Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD MEETING AGENDA

https://zoom.us/j/97686560201

October 15, 2021
9:30AM-11:30AM

I. Roll Call (5 minutes)

II. Audience Participation (see guidelines below) (5 minutes)

III. Board Response to Audience Participation (5 minutes)

IV. Consent Agenda (Attachment #1) (5 minutes) **ACTION**
A. WCCMH Board Meeting Minutes and Actions-9/17/21 (Attachment #1A)
B. WCCMH Fall 2021 Staff Quarterly Newsletter
C. CMHPSM Policies - Reviewed and Recommended for Approval by Regional Operations Committee
1. Debarment, Suspension and Exclusion Policy (Attachment #1B1)
2. Employee Competency and Credentialing Policy (Attachment #1B2)
3. Incident Reporting Policy (Attachment #1B3)
4. Trauma Informed Practice Policy (Attachment #1B4)

V. Treasurer's Report **ACTION** (20 minutes)
- Financial Status Report (Attachment #2) **N. Phelps ACTION**
- WCCMH Millage and CCBHC Financial Status Report (Attachment #3) **N. Phelps ACTION**

VI. Executive Director Report-**T. Cortes** (15 minutes)

VII. CMHPSM Regional Update (10 minutes)
- September 8, 2021 CMHPSM Meeting Minutes and Actions (Attachment #4)
- October 13, 2021 CMHPSM Board Meeting Update

VIII. New Business (30 minutes)
- Washtenaw County Board terms expiring 3/31/22
  - B. King
  - A. LaBarre
  - Vacant (posted on website for remainder of C. Richardson term)
  - K. Scott

- Consumer Advisory Council Update on Strategic Planning **M. Hershberger/B. Higman**
- WCCMH Board and Committee Meeting Schedule (Attachment #5) **S. Amos O'Neal**

IX. Old Business (20 minutes)
- CCBHC Update **T. Cortes/M. Harding**
- Strategic Planning Update **M. Harding**

X. Items for Future Discussions (5 minutes)
- Development of Reserve Capital
- COVID-19 Related Priorities Discussion
- Employee Engagement Survey

XI. Adjournment of Public Meeting

Audience Participation Guidelines:
- Three (3) minutes are allowed per speaker
- Speakers are asked to bring a copy of their concerns/comments in writing
- Resolutions on issues will be brought to the appropriate committee as necessary

Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

Instructions to join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. https://zoom.us/j/97686560201

Or One tap mobile:
+19292056099,97686560201# US (New York)
+12678310333,97686560201# US (Philadelphia)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 929 205 6099 or +1 267 831 0333 or +1 312 626 6799 or +1 646 518 9805

Webinar ID: 976 8656 0201

International numbers available: https://zoom.us/u/akMz72P02

Effective March 17, 2021 the Washtenaw County Board of Commissioners has approved the continuation of all public meetings to be held virtually until December 31, 2021, per resolution #21-050.

Audience Participation Guidelines:

- Three (3) minutes are allowed per speaker
- Speakers are asked to bring a copy of their concerns/comments in writing
- Resolutions on issues will be brought to the appropriate committee as necessary

ATTACHMENT #1
OCTOBER 2021

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD

OCTOBER 15, 2021

CONSENT AGENDA

A. WCCMH Board Meeting Minutes and Actions-9/17/21
B. WCCMH Fall 2021 Staff Quarterly Newsletter
C. CMHPSM Policies-Reviewed and Recommended for Approval by Regional Operations Committee:
    1. Debarment, Suspension and Exclusion Policy
    2. Employee Competency and Credentialing Policy
    3. Incident Reporting Policy
    4. Trauma Informed Practice Policy

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH BOARD MEETING MINUTES *DRAFT*

https://zoom.us/j/99931830341

September 17, 2021
9:30am

K. Walker called the meeting to order at 9:33 am.

ROLL CALL:

S. Antonow attending remotely from Ann Arbor, Washtenaw County, MI
A. Dusbiber attending remotely from Ann Arbor, Washtenaw County, MI
N. Graebner-Sundling attending remotely from Chelsea, Washtenaw County, MI
B. Higman attending remotely from Ann Arbor, Washtenaw County, MI
R, Jefferson attending remotely from Ypsilanti Twp, Washtenaw County, MI
B. King attending remotely from Ann Arbor, Washtenaw County, MI
A. LaBarre attending remotely from Ann Arbor, Washtenaw County, MI
M. Udow-Phillips attending remotely from Superior Twp, Washtenaw County, MI
K. Walker attending remotely from Pittsfield Twp, Washtenaw County, MI

MEMBERS ABSENT: D. Strong, K. Scott

STAFF PRESENT: M. Harding, H. Linky, R. Dornbos, N. Phelps, L. Higle, K. Snay, S. Amos O'Neal, M> Tasker, t. Florence, S. Swisher, M. Taylor

OTHERS PRESENT: L. Lutomski, J. Martin, B. Reiter, A. Cisneros, N. Heine

K. Walker notified the Board that C. Richardson has submitted her resignation for the WCCMH Board and the PIHP Board. The WCCMH Board vacancy will be posted to the public website and the Washtenaw County BOC will make an appointment to fill the remainder of her term.

I. Introductions
   None

II. Audience Participation
- None

III. Board response to audience participation
- None

IV. Consent Agenda Actions (Attachment #1)
- WCCMH Board Meeting Minutes and Actions-8/20/21
- WCCMH Budget-Finance Committee Meeting Minutes and Actions-8/9/21
- CCCBHC Presentation
- Millage Committee:
  - WCCMH Millage Advisory Committee Meeting Minutes and Actions-8/9/21
  - Millage, Process, Investments and Progress Update
  - CARES Dashboard
  - CHRT Communications Update
  - Millage Funding Proposals approved at Millage Advisory Committee on 9/13/21
    a. Student Advocacy Center-Check and Connect/Education Advocacy Funding Request totaling $186,195.00
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-8/11/21

MOTION BY A. LABARRE, SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT AND APPROVE THE SEPTEMBER 17, 2021 WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**
JEFFERSON	**NOT PRESENT AT TIME OF VOTE**	**KING**	**Y**
LABARRE	**Y**	**SCOTT**	**N/A**
STRONG	**N/A**	**UDOW-PHILLIPS**	**Y**
WALKER	**Y**		

MOTION CARRIED

R. Jefferson joined the meeting at 9:41am.

N. Phelps requested consolidating the WCCMH Financial Status Report (Attachment #2), Contracts and Leases (Attachment #3) and the WCCMH Millage and CCBHC Financial Status Report (Attachment #4) as one action item for the sake of time.

MOTION BY B. HIGMAN SUPPORTED BY M. UDOW-PHILLIPS TO COMBINE THE FINANCIAL STATUS REPORT, CONTRACTS AND LEASES AND WCCMH MILLAGE AND CCCBHC FINANCIAL STATUS REPORTS INTO ONE ACTION ITEM.

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**
JEFFERSON	**Y**	**KING**	**Y**
LABARRE	**Y**	**SCOTT**	**N/A**
STRONG	**N/A**	**UDOW-PHILLIPS**	**Y**
WALKER	**Y**		

MOTION CARRIED

V. Treasurer's Report
- N. Phelps reviewed the Financial Status Report (Attachment #2) for the month ending July 31, 2021.

VI. Contracts (Attachment #3)
- M. Taylor presented the Contracts and Leases to the Board (Attachment #3).
  - Eisenhower Center to provide Licensed Residential Services for a term of August 26, 2021 through September 30, 2022.
  - National Assessment Center estimated amount of $20,650.00 to provide Youth Assessment Center consultation and technical assistance for a term of October 1, 2021 through September 30, 2022.
  - Student Advocacy Center estimated amount of $186,195.00 to provide Education Advocacy & Check Connect Mentoring Program for a term of October 1, 2021 through September 30, 2022.

VII. Millage and CCBHC Financial Status Report
- N. Phelps presented the Millage and CCBHC Financial Status Report (Attachment #4) to the Board for the period ending July 31, 2021.

MOTION BY A. DUSBIBER, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE WCCMH TREASURERS REPORT ENDING JULY 31, 2021, CONTRACTS AND LEASES AND THE WCCMH MILLAGE AND CCBHC FINANCIAL STATUS REPORT ENDING JULY 31, 2021 AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**
JEFFERSON	**Y**	**KING**	**Y**
LABARRE	**Y**	**SCOTT**	**N/A**
STRONG	**N/A**	**UDOW-PHILLIPS**	**Y**
WALKER	**Y**		

MOTION CARRIED

VIII. Executive Director report

- M. Harding presented the Executive Director report to the WCCMH Board.
- State Level Update
  - Two groups have been formed to address the direct care worker crisis.
  - State Representative Felicia Brabec has scheduled listening tours to provide input on the Shirkey and Whiteford system transformation bills. M. Udow-Phillips will send this schedule to R. Dornbos to distribute to the board.
  - CCBHC rates are expected today.
  - MDHHS is anticipating another bout of COVID and is prepping for an influx over the next few months.

- Local Update
  - WCCMH is experiencing a staffing crisis that is causing stress on case managers, crisis workers and other front-line staff. Washtenaw is competing with larger organizations that are receiving revenues to increase mental health workers. T. Cortes plans to work with labor partners on creative ideas on recruiting and retention.
  - BOC passed the WCCMH FY 2022 Budget and the living wage ordinance exemptions that were brought forward. Commissioner Scott plans to look at the exemption process moving forward.
  - Washtenaw County is reviewing the vaccine mandates and how it affects WCCMH and the providers.

IX. Discussion Items

- Strategic Planning Discussion (Attachment #5)
  - M. Harding presented the Proposed Strategic Planning Timeline/Process document with the Board.
  - Expecting draft report from CHRT in October.
  - The Board preferred the Mission Statement #2 option along with the edits from this meeting.
  - M. Harding will distribute the updated timeline to the board. Looking at development of plan for board review will be later in October/November.

X. CMHPSM Regional Update

- The CMHPSM minutes (Attachment #7) from August 11, 2021 were reviewed.
- M. Harding provided an update from the September 8, 2021 Regional Board meeting.

XI. New Business

- Washtenaw County CMH Board of Directors Annual Calendar (Attachment #7)
  - K. Walker discussed the Annual Board of Directors Calendar.

- 2022 Washtenaw County CMH Board-Committee Meetings Schedule (Attachment #8)
  - K. Walker discussed the 2022 CMH Board-Committee meeting schedule.
  - R. Dornbos will send meeting invitations to the Board and committees for these meeting dates.

XII. Old Business

- CCBHC Update
  - M. Harding provided an update on the CCBHC.
  - The application for the CCBHC certification process is about 95% complete.
  - Waiting on rates so that revenue projections can be done.

- Provider Presentation Discussion (Attachment #9)
    - H. Linky introduced S. Brown from Renaissance and L. Lutomski from Synod.
    - This is a follow up to the June presentation given at the Combined Finance and Program Committee meeting.
    - Recommendation to have an advocacy strategy on this issue and include the BOC in these efforts.

XIII. Items for future discussion

- Development of Reserve Capital at the CMHSP level
- COVID-19 Related Priorities Discussion
- Employee Engagement Survey
- Advocacy strategy around direct care worker wage issue-staffing crisis in general
- BOC recommendations for American Rescue Plan funds for economically disadvantages communities in regard to accessing mental health services.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ADJOURN THE WCCMH BOARD MEETING.

Meeting adjourned at 11:21 AM.

ATTACHMENT #1B
OCTOBER 2021

CMH Quarterly

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH - FALL 2021

TRISH'S UPDATE

Happy Fall CMH!

Although things are certainly far from "normal," it is good to see that we have moved closer to *normal-ish*.

Thinking back to this time last year I vividly remember hearing the voices of my boy's teachers panicking over crashing software systems, or watching colleagues known and unknown make heroic attempts at (not) parenting through squares on my computer screen, all the while running through a list of places and people I wish I could be with. It is with great excitement and gratitude that my family and I are once again taking part in activities that once seemed mundane and greatly underappreciated! All that being said, we still have a ways to go in feeling more normal.

One area where we are all wanting to feel more normal is in the space of the significant workforce shortage we are all experiencing. **The impact of the workforce shortage is felt everywhere** and the health care industry and CMH system has not been spared. I want you all to know that there is not a day that goes by without having lengthy discussions on how to resolve the staffing issues that are occurring. These discussions are the number one agenda item at state level meetings, regional meetings, and local meetings. Long term solutions will take time and short term solutions are desperately needed. In the coming days and weeks you will be seeing some of those efforts and there is certainly more to come.

As always, there are many, many initiatives going on currently- CCBHC implementation, strategic planning and state level advocacy to name a few. We will be sending out invites soon for a virtual all staff meeting scheduled for October and I am excited to be able to share more details with you all at the time.

The one item that I do want you to be aware of is the need for legislative advocacy. Senator Shirkey and Representative Whiteford have both introduced bills that, if passed, will leave gaping holes in our safety net system that has been woven at the local level over decades. We will be sending out “action alerts” that are a very easy way to alert your legislators of concerns I/we have regarding these bills. Please take a moment to read these and take whatever action you are comfortable with. As always, I am happy to answer any questions.

With that, I hope you and yours are all safe, happy and healthy. I want to thank you all for the incredible work that you do. I know that these have been and continue to be challenging times and I am incredibly grateful for the work that you do to serve our community.

Always looking forward,
Trish

HELLO! & HOORAY!

Welcome New Hires!

Andrew G
Ashley D
Beth P
Bryan K
Emily S
Jessica S
Joel M
Jonathan A
Kelly H
Kristo R
Leo H
Lydia S
Maris B
Matthew C
Meghan P
Melissa G
Michael C
Natalie F
Osberita N
Webb L

Congratulations Transfers!
Carmen M

Caryette F
Corrie F
Dea L
Evan G
Jessica M
Jessica S
Katie S
Kiarra P
Lyla R
Sara C
Sarah S
Shane R
Tomekia S

MENTAL ILLNESS AWARENESS WEEK – OCTOBER 4–10, 2021

Each year, millions of Americans face the reality of living with a mental health condition. However, mental illness affects *everyone* directly or indirectly through family, friends or coworkers.

That is why each year during the first week of October, NAMI and participants across the country raise awareness of mental illness, fight discrimination and provide support through **Mental Illness Awareness Week (MIAW).**

We believe that mental health conditions are important to discuss year-round, but highlighting them during MIAW provides a dedicated time for mental health advocates across the country to come together as one unified voice. Since 1990, when Congress officially established the first full week of October as MIAW, advocates have worked together to sponsor activities, large or small, to educate the public about mental illness.

This year's MIAW is centered around our new awareness campaign, *"Together for Mental Health,"* where we will focus on the importance of advocating for better care for people with serious mental illness (SMI). Each day throughout the week, we will be raising the voices of people with lived experience to talk about SMI and the need for improved crisis response and mental health care.

FLU SEASON IS UPON US ~ HERE'S WHAT YOU NEED TO KNOW

Flu season is fast approaching and CMH has prepared a presentation opening soon in Relias that will help explain the benefits of the shot in simple terms. You'll want to remember to return the Informed Decision/Declination form no matter what.

Vaccination Clinics are planned for October to make getting your flu shot super easy and convenient.

Check in with your supervisor, PA or Infection Control Committee member if you have any questions.

And for good prevention and everyone's safety, don't forget to keep your mask on!

CMH CARES IN THE NEWS

Congratulations to Melissa T and her team for the positive radio spot on WEMU.

This week for "On the Ground Ypsi," a weekly conversation with Concentrate Media's Sarah Rigg and WEMU's Lisa Barry, they talk with Melisa T, the program coordinator for the Washtenaw County "CARES team," about the mental health services they provide to the community funded by a 2018 county public safety and mental health preservation millage.

Click here to listen to the interview (or read the transcript)

OFFICE OF RECIPIENT RIGHTS UPDATE

The Rights Office has a few changes to announce!

Please welcome Sarah S. to the Washtenaw Rights Office. Sarah was previously located at the Rights Office at Livingston County Community Mental Health.

Please welcome Evan G as WCCMH's Fair Hearings Officer. He will also be assisting Livingston CMH with appeals.

Katie S. is now the Director of Recipient Rights and Compliance as Shane R.is now the Clinical Director for WCCMH.

We look forward to working with you all in these new roles!

EAT UPDATE

Hope that the Fall is off to a great start. You might have noticed in your mailbox that the EAT (Employee Activities Team) made a Restart 2021 bag for all employees. The committee hopes that all staff enjoy this small token of gratitude. The hard work and dedication that is done on behalf of WCCMH is noticed and appreciated.

You might have also seen that the Staff Recognition bulletin boards have been updated at each of the sites with a theme of **Now Showing- Take 2 for 2020**. Check them out and write up a colleague on a task done for others, a gesture of Thanks or a job well done.

If there are staff interested in joining the EAT committee please contact Brandie H.

SDC UPDATE

You may have heard that Suicide Risk Assessment is expected to be an area of interest in the upcoming Joint Commission audit (Look out for it in 2022!). As a result, we are opening more than a few class dates to accommodate getting all of our clinicians up to date on the CSSR.

If your supervisor hasn't already asked you to register, let this nudge you along- **log in to Relias and register for one of the upcoming "CSSR - Suicide Risk Assessment" trainings.**

Additional offerings continue to be available on a quarterly basis through Zoom with the link made available to you once you register.

The Essential Trainings (Rights, G&A, and Cultural Competency) are also accessible year-round to complete online. As your due dates come up simply browse to find the class, click on the title, and get going!

And speaking of Essential Trainings...

QUARTERLY TRAINING REMINDER

Limited English Proficiency (LEP) is our assigned training for Fall.

Your supervisor will schedule this as a team training or you will be able to complete it individually through Relias and submit your completion certificate for credit. As usual, watch for emails, instructions and reminders so you don't miss this requirement.

This training runs from October 1 to December 31 and will not be available outside of those dates.

[Safety Refresher ends September 30. Your updated Next of Kin form is **required** along with the certificate to receive full credit.]

WCCMH CELEBRATION OF SUCCESS!

WCCMH will be hosting another virtual Celebration of Success this year.

Hoorah! We get to celebrate success in the lives of those we serve. How have you seen those you serve succeed in the midst of this past year of Pandemic?

For many we serve, this is the highlight of their year as they get to see how much they and others have actually accomplished. We are hoping to improve this event over last year. **If each team could nominate 3 folks or so who are making significant progress, we will get to celebrate not only who has succeeded that we serve, but also how we have made a difference amid difficult circumstances.**

If you are like many others, you need a dose of encouragement and this is just the opportunity to encourage others with the progress of those we serve and we would also be honoring you for how you have played a key role in the restoration of those you serve.

Please, check your email for an electronic submission form to nominate someone you have helped throughout the year.

THANKS TO OUR CONTRIBUTORS

Trish C
Katie H
Brandie H
Jack S
Katie S

THANKS FOR READING!

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** **Debarment, Suspension and Exclusion**
Committee/Department: Network Management Committee	**Local Policy Number (if used)**
Implementation Date (2 weeks from final approval)	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To prohibit doing business with any individual or entity that is known to be debarred, excluded or suspended from participation in any Federal funded health care program.

II. REVISION HISTORY

DATE	MODIFICATION
7/19/2017	New policy
Will be the regional approval date	3-year review

III. APPLICATION

This policy applies to all staff and board members of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), all staff and board members of the regional Community Mental Health Service Programs (CMHSPs), all staff, board members and owners (5% ownership stake or greater) of Substance Use Disorder (SUD) Core Service Providers, and owners (5% ownership stake or greater), board members and executive and/or leadership level staff of contracted service entities funded by or through the CMHPSM, pPartner CMHSPs or Substance Use Disorder Core Providers.

IV. DEFINITIONS

Community Mental Health Partnership oOf Southeast Michigan (CMHPSM): The Regional Entity that serves as the Pre-Paid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and

substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

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

Disclosing Entity: All CMHPSM, partner CMHSPs or SUD Core Service Provider entities sub-contractors and consultants funded with federal dollars (Medicaid, Block Grant, etc.).

V. POLICY

The CMHPSM, its partner CMHSPs and SUD Core Service Providers may only conduct business utilizing federal funding with individuals and/or entities that meet the standards outlined within this policy.

VI. STANDARDS

A. Disclosing Entity Attestation – All CMHPSM, partner CMHSPs or SUD Core Service ~~core~~ Pproviders that contract with federal funding (Medicaid, Block Grant, etc.) must require the following attestations be made applicable to sub-contracted individuals and/or entities within their sub-contracts:

1. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or PIHP;
2. Have not, within a three-year period preceding the current fiscal year, been convicted of or had a civil judgment rendered against him/her for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction ~~of contract under a public transaction~~; violation of Federal or State antitrust statutses or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State, or local) with commission of any of the offenses enumerated in (2) above, and;
4. Have not, within a three-year period preceding the current fiscal year, had one or more public transactions (Federal, State, or local) terminated for cause or default.

B. Identifying Information – The CMHPSM, partner CMHSPs and SUD Ccore Service Pproviders, shall obtain the following identifying information from the required disclosers outlined in Standard C:~~.~~

1. **Individuals:**
    - **a. First Name;**
    - **b. Middle Name;**
    - **c. Last Name;**
    - **d. Date of Birth;**
    - **e. National Provider Identification (NPI)***
      (*Only if individual has been assigned a~~n~~ NPI number. Not all individuals will have a~~n~~ NPI number as it is associated with clinical service delivery.)

f. Social Security Number.

2. **Entities:**
   - **a.** Entity's Organizational Name;
   - **b.** Entity's Doing Business As (DBA) Name if different than Organizational Name;
   - **c.** Entity's Federal Employer Identification Number (EIN).

C. Required Disclosers – The CMHPSM and its partner CMHSPs shall collect the previously cited identifying information in Standard B from the following individuals and entities:

1. **Required Individual Disclosers**

a. Direct Employees:
- All direct employees of the CMHPSM;
- All direct employees of the partner CMHSPs;
- All direct employees of the SUD Core Service Provider.

b. Direct Board Members:
- CMHPSM Board Members;
- CMHSP Board Members;
- SUD Core Service Provider Board Members.

c. Direct Owners:
- All individuals with an ownership stake of 5% or more of an SUD Core Service Provider that is not a governmental entity.

d. Licensed Independent Practitioners (LIPs):
- LIPs contracted with the CMHPSM;
- LIPs contracted with a Partner CMHSP;
- LIPs contracted with an SUD Core Service Provider.

e. Individual Consultants:
- Consultants contracted with the CMHPSM;
- Consultants contracted with a Partner CMHSP;
- Consultants contracted with an SUD Core Service Provider.

2. **Required Entity Disclosers and Associated Individuals Disclosers**

a. Entity:
- All contracted service provider entities contracted with the CMHPSM, a partner CMHSP and/or a SUD Core Service Provider to deliver federally funded services. All legal name(s) and associated employer identification numbers must be disclosed by the entity.

b. Individuals Associated with an Entity:
- Owners - All individuals with an ownership stake of 5% or more of a contracted service provider entity contracted with the CMHPSM, a partner CMHSP and/or a SUD Core Service Provider to deliver federally funded services
- Board Members - All Board Members of a contracted service

provider entity contracted with the CMHPSM, a partner CMHSP and/or a SUD Core Service Provider to deliver federally funded services.

- Managing Employees - All managing or leadership level employees of a contracted service provider entity contracted with the CMHPSM, a partner CMHSP and/or a SUD Core Service Provider to deliver federally funded services. For example: Executive Directors, Chief Level Positions (CEO, CFO, COO, CIO), Clinical Directors, Program Directors, and any other employees determined to be in a management or leadership position, ~~level.~~

D. Debarment and Exclusion Verification List – The CMHPSM and partner CMHSPs are required to collect the identifying information identified in Standard B, on all required reporters identified in Standard C, to create the Debarment and Exclusion Verification List. The data within the Debarment and Exclusion Verification List must be collected at the following instances as required by 42 CFR 455.104:

1. Upon submission of a provider credentialing application to join the CMHPSM provider network.
2. Upon submission of a provider re-credentialing application to continue participation as a CMHPSM network provider.
3. Upon execution of a service contract or re-execution of a service contract.
4. Within 35 days of change of ownership of sub-contracted entities contracted with the CMHPSM, partner CMHSPs or SUD Ccore Service Pproviders.

E. Monthly Monitoring – The CMHPSM and partner CMHSPs shall create individual monthly monitoring lists to be verified through the CMHPSM monthly verification process. The CMHSPs will create their monthly monitoring lists individually.

1. The CMHPSM will conduct the monthly verification searches on behalf of the CMHPSM region, based upon the debarment and exclusion verification lists compiled ~~individually~~ by the CMHPSM itself from~~f,~~ the partner CMHSPs and SUD Core Service Providers.~~s information lists compiled by the CMHSP~~.
2. The CMHPSM will utilize software or other processes to ensure that individuals and entities on the compiled CMHPSM debarment and exclusion verification list are not found on any of the federal or state databases which identify debarred, excluded or suspended individuals and entities.
3. Monthly search results will be returned to the partner CMHSPs and SUD Core Service Providers. Individuals and entities initially found to match records found in any state or federal debarment and exclusion list will be further verified by the following:
    - **a.** Any individuals initially identified as matching a record found in a federal or state debarment, exclusion or suspension database by first, middle, last name and date of birth will be notified by the CMHPSM, CMHSP or SUD Core Provider that the individual has a relationship with.~~.~~
    - **b.** The CMHPSM will conduct all verification/substantiation activities for individuals and entities with direct relationships with the CMHPSM. The CMHSP or SUD Core Provider with the direct relationship with the individual or entity will conduct all further verification information gathering activities after the initial monthly search conducted by the CMHPSM.

4. The CMHPSM, CMHSP and SUD Core Providers are unable to employ, fund or contract with individuals or entities if they are substantiated to be on any state or federal debarment and exclusion list. Individuals and/or entities that are debarred, suspended and/or excluded from federal participation are immediately deemed ineligible for any CMHPSM, CMHSP or SUD Core Service Provider payments utilizing federal funds.

F. Notification of Program Related Convictions

1. **Notification from CMHSP Partner or SUD Core Service Provider**
   The partner CMHSPs and SUD Core Service Providers must immediately notify the CMHPSM and MDHHS if any individuals or entities disclose, attest to, or are found to have been convicted of program related crimes as identified in Section 1128 (a) and 1128(b) (1) (2) or (3) of the Social Security Act.

2. **Notification by CMHPSM**
   The CMHPSM will immediately notify MDHHS if any individuals or entities disclose, attest to, or are found to have been convicted of program related crimes as identified in Section 1128 (a) and 1128(b) (1) (2) or (3) of the Social Security Act.

VII. EXHIBITS

Exhibit A. CMHPSM Debarment Information Collection Form for Organizations (Link)

VIII. REFERENCES

Federal Regulation 45 CFR Part 76
Balanced Budget Amendment 438.214(d)
42 CFR Part 455 Subpart B
Section 1128 (a) and 1128(b) (1) (2) or (3) of the Social Security Act
MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract Section (Section 18.1.3 in FY~~16~~21 Contract)
CMHPSM Debarment Information Collection Form for Organizations (Link)

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN/PIHP	*Policy and Procedure* Employee Competency & Credentialing Policy
Committee/Department: **Network Management Committee**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from final approval)**	**Regional Approval Date**

Reviewed by:	Recommendation Date:
ROC	
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure that staff competencies are at a high level through ongoing assessment of their capacity to provide safe, effective, high-quality mental health and substance use disorder (SUD) care to Community Mental Health Partnership of Southeast Michigan (CMHPSM) consumers/individuals served.

II. REVISION HISTORY

DATE	MODIFICATION
	Revised to reflect the new regional entity.
3/22/2021	

III. APPLICATION

This policy applies to all CMHSP staff of the CMHPSM.

IV. POLICY

All employees will be competent to perform the responsibilities duties assigned to them.

V. DEFINITIONS

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

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Competence: The knowledge, ~~skills~~skills, and abilities a person possesses to perform tasks correctly and effectively.

Credentials Review: The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide the mental health services based on established criteria.

Integrated Care: Bringing together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency (World Health Organization).

Primary Source Verification: The source from which the applicant obtained written documentation of licensure, education, or other qualifications. Primary source includes federal and state licensing boards, letters from professional schools and letters from postgraduate education or postdoctoral programs for completion of training, or designated equivalent sources

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

VI. STANDARDS

1. Competence shall be assessed at time of hire and at least annually.
2. The CMHSP/SUD Core Service Provider shall have a process to assign clinical responsibilities that includes review of licensure, certification, and/or registration.
3. Before assigning initial clinical responsibilities, the CMHSP/SUD Core Service Provider shall verify the identity of staff seeking clinical responsibilities by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport).
4. Initial competencies will be verified during the hiring process, via interviews, review of education, and the orientation process. Training needs will be identified, as applicable.
5. Before assigning initial, renewed, or revised clinical responsibilities for employees whose jobs require state licensure/certification/registration, the CMHSP/SUD Core Service Provider shall:
   - Use primary sources when documenting the training specific to the clinical responsibilities requested.
   - For all employees, whose jobs require a baccalaureate degree or higher, confirmation of degree will be obtained and verified from the primary source.

- Assure staff being reviewed for clinical competencies do not have issues with licensure, certification, sanctions, or criminal activity that would affect their ability to perform their clinical responsibilities

6. The CMHSP/SUD Core Service Provider shall establish~~es~~ program/service-specific criteria for each clinical responsibility. These criteria include the following:
   - Current licensure and/or certification as appropriate, verified with the primary source
   - Successful completion of training
   - Peer or faculty recommendation
   - Evidence of the ability to perform the assigned clinical responsibilities
7. The CMHSP/SUD Core Service Provider shall ensure that staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence.
8. Employees shall receive supervision, including clinical supervision as appropriate to their position, on a regular basis.
9. Supervisors shall assess the competency of ~~all CMHPSM~~ employees through supervision, observation, and performance evaluation. Performance evaluations for clinical staff who are supervised by another discipline will include peer review by their own discipline.
10. On-going competencies will be monitored through supervision and documented on annual performance evaluations.
11. Clinical staff competencies will be documented on the Employee Competencies Checklist (Exhibit A).
12. Nonclinical staff competencies will be documented through performance evaluations based on employee job descriptions.
13. All employees are expected to display cultural sensitivity and awareness of the role of culture in the delivery of services
14. All employees are expected to have competence in integrated healthcare.
15. All employees are expected to have competence in applicable principles and practices of recovery and ~~recovery-oriented~~recovery-oriented systems of care.
16. All employees are expected to meet the applicable provider requirements of the Medicaid Provider Manual.
17. Programs which employ the use of glucometer, breathalyzer or other waived tests will ensure and document employee competency on those tests during orientation and annual performance reviews.
18. Before assigning renewed or revised clinical responsibilities to staff who are permitted by law and the organization to practice independently, the CMHSP/SUD Core Service Provider need to assure the following occurs:
    - Reviews information from any of the organization's performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills.
    - Evaluates the results of any peer review of the individual's clinical performance.
    - Reviews any clinical performance in the organization that is outside acceptable standards.
    - Evaluates the staff member's written statement that no health problems exist that could affect his or her ability to perform the requested clinical responsibilities, including consideration of the applicability of the Americans with Disabilities Act and/or the Rehabilitation Act of 1974.
    - Evaluates any challenges to licensure or registration.

- Evaluates any voluntary and involuntary relinquishment of license or registration.
- Evaluates any voluntary or involuntary limitation, reduction, or loss of clinical responsibilities
- Evaluates any professional liability actions that resulted in a final judgment against the staff member.
- Queries the National Practitioner Data Bank (NPDB) at the time of initial assigning of clinical responsibilities, as well as at least every two years thereafter for information on physicians and dentists who are assigned clinical responsibilities.
- Evaluates ~~the~~ whether the requested clinical responsibilities are consistent with the population(s) served by the organization.
- Evaluates whether the requested clinical responsibilities are consistent with the program or site-specific care, treatment, or services provided.
- Confirms the staff member's adherence to organization policies, procedures, rules, and regulations.

VII. EXHIBITS

A. Employee Competency Checklist

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
MICHIGAN PIHP/CMHSP PROVIDER QUALIFICATIONS PER MEDICAID SERVICES & HCPCS/CPT CODES	X	
Joint Commission- Behavioral Health Standards	X	HR.3.10; HR.4.10
CMHPSM PIHP/CSSN Monitoring of Delegated Functions	x	CSSN Review; Contract Language
Culturally and Linguistically Appropriate Services Policy	X	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Employee Name: _____ Date: _____

Part I – Population-Specific Competencies

□ 1. Children with intellectual/developmental disability
Demonstration of knowledge of the following:
- □ Childhood & adolescent development
- □ Specific conditions/syndromes associated with intellectual/developmental disabilities
- □ Resources and supports available to persons with intellectual/developmental disabilities & families
- □ Principles of Person-Centered Planning/Family-Centered Planning
- □ Special education/school system
- □ Integrated Healthcare

□ 2. Adults with intellectual/developmental disability
Demonstration of knowledge of the following:
- □ Human development across the ~~life-span~~lifespan
- □ Specific conditions/syndromes associated with intellectual/developmental disabilities
- □ Resources and supports available to persons with intellectual/developmental disabilities ~~& families~~& families
- □ Principles of Person-Centered Planning
- □ Special education/school system
- □ Integrated Healthcare

□ 3. Children with serious emotional disturbance
Demonstration of knowledge of the following:
- □ Childhood & adolescent development
- □ Emotional disorders/mental illnesses of childhood & adolescence
- □ Family Dynamics
- □ Parenting skills/strategies
- □ Human service system for children (Court, Schools, Spec. Ed., Child Welfare, etc.)
- □ Principles of Person-Centered Planning/Family-Centered Planning
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 4. Adults with serious & persistent mental illness
Demonstration of knowledge of the following:
- □ Signs & symptoms of major mental illness
- □ Acute symptoms of mental illness

- □ Medications used to treat symptoms of mental illness & common side effects
- □ Supports/resources available in the community for persons with SPMI & their families
- □ Principles of Person-Centered Planning & Recovery Model
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 5. Older adults with serious & persistent mental illness

Demonstration of knowledge of the following:

- □ Mental illness unique to the elderly population
- □ Special needs of the elderly
- □ Medication issues/concerns unique to older adults with SPMI
- □ Community resources available to older adults with SPMI & their families
- □ Principles of Person-Centered Planning & Recovery Model
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 6. Co-Occurring Disorders: mental illness and substance abuse

Demonstration of knowledge of the following:

- □ Theories of addiction and recovery
- □ Stages of change
- □ Motivational Interviewing
- □ Signs & symptoms of substance abuse
- □ Signs & symptoms of major mental illness
- □ Issues unique to co-occurring mental illness & substance abuse
- □ Medication used to treat mental illness, side effects, interaction with street drugs/alcohol
- □ Community resources & supports available to persons with mental illness & substance abuse and their families
- □ Integrated Healthcare

Part II – Competencies Needed to Deny, Reduce, Suspend or Terminate Services

□ Emergency Services (Inpatient, Crisis Residential and Partial Hospital) for the following populations:

□ DD-C	□ DD-A	□ SED	□ MI-A	□ MI-OA	□ Co-Occ	□ Sub. Ab

Demonstration of knowledge of the following:

- □ Evaluation of Mental Health Service Needs
- □ Evaluation of Substance Abuse Service Needs
- □ Treatment Planning Process (Crisis Planning, Diversion Planning)
- □ Service Authorization Process
- □ Service Eligibility Criteria
- □ CMH and Community Services, Supports and Other Resources
- □ Treatment (Crisis Intervention, Inpatient, Crisis Residential, Other Alternative Services)

□ Non-Emergency Services (all other) for the following populations:

□ DD-C □ DD-A □ SED □ MI-A □ MI-OA □ Co-Occ □ Sub. Ab

Demonstration of knowledge of the following:

- □ Evaluation of Mental Health Service Needs
- □ Evaluation of Substance Abuse Service Needs
- □ Treatment Planning Process
- □ Service Authorization Process
- □ Service Eligibility Criteria
- □ CMH and Community Services, Supports and Other Resources
- □ Treatment

Part III – Competency Assessment Methods

□ **After-Hire**	□ **New-Hire**
□ Annual Staff Evaluation	□ Resume
□ Clinical Case Record Review	□ Primary Source
□ Peer Review	□ Interview Results
□ Observation	□ Reference Check
□ Supervision Discussions	□ Other: _____
□ Consultation with other supervisors/directors	□ Consumer Feedback

Part IV – Training Needs & Plan

_____

_____

_____

_____ _____

Supervisor's signature Date

_____ _____

Employee's signature Date

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* Incident Reporting
Committee/Department: Clinical Performance Team and Regional Compliance	Local Policy Number (if used)
Implementation Date (2 weeks from final approval)	Regional Approval Date (date of last CMH board's approval)

Reviewed by:	Recommendation Date:
ROC	9/8/2021
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To provide guidelines for timely reporting, monitoring, ~~reviewing~~reviewing, and evaluating unusual and/or unexpected incidents which occur in the course of providing behavioral ~~mental~~ health services to consumers/individuals served.

To ensure that the information derived from incident reporting ~~this process~~ is used to identify opportunities for improvement.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
8/29/2017	Due for regional review.
Regional Approval Date	Due for regional review/updates

III. APPLICATION

This policy applies to all staff, students, volunteers and providers, whether they are licensed independent practitioners, contractual organizations or providers hired through self-determination/choice voucher arrangements within the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

It is the policy of the CMHPSM that unusual and significant incidents (as defined below) involving active ~~consumer~~consumers/individuals served~~s~~ will be reported and investigated in a timely manner, with appropriate follow up and/or remedial action steps taken to prevent re-occurrence. The Incident Reporting process is a retrospective peer review process to improve services or enhance treatment for ~~consumer~~consumers/individuals served~~s/customers~~. Any records, data and knowledge collected in this process are confidential and considered peer review documents, and are to be protected as such. T~~;t~~herefore this information is not available by record requests, under the Freedom of Information Act (FOIA) or by ~~court~~ subpoena~~.~~

V. DEFINITIONS

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

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Incident: An unusual or significant event that disrupts or adversely affects the course of treatment or care of a ~~consumer~~consumer/individual served~~/customer~~. Unusual or significant events should be identified on an individual case by case basis and may be different based on individual ~~consumer~~consumer/individual served needs/treatment. Incidents may include but are not limited to:

- The death of a ~~consumer~~consumer/individual served.
- Any injury of a ~~consumer~~consumer/individual served, explained or unexplained.
- An unusual medical problem.
- Sentinel or adverse event.
- Environmental emergencies/incidents that could have caused an injury.
- Problem behaviors not addressed in a plan of service, such as breaking things, attacking other people, or setting fires.
- Suspected abuse or neglect of a ~~consumer~~consumer/individual served.
- Inappropriate sexual acts.
- Suspected sexual abuse.
- Medication errors.
- Medication refusals, unless addressed in the plan of service.
- Suspected criminal offenses involving ~~consumer~~consumers/individuals served~~s~~.
- Every use of physical intervention.
- Any significant event in the community involving a ~~consumer~~consumer/individual served.
- A traffic accident involving ~~consumer~~consumers/individuals served~~s~~.
- A ~~consumer~~consumer/individual served leaving the home without permission or notice.
- ~~Consumer~~Consumer/individual served arrest or conviction.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, developmental disabilities, and substance use disorder needs.

VI. STANDARDS

All employees, contractors, or volunteers who witness, discover, or are notified of unusual incidents shall:

A. Take immediate action to protect, comfort, and arrange for emergency medical treatment as necessary if the ~~consumer~~consumer/individual served has sustained an injury.

B. Immediately, verbally notify the appropriate supervisor and attending medical staff of any apparent serious injury, medication error or unexplained injury.

C. Complete the Incident Report (IR), ensuring that all information is filled in completely, and give report to program supervisor or home manager as soon as possible, but no later than the end of the shift in which the incident occurred.

~~C.~~D. Ensure the IR has been properly coded.

~~D.~~E. The IR form must either be completed on paper and scanned directly into electronic record` by the provider, or entered electronically directly into electronic record by the CMHSP or contracted provider. The CMHSP or contracted provider will be responsible and accountable for ensuring the accuracy and thoroughness of the information being reported on the IR form. Any provider seeking a different arrangement for submitting IRs must request an exception, in writing, from the Executive Director of the appropriate organization.

~~E.~~F. Only one IR should be completed per ~~consumer~~consumer/individual served event. Other ~~consumer~~consumers/individuals served~~s~~ involved or staff present should be noted in the appropriate space on the IR form.

~~F.~~G. ~~Consumer~~Consumer/individual served ~~i initials should be used in the "What Happened" and "Actions Taken" fields.~~ncidents that require a physical intervention or a call to 911/police are to include a start and stop time of the incident.

~~G.~~H. All employees, contractors, or volunteers will also adhere to reporting requirements of 1982 Public Act 591, Adult Protective Services Act, 1975 Public Act 238, as amended, Child Protection Act and 1998 Public Act 32, Mandatory Report of Abuse Act, and the Sentinel Event Reporting Requirements. (See Regional Abuse and Neglect Policy and Sentinel Event Policy.)

~~H.~~I. Staff of some programs (i.e. day programs and residential services) should familiarize themselves with applicable procedures for reporting certain types of incidents to the appropriate licensing or regulatory bodies (DHS, OSHA, etc.) A copy of the report will be attached to IR form and submitted for internal processing in accordance with this policy.

~~I.~~J. Staff must verbally report any known or suspected Recipient Rights violation to the Office of Recipient Rights (ORR) immediately but no later than the next business day.

~~J.~~K. For case managers who are on leave longer than 24 hours, the case manager and their supervisor shall ensure that IRs are processed as required in their absence.

~~K.~~L. Statistical information logged for each IR will be aggregated and reported by the CMHSPs quarterly or more frequently via their local performance improvement processes. CMHSPs shall report trends and patterns to the CMHPSM Clinical Performance Team (CPT) at the frequency determined by CPT. CPT is responsible for identifying any region-wide trends and opportunities for systems improvement. CPT assists the CMHSPs in identifying trends, sharing best practices, and determining whether areas identified for improvement should be addressed locally or at the affiliate level.

~~L.~~M. Scanned or electronically entered IRs will remain in electronic format. ~~indefinitely.~~ Originals should be shredded.

~~M.~~N. Licensed Adult Foster Care providers shall ensure IRs are accessible on site via CMHPSM electronic record or shall keep a copy of written Incident Reports in the home for not less than 2 years in accordance with Licensing Rule 400.14311.

~~N.~~O. The fact that an incident occurred, as it relates to clinical service/treatment needs of the individual, shall be documented in the client record. However, the incident report itself as a process or a document, the details of the incident, and the processes around incident reporting are considered peer review activities, and as such, will not be made part of the electronic/clinical record or discussed in the clinical record.

~~O.~~P. All related records, data and knowledge, including minutes collected for or by individuals/committees assigned a peer review function, are confidential, are not public record and, therefore:

1. Do not appear in the client record;
2. Are not subject to court subpoena pursuant to MCL333.21515, MCL331.521, MCL331.533;
3. Disclosure or duplication of Incident Reports is absolutely prohibited except as provided in this policy.~~;~~

~~P.~~Q. The reporting of incidents as described in this policy is a peer review function to improve the quality of client care. IRs and the information contained therein are ~~is~~ protected as confidential and as peer review documents, and ~~will~~ therefore will be circulated only to CMHSP staff with a direct need to know. Any care coordination or case management around incident reporting will include the protection of IRs as peer review documents.

~~Q.~~R. Should an IR be completed for a provider who is not providing Mental Health/Substance Use Disorder Services, the supervisor shall notify the CMHSP of the incident to ensure any contractual obligations are followed as needed.

VII. EXHIBITS

A. Michigan Department of Licensing & Regulatory Affairs, Bureau of Community & Health Systems, form BCAL-4607: ~~Michigan DHS AFC Licensing Division – Incident/Accident Report~~ https://www.michigan.gov/lara/0,4601,7-154-89334_63294_27717---,00.html

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	438.10 (d)
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Department of Licensing and Regulatory Affairs (LARA)		R400.14311
~~Department of Human Services Licensing Regulations~~	~~X~~	~~R400.14311~~
Joint Commission- Behavioral Health Standards	X	IM 6.20 (3) is the citation for Joint Commission 06-07 BH standards regarding Incident reports. Also PI.1.10, PI 2.20 and PI
MCL PA 368 of 1978	X	333.21515
MCL- PA 430 2004	X	330.1143a & 330.1143b (9) 330.1748 (9)
MDHHS 1987 Administrative Rules	X	R330.7046
MDHHS PIHP ~~Medicaid~~ Contract	X	~~Attachment P6.7.11~~
~~All employees, contractors, or volunteers who witness, discover, or are notified of unusual incidents~~ MDHHS CMHSP Contract		
CMHPSM Peer Review Policy	X	
CMHPSM Abuse and Neglect Policy	X	
CMHPSM Sentinel Event Policy	X	

IX. PROCEDURES

WHO	DOES WHAT
All employees, contractors, or volunteers who witness, discover, or are notified of unusual incidents	1. Take immediate action to protect, comfort, and arrange for emergency medical treatment of the ~~consumer~~consumer/individual served as necessary. 2. Immediately, verbally notify the appropriate supervisor and attending medical staff of the incident if any of apparent serious injury, medication error or unexplained injury. 3. Complete the Incident Report, ensuring that all information is filled in completely, and give report to program supervisor or home manager as soon as possible, but no later than the end of the shift in which the incident occurred.

WHO	DOES WHAT
	• The form may be completed either on paper or within the electronic record system. • Only one IR should be completed per ~~consumer~~consumer/individual served event. Other ~~consumer~~consumers/individuals served~~s~~ involved or staff present should be noted in the appropriate space on the IR form. • ~~Consumer~~Consumer/individual served ~~initials should be used in the "What Happened" and "Actions Taken" fields.~~ 4. Verbally report any known or suspected Recipient Rights violations to the Office of Recipient Rights as soon as possible, but no later than the next business day. ~~4.~~5. Incidents that require emergency use of physical management or a call to 911/police are to include a start and stop time of the incident.
Program Supervisor/Home Manager or Designee	1. Take any further action necessary to assure treatment, protection and comfort of the individual 2. Ensure that the appropriate staff are notified of the details. 3. Ensure that staff documentation in Incident Report is complete and accurate, including a thorough description of the incident and action taken. 4. Complete supervisor section of the form with comments regarding action to remedy or prevent future recurrence of the incident. 5. Code the incident report for entry into data system 6. Within 24 hours of the Incident, the IR form must either be completed on paper and scanned directly into Encompass by the provider or entered electronically directly into the electronic record by the CMHSP or contracted provider. The CMHSP or contracted provider will be responsible and accountable for ensuring the accuracy and thoroughness of the information being reported on the IR form. Any provider seeking a different arrangement for submitting IRs must request an exception, in writing, from the Executive Director of the appropriate organization. 7. If the incident report is of a critical nature (e.g. involves death, serious injury, abuse, neglect, or possible sexual contact), shall make a verbal report to the client services manager (CSM) and Office of Recipient Rights (ORR) by telephone as soon as possible, but no later than the next business day. • Submit a copy of the incident report immediately to the CMHSP. • Other types of incidents such as illness may require notification to a physician or nurse as indicated in the treatment plan or provider policies.

WHO	DOES WHAT
	8. Verbally report any known or suspected Recipient Rights violations to the Office of Recipient Rights as soon as possible, but no later than the next business day.
Data Entry Clerk or other Designee	1. Scan the report and enter header information into the electronic record 2. Upon scanning, the report will be immediately made available for: a. Case Responsible Person b. Recipient Rights c. Medical Records d. Others as needed 3. Shred original IR
Case Responsible Person	1. Review IR within one (1) business day and contact the home manager/program supervisor for clarification as necessary. 2. Inform home manager/program supervisor of any concerns. 3. Add clarifying information regarding the incident when applicable 4. Choose a set of additional peer reviewers who should be informed of the incident and forward to them, if needed. 5. Verbally report any known or suspected Recipient Rights violations to the Office of Recipient Rights as soon as possible, but no later than the next business day. 6. Assure any IR that documents emergency use of physical management is routed to either the ~~consumer~~consumer/individual~~'~~s behavioral psychologist (if applicable) or the BTC chairperson for reviewing and reporting to the CMHPSM QI program. 7. Document in the clinical record the fact that an incident occurred~~, and~~ specific to any clinical follow up that was done. Staff should not reference the Incident Report itself or the incident reporting process in the clinical record.
CMH Supervisor notified of unusual incident involving ~~consumer~~consumers/individuals served~~s~~	1. Take any further action necessary to ensure treatment, comfort and protection of the ~~consumer~~consumer/individual served including arrangements for medical care and transportation. 2. Immediately, verbally inform the Executive Director or designee and the Office of Recipient Rights if the incident involves: a. An apparent or suspected serious injury

WHO	DOES WHAT
	b. The death of a ~~consumer~~consumer/individual served c. Suspicion of abuse or neglect by a staff member
Additional clinical reviews	1. Review the incident within 3 working days. 2. Add comments regarding follow-up actions when applicable.
Recipient Rights Officer	1. Reviews all Incident Reports for allegations of Recipient Rights violations. 2. Requests remedial action, as applicable, in effort to prevent recurrence of rights violations.

Date Received:_____
Date Reviewed:_____Initials: ____
Action: __No Follow-Up Needed
__Phone Call Follow-Up
__SI Opened

AFC LICENSING DIVISION - INCIDENT / ACCIDENT REPORT

Michigan Department of Licensing and Regulatory Affairs

Name of Facility/Home	License Number	Name of Person Directly Involved	Resident / Employee / Visitor
Facility Address		Address	
Facility Phone		City/State/Zip Code	
Licensee Name		Phone	Case Number (if applicable)

OTHER PERSON(S) INVOLVED / WITNESSES:

Name	Resident / Employee / Visitor	Name	Resident / Employee / Visitor
Name	Resident / Employee / Visitor	Name	Resident / Employee / Visitor

FACTS OF THE INCIDENT (*ATTACH ADDITIONAL PAGES AS NEEDED*):

Date of Incident	Time: AM / : / PM	Name of Employee Assigned to Resident (if Applicable)	Location of Incident (Kitchen, Yard, etc.)

Explain What Happened / Describe Injury (if any) (Attach separate sheet if necessary):

Action taken by Staff / Treatment Given (Attach separate sheet if necessary):

Corrective Measures Taken to Remedy and/or Prevent Recurrence (Attach separate sheet if necessary):

Name of Treating Physician / Health Care / Medical Facility / Hospital	Phone Number	Date Care Given	Time: AM / : / PM

Physician's Diagnosis of Injury, Illness or Cause of Death, if known

PERSON(S) NOTIFIED:

AFC Licensing	Notification Date / Time Written Notice / Date	Adult Protective Services (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Office of Recipient Rights (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date	Law Enforcement Agency (if applicable)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date	Other (please specify)	Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

BCAL-4607 (Rev. 1-16) Previous editions 7-15 & 4-15 may be used.

COPY DISTRIBUTION: Resident Record, Licensing Consultant, Responsible agency (if required by rule) and Designated representative

LICENSING RULES FOR AFC SMALL AND LARGE GROUP HOMES
R 400.15311 Investigation and reporting of incidents, accidents, illnesses, absences, and death.
Rule 311.(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:
(a) The death of a resident.
(b) Any accident of illness that requires hospitalization.
(c) Incidents that involve any of the following:
(i) Displays of serious hostility. (ii) Hospitalization.
(iii) Attempts at self-inflicted harm or harm to others.
(iv) Instances of destruction to property.
(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the
Public Acts of 1988.
(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following:
(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency. (b) Contact the local police authority.
(4) A licensee shall make a reasonable attempt to locate the resident through means other than those specified in subrule (3) of this rule.
(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor.
"Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
(a) The name of the person who was involved in the accident or incident.
(b) The date, hour, place, and cause of the accident or incident.
(c) The effect of the accident or incident on the person who was involved and the care given.
(d) The name of the individuals who were notified and the time of notification.
(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved. (f) The corrective measures that were taken to prevent the accident or incident from happening again.
(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not
less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

LICENSING RULES FOR AFC FAMILY HOMES R 400.1416 Resident health care.
Rule 16. (1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's
physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home. (2) A licensee shall maintain a health care appraisal on file for not less than 2 years from the resident's admission to the home.
(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years. (4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by
telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of any of the following:
(a) The death of a resident.
(b) Any accident or illness requiring hospitalization.
(c) Incidents involving displays of serious hostility, hospitalization, attempts at self-inflicted harm or harm to others, and instances of
destruction to property.
(5) A copy of the written report required in subrule (4) of this rule shall be maintained in the home for a period of not less than 2 years. A
department form shall be used unless prior authorization for a substitute form has been granted in writing by the department.

R 400.1417 Absence without notice.
Rule 17. (1) If a resident is absent without notice, the licensee or responsible person shall do both of the following:
(a) Make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency.

(b) Contact the local police authority.
(2) A licensee shall make a reasonable attempt to pursue other steps in locating the resident.
(3) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a
resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.

LICENSING RULES FOR AFC CONGREGATE FACILITIES R 400.2404 Illnesses and accidents.
Rule 404. (1) In case of an accident or sudden adverse change in a resident's physical condition or adjustment a congregate facility shall
obtain needed care immediately and notify the responsible relative and the person or agency responsible for placing and maintaining the resident in the congregate facility.
(2) An occurrence of a reportable communicable disease as defined by the laws of this state or the rules implementing such laws shall be
reported immediately to the local health department and the department.
(3) Immediate investigation of the cause of an accident or incident involving a resident, employee or visitor shall be initiated by a
congregate facility licensee or administrator and an appropriate accident record or incident report completed and maintained. Within 72 hours,
serious accidents requiring medical attention shall be reported to the department for remedial review.

R 400.2405 Deaths of Residents.
Rule 405. When a resident dies, a congregate facility licensee or administrator shall notify immediately the resident's physician, the next of kin or legal guardian and the person or agency responsible for placing and maintaining the resident in the congregate facility. Statues applicable to the reporting of sudden or unexpected death shall be observed. The death shall be reported to the department within 72 hours.

AUTHORITY: P.A. 218 of 1979 COMPLETION: Is Required CONSEQUENCE: Violation of Adult Foster Care Administrative Rule	LARA is an equal opportunity employer/program.

BCAL-4607 (Rev. 1-16) Previous editions 7-15 & 4-15 may be used.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	Policy and Procedure: *TRAUMA-INFORMED PRACTICE*
Department: Clinical Performance Team Author:	Local Policy Number (if used)
Implementation Date {will be 2 weeks from Regional Approval Date (last CMH Board's approval)}	Regional Approval Date

Reviewed by	Recommendation Date
ROC	9/1/2021
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure that services and programs are supportive of trauma issues and avoid retraumatization for all persons served by the CMHPSM, based on understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Original document
5/16/2017	Scheduled Review
Will be final Regional approval date	Scheduled Review

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM). This includes some Licensed Independent Practitioners and all subcontracted providers and substance abuse agencies under contract with the CMHPSM.

IV. POLICY

The CMHPSM will create and maintain a physically and emotionally 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~~consumer/individual-driven services.

V. DEFINITIONS

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

Trauma: Traumatic experiences can be dehumanizing, shocking, or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual, or institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection.

Trauma-Informed Care: As an approach that appreciates that healing is possible, trauma-informed care engages people with histories of trauma, recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. This approach seeks to shift the paradigm from one that asks, "What's wrong with you?" to one that asks "What has happened to you?" Every part of a trauma-informed system's organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.

VI. STANDARDS

1. Early Screening and Comprehensive Assessment of Trauma
   a. The initial (first encounter with the agency) intake, assessment, and documentation process includes questions designed to sensitively and respectfully explore prior (including early childhood) and current trauma-related experiences.
   b. CMHPSM clinicians recognize that some ~~consumer~~consumers/individuals served~~s~~ may not be able or willing to reveal traumatic life experiences early on in the intake/assessment process, given the sensitive nature of the topic, and will make efforts to revisit these issues based on an assessment of a ~~consumer~~consumer/individual's readiness.
   c. The screening and assessment process is sufficiently thorough and focused on symptoms, behaviors and trauma-related issues to allow for the determination of a diagnosis associated with trauma, such as PTSD. The ongoing process allows for

the gathering of new trauma-related information leading to potential changes in diagnosis as well as appropriate treatment objectives, goals, and services.

2. ~~Consumer~~Consumer/individual-Driven Care and Services
   a. There is ~~consumer~~consumer/individual served representation throughout the CMHPSM, and the organization has a formal system in place to continuously gather ~~consumer~~consumer/individual served feedback, identify problem areas, and make improvements as needed. A high priority is placed on assessing ~~consumer~~consumer/individuals' perception of safety, choice, collaboration trust, and empowerment.
   b. The ~~consumer~~consumer/individual's voice and choice are represented and encouraged. ~~Consumer~~Consumers/individuals served~~s~~ receive information about their rights and program opportunities, education about the impact of trauma, and exploration of options to ensure that they participate fully in making informed decisions about every aspect of their care.

3. Trauma-Informed Educated and Responsive Workforce
   a. The CMHPSM places a high emphasis on the active participation and buy-in of leadership in all trauma-informed care efforts.
   b. All staff (administrators/supervisors, practitioners, employed ~~consumer~~consumers/individuals served~~s~~, and support staff) in the CMHPSM are educated about what it means to be a trauma-informed care organization.
   c. Hiring practices indicate that candidates who have training and experience in trauma-related interventions and services, are highly valued and preferred, and job performance evaluations clearly describe staff expectations and behaviors that are aligned with trauma-informed care principles.
   d. Supervisors and practitioners receive training in trauma specific evidence-based and emerging best practices on an ongoing basis.
   e. Support staff receives ongoing training, performance evaluations, and supervisory assistance in integrating trauma-informed care principles in their work.
   f. The CMHPSM recognizes that staff success and satisfaction with their work might be affected by their personal trauma histories, compassion fatigue, secondary trauma (e.g. vicarious trauma), and the lack of organizational supports. The CMHPSM also creates an environment that is safe and comfortable for staff to share personal and work-related stressors and receive support through supervision, an Employee Assistance Program, or other professional services, or education to increase awareness about the impact of stress on work performance and develop personally meaningful and useful stress management strategies.

4. Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices
   a. The CMHPSM emphasizes the role of traumatic life experiences as key contributing factors in the development of many mental health, substance use, and physical health problems rather than placing an emphasis on personal deficits, weaknesses, and disorders. "What happened to you?" rather than "What is wrong with you?"

b. The CMHPSM routinely assists ~~consumer~~consumers/individuals served~~s~~ to develop a wellness plan that is designed to prevent and manage a crisis. All staff directly involved in the ~~consumer~~consumer/individual's treatment is informed about the ~~consumer~~consumer/individual's wellness plan and how they can support it.
c. The CMHPSM offers an array of trauma specific services, which are evidence-based, evidence-informed, and/or emerging best practices. The array is sufficiently broad to meet ~~consumer~~consumer/individual served preferences and needs.
d. The CMHPSM provides trauma-related information that will assist other service providers to develop a service plan that will promote effective care and reduce the likelihood of retraumatization.

5. Create Safe and Secure Environments
   a. The CMHPSM has a system in place to identify and implement policies, procedures, environmental conditions, activities, social climate, documentation, and treatment practices that promote a safe and secure environment in order to reduce the likelihood of re-traumatization or re-victimization.
   b. The CMHPSM has a system in place for ~~consumer~~consumers/individuals served~~s~~ and staff to "safely" let the organization know when practices, interpersonal interactions, and/or the environment are unsafe and inconsistent with trauma-informed care without fear of reprisal.
   c. The CMHPSM ensures that staff is educated and trained in using trauma-informed care approaches to prevent and manage incidents that create serious emotional distress for both staff and ~~consumer~~consumers/individuals served~~s~~.
   d. The CMHPSM recognizes that seclusion, restraint or the overuse of medication to control a person's behavior, can result in re-traumiatization or re-victimization. Thus, there is a system in place to utilize non-coercive approaches that promote empowerment, choice, and involvement of ~~consumer~~consumers/individuals served~~s~~.

6. Engagement in Community Outreach and Partnership Building
   a. The CMHPSM assumes a leadership role in engaging and educating community partners (e.g. courts, police, emergency services, hospitals, the general public, Child and Adult Protectives Services, MDHHS, etc.) about trauma-informed care and minimize re-traumatization.
   b. The CMHPSM engages external partners in the care of individual ~~consumer~~consumers/individuals served~~s~~, with their permission and involvement, to promote and ensure system-wide trauma-informed care.

7. Ongoing Performance Improvement and Evaluation
   a. The CMHPSM has a system in place to regularly measure its performance in the above standards.

VII. EXHIBITS

None

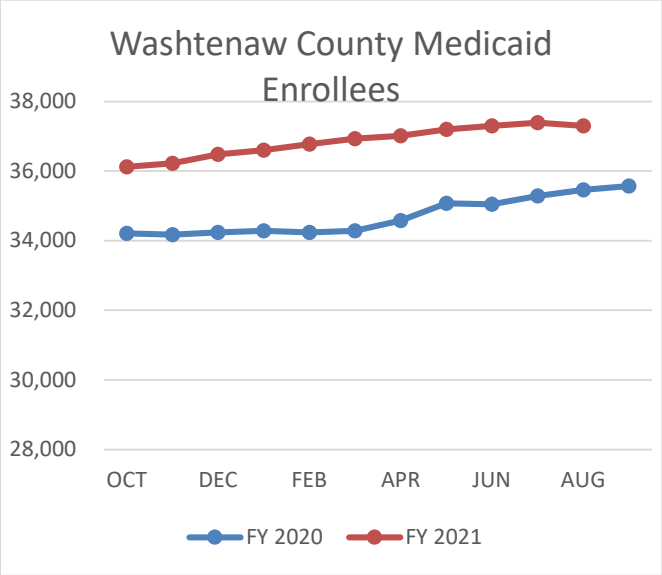
VIII. REFERENCES

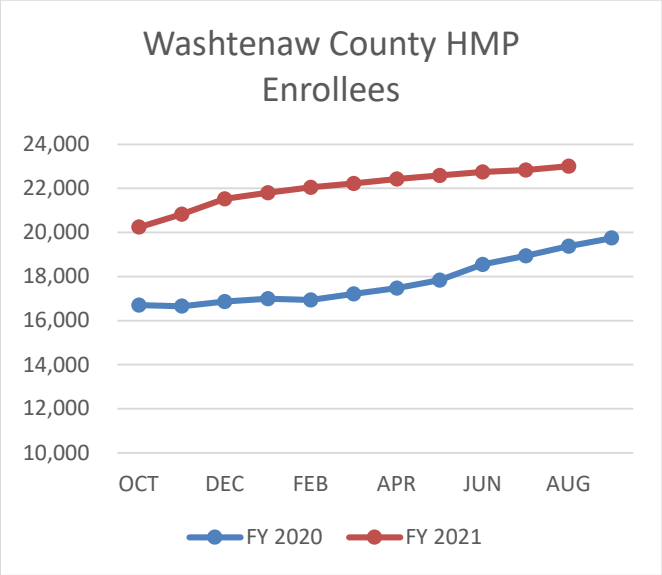
A. SAMHSA's National Center for Trauma-Informed Care (NCTIC) Website
B. Oregon Department of Human Services & Oregon State Hospital Trauma Policy Presentation: Pat Davis-Salyer M. Ed., Education & Development Department (http://www.oregon.gov/oha/amh/pages/trauma.aspx)
C. National Council for Community Behavioral Healthcare Organizational Self-Assessment: Adoption of Trauma-Informed Care Practice
D. CMHPSM Physical Management and Restraint Policy
E. Joint Commission Behavioral Health Standards
F. MDHHS PIHP Contract
G. MDHHS CMHSP Contract

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2021: For the period ending August 31, 2021
Prepared: October 4, 2021

1. Washtenaw County Enrollees

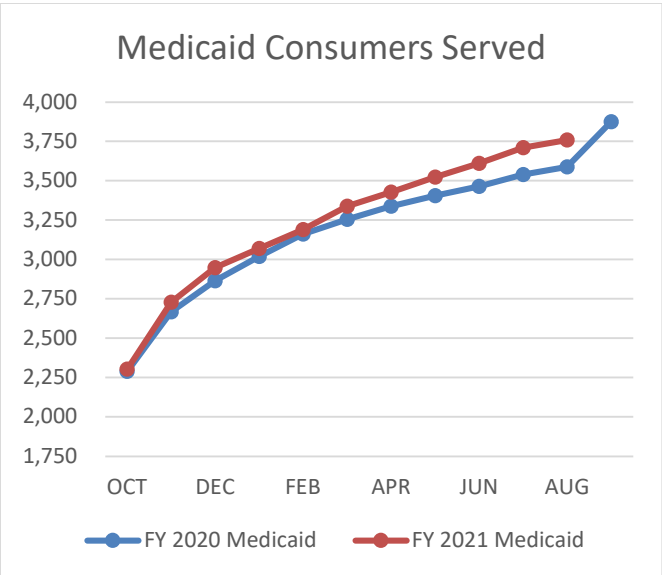
A summary of FY 2021 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

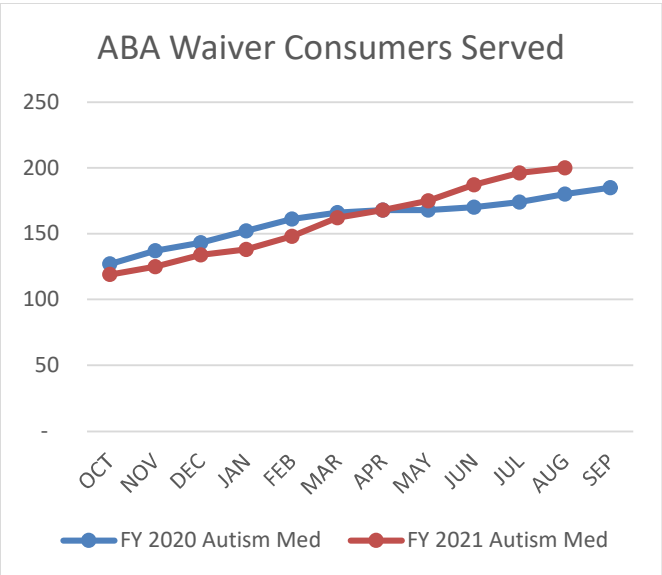




Washtenaw County Medicaid Enrollees were 37,298 in August 2021. This is a 5.17% increase from the same time last year (1,835 more enrollees than in August 2020). Healthy Michigan enrollment in August 2021 was 23,007. This is a 18.75% increase from the same time last year (3,633 more enrollees than in August 2020).

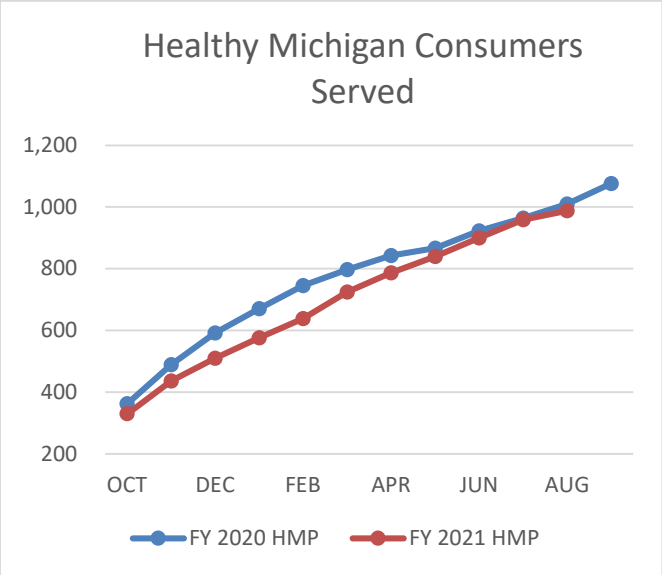
2. WCCMH Consumers Served to Date

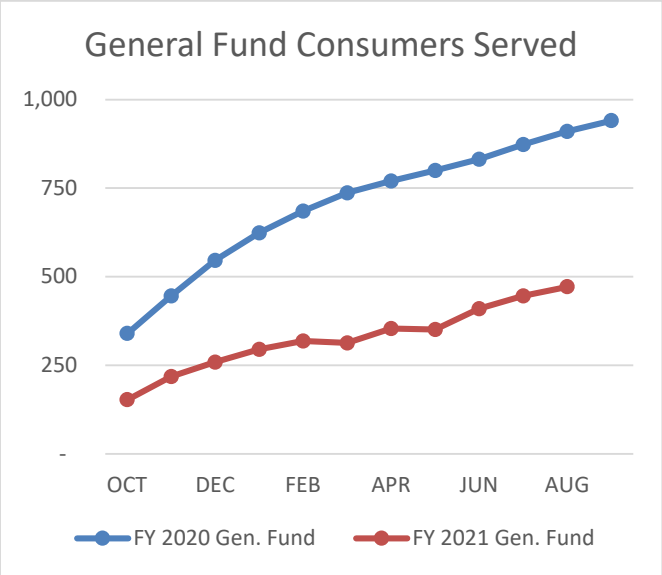




Medicaid consumers served through August 2021 are 3,759. This is 172 more consumers than the prior year (3,587 consumers were served through August 2020).

ABA Waiver consumers served through August 2021 are 200. This is the same number of consumers as prior year (180 consumers were served through August 2020).





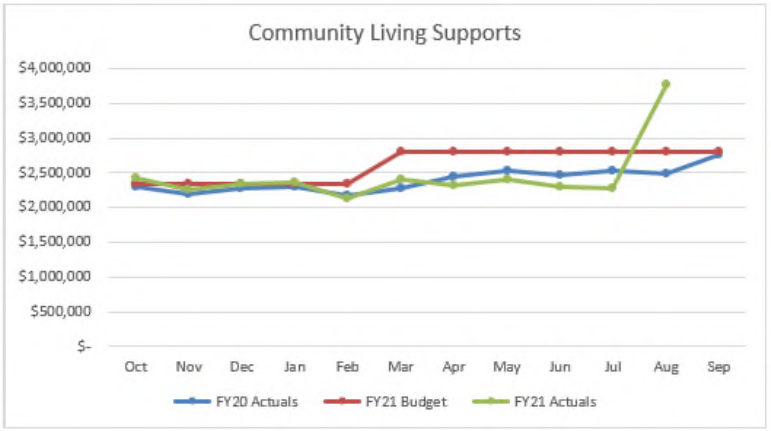
Healthy Michigan consumers served through August 2021 were 988. This is 21 less consumers than the same period last year.

General Fund consumers served through August 2021 were 472. This is 438 less consumers than the same period last year.

3. Financial Statement Highlights

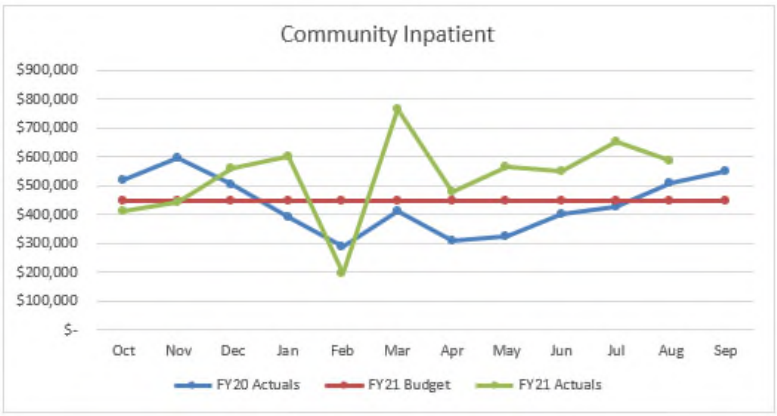
a. CLS service costs to date are estimated to be $28.5 Million and $99,000 under budget. The costs year to date is 8.67% more than this time last year. During the month of August, a stability payment was passed through from the PIHP to the CLS providers. This lump sum was fully expensed in the month of August and reflected in the graph below.

	FY20 Actuals	FY21 Budget	FY21 Actuals	YTD % Change
Oct	$ 2,290,691	2,335,165	$ 2,425,748	5.90%
Nov	2,198,453	2,335,165	2,264,702	4.48%
Dec	2,269,119	2,335,165	2,345,978	4.12%
Jan	2,287,654	2,335,165	2,365,292	3.93%
Feb	2,166,793	2,335,165	2,132,487	2.87%
Mar	2,276,977	2,804,524	2,403,018	3.32%
Apr	2,436,420	2,804,524	2,328,696	2.13%
May	2,535,453	2,804,524	2,410,173	1.16%
Jun	2,462,540	2,804,524	2,290,635	0.20%
Jul	2,518,980	2,804,524	2,283,397	-0.82%
Aug	2,486,795	2,804,524	3,768,207	4.20%
Sep	2,762,607	2,804,524		



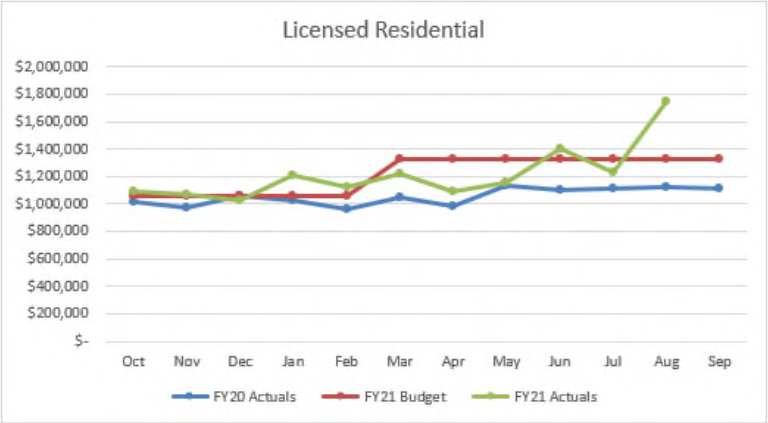
b. Community Inpatient costs to date are $5.8 Million. The costs year to date are 23.99% more than this time last year and $888,000 over budget.

	FY20 Actuals	FY21 Budget	FY21 Actuals	YTD % Change
Oct	$ 518,019	$ 447,917	$ 411,150	-20.63%
Nov	595,144	447,917	444,907	-23.10%
Dec	506,426	447,917	560,543	-12.53%
Jan	393,137	447,917	601,931	0.29%
Feb	290,304	447,917	194,823	-3.89%
Mar	411,873	447,917	767,313	9.79%
Apr	310,948	447,917	480,817	14.40%
May	323,671	447,917	567,208	20.28%
Jun	402,174	447,917	548,208	22.00%
Jul	426,500	447,917	653,771	25.19%
Aug	512,121	447,917	584,676	23.99%
Sep	550,126	447,917		



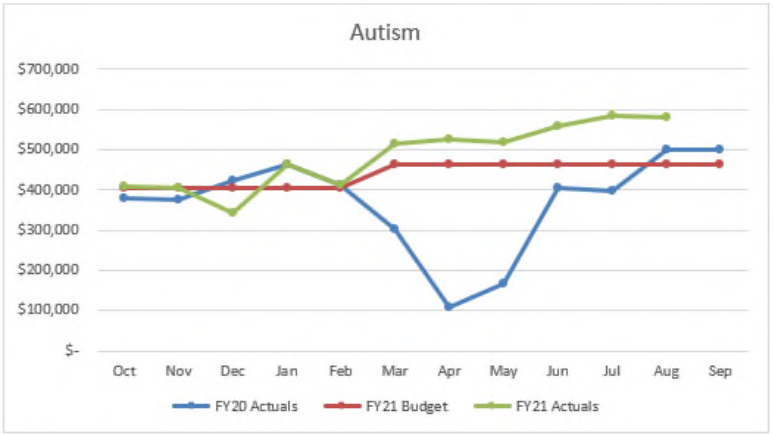
c. Licensed Residential costs to date are $13.3 Million and $6,500 under budget. The costs year to date are 15.91% more than this time last year. During the month of August, a stability payment was passed through from the PIHP to the Licensed Residential providers. This lump sum was fully expensed in the month of August and reflected in the graph below.

	FY20 Actuals	FY21 Budget	FY21 Actuals	YTD % Change
Oct	$ 1,011,548	$ 1,058,350	$ 1,093,095	8.06%
Nov	968,709	1,058,350	1,073,263	9.40%
Dec	1,055,503	1,058,350	1,028,927	5.25%
Jan	1,022,251	1,058,350	1,211,062	8.58%
Feb	959,842	1,058,350	1,118,469	10.10%
Mar	1,047,035	1,327,021	1,225,127	11.30%
Apr	987,543	1,327,021	1,093,521	11.22%
May	1,137,635	1,327,021	1,159,115	9.92%
Jun	1,106,832	1,327,021	1,399,305	11.89%
Jul	1,114,786	1,327,021	1,228,220	11.70%
Aug	1,124,986	1,327,021	1,742,223	15.91%
Sep	1,109,577	1,327,021		



d. Applied Behavior Analysis/Autism service costs to date are $5.3 Million. The costs year to date are 35.26% more than this time last year due to pandemic related factors and $468,000 over budget.

	FY20 Actuals	FY21 Budget	FY21 Actuals	YTD % Change
Oct	$ 377,299	$ 405,991	$ 408,109	8.17%
Nov	376,345	405,991	404,662	7.85%
Dec	421,658	405,991	342,956	-1.67%
Jan	461,206	405,991	464,654	-0.99%
Feb	412,563	405,991	410,998	-0.86%
Mar	301,850	464,421	512,641	8.21%
Apr	107,090	464,421	525,526	24.88%
May	165,001	464,421	518,865	36.80%
Jun	404,100	464,421	558,191	36.98%
Jul	397,582	464,421	584,957	38.16%
Aug	500,967	464,421	578,244	35.26%
Sep	501,047	464,421		



e. Internal staffing expenses are trending under budget due to medical benefit savings for the first quarter and difficulty recruiting for budgeted vacant positions.

4. PIHP Revenue Key Points

a. Medicaid and Healthy Michigan Plan revenues are collected from the PIHP.
b. By funding source, Medicaid is showing a surplus of $4.3 Million through August.
c. By funding source, HMP is showing a deficit of $1.1 Million through August.
d. Combined, the PIHP surplus is $3.2 Million through August.
e. CARES Act funding related to Direct Care Worker wages will be cost settled separately and any unspent funds must be returned to the State and cannot be retained by the PIHP.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a surplus of $2.6 Million.

6. Local Key Points

a. The majority of Local Funding comes from Washtenaw County.

b. Local Funds are showing a surplus of $46,000 through August 2021.

c. Uses of Local Funding include:

i. The 10% GF Match of non-residential services
ii. Local contribution – required by MDHHS
iii. Local share for State Facilities
iv. Shelter expenses and other Local needs

7. Fund Balance

WCCMH currently has no fund balance available for fiscal year 2021.

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
AUGUST 2021 FYTD

		Total
Medicaid **		
Revenue		
B & B3	$	41,288,976
HSW		23,151,132
DCW		6,840,605
Child Waiver/SED Waiver		954,952
Autism		4,514,882
Prior Year Adjustments		-
Care for Caid		18,809
Total Medicaid Revenue	$	76,769,356
Total Medicaid Expense	$	72,452,684
Medicaid Surplus/(Deficit)	$	4,316,672
Healthy Michigan **		
Revenue	$	5,383,740
Expense		6,486,477
Healthy MI Surplus/(Deficit)	$	(1,102,736)
General Fund		
Revenue		
CMH Operations	$	3,549,728
CMH Operations Contra		-
GF Carryforward		175,491
Categorical		-
Redirect To Injectable Meds.		-
Funding Fr. Other Local Sources		63,174
Total General Fund Revenue	$	3,788,393
Total General Fund Expense	$	1,117,061
General Fund Surplus/(Deficit)	$	2,671,332
Injectable Meds		
Revenue	$	94,808
Expense		83,807
Inj. Meds. Surplus/(Deficit)	$	11,001
Grants And Contracts		
Revenue	$	1,165,054
Expense		1,165,054

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
AUGUST 2021 FYTD

		Total
Grants & Cont. Surplus/(Deficit)	$	-
CMHSP To CMHSP		
Revenue	$	610,647
Redirect to GF		(63,174)
Expense		547,474
CMHSP to CMHSP Surplus/(Deficit)	$	-
Local		
Revenue	$	1,417,397
Expense		1,370,434
Local Surplus/(Deficit)	$	46,963
Private Grant & All NOR		
Revenue	$	215,847
Expense		215,847
Priv. Grant & NOR Surplus/(Deficit)	$	-
Grand Total		
Revenue	$	89,580,228
Expense		83,636,996
Grand Total Surplus/(Deficit)	$	5,943,232

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	3,224,937
WCCMH Surplus/(Deficit)		2,718,295
	$	5,943,232

Washtenaw County Community Mental Health
Budget to Actuals
For Eleven Months Ending August 31, 2021

	Current Fiscal Year				
	FY 2021 Amended Budget	FY 2021 Amended Budget YTD	FY 2021 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 42,678,933	$ 39,122,355	$ 41,288,976	$ 2,166,621	5.54%
HSW	24,674,716	22,618,490	23,151,132	532,642	2.35%
Children & SED Waivers	894,097	819,589	954,952	135,363	16.52%
Healthy Michigan Capitation	5,875,998	5,386,332	5,383,740	(2,592)	-0.05%
Autism Capitation	4,657,841	4,269,688	4,514,882	245,194	5.74%
CARES Act DCW	7,297,312	6,689,203	6,840,605	151,402	2.26%
TOTAL PIHP Revenue	$ 86,078,897	$ 78,905,656	$ 82,134,287	$ 3,228,632	4.09%
MDHHS Revenue					
State General Funds	$ 4,047,922	$ 3,710,595	$ 3,725,219	$ 14,624	0.39%
Grants & Earned Contracts	1,779,812	1,631,494	1,320,012	(311,482)	-19.09%
All Other Revenue					
County Appropriation	$ 1,748,770	$ 1,603,039	$ 745,506	$ (857,533)	-53.49%
Project Revenue	782,545	717,333	630,697	(86,636)	-12.08%
All Other	1,917,652	1,757,848	2,262,775	504,927	28.72%
TOTAL Operating Revenue	**$ 96,355,598**	**$ 88,325,965**	**$ 90,818,496**	**$ 2,492,531**	2.82%
Operating Expenses					
Administrative Expenses					
General Administration	$ 5,624,552	$ 5,155,839	$ 4,610,064	$ (545,775)	-10.59%
Program Administration	3,304,826	3,029,424	2,594,363	(435,061)	-14.36%
Residential Services					
Community Living Supports	$ 31,307,490	$ 28,698,533	$ 28,599,399	$ (99,134)	-0.35%
Licensed Residential	14,580,900	13,365,825	13,372,327	6,502	0.05%
Outpatient Services					
Autism Services	$ 5,280,900	$ 4,840,825	$ 5,309,804	$ 468,979	9.69%
Case Management	5,221,985	4,786,820	3,859,595	(927,225)	-19.37%
Supports Coordination	2,535,741	2,324,429	2,134,322	(190,107)	-8.18%
Skill Building	4,256,172	3,901,491	2,427,519	(1,473,972)	-37.78%
Supported Employment	1,364,871	1,251,132	1,219,449	(31,683)	-2.53%
Psychiatry	2,770,122	2,539,279	2,496,353	(42,926)	-1.69%
Nursing Services	2,353,003	2,156,919	1,859,555	(297,364)	-13.79%
Therapy Services	1,875,621	1,719,319	1,577,097	(142,222)	-8.27%
All Other	7,441,765	6,821,618	6,367,365	(454,253)	-6.66%
Other Expenses					
Community Inpatient	$ 5,375,000	$ 4,927,083	$ 5,815,347	$ 888,264	18.03%
Local Matches & Shelter	1,282,838	1,175,935	1,375,864	199,929	17.00%
Grants & Earned Contracts	1,779,812	1,631,494	1,256,839	(374,655)	-22.96%
TOTAL Operating Expenses	**$ 96,355,598**	**$ 88,325,965**	**$ 84,875,262**	**$ (3,450,703)**	-3.91%
Revenue Over/(Under) Expenses	-	-	5,943,234	5,943,234	

Washtenaw County Community Mental Health
Budget to Actuals
For Eleven Months Ending August 31, 2021

	Prior Year Comparison			
	FY 2021 YTD Actuals	FY 2020 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 41,288,976	$ 39,378,036	$ 1,910,940	4.85%
HSW	23,151,132	23,588,029	(436,897)	-1.85%
Children & SED Waivers	954,952	897,297	57,655	6.43%
Healthy Michigan Capitation	5,383,740	4,746,707	637,033	13.42%
Autism Capitation	4,514,882	4,576,583	(61,701)	-1.35%
CARES Act DCW	6,840,605	-	6,840,605	
TOTAL PIHP Revenue	$ 82,134,287	$ 73,186,652	$ 8,947,635	12.23%
MDHHS Revenue				
State General Funds	$ 3,725,219	$ 3,331,743	$ 393,476	11.81%
Grants & Earned Contracts	1,320,012	1,450,921	(130,909)	-9.02%
All Other Revenue				
County Appropriation	$ 745,506	$ 777,020	$ (31,514)	-4.06%
Project Revenue	630,697	430,046	200,651	46.66%
All Other	2,262,775	2,142,508	120,267	5.61%
TOTAL Operating Revenue	**$ 90,818,496**	**$ 81,318,890**	**$ 9,499,606**	11.68%
Operating Expenses				
Administrative Expenses				
General Administration	$ 4,610,064	$ 4,482,421	$ 127,643	2.85%
Program Administration	2,594,363	2,699,402	(105,039)	-3.89%
Residential Services				
Community Living Supports	$ 28,599,399	$ 26,317,611	$ 2,281,788	8.67%
Licensed Residential	13,372,327	11,536,671	1,835,656	15.91%
Outpatient Services				
Autism Services	$ 5,309,804	$ 3,925,662	$ 1,384,142	35.26%
Case Management	3,859,595	3,960,630	(101,035)	-2.55%
Supports Coordination	2,134,322	1,824,324	309,998	16.99%
Skill Building	2,427,519	3,937,751	(1,510,232)	-38.35%
Supported Employment	1,219,449	1,379,378	(159,929)	-11.59%
Psychiatry	2,496,353	2,246,001	250,352	11.15%
Nursing Services	1,859,555	1,904,938	(45,383)	-2.38%
Therapy Services	1,577,097	1,545,689	31,408	2.03%
All Other	6,367,365	5,548,089	819,276	14.77%
Other Expenses				
Community Inpatient	$ 5,815,347	$ 4,690,318	$ 1,125,029	23.99%
Local Matches & Shelter	1,375,864	1,312,809	63,055	4.80%
Grants & Earned Contracts	1,256,839	1,380,819	(123,980)	-8.98%
TOTAL Operating Expenses	**$ 84,875,262**	**$ 78,692,513**	**$ 6,182,749**	7.86%
Revenue Over/(Under) Expenses	5,943,234	2,626,377	3,316,857	

Washtenaw County Community Mental Health (WCCMH)
Summarized Month End Tracking

Prior Year FY 2020	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**
Total Revenue	$ 6,420,879	$ 12,762,586	$ 19,557,248	$ 27,034,137	$ 33,790,813	$ 41,347,119	$ 48,354,984	$ 55,979,589	$ 64,750,232	$ 72,489,244	$ 80,554,716	
Total Expense	$ 7,061,564	$ 13,824,563	$ 21,701,361	$ 28,573,303	$ 35,391,004	$ 42,808,785	$ 49,403,569	$ 56,153,455	$ 63,224,817	$ 70,893,620	$ 77,864,354	
Surplus / (Deficit)	$ (640,685)	$ (1,061,977)	$ (2,144,113)	$ (1,539,166)	$ (1,600,191)	$ (1,461,666)	$ (1,048,585)	$ (173,866)	$ 1,525,415	$ 1,595,624	$ 2,690,362	$ -

Current Year FY 2021	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**
Total Revenue	$ 7,755,401	$ 15,310,244	$ 23,580,591	$ 31,333,092	$ 38,921,338	$ 47,115,196	$ 56,134,326	$ 64,236,863	$ 72,980,573	$ 81,144,669	$ 90,818,496	
Total Expense	$ 6,390,300	$ 13,468,771	$ 20,308,564	$ 28,129,172	$ 35,311,210	$ 42,743,574	$ 50,665,179	$ 58,492,671	$ 66,459,411	$ 75,089,495	$ 84,875,262	
Surplus / (Deficit)	$ 1,365,101	$ 1,841,473	$ 3,272,027	$ 3,203,920	$ 3,610,128	$ 4,371,622	$ 5,469,147	$ 5,744,192	$ 6,521,162	$ 6,055,174	$ 5,943,234	$ -

Washtenaw County Community Mental Health
Millage and CCBHC Grants Budget to Actuals
For Eight Months Ending August 31, 2021

Millage Budget

	Annual Budget	Budget YTD	YTD Actual	YTD Actual O/(U) YTD Budget
Millage Revenue				
Millage	$ 6,565,388	$ 4,376,925	$ 6,757,986	$ 2,381,061
Millage Interest Revenue	-	-	21,543	21,543
Millage GASB31 Adjustment	-	-	(73,911)	(73,911)
	$ 6,565,388	$ 4,376,925	$ 6,705,618	$ 2,328,693
Millage Expenses				
Salary	$ 2,395,000	$ 1,596,667	$ 1,226,853	$ (369,814)
Fringe	1,339,513	893,009	629,800	(263,208)
Contractors	1,500,000	1,000,000	643,820	(356,180)
Trainings	140,000	93,333	4,600	(88,734)
Operating Expenses	782,500	521,667	273,777	(247,890)
Fleet Charges	60,000	40,000	8,883	(31,117)
Client Care	78,500	52,333	63,636	11,303
Cost Allocation Plan	70,875	47,250	187,139	139,889
Furniture & Equipment	100,000	66,667	-	(66,667)
Depreciation Expense	10,000	6,667	-	(6,667)
Telephone	50,000	33,333	16,754	(16,580)
All Other Expenses	39,000	26,000	9,081	(16,919)
Total Millage Expenses	$ 6,565,388	$ 4,376,925	$ 3,064,343	$ (1,312,582)
Revenue Over/(Under) Expenses		-	3,641,275	3,641,275
	-			

*** Millage Fund Balance at the close of 2020 is $5,056,178

CCBHC Grant

January 2021 - December 2021				
CCBHC #2 - Year 2 Grant Revenue	$ 2,250,971	$ 1,500,647	$ 1,223,990	$ (276,657)
CCBHC #2 - Year 2 Grant Expenses				
Salary	$ 1,166,672	$ 777,781	$ 706,025	$ (71,756)
Fringe	765,442	510,295	395,098	(115,197)
Trainings	9,660	6,440	-	(6,440)
Telephone	16,050	10,700	8,559	(2,141)
Operating Supplies	22,263	14,842	2,004	(12,838)
Client Care	66,250	44,167	1,167	(43,000)
Indirect Costs	204,634	136,423	111,137	(25,286)
Total Expenses	$ 2,250,971	$ 1,500,647	$ 1,223,990	$ (276,657)
Revenue Over/(Under) Expenses	(0)	-	-	-

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
September 8, 2021
***Meeting held electronically via Zoom**

Members Present: (physical location) Judy Ackley (Ann Arbor, MI), Susan Fortney (Ida, MI), Roxanne Garber (Howell, MI), Bob King (Ann Arbor, MI), Sandra Libstorff (Monroe, MI), Molly Welch Marahar (Ann Arbor, MI), Randy Richardville (Monroe, MI), Mary Serio (Howell, MI), Sharon Slaton (Brighton Township, MI), Ralph Tillotson (Adrian, MI)

Members Absent: Greg Adams, Katie Scott

Staff Present: Kathryn Szewczuk, Stephannie Weary, James Colaianne, CJ Witherow, Matt Berg, Lisa Jennings, Nicole Adelman, Connie Conklin, Mike Harding, Taylor Gerdman, Dana Darrow

Guests Present:

I. Call to Order
Meeting called to order at 6:06 p.m. by Board Chair S. Slaton.

II. Roll Call
- An electronic quorum of members present was confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by R. Tillotson, supported by M. Serio, to approve the agenda
Motion carried
Voice vote, no nays

IV. Consideration to Approve the Minutes of the August 11, 2021 Regular Meeting and Waive the Reading Thereof
Motion by S. Fortney, supported by R. Garber, to approve the minutes of the August 11, 2021 regular meeting and waive the reading thereof
Motion carried
Voice vote, no nays

V. Audience Participation
None

VI. Old Business
a. Board Review – September Finance Report – FY2021 as of July 31st
- M. Berg presented. Discussion followed.

VII. New Business

a. Board Action – FY2021 Contracts
Motion by R. Garber, supported by B. King, to authorize the CEO to execute the contract amendment for MILO Detroit as presented
Motion carried
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

b. Board Action - October 2021 Provider Premium Pay Extension
Motion by R. Tillotson, supported by B. King to approve the pass through of $1,288,802.96 in funding from the CMHPSM to cover the regional extension of provider premium pay for the month of October 2021
Motion carried
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

c. Board Action - FY2022 Budget
Motion by B. King, supported by R. Garber, to approve the Fiscal Year 2022 budget and allocations as presented, including authorization for the CMHPSM CEO to sign the included FY2022 expense contracts
Motion carried
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

d. Board Action - FY2022 Contract List
- The FY2022 Contract list was approved in the Board approval of the FY2022 Budget.

e. Board Action - CMHPSM Retirement Plan Vendor Change
Motion by B. King, supported by M. Welch Marahar, to authorize the CMHPSM Regional Board Secretary to sign three distinct resolutions authorizing a transition of the CMHPSM's 401a and 457 defined contribution retirement plans to the Municipal Employees' Retirement System (MERS) effective September 8, 2021
Motion carried
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

f. Board Action - Employee Handbook
Motion by B. King, supported by J. Ackley, to approve the CMHPSM employee handbook with the included revisions
Motion carried
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

g. Board Action - Election Chair/Committee for October Officers Election
- Caroline Richardson has resigned from both the CMH and Regional Boards. The Regional Board would like to acknowledge Ms. Richardson's years of service on the board. Staff will develop a proclamation for the board's review and approval.
- R. Garber volunteered to serve as the Election Chair for next month's election.

VIII. Reports to the CMHPSM Board
a. Report from the SUD Oversight Policy Board (OPB)
- J. Colaianne provided an overview of the August OPB meeting.

b. CEO Report to the Board
- J. Colaianne presented the CEO Report, which included updates from the CMHPSM, Region, and State. See CEO report in packet for details.

IX. Adjournment

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

Meeting adjourned at 7:36 p.m.

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Judy Ackley, CMHPSM Board Secretary