the Pokagon Band of Potawatomi worked to implement and enroll uninsured or underinsured clients in peer recovery support services. Tribes provided peer recovery support services to over 350 individuals.

The ITC contracted with four different tribes to provide telehealth services: Bay Mills Indian Community, Grand Traverse Bay Band of Ottawa/Chippewa Indians, Lac Vieux Desert Band of Lake Superior Chippewa, and the Pokagon Band of Potawatomi Indians. These four tribes enrolled 77 clients in telehealth services.

The ITC also used funds to establish tribal action plans. Tribal action plans are strategic plans that outline the goals of a tribe in responding to opioid use and misuse. Historically few tribes have established tribal action plans; however, these plans are important for partnering with federal agencies. At the end of NCE project year, three tribes had completed tribal action plans and one tribe was very near completion.

Government Performance and Results Act (GPRA)

The Government Performance and Results Modernization Act of 2010 (GPRA) requires all SAMHSA grantees to collect and report performance data. In practice, GPRA refers to the CSAT GPRA Client Outcome Measures for Discretionary Programs instrument. The GPRA is a series of three interviews conducted at program intake, six months following intake, and discharge. Only clients who receive treatment or recovery services funded by the SOR Prime and Supplemental grants are required to complete the GPRA series of surveys. GPRA data is not representative of the population of OUD treatment recipients throughout Michigan. Individuals receiving treatment funded by SAMHSA Substance Abuse Block Grant, Public Act 2, Healthy Michigan Plan, private insurance, or private pay are not required to complete GPRA data collection.

Statewide Summary

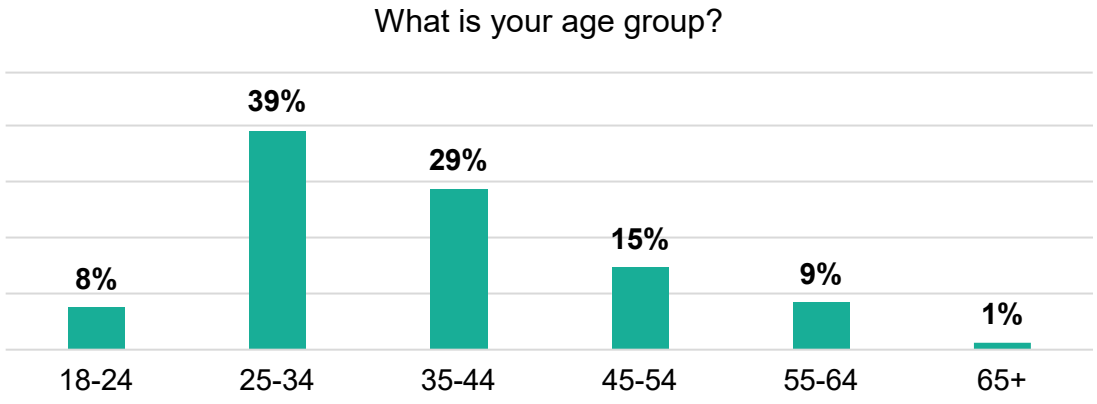
GPRA data collection for the SOR grant began in June of 2019 and ended September 2021. Through the three-year grant period from October 2019 – September 2021, provider staff at SOR Prime and Supplemental funded agencies completed GPRA intake interviews for 3,408 clients. Providers completed 1,660 discharge GPRAs and 2,020 six-month follow-up (6MFU) GPRAs.

GPRA Submissions by Interview Type			
	Intake	**Discharge**	**6-Month Follow-Up**
Year 1	224	11	0
Year 2	1,640	590	568
NCE	4,055	1,059	1,452
Total	3,408	1,660	2,020

Intake

Demographics

The GPRA collects demographic data on all clients including gender, race and ethnicity, education, and age group. Clients report these data points at every phase of the GPRA interview process. Demographic data from the three-year grant period indicates that at intake 63% of clients are male, 96% are not Hispanic or Latino, and 76% are white, 9% are multi-racial, and 9% are Black or African American. The most common age range for GPRA clients is between 25 and 34 years old.

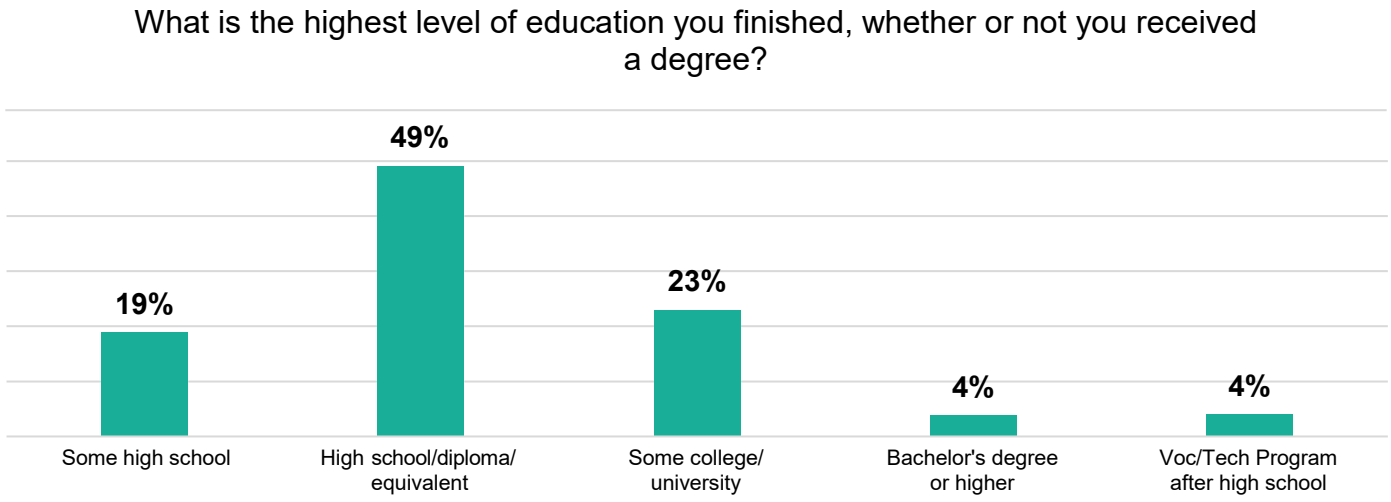


Pregnancy

The GPRA collects data on pregnancy from all clients identifying as female, transgender and/or other. Reported pregnancy rates remain consistent throughout the GPRA interview timeline. Of the 1,237 clients identifying as female at intake, 3% (n = 37) indicated they were currently pregnant.

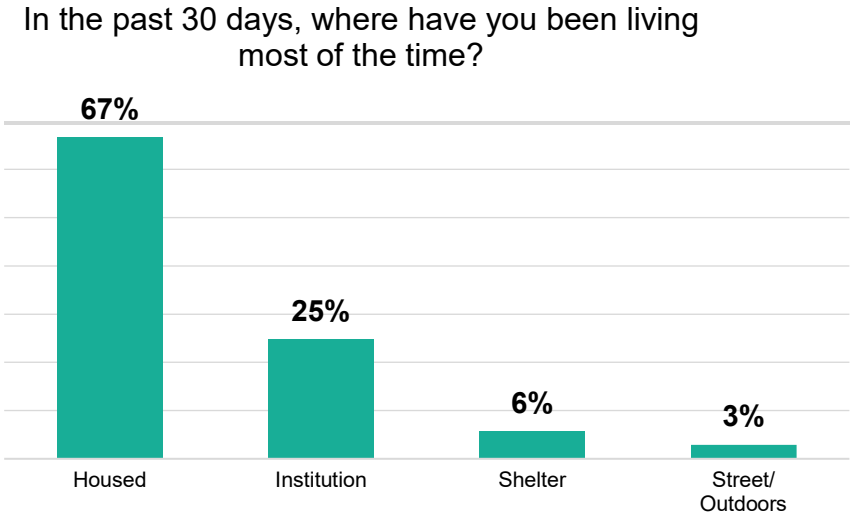
Education

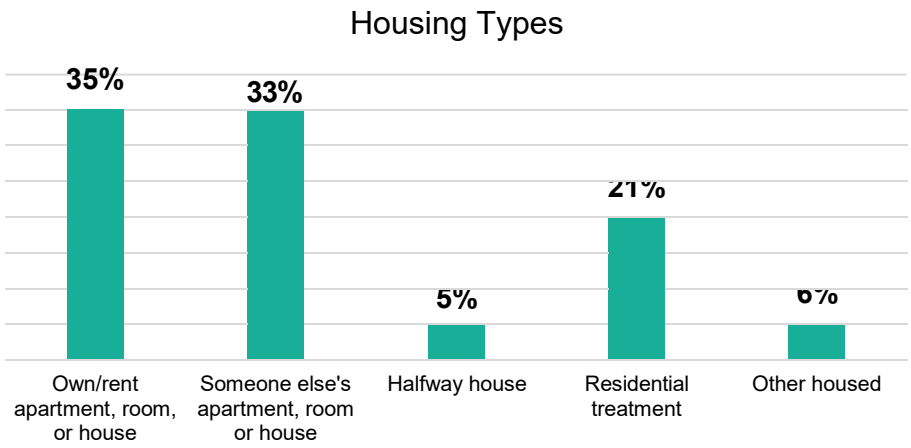
Clients completing the GPRA indicate their highest completed level of education. While almost half (49%) have completed high school, 19% did not. Few clients (8%) obtained a bachelor's degree or vocational or technical degree after high school.



Housing

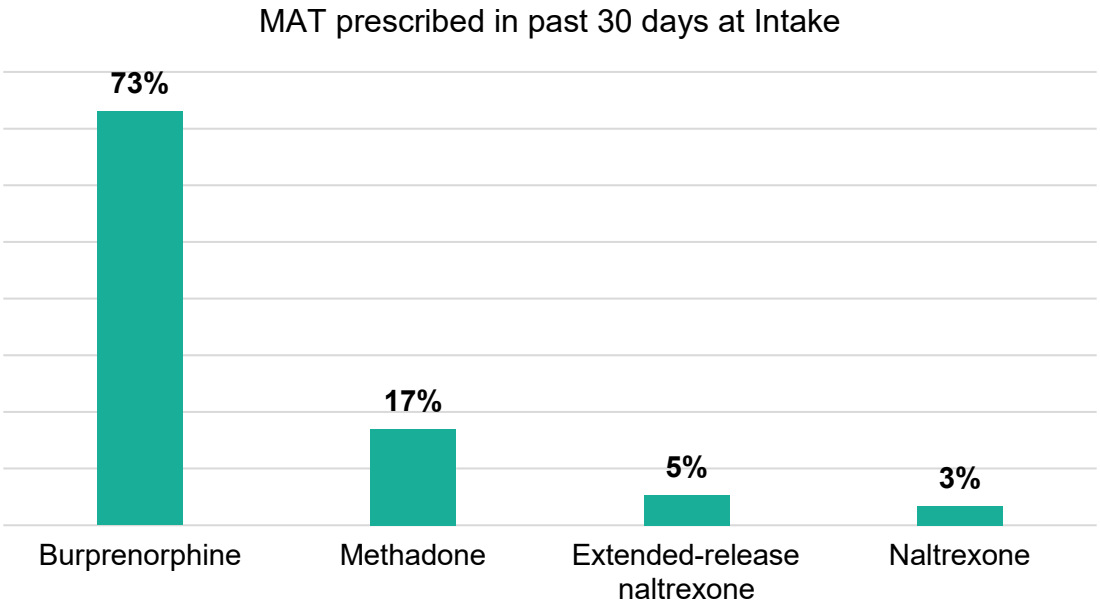
The GPRA collects data on the housing status of clients within the past 30 days of each interview. SAMHSA defines housing status as residing in one location for at least 14 days. At intake, most clients were housed (67%), although 25% were living in an institution, and another 9% were living in a shelter or on the streets.





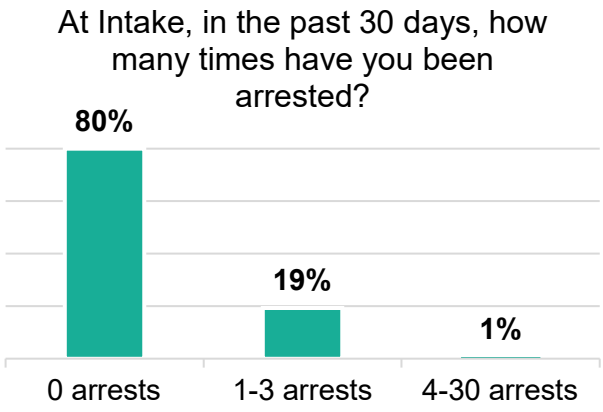
OUD Diagnosis and MAT

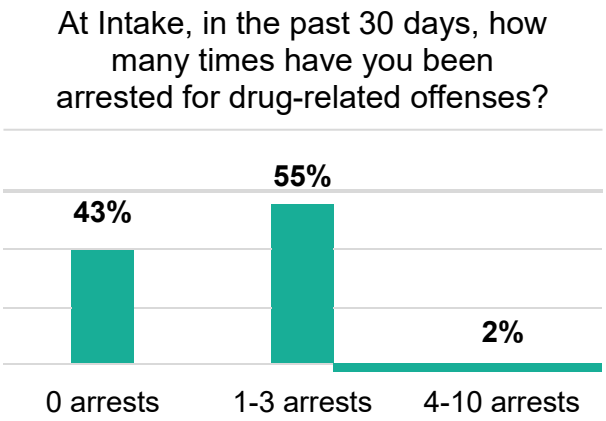
At each GPRA interview, clinicians ask clients whether they have been diagnosed with an OUD in the past 30 days. If a client indicates they have been diagnosed with an OUD, a follow up question asks if the client was prescribed an FDA-approved medication to treat the OUD in the past 30 days. Of those individuals who were prescribed MAT (n = 995), most were prescribed buprenorphine.

