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/91445894500

November 19, 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-10/15/21 (Attachment #1A)
B. WCCMH Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions-9/13/21 (Attachment #1B)
C. WCCMH Program-Quality Committee Meeting Minutes and Actions-8/9/21 (Attachment #1C)
D. WCCMH Program Committee Dashboard FY2021, Qtr. 3 (Attachment #1D)
E. MILLAGE COMMITTEE:
    1. WCCMH Millage Advisory Committee Meeting Minutes and Actions-9/13/21 (Attachment #1E1)
    2. Millage Process, Investments and Progress Update (Attachment #1E2)
    3. CARES Dashboard (Attachment #1E3)
    4. NAMI Update (Attachment #1E4)
    5. Strategic Planning Update (Attachment #1E5)
F. CMHPSM Policies - Reviewed and Recommended for Approval by Regional Operations Committee
    1. Access System Policy (Attachment #1F1)
    2. Consumer Appeals Policy (Attachment #1F2)
    3. Consumer Employment Policy (Attachment #1F3)
    4. Coordination of Integrated Healthcare Policy (Attachment #1F4)
    5. Corporate Compliance Policy (Attachment #1F5)
    6. Peer Review Policy (Attachment #1F6)
G. WCCMH Consumer Advisory Council Meeting Minutes and Actions-9/8/21 (Attachment #1G)
H. WCCMH Consumer Advisory Council Meeting Minutes and Actions-10/13/21 (Attachment #1H)

V. Treasurer's Report **ACTION** (20 minutes)

- WCCMH Millage and CCBHC Financial Status Report (Attachment #2) **N. Phelps ACTION**
- Contracts and Leases (Attachment #3) **M. Taylor ACTION**
- Executive Director Authorizations (Attachment #4) **M. Taylor ACTION**

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

VII. CMHPSM Regional Update (10 minutes)

- October 13, 2021 CMHPSM Meeting Minutes and Actions (Attachment #5)
- November 10, 2021 CMHPSM Board Meeting Update

VIII. New Business (30 minutes)

- Washtenaw County Board Appointment for a term ending March 31, 2022 (Attachment #6)
    - Alfreda Rooks
- WCCMH FY2022 Budget Amendment (Attachment #7) **N. Phelps ACTION**
- WCCMH & WCSO Collaboration Update **J. Clayton/L. Gentz** (Attachment #8)

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.

IX. Old Business (20 minutes)
- CCBHC Update **T. Cortes/M. Harding**
- Strategic Planning Update (Attachment #9) **T. Cortes/M. Harding**

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

XI. Adjournment of Public Meeting

Instructions to join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. https://zoom.us/j/91445894500

Or One tap mobile:
+12678310333, 91445894500# US (Philadelphia)
+13126266799, 91445894500# US (Chicago)

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

Webinar ID: 914 4589 4500

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

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

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD

NOVEMBER 19, 2021

CONSENT AGENDA

A. WCCMH Board Meeting Minutes and Actions-10/15/21
B. WCCMH Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions-9/13/21
C. WCCMH Program-Quality Committee Meeting Minutes and Actions-8/9/21
D. WCCMH Program Committee Dashboard FY2021, Qtr. 3
E. Millage Committee:
    1. WCCMH Millage Advisory Committee Meeting Minutes and Actions-9/13/21
    2. Millage Process, Investments and Progress Update
    3. CARES Dashboard
    4. NAMI Update
    5. Strategic Planning Update
F. CMHPSM Policies-Reviewed and Recommended for Approval by Regional Operations Committee:
    1. Access System Policy
    2. Consumer Appeals Policy
    3. Consumer Employment Policy
    4. Coordination of Integrated Healthcare
    5. Corporate Compliance Policy
    6. Peer Review Policy
G. WCCMH Consumer Advisory Council Meeting Minutes and Actions-9/8/21
H. WCCMH Consumer Advisory Council Meeting Minutes and Actions-10/13/21

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

https://zoom.us/j/97686560201

October 15, 2021
9:30am

K. Walker called the meeting to order at 9:31 am.

ROLL CALL:	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 K. Scott attending City of Ann Arbor, Washtenaw County, MI D. Strong attending remotely from Mishawaka, IN M. Udow-Phillips attending remotely from Superior Twp, Washtenaw County, MI K. Walker attending remotely from Pittsfield Twp, Washtenaw County, MI
MEMBERS ABSENT:	S. Antonow, A. LaBarre
STAFF PRESENT:	T. Cortes, M. Harding, N. Phelps, R. Dornbos, S. Amos O'Neal, H. Linky, S. Ray, D. Howell, K. Snay, L. Higle, M. Taylor, M. Hershberger, E. Mix, N. Muraca, B. Hagaman
OTHERS PRESENT:	T. Gavalier, G. Nelson, A. Cisneros, G. Nelson, S. Swisher

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-9/17/21
- WCCMH Fall 2021 Staff Quarterly Newsletter
- CMHPSM Policies-Reviewed and Recommended for Approval by Regional Operations Committee:
  - Debarment, Suspension and Exclusion Policy
  - Employee Competency and Credentialing Policy
  - Incident Reporting Policy
  - Trauma Informed Practice Policy

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. DUSBIBER TO ACCEPT AND APPROVE THE OCTOBER 15, 2021 WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**N/A**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**
JEFFERSON	**Y**	**KING**	**Y**
LABARRE	**N/A**	**SCOTT**	**Y**

STRONG	**Y**	**UDOW-PHILLIPS**	**Y**
WALKER	**Y**		

MOTION CARRIED

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

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY B. HIGMAN TO ACCEPT AND APPROVE THE WCCMH TREASURERS REPORT ENDING AUGUST 31, 2021.

ROLL CALL VOTE:

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

MOTION CARRIED

VI. Millage and CCBHC Financial Status Report
- N. Phelps presented the Millage and CCBHC Financial Status Report (Attachment #3) to the Board for the period ending August 31, 2021.

MOTION BY B. KING, SUPPORTED BY D. STRONG TO ACCEPT AND APPROVE THE WCCMH MILLAGE AND CCBHC FINANCIAL STATUS REPORT ENDING AUGUST 31, 2021.

ROLL CALL VOTE:

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

MOTION CARRIED

VII. Executive Director report
- T. Cortes presented the Executive Director report to the WCCMH Board.
- State Level Update
  - The Directors Forum met recently. Mental Health budget at the State level shows an increase of 2% in the rates. The budget is allocating money towards Children's Services, a 5-year plan to help address crisis stabilization units (which is what we are doing at 750 currently), additional revenue to expand behavioral health homes, and allocated a $2.35 increase for direct care workers.
  - Senator Shirkey bill is likely going to pass through the Senate.
  - F. Brabec will be at the Learning Resource Center on 11/15/21 at 5:30pm for her listening session.
  - Continue to address the workforce shortages across the State at all levels within the system. T. Cortes met yesterday with other CMH Directors across the State, Washtenaw County is doing a bit better than others as it pertains to the workforce shortage.

- Local Update
  - T. Cortes met recently with Governmental Consultant Services, Inc (GCSI), G. Dill, Commissioner S. Shink and Commissioner A. LaBarre, K. Walker, and M. Udow-Phillips to look at additional strategies regarding direct care worker wages.
  - T. Cortes continues to work on recruitment and retention with County Administration and Human Resources since the beginning of summer. WCCMH has been posting on external sites like Indeed and advertising at job fairs and local universities. Some headway has been made with the County to introduce a pilot in WCCMH that will be brought forward to the Commissioners for some incentives around recruitment and retention of staff. There will be a committee working closely with County HR on additional strategies.
  - Staff have been extremely busy with CCBHC since it went live on 10/1/21. T. Cortes acknowledged M. Harding for all of his hard work on getting us where we are at with CCBHC. The State recently recognized WCCMH for its efforts.
  - Moving forward with WCCMH becoming the single point of entry for Substance Use Disorder (SUD). Staff will bring a process for this transition to the Board by January 2022.
  - The Las Enforcement Assisted Diversion (LEAD) Program is moving forward with several efforts. Sheriff Clayton, L. Gentz, T. Cortes and D. Jackson will bring a full report to the Board in December that will include different intercepts and how/where they are moving forward.
  - F. Brabec will be holding a listening session on November 15th. R. Dornbos will send this information to the board.

VIII. CMHPSM Regional Update

- The CMHPSM minutes (Attachment #4) from September 8, 2021 were reviewed.
- T. Cortes presented an update on the October 13, 2021 Regional Board meeting.
- The Regional Board gave C. Richardson a proclamation for her years of service on the board.
- K. Walker stated that with the resignation of C. Richardson from the WCCMH Board that has created a vacant spot on the CMHPSM Board. Washtenaw is required to have 3 spots filled on the CMHPSM Board. We will need to get a replacement on the PIHP Board to fill her space. Anyone interested is to contact K. Walker.

IX. New Business

- Washtenaw County CMH Board terms expiring March 31, 2022.
  - K. Walker stated that the following members terms are set to expire on March 31, 2022.
    - B. King-Community Member
    - A. LaBarre-BOC Representative
    - Vacant (C. Richardson vacancy already posted on County website)
    - K. Scott-Secondary Consumer
  - These vacancies will be posted on the County website and if interested to please notify R. Dornbos
  - Request to have C. Richardson attend the next WCCMH Board meeting so that she can be recognized for her years of service on this board. T. Cortes will reach out to her to see if she can attend.
- Consumer Advisory Council Update on Strategic Planning
  - M. Hershberger and B. Higman discussed the CMH Strategic Plan
  - The CAC has designed a process on how to share recovery stories called Story Jam. The goal is to have something to present to the WCCMH Board in December.
  - Celebration of Success is scheduled for the end of October as a Facebook live event. M. Hershberger will send the notification to R. Dornbos to distribute to WCCMH Board.

- WCCMH Board and Committee Meeting Schedule
  - S. Amos O'Neal discussed options for a revised meeting schedule for the WCCM Board and committees for 2022.
  - Rhonda will send out bylaws to members. Updates to the bylaws need to be made. Staff will start the process of revising the bylaws with track changes and will bring recommendations to the Board.
  - Request to revisit the meeting schedule and bylaws at the November Board meeting.
  - Request to have virtual participation an option for future Board and Committee meetings.

X. Old Business
- CCBHC Update
  - M. Harding provided an update on the CCBHC.
  - Provisional status allows us to receive the payments and start enrollment of individuals.

- Strategic Planning Update
  - M. Harding and T. Cortes provided an update on the Strategic Plan.

N. Phelps notified the WCCMH Board that the September Financial Report does not come to the board in the form of a Monthly Financial Report so there will be no report presented in November.

XI. Items for future discussion
- Development of Reserve Capital at the CMHSP level
- COVID-19 Related Priorities Discussion
- Employee Engagement Survey
- Strategic Planning
- Bylaw review/revisions

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY B. KING TO ADJOURN THE WCCMH BOARD MEETING.

Meeting adjourned at 11:11 AM.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

WCCMH BUDGET-FINANCE AND PROGRAM-QUALITY COMBINED COMMITTEE MEETING MINUTES

DRAFT

September 13, 2021

https://zoom.us/j/99244805581

1:00 pm

ROLL CALL: 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 Van Buren Twp, Wayne County, MI
D. Strong attending remotely from Scio Twp, Washtenaw County, MI
M. Udow-Phillips attending remotely from Ann Arbor, Washtenaw County, MI
K. Walker attending remotely from Cadillac, Wexford County, MI

MEMBERS ABSENT: S. Antonow, A. Dusbiber. B. King, K. Scott

STAFF PRESENT: T. Cortes, M. Harding, N. Phelps, E. Spring, H. Linky, S. Amos O'Neal, K. Snay, M. Taylor, S. Ray. B. Hagaman, L. Higle, M. Tasker, L. Gentz

OTHERS PRESENT: L. Lutomski, T. Gavalier, M. Creekmore

N. Graebner-Sundling called the meeting to order at 1:05 pm.

I. Introductions
- None

II. Audience Participation
- None

III. Board Response to Audience Participation
- None

IV. Budget-Finance Committee Meeting Minutes and Actions from 8/9/21.
- The Budget-Finance Committee Meeting Minutes and Actions from 8/9/21 were reviewed. (Attachment #1A)

MOTION BY D. STRONG, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE MINUTES AND ACTIONS FROM THE AUGUST 9, 2021 WCCMH BUDGET-FINANCE COMMITTEE MEETING.

ROLL CALL VOTE:

ANTONOW	**NOT ON BUDGET-FINANCE COMMITTEE**	**DUSBIBER**	**NOT ON BUDGET-FINANCE COMMITTEE**
GRAEBNER	**Y**	**HIGMAN**	**NOT ON BUDGET-FINANCE COMMITTEE**
JEFFERSON	**Y**	**KING**	**N/A**
SCOTT	**N/A**	**STRONG**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**NOT ON BUDGET-FINANCE COMMITTEE**

MOTION CARRIED

V. Program-Quality Committee Meeting Minutes and Actions from 8/9/21.
- The Program-Quality Committee Meeting Minutes and Actions from 8/9/21 were reviewed. (Attachment #1B)

THERE WAS NOT A QUORUM OF THE PROGRAM-QUALITY COMMITTEE SO THIS ITEM WILL BE BROUGHT FORWARD AT THE NEXT WCCMH PROGRAM-QUALITY COMMITTEE MEETING.

VI. Financial Status Reports (Attachment #2)
- N. Phelps reviewed the Financial Status Report for the month ending July 31, 2021.

MOTION BY D. STRONG , SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE FINANCIAL STATUS REPORT THROUGH JULY 31, 2021 AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**NOT ON BUDGET-FINANCE COMMITTEE**	**DUSBIBER**	**NOT ON BUDGET-FINANCE COMMITTEE**
GRAEBNER	**Y**	**HIGMAN**	**NOT ON BUDGET-FINANCE COMMITTEE**
JEFFERSON	**Y**	**KING**	**N/A**
SCOTT	**N/A**	**STRONG**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**NOT ON BUDGET-FINANCE COMMITTEE**

MOTION CARRIED

VII. Contracts and Leases
- M. Taylor presented the contracts and leases to the committee. (Attachment #3)
- There is a correction on the contract list-both contracts for Student Advocacy Center are funded by millage and not Medicaid so this will be one contract. This contract will need approval from the Millage Advisory Committee prior to board approval.

MOTION BY D. STRONG, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE CONTRACTS AND LEASES WITH THE CORRECTION ON THE STUDENT ADVOCACY CENTER CONTRACT TO BE FUNDED BY MILLAGE AND PENDING MILLAGE ADVISORY COMMITTEE APPROVAL.

ROLL CALL VOTE:

ANTONOW	**NOT ON BUDGET-FINANCE COMMITTEE**	**DUSBIBER**	**NOT ON BUDGET-FINANCE COMMITTEE**
GRAEBNER	**Y**	**HIGMAN**	**NOT ON BUDGET-FINANCE COMMITTEE**
JEFFERSON	**Y**	**KING**	**N/A**
SCOTT	**N/A**	**STRONG**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**NOT ON BUDGET-FINANCE COMMITTEE**

MOTION CARRIED

VIII. Regional Finance Update
- N. Phelps presented the Regional Finance Update to the committee.

- PIHP did approve their budget recently and there will be a budget amendment for CMH coming soon.

IX. Old Business

- CCBHC Update
  - T. Cortes, T. Florence, M. Harding, and N. Phelps presented an update on the CCBHC.
  - This CCBHC presentation will be sent out to the board and committee after this meeting and will be included in the board packet for September.

R. Jefferson joined the meeting at 1:31pm.

X. New Business

- October Committee meetings cancelled
  - Due to a County holiday on October 11th the WCCMH Committee meetings have been cancelled.

- Program Education Presentation-Wraparound and SED Waiver (Attachment #4)
  - Due to time issues, this will be brought to the next Program-Quality Committee.

XI. Items for Future Discussions

- Accounts Receivable (Budget-Finance Committee)
- Cost Per Case Comparisons (Budget-Finance Committee)
- Important data points on CARES implementation impact on hospitals-return rates to hospitals and what the impact on caseloads is as well as other Millage Investments (Program-Quality Committee)
- Looking at call data and how it affects the CARES Team (Program-Quality Committee)
- CCBHC-specifically wanting to know more about how we are positioned on the evidence-based practices they require of CMH/staffing/gaps (Program-Quality Committee)
- Program Education Presentation-Wraparound and SED Waiver (Program-Quality Committee-November)

MOTION BY D. STRONG, SUPPORTED BY R. JEFFERSON TO ADJOURN THE BUDGET-FINANCE AND PROGRAM-QUALITY COMBINED COMMITTEE MEETING.

XII. Meeting adjourned at 2:31 pm.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH PROGRAM-QUALITY COMMITTEE MEETING MINUTES *DRAFT*
https://zoom.us/j/92176238502
August 9, 2021
2:00 pm

ROLL CALL:	S. Antonow attending remotely from Ypsilanti, Washtenaw County, MI A. Dusbiber attending remotely from Ann Arbor, Washtenaw County, MI B. Higman attending remotely from Ann Arbor, Washtenaw County, MI R. Jefferson attending remotely from Ypsilanti Twp, Washtenaw County MI K. Walker attending remotely from Pittsfield Twp, Washtenaw County, MI
MEMBERS ABSENT:	B. King, K. Scott
STAFF PRESENT:	T. Cortes, M. Harding, K. Hoener, N. Phelps, B. Hagaman, L. Gentz, S. Lefferts, L. Higle, K. Hoener, T. Florence, C. Johnson, W. Wieger, J. Stacy, C. Wilde, E. Mix, R. Dornbos, S. Amos O'Neal
OTHERS PRESENT:	G. Dill, L. Lutomski, T. Gavalier

S. Antonow called the meeting to order at 3:05 pm.

I. Introductions
- T. Cortes, introduced K. Hoener, J. Stacy, E. Mix, C. Wilde, C. Johnson, B. Wieger who will be presenting later in the meeting.

II. Audience Participation
- None

III. Board Response to Audience Participation
- None

IV. Budget- Committee and Program-Quality Combined Committee Meeting Minutes and Actions from 6/14/21
- The Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions from 6/14/21 were reviewed. (Attachment #1)

MOTION BY K. WALKER, SUPPORTED BY B. HIGMAN TO APPROVE THE MINUTES AND ACTIONS FROM THE JUNE 14, 2021 BUDGET-FINANCE AND PROGRAM-QUALITY COMBINED COMMITTEE MEETING.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
HIGMAN	**Y**	**JEFFERSON**	**N/A**
SCOTT	**N/A**	**WALKER**	**Y**

MOTION CARRIED

V. Discussion Items
- Program Education Presentation-PORT/PATH
  - K. Hoener, J. Stacy, C. Wilde, C. Johnson, W. Wieger, E. Mix presented the PORT/PATH presentation to the committee. (Attachment #2)

VI. Old Business
- CCBHC Update
  - M. Harding presented an update on the CCBHC.
  - The Companion guide was released last week and there was a lot of clarity on service delivery.
  - The WCCMH Clinical teams are reviewing and looking at opportunities to see how to enhance/broaden services.
  - The certification process should begin early October.
  - Currently there are not any concrete rates in the companion documents but they did release placeholder rates and waiting for them to be finalized.

VII. New Business
- Programmatic Updates
  - T. Cortes discussed the programmatic updates with the committee.
  - In 2014-2015 Washtenaw County was one of the original health homes in the State of Michigan.
  - WCCMH was paying to participate in this program previously and was one of the largest health home enrollees in the State. There is additional funding in the Governor's budget to increase health home funding.
  - T. Cortes recently met with the State to possibly engage WCCMH as one of the health homes in the state with the earliest implementation date of April 2022.

- Program Committee Dashboard-FY2021, Qt. 2
  - T. Florence and L. Higle presented the FY2021, Qtr. 2 Program Committee Dashboard to the committee.
  - There were no sentinel events for this period.

VIII. Items for Future Discussions
- Important data points on CARES implementation impact on hospitals-return rates to hospitals and what the impact on caseloads is as well as other Millage Investments
- Looking at call data and how it affects the CARES Team
- CCBHC-specifically wanting to know more about how we are positioned on the evidence-based practices they require of CMH/staffing/gaps.

MOTION BY K. WALKER, SUPPORTED BY B. HIGMAN TO ADJOURN THE PROGRAM-QUALITY COMMITTEE MEETING.

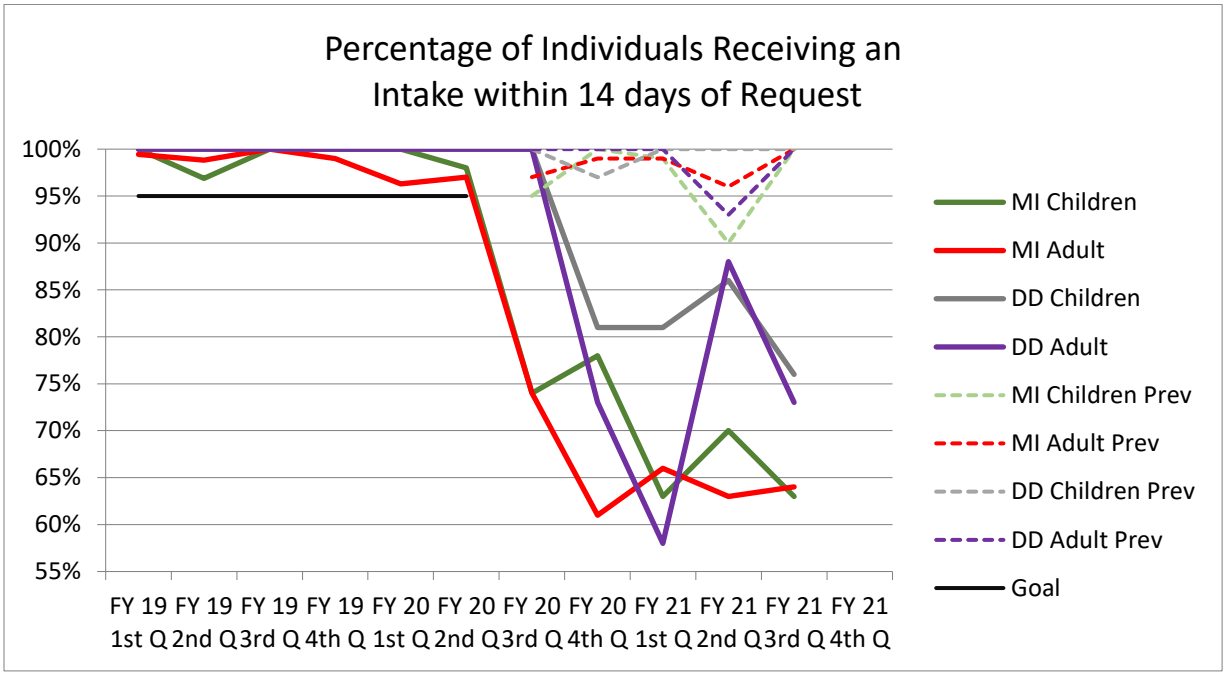
IX. Meeting adjourned at 4:02 pm.

Program and Quality Board Committee
Dashboard Data FY 2021 3rd Qtr (April - June 2021)

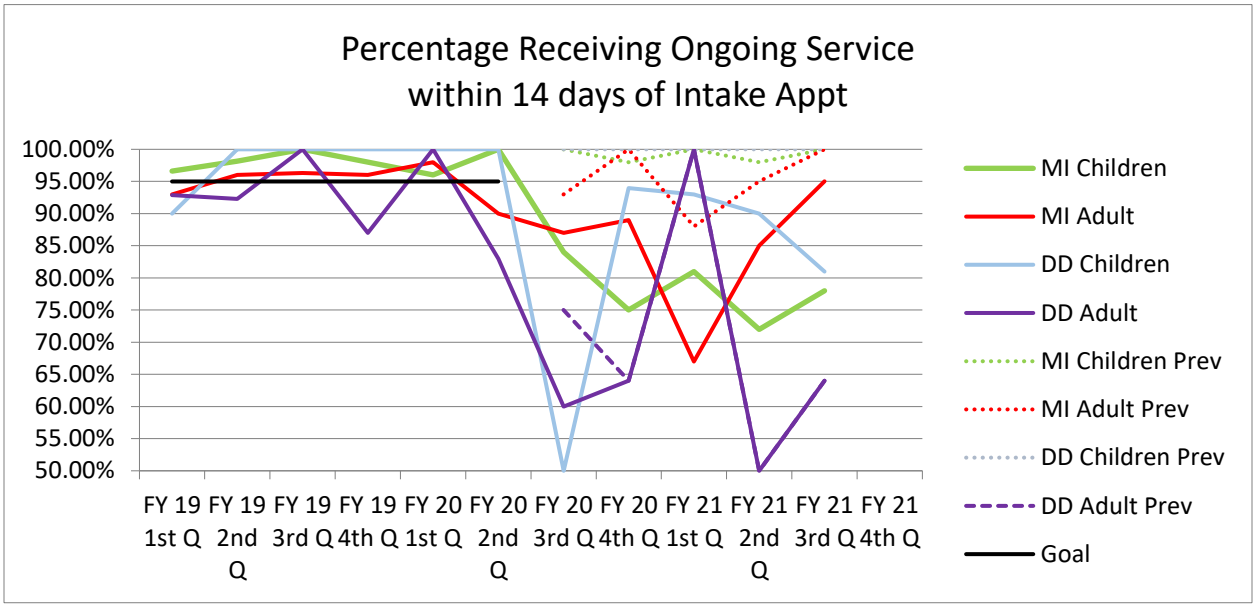
As of April 1 2020, the Michigan Department of Health and Human Service (MDHHS) changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to Ongoing Service) and removed the 95% historical expected goal.

The major change in the operational definition does not allow accounting for consumer choice and for counting every request of service. Consumer choice is indicated by requesting an appointment outside of the 14 day window, rescheduling, canceling or not attending an appointment. If an individual requests a service, is found eligible but declines our services or even passes away, this is still considered "out of compliance". Therefore, across the State, percentage numbers are significantly different. MDHHS is treating the first year as baseline collection.

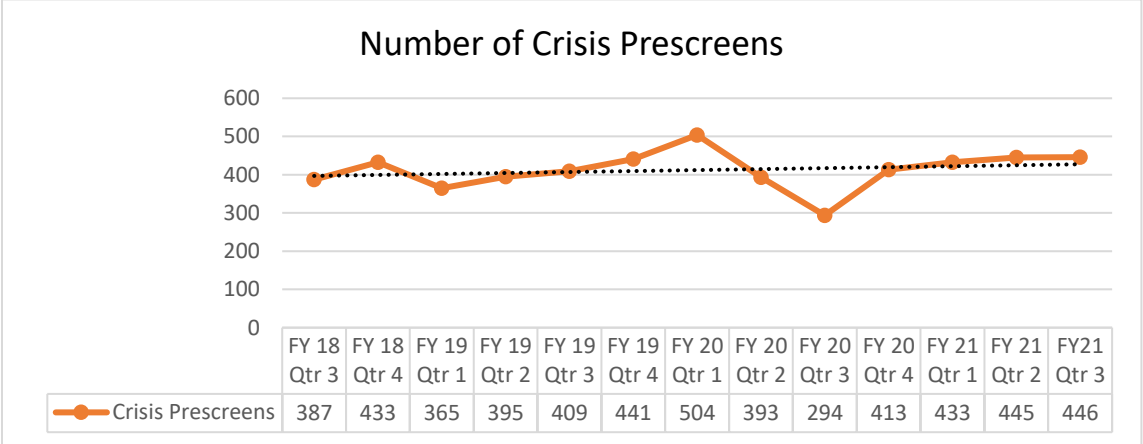
The "dashed lines" indicate where our compliance would have been under previous definitions. The data points are detailed in the tables below the graphs.

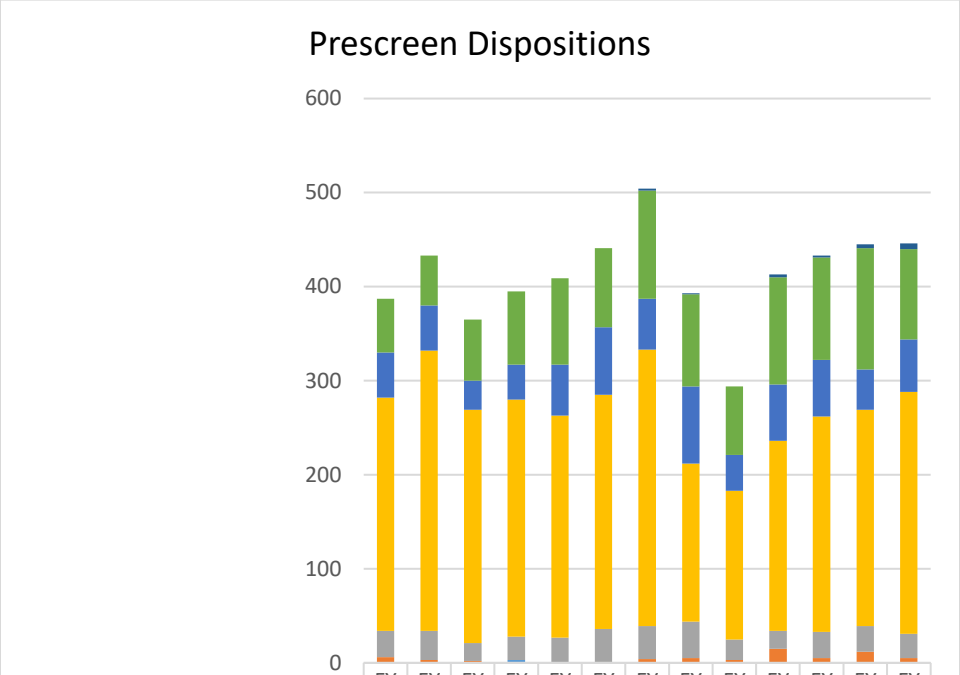


FY 21 3rd Qtr Intake Appt within 14 days Detail						
Population	Total # of new persons requesting service	Number receiving appt. within 14 days of request	State defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- was formerly removed from the denominator	Percent Compliant by new State definition	Percent Compliant in previous definition
MI Child	113	71	42	42	63%	100%
MI Adult	169	108	61	61	64%	100%
DD Child	33	25	8	8	76%	100%
DD Adult	15	11	4	4	73%	100%

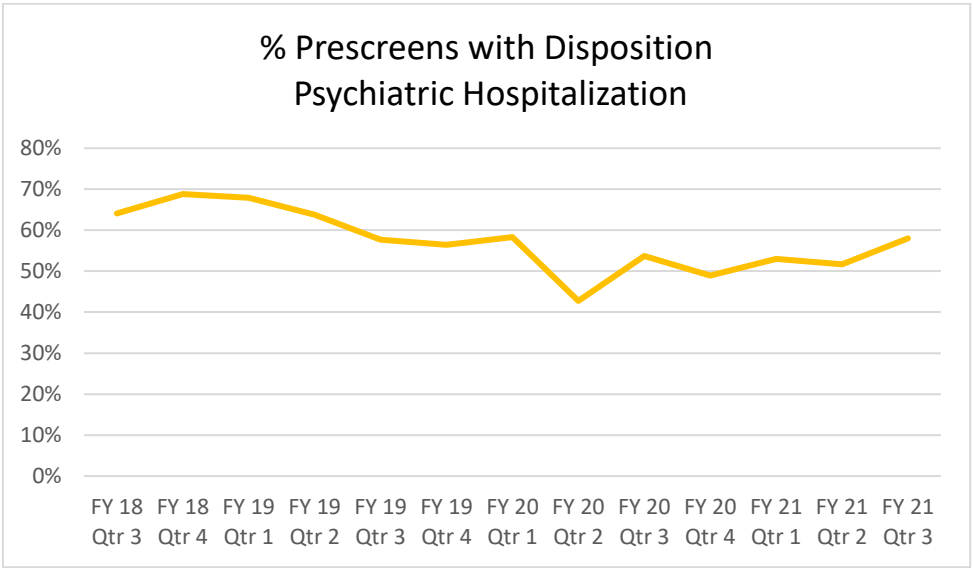


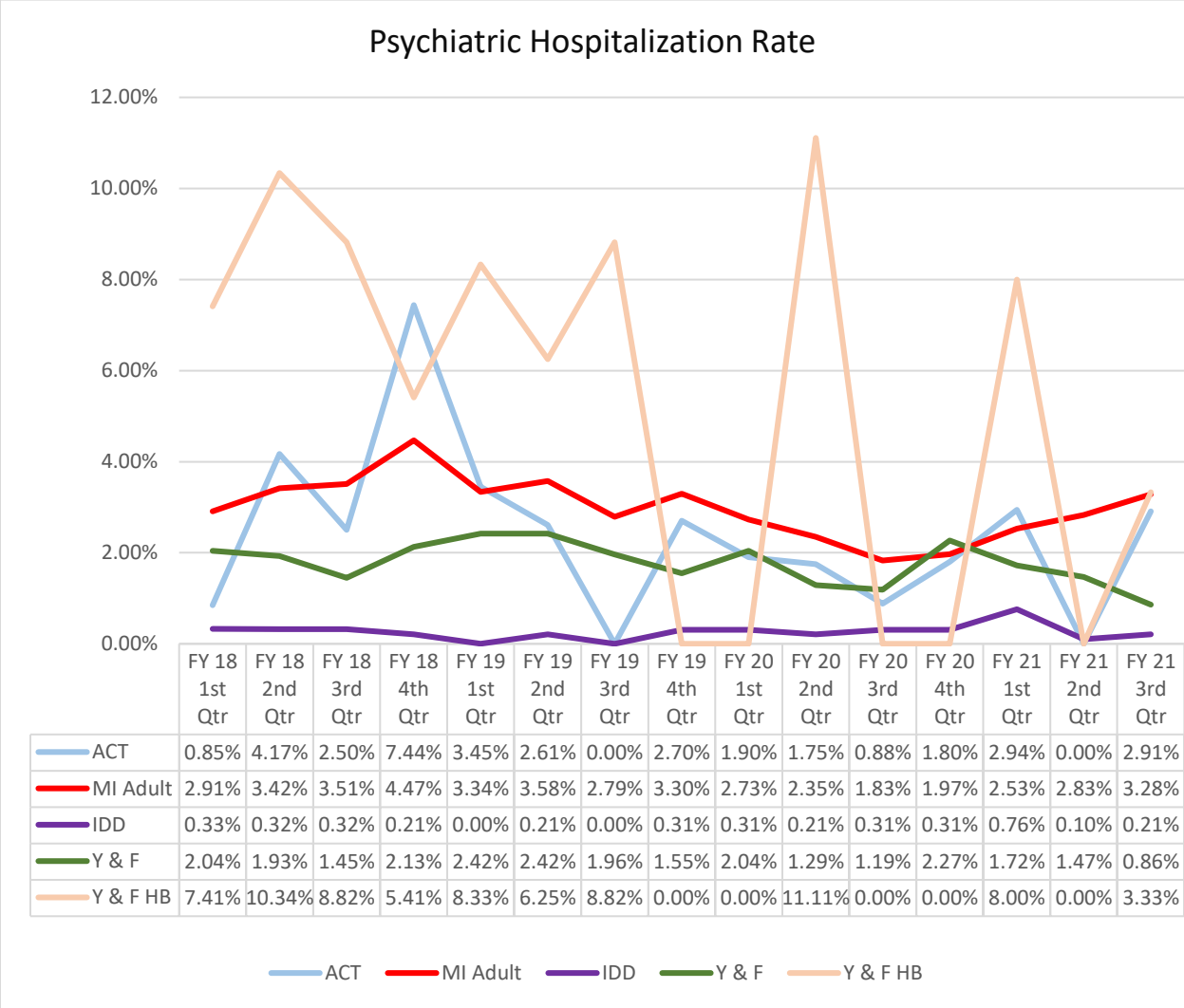
FY 21 3rd Qtr Detail Ongoing Service						
Population	# of New Persons Eligible for Service	# of New Persons who started a new service within 14 days of eligibility	State Defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- used to be removed from the denominator	Percent Compliant under new definition	Percent Compliant under previous definition
MI Child	68	53	15	15	78%	100%
MI Adult	98	93	5	4	95%	99%
DD Child	31	25	6	5	81%	100%
DD Adult	11	7	4	4	64%	63%





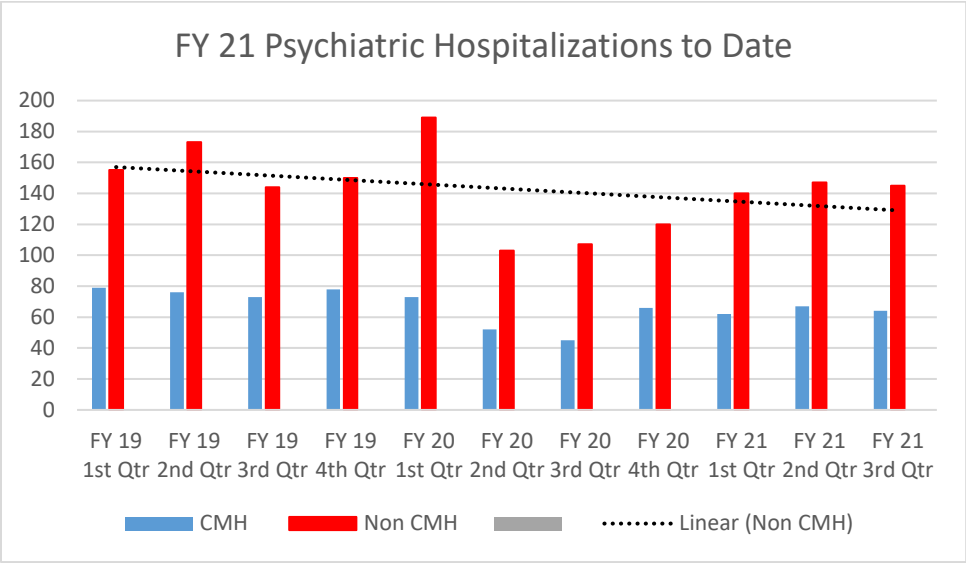
	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3
Blank							2	1		3	2	4	6
Partial Hospitalization	57	53	65	78	92	84	115	98	73	114	109	129	96
Outpatient/ Support Services	48	48	31	37	54	72	54	82	38	60	60	43	56
Inpatient Admission	248	298	248	252	236	249	294	168	158	202	229	230	257
Crisis Residential	28	31	19	25	27	35	35	39	22	19	28	27	26
Crisis Outreach	6	3	1			1	4	5	3	15	5	12	5
Admission & Discharge Plan	0	0	1	3									

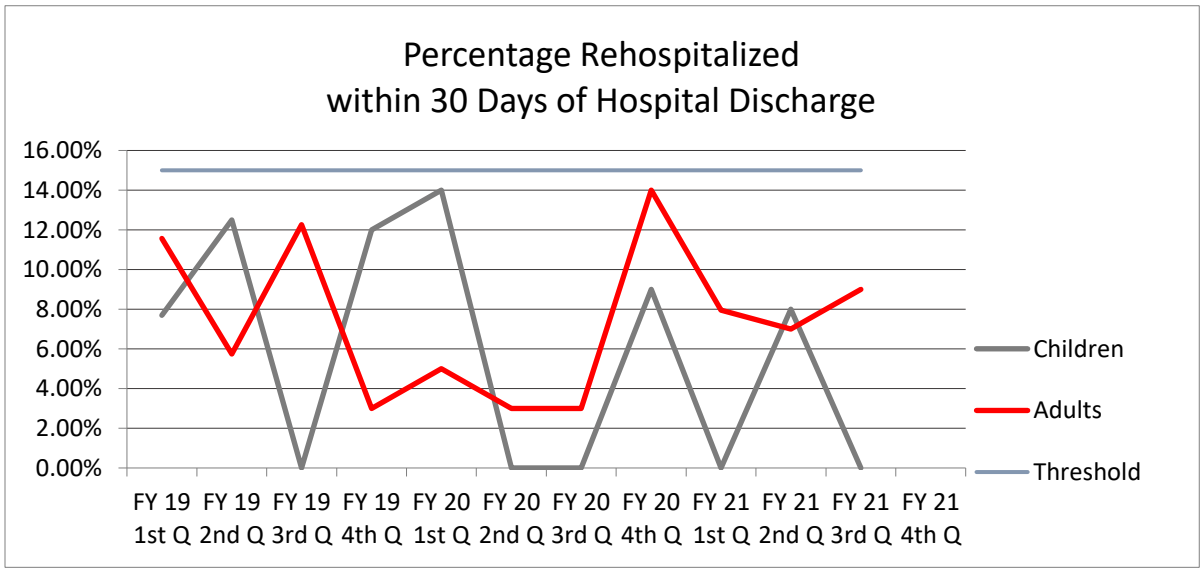




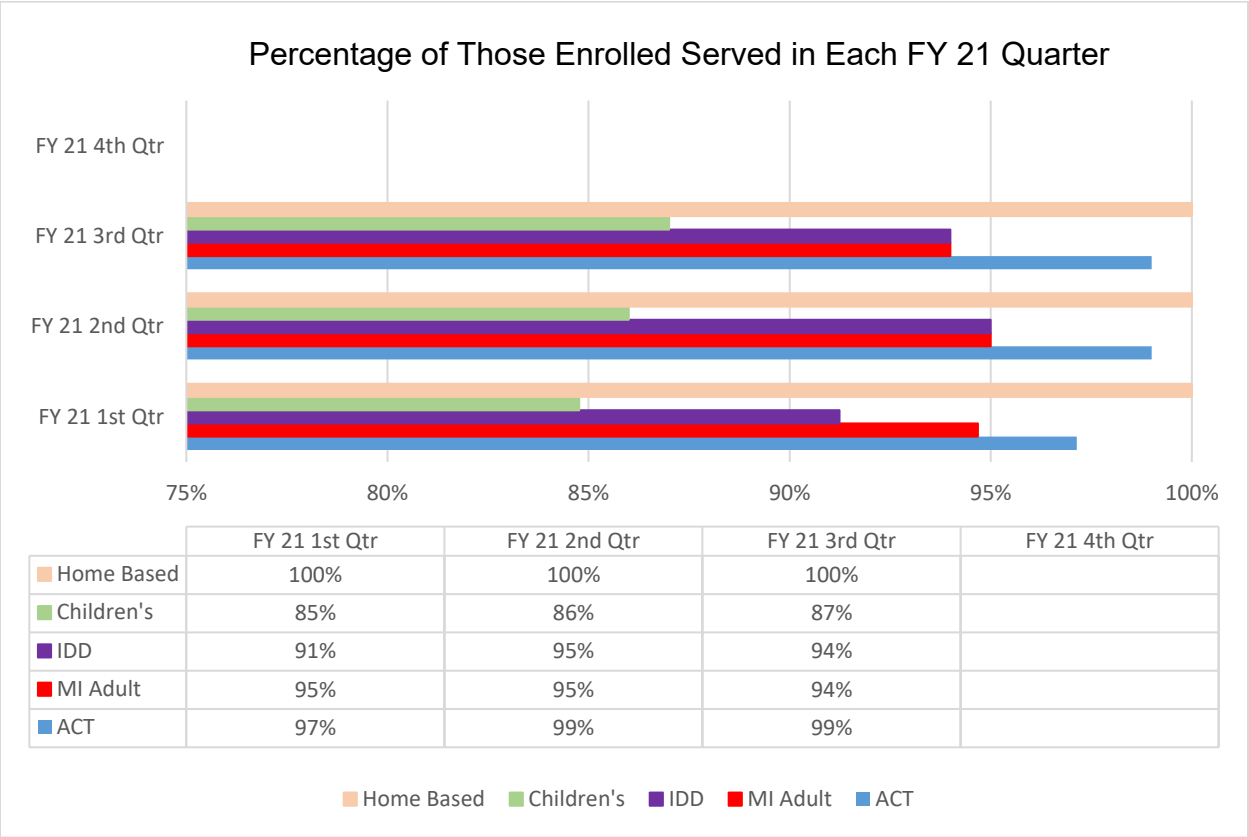
	FY 18 1st Qtr	FY 18 2nd Qtr	FY 18 3rd Qtr	FY 18 4th Qtr	FY 19 1st Qtr	FY 19 2nd Qtr	FY 19 3rd Qtr	FY 19 4th Qtr	FY 20 1st Qtr	FY 20 2nd Qtr	FY 20 3rd Qtr	FY 20 4th Qtr	FY 21 1st Qtr	FY 21 2nd Qtr	FY 21 3rd Qtr
ACT	0.85%	4.17%	2.50%	7.44%	3.45%	2.61%	0.00%	2.70%	1.90%	1.75%	0.88%	1.80%	2.94%	0.00%	2.91%
MI Adult	2.91%	3.42%	3.51%	4.47%	3.34%	3.58%	2.79%	3.30%	2.73%	2.35%	1.83%	1.97%	2.53%	2.83%	3.28%
IDD	0.33%	0.32%	0.32%	0.21%	0.00%	0.21%	0.00%	0.31%	0.31%	0.21%	0.31%	0.31%	0.76%	0.10%	0.21%
Y & F	2.04%	1.93%	1.45%	2.13%	2.42%	2.42%	1.96%	1.55%	2.04%	1.29%	1.19%	2.27%	1.72%	1.47%	0.86%
Y & F HB	7.41%	10.34%	8.82%	5.41%	8.33%	6.25%	8.82%	0.00%	0.00%	11.11%	0.00%	0.00%	8.00%	0.00%	3.33%

FY 21 3rd Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	103	3 (0)	2.91%
MI Adult	1583	52 (13)	3.28%
IDD	956	2 (1)	0.21%
Y & F	701	6 (0)	0.86%
Y & F Home Based	30	1 (1)	3.33%





FY 21 3rd Qtr Detail Readmit within 30 days of Discharge			
Population	# Discharged and Core Team Assignment	# Readmitted within 30 days of Discharge	% Readmit
Child	18	0	0%
Adult	100	9	9%



	FY 21 1st Qtr	FY 21 2nd Qtr	FY 21 3rd Qtr	FY 21 4th Qtr
Home Based	100%	100%	100%	
Children's	85%	86%	87%	
IDD	91%	95%	94%	
MI Adult	95%	95%	94%	
ACT	97%	99%	99%	

Critical Event Data Reported Thru Qtr 3 FY 2021

Critical Events are population and category driven with definitions mandated by MDHHS. Besides reporting deaths, events are typically reflective of ER treatment or Hospital admissions due to injury or medication error and involve Waiver or Residential clients. Arrests are only reported when the individual is either a recipient of a Waiver or is in a Specialized AFC setting.

	Team at Event	Type	Total
Qtr 1	IDD	Emergency Medical Treatment	3
		Non Suicide Death	4
	MI Adult	Non Suicide Death	13
		Suicide	1
	ACT	Non Suicide Death	1
Qtr 1 Total			22
Qtr 2	Children's	Non Suicide Death	1
	IDD	Non Suicide Death	6
	Adult MI	Non Suicide Death	9
Qtr 2 Total			16
Qtr 3	DD Adult	Non Suicide Death	6
	MI Adult	Non Suicide Death	7
		Suicide Death	1
Qtr 3 Total			14

Mortality Data Thru Qtr 3 FY 2021

Cause of Death	Number of Deaths FY 16	Number of Deaths FY 17	Number of Deaths FY 18	Number of Deaths FY 19	Number of Deaths FY 20	Number of Deaths FY 21
Aspiration Pneumonia				1	2	2
Cancer	10	10	8	9	7	9
Cardiovascular	16	8	13	14	14	5
Dehydration			1			
Drug Abuse	8	6	12	5	8	2
Endocrine System (Diabetes)						1
Environmental Hypothermia				1		
Gastrointestinal	1				3	1
Hip Fracture Complications			1			
Homicide		1	3			
Inanition					2	
Infection					4	5 (4 - COVID 19)
Kidney Disease	2	1	1		1	
Liver Disease		1	2		2	3
Metabolic				1		
Muscular Dystrophy	1					
Natural/Other		3	1			
Neurological	5	2	2	1	3	5
Respiratory	6	4	5	9	10	4
Sturge Weber Syndrome	1					
Suicide	2	3	2	2	5	2
Trauma	1		1	2		2
Unknown	5	3	9	10	8	8
Grand Total	**58**	**47**	**65**	**55**	**67**	**49**

Sentinel Events: There were no sentinel events in the third quarter.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH MILLAGE ADVISORY COMMITTEE MEETING MINUTES *DRAFT*

https://zoom.us/j/97961494137

September 13, 2021

3:30 pm

N. Graebner-Sundling called the meeting to order at 3:32 pm.

ROLL CALL:	A. Carlisle attending remotely from Ann Arbor, Washtenaw County, MI N. Graebner-Sundling attending remotely from Chelsea, Washtenaw County, MI H. Heaviland attending remotely from Scio Twp, Washtenaw County, MI B. Higman attending remotely from Ann Arbor, Washtenaw County, MI D. Jackson attending remotely from Ypsilanti Twp, Washtenaw County, MI J. Martin attending remotely from Scio Twp, Washtenaw County MI M. Udow-Phillips attending remotely from Superior Twp, Washtenaw County, MI G. Waddles, Jr. attending remotely from Ypsilanti, Washtenaw County, MI K. Walker attending remotely from Cadillac, Wexford County, MI
MEMBERS ABSENT:	R. Rion, R. Jefferson, B. King, A. LaBarre
STAFF PRESENT:	T. Cortes, N. Phelps, R. Dornbos, L. Gentz, M. Taylor, L. Gentz, K. Snay, T. Florence, L. Higle, M. Harding
OTHERS PRESENT:	L. Lutomski, T. Jurries, M. Creekmore, P. Stone-Palmquist, M. Creekmore., E. Spanier, G. Powers, J. Gardner

I. Introductions
- L. Gentz introduced G. Powers and E. Spanier from CHRT and P. Stone-Palmquist and T. Jurries from the Student Advocacy Center who will be presenting later in the meeting.

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Millage Advisory Committee Minutes and Actions from 8/9/21 (Attachment #1)
- Millage Advisory Committee Minutes and Actions of 8/9/21 were reviewed.

MOTION BY J. MARTIN, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE MINUTES AND ACTIONS FROM THE AUGUST 9, 2021 MILLAGE ADVISORY COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

CARLISLE	**Y**	**GRAEBNER-SUNDLING**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
JACKSON	**Y**	**JEFFERSON**	**N/A**
KING	**N/A**	**LABARRE**	**N/A**
MARTIN	**Y**	**RION**	**N/A**
UDOW-PHILLIPS	**Y**	**WADDLES, JR.**	**Y**
WALKER	**Y**		

MOTION CARRIED

V. Discussion Items

- Millage Process, Investments and Progress Update (Attachment #2A)
  - L. Gentz referred to them Millage Process, Investment and Progress Update (Attachment #2A) for the sake of time.

- CARES Dashboard-New Design Review (Attachment #2B)
  - M. Tasker reviewed the CARES Dashboard (Attachment #2B) for August 2021 with the committee.

VI. Financial Budget Update (Attachment #3)

- N. Phelps presented the Financial Budget update ending July 31, 2021 to the committee.

VII. Old Business

- Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
  - D. Jackson presented the WCSO Millage and Financial Status Update to the committee.
  - The DLIVE (Community violence intervention group out of Detroit) has an October 1st start date. This will help to interrupt violence and intervention regarding violence within Washtenaw County.
  - The LEAD Program Coordinator will start in 2 weeks and is paid with Millage funding. October 1st is the goal to take the first referral.

VIII. New Business

- CHRT Communications Update (Attachment #4)
  - E. Spanier and G. Powers presented the CHRT Communications Update to the committee.

- Student Advocacy Center-Check and Connect/Education Advocacy Funding Request (Attachment #5)
  - P. Stone-Palmquist and T. Jurries presented the Student Advocacy Center-Check and Connect/Education Advocacy Funding Request to the committee.
  - Requesting Millage Funding for $50,500.00 for Education Advocacy and $135,695.00 for Check and Connect. Total Millage funding request is for $186,195.00.

MOTION BY G. WADDLES, JR, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE STUDENT ADVOCACY CENTER-CHECK AND CONNECT/EDUCATION ADVOCACY FUNDING REQUEST FOR A TOTAL FUNDING REQUEST OF $186,195.00.

ROLL CALL VOTE:

CARLISLE	**Y**	**GRAEBNER-SUNDLING**	**Y**
HEAVILAND	**ABSTAINED**	**HIGMAN**	**Y**
JACKSON	**Y**	**JEFFERSON**	**N/A**
KING	**N/A**	**LABARRE**	**N/A**
MARTIN	**Y**	**RION**	**N/A**
UDOW-PHILLIPS	**Y**	**WADDLES, JR.**	**Y**
WALKER	**Y**		

MOTION CARRIED

IX. Items for Future Discussions
- Youth Assessment Center
- Millage Investment Plan
- Youth Needs Discussion
- Updated Millage Commitments

MOTION BY A. CARLISLE, SUPPORTED BY M. UDOW-PHILLIPS TO ADJOURN THE MEETING.

Meeting adjourned at 4:33 pm.

Washtenaw County Mental Health and Public Safety Millage
Initiative Dashboard

Initiative	New or expanded services	Crisis services	Stabilization services	Integrated & coordinated	Peer support services	SUD services	Housing services	Education & prevention	Reducing stigma	Adult-focused	Youth-focused	Cross-sector collaboration	Needs assessment &	Grants: supplements millage	Status	Date Implemented, Expected, or Completed
Washtenaw CARES	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			Implemented	May 2019
CCBHC	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓	Implemented	May 2019
750 Towner assessment center	✓	✓	✓	✓						✓		✓			Implemented	March 2020
NAMI peer project	✓				✓					✓		✓			In progress	2020
Mental Health First Aid training								✓	✓	✓	✓	✓			In progress	2020
Youth assessment center	✓							✓			✓	✓	✓	✓	In progress	Ongoing
Youth court therapeutic CSM position	✓										✓	✓			Implemented	December 2020
31N WISD school MH project	✓							✓	✓		✓	✓			In progress	Ongoing
Mini-grant Anti-stigma campaign w/WISD								✓	✓		✓	✓			In progress	Ongoing
Anti-stigma campaign w/public health								✓	✓	✓	✓	✓			In progress	Ongoing
Corner psychiatry access	✓	✓	✓	✓							✓	✓			Implemented	November 2019
SUD system transformation	✓					✓		✓	✓	✓	✓	✓	✓	✓	In progress	Expected 2022
MAT in jail	✓					✓				✓		✓		✓	Implemented	January 2020
LEAD initiative	✓							✓		✓	✓	✓		✓	In progress	Expected Oct 1
Housing RFP w/OCED	✓	✓	✓				✓			✓	✓	✓			In progress	January 2020
Washtenaw Health Plan	✓			✓				✓		✓					In progress	Expected Oct 1
Student Advocacy Center	✓							✓			✓				In progress	Expected Oct 1
Ozone Psychiatry Access	✓						✓				✓	✓			Implemented	June 2021
5 Healthy Towns										✓	✓	✓	✓		In progress	Ongoing

Initiative Descriptions

Plan and Integrate

Initiative	*Status*	*Updates?*
LEAD	Project is experiencing a brief delay due to case management staffing. 2 positions are posted, and interviews are being scheduled.	
Youth Assessment Center	Met with NAC to begin the technical assistance. Establishing additional stakeholders who should be invited to participate in planning and additional conversations that need to occur with sector leaders.	**No**
Community Response to MH Crisis	Focus groups are being conducted by WCSO with key stakeholders. Ultimate outcomes are being edited and focus group feedback is being incorporated.	**No**
Rethink Health/5 Healthy Towns	SJM Chelsea SAMSHA grant approval looks promising, still awaiting formal approval. NAMI continues their work with targeted outreach, grief and loss groups in Manchester congregations and prepping for a clergy conference in the fall. One Big Connection website is live. Flyer campaign focused on grocery stores and carryout restaurants being planned and community meetings road show is in development to share One Big Connection and highlight mental health resources in the region, including CARES.	**No**
5HT Intergenerational Populations Project	Findings have been reviewed and next steps are being identified.	**No**
SUD System Transition	A slow roll out is occurring of the access to SUD services changing to the WCCMH Access Department. The full transition will begin early in 2022.	

Expand Services

Initiative	*Status*	*Updates?*
CARES/Crisis/750/CCBHC	See M. Tasker Report	
Housing RFP	Avalon provided updated data back to Jan 2021 showing 100 individuals served monthly on average, with the top 6 services including: Early Intervention of Emerging Problems, Eviction Prevention, Household Skills and Safety, Outreach and Engagement, Referrals and Linkages and Mental and Physical Health Navigation. SAWC continues to work closely with CMH on their crisis housing project. OCED will be coming back to the MAC to provide an update on the RFP projects early next year.	**No**

Initiative Descriptions

31 N/ WISD Mini Grants	Working with them to establish mini grant funding priority areas for the year and establishing quarterly outcome reporting for the 31 N. initiative as the result of the new proposal approved in August.	**No**
Youth Center MHP	Position in place and going well. Psychiatry supports will be reduced to 4 hrs/week and moved to Ozone to support community-based justice involved youth.	**No**
Justice Involved Youth Ozone Psychiatry Access	4 hours of psychiatry is being provided at Ozone House.	**No**
Corner Health Psychiatry Expansion	CMH increased psychiatry time at Corner Health from 1 to 2 full days/week.	**No**
Jail MAT	Up and running since January 2021	**No**
Washtenaw Health Plan	The contract is completed, and services are being established. A quarterly report should be available for the MAC after 1/1/22.	
Student Advocacy Center	The contract is being completed since the MAC approved the funding in September. Due to their work coinciding with the academic calendar their first MAC report will be available for review in March.	

Communicate and Evaluate

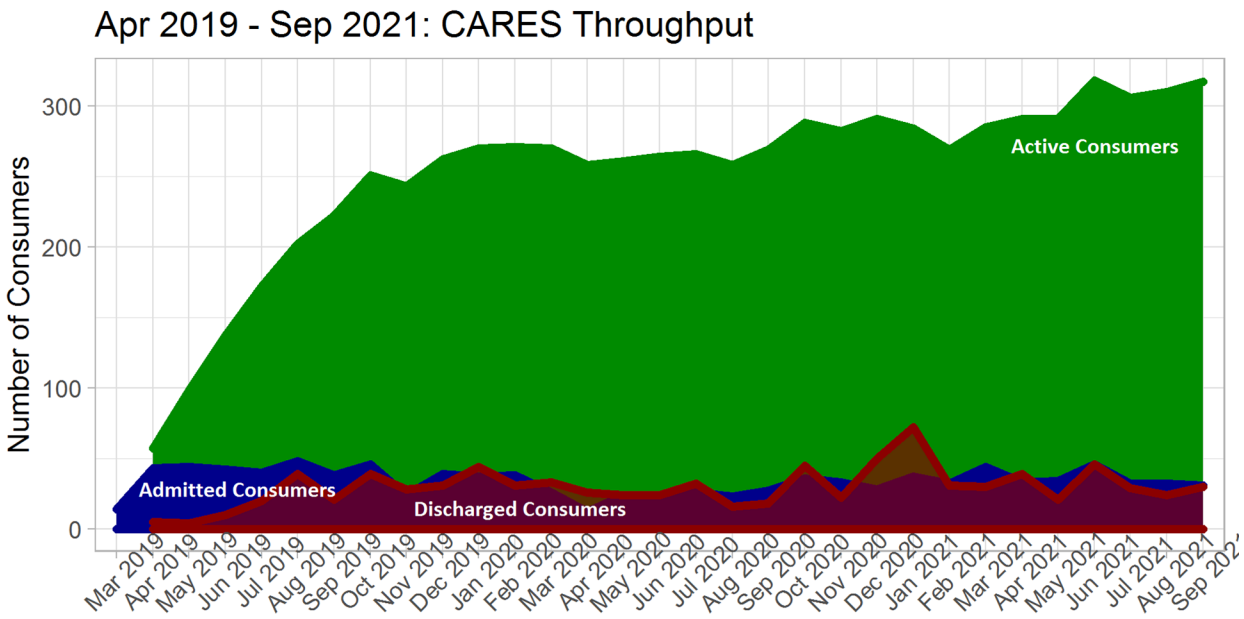
Initiative	*Status*	*Updates?*
NAMI Peer Project	Presentation during this meeting.	
Anti-Stigma Campaign	Public Health is drafting their new strategy and will have it to present to the MAC in January. They are continuing the strategies identified in the previous plan, utilizing unspent money due to Covid. They have completed focus groups to make adjustments to the strategies and are continuing advertising.	
MHFA/YMHFA Education initiatives	Trainings are underway and going well. From July-September 4 YMHFA trainings were conducted with 36 school-based staff trained. MHFA has conducted 1 training through Ann Arbor YMCA and has another scheduled in November.	
Millage Comms Strategy	New communication strategy and campaign underway. New billboards and advertising are up across Washtenaw County.	

Washtenaw County Community Mental Health – CARES Report September 2021

Last Updated: 09/30/2021

CARES THROUGHPUT

Cares Throughput is about consumers entering, leaving, and remaining active in the program. June 2021 marked the first increase in active consumers beyond Pre-Covid levels and this seems to be holding in recent months.



Month	# Active Cases	CARES Adm Cases	CARES Disc Cases
Mar-19		14	
Apr-19	58	44	5
May-19	99	44	4
Jun-19	138	42	10
Jul-19	173	40	20
Aug-19	203	48	39
Sep-19	224	39	21
Oct-19	253	46	39
Nov-19	245	24	28
Dec-19	264	39	31
Jan-20	272	37	44
Feb-20	273	38	31
Mar-20	272	26	33
Apr-20	259	12	26
May-20	262	24	24
Jun-20	265	23	24

Jul-20	267	26	32
Aug-20	259	23	16
Sep-20	270	27	18
Oct-20	290	37	45
Nov-20	285	34	22
Dec-20	293	28	50
Jan-21	284	37	72
Feb-21	269	32	31
Mar-21	285	44	30
Apr-21	291	33	39
May-21	291	34	21
Jun-21	318	46	46
Jul-21	306	32	29
Aug-21	310	32	24
Sep-21	317	31	30

Referrals to CARES by Month

Also known as automatic enrollment in CARES

Note that when there are less automatic enrollment/referrals this generally leads to a decrease in the number of current (or active) CARES Admissions.

Referral Month	# New CARES Referrals
Mar-19	37
Apr-19	77
May-19	80
Jun-19	62
Jul-19	58
Aug-19	70
Sep-19	67
Oct-19	71
Nov-19	67
Dec-19	62
Jan-20	77
Feb-20	59
Mar-20	40
Apr-20	21
May-20	39
Jun-20	44
Jul-20	40

Aug-20	33
Sep-20	45
Oct-20	72
Nov-20	61
Dec-20	48
Jan-21	52
Feb-21	48
Mar-21	73
Apr-21	72
May-21	68
Jun-21	58
Jul-21	57
Aug-21	77
Sep-21	67

Emergency Contact Notes by Month

Note that there were less Emergency Contact Notes across the board for WCCMH clients and the WCCMH-CARES clients during the government shutdown. As the shutdown is over, it seems like Emergency Contact Notes are on the rise again and becoming more stable.

ER_Note_Month	Yr	Mon	Num_ER_Notes	num_CRCT_cases	num_Cares_cases
Mar-18	2018	3	1	1	0
Apr-18	2018	4	100	76	2
May-18	2018	5	97	82	1
Jun-18	2018	6	124	100	1
Jul-18	2018	7	123	90	5
Aug-18	2018	8	118	96	3
Sep-18	2018	9	147	101	3
Oct-18	2018	10	183	102	3
Nov-18	2018	11	182	83	3
Dec-18	2018	12	205	102	1
Jan-19	2019	1	173	86	5
Feb-19	2019	2	200	106	8
Mar-19	2019	3	253	125	14
Apr 2019	2019	4	229	133	9
May 2019	2019	5	237	130	9
Jun 2019	2019	6	245	130	22
Jul 2019	2019	7	229	126	22
Aug 2019	2019	8	210	128	21
Sep 2019	2019	9	245	131	5

Oct 2019	2019	10	305	157	15
Nov 2019	2019	11	242	131	9
Dec 2019	2019	12	268	138	15
Jan 2020	2020	1	230	130	15
Feb 2020	2020	2	223	134	5
Mar 2020	2020	3	121	82	5
Apr 2020	2020	4	57	51	6
May 2020	2020	5	66	55	3
Jun 2020	2020	6	168	94	7
Jul 2020	2020	7	312	110	10
Aug 2020	2020	8	206	98	7
Sep 2020	2020	9	248	95	3
Oct 2020	2020	10	227	88	5
Nov 2020	2020	11	209	87	3
Dec 2020	2020	12	104	55	5
Jan 2021	2021	01	158	79	7
Feb 2021	2021	02	107	65	5
Mar 2021	2021	03	171	99	6
Apr 2021	2021	04	258	124	12
May 2021	2021	05	221	126	8
Jun 2021	2021	06	202	115	5
Jul 2021	2021	07	261	80	1
Aug 2021	2021	08	252	111	6
Sep 2021	2021	09	160	83	1

Gender

The data here should be considered as a work in progress since this data was not collected initially due to a number of factors. Most significantly, this data covers all clients subjected to the 'automatic referral' system which means that we are lacking information for many of these cases.

Gender	**# Cases Referred**	**# Active at least 1 Day 3/1/19 – present Cases**
Female	702	545
Male	633	499
Other (Specify)	1	0
Transgender	1	0
Total	**1337**	**1044**

Race

This data is collected from everyone during the initial screening and referral process.

Race	# CARES cases	%
White	611	58.5%
Black or African American	294	28.2%
Other race	64	6.1%
-missing value-	40	3.8%
Asian	20	1.9%
Refused to Provide	10	1.0%
American Indian (non-Alaskan)	3	0.3%
Native Hawaiian or other Pacific	2	0.2%
Total	**1044**	100.0%

Typical Length of Stay for Cases that Already Closed

We expect the mean and median to continue to grow as time continues and to fully stabilize after CARES has been fully functioning for two years. We are approaching the two year mark at this time, but it is good to keep in mind that we should consider July 2021 the two year mark since enrolling all of the clients that we previously could not serve was a 3 month process; see throughput chart or graph for a better understanding.

	Days
Median	102
Mean	148.4
Min	1
Max	802Z

City/Zip Code for Open Cases

The cases here are open by automatic referral and not necessarily fully admitted which is why these numbers are greater than the throughput numbers which requires an initial Assessment and Plan.

Zip Code	# CARES cases	Percent
48197	271	26.0%
48198	239	22.9%

48103	131	12.5%
48104	93	8.9%
48108	80	7.7%
48105	56	5.4%
48176	31	3.0%
	17	1.6%
48160	16	1.5%
48189	16	1.5%
48118	13	1.2%
48130	12	1.1%
48158	11	1.1%
48111	9	0.9%
48191	8	0.8%
48107	6	0.6%
48169	4	0.4%
48167	3	0.3%
48137	3	0.3%
48184	2	0.2%
49240	2	0.2%
98118	1	0.1%
48185	1	0.1%
48188	1	0.1%
48178	1	0.1%
48168	1	0.1%
48174	1	0.1%
48224	1	0.1%
48238	1	0.1%
48240	1	0.1%
48348	1	0.1%
48386	1	0.1%
48612	1	0.1%
49021	1	0.1%
49229	1	0.1%
49236	1	0.1%
48141	1	0.1%
48116	1	0.1%
48131	1	0.1%
48036	1	0.1%
48109	1	0.1%
48106	1	0.1%
Total	**1044**	**100%**

City	# CARES cases	Percent
YPSILANTI	511	48.9%
Ann Arbor	373	35.7%
Saline	32	3.1%
MILAN	16	1.5%
Whitmore Lake	16	1.5%
Chelsea	13	1.2%
Dexter	12	1.1%
Manchester	11	1.1%
Willis	8	0.8%
	7	0.7%
Belleville	7	0.7%
Northville	4	0.4%
Pinckney	4	0.4%
Detroit	3	0.3%
Gregory	3	0.3%
Grass Lake	2	0.2%
Van Buren Twp	2	0.2%
Wayne	2	0.2%
Westland	1	0.1%
White Lake	1	0.1%
Redford	1	0.1%
Romulus	1	0.1%
Seattle	1	0.1%
South Lyon	1	0.1%
Superior Township	1	0.1%
Taylor	1	0.1%
Inkster	1	0.1%
Dundee	1	0.1%
Beaverton	1	0.1%
Bellevue	1	0.1%
Brighton	1	0.1%
Britton	1	0.1%
Canton	1	0.1%
Clarkston	1	0.1%
Clinton	1	0.1%
Clinton Twp	1	0.1%
Total	**1044**	**100%**

Age Groups for Consumers Active at least 1 Day in CARES

Age Category	# CARES Adm Cases
	1
0-16	34
17-19	52
20-24	135
25-29	149
30-34	141
35-39	117
40-44	92
45-49	73
50-54	88
55-59	70
60-64	36
65-69	35
70+	21
Total	**1044**

Funding Sources for Consumers

Funding Sources	Medicare	# CARES cases	Percent
	N	462	44.3%
	Y	35	3.4%
HMP	N	322	30.8%
Medicaid	N	189	18.1%
Medicaid	Y	28	2.7%
S/D	N	3	0.3%
S/D	Y	5	0.5%
	Total	**1044**	**100%**

Commercial Insurance

This provides a glimpse of other insurance types that clients have in CARES, but only captures those individuals whose insurance information was entered into the EHR.

Private INS	# CARES cases	Percent
BLUE CROSS BLUE SHIELD OF MI,	22	2.1%
HUMANA CHOICE PPO MEDICARE PLAN,	6	0.6%

BLUE CARE NETWORK OF MICHIGAN,	4	0.4%
PRIORITY HEALTH MEDICARE,	3	0.3%
BLUE CARE NETWORK (PO 68710),	2	0.2%
Blue Care Network Advantage,	2	0.2%
CIGNA MEDICAL,	2	0.2%
United Healthcare Community Plan,	2	0.2%
AETNA PPO,	1	0.1%
AETNA US HEALTHCARE,	1	0.1%
BLUE CARE NETWORK OF MICHIGAN, BLUE CARE NETWORK PILOT,	1	0.1%
COFINITY,	1	0.1%
MEDICARE PLUS BLUE OF MI,	1	0.1%
MENTAL HEALTH COURT,	1	0.1%
MERIDIAN CARE EXTRA HMO SNP,	1	0.1%
MERIDIAN HEALTH PLAN INC,	1	0.1%
MOLINA MARKETPLACE MI,	1	0.1%
PRIORITY HEALTH MI,	1	0.1%
STATE FARM MEDICARE SUPPLEMENT INS,	1	0.1%
TriCare East Region Claims,	1	0.1%
United Healthcare,	1	0.1%
WELLCARE HEALTH PLANS,	1	0.1%
Total	**57**	**5%**

#7 CARES Services Detail by CPT - w 0 units		
Service Category	**# SAL Documents**	**# Cases**
Targeted Case Management	15369	1109
Med Reviews	2838	502
Peer Services	2303	257
RN Services	1242	401
Intake Assessments	1062	860
Psych Evals	844	694
Injections	366	49
Wellness Note	330	184
Nursing Assessments	29	28
S0316	13	7
Therapy Group Notes	5	4
J2426	3	1
S9470	2	2
J3490	1	1

99212	1	1
99213	1	1
Total	**24409**	

#8 Count by Type of Service		
Type of Service	**# CARES cases**	**Percent**
Mood disorders	868	83.1%
Personality Disorders	134	12.8%
Psychosis	130	12.5%
SED	110	10.5%
SUD	347	33.2%
Total duplicate count	**1589**	


NAMI
National Alliance on Mental Illness
Washtenaw County
ATTACHMENT #1E4
NOVEMBER 2021
2020 - 2021 Millage
Funded Activities
2020-2021 MILLAGE FUNDED ACTIVITIES | 10/28/2021

NAMI

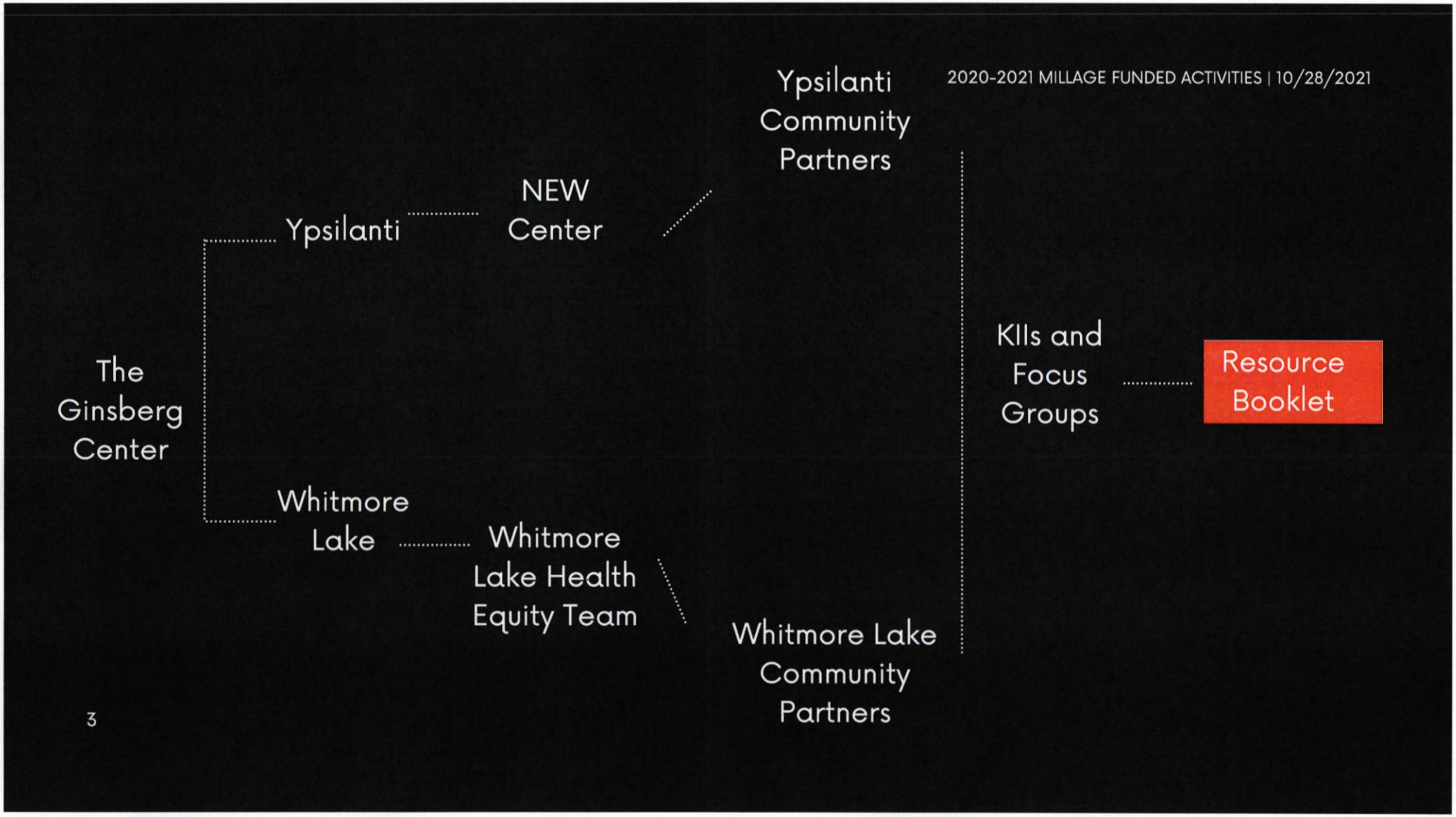
National Alliance on Mental Illness

Washtenaw County

NAMI Washtenaw County is a local affiliate of the National Alliance on Mental Illness, the largest grassroots mental health organization in the country. For over 35 years our affiliate has strived to improve the lives of those who live with a mental health condition and their loved ones.

Judy Gardner
Executive Director
NAMI Washtenaw County

Maria Alfonso
Project Manager
NAMI Washtenaw County


Ypsilanti Community Partners
NEW Center
Ypsilanti
The Ginsberg Center
Whitmore Lake
Whitmore Lake Health Equity Team
Whitmore Lake Community Partners
KIIs and Focus Groups
Resource Booklet

2020 Timeline

January

- Partnership with the Ginsberg Center CTAC team for training and guidance on focus group and KII facilitation
- 1/16 - St. Joseph Mercy Electronic Medical Records Training (Medical System and Community Organization Partnerships)
- 1/20 - Outreach at the Jewish Family Services Diversity Day

February

- Ending the Silence (ETS) presentation
  - Whitmore Lake High School
  - CMH Consumer Advisory Council
  - Lansing High School
  - Central Academy High School Teachers and Staff
- 2/23 - Screenagers screening partnership with First United Methodist Church

March

- YCS FACES Conference - Leadership of the CARES Team (canceled due to COVID-19)
- 3/12 - COVID-19 related suspension of support groups and transition to online programming
- ETS for Pinckney High School

April

- 4/13 - NAMI WC Online Support Groups and Classes Start
- 4/23 - ETS for Washtenaw Community College

July

- 7/22 - ETS for SRSLY Chelsea and the 5 Healthy Towns Initiative

September

- 9/24 - New support group formed: NAMI Friends & Family support group for Washtenaw Community College students

October

- 10/1 - Ypsilanti teens focus group in partnership with the Corner Health Center
- New Peer-to-Peer class was formed for young adults (18-25) in partnership with the Corner Health Center
- 10/24 - Whitmore Lake caregivers' focus group in partnership with the Northfield Township Area Library
- 10/27 - First annual Faith Leader's Conference

November

- 11/19 - ETS for SRSLY Chelsea and the 5 Healthy Towns Initiative

December

- Ending the Silence presentations
  - 12/7 Washtenaw Community College
  - 12/10 Washtenaw Community College
- NEW Center partnership begins
- New Support group formed: NAMI Young Adult support group (ages 18-30) in partnership with the Corner Health Center
- 12/16 KII

2021 Timeline

January

- New support group formed: Fellowship and Care for the Faith Leader

February

- 2/4 - Focus group for caregivers
- 2/20 - ETS for Wisdom Warriors

March

- 3/1 to 3/11 - 8 ETS presentations for Ypsilanti High School
- 3/22 - ETS for Community High School

April

- ETS presentations
  - ETS for Parents with the 5 Healthy Towns Initiative
  - ETS for Parents at the Ypsilanti Town Hall Meeting
  - 2 ETS for Washtenaw Community College

May

- ETS presentations
  - ETS for Lansing High School
  - ETS for SRSLY Chelsea with the 5 Healthy Towns Initiative

July

- YCS Boots on the Ground project
- ETS presentations
  - ETS for Youth Mental Health & HIV Training
  - ETS for Behavioral Health Crisis Training for the Washtenaw Community College Police Academy
- 7/27 - Outreach at YCS Jazz in the Parking Lot
- 7/30 - Outreach at Northfield Township Community & Senior Center Movies Under the Stars

August

- 8/27 - Outreach at Northfield Township Community & Senior Center Movies Under the Stars

September

- ETS presentation
  - ETS for Behavioral Health Crisis Training for the Washtenaw Community College Police Academy
  - ETS for Big Brothers and Big Sisters of Washtenaw
- 9/10 - Outreach at Northfield Township Community & Senior Center Movies Under the Stars
- 9/15 - Outreach with WISD and SuccessBy6
- 9/30 - Navigating a Mental Health Crisis "Before" with Michigan Medicine and CMH

October

- Mental Health 101 presentation
  - St. Andrew the Apostle Church
  - 3 presentations for U of M Business and Finance Department
- 10/7 - Navigating a Mental Health Crisis "During" with Michigan Medicine and CMH
- 10/14 - Navigating a Mental Health Crisis "After" with Michigan Medicine and CMH
- 10/27 - 2 ETS presentations for Community High School

November

- 11/5 - ETS for Brighton High School
- 11/9 - Faith Leaders' Conference in partnership with 5 Healthy Towns, Rethink Health, and CMH

Marketing Growth

1 NAMIWC Website

- 2021 - 28,791 page views, 12,486 sessions, 8,564 new users
- Pageviews up 16.08% from 2020

2 Mailchimp

- Email list growth from 1279 to 1418

3 Facebook

- Follower growth from 537 on Jan 1, 2020 to 829 Oct. 2021

4 Youtube

- 208 total views on Navigating a Mental Health Crisis series

5 Instagram

- Post reach increased 77.9% compared to 2020

Current Project: Resource Booklet

Why a Resource Booklet?

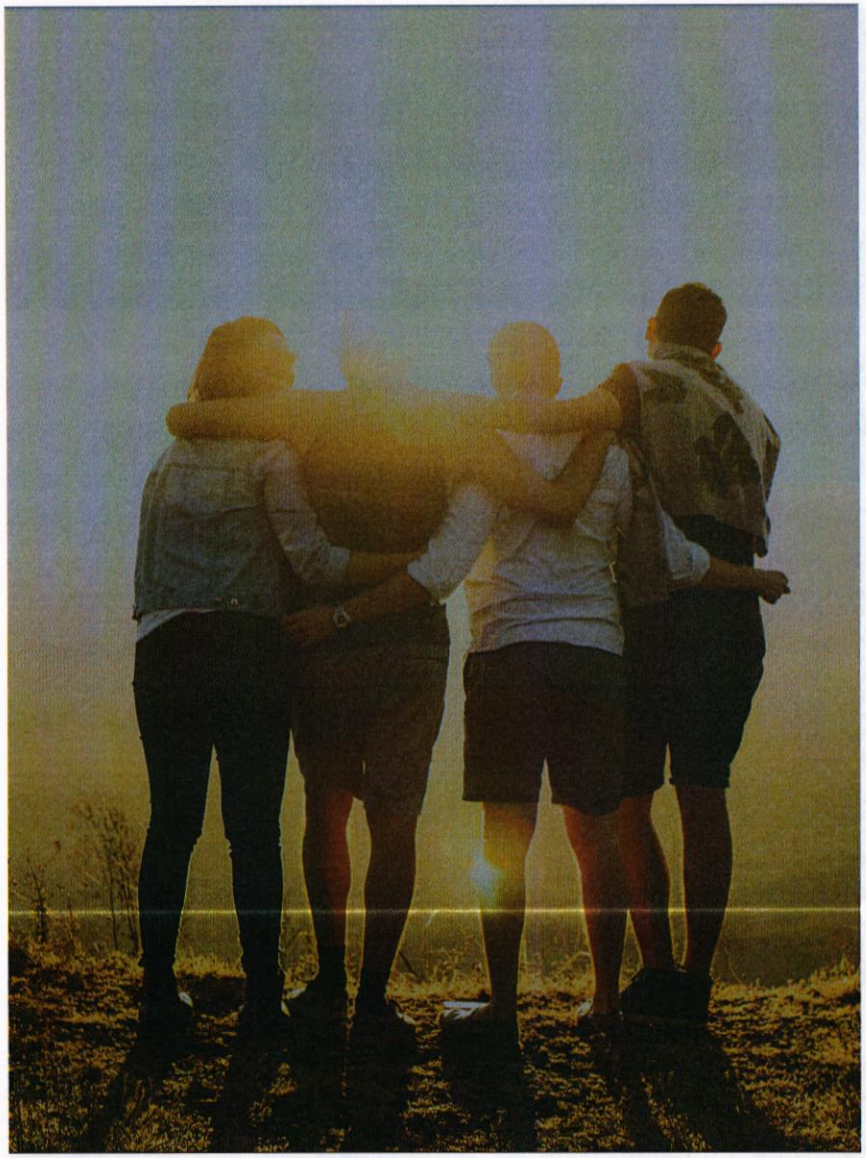
- Awareness: One of the core take aways of our KIIs and Focus Groups was that many local nonprofits and community organizations either do not know about CMH/CARES services or do not understand what services are available and how to access them. Understanding of these services is essential to improving outcomes for those with a mental health condition
- Accessability: Many of our target communities lack access to reliable internet and transportation. Plus, individuals without caregivers can struggle to support their own health while ill. The continuing mission of our work is to create tools that will allow anyone to access help regardless of their lack of resources or severity of illness
- Privacy: Even with the increase in conversations about mental health, the topic remains highly stigmatized. A booklet can act as the first point of contact for community members who need support but are too ashamed to ask for it

Major Goals

- Provide enough guidance on local health systems and mental health jargon so that individuals can better advocate for their needs
- Educate nonprofit partners related to the SDOH in local mental health care
- Create a diverse booklet that takes into account minority mental health concerns and is designed wth usability in mind

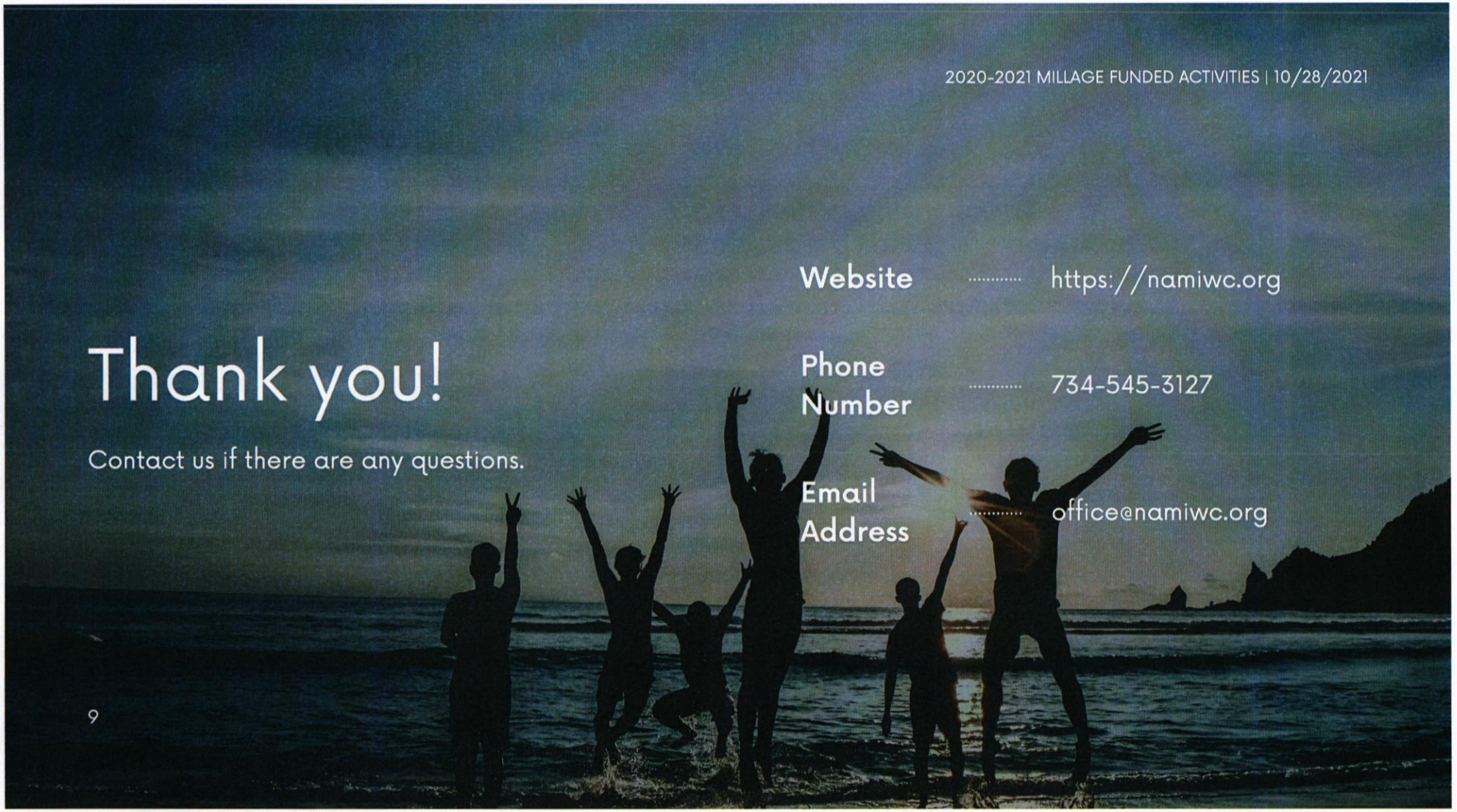
Outreach Plan

- Supply printed copies to all partners including law enforcement, health nonprofits, community spaces, etc.
- Provide a digital version of the booklet that can be accessed on any type of device
- A streamlined web system where anyone can request print or digital copies



Partnerships

- The Ginsberg Center
- St. Joseph Mercy
- Jewish Family Services
- Whitmore Lake High School
- Whitmore Lake Senior and Community Center
- Northfield Township Area Library
- Washtenaw County Community Mental Health
- First United Methodist Church
- Ypsilanti Community Schools
- Washtenaw Community College
- NEW Center
- The Corner Health Center
- WISD
- WISD SuccessBy6 Trusted Parent Advisors
- Washtenaw Community College Police Academy
- Michigan Medicine Department of Psychiatry
- Big Brothers and Big Sisters of Washtenaw
- VA Ann Arbor Healthcare System
- Hope Clinic
- Whitmore Lake Health Equity Teams



Thank you!

Contact us if there are any questions.

Website ..... https://namiwc.org

Phone Number 734-545-3127

Email Address ..... office@namiwc.org

ATTACHMENT #1E5
NOVEMBER 2021

Washtenaw County Community Mental Health (WCCMH)

"Putting It All Together"

12/18/20

How did we get where we are today?

ATTACHMENT #1E5
NOVEMBER 2021

MISSION

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

VISION

All residents can secure supports to pursue recovery, improve quality of life, and reach their full potential.

VALUES

Excellence **Growth** **Well-being**

Inclusion **Community** **Accountability**

2016 - 2022 Four Strategic Goal Areas

Serve with Excellence

CMH serves in alignment with the principles of self-determination, with a focus on health, well-being and integrated care, and a commitment to data-informed continuous improvement.

Engage, Educate and Empower the Community

The Washtenaw County community understands the needs of and resources for persons with mental illness, serious emotional disorders and intellectual and developmental disabilities. The successes and challenges in ensuring a good quality of life for these persons are known in the broader community.

Secure and Steward Resources

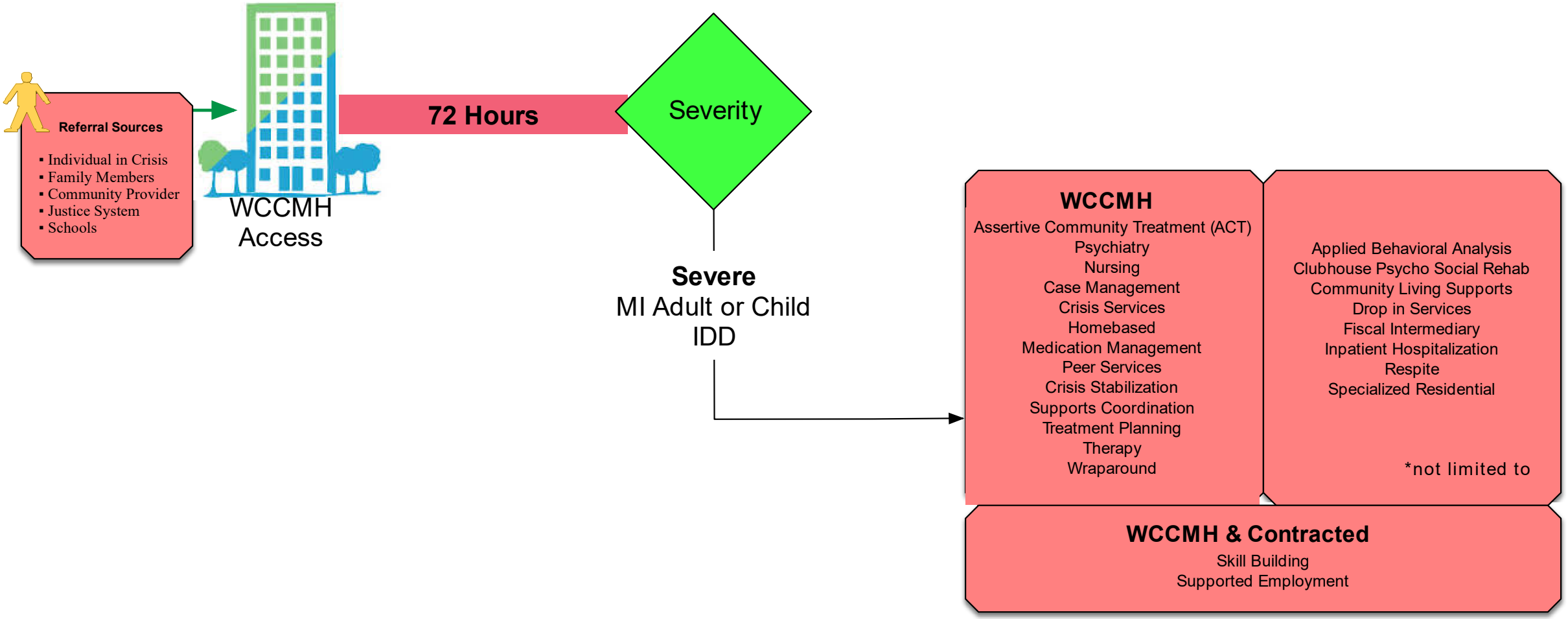
CMH secures and manages resources effectively to meet the quality of life and recovery needs of the people we serve. CMH works closely with partners and the broader Washtenaw County community to pursue and secure alternative funding streams to support prevention strategies, equity and access across the community.

Learn and Grow

CMH builds and uses the knowledge, skills, and commitment of the CMH staff, provider network partners and volunteers to meet the needs of the community we serve. CMH staff and the provider network are supported, valued, and empowered to serve. Opportunities for learning are well known and well developed.

ATTACHMENT #1E5
NOVEMBER 2021

2016 CMH Service Delivery



Washtenaw County Mental Health and Substance Use Service Gaps Assessment

July 2006

- **Provider-Supply Issues Causing Delayed Receipt of Appropriate Services**
  - Extended Wait Times in Psychiatric Emergency Departments
  - Delays Receiving Mental Health Services for Certain Subpopulations
  - Delayed Discharges from Inpatient Settings
- **Gaps Associated with Funding/Reimbursement**
  - Community Providers are Challenged Managing Higher Acuity Patients
  - Lack of Reimbursement for Case Management Services
- **Mislabeling of Students with Mental Health Needs**

WASHTENAW HEALTH INITIATIVE

Mental Health and Substance Use Work Group

Millage November 2017

The millage resolution identified these four categories of services:

- **Crisis-** Offer immediate mental health and substance use disorder crisis assessment, referral, treatment and support diversion from jail, emergency departments, and inpatient stays. Enhance support services post crisis engagement.
- **Stabilization-** Provide services that stabilize and support recovery and enhance quality of life for adults and youth regardless of insurance status. Reach out to individuals who experience obstacles in securing supportive services: lack of resources, homelessness, distrust, and stigma.
- **Jail Services-** Enhance mental health and substance use disorder assessment and treatment in the jail. Support diversion options and offer expanded education and support to first responders.
- **Prevention-** Support mental health awareness, prevention, and early intervention programming in partnerships with families, schools, faith communities, libraries, law enforcement, and health care providers.

What does success look like?

A comprehensive, integrated system of care


Plan and Integrate
Expand Services
Evaluate and Communicate

2020 WCCMH Service Delivery

CARES

Ongoing:
- Case Management
- Psychiatry
- Medication Management
- Nursing Services
- Psychotherapy
- Peers

Coordination

Community Partners*

- Packard
- Corner Health
- St. Joseph Chelsea
- Ypsilanti Family Practice
- Law Enforcement
- HVA
- Shelter Association
- Ozone House
- Avalon
- Juvenile Justice System
- WISD/ School Districts

*not limited to

Mild to Moderate
MI Adult or Child

Referral Sources
- Individual in Crisis
- Family Members
- Community Provider
- Justice System
- Schools

WCCMH Access

72 Hours

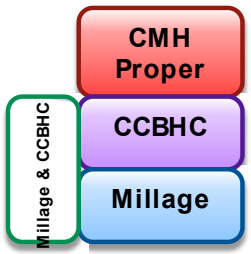
Severity

Stabilization

23.5 Hour Observation
- Case Management
- Psychiatry
- Medication Management
- Nursing Services
- Psychotherapy
- Peers

Severe
MI Adult or Child
IDD

Funding Color Key



WCCMH
- Assertive Community Treatment (ACT)
- Psychiatry
- Nursing
- Case Management
- Crisis Services
- Homebased
- Medication Management
- Peer Services
- Crisis Stabilization
- Supports Coordination
- Treatment Planning
- Therapy
- Wraparound

Contracted *
- Applied Behavioral Analysis
- Clubhouse Psycho Social Rehab
- Community Living Supports
- Drop in Services
- Fiscal Intermediary
- Inpatient Hospitalization
- Respite
- Specialized Residential

*not limited to

WCCMH & Contracted
- Skill Building
- Supported Employment

Where do we go now?

ATTACHMENT #1E5
NOVEMBER 2021

Strategic Planning Guiding Document Contents

- Current Mission Statement
- Proposed Mission Statement
- Environmental Drivers
- Strategic Planning Process
- Current Strategic WCCMH Plan
- Current Strategic County/WCCMH Millage Plan

WCCMH Mission, Vision and Values

CURRENT MISSION 2017-2022

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

PROPOSED MISSION 1

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

PROPOSED MISSION 2

To promote hope, recovery, resilience and advance health equity in Washtenaw County by providing, high quality, integrated behavioral health services to adults and youths with intellectual/development disabilities, mental health and/or substance use needs. ~~individuals.~~

VISION

All residents can secure supports to improve their quality of life and reach their full potential.

VALUES

Excellence

We provide the highest level of service to promote recovery, quality of life and self-sufficiency through proven and innovative practices. We recognize that the foundation of excellent service is our relationships.

Growth

We believe in the capacity for change at every stage of development. We grow through shared learning, lived experiences and mentoring.

Well-being

We cultivate well-being through a commitment to physical and emotional safety, active listening, and a culture of appreciation.

Inclusion

Together we build a welcoming, respectful environment for all people. Through active engagement and shared decision-making, we build a stronger community.

Community

We develop strong, trusting partnerships with the people we serve, in our broader community, and within our own organization while advancing health equity.

Accountability

We are accountable to those we serve, to the larger community, and to each other for the equitable, ~~ethical~~, effective, and efficient use of our resources.

Environmental Drivers

Access to Care

- Shortage of staff statewide with long waiting times and difficulty in accessing care or needs not getting met due to decreased staffing
- CMH system reform efforts are being driven by concerns about access and inconsistent statewide availability of services - encouraged to find ways to increase/improve access
- Access to youth behavioral health services
- A severe statewide psychiatric hospital bed shortage with long waits for care
- A lack of a single point of access for all behavioral health services including substance use disorders

Performance/Quality

- Uneven metrics/performance by PHIPs and pressure from MCOs to shift payment from PIHPs to MCOs with competing bills in the legislature from Shirkey and Whiteford
- Current CMH system collects a lot of data but lacks a clear dashboard of metrics for accountability and performance
- State rate setting efforts expected to put emphasis on cost efficiency and effectiveness etc.

Expansion of Services

- Federal expansion of mental health funding and designation of Michigan at a CCBHC state and recently approved funding in Michigan state budget
- Passage of millage since the last strategic plan that shifted focus from exclusively mandated services for “eligible” individuals to comprehensive services for the general community
- Greater need for focus on prevention, early intervention and community education

Other Drivers

- Inconsistency of support for Behavioral Health services by the State of Michigan
- Importance of telemedicine and the infrastructure to support it (i.e. broadband internet, county infrastructure and internet)
- Staffing

Strategic planning proposed process for discussion purposes:

I. Review and modify the Mission and Vision statements

II. Proposed Timeline/Process
- Environmental Assessment (June – August)
- CHRT Gap Analysis (August – September)
- Develop strategies and priorities (October – December)
- Board and MAC Input and Approval (January)

III. Public Stakeholder Input/Outreach (July -October)
- Consumer Advisory
- Recipient Rights Advisory Committee
- Provider Network including local hospital systems
- Staff (Survey)
- Community Stakeholders
    i. Millage Advisory Committee
    ii. CHRT Preliminary Interviews for Gap Analysis
        a. PES, ROSC Provider, Coordinating Agency, Avalon, MDHHS Medical Director, Chair of Psychiatry of Michigan Medicine, NAMI

IV. Implement Strategies

V. Report on progress towards strategies

VI. Evaluate based on performance measures

Millage Advisory Committee (MAC) (meets monthly)		
Nancy Graebner-Chair	3/31/2024	WCCMH Board (St. Joseph Mercy Hospital)
Barb Higman	3/31/2023	WCCMH Board (Primary Consumer)
Ricky Jefferson	3/31/2023	WCCMH Board (Board of Commissioners)
Bob King	3/31/2022	WCCMH Board (Member at Large)
Andy LaBarre	3/31/2022	WCCMH Board (Board of Commissioners)
Marianne Udow-Phillips	3/31/2024	WCCMH Board (Community Member)
Kari Walker	3/31/2024	WCCMH Board (Secondary Consumer)
Amanda Carlisle	3/31/2022	Washtenaw Housing Alliance
Holly Heaviland	3/31/2024	Washtenaw Intermediate School District
Derrick Jackson	3/31/2023	Washtenaw County Sheriff's Office
John Martin	3/31/2024	Community Member
Ray Rion	3/31/2023	Packard Health
George Waddles	3/31/2022	Community Member

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

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

I. PURPOSE

To establish policies for the provision of Community Mental Health Partnership of Southeast Michigan (CMHPSM) access system services.

II. REVISION HISTORY

DATE	MODIFICATION
Will be Regional approval date	3-year review
5/2/18	Revised References
2/14/18	Revised to reflect the name change of MDCH to MDHHS
12/11/14	Updated to include new program guidelines and references.
5/3/13	Revised to reflect the new regional entity effective January 1, 2014.
3/10/10	

III. APPLICATION

The policy applies to all CMHPSM staff responsible for provision of and/or oversight of access system services within the CMHPSM.

IV. POLICY

It is the policy of the CMHPSM to provide a welcoming, responsive, access system 24 hours a day, 7 days a week for all consumers/individuals served who contact the CMSHPSM seeking information, services, and/or support systems for behavioral health care needs (including developmental disabilities, mental health, substance use, or co-occurring disorders). Access system services are delegated by the CMHPSM to Community Mental Health Services Programs (CMHSP) in the region or through contractual arrangements with providers. All access system services will be provided in accordance with all applicable access and availability standards.

V. DEFINITIONS

Access management services: Those responsibilities associated with determining a consumer/individual's eligibility for support from the public mental health and substance use disorder care system; managing resources (including capacity, availability and accessibility of resources to meet service and demands); ensuring compliance with various funding eligibility and service requirements; and assuring associated quality of care. Activities to carry out these responsibilities include information services, screening, service authorization, and appropriate referral and placement into the public mental health and substance use disorder care system, or linkage to other community resources.

Access system: A coordinated and integrated arrangement of administrative and clinical resources that: (1) provides information about the public mental health and substance use disorder care systems' covered services; (2) ensures the consumer/individual's appropriate need identification, and linkage to any crisis services to address any emergent needs; (3) renders a defined eligibility determination and authorizes the comprehensive assessment; and (4) coordinates the efficient provision of supports from the public mental health and substance use disorder care system. The access system is an arrangement of coordinated functions that provides screening and eligibility determination; it is not a building or a place.

American Society of Addiction Medicine (ASAM): Organization that establishes the criteria for determination of level of care for substance use disorders based on the following dimensional criteria:

- Dimension 1: Acute Intoxication and/or Withdrawal Potential
- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use or Continued Problem Potential
- Dimension 6: Recovery/Living Environment

Applicant: Consumer/individual served who requests mental health, developmental disabilities, substance use disorder, or co-occurring mental illness and substance use disorder services through the access system.

Assessment: The face-to-face comprehensive bio-psychosocial and/or clinical evaluation that obtains appropriate and necessary information about each consumer/individual served seeking entry into a public mental health and substance use disorder care setting or service. The information is used to match a consumer/individual's need with the appropriate care setting, care level and service intervention.

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 Michigan Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health

organization. CMHSPs are individually responsible for administering the general fund benefit for their designated counties.

Core Substance Use Disorder Provider: Provider designated to serve as the access management system for substance use disorder services.

Crisis situation: A situation in which a consumer/individual served is experiencing a medical or psychiatric emergency or is suicidal or homicidal, thereby requiring an immediate referral/intervention to a provider specializing in the service most appropriate to the consumer/individual's situation and needs.

Emergent situation: A situation in which a consumer/individual served is experiencing a serious mental illness or a developmental disability, or a minor is experiencing a serious emotional disturbance, and one of the following applies: (1) The consumer/individual served can reasonably be expected within the near future to physically injure himself or herself, or another consumer/individual served, either intentionally or unintentionally; (2) The consumer/individual served is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the consumer/individual served or to another consumer/individual served; or (3) The consumer/individual's judgment is so impaired that he or she is unable to understand the need for treatment, and in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the consumer/individual served or to another consumer/individual served. Emergent situations require immediate attention by the access system with a decision to be made about the disposition and linkage to state and federally approved medically necessary services within 3 hours of initial contact.

Qualified practitioner: A professional practitioner, provider or staff member who is qualified to provide public mental health and substance use disorder care, treatment, support or services by virtue of one or more of the following: education, licensure, certification, competence, experience, and/or applicable law or regulation.

Pre-paid Inpatient Health Plan (PIHP): Organizations in Michigan that manage designated geographic areas for the Medicaid mental health, developmental disabilities, and substance use disorder services outlined in the 1915(b) and 1915(c) waivers that created the CMHSP managed care model in the State.

Procedure manual: A written set of documents developed and maintained locally by each CMHPSM Community Mental Health Services Program (CMHSP) that details how the staff will provide access system services to meet the Access System Policy requirements and standards.

Routine situation: A situation where the consumer/individual served appears to have mental health, developmental disability, and/or substance use disorder needs requiring an assessment by a professional.

Screening: A brief telephone or face-to-face triage that determines the need for immediate mental health, developmental disability, and/or substance use disorder services authorization for initial entry into the public mental health system, substance

use disorder treatment services, or referral to community resources. Triage results in the determination of whether the consumer/individual's call/walk-in is emergent, urgent, or routine. The purpose of a screening is to connect the consumer/individual served to services/resources as quickly as possible.

Urgent situation:

1. Mental Health Services: A situation in which a consumer/individual served is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment, or support services. Urgent situations require a face-to-face assessment within 24-48 hours by a professional appropriate to the consumer/individual's condition.
2. Substance Use Disorders: A situation that requires a priority population to be seen within 24 hours according to MDHHS Waitlist and Priority Population Management Guidelines.[1] A consumer/individual served who is pregnant and has a substance use disorder is considered high-priority.

VI. STANDARDS

A. CMHPSM access system key functions include:
   a. Welcoming all consumers/individuals served by demonstrating empathy, providing the opportunity for the consumer/individual served to describe their situation, exhibiting excellent customer service skills, and working with consumers/individuals served in a non-judgmental way.
   b. Screening consumers/individuals served who contact the access system for services to determine whether the consumer/individual's need is a crisis, emergent, urgent, or routine, including the consumer/individual's perception of the urgency of their situation in the urgency determination.
   c. Determining an consumer/individual's eligibility for Medicaid specialty services and supports, other Medicaid-funded programs, MI Child or, for those who do not have any of these benefits, as an consumer/individual served whose presenting needs for mental health/substance use disorder services make them a priority to be served.
   d. Collecting and documenting information from consumers/individuals served for decision-making and reporting purposes. Information related to service requests will be documented in the consumer/individual's electronic medical record.
   e. Referring consumers/individuals served in a timely manner to the appropriate mental health practitioners, substance use disorder services, or community resources that may meet their needs.
   f. Informing consumers/individuals served about all the available mental health and substance use disorder services and providers and their due process rights under all applicable Medicaid programs, MI Child, and the Michigan Mental Health Code.
   g. Conducting outreach to under-served and hard-to-reach populations and maintaining accessibility to the community-at-large.

B. Welcoming
   a. All consumers/individuals served contacting the CMHPSM, including all Michigan residents and regardless of where the consumer/individual served lives, will be assisted through the access system. All staff will be welcoming, accepting and helpful with the applicant's request for service.
   b. CMHPSM access system services are available through toll free access telephone lines 24 hours a day, 7 days per week including in-person and telephone access for hearing impaired consumers/individuals served.

1. The access system telephone lines accommodate Limited English Proficiency (LEP), are accessible for consumers/individuals served with hearing impairments and have electronic caller identification if locally available.
2. Access system telephone lines are answered by a live representative from the access system. Callers will not encounter telephone "trees," will not be put on hold or sent to voicemail until they have spoken to a representative from the access system to express their situation and circumstances, and it is determined that their situation is not urgent or emergent.
3. Consumers/individuals served calling the CMHPSM access system with a crisis/emergent need will be immediately transferred to a qualified practitioner without requiring the consumer/individual served to call back.
4. Consumers/individuals served calling the CMHPSM access system with non-emergent needs will not be kept on hold waiting for a screening for more than three (3) minutes without being offered an option of being called back. Any subsequent call back will occur within one (1) business day of the initial contact.
5. Decentralized access systems have a mechanism in place to forward the call to the appropriate access portal without the consumer/individual served having to re-dial.

c. The CMHPSM access system will provide a timely, effective response to all consumers/individuals served who walk in.
    1. For consumers/individuals served who walk into a CMHPSM access system service location with urgent or emergent needs, an intervention will be initiated immediately.
    2. Consumers/individuals served who walk into a CMHPSM access system service location to request routine services will be screened or other arrangements made within thirty (30) minutes.

d. The CMHPSM access system maintains the capacity to immediately accommodate consumers/individuals served who present with:
    1. LEP and other linguistic needs
    2. Diverse cultural and demographic backgrounds
    3. Visual impairments
    4. Alternative needs for communication
    5. Mobility challenges

e. The CMHPSM access system will address financial considerations, including county of financial responsibility as a secondary administrative concern, only after any urgent or emergent needs are addressed. Access system screening and crisis intervention services do not require prior authorization. Screening and referral will never require financial contribution from the consumer/individual served being served.

f. The access system will provide applicants with a summary of their rights guaranteed by the Michigan Mental Health Code or Substance Abuse Administrative Rules, including information about their rights to the person-centered planning process, and will assure that they have access to the pre-planning process (as applicable) as soon as the screening and coverage determination processes have been completed.

C. The CMHPSM access system screening for crises:

a. Access system staff shall first determine whether the presenting mental health or substance use disorder need is emergent, urgent, or routine and will address emergent and urgent needs first. To assure understanding of the problem from

the point of view of the consumer/individual served who is seeking help, methods for determining emergent or urgent situations will incorporate "caller or client-defined" crisis situations. Staff will demonstrate empathy as a key customer service method.

b. The CMHPSM has emergency intervention services with sufficient capacity to provide clinical evaluation of the problem, to provide appropriate intervention, and to make timely disposition to admit to inpatient care or refer to outpatient services. Emergency intervention services will be provided through telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team interaction, and dispatching staff to an emergency room, as appropriate. Access system staff will perform or arrange for inpatient assessment and admission, alternative hospital admissions placements, or immediate linkage to a crisis practitioner for stabilization, as applicable.
c. The access system crisis assessment will include an inquiry as to the existence of any established medical or psychiatric advance directives relevant to the provision of services.
d. CMHPSM will provide coverage and provision of post-stabilization services for Medicaid beneficiaries once the consumer/individual's crisis is stabilized. Consumers/individuals served who are not Medicaid beneficiaries but who need mental health or substance use disorders services and supports following crisis stabilization will be referred back to the access system for assistance.

D. The CMHPSM access system will make coverage eligibility determinations for public mental health or substance use disorder treatment services
   a. The CMHPSM will ensure access to public mental health services in accordance with the Michigan Department of Health and Human Services (MDHHS)/ PIHP and MDHHS/CMHSP contracts and:
      1. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the consumer/individual served is a Medicaid beneficiary.
      2. Any applicable Medicaid program in the Medicaid Provider Manual.
      3. The MI Child Provider Manual, if the consumer/individual served is a MI Child beneficiary.
      4. The Michigan Mental Health Code and the MDCH Administrative Rules, if the consumer/individual served is not eligible for a Medicaid program. or MI Child. The CHMPSM will serve consumers/individuals served with serious mental illness, serious emotional disturbance, developmental disabilities substance use disorders, giving priority to consumers/individuals served with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these consumers/individuals served have been addressed, consumers/individuals served with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM) will be served based upon CMHPSM/CMHSP priorities and within funding available.
   b. The CMHPSM ensures access to public substance use disorder treatment services in accordance with the MDHHS/PIHP and MDHHS contracts, and:
      1. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the consumer/individual served is enrolled in a Medicaid program.
      2. The MI Child Provider Manual, if the consumer/individual served is a MI Child beneficiary.

3. The priorities established in the Michigan Public Health Code, if the consumer/individual served is not eligible for Medicaid or MI Child.

c. The CMHPSM ensures that all screening tools and admission criteria to determine eligibility are valid, reliable, and uniformly administered.
d. The CMHPSM access system will utilize the ASAM PPC 2R to make eligibility determinations and level of care placement decisions.
e. The CMHPSM access system is capable of providing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) corrective or ameliorative services that are required by the MDHHS/PIHP specialty services and supports contract.
f. When a clinical screening is conducted, the access system will provide a written (hard copy or electronic) screening decision of the consumer/individual's eligibility for admission based upon established admission criteria. The written decision will include:
    1. Identification of presenting problem(s) and need for services and supports.
    2. Initial identification of population group (developmental disability, mental illness, severe emotional disturbance, or substance use disorder) that qualifies the consumer/individual served for public mental health and substance use disorder services and supports.
    3. Legal eligibility and priority criteria (where applicable).
    4. Documentation of any emergent or urgent needs and how they are immediately linked for crisis service.
    5. Identification of screening disposition.
    6. Rationale for system admission or denial.
g. The CMHPSM access system identifies and documents any third-party payer source(s) for linkage to appropriate referral source, either in or out of network.
h. The CMHPSM access system will not deny an eligible consumer/individual served a service because of the consumer/individual served/family income or third-party payer source.
i. The CMHPSM access system will document the referral outcome and source, either in-network or out-of-network.
j. The CMHPSM access system will document when an consumer/individual served with mental health needs, but who is not eligible for any Medicaid program, is placed on a waiting list for service and why.

E. Collecting information:
    a. The CMHPSM access system will avoid duplication of screening and assessments by using the assessments already performed or by forwarding information gathered during the screening process to the provider receiving the referral, in accordance with the applicable federal/state confidentiality guidelines (e.g. 42 CFR Part 2 for substance use disorders).
    b. The access system shall have procedures for coordinating information between internal and external providers, including Medicaid Health Plans and primary care physicians.
    c. All CMHPSM screening and assessment information will be documented in the CMHPSM electronic medical record system.

F. Referral to PIHP or CMHSP Practitioners:
    a. The CMHPSM access system will ensure that applicants are offered appointments for assessments with mental health professionals of their choice within the MDHHS/PIHP and CMHSP contract-required standard timeframes. Staff will follow up to ensure the appointment occurred.

b. The CMHPSM access system will ensure that, at the completion of the screening and coverage determination process, consumers/individuals served who are accepted for services have access to the person-centered planning process.
c. The CMHPSM access system shall ensure that the referral of consumers/individuals served with substance use disorders or co-occurring mental illness and substance use disorders to PIHP or CMHSP or other practitioners must be in compliance with the confidentiality requirements of 42 CFR.

G. Referral to community resources:
   a. The CMHPSM access system shall refer Medicaid beneficiaries who request mental health services, but do not meet eligibility for specialty supports and services, to their Medicaid Health Plans or Medicaid fee-for-service providers.
   b. The CMHPSM access system shall refer consumers/individuals served who request mental health or substance use disorder services but who are not eligible for Medicaid-covered mental health and substance use disorder services, nor who meet the priority population criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance use disorder services, to alternative mental health or substance use disorder treatment services available in the community.
   c. The CMHPSM access system will provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to consumers/individuals served who request it.

H. Informing consumers/individuals served:
   a. General – The CMHPSM access system will provide information about, and help consumers/individuals served connect as needed with
      1. The CMHPSM Customer Services Department, peer support specialists, or other internal supports
      2. Local community resources, such as transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate.
   b. Rights:
      1. The CMHPSM access system will provide Medicaid beneficiaries information about the local dispute resolution process and the State Medicaid Fair Hearing process. When an consumer/individual served is determined ineligible for Medicaid, mental health or substance use disorder services, he/she is notified both verbally and in-writing of the right to request a second opinion; and/or file an appeal through the local dispute resolution process; and/or request a State Fair Hearing.
      2. The CMHPSM access system will provide persons with substance use disorders, or persons with co-occurring substance use/mental illness with information regarding local substance use disorder Recipient Rights.
      3. When an consumer/individual served with mental health needs, who is not a Medicaid beneficiary, is denied community mental health services, for whatever reason, he/she is notified of the right under the Mental Health Code to request a second opinion. That consumer/individual served will also be provided with the option of pursuing the local dispute resolution process.

4. The CMHPSM access system will schedule and provide for a timely second opinion, when requested, from a qualified health care professional within the network, or arrange for the consumer/individual served to obtain one outside the network at no cost to the consumer/individual served. The consumer/individual served has the right to a face-to-face determination, if requested.
5. The CMHPSM access system ensures the consumer/individual served and any referral source (with the consumer/individual's consent) are informed of the reasons for denial and will recommend alternative services and supports or disposition.

c. Services and providers available:
   1. The CMHPSM access system will assure that applicants are provided comprehensive and up-to-date information about the mental health and substance use disorder services that are available and the providers who deliver them.
   2. The CMHPSM access system will assure that there are available alternative methods for providing the information to consumers/individuals served who are unable to read or understand written material, or who have limited English proficiency (LEP).

I. Administrative functions:
   a. The CMHPSM has written policies, procedures, and plans that demonstrate the capability of its access system to meet access system standards.
   b. Community outreach and resources
      1. The CMHPSM has an active outreach and education effort to ensure the network providers and the community are aware of the access system and how to use it.
      2. The CMHPSM has regular and consistent outreach efforts to commonly un-served or underserved populations who include children and families, older adults, homeless persons, members of ethnic, racial, linguistic and culturally diverse groups, persons with dementia, and pregnant women.
      3. The CMHPSM assures that the access system staff are informed about, and routinely refer consumers/individuals served to, community resources that not only include alternatives to public mental health or substance use disorder treatment services, but also resources that may help them meet their other basic needs.
      4. The CMHPSM maintains linkages with the community's crisis/emergency system, liaisons with local law enforcement, and has protocols for jail diversion.
   c. Oversight and monitoring:
      1. The CMHSP's medical directors are involved in the review and oversight of the CMHPSM access system policies and clinical practices.
      2. The CMHPSM assures the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, MI Child Provider Manual, the Michigan Mental Health Code, the Michigan Public Health Code, and the MDHHS/PIHP and CMHSP contracts.
      3. The CMHPSM has mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services.

4. The CMHPSM monitors provider capacity to accept new consumers/individuals served and be aware of any provider organizations not accepting referrals at any point in time.
5. The CMHPSM routinely measures telephone answering rates, call abandonment rates and timeliness of appointments and referrals. Any resulting performance issues are addressed through the CMHPSM Quality Improvement Plan.
6. The CMHPSM assures that the access system maintains medical records in compliance with state and federal standards.
7. The CMHPSM staff work with consumers/individuals served, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

d. Waiting Lists:
   1. The CMHPSM ensures that the CMHSPs have policies and procedures for maintaining a waiting list for consumers/individuals served not eligible for Medicaid, MI Child, or Healthy Michigan and who request community mental health services but cannot be immediately served. The policies and procedures minimally assure:
      i. No Medicaid, MI Child, or Healthy Michigan beneficiaries are placed on waiting lists for any medically necessary Medicaid, MI Child, or Health Michigan service.
      ii. A local waiting list will be established and maintained when the CMHSP is unable to financially meet requests for public mental health services received from those who are not eligible for Medicaid, MI Child, or Healthy Michigan. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
      iii. Consumers/individuals served who are not eligible for Medicaid, Healthy Michigan, or MI Child who receive services on an interim basis that are other than those requested will be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
      iv. Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
      v. Use of a defined process to contact and follow-up with an consumer/individual served on a waiting list who is awaiting a mental health service.
      vi. Reporting, as applicable, of waiting list data to the Michigan Department of Health and Human Services as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.

J. All CMHPSM CMHSPs and SUD core providers will maintain written Access System procedures that detail how the access system standards identified in the Access System Policy are met locally.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al.	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
American Society of Addition Medicine, Inc (ASAM)	X	
ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders 2nd Edition, 2001	X	
HITECH Act of 2009	X	
Current Joint Commission Behavioral Health Standards	X	
MDHHS Medicaid Contract	X	
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual	X	
Michigan Mental Health Code Act 258 of 1974	X	
Assessment Policy	X	
Confidentiality & Access to Clinical Records Policy	X	
Consumer Appeal Policy CMHPSM	X	
Customer Services Policy CMHPSM	X	
Culturally & Linguistically Appropriate Services Policy	X	
Employee Competency & Credentialing Policy	X	
Notice of Privacy Practices and Consumer Complaints for Protected Health Information Policy	X	
Person Centered Planning Policy	X	
Right to Dignity and Respect Policy	X	
Services Suited to Condition Policy	X	
Training Policy	X	
Utilization Management/Review Policy	X	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTMICHIGAN/PIHP	***Policy and Procedure*** ***Appeals Policy***
Department: Regional UM Committee	**Local Policy Number (if used)**
Implementation Date (2 weeks from Regional Approval Date)	**Regional Approval Date (date of last CMH board's approval)**

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

I. PURPOSE

To establish policy and procedures to receive and resolve appeals regarding the denial, suspension, reduction, or termination of services; the timeliness of service provision; family support subsidy appeals; second opinion requests; local level appeals, and state level appeals.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
6/5/2015	Revised to reflect the External Quality Review recommendations.
2/24/2017	Revised to reflect Section 942 of P A 268 of 2016 Revised Memo 12 15 16
10/1/2017	Revised to reflect the revised Managed Care Rules.
1/28/19	Revised to reflect corrections from EQR review
Regional Approval Date	Revised to reflect new ABD language that provides grievance rights only.

III. APPLICATION

All regional staff of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), all Community Mental Health Service Provider (CMHSP) staff, students and volunteers, all Recovery Oriented System of Care (ROSC) Core Providers, and contractual providers.

IV. POLICY

All grievance processes will be initiated at the local Board level and will be handled by the local Customer Services department of each local Board. All policy and procedures for grievance processes can be found in the CMHPSM Customer Services Policy.

All appeal processes will be initiated at the local Board level and will be handled locally. Each CMHSP/ROSC Core Provider shall have a designee to handle internal/local appeals until:

a. A Medicaid consumer/individual served requests a State Fair Hearing with the Michigan Office of Administrative hearings and Rules (MOAHR) after receiving notice that an adverse benefit determination (ABD) was upheld by the Local Dispute Resolution Committee (LDRC).
b. A Medicaid consumer/individual served initiates a State Fair Hearing with MOAHR because the PIHP/CMHSP failed to adhere to the notice and timing requirements. (When this occurs, a consumer/individual served is deemed to have exhausted the internal appeals processes).
c. A Non-Medicaid consumer/individual served completes the local appeal/Local Dispute Resolution Process and requests a Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution Hearing.

Upon the request of a state level hearing/appeal, the designated Fair Hearings Officer will assume responsibility for the process in collaboration with the local Board. This includes working in conjunction with MOAHRMOAHRon behalf of the local Board, representing the local Board for the State Fair Hearing requests and representing the local Board for MDHHS Alternative Dispute Resolution requests.

All appeal processes will be handled by the PIHP and its region in accordance with the procedures attached to this policy. All appeal processes shall be:

1. Timely
2. Fair to all parties
3. Administratively simple
4. Objective and credible
5. Accessible and understandable to consumers/individuals served and providers
6. Cost and resource efficient
7. Subject to quality improvement review

These processes shall:

i. Not interfere with communication between consumers/individuals served and their service providers.
ii. Assure that service providers who participate in an appeal process on behalf of a consumer/individual served are free from discrimination or retaliation.
iii. Assure that a consumer/individual served/legal representative who files an appeal is free from discrimination or retaliation.

V. DEFINITIONS

Access Staff – Staff designated to provide intake and/or assessment of an applicant's/consumer/individual's eligibility and/or medical necessity for requested services. Staff provide screenings and referrals using diagnostic criteria for mental health and substance abuse services. Staff also assess the needs of callers, make appropriate

referrals, and provide authorization of mental health and substance use disorder services based on consumer/individual served/individual served need, eligibility, and available funding resources.

Action (also referred to as adverse action) – A benefit/service determination related to Non-Medicaid/General Funds by which the CMHSP determines any of the following covered by Non-Medicaid/General Funds:

- Denial of inpatient psychiatric hospitalization or denial of a requested alternate service if inpatient is denied.
- Denial of services where there are rights to a second opinion.
- Suspension, reduction, or termination of reduction of existing supports/services.

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

Adequate Notice - Written notice to an applicant/consumer/individual served/ legal representative that a service is being approved or an adverse benefit determination (ABD) has occurred that is not a suspension, reduction or termination.

Administrative Law Judge (ALJ) - A person designated by the state to serve as a judge for the Michigan Administrative Hearing System to conduct Medicaid State Fair Hearings.

Advance Notice - Written notice of an ABD or action to a consumer/individual served/legal representative that a service is being suspended, reduced, or terminated. For Medicaid consumers/individuals, this notice must be mailed at least 10 days before the effective date of the service change. For Non-Medicaid consumers/individuals, this notice must be mailed at least 30 days before the effective date of the service change.

Adverse Benefit Determination (ABD) – A benefit/service determination specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following for Medicaid services:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or part, of a payment for service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.
4. T
5. The failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning process and as authorized by the PIHP/CMHSP.
6. The failure of a PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request.
7. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer/individual’s request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.

8. The denial of a consumer/individual's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other consumer/individual served financial liabilities.
9. The failure of the PIHP/CMHSP to act within the required timeframes regarding standard resolution of appeals.

Alternative Dispute Resolution Process - A program of the Michigan Department of Health & Human Services with responsibility for conducting an appeal which was not resolved at the local level through the LDRP. This process may occur after the LDRP review has been exhausted and Community Mental Health (CMH) upholds the adverse action at the local appeal.

Applicant - An individual, or his/her legal representative, who makes an initial request for mental health or substance use disorder services, including services provided by agencies under contract to the PIHP.

Authorized Hearing Representative (AHR) - Any person designated in writing by a consumer/individual served (or the consumer/individual's legal representative) to stand in for or represent the consumer/individual served during a local/internal or state level appeal, or a representative/parent of a minor, or the consumer/individual's spouse, widow, or widower, if there is no one else with authority to represent the consumer/individual served.

Community Mental Health Partnership of 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.

Consumer/individual served - An individual who is receiving mental health or substance use disorder services, including services provided by entities under contract with the PIHP.

Core Provider - A local provider of substance use disorder services utilizing the ROSC model that provides for and/or coordinates all levels of care for consumers/individuals with substance use disorders.

Denial - An action taken by the CMHSP with Non-Medicaid/General Funds services, by which a service is denied in whole, denied in part, or currently authorized services or supports are to be suspended, terminated, or reduced. This is also known as an Action or Adverse Action.

Delay – An action specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following and for which Medicaid consumers/individuals have a right to file a grievance:

1. A delay in making a standard/routine service authorization decision of a service request within 14 calendar days from the date of receipt of the request. The

decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.

2. A delay in making a decision regarding a request for an expedited service authorization decision within 72 hours from the receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
3. A delay in resolving standard internal appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. The resolution timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
4. A denial of a request for an expedited appeal. The request for an expedited appeal within 72 hours can be denies and extended (hence delayed) to the standard 30-day appeal time frame if the consumer/individual served is notified of the right to file a grievance.
5. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.

Expedited Appeal – The prompt review of an ABD or action, requested by a consumer/individual served/legal representative or a provider on behalf of the consumer/individual served, when the time necessary for the normal/standard review process could seriously jeopardize the consumer/individual's life or health or ability to attain, maintain or regain maximum function. If the consumer/individual served/legal representative requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the consumer/individual's provider makes the request, or supports the consumer/individual's request, the PIHP/CMHSP must grant the request.

Fair Hearings Officer (FHO) –Person assigned by the CMHSP Board for mental health appeals, or by PIHP for Substance Use Disorder (SUD) appeals, to handle state level appeals, maintain appeals-related data, and report this data to the PIHP.

Grievance – An expression of dissatisfaction about any matter related to PIHP/CMHSP service issues, other than an adverse benefit determination or action, which does not involve a Recipient Rights complaint. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer/individual served. Grievances not completed according to time frames are also considered a Medicaid ABD and are appealable.

Grievance Process - Impartial local level review of a consumer/individual's grievance.

Grievance and Appeal System – Processes the PIHP implements to handle appeals, grievances and the collecting and tracking of appeal and grievance information.

Internal Appeal – A request for the PIHP/CMHSP to review a Medicaid ABD at the local level.

Legal Representative – The representative, parent of a minor, or other person authorized by law to represent an applicant/consumer/individual served.

Local Appeal – A request for the PIHP/CMHSP to review a denial, suspension, termination or reduction of Non-Medicaid/General Funds services and/or supports at the local level.

Local Dispute Resolution Process (LDRP) - A review of a Non-Medicaid/General Funds local appeal convened by the local entity (either the CMHSP or the ROSC Core Provider). The LDRP for mental health services is chaired by the designee of the CMHSP Director; the LDRP for substance use disorder services is chaired by the SUD Director. The LDRP has the responsibility for reviewing local appeals regarding mental health or substance use disorder services covered with Non-Medicaid/General Funds by the PIHP/Core Provider and those of its contract agencies.

Medicaid Services – Services provided to a consumer/individual served under the authority of the Medicaid State Plan, EPSDT coverage, 1915(i) waiver, the 1115 demonstration waivers, and/or the 1915(c) program waivers (Habilitation Supports, SED or Children's Waivers..

Mediation - An informal dispute resolution process in which an impartial, neutral individual who has no authoritative decision-making power assists parties to reach their own settlement of issues in a confidential setting.

Michigan Office of Administrative Hearings and Rules (MOAHR) - The entity charged by the state with responsibility for conducting Medicaid State Fair Hearings.

Notice of Resolution – Written statement of the PIHP/CMHSP resolution of a grievance or appeal, which must be provided to the consumer/individual served as described in *42 CFR 438.408*.

Recipient Rights Complaint – A written or verbal statement by a consumer/individual served or anyone acting on behalf of a consumer/individual served alleging a violation of a consumer/individual's legally protected rights, including rights cited in the Michigan Mental Health Code, Chapter 7, which is resolved through the processes established in Chapter 7A.

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, intellectual/developmental disabilities, and substance use disorder needs.

Service Authorization – PIHP/CMHSP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

State Fair Hearing – (Also called a Medicaid Fair Hearing). An Administrative Law Judge (ALJ) from MOAHRcompletes an impartial state level review of a decision made by the PIHP or the local CMHSP, or one of its contract agencies, regarding Medicaid services.

Utilization Review (UR) - Process in which established criteria are used to recommend or evaluate services provided in terms of cost effectiveness, medical necessity, and efficient use of resources.

VI. STANDARDS

A. General Standards

1. Grievance and Appeal System: Processes shall be in place for consumers/individuals served and promote the resolution of concerns as well as support and enhance the goal of improving the quality of services.

2. Consumers/individuals served/legal representatives shall be informed of their right to access the grievance and appeal processes, if they are dissatisfied or concerned at any point during the delivery of mental health services or supports.

3. Customer Services and the Office of Recipient Rights (ORR) shall assist applicants/consumers/individuals served/legal representatives of their legal rights to access all grievance and/or appeal processes which they are eligible.

4. Providers shall be informed of their right to access the appeal process when they are denied or limited authorization for services, or when they wish to file an expedited appeal on behalf of a consumer/individual served.

5. Providers, acting on behalf of a consumer/individual served/applicant and with the consumer/individual's/legal representative's written consent, may file an appeal as the consumer/individual's Authorized Hearing Representative (AHR).

6. If an external/contractual provider makes a service request on behalf of a consumer/individual served, and that request results in an adverse benefit determination/action, both the provider and the consumer/individual served/guardian will be notified of the adverse benefit determination/action. Notice to the provider can be verbally or in writing. Notice to the consumer/individual served/guardian shall follow written notice requirements as outlined in this policy.

7. If the consumer/individual served/legal representative is not aware of the provider's service request, and the matter warrants involving the consumer/individual served/legal guardian in the request process (i.e., will warrant a change in the Individual Plan of Service (IPOS) that the consumer/individual served/legal representative would need to agree to), CMHSP staff will inform the consumer/individual served/legal representative regarding the request.

8. Level of Appeals: The PIHP/CMHSP may only have one level of appeal for consumers/individuals served.

B. Timeliness of Authorization/Service Decisions

1. State and federal regulations require that specific service decisions shall be made within certain time frames. If these times frames (described below) are not met they are considered denials/Adverse Benefit Determinations or decisions with grievance rights, and staff shall follow the same processes for providing consumers/individuals served/legal representatives with notices of their appeal or grievance rights as outlined in this policy.
2. Authorization decisions at the initial request for services, or request for

hospitalization shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent.

3. Authorization decisions for Medicaid consumers/individuals served currently receiving services shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance for this delay.

4. A standard service authorization decision may be extended an additional 14 calendar days if the consumer/individual served or legal representative requests an extension or if the PIHP/CMHSP/Core Provider justifies a need for additional information and the extension is in the consumer/individual's interest.

5. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ ROSC Core Provider must:

i. make reasonable efforts to give the member prompt oral notice of the delay;
ii. provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a grievance if he or she disagrees with that decision;
iii. Within two calendar days, provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision;
iv. issue and carry out its determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

consumer/individual servedconsumer/individual servedconsumer/individual

6. Medicaid covered services shall begin within 14 days from when the authorization was completed, except in cases where the consumer/individual served agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14-day time frame and the consumer/individual served does not agree to an extension, this shall be considered an ABD and staff shall provide the consumer/individual served/legal representative with notice of the denial.

7. Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/individual served/legal guardian requests, or the PIHP/CMHSP determines that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life or health or ability to attain, maintain, or regain maximum function. In these cases, a decision must be made, and written/electronic notice provided no later than 72 hours from receipt of the request for service.

8. The PIHP/CMHSP may extend the 72-hour time period by up to 14 calendar days if the consumer/individual served/legal representative requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer/individual's interest. If the PIHP/CMHSP extends the timeframe, it must:
   i. give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe,
   ii. inform the consumer/individual served/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and
   iii. make a determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.

9. Consumer/individual served requests for an expedited review of an authorization decision can be denied; if it is denied the consumer/individual served shall receive notice of denial for an expedited review and standard 14-day timeframes for an authorization decision shall still be met.

10. If a provider requests an expedited review of an authorization decision, such a request from a provider cannot be denied; the review shall follow the expedited process and the provider shall be informed within 72 hours on whether the service request will be approved or denied.

C. Filing and Timeliness Requirements

1. Grievances: A consumer/individual served/legal representative may file a grievance at any time. The PIHP/CMHSP/SUD Core Provider shall resolve grievances and sent written notice of the grievance outcome within 60 days of receipt.

2. Appeals:

a) Medicaid Appeals: Following receipt of notification of an Adverse Benefit Determination (ABD) by a PIHP/CMHSP, a consumer/individual served/legal representative has 60 calendar days to request an internal appeal with the PIHP/CMHSP. An internal appeal must be resolved within 30 days of receipt.

   i. The 30 day timeframe for an internal appeal may be extended by up to 14 calendar days a consumer/individual served/legal representative requests an extension or if the CMHSP/PIHP finds that there is a need for additional information that would be in the best interest of the consumer/individual served. If the timeframe for an internal appeal is extended, notice of the consumer/individual's right to file a grievance on this decision must be provided.
   ii. A consumer/individual served/legal representative may request a State Fair Hearing within 120 calendar days after receiving notice that the ABD was upheld by the internal appeal.
   iii. If the PIHP/CMHSP does not meet the notice or internal appeal timing requirements, the consumer/individual served has the immediate right to file a State Fair Hearing.

b) Non-Medicaid/General Fund Appeals: Following receipt of an action by the CMHSP, a consumer/individual served/legal representative has 30 calendar days to request a local

appeal with the CMHSP. A consumer/individual served/legal representative may request an Alternative Dispute Resolution Process with the state within 10 calendar days after receiving notice that the action was upheld by the local appeal/LDRP.

D. Notice of Approved Services

Approval of services is not considered an ABD, and therefore does not require notice of appeal rights. State regulation requires that consumers/individuals served/legal representatives receive an estimated cost of services as part of their Individual Plan of Service.

E. Second Opinion Process

1. All applicants/consumers/individuals served/legal representatives may request a second opinion for a denial of access to services and of access to hospitalization within 30 days of the denial. A second opinion will be provided within the PIHP/CMHSP at no extra cost to applicants/consumers/individuals served by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.
2. Non-urgent requests for a second opinion will be completed for applicants/consumers/individuasl served within five (5) business days from the receipt of the request.
3. Upon completion of the second opinion, the applicant/consumer/individual served will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion; this notification will be followed by a written notification within five (5) business days from the completion of the second opinion.
4. Urgent requests for a second opinion will be provided to consumer/individual served with Medicaid within 72 hours.
5. Urgent requests for a second opinion will be provider to Non-Medicaid consumer/individual served within three (3) business days.
6. Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer/individual served clinical need, and no later than 24 hours of when the service was requested.
7. consumer/individual servedIf the second opinion upholds the original denial, the notification to the applicant/consumer/individual served shall include the next steps available to them, including filing a recipient rights complaint.
8. If the second opinion reverses the original denial, staff (Access, Psychiatric Emergency Services, or the local designee) shall arrange for services to be provided per the appropriate required timeframes for authorization decisions.

F. Timeliness of Providing Notice of an Adverse Benefit Determination/Adverse Action

Consumers/individuals served/legal representatives shall receive written notice of an ABD/action that meets federal and state requirements for timeliness.

1. Timeliness of Notice for <u>Medicaid</u> Beneficiaries:

a. For a Service Authorization decision that denies or limits services, notice must be provided to the consumer/individual served within 14 days following receipt of the request for service for standard authorization decisions, or within 72 hours after

receipt of a request for an expedited authorization decision.

b. The CMHSP/PIHP/ROSC Core Provider may be able to extend the standard Service Authorization timeframe up to 14 additional calendar days, if:
   (i) The consumer/individual served, or the provider, requests extension; or
   (ii) The CMHSP/PIHP/ROSC Core Provider justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer/individual's interest.

c. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ROSC Core Provider must:
   (iii) provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a Grievance if he or she disagrees with that decision; and
   (vi) issue and carry out its determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

d. Advance Notice of Adverse Benefit Determination is required for service authorization decisions that are reductions, suspensions or terminations of previously authorized/currently provided Medicaid Services. Advance Notice of an ABD must be provided to the consumer/individual served/legal representative at least ten (10) calendar days prior to the proposed effective date.

e. If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP must reinstate services to the level before the action if services have been reduced, terminated, or suspended.

f. <u>Limited Exceptions to Advance Action Notice of an ABD:</u>
   The PIHP may mail an adequate notice of action instead of advance action notice, not later than the date of action to terminate, suspend or reduce previously authorized services, if:

   i. The CMHSP/PIHP has factual information confirming the death of a consumer/individual served/applicant;
   ii. The CMHSP/PIHP receives a clear written statement signed by a consumer/individual served/legal representative that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the consumer/individual served/legal representative understands that this must be the result of supplying that information;
   iii. The consumer/individual served has been admitted to an institution where he/she is ineligible under the plan for further services;
   iv. The consumer/individual's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address;
   v. The CMHSP/PIHP establishes that the consumer/individual served/applicant has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
   vi. A change in the level of medical care is prescribed by the consumer/individual's physician;
   vii. The notice involves an adverse determination made with regard to

the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. The date of action will occur in less than 10 calendar days.

ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the consumer/individual served (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

g. If the PIHP/CMHSP does not meet the requirements of providing notice or of internal appeal timing requirements, the consumer/individual served has the immediate right to file a State Fair Hearing.

2. Timeliness of Notice for <u>Non-Medicaid/General Funds</u> Consumers Beneficiaries:

a. Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced, whether through a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when there is not an identifiable UR unit, the CMHSP/PIHP/ROSC Core Provider must inform the consumer/individual served with written notification of the change at least 30 days prior to the effective date of the action.

b. Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

G. Content of Notice

1. Consumers/individuals served/legal representatives shall receive written notice of an ABD/action with content that meets federal and state requirements.
    a. **<u>Content of a Medicaid Notice</u> shall explain the following**:
        i. The ABD the PIHP/CMHSP intends to make or has already made.
        ii. The reasons for the ABD.
        iii. The consumer/individual's right to request an appeal of the PIHP's/CMHSP's ABD, including information on exhausting the PIHP's/CMHSP's one level of appeal and the right to request a State Fair Hearing.
        iv. The right for consumers/individuals served/legal representatives to have an AHR and the timeframes for requesting appeals.
        v. Before and during the appeal, the right of the consumer/individual served/legal representative and/or AHR to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the consumer/individual's ABD. This shall occur in a timely manner sufficient for preparation of their case for the appeal.
        vi. How to submit written comments or information relevant to the appeal.
        vii. The procedure for exercising their appeal rights.
        viii. The circumstances under which an appeal process can be expedited and how to request it.
        ix. The consumer/individual's right to have benefits continue pending

resolution of the appeal, how to request that benefits be continued, and the circumstances under which the consumer/individual served may be required to pay the cost of these services. A consumer/individual served may be required to pay the cost of the services if:

1) The decision was upheld.
2) The consumer/individual served/legal representative/AHR withdraws their appeal request.
3) The consumer/individual served/legal representative/AHR does not attend the appeal.

x. Notice of denials given to providers/practitioners shall include information on the opportunity for providers to discuss any denial decision with the reviewer and how to contact the reviewer.

b. **Content of a Non-Medicaid/General Funds Notice** shall explain the following:
   a. A statement of what action the CMHSP intends to take.
   b. The reasons for the intended action.
   c. The specific justification for the intended action.
   d. An explanation of the LDRP.

H. Handling of Appeals:

1. All PIHP/CMHSP entities will:
   a. Ensure that written materials will be provided to consumers/individuals served, legal representatives and AHRs in a language and format that is easily understood.

   b. If an applicant/consumer/individual served requires written materials in alternative formats (i.e., visual/hearing impairments or limited English proficiency), materials will be provided free of charge and in ways to meet their needs. Large print materials must be typed in a font large enough and no less than an 18-point font for the individual to read. (See the Regional Customer Services Policy for further information about written materials).

   c. Give consumers/individuals served/legal representatives reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes but is not limited to auxiliary aids and services upon request, such as providing free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. This shall occur in accordance with PIHP policies on interpreters and/or limited English proficiency.

2. Any staff/designee handling appeals of ABDs/actions shall:

   a. Acknowledge the receipt of each internal/local appeal in writing within 5 calendar days to the consumer/individual served/legal representative and when applicable, the AHR. Requests for internal/local appeals received orally will be treated as a formal appeal request to establish the earliest possible filing date for a local appeal. An oral appeal must be confirmed in writing unless the applicant/consumer/individual served, legal representative/provider requests expedited resolution of an appeal.

   b. Ensure that the individuals who make decisions on appeals are individuals who:
      i. Were not involved in any previous level of review or decision making nor a subordinate of

any such individual.

ii. If deciding any of the following, are individuals who have the appropriate clinical expertise in treating the consumer/individual's condition:
    (i) An appeal of a denial that is based on lack of medical necessity.
    (ii) A grievance regarding denial of expedited resolution of an appeal
    (iii) A grievance or appeal that involves clinical issues.

c. Take into account all comments, documents, records and other information submitted by the consumer/individual served/legal representative without regard to whether such information was submitted or considered in the initial ABD/action.

d. Provide the consumer/individual served/legal representative a reasonable opportunity, in person or in writing, to present evidence and testimony and make legal and factual arguments. The PIHP/CMHSP must inform the consumer/individual served/legal representative of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and in the case of expedited resolution.

e. Provide the consumer/individual served/legal representative the consumer/individual's case file, including medical records, other documents, records, and any new or additional evidence considered, relied upon, or generated by the PIHP/CMHSP in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

f. Include, as parties to the appeal, the consumer/individual served/legal representative; or the legal representative of a deceased consumer/individual's estate.

g. Ensure Medicaid consumers/individuals served with a Medicaid spend down receive Medicaid notices of appeal. MAHS, in conjunction with the designated FHO, will determine whether the consumer/individual served had active Medicaid during the time of the decision and is eligible for a State Fair Hearing. If a consumer/individual served with a Medicaid spend down is not eligible for a State Fair Hearing, he/she shall be given the rights to Non-Medicaid appeals processes.

h. Ensure services continue to be provided for consumers/individuals served where applicable during a local/internal or state appeal process without interruption and regardless of the original authorization period, if the consumer/individual served requests to continue to receive the services during this process within the required timeframes.

i. Ensure Medicaid consumers/individuals served may continue services, if the appeal request is received within 10 days of the notice of the ABD and includes a written request to continue services. If the ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer/individual served for services provided during the appeal and State Fair Hearing. (Recoupment must be consistently applied).
   If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP must reinstate services to the level before the action if services have been reduced, terminated, or suspended.
   If the PIHP/CMHSP continues or reinstates the consumer/individual's benefits, at the consumer/individual's/legal representative's request, while the internal Appeal or State Hearing is pending, the PIHP/CMHSP must continue benefits until one of the following occurs:
   i. The consumer/individual served/legal representative withdraws the internal appeal or request for State Fair Hearing.

ii. The consumer/individual served/legal representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP/CMHSP sends the consumer/individual served notice of an adverse resolution to the consumer/individual's/legal representative's internal appeal.
iii. A State Fair Hearing office issues a decision adverse to the consumer/individual served/legal representative.

j. If the Administrative Law Judge reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished while the appeal was pending the CMHSP/PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

k. Ensure Non-Medicaid/General Funds may continue at the discretion of the CMHSP until the outcome of the local appeal is completed, if a consumer/individual served requests a local appeal of a reduction, suspension, or termination within 30 days of the date of the notice and in that request includes a written request to continue services. If the local appeal is upheld, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer/individual served for services provided during the local appeal and MDHHS Alternative Dispute Resolution Process. Recoupment must be consistently applied.

l. Ensure that staff provide notice of appeal rights through the use of/entry into the Consumer Notice Module in the regional electronic record, which will generate the appropriate forms as described in this policy. The only exception to this standard is in cases where staff/providers do not have access to the electronic record. In these cases, staff will provide paper/manual notice.

I. Resolution and Notification: General Standards

1. The Internal/Local Appeal Coordinator will follow the receipt process for requests for internal/local appeals.
2. PIHP/CMHSP person(s) reviewing internal/local appeals will follow processes for conducting internal/local appeals.
3. Review of all internal/local appeals will include:
    a. A full investigation of the substance for the appeal and any aspects of clinical care involved.
    b. The opportunity for the consumer/individual served/legal representative/Authorized Hearing Representative to be present at the internal/local appeal and bring anyone they wish to testify on their behalf.
    c. The opportunity for the consumer/individual served/legal representative to submit written comments, documents, or other information before or during the internal/local appeal meeting.
4. Expedited resolution of internal/local appeals shall be carried out in cases when, by request from the consumer/individual served/legal representative, the PIHP/CMHSP determines or the provider indicates (in making the request on the consumer/individual's behalf or supporting the consumer/individual's request) that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life, physical or mental health or ability to attain, maintain, or regain maximum function.
5. A consumer/individual's request for an expedited appeal can be denied by the PIHP/CMHSP in cases that do not met the criteria for an expedited appeal.
6. A provider's request for an expedited appeal cannot be denied by the PIHP/CMHSP.

In cases where the provider is requesting an expedited appeal the appeal review must be expedited.

H. Medicaid Internal/ Appeal Process:

1. Medicaid internal appeals shall be completed (including the disposition sent out) within 30 calendar days of receipt of the request for an internal appeal with exception of expedited appeals. The 30-day timeframe may be extended by up to 14 calendar days if the consumer/individual served/legal representative request the extension or the PIHP shows that there is need for additional information and the delay is in the consumer/individual's best interest. If the PIHP extends the timeframe not at the request of the consumer/individual served, it must:
    a. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the delay,
    b. Within 2 calendar days give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served/legal representative of the right to file a grievance if he or she disagrees with that decision, and
    c. Resolve the appeal as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.

2. **Medicaid Expedited Appeals:** The expedited internal appeals for Medicaid beneficiaries must be resolved and notice of disposition given no later than 72 hours from the request. In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable, based on clinical judgment of a consumer/individual's needs. As with appeals of reductions, suspensions or terminations, the consumer/individual's services will continue until a decision is made, if requested within 10 days of ABD.
3. For expedited resolution of Medicaid internal/local appeals**,** the PIHP/CMHSP may extend the 72-hour notice of disposition time frame by up to 14 calendar days if the consumer/individual served/legal representative requests an extension or, if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the consumer/individual's best interest. (Justification for the extension must be documented).
4. If PIHP, CMHSP, or ROSC Core Provider extends the timeframes not at the request of the enrollee, it must complete all of the following:
    i. Make reasonable efforts to give the enrollee prompt oral notice of the delay.
    ii. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
    iii. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
5. If the request for an expedited resolution of a Medicaid internal appeal is denied, the PIHP/CMHSP must:
    a. Transfer the internal appeal to the timeframe for standard resolution or no longer than 30 calendar days from the date the PIHP/ CMHSP received the appeal;

b. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/individual served/legal representative written notice of the denial for an expedited appeal within two (2) calendar days;
c. Inform the consumer/individual served/legal representative of their right to file a grievance for denial of an expedited appeal.

6. For Medicaid internal appeals, if the CMHSP/PIHP reverses a decision to deny authorization of services that the consumer/individual served received while the appeal was pending, the CMHSP/PIHP must pay for those services.

7. **Medicaid Internal Appeal – Notice of Resolution**: A written letter of resolution shall be provided to the consumer/individual served/legal representative/AHR within 30 calendar days of the receipt of the request for internal appeal. The written resolution must include:

   a. The results of the resolution and the date it was completed.

   b. When the appeal is not resolved wholly in favor of the consumer/individual served, the notice of disposition must also include notice of the following:
      i. The consumer/individual's right to request a State Fair Hearing and how to do so.
      ii. The Right to request to receive benefits while the State Fair Hearing is pending and how to make the request.
      iii. The potential liability for the cost of those benefits, if the hearing decision upholds the PIHP's ABD.
      iv. The right to contact Customer Services or the Office of Recipients Rights.

   c. If the consumer/individual served/legal representative continues to receive the service pending the appeal, the consumer/individual served may have to repay the cost of the service. This may happen if:

      i. The proposed suspension, reduction or termination of services is upheld in the appeal decision.
      ii. The consumer/individual served/legal representative/AHR withdraws their appeal request.
      iii. The consumer/individual served/legal representative/AHR does not attend the appeal.

I. Non-Medicaid Local Appeal Process:

1. Non-Medicaid/General Fund local appeals shall be completed within 45 days of the receipt of the request for a local appeal with exception of expedited appeals.

2. Non-Medicaid/General Fund Expedited Appeal

   a. If psychiatric inpatient services are denied for Non-

Medicaid/General Fund consumers/individuals served, the consumer/individual served/legal representative must be informed of their right to the LDRP, with the decision from that process to be reached within 3 business days.

b. If the CMHSP does not recommend hospitalization and an alternative service requested by the consumer/individual served/legal representative is denied, the CMHSP must inform the consumer/individual served/legal representative of his/her ability to access the LDRP. The decision from that process for these persons must be reached within 3 business days.
c. The CMHSP must communicate the decision of the LDRP and inform the consumer/individual served/legal representative of the right to access the MDHHS Alternative Dispute Resolution Process, if unsatisfied with the outcome of the LDRP.

1. N**on-Medicaid/General Fund Local Appeal – Notice of Resolution:** At the completion of a LDRP, the CMHSP must provide the consumer/individual served/legal representative written notification of the LDRP decision and subsequent avenues available, if he/she is not satisfied with the result, including the rights of consumers/individuals served without Medicaid coverage to access the MDHHS Alternative Dispute Resolution Process after exhausting the local dispute resolution procedures.

J. State Level Appeal Process:

1. State level appeal processes for Medicaid and Non-Medicaid consumers/individuals served will be followed in accordance with federal and state requirements, per the current Michigan Administrative Hearing System Pamphlet and the MDHHS contract.

2. State Medicaid Fair Hearings:

a. After the internal appeal has been exhausted, a Medicaid consumer/individual served may request a State Fair Hearing, if the PIHP/CMHSP upholds the ABD. If the PIHP/CMHSP does not adhere to the notice and timing requirements in 42CFR 438.408, the consumer/individual served is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.

b. A consumer/individual served must request a State fair hearing not later than 120 calendar days from the date of the PIHP's/CMHSP's notice of resolution.

c. The parties to the State Fair Hearing include the PIHP/CMHSP as well as the consumer/individual served/legal representative or the representative of a deceased consumer/individual's estate.

d. If ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP may recover against the consumer/individual served for services provided during the internal appeal and State Fair Hearing.

e. If the Administrative Law Judge at the State Fair Hearing level reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished

while the appeal was pending, the CMHSP/PIHP must authorize, pay for, and/or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

3. **Non-Medicaid State Appeals**:

   a. After exhausting the local dispute resolution procedures, a Non-Medicaid consumer/individual served may request the MDHHS Alternative Dispute Resolution Process if the CMHSP upholds the action.

   b. A consumer/individual served must request the Local Dispute Resolution Process within 10 days from the written notice of the LDRP outcome.

   c. MDHHS shall review all requests within two business days of receipt.

   d. If MDHHS agrees with the CMHSP, the consumer/individual served may be required to pay for the extended services.

K. Family Support Subsidy Appeals

1. All Family Support Subsidy appeals are handled by the local CMHSP.

2. If a Family Support Subsidy Application is denied or services are terminated, the CMHSP will send the consumer/individual's parent or legal representative a memorandum stating the reason for ineligibility and timeline for an appeal.

3. If the parent or representative had an income increase that resulted in the family exceeding the statutory limit, and the parent or representative did not notify the CMH within two weeks of the change, the CMHSP shall send the parent or representative a memorandum explaining that the subsidy will be terminated, and any amount illegally received will be repaid together with interest as provided in Administrative Rule 330.1621. Repayment of these services will be arranged through the state FSS program.

4. The parent/legal representative has 60 days to file an appeal from the date of the notice of ineligibility or termination. This may be done by letter or by a local Non-Medicaid appeal form available from the local CMHSP.

5. If the parent/legal representative requests an FSS appeal within 60 days, the CMHSP shall conduct an FSS hearing in the manner provided for a contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969

6. Using a "reasonable person" standard, the CMHSP determines if the denial or termination of the subsidy will pose an immediate and adverse impact upon the consumer/individual's health and safety. If so, the CMHSP hears the appeal within one business day. If not, the CMHSP follows the steps below.

   a. Sends parent or legal representative notice of receipt of appeal, indicating the following information about the scheduled hearing:

i. Date, hour, place, and nature of hearing.
ii. Statement of legal authority and jurisdiction under which the hearing is to be held.
iii. Reference to statues and rules involved, and
iv. Short and plain statement of the matters asserted.
v. If the timeline for an appeal was exceeded, sends a response indicating that the appeal was not received within two months of the action, and no further appeal rights are warranted.

L. Record Keeping Requirements:

a. PIHPs shall ensure the maintenance of records for second opinions, local appeals, and copies of State appeals. The PIHP must review the information as part of its ongoing monitoring procedures. The record of each appeal must contain, at a minimum, all of the following information:

i. A general description of the reason for the appeal.
ii. The date and time the appeal was received.
iii. Date and type of adverse benefit determination associated with the appeal.
iv. Whether ABD timeframes were met in providing notice
v. Service(s) related to the appeal.
vi. Whether an expedited appeal review was requested
vii. Whether and expedited appeal request was approved or denied.
viii. Whether expedited appeal timeframes were met (where applicable)
ix. The date of each review or, if applicable, review meeting.
x. Evidence that individuals who made the decisions on appeals were not involved in any previous level of review or decision making, nor are subordinates of any such individual.
xi. Resolution at each level of the appeal, if applicable, including whether original ABD was upheld or not, in full or in part.
xii. Date and time of resolution at each level, where applicable.
xiii. Name of the covered person for whom the appeal was filed.
xiv. If the person had an AHR, and the name of the AHR where applicable.

b. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

M. Performance Improvement

1. Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, LDRC requests/resolutions, MOAHRAdministrative Hearing requests/resolutions, and MDHHS Alternative Dispute Resolution requests/resolutions. This information will be reported and reviewed by the PIHP UM Committee quarterly and provided to the PIHP Director of Quality and Compliance quarterly.

2. Quarterly aggregate reports of appeals data shall be provided by the PIHP

Compliance Manager /PIHP Utilization Management Committee Chair to the PIHP Clinical Performance Team as the PIHP Quality Assurance and Performance Improvement Program (QAPIP) entity for their review and recommendations on any trends or improvement opportunities.

VII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Medicaid Managed Care Rule 42 CFR Parts 432, 433, 438 et al.	X	
Michigan Mental Health Code Act 258 of 1974 as amended	X	Section 100b,409(4),705
MDHHS/PIHP Medicaid Contract and Attachments	X	4.4.1.1 Person Centered Planning Practice Guideline; 6.3.1.1 Grievance & Appeal Technical Requirement Process
MDHHS Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings.	X	
MDHHS/CMHSP General Funds Contract	X	3.1.1 Access System Standards; 6.3.2.1 CMHSP Local Dispute Resolution Process; 6.3.2.2 Family Support Subsidy Program
Family Support Subsidy Act, Public Act 249 of 1983, as amended.	X	
Administrative Procedures Act of 1969, Public Act 306 of 1969	X	Sec. 24.271-24.287.
MDHHS Administrative Rules	X	
MDHHS Policy Hearing Authority Decision #01-0358CMH, and subsequent MDHHS clarifications	X	
CMHPSM Office of Recipient Rights Policy	X	
CMHPSM Culturally and Linguistically Relevant Services Policy	X	
CMHPSM /Limited English Proficiency Policy	X	
CMHPSM Utilization Management Policy	X	
CMHPSM Customer Services Policy	X	
MI Medicaid Provider Manual	X	Coordination of Benefits Chapter; Behavioral Health and Intellectual and Developmental Disabilities

		Supports & Services Chapter
MOAHRMOAHR Administrative Hearings Pamphlet	X	
Section 942 of PA 268 of 2016	X	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	***Policy*** ***Consumer Employment***
Department: Clinical Performance Team	**Local Policy Number (if used)**
Implementation Date (2 weeks from Regional Approval Date)	**Regional Approval Date (date of last CMH board's approval)**

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

I. PURPOSE

To ensure consistency across the region in meeting standards of good clinical practice in respecting and supporting the work preferences and choices of people with severe and persistent mental illness, intellectual and developmental disabilities, and substance use disorders (SUD) while fulfilling the mandates of the Americans with Disabilities Act (ADA) with respect to community integration.

II. REVISION HISTORY

DATE	MODIFICATION
7/24/2014	Policy creation
2/13/2018	Regular review
Will be regional approval date	3-year 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).

IV. POLICY

The CMHPSM recognizes meaningful work to be a basic need and affirms the right of

all consumers/individuals served of public behavioral health services to pursue vocational options of their choice. The CMHPSM, in its contract arrangements with the CMHSPs in the region, shall foster the provision of services and supports that promote meaningful work for consumers/individual served.

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.

Competitive work: In integrated settings means work in the community for which anyone - with or without a disability - can apply and that pays at least minimum wage.

Core Provider: A local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

Meaningful: adding value, or purpose to somebody's life.

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.

Work: Paid employment or other productive activity, such as supported employment, integrated employment, microenterprise, or volunteer jobs.

VI. STANDARDS

A. All consumers/individuals served will be afforded the opportunity to pursue competitive work using Person Centered Planning processes, staff shall educate consumers/individuals served about vocational options and supports available and shall assist consumers/individuals served in pursuing work that is meaningful to consumers/individuals served and aligns with consumer/individual's preferences. The Person Centered Planning process shall provide for ongoing assessment of the consumer/individual's vocational needs.

B. A consumer/individual's options for work must be discussed in the Person Centered Planning process and included in the individual plan of service, with the recognition that some consumers/individuals served may choose volunteering, education/training, or unpaid internships as a means leading to future work.

C. The process of identifying meaningful work shall be directed by the consumer/individual's interests, involvement, and informed choice. The process

shall be sensitive to the consumer/individual's cultural and ethnic preferences and give consideration to them.

D. Vocational choices shall encourage and support the consumer/individual's self-sufficiency. Staff shall provide assistance to consumers/individuals served in ensuring their vocational opportunities are integrated in the community and that wages and benefits are competitive, wherever possible.

E. Staff will ensure consumers/individuals served are linked to accurate and timely information about the continuation of federal and state benefits in preparation for and while they are competitively employed.

F. The CMHSP shall ensure any opportunities consumers/individuals served pursue for which the CMHSP provides services/supports occur in working environments that are accessible to the consumer/individual served and in compliance with applicable state and local standards for occupancy, health and safety.

VI. EXHIBITS

None

VII. REFERENCES

1. Medicaid Managed Specialty Supports and Services Program FY20: Attachment P 7.10.2.6, MDHHS Employment Works! Policy

2. CMHPSM Person Centered Planning Policy

3. CMHPSM Work Performed by Recipients Policy

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	***Policy*** ***Coordination of Integrated Healthcare***
Department: Clinical Performance Team	**Local Policy Number (if used)**
Implementation Date (2 weeks from Regional Approval Date)	**Regional Approval Date (date of last CMH board's approval)**

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

I. PURPOSE

To establish standards for staff to follow in the integration/coordination of behavioral health (mental and substance use disorders) and physical health (primary care and specialty healthcare) services.

II. REVISION HISTORY

DATE	MODIFICATION
10-28-2013	Revised to reflect the new regional entity effective January 1, 2014. Policy was formerly known as Coordination of Primary Care.
10-3-2016	Change title from Coordination of Healthcare to Coordination of Integrated Healthcare. Update language and include coordination with the Medicaid Health Plans
02/20/2020	Standard 3-year review. There were no content changes.
Will be Regional Approval Date	Updates to reflect HIPAA permitted uses and disclosures

III. APPLICATION

This policy applies to all staff, students, volunteers and/or contractual agencies within

the regional provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

The CMHPSM views and serves ~~consumer~~consumers/individuals served~~s~~ holistically, making no artificial separation between mind and body. All services shall be coordinated, collaborative and integrated.

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.

Covered Entity: A health care provider, a health care plan, and or a healthcare clearinghouse. For the purposes of this policy this includes mental health providers.

Health Care Operations: are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.

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).

Medicaid Health Plan (MHP): A licensed health plan selected by the Michigan Department of Health and Human Services to manage the physical healthcare benefits for Medicaid Recipients in Michigan who are enrolled in a Health Maintenance Organization (HMO) as allowed under the Michigan Managed Care Waivers approved by the Center for Medicare and Medicaid Services (CMS).

Payment: encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual[21] and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual.

Primary Care: Services provided by general practitioners or general clinics.

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.

Specialty Health Care: Services provided by medical specialists to treat a specific disease, condition or symptom. Examples may include pediatricians, surgeons, oncologists, cardiologists, podiatrists, OB/GYNs, pain management specialists, addictionologists, and rehabilitation specialists.

Treatment**:** is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.

VI. STANDARDS

A. Under HIPAA laws, providers are permitted, but not required, to use and disclose personal health information (PHI) orally, on paper, by fax, or electronically, for certain activities without first obtaining an individual's authorization. These activities including for the purpose of treatment, payment, and for health care operations of the disclosing entity or the recipient entity when the appropriate relationship exists. This permissible use of information exchanges applies to mental health information.

B. Any sharing of substance use information in relation to care integration services with Primary Care and Specialty Care Providers (PCPs and SCPs) is protected separately under 42CFR Part 2 and **does** require the completion of current and 42CFR Part 2 compliant release of information obtained from the ~~consumer~~consumer/individual served/or legal guardians in accordance with the Confidentiality and Access to ~~Consumer~~Consumer/individual served Records policy.

C. In sharing information that is permissible by HIPAA without a ~~consumer~~consumer/individual served/guardian's authorization, staff will consider what is in the ~~consumer~~consumer/individual's best interest for meeting their care needs, goals, and assuring their health and safety, and ensure this reason and the permissible disclosure is documented in the ~~consumer~~consumer/individual's record.

D. While the ~~consumer~~consumer/individual's written consent is allowed, it is not to be used as a barrier to coordination of care that is permissible by HIPAA and in the best clinical interest of the ~~consumer~~consumer/individual served. In cases where a ~~consumer~~consumer/individual served/guardian objects to such disclosure, staff will discuss these concerns with the ~~consumer~~consumer/individual served/guardian, explain the clinical allowable reason for recommending the sharing of such information, and ensure the ~~consumer~~consumer/individual served/guardian is aware of the decision the entity has made on whether to share the HIPAA permissible information.

E. The appropriate relationship for permissible disclosures of PHI includes:
   1. Both covered entities must have or have had a relationship with the patient (can be a past or present patient)
   2. The PHI requested must pertain to the relationship.
   3. The discloser must disclose only the minimum information necessary for the health care operation at hand. Under HIPAA's minimum necessary provisions, a provider must make reasonable efforts to limit PHI to the minimum necessary to accomplish the

purpose of the use, disclosure or request. (45 CFR 164.502(b)). WILL DELETE

F. Providers receiving the permissible PHI are responsible for safeguarding that PHI and otherwise complying with HIPAA, including with respect to subsequent uses or disclosures or any breaches that occur.

G. ~~All care integration services with Primary Care and Specialty Care Providers (PCPs and SCPs) require the completion of current and appropriate releases of information obtained from the consumer/or legal guardians in accordance with the Confidentiality and Access to Consumer Records policy.~~ All refusals of written consent to release information will be documented in the recipient's clinical record.

H. Information shared for coordination of care that is permissible by HIPAA will be documented in the ~~consumer~~consumer/individual's record.

I. HIPAA permitted uses and disclosures must be addressed in all Notice of Privacy Practices used by providers in the CMHPSM region.

~~A.~~J.

~~B.~~K. Care Coordination activities between the MHPs and the CMHPSM/CMHSPs will occur using the MDHHS Care Connect 360 (CC360) which contains healthcare information concerning mutually served individuals.

a. MDHHS manages the HIPAA requirements of CC360. Information that is available in CC360 may be used for MHP/PIHP Care Coordination activities as required in the MDHHS PIHP and MHP contracts.
b. HOWEVER, data/information not readily available in CC360, such as information related to substance abuse diagnoses and/or treatment, require that the appropriate releases of information obtained from the recipient and/or legal guardians in accordance with the Confidentiality and Access to Consumer Records policy. All refusals of release will be documented in the ~~consumer~~consumer/individual's clinical record.
c. The CMHPSM and the CMHSP will coordinate obtaining necessary releases and the development of the agenda for each Care Coordination meeting with the individual MHPs. In addition, any plans for follow up regarding a mutually served individual shall be included on agendas.
d. MHP/PIHP/CMHSPs will occur at least monthly and mutually served individuals who meet the MDHHS definition as a high risk/high utilizer will be discussed during MHP/PIHP/CMHSP care coordination meetings. An action plan to assist the mutually served individual shall be recorded in CC360.
e. Ongoing monitoring and follow-up shall be incorporated into the Individual Plan of Service (IPOS) including goals and objectives resulting from Care Coordination meetings with the individual's MHP. Progress Notes shall document the steps and activities taken by the PIHP/CMHSP in accordance with the Care Coordination Plan developed with the MHP.

Primary Care Standards

~~C.~~L. The CMHPSM shall ensure that integration with primary care will include the following:

~~1. Staff shall ensure an active signed release of information is secured from the recipient. If the consumer refuses to sign a release, then encouraging this type of coordination will be addressed as part of ongoing treatment.~~

~~2.~~1. Staff will notify primary care physicians (PCPs) when a

~~consumer~~consumer/individual served starts services.

~~3.~~2. Staff shall contact the PCP when a ~~consumer~~consumer/individual served ends services.

~~4.~~3. Staff, when aware, shall inform the PCP when a ~~consumer~~consumer/individual served has an inpatient psychiatric admission.

~~5.~~4. Staff shall notify the PCP of any significant medication changes or lab results when determined to be necessary by a CMHSP physician, nurse practitioner, or nurse.

~~6.~~5. Staff shall initiate and maintain ongoing collaboration with the PCP as part of the treatment planning process in order to ensure coordination of care.

~~7.~~6. Staff shall encourage ~~consumer~~consumers/individuals served~~s~~ to make optimal use of their primary care services by sharing all medical concerns, both major and minor. If a ~~consumer~~consumer/individual served has a PCP but is not utilizing the PCP, staff shall encourage the ~~consumer~~consumer/individual served in making the appropriate contact(s) with the PCP.

~~8.~~7. When a ~~consumer~~consumer/individual served does not have a primary care physician (PCP), staff shall make ongoing efforts to assist in linking the ~~consumer~~consumer/individual served with one.

~~D.~~M. Staff will ensure that the ~~consumer~~consumer/individual's need for primary care services is incorporated into person centered planning and assessments. Any identified need for primary care shall be documented in the ~~consumer~~consumer/individual's individual plan of services. Consultation with physicians and nurses will be made to assist in identifying any medical issues to be addressed by the PCP.

~~E.~~N. If assessed to be potentially beneficial to the ~~consumer~~consumer/individual served, staff shall initiate communication with the PCP when the ~~consumer~~consumer/individual served:

1. Has behavioral health, substance ~~ab~~use, co-occurring and/or physical health concerns. The sharing of substance use information will require a 42CFR Part 2 compliant written release of information.
2. Requires access to specialized medical assessments and services.
3. Has difficulty accessing either or both of the mental and physical healthcare systems.
4. Is referred by their primary care physician or vice-versa.
5. Requires ongoing direct care / home help support for physical conditions.

~~F.~~O. As necessary and where allowable by law, staff shall make efforts to ensure that relevant behavioral health and physical health records are shared by CMHSP and PCP/SCP staff

~~G.~~P. Any physicians, nurse practitioners, or nurses within the CMHSP system may also engage in the following coordination efforts when deemed necessary:

1. Provide consultation to nurses and others regarding the coordination of care between the CMHSP and primary care physicians
2. Provide consultation to nurses and others regarding specific cases in which there are questions regarding medication interactions, interactive effects between psychiatric and physical symptoms and / or changes in status.
3. Assist in the development, review and revision of this policy

4. Provide consultation/training/education to physical healthcare providers in the community as needed or requested

Specialty Medical Healthcare Coordination

~~H.~~Q. The need or involvement of specialty care shall be incorporated into the CMHSP assessment and re-assessment process. Where those needs exist, CMHSP staff will communicate with the primary care physician to determine who will take the lead in coordinating care with specialty health care practitioners.

~~I.~~R. In those instances when CMHSP takes the lead, coordination, collaboration, and integration shall be an integral part of the IPOS.

Coordination between Mental Health and SUD providers

~~J.~~S. The CMHPSM shall ensure that integration between Mental Health and SUD services will include the following:

1. For the exchange of SUD-related information, s~~S~~taff shall ensure an active signed release of information is secured from the ~~consumer~~consumer/individual served that meets all 42CFR Part 2 requirements for the exchange of SUD information. If the ~~consumer~~consumer/individual served refuses to sign a release, then encouraging this type of coordination will be addressed as part of ongoing treatment.

~~1.~~2. For the exchange of physical or mental health related information, such information sharing between providers is permissible under HIPAA for the purposes of treatment or healthcare operations without signed consent.

~~2.~~3. Staff will notify all involved treatment providers when a ~~consumer~~consumer/individual served starts services.

~~3.~~4. Staff shall contact all involved treatment providers when a ~~consumer~~consumer/individual served ends services.

~~4.~~5. Staff, when aware, shall inform all involved treatment providers when a ~~consumer~~consumer/individual served has a significant change in level of care, e.g. hospitalization, residential placement.

~~5.~~6. Staff shall notify all involved treatment providers of any significant medication changes or lab results.

~~6.~~7. Staff shall initiate and maintain ongoing collaboration with all involved treatment providers as part of the treatment planning process in order to ensure coordination of care.

~~7.~~8. Staff shall ensure that the ~~consumer~~consumer/individual's needs for Mental Health or SUD services are incorporated into service planning and assessments. These needs shall be addressed on an ongoing basis in accordance with the ~~consumer~~consumer/individual's readiness for change.

VII. EXHIBITS

None

VIII. REFERENCES

A. Medicaid Managed Care Rules, 42 CFR Part 438, Sub-Part D ~~Balanced Budget Act;~~ Coordination and Continuity of Care Standards 438.208 (b)~~,~~ (c)

B. Health Information Portability and Accountability Act (HIPAA): Privacy of Individually Identifiable Health Information: 45 CFR Part 164

C. Health and Human Service resource documents: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html
~~B.~~D. 42CFR Part 2, Confidentiality of Substance Use Disorder Patient Records
~~C.~~E. Michigan Mental Health Code
~~D.~~F. The Joint Commission Standards
~~E.~~G. MDHHS/ PIHP Contract
~~F.~~H. CMHPSM/CMHSP/SUD Provider Contracts

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	***Policy*** ***Corporate Compliance***
Department: Regional Compliance Committee	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

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

I. PURPOSE

To establish policy that ensures the Community Mental Health Partnership of Southeast Michigan (CMHPSM) complies with all relevant federal, state, and local laws, rules, and regulations and other standards set forth by accrediting organizations and professional licensure requirements.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
1/27/2017	Revised to reflect regional compliance activities.
Will be Regional Approval Date	Scheduled Review. Revised to reflect Compliance Plan.

III. APPLICATION

All CMHPSM officials, employees, board members, students, volunteers, and providers under contract with the CMHPSM network shall be responsible for abiding by all compliance, confidentiality, and ethics standards as set forth in this policy.

IV. POLICY

All staff, board members, students, volunteers, and providers with the CMHPSM network shall comply with all federal, state, and local laws, rules, and regulations

applicable to the region's business lines, as well as other standards set forth by accrediting organizations and professional licensure requirements. Due to the collaborative nature amongst the CMHPSM members, including integrated elements of the data systems, all members of the region shall coordinate efforts to ensure the security and privacy of protected health information, and to ensure compliance with all other applicable regulations, laws, and standards.

V. DEFINITIONS

Abuse: Practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.

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 Programs (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.

Fraud: An intentional deception or misrepresentation by a person with the knowledge that the deception could result in an unauthorized benefit to him/herself or another person. This definition is not meant to limit the meaning of fraud as it is defined under applicable federal or state laws.

Healthcare Information: Any information, whether oral or recorded in any form or medium that: (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and that (b)relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

Protected Health Information (a.k.a. confidential information): All personally identifiable information and material about a consumer/individual served in any form or medium, and the information that an individual is or is not receiving services.

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.

Risk Assessment or Risk Analysis: The process of selecting appropriate measures to protect against particular dangers to computer systems, data, clinical records, and violations of regulatory and compliance standards.

Waste: Inappropriate utilization and/or inefficient use of resources.

VI. Standards

A. CMHPSM and each CMHSP shall ensure the security, privacy, integrity, and confidentiality of all consumer/individual served-related information in accordance with professional ethics and legal requirements.

B. Policies and procedures necessary to ensure compliance with federal, state, and local laws, rules, and regulations are maintained by the regional entity, which issues these policies and procedures to providers within the CMHPSM network.

C. The CMHPSM and each CMHSP shall ensure that their staff, students, and board members receive compliance training that includes state and federal compliance standards and reporting requirements. Such training shall include at a minimum, standards and reporting requirements related to HIPAA, HITECH, federal Medicaid regulations, and state regulations.

D. No director or board member of the CMHPSM, or any person with an employment, consulting, or other arrangement with the CMHPSM, can be a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or anyone who is an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

E. All CMHPSM staff, board members, students, volunteers, and providers are expected to conduct themselves in an ethical manner while performing their duties.

F. Sanctions will be enacted against any employee, board member, student, or volunteer of the CMHPSM or its providers who violates this compliance policy. Sanctions are set forth in the CMHPSM Sanctions for Breaches of Corporate Compliance or Confidentiality policy.

G. All board members shall adhere to the standards in this policy, the CMHPSM Compliance Plan, and other relevant state and federal compliance laws where it applies to their board duties. Any compliance-related issue and/or violation of a compliance standard by a board member shall be reported to the appointing entity. Alleged misconduct will be referred to both the relevant local and CMHPSM boards.

H. Any relevant issue of compliance by/with a board member will be addressed by the local CMH board or respective entity. Any necessary sanctioning of board members will be the responsibility of the appointing body.

I. To ensure compliance, the CMHPSM shall have an individual identified as the CMHPSM's Compliance Officer. The CMHPSM Compliance Officer shall ensure that the CMHPSM expediently investigates any reports of fraud/abuse, maintains data on compliance issues, and reports relevant data to state and federal entities where required. Such investigations shall be the role of the CMHPSM or the local CMHSP designee, as outlined by CMHSP contract/agreement. Investigations that

result in suspected fraud shall be reported to the CMHPSM Compliance Officer using the Michigan Office of Inspector General Fraud Referral Form.

J. Each CMHSP shall have a designated Compliance coordinator identified to take local reports of alleged fraud/abuse, maintain local data, report compliance issues and data to the CMHPSM Compliance Officer, and serve on the CMHPSM Compliance Committee. This CMHSP Compliance role shall be assigned by the CMHSP Director.

K. Reports of alleged fraud/abuse shall be made in accordance with the CMHPSM Compliance Plan, and include at minimum:
- Persons involved (both those affected and those alleged)
- Source of complaint
- Type of provider and service(s) involved
- Nature of complaint
- Approximate dollars involved
- Legal & administrative disposition of the case including any finding(s) and action(s) taken

L. The CMHPSM Compliance Officer shall maintain and provide oversight to a CMHPSM Corporate Compliance Committee with membership appointed by the Regional Operations Committee (ROC). The Corporate Compliance Committee is charged with the development, coordination, and oversight of the CMHPSM's compliance efforts, including:
- Review annual regional compliance audits to ensure adherence with established policies, procedures, and laws. If deficiencies are detected, require submission of corrective action plans and monitoring of said plans.
- Review any changes in law, regulations, or standards and identify any areas of need in organizational policy, procedure, practice, and training.
- Review risk analysis and risk management functions necessary to assure the privacy and security of protected health information.
- Review risk analysis and risk management functions necessary to ensure areas of risk are assessed and corrected in compliance with laws, rules, and regulations.
- Monitor regional plans of correction and make any necessary recommendations, including performance improvement activities/recommendations as a result of assessed areas of need.

The Regional Corporate Compliance Committee is also given authority to assign ad hoc members or use specialized consultants to complete its work.

H. The responsibility for ensuring compliance with the security of health-related information shall be assigned to the Regional Corporate Compliance Committee with membership appointed by the Regional Operations Committee (ROC). The director of each local CMHSP shall appoint a local Security Officer to provide local oversight in ensuring local compliance and information dissemination. Each local CMHSP member of the CMHPSM may also establish a local Compliance/Security committee at their discretion in ensuring local compliance with all laws, rules, regulations, and standards.

I. Reports of the results of all annual compliance audits shall be shared with the ROC, which will assign further implementation of plans of correction to applicable committees.

J. Due to the collaborative nature amongst the CMHPSM members, including integrated elements of the data systems, all members of the region (the PIHP and the CMHSPs) shall coordinate efforts to ensure the security and privacy of protected health information, and shall ensure compliance with all other applicable regulations, laws and standards. External application of standards shall be defined in Chain of Trust Agreements and/or contract language.

VII. EXHIBITS

None

VIII. REFERENCES

A. 45 CFR, Parts 400 and 438 (Balanced Budget Act)
B. 45CFR Part 164 (Health Information Portability and Accountability Act)
C. The Joint Commission Standards
D. MDHHS PIHP Contract
E. MDHHS CMHSP Contract
F. CMHPSM Sanctions for Breaches of Corporate Compliance or Confidentiality Policy
G. CMHPSM Confidentiality and Access to Clinical Records Policy
H. Deficit Reduction Act of 2005
I. Patient Protection and Affordable Care Act of 2010
J. CMHPSM Compliance Plan
K. Federal False Claims Act, 31 U.S.C. §3729
L. Michigan Medicaid False Claims Act, Act 72 of 1977 §§400.601-.615 as amended through 2006

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** ***Peer Review***
Department: Regional Compliance Committee	**Local Policy Number (if used)**
Implementation Date (2 weeks from Regional Approval Date)	**Regional Approval Date (date of last CMH board's approval)**

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

I. PURPOSE

This policy is to define peer review functions as it relates to practice of care of the Community Mental Health Partnership of the Southeast Michigan (CMHPSM).

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity effective January 1, 2014.
6/21/2017	Due for review.
Will be Regional Approval Date	Due for 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).

IV. POLICY

The CMHPSM will identify and correct processes or variations in care/services that may lead toward undesirable or unanticipated events affecting consumers/individuals served or consumer/individual served care. Peer review will be utilized in order to establish evaluation mechanisms for clinical care and service delivery that identify opportunities for improving care.

V. DEFINITIONS

Adverse Event: Events that do not qualify as Sentinel Events but are serious and could identify process improvements. During the process of reviewing an event, the

director/designee will determine if an event is an adverse event when it does not qualify as a Sentinel Event.

Clinical Supervision/Case Conferences: Team meetings and/or regular meetings held by clinical service staff where consumer/individual served care and clinical planning takes place, including peer/supervisor suggestions are given to assist in treatment.

CMHPSM Incident Report: Written reports of unusual incidents related to consumer/individual served care that disrupts or adversely affects the course of treatment or care of an individual consumer/individual served or the program caring for others.

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.

Peer: Any physician/psychiatrist, social worker, psychologist, nurse, nurse practitioner and/or other clinical professionals who meet basic qualifications with clinical experience and training to provide an evaluation of a specific significant issue or general case or process review. The peer(s) involved in the review shall have the same license/credentials as the person or persons involved in the event or service process.

Peer Review: A process in which mental health/substance use disorder professionals evaluate the clinical competence and quality and appropriateness of care/services provided to consumers/individuals served. The review may focus on an individual event or aggregate data and information on clinical practices. These processes are confidential in accordance with section 748(9) of the Mental Health Code Act 258 of 1974.

Performance Improvement: A systematic way of addressing improvement opportunities that involve the use of soft (facilitation techniques, problem solving processes) and hard (data analysis, statistical tests) skills to understand, recommend and implement change.

Regional and Internal Clinical Review Process: A process with identified and trained staff that performs case reviews of the consumer/individual served PCP and the clinical services being delivered.

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.

Root Cause Analysis: A process for identifying the basic or causal factors that underlies variation in performance, including the occurrence, or possible occurrence, of a sentinel event.

Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome, i.e if the event had continued or were to recur, the individual would risk death or major permanent loss of function.

Utilization Review: Analysis of the patterns of service authorization decisions and service usage in order to determine the means for increasing the value of services provided (minimize cost and maximize effectiveness/appropriateness).

VI. STANDARDS

A. The CMHPSM declares that the following business functions and analysis are all defined as Peer Review Functions:

1. Sentinel or Adverse Event Reports/Root Cause Analysis
2. CMHPSM Incident Reports and Data
3. Critical Event Data
4. Regional and Internal Clinical Reviews
5. Internal Ethics Consultation
6. Case Conferencing and Clinical Supervision or Team Meetings
7. Utilization Review

B. In accordance to the Michigan Mental Health Code 330.1143a, the Administrative Rules R 330.7046, Public Health Code Act 368 of 1978 Section 333.20175 & 333.21515, all records and information obtained during Peer Review Functions are confidential and shall be used only for the purpose of reviewing the quality and appropriateness of care for improved practices. All documents created during and as a result of the Peer Review Functions shall not be public record or available through the Freedom of Information Act (FOIA) and are not subject to court subpoena.

C. Reports or Forms completed as a part of a peer review process shall be kept as peer review documents and shall not be kept as a part of a consumer/individual served clinical record. A summary of the incident (reported on the form/report) shall be included in the consumer/individual's clinical record for any consumer/individual served involved in accordance with the requirements of the Administrative Rules 330.7046.

D. Incident report information shall be maintained in a database and reports kept separate from the clinical record.

E. Peer Review Process analysis of events or clinical practices shall be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and/or national standards.

F. Risk Management and Corporate Counsel shall be consulted as needed during any peer review function.

G. Peer Review Functions/Processes shall adhere to all laws and policies including the reporting of any disciplinary action taken by an agency/organization against a health professional licensed or registered in the state that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. "Adversely affects" means the reduction, restriction, suspension revocation, denial or failure to review the clinical privileges of a licensee or registrant.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	330.1143a
Administrative Rules	X	R 330.7046
Michigan Compliance Laws- Public Health Act 368 of 1978	X	333.20175 & 333.21515
The Joint Commission	X	Sentinel Events, Performance Improvement
MDHHS Medicaid Contract	X	Health and Safety 2.7
Division of Adult Foster Care Licensing: Adult Foster Care Small Group Homes	X	R 400.14311
CMHPSM Critical Incident, Sentinel Event and Risk Event Policy	X	

IX. PROCEDURES

None

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH CONSUMER ADVISORY COUNCIL MEETING – Minutes

September 8, 2021

Members Present on the Call: Pam Rathbun (president), Jason Zurawski (secretary), Barb Higman, Alayna Manzanares, Lisa Porzondek, Melissa Vaden.
Staff: Mert Hershberger.
Guests: Rep. Yousef Rabhi (state legislator), Alexi Chapin-Smith (legislative aide), Mark Creekmore (NAMI-Washtenaw), Leo Hanifin (potential member)
Members Absent: Ed Howlett

I. Meeting called to order at: _ 12:30__ pm _.
MOTION BY _ Melissa _ - SUPPORTED BY _Barb _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) CONSUMER ADVISORY COUNCIL (CAC) CONSENT AGENDA with amendment. MOTION CARRIED.

II. **Melissa:** She shared her story successfully, emphasizing the role of DBT and the PLEASE set of skills in her presentation. She is hoping to refine her skills in speaking and presenting to classes over time.

III. **Representative Yousef Rabhi and aide Alexi Chapin-Smith:** Talked about the various merits or demerits seen in the Whiteford and Sherkey plans in the state legislature and the lack of feedback from the governor. Rep. Rabhi emphasized his desire for a one payor system and the importance of keeping publicly-funded mental health care publicly accountable. Both talked about the risks of entrusting all public mental health dollars into the care of private HMOs.

IV. **Walk-A-Mile in My Shoes online Rally.** "keeping mental health care affordable and accessible while maintaining the priorities of the recipients." Lisa as speaker. Sally reported that the Administration would not be able to support a large group going to Lansing due to the Delta Variant of COVID.

V. **Story Jam with NAMI and Speaker's Bureau** (Speaker's Bureau meeting postponed to Sunday, October 3, 2021 5pm Paesano's on Washtenaw just West of Arborland.)

a. **Mark Creekmore presented the idea of partnering between NAMI-Story Jams and Avalon Vocal.** Telling a story specifically for an "ask" for specific help. Whereas as the Speaker's Bureau is more oriented around reducing stigma and helping others understand what it is like to live with mental illness and how to have hope in the midst. Story Jams are for 2-3 minute long stories. WC-CMH is revising its Strategic Plan and NAMI is seeking how to improve the functioning of CMH. Possible craft or skill teaching groups like Melissa had mentioned regarding cards. Melissa mentioned having different therapies: introducing new options that are evidence based that work for individuals.

VI. **Newsletter:** Mert emailed out the newsletter Tuesday. Let's start on a new newsletter. Barb mentioned possibly writing more on the history of Mental Health Care in Washtenaw County.

VII. **NAMI Walks: August 28, 2021 on Belle Isle.** Barb to report: $6,000 raised. Still accepting donations. It was a fun day. Local walk next year.

VIII. **Celebration of Success:** Mert will resend a reach-out to Sally to find out the numbers and date. Mert will solicit proposals for Card content for the cards that Melissa is making.

IX. **Fresh Start**: Melissa reported no significant change. Mert reported on a series by the CMH-Health & Wellness Team on various topics related to Health & Wellness. Through the first part of October on Wednesdays.

X. **Additional members to suggest**: Leo Hanifin, peer with the CARES Team at 750 Towner (May be interested in helping with 2-D graphic arts, for example with the state-wide CMH art show, and the partnership with NAMI Story Jams mentioned.

XI. **Meeting adjourned at _2pm_ motion by _Alayna _ supported by _everyone else_.**

The next meeting will be October 13, 2021 via Zoom at 12:30pm. (Please log in by 12:20pm to make sure we are all ready to participate by 12:30pm.)

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH CONSUMER ADVISORY COUNCIL MEETING – MINUTES

October 13, 2021

Members Present on the Call: Pam Rathbun (president), Jason Zurawski (secretary), Leo Hanifin, Barb Higman, Alayna Manzanares, Lisa Porzondek, Melissa Vaden.
Staff: Mert Hershberger (Liaison), Sally Amos-O'Neal (Director of Customer Service).
Members Absent: Ed Howlett.

I. Meeting called to order at: _ 12:30_ pm _.

MOTION BY _ Jason_ - SUPPORTED BY _Alayna _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) CONSUMER ADVISORY COUNCIL (CAC) CONSENT AGENDA. MOTION CARRIED.

II. Barb reported that over $7,000 has been raised by **NAMI Walks for NAMI-Washtenaw**.

III. Walk-A-Mile in My Shoes online Rally: Lisa, Darren, Cristobal, 1 consumer, and Mert went; Lisa spoke. Event was abbreviated. Lisa and Darren were interviewed by Channel 7.

IV. **Story Jam with NAMI & Speaker's Bureau & Avalon (Formally lead by the WC-CMH-CAC)** Barb led the discussion with a little help from Mert. She has a flyer that will be sent out to various groups and through peers at CMH and other venues. Barb will finish editing the flyer and then send it to the CAC. Mert will forward it to CMH peers and l-cmh. It will be over Zoom. Either Tuesdays, Oct 26 and Nov 2 in the afternoon, or Wednesdays, Oct 27 and Nov 3 in the evening.

V. Newsletter: Barb is almost finished writing an article on the history of mental health care in Washtenaw County. Lisa is planning to write for the winter edition on MiAble accounts that allow those on disability by an early enough time to set aside $15,000/year into an account for any personal living expenses.

VI. **Celebration of Success:** Sally reported 11 nominations thus far for the Celebration, hopefully a few more will come in. Melissa did a great job on cards. Mert will deliver them. A pre-recorded event will launch on Wednesday, November 17, 2021 at 5:30 via Facebook. The goal will be to have nominators read the accolades and record them by the first weekend in November and the recording edited by the next week.

VII. **Fresh Start**: Sally reported: Fresh start is still operating virtually, and now at the Club Hub at 2140 Ellsworth with limited capacity.

VIII. **Art Show plans**: Limit 2 submissions per artist from Washtenaw CMH, of those 3 will be sent on to the region along with 3 from each of the other 3 counties. Then 2 works of art will go from our region to the state, each of these two finalist artists will receive $100. Art not sent to the region will be returned to the artists. Artwork that reached the region but not to the state will get recognition by being posted around the facilities of CMH.

IX. **Additional members to suggest**: Leo Hanifin, peer with the CARES Team at 750 Towner, was unanimously welcomed onto the council. Mert will send him the accompanying paperwork.

X. **Meeting adjourned at _1:29 pm_ motion by _Alayna _ supported by _Lisa, and all cheered the accomplishments _.**

The next meeting will be November 10, 2021 via Zoom at 12:30pm. (Please log in by 12:20pm to make sure we are all ready to participate by 12:30pm.)

Washtenaw County Community Mental Health
Millage and CCBHC Grants Budget to Actuals
For Nine Months Ending September 30, 2021

Millage Budget

	Annual Budget	Budget YTD	YTD Actual	YTD Actual O/(U) YTD Budget
Millage Revenue				
Millage	$ 6,565,388	$ 4,924,041	$ 6,757,986	$ 1,833,945
Millage Interest Revenue	-	-	24,545	24,545
Millage GASB31 Adjustment	-	-	(73,911)	(73,911)
	$ 6,565,388	$ 4,924,041	$ 6,708,620	$ 1,784,579
Millage Expenses				
Salary	$ 2,395,000	$ 1,796,250	$ 1,355,898	$ (440,352)
Fringe	1,339,513	1,004,635	692,942	(311,693)
Contractors	1,500,000	1,125,000	926,396	(198,604)
Trainings	140,000	105,000	4,600	(100,400)
Operating Expenses	782,500	586,875	306,183	(280,692)
Fleet Charges	60,000	45,000	9,269	(35,731)
Client Care	78,500	58,875	64,769	5,894
Cost Allocation Plan	70,875	53,156	210,532	157,376
Furniture & Equipment	100,000	75,000	-	(75,000)
Depreciation Expense	10,000	7,500	-	(7,500)
Telephone	50,000	37,500	19,017	(18,483)
All Other Expenses	39,000	29,250	9,258	(19,992)
Total Millage Expenses	$ 6,565,388	$ 4,924,041	$ 3,598,863	$ (1,325,178)
Revenue Over/(Under) Expenses		-	3,109,757	3,109,757
	-			

*** 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	$ 1,688,228	$ 1,544,296	$ (143,932)
CCBHC #2 - Year 2 Grant Expenses				
Salary	$ 1,166,672	$ 875,004	$ 815,495	$ (59,509)
Fringe	765,442	574,082	458,936	(115,146)
Trainings	9,660	7,245	-	(7,245)
Telephone	16,050	12,038	9,624	(2,413)
Operating Supplies	22,263	16,697	130,472	113,774
Client Care	66,250	49,688	1,167	(48,521)
Indirect Costs	204,634	153,475	128,603	(24,873)
Total Expenses	$ 2,250,971	$ 1,688,228	$ 1,544,296	$ (143,932)
Revenue Over/(Under) Expenses	(0)	-	-	-

ACTION REQUESTED: To approve the following contract(s):

BACKGROUND:

1. Washtenaw Health Plan (WHP): will coordinate and expand mental health services to WHP members, expand existing provider capacity, and will provide outreach, communication, insurance navigation and connection to services in the Latinx and youth communities.

Service Contracts

Contractor	Funding	Estimated Budget	Contract Term	Service Description
1. Washtenaw Health Plan	Millage	$165,000	October 1, 2021-September 30, 2022	See above for service description

RECOMMENDATIONS: To approve the contract(s) listed above.

Executive Director Contract Authorizations
November 2021 Finance Committee Meeting

ACTION REQUESTED: Acceptance of the Executive Director's signature on contracts with a value of less that $25,000

Contracts

Contractor	Amount	Term	Purpose	Approval Date
JCJ Contracting	$3,438	9/10/21-9/30/21	Driveway Repair	

Recommendation: Acceptance

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
October 13, 2021
***Meeting held electronically via Zoom**

Members Present: (physical location) Judy Ackley (Palmyra, MI), Greg Adams (Adrian, MI), Roxanne Garber (Howell, MI), Sandra Libstorff (Monroe, MI), Molly Welch Marahar (Ann Arbor, MI), Randy Richardville (Monroe, MI), Sharon Slaton (Brighton Township, MI), Ralph Tillotson (Adrian, MI)

Members Absent: Susan Fortney, Bob King, Katie Scott, Mary Serio

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

Guests Present:

I. Call to Order
Meeting called to order at 6:01 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. Garber, supported by G. Adams, to approve the agenda
Motion carried
Voice vote, no nays

IV. Consideration to Approve the Minutes of the September 8, 2021 Regular Meeting and Waive the Reading Thereof
Motion by R. Garber, supported by M. Welch Marahar, to approve the minutes of the September 8, 2021 regular meeting and waive the reading thereof
Motion carried
Voice vote, no nays

V. Audience Participation
None

VI. Election of Board Officers
Motion by R. Garber, supported by M. Welch Marahar, approve the following slate of officers for FY22
- **Chair: Sharon Slaton**
- **Vice-Chair: Judy Ackley**
- **Secretary: Sandy Libstorff**

Motion carried

Vote
Yes: Ackley, Adams, Garber, Libstorff, Welch Marahar, Richardville, Slaton, Tillotson
No:
Absent: Fortney, King, Scott, Serio

VII. Old Business
a. Board Review – October Finance Report – FY2021 as of August 31st
- M. Berg presented.

VIII. New Business
a. Board Action – Proclamation for Dr. Caroline Richardson
Motion by R. Tillotson, supported by M. Welch Marahar, to authorize the CMHPSM Board Chair to sign the proclamation recognizing Dr. Richardson
Motion carried
Voice vote, no nays

b. Board Action – Provider $2.35 Premium Pay Passthrough
Motion by M. Welch Marahar, supported by R. Garber, to approve the pass-through funding to include $2.35/hour plus employer expenses for premium pay eligible services delivered in FY2022. State appropriated pass-through funding was included in the recently approved State of Michigan FY2022 budget
Motion carried
Vote
Yes: Ackley, Adams, Garber, Libstorff, Welch Marahar, Richardville, Slaton, Tillotson
No:
Absent: Fortney, King, Scott, Serio

c. Board Action – Contracts
Motion by G. Adams, supported by M. Welch Marahar, to authorize the CEO to execute additional COVID FY2022 Block Grant funds, as well as the Women's Specialty Services (WSS) funds as presented contracts list
Motion carried
Vote
Yes: Ackley, Adams, Garber, Libstorff, Welch Marahar, Richardville, Slaton, Tillotson
No:
Absent: Fortney, King, Scott, Serio

d. Board Information – Signed Contracts Within CEO Authority
- J. Colaianne shared the details of the termination fee for the Mutual of Omaha service.

IX. Reports to the CMHPSM Board
a. Report from the SUD Oversight Policy Board (OPB)
- N. Adelman provided an overview of the September OPB meeting. OPB primarily reviewed FY22 block grant funding allocations. OPB plans to issue a resolution regarding the behavior health redesign proposals.

b. SUD Media Campaign Videos

- The region is relaunching the naloxone and stories of recoveries campaigns to spread the message of recovery. The campaigns will be released via Facebook, Pandora and at gas stations.

c. Strategic Plan FY2021 Q4 Metrics Report
   - J. Colaianne provided a status update.

d. 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.

X. Adjournment

Motion by M. Welch Marahar, supported by G. Adams, to adjourn the meeting
Motion carried

Meeting adjourned at 6:41 p.m.

_____
Sandra Libstorff, CMHPSM Board Secretary

A RESOLUTION APPOINTING A MEMBER TO THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD

WASHTENAW COUNTY BOARD OF COMMISSIONERS

November 3, 2021

WHEREAS, the Washtenaw Community Health Organization Board was established to provide an integrated health care delivery system to provide mental health, substance abuse and primary and specialty health care to Medicaid, low income and indigent consumers as defined by the Mental Health Code and Medicaid Eligibility Guidelines; and

WHEREAS, the Washtenaw County Board of Commissioners has approved the creation of a Washtenaw County Community Mental Health (CMH) Board (15-0136); and

WHEREAS, the Washtenaw County CMH Board will be comprised of 12 members, appointed by the Board of Commissioners and must meet the following composition requirements:

- At least 1/3 of the membership shall be primary consumers or family members, and of that 1/3 at least 1/2 of those members shall be primary consumers.
- Not more than 4 members of a board may be County Commissioners.
- Not more than 1/2 of the total board members may be state, county, or local public officials

WHEREAS, a primary consumer is an individual who has received or is receiving services from the Department of Community Health or a community health services program or services from the private sector equivalent to those offered by the Department of Community Health or a Community Mental Health Program; and

WHEREAS, one vacancy exists from the following sectors: University of Michigan Health System

NOW THEREFORE BE IT RESOLVED that the Washtenaw County Board of Commissioners hereby appoints the following members to the Washtenaw County Community Mental Health Board:

Name	Representation	Expiration	Predecessor
Alfreda Rooks	University of Michigan	March 31, 2022	Caroline Richardson

Washtenaw County Community Mental Health

Fiscal Year 2022 Budget Amendment Details

November 2021

REVENUES:

Medicaid:

- PIHP Revenue has been updated to reflect the budgeted amounts reflected in the FY22 PIHP Budget.
- Overall, the capitation reflects a $610,366 increase over the original WCCMH FY22 Budget.
- A "Direct Care Worker Pass-Through" category has been added to reflect the anticipated funding needed for this effort.
- A "CCBHC Supplementary" category has been added as a placeholder pending further analysis of CCBHC revenue.

Other:

- Small adjustments to other categories are incorporated to reflect the most up to date information.

EXPENSES:

CCBHC Expenses:

- CCBHC expense recognition is still being determined as management works to understand the costing/reporting requirements, EMR updates and impacts to existing millage/CCBHC grant funding splits.

Contracted Services:

- Updates to contracted services to reflect the anticipated cost of the "Direct Care Worker Pass-Through" effort.

Other:

- Small adjustments to other categories are incorporated to reflect the most up to date information.

Washtenaw County Community Mental Health
Fiscal Year 2022
Proposed Budget Amendment

	FY 2022 Original Budget	FY 2022 Amended Budget	Amended Over/(Under) Original Budget
Operating Revenue			
PIHP Revenue			
Medicaid Capitation:			
Medicaid (b) & 1115i	$ 43,503,203	$ 44,526,405	$ 1,023,202
HSW	25,102,700	25,368,146	265,446
Children & SED Waivers	894,097	1,044,210	150,113
Healthy Michigan Capitation	7,000,000	6,284,882	(715,118)
Autism Capitation	6,000,000	5,886,723	(113,277)
Direct Care Worker Pass-Through	-	8,020,332	8,020,332
CCBHC Supplementary	-	2,000,000	2,000,000
TOTAL PIHP Revenue	$ 82,500,000	$ 93,130,698	$ 10,630,698
MDHHS Revenue			
State General Funds	$ 4,235,050	$ 4,235,050	$ -
Grants & Earned Contracts	1,779,812	1,790,168	10,356
All Other Revenue			
County Appropriation	$ 1,748,770	$ 1,751,761	$ 2,991
Project Revenue	847,984	847,984	-
All Other	1,917,652	1,917,652	-
TOTAL Operating Revenue	**$ 93,029,268**	**$ 103,673,313**	**$ 10,644,045**
Operating Expenses			
Administrative Expenses			
General Administration	$ 6,279,421	$ 6,279,421	$ -
Program Administration	3,304,826	3,304,826	-
Residential Services			
Community Living Supports	$ 26,750,000	$ 31,543,612	$ 4,793,612
Licensed Residential	13,000,000	15,755,397	2,755,397
Outpatient Services			
Autism Services	$ 5,520,000	$ 5,732,206	$ 212,206
Case Management	4,758,950	4,758,950	-
Supports Coordination	2,806,291	2,806,291	-
Skill Building	4,294,135	4,462,153	168,018
Supported Employment	1,463,965	1,463,965	-
Psychiatry	2,861,899	2,861,899	-
Nursing Services	2,281,750	2,281,750	-
Therapy Services	2,088,044	2,088,044	-
All Other	8,457,337	9,161,793	704,456
CCBHC Services	-	2,000,000	2,000,000
Other Expenses			
Community Inpatient	$ 6,100,000	$ 6,100,000	$ -
Local Matches & Shelter	1,282,838	1,282,838	-
Grants & Earned Contracts	1,779,812	1,790,168	10,356
TOTAL Operating Expenses	**$ 93,029,268**	**$ 103,673,313**	**$ 10,644,045**
Revenue Over/(Under) Expenses	-	-	-

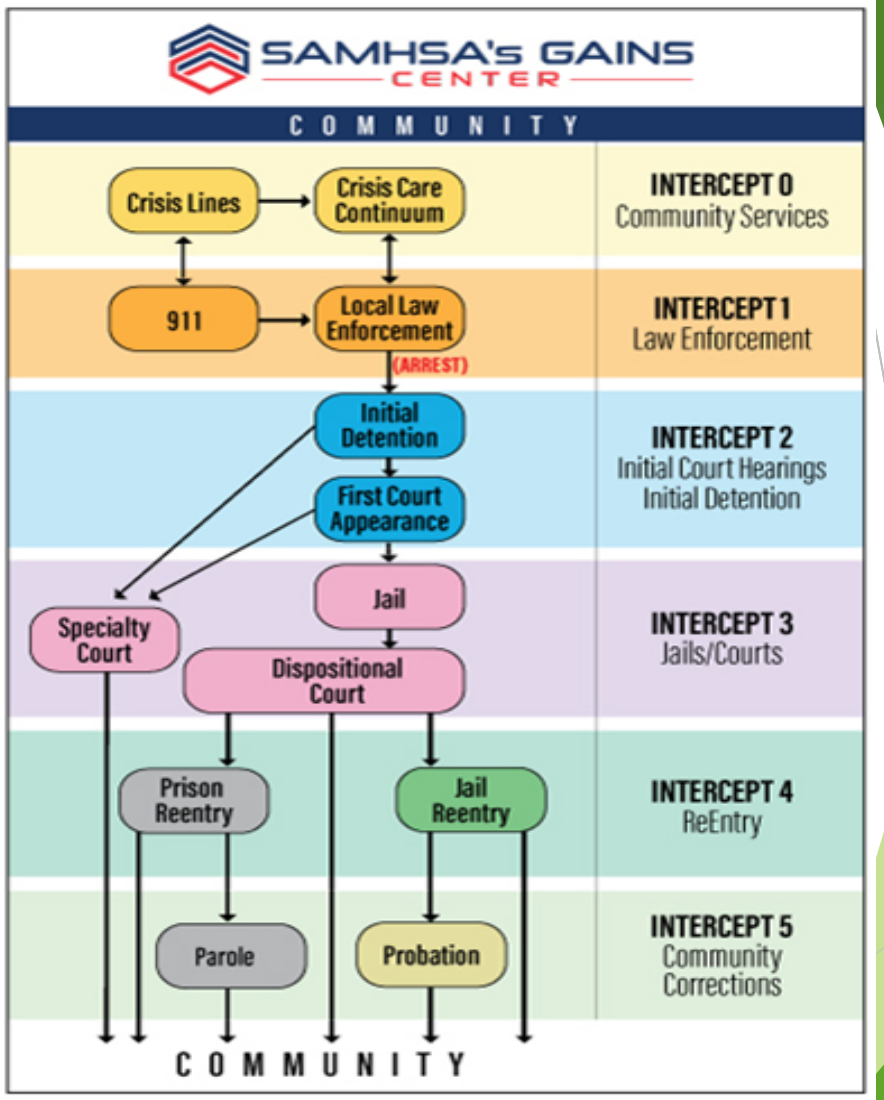
ATTACHMENT #8
NOVEMBER 2021

WCCMH & WCSO Collaboration Update:

Sequential Intercept Map Enhancements

Sheriff Clayton, Trish Cortes, Lisa Gentz

Sequential Intercept Map Review



What have we done?

Intercept 0
Community Services

Enhancements
- SURE
- Outreach Team

WCSO Post-Millage
- WeLIVE
- SURE expansion
- Outreach Team Expansion (LEADD, Reentry, WeLIVE)

WCCMH Millage
Enhancements Adult
- Expanded Mobile Crisis Team
- CARES
- 750

Enhancement Juvenile
- Expanded Mobile Crisis
- CARES
- 31 N. Social worker
- First Contact/Assessment Center Technical Assistance
- LEAD CSM

Intercept 1
Law Enforcement

Cultural Shift
- Engagement focus
- Problem based

Training
- MIIS

Tools
- 24-7 Crisis Line

WCSO Post-Millage
- MIIS Expansion
- LEADD
- Vital Strategies Grant
- *Countywide CIT*
- *Diversion Deputy*

WCCMH Millage
Enhancements Adult and Juvenile
- CMH/CNT
- Crisis Team available for LE co-response

Intercept 2
Initial Detention/ Initial Hearing

Enhancements
- Pre arraignment risk assessment by CSL's

WCCMH Millage
Enhancements Juvenile
- CMH staff embedded at Youth Center

Intercept 3
Jails/Courts

Enhancements
- Jail programming evaluation
- ITR Outreach
- MH service expansion
- MRT
- Empowering Services
- MAT program
- Naloxone kits
- Screening & Assessments

Training
- SIM

WCSO Post-Millage
- *MH Unit*
- *MH Unit Manager*
- *Programming Card*

WCCMH Millage
Enhancements Adult
- CMH provider MH and Sobriety Courts

Enhancements Juvenile
- CMH staff embedded at Youth Center

Intercept 4
Reentry

Cultural Shift
- Reentry for all

Model Selection
- TJC
- NIC Evaluation

Enhancements
- MH redesign
- Education redesign
- SUD services
- Discharge planning
- Interdisciplinary team meeting

WCSO Post-Millage
- Reentry Coord.
- Reentry Case Mgrs.
- Reentry Peers
- IRI Grant/Housing Vouchers

WCCMH Millage
Enhancements Adult
- Re-entry team member
- Service connection while in custody
- Peer supports connection

Enhancement Juvenile
- Service connection while in custody

Intercept 5
Community Corrections

Enhancements
- Peer2Peer
- Anger Management
- Vocational Cert
- Pretrial Program expansion
- Electronic Monitoring
- MRT
- SUD services

WCSO Post-Millage
- *BH Specialist*
- Supervision Agent
- CSL
- Drug Testing Agent
- Admin Assistant

Additional Opportunities Adult System

Intercept 0

- LE Drop off at 750

Intercept 1

- Coordinated Response
- Co-Response
- Dispatch Training

Intercept 2 and 3

- Focus of the Diversion Council
- Boundary Spanners-provide system wide coordination between criminal legal system and the treatment system

Intercept 4

- Housing Connection

Additional Opportunities Juveniles

Intercept 0

- First Contact Program/Assessment Center- focus on prevention, support connection, wrap around family support, chronic absenteeism and law enforcement diversion for status offenses

Intercept 1

- Coordinated Response
- Co-Response
- Dispatch Training
- First Contact Program/Assessment Center

Intercept 2

- Assessment Center

Questions?

Strategic Planning Guiding Document Contents

- Current Mission Statement
- Proposed Mission Statement
- Environmental Drivers
- Strategic Planning Process
- CHRT Report
- Unite Report
- Current Strategic WCCMH Plan*
- Current Strategic County/WCCMH Millage Plan*

*Attached to version one and will be attached to the final

WCCMH Mission, Vision and Values

CURRENT MISSION 2017-2022

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

PROPOSED MISSION 1

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

PROPOSED MISSION 2

To promote hope, recovery, resilience and advance health equity in Washtenaw County by providing, high quality, integrated behavioral health services to adults and youths with intellectual/development disabilities, mental health and/or substance use needs. ~~individuals.~~

VISION

All residents can secure supports to improve their quality of life and reach their full potential.

VALUES

Excellence

We provide the highest level of service to promote recovery, quality of life and self-sufficiency through proven and innovative practices. We recognize that the foundation of excellent service is our relationships.

Growth

We believe in the capacity for change at every stage of development. We grow through shared learning, lived experiences and mentoring.

Well-being

We cultivate well-being through a commitment to physical and emotional safety, active listening, and a culture of appreciation.

Inclusion

Together we build a welcoming, respectful environment for all people. Through active engagement and shared decision-making, we build a stronger community.

Community

We develop strong, trusting partnerships with the people we serve, in our broader community, and within our own organization while advancing health equity.

Accountability

We are accountable to those we serve, to the larger community, and to each other for the equitable, ~~ethical~~, effective, and efficient use of our resources.

Environmental Drivers

Access to Care

- Shortage of staff statewide with long waiting times and difficulty in accessing care or needs not getting met due to decreased staffing
- CMH system reform efforts are being driven by concerns about access and inconsistent statewide availability of services - encouraged to find ways to increase/improve access
- Access to youth behavioral health services
- A severe statewide psychiatric hospital bed shortage with long waits for care
- A lack of a single point of access for all behavioral health services including substance use disorders

Performance/Quality

- Uneven metrics/performance by PHIPs and pressure from MCOs to shift payment from PIHPs to MCOs with competing bills in the legislature from Shirkey and Whiteford
- Current CMH system collects a lot of data but lacks a clear dashboard of metrics for accountability and performance
- State rate setting efforts expected to put emphasis on cost efficiency and effectiveness etc.

Expansion of Services

- Federal expansion of mental health funding and designation of Michigan at a CCBHC state and recently approved funding in Michigan state budget
- Passage of millage since the last strategic plan that shifted focus from exclusively mandated services for “eligible” individuals to comprehensive services for the general community
- Greater need for focus on prevention, early intervention and community education

Other Drivers

- Inconsistency of support for Behavioral Health services by the State of Michigan
- Importance of telemedicine and the infrastructure to support it (i.e. broadband internet, county infrastructure and internet)
- Workforce recruitment and retention challenges
- The pandemic has forced isolation and created other stresses.
- Racial and economic disparities in health status and in access to health care have become more obvious as people of color and lower income people bore disproportionate risks from COVID.
- Excessive use of force and underutilization of behavioral science principles on the part of police officers and especially in interactions of white officers and citizens of color have led to a growing public chorus for reform of how society deals with people in crisis.

Strategic planning proposed process for discussion purposes:

I. Review and modify the Mission and Vision statements

II. Proposed Timeline/Process
- Environmental Assessment (June – August)
- CHRT Gap Analysis (August – September)
- Develop strategies and priorities (October – December)
- Board and MAC Input and Approval (January)

III. Public Stakeholder Input/Outreach (July -October)
- Consumer Advisory
- Recipient Rights Advisory Committee
- Provider Network including local hospital systems
- Staff (Survey)
- Community Stakeholders
    i. Millage Advisory Committee
    ii. CHRT Preliminary Interviews for Gap Analysis
        a. PES, ROSC Provider, Coordinating Agency, Avalon, MDHHS Medical Director, Chair of Psychiatry of Michigan Medicine, NAMI

IV. Implement Strategies

V. Report on progress towards strategies

VI. Evaluate based on performance measures

Strategic Planning Guiding Document 2021

Millage Advisory Committee (MAC) (meets monthly)		
Nancy Graebner-Chair	3/31/2024	WCCMH Board (St. Joseph Mercy Hospital)
Barb Higman	3/31/2023	WCCMH Board (Primary Consumer)
Ricky Jefferson	3/31/2023	WCCMH Board (Board of Commissioners)
Bob King	3/31/2022	WCCMH Board (Member at Large)
Andy LaBarre	3/31/2022	WCCMH Board (Board of Commissioners)
Marianne Udow-Phillips	3/31/2024	WCCMH Board (Community Member)
Kari Walker	3/31/2024	WCCMH Board (Secondary Consumer)
Amanda Carlisle	3/31/2022	Washtenaw Housing Alliance
Holly Heaviland	3/31/2024	Washtenaw Intermediate School District
Derrick Jackson	3/31/2023	Washtenaw County Sheriff's Office
John Martin	3/31/2024	Community Member
Ray Rion	3/31/2023	Packard Health
George Waddles	3/31/2022	Community Member

Strategic Planning Guiding Document 2021

ATTACHMENT #9
NOVEMBER 2021

CHRT

Mental health services in Washtenaw County

Recent progress and remaining challenges

NOVEMBER 18, 2021

CENTER FOR HEALTH
AND RESEARCH
TRANSFORMATION

2929 Plymouth Rd, Ste 245,
Ann Arbor, MI 48105
734 998-7555
chrt-info@umich.edu

CHRT.ORG

CHRT

MENTAL HEALTH SERVICES IN WASHTENAW COUNTY

Introduction

In recent years, four major system-level changes have taken place in the financing of and demand for behavioral health services in Washtenaw County. These system changes shape individuals' experiences with the behavioral health system today. First, when the state expanded Medicaid coverage in 2014, the state legislature reduced general funds for community mental health service providers by approximately sixty percent. This reduction in funding led to severely reduced behavioral health services for individuals not covered by Medicaid.[1] Washtenaw County Community Mental Health (WCCMH) had to send many individuals with Medicare or private coverage to community providers for their services, and appropriate specialty providers were hard to find because of the high patient acuity levels.

Second, in November 2017, the Washtenaw County Public Safety and Mental Health Preservation Millage (the millage) passed, generating $5-6 million dollars in annual funding for mental health services, with programming starting in 2019. The millage programming focuses on prevention, crisis care, stabilization, and diversion services, regardless of an individual's insurance status.

Third, in 2018 the WCCMH was awarded a Certified Community Behavioral Health Clinic (CCBHC) expansion grant to deliver a wide range of behavioral health services targeted to uninsured and underinsured residents with serious mental illness, serious emotional disturbances, substance use disorders and co-occurring disorders. In 2020 Michigan became a CCBHC demonstration state,[2] and in October 2021 the WCCMH was identified as one of 13 CCBHCs to receive prospective cost-based Medicaid reimbursement for CCBHC services.

Finally, in addition to these financing changes, the COVID-19 pandemic that started in early 2020 has caused a notable rise in the prevalence of behavioral health disorders and has exacerbated a shortage of healthcare workers, especially in inpatient settings.[3] The pandemic has also had a disproportionately negative impact on health outcomes for people of color.[4] Medicaid enrollment is much higher during the pandemic due to both job loss and to maintenance of eligibility requirements during the public health emergency that retain higher numbers of individuals in the program. In Washtenaw County, enrollment in the Healthy Michigan Plan in October 2021 was 44% higher than in December of 2019 [see Appendix II]. Among other things this may expand the numbers of people qualifying for CMH services and may change the ways that many behavioral health services are delivered, such as increased use of telehealth services.[5]

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[1] Community Mental Health Association of Michigan, 2019. The perfect storm for fiscal distress in Michigan's mental health system: The convergence of revenue and demand factors leading to the current fiscal stress in Michigan's public mental health system https://cmham.org/wp-content/uploads/2019/10/Perfect-storm-for-fiscal-distress-in-Michigans-public-mental-health-system-revised-10.1.2019.pdf

[2] Certified Community Behavioral Health Clinics (CCBHCs) https://chrt.org/wp-content/uploads/2021/01/CCBHCs-An-Overview_FINAL.pdf

[3] Nirmita Panchal , Rabah Kamal , Cynthia Cox Published: Feb 10, 2021

The Implications of COVID-19 for Mental Health and Substance Use

https://www.kff.org/report-section/the-implications-of-covid-19-for-mental-health-and-substance-use-issue-brief/

[4] Artiga, S., Corallo, B., Pham O. August 17, 2021. Racial Disparities in COVID-19: Key Findings from Available Data and Analysis. Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/

[5] Gifford, K., Lashbrook, A., Barth S., Nardone, M. Oct. 27, 2021. States Response to Covid-19 Challenges but also take advantage of new opportunities to address long standing issues. Kaiser Family Foundation. https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-benefits-and-telehealth/

In the context of these extensive system changes, this report describes stakeholders' perceptions of progress toward building a comprehensive system of behavioral health care in Washtenaw County. The report also highlights important remaining gaps in services and includes recommendations for next steps in program development and community services.

Key Findings

- The Crisis, Access, Resources, Engagement and Support (CARES) services have improved access to behavioral health services, especially for those previously struggling to find services in the community, and for those in crisis.
- Millage funding for programs and services focused on jail diversion have created opportunities for law enforcement and behavioral health providers to work together to serve county residents more effectively, and to ensure that individuals with behavioral health needs get more timely evaluation and appropriate services.
- The most substantial persistent gaps in behavioral health services are in services for youth, including substance use and harm reduction services, residential services, and targeted programming for at-risk subpopulations. Additional gaps include rural areas of the county are underserved by behavioral health services; lack of adequate supply of supportive housing; and continued inadequate supply of behavioral health providers and long wait times for psychiatric emergency services.

Methods

We conducted 15 semi-structured interviews with community leaders whose patients/clients/constituents require and/or access behavioral health services in the county. [See Appendix I for list of interviewees]. Through these interviews we gathered insights about improvements in the provision of behavioral health services in Washtenaw County, especially as related to millage-funded programming, and observations of where gaps in behavioral healthcare remain.

In addition to gathering interview data, we summarized existing relevant county-level data from the Behavioral Risk Factor Surveillance System (BRFSS), the Michigan Department of Health and Human Services (MDHHS), Washtenaw County Community Mental Health (WCCMH), and Michigan Medicine's Psychiatric Emergency Services (MM PES).

Findings

Most stakeholders interviewed for this report identified some improvements in the behavioral health system in the county that they attributed to millage funding. All stakeholders were able to identify gaps in behavioral health services that remain for specific subpopulations in need of mental health or substance use services. These insights are summarized below.

CHRT MENTAL HEALTH SERVICES IN WASHTENAW COUNTY

Improvements in Behavioral Health Services

Better Access through CARES Services

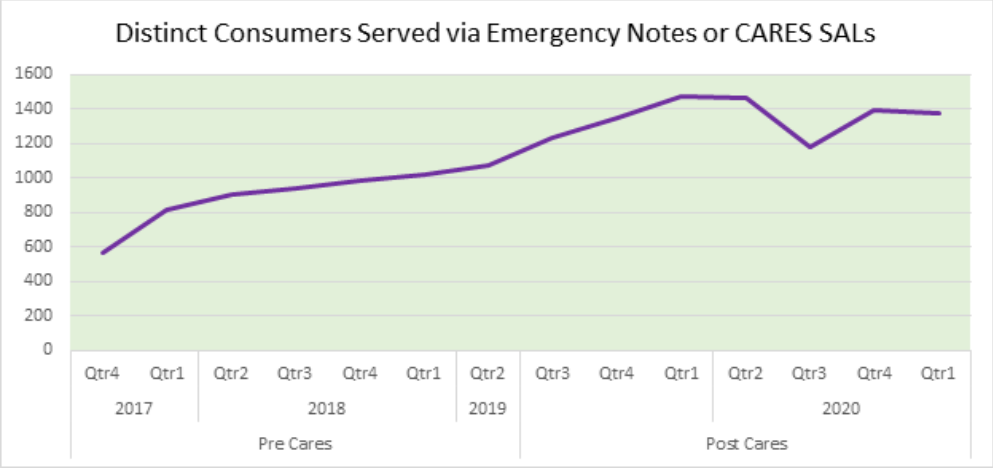
More than half of interviewees directly cited the services of the millage-funded Crisis, Access, Resources, Engagement and Support (CARES) program as responsible for important improvements in behavioral health services in the county. The 24/7 availability of the CARES team was called a "game changer" by numerous people, especially for meeting the needs of the mild to moderate population and for those in crisis. The CARES team was credited with increasing access to behavioral health services in various ways, including: improved timeliness of crisis care and community response services; more direct access to services through streamlined referrals and improved connections with providers, including SUD providers; access for those with mild/moderate conditions and those with co-occurring conditions who previously had trouble accessing care through community providers; and shorter wait times for CMH evaluations in emergency settings. The new crisis center was cited as likely reducing the interface with law enforcement for many with behavioral health needs. The crisis team was described as a good partner to sheriff's officers and was directly credited by one interviewee with life-saving interventions. Beginning in January 2022, the intake and referral processes for substance use treatment in the county will be changed to incorporate a single access point at WCCMH, in response to input from a community process in 2018-2019 called Able Change, a Systems Transformation Process.

CARES services were piloted in April 2019 and implemented in July 2019. One interviewee said that the impact was "...immediately and tremendously beneficial." With the CARES team available to treat the highest acuity patients who need specialty care, Packard Health providers have more internal capacity to treat more patients and to better integrate primary and behavioral health services. Closer integration has dramatically improved both providers' experiences and the experiences of patients seeking care.

Greater Numbers of Consumers Served

Data from WCCMH shows that the implementation of CARES services corresponded with an upward trend in the total numbers of individuals in the county being served [See Chart 1 below]. This upward trend began prior to CARES implementation, but became more pronounced with piloting and full implementation, rising from 569 distinct cases in late 2017 to almost 1,400 by late 2020. The dip in 2020 (Quarter 3) corresponds with the onset of the COVID-19 pandemic.

Chart 1



Source: WCCMH CARES Data Review, CARES SALs = Service Activity Logs

While the COVID-19 public health emergency was recently extended through January 2022,[6] when it does end, Medicaid eligibility redeterminations will no doubt lead to reductions in Medicaid enrollment. As many in Washtenaw County are disenrolled and become uninsured or underinsured for behavioral health services, the expanded CARES team will serve as an important safety net for Washtenaw residents no matter their insurance status.

Programming Addresses Stigma

The stigma associated with mental health and substance use needs is a barrier to accessing services, yet it is not easy to address or easy to measure success in stigma reduction.[7] Interviewees that work with certain subpopulations such as African American men, youth, or west/east side communities shared positive views of programming to reduce stigma associated with behavioral health services. The #wishyouknew campaign was specifically identified as engaging and far reaching for youth and adults, encouraging conversations about mental health issues. Millage funding supported small grants for campaigns in schools and other educational efforts that increased awareness of behavioral health issues and available services. Youth and families can now access behavioral health services with fewer barriers, in settings where they also access primary care. They can also access social services and in more streamlined ways than were available prior to millage-funded programming. Support groups formed by and for Black men around mental health and emotional wellness were also identified as signs of progress in reducing stigma as a barrier to receiving appropriate behavioral health services.

Improvements for Justice-involved Individuals with Behavioral Health Needs

Millage funding supports programs that create opportunities for law enforcement and behavioral health providers to work together to serve county residents more effectively. Interviewees pointed to better connections between jails and SUD providers, including the ability to begin Medication Assisted Treatment (MAT) during incarceration as a method of harm reduction. As individuals leave the criminal justice system already connected to the services they need, they may more successfully transition back to their community and address mental health and substance use disorder needs. Stakeholders also cited diversion efforts such as timely behavioral health assessments and case management services to ensure that justice-involved individuals with behavioral health needs can receive appropriate services.

Educational programming for law enforcement and new positions for re-entry coordination, case managers and peers were all cited by interviewees as important improvements achieved with millage funding. Two stakeholders directly shared that the Sheriff's office now has the capacity to invest in more non-traditional policing approaches. For example, peer services can help bridge gaps between the community and law enforcement, fostering relationships where trust is needed. Another cited benefit is the ability to use millage funds to leverage more funding for diversion and other services, such as a grant from the US Department of Justice focused on innovative re-entry programs.

Further examples of improvements include crisis teams that go directly to clients' homes to address behavioral health issues and by doing so in some cases prevent legal action; judges can work closely with WCCMH staff to provide mental health services to support individuals diverted from incarceration; for those charged and incarcerated there are expanded services in jails, including connections to social workers, for individuals who need both behavioral and mental health connections. One interviewee noted that these services may reach a higher proportion

[6] HHS renews public health emergency. October 15, 2021. https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/News/2020/HHS-Secretary-Renews-Public-Health-Emergency.aspx

[7] B.G. Link, E.L. Struening, M. Rahav, J.C. Phelan, L. Nuttbrock. J Health Soc Behav, 38 (2) (1997), pp. 177-190. On Stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse

of Black residents, as they are disproportionately incarcerated. If programmatic approaches lead to reductions in recidivism, over time this could lessen this over-representation in the criminal justice system in Washtenaw County.

Remaining Gaps in Behavioral Health Services

Insufficient Support for Youth and Family Services

Nearly every interviewee identified services for youth and their families as important gaps to address in behavioral health services in Washtenaw County. There are particular gaps in substance use services for school-age youth, for vulnerable subpopulations of youth, and in behavioral health services for justice-involved youth.

Early indicators of mental health and SUD issues in youth, such as chronic absenteeism in school, can serve as entry points/indicators for services and interventions. Yet interviewees indicated that few effective initiatives tied to early indicators are currently in place in the county. Schools do not have the capacity to provide home or school-based interventions and require more resources or outside support to address this gap. Similarly, there is a gap in care at the onset of mental illness when youth present with symptoms of illness but have not yet met criteria for "persistent" illness. One interviewee emphasized that a primary care or other provider may identify a mental health problem near onset of symptoms, but typically cannot engage CMH services without evidence that a condition is yet persistent. This leaves the family and youth in a holding pattern, unable to get timely, specialized care they need.

Interviewees indicated that there are not enough youth substance use treatment or harm reduction services. Young people need trusted adults for communication and support, and the county needs providers that specialize in working with youth in addition to current substance use treatment. Several subpopulations of youth require targeted funding and resources, including LGBTQ youth, youth on the autism spectrum, and Black, Latinx and other youth of color. Anti-racism efforts, suicidality awareness, and bullying prevention remain issues of concern and are topics that require investment and programming.

Limited Geographic Reach of Services

Many interviews revealed stakeholders' concerns that rural areas of the county, including Manchester and areas on the west side, as well as parts of Whitmore Lake have had unmet behavioral health needs for many years, and that new millage-funded programming may not be reaching those same areas. Rural areas have fewer behavioral health and other providers, and transportation to Ann Arbor or other areas of the county can be difficult, furthering isolation and lack of perceived support. This may be particularly difficult for the elderly in rural areas, who have been hit particularly hard by the increased isolation due to the pandemic. One interviewee said, "Clients on the west side and in more rural areas don't know or have access to all the things the millage provides, except through the jail-- we don't want them to find services that way."

Lack of Available Supportive Housing

Access to housing - supportive, transitional, and affordable housing - is a longstanding gap across Washtenaw County. A number of interviewees discussed the role of housing as a social need that impacts behavioral health and other health outcomes. One shared particular concern about the subset of people with lower substance use issues and higher mental health acuity who need longer-term housing options. Another identified the housing needs for individuals being discharged from hospitalizations or being released from jail.

Behavioral Health Provider Capacity is Still Limited

Washtenaw County has the lowest ratio of population to mental health providers in the state (180:1 compared to 360:1 in the state overall) and yet historically has faced many of the same capacity problems for psychiatry visits and services of other specialty providers that counties with many fewer mental health professionals face.[8] Behavioral health providers, crisis beds, SUD treatment and staffed inpatient beds have historically been limited in Washtenaw County and across the state, and generally remain as challenging issues today.[9] A number of interviewees mentioned the effort to improve capacity to respond to crises through the new crisis center (750 Towner). The small center will eventually provide access to 5 beds for individuals but has been limited to 3 beds during the pandemic. The increased provision of community-based services through CARES services and other millage-funded initiatives may, over time, help to slow demand for behavioral health crisis and inpatient services in the county.

Psychiatric ED Wait Times Impacted by Pandemic

Perhaps one of the most persistent and burdensome problems in the behavioral health system is long wait times for emergency mental health services, particularly for children in need of care and their families. Wait times in psychiatric emergency departments have been a challenge in Washtenaw County and across the state for many years. In a 2016 gaps analysis report,[10] overall wait times in Michigan Medicine Psychiatric Emergency Services (MM PES) averaged approximately 12 hours for all patients. Recent data from MM PES shows that although wait times had fallen in the years prior to the pandemic, today they are essentially at the same level as in 2016. Those with public insurance - Michigan Medicaid or Medicare - wait longer than those with commercial insurance or self-pay/uninsured, and those waiting to be transferred to another facility or admitted to an inpatient psychiatric unit experience the longest wait times. Extended wait times today are caused in part by reduced inpatient resources (e.g., reduced inpatient staffing) because of the current pandemic that started in early 2020. [See Charts 2,3 and 4 below for wait times by age, by insurance type, and discharge disposition]

[8] County Health Rankings and Roadmaps, University of Wisconsin Population Health Institute, 2020: Mental health providers in Michigan | County Health Rankings & Roadmaps

[9] Rhyan, C., Turner, A., Ehrlich, E., Stanik, C. July 2019. Access to Behavioral Health Care in Michigan: Final Report. Altarum. https://altarum.org/sites/default/files/uploaded-publication-files/Altarum_Behavioral-Health-Access_Final-Report.pdf

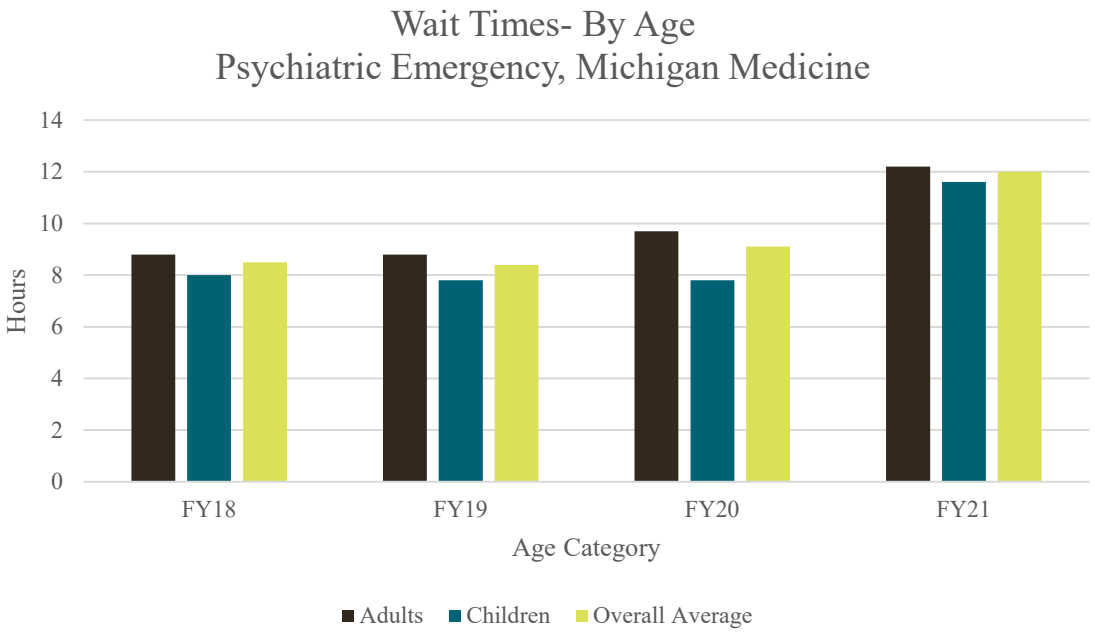
[10] Baum, N., Bondalapeti, K. July 2016. Washtenaw County Mental Health and Substance Use Service Gaps Analysis. Washtenaw Health Initiative.

https://washtenawhealthinitiative.org/wp-content/uploads/2016/11/Washtenaw-County-Mental-Health-and-Substance-Use-Service-Gaps-Assessment-003.pdf

CHRT

MENTAL HEALTH SERVICES IN WASHTENAW COUNTY

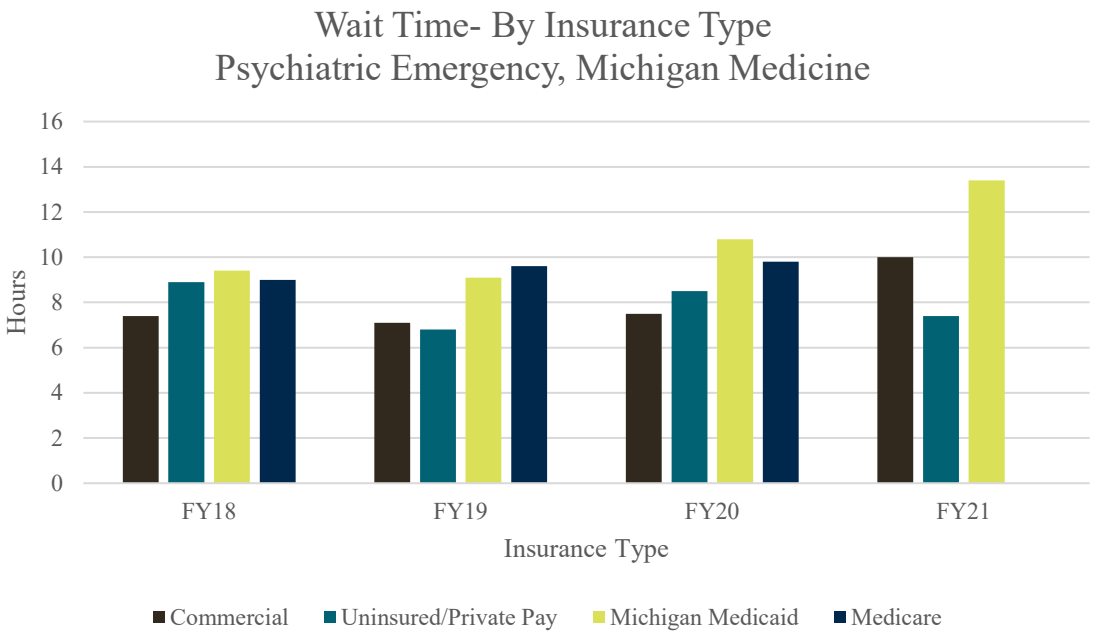
Chart 2



Source:

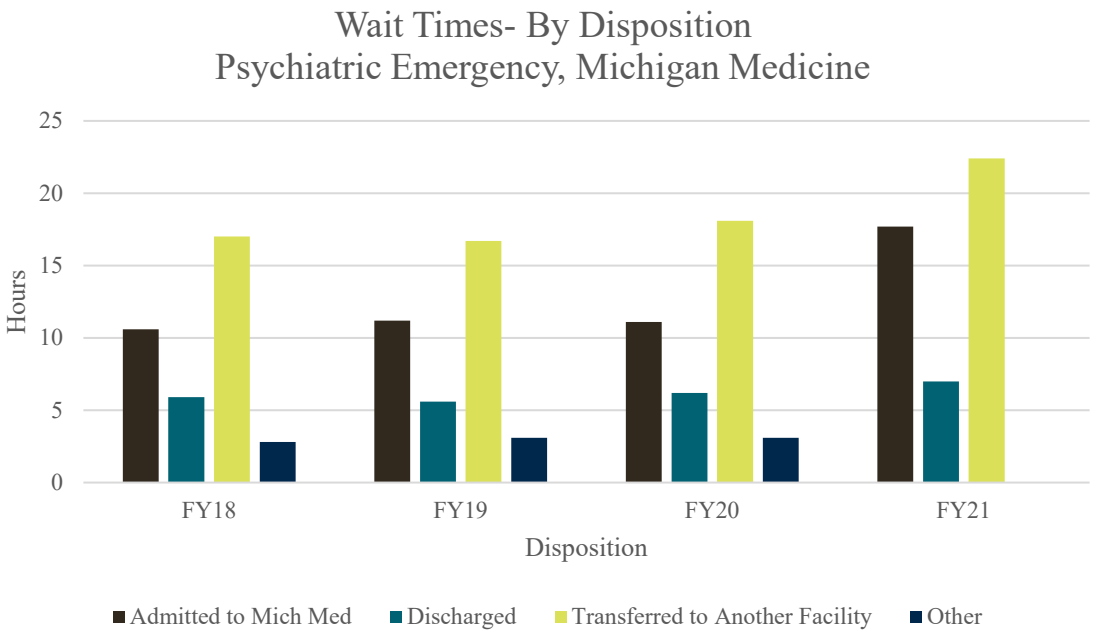
Michigan Medicine; FY = July 1-June 30.

Chart 3



Source: Michigan Medicine; FY = July 1-June 30.

Chart 4



Source: Michigan Medicine; FY = July 1-June 30;
"Other" includes transfer to Adult Emergency, Children's Emergency, left before evaluation or treatment complete, among others

Additional Findings

Increased Behavioral Health Community Burden

We know that most communities are experiencing an increase in behavioral health burden during the pandemic.[11,12] Washtenaw County data collected from 1/1/20-2/28/21 showed that 16.9% of adults in the county experienced 14 or more poor mental health days in the past 30 days, up from 15.4% in 2019. Also, during that period, 9.3% of adults in the county experienced activity limitation (defined as either poor physical health or poor mental health keeping respondents from doing their usual activities), up from 6.1% in 2019. For both of these measures, Washtenaw County residents fared worse in 2020 than state residents overall. [See Table below]

[11] Panchal, N., Kamal, R. and Cox, C. 2021. The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation.

https://www.kff.org/report-section/the-implications-of-covid-19-for-mental-health-and-substance-use-issue-brief/.

[12] Vahratian, A., Blumberg, S., Terlizzi, E., and Schiller, J. 2021. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic - United States, August 2020-February 2021. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, 70(490-494. https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e2.htm

2018-2020 Prevalence of Mental Health/Substance Use, Michigan and Washtenaw County

	Michigan						Washtenaw County					
	2018		2019		2020		2018		2019		2020	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Poor Mental Health (14+ days)[1]	14.3	(13.4-15.2)	14.3	(13.4-15.2)	15.8	(14.7-17.0)	18.2	(13.7-23.6)	15.4	(11.3-20.7)	16.9	(11.9-23.4)
Activity Limitation (14+ days)[2]	10.5	(9.8-11.3)	9.6	(8.8-10.4)	9.1	(8.3-10.1)	6.3	(4.1-9.6)	6.1	(3.9-9.4)	9.3	(6.0-14.0)
No Personal Health Care Provider[3]	14.9	(14.0-15.9)	14.5	13.6-15.6)	14.5	(13.3-15.7)	17.5	(13.2-22.8)	12	(8.7-16.3)	12.9	(9.0-18.3)
No Health Care Access During Past 12 Months Due to Cost[4]	11.8	(11.0-12.7)	11.7	10.8-12.6)	7.9	(7.1-8.8)	8.9	(6.1-12.9)	9	(6.0-13.2)	8.1	(4.5-14.2)
No Routine Checkup in Past Year[5]	20.5	(19.4-21.5)	19.8	18.7-20.9)	23.4	(22.1-24.8)	22.7	(18.3-27.7)	21.8	(17.3-27.1)	31	(24.8-38.0)
Have serious difficulty concentrating, remembering, or making decisions[6]	4.8	(4.3-5.4)	13.4	12.5-14.4)	12.2	(11.1-13.3)	1.3	(0.7-2.6)	8.4	(5.5-12.5)	10.4	(6.9-15.4)

95% CI = 95% Confidence Interval

[1] Among all adults, the proportion who reported 14 or more days of poor mental health, which includes stress, depression, and problems with emotions, during the past 30 days.

[2] Among all adults, the proportion who reported 14 or more days in the past 30 days in which either poor physical health or poor mental health kept them from doing their usual activities, such as self-care, work, recreation.

[3] Among all adults, the proportion who reported that they did not have anyone that they thought of as their personal doctor or health care provider.

[4] Among all adults, the proportion who reported that in the past 12 months, they could not see a doctor when they needed to due to the cost

[5] Among all adults, the proportion who reported that they did not have a routine checkup in the past year.

[6] Among all adults, the proportion who reported having serious difficulty concentrating, remembering, or making decisions.

Data Source: Michigan Department of Health and Human Services, Behavioral Risk Factor Surveillance System (BRFSS)

Little Awareness of Millage-funded Programming

"As a citizen, I wonder where the money's gone. I'm in a better position to know than most, and I don't know."
-Interviewee

Several of the stakeholders we interviewed shared their own general lack of knowledge about millage-funded behavioral health programming and services and suggested that members of the public likely know even less. Our interviews preceded advertising and other communications planned to roll out in 2022 to educate the wider community about the millage. Those communications will highlight millage initiatives, including the expanded access to services for mild/moderate needs and regardless of ability to pay, and spread awareness about the existence of the CARES team services. People working in behavioral health, primary care and emergency services are still learning how to engage the CARES team, which illustrates a broader need to educate community providers about new millage-funded services.

In addition, none of our interviewees referred to CCBHC services without prompting when discussing behavioral health system improvements or gaps in care. Both CCBHC services and millage programming are helping to serve uninsured/underinsured/underserved populations as well as individuals across the acuity spectrum of behavioral health needs. Many people in the community, including providers, may not know the source of funding for these services, but broader knowledge about CCBHC services may help providers make referrals and help individuals in the community better access low barrier integrated services.

Recommendations

Behavioral health needs are increasing at the same time that Washtenaw County is expanding behavioral health services through millage programming and CCBHC services. While we may not be able to distinguish the direct impacts of the pandemic from other broad system changes, it is reasonable to assume that gaps in behavioral health services would be even greater than those identified here without millage funding. With Millage funding available through 2026, WCCMH and the millage advisory committee have the opportunity to focus funding and efforts in gap areas highlighted by key stakeholders. Below, we have developed recommendations based on our findings.

1. **Focus on youth programming** for primary and secondary prevention of mental health crises, serious mental illness, and substance use disorder. Support behavioral health services directed at early intervention points, such as identification of school absenteeism and early identification of symptoms in clinical settings before conditions are persistent. School-based interventions may require braiding of education (31N) and health funding to support interventions. For families, continue to support and expand programs such as SURE Moms that provide peer support for parents and help shape relationships between police and communities while focusing on the needs of justice-involved youth. Programming should coordinate more directly with public defenders (and others with important roles in existing system structures) to help connect people to mental health services. Public defenders have existing relationships with families and can foster important connections for people who need services.

   At the community level, continue effective public awareness and anti-stigma activities ala #wishyouknew, possibly focused on SUD and treatment, and continue support for popular mini grants to schools. These activities should include both broad messaging as well as more focused information for vulnerable subpopulations such as LGBTQ youth or specific racial or ethnic groups. One interviewee specifically recommended more programming at the middle school level where many behavioral health issues "incubate." Alignment of programming with community needs assessment data may also create opportunities to connect health systems to community-level interventions.

2. **Continue to expand crisis response capacity**. The 750 Towner center is an important but limited step forward in expanding available crisis care services. Interviewees suggested that it will be important for providers to partner and collaborate to provide crisis services. In particular, two interviewees suggested that the Michigan Medicine crisis support clinic could be quite helpful if it could be expanded, but that it currently has too few hours and providers. Many interviewees suggested that some progress is being made in the area of dual response and alternative response mechanisms, but that the community wants to see more of this type of improvement. Decriminalizing mental health and substance use crises as much as possible is an important community goal. Invest in additional harm reduction services for people who are actively using substances but not seeking or ready for treatment. This population may consume a lot of resources and harm reduction outreach creates the space for relationship building and better health outcomes for this demographic.

3. **Ensure that programming reaches rural areas of the county** in addition to the more populated areas. Focus publicity about availability of services, including mobile services, on the far west and east sides of the county. One interviewee suggested that since many elderly and low-income individuals in rural areas are not on-line it will be important to work with existing, trusted information sources such as faith-based organizations, community-based organizations, and neighborhood associations. Another shared the

sentiment that it is important that rural residents feel "seen and heard" by county leadership and those providing services. One approach to increasing community involvement would be to include rural residents or others with particular lived experience on the Millage Advisory Committee.

If successful programming means a more comprehensive and integrated system of behavioral health care that serves all Washtenaw County residents, the WCCMH through millage-funded projects and partnership and CCBHC services is making progress in important and meaningful ways. This report highlights many community advancements in the provision of behavioral health services, but much work is yet to be done. One interviewee summed up by saying that the programming funded by the millage is necessary but not sufficient, and added, "I'm glad we have these new, additional millage services. [The millage funding] is not enough to meet all the needs in the community. That said, I hope it doesn't go away."

Appendices

Appendix I

The following key stakeholders were interviewed for this report:

- Nicole Adelman (Substance Use Services Director, Community Mental Health Partnership of Southeast Michigan)
- Joseph Burke (15th District Court Judge)
- Anna Byberg (President, Dawn Farm)
- Trish Cortes (Executive Director, Washtenaw County Community Mental Health)
- Lisa Gentz (Program Administrator, Millage Initiatives, Washtenaw County Community Mental Health)
- Holly Heaviland (Executive Director, Washtenaw Intermediate School District; WCCMH Millage Advisory Committee (MAC) member)
- Victor Hong (Medical Director, Michigan Medicine Psychiatric Emergency Service)
- Derrick Jackson (Director of Community Engagement, Washtenaw County Sheriff's Office; MAC member)
- Jason Maciejewski (District 1 County Commissioner)
- Aubrey Patino (Executive Director, Avalon Housing)
- Caroline Richardson (M.D. Michigan Medicine, Family Medicine Specialist, Ypsilanti Health Center; past WCCMH Board member)
- Ray Rion (Medical Director, Packard Health; WCCMH MAC member)
- Alfreda Rooks (Director of Community Health Services, Michigan Medicine)
- Delphia Simpson (Washtenaw County Public Defender)
- Versell Smith (Executive Director, The Corner Health Center)
- George Waddles, Jr. (Pastor, Second Baptist Church, Ypsilanti Michigan; MAC member)

CHRT MENTAL HEALTH SERVICES IN WASHTENAW COUNTY

Appendix II

Change in Medicaid and Health Michigan Plan Enrollment, Washtenaw County and Michigan, 2018-2021

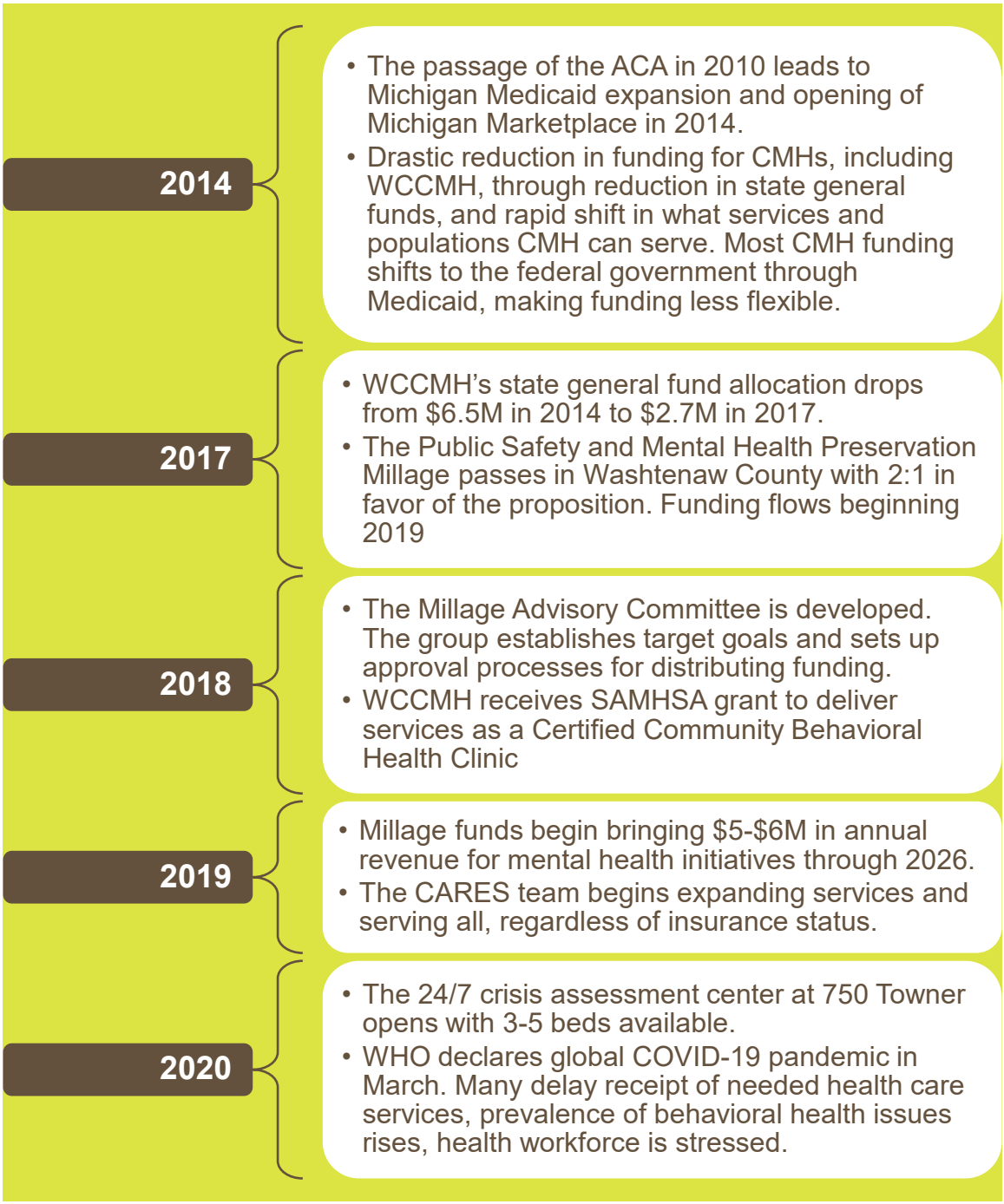
Medicaid and HMP Enrollment, Washtenaw County and Michigan, 2018-Oct 2021								
	2018	2019		2020		2021		
HMP Only Enrollment								
		June	Dec	June	Dec	June	Oct	Increase from Dec 2019 - Oct 2021
Washtenaw County	13,453	13,338	13,422	14,967	17,347	18,994	19,393	44%
Michigan	534,464	526,717	532,073	597,291	688,478	750,325	766,539	44%
Medicaid and HMP Enrollment								
Washtenaw County	38,244	38,146	38,278	40,860	44,649	47,183	48,194	26%
Michigan	1,750,308	1,727,861	1,751,830	1,883,488	2,042,712	2,145,995	2,185,498	25%
Source: MDHHS https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78576-15064--,00.html								

CHRT

MENTAL HEALTH SERVICES IN WASHTENAW COUNTY

Appendix III

Timeline: Community mental health policy changes and impact on Washtenaw County



ATTACHMENT #9
NOVEMBER 2021

CHNA
IMPLEMENTATION STRATEGY FY2022-2024

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

ST. JOE'S
A Member of Trinity Health

M HEALTH
ST. JOSEPH MERCY CHELSEA

Table of Contents

UNITE Community Health Needs Assessment Implementation Strategy FY 2022-2024

Introduction

In 2021, for the third time, all not-for-profit hospitals in Washtenaw County, Michigan collaborated to conduct a joint Community Health Needs Assessment (CHNA) and Implementation Plan (IP) for the shared geographic region of Washtenaw County. The hospitals, Michigan Medicine (UMH), St. Joseph Mercy Ann Arbor (SJMAA), and St. Joseph Mercy Chelsea (SJMC), conducted a collaborative community health data collection and assessment process in partnership with Washtenaw County Public Health Department and area health coalitions. The process was facilitated by the Washtenaw Health Initiative.

The collaborative, named Unified Needs Assessment Implementation Plan Team Engagement (UNITE), aims to promote health and improve the health equity of our community. To do so, it uses a shared leadership structure and continuously engages the community to develop a unified health assessment and implementation plan. The UNITE group collected data through focus groups and key informant interviews. Additionally, the group assessed data from a variety of quantitative and qualitative sources, including both primary and secondary data.
The three hospitals continued to utilize support from the Washtenaw Health Initiative (WHI), which acted as a facilitator for the collaborative CHNA and Implementation Plan process. The WHI is a voluntary, county-wide collaboration focused on improving access to coordinated care for the low-income, uninsured, and Medicaid populations in Washtenaw County, Michigan.

The UNITE group completed the CHNA and IP in adherence with federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from community members and various community organizations.

Board Approval

The Community Health Needs Assessment Implementation Plan (CHNA-IP) was approved by the local boards as follows:

- Michigan Medicine CHNA-IP was adopted by the board on November 4, 2021.
- St. Joseph Mercy Ann Arbor CHNA-IP was adopted by the board on October 27, 2021.
- St. Joseph Mercy Chelsea (SJMC) CHNA-IP was recommended for adoption by the local Board of Trustees on October 26, 2021, and adopted by the Joint Venture Board on October , 2021.

CHNA Implementation Plan Availability

The complete CHNA-IP report is available electronically at:

- www.uofmhealth.org/community-health-needs-assessment or
- www.stjoesannarbor.org under the Community Benefit tab or
- www.stjoeschelsea.org under the Community Benefit tab

Or printed copies are available at:

- 3621 S. State St., Ann Arbor MI, 48108
- 5301 McAuley Drive, Ypsilanti, MI 48197
- 775 S. Main St, Chelsea, MI 48118

Description of Hospitals

For more information about each institution see Appendix A (page 37) in the Community Health Needs Assessment.

Identification and Prioritization of Community Health Needs

Members of the UNITE group analyzed data from multiple data sources, community focus groups, and key stakeholder/informant interviews to determine potential priority areas. Those needs were then prioritized based on several factors including the number of people impacted, severity of the problem, ability to positively impact the priority, alignment with institutional missions, and impact on health equity. The data show that the three priority areas, listed below, identified in the group's 2016 and 2019 CHNA, continue to be significant areas of need across the community:

- Mental Health and Substance Use Disorders
- Obesity and related illnesses
- Pre-conceptual and Perinatal health

Therefore, the UNITE group renewed its commitment to addressing these three priorities and doing so through the lens of social determinants of health (SDOH) and health equity.

Strategies

In developing the implementation plan, the UNITE group continued to dig deeper into the root causes underlying three SDOH domains that they agreed had a significant impact on the top CHNA health priorities. These domains were (i) housing, (ii) poverty and (iii) social isolation.

UNITE used the Community Anti-Drug Coalition of America (CADCA) model to conduct a root cause analysis (RCA) around local community conditions and contributing factors to the prioritized health needs. This model asks the questions – what is the problem, why is it a problem, and why is it a problem here? The CADCA structure incorporates the following strategies for creating positive change: Provide Information and Education, Build Skills/Training, Provide Support, Enhance Access/Reduce Barriers, Change Consequences (Positive and Negative), Change Physical Design, Modify Policies. This is a model that has been used in helping to address reduction of substance abuse across the United States.

In addition, the UNITE group identified the following as areas of rapidly escalating seriousness that needed to be addressed as part of an implementation strategy: (i) climate change, (ii) incarceration and (iii) medical debt.

Significant health needs that will not be addressed

Michigan Medicine, St. Joseph Mercy Ann Arbor, and St. Joseph Mercy Chelsea acknowledged the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. Michigan Medicine, St. Joseph Mercy Ann Arbor, and St. Joseph Mercy Chelsea will not take action on the following health needs within this plan:

- **COVID-19--** is not addressed in this Implementation Plan but will be addressed by each hospital through plans that have been collaborated on by each health system and the health department. These plans include things such as vaccine clinics and COVID-19 education.

This implementation strategy specifies community health needs that the hospitals have determined to address in whole or in part and that are consistent with its mission. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2022-2024	
CHNA SIGNIFICANT HEALTH NEED:	Mental Health & Substance Use Disorders
CHNA REFERENCE PAGE:	29

BRIEF DESCRIPTION OF NEED:

The average Washtenaw adult reported 4.6 mentally unhealthy days in the past month.

Washtenaw County started collecting local data on adolescent suicide rates in 2004 and since there was an alarming increase in suicide and suicide attempts. It is known that by preventing and treating anxiety and depression suicide and suicide attempts can be prevented. Local data shows that 32% of high school students experience depression and other mental health problems within the last year and 17.1% reported having seriously considered suicide in the past year.

Additionally, both prescription and recreational drug use are creating negative issues within Washtenaw County. There has been an increase in opioid-related overdose deaths from 2011 (29 deaths) to 2020 (61 deaths) in Washtenaw County (Source: Washtenaw County Medical Examiner and Washtenaw County Health Department, Waller, A.). Marijuana use by teens has increased over the past 8 years in the county, as has the use of e-cigarettes, or "vaping".

GOAL: Reduce the prevalence and negative impacts of substance use and mental illness in greater Washtenaw County.

OBJECTIVES:

1. Reduce the percent of adults who experienced 14 or more days in which their mental health was not good in the past month from 16.5% to 15% by 2024. (Source: BRFSS 2017-2019, accessed on healthforallwashtenaw.org)
    1.1. Increase mental health provider rate by 10% (current rate is 566 providers per 100,000 and goal is to achieve at least 623 providers per 100,000) by 2024. (Source: 2020 County Health Rankings, accessed on healthforallwashtenaw.org)
2. Reduce the proportion of adolescents who seriously considered attempting suicide during the past 12 months from 17.1% to 13.1% among high school students, and from 16.7% to 11.9% among middle school students by 2024. (Source: MiPHY survey, Washtenaw County Report)
3. Decrease the proportion of high school students who used e-cigarettes, alcohol or marijuana in the past month by 2024 (Source: MiPHY survey, Washtenaw County Report)
    3.1. E-cigarettes: reduce recent use from 15.5% to 12.3%
    3.2. Alcohol: reduce recent use from 14.9% to 8.3%
    3.3. Marijuana: reduce recent use from 14% to 10.4%
4. Reduce the number of annual adult opioid fatal overdoses in Washtenaw County from 61 to 49 by 2024 (Source: WCHD, Opioid Data | Washtenaw County, MI)

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED FISCAL YEARS 2022-2024, UNLESS OTHERWISE NOTED:

Michigan Medicine:

1. Provide health information to the Deaf, Deaf/Blind, and Hard of Hearing through Speakers series using American Sign language in the community.

2. Provide screenings and interventions in the community to youth experiencing mental illnesses or suicidal ideation.
3. Provide mental health support sessions for families in the community that have a child with mental illness.
4. Provide translated materials to social service agencies and provide mental health screenings in ASL through UMH Interpreter Services and Family Medicine.
5. Through Michigan Medicine's grants program, support community organizations, programs, and advocacy that contributes to delivery and access to mental health and substance abuse programs and services to adults and youth regardless of insurance status.
6. Provide 1-3 professional development opportunities to train professionals on the prevention of Elder Abuse.
7. In Straight Talk-Youth Fire setting Prevention program, utilize cognitive-behavioral therapy and motivational interviewing to promote behavior change among youth who have set a fire(s).

St. Joseph Mercy Ann Arbor:

1. Increase mental health providers/services through supporting Community Mental Health in the implementation of the Certified Community Behavioral Health Clinic (CCBHC) of Washtenaw County.
2. Connect patients & community members to peer recovery coaches, Sexual Assault Nurse Examiners and community health workers to address mental health and substance use disorder.
3. Partner with Hope Clinic to better integrate Behavioral Health within the safety net care model at the point of care and proactively call patients to obtain Behavioral Health Services.
4. Support and promote drug take-back events within Washtenaw County medication disposal network, specifically 48197/48198.

St. Joseph Mercy Chelsea:

1. Support and facilitate SRSLY coalitions in Chelsea (48118), Dexter (48130), Manchester (48158) and Stockbridge (49285) to prevent youth substance abuse and promote mental health.
2. Partner in "One Big Thing" initiative to address mental health.
3. Implement the Project SUCCESS program in local middle and high schools.
4. Continue and expand support groups in the service area.
5. Collaborate with schools and other community partners to address mental health needs of youth through education, skill-building and stigma reduction.
6. Facilitate access to care through the Behavioral Health Navigators.
7. Participate in local coalitions and activities related to increasing social support, improving mental health, and reducing substance use.

Joint Hospital Systems Actions:

1. Increase health system collaboration around mental health and substance use disorder activities, as guided by the community.
2. Maintain health system and community supported programs and policies that reduce substance use disorder, and improve mental health.
3. Participate in local coalitions (i.e. Washtenaw Health Initiative Mental Health & Substance Use Disorder workgroup, Washtenaw SUD System Transformation, Washtenaw County Community Mental Health Board, etc.) and activities related to increasing behavioral health access and addressing root causes (i.e. trauma)

4. Explore and support efforts to increase the number and diversity of mental health providers within our health systems and through community providers.
5. Advocate for policies that reduce barriers to training and employment in the field of social work and mental health care providers.
6. SJMC and SJMAA: Increase rates of screening and referral to cessation services for patients using tobacco.
7. SJMC and SJMAA: Partner with local law enforcement and Washtenaw County to promote safe disposal of unused medications
8. SJMC and SJMAA: Expand the presence of Faith Community Nursing staff throughout the community to provide mental health and substance use disorder education support through faith communities.
9. SJMAA and UMH: Support/continue work through the Michigan Opioid Collaborative including seeking extension/expansion of grant funding for Medication Assisted Treatment and advocacy for Opioid Task Force legislation
10. SJMC and SJMAA: Utilize Community Resource Directory to help support mental health and substance use disorder initiatives

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Reduce tobacco use among adult patients.
2. Reduce misuse of prescription medications.
3. Reduce youth substance abuse.
4. Improve outcomes for participating students in Project SUCCESS.
5. Increase participation in support groups.
6. New policies or programs to support mental health among youth.
7. New policies to support reduction in substance use among youth and adults.
8. Improve access to mental health services.
9. Improve social support among service area residents.
10. Increased number of faith communities active in the health ministry network through Faith Community Nursing.
11. Increase number of individuals engaged in tobacco cessation programming.
12. Decrease wait time to obtain behavioral health services.
13. Increase drug disposal in Washtenaw County.
14. Increase mental health providers.
15. Decrease self-harm injuries and suicide attempts among adolescents.

PLAN TO EVALUATE THE IMPACT:

Michigan Medicine:
The Community Health Coordinating Committee will monitor progress of community grant programs' impact. Community Health Services staff will collect various metrics from staff on ongoing community benefit programming.

For data inquiries please contact Community Health Services: 734-998-2156 or email communitybenefit@med.umich.edu.

St. Joseph Mercy Ann Arbor:
The SJMAA Community Health Council will monitor progress towards these outcomes by regularly collecting and analyzing program data. Each program has defined process and outcome measures to evaluate impact. This data is collected and reported at regular intervals. Data sources include surveys,

focus groups, key stakeholder interviews and archival data from hospital, law enforcement, school, and other records.

For data inquiries, please contact SJMC/SJMAA staff through www.stjoeshealth.org/cbm 'Contact' icon at the bottom of the webpage.

St. Joseph Mercy Chelsea:
The SJMC Community Health Improvement Council will monitor progress towards these outcomes by regularly collecting and analyzing program data. Each program has defined process and outcome measures to evaluate impact. This data is collected and reported at regular intervals. Data sources include surveys, focus groups, key stakeholder interviews and archival data from hospital, law enforcement, school, and other records.

For data inquiries, please contact Reiley Curran, at (734) 593-5279, or reiley.curran@stjoeshealth.org.

PROGRAMS AND RESOURCES THE HOSPITALS PLANS TO COMMIT:

- Staff time to support the implementation of the actions listed above.
- Supplies and marketing for programs.
- Funding for programs, organizations, and advocacy.

COLLABORATIVE PARTNERS: Mental Health & Substance Use Disorders

	Michigan Medicine	St. Joseph Mercy-Ann Arbor	St. Joseph Mercy-Chelsea
5 Healthy Towns Foundation			✓
Ann Arbor Area Community Foundation	✓	✓	
Catholic Social Services		✓	
Chelsea Ministerial Association			✓
Chelsea Police Department			✓
Chelsea School District			✓
Chelsea Senior Center			✓
Chelsea Wellness Coalition			✓
Chelsea-area Chamber of Commerce			✓
City of Chelsea			✓
City of Dexter			✓
Community Family Life Center	✓		
Community Health Access Initiative	✓		
Corner Health Center	✓		
Dawn Farms		✓	
Dexter Chamber of Commerce			✓
Dexter Community Schools			✓
Dexter Internal Medicine			✓
Dexter Ministerial Association			✓
Dexter Senior Center			✓
Dexter Wellness Coalition			✓
EMU Family Empowerment Program	✓	✓	
Faith in Action		✓	✓
Grass Lake Community Wellness Initiative			✓
Grass Lake School District			✓

Grass Lake Senior Center			✓
Home of New Vision		✓	
Hope Clinic	✓	✓	
Huron Valley Ambulance Community Paramedics		✓	
Jewish Family Services	✓		
Legal Services of South Central Michigan (Michigan Advocacy Program)	✓		
Manchester Community Schools			✓
Manchester Wellness Coalition			✓
Michigan Medicine Dept. of Family Medicine			✓
Michigan Organization for Adolescent Sