LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD

VISION

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

AGENDA
February 28, 2019
705 N. Zeeb Road, Ann Arbor
Patrick Barrie Conference Room
9:30 a.m. – 11:30 a.m.

1. ***Introductions & Welcome Board Members***– 5 minutes

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

3. Approval of January 24, 2019 OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business – 15 minutes
   a. Finance Report {Att. #2} (Board Action) – 15 minutes

6. New Business – 35 minutes
   a. CCAR Training {Att. #3} – (Board Action/refresher)
   b. ABLE CHANGE PROCESS {Att. #4a #4b} – Discussion
   c. DATA REVIEW
      1. Treatment trends {Att. #5a-d} Discussion
      2. Narcan saves report {Att. #6}

7. Report from Regional Board (Discussion) – 15 minutes

8. SUD Director Updates (Discussion) – 10 minutes
   a. Grants and program implementation
   b. MDOC services status

Next meeting: February 28, 2019

Parking Lot:

LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
January 24, 2019 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present:	David Oblak, Dianne McCormick, William Green, Tom Waldecker, Kim Comerzan, Mark Cochran, Blake LaFuente, John Lapham, Ralph Tillotson, Monique Uzelac
Members Absent:	Amy Fullerton, Charles Coleman, Susan Webb, Dave O'Dell
Guests:	Jackie Bradley
Staff Present:	Stephannie Weary, Marci Scalera, Suzanne Stolz, Amy Johnston, Dana Darrow, Jane Terwilliger, Katie Postmus, Jane Goerge, Nicole Adelman, Erika Behm

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

1. Discussion with Jane Terwilliger – Review of Administrative Hearing
   - J. Terwilliger provided an overview of funding within the region, and the actions being taken to address funding shortfalls.
   - Each CMH has a plan for achieving administrative efficiencies.
   - No SUD funds are being used to cover mental health deficits.
   - OPB supports the continued separation of SUD funds from the mental health deficit.

2. Introductions

3. Approval of the Agenda

   Motion by K. Comerzan, supported by D. McCormick, to approve the agenda
   Motion carried

4. Approval of the October 25, 2018 OPB meeting minutes

   Motion by T. Waldecker, supported by J. Lapham, to approve the October 25, 2018 OPB minutes
   Motion carried

5. Audience Participation
   - None

6. Old Business
   1. Finance Report
      - S. Stolz presented. Discussion followed.
   2. **PA2 funding back up**
      - Discussed the issue of how PA2 funds are used to cover any gaps in services or to sustain programs where funding is ending. OPB agreed that this has been the general practice and continues to support the use of funds when needed, based

on actual utilization for each respective county. Finance will continue to provide information to the OPB as funds are used for this purpose.

7. New Business
   a. Monroe Access Services
      Board Action
      Motion by T. Waldecker, supported by W. Green, to approve funding for Monroe CMHA access for a total of $66,524.50 annually through PA2 funds and/or block grant
      Motion carried

      - Staff will be a Monroe CMH employee. The position will expand the capacity to manage the SUD calls in Monroe.
      - In the last year there has been some concern around having just 1 person for the entire county to perform screenings for SUD access. Monroe had expressed an interested in working more with people with substance use disorders.

   b. New Vendor for Women's Recovery Housing
      Board Action
      Motion by T. Waldecker, supported by J. Lapham, to approve funding for Marie's House of Serenity, a new Recovery Housing program opening in Ypsilanti
      Motion carried

   c. Vaping proposal
      Board Action
      Motion by J. Lapham, supported by M. Uzelac, to approve PA2 funding for regional FY19 youth vaping/e-cigarette prevention efforts provided by Karen Bergbower and Associates (KBA)
      Motion carried

   d. Membership Status
      - Monroe: M. Cochran's reappointment will go to the Monroe MH board on February 27, 2018. K. Comerzan's reappointment has been approved.
      - Washtenaw: B. LaFuente's reappointment by the Washtenaw BOC will extend through June 2019, at which time he will relocate.
      - Livingston has 2 vacancies
      - Lenawee has 1 vacancy.
   e. Kratom Information
      - Monroe has experienced problems with Kratom use.
      - OPB discussed the prevalence of kratom.
      - K. Postmus suggested including information about kratom as part of the vendor education packet for smoking/vaping.

8. Report from Regional Board
   - See agenda item #1 for J. Terwilliger's update.

9. SUD Director Updates
   - M. Scalera has submitted her retirement notice, effective 6/28/19. After retirement, she will be available to consult if needed.
   a. Mini-grants
      - Each county gets $5k at the start of each year fiscal year.

- The Monroe Youth Summit was approved by M. Scalera under the mini-grants arrangement.

b. Grants and program implementation
   - Monroe opened its Engagement Center in November. There were over 50 admissions in the first month. The center has been well-received.
   - The SOR grant started Dec. 1, 2018. There were some NARCAN-related expenses.
   - In the works: Recovery housing, increase of jail MAT services, Work It contract.

c. LARA License Impact
   - M. Scalera provided the new licensing rules to OPB.

d. MDOC services status
   - The MDOC contact is still in the planning phase of turning over responsibility of authorizing services for parolees for clinical services to the PIHPs.
   - Implementation is expected in October 2019.

e. OPB Meeting Alerts
   - How should we alert OPB members of last-minute cancellations? OPB requested texts.

10. Adjourn

Motion by T. Waldecker, supported by J. Lapham, to adjourn the meeting
Motion carried

Meeting adjourned at 11:30 p.m.

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
December 2018 FY19

Summary Of Revenue & Expense	Funding Source							Total Funding Sources
	Medicaid	Healthy Michigan	SUD - Block Grant	SUD - SOR	SUD - STR	Gambling Prev	SUD-COBO/PA2	
Revenues								
Funding From MDCH	606,786	1,105,922	1,408,882	133,333	139,687	33,333		$ 3,427,943
PA2/COBO Tax Funding Current Year	-	-	-	-	-	-	465,015	$ 465,015
PA2/COBO Reserve Utilization	-	-	-	-	-	-	391,108	$ 391,108
Other	-	-	-	-	-	-	-	$ -
Total Revenues	$ 606,786	$ 1,105,922	$ 1,408,882	$ 133,333	$ 139,687	$ 33,333	$ 856,123	$ 4,284,066
Expenses								
Funding for County SUD Programs								
CMHPSM				16,880	118,519	14,399		149,798
Lenawee	114,119	220,086	128,218				70,385	532,808
Livingston	75,223	138,873	229,706				141,462	585,263
Monroe	75,616	152,675	227,725				77,347	533,363
Washtenaw	281,017	771,485	390,900				231,224	1,674,626
Total SUD Expenses	$ 545,974	$ 1,283,119	$ 976,548	$ 16,880	$ 118,519	$ 14,399	$ 520,418	$ 3,475,858
Administrative Cost Allocation	27,002	63,453	62,360	912	6,400	778	-	$ 160,904
Total Expenses	$ 572,976	$ 1,346,572	$ 1,038,909	$ 17,792	$ 124,919	$ 15,177	$ 520,418	$ 3,636,762
Revenues Over/(Under) Expenses	$ 33,810	$ (240,650)	$ 369,973	$ 115,542	$ 14,768	$ 18,157	$ 335,705	$ 647,304

Current fiscal year utilization of PA2	Revenues	Expenditures	Revenues Over/(Under) Expenses
PA2 by County			
Lenawee	68,628	70,385	(1,757)
Livingston	206,696	141,462	65,234
Monroe	151,279	77,347	73,932
Washtenaw	429,520	231,224	198,295
Totals	$ 856,123	$ 520,418	$ 335,705

Unallocated PA2	FY 18 Beginning Balance	FY18 Projected Utilization *	FY19 Projected Beginning Balance	FY19 Projected Utilization	FY20 Projected Utilization	FY20 Projected Ending Balance
Lenawee	961,376	(38,182)	923,194	(222,723)	(222,723)	477,747
Livingston	2,646,564	(6,539)	2,640,025	(613,133)	(613,133)	1,413,759
Monroe	708,058	(2,419)	705,639	(164,037)	(164,037)	377,565
Washtenaw	2,583,425	(185,832)	2,397,593	(598,506)	(598,506)	1,200,582
Total	$ 6,899,423	$ (232,972)	$ 6,666,451	$ (1,598,399)	$ (1,598,399)	$ 3,469,653

* FY18 Projected Utilization is based on estimated use of PA2 to cover deficits of treatment and prevention in Medicaid and HMP.

Attachment #
2/28/19

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date: FEBRUARY 28, 2019

Action Requested: Peer Recovery Coach Academy - The Recovery Coach Academy is required for peers who are working in the coaching capacity with our provider organizations, CMH's and projects related to treatment and prevention in our region. Having a Certified Recovery Coach enables these services to be covered through Medicaid and Block grant funding. The CMHPSM has supported these large trainings around the region over the years. We would like to offer a maximum of 40 slots for this training. Individuals who are in stable recovery for two years and who are certified are eligible for employment in the substance use field. Many of these folks go on to further their education and move along the career ladder as clinicians, case managers and leaders. This training will be for all interested persons in recovery within our region. It is a five-day intensive training. The objectives are as follows:

1) Describe the roles and functions of a Recovery Coach
2) List the components, core values and guiding principles of recovery
3) Build skills to enhance relationships
4) Discuss co-occurring disorders and medicated-assisted recovery
5) Describe stages of change and their applications
6) Address ethical issues
7) Experience wellness planning
8) Practice newly-acquired skills

Budget: Total request – not to exceed $15,500
Trainer and manuals - $300/person – max 40 persons; includes manuals
Materials - $400
Food $10 x 40 persons x 5 days $2000
Venue: Holiday Inn Express - $200 x5 = $1000

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

Workforce development is a strategic objective for the SUD system, CMHSP and state. Expansion of qualified peers to fill positions region wide is necessary as state and federal expansion grants rely heavily on recovery coaches.

Recommendation:

Approval of maximum $15,500 PA2 Funds for Recovery Academy training

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date:

May 24, 2018

Action Requested:

Approve funding for trainings out of PA 2 funds

Background:

1. This region is in need of access to ASAM Certification Training as the move to improve access to services increases; clinicians having a better understanding of the level of care assessment that aligns with the GAIN assessment tool mandated by the state and to increase the knowledge base of the field within our region. While the state arranged 5 ASAM trainings this year, they filled up within 24 hours and our region staff could not access any space. Staff are requesting funding the specialized training regionally and inviting nearby PIHP's to help support the training and paying for their region's attendees. The cost for this training would be just under $10,000.
2. There have been multiple requests across the region to host another CCAR training for peers. The cost of the full training for up to 40 attendees is approximately $15,000. The last training was held in April 2017.

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

Ensure recovery focused services; support professional development for peers and staff, meet required credentialing standards.

Recommendation:

Approval of PA2 funding for regional trainings

Ideal Coordinated and Aligned System

Promoting Wellbeing and reducing harm from substance use in Washtenaw County

Shared Values

Client-centered/driven

Equitable

Holistic

SUD Need Identified

- Universal screening tool/process
- Community awareness of SUD
- No wrong door, outreach

Warm Handoff to Intake, follow-up

Peer supports

Centralized Intake

- Efficient, Accessible intake process
- Direct connection to appropriate service pathway
- Centralized waitlist management

Warm Handoff to Services, follow-up

Peer supports

System and process to share client data

Integrated Array of Accessible Supports

- Full spectrum of high-quality supports
- Integrated and Aligned
- Accessible

Aftercare Plan created

Warm Handoff

Peer supports

Aftercare & Reengagement

- Seamless transition to aftercare services and supports
- Successfully re-engages in community

People experiencing substance use disorders participating in decision-making at all levels

Shared monitoring, learning and evaluation system

Ideal Coordinated and Aligned System

Promoting Wellbeing and reducing harm from substance use in Washtenaw County

Shared Values

Client-centered/driven
- Person-centered approach
- User friendly
- Supportive across all *stages of change*
- Responsive to needs ("*meeting people where they are at*")
- Empowerment-driven (clients as "*change agents*")
- Shared service planning (provider and client)
- Grounded in family engagement principles

Equitable
- Equity-oriented
- Grounded in cultural humility
- Trauma-informed

Holistic
- Grounded in wrap-around philosophy
- Solution-oriented
- Prevention-focused
- Positioned to promote well-being
- harm reduction ideology
- Connected to the peer-support/recovery community

SUD Need Identified

- **Universal screening tool/process**
  - state-wide tool
  - Trained staff
- **Community awareness of SUD**
- **No wrong door, outreach**
  - Health Care System/ER
  - Social Service System
  - Criminal Justice System
  - Education System
  - Natural Supports (e.g. Family, Church)
  - Individuals

Warm Handoff to Intake, follow-up

Peer supports

Centralized Intake

- **Efficient, accessible assessment/intake process**
  - Short process
  - Uses universal assessment tool that is user friendly (for both clients and staff) and includes needs outside SUD (e.g., basic needs, SDOH)
  - Multiple modalities (online, in-person, phone, mobile) with translation available
  - Use of electronic health records
- **Direct connection to appropriate service pathway**
  - Immediate connection (not multiple hoops)
  - Based on consumer's needs and desires
  - Full menu of services & approaches available to everyone
  - Available regardless of client's ability to pay
  - No eligibility limits until stabilized
- **Centralized waitlist management**

Warm Handoff to Services, follow-up

Peer supports

System and process to share client data

Integrated Array of Accessible Supports

- **Full spectrum of high-quality supports**
  - SUD, medical, beh. health, peer support, MAT, PRC
  - secondary consumer support (e.g., family members)
  - Novel approaches to engagement + recovery (smartphones)
- **Integrated and Aligned**
  - Cross-sector providers working together (e.g., regular case meetings with interdisciplinary teams)
  - Regular communication, sharing information
  - Centralized case management
  - Unified Continuum of Care
  - Co-location/co-delivery/co-occurring competencies
  - Integrated SUD/MH treatment
- **Accessible**
  - Accessible locations (could be at home)
  - Timely and available 24/7
  - Transportation supports

Aftercare Plan created

Warm Handoff

Peer supports

Aftercare & Reengagement

- **Seamless transition to aftercare services and supports**
  - Continuity of care
  - Engagement with recovery community
- **Successfully re-engages in community**
  - Consumer does not experience stigma or shame from community
  - Conditions for healthy living (guaranteed supportive housing, social support, living wage jobs, child care, etc.)

People experiencing substance use disorders participating in decision-making at all levels

Shared monitoring, learning and evaluation system: Shared data platform, universal outcome measures (about clients and care coordination) reviewed regularly by representative group, quantitative and qualitative data

Barriers to Coordinated and Aligned System

*Barriers in **red** are most actionable

Promoting Wellbeing and reducing harm from substance use in Washtenaw County

Shared Values

BARRIERS in general:

- **Agencies have distinctive missions that overstate differences and discourages collaborations**
- Lack of integrated funding philosophies, models, and strategies across funders
- Different treatment approaches/ philosophies between providers (example: Harm reduction vs. abstinence-based)

BARRIERS to Client-centered/driven

- Systems driven, not person's needs driven

BARRIERS to Equitable

- **Some providers hold implicit biases**
- **Limited translation supports** (for those who do not speak English as a first language) during all phases of Service Delivery (including recovery community services/community supports)
- **Lack of trauma-in formed practices**
  - Lack of staff training
  - Lack of safe spaces (e.g., lobbies with glass, choice of space)
- **Barriers for clients from disadvantaged groups**
  - lacking citizenship or legal resident status, official identification (license, passport, birth certificate)
  - Youth
  - non-Christians
  - clients who lack: literacy, transportation, childcare, phone access

BARRIRES to Holistic

- Limited consideration to basic health needs (food, shelter) within treatment

SUD Need Identified

BARRIERS to Universal screening tool/process

- **Varied intake screening and assessment tools**

BARRIERS to Community awareness of SUD

- **Education limited or not reaching right populations**
- **Lack of trust in accessing** SUD and MH systems
- Lack of knowledge/ awareness of service options
- Cultural beliefs about accessing SUD and MH supports

BARRIERS to No wrong door, outreach

- **Cross-sector providers lack capacity to effectively refer to SUD system**
- **Lack of training, discomfort**
- Existing stigmas re: SUD and MH

BARRIERS to:

Warm Handoff to Intake, follow-up
No follow-up standards, processes

Peer supports
Lack of peer services available

Centralized Intake

BARRIERS to Efficient, Accessible intake process

- **Lengthy screening and assessment tools/process** - lots of paperwork for providers and clients, clients calling each day
- **No universal assessment tool** (partly due to legal and funding requirements)
- Lack of Centralized Access point - multiple intake points and processes (e.g., SUD and MH are separate intake processes)
- Limited intake options (i.e. in-person, online, etc.)
- As result: clients have hard time completing, increases distrust of system

BARRIERS to Appropriate service pathway identified

- **Policies in place that randomly assign (based on client's birthday) new clients to 1 of 2 varied treatment options**; this random assignment of service offerings does not always best meet clients' needs.
- **Some service providers lack knowledge of service options and pathways**
- Different referral criteria largely contingent on funding
- Competition among referral agencies (more clients=more $/sustained funding)
- Client has to complete multiple steps to qualify for services
- Lack of "*no cost consideration*" practices in place
- Eligibility restrictions before client is stabilized (prolonged wait time if not a priority evaluation)
- Capturing only people ready/interested in treatment

BARRIERS to Centralized waitlist management

- **Waitlist management gap**

BARRIERS to:

Warm Handoff to Services, follow-up
No follow-up standards, processes

Peer supports
Lack of peer services available

System and process to share client data

- **No universal Release of Information/shared client consent form**; challenge of confidentiality laws (HIPAA)
- Lack of centralized, coordinated electronic data infrastructure to share client health data (including historical data) across agencies and services

Integrated Array of Accessible Supports

BARRIERS to Full spectrum of high-quality supports (focus of action teams)

- **Lack of support for providers (clinical supervisors)**
- **Lack of awareness within the system of how to best/comprehensively treat dual diagnosis**
- **Lack of provider awareness of relapse triggers**
- lack of full spectrum of services*
- Lack of crisis services available at all service points; underdeveloped mobile crisis or mobile outreach
- Lack of providers (especially on East side of county)
- Lack of provider certification/professionalization in the field

BARRIERS to Integrated and Aligned

- **Providers within different parts of the system have overlapping competencies; creating role confusion and competency redundancies**
- **Limited co-locations/co-delivery**
- **Lack of multidisciplinary training**
- **Lack of cross-sector complex case meetings/conferences/ interdisciplinary teams**
- **Providers can't attend meetings**
- 2 separate (and varied) Continuums of Care within the system
- Lack of coordination between providers*
- Coordination relationship dependent
- Lack of primary care provider integration
- Lack of centralized Care Managers

BARRIERS to Accessible (action team focus)

- Limited service time offerings (example: No 24/7 access to detox, outpatient, behavior health)
- Lack of timely appointments (lack of providers = long waitlists) - as result: Lose clients post-intake, as care isn't immediate ("*loss to care*"/"*loss to follow-up*")
- Lack of accessible locations
- Limited transportation supports (especially out-county)
- Limited childcare supports

BARRIERS to:

Aftercare Plan created

Warm Handoff

- **No follow-up standards, processes**
- **Ineffective communic-ation related to transitions**
- Bureaucracy

Peer supports

- **Lack of peer services available**

Aftercare & Reengagement

BARRIERS to Seamless transition to aftercare services and supports

- **Current transitions aren't flexible**
- **Lack of engagement with the recovery community**
- Lack of resources for aftercare

BARRIERS to Successfully re-engages in community

- Lack of community housing
- Lack of safe community spaces

BARRIERS to People experiencing substance use disorders participating in decision-making at all levels

BARRIERS to Shared monitoring, learning and evaluation system: Absence of universal, system-wide outcome measures; Lack of data infrastructure and evaluations in place to monitor client outcomes and coordinated care processes; Limited data; Mistrust of data; Categories to select for outcomes don't apply to SUD services; Certain measures are required by some agencies and not others

Vision: Health Equity

Wellbeing

- Increased Recovery
- Improved Mental Health
- Educational Attainment
- Gainful Employment/ Reduced Poverty
- Expanded Social Support/Connections
- Housing Stability
- Quality of Life

Reduced Harm from Substance Use

- People Accessing Appropriate Substance Use Treatment
- Decreased Overdose Deaths
- Reduced Suicide/Suicide Attempts
- Fewer Emergency Room Visits
- Reduced Accidents from Substance Use
- Improved Maternal and Newborn Outcomes
- Reduced Adverse Child Experiences (ACEs)
- Decreased Child Welfare Contacts
- Reduced Legal Involvement
- Less Violence and Crime

Community System Conditions

What we need to put in place to achieve Vision

Effective System Conditions

- Integrated and Coordinated System
- Reduced Service Access Barriers
- Aligned and Sufficient Funding
- Quality, Person-centered Treatment on Demand
- Diverse Residents Engaged in Decision-making
- Universal Assessment Based on Need
- Shared Data and Measures
- Integrated Community of Care
- Diversity in Workforce

Community Living Conditions

- Affordable Safe Housing
- Sense of Community
- Reduced Stigma around Substance Use
- Accessible Transportation
- Living Wage Jobs
- Outcome Inequities Eliminated

CMHPSM MONROE COUNTY SUD DATA

The following data describes Monroe County clients receiving substance use disorder services. Admissions may be in any treatment level of care. Clients could have multiple admissions during the year. A "unique client" is a count of individuals, rather that the number of admissions.

TOTAL ADMISSIONS IN MONROE COUNTY BY YEAR:	TOTAL NUMBER OF UNIQUE CLIENTS	TOTAL NUMBER OF ADMISSIONS	TOTAL NUMBER OF ADOLESCENTS AND YOUNG ADULTS <=20 UNIQUE	TOTAL NUMBER OF ADOLESCENT ADMISSIONS
2018	813	1201	26	32
2017	738	1116	32	38
2016	577	904	25	38

This chart looks at admission into services by level of care. In 2018, the CMHPSM began providing incentive funds for office based opioid treatment (OBOT) in primary care clinics to provide medication assisted treatment (MAT) as a way of expanding this service to persons with opiate use disorders. *(2018 saw a transfer from one ORT provider to another, which caused a doubling of admissions in ORT. Unique client number are more accurate in total count)

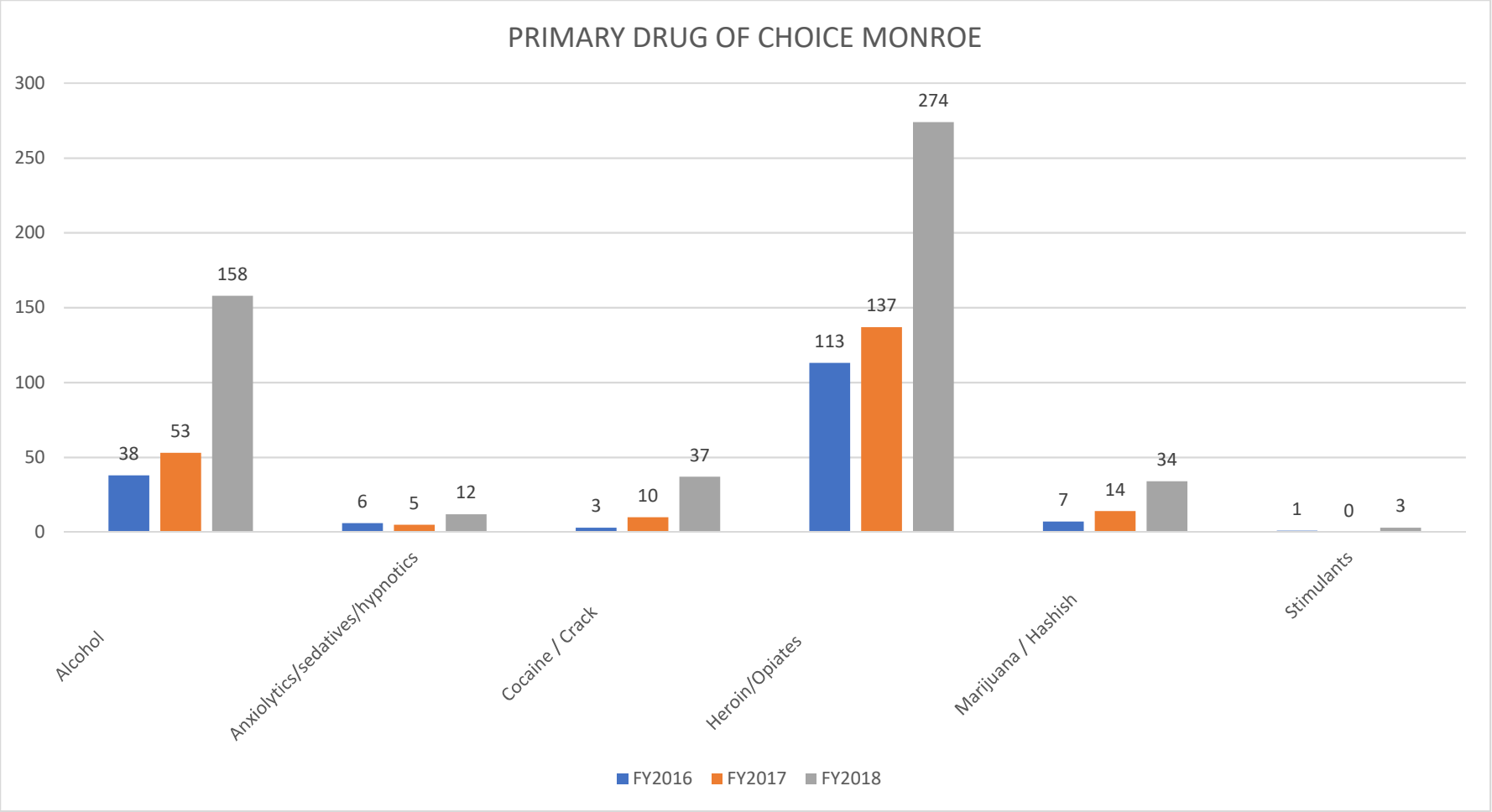
TOTAL ADMISSIONS IN MONROE COUNTY BY YEAR:	Withdrawal Management (Detox)	ORT (Methadone)	MAT - OBOT	ST RES	LT RES	OUTPATIENT
2018	166	340*	104	84	3	558
2017	277	234		102	9	555
2016	304	110		87	5	446

Living situation upon admission

Housing	2016	2017	2018
Dependent living (SUD)	545	644	109
Homeless	99	125	54
Independent living (SUD)	236	347	355

Att. #5a

When individuals are assessed, they identify what their primary drug of choice is and treatment is built around their clinical need, which includes level of care, stage of readiness for change, and other factors. Clients may also have secondary and tertiary drug of choice. This date in not included in this chart.



Att. #5a

This data describes categories provider select related to reason for discharge. Clients may receive multiple levels of care at different providers. These are coded as transfers but are considered an ongoing episode of care. Clients leave treatment by choice, often through no shows. Providers must discharge the case after 90 days but do attempt to contact clients who do not return. Data shows persons with addictive disorders often have multiple relapses and treatment episodes as they move towards recovery.

Discharge Reason	2016	2017	2018
Death	1	5	2
Dropped out of treatment	344	393	259
Incarcerated or released /courts	42	61	51
Other	20	15	20
Terminated by facility	25	17	28
Transfer to another treatment	107	81	63
Treatment completed	299	318	216

CMHPSM LENAWEE COUNTY SUD DATA 2016-2018

The following data describes Lenawee County clients receiving substance use disorder services. Admissions may be in any treatment level of care. Clients could have multiple admissions during the year. A "unique client" is a count of individuals, rather that the number of admissions.

TOTAL ADMISSIONS IN LENAWEE COUNTY BY YEAR:	TOTAL NUMBER OF UNIQUE CLIENTS	TOTAL NUMBER OF ADMISSIONS	TOTAL NUMBER OF ADOLESCENTS AND YOUNG ADULTS <=20 UNIQUE	TOTAL NUMBER OF ADOLESCENT ADMISSIONS
2018	609	860	37	44
2017	614	871	40	46
2016	418	569	27	27

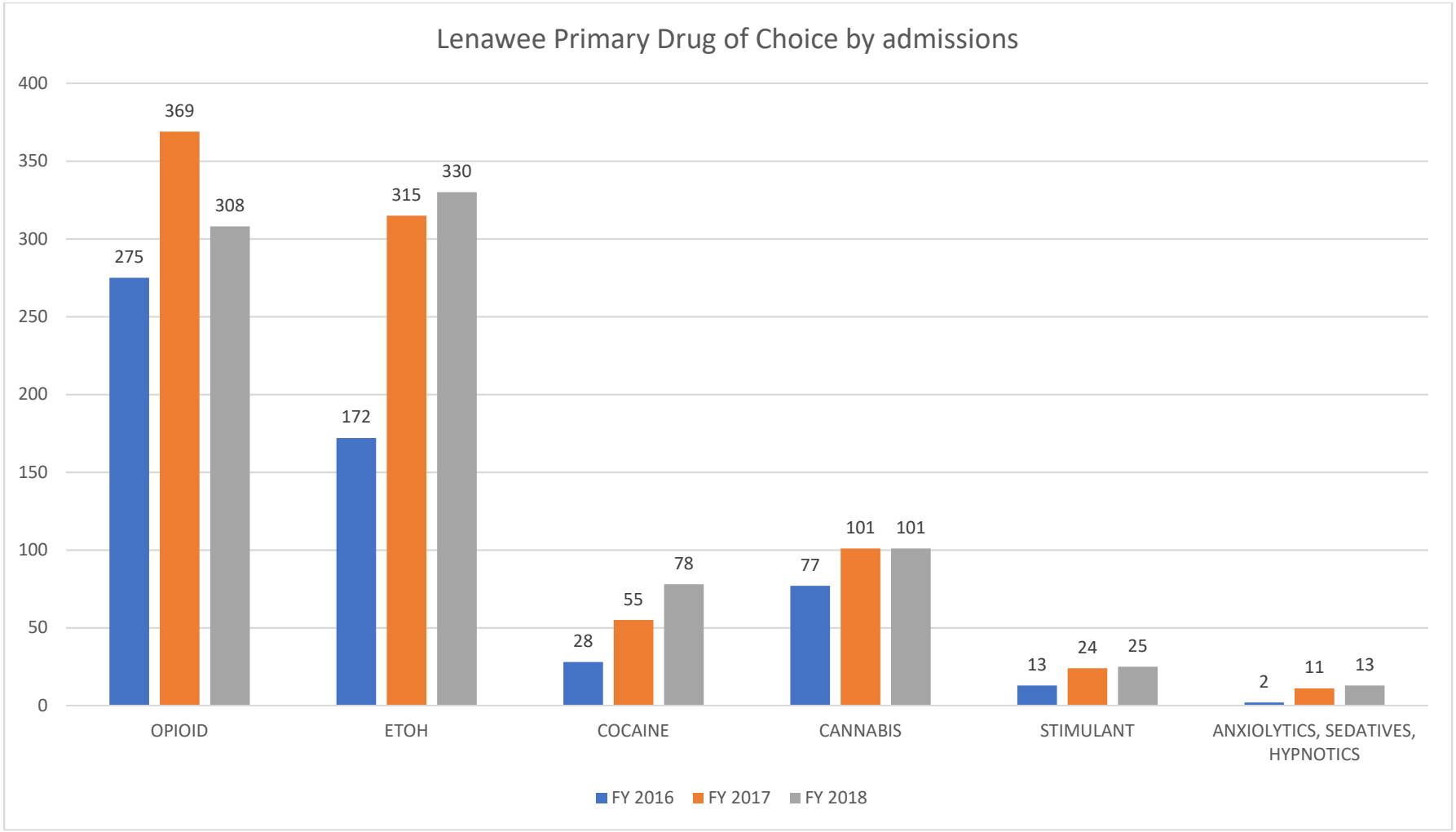
This chart looks at admission into services by level of care. In 2018, the CMHPSM began providing incentive funds for office based opioid treatment (OBOT) in primary care clinics to provide medication assisted treatment (MAT) as a way of expanding this service to persons with opiate use disorders.

TOTAL ADMISSIONS IN LENAWEE COUNTY BY YEAR:	Withdrawal Management (Detox)	ORT (Methadone)	MAT - OBOT	ST RES	LT RES	OUTPATIENT
2018	99	46		63	89	563
2017	117	52		49	91	563
2016	85	44		60	58	322

Living situation upon admission

Housing	**2016**	**2017**	**2018**
Dependent living (SUD)	377	559	363
Homeless	54	63	70
Independent living (SUD)	138	240	427

When individuals are assessed, they identify what their primary drug of choice is and treatment is built around their clinical need, which includes level of care, stage of readiness for change, and other factors. Clients may also have secondary and tertiary drug of choice. This date in not included in this chart.



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Discharge Reason	2016	2017	2018
Death	4	7	2
Dropped out of treatment	219	344	308
Incarcerated or released /courts	32	50	33
Other	17	38	14
Terminated by facility	12	17	14
Transfer to another treatment	96	121	82
Treatment completed	164	234	176

CMHPSM LIVINGSTON COUNTY SUD DATA

The following data describes Livingston County clients receiving substance use disorder services. Admissions may be in any treatment level of care. Clients could have multiple admissions during the year. A "unique client" is a count of individuals, rather that the number of admissions.

TOTAL ADMISSIONS IN LIVINGSTON COUNTY BY YEAR:	TOTAL NUMBER OF UNIQUE CLIENTS	TOTAL NUMBER OF ADMISSIONS	TOTAL NUMBER OF ADOLESCENTS AND YOUNG ADULTS <=20 UNIQUE	TOTAL NUMBER OF ADOLESCENT ADMISSIONS
2018	276	364	10	10
2017	196	261	6	8
2016	164	207	6	6

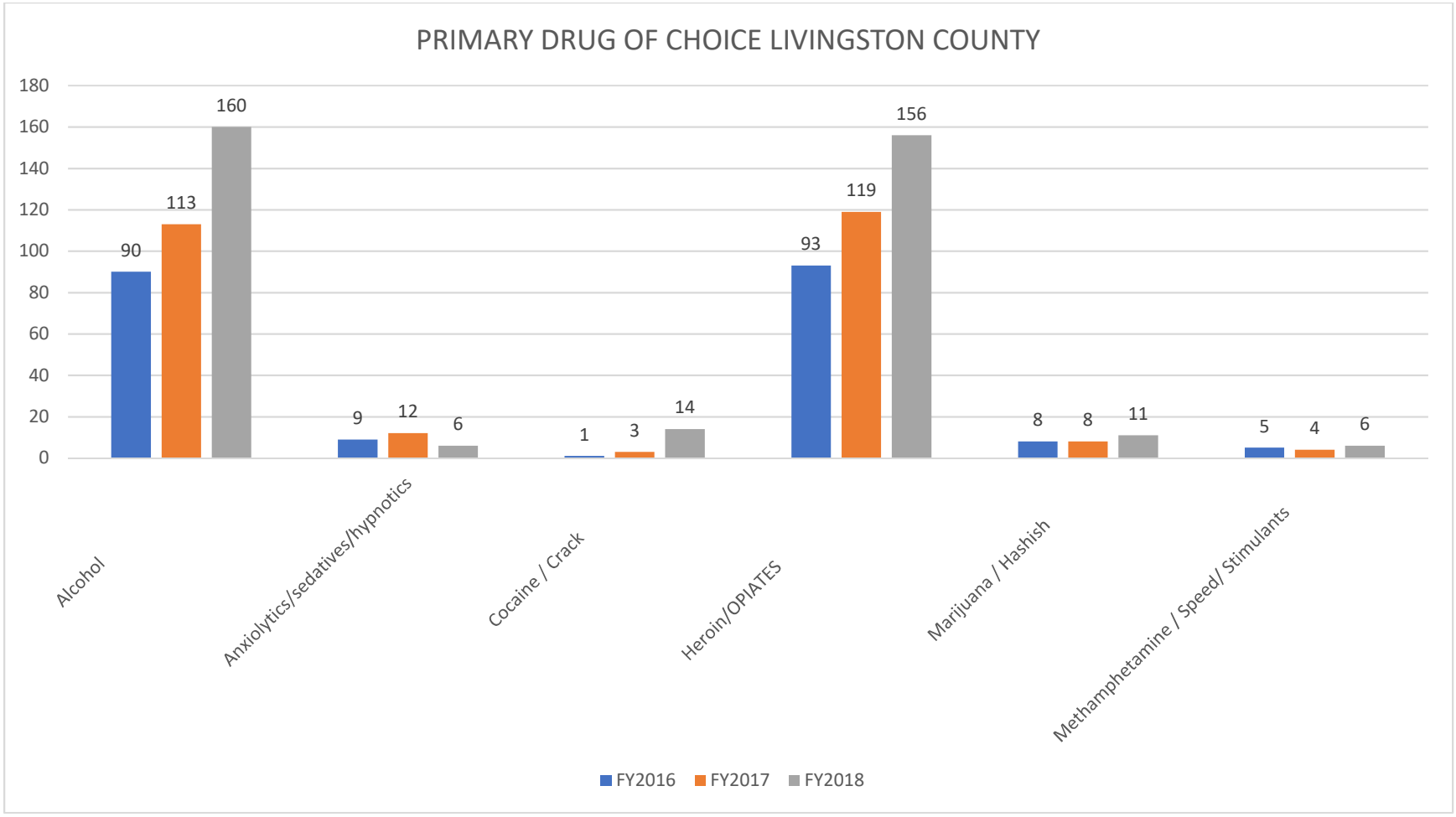
This chart looks at admission into services by level of care. In 2018, the CMHPSM began providing incentive funds for office based opioid treatment (OBOT) in primary care clinics to provide medication assisted treatment (MAT) as a way of expanding this service to persons with opiate use disorders.

TOTAL ADMISSIONS IN LIVINGSTON COUNTY BY YEAR:	Withdrawal Management (Detox)	ORT (Methadone)	MAT - OBOT	ST RES	LT RES	OUTPATIENT
2018	51	48		47	22	196
2017	50	46		41	22	102
2016	36	29		26	8	108

Living situation upon admission

Housing	2016	2017	2018
Dependent living (SUD)	140	159	111
Homeless	19	25	31
Independent living (SUD)	48	77	221

When individuals are assessed, they identify what their primary drug of choice is and treatment is built around their clinical need, which includes level of care, stage of readiness for change, and other factors. Clients may also have secondary and tertiary drug of choice. This date in not included in this chart.



This data describes categories provider select related to reason for discharge. Clients may receive multiple levels of care at different providers. These are coded as transfers but are considered an ongoing episode of care. Clients leave treatment by choice, often through no shows. Providers must discharge the case after 90 days but do attempt to contact clients who do not return. Data shows persons with addictive disorders often have multiple relapses and treatment episodes as they move towards recovery.

Discharge Reason	2016	2017	2018
Death	1	2	2
Dropped out of treatment	89	87	71
Incarcerated or released /courts	4	5	5
Other	9	8	3
Terminated by facility	3	3	4
Transfer to another treatment	55	73	77
Treatment completed	25	41	41

CMHPSM WASHTENAW COUNTY SUD DATA

The following data describes Washtenaw County clients receiving substance use disorder services. Admissions may be in any treatment level of care. Clients could have multiple admissions during the year. A "unique client" is a count of individuals, rather that the number of admissions.

TOTAL ADMISSIONS IN WASHTENAW COUNTY BY YEAR:	TOTAL NUMBER OF UNIQUE CLIENTS	TOTAL NUMBER OF ADMISSIONS	TOTAL NUMBER OF ADOLESCENTS AND YOUNG ADULTS <=20 UNIQUE	TOTAL NUMBER OF ADOLESCENT ADMISSIONS
2018	2088	2602	42	57
2017	1361	2547	40	45
2016	1154	2196	38	47
2015	914	1700	30	50

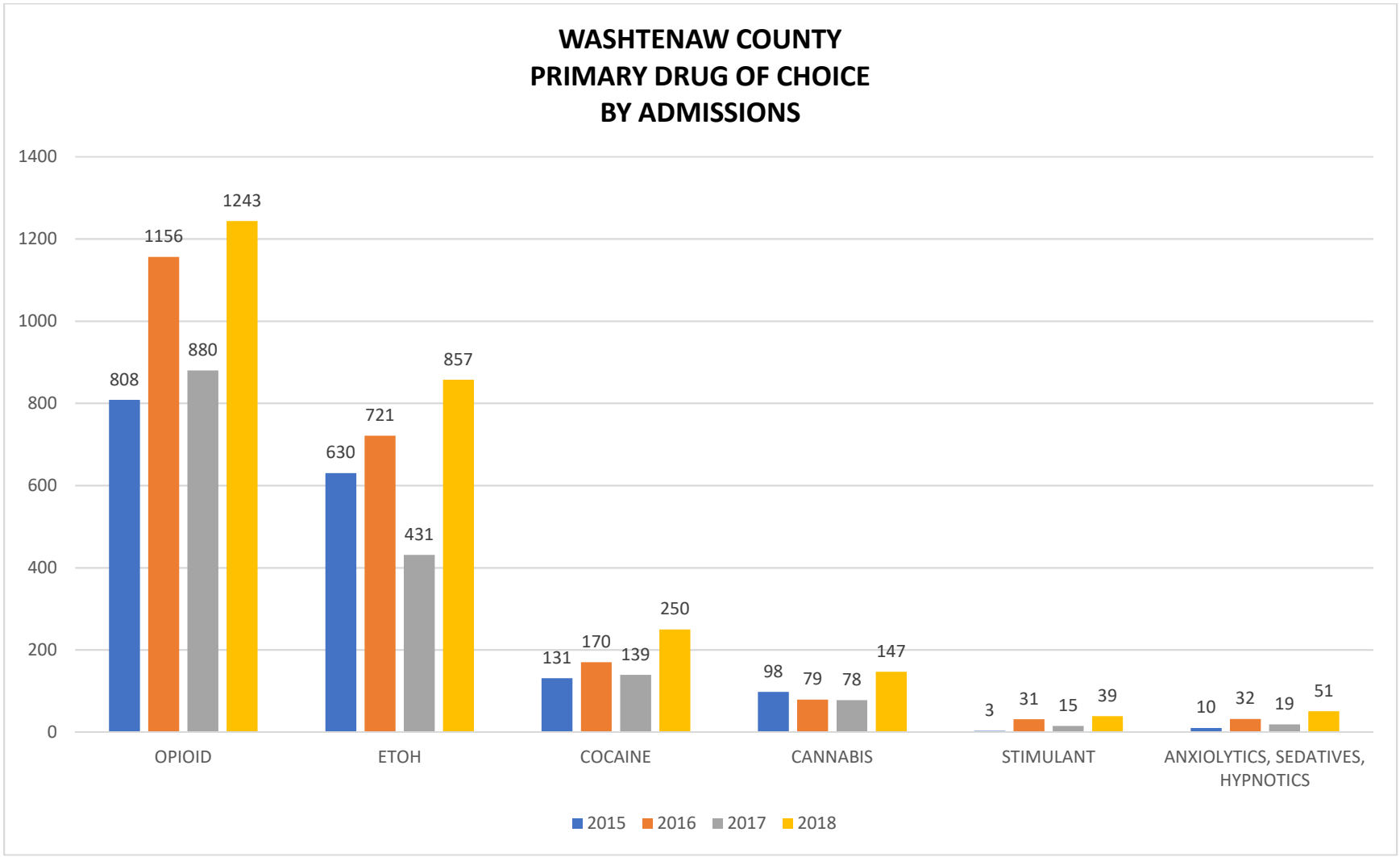
This chart looks at admission into services by level of care. In 2018, the CMHPSM began providing incentive funds for office based opioid treatment (OBOT) in primary care clinics to provide medication assisted treatment (MAT) as a way of expanding this service to persons with opiate use disorders.

TOTAL ADMISSIONS IN WASHTENAW COUNTY BY YEAR:	Withdrawal Management (Detox)	ORT (Methadone)	MAT - OBOT	ST RES	LT RES	OUTPATIENT
2018	532	492	143	401	131	1557
2017	619	456		412	82	1568
2016	647	324		369	55	1255
2015	352	173		239	35	645

Living situation upon admission

Housing	**2015**	**2016**	**2017**	**2018**
Dependent living (SUD)	152	637	750	633
Homeless	616	601	551	632
Independent living (SUD)	934	621	789	1301

When individuals are assessed, they identify what their primary drug of choice is and treatment is built around their clinical need, which includes level of care, stage of readiness for change, and other factors. Clients may also have secondary and tertiary drug of choice. This date in not included in this chart.



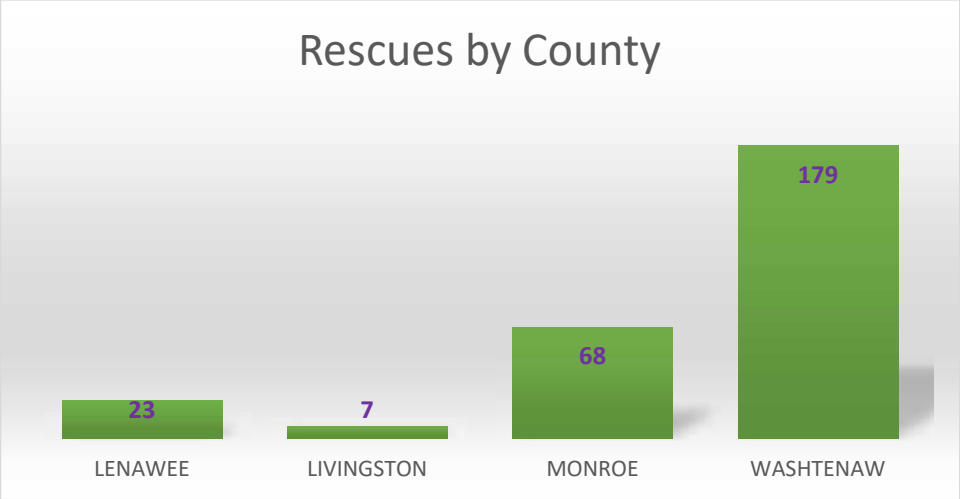
This data describes categories provider select related to reason for discharge. Clients may receive multiple levels of care at different providers. These are coded as transfers but are considered an ongoing episode of care. Clients leave treatment by choice, often through no shows. Providers must discharge the case after 90 days but do attempt to contact clients who do not return. Data shows persons with addictive disorders often have multiple relapses and treatment episodes as they move towards recovery.

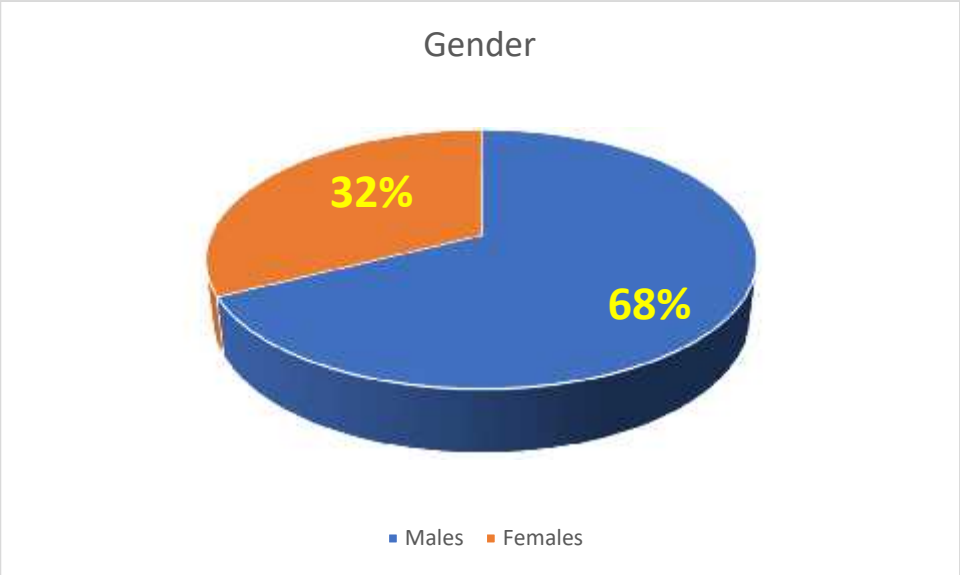
Discharge Reason	2016	2017	2018
Death	3	4	6
Dropped out of treatment	640	669	520
Incarcerated or released /courts	12	19	25
Other	154	169	50
Terminated by facility	39	38	48
Transfer to another treatment	670	731	655
Treatment completed	315	349	315

REGIONAL NALOXONE SAVES

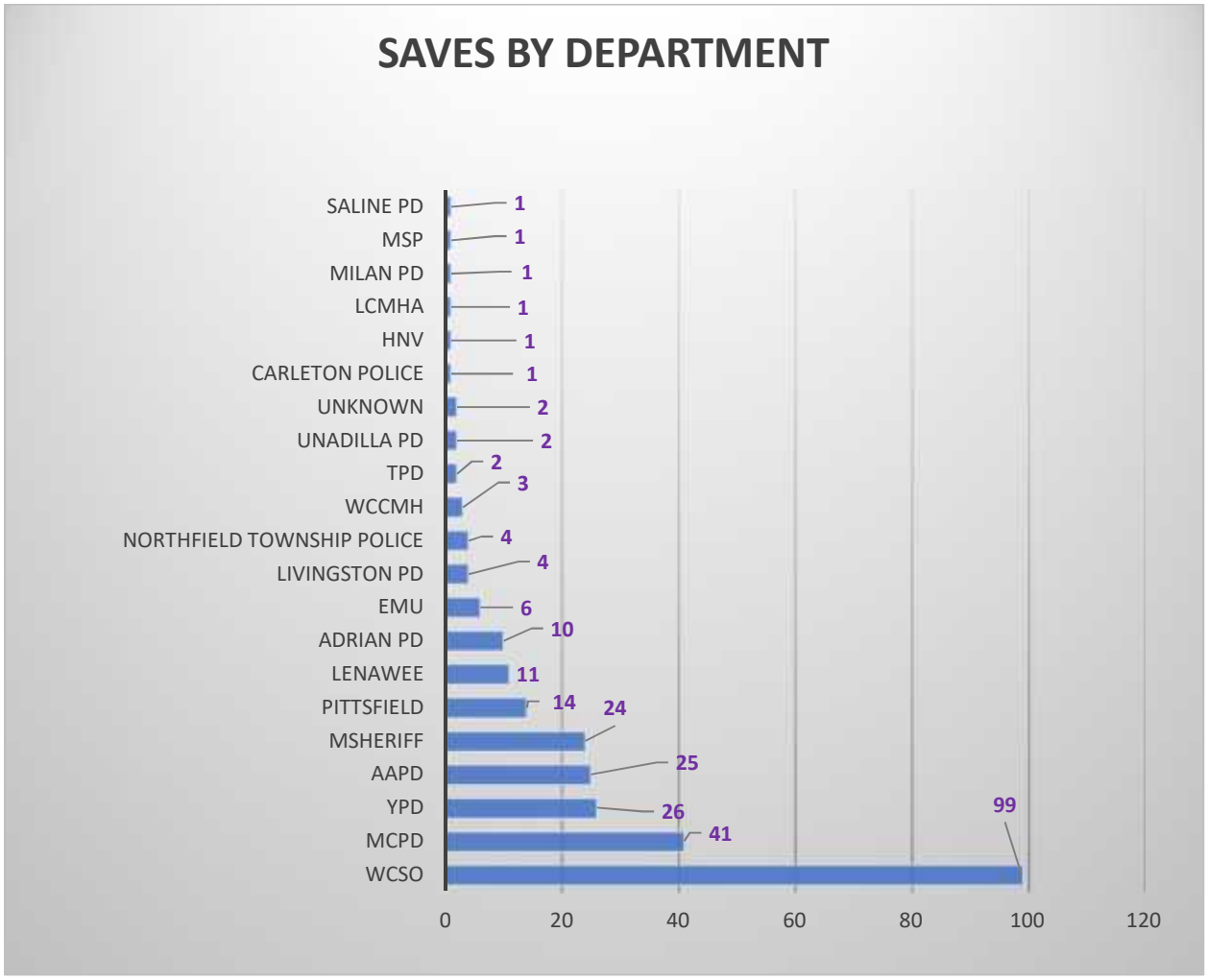
2017 -2018

342 Overdose Saves in the region reported through Law Enforcement





Average age is 34 years old, with the youngest being 10, and the oldest being 72. Median is 31 years old.



9 clients are active in newly funded Medication Assisted Treatment programs at the primary care clinics.

Description of where individual was found:

AATA BATHROOM
back against the bathroom
back seat of car
back seat of patrol car, vomit, unresponsive
bathroom
bathroom by mother
bathroom floor

bathroom stall
bathroom with a needle near sink
bathtub
bed
bedroom
bedroom floor
bedroom floor surrounded by ice
by friend
by his brother
by the family member
by the father
caller threw water on the person
car running
chair in garage
citizen
cold to touch, little to no breathing
collapsed
collapsed in kitchen
collapsed on bathroom floor
collapsed on sidewalk
collapsed on the floor
driver seat of vehicle
dropped off front yard
E. MI Ave & Prospect
employee
employer
family
floor
floor collapsed, friend gave naloxone and left
floor in living room with a pillow, mouth foaming
floor of mobile home
found by 7th grade son with needle in arm
Found by friend
found by mother slumped in back
friends
front passenger seat of car
gas station
getting his hair cut
ground
Grove Road
Haymakers restaurant
house manager
in back bedroom unconscious

in bathroom pulled into living room
in bedroom
in courtyard
in recliner found by son 10 y.o
in room on floor
in seizure
inside vehicle
kitchen floor
laid on his back in the kitchen
landlord
laying face down in the grass
laying on ground, friend doing CPR
laying on his back in bedroom
laying on kitchen floor
living room floor drenched in water
locked bathroom door
lying in bath tub, water running
lying in bed with pills in hand
lying in bedroom with head near foot of bed
lying in garage
lying in the bathroom found by sons 6 & 7 y.o
lying in the hallway outside of apt
lying on air mattress
lying on back
lying on back in restroom
lying on back kitchen
lying on back on bed
lying on bathroom floor
lying on bed
lying on bedroom floor
lying on bedroom floor with head on a car battery
lying on couch
lying on floor
lying on floor kitchen
lying on floor of kitchen
lying on grass
lying on ground N side of restaurant
lying on ground, black foam on mouth
lying on hallway
lying on kitchen floor
lying on living room
lying on parking lot
lying on pullout couch

lying on the driveway
lying on the floor
lying on the floor with 12 empty Rx bottles
lying on the kitchen floor
lying supine on kitchen floor
mother found son turning blue and gurgling
MVA-crashed into a mailbox, witness saw the crash
nephew
officer call
on bed, unresponsive
on ground
on the floor in the bedroom
other residents
others in home
PARKING LOT
passed out in bathroom
passed out on bathtub
passed out on hotel bed
passenger passed out in seat on a bus
passenger seat
restroom
roadway, driving
room
sidewalk
single vehicle crash
sister found brother unconscious
sitting in a chair at the kitchen table slumped over
sitting in chair
sitting straight up with his head slumped forward
sitting with a bystander, unresponsive
Slumped back in driver seat in car
slumped in bathroom
slumped over in drivers seat
sofa, 0 pulse
Sonya observed Amanda and called 911
suddenly fell and stopped moving while leaving
textile/McKean rd.
traffic stop
unconscious in the bathroom, needle near by
unconscious on bathroom floor
unconscious, turning blue on dock at city park
under a bridge
unresponsive on back patio

Att. #6

unresponsive on kitchen floor
unresponsive on the couch
upstairs bedroom, hands clinched into fists
vehicle in movie theatre parking lot
vehicle in parking lot of Walmart
was intoxicated initially and then overdosed