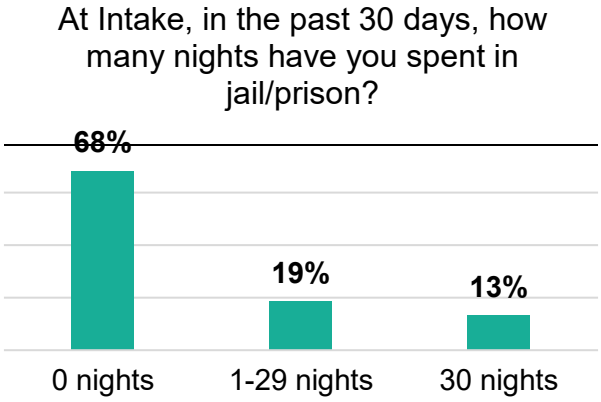


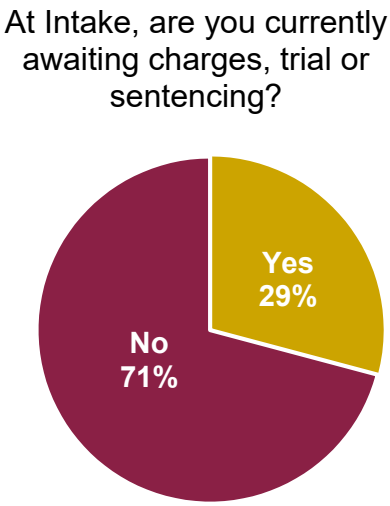
Crime and Criminal Justice

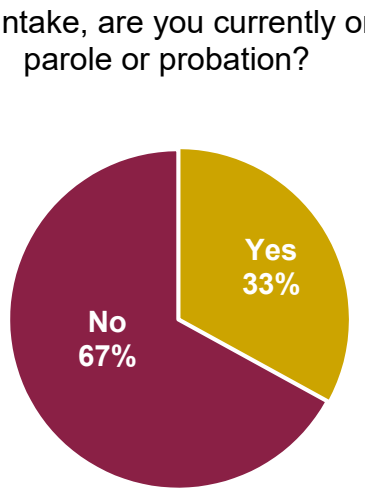
The GPRA collects data on clients' experience with crime and the criminal justice system. At intake, most (80%) clients report no arrests in the past 30 days and 68% report spending zero nights in jail or prison in the past 30 days. For the past 30 days, 43% indicated they had no arrests for drug-related offenses, 55% report 1-3 arrests due to drug-related offenses, and 2% report 4-10 drug related arrests. At intake, no clients reported more than 10 arrests in past 30 days. Most clients report at intake they are not awaiting charges, trial or sentencing (68%), nor on parole or probation (67%).









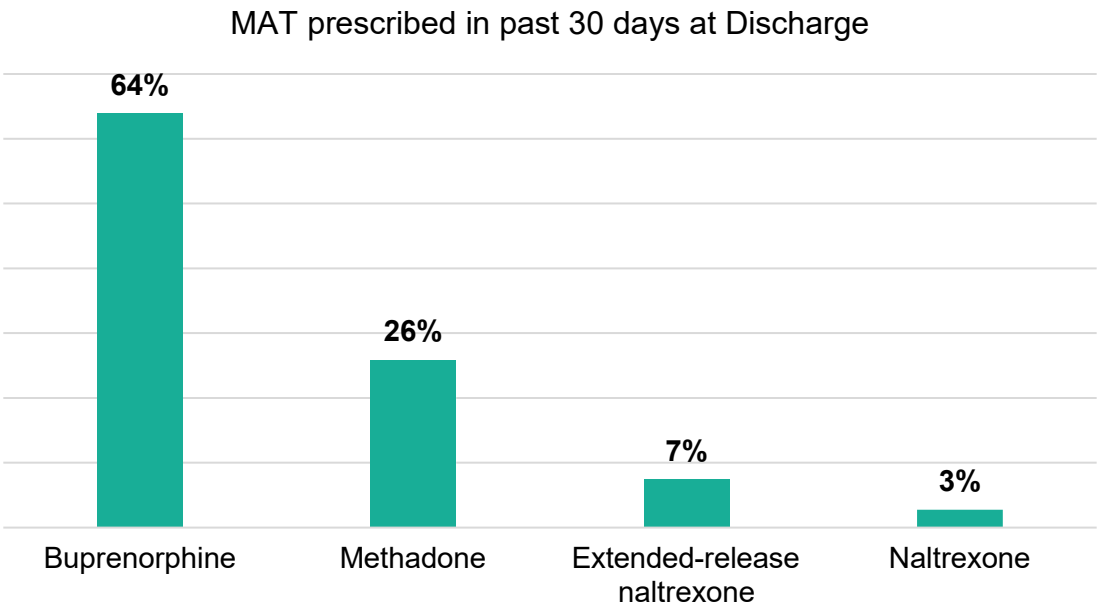


Discharge

GPRA providers conduct the discharge GPRA at the conclusion of providing SOR funded services to the client.

MAT

Fewer clients reported being prescribed MAT within the last 30 days at discharge compared to intake. Among clients who reported being prescribed an FDA-approved medication for OUD within the last 30 days at discharge (n = 255), most were prescribed buprenorphine.



Treatment Services

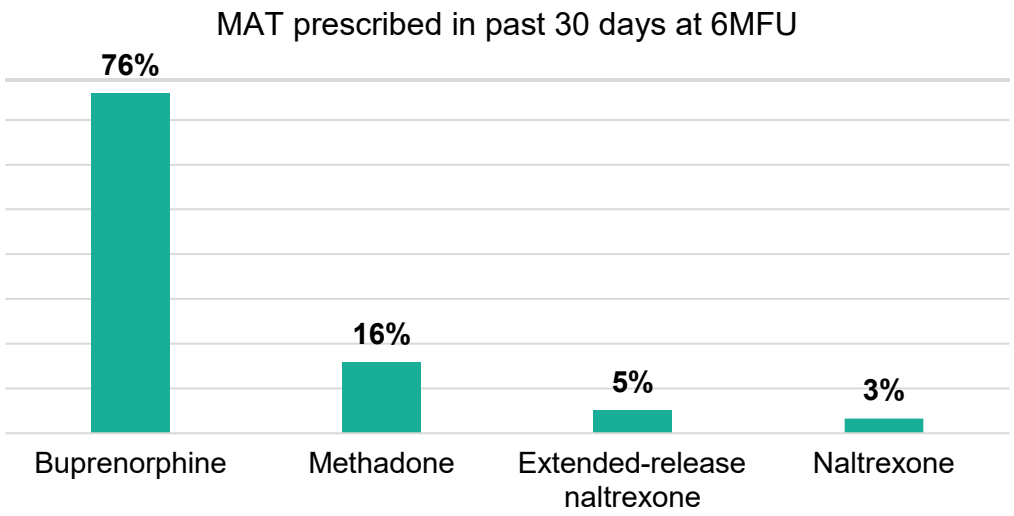
The discharge GPRA asks providers to select any treatment service received by the client during their SOR funded treatment period. The client rate for treatment services at discharge indicates that recovery support (78%) and peer coaching or mentoring (74%) are treatment services provided most often by SOR funded agencies. There is variation among the remaining treatment services offered on the discharge GPRA. Recovery coaching was reported on 48% of discharge GPRA. Assessment (35%) and treatment/recovery planning (29%) followed as the most often reported treatment service received.

Six-Month Follow-Up

The 6MFU GPRA is conducted six months after the initial intake interview is conducted. SAMHSA allows for a three-month window to complete the 6MFU that opens at five months from the intake interview date and closes at eight months after the intake interview date.

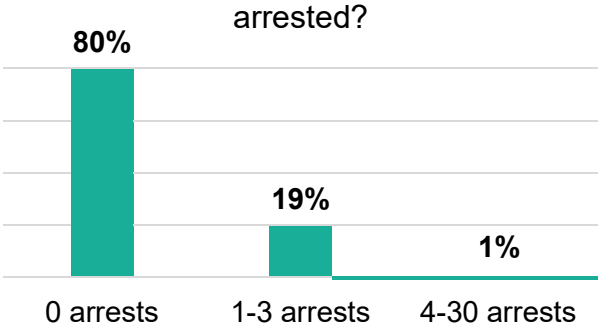
MAT

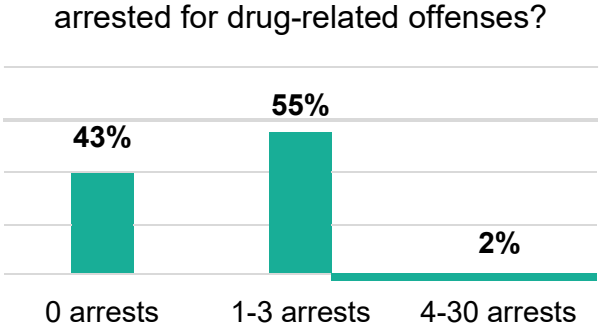
Among clients who reported being prescribed an FDA-approved medication for OUD at 6MFU (n = 393), most were prescribed buprenorphine.

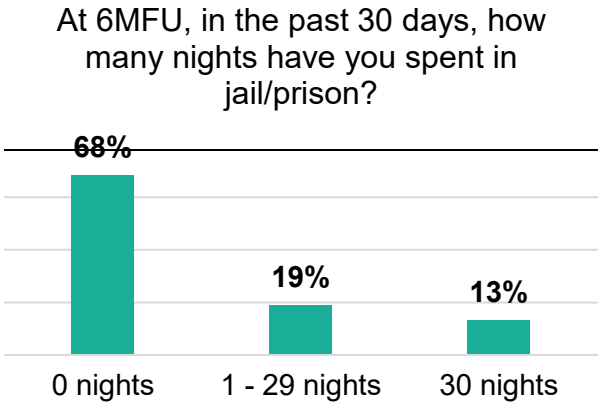


Crime and Criminal Justice

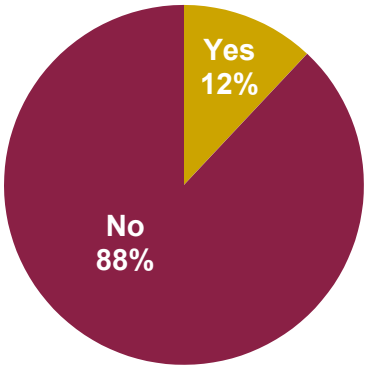
At 6MFU, clients report their experience with crime and the criminal justice system in the past 30 days. Ninety-five percent of clients report at six months that they had no arrests in the past 30 days, 4% report 1-3 arrests in that time frame and 1% represent 4-10 arrests. If a client indicates any arrests in the past 30 days, they are asked whether any arrests were drug-related offenses. At 6MFU 45% of clients report zero arrests for drug-related offenses, while 51% report that 1-3 arrests were due to drug related offenses and 4% report 4-10 arrests were for drug related offenses. Additionally, 88% of clients report they are not awaiting charges, trial or sentencing and 73% report they are not on probation or parole.



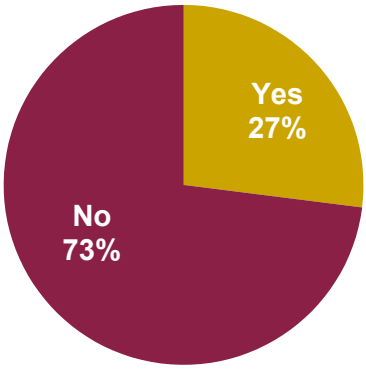




Are you currently awaiting charges, trial or sentencing?

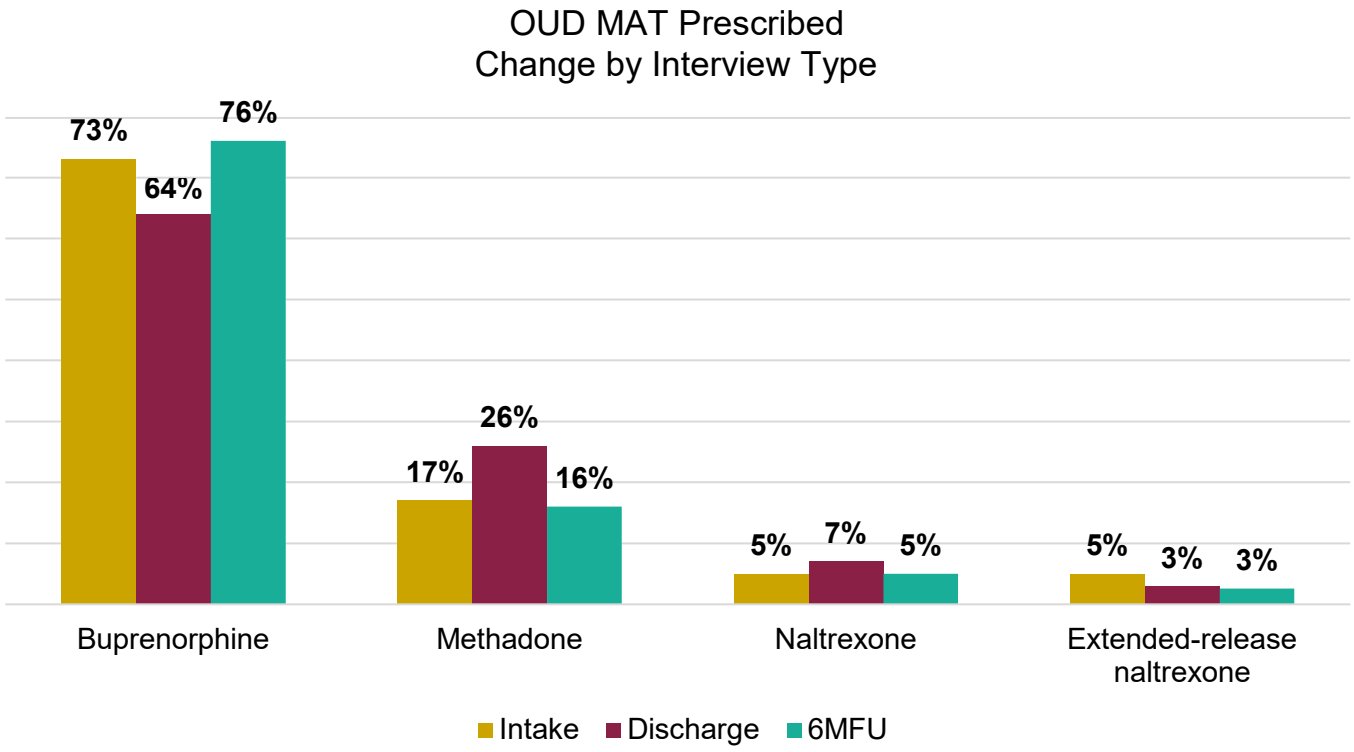


Are you currently on parole or probation?



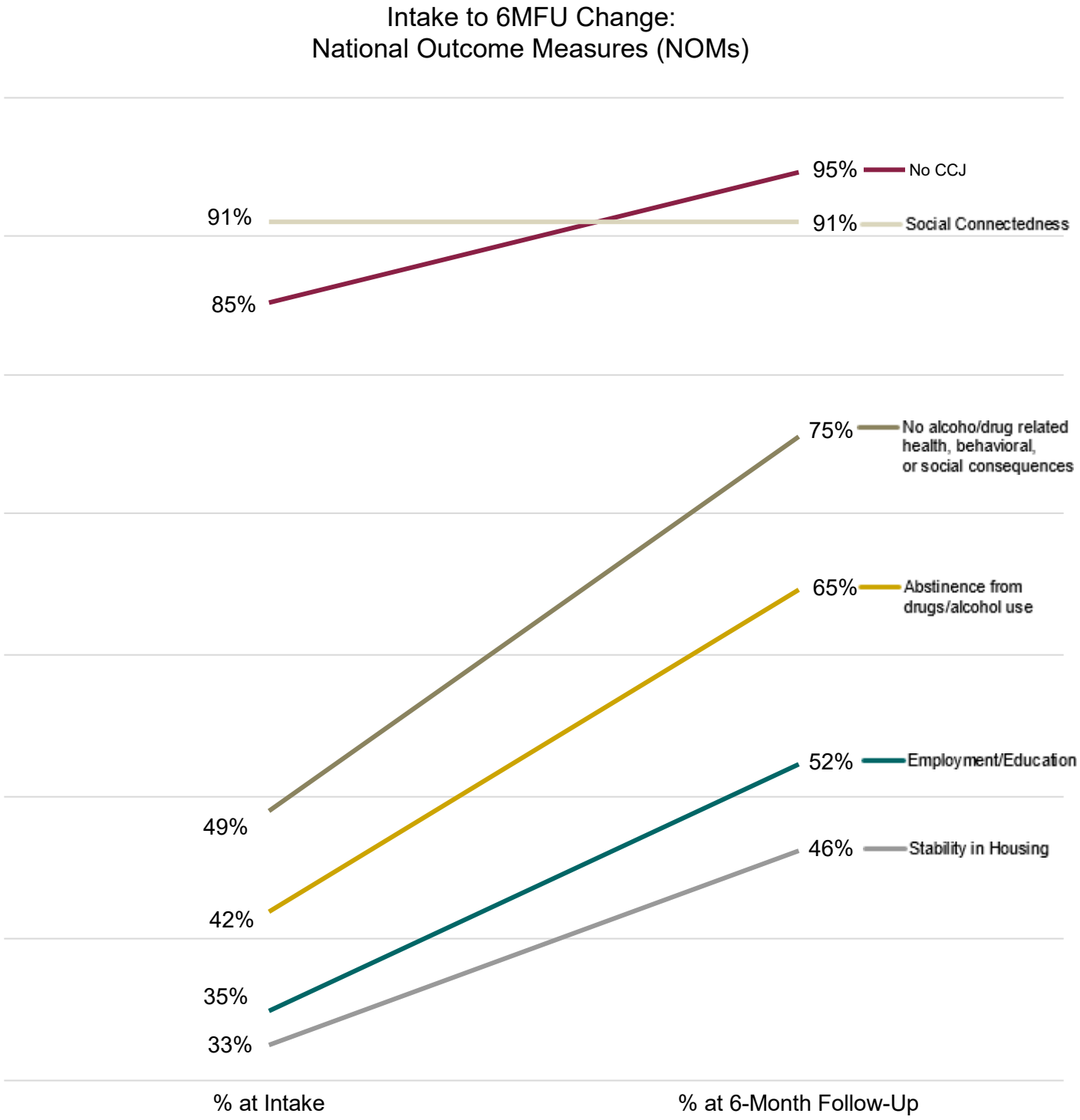
Changes across Time

The number of clients with new MAT prescriptions decreased substantially after intake. Regardless of the time point, buprenorphine remained the most commonly prescribed medication for OUD.



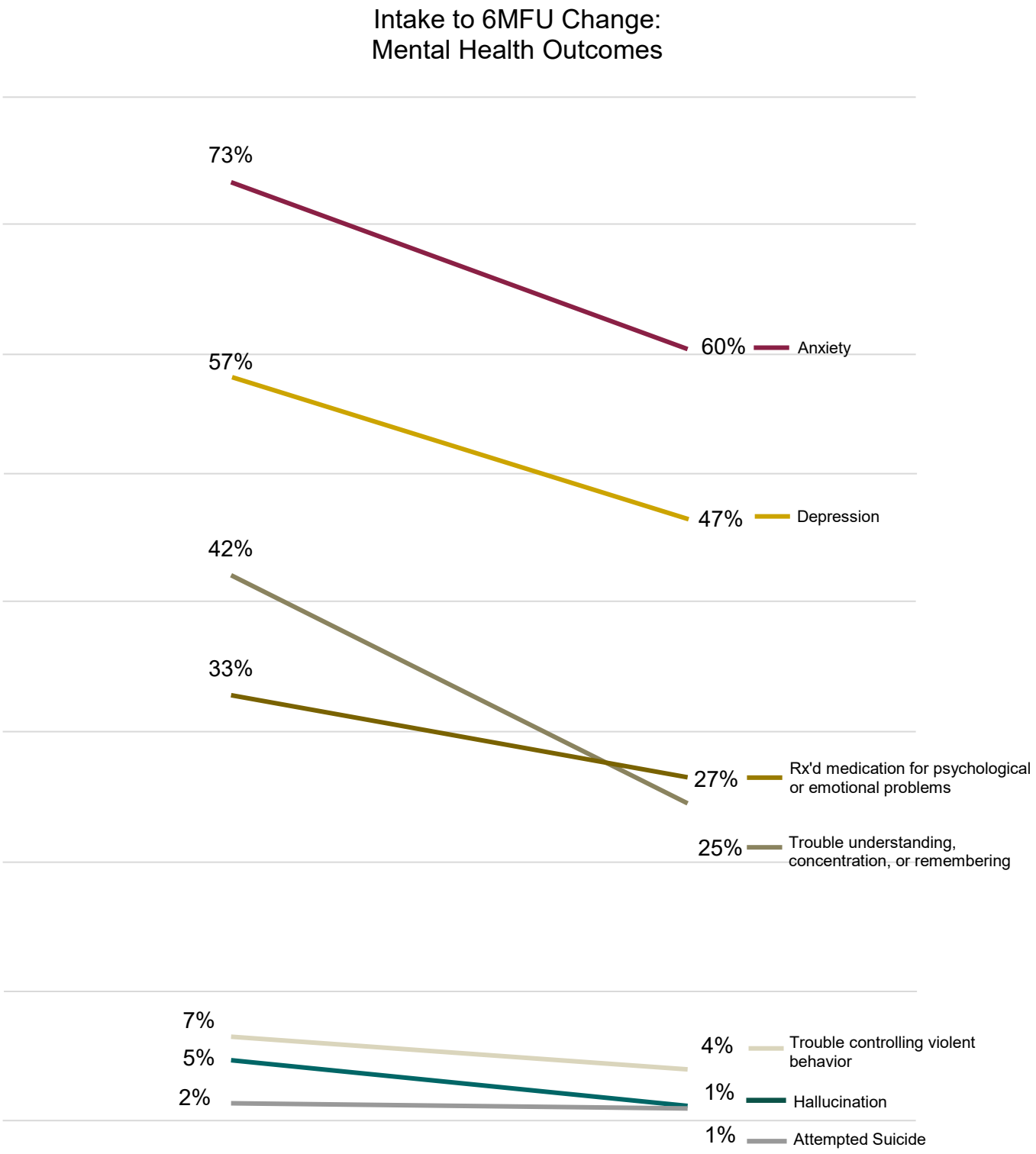
National Outcome Measures (NOM)

Overall, clients indicated an improvement on NOM from intake to 6MFU. The graph below shows the percent of clients who indicated positive endorsement of each NOM including no crime or criminal justice (No CCJ) activity within the last 30 days, social connectedness, no drug or alcohol related consequences, abstaining from substance use, educational or employment attainment, and housing stability.



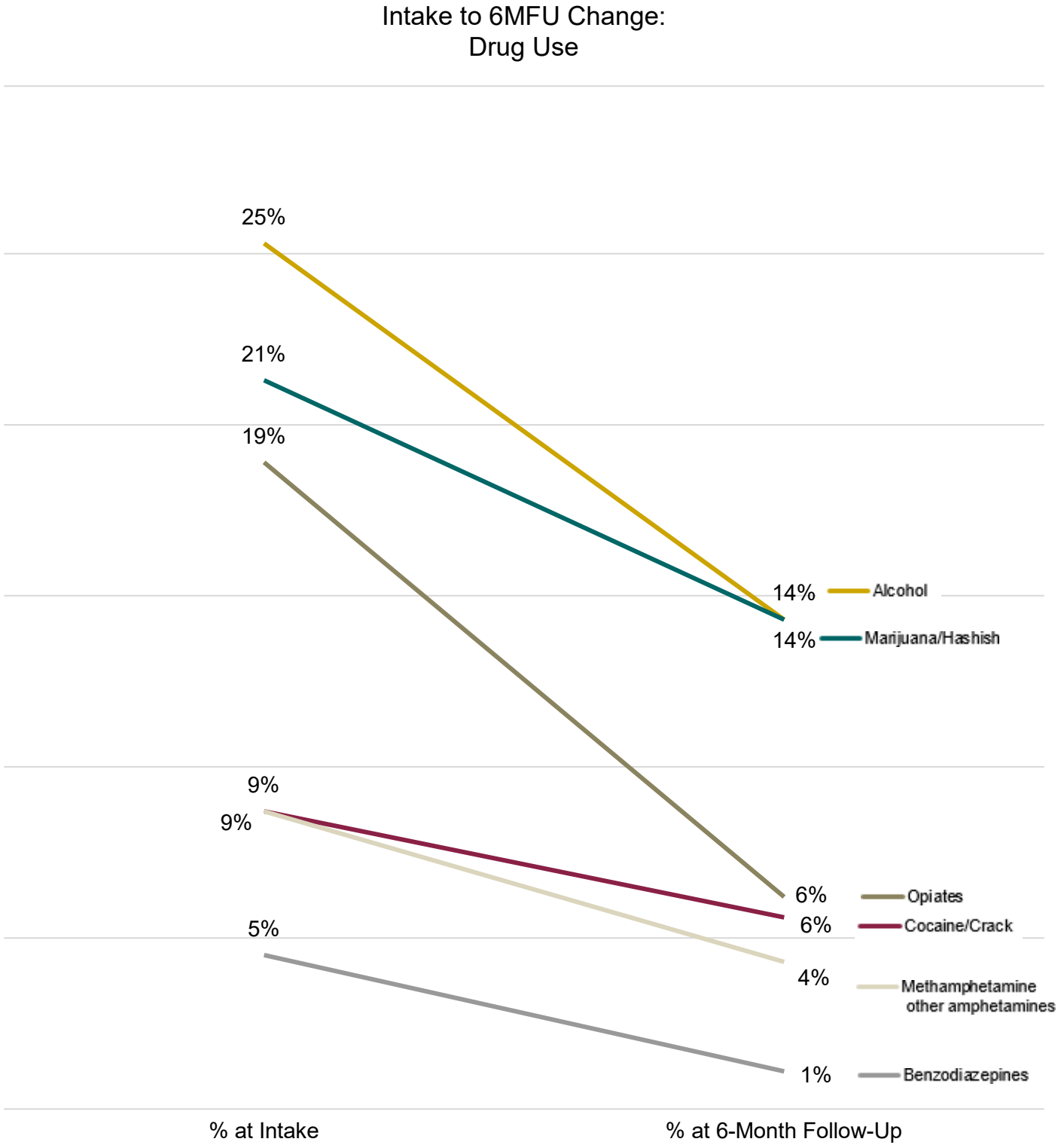
Mental Health Outcomes

Mental health outcomes consistently improved across grant duration. Overall, at 6MFU client reports reduction in trouble understanding, concentrating or remember (17% reduction) and less anxiety (13% reduction).



Drug Use Outcomes

Overall, client report less drug and alcohol use at 6MFU. Opioid use decreased by 13% between Intake and 6MFU and alcohol use decreased by 11% in the same period. Clients reported less than 1% or less for non-prescription methadone, hallucinogens/psychedelics, barbiturates, non-prescription GHB, ketamine, other tranquilizers, downers, sedatives, or hypnotics, and inhalants.



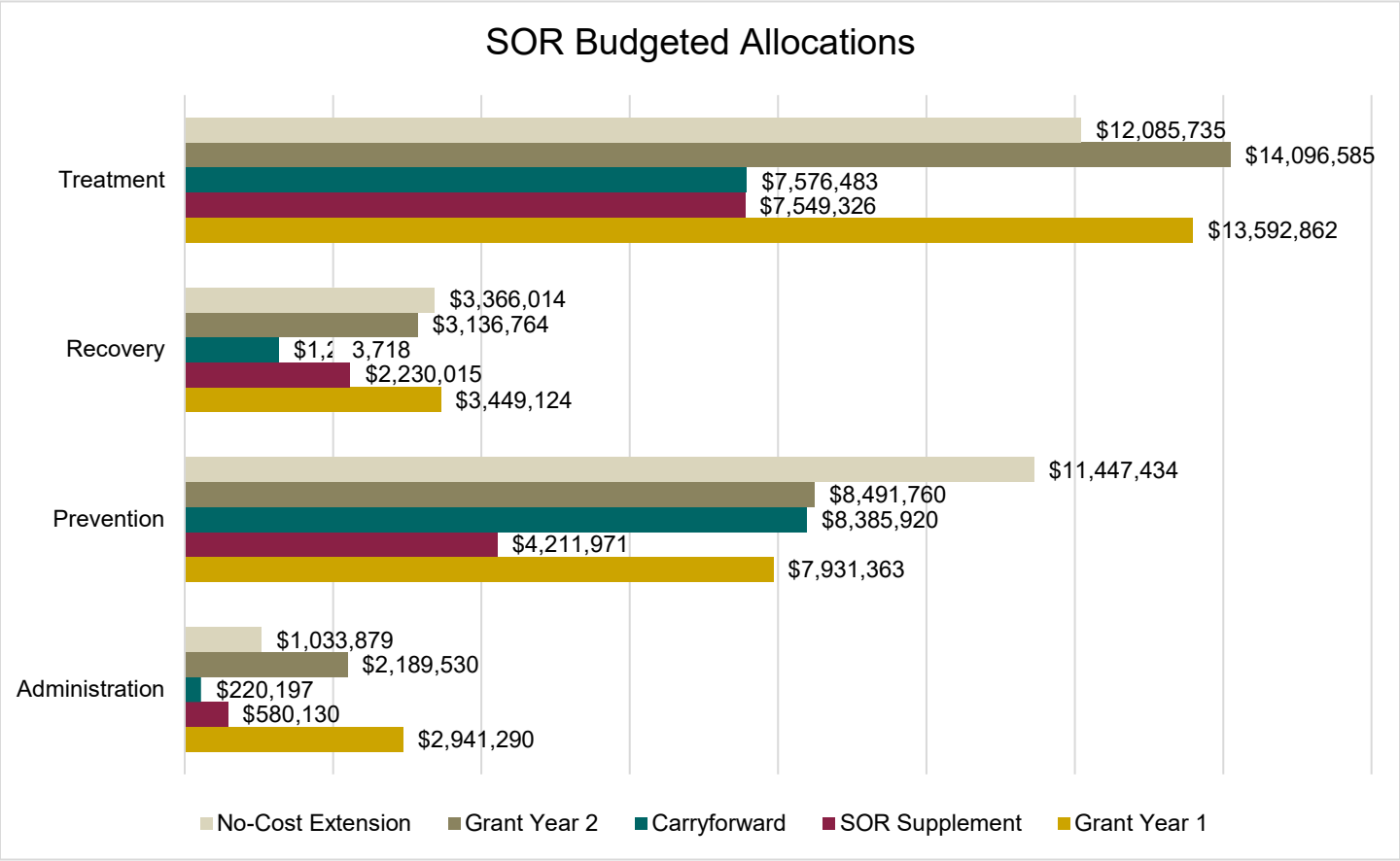
Evaluation Methods

Program/Activity	Indicators and Data	Source
Youth/Family Oriented Prevention EBP	• # of providers trained • # participants enrolled	PIHPs: monthly
OEND with Harm Reduction	• # of naloxone kits purchased • # of naloxone kits distributed • # of new communities/sites with distribution • # of individuals trained • # of kits used; # of saves (if possible)	PIHPs: monthly
NARCAN Portal	• Type of organization • # of participating organization by type • # of NARCAN kits requested	MDHHS tracking
Statewide Media Campaign	• Mode of delivery • Status of campaign creation • # of views/hits	Brogan & Partners: as requested
Michigan CARES	• Track meetings and progress • Curriculum updates • # of participants enrolled • Post participation satisfaction survey	MI CARES: monthly
Older Adult Prevention EBPs	• Type of program • # of programs delivered • # of participants & location	MSUE: monthly
Michigan OPEN	• Materials developed • # of trainings delivered • Track meetings and progress • Hospital partners • # naloxone kits distributed to EDs	Michigan OPEN: monthly
Local Health Department Access to Overdose Data	• Status of local health departments' statement of work • Status of evaluation development in local health departments	MDHHS Public Health: quarterly
Syringe Service Programs	• # of participant encounters • # of participants referred to substance use treatment • # of naloxone kits distributed • # of overdoses reversed • # of HIV tests conducted • # of HCV tests conducted • # of HAV vaccinations provided • # of HBV vaccinations provided	MDHHS Public Health: monthly
Michigan Automated Prescription System (MAPS)	• # of MAPS integrations • # of MAPS integrations pending • # of MAPS online registered users • # of total MAPS users	LARA: quarterly

Peers in FQHCs, Urgent Care, and other out-patient settings for SBIRT	• # of peers hired • Training peers attended • Hours a week staffed • # of new FQHCs/ Urgent Care clinics engaged • # of clients engaged • # of screenings conducted • # of referrals made	PIHPs: monthly
Mobile Care Units	• # of people served • # of services delivered by type • Days/hours of service • Geographic area covered	PIHPs: monthly Michigan Primary Care Association: monthly
OUD Treatment Services	• # of individuals served • Services paid for by type	PIHPs: monthly
Opioid Health Homes	• Status of contracting process with providers • # of clients served	PIHP Regions 1, 4, 9: monthly
Direct Provider Support for MAT	• Track meetings and progress • # patients initiated • # patients referred to outpatient treatment • # patients received prescriptions	MOP: monthly
Jail-Based MAT Expansion	• # of people served • Services provided by type • # of trainings conducted • Client status of post release MAT services	PIHPs and MOP: monthly
Telehealth to Support Rural Counties	• Status of program implementation • # of individuals served & location • Services provided by type	MOC: monthly
MISSION MI-REP Expansion	• # of individuals served & location • Services provided • Staffing updates	MI-REP: monthly
HNH	• # of intakes conducted • # of referrals • # of individuals engaged in treatment • # naloxone kits distributed • # trainings	HNH: monthly
Angel Program	• # of MSP posts • # of naloxone kits distributed • # of individuals assisted	MSP: quarterly
Recovery Housing	• # of individuals served • Type of services received	PIHPs: monthly
IPS	• # of participating sites • # of individuals enrolled • # of individuals who secure employment	PIHPs: monthly
OUD Recovery Services	• # of individuals served • Services paid for by type	PIHPs: monthly
ITC Peer Recovery Support	• # of individuals served • Status of Tribal Action Planning	ITC: quarterly

Financial Overview

The SOR Prime grant awarded Michigan $27,914,639 per year for two years. In June of 2019, Michigan also received a one-time SOR Supplemental allocation of $14,571,442. At the completion of Project Year 1, Michigan submitted a carryforward request for an unspent amount of $17,446,318, which was approved to continue expansion of the program and initiatives. With the completion of Project Year 2, Michigan submitted a No-Cost Extension application for unspent funds for an additional year, in the amount of $27,933,062, which was also approved. Michigan was required to allocate funding to subgrantees according to the budget and narrative that was set forth in the grant application. Chart One indicates the budgeted allocations for each grant year as well as allocations for the unspent funds. Subgrantees were required to submit a formal proposal and budget to MDHHS detailing how they would expend the funds allocated to them. Upon receipt of the funding, subgrantees were required to submit monthly Financial Status Reports to report their expenditures to MDHHS for reimbursement.



To monitor spending patterns and track all expenditures, OROSC collected Financial Status Reports (FSR), quarterly budget reports, and conducted fiscal monitoring to assess the needs of programmatic partners.

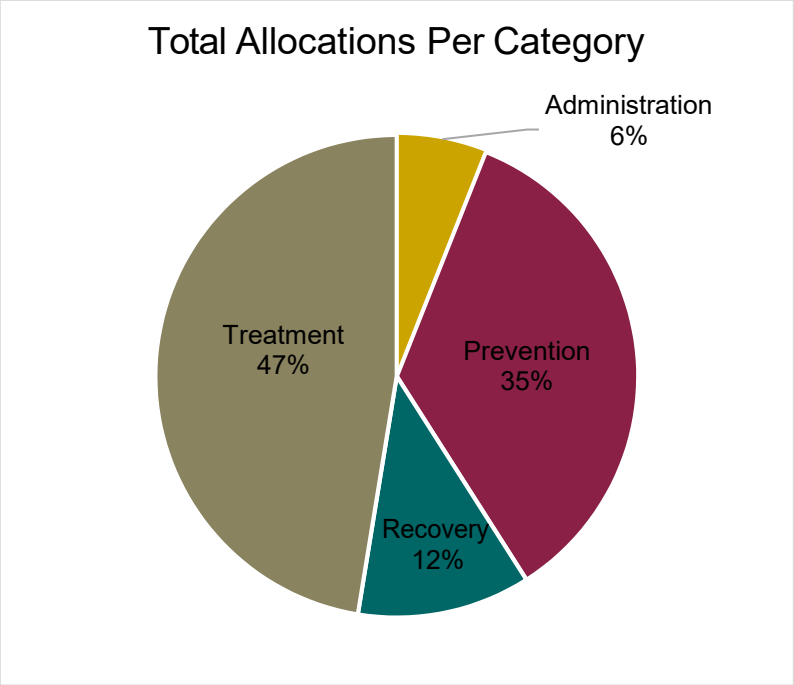


Chart Two displays the allocations through the entire period of SOR across the four spending categories. The largest portion of funds was allocated to treatment initiatives, which was 47% of the total funding for all three years of SOR, in the amount of $54,900,991. Prevention initiatives had the second largest funding allocations of 35%, in the amount of $40,468,448. Recovery and administration allocations were 12% and 6%, with their allocations being $13,445,635 and $6,965,026, respectively. The administration allocation includes MDHHS and subrecipient allocations, but it does not exceed the 5% cap allowed by SAMHSA that only pertains to the Administration costs of MDHHS.

Implementation and Lasting Impacts

The following section provides findings from interviews conducted with PIHP directors in July 2021. Interviews focused on directors' assessment of the grant implementation and what they thought was most impactful in their regions.

Communication

PIHP Directors were asked how they communicated details of the grant to the providers in their network. All 10 PIHP directors reported using a combination of strategies that included online meetings and email. Regular reporting from the providers to the PIHP were also important.

> *"The providers do a wonderful job of sending the information. Whenever I needed anything I would say, 'Hey, this is what I need', especially with the monthly and the quarterly reports. So, I try to make it … as easy as possible, because I know that's not always an easy thing."*

> *"We tried to be consistent in our communication. We made sure that we understood their (providers) requirements from the Department, amended any contracts that needed to be made, and then sent out the communication via email.*

Five of the directors reported that meeting individually with each provider worked best to review expectations. Multiple and timely communication strategies helped to strengthen connection.

> *"We spelled out and outlined all of the expectations there (in our contract process) and that really drives the communication process and questions behind it because they (providers) have a full outline of the expectations of the grant and its programs."*

> *"We provided information ahead of time before we even really knew the plans so that we could let them (providers) know what was coming our way, what the purpose of the funding was for, and to also solicit any feedback or ideas about programming or gaps and services that they thought were needed in our system."*

Improving Access to Treatment

PIHP directors were asked about strategies that improve treatment that did not involve funding. Four directors mentioned better communication with the state as a facilitator. Two directors mentioned partnerships, such as with hospitals or law enforcement that facilitate treatment. Two directors mentioned staff training as an important facilitator to improve treatment.

PIHP directors were asked about policies that affected treatment improvement. Four mentioned that those who are incarcerated are no longer Medicaid eligible and this influenced continuity of care.

> *"With the source of funding we're supporting jail-based MAT treatment, and so we have providers going into the jail and you know they're doing the methadone or suboxone revisit all with the counseling, and this is an allowable cost under the SOR grant. But because an individual who becomes incarcerated, their Medicaid … turns off, and they're not Medicaid eligible. That's not a program that we can continue with the Medicaid thing. And so, I do see that as a barrier for those with an OUD is just providing that continuity of care maintaining or keeping this program sustainable beyond the SOR program."*

Three directors mentioned the positive impact of the decision to distribute Naloxone centrally as a simplified process. In addition, two directors reported that the availability of funding to support recovery housing was positive.

> *"I think, and I don't know if this would go under policy, but it was really more of an administrative decision to implement a Naloxone portal by the Department, and I think that has been a positive. A centralized location to request Naloxone has simplified our process quite a bit."*

Workforce Challenges

All 10 PIHP directors reported an acute shortage of master level educated clinicians. They cited continuing education and supervision requirements that hinder retention. This was exacerbated by the COVID-19 pandemic. There was also discussion about the challenges of becoming a peer recovery coach. Several directors mentioned difficult requirements especially that peer recovery coaches must have experience in the public system.

> *"We are struggling to get masters level clinicians to work there, but also to retain … there's still a lot of stigma that exists. …and then the other thing that we've been dealing with is COVID in that clinicians are able to do exclusive telehealth now, even with out-of-state locations, but they can still work from home and they're getting paid more. So, we have a workforce shortage."*

> *"Some of the ones that affected the delivery of service were limitations on who could receive the peer training requirements. Ideally, we would have liked those to have gone through the state training so that they could become a certified peer. However, that provided some obstacles, because they had the requirement that you must also have lived experience as a peer. Because they didn't qualify to take that state level training that is since going to be removed. It's just been really difficult ever since COVID hit to have proper staffing for any services. Historically, we've had issues with providing services to the Medicare clients, because of the restrictions of it having to be an LMSW."*

Infrastructure Changes as a Result of SOR funding

All PIHP Directors reported infrastructure changes that occurred during the SOR funding period. Five directors discussed the addition of transportation vehicles that will be used beyond the funding period. Four directors discussed much-needed repairs to recovery housing. In addition, four directors referenced the newly trained staff, particularly in the use of evidence-based prevention programming.

> *"We have been able to add recovery housing in our region, which is so needed. It's been a huge help, and I know, one of the biggest things we hear is 'we don't have money to buy the home or to provide the updates that (are) needed to make it habitable', and at least now we can make it habitable. These funds just really helped with that. That was huge. That was just fantastic. I think that's probably the biggest change that we've seen."*

> *"We participated in as many of the state trainings as possible. The state was really good about providing several trainings for the programming."*

The creation of partnerships and reduction of stigma with partners such as jails and hospitals were also discussed.

> *"I think it's been either the medical facilities or the jail's perception of substance use and folks with substance use disorder, and so it took us a while to get going with a lot of these projects because of*

that. They just didn't want to really deal with that. There wasn't an understanding … and so our providers did a great job of working with the medical facilities and jails to start those conversations to raise awareness. That is that piece that helped, but it's taken a while. I mean we had to do a lot of work up front… It did take a while to work with staff and with other agencies that might have some thoughts about substance use disorder and being able to work with them and overcome that has been good. It always helps to come in and say, 'hey we have this program, but we have funding for this program, and this is what we want to accomplish.'"

Staffing Changes

Almost all (nine) of the directors reported that the funding was used to hire additional staff, most notably was additional peer recovery coaches in seven of the regions. Overall, funding was also provided for training, and this led to the expansion of services in most areas.

> *"The (providers) were able to … get staff to provide the services and then with the trainings were able to get qualified staff... That was the big piece … to expand their service array. We were able to get into jails and provide services there again with the medical community."*

Expansion of Evidence-Based Practices

Directors reported a variety of examples where evidence-based practices were expanded with SOR Prime and Supplemental funding. Seven mentioned the expansion of Medication Assisted Treatment (MAT) in jails. Six mentioned how, overall, MAT use (Vivitrol ®, and Suboxone ®) was expanded in their communities. Six directors mentioned the expanded use of peer recovery coaches, while four mentioned additional recovery housing capacity.

> *"I think that up until just a few years ago, most of our providers believed that abstinence-based programming was the only way for a person to find their recovery path. We had very limited MAT providers, and so … with the assistance of the grant, with the assistance of some of the training opportunities, that and conferences that people were able to attend. …we …were able to help people understand the disease of addiction. That opened up some greater paths to programming and evidence-based services."*

> *"It's the additions of sites where people can receive services, like the mobile care unit is reaching out into different locations where MAT services aren't available and Project ASSERT wasn't necessarily available, and now, they're in 14 different locations throughout the area where people can get recovery coaching in a front lobby and things like that. So, I would imagine that would result in client satisfaction increases."*

> *"It was a service that they may not have had access to previously, so … we got a lot of positive feedback from inmates at the county jail, because before they may have been stopping their medication when they got incarcerated and now they are able to continue and then…resume once they were released. …I think that there was some positive feedback and the fact that it was something that they needed."*

Examples of how the quality of services were improved

Most (eight) of the directors mentioned that services were now offered where they previously had not been available. These included MAT programs (seven mentions), mobile services (five mentions), and coordination of care post release from jail (four mentions).

"I know a lot of the projects we had were for folks who might not have been served, or we might not have been serving before. …being able to serve those folks and being able to provide the appropriate levels of care, especially with the jail medication assisted treatment programs, we were able to provide services to folks and provide the services they need. And then help with that coordination of care after they're released from jail and then, with getting folks into basically the most appropriate levels of care for them. That coordination piece of getting them there has been really, really helpful."

Initiatives that were not implemented

Five of the directors reported that they were unable to implement programming in either a jail or hospital because of the challenges of securing buy-in.

"Well, there is a program that's really cool if you can get it to implement well and that's Project ASSERT, and we tried really hard to do that …and so we embedded a peer recovery coach in the ER and it worked for a while, but then the peer recovery coach quit. …what we ran into was that the hospital didn't want to have anyone else working there, because they knew it was a grant funded position. … that was disappointing with Project ASSERT and then we tried to get that up and running in (another) hospital. The administration talked the good talk, but they wouldn't actually at the end of the day allow us to come in and actually do the programming, so we had to completely pivot everything."

One director suggested engaging the state to help educate hospital leadership to understand the effectiveness of Project ASSERT, and how it has been successful at other hospitals.

Most lasting impacts of SOR

All of the directors reported the grant funding expanded program capacity and helped get the appropriate services and level of care to clients. Directors also reported that they believed the funding was used to reduce overdoses (eight mentions). Seven directors reported that they believe changing the perspectives of the community about substance use disorders was also an important outcome of the initiative. Other initiatives that would continue were development of recovery housing and mobile care units.

"I think the lesson learned was to be able to provide enough admin attention and admin support at the PHP level to each and every provider, because they were new initiatives and they started out with kind of a vague understanding and so as the state added SOR Coordinators, that was a really helpful addition and to be able to have those provider meetings was really helpful."

"As a lasting impression, we are a region who fully intends to find ways to sustain those recovery houses and the peer recovery coaching staffing across the region. In fact, we want to continue to grow both of those areas."

"I think our biggest successes were having every jail offer MAT. …our conversations when we first started were not pleasant with our local sheriff's office. Now… this is the greatest program, and we are saving lives with Naloxone and overdoses every month. That is certainly a thing to be proud of... I think that you can say we have literally helped save a lot of lives. I think that's pretty powerful."

Overall, the SOR funding was used to expand treatment by building skills and hiring staff. The addition of mobile units and recovery housing repairs further expanded capacity to provide treatment. Overall, directors were positive about the impact of this funding.

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