COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

BOARD MEETING

Patrick Barrie Room

3005 Boardwalk Dr., Ste. 200, Ann Arbor, MI

Wednesday, August 9, 2023 6:00 PM

Dial-in Number Options:
1-312-626-6799, 1-646 876-9923, or
1-346-248-7799
Meeting ID: 443 799 086

Join by Computer:
https://zoom.us/j/443799086
Please wait to be admitted from the Zoom waiting room at 6:00 pm.

Agenda

		Guide
I.	Call to Order	1 min
II.	Roll Call	2 min
III.	Consideration to Adopt the Agenda as Presented	2 min
IV.	Consideration to Approve the Revised Minutes of the 4-12-2023 Meeting and Waive the Reading Thereof {Att. #1}	2 min
V.	Consideration to Approve the Minutes of the 6-14-2023 Meeting and Waive the Reading Thereof {Att. #2}	2 min
VI.	Audience Participation (3 minutes per participant)	
VII.	Questions and Answers with Michigan State Representatives: Felicia Brabec and Carrie Rheingans	15 min
VIII.	Old Business a. Board Information: FY2023 Finance Report through June 30, 2023 {Att. #3} b. Board Action: CEO Performance Review Goals {Att. #4}	15 min
IX.	New Business a. Board Information: FY2024 Budget Preview {Att. #5} b. Board Action – Roxanne Garber Acknowledgement {Att. #6} c. Board Action – Contracts {Att. #7} d. Board Action – Provider Stabilization {Att. #8} e. Board Action – FY2023Q2 Quality Assessment and Performance Improvement Plan (QAPIP) Status Report {9,9a} f. Board Action – FY2024-26 Substance Use Services Strategic Plan {Att. #10,10a,10b}	60 min
X.	Reports to the CMHPSM Board a. SUD Oversight Policy Board {Att. #11} b. Board Information: CEO Report to the Board {Att. #12} c. Employee Engagement Survey {Att. #13}	10 min
XI.	Adjournment	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
April 12, 2023

Members Present: Judy Ackley, Patrick Bridge (remote), LaMar Frederick, Bob King, Molly Welch Marahar, Alfreda Rooks, Mary Serio, Holly Terrill, Ralph Tillotson

Members Absent: Roxanne Garber, Annie Somerville

Staff Present Kathryn Szewczuk, Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Connie Conklin, Stacy Pijanowski, CJ Witherow, Heather Schubbe

Guests Present: Margaret Debler, Andrew Brege

I. Call to Order
Meeting called to order at 6:03 p.m. by Board Chair B. King.

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by R. Tillotson, supported by M. Welch Marahar, to approve the agenda
Motion carried

IV. Consideration to Approve the Minutes of the 2-8-2023 Meeting and Waive the Reading Thereof
Motion by J. Ackley, supported by M. Serio, to approve the minutes of the 2-8-2023 meeting and waive the reading thereof
Motion carried

V. Audience Participation
None

VI. Old Business
a. Board Information: March Finance Report – FY2023 as of February 28th
- M. Berg presented.

VII. Closed Session with CMHPSM Attorneys on Lawsuit
Motion by B. King, supported by M. Serio, to go into closed session to discuss litigation and trial strategy with attorneys regarding Case No. 2:16-cv-10936-PDB-EAS, pending in the Eastern District of Michigan, because discussion in open session will be detrimental to our financial, settlement, and trial positions in the case
Motion carried
Roll Call Vote
Yes: Ackley, Frederick, King, Welch Marahar, Rooks, Serio, Terrill, Tillotson
No:
Non-voting: Bridge
Absent: Garber, Somerville

- The Regional Board entered into closed session to meet with attorneys M. Debler and A. Brege. Staff members J. Colaianne, C. Witherow, and S. Weary were also present.
- M. Welch Marahar exited the meeting due to conflict of interest.
- All other meeting attendees were excused from the meeting.

Motion by M. Serio, supported by R. Tillotson, to re-enter in to open session
Motion carried
Roll Call Vote
Yes: Ackley, Frederick, King, Welch Marahar, Rooks, Serio, Terrill, Tillotson
No:
Non-voting: Bridge
Absent: Garber, Somerville
Recused: Welch Marahar

- Meeting attendees were re-admitted into the meeting.

VIII. CEO Performance Review Committee Update

- M. Serio presented the compiled SWOT feedback from board members, OPB members, and CMH directors. The positive review does not require any corrective action related to CEO performance.
- The CEO Evaluation Committee and J. Colaianne will meet to develop clear and tangible goals for next year's review.

IX. New Business

a. Board Action: FY2023 Q1 QAPIP Status Report
   - C. Witherow presented.
   - There were no significant risks for any of the indicators.
     Motion by M. Welch Marahar, supported by R. Tillotson, to approve status report of the FY2023 Q1 Quality Assessment and Performance Improvement Program (QAPIP)
     Motion carried

b. Board Action: SIS Assessor Transition / SIS Quality Lead Elimination
   Motion by R. Tillotson, supported by A. Rooks, to approve recommended job title changes for CMHPSM positions #112, #113 and #128. Reduce one position to a temporary status through 9/30/2023. Approve elimination of CMHPSM position #114 effective 4/12/2023.
   Motion carried

c. Board Action: Contracts
   Motion by M. Welch Marahar, supported by M. Serio, to authorize the CEO to execute the contracts/amendments as presented
   Motion carried

d. Board Information: CEO Contract Authority Update
   - J. Colaianne approved the region's participation of the CMHPSM at 5.4% of an Michigan Consortium of Healthcare Excellence (MCHE) project with the other 8 MCHE members, enacted within CEO contract authority.

e. Board Information: Annual Board Governance Review
   - The Board will review the Board Governance Manual and policies listed below and forward any concerns/questions to the CEO. These items will be presented to the board in June for approval.
     i. Board Governance Manual
     ii. CMHPSM Bylaws
     iii. CMHPSM CEO Authority – Employee Position Control and Compensation

iv. CMHPSM CEO General Scope of Authority
v. Conflict of Interest Policy
vi. Financial Stability & Risk Reserve Management
vii. Investing
viii. Procurement

X. Reports to the CMHPSM Board

a. Board Information: FY2023 Q1-Q2 Strategic Metrics Report
   - J. Colaianne presented the 6-month report.
   - Going forward, an explanation of quadruple aim will be included in the report.

b. Board Information: CEO Report to the Board
   - J. Colaianne's written report includes updates from staff, regional and state levels. Please see the report in the board packet for details.

c. Update on CMHPSM Finance Department Incident
   - J. Colaianne advised the board of a situation in which the PIHP sent money to a false vendor based on a bad actor gaining control of a provider's email address. Staff didn't follow established process in verifying contact through phone or video call.
   - The PIHP continues to work with the Ann Arbor Police Department, the Michigan Municipal Risk Management Authority (MMRMA), and JP Morgan Chase bank fraud department, in an attempt to reclaim the money.
   - The funds will have to come out of PBIP, which are the only local dollars the PIHP has.
   - J. Colaianne will continue to update the board.

d. Lakeshore PIHP Deficit Lawsuit Update
   - Lakeshore won their lawsuit against the state of Michigan, regarding the use of current year's funds to pay past-year's deficits.

XI. Adjournment

Motion by A. Rooks, supported by M. Serio, to adjourn the meeting
Motion carried

Meeting adjourned at 7:45 p.m.

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Judy Ackley, CMHPSM Board Vice-Chair

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
June 14, 2023

Members Present: Judy Ackley, Patrick Bridge, Rebecca Curley, Bob King, Molly Welch Marahar, Rebecca Pasko, Mary Serio, Holly Terrill, Ralph Tillotson

Members Absent: LaMar Frederick, Roxanne Garber, Alfreda Rooks, Annie Somerville

Staff Present Kathryn Szewczuk, Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Connie Conklin, Stacy Pijanowski, CJ Witherow, Lisa Graham

Guests Present: Derek Miller

I. Call to Order
Meeting called to order at 6:15 p.m. by Board Vice-Chair J. Ackley.

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by M. Welch Marahar, supported by R. Tillotson, to approve the agenda
Motion carried

IV. Consideration to Approve the Minutes of the 4-12-2023 Meeting and Waive the Reading Thereof
Motion by M. Serio, supported by H. Terrill, to approve the minutes of the 4-12-2023 meeting and waive the reading thereof
Motion carried

V. Audience Participation
None

VI. Board Action: FY2022 Financial Audit Presentation
- Auditor Derek Miller from Roslund Prestage & Company presented the FY22 financial audit presentation.

VII. Old Business
a. Board Information: May Finance Report – FY2023
   - M. Berg presented; discussion followed.
b. Board Information: Discussion on FY2018 Deficit and Next Steps
   - J. Colaianne provided an update.
   - The region's preference is to resolve the deficit before the end of this fiscal year. The next step will be to propose a plan to MDHHS.
c. Board Action: Annual Board Governance Review from April 2023
   Motion by R. Tillotson, supported by M. Welch Marahar, to approve the Board Governance manual, CMHPSM bylaws, and board governance policies as presented
   Motion carried

i. Board Governance Manual
ii. CMHPSM Bylaws
iii. CMHPSM CEO Authority – Employee Position Control and Compensation
iv. CMHPSM CEO General Scope of Authority
v. Conflict of Interest Policy
vi. Financial Stability & Risk Reserve Management
vii. Investing
viii. Procurement

d. Board Information: CEO Performance Review Goals
   - M. Serio presented the draft CEO performance goals. The goals will be updated and presented to the full board in August for final approval.

VIII. New Business

a. Board Member Action: Conflict of Interest Form Completion
   - Board members will complete and return the form to staff.
b. Board Information: Strategic Plan Development Timeline
   - J. Colaianne provided an outline of the timeline for developing the strategic plan.
   - Strategic plan reports to the Board will continue to be presented every six months.
c. Board Action: Contracts
   Motion by M. Welch Marahar, supported by M. Serio, to approve the presented contracts and agreement
   Motion carried
d. Board Action: CMHPSM Board Secretary Election
   - R. Pasko volunteered to complete the Board Secretary term through the end of FY2023.
e. Board Information: Conflict Free Access and Planning Options
   - J. Colaianne provided an overview of the 4 options the state has proposed.
   - J. Colaianne presented a draft resolution that addresses the state's proposed changes.

f. Board Action: Conflict Free Access and Planning Resolution
   Motion by M. Serio, supported by H. Terrill, to approve the CMHPSM Regional Board of Directors resolution opposing the proposed draft policy models related to conflict free access and planning in the public behavioral health system, with changes as discussed
   Motion carried
   M. Welch Marahar abstained from the vote

IX. Reports to the CMHPSM Board

a. SUD Oversight Policy Board
   - N. Adelman provided an overview of the April OPB meeting. Discussion topics included FY2024 funding, opioid settlement funds, and the PHE/Medicaid changes.
b. Board Information: CEO Report to the Board
   - J. Colaianne's written report includes updates from staff, regional and state levels. Please see the report in the board packet for details.

X. Questions and Answers with Michigan State Representatives:
Felicia Brabec and Carrie Rheingans
The representatives were unable to attend. Agenda item tabled until August.

XI. Adjournment

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

- Meeting adjourned at 7:42 p.m.

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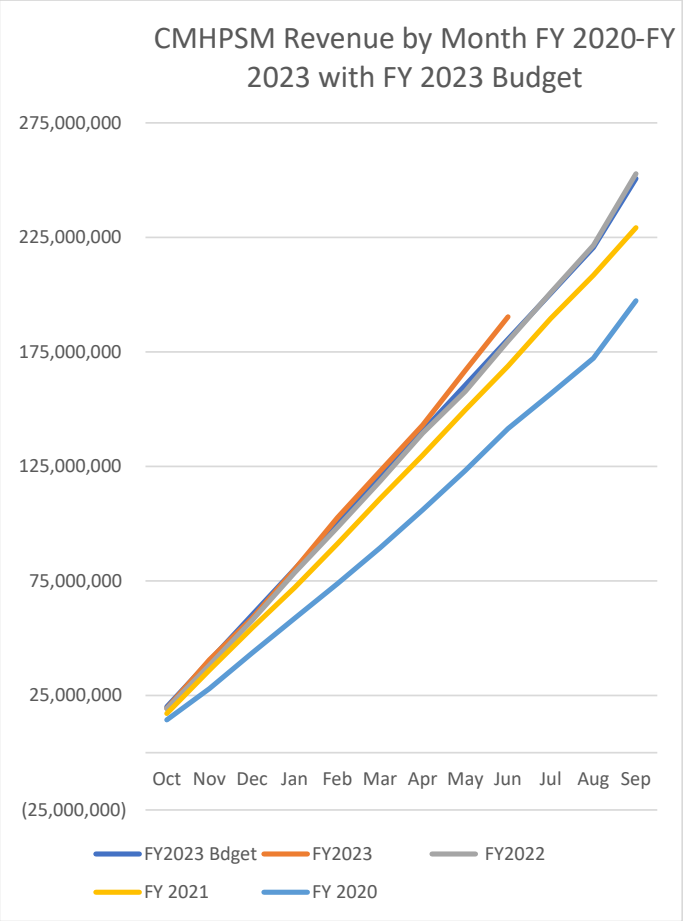
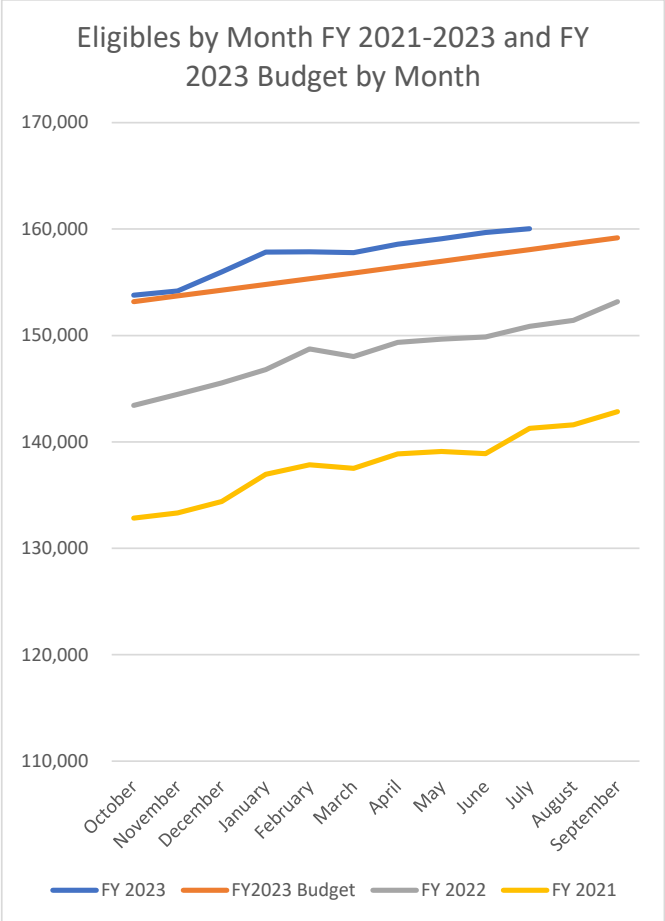
Rebecca Pasko, CMHPSM Board Secretary

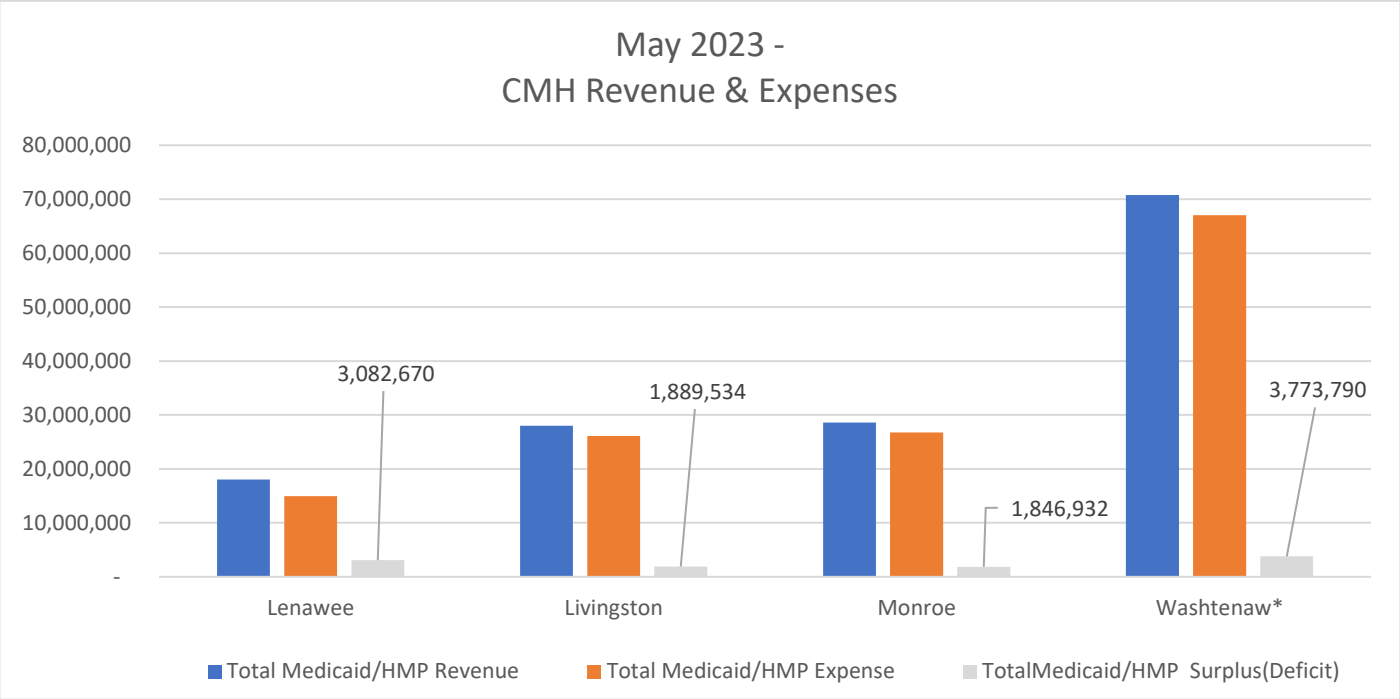
Community Mental Health Partnership of Southeast Michigan
Financial Summary for June 30, 2023





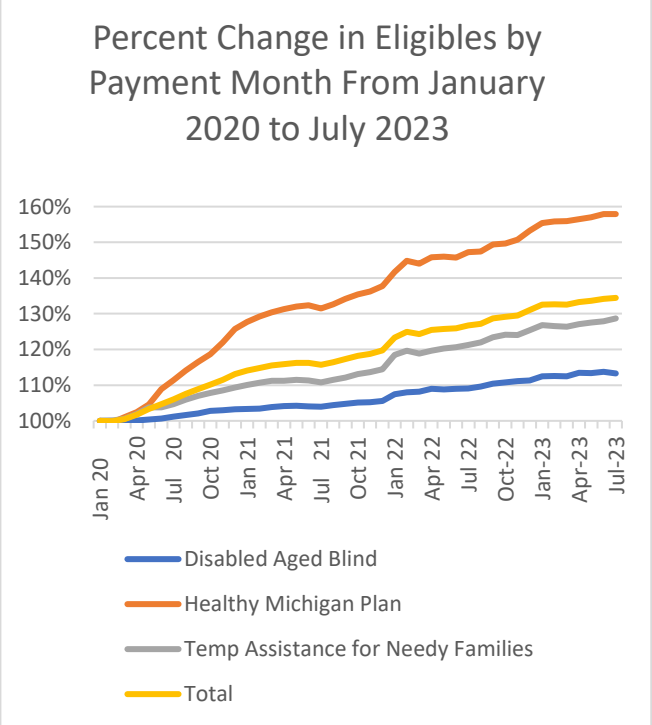
Operating Activities	Budget R1 FY 2022	YTD Budget	YTD Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected to Budget
MH Medicaid Revenue	221,239,514	158,429,636	167,885,091	9,455,456	-6.0%	245,306,257	24,066,743
MH Medicaid Expenses	224,202,551	167,514,322	168,523,652	(1,009,330)	-0.6%	229,954,836	5,752,285
MH Medicaid Net	(2,963,037)	(9,084,686)	(638,561)	8,446,126	-93.0%	15,351,421	18,314,458
SUD/Grants Revenue	26,232,600	18,282,910	20,192,514	1,909,604	10.4%	27,128,194	895,594
SUD/Grants Expenses	22,804,150	17,104,113	17,368,170	(264,058)	1.5%	22,009,302	(794,848)
SUD/Grants Net	3,428,450	1,178,797	2,824,344	1,645,547	139.6%	5,118,892	1,690,442
PIHP							
PIHP Revenue	3,219,911	2,175,950	2,231,723	55,773	2.6%	3,219,911	-
PIHP Expenses	3,197,487	2,159,132	2,150,228	(8,904)	0.4%	3,197,487	-
PIHP Total	22,424	16,818	81,495	64,677	-384.6%	22,424	-
Total Revenue	**250,692,025**	**178,888,495**	**190,309,328**	**11,420,833**	**6.4%**	**275,654,362**	**24,962,337**
Total Expenses	**250,204,188**	**186,777,567**	**188,042,050**	**(1,264,484)**	**-0.7%**	**255,161,624**	**4,957,437**
Total Net	**487,837**	**(7,889,071)**	**2,267,278**	**10,156,349**	**-128.7%**	**20,492,737**	**20,004,900**

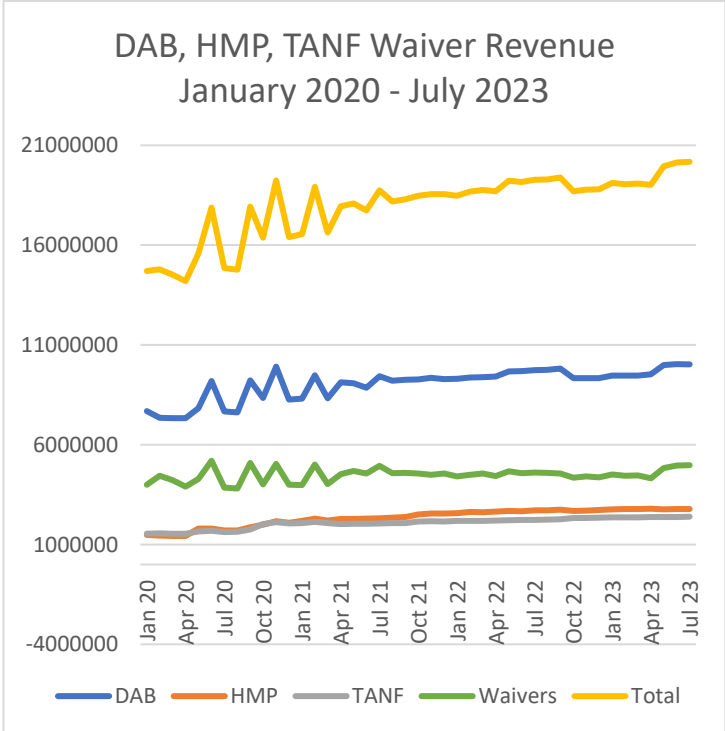
Regional CMH Revenue and Expenses
Regional Charts



March	Lenawee	Livingston	Monroe	Washtenaw*	Region
Total Medicaid/HMP Revenue	18,015,062	27,984,197	28,610,764	70,791,170	145,401,193
Total Medicaid/HMP Expense	14,932,392	26,094,663	26,763,832	67,017,380	134,808,267
TotalMedicaid/HMP Surplus(Deficit)	3,082,670	1,889,534	1,846,932	3,773,790	10,592,926
Surplus Percent of Revenue	17%	7%	6%	5%	7%

* Includes CCBHC Revenue and Expense





Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenue and Expenses Notes
Period Ending June 30, 2023

SUMMARY PAGE

1. The following chart compares the liquid assets of CMHPSM at June 30 of 2023 and 2022.

Asset Type	Description	2023	2022
Cash	Operations	6,409,628	9,178,625
	ISF		15,026,143
	PA2 Reserve		6,188,817
	Total Cash	$ 6,409,628	$ 30,393,584
Investments*	CD	-	15,335
	Money Market	9,920,967	
	US Treasuries	20,217,855	
	Total Investments	$ 30,138,822	$ 15,335
Total Liquid Assets		$ 36,548,450	$ 30,408,919

* Includes ISF and PA2 Reserve

2. Eligible Medicaid recipients remained steady from May to June of 2023.

Medicaid Mental Health

1. Current Medicaid revenues less expenses show a net loss of ($638,561) compared to a budgeted deficit of ($9,084,686). The positive difference is due to strong Medicaid revenue and a recent change in rates from MDHHS.

Medicaid and Grant SUD

1. SUD Medicaid/HMP shows a surplus of $2,824,344 compared to a budget of $1,645,547.

PIHP Administration

1. PIHP Administrative Revenue and Expenses are both within 5% of the budget.
2. Overall, the FY 23 surplus is $10,156,349 ahead of budget.

Projected Year-end 2023

1. The PIHP is showing strong Medicaid revenue for two reasons, the first is continued strong eligible enrollment despite the end of continuous Medicaid enrollment. Also, MDHHS revised CMHPSM's rate by over 5% in April. This increased monthly revenue by at least $1M over what was in the budget. Including the $14.9M carry forward, CMHPSM is projecting at least a $20M surplus before MDHHS Lapse back.

FY 2018 & FY 2019 DEFICIT UPDATE

The following charts were copied from the FY 22 Financial Audit presented to the Board in May of 2023.

Note 7 Shows the total amount due to the PIHP from MDHHS as of 9/20/22. This amount includes $10,997,115 due to the PIHP for Fiscal Year 2018 & 2019.

Note 10 shows the total amount due from the PIHP to the CMHs. This amount includes the $10,997,115 due from MDHHS.

Note 6 shows the amount of Funds held by the CMHs for Fiscal Year 2020, 2021 and 2022. These amounts will be cost settled when FY 2018 & 2019 are cost settled with the state.

NOTE 7 - DUE FROM MDHHS

Due from MDHHS as of September 30th consists of the following:

Description	Amount
Due from MDHHS - PBIP/Withhold	2,053,505
Due from MDHHS - FY18 State Shared Risk	7,517,412
Due from MDHHS - FY19 State Shared Risk	3,479,703
Due from MDHHS - HRA 4th Quarter	1,273,262
Grants Receivable	1,570,606
Totals	15,894,488

NOTE 10 - DUE TO AFFILIATE PARTNERS

Due to Affiliate Partners as of September 30th consists of the following:

Description	Amount
Community Mental Health Services of Livingston County	3,164,312
Monroe Community Mental Health Authority	6,847,718
Washtenaw County Community Mental Health	14,092,245
Total	24,104,275

NOTE 6 - DUE FROM AFFILIATE PARTNERS

Due from other affiliate partners as of September 30th consists of the following:

Description	Amount
Lenawee Community Mental Health Authority	6,974,176
Community Mental Health Services of Livingston County	7,572,498
Monroe Community Mental Health Authority	688,490
Washtenaw County Community Mental Health	8,938,263
Totals	24,173,427

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues and Expenditures
For the Period Ending June 30, 2023

	Budget FY 2023	YTD Budget	YTD Actual	Actual O(U) Budget	Percent Variance	Projected Year-End	Projected O(U) Budget
MEDICAID							
MEDICAID REVENUE							
Medicaid (b) & 1115i	116,734,441	87,550,831	91,023,521	3,472,690	-4.0%	123,095,535	6,361,094
Medicaid Waivers	53,639,152	40,229,364	40,654,692	425,329	-1.1%	55,530,982	1,891,830
Healthy Michigan Revenue	18,448,797	13,836,597	15,442,827	1,606,230	-11.6%	20,838,331	2,389,534
Medicaid Autism	16,267,125	12,200,343	11,791,501	(408,842)	3.4%	15,895,924	(371,201)
Prior Year Carry Forward	10,000,000	-	-	-	0.0%	14,993,512	4,993,512
Behavioral Health Home	650,000	487,500	508,521	21,021		729,633	79,633
CCBHC	2,000,000	1,500,000	5,797,365	4,297,365	-286.5%	8,889,012	6,889,012
HRA MCAID Revenue	2,000,000	1,500,000	1,283,128	(216,872)		2,566,256	566,256
HRA HMP Revenue	1,500,000	1,125,000	1,383,536	258,536		2,767,072	1,267,072
Medicaid Revenue	**221,239,514**	**158,429,636**	**167,885,091**	**9,455,456**	**-6.0%**	**245,306,257**	**24,066,743**
MEDICAID EXPENDITURES							
IPA MCAID	2,031,950	906,049	906,049	(0)	0.0%	1,892,099	(139,851)
IPA HMP	223,517	106,296	106,296	(0)	0.0%	212,593	(10,925)
HRA MC	2,000,000	1,383,536	1,383,536	-	0.0%	2,767,072	(767,072)
HRA HMP	1,500,000	1,283,128	1,283,128	-	0.0%	2,566,256	(1,066,256)
Lenawee CMH						-	-
Medicaid (b) & 1115i	14,652,005	10,989,004	11,668,309.92	(679,306)	-6.2%	15,557,747	905,741
Medicaid Waivers	6,332,531	4,749,398	4,442,741.64	306,657	6.5%	6,178,239	(154,292)
Healthy Michigan Expense	4,719,346	3,539,510	3,250,368.27	289,141	8.2%	4,333,824	(385,522)
Autism Medicaid	1,322,668	992,001	910,965.15	81,036	8.2%	1,214,620	(108,048)
Behavioral Health Homes	60,000	45,000	30,574	14,426		47,420	(12,580)
DHIP		-	55,067	(55,067)		73,599	73,599
Lenawee CMH Total	**27,086,551**	**20,314,913**	**20,358,026**	**(43,113)**	**-0.2%**	**27,405,450**	**318,899**
Livingston CMH							-
Medicaid (b) & 1115i	22,712,650	17,034,487	17,930,737	(896,250)	-5.3%	23,907,650	1,195,000
Medicaid Waivers	10,347,972	7,760,979	6,535,167	1,225,812	15.8%	8,895,174	(1,452,797)
Healthy Michigan Expense	4,135,002	3,101,251	2,897,715	203,537	6.6%	3,863,619	(271,382)
Autism Medicaid	5,771,052	4,328,289	4,044,221	284,068	6.6%	5,392,294	(378,758)
Behavioral Health Homes	60,000	45,000	35,253	9,747		54,908	
DHIP		-	97,956	(97,956)		116,488	116,488
Livingston CMH Total	**43,026,675**	**32,270,006**	**31,541,048**	**728,958**	**2.3%**	**42,230,134**	**(796,542)**
Monroe CMH							-
Medicaid (b) & 1115i	26,401,165	19,800,874	20,709,785	(908,910)	-4.6%	27,613,046	1,211,881
Medicaid Waivers	10,770,650	8,077,987	7,467,164	610,823	7.6%	10,290,944	(479,705)
Healthy Michigan	3,285,257	2,463,943	2,259,590	204,353	8.3%	3,012,786	(272,471)
Autism Medicaid	2,606,757	1,955,067	1,792,919	162,149	8.3%	2,390,558	(216,199)
Behavioral Health Homes	60,000	45,000	72,144	(27,144)		96,192	
DHIP		-	12,708	(12,708)		231,564	231,564
Monroe CMH Total	**43,123,829**	**32,342,871**	**32,314,309**	**28,562**	**0.1%**	**43,635,091**	**511,262**
							-
Washtenaw CMH							-
Medicaid (b) & 1115i	53,825,070	40,368,803	43,351,058	(2,982,256)	-7.4%	57,801,411	3,976,341
Medicaid Waivers	34,351,501	25,763,626	21,572,542	4,191,084	16.3%	29,295,989	(5,055,512)
Healthy Michigan Expense	7,597,382	5,698,036	5,185,028	513,009	9.0%	6,913,371	(684,011)
Autism Medicaid	7,116,076	5,337,057	4,856,546	480,511	9.0%	6,475,395	(640,681)
CCBHC	1,980,000	1,485,000	5,356,871	(3,871,871)	-260.7%	8,315,240	6,335,240
Behavioral Health Homes	340,000	255,000	270,561	(15,561)	-6.1%	387,552	47,552
DHIP		-	38,653	(38,653)		57,185	57,185
Washtenaw CMH Total	**105,210,029**	**78,907,522**	**80,631,259**	**(1,723,737)**	**-2.2%**	**109,246,142**	**4,036,113**
Medicaid Expenditures	**224,202,551**	**167,514,322**	**168,523,652**	**(1,009,330)**	**-0.6%**	**229,954,836**	**5,752,285**
Medicaid Total	**(2,963,037)**	**(9,084,686)**	**(638,561)**	**8,446,126**	**-93.0%**	**15,351,421**	**18,314,458**

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues and Expenditures
For the Period Ending June 30, 2023

	Budget FY 2023	YTD Budget	YTD Actual	Actual O(U) Budget	Percent Variance	Projected Year-End	Projected O(U) Budget
SUD/GRANTS							
SUD/GRANTS REVENUE							
Healthy Michigan Plan SUD	10,344,199	7,758,150	8,245,412	487,262	6.3%	11,160,897	816,698
Medicaid SUD	3,473,674	2,605,255	3,078,403	473,147	18.2%	4,150,241	676,567
PA2 - Tax Revenue (Est)	1,800,000	239,621	946,760	707,139	295.1%	1,800,000	-
PA2 - Use of Reserve (Est)	890,159	386,458	117,174	(269,284)	-229.8%	900,000	-
Federal/State Grants	9,249,568	6,937,176	7,007,093	69,917	1.0%	8,347,813	(901,755)
Opioid Health Homes	475,000	356,250	797,673	441,423	55.3%	769,243	
SUD/Grants REVENUE	**26,232,600**	**18,282,910**	**20,192,514**	**1,909,604**	**10.4%**	**27,128,194**	**895,594**
				0			
SUD/GRANTS EXPENDITURES				0			
SUD Administration							
Salaries & Fringes	1,244,808	933,606	752,676	(180,930)	-19.4%	752,676	(492,132)
Contracts	309,168	231,876	100,151	(131,725)	-56.8%	100,151	(209,017)
Board Expense	1,000	750	317	(433)	-57.8%	317	(683)
Other Expenses	182,175	136,631	89,159	(47,472)	-34.7%	89,159	(93,016)
Indirect Cost Recovery	0	-		0			-
SUD Administration	**1,737,151**	**1,302,863**	**942,303**	**(360,560)**	**-27.7%**	**942,303**	**(794,848)**
Lenawee SUD Services	2,141,943	1,606,457	1,559,005	(47,452)	-3.0%	2,141,943	-
Livingston SUD Services	2,566,539	1,924,905	1,725,646	(199,259)	-10.4%	2,566,539	-
Monroe SUD Services	2,952,548	2,214,411	2,736,575	522,164	23.6%	2,952,548	-
Washtenaw SUD Services	6,560,499	4,920,374	6,129,262	1,208,888	24.6%	6,560,499	-
Opioid Health Homes	380,000	285,000	500,333	215,333	75.6%	380,000	-
Veteran Navigation	200,000	150,000	119,822	(30,178)	-20.1%	200,000	-
COVID Grants	2,160,575	1,620,431	1,395,801	(224,630)	-13.9%	2,160,575	-
SOR	3,201,294	2,400,971	1,816,994	(583,976)	-24.3%	3,201,294	-
Gambling Prevention Grant	200,000	150,000	32,403	(117,597)	-78.4%	200,000	-
Tobacco	4,000	4,000	169	(3,831)		4,000	-
Women's Specialty Services	699,601	524,701	409,856	(114,844)	-21.9%	699,601	-
		-					
SUD/Grants Expenditures	**22,804,150**	**17,104,113**	**17,368,170**	**(264,058)**	**1.5%**	**22,009,302**	**(794,848)**
SUD/Grants Total	**3,428,450**	**1,178,797**	**2,824,344**	**1,645,547**	**139.6%**	**5,118,892**	**1,690,442**
PIHP							
PIHP REVENUE							
Incentives (Est)	2,002,943	1,502,207	1,532,127	29,920	2.0%	2,002,943	-
Local Match	940,504	466,395	466,395	-		940,504	-
Other Income	276,464	207,348	233,201	25,853	12.5%	276,464	-
PIHP Revenue	**3,219,911**	**2,175,950**	**2,231,723**	**55,773**	**2.6%**	**3,219,911**	**-**
PIHP EXPENDITURES							
PIHP Admin		-					
Local Match	940,504	466,395	466,395	-	0.0%	940,504	-
Salaries & Fringes	1,465,246	1,098,934	987,131	(111,804)	-10.2%	1,465,246	-
Contracts	520,386	390,289	391,446	1,157	0.3%	520,386	-
Other Expenses	269,351	202,013	303,892	101,878	50.4%	269,351	-
PIHP Admin	**3,195,487**	**2,157,632**	**2,148,864**	**(8,769)**	**0.4%**	**3,195,487**	**-**
							-
Board Expense	2,000	1,500	1,365	(135)	-9.0%	2,000	-
PIHP Expenditures	**3,197,487**	**2,159,132**	**2,150,228**	**(8,904)**	**0.4%**	**3,197,487**	**-**
PIHP Total	**22,424**	**16,818**	**81,495**	**64,677**	**384.6%**	**22,424**	**-**
							-
Organization Total	**487,837**	**(7,889,071)**	**2,267,278**	**10,156,349**	**-128.7%**	**20,492,737**	**20,004,900**
Totals							
Revenue	250,692,025	178,888,495	190,309,328	11,420,833	**-6.4%**	275,654,362	24,962,337
Expenses	250,204,188	186,777,567	188,042,050	(1,264,484)	**0.7%**	255,161,624	4,957,437
Net	487,837	(7,889,071)	2,267,278	10,156,349	**-128.7%**	20,492,737	20,004,900

Draft CEO Performance Goals (May 2023- April 2024)

CMHPSM Finance and Reporting

1. CEO will ensure that 100% of contractually required reports are submitted on a timely basis during each fiscal year by CMHPSM staff. (The CMHPSM was required to submit 85 pre-scheduled contractually required reports related to FY2022, other ad-hoc reports were required as well)
2. CEO will ensure that the CMHPSM region receives 100% of PIHP only performance incentive bonus payment (PBIP) revenue and 85-100% of PIHP / MHP shared metric PBIP revenue. Final award notices from MDHHS are typically sent in March each year.
3. CEO will resolve FY2018 deficit issue with MDHHS by 12/31/2023.

CMHPSM Service Delivery Goals

1. CEO will coordinate with the Regional Operations Committee on a monthly basis with regional network management committee and regional encounter data integrity committee information. Service access, network adequacy, encounter and waiver data are discussed in these committees and this information drives regional solutions to service delivery issues.
2. CEO will ensure that service access within the region is monitored, and state access standards are maintained or improved for all Medicaid/Healthy Michigan covered services, monitored through Michigan Mission Based Performance Indicator System (MMBPIS) indicators: #1, #2 & #3.

PIHP/CMHSP Relationship Goals

1. CEO will maintain or improve CEO performance review scores as scored by the CMHSP directors in April every year.
2. CEO will develop a new “PIHP value” survey related to CMHPSM functioning to establish a baseline review of PIHP added value to the region by 12/31/2023. Re-issue it annually or every other year to the CMHSPs. Survey questions would be directed to regional committee members and CMHSP directors.

Board Relationship

1. Oversee development of the FY2024-26 CMHPSM Strategic Plan and related metrics with the CMHPSM Regional Board of Directors by 9/30/2023.
2. Develop a new CEO performance survey tool that is more quantitative in scoring, for April 2024 CEO performance review by 7/1/2023. Participants: Regional Board Members, CMHSP Directors, Oversight Policy Board Members, other stakeholders as identified by the Board.

CMHPSM Employee Goals

1. CEO will meet with all individual CMHPSM employees by 1/31/2024 for “stay interview”. Currently the CEO typically only meets with non-direct reports for HR issues, specific projects or similar meetings.

2. CEO will maintain employee morale and maintain or improve employee satisfaction survey results scores from previous year during the annual survey every July.
3. CEO will schedule and oversee programmatic presentation sections from subject matter experts for the Regional Board on a quarterly basis.

Community Mental Health Partnership of Southeast Michigan
Draft Budget Presentation for FY 2024

Description	Budget FY 2023	YTD 6/30/23	Projected YE 2023	Low Draft Budget FY 2024	High Draft Budget FY 2024
MEDICAID					
MEDICAID REVENUE					
Medicaid (b) & 1115i	116,734,441	91,023,521	124,095,535	104,798,345	100,877,939
Medicaid Waivers	53,639,152	40,654,692	55,530,982	58,557,421	58,557,421
Healthy Michigan Revenue	18,448,797	15,442,827	20,838,331	14,021,085	25,409,091
Medicaid Autism	16,267,125	11,791,501	15,895,924	14,603,811	14,603,811
Prior Year Carry Forward	10,000,000	-	14,993,512	14,993,512	14,993,512
Behavioral Health Home	650,000	508,521	729,633	750,000	750,000
CCBHC - Supplemental	2,000,000	5,797,365	8,889,012	14,500,000	14,500,000
CCBHC - Medicaid/HMP		-		14,500,000	14,500,000
HRA MCAID Revenue	2,000,000	1,283,128	2,566,256	2,600,000	2,600,000
HRA HMP Revenue	1,500,000	1,383,536	2,767,072	2,600,000	2,600,000
Medicaid Revenue	**221,239,514**	**167,885,091**	**246,306,257**	**241,924,174**	**249,391,774**
MEDICAID EXPENDITURES					
IPA MCAID	2,031,950	906,049	1,892,099	2,052,099	2,052,099
IPA HMP	223,517	106,296	212,593	292,593	292,593
HRA MC	2,000,000	1,383,536	2,767,072	2,600,000	2,600,000
Lenawee CMH					
Medicaid (b) & 1115i	14,652,005	11,668,310	15,557,746.56	17,843,611	15,630,000
Medicaid Waivers	6,332,531	4,442,742	6,178,238.79	6,606,953	6,832,531
Healthy Michigan Expense	4,719,346	3,250,368	4,333,824.36	2,537,816	4,350,000
Autism Medicaid	1,322,668	910,965	1,214,620.20	1,096,819	1,182,668
Behavioral Health Homes	60,000	30,574	47,420	50,000	50,000
DHIP		55,067	73,599		
Lenawee CMH Total	**27,086,551**	**20,358,026**	**27,405,450**	**28,135,199**	**28,045,199**
Livingston CMH					
Medicaid (b) & 1115i	22,712,650	17,930,737	23,907,650	25,958,028	24,260,000
Medicaid Waivers	10,347,972	6,535,167	8,895,174	9,563,961	9,500,000
Healthy Michigan Expense	4,135,002	2,897,715	3,863,619	2,467,711	3,863,619
Autism Medicaid	5,771,052	4,044,221	5,392,294	5,309,239	5,491,052
Behavioral Health Homes	60,000	35,253	54,908	55,000	55,000
DHIP		97,956	116,488		
Livingston CMH Total	**43,026,675**	**31,541,048**	**42,230,134**	**43,353,939**	**43,169,671**
Monroe CMH					
Medicaid (b) & 1115i	26,401,165	20,709,785	27,613,046	22,014,214	21,860,000
Medicaid Waivers	10,770,650	7,467,164	10,290,944	11,035,801	10,800,000
Healthy Michigan	3,285,257	2,259,590	3,012,786	2,860,301	3,012,786
Autism Medicaid	2,606,757	1,792,919	2,390,558	2,066,470	2,120,000
CCBHC Medicaid/HMP				6,000,000	6,000,000
CCBHC Supplemental				6,000,000	6,000,000
Behavioral Health Homes	60,000	72,144	96,192	96,500	96,500
DHIP		12,708	231,564		
Monroe CMH Total	**43,123,829**	**32,314,309**	**43,635,091**	**50,073,286**	**49,889,286**
Washtenaw CMH					
Medicaid (b) & 1115i	53,825,070	43,351,058	57,801,411	49,619,192	50,877,113
Medicaid Waivers	34,351,501	21,572,542	29,295,989	31,350,706	31,424,890
Healthy Michigan Expense	7,597,382	5,185,028	6,913,371	6,155,256	5,978,371
Autism Medicaid	7,116,076	4,856,546	6,475,395	7,423,397	5,810,091
CCBHC Medicaid/HMP				8,500,000	8,500,000
CCBHC Supplemental	1,980,000	5,356,871	8,315,240	8,500,000	8,500,000
Behavioral Health Homes	340,000	270,561	387,552	390,000	390,000
DHIP		38,653	57,185		
Washtenaw CMH Total	**105,210,029**	**80,631,259**	**109,246,142**	**111,938,551**	**111,480,465**
Medicaid Expenditures	**224,202,551**	**168,523,652**	**229,954,836**	**241,045,667**	**240,129,313**
Medicaid Total	**(2,963,037)**	**(638,561)**	**16,351,421**	**878,507**	**9,262,461**

Community Mental Health Partnership of Southeast Michigan
Draft Budget Presentation for FY 2024

Description	Budget FY 2023	YTD 6/30/23	Projected YE 2023	Low Draft Budget FY 2024	High Draft Budget FY 2024
SUD/GRANTS					
SUD/GRANTS REVENUE					
Healthy Michigan Plan SUD	10,344,199	8,245,412	11,160,897	7,861,592	7,861,592
Medicaid SUD	3,473,674	3,078,403	4,150,241	3,118,490	3,118,490
PA2 - Tax Revenue (Est)	1,800,000	946,760	1,800,000	1,825,000	1,825,000
PA2 - Use of Reserve (Est)	890,159	117,174	900,000	900,000	900,000
Federal/State Grants	9,249,568	7,007,093	8,347,813	7,838,437	7,838,437
Opioid Health Homes	475,000	797,673	769,243	850,000	850,000
SUD/Grants REVENUE	**26,232,600**	**20,192,515**	**27,128,194**	**22,393,519**	**22,393,519**
SUD/GRANTS EXPENDITURES					
SUD Administration					
Salaries & Fringes	1,244,808	752,676	991,236	1,040,798	1,040,798
Contracts	309,168	100,151	27,821	30,000	30,000
Board Expense	1,000	317	602	650	650
Other Expenses	182,175	89,159	84,773	87,500	87,500
Indirect Cost Recovery	0	-		0	0
SUD Administration	**1,737,151**	**942,303**	**1,104,432**	**1,158,948**	**1,158,948**
Lenawee SUD Services	2,141,943	1,559,005	2,078,674	2,182,608	2,182,608
Livingston SUD Services	2,566,539	1,725,646	2,294,237	2,408,949	2,408,949
Monroe SUD Services	2,952,548	2,736,575	3,642,238	3,824,350	3,824,350
Washtenaw SUD Services	6,560,499	6,129,262	8,172,350	8,580,967	8,580,967
Opioid Health Homes	380,000	500,333	667,110	680,000	680,000
Veteran Navigation	200,000	119,822	159,763	192,000	192,000
COVID Grants	2,160,575	1,395,801	1,874,209	478,408	478,408
SOR	3,201,294	1,816,994	2,422,659	3,201,294	3,201,294
Gambling Prevention Grant	200,000	32,403	43,204	206,701	206,701
Tobacco	4,000	169	225	4,000	4,000
Women's Specialty Services	699,601	409,856	546,475	350,489	350,489
		-			
SUD/Grants Expenditures	**22,804,150**	**17,368,170**	**23,005,576**	**23,268,713**	**23,268,713**
SUD/Grants Total	**3,428,450**	**2,824,345**	**4,122,618**	**1,298,273**	**1,298,273**
PIHP					
PIHP REVENUE					
Incentives (Est)	2,002,943	1,532,127	2,028,048	495,921	495,921
Local Match	940,504	466,395	466,395	-	-
Other Income	276,464	233,201	182,117	350,000	350,000
PIHP Revenue	**3,219,911**	**2,231,723**	**2,676,560**	**444,838**	**444,838**
PIHP EXPENDITURES					
PIHP Admin		-			
Local Match	940,504	466,395	621,860	-	-
Salaries & Fringes	1,465,246	987,131	1,468,156	1,541,564	1,541,564
Contracts	520,386	391,446	513,603	525,000	525,000
Other Expenses	269,351	303,892	518,582	520,000	520,000
PIHP Admin	**3,195,487**	**2,148,864**	**3,122,201**	**2,586,564**	**2,586,564**
Board Expense	2,000	1,365	1,892	2,000	2,000
PIHP Expenditures	**3,197,487**	**2,150,229**	**3,124,093**	**2,588,564**	**2,588,564**
PIHP Total	**22,424**	**81,494**	**(447,533)**	**(2,143,726)**	**(2,143,726)**
Organization Total	**487,837**	**2,267,278**	**20,026,506**	**17,759,228**	**17,759,228**
Totals					
Revenue	250,692,025	190,309,329	276,111,011	264,762,530	272,230,131
Expenses	250,204,188	188,042,050	256,084,505	266,902,944	265,986,590
Net	487,837	2,267,278	20,026,506	(2,140,413)	6,243,541

Discussion of Draft FY2024 CMHPSM Budgets

1. Due to the extension of the June re-enrollment cohort deadline from June 30 to July 31, we do not have reliable data to base eligibility projections as of yet. Milliman is also awaiting Michigan re-enrollment data and is using national trends as a placeholder for now. We have created two budget estimates for this draft budget. The numbers in the Low Budget assume flat eligibility at the budgeted FY2023 level. The High Budget assumes we start at the increased actual 2023 eligibility level and will experience a slower decline to the FY2023 budgeted level over the course of FY2024. We hope to receive more information on eligible individual trends before the September Regional Board meeting, Milliman is currently estimating a mid-August date for final FY2024 rate information.

2. As of this writing, preliminary or draft Per-Member Per Month (PMPM) capitation rates are available for FY2024 budget making purposes. We anticipate final rates to be available in mid-August. The Low and High budgets both use the amended FY2023 capitation rates, which were recently revised and has positively impacted our region's revenue. The FY2023 rates include flat DAB rates, a (24%) reduction in HMP rates, a (4.5%) reduction in TANF rates, and an 11.3% increase in HSW rates.

3. At a preliminary rate-setting meeting in June, MDHHS/Milliman proposed a significant change to the way Medicaid revenue is distributed. The Medicaid/HMP funding of CCBHCs would be removed from the capitated payment amounts. The Medicaid/HMP funding of the CCBHC sites would be paid to them based on a fee schedule for Medicaid/HMP eligible services. The balance of the PPS-1 rate paid to the CCBHCs would come from the state supplemental CCBHC payment.

   In both draft budgets, both Washtenaw and Monroe are shown with CCBHC Medicaid Revenue and CCBHC Supplemental Revenue. The preliminary information included a PPS-1 Rate for Washtenaw. The PPS-1 Rate for Monroe was taken from the Cost Report included in Monroe's application to become a CCBHC.

4. Both draft FY2024 budgets include 29 CMHPSM employees, which is a decrease from the 30 approved positions for FY2023. We have also included a 3% COLA increase for all positions in both draft budgets.

5. The draft budgets both include $1.8M in PA2 revenue and $7.8M in grant activity.

Regional Board Action Request

Board Meeting Date: August 9, 2023

Action Requested: Approving the CMHPSM Board Chair to sign a formal proclamation acknowledging the six years of service by Roxanne Garber to the PIHP region as a CMHPSM Regional Board member

Recommendation: Approval for the CMHPSM Board Chair to sign the proclamation

WHEREAS the Community Mental Health Partnership of Southeast Michigan through effective partnerships, ensures and supports the provision of quality integrated care that focuses on improving the health and wellness of people living in our region; and

WHEREAS Roxanne Garber, as of July 12, 2017, served as a member of the CMHPSM Regional Board, including 1 term as the Board Secretary and 1 term on the CEO Evaluation Committee, and strove to accomplish the mission of the Community Mental Health Partnership of Southeast Michigan as a Regional Board member; and

Now, therefore, the Community Mental Health Partnership of Southeast Michigan Regional Board of Directors does hereby proclaim their appreciation to Roxanne Garber for six years of service to the region, today August 9, 2023.

_____

Bob King

CMHPSM Board Chair

Attachment #7 – August 2023

Regional Board Action Request – Contracts

Board Meeting Date: August 9, 2023

Action(s) Requested: Approval for the CEO to execute the contracts/amendments listed below.

Organization - Background	Term	Funding Level	Funding Source
TM Group – The CMHPSM brought a not to exceed $60,000 request to our June 2023 meeting, that request has been revised and now includes the first year of software and support for the additional funding. We collected quotes from other vendors and had an initial planning meeting to determine the products needed for this regional finance product. The TM Group will be our licensed Microsoft support partner and consult on system setup including integrations between our electronic medical record: CRCT and our financial platform. The CMHSPs and the PIHP will each have installations of Business Central, a Microsoft product. Installation and first year annual support estimate of 314 hours, project, and planning implementation fee: $83,400. Annual ongoing support hours after the first years are projected to be far fewer than current financial software setup. Annual ongoing Microsoft Business Central software licensing and related subscription fees: $24,816	8/1/2023 - 9/30/2024	Not to exceed $108,216.	Administrative License Agreement and Support Vendor

Recommend: Approval

Regional Board Action Request – FY2023 Provider Stabilization Funding

Board Meeting Date: August 9, 2023

Action Requested: Allocate funding to the CMHSPs to assist the regional provider network in delivering essential face-to-face services. A 4% rate adjuster funding amount was calculated based upon actual services delivered during FY2023 Q1 and Q2 (October 1 – March 31). The projected revenue will be provided to the CMHSPs to pass through to the regional provider network. Service provider rate adjuster payments will be made based upon actual services delivered throughout FY2023.

Projected FY2023	**Medicaid**	**HMP**	**Total**
Lenawee MH/IDD & SUD Services	$394,396	$27,761	**$422,157**
Livingston MH/IDD & SUD Services	$697,402	$14,274	**$711,675**
Monroe MH/IDD Services	$756,565	$2,993	**$759,559**
Washtenaw MH/IDD Services	$1,680,925	$30,009	**$1,710,934**
Monroe SUD Services (CMHPSM)	$8,517	$28,147	**$36,664**
Washtenaw SUD Services (CMHPSM)	$40,496	$118,136	**$158,632**
Total Funding for Region	**$3,578,302**	**$221,319**	**$3,799,621**

Background: Rate adjuster eligible services are unlicensed community living supports, licensed community living supports and personal care services, SUD residential, supported employment, and crisis residential. These funds cover rate adjuster payments based upon actual services delivered between October 1, 2022 and September 30, 2023. This funding will be directed to providers to cover additional expenses related to delivering services during this period, including overtime, retention, and recruitment costs.

Connection to PIHP/MDHHS Contract, Regional Strategic Plan or Shared Governance Model: The CMHPSM Regional Board of Directors approves the CMHPSM budget.

Recommend: Approval

FY2023 Q2 QAPIP Measures of Performance Q2 Status Report

FY2023 Q2 Status Indicators:	Green- Meeting or Exceeding State Benchmark	White – in-process or data is not yet available as of this status report.	Orange – Not currently meeting benchmark as of this status report.	Grey – No benchmark or establishing baseline.

Michigan Mission Based Performance Indicator System	FY2023 Q2 Status Report:	Full QAPIP Source:
CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	State goal 95% Q2 Performance: Children - 100%	Pages 23-24
CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	State goal 95% Q2 Performance: Adults - 99.08%	Pages 23-24
CMHPSM will meet or exceed the standard for Indicator 2. A The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	Baseline year continued in FY2023 with no state goal to date. Q2 Performance: Children with MH Dx – 59% (slight decrease from Q1 61%) Adult with MH Dx - 53% (slight decrease from Q1 56%) Children with DD Dx - 67% (slight increase from Q1 65%) Adults with DD Dx - 49% (decrease from Q1 60%)	Pages 23-24 Note: this is an overall regional average. Some CMHs met over exceeded the internal 70% threshold
CMHPSM will meet or exceed the standard for Indicator 2 b. The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. (No Standard)	Baseline year continued in FY2023 with no state goal to date. Q2 Performance: Persons with SUD Dx - 58% (slight decrease from Q1 62%)	Pages 23-24
CMHPSM will meet or exceed the standard for Indicator 3 Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	Baseline year continued in FY2023 with no state goal to date. Q2 Performance: Children with MH Dx – 68% (slight decrease from Q1 72%) Adult with MH Dx - 73% (no change from Q1) Children with DD Dx - 70.5% (decrease from Q1 84%) Adults with DD Dx - 90% (slight increase from Q1 89%)	Pages 23-24

<table>
<tr><th>Michigan Mission Based Performance Indicator System</th><th>FY2023 Q2 Status Report:</th><th>Full QAPIP Source:</th></tr>
<tr><td>CMHPSM will meet or exceed the standard for Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)</td><td>State goal 95%
Q2 Performance: Children - 97.83% (increase from QI 94.44%)</td><td>Pages 23-24</td></tr>
<tr><td>CMHPSM will meet or exceed the standard for Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)</td><td>State goal 95%
Q2 Performance: Adults – 97.83% (increase from Q1 94.92%)</td><td>Pages 23-24</td></tr>
<tr><td>CMHPSM will meet or exceed the standard for Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)</td><td>State goal 95%
Q2 Performance: All - 98.5% (increase from QI 95.73%)</td><td>Pages 23-24</td></tr>
<tr><td>CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)</td><td>State goal 15%
Q2 Performance: Children- 6% (slight decrease from Qi 6.35%)
*lower # = improved performance as reduction in recidivism</td><td>Pages 23-24</td></tr>
<tr><td>CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)</td><td>State goal 15%
Q2 Performance: Adults - 14.02%
*lower # = improved performance as reduction in recidivism</td><td>Pages 23-24</td></tr>
<tr><td>CMHPSM will demonstrate and increase in compliance with access standards for the SUD priority populations. (Baseline)</td><td>FY23 Q1 and Q2:
<table>
<tr><th>%</th><th>Oct-22</th><th>Nov-22</th><th>Dec-22</th><th>Jan-23</th><th>Mar-23</th></tr>
<tr><td>Liv</td><td>89</td><td>100</td><td>100</td><td>82</td><td>72</td></tr>
<tr><td>Len</td><td>100</td><td>100</td><td>91</td><td>100</td><td>100</td></tr>
<tr><td>Mon</td><td>47</td><td>67</td><td>35</td><td>56</td><td>77</td></tr>
<tr><td>Wash</td><td>73</td><td>79</td><td>77</td><td>82</td><td>85</td></tr>
<tr><td>PIHP Avg</td><td>77.25</td><td>86.5</td><td>75.75</td><td>80</td><td>83.5</td></tr>
</table></td><td>Pages 36, 45, 46, 57, 61</td></tr>
</table>

BH TEDS Data	FY2023 Q2 Status Report:	Full QAPIP Source:
Increase identification of veterans (military fields) to support increase in utilization of Veterans Navigation services.	State Goal 95% compliance for crisis and non-crisis encounters **As of latest state report within Q2 on *4/20*/23:**	Pages 46, 57, 60

Maintain overall BHTEDS completion rates to state 95% standard during FY2023. Improve crisis encounter BHTEDs completion to 95% during FY2023.	MH Encounters – 94.16% (has since increased - see current data Crisis Encounters – 95.29% SUD Encounters – 89.86 (has since increased – see current data **Current Data:** MH Encounters – 97.4% Crisis Encounters – 98.6% SUD Encounters – 99%	

Performance Improvement Projects	FY2023 Q2 Status Report:	Full QAPIP Source:
PIP 1: The racial disparities of no-shows for the initial Biopsychosocial Assessment (BPS) in individuals accessing CMH services will be reduced or eliminated. (FY22 Baseline)	FY2022 CMHPSM received a score of 100% on the PIP after resubmission. FY23 PIP Submission was due to HSAG 7/14/23 and submitted by the PIHP on 7/13/23. Barriers were identified, and interventions initiated on 1/1/2023 that include offering same day appointments, providing transportation assistance, and staff training tools to improve communication. Data analysis of the outcomes of interventions is not due to the federal auditors until June/July 2024. Data to date shows a shift to Monroe CMH no longer showing racial disparity of no-show rates for the region. Overall no-show rates are increasing. Data and compliance with application of interventions is being monitored monthly.	Pages 26-27

Performance Improvement Projects	FY2023 Q2 Status Report:	Full QAPIP Source:
PIP 2: Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Contributing Factors: Shift in allowable telehealth post PHE; Access staffing resources FY22 Overall Annual Performance: Child SED - 65% Adult MI- 57% Child IDD- 73% Adult IDD- 65% FY23 Q2 Performance: Children with MH Dx – 59% Adult with MH Dx - 53% Children with DD Dx - 67% Adults with DD Dx - 49%	Pages 26-27

Assessment of Member Experiences	FY2023 Q2 Status Report:	Full QAPIP Source:
Percentage of children and/or families indicating satisfaction with mental health services. (Standard 85%/) Percentage of adults indicating satisfaction with mental health services. (Standard 85%) Percentage of individuals indicating satisfaction with long-term supports and services. (Standard 85%)	FY2023 survey has been developed and is process with plans for completion by end of July 2023 and data analysis by end of FY23.	Pages 34-35
Percentage of consumers indicating satisfaction with SUD services. (Standard 85%/ 4 Likert score) ***State no longer requires RSA***.	Workplans from FY22 data are in process. Areas of focus to date include: • Expand role and involvement of Consumer Advisory Committee (CAC) to increase involvement of persons with SU/SA and recovery community • Expand ways to provide resources to those seeking employment • Increase collaborations with recovering community Regional Co-Occurring Workgroup assessing alternate survey to potentially replace RSA in FY2023	Page 36

Member Appeals and Grievance Performance Summary	FY2023 Q2 Status Report:	Full QAPIP Source:
The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness and documentation standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	New FY23 Appeals analysis report completed 100% compliance with timeliness Case monitoring of documentation for Q1 and Q2 was completed. Reports and corrective action being prepared.	Pages 11,16,32,34
The percentage (rate per 100) of Medicaid grievances are resolved with a compliant written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	New FY23 Grievance analysis report completed 100% compliance with timeliness Case monitoring of documentation for Q1 and Q2 was completed. Reports and corrective action being prepared.	Pages 11,15,32,34

Adverse Event Monitoring and Reporting	FY2023 Q2 Status Report:	Full QAPIP Source:
The rate of critical incidents per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	FY22 compiled Critical Events data analysis completed Monitoring of reporting compliance with new state MiCAL reporting system in process FY23 Q1 and Q2 Critical Events data analysis completed <u>FY23 Q2:</u> 100% submission of events within timeframes 75% accepted by state due to state system issues that don't allow for updates through CRCT 3.2 events per 1000 members served – decrease from FY23 Q1 of 4.9 per 1000 members served	Pages 26-29

Adverse Event Monitoring and Reporting	FY2023 Q2 Status Report:	Full QAPIP Source:
The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal) Ensure compliance with timely and accurate reporting of critical and sentinel events (100%) 100% CEs reporting 100% timely reporting	FY22 and FY23 data are not comparable due to reporting changes FY23 Q2: The rate of suicide for FY23 Q2 was 0 per 1000 members served. The overall mortality rate was 2.63 deaths per 1000 members served. Both mortality rates decreased from FY23 Q1 Compliance reporting inconclusive due to state system errors. 100% timeliness reporting	Pages 26-29
Quarterly report and analysis of type, trends over time (including mortality), events per 1,000, regional trends over time starting with 2022, analysis of trends by service, engagement in treatment, precipitating events. Analysis of CE trends for potential PI projects	FY22 Analysis completed 11/18/22 FY23 Q2 Analysis completed 3/29/23 – potential trends and improvements to be presented at April 2023 CPT Committee for review/approval.	Pages 26-29
The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year.	No SE occurrences during FY23 Q1 and Q2	Pages 26-29
Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care. 100% reported to PIHP and state 100% timeframes met 3-day review of critical events (CEs) that are sentinel events (SEs) 100% RCA completion	No SE occurrences during FY23 Q1 and Q2 Data reviewed monthly Reporting template to be re-sent to Regional CPT quarterly	Pages 26-29

Joint Metrics	FY2023 Q2 Status Report:	Full QAPIP Source:
Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%)	Q2 Performance: 100% CMHPSM, the MHPs, and the CMHSPs completing meeting, identifying those with high risk or high utilization of services to include in reviews, and reviewing potential interventions to better serve and stabilize those consumers.	Pages 24-25

Joint Metrics	FY2023 Q2 Status Report:	Full QAPIP Source:
The percentage of discharges for **adults** (18 years or older) who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-58%) Measurement period will be calendar year 2021.	Q2 PIHP Overall Specific Performance (MMBPIS Indicator #4): 86% (inpatient psychiatric specific follow up within 7 days) Overall PIHP FUH rate: 63% (known or opened to PIHP/CMH – 81%) PIHP/MHP shared rate: 65%	Pages 24-25
The percentage of discharges for **children** (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-70%) Measurement period will be calendar year 2021.	Q2 PIHP Overall Specific Performance (MMBPIS Indicator #4): 94% (inpatient psychiatric specific follow up within 7 days) Overall PIHP FUH rate: 80.6% PIHP/MHP shared rate: 82%	Pages 24-25
Racial/ethnic group disparities will be reduced. CMHPSM will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children). (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period will be a comparison of calendar year 2020 with calendar year 2021.	Most recent data from state dated 12/31/2022 shows no change in disparity	Pages 24-25

Joint Metrics	FY2023 Q2 Status Report:	Full QAPIP Source:
Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days. (Standard 27%) Measurement period will be calendar year 2021.	**Most recent state data from 12/31/22** CMHPSM: 45.6% Denominator 1245 Numerator: 568 (increase from 26% QI) MHPs: Den Num % 73 33 45% 385 176 46% 73 31 42% 365 178 49% 136 52 38% 129 62 48%	Pages 24-25
Reduce the disparity measures for FUA. Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period will be a comparison of calendar year 2020 with calendar year 2021.	Disparity increased Review of causes and potential interventions in process CMHPSM continues to advocate for allowing peer recovery supports to count in performance data.	Pages 24-25

Performance Based Incentive Payments (PBIP)	FY2023 Q2 Status Report:	Full QAPIP Source:
CMHPSM will improve or maintain data quality on BH-TEDS military and veteran fields. Data will be analyzed and monitored for discrepancies between VSN and BH-TEDS data. Identification of beneficiaries who may be eligible for services through the Veterans Administration.	State Goal 95% compliance for crisis and non-crisis encounters **As of latest state report on 4/20/23:** MH Encounters – 94.16% Crisis Encounters – 95.29% SUD Encounters – 89.86% **Current Data:** MH Encounters – 97.4% Crisis Encounters – 98.6% SUD Encounters – 99%	Page 57

Performance Based Incentive Payments (PBIP)	FY2023 Q2 Status Report:	Full QAPIP Source:
Increased data sharing with other providers through sending ADT messages for purposes of care coordination through health information exchange. (narrative report)	Due 11/15/2023, in compliance to date.	Page 60
CMHPSM will participate in DHHS-planned and DHHS-provided data validation regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment within 14 calendar days of the diagnosis received: (1. Initiation of AOD Treatment) *No state threshold set yet*	Validation due dates determined by the state upon request. Currently in 100% compliance with participation. State reports IET indicators will be sunset as PBIP metrics in FY24	Page 25
CMHPSM will participate in DHHS-planned and DHHS-provided data validation regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit. (2. Engagement of AOD Treatment) *No state threshold set yet*	Validation due dates determined by the state upon request. Currently in 100% compliance with participation. State reports IET indicators will be sunset as PBIP metrics in FY24	Page 25
CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report)	Due 11/15/2023, in compliance to date.	Page 60

Priority Measures	FY2023 Q2 Status Report:	Full QAPIP Source:
Clinical SUD		
CMHPSM SUD providers will meet ASAM continuum completion rates (Target 95%) CMHPSM SUD providers will meet priority population timelines (Target 95%)	Data is being tracked monthly System fixes were identified in FY23Q1 and corrected. **ASAM Continuum Completion Rates**: FY23 Q1 – 83.6% completion (total 738 cases) FY23 Q2 – 83.6% completion (total 788 cases)	Pages 13-14, 38, 61

<table>
<tr>
<td>CMHPSM SUD Provider decrease in open SUD wrapper admissions without service and increase in closed cases.
Monthly data reviews and quarterly data analysis reporting. (Target 95%)</td>
<td>FY23 Q1 and Q2 Priority Population: Access Screenings Meeting Timeliness Requirements 75% threshold for CAP
<table>
<tr><th>March 2023</th><th>Jan 2023</th><th>Dec 2022</th><th>Nov 2022</th><th>Oct 2022</th></tr>
<tr><td>Liv - 72% (8/11)
Len – 100% (12/12)
Mon – 77% (17/22)
Wash – 85% (23/27)</td><td>Liv - 82% (9/11)
Len – 100% (3/3)
Mon – 56% (9/16)
Wash – 82% (23/28)</td><td>Liv - 100% (6/6)
Len – 91% (11/12)
Mon – 35% (6/17)
Wash – 77% (31/40)</td><td>Liv- 100% (6/6)
Len –100% (6/6)
Mon –67% (14/21)
Wash – 79% (26/33)</td><td>Liv- 89% (7/8)
Len –100% (11/11)
Mon –47% (7/15)
Wash – 73% (29/40)</td></tr>
</table>
SUD Wrapper Data: Monthly data reviews and quarterly data analysis reporting was completed in full (100%) for Q1 and Q2. Internal threshold set for 20% of expired requests (80% requests met or record closed)</td>
<td></td>
</tr>
</table>

Utilization Management/LTSS	FY2023 Q2 Status Report:	Full QAPIP Source:
Assess validity and reliability of LOCUS application across the region. a. Increase in timely completion of LOCUS (at intake, before annual BPS signed b. Percentage of LOCUS score changes over time. Significant score changes show medical necessity c. Percentage of LOCUS overrides do not exceed 10% d. Clear documentation of overrides e. LOCUS score is accurately reflected in parity Level of Care in clinical record	Pending development of parity analysis program – extended to September 2023	Pages 31-33

Utilization Management/LTSS	FY2023 Q2 Status Report:	Full QAPIP Source:
Correct timeframes used for advance action notice (Target 100%) Accurate use of reduction, suspension, or termination decisions. (Target 100%) ABDs provide service denial reasons in language understandable to person served. Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.	Data analysis of FY23Q2 completed Correct timeframes used for advance action notice - 100% Accurate use of reduction, suspension, or termination decisions 6 of 914 applicable ABDs were suspension errors (delay in service) (.65%) CMH was provided feedback to retrain staff. ABDs provide service denial reasons in language understandable to person served: Content errors were found in 33 of 1610 cases for Q2 of FY23 (2%) Timeliness errors found in 22 of 440 ABDs for Q2 of FY23 (5%) 14-day timeliness data inconclusive due to some system errors. Q3 analysis will include review of exceeded timeframes due to system/data entry error	Pages 31-33
Assess overutilization of services: Identify any services by population that indicate overutilization. Where indicated develop interventions to address overutilization. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.	LTSS data dimensions completed During Q1 Project determined: Review of inpatient recidivism as potential overutilization of using following factors: LTSS, services/status before admission, Whether f/u done within 7 days post discharge and service type. FY23 Q2: Data analysis structure in process	Pages 31-33

Utilization Management/LTSS	FY2023 Q2 Status Report:	Full QAPIP Source:
Assess underutilization of services: Identify any services by population that indicate underutilization. Where indicated develop interventions to address underutilization. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.	LTSS data dimensions completed During Q1 Project determined: Assess potential underutilization of HSW members not receiving monthly services that qualify them for HSW enrollment, and potential risks with the ending of public health emergency and subsequent enrollment exceptions. FY23 Q2: Data analysis structure created and is in testing	Pages 31-33
Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).	Pending FY23 PIHP monitoring of CMHSPs (onset by 9/30/23, completion by 12/31/23)	Pages 31-33
Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%).	Pending development of parity analysis program FY23 Q2: Analysis structure created and in testing.	Pages 31-33
Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%). Implement an inner rater reliability with the MCG Indicia parity system for psychiatric inpatient, crisis residential, and partial hospitalization service decisions.	MCG IRR training in process with completion by 4/30/23 and initiation of MCG IRR program 5/1/23, with full completion and analysis of FY23 data by 9/30/23 Delay in 9/30/23 completion goal due to access updates needed to system. System delays addressed; new completion date set for 12/30/23.	Pages 31-33

Behavior Treatment	FY2023 Q2 Status Report:	Full QAPIP Source:
Consistent quarterly reporting of BTC data (100%) Consistent data analysis of BTC data (100%)	100% reporting of BTC data FY2023 Q1 and Q2 100 consistent BTC data analysis FY2032 Q1 and Q2 BTC data analysis completed. Trends included needing some data further delineated, and the need to include whether relevant BTC information is clearly documented in the Individual's Plan of Service (IPOS) as the data was inconclusive in these areas. 7/27/23 review set with BTC chairs for data reporting improvements	Pages 29-30
The percentage of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques.	Data analysis as baseline measure was assessed for FY2022 Findings included: need for revision of data report to ensure one data element per field and all required elements met. Data report was updated, to train BTC staff for implementation by FY23 Q2 data analysis. Meeting with regional BTC chairs/data reporting staff set for 7/26/23. Some elements will need to be included in PIHP monitoring of CMHSPs in FY23 (whether IPOS updated after increase in events, special consent completed) Assessing if FY22/FY23 baseline possible based on needed revision between FY22 and FY23 reporting template	Pages 29-30

Clinical Practice Guidelines	FY2023 Q2 Status Report:	Full QAPIP Source:
CPGs reviewed at least annually.	Annual review scheduled for FY23 Q3 at Regional CPT meeting on 5/18/23	Pages 30-31
CPGs published to both provider network and members.	In process, due 9/30/23	Pages 30-31

Provider Monitoring	FY2023 Q2 Status Report:	Full QAPIP Source:
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	CMHPSM review of CMHSP Access departments completed. Two CMHSP CAPs submitted, 2 CMHSP CAPs pending. Auditing of LIP, Organization, and CMHSP staff credentialing/recredentialing records has been completed. Trends included clear documentation all reviews elements checked (CMH staff) Strengths – clear documentation of findings FY23 Q1 was a review to establish baseline. Training resources will be provided and review of FY23 Q4 will be conducted during QI of FY24 to assess for any improvements. CMHPSM reviews of CMHSP clinical compliance to be started by 9/30/23 and completed by 12/30/23 and included in FY23 QAPIP Evaluation.	Pages 36-42
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Auditing of LIP, Organization, and CMHSP staff credentialing/recredentialing records has been completed. CMHPSM reviews of CMHSP clinical compliance to be started by 9/30/23 and completed by 12/30/23 and included in FY23 QAPIP Evaluation.	Pages 36-42
Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.	FY23 Q1 and Q2 data report submitted to the state on 5/15/23 due date. Auditing of LIP, Organization, and CMHSP staff credentialing/recredentialing records has been completed. Trends included clear documentation all reviews elements checked (CMH staff) Strengths – clear documentation of findings FY23 Q1 was a review to establish baseline. Training resources will be provided and review of FY23 Q4 will be conducted during Q1 of FY24 to assess for any improvements.	Pages 36-42

Provider Monitoring	FY2023 Q2 Status Report:	Full QAPIP Source:
Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.	First FY23 state data report due 5/15/23 Auditing of LIP, Organization, and CMHSP staff credentialing/recredentialing records has been completed. Trends included clear documentation all elements checked (CMH staff) Strengths – clear documentation of findings FY23 Q1 was a review to establish baseline. Training resources will be provided and review of FY23 Q4 will be conducted during Q1 of FY24 to assess for any improvements.	Pages 36-42
Complete assessment of FY22 CMHPSM audits of CMHSP Access functions (CMH and SUD) and development performance improvement projects where indicated based on findings and resultant CAPs.	CMHPSM review of CMHSP Access departments completed. Two CMHSP CAPs submitted, 2 CMHSP CAPs pending. Data analysis found opportunities for improvement in: • Clearer documentation of resource/information sharing • Clearer documentation of denial/medical necessity decisions FY22 was a review to establish baseline. Training resources will be provided through Regional UM/UR and the PIHP will conduct service denial data analysis. A review of FY23 will be conducted during QI of FY24 to assess for any improvements.	Pages 36-42
CMHPSM will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule (MDHHS HCBS CAP Guidance form).	CMHPSM Waiver Coordinator launched a new review of HCBS providers for FY23. 7 nonresidential and 26 residential providers have been reviewed in FY23. Findings were related to policy revisions needed and ensuring some individual restrictions were clearly noted in the plan. There were no findings requiring provider sanctions or changes to HCBS status. 27 of 341 providers are being reviewed at MDHHS for heightened scrutiny with no determinations to date.	Pages 36-42

Health Home (OHH, BHH, CCBHC) Performance Measures	FY2023 Q1 Status Report:	Full QAPIP Source:
Meet or exceed OHH performance benchmarks.	100% compliance with meeting reporting requirements 5 active OHH providers Performance of benchmarks/Pay for Performance pending MDHHS reporting	Page 63
Meet or exceed BHH performance benchmarks.	100% compliance with meeting reporting requirements All four CMHs BHH certified and enrolling members Performance of benchmarks/Pay for Performance pending MDHHS reporting	Page 63
Meet or exceed federally defined QBP measures and benchmarks for CCBHCs.	100% compliance with meeting reporting requirements Performance of benchmarks/Pay for Performance pending MDHHS reporting	Page 63

Regional Board Action Request – FY2023 Q2 QAPIP Measures of Performance Status Report

Board Meeting Date:	August 9, 2023
Action Requested:	Review and approve status report of the FY2023 Q2 Quality Assessment and Performance Improvement Program (QAPIP).
Background:	The CMHPSM is committed to ensuring quality service provision through review of evidence and the monitoring of the health and welfare of the region's recipients by developing a quality management program. Some of the key functions of a Quality Management Program includes developing and evaluating the QAPIP Program on an annual basis, providing regular status reports, and seeking feedback and recommendations. Quarterly reports are also thoroughly reviewed by our regional committees and CMHSP partners.
Connection to:	PIHP/MDHHS Contract, AFP, Regional Strategic Plan and Shared Governance Model
Recommend:	Approval

Region 6 CMHPSM Substance Use Services
FY24 – FY26 Strategic Plan Executive Summary
August 1, 2023

The goal of this plan is to guide the work of Region 6 to provide a Recovery Oriented System of Care including an array of services including prevention, harm reduction, treatment and recovery. Regional data is utilized in this plan with focus on specific issues and areas as needed to help identify related priorities. Many data sources were utilized to support this work including the 2023 CMHPSM Substance Use Services Community Survey; Substance Use Services and Oversight Policy Board prioritization; a focus group of local providers, OPB members and CMHPSM staff; CMHPSM Electronic Health Record and local substance use data. Gaps and barriers were identified, as were strengths.

In addition to the narrative summary, two logic models are required. One for Prevention, and one for Treatment/Recovery. There are some nuances to these plans to note. First, the state mandates the priority areas for Prevention. However, the remaining information is local to the region. Each of the below priority areas are addressed by local programming currently funded by CMHPSM. This funding was procured through an RFP process for FY2021 for a two-year period. It was extended to FY23 due to unknown funding allocations. Each of these areas are data driven, have Evidence Based Interventions and Evaluation Plans associated with them and are monitored annually. They also produce Program Briefs at year end, which can be found on our website for the past two years here: https://www.cmhpsm.org/sud-prevention. The Treatment/Recovery logic model includes two goals that apply across the entire array of services including prevention, harm reduction, treatment and recovery.

The Prevention Priority Areas Include:

1. To reduce childhood and underage drinking
2. To reduce prescription and over-the-counter drug abuse and misuse
3. To reduce youth access to tobacco and electronic nicotine products
4. To reduce illicit drug use

In the narrative are more detailed descriptions of related initiatives including our Designated Youth Tobacco Use Representatives (DYTUR), as well as coalition work including a new initiative funded by MDHHS called Michigan Partnership for Advancing Coalitions (MI PAC). The focus on MI PAC is on tobacco, marijuana and vaping, with a regional collaborative addressing health disparities in each county.

The Treatment/Recovery Priority Areas Include:

1. Reduction in health disparities among high-risk populations receiving prevention, treatment and recovery services.
2. Expansion and enhancement of an array of services within the Recovery Oriented System of Care
3. Increase sustainability of programming with diversified funding

Again, the narrative includes more detailed descriptions including awareness campaigns to increase knowledge of how to reach services when needed, ensuring providers are addressing health disparities using measurable outcomes, training Access staff across the region, supporting providers in coordinating services with local partners to address social determinants of health, and addressing sustainable funding through opportunities including Opioid Settlement Funds.

August 1, 2023

Mr. Bob King, Chair
Board of Directors
Community Mental Health Partnership of Southeast Michigan
3005 Boardwalk Dr., Ste. 200
Ann Arbor, MI 48108

RE: Oversight Policy Board Substance Use Disorder Strategic Plan

Chair King and Members of the Board:

Please be advised that on Thursday, June 22, 2023, the SUD Oversight Policy Board (OPB) held its regular meeting. At that meeting, the Board participated in a planning session and discussion in preparation for the development of the FY24-26 SUD Strategic Plan which is due to the State of Michigan later this month.

Following discussion, the OPB approved a motion to authorize me to transmit the completed strategic plan to the Regional Board from the OPB.

While the FY2024-26 SUD Strategic Plan will receive additional review and discussion at future OPB meetings, please let this letter serve as notice of the action taken thus far, and their recommendation for submission of the FY2024-2026 SUD Strategic Plan to MDHHS by the August deadline. Any additional changes or revisions to the plan will be presented to the CMHPSM Regional Board at future meetings.

If I can provide any additional information regarding the actions of the Oversight Policy Board, please do not hesitate to contact me at (734) 265-6116.

Regards,

Mark Cochran, Chair
Oversight Policy Board

REGION 6
COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

THREE-YEAR STRATEGIC PLAN FOR SUBSTANCE USE PREVENTION, TREATMENT, AND RECOVERY SERVICES

Fiscal Years 2024-2026

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This strategic plan for Region 6 by the Community Mental Health Partnership of Southeast Michigan (CMHPSM) will be implemented and guide services from FY24 through FY26. Utilizing the Recovery Oriented System of Care (ROSC) model, this plan focuses on prevention, harm reduction, treatment and recovery. It aligns with the goals of the Substance Use, Gambling and Epidemiology (SUGE) Strategic Plan and the associated primary focus areas as outlined in the guidelines for this report. Below are the narrative responses addressing the key components necessary for an array of programs and services necessary for this region's journey toward recovery. Attachments are included to support the information below including data tables, logic models and an implementation plan.

1. **A narrative identifying and prioritizing substance use disorder problems impacting the community with respect to ROSC that includes prevention, treatment, and recovery services, as well as all other services necessary to support recovery. The narrative should include identification of related long term and short-term consequences at the regional/community level. There should be evidence of an epidemiological profile in the prioritization of substance use disorder issues/problems.**

DEMOGRAPHIC PROFILE OF REGION 6

CMHPSM is the Prepaid Inpatient Health Plan (PIHP) for Region 6, representing Lenawee, Livingston, Monroe and Washtenaw counties to provide an array of services representing the ROSC model, which includes prevention, harm reduction, treatment and recovery. Regional data is utilized in this plan to support regional substance use priorities with focus on specific issues and priorities identified.

Located in southeast Michigan, Region 6 is connected by several major highways and interstates, borders Ohio, and is located within close proximity to the Canadian border. Michigan is determined to be a critical drug-trafficking region and is listed as an Office of National Drug Control Policy High Intensity Drug Trafficking Area (HIDTA). To qualify for HIDTA consideration, an area must meet certain criteria including being an area of significant illegal drug importation. (source: HIDTA (dea.gov); HIDTA-map-May-2023.pdf (whitehouse.gov); hidtaprogram.org/summary.php) Based on 2022 US Census Quick Facts data (https://data.census.gov), 816,713 individuals reside in the region, with 45% of individuals residing in Washtenaw County, making the other three counties much more rural. Lenawee County is particularly rural, representing only 12% of the region's population. As in most rural areas, many individuals are impacted by accessibility barriers including lack of mass transit, reliable internet, and social service providers. Across the region, males and females are almost evenly split with an average of 49.7% being female.

In terms of race and ethnicity, 89% of the region identifies as white, and 5% identify as African American/Black. Across the region, an average of 5% identify as Hispanic/Latino/a/x, with the highest average (9%) identifying as such in Lenawee County. An average of 2.4% identify as being of two or more races. When considering all racial factors, there are vast differences by county and within specific areas of certain counties. In Washtenaw County 12.4% of individuals identify as Black, while in Livingston County only .7% do. Significant differences exist within each county, such as Ann Arbor, a county located in Washtenaw County. Ann Arbor "is the 5th most poverty-segregated community in the nation, and 8th in the nation for overall economic segregation." (2017 Washtenaw County Assessment of Fair Housing; www.washtenaw.org). Within Washtenaw County, 73% of Ann Arbor identified as white, while just under 8% identified as Black/African American. Ypsilanti is made up of 62% of individuals identifying as white and 29% identifying as Black/African American. Data on ethnicity and race in the United States is often lumped into five or size broad categories, in ways that can render

communities invisible or hide disparate impacts of inequality on subgroups. (Source: https://researchdata.wisc.edu/data-equity/the-impact-of-data-invisibility-and-the-need-for-disaggregation/) This plan will focus on outreach and other services to reach specific communities with health disparities and those disproportionately impacted by social determinants of health. Additional information highlighting data invisibility within our counties is addressed in the Treatment and Recovery Logic Model data resources attachment.

According to County Health Rankings 2023 Data (https://www.countyhealthrankings.org/reports), an average of 12% of individuals in the region consider themselves to have fair or poor health, slightly lower than the state average of 15%. This report also shows 17.5% of adults reporting currently smoking, 134 of the annual 1,502 alcohol-impaired driving deaths; 5% in the region report being uninsured (state average is 6%). The average unemployment rate in the region is also 5% vs. 6% in the state. In addition, a regional average of 9.5% of individuals live in poverty. An average of 5% under 65 have no health insurance, with a higher than average rate in Lenawee County at 7%.

The US Census does not yet collect county level sexual orientation data. They do, collect LBGTQ data at the state level, which was estimated at 4% of Michigan's population. In a more recent survey conducted by the US Census called the Household Pulse Survey, still statewide, it was identified an average of 7% of individuals 18 years or older in Michigan identify as LBGT. The survey breaks down transition age youth (18-24 years) nationally, and 25% percent of these youth identify as LBGT. https://www.census.gov/library/visualizations/interactive/sexual-orientation-and-gender-identity.html. County level data from youth is available for those completing the MiPHY survey from school year 2021-2022 that shows Lenawee, Monroe and Washtenaw counties (Livingston has not completed since 2018). The regional average of high school student respondents identifying as "gay, lesbian, bisexual or some other way" is 23% and those "unsure about their sexual orientation (questioning)" is 5.4%. This is limited as it does not include out of school youth.

According to the American Community Survey 2017 conducted by the National Center for Educational Statistics (www.nces.ed.gov), literacy rates are low throughout the region with the percentage of adults proficient in literacy at 45% (Lenawee), 60% (Livingston), 45% (Monroe) and 65% (Washtenaw). The percentages are even lower for proficiency in numeracy. An average of .8% of individuals 5+ years of age in the region reported they do not speak English well. Language barriers along with physical barriers add to a burden to accessing services for individuals across the region. Technology can both increase ease of access but also create a barrier for those without reliable internet or technology access, particularly for those in rural communities. As the use of telehealth became evident as a benefit during the COVID pandemic, particularly for those in rural settings, it also became evident that there are disparities in who has access to this technology, especially for those in rural settings. 2022 US Census Quick Fact Data shows an average of 88% of individuals across the region say they have a broadband internet subscription (which is not the equivalent of reliable internet). Of these, Washtenaw and Livingston counties are both above 90%, with Lenawee and Monroe counties at 85%. An average of 9% of the region report not having a computer with internet access, with 11% and 12% in Lenawee and Monroe counties respectively.

The Region 6 CMHPSM 2023 Community Survey identified a lack of regional prevention and treatment services available for youth. With an average of 20% of the population in the region being under 18 years of age, addressing the gap in youth services is of critical importance. With a gap in the region and

across the state, addressing this need will require more than just additional providers, we will need to consider adding a wide array of services. While only two residential SUD treatment youth providers in the state take Medicaid and three outpatient providers in the region, few, if any requests are made each year for these services. Creativity in filling this gap is required and will be seen in this plan through compiling a comprehensive array of available services outside of traditional FFS treatment and ensuring new services are created if needed to fill the gap; and an educational campaign to ensure services are well known. Any youth focused services will need to center on those experiencing health disparities and barriers related to Social Determinants of Health. County Health Rankings 2023 Data (https://www.countyhealthrankings.org/reports) reports an average of 11% of children live in poverty in the region, and the racial/ethnic disparities are clear, with 22% of Black children and 16% of Hispanic children vs. 9% of white children living in poverty.

In 2017, MDHHS created a state funded program to support a Veterans Navigator in regions across the state, and in 2022 added an additional essential resource of a Peer Resource Specialist. The role of both is to connect Veterans and Military Families to services, primarily behavioral health services. With 38,500 Veterans living in region 6 according to 2022 US Census Quick Facts data, the services provided by the Veterans Navigator and Peer Resource Specialist are crucially important and essential. As CMHPSM continues to train Access staff and other providers to know about this resource, Veterans have been identified as a population of focus in this strategic plan. Data is being tracked and analyzed to determine the needs to best connect this population to services.

TREATMENT UTLIZATION DATA

CMHPSM recognizes the importance of targeting needs and strategies to promote healthy communities and individual well-being. We continue to use a data-driven approach to drive substance abuse prevention and treatment efforts throughout the region. Using data from our electronic health record (EHR), *Comprehensive Record for Consumer Treatment* (*CRCT*), a Power BI Dashboard has been created to help monitor treatment utilization. CMHPSM also utilizes surveys, such as the Region 6 CMHPSM Recovery Self-Assessment (RSA), to ensure service providers, including our mental health partners, are embedding the recovery principles and practices and that our clients experience recovery focused care. This is discussed further in the Treatment Evaluation section below.

According to the attached Region 6 CMHPSM FY21 – FY23 Service Volume Analysis attachment, alcohol, heroin, cocaine, and sedatives are the top four primary substances used. There were 1,546 admissions for alcohol; 464 for cocaine, 817 for heroin, 226 for prescription opioids, 270 for methamphetamines and 136 for marijuana. The primary drug of choice is alcohol, followed by heroin, cocaine/crack and methamphetamines. This has been an ongoing concern of providers and the community overall, as we address the opioid epidemic, not to overlook the ongoing significant alcohol issue. This is considered a gap in services that will be addressed, not by decreasing programs for individuals with opioid use disorder (OUD) but by ensuring alcohol is not overlooked as it seems to have been. CMHPSM receives funding through the State Opioid Response (SOR) funds which has added stimulant use disorder to the substances of focus to help expand program options through this funding. According to attached Service Volume Analysis, Washtenaw County has the majority of admissions for alcohol and cocaine. While still more than half of heroin admissions are in Washtenaw County, Monroe County's rates are much higher than the other two counties; and for prescription opioids, Washtenaw and Monroe counites have the same number of admissions. Methamphetamine use

is most common in Lenawee County, and marijuana admissions are highest in Washtenaw County, but not far behind in Livingston County.

This data set also shows service volume by gender, and when identifiable, shows significantly higher use by men. The majority of volume increase is due to more men receiving admissions at an even higher rate of growth than women. In age, 32-42 years old are the most common service users (when identifiable); the prior and subsequent decade generations are lower but at similar rates As mentioned throughout this plan, and one of many reasons for addressing health disparities in the region, white men and women use services significantly more than other racial/ethnic combinations.

Despite increased awareness of the opioid epidemic, between 2020 and 2021, our region saw a substantial increase in overdose death rates among individuals, supporting the need for more strategic programming: Hispanic/Latino/a/x had a 71% increase (with an overall rate in 2021 of 32%) with whites increasing 20% (with an overall rate in 2021 of 25%). And while Black individuals had no change in rates between years, they remain the population with the highest drug overdose death rate at 39%. Individuals ages 25-34 had a 70% increase with the next highest age group being 55-64 year olds at a 30% increase and 15-24 year olds at a 38% decrease. Females increased 30% while males had a 9% increase. This data can be found in the treatment/recovery logic model data section and is sourced from the Michigan Substance Use Vulnerability Index (www.michigan.gov/opioids).

Finally, the County Health Rankings Data shows an average of 22% of the region reporting excessive drinking, compared to 20% statewide. One highlight of the community survey is that respondents identified alcohol used as the biggest substance of issue in the region. Behavioral Health Treatment Episode Data Set (BHTEDS) data also supports the community survey data with the primary drug of choice overall for all counties is alcohol. While the opioid epidemic and other emerging substances cannot be ignored, neither can alcohol use, which has unfortunately not been as widely and publicly addressed in the past several years. This data can be found in the supporting treatment/recovery logic model and is sourced from www.michigan.gov/opioids/category-data Other data supporting use across the region related to youth use can be found in the prevention logic model attachment and is sourced from https://mi-suddr.com/.

PREVENTION PROGRAMS:
CMHPSM funds substance use prevention programs, initiatives, and coalitions within the four-county region. Prevention providers utilize data to guide local decisions and create a comprehensive plan for programming based on the Strategic Prevention Framework (SPF). The SPF is an outcome-based, data driven, population-level approach to substance use prevention planning. SPF includes five steps: assessment, capacity, planning, implementation, and evaluation. All five steps in the SPF process must be conducted in a culturally competent manner and with a goal of sustainability.

Prevention implementers focus on one or more of the following CMHPSM priority areas: (1) reducing childhood and underage drinking; (2) reducing prescription and over the counter drug abuse/misuse; (3) reducing youth access to tobacco and nicotine; and (4) reducing illicit drug use. Epidemiological evidence is required by the prevention provider/entity to support the selection of a priority area in a specific community. Prevention providers utilize an Evidence-Based Intervention (EBI) Implementation & Evaluation Plan designed to elicit a logical sequence of information that includes the identification of consequences/supportive data and the associated underlying causes in a specific community; the

selection and implementation of EBIs and prevention strategies based on the data; and the verification of results/outcomes. Consequences identified are dependent on the specific provider and can be found in the Region 6 CMHPSM FY24 - 26 Prevention Logic Model attachment. Some examples include traffic crash deaths/injuries; delinquent/problem behavior; early onset addiction; legal consequences; school failure and social connectedness. Funded programs are required to use SMART (Centers for Disease Control and Prevention) criteria: specific, measurable, achievable, realistic, and time-phased and report on each outcome (mid-year & year-end). An evaluation method for each outcome is required. This provides both the funded agencies and CMHPSM the opportunity to quantify, monitor, and evaluate progress toward achieving targeted outcomes.

Given the timing of this strategic plan, data driven objectives/outcomes are not yet finalized for the upcoming fiscal year. Data is included in the Prevention Logic Model attachment as well as in the Region 6 FY24 – FY26 Treatment and Recovery Logic Model attachment data tabs, as this data supports needs across the array of services. In addition, data is found in the Region 6 CMHPSM 2023 Community Survey, where 76% of respondents reported prevention education for youth would be helpful to reduce stigma of people using substances, with 67% reporting more substance use prevention programs are needed in the region overall. This is also highlighted in the Treatment and Recovery Logic Model in the first goal about health disparities, which encompasses prevention programs. Additional data can be found in this attachment from the Michigan Substance Use Vulnerability Index, informing prevention programs. For example, all drug overdose reported for youth 15-24 across the region is down from 12% in 2020 to 7.6% in 2021. Again, this data is regional and it is expected of providers to utilize local data to inform their specific interventions.

PREVENTION PROGRAMS

Gaps and barriers are addressed by the programs funded below. As stated throughout this plan, this includes alcohol use, vaping, adolescents/youth and older adults. For a detailed description of these programs, please see the Region 6 CMHPSM 2023 Substance Use Services Guide:

- Catholic Charities of Southeast Michigan, Monroe County
  Program: Student Prevention Leadership Teams (SPLT): Peer School Based Program
- Catholic Social Services of Washtenaw County
  Programs: Get Connected/CAGE Screenings: Older Adult EBI and Screening
- Eastern Michigan University, Washtenaw County
  Programs: Prevention Theatre Collective (PTC)/Botvin LifeSkills Transitions, Prime for Life, and Botvin LifeSkills Training: School and Community Based EBIs
- Jefferson Schools, Monroe County
  Program: Catch My Breath: School Based Student Assistance Program
- Karen Bergbower & Associates, Region-Wide
  Program: Designated Youth Tobacco Use Representative (DYTUR)
- Livingston County Catholic Charities
  Programs: Community Mobilizing for Change on Alcohol (CMCA), Curriculum Based Support Groups (CBSG), Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), and Youth Led Prevention (YLP): Community Based and School Based EBIs; Program for youth educators, parents and communities.
- Monroe County Intermediate School District
  Program: Nurturing Parenting/Parents as Teachers: EBI for Parents of young children
- Ozone House, Washtenaw County

Program: The Engagement Program: Community Based SBIRT
- Parkside Family Counseling, Lenawee County
  Program: Prevention & Education Groups: Community Based prevention and engagement groups
- Paula's House, Lenawee County
  Program: Celebrating Families: EBI for parents and children in recovery housing
- St. Joseph Mercy Chelsea– Trinity Health, Washtenaw County
  Program: Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students): School Based EBI
- United Way of Lenawee & Monroe
  Program: Botvin LifeSkills Training and Monroe County Substance Abuse Coalition (MCSAC) School Based EBI and Community Coalition

Michigan Partnership to Advance Coalitions (MI PAC) – Region-Wide
SAMHSA funded a Strategic Prevention Framework-Partnership for Success 2022 Grant in Michigan, awarded to and with primary oversight by MDHHS/SUGE. This project has a 5-year implementation cycle. The focus of this project is strengthening state and community-level prevention capacity to identify and address local substance use prevention concerns around tobacco, electronic cigarettes, and marijuana. SPF is expected to be used to ensure a community engagement model grounded in public health principles (including being data-driven) and focused on providing EPIs to high-risk, underserved communities. The two prevention priority areas include statewide coalition training and technical assistance; and establishing, reestablishing, or enhancing underserved regional or community prevention coalitions with the support of SUGE, Wayne State and Prevention Network. Main expectations include a community needs assessment, capacity building, planning, implementation, and evaluation of coalition work related to the prevention priority areas and communities identified. Region 6 will work with coalitions on addressing health disparities in their local communities.

MI PAC Coalitions:
Lenawee County Community Mental Health Authority- Substance Use Coalition, Livingston County Catholic Charities- Livingston County Community Alliance, United Way of Lenawee & Monroe Counties- Monroe County Substance Abuse Coalition (MCSAC), Washtenaw County Health Department- Coalition name TBD

YOUTH ACCESS TO TOBACCO
Youth access to tobacco and nicotine products can lead to addiction and health problems. One of the emerging trends of the past several years has been the use of vaping, which involves both tobacco and marijuana. MiPHY data found in the Prevention Logic Model attachment shows a regional average of 17% of high school aged youth completing the survey reporting vaping in the past 30 days. This was also identified in the Region 6 CMHPSM 2023 Community Survey as a key issue for youth, with 51% of respondents identifying vaping as the main substance use issue for youth in the region. The following processes are used in the CMHPSM region, in addition to mandated Synar Compliance Checks, to reduce youth access to tobacco and nicotine products:

Vendor Education: DYTURs are required to provide vendor education to at least 50% of the tobacco/Electronic Nicotine Device (ENDs) retailers within each county of the region. DYTURs prioritize visiting new retailers, retailers that failed a Non-Synar or Synar compliance check in the previous two years, and retailers that did not receive a visit in the previous year. DYTURs consult the FDA website to review retailers within our region that failed their FDA compliance check and provide them with an

education visit. During the visits, DYTURs discuss the Michigan Youth Tobacco Act and changes in federal or state legislation, provide and post birthdate signs and other educational materials, and emphasize retailers' role in youth tobacco/nicotine access prevention. The Michigan Youth Tobacco Act was amended to prohibit the sale of tobacco to youth under 21.

Karen Bergbower and Associates (KBA), located in Livingston County, has been the regional provider to address this issue for CMHPSM. In addition to doing the required work detailed in this plan, KBA receives a small amount of funds to support additional work specifically to address the use of Electronic Nicotine Delivery Systems (ENDS) and related consequences. KBA was approved to utilize this additional funding to recruit and train youth and community partners to work with schools to strengthen substance-free/tobacco-free/smoke-free policies to include nicotine, e-cigarettes, and related vaping paraphernalia during FY 24. Future plans will be determined after the first year is evaluated. KBA will continue to participate in coalition meetings and other capacity building initiatives, contact with Tobacco Section policy staff, meet with schools and community partners, identify of a model comprehensive policy, train youth and partners to advocate for schools to adopt the new policy, and mail 100% of the school districts in the region of the model policy and letter encouraging adoption.

Non-Synar Compliance Checks: Regional DYTURs are required to partner with local law enforcement to conduct Non-Synar Compliance Checks with at least 25% of the tobacco/ENDs retailers within each county of the region. Law enforcement issue citations to retailers that have violated the law. After compliance checks are completed, each retailer checked receives a letter from the DYTUR. Retailers that were compliant receive a letter congratulating them, while retailers that failed receive a letter reminding them of the importance of checking all IDs to verify age and comply with the law. DYTURs personally follow-up with each of the retailers that failed their check to provide additional education and to address retailer questions. According to the state guidelines every region should choose a minimum of 25%, however, if a region or designated catchment area has exceeded the maximum 20% retailer violation rate (RVR) as prescribed by the federal Synar Amendment, for three consecutive years, select 50% of the establishments from the MRL within that PIHP region. Region 6 has been below 20% consecutively for more than three years.

Community Engagement: Regional DYTURs participate in numerous community events and speaking engagements, and consistently seek opportunities to keep communities up to date on tobacco and ENDs-related trends with our region's youth. DYTURs provide press releases, individual classroom presentations within regional school districts, and participate in community fairs, open houses, and health events. To remain up to date in tobacco/ENDs-related data, evidence-based and promising practices, and changes to federal and state legislation, DYTURs partner with local coalitions and state-wide coalitions and workgroups, including the Tobacco Free Michigan Coalition and the MDHHS E-Cigarette Workgroup.

Over the course of FY24 – FY26, the CMHPSM would like to further develop and improve our region's ENDs prevention efforts to address the prevalence of vaping amongst our region's youth, including staying up to date with emerging trends and products. Additionally, we would like to cultivate a working partnership with the FDA Inspector(s) assigned to conduct federal compliance checks within our region to share data and strategies. We will continue to support the following efforts to decrease sales to minors at the federal, state, and local levels:

- Support restrictions in the sale of flavored ENDs products
- Support state tax increase on tobacco products
- Mandate the use of computerized identification methods which cannot be bypassed
- Increase penalties for first time and repeat offenders
- Increase communication between retailers and law enforcement
- Empower retailers to know and understand their rights
- Encourage retailers to call local law enforcement at every underage purchase attempt
- Explain to businesses the higher cost of taxes when they sell to minors i.e. long-term health care costs, loss of employee work time, higher premiums on insurance etc.

GAMBLING DISORDER PREVENTION PROGRAM

Gambling Disorders present additional addiction issues impacting our communities. Gambling Disorder is a significant impediment to recovery with financial, legal, social, vocational, familial, physical, and emotional impact. Recent data indicates individuals experiencing Gambling Disorder have been found to also present with a broad range of co-occurring behavioral health disorders. According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 73.2% of pathological gamblers had an alcohol use disorder; 38.1% had a drug use disorder; 49.6% had a mood disorder; 60.8% had a personality disorder and 15-20% attempted suicide. CMHPSM participates in the State's Michigan Gambling Disorder Prevention Projects (MGDPP) work to increase Gambling Disorder awareness, promote treatment, and reduce Gambling Disorder among youth, young adult and adult populations. Region 6 utilizes a regional gambling disorder workgroup to implement the Strategic Prevention Framework to address local needs. Results from a needs assessment in FY23 showed the following:

- More than half (58%) of youth responding to the online community survey reported no one had ever talked to them about potential risks of gambling and only 53% of parents of teens reported they had talked to their youth about risks. In addition, 31% of youth reported gambling with family members.
- Only 51% of adult residents reported they would know where to find help for a problem.
- Almost 1 in 4 adult residents reported that individuals with a gambling problem are to blame for the problem. This stigmatized belief can decrease willingness to seek help.
- 38% of adults report having ever worried that someone in their family, or a close friend, might have a gambling problem.

As part of this project, CMHPSM has incorporated the use of the National Opinion Research Center DSM-IV Screen (NODS), based on DSM criteria for Gambling Disorder, at SUD intakes in the region. A positive NODS assessment would result in a possible treatment plan goal and referral to the MDHHS Gambling Disorder Helpline. CMHPSM has a goal for 85% of SUD client intakes to include a completed NODS CLiP and has consistently surpassed that goal since its implementation in November 2019.

HARM REDUCTION

This strategic plan's continuum of services in the ROSC model is not complete without the mention of harm reduction services. While not new a new model, it is unfortunately not widely adopted as an acceptable approach for active users to get support in their life. Harm Reduction programs support individuals in their recovery journey, whether this is to be to stay safe, alive, reduce/stop use, or get

connected to other help they may need. In the Region 6 CMHPSM 2023 Substance Use Community Survey, providers showed a considerable gap in knowledge regarding syringe access was present, with many questioning the effectiveness of such an effort. Following national organizations such as the Harm Reduction Coalition, it is a focus of this strategic plan, to "increase access to evidence-based harm reduction strategies like overdose prevention and syringe access programs" (www.harmreduction.org).

The essential need for an increase in harm reduction services was specifically mentioned at multiple points in our information gathering process including with the Oversight Policy Board, Substance Use Services Team, the Community Focus Group and Michigan Substance Use Vulnerability Index data from the Region 6 CMHPSM FY24 – FY26 Treatment and Recovery Logic Model. The community identified a range of levels of acceptance of harm reduction tactics. Not only are active substance users a priority for CMHPSM to address in terms of tertiary prevention and linkages to community resources, these individuals need a trusted resource if and when they are ready to be connected to substance use treatment, no matter what pathway they choose. This includes individuals with Opioid Use Disorder, as well as other substances. CMHPSM identifies harm reduction as a potential pathway to recovery. In the region, there is no one within a 15 minute drive of an SSP in Lenawee County, .5% in Livingston, with greater access in Monroe and Washtenaw counties at 55% and 83% respectively (www.michigan.gov/opioids/category-data).

Harm Reduction services can even be found in our region's Overdose Education and Naloxone Distribution (OEND) programs. One new strategy this fiscal year has been to fund $35,188 through SOR 3 OEND funding to regional providers for the implementation of nalox-boxes and Naloxone vending machines. Additional funding was also provided through SOR3 OEND to purchase supplies for overdose rescue kits and supplies for the naloxone vending machines such as fentanyl testing strips, harm reduction resources and educational materials.

Another example of harm reduction services includes a pilot SUD Health Home funded in FY23 by COVID BG at Avalon Housing, a permanent supportive housing provider in Washtenaw County. This provider is also funded to implement integrated care and harm reduction services. To live at Avalon, a person has to be considered chronically homeless and have a disability. Avalon identifies a vast majority of their residents to be active substance users or to be in recovery from an SUD. This pilot project allows Avalon staff to provide care coordination and increased peer support services, to ensure the individuals at their residences with substance use disorders are connected to as many providers as possible, including those that address substance use specifically, and social determinants of health. The population of individuals living at Avalon are some of the most vulnerable in our community. This program is modeled after Opioid Health Homes, detailed below.

HARM REDUCTION PROGRAMS

For a detailed description of these programs, please see the Region 6 CMHPSM 2023 Substance Use Services Guide:

- Unified: HIV Health and Beyond, Region-wide
  Program: Harm Reduction and Community Outreach
- Avalon Housing, Washtenaw
  Program: Harm Reduction and Integrated Care and SUD Health Home
- Salvation Army Harbor Light, Monroe
  Program: Syringe Access Program (not funded by CMHPSM)

- Home of New Vision, Washtenaw County
  Program: Recovery Opioid Overdose Team (ROOT)
- Lenawee County CMHA; Livingston County CMHA; Catholic Charities of Southeast Michigan, Monroe; Home of New Vision, Washtenaw County
  Program: Engagement Centers
- Ozone House, Washtenaw
  Program: Youth Pro-Social Events
- Washtenaw County Health Department
  Program: Media Campaign: Recovery focused region-wide campaign building off of prior CMHPSM media campaign "Is Possible" and will include Harm Reduction messaging.

TREATMENT

CMHPSM funds substance use disorder treatment programs and services within the region utilizing multiple sources including fee for service (FFS) Medicaid/HMP and Block Grant, as well as several grant funded programs. CMHPSM has an open procurement process and determines need based on data driven network adequacy, as well as funds available by specific grants. Providers utilize treatment EBIs approved by the region to guide programming to create a person-centered approach to treatment for individuals depending on need. This is one key aspect of this three-year strategic plan CMHPSM hopes to increase - that of exploring and expanding on multiple pathways of recovery for individuals based on meeting their specific medical, cultural, recovery needs as well as individual choice. While this has included traditional 12 step abstinence-based programming, after research and evaluation is completed, CMHPSM hopes to expand the referral options to accommodate multiple pathways to recovery, again, based on medical, cultural, recovery needs as well as individual choice. The processes must be conducted in a manner with cultural humility and equity at the core.

Treatment providers offering licensed substance use treatment services through Medicaid or Block Grant funds receive referrals from an Access Department located at the CMHSP in each county. A phone screening is conducted using the evidence based ASAM Criteria, medical necessity to determine level of care, and providing the individual with provider choice when making their treatment decisions. Lenawee and Livingston counties are delegated substance use funds and oversee Access Departments and contracts with SUD FFS treatment providers in their counties. Monroe County CMH and Washtenaw County CMH both oversee their own Access Department. CMHPSM holds contracts with the SUD FFS treatment providers.

Upon admission, an ASAM Continuum Assessment is required to ensure appropriate level of care and documentation of biopsychosocial elements to help inform an individualized treatment plan. Through required quarterly Block Grant provider reports, while the regional goal is 85%, virtually all providers report 100% of individuals served receive an assessment, level of care determination, and appropriate treatment plan. SUD treatment providers are contractually required to be trained in and provide services in a culturally competent manner and this training is monitored annually through the regional recredentialing process or through CMHPSM treatment provider monitoring. As part of this plan, specific objectives will be required to ensure individuals' cultural needs are assessed and addressed in their treatment and recovery plans. As explained below, regional trainings have started and will continue to help providers better understand different cultures and how to operationalize cultural humility in their work through treatment plans and recovery-based activities.

Treatment providers use EBIs determined by the regional Clinical Performance Team and are aligned with MDHHS/SUGE guidance, following the state Treatment Policies on Individualized Treatment and Planning, as well as Outpatient and Residential Treatment Continuum of Service policies. Interventions used include Motivational Interviewing, CBT, DBT, Trauma Informed Care and Contingency Management (expected to expand in the future). A full list can be found in Attachment III Region 6 Clinical Practice Policy EBPs List 2023. Given the timing of this strategic plan, data driven objectives/outcomes are not yet finalized for the upcoming fiscal year.

The CMHPSM Treatment Team is led by the Clinical Treatment Coordinator and includes the Substance Use Services Director, Utilization and Treatment Specialist and Priority Population Care Navigators. The designated Clinical Treatment Coordinator oversees all SUD treatment services for the CMHSPM and works in conjunction with treatment providers to ensure treatment services are provided appropriately and oversees annual monitoring. CMHSPM monitors each of the programs' expenditures and reviews its clinical documentation and processes. Annual monitoring includes reviewing the providers' policy and procedures, staff qualifications, admissions and discharges, clinical progress notes and treatment plans.

TREATMENT PROGRAMS

The programs listed below are either located within the region or outside of the region. A full list of providers and services offered are included in Attachment IV. This array of services includes virtually all ASAM levels of care. As this plan is submitted, the remaining levels are being finalized. Single Service Agreements can be made with other providers as needed if for some reason the provider network does not meet the needs of the individual served. For a detailed description of these programs, please see the Region 6 CMHPSM 2023 Substance Use Services Guide:

- FFS SUD Treatment Programs - Medicaid/HMP/BG
    - In Region providers: Salvation Army Harbor Light (Monroe); Catholic Charities of Southeast Michigan (Monroe); Passion of Mind (Monroe); Therapeutics (Livingston, Monroe, Washtenaw); Ann Arbor Comprehensive Treatment Center (Washtenaw); Home of New Vision (Washtenaw); Dawn Farm (Washtenaw); Catholic Social Services (Washtenaw); Trinity Addiction Recovery Services (Washtenaw); Livingston County Catholic Charities (Livingston); Key Development Center (Livingston); Parkside Family Counseling (Lenawee); Catholic Charities of Lenawee, Jackson and Hillsdale (Lenawee); McCullough Vargas and Associates (Lenawee)
    - Out of Region providers: Personalized Nursing Light House (Wayne); Sacred Heart (Macomb); Hegira Health/Oakdale Recovery Center (Wayne); Bear River Health – (Otsego and Charlevoix); Community Medical Services (Wayne); Kalamazoo Probation Enhancement Program (Kalamazoo), Flint Odyssey House (Genesee)

RECOVERY

Many programs are funded to support recovery at every stage for individuals. Services are available for individuals to support individualized recovery including while they are actively using and not yet ready for services, once they are considering accessing services, while receiving treatment or care coordination, and after substance use treatment services are received.

Recovery support services are most commonly received through peers, individuals with lived experience. Different funding requirements and programs allow for lived experience alone to consider oneself a peer or may require certain levels of training. Peers have become increasingly utilized in the ROSC model and are now more than ever recognized as essential to the recovery process. CMHPSM

funds many programs utilizing peers. According to MDHHS MSA Bulletin MSA 21-38, "an evidence-based practice, peer support is valuable not only for the person receiving services, but also for behavioral health and integrated care professionals including the systems in which they work… Research and experience show that peer support specialists have a transformative effect on both individuals and systems. Peer support has been shown to improve quality of life, improve engagement and satisfaction with services and supports, improve whole health including chronic conditions, decrease hospitalizations and inpatient days, and reduce the overall cost of services."

Recovery Community Organizations (RCOs) are essential in using peers to support those in the recovery process. According to the Alliance for Recovery Centered Organizations (https://facesandvoicesofrecovery.org/programs/arco/) RCOs are intended to work closely with individuals in the recovery community to increase and support long-term recovery. Strategies to accomplish this include education, policy advocacy and peer-based recovery support services. CMHPSM supports three RCOs in the region, in Livingston, Monroe and Washtenaw counties. ARPA funding has been requested from MDHHS to start an RCO in Lenawee County in FY24.

Additional programs listed below that heavily utilize peers includes Project ASSERT, which places a peer directly in an emergency department to connect with individuals when they present with a substance use disorder. As seen below, three Project ASSERT programs are funded by SOR funds in Region 6, with a fourth recently starting in Livingston County with local funds.

According to the Michigan Association of Recovery Residences (MARR) (www.Michiganarr.com), an affiliate of the National Association of Recovery Residences (NARR), (www.narronline.org), the concept of recovery housing is a standard based on the Social Model of Recovery Philosophy. The NARR mission is to support persons in recovery through quality recovery housing. NARR and MARR work with government and community-based agencies to ensure more accessible recovery housing opportunities. All regions across Michigan, and as mandated by the State Opioid Response grant, require MARR certification of all funded recovery residences. CMHPSM has been working closely with recovery residences throughout the region, and has only one agency left to become certified for reasons detailed below. Recovery housing utilizes peers as an essential part of the recovery process.

CMHPSM funds recovery homes throughout the region. Some gaps in this area were identified below by the Oversight Policy Board and by the Region 6 CMHPSM 2023 Substance Use Services Community Survey. As is evident in this plan, not all agencies have all aspects cultural humility in place, and it became evident this year work was needed to be done with MARR on standards and inclusivity related to gender identity. MARR was open to conversation, training and is working together with several PIHPs to hopefully develop an inclusivity statement and expectation on gender identity and inclusivity in recovery residences in the upcoming months.

RECOVERY PROGRAMS

For a detailed description of these programs, please see the Region 6 CMHPSM 2023 Substance Use Services Guide:

Recovery Community Organizations – Livingston CMHA, Recovery Advocates In Livingston (RAIL); CCSEM Recovery Advocacy Warriors (RAW), Monroe; Home of New Vision, Washtenaw, Washtenaw Recovery Advocacy Project (WRAP)

See OUD section for more information.

- Catholic Charities of Southeast Michigan, Monroe; Home of New Vision, Washtenaw Project ASSERT

- Recovery Support Services – CCSEM, Monroe, RSS; Dawn Farm, Washtenaw, RSS and Recovery Court Peers; Home of New Vision, Washtenaw, RSS
- Recovery Housing – RAIL, Livingston; Paula's House, Monroe; Ty's House, Monroe; Dawn Farm, Washtenaw; Home of New Vision, Washtenaw

COMMUNICABLE DISEASE SERVICES

CMHPSM was in the process of approving a revised Regional Communicable Disease Policy, when MDHHS came out with their request for feedback on a new statewide policy. Now that this policy is finalized, CMHPSM will update the regional policy, expected by the end of FY23 and has continued to build upon the current communicable disease framework. Communicable disease screening is not limited to SUD clients and is provided in the community as needed. In addition, referrals to local resources are provided widely through all CMHPSM programs including prevention and mental health services.

Contracting with Unified: HIV Health and Beyond (UHHB), CMHPSM continues to provide communicable disease education services to clients at the provider programs and in the community, and to provide harm reduction outreach services in the region. This includes mobile syringe support program (SSP) services, with the ability of expansion through an additional mobile unit. As part of the SUD treatment provider monitoring process, substance use treatment providers use risk assessments and referrals to local resources when necessary. Communicable disease training is a policy requirement for staff and providers. Bringing this expertise to the community is the role of UHHB, and they do provide health education/HIV/HCV/STI information to the community on behalf of the CMHPSM using local funds. UHHB is offering Hepatitis C testing on the mobile unit as well as part of their overall HIV/STI testing services. The Salvation Army Harbor Light in Monroe County has started a harm reduction program, embracing true harm reduction strategies, and this could begin to incorporate more HIV/HCV/STI testing. UHHB continues to build relationships across the region to conduct harm reduction services, including communicable disease testing and education across the region.

2. A narrative, based on the epidemiological profile, identifying, and explaining data- driven goals and objectives that can be quantified, monitored, and evaluated for progress (increase in access to SUD services, behavior change, quality improvement, and positive treatment outcomes, an increase in recovery support services, and improvement in wellness) over time.

Based on the epidemiological profile above; an analysis of existing services including strengths and gaps; prioritization, SWOT analysis and focus groups with community, board and staff; and a region-wide community survey; quantifiable, monitored and evaluated goals and objectives were developed. They are detailed further in the logic model section below, and are summarized here. All parts of this plan have data-driven goals, as seen in the logic model. While CMHPSM has goals specific to our work, they then guide the work of our providers, that we expect to in turn, create data driven goals on their own, based on more localized data and programming. For example, CMHPSM intends to have a health equity goal, which will guide the health equity goals we expect each provider to have. Each of their goals will in turn be specific to their agencies, locations and populations identified for focus. Below is a summary of the goals and objectives identified for this plan that can be quantified, monitored and evaluated. It is expected improvements will be seen over time, and will be reported to CMHPSM Leadership, the Regional Operations Committee, Oversight Policy Board and Regional Board.

PREVENTION

CMHPSM has for years funded substance use disorder prevention programs, initiatives, and coalitions across the four-county region with PA2 and Block Grant funds. Over the past several years, prevention programs have been added through STR/SOR, COVID Block Grant, ARPA and now SAMHSA PFS funds, expanding the reach of prevention across the region.

Substance use and misuse continues to be associated with individual, family, and community issues. CMHPSM understands the importance of targeting needs and strategies to promote healthy communities and individual well-being. Critical to success in substance abuse prevention is the implementation of EBIs targeted to multiple sectors within a community. Providers are required to note local, regional, or state data that has been identified, compiled, and used to support the consequence/primary problem for their selected community. Data drives the entire prevention effort and includes the identification of the primary problem, supportive data, associated intervening variables/risk and protective factors, evidence-based strategies, geographic area, population type and activity related short term outcomes.

MONITORING & EVALUATION

Prevention providers utilize an EBI Implementation & Evaluation Plan that includes the identification of consequences/supportive data and the associated underlying causes in a specific community; the selection and implementation of evidence-based interventions and prevention strategies based on the data; and the verification of results/outcomes. The plan provides information that demonstrates the relationship between the elements of the intervention and the expected outcome. In turn, the short-term outcome must specifically address the intervening variables/risk and protective factors which initially drove the selection of the evidence-based intervention.

Coalitions are required to develop and utilize a Coalition Strategic Plan for Community-Level Change based on the Community Anti-Drug Coalitions of America's Seven Strategies for Community Level Change: Provide information; Enhance Skills; Provide Support; Enhance Access/Reduce Barriers; Change Consequences; Change Physical Design; and Modify/Change Policies. A new regional collaborative has been funded to build capacity for coalitions around health disparities as they relate to tobacco, marijuana and vaping in each county in the region.

Funded programs are required to use SMART (CDC) criteria: specific, measurable, achievable, realistic, and time-phased and report on each outcome (mid-year & year-end). An evaluation method for each outcome is required. This provides both the funded agencies and CMHPSM the opportunity to quantify, monitor, and evaluate progress toward achieving targeted outcomes. Given the timing of this strategic plan, data driven objectives/outcomes are under development and not yet finalized.

TREATMENT AND RECOVERY

The CMHPSM will continue to review trends in treatment such as primary drug of choice, co-occurring services, timeliness data and other program specific outcome measures. While treatment strategies are individually client driven; availability of programming to manage the need will change as more innovative programming is developed to target the growing problems, such as heightened focus on alcohol use, specific populations such as adolescents, veterans, older adults and those with OUD, as well as awareness of programs through outreach to the community. The implementation of new and innovative services and efforts to bring the community together to partner on addressing social

determinants of health and their impact on substance use are expected to make an impact. CMHPSM is committed to continual monitoring and evaluation of the impact of our efforts using both internal and external data sources, such as county specific indicators through epidemiological means and in partnership with others. Again, this speaks to the importance of ROSC, as the voice and indicators from within the community are key to informing the multiple pathways of services.

CMHPSM PRIORITY AREAS

A reduction in health disparities among individuals from populations not accessing prevention, harm reduction, treatment and recovery services is specifically in the treatment/recovery logic model, and is a goal for all services including prevention, as well as internally to CMHPSM. CMHPSM recognizes the impact of health equity on the array of services and the unique challenges it creates in our communities. This is a vital time for substance use services as the associated concerns are varied and complex and include equitable access to services, individualized services, cultural humility and support throughout the process. Providers are being encouraged to consider the ongoing and immediate impact of health disparities associated with substance use in their respective communities. In this plan, providers will soon be required to demonstrate how their proposed efforts could be applied ensuring cultural humility and equity based on data to inform them on populations of focus. Prevention providers will be informed that potential adjusted methodologies will ultimately be addressed with the program developer and integrated into EBIs as needed, to ensure fidelity is maintained, while still having cultural humility. These efforts and outcomes will be taken into consideration for funding in future years. Training and technical assistance will be provided, as will guidance from CMHPSM in terms of our own internal review of policies and procedures, and expected goals and outcomes.

One of the gaps in our region is access to services, due to a lack of knowledge of the services, and also due to an inability to understand how to access them. Data from the community shows this to be the case for the general population as well as for specific populations that clearly are not accessing services at the expected levels, such as youth and communities of color. Once it is better understood what messages are needed and the wide array of service available to address community needs, awareness campaigns will be created across the region and implemented to help improve people's ability to access existing services through the existing system. It is also the goal to work within the system to make improvements and ensure standardized training and processes to facilitate access once people know how.

An expansion and enhancement within the ROSC array of services is essential to increase access to all services and promote life enhancing recovery and wellness for individuals and families. CMHPSM must expand treatment services to include ongoing support and multiple coordinated strategies to support treatment and recovery. CMHPSM will address barriers to accessing to services including not knowing what services are available, so more options than traditional FFS treatment are available such as harm reduction, SBIRT and SMART Recovery; to address specific populations and ensure their needs are met in traditional and creative ways, including youth, older adults, people not accessing services and priority populations. It is also essential to ensure people in need know how to access services and one additional way to improve this is to standardize the Access process to ensure individuals are screened and documented appropriate and in a standard manner. This will facilitate the ease of people calling, reaching an individual, and seamlessly getting through the system to the services they need. Finally, ensuring social determinants of health are addressed to support individuals throughout the process from access through recovery to ensure access to transportation, housing and other essential needs; and ensuring there

are enough providers and staff available to address the needs of the community through procurement and workforce capacity initiatives.

As this plan attempts to identify multiple pathways to recovery, connecting people to peers and other community partners, anti-stigma, and awareness campaigns of what services are available and how to access them, the 2023 CMHPSM Substance Use Survey shows the need for this work to occur. When asked which are the biggest barriers to getting treatment for substance use community respondents ranked stigma-related barriers in the following order: Fear of losing my job (49%), cost/lack of health insurance (49%), fear of going to jail/prison (42%), lack of treatment options (42%), lack of childcare (42%), judgment of others (35%) and fear of provider stigma (33%).

Finally, it is essential for existing funded providers to incorporate sustainability into their funded programs. CMHPSM will assist providers in sustainability by building sustainability into funding opportunities as well as reporting. It will be encouraged for providers to seek alternative and/or additional funding opportunities so they are not solely reliant on CMHPSM funding, as it has the potential to decrease. There are also more sustainable opportunities communities need to advocate for, including Opioid Settlement Funds and even possibly marijuana tax dollars.

MONITORING & EVALUATION
Treatment and Recovery providers are monitored and evaluated according to many methods detailed in other parts of this plan, including Electronic Health Record data as compiled in a Power BI dashboard to monitor increased access and utilization. Quarterly reports are required to ensure services are being provided as intended and will include, by the end of FY24, measurable outcomes related to health disparities. Provider monitoring will occur to ensure implementation of truly individualized, person-centered treatment planning. Potential changes in access to services will be tracked following changes in internal policies and procedures. Finally, community surveys and regional needs assessments will continue to be implemented to ensure services are meeting the needs of all individuals in the region, particularly those identified as being most in need.

REGION 6 2022 RECOVERY SELF ASSESSMENT (RSA) Consumer Data Report (Attachment)
This survey is completed annually by individuals receiving substance use services and is collected through substance use treatment providers and community mental health (CMH) providers. This data is also collected for staff and administrators of programs for comparison and analysis, and to help create county action plans, but for the purposes of this plan, we are focusing solely on the version completed by individuals served. Each county creates an action plan based on this data to help improve the recovery experience for individuals receiving substance use services in the region.

Region 6 CMHPSM 2023 SUBSTANCE USE COMMUNITY SURVEY (Attachment)
Each fiscal year, CMHPSM releases a substance use community survey. Despite being sent out assertively through listserv emails, and through social media ads, response rate was low. There are a number of potential reasons for low survey response rate, and CMHPSM will continue to find innovative ways to increase response. Attached is a summary of the findings. These responses apply to the array of services provided from prevention, harm reduction, treatment, recovery and this year included questions on health disparities.

Community participants:

1. Listed alcohol, marijuana, and vaping as the top three substance use problems
2. Expressed mixed response to their counties' current capacity or resources – (e.g., housing for both adults and youth to address them).
3. Question if the current access process works for all seeking services.
4. Reported not receiving sufficient services.

Provider participants:

1. Report alcohol and heroin as the most common issues in the region.
2. Vaping and marijuana as the top issues for youth.
3. Question whether their county has enough resources to address substance use, particularly the youth population. Comments suggest counties do not know how to address youth needs.
4. Report substance use services are difficult to access, often due to insurance, awareness, approval process, location, and income.
5. Report stigma is a considerable barrier to care, with not enough done to address it.
6. were aware of and comfortable administering Naloxone.
7. Value telehealth and are very supportive of MAT/MOUD; yet many respondents still do question the utility of MOUD & MAT treatment efficacy.
8. Demonstrate a considerable gap in knowledge regarding syringe access, with many questioning its effectiveness.
9. Repeatedly requested training (for all types).
10. Reported a predominant issue as staff capacity, with a strong request for training, public policy support and continuing credits

REGION 6 CMHPSM COMMUNITY FOCUS GROUP (Attachment)
This focus group was attended by individuals from across the region, and included OPB members, providers, people with lived experience, probation officers, and agencies representing communities with health disparities. Some of the main themes from this group were that access to providers is limited and not equitably distributed; there need to be community-based alternatives to use/treatment; there are limited treatment options for people with specific health concerns or certain age groups, specifically youth; recovery housing needs to be more inclusive and accepting of special populations; and there is a need for increased awareness of substance use services among community members and providers, including primary care providers. All these themes feed into the current strategic plan, specifically the treatment/recovery logic model.

3. A narrative illustrating goals, objectives, and strategies for coordinating services with public and private service delivery systems.

CMHPSM has a long history of public/private partnerships to enhance services for the region. The original Engagement Center (EC) in Washtenaw County in 2009 was supported by hospital systems; emergency medical services, community mental health, private foundations, and law enforcement. Coming together to address a need, regardless of public funding eligibility, to find a solution to problems individuals were experiencing in crisis. This scenario has now been repeated in the ultimate existence of all three ECs in the remaining counties of the region. This is especially relevant as the opioid epidemic left many individuals in need of a safe, welcoming place to assist with crisis and connection to necessary services. Each EC received support from sources other than the CMHPSM for acquisition of space, startup funding, materials, and other ongoing supports. Unfortunately, the ECs have

become reliant on sustained funding opportunities through CMHPSM. This is addressed later in this plan's sustainability goal.

Similar coordination of relationships occurred more recently with the start-up of Jail Based MAT/MOUD programs. While only two of the four counties in the region currently have active programs, all four counties continue to work across systems to develop and expand these programs. These systems include CMHPSM, local CMHs, sheriffs and jail administrators, substance use treatment providers, county jail health/medical providers, the University of Michigan clinicians, and pharmaceutical companies. Not only is it essential to provide educational services within the jail, but these cross systems teams have worked together with providers in the community to reduce stigma in the attempt to increase resources for individuals upon release. As discussed later in the plan, this is a significant time in a person's recovery.

Coordination of care between primary care physicians through FQHCs have occurred over the past several years, starting with the introduction of MAT/MOUD through State Targeted Response (STR) funds, and more recently through the initiation of Opioid Health Homes. Two of the five Opioid Health Home Partners in the region are with FQHCs, not otherwise contracted with CMHPSM to provide substance use services.

CMHPSM is increasingly involved in various prevention coalitions and collaboratives in each county within the region. They represent both public and private entities, including education, faith communities, youth-based services, housing, older adult services, community foundations, health systems, foster-care and adoption services, law enforcement, universities, hospitals, recovery communities and advocacy groups. Because these relationships have been built between public and private sectors, opportunities for addressing community issues are able to cross systems for solutions and strategies.

Prevention providers also implement primary prevention strategies that require them to implement and report on efforts that they conduct in partnership with private businesses in their community such as Communities Mobilizing for Change Against Alcohol, and necessitates a partnership between local coalitions and alcohol retailers; coalition partnerships with local pharmacies, law enforcement and churches to provide safe medication disposal and the Big Red Barrel. Overdose Education and Naloxone Distribution has also been a great example of collaboration between public and private sectors. Requests are received for training and naloxone kits from law enforcement, private businesses, libraries, schools, and multiple non-profit providers.

CMHPSM has received federal funding for the opioid epidemic and COVID pandemic presenting opportunities for public/private partnerships through SOR, COVID Block Grant, ARPA. Partners now provide prevention, treatment, harm reduction and recovery programs including EMU and St. Joseph Mercy Chelsea with prevention EBIs; U of M leading the training initiative on OEND; Michigan Medicine and Trinity Health Systems on Project ASSERT; Workit Health, a private national company offering virtual MOUD; Family Medical Center and Packard Health, both FQHCs and OHH Partners; Washtenaw and Monroe County Jails providing Jail Based MAT/MOUD; and Washtenaw Intermediate School District providing Youth Outreach.

CMHPSM will continue to participate in collaborative efforts to support building healthy, recovery friendly communities; identify and address comprehensive needs on collaborative coalitions to

champion public/private sector initiatives with a recovery focused perspectives in the recovery community; with professionals and other key community members (courts, healthcare, human services, mental health, prevention and treatment providers, veterans, education, housing, faith-based, etc.) charged with building recovery supports for persons served across the continuum. CMHPSM will use data to inform the process and determine community priorities and identify gaps; advocate for the voice of recovery to be incorporated across systems through enhancing programs using the expertise of people with lived experience; coordinate needs assessments, outcome evaluations and surveys with the public to address issues collaboratively; assess provider capabilities to implement recovery focused services and ensure that any needed modifications are identified, and strategies are developed; publish results of annual monitoring and provider status on CMHPSM website; participate in planning discussions within CMHPSM systems to promote integration of prevention, treatment and recovery focused services as service delivery changes are considered; and ensure the OPB has adequate representation in these discussions at the regional board level.

4. A summary of key decision-making processes and findings undertaken by the SUD Policy Oversight Board or other regional advisory or oversight board.

The Region 6 Oversight Policy Board (OPB) is an active body meeting throughout the year, made up of 16 members from our region including two representatives appointed by each county Board of Commissioners and two members appointed by each CMHPSM Regional Board with recommendations from each respective CMH Board. Each county has at least one member representing a person with lived experience. All representatives serve a three-year term. The OPB's mission is to support the CMHPSM Regional Board's ability to make an informed decision of maximum benefit by representing voices of the community, discussing trends and concerns; to make recommendations on comprehensive array of substance abuse services.

A new RFP is expected to be released in FY24 after new prioritization occurs, including our current health equity process. Much was taken into consideration over the past several years, resulting in the current continuation year funding. Significant changes in funding required this approach including State Opioid Response (SOR) funds; COVID Block Grant and ARPA funds; utilization of PA2 funds to address gaps in services and fund essential programs; and a decrease in SABG funds. OPB responds to funding recommendations with ultimate approval of PA2 funding by county for programs each year.

Requested programs and initiatives that fit into programming priorities identified in the current strategic plan for FY21-23. For this current strategic plan, the OPB completed a priority analysis of the regional substance use services and supports in our region, specifically addressing health disparities. The analysis helped identify priorities, gaps, barriers and strengths of substance use programs and providers in our region. Some main issues identified included:

- Address barriers to equal access
- Increase knowledge of access and available services, including to active substance users
- Build relationships with existing harm reduction services
- Consider careful and spending of PA2 to maintain a reserve for programs and special needs.
- Support workforce capacity for providers
- Identify limited services in certain geographic areas
- Increased funding for peers
- Support recovery housing for people with children and those on MOUD
- Support social determinants of health and care coordination

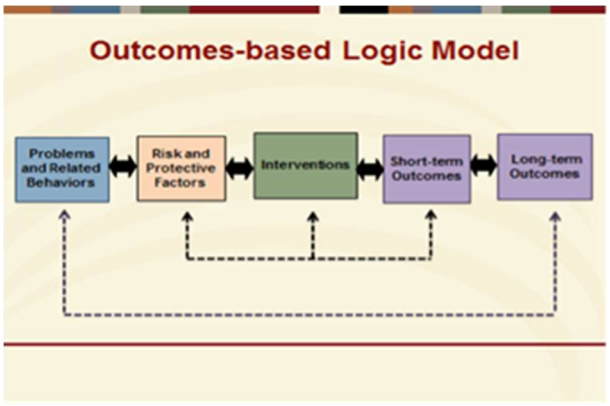
- Coordinate with the justice system to address and acknowledge systemic racial disparities and the impact on the substance use service in our region

The OPB is dedicated to sustaining initiatives in our region. Understanding the value of community collaboration and recognizing the importance of continuing previously grant funded projects, the OPB has provided guidance, sustainability and ensured that services are available to those in our communities. The CMHPSM OPB has been vital in the progress and completion of previous goals, and is dedicated to continuing the work needed in our communities.

5. **A narrative complete with a detailed logic model for selecting and implementing evidence-based programs, policies, and practices for implementing a recovery-oriented system of care that includes prevention, treatment, and recovery services as well as all other services in your array necessary to support recovery.**

For prevention, treatment, recovery and other services in the CMHPSM region, the selection and implementation of evidence-based programs, policies and practices for implementing a recovery-oriented system of care is driven by the identification of priority areas, consequences, and intervening variables. Logic models were developed and are attached to show detail.

REGION 6 CMHPSM FY24 – FY26 PREVENTION LOGIC MODEL (Attachment)
As stated previously in this plan, data drives prevention efforts and includes the identification of the primary problem(s), supportive data, associated intervening variables/risk and protective factors, evidence-based strategies, geographic area, population type and activity related short term outcomes. CMHPSM prevention providers were required to provide a logical sequence of information in planning for the next fiscal year. As shown in the graphic below, an Outcomes-based Logic Model depicts the connection between the problem, risk/protective factors, intervention/strategies, short-term outcomes and long-term outcomes (SAMHSA). Programs in each county provide examples of consequences and intervening variables by focus area. These include factors identified as strongly related to and influencing the occurrence and magnitude of substance use and associated consequences as seen in Attachment X. Depending on data to support the consequences and intervening variables in the provider's selected county and/or community.



SAMHSA

As demonstrated in the Prevention Logic Model (Attachment x), CMHPSM plans to address the following overall goals: (1) to reduce childhood and underage drinking, (2) to reduce prescription and over-the-counter drug abuse/misuse, including opioids, (3) to reduce youth access to tobacco and

nicotine, and (4) reduce illicit drug use. The development of a SPF Implementation Plan is designed to elicit a logical sequence of information that includes the identification of consequences/supportive data and the associated underlying causes in a specific community; the selection and implementation of evidence-based interventions and prevention strategies based on the data; and the verification of results/outcomes. The attached logic model includes selected consequential/problem data from provider proposals to demonstrate the outcome-based approach to prevention in our region.

As shown in the Prevention Logic Model attachment, providers target intervening variables such as perceived risk and peer pressure, norms that support use, easy access, attitudes and intentions toward use, community norms and accessibility; lack of knowledge of risks and consequences in each area, low perceived risk, negative peer influence, cultural history, lack of refusal skills, lack of coping and refusal skills, lack of knowledge of drug interactions, negative school attitude, low perceived risk of future and antisocial behavior. Other intervening variables include protective factors such as refusal/problem solving skills, coping skills, increased perception/knowledge of risks, screening and referral, education, development of refusal skills, problem solving and coping skills, and increased knowledge of substances. The Center for Substance Abuse Prevention (CSAP) strategies are identified for each EBI and SMART Outcomes are developed. Given the timing of this strategic plan, data driven outcomes are not yet finalized for the upcoming fiscal year. The long-term outcomes are ultimately the overall four priority areas listed above.

Programs identified in the attached logic model highlight the Block Grant and PA2 funded programs identified by the SPF process. Additional prevention programs funded by sources such as SOR, COVID Block Grant and ARPA had less time to go through the SPF process locally. Specific EBIs were designated by fund source as allowable. As the allocation process is expedited for these fund sources due to required timelines, when communities identified and requested funds, data is requested to support the need, and EBI Implementation plans are created with the same intervening variables, protective factors and goals identified. Funded prevention programs are all listed in the attached Region 6 CMHPSM Substance Use Services Program Guide. Tobacco planning and activities are included in the logic model with DYTUR as well as tobacco/ENDS programming.

REGION 6 CMHPSM FY24 – FY26 TREATMENT AND RECOVERY LOGIC MODEL (Attachment)
Data drives treatment efforts and includes the identification of the levels of care and interventions needed to ensure network adequacy to meet the needs of the region and the array of a ROSC with multiple pathways to recovery. As such, three priorities were identified: 1. Reduction in health disparities among high-risk populations receiving prevention, treatment and recovery services; 2. Expansion and enhancement of an array of services within the Recovery Oriented System of Care; 3. Increase sustainability of programming with diversified funding.

HEALTH DISPARITIES AND HEALTH EQUITY
The Treatment/Recovery Logic Model includes an overarching goal of health disparities and increasing health equity. This will be expected of the region as a whole, for all providers, including prevention programs. For this reason, it was not included in the Prevention Logic Model to limit duplication of efforts. It is the intent of CMHPSM to ensure training and support for our agency and providers in ongoing health disparity work with the ultimate goal of having measurable outcomes to impact health equity in the region. For ROSC, the array of services expected is really highlighted in two areas: 1) to provide multiple pathways to recovery, as a way to decrease the barriers to traditional FFS treatment and

acknowledge truly individualized ways people recovery; and 2) to ensure widespread knowledge for how to access all regional services available on the continuum, ensuring a focus on specific populations with gaps in access or equity in services.

ARRAY OF SERVICES

CMHPSM treatment providers are monitored closely to ensure appropriate oversight. The existing provider network meets the needs of the community overall in terms of numbers as there is not a waitlist and services are not denied due to lack of providers, as can be seen in the Treatment Services Utilization Attachment. The goals set by the region are for at least 50% of individuals to receive an admission to treatment services within 14 days of their request and that goal is met each quarter, with the first three quarters of this fiscal year averaging 72%. Unfortunately, since COVID, there has been a challenge with workforce capacity, causing intermittent gaps in services.

While the above stated goals are being met, there were still gaps identified, the first internally by staff. According to CMHPSM EHR reports, 72% of individuals served by Block Grant got into services within 14 days. According to Medicaid/HMP, the average time to treatment from 2018 – 2022 is 4.25 days. One goal identified in the logic model is to work with the Access departments to streamline training and processes to ensure all Access department staff receive the same training, conduct the same screenings in the same way, and know about all services available, even outside the traditional array of FFS providers, to allow for more access to the multiple pathways of recovery mentioned above. They will also work with the Priority Population Care Navigator to expedite admissions for priority populations.

Only 53% of respondents in the Region 6 CMHPSM 2023 Substance Use Services Community Survey said they knew how to access services if they needed them. In addition, while individuals who do know where to call are getting into treatment in a timely way, 46% of survey respondents stated they did not get what they needed from their treatment provider when services were received. As a result of this and known health disparities in access described below, the attached logic model shows plans for a region-wide education campaign to be developed and implemented to improve knowledge in the community of how to access existing services. The logic model also highlights a focus on multiple pathways to recovery, hopefully addressing the low response rate of those not getting what they needed from their provider. If a larger variety of treatment options are provided, the expectation is that more people will get what they need.

In this survey, 40% of respondents disagreed enough resources are available in the county to address youth specifically. This is a state-wide issue, and an ongoing topic at monthly Substance Use Directors meetings. While data show youth are clearly using substances, they and/or their parents are not requesting services from CMHPSM or other regions. This causes challenges for providers to sustain programs, when there are not enough referrals. As a result, in addition to the educational campaign being targeted to specific populations, such as youth, alternatives to traditional treatment or multiple pathways to recovery will be coordinated as a region and incorporated into our ROSC array of services. This will allow for youth and others to have more options than traditional FFS treatment when they may not meet medical necessity or may not be ready for more traditional treatment programs. A meeting is currently set between CMHPSM and Washtenaw CMH to begin discussions on how to address this issue creatively in Washtenaw County, utilizing multiple pathways for both new and existing programs.

In the Region 6 CMHPSM 2023 Substance Use Services Survey 58% stated peers and case managers were available for recovery supports when needed. Through required quarterly Block Grant provider reports, while the regional goal is 80%, virtually all providers report 100% of individuals being offered Recovery Support Services when needed. CMHPSM strongly supports peer services and funds them in many different ways to the extent possible with funds available. At the same time, 44% of individuals stating recovery housing was not available when needed, which is a recovery support service that clearly needs more attention, particularly in certain geographic areas.

SUSTAINABILITY

It is in the best interest of CMHPSM and the region to support providers in ensuring their programs are sustainable, beyond CMHPSM funding Supplemental funding, particularly grant funding is variable and often has parameters that differ between fund sources (for example, OUD/StUD specific). CMHPSM is not immune to the challenges of fluctuating funding, particularly as many of our grant fund sources have firm end dates including COVID Block Grant, ARPA, and SOR. Additional challenges exist with funding such as Block Grant and PA2 as funds must be allocated where eligible and as needed, with OPB historically prioritizing treatment services over additional programming. Without SOR, COVID BG, ARPA and PA2, Region 6 stands to lose nearly $11M. This would decimate the infrastructure of the services provided outside FFS treatment. It is essential for CMHPSM to support providers in accessing alternative fund sources such as Opioid Settlement Funds and possibly marijuana tax dollars in a coordinated manner by connecting community providers and programs with each other and municipalities and communities as much as possible.

In reviewing the Michigan Substance Use Vulnerability Index (www.michigan.gov/opioids), the region scores relatively well in comparison to other counties across the state. Overall, Region 6 is low in vulnerability, with each county lower than the state average. Lenawee and Monroe counties have substance use burdens comparable to the county average, with Livingston and Washtenaw counties burdens better than the county average. Lenawee and Livingston counties substance use resource scores are comparable to the county average, while Monroe and Washtenaw counties substance use resource scores are better than the county average. While the overall Substance Use Vulnerability score for Region 6 is encouraging, the positive score overshadows zip codes within our counties that have disproportionate health disparities as mentioned above.

6. **Provision of an allocation plan, derived from input of the OPB or other regional advisory or oversight board for funding a ROSC model that includes prevention, treatment and recovery, as well as all other services in your array, necessary to support recovery in identified communities of greatest need consistent with a data-driven, needs-based approach and evidence-based practices. The allocation plan for prevention, treatment, and recovery targeted services must include the following:**

CMHPSM released a Request for Proposals (RFP) in FY21 under the authorization of the OPB, for prevention services in our region that highlighted four priorities mentioned above and in the logic model, as well as other priorities for locally funded treatment and recovery services such as: collaboration with justice systems; services for youth; peer recovery services; recovery housing; integrated primary care models; addressing emerging substance trends; engagement centers; recovery community organizations; and harm reduction services. Providers were not limited to these areas and could propose providing other programming by providing epidemiological evidence of the issue in the specific region.

Under Block Grant, the funding set aside for Prevention Services mandates 20% of the Community Grant allocation. CMHPSM uses PA2 dollars to supplement prevention initiatives. All prevention service providers are required to utilize EBIs, with some flexibility built in, if it is documented and evaluated, and demonstrate implementation of the strategic prevention framework along with ensuring a ROSC focus.

SUD Treatment services in our region are recovery focused and include a range of recovery supports. Providers are required by contract to provide a full continuum of care that includes a ROSC model and recovery plan that addresses goals and objectives and is based on medical necessity. The intent is to maintain treatment funding levels subject to the availability of funds and based on population and need. Evidence based practices are utilized by the provider network in their treatment practices, and include, but are not limited to Motivational Interviewing, Cognitive Behavioral Therapy; Dialectal Behavioral Therapy; Contingency Management (hopefully in the future); and others. Recovery supports in the form of coaching; recovery housing and case management are also provided as part of the available services coordinated across the system. Telehealth services were introduced very effectively as part of the COVID-19 response, and now that the PHE has ended, will be used as allowable and appropriate to help facilitate access to services. Medication for Opioid Use Disorder is provided through primary care and specialty OTP providers.

CMHPSM regularly reviews the contracted network provider panel to ensure adequate capacity to meet the needs of the population served. This is done by having an open panel for fee for service providers and an RFP for special services. Based upon data, CMHPSM includes communication with providers and the community to determine specific needs. Where capacity is limited in a particular area of the region, CMHPSM will attempt to seek providers able to fill that gap or increase capacity with existing providers either through a contract or a single service agreement if needed. While there are no tribal entities in our region, services are open to any Native Americans/Indigenous people and should receive culturally competent services from our providers as all others are expected to. There is limited service availability for persons with hearing impairments and vision impairments, although, the service providers will make all attempts for accommodations in order to assist the client.

Older adults are another population to expand services as the population ages, and persons with SUD may need different approaches or clinical strategies. In many communities, the population is aging. The region's residents 65 years and older represent an average of 18% of the region's population, with the number expected to increase. Expansion of services for older adults has been identified as a need in our region. As this population ages, the need for unique approaches to SUD strategies will be paramount. Prevention services will also expand to include those caring for elders. This may include but is not limited to caregivers, family members and community professionals.

The Region 6 CMHPSM 2023 CMHPSM Substance Use Services Community Survey indicated that improvement is needed in areas listed above including ease of access to services; adolescent treatment and recovery services; expanded recovery housing opportunities; and prevention services in areas where they are limited. To address this, CMHPSM has included these as priorities in the current plan and when it is possible to release the next RFP, it will focus on these needs. Additionally, the OPB has maintained a spending strategy for PA2 funds that initially looks at the available revenue and savings by county, then issues the specialty services funding that is county specific. The OPB maintains a specific

reserve to ensure PA2 funds are available to cover potential gaps in Block Grant funded services and supports Medicaid treatment services where funding is limited, which is expected to potentially increase significantly in the upcoming years.

CMHPSM Trauma-Informed Practice Policy requires all providers to maintain a safe, calm and secure environment with supportive care, a system-wide understanding of trauma prevalence and impact, recovery and trauma specific services and recovery-focused, consumer driven services by policy. Trauma informed services are required to be evidenced based. The use of Adverse Childhood Experiences (ACES) has increased over the years and many have incorporated this as part of their assessment processes. Use of this assessment process has assisted the provider in determining treatment approaches for their clients to better meet their needs.

Providers are also contractually obligated to provide services to the priority populations within the required timeframes, while managing any potential priority population waitlists, as well as submitting their reports to the CMHPSM treatment coordinator on a monthly basis for state submission. Priority Populations include pregnant injection drug users (IDUs), pregnant substance users, IDUs, individuals at risk of losing custody of their children, and newly added in 2020, individuals referred by MDOC. Contracts also require adherence to the Access Policy which specifies the urgency of admission for priority populations. A specific Priority Population Care Navigator position was funded by MDHHS to support priority populations in getting into services according to state guidelines. Following two years of monitoring, it became clear the Access screening system was not the issue. Instead, the challenge is ensuring once a referral to a substance use treatment provider is received, that admissions to the provider occur on time. Reports are built into the CMHPSM EHR which providers are expected to run regularly to see referrals. The Priority Population Navigators will keep a detailed list of individuals immediately upon screening and will track as they are referred to a provider. This active list will be maintained until the individual is admitted into services.

7. **A 3 year implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery**

Please see **CMHPSM FY24-FY26 IMPEMENTATION PLAN AND TIMELINE** (Attachment)

8. **An evaluation plan that identifies baseline, process and outcome data for implementing a ROSC that includes prevention, treatment, and recovery services as well as all other services necessary to support recovery.**

This plan will be evaluated regularly by the CMHPSM Substance Use Services Team, Regional Operations Committee and OPB using the Implementation Plan and Timeline attachment. The overarching priorities and measurable goals will be included directly as part of the overall CMHPSM Strategic Plan, to be evaluated by the CEO, Leadership Team and Regional Board. This plan is was developed intentionally to improve services, fill gaps and build on strengths in the CMHPSM Substance Use Services program array and will be followed as intended and revised as needed with time. Evaluation processes are built in throughout the plan to ensure the priorities are addressed.

PREVENTION SERVICES – Evaluation Process and Procedures:
To promote the success of ROSC and continue to make improvements in implementing this model, CMHSPM recognizes the importance of evaluating the progress on various substance abuse prevention, treatment, and other health indicators in the region. Thus, specific outcome data will be utilized and

monitored in service areas necessary to support recovery, and adjustments made where necessary, to enhance the opportunity for success.

Evidence-based Implementation and Evaluation Plans are used by providers to identify the major components of each program, track progress on implementation, and report to the CMHPSM on program outcomes. EBI Prevention Program Assessment and Fidelity Forms are used to report fidelity measures and any deviations related to the model program. Providers are required to identify and utilize program evaluation methods to measure their respective SMART outcomes. CMHSPM staff will monitor and review the progress toward achieving program outcomes and provide consultation to agencies as needed, and through formal mid-year and year-end reporting.

Pre and post tests are administered to evaluate specific local programs as appropriate and are utilized to provide continuous program improvement. Coalitions also are required to assess their work ongoing. This is measured through reports to CMHPSM for the funded coalition work implemented including MCSAC, LCCA and MI PAC coalitions. As trends change and feedback is received, programs are expected to be responsive because they are data driven, through the SPF process.

PREVENTING YOUTH ACCESS TO TOBACCO – Evaluation Process and Procedures:
CMHPSM will continue to use a comprehensive approach to ultimately decrease youth access to tobacco and nicotine products. Vendor Education and Non-Synar Compliance Checks will target stores that sold tobacco during the prior year's compliance checks, new retailers from the updated Master Retailer List, and stores that did not receive a visit within the previous year.

DYTURs consult the FDA website to review the list of retailers within our region that have failed their FDA compliance check and provide them with an education visit and/or Non-Synar Compliance Check. Focused attention will be put on retailers that sell both tobacco products and ENDs. Targeted vendor education to at least 50% of the retailers within each county of the region has helped reduce our Regional Retailer Violation Rate (RVR) over the last five years; in fact, our regional RVR has remained below 17% between FY 2020 through FY 2022. In FY 2020, the RVR was 6.60%, in FY 2021, the RVR was 13.3%, and in FY2022 the RVR was 16.30%. We plan to maintain our region's 80% compliance rate. The DYTUR project is part of a larger effort to determine the sales rates of tobacco, vaping and alternative nicotine products to individuals under the age of 21 as part of Michigan's compliance with the Synar amendment and observance of the federal Tobacco 21 law. Through Vendor Education, DYTURs will continue to be empower retailers to know and understand their right to deny sales if they determine tobacco will be given to a minor or calling in attempted sales to law enforcement.

DYTURs will continue to be involved with community coalitions, such as the Lenawee Substance Abuse Prevention Coalition, the Monroe Substance Abuse Prevention Coalition, the Livingston County Community Alliance, and the newly formed Washtenaw County Coalition, to educate potential partners about the negative consequences of tobacco and ENDs use, as well as engaging youth and community partners in compliance efforts. Classroom and community education will also continue to serve in increasing awareness about tobacco and ENDs. Our goal is to reduce youth access to tobacco using the multi-level strategies identified above which include education, compliance checks, and enforcement of the Michigan Youth Tobacco Act.

The newest goal for the small amount of additional tobacco funds outside these funds includes advocating for policy changes within schools across the region around ENDS. This project requires quarterly reports to show evaluation of programming.

TREATMENT AND RECOVERY SERVICES – Evaluation Process and Procedures:
The experience with ongoing implementation of ROSC principles has led to sustained engagement, involvement of persons in recovery at all levels, and redistribution of funding that sustain services across the year. Consumer and community feedback surveys are implemented every year to verify their experience of the services provided. Additionally, review of specific utilization data; state data indicators and evaluation elements inform the process for modification and change when necessary.

As seen in the Region 6 CMHPSM Service Volume Analysis, while there is a small spike in 2022 this could be the result of change in Access providers or COVID. The demand for more residential and withdrawal management beds within Washtenaw County is actually more stable. However, this remains a priority for Livingston and Lenawee counties where these services are either very limited or not available, requiring out of county services. The ability to provide recovery housing for individuals in early recovery enables individuals without stable housing to benefit from treatment while they seek employment or obtain benefits to cover the cost of their housing. This is especially critical for new moms or those with small children to be able to live in a supported environment while in early recovery and unable to return to work. For the first three quarters of FY23, CMHPSM was able to provide recovery housing for 13,421 bed nights for 275 unique individuals supported through Block Grant, SOR, COVID BG and ARPA, including quarantine housing for those with COVID until they could enter a recovery residence. However, Block Grant funds limits this to sixty days. Measuring the impact of programs such as this is important.

The opioid epidemic created the need to expand services to non-traditional settings, such as primary care and virtual. New ways to reach individuals who are isolated in “service deserts” where there is limited transportation and other resources has been paramount in the last few years. COVID-19 highlighted the need to be responsive with the use of telehealth services. As the PHE has ended, more limited use of telehealth will need to be evaluated. Integrating treatment into non-traditional settings, such as primary care, corrections, ERs and housing sites have made it necessary to review system implementation overall and ensure the original goals and objectives for transformation are current and relevant.

To determine if the system still meets the needs of those we serve, we must have ongoing evaluation processes in place to ensure we are maximizing efficiencies, clinical impact and equity as the priority for modernization and adjustment of practices. An example of this is the review of specific outcome measures as part of provider contracts. This provides clarification of expectations leading to achieving further integration and meeting performance standards necessary for funding requirements. One significant change made based on evaluation over the past several years, was to return two Core Providers (Home of New Vision and Dawn Farm) to traditional FFS providers, and remove the Access function from their roles. As this is in the first ,year of implementation, evaluation is imminent. On time quarterly reporting is required, performance indicators and Power BI metrics are reviewed at quarterly provider meetings, and throughout the year by the treatment team.

For Administration and use of Public Funds evaluation, funds spent on services are monitored on a monthly basis by comparing general ledger and financial status report data with the service level data submitted through CRCT. Service level data is reported by CPT code and by funding source. It can be detailed by provider level and also summarized across the PIHP. CPT codes are cross-walked to level of care and includes any modifiers being reported, including integrated health services and recovery supports. This level of detail allows the CMHPSM to keep apprised of any significant changes in service level and to monitor individual providers operating within the system to ensure the full array of services are being provided and follow any trends.

For Health and Safety, CMHPSM measures Sentinel Events (SE) across the region, and is in the process of creating an SUD specific SE policy, as the current one is combined with Mental Health Incident Reporting and is very confusing to providers. There is a new system where SUD treatment providers have a CMHPSM specific template they are to submit within 24 hours of a suspected SE. Designated SUD treatment team staff enter this into the regional PCE system within 24 hours, which feeds directly into the CRM. It was also determined notification of an SE is to be emailed to MDHHS, at least in the interim as the new CRM process is finalized. SEs are tracked and providers are expected to do their own root cause analysis for the event. If trends occur with a provider, CMHPSM staff will intervene.

CMHPSM now utilizes a quarterly dashboard of indicators to measure specific outcomes on a regular basis and has incorporated performance levels to ensure compliance and accountability. This report indicates the evaluation mechanisms to be utilized to track performance in specific domains including requests by provider, how frequently providers run referral reports, priority requests meeting admission time requirements, admission time within 14 days of request, services within 14 days of detox discharge, open cases receiving services in the quarter, discharges with improved Stage of Change, discharges with reduced use, and new to the dashboard is SUD health disparity data highlighting populations of focus mentioned in this plan, including youth, those identifying as African American/Black and Latino/a/x.

WOMEN'S SPECIALITY SERVICES – Evaluation Process and Procedures:
Evaluation plans must include number/type of services currently available in the region, including strengths and deficits; a plan that illustrates and measures the effect of strategies used to address identified women's issues and expand services; EBIs implemented; and the integration of trauma responsive services, including Enhanced Women's Services.

The CMHPSM ensures service availability to the Women Specialty Services (WSS) eligible population in all four counties within our region. Eligible women are defined as, "those who are either pregnant or parenting, or those involved with the child welfare system that are at risk of losing or attempting to regain custody of their children." These populations have also been identified as a federal or state priority for admission to treatment. Other eligible primary caregivers also have access to ancillary services. There are four in-region WSS providers and another two out of region WSS providers contracted with CMHPSM. These six providers seem to meet the need of the region in their ability to provide ongoing access to integrated trauma-responsive services across the continuum of care.

WSS is available for eligible individuals raising their own minor children. WSS funding is restricted to assuring access for pregnant, post-partum individuals with a substance use disorder, as well as other primary caregivers raising their children and who are in treatment. Services assist with provision of transportation, childcare, and medical care for those who are eligible and their children. Michigan law extends priority population status to individuals with children in their custody who have been removed

from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, individuals shown to be the primary caregivers for their children are also eligible to access ancillary services such as childcare, transportation, case management, therapeutic, interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

The Regional Women's Specialty Treatment Services Policy, closely aligned with the related MDHHS policies and treatment technical advisories, guides services for all providers in the region. Support for WSS includes the ongoing expansion of peer supports working alongside case managers adding more support to women in early recovery. Access to women's specific recovery housing and MOUD friendly and specific recovery housing has added more benefit to women struggling with OUD.

Enhanced Women's Services to individuals with OUD are provided by Home of New Vision in Washtenaw County and Catholic Charities of Southeast Michigan in Monroe County. The regional policy details services and refers to MDHHS Enhanced Women's Services Treatment Technical Advisory #08 which requires enhanced services to include integration of trauma services. Pregnant women with opioid use disorder are typically seen through the local high risk OBGYN clinics and referred to the ORT programs for the term of the pregnancy. They are followed by the Women and Families case manager for any additional service needs and provided enhanced services. Providers coordinate with OB/GYN physicians, who may receive consultation from an addictionologist as needed.

Providers are monitored to ensure staff are trained to provide services addressing such issues, and over the past year, outreach efforts have increased and are expected to continue to ensure individuals are aware of such services. Training for providers and Access staff will also be conducted to ensure all staff are aware of eligible individuals and the benefits of these services.

In FY22, WSS programs reported serving 183 individuals with dependent children, 48 individuals trying to regain custody of their children, 19 pregnant individuals, and 329 children. The evidence-based interventions implemented included gender specific (women's) groups: Home of New Vision groups with CBT, mindfulness, stages of change and trauma informed care; Key Development's trauma informed gender specific (women's) groups called Trauma Recovery Empowerment Model for Women and Women's Thinking Matters; MVA started gender specific (women's groups) called Seeking Safety, and STEP Parenting Curriculum and is attempting to start additional trauma groups. MVA did acknowledge in this report challenges due to very poor attendance and is working on strategies to improve program delivery.

These services could be utilized more frequently as they are often underspent and see a low number of consumers, when it is likely more could benefit. One strength is our provider's commitment to this service and the special needs of the individuals accessing it. One overarching deficit is the name of the program, and the willingness to access it by any consumer who is the primary caregiver in services. The above mentioned awareness campaign of existing services would ensure WSS is made widely known as it can greatly support certain priority populations. CMHPSM is also hopeful the Priority Population Care Navigator will facilitate connections to WSS programs, as pregnant individuals and those at risk of losing custody of their children are priority populations and eligible for WSS services.

Women Specialty Services will be sustained by utilizing cross-systems collaboration and the involvement of informal supports to promote a person's recovery; utilizing a client-centered, goal-

oriented approach to accessing and coordinating services across multiple systems; establishing linkages to enhance a person's access to services to meet those identified needs; and coordinating and monitoring service provision through active cross-system communication and coordinated treatment/service plans

Gender specific services are not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered. The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment. Treatment and services should build on women's strengths and competencies, and promote independence and self-reliance. A model that emphasizes the importance of relationships in a woman's life and attempts to address the strengths as well as the problems arising for women from a relational orientation.

CMHSPM monitors each of the WSS programs expenditures and reviews its WSS programs during site visits. A new statewide reciprocity monitoring tool is being develop to begin utilizing in FY24 that will support this process in ensuring providers are meeting the required standards including reviewing WSS policy and procedures, progress notes and treatment plans. Two CMHPSM staff attend statewide trainings, meetings and workshops, as required.

- WSS Providers- There is one in each county, and two out of region providers:
  - Home of New Vision (Washtenaw), Catholic Charities of Southeast Michigan (Monroe), Key Development Center (Livingston), McCullough Vargas (Lenawee), Sacred Heart (Wayne), Personalized Nursing Light House (Wayne)

PERSONS WITH OPIOID USE DISORDERS – Evaluation Process and Procedures:
Evaluation plans must include: Number and type of services currently available to the individuals in the region, reflecting current knowledge and research related to opioid use disorder and the service type based on current standards identified for treatment of opioid use disorder. Provide a plan that illustrates and measures the effect of the research-based strategies and evidence-based services used to address the needs of individuals with opioid use disorder.

Key services available include OTP FFS treatment detailed in the Treatment section above. Services for individuals with OUD have expanded since STR and SOR funds have been utilized over the past several years, are addressed through existing programs.

OPIOID HEALTH HOMES (OHH) are Medicaid/HMP funded programs that focus on care coordination, specifically for individuals with Opioid Use Disorders. While not treatment specific, OHH services were designed to help beneficiaries connect to medically necessary services and to address the complexity of comorbid physical and behavioral health conditions. Participation in OHH is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care. Michigan's OHH model is comprised of a team of providers, including a Lead Entity (LE) and designated Health Home Partners (HHPs). As guided by the MDHHS OHH Handbook, CMHPSM as

LE for Region 6, ensures all HHPs follow the six core health home services of the program: comprehensive case management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

CMHPSM began to implement OHH in FY21 utilizing SOR II funding. The one-year SOR funding was utilized to identify health home partners, work with existing PIHPs and OHHs to develop policies and procedures, provide necessary training, and prepare for OHH to begin in FY22. In FY22 CMHPSM began offering OHH services, starting with one HHP and expanding to four by the end of FY22. In FY23, a fifth HHP was added, increasing the availability of this service across the region. At the start of OHH's implementation in Region 6, there were only three beneficiaries enrolled in OHH. As of June 2023, there were 337 individuals enrolled across the five health home partners mentioned. This is CMHPSM's highest number of enrollments to-date. A total of 403 individuals have enrolled since the start of the program. Each HHP receives one payment for at one service per month, as long as at least one service occurred. During FY22, all HHPs in Region 6 met their Pay-for-Performance goals, earning them a monetary bonus.

Peers are an integral part of OHH and are often the individuals who work one-on-one with beneficiaries within our HHPs. The use of peers to engage and support individuals with OUD and connect them with needed supports documented in a care plan shaped by a social determinants of health screening tool, helps identify and connect individuals to services, including MOUD, to facilitate and maintain their recovery. Upon the program's rollout, there was a statewide advertising campaign for OHH in Region 6. This campaign alone made over twenty-five million impressions through gas pump toppers, social media, and a mobile campaign. However, as this is still a new program, CMHPSM continues to work with providers across the region including Access Departments, Harm Reduction programs, jails, and others, to ensure awareness of OHH is widespread, especially since the statewide campaign was limited to nine and a half months. As part of this strategic plan, peers at HHPs are one way to help facilitate the barriers found in jail-based MAT discharge planning and transitions to MOUD upon release, particularly when releases are unexpected and overall, as a vital resource; as well as increasing OHH as a referral option for individuals seeking services.

OHH is a fairly new program and will be evaluated starting the end of FY23. A Power PI Dashboard has been created that shows enrollment and disenrollment rates, average encounters per person per month, and demographics to analyze disparities. Additional metrics can be added to this evaluation method as identified. These are reviewed internally, and are discussed at state and regional meetings. Quarterly reports will begin to be required by providers starting in FY24 to review outcomes including health disparities.

JAIL-BASED MAT/MOUD programs are located in Monroe and Washtenaw County Jails in collaboration with local CMHs and OTPs. The goal is to continue or initiate MAT/MOUD in jail, and increase discharge planning to connect to community providers upon release, ultimately to ensure continuity of care, and decrease the chances of overdose during a very risky time for these individuals. Care coordination, motivational interviewing, CBT, and DBT are just a few of the EBIs utilized. This plan seeks to increase coordination with peers, particularly through OHH, when appropriate, so individuals are connected to a person with lived experience to help navigate services. For the first three quarters of FY23, Monroe County served 217 individuals, and Washtenaw County served 72 individuals through these programs. This is currently also being developed in Livingston and Lenawee counties. There is a current

gap in services in Lenawee County. While there are enough treatment providers, they either have workforce capacity issues or stigma issues that prevent them from providing MOUD to individuals. This is particularly true for clinicians affiliated with the large local health system in this county and is actively being addressed through multiple avenues in the community with the support of Lenawee CMHA and CMHPSM. Work is currently being done and will be expanded through this plan, to ensure connection of peers, particularly through OHH, to individuals in jail and during discharge.

The introduction of OHH has resulted in the elevation of the role of peers to support individuals with OUD. This has been accepted by Medicaid as a billable service, supporting the effectiveness of the model and current standard identified to support treatment for OUD. This plan will increase efforts for HHPs to work with incarcerated individuals when possible, and be a better known resource as a pathway to recovery outside of FFS treatment. The addition of BG funds available allows for increased coordination with jails and for those needing to reenroll in Medicaid from the PHE end as well, to have services available and support in reenrollment.

Peers working with individuals with OUD is extensive in the region. Project ASSERT places peers in hospital emergency departments with two hospitals in Washtenaw County and one in Monroe County, report for the first three quarters of FY23 the two hospitals in Washtenaw County served 205 individuals and Monroe County served 58 individuals.

Other programs specific to OUD that utilize peers include Engagement Centers, where individuals actively using can get connected to services, have a safe space when not connected to treatment services, and receive recovery support. Recovery Housing is available for individuals with OUD at all residences including two houses specifically housing individuals on MOUD. Finally, RCOs also work closely with individuals with OUD to support them in the recovery process and are funded by SOR as well. The final SOR funded program is Workit Health, which provides MOUD treatment utilizing virtual programming to ensure the most accessible treatment possible, particularly for those in rural areas and with transportation challenges.

Prevention EBIs are also utilized in Region 6 to address individuals with OUD. These include the SOR funded Prevention EBIs detailed above that address OUD such as Celebrating Families (in a recovery residence), Prime for Life, and Botvins, as well as the other prevention programs that address prescription drug use, general substance use/misuse such as Project SUCCESS.

Finally, clearly Overdose Prevention and Naloxone Distribution (OEND) provides extensive training and mass distribution of naloxone, rescue kits and vending machines across the region To date, (since October 2022), CMHPSM has distributed 2,405 naloxone/naloxone rescue kits so far this fiscal year. This leads into the Harm Reduction programs detailed above working with active injection drug users to help reduce harm, increase health and link to services including treatment when people are ready.

SOR funded programs are evaluated through monthly, quarterly and year end reports submitted to and evaluated by the State and Wayne State University. OUD Treatment, Outpatient Peer Support, Recovery Housing, Jail Based MOUD and other ongoing programs are evaluated by GPRA assessments at intake, 6-month follow-up, and discharge. SOR funded prevention programs are also evaluated by pre- and post-tests completed by program participants.

- OHH – Packard Health (Washtenaw); Passion of Mind (Monroe); Therapeutics (Monroe, Washtenaw, Livingston); Family Medical Center (Lenawee, Monroe)
- MAT/MOUD Treatment- Workit Health (Regional)
- Jail Based MAT/MOUD- Lenawee CMHA, Monroe CMHA, Therapeutics
- Coalitions: Washtenaw Health Initiative Opioid Task Force; Monroe County Opioid Task Force, and other substance use coalitions across the region

9. Evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent and equitable manner.

Health disparities have been discussed and demonstrated in data throughout this plan. It is the intent of CMHPSM to continue our current work toward increasing health equity throughout our region. The CMHPSM Culturally and Linguistically Relevant Services Policy requires all providers to address the treatment and needs of individuals served and their families, with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, abilities, and language. Services and staff are to ensure ongoing work toward cultural competence, now known as more of a process to address cultural humility. The policy also states providers must ensure cultural and language are addressed respectfully and assessed initially and annually, and ensure plans of service are personalized and address cultural issues and any language needs This policy requires training all provider staff during orientation and is monitored by CMHPSM annually.

During FY23, a Health Equity Team was created including the CMHPSM Substance Use Services (SUS) Director, SUS staff, CEO and Regional Coordinator. Along with the Regional Operations Committee and the OPB, this team will review and revise policies, programs and practices to ensure equity and cultural humility as is included in the treatment/recovery logic model for the entire ROSC system of care. The evaluation process is detailed in Attachment X Implementation Plan and Timeline. CMHPSM SUS policies and processes will be reviewed by the Health Equity Team with input obtained from specific groups (e.g., Regional Community Advisory Committee, funded providers representing specific populations). The initial team, SUS Team, then the Regional Operations Committee (ROC), will communicate and achieve buy in from their local respective areas through the region. ROC will make recommendations for policy updates to OPB for approval. Policy updates will be clearly communicated to all contracted providers and will be posted on the CMHPSM website.

It is important to acknowledge changes in language throughout resource materials and other documents, which continue to evolve as needed. For example, “cultural competence” is referred in this plan as “cultural humility,” acknowledging we must approach cultures with humility, and embrace an ongoing process of learning and behavior change in the context of power, privilege and society. (Tervalon and Murray-Garcia; Journal of Health Care for the Poor and Underserved; 1998). As mentioned in the MDHHS *Transforming Culture and Linguistic Theory into Action: A Toolkit for Communities, 2016,* the place to start working toward cultural humility is self-awareness. This is true as well as the CMHPSM SUS Team looks internally first, to ensure our processes and procedures are in place, so that policies, programs and practices are conducted with cultural humility and in an equitable manner. We must also create a goal for our region to allow our providers to follow this path toward ensuring increased health equity through creating measurable outcomes aligned with the regional goal.

Through the development of this plan, the CMHPSM SUS Team and identified key Leadership staff through the “Health Disparities to Health Equity” initiative have spent the past year learning about the concepts of Diversity, Equity, Inclusion and Belonging; foundations of Health Disparities and Health

Equity; specifics about different cultures; how to use data to better understand who in our region is impacted the most, and finally, how to use that information throughout the FY24-26 strategic plan.

Also used as a reference, from the *MDHHS Office of Equity and Minority Health "Addressing Health Disparities in Diverse Communities: A Systematic Review of the Literature" (Michigan.gov)*, data will be heavily used, input from communities will be gathered as true partners, and social determinants of health will be considered and incorporated throughout our work. All of this will be explained to and shared with providers, to ensure organizations funded by CMHPSM are practicing inclusion and cultural humility and are actively implementing changes at the programmatic level to address health equity. This will be done through ongoing training of the workforce and requiring measurable outcomes.

Power BI allows the region to closely see what percentage of individuals are calling with requests for service, and how many of those requests turn into admissions to treatment. A dashboard was created for SUD treatment services and will start to be reviewed during FY24. The CMHPSM Data Analyst has determined African Americans and Latino/a/x individuals are not making it to SUD treatment system with enough numbers to even evaluate data to show disparities within the system in terms of outcomes. This will be reported on starting FY24. To help address the example of the health disparity data above, CMHPSM is funding specific providers to help ensure internal understanding and appropriateness of access to and provision of services; and community understanding of the services available.

Aligned with the *MDHHS 2022-2024 Social Determinants of Health Strategy: Michigan's Roadmap to Equity*, CMHPSM is committed to "Addressing the social determinants of health through a collaborative, upstream approach to remove barriers to social and economic opportunity, improve health outcomes, and advance equity." While CMHPSM will work with providers, we will also work internally to ensure our policies follow the *Health in All Policies* approach in this document, working toward policing addressing SDOH with the ultimate goal of closing gaps in health and equity. As mentioned above, to guide our providers in the equity process, we must look internally to lead the initiative across the region.

Through the development of this plan, including training, focus groups, surveys, workshops and many discussions, the CMHPSM SUS Team continue to learn where the needs are; who is in need; what may be most helpful to those specific populations. Throughout this plan are examples of ways CMHPSM is addressing this issue, with one example being the expansion of prevention EBIs to work with the developer and community to ensure EBIs can be utilized in creative ways that are shown to work with diverse and specific communities. It is expected that CMHPSM will provide overarching guidance and providers will address these issues through very individualized services whether that be in SUD treatment programs, prevention, harm reduction or recovery, at all stages of the ROSC continuum.

Region 6 CMHPSM FY24 – FY 26 Treatment and Recovery Logic Model

Priority:	Objectives	Strategies:	Inputs	Partners	Outputs	Short-Term Outcome	Intermediate Outcomes	Long Term Outcomes
1. Reduction in health disparities among high-risk populations receiving prevention, treatment and recovery services.	Understand and address health disparities in access to and provision of services.	1a. Provide information; Modify/Change/develop policies	CMHPSM analyzes regional data related to health disparities.	CMHPSM staff; Regional Board, ROC, Leadership, OPB	Published report of regional data; documented CMHPSM Goals; Number of Identified processes/procedures recommended to OPB for revision	CMHPSM will publish a regional data report relating to health disparities by Quarter 3 of FY24.	CMHPSM will have documented health disparity focused goals, driven by data in place by Quarter 4 of FY24.	CMHPSM conducts internal review of processes/procedures to address health disparities in access and provision of services and identifies changes to recommend to OPB and revises 80% of identified process/procedures by Q1 of FY25.
		1b. Enhance Skills	CMHPSM creates process to monitor and track funded providers health disparity focused goals.	CMHPSM staff; funded providers	Monitoring process; number of training opportunities; evaluation process for provider goals	CMHPSM provides technical assistance, training opportunities, and goal setting requirements to providers to address health disparities by Q4 of FY24.	Providers develop internal goals related to regional goal(s) with technical assistance provided by CMHPSM staff by Q1 of FY25.	80% of contracted providers have at least one measurable health disparity goal by Q1 of FY25

Region 6 CMHPSM FY24 – FY 26 Treatment and Recovery Logic Model

Priority:	Objectives	Strategies:	Inputs	Partners	Outputs	Short-Term Outcome	Intermediate Outcomes	Long Term Outcomes
2. Expansion and enhancement of an array of services within the Recovery Oriented System of Care	Increase in access to recovery services, promote life enhancing recovery and wellness for individuals and families	2a. Provide Information; Provide Support	CMHPSM will identify and compile updated list of all available regional SUD services.	CMHPSM staff, OPB, Media/Marketing Agency, community partners, providers	Updated list of all available services; Developed educational campaign materials	With community partners/providers CMHPSM will identify barriers to those seeking services (stigma, lack of community awareness) including multiple pathways to recovery and identified special populations (youth, veterans, people with OUD, older adults, criminal justice involved, pregnant individuals, and individuals with COD).	Development of regional educational campaign(s) relating to available services that addresses stigma and community awareness by Q3 of FY25.	By FY26, there will be an increase in community awareness and individuals accessing Substance Use Services as reported in Region 6 Community Survey.

Region 6 CMHPSM FY24 – FY 26 Treatment and Recovery Logic Model

Priority:	Objectives	Strategies:	Inputs	Partners	Outputs	Short-Term Outcome	Intermediate Outcomes	Long Term Outcomes
2. Expansion and enhancement of an array of services within the Recovery Oriented System of Care	Increase in access to recovery services, promote life enhancing recovery and wellness for individuals and families	2b. Enhancing Access/Reducing Barriers; Provide Support	CMHPSM will work with community partners/ providers to identify SDOH (econ. stability, education, health care access and quality, neighborhoods, social and community context) affecting access to services.	CMHPSM staff, OPB, community partners, providers	# of identified SDOH affecting access to services; number of identified community partners	With partners/ providers, CMHPSM will identify partnerships and resources available to address SDOH (childcare, transportation, legal assistance, housing) to increase ease, ability and opportunity to utilize services by Q1 of FY25.	Development of regional resource list of available supports.	By Q2 of FY25, CMHPSM will have a process using a network of supports with community partners to increase access services.

Region 6 CMHPSM FY24 – FY 26 Treatment and Recovery Logic Model

2. Expansion and enhancement of an array of services within the Recovery Oriented System of Care	Increase in access to recovery services, promote life enhancing recovery and wellness for individuals and families	2c. Modify/change/develop policies and Enhancing Skills	CMHPSM will create regional, standardized training and processes for Access staff.	CMHPSM staff, CMHSPs, OPB, Regional Board, providers	Standardized training metrics; standardized regional process	By Q4 of FY24, CMHPSM will create a process to identify and evaluate internal barriers to Access System; and create regional Access staff training and processes.	By Q1 of FY25 CMHPSM will create regional standardized Access staff training and processes.	By Q1 of FY25 90% of Access staff will participate in standardized training
	Expand treatment services to include ongoing support and multiple coordinated strategies to support recovery.	2d. Provide Information	CMHPSM will facilitate a process for ongoing review of regional needs to identify service gaps and opportunities for program/service implementation and expansion.	CMHPSM staff, OPB, Regional Board, Providers, Community Partners	Formalized process for ongoing review of regional needs; process for publishing of regional needs for discussion at regional meetings (Regional Board, ROC, CMHPSM Leadership, OPB, Etc.)	By Q2 of FY24, CMHPSM will review needs to incorporate local data for behavioral health and primary care for persons at-risk for and with COD; harm reduction for persons living with OUD; criminal justice involved; trauma responsive; and special populations (e.g., youth, substance exposed infants, older adults, veterans)	By Q2 of FY24 CMHPSM will share review findings and local data at regional meetings for ongoing feedback and discussion.	1-2 provider opportunities will be identified from to fill gaps in services with existing financial resources through active procurement process by Q3 FY24.

Region 6 CMHPSM FY24 – FY 26 Treatment and Recovery Logic Model

Priority:	Objectives	Strategies:	Inputs	Partners	Outputs	Short-Term Outcome	Intermediate Outcomes	Long Term Outcomes
3. Increase sustainability of programming with diversified funding	Provide ongoing support to community partners and contracted partners to increase sustainability of SUD programs with diversified funding for treatment services and strategies to support recovery.	3a. Provide Information; Provide Support	Identified regional sustainability needs; identified funding opportunities; collaboration connections and support	`CMHPSM staff; OPB, Regional Board, Providers, Community Partners, Local Municipalities, State and Federal Funding Agencies	Identified regional sustainability needs and potential funding opportunities (ex. Opioid settlement funds; other grants, etc.)	Ongoing and by Q2 of FY25, CMHPSM will identify regional sustainability funding needs.	Ongoing and by Q3 of FY25, CMHPSM will share external opportunities for diversified funding as applicable/available.	By Q4 of FY25, CMHPSM will create a formalized process to support and encourage providers to access funding opportunities in coordinated efforts to ensure sustainability of services (e.g. Opioid Settlement Funds, Marijuana Tax Dollars).

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce childhood and underage drinking	**LIVINGSTON:** **Delinquent/problem behavior** In 2017 there were 44 filings in District Court for Minor in Possession of Alcohol. There were 33 filings in 2018 and 41 filings in 2019 (53rd District Court Probation Department, 6/17/20). Because Minor of Possession of Alcohol became a Civil Infraction in 2018, the District Court filings include anyone under the age 21. **Traffic crash deaths/injuries** Traffic crash deaths/injuries are another consequence of childhood and underage drinking. Alcohol-related traffic crashes involving at least one driver 16 to 20 years of age who had been drinking, caused an annual average of 121 deaths and serious injuries in Michigan each year between 2008 and 2017 (Michigan Epidemiological Profile, MDHHS, December 2019).	**LIVINGSTON:** **Low perceived risk** **Perceived peer pressure** **Norms that support use** **Easy access** **Attitudes & Intentions Toward Use** **Community Norms** **Accessibility**	**LIVINGSTON:** **Communities Mobilizing for Change on Alcohol** Mobilizes communities to act on underage drinking, illicit drug use, and Rx abuse/misuse by addressing policies and practices **Curriculum Based Support Group** Intervention for selective and indicated populations of children and youth at elevated risk for substance use/abuse, delinquency, and violence **Project SUCCESS** SAMHSA model that utilizes individual and small group counseling sessions and large group prevention education sessions to increase	**LIVINGSTON:** **Info Dissemination** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Community-based Process** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Education** Communities Mobilizing for Change on Alcohol Curriculum Based Support Group Project SUCCESS Youth Led Prevention **Environmental** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Alternatives** Youth Led Prevention **Problem ID and Referral**	**LIVINGSTON:** Decrease alcohol access to underage youth Increase knowledge on risks Maintain or improve non-use attitudes towards substances Increase protective factors Increase willingness to discuss substance abuse amongst parents and children Increase awareness of resources	**LIVINGSTON:** Reduce childhood and underage drinking.

	Locally, many Livingston county students admit riding with someone who had been drinking or driving after drinking. Specifically, 18.3% of middle school students and 10.6% of high school students rode in a car or other vehicle driven by someone who had been drinking alcohol one or more times during the past 30 days (Livingston County MiPHY 2017-18). **Early addiction** The average age of first use of alcohol among high school students is 14.3 years (Livingston County MiPHY 2017-18) and the average age of first use of alcohol among 7th graders is 11.1 years (Livingston County MiPHY 2017-18).		protective factors and reduce risk factors **Youth Led Prevention** Peer-to-peer program engages educators, parents, and communities by combining environmental and individual strategies to support positive attitudes, choices, and behaviors by youth	Curriculum Based Support Group Project SUCCESS		

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce childhood and underage drinking	**MONROE:** **Early onset of addiction** **Legal consequences** **Disruption in the learning process** The MiPHY 15-16 data indicates 29% of Monroe County high school students have reported ever being drunk, however, new MiPHY data released in 2018 shows a decline and a new statistic of 24.8% of high school students ever being drunk, also the 2017-2018 MiPHY data shows 65.8% of Monroe County high school students report it's easy or very easy to obtain alcohol. In the 2019-2020 school year, the Monroe County Student Assistance Program Coordinator received 13 Monroe County high school student referrals for alcohol use.	**MONROE:** **Lack of knowledge of the risks and consequences associated with alcohol use** **Lack of knowledge** **Easy access to alcohol** **Use influenced by peers**	**MONROE:** **Student Prevention Leadership Teams** Utilizes Ohio Youth Led Prevention Network model to engage students in developing data-driven school-wide campaigns to educate peers	**MONROE:** **Information dissemination** Student Prevention Leadership Teams **Education** Student Prevention Leadership Teams	**MONROE:** Increase knowledge of risks and consequences of underage alcohol use	**MONROE:** Reduce childhood and underage drinking

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce childhood and underage drinking	**WASHTENAW:** **Early Addiction (mortality, morbidity and addiction)** The Substance Abuse and Mental Health Services Administration reports that young people who begin drinking before age 15 are six times more likely to develop alcohol dependence and are two and a half times more likely to become abusers of alcohol than those who begin drinking at age 21. **Education and Social Connectedness: School failure** According to the Center for Educational Performance and Information, the 4-year graduation rate of students from Ann Arbor Public Schools has decreased from 2018 from 92.63% to 89.46%. Additionally, the 2019-2020 MiPHY report stated that 43.1% of high school students in Washtenaw County do not feel what they are learning in	**WASHTENAW:** **Low perceived risk of ATOD use** **Lack refusal skills** **Social norms** **Lack of knowledge** **Negative peer influence** **Cultural history** **Peer pressure/ rejection** **Lack of community bond** **Low perceived risk of future (school & career) consequences** **Antisocial behavior and delinquency**	**WASHTENAW:** **Prevention Theatre Collective/Botvin LST Transitions** Utilizes peer-to-peer outreach, prevention research and local data, and theatre modalities to shift knowledge and attitudes. **Botvins Transitions** Interactive, skill-based curriculum designed to promote positive health and personal development **Project SUCCESS** SAMHSA model that utilizes individual and small group counseling sessions and large group prevention education sessions to increase protective factors and reduce risk factors	**WASHTENAW:** **Info dissemination** Prevention Theatre Collective/Botvins Transitions Project SUCCESS **Education** Prevention Theatre Collective/Botvins Transitions Project SUCCESS **Environmental** Project SUCCESS **Problem ID & referral** Project SUCCESS	**WASHTENAW:** Increase knowledge of ATOD facts and related health risk & consequences Stronger attitude against substance use Improve skills Improve academic achievement Improve school attendance Increase knowledge about the risks and consequences of underage alcohol use Improve coping and decision-making skills Improve ability to handle peer pressure Decrease 30-day use Improve coping skills Change in anti-social behavior/delinquency	**WASHTENAW:** Reduce childhood and underage drinking

	school is going to be important in their future life. **Social Connectedness - Community Alienation Family Conflict** **Interference with Education, Truancy, School Failure, Family Conflict** In Washtenaw County, high school students who reported recent binge drinking were almost 3 times more likely to report failing grades (8.7% vs. 23.6%) and students reporting recent marijuana use were 2.5 times more likely to report failing grades (11.8% vs. 31.2%) (Source: 2018 MiPHY).	**Low perceived risk of future/school consequences** **Lack of coping skills** **Anti-social behavior/ delinquency** **<u>Protective Factors:</u>** **Refusal/problem solving skills** **Coping skills** **Increase perception/know. of risk of underage alcohol use** **Screening & referral**			Improvement in ability to handle peer pressure Increase knowledge of Michigan law and school policy for underage drinking Improve relationships Increased connectedness	

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce prescription and over-the-counter drug abuse and misuse	**LIVINGSTON:** **Delinquent/criminal/ problem behavior** From 2017-2018 school year to the 2019-20 school year, 23 Livingston County public high school and middle school students were caught at school or at a school event under the influence of or in possession of prescription drugs and 2 were caught under the influence of or in possession of over the counter drugs (Aggregate Informal Report from 5 School Administrators, June 2020). **Opiate related overdoses and deaths** According to the Livingston County Sheriff Department Annual Report (2018), law enforcement in the county responded to124 reports of overdose incidents as the Central Dispatch Cad Status Monitor reported them. Of these responses, 24 were fatal overdoses.	**LIVINGSTON:** **Low perceived risk** **Perceived peer pressure** **Norms that support use** **Easy access** **Attitudes & Intentions Toward Use** **Community norms** **Accessibility**	**LIVINGSTON:** **Communities Mobilizing for Change on Alcohol** Mobilizes communities to act on underage drinking, illicit drug use, and Rx abuse/misuse by addressing policies and practices **Curriculum Based Support Group** Intervention for selective and indicated populations of children and youth at elevated risk for substance use/abuse, delinquency, and violence **Project SUCCESS** SAMHSA model that utilizes individual and small group counseling sessions and large group prevention education	**LIVINGSTON:** **Info Dissemination** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Community-based Process** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Education** Communities Mobilizing for Change on Alcohol Curriculum Based Support Group Project SUCCESS Youth Led Prevention **Environmental Strategies** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Alternatives** Youth Led Prevention	**LIVINGSTON:** Increase knowledge of risks of taking prescription drugs not prescribed to you Maintain or improve non-use attitudes towards substances Increase protective factors Increase willingness to discuss substance abuse amongst parents and children Increase knowledge of safe disposal Increase awareness of resources	**LIVINGSTON:** Reduce prescription and over-the-counter drug abuse and misuse

			sessions to increase protective factors and reduce risk factors **Youth Led Prevention** Peer-to-peer program engages educators, parents, and communities by combining environmental and individual strategies to support positive attitudes, choices, and behaviors by youth	**Problem ID and Referral** Curriculum Based Support Group Project SUCCESS		

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce prescription and over-the-counter drug abuse and misuse, including opiates	**MONROE:** **Expedited onset of addiction, death, and interference with education.** The 2015-2016 MiPHY data shows 18.7% of Monroe County high school students have reported using a prescription drug not prescribed to them, however, new MIPHY data, released in 2018 shows a decline and a new statistic of 11.4% of Monroe County high school students reporting using a prescription drug not prescribed to them.	**MONROE:** **Students and families lack information about safe medication disposal** **Students lack knowledge of the risks and consequences associated with prescriptions**	**MONROE:** **Student Prevention Leadership Teams** Utilizes Ohio Youth Led Prevention Network model to engage students in developing data-driven school-wide campaigns to educate peers	**MONROE:** **Information dissemination** Student Prevention Leadership Teams **Education** Student Prevention Leadership Teams	**MONROE:** Increase knowledge of risks and consequences of prescription and over-the-counter drug abuse and misuse Increase awareness of safe disposal	**MONROE:** Reduce prescription and over-the-counter drug abuse and misuse

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce prescription and over-the-counter drug abuse and misuse, including opiates	**WASHTENAW:** **Health Problems, Concerns, Issues & Addiction Escalation Social Isolation & Interference with Education Community Alienation** The Washtenaw County 2015 Health Improvement Plan (HIP) Survey notes the highest percentage (15.6%) of respondents in the 18-24 age range have 'misused drugs and substances in the past year (Community Health Improvement Plan, 2015). Additionally, according to the same report, "Approximately 5% of Washtenaw County high school students and 15% of middle school students report misusing prescription drugs such as painkillers during the past 30 days." According to the 2019 Michigan Profile for Healthy Youth (MiPHY) 78% of those surveyed (Ann Arbor Public Schools, primarily), prescribed	**WASHTENAW:** **Low perception of risk** **Refusal skills lacking** **Social norms and attitudes** **Lack of knowledge of prescriptions** **Lack of knowledge on drug interactions** **Lack of family supervision of medication and storage** **Easy access through family** **Self-medicate because undiagnosed or cannot afford medication**	**WASHTENAW:** **Prevention Theatre Collective/Botvin LST Transitions** Utilizes peer-to-peer outreach, prevention research and local data, and theatre modalities to shift knowledge and attitudes. **Botvins Transitions** Interactive, skill-based curriculum designed to promote positive health and personal development **Get Connected** Provides education and resources on medication, alcohol, and mental health to seniors and their caretakers	**WASHTENAW:** **Information dissemination** Prevention Theatre Collective/Botvins LST Transitions Get Connected Program for Seniors CAGE Screening **Education** Prevention Theatre Collective/Botvins LST Transitions Get Connected Program for Seniors CAGE Screening **Problem ID and referral** Get Connected Program for Seniors CAGE Screening	**WASHTENAW:** Increase knowledge of ATOD facts and related health risk & consequences Stronger attitude against substance use Improve skills Improve academic achievement Improve school attendance Increase knowledge of risks and consequences of prescription and over-the-counter drug abuse and misuse Increase knowledge of community resources Increase knowledge of proper disposal Improve coping and decision-making skills Increased connectedness	**WASHTENAW:** Reduce prescription and over-the-counter drug abuse and misuse

	drugs not prescribed to them demonstrate a moderate or great risks, but this percentage drops significantly with African-American students, Latino students and those academically challenged. Misuse of prescription drugs can often be peer driven, and thus addressing the context of use as well as its impact is the best preventive strategy. According to the most recent National Survey on Drug Use and Health (2018), prescription drugs that are misused are mainly obtained from friends or close family, which include peers and cousins. More than half (51.3%) of people who misused pain relievers in the past year obtained the pain relievers the last time from a friend or relative.	**Low community bonding** **Negative peer influence** **Negative school attitude** **Anti-social behavior/ delinquency**	**CAGE Screening** Screening tool to help ID risk factors and signs of substance use/misuse in older adults. Screened individuals provided with referrals for SUD treatment or med management			

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on SMART outcomes related to their strategies	Long Term Outcome
To reduce youth access to tobacco and electronic nicotine products	**MONROE:** **Addiction, poor health, and struggles with managing stress in a healthy way.** The 2017-2018 MiPHY data shows that 26.5% of Monroe County high school students used an electronic vapor product during the past 30 days. Monroe County Student Assistance Program Coordinator received 23 high school student referrals for electronic vape use during the 2019-2020 school year.	**MONROE:** **Students lack knowledge of risks and consequences associated with tobacco/nicotine use and addiction** **Students lack refusal and healthy coping skills to address peer pressure and immediate stressors**	**MONROE:** **Student Prevention Leadership Teams** Utilizes Ohio Youth Led Prevention Network model to engage students in developing data-driven school-wide campaigns to educate peers	**MONROE:** **Information dissemination** Student Prevention Leadership Teams **Education** Student Prevention Leadership Teams	**MONROE:** Increase knowledge of risks and consequences of tobacco and nicotine product use Increase refusal and healthy coping skills	**MONROE:** Reduce youth access to tobacco and electronic nicotine products

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on detailed SMART outcomes related to their strategies	Long Term Outcome
To reduce youth access to tobacco and nicotine	**WASHTENAW:** **Interference with Education, Truancy, School Failure, Family Conflict, Screening Brief Intervention & Referral (SBIRT)** Measure from 2018 MiPHY Survey Rates (rounded to nearest whole number in most cases) Recent vaping/e-cigarette use (past 30 days) 21% - 35% Recent cigarette use (past 30 days) 1.5% – 3.2%	**WASHTENAW:** **Perceived peer pressure** **Anti-social behavior/ delinquency** **Low perceived risk of future/school consequences** **Lack of coping skills** **Protective Factors** **Prevention education – refusal skills/problem-solving skills, coping skills** **Increase knowledge of risk of tobacco, electronic cigarettes and vape use** **Screening & referral**	**WASHTENAW:** **Project SUCCESS** SAMHSA model that utilizes individual and small group counseling sessions and large group prevention education sessions to increase protective factors and reduce risk factors	**WASHTENAW:** **Information dissemination** Project SUCCESS **Education** Project SUCCESS **Environmental** Project SUCCESS **Problem ID and referral** Project SUCCESS	**WASHTENAW:** Increase knowledge or risks and consequences of tobacco and electronic nicotine product use Decrease 30-day use Improve ability to handle peer pressure Improve coping skills Change in anti-social behavior/delinquency Increase knowledge of Michigan law and school policy Improve relationships	**WASHTENAW:** Reduce youth access to tobacco and nicotine

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

To reduce youth access to tobacco and nicotine	**REGION-WIDE:** **FY 2022 Retailer Violation Rate 16.3%** **LENAWEE**: Percentage of students who reported sort of easy or very easy to get cigarettes- 35.8% (2022 MiPHY) **LIVINGSTON**: Percentage of students who reported sort of easy or very easy to get cigarettes- 46% (2018 MiPHY) **MONROE**: Percentage of students who reported sort of easy or very easy to get cigarettes- 35.7% (2022 MiPHY) **WASHTENAW**: Percentage of students who reported sort of easy or very easy to get cigarettes- 27.3% (2022 MiPHY)	**REGION-WIDE:** **Retail access** **Easy access to tobacco** **Norms that support electronic nicotine product use** **Perceived peer pressure** **Low perception of harm**	**REGION-WIDE:** **Tobacco/Electronic Nicotine Product Retailer Education** Educate tobacco and electronic nicotine product retailers on risks of selling tobacco and electronic nicotine products to underage youth and importance of checking ID. **Non-Synar Compliance Checks** Conduct tobacco and electronic nicotine product retailer compliance checks in partnership with local law enforcement to enforce the Michigan Youth Tobacco Act. **Regional Vaping Prevention Initiative** Educate communities and build coalition capacity; contact with Tobacco Section policy staff; communicate and meet with schools	**REGION-WIDE:** **Environmental:** Retailer Education Synar compliance checks Non-Synar compliance checks **Community Based Process:** Regional Vaping Prevention Initiative – Vaping Is Nicotine presentations	**REGION-WIDE:** Decrease youth access to tobacco and nicotine products Increase knowledge regarding Michigan Youth Tobacco Act Increase knowledge on risks and consequences of youth tobacco and nicotine product use Decrease likelihood of youth e-cigarette use	**REGION-WIDE:** Reduce youth access to tobacco and electronic nicotine produces

			and community partners; identify a model comprehensive policy, train youth and partners to advocate for schools to adopt the new policy; mailing to 100% of the school districts in the region of the model policy.			

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on detailed SMART outcomes related to their strategies	Long Term Outcome
To reduce illicit drug use	**LIVINGSTON:** **Delinquent/criminal/ problem behavior** In 2016, there were 33 petitions filed in Livingston County Juvenile Court for Possession of Marijuana (Livingston County Juvenile Court, 2/13/17). In 2019, there were 56 total drug-involved traffic crashes within Livingston County, including 3 fatal crashes; 8 drug-involved crashes had drivers age 15 to 20 (Michigan Traffic Crash Facts by County, Michigan Office of Highway Safety Planning, June 2020). **Early addiction** In 2018, 990 Michigan youths 12 to 17 years of age, were admitted to treatment for marijuana as the primary substance use, accounting for 63.5% of all substance abuse treatment Admissions (Michigan Epidemiological Profile, MDHHS, December 2019).	**LIVINGSTON:** **Low perceived risk** **Perceived peer pressure** **Norms that support use** **Easy access** **Attitudes & Intentions Toward Use** **Community Norms** **Accessibility**	**LIVINGSTON:** **Communities Mobilizing for Change on Alcohol** Mobilizes communities to act on underage drinking, illicit drug use, and Rx abuse/misuse by addressing policies and practices **Curriculum Based Support Group** Intervention for selective and indicated populations of children and youth at elevated risk for substance use/abuse, delinquency, and violence **Project SUCCESS** SAMHSA model that utilizes individual and small group counseling sessions and large group	**LIVINGSTON:** **Info Dissemination** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Community-based Process** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Education** Communities Mobilizing for Change on Alcohol Curriculum Based Support Group Project SUCCESS Youth Led Prevention **Environmental Strategies** Communities Mobilizing for Change on Alcohol Project SUCCESS Youth Led Prevention **Alternatives** Youth Led Prevention	**LIVINGSTON:** Increase knowledge on risks associated with substance use/abuse Maintain or improve non-use attitudes toward alcohol and other drugs Increase protective factors Increase willingness to discuss substance abuse amongst parents and children Increase awareness of resources	**LIVINGSTON:** Reduce illicit drug use

			prevention education sessions to increase protective factors and reduce risk factors **Youth Led Prevention** Peer-to-peer program engages educators, parents, and communities by combining environmental and individual strategies to support positive attitudes, choices, and behaviors by youth	**Problem ID and Referral** Curriculum Based Support Group Project SUCCESS		

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on detailed SMART outcomes related to their strategies	Long Term Outcome
To reduce illicit drug use	**MONROE:** **Fetal effects of prenatal exposure to illicit drugs** In 2019 73 infants who were prenatally exposed to alcohol, tobacco, illicit drugs such as heroin, cocaine and marijuana, and/or prescription drugs were referred for services currently provided through this program. This increased from 2015, when 67 infants were referred, and from 2014, when 42 infants were referred. **Interference with education**. There are currently 36 children in Monroe County who are receiving services due to ATOD exposure and/or developmental impact of parental substance use disorder. The majority of these children have at least a 20% delay in one area of development (language/communication, cognitive, physical (fine/gross motor), social/emotional). **Health issues, legal issues, and development of poor coping skills.** 14.8% of Monroe County high school students have	**MONROE:** **Lack of knowledge of use during pregnancy** **Lack of supports (community and family)** **Poor parental and family norms/ attitudes** **Low academic achievement with negative attachment to school** **Students lack knowledge of the risks and consequences associated with marijuana use** **Increased access of marijuana to youth** **Students marijuana use is influenced by peers**	**MONROE:** **Nurturing Parenting/Parents as Teachers** Parent educators provide support, education, and group connection opportunities to families with a child from 0-3 who has been prenatally exposed to substances **Student Prevention Leadership Teams** Utilizes Ohio Youth Led Prevention Network model to engage students in developing data-driven school-wide campaigns to educate peers	**MONROE:** **Information dissemination** Nurturing Parenting/Parents as Teachers Student Prevention Leadership Teams **Education** Nurturing Parenting/Parents as Teachers Student Prevention Leadership Teams **Problem ID and referral** Nurturing Parenting/Parents as Teachers	**MONROE:** Increase parenting knowledge and improved attitudes Increase access to community support services Increase knowledge of risk of substance use prenatally and postnatally Decrease risk of maladaptive parenting practices/ norms/attitude Developmental screening for children Knowledge of facts, risks and consequences associated with marijuana use	**MONROE:** Reduce illicit drug use

	reported using marijuana in past 30 days of survey. (MiPHY 2017-2018). Monroe County Student Assistance Program Coordinator received 43 high school student referrals for marijuana use during the 2019-2020 school year.					

Region 6 CMHPSM FY24 – FY26 Prevention Logic Model

2023-2024 CMHPSM Priority Area	Consequence (Primary Problem) Select Data	Intervening Variables	EBI/Strategy	Activity/Strategy	Immediate Outcome *Funded providers track and report on detailed SMART outcomes related to their strategies	Long Term Outcome
To reduce illicit drug use	**WASHTENAW:** **Interference with Education, Truancy, School Failure, Family Conflict** Measure from 2018 MiPHY Survey Rates (rounded to nearest whole number in most cases) Perception of risk of marijuana use 45% - 57% and Peer Group Use – marijuana (report most or all of their friends had used marijuana in the past month) 12% - 14%	**WASHTENAW:** **Low perception of risk of use** **Social norms, attitudes, and beliefs** **Lack of knowledge** **Perceived peer pressure** **Anti-social behavior/ delinquency** **Low perceived risk of future/school consequences** **Lack of coping skills** **Anti-social behavior/ delinquency** **Low community bonding** **Negative family environment** **Early drug experimentation**	**WASHTENAW:** **Prevention Theatre Collective/Botvin LST Transitions** Utilizes peer-to-peer outreach, prevention research and local data, and theatre modalities to shift knowledge and attitudes. Participants also receive college credit through EMU **Botvins Transitions** Interactive, skill-based curriculum designed to promote positive health and personal development **Project SUCCESS** SAMHSA model that utilizes individual and small group counseling sessions and large group prevention education sessions to increase protective factors	**WASHTENAW:** **Info dissemination** Prevention Theatre Collective/Botvin LST Transitions Project SUCCESS **Education** Prevention Theatre Collective/Botvin LST Transitions Project SUCCESS **Environmental** Project SUCCESS **Problem ID & referral** Project SUCCESS	**WASHTENAW:** Increase knowledge of ATOD facts and related health risk & consequences Stronger attitude against substance use Improve skills Improve academic achievement Improve school attendance Increase knowledge of risks and consequences Increased connectedness Decrease 30-day use Improve ability to handle peer pressure Improve coping skills Change in anti-social behavior/delinquency	**WASHTENAW:** Reduce illicit drug use

		Neighborhood stability and attachment **Protective Factors Prevention education – refusal skills/problem-solving skills, coping skills Increase knowledge of risk** **Screening & referral**	and reduce risk factors		Increase knowledge of Michigan law and school policy Improve relationships Improve awareness of risks and consequences of marijuana use	

MICHIGAN PROFILE FOR HEALHTY YOUTH (MI-PHY)
Past 30 Day Use – High School

	Alcohol	Cocaine	Binge drinking	Meth	Vaping	Rx use	Inhalant	Cigarette
Lenawee	12.7	0.3	6.5	0.1	16	2.8	1.4	1.6
Livingston	18.2 (2018)	0.3 (2018)	10.6 (2018)	0.3 (2018)	28 (2018)	3.7 (2018)	1.1 (2018)	4.5 (2018)
Monroe	10.5	0.1	5.6	0.1	13.6	2.6	1.0	1.4
Washtenaw	10.8	0.1	6.0	0.5	9.4	2.4	1.0	1.0

Regional Board Action Request – FY2024-26 Substance Use Services Strategic Plan

Board Meeting Date:	August 9, 2023
Action Requested:	Review and approval for the CMHPSM CEO to sign and submit the FY2024-26 Substance Use Services Strategic Plan.
Background:	The CMHPSM is required to submit a Substance Use Services strategic plan that meets MDHHS requirements by August 15, 2023. The Oversight Policy Board has been involved with the development of the plan but has not approved the full version of this plan (please see the accompanying letter from the OPB chair). The Oversight Policy Board will monitor both the plan and outcomes over the term of the plan.
Connection to:	PIHP/MDHHS Contract, AFP, Regional Strategic Plan and Shared Governance Model
Recommend:	Approval for the CMHPSM CEO to sign and transmit the Substance Use Services strategic plan to MDHHS by the deadline.

Oversight Policy Board Minutes
June 22, 2023
Patrick Barrie Conference Room
3005 Boardwalk Drive, Suite 200
Ann Arbor, MI 48108

Members Present:	Mark Cochran, Amy Fullerton (remote), Annette Gontarski, Molly Welch Marahar, Dave Oblak, Dave O'Dell, David Stimpson, Ralph Tillotson, Tom Waldecker
Members Absent:	Kim Comerzan, Ricky Jefferson, Susan Longsworth, Monique Uzelac
Guests:	Jubin Cheruvelil, Adam Franti
Staff Present:	Stephannie Weary, James Colaianne, Nicole Adelman, Matt Berg, CJ Witherow, Danielle Brunk, Joelen Kersten, Jackie Bradley (Lenawee), Alyssa Tumolo, Jane Goerge, Rebecca DuBois, Stacy Pijanowski, Heather Schubbe, James Luckey, Liz Stankov, Michelle Sucharski

Board Chair M. Cochran called the meeting to order at 9:31 a.m.

1. Introductions

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

3. Approval of the April 27, 2023 Oversight Policy Board minutes
   Motion by D. Stimpson, supported by M. Welch Marahar, to approve the April 27, 2023 OPB minutes
   Motion carried

   - M. Cochran acknowledged Kim Comerzan' s service on the OPB. She is retiring from the Monroe County Health Department and will also leave the OPB.
   - M. Cochran acknowledged D. O'Dell's 20 years of sobriety as of June 15, 2023.

4. Audience Participation
   - None

5. Old Business
   a. Finance Report
      - M. Berg presented.
   b. FY24 Funding Update – continuation RFI
      - Providers have been notified that FY24 will be a continuation year; they will receive approximately the same as last year, could be less based on circumstances including performance or cuts in funding from the state.
      - SOR funds should stay the same, Substance Abuse Block Grant treatment funding should stay the same, SABG prevention increased; COVID block grant ends in 3/2024, ARPA is still unknown. Received approval from MDHHS to request a significant amount more so COVID BG funded programs can continue through the year but have not heard back.

6. New Business
   a. Membership Update
      - T. Waldecker, A. Fullerton and R. Tillotson would all like to continue for another term on the OPB. S. Weary will follow up with their respective appointing bodies.
      - K. Comerzan's replacement has been named and will be submitted to the Monroe Board of Commissioners for official appointment.
   b. Health Disparities to Health Equity Initiative
      - J. Cheruvelil (Nyaa Health) led OPB on the Board's role in combating health disparities.
   c. Strategic Planning Session - Board Action Request- Policy Updates
      - Input from OPB for FY24-26 strategic planning. Due in August.

      SWOT Analysis
      - ❖ T. Waldecker: Communication to active users re: available services. Targeting people are low income. Who's our audience for this funding?
      - ❖ M. Welch Marahar: a strength is that the system is driven by ensuring access to services, more so than cost-effectiveness. Cost-effectiveness isn't the driver of decision-making, which would be important to include in the mission statement.
      - ❖ OPB requested input into updates into mission, and/or perhaps OPB should have its own mission.

      What would OPB members like to see:
      - ❖ D. Oblak: better funding for those in the jails and in the court system. Incarceration disparity in terms of race.
      - ❖ M. Welch Marahar: coordination with the jails (release dates, services needed post-jail, medications post-jail, etc., handoff.). Housing. A lot of things don't matter if someone doesn't have housing. And there is a waiver on the BH side that allows for Medicaid to be spent on housing case management. Another handoff that's needed: relationship building with harm reduction services.
      - ❖ M. Cochran: help to understand more of what we do in the housing arena.

      Online review of the Strategic Plan by OPB:
      - ❖ Official OPB vote will happen at the August meeting.
      - ❖ Today's discussion will lead to a draft that OPB will review via email.

      Motion by M. Welch Marahar, supported by D. Stimpson, to authorize OPB Chair M. Cochran to sign the strategic plan submission letter for preliminary approval from the state.
      Motion carried

7. Report from Regional Board
   - At the June Regional Board meeting, the board approved its governance policies, reviewed the CEO performance goals, and discussed strategies for finalizing repayment of the FY2018 deficit.

8. SUD Director Updates
   a. CEO Update
      - J. Colaianne's written report includes updates from staff, regional and state levels. Please see the report in the board packet for details.
   b. Staffing
      - Care Navigator position: there was an interview yesterday, staff is hopeful of filling the position soon.

c. Michigan Association of Recovery Residences (MARR) Update
   - A meeting was held with a group of SUD Directors, MARR, ACLU and several Recovery Residences to discuss issues related to gender identity and inclusivity. SUD directors across the state are drafting language with support of MARR regarding the expectation of inclusivity at recovery homes.

9. Adjournment
   Motion by R. Tillotson, supported by D. O'Dell, to adjourn the meeting
   Motion carried

   - Meeting adjourned at 11:23 a.m.

***Next meeting: Thursday, August 24, 2023**
Location 3005 Boardwalk, Suite 200; Patrick Barrie Room

CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors

August 3, 2023 for the August 9, 2023 Meeting

CMHPSM Update

- The CMHPSM held all-staff meetings on June 12, 2023 and July 10, 2023.
- The CMHPSM leadership team continues to meet on a weekly basis on Tuesdays.
- The employee engagement survey was issued in July and the results have been transmitted to the Board and included in this month's board packet. The CMHPSM Employee Engagement committee will begin its review of the survey results and leadership will work to review engagement proposals.

COVID-19 Update

- The following webpage was created on our CMHPSM regional website related to the end of the public health emergency: https://www.cmhpsm.org/phe-end

CMHPSM Staffing Update

- The CMHPSM currently has no open positions:
  - We have Jessy Macumber starting with us in August as an SUD Care Navigator, we're excited to have Jessy join the team.
- More information and links to job descriptions and application information can be found here: https://www.cmhpsm.org/interested-in-employment

Regional Update

- Our regional committees continue to meet using remote meeting technology and expect we will continue to do so until that option is no longer feasible.
- The Regional Operations Committee continues to schedule to meet on a weekly basis.

Statewide Update

- PIHP CEO meetings are being held remotely on a monthly basis. Since our last Regional Board meeting, the PIHP CEOs met on August 1, 2023, our July meeting was cancelled due to the holiday.
- The PIHP CEO / MDHHS operations meetings with MDHHS behavioral health leadership staff was held on August 3, 2023. I provide a summary of those meetings to our regional directors at our Regional Operations Committee meetings each month.
- MDHHS re-enrollment processes began in April and May for individuals with a June re-enrollment date. The process will progress through subsequent re-enrollment months over a 12-to-14 month period to not overwhelm the MDHHS enrollment systems. The following page has been created on our CMHPSM website to provide information on the Medicaid enrollment restart: https://www.cmhpsm.org/medicaid-enrollment-restart
- We are awaiting final FY2024 capitation rates which are estimated to be available in mid-August. We will be utilizing the best information we have available on rates and eligible individual levels to develop our final FY2024 budget for the September CMHPSM Board of Directors meeting.

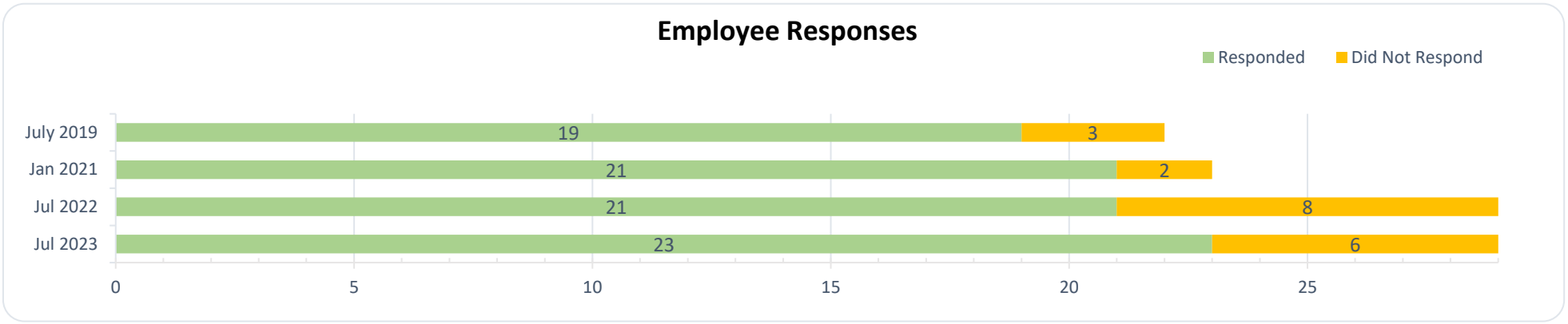
Future Update

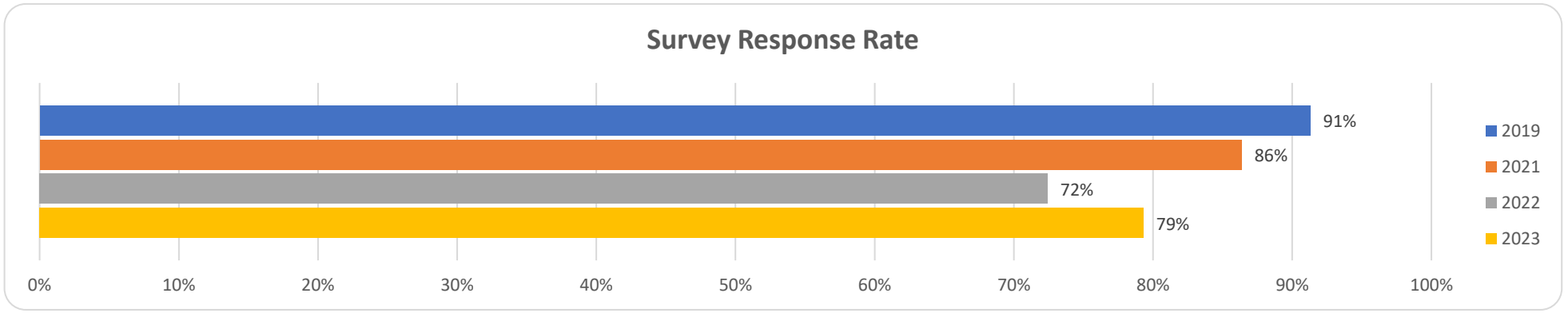
- We are planning to cover the following items at our September 2023 meeting:
  - FY2024-FY2026 Strategic Plan Input (Pushed from August Agenda)
  - Final FY2024 CMHPSM Budget
  - Update on FY2018 Deficit Resolution

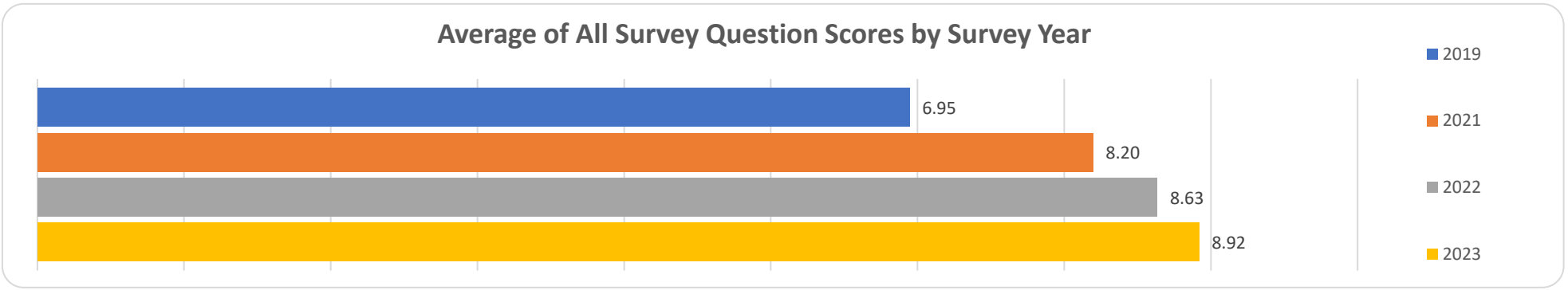
Respectfully Submitted,

James Colaianne, MPA

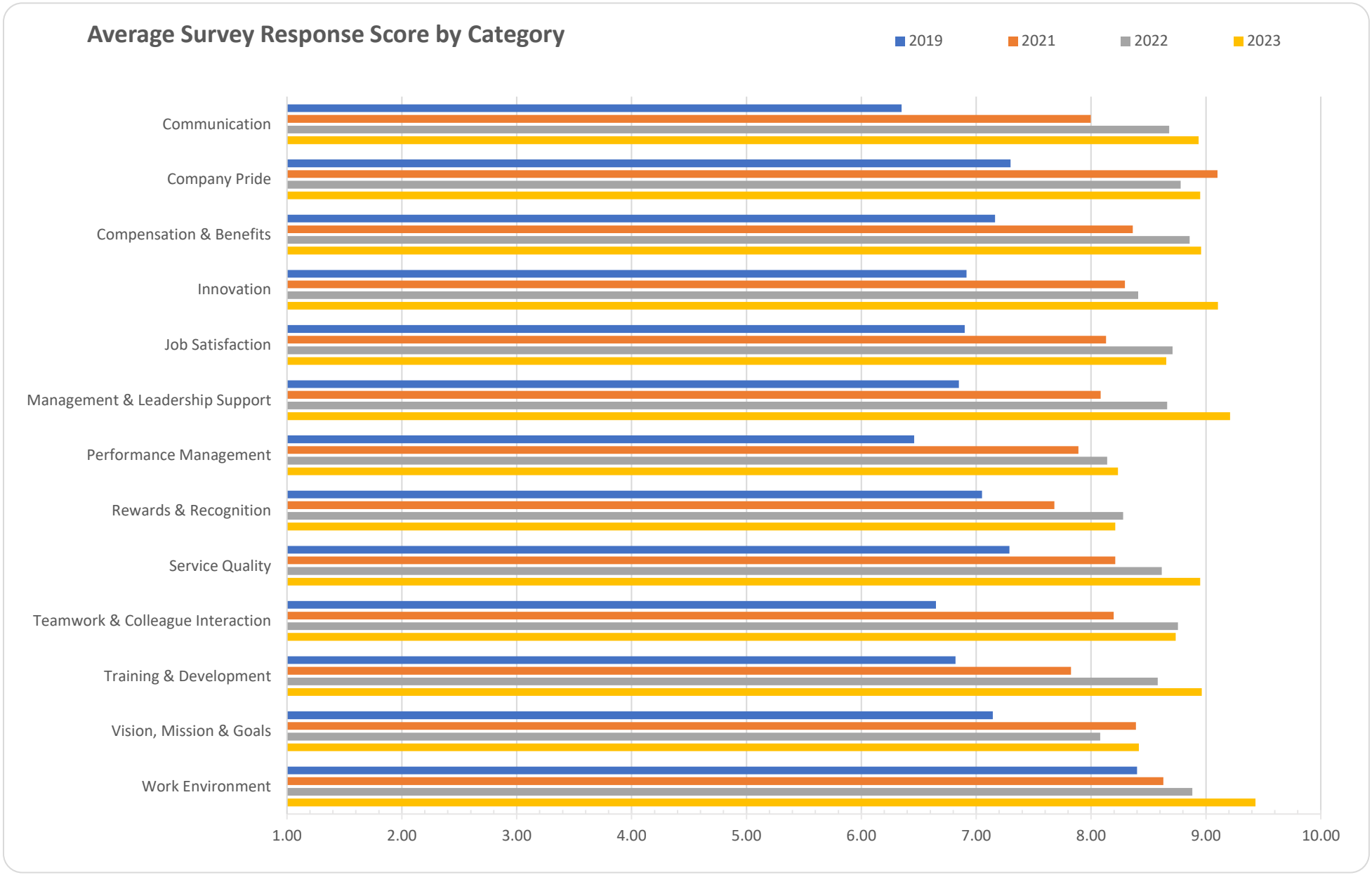
CMHPSM Employee Engagement Survey Results





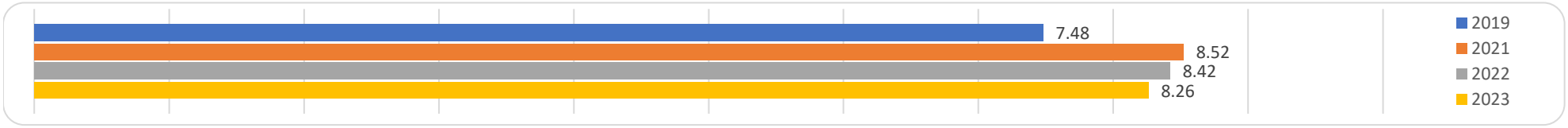


CMHPSM Employee Engagement Survey Results



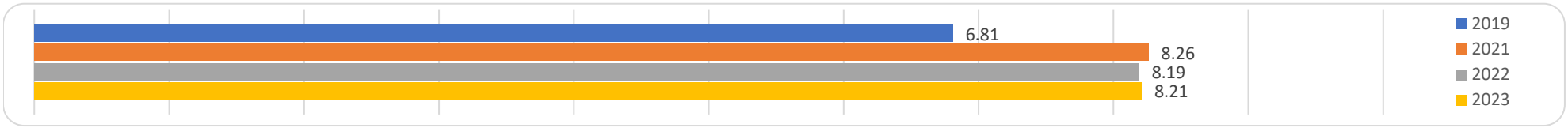
CMHPSM Employee Engagement Survey Results

1 I understand how I contribute to the organization's mission and vision for the future. **Category: Vision, Mission & Goals**



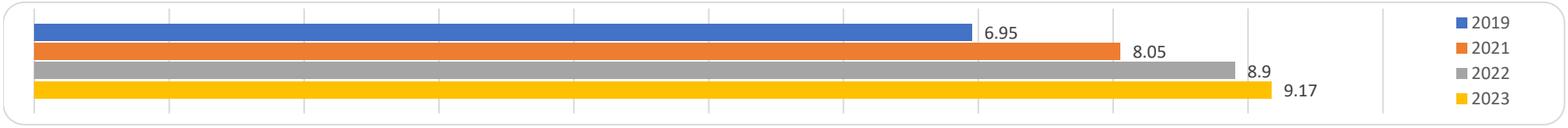
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	1	1	1	2	0	2	6	4	4	7.48	21	
2021	1	0	0	0	0	1	0	6	3	8	8.52	19	+13.9%
2022	0	0	1	1	0	0	3	2	7	7	8.42	21	-1.2%
2023	0	0	1	0	0	0	6	3	9	4	8.26	23	-1.9%

2 Goals and objectives for my position within the organization are clearly defined. **Category: Vision, Mission & Goals**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	2	0	1	3	0	4	8	2	1	6.81	21	
2021	1	0	0	0	0	0	4	3	6	5	8.26	19	+21.3%
2022	0	0	1	0	1	2	2	3	6	6	8.19	21	-0.8%
2023	1	0	0	0	0	0	4	7	6	5	8.21	23	+0.2%

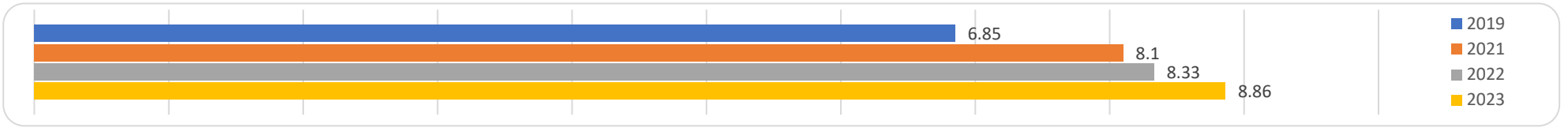
3 I have confidence in this organization's leadership. **Category: Management & Leadership Support**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	2	0	1	2	0	1	6	5	2	6.95	20	
2021	2	0	0	1	0	0	1	2	6	7	8.05	19	+15.8%
2022	0	0	0	0	0	2	1	3	6	9	8.90	21	+10.6%
2023	0	0	0	1	0	0	2	0	7	13	9.17	23	+3.0%

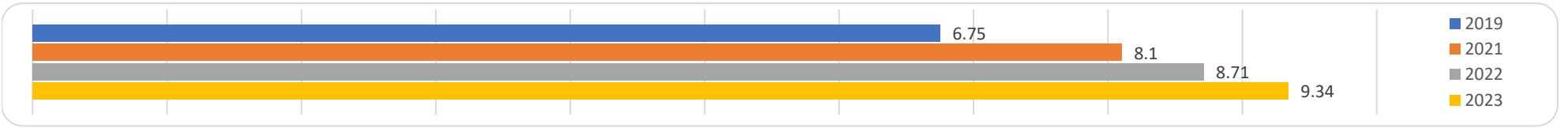
CMHPSM Employee Engagement Survey Results

4 My manager clearly communicates their expectations of me. **Category: Management & Leadership Support**



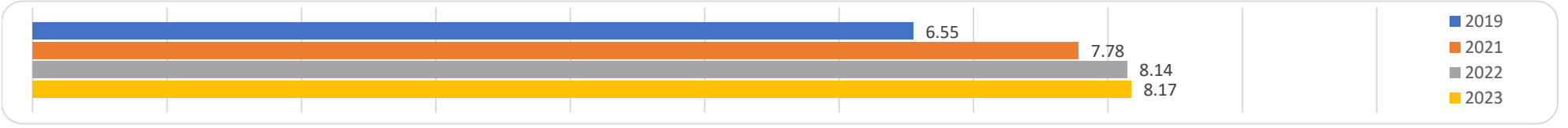
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	1	1	2	0	4	4	3	3	6.85	20	
2021	2	0	0	0	0	1	1	3	5	7	8.1	19	+18.2%
2022	0	0	0	2	0	3	0	4	3	9	8.33	21	+2.8%
2023	0	0	0	1	0	0	1	5	7	9	8.86	23	+6.4%

5 My manager supports and encourages me. **Category: Management & Leadership Support**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	2	1	1	1	1	2	4	4	3	6.75	20	
2021	2	0	0	0	1	1	0	2	5	8	8.1	19	+20.0%
2022	0	0	0	0	2	3	0	2	1	13	8.71	21	+7.5%
2023	0	0	0	0	0	1	0	3	5	14	9.34	23	+7.2%

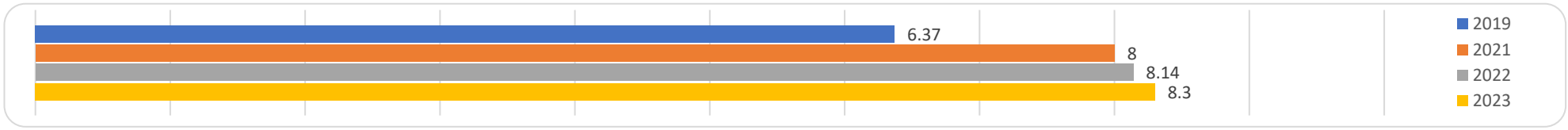
6 My performance standards are clearly defined. **Category: Performance Management**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	0	1	4	2	2	5	2	2	6.55	20	
2021	2	0	0	1	0	1	0	5	4	6	7.78	19	+18.8%
2022	0	0	1	0	1	3	2	3	3	8	8.14	21	+4.6%
2023	0	0	0	1	1	1	3	6	6	5	8.17	23	+0.4%

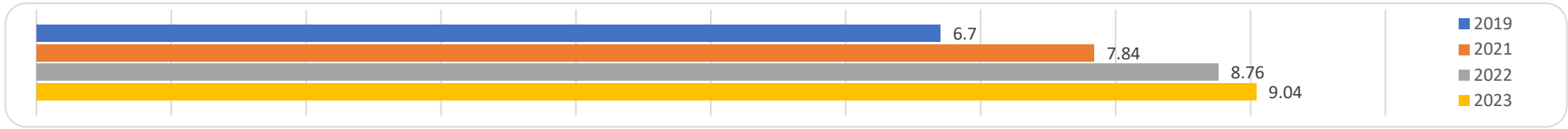
CMHPSM Employee Engagement Survey Results

7 I receive frequent feedback on my performance and the quality of my work. **Category: Performance Management**



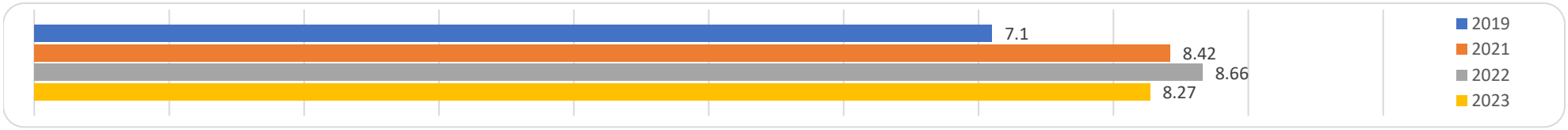
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	0	2	4	1	1	6	1	2	6.37	19	
2021	1	0	0	2	0	1	1	3	4	7	8	19	+25.6%
2022	0	0	0	2	2	1	1	3	4	8	8.14	21	+1.8%
2023	0	0	0	1	1	1	2	7	4	7	8.3	23	+2.0%

8 I have the resources I need to do high-quality work. **Category: Job Satisfaction**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	2	0	3	2	4	3	2	3	6.7	20	
2021	2	0	0	1	0	1	1	4	2	8	7.84	19	+17.0%
2022	0	0	0	0	1	2	0	5	3	10	8.76	21	+11.7%
2023	0	0	0	0	0	0	2	4	8	9	9.04	23	+3.2%

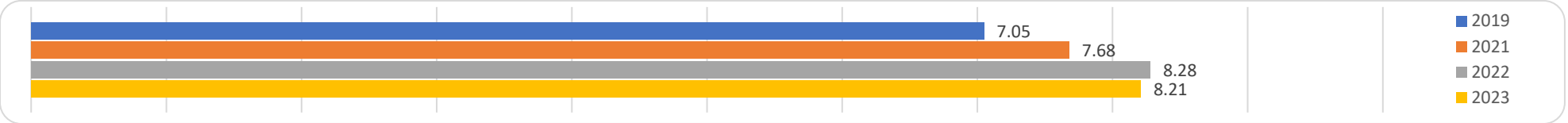
9 I have the opportunity to demonstrate what I do best in my role. **Category: Job Satisfaction**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	1	1	2	1	4	3	4	3	7.1	20	
2021	1	0	0	0	0	2	0	4	5	7	8.42	19	+18.6%
2022	0	0	0	0	1	2	1	4	4	9	8.66	21	+2.9%
2023	0	0	0	1	1	0	3	7	4	6	8.27	22	-4.5%

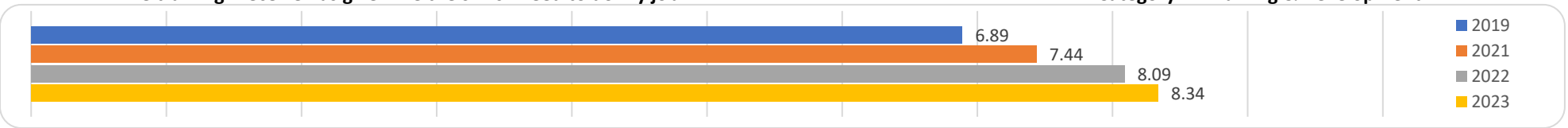
CMHPSM Employee Engagement Survey Results

10 Recently, I have been recognized for doing good work. **Category: Rewards & Recognition**



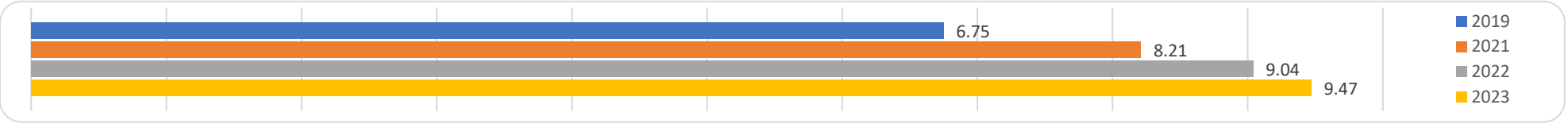
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	1	1	1	3	2	2	3	3	4	7.05	20	
2021	2	0	0	0	0	2	1	6	3	5	7.68	19	+8.9%
2022	0	0	0	0	2	3	0	6	2	8	8.28	21	+7.8%
2023	0	0	0	0	1	2	5	5	3	7	8.21	23	-0.8%

11 The training I receive has given me the skills I need to do my job. **Category: Training & Development**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	0	1	2	0	4	5	4	1	6.89	19	
2021	2	0	1	0	0	1	1	7	0	6	7.44	18	+8.0%
2022	0	0	1	1	0	1	5	3	2	8	8.09	21	+8.7%
2023	0	0	0	0	3	0	2	5	7	6	8.34	23	+3.1%

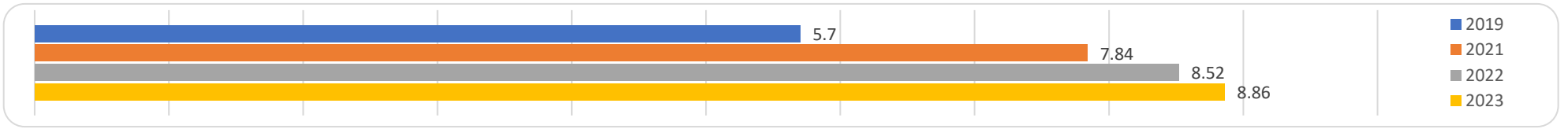
12 I am encouraged to learn and develop new skills. **Category: Training & Development**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	2	0	1	2	1	4	3	2	4	6.75	20	
2021	2	0	0	0	0	2	0	2	4	9	8.21	19	+21.6%
2022	0	0	0	0	0	1	3	2	3	12	9.04	21	+10.1%
2023	0	0	0	0	0	0	0	2	8	13	9.47	23	+4.8%

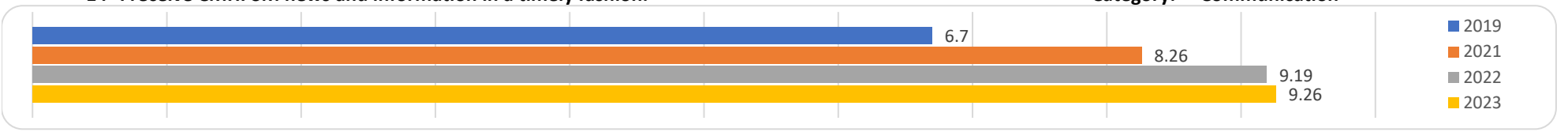
CMHPSM Employee Engagement Survey Results

13 Communication is open and honest in this organization. **Category: Communication**



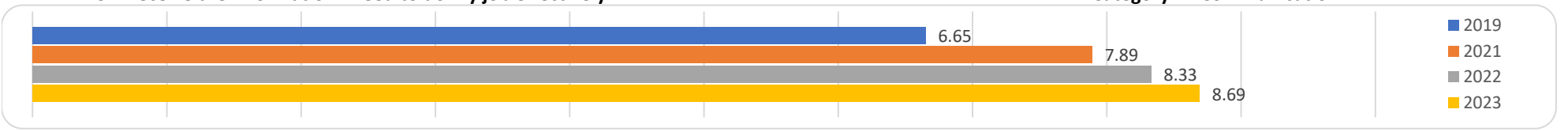
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	2	2	0	2	3	2	3	4	0	2	5.7	20	
2021	2	0	0	1	0	0	0	5	7	4	7.84	19	+37.5%
2022	0	0	0	0	2	1	4	1	3	10	8.52	21	+8.7%
2023	0	0	0	0	0	2	1	6	3	11	8.86	23	+4.0%

14 I receive CMHPSM news and information in a timely fashion. **Category: Communication**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	1	3	0	3	2	2	2	5	6.7	20	
2021	1	0	0	2	0	0	0	3	6	7	8.26	19	+23.3%
2022	0	0	0	0	0	1	1	2	6	11	9.19	21	+11.3%
2023	0	0	0	0	0	0	0	5	7	11	9.26	23	+0.8%

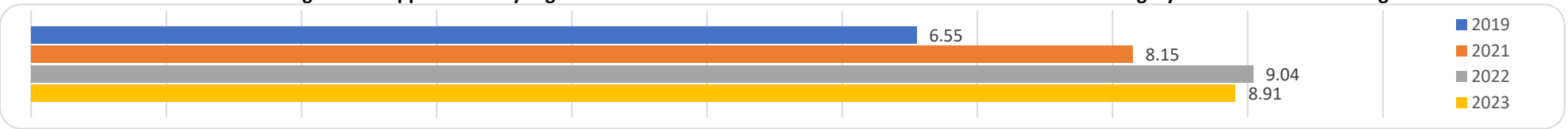
15 I receive the information I need to do my job effectively. **Category: Communication**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	1	3	0	1	5	2	2	4	6.65	20	
2021	2	0	0	1	0	0	1	4	5	6	7.89	19	+18.6%
2022	0	0	1	0	1	1	1	7	2	8	8.33	21	+5.6%
2023	0	0	0	0	0	1	1	9	5	7	8.69	23	+4.3%

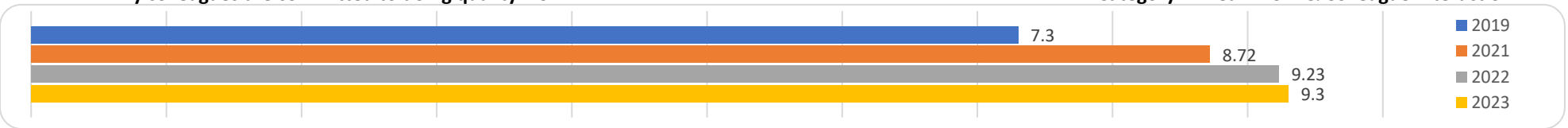
CMHPSM Employee Engagement Survey Results

16 Teamwork is encouraged and supported in my organization. **Category: Teamwork & Colleague Interaction**



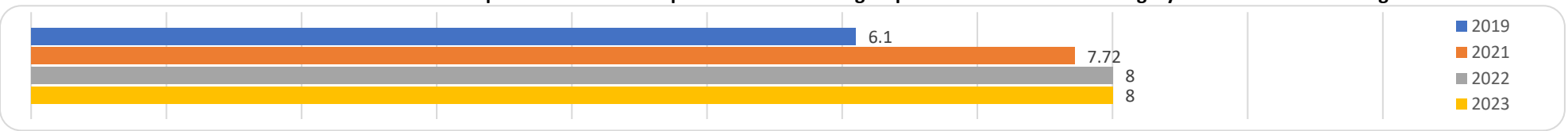
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	2	1	3	1	0	3	1	3	5	6.55	20	
2021	2	0	0	0	0	0	2	4	3	8	8.15	19	+24.4%
2022	0	0	0	0	0	0	3	3	5	10	9.04	21	+10.9%
2023	0	0	0	0	0	1	3	4	4	11	8.91	23	-1.4%

17 My colleagues are committed to doing quality work. **Category: Teamwork & Colleague Interaction**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	0	1	2	2	4	2	5	3	7.3	20	
2021	1	0	0	0	0	0	2	1	6	8	8.72	18	+19.5%
2022	0	0	0	0	0	0	2	3	4	12	9.23	21	+5.8%
2023	0	0	0	0	0	0	0	7	2	14	9.3	23	+0.8%

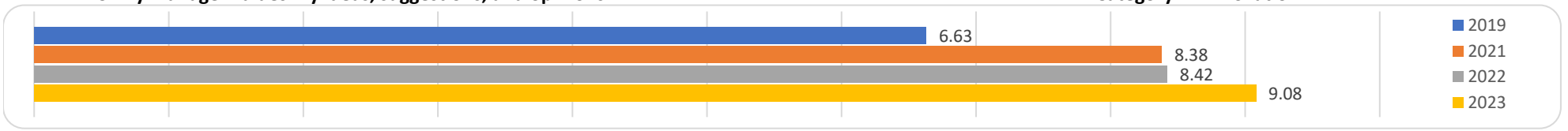
18 There is effective communication and cooperation between departments and work groups. **Category: Teamwork & Colleague Interaction**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	2	2	0	2	1	4	6	1	1	6.1	20	
2021	2	0	0	1	0	0	2	3	5	5	7.72	18	+26.6%
2022	0	0	0	0	0	5	2	6	4	4	8	21	+3.6%
2023	0	0	0	1	1	2	5	5	2	7	8	23	0.0%

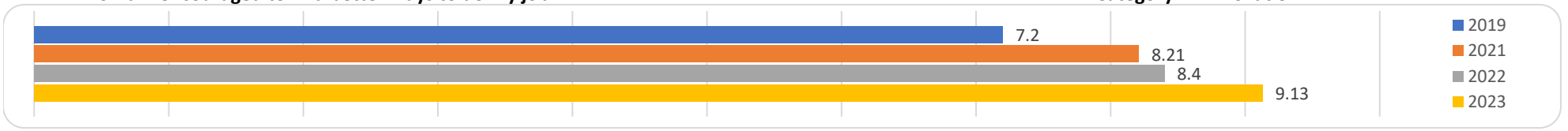
CMHPSM Employee Engagement Survey Results

19 My manager values my ideas, suggestions, and opinions. **Category: Innovation**



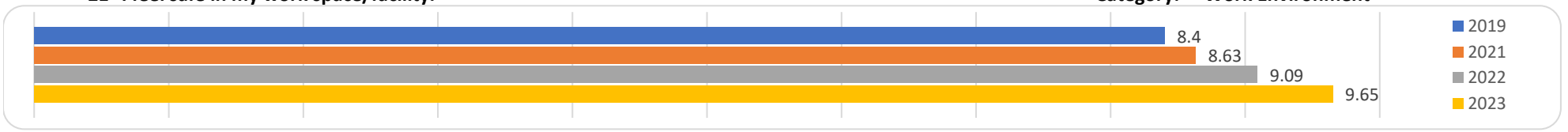
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	2	0	2	0	4	1	2	4	3	6.63	19	
2021	2	0	0	0	0	0	0	4	3	9	8.38	18	+26.4%
2022	0	0	0	0	2	2	1	3	6	7	8.42	21	+0.5%
2023	0	0	0	0	0	0	1	6	6	10	9.08	23	+7.8%

20 I am encouraged to find better ways to do my job. **Category: Innovation**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	1	0	0	2	3	3	2	4	4	7.2	20	
2021	2	0	0	0	0	1	1	4	1	10	8.21	19	+14.0%
2022	0	0	2	0	0	1	2	1	6	8	8.4	20	+2.3%
2023	0	0	0	0	0	1	0	4	7	10	9.13	22	+8.7%

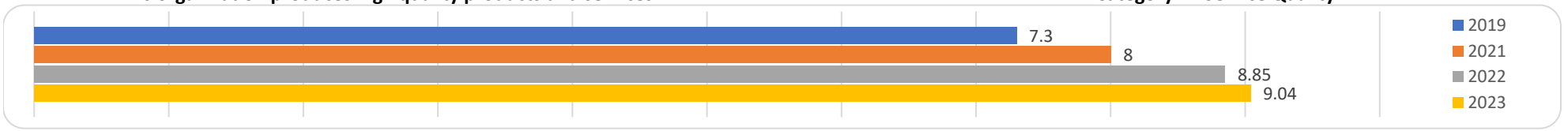
21 I feel safe in my work space/facility. **Category: Work Environment**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	0	0	0	2	1	4	3	9	8.4	20	
2021	2	0	0	0	0	0	0	2	4	11	8.63	19	+2.7%
2022	0	0	0	1	0	1	0	4	1	14	9.09	21	+5.3%
2023	0	0	0	0	0	0	1	1	3	18	9.65	23	+6.2%

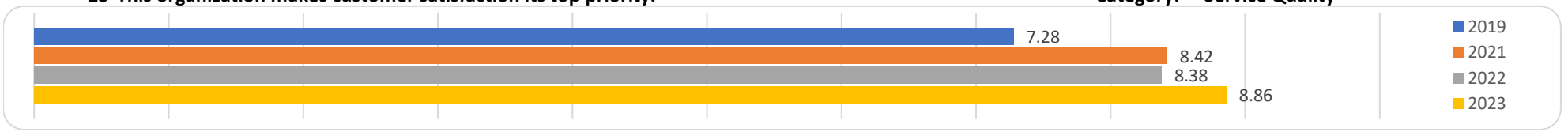
CMHPSM Employee Engagement Survey Results

22 This organization produces high quality products and services. **Category: Service Quality**



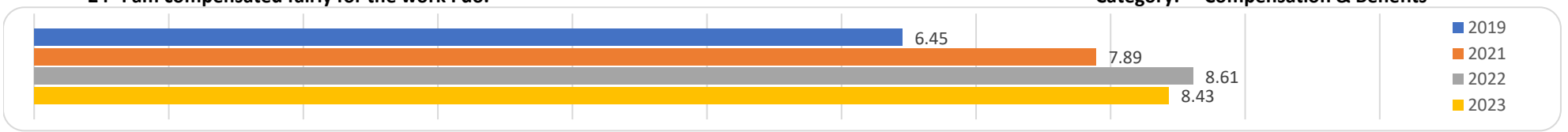
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	0	1	1	2	5	4	3	3	7.3	20	
2021	1	0	1	0	0	0	2	6	4	5	8	19	+9.6%
2022	0	0	0	0	1	1	1	3	5	9	8.85	20	+10.6%
2023	0	0	0	0	0	1	0	5	7	9	9.04	22	+2.1%

23 This organization makes customer satisfaction its top priority. **Category: Service Quality**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	0	0	3	0	4	5	3	2	7.28	18	
2021	1	0	0	0	0	0	2	5	5	6	8.42	19	+15.7%
2022	0	0	0	0	0	2	5	4	3	7	8.38	21	-0.5%
2023	0	0	0	0	0	1	1	6	6	8	8.86	22	+5.7%

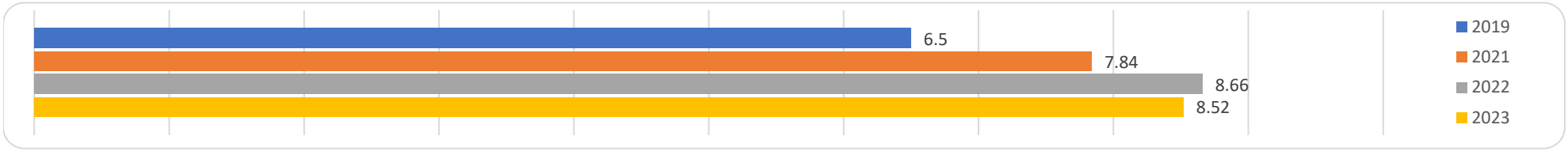
24 I am compensated fairly for the work I do. **Category: Compensation & Benefits**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	1	3	0	5	0	3	3	2	3	6.45	20	
2021	1	0	0	0	1	0	4	5	4	4	7.89	19	+22.3%
2022	0	0	0	0	0	2	1	6	6	6	8.61	21	+9.1%
2023	1	0	0	0	0	0	3	6	6	7	8.43	23	-2.1%

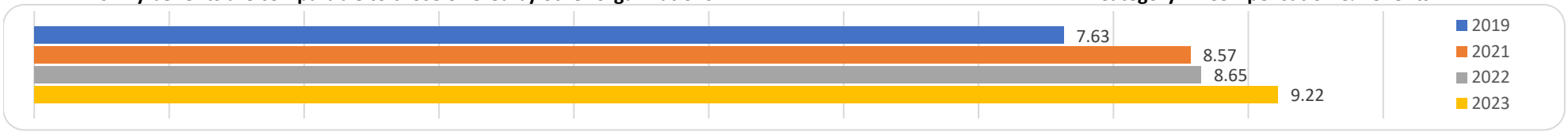
CMHPSM Employee Engagement Survey Results

25 My salary is competitive with similar jobs I might find elsewhere. **Category: Compensation & Benefits**



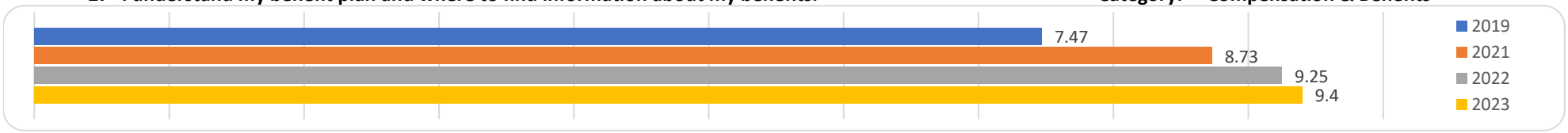
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	1	2	2	3	1	3	3	2	3	6.5	20	
2021	1	0	1	0	1	0	2	6	2	6	7.84	19	+20.6%
2022	0	0	0	0	0	2	0	8	4	7	8.66	21	+10.5%
2023	0	0	0	0	0	0	5	8	3	7	8.52	23	-1.6%

26 My benefits are comparable to those offered by other organizations. **Category: Compensation & Benefits**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	0	0	0	3	2	6	1	2	5	7.63	19	
2021	1	0	0	1	0	0	0	4	4	9	8.57	19	+12.3%
2022	0	1	0	0	0	0	2	5	3	9	8.65	20	+0.9%
2023	0	0	0	0	0	0	1	3	8	10	9.22	22	+6.6%

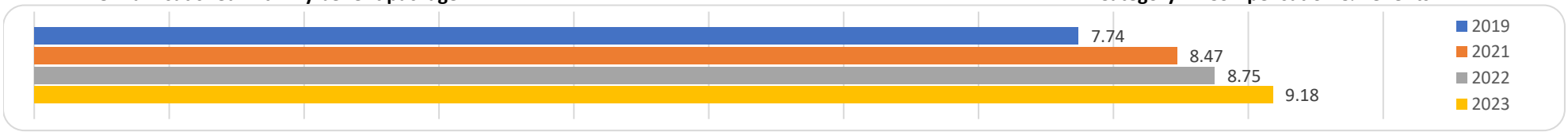
27 I understand my benefit plan and where to find information about my benefits. **Category: Compensation & Benefits**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	0	0	2	2	2	4	2	2	5	7.47	19	
2021	1	0	0	0	0	0	1	4	4	9	8.73	19	+16.9%
2022	0	0	0	0	0	0	1	3	6	10	9.25	20	+6.0%
2023	0	0	0	0	0	0	0	4	5	13	9.4	22	+1.6%

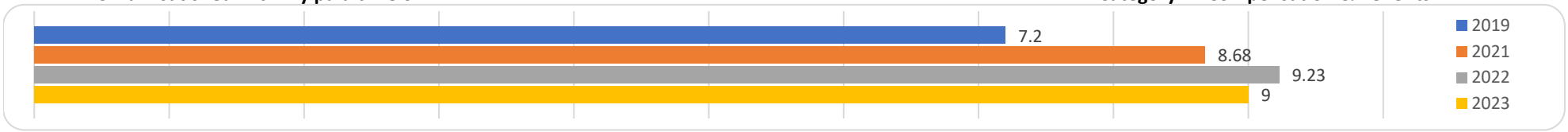
CMHPSM Employee Engagement Survey Results

28 I am satisfied with my benefit package. **Category: Compensation & Benefits**



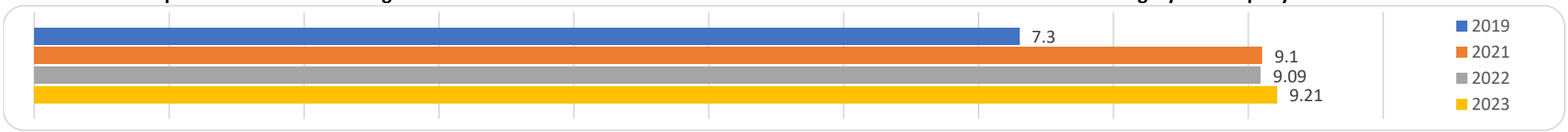
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	0	0	0	1	2	1	6	2	1	6	7.74	19	
2021	1	0	0	0	1	1	2	1	3	10	8.47	19	+9.4%
2022	0	0	0	0	0	1	1	7	4	7	8.75	20	+3.3%
2023	0	0	0	0	0	0	1	4	7	10	9.18	22	+4.9%

29 I am satisfied with my paid time off. **Category: Compensation & Benefits**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	1	1	2	1	5	1	3	5	7.2	20	
2021	1	0	0	0	0	2	1	1	3	11	8.68	19	+20.6%
2022	0	0	0	0	0	0	1	5	3	12	9.23	21	+6.3%
2023	0	0	0	0	0	1	3	3	4	12	9	23	-2.5%

30 I am proud to work for this organization. **Category: Company Pride**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2019	1	0	1	2	0	2	4	2	2	6	7.3	20	
2021	1	0	0	0	0	0	0	2	4	12	9.1	19	+24.7%
2022	0	0	0	0	0	0	4	3	1	13	9.09	21	-0.1%
2023	0	0	0	0	1	0	0	4	5	13	9.21	23	+1.3%

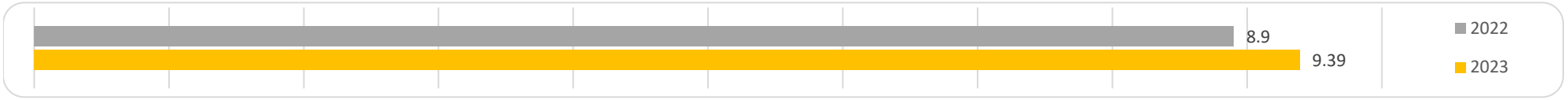
CMHPSM Employee Engagement Survey Results

2022/2023 Survey Questions

31 I feel that I'm making a difference in my community working for this organization.* **Category: Company Pride**

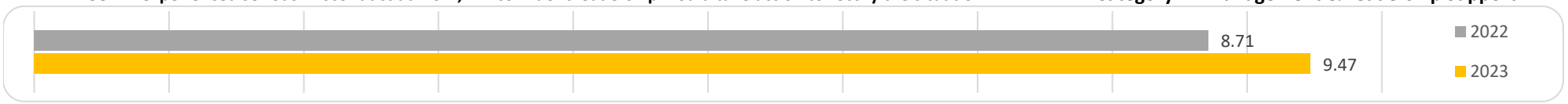
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	1	0	0	0	2	7	5	6	8.47	21	
2023	0	0	0	0	1	1	0	7	7	7	8.69	23	+2.6%

32 I'm satisfied with the amount of flexibility I have in my work schedule and workspaces.* **Category: Work Environment**



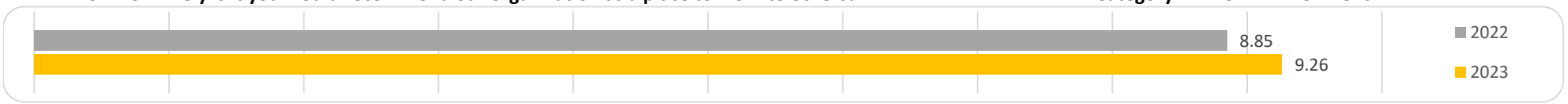
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	0	2	0	0	1	3	2	13	8.9	21	
2023	0	0	0	0	0	0	1	3	5	14	9.39	23	+5.5%

33 If I experienced serious misconduct at work, I'm confident leadership would take action to rectify the situation.* **Category: Management & Leadership Support**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	0	0	1	1	3	3	3	10	8.71	21	
2023	0	0	0	0	0	0	1	1	7	14	9.47	23	+8.7%

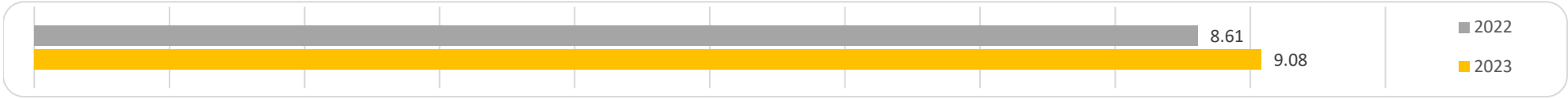
34 How likely is it you would recommend our organization as a place to work to others?* **Category: Work Environment**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	0	1	0	1	2	2	4	11	8.85	21	
2023	0	0	0	0	1	0	0	3	6	13	9.26	23	+4.6%

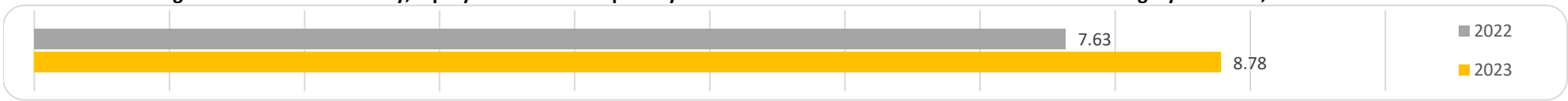
CMHPSM Employee Engagement Survey Results

35 I feel that I'm growing professionally being a part of this organization* **Category: Training & Development**



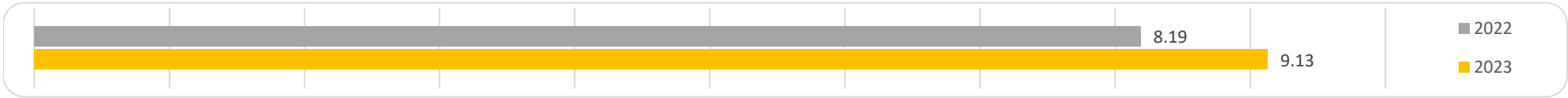
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	1	0	0	2	1	4	3	10	8.61	21	
2023	0	0	0	1	0	0	1	3	6	12	9.08	23	+5.5%

36 The organization makes diversity, equity and inclusion a priority.* **Category: Vision, Mission & Goals**



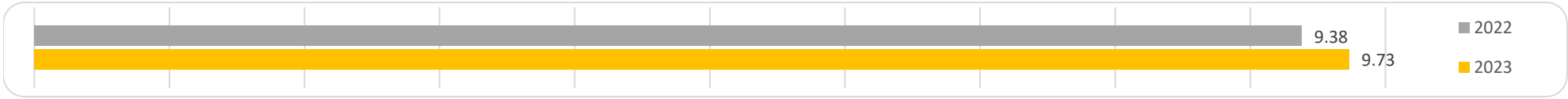
Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	0	1	1	3	4	3	4	3	7.63	19	
2023	0	0	0	0	0	2	2	3	8	8	8.78	23	+15.1%

37 The organization cares about my mental well being.* **Category: Work Environment**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	0	0	2	3	1	5	3	7	8.19	21	
2023	0	0	0	0	0	0	1	3	11	8	9.13	23	+11.5%

38 I feel the organization has respected my general health and well-being during the COVID pandemic.* **Category: Work Environment**



Survey	1	2	3	4	5	6	7	8	9	10	Average	Responses	Δ Previous Year
2022	0	0	0	0	0	1	0	2	5	13	9.38	21	
2023	0	0	0	0	0	0	0	0	6	17	9.73	23	+3.7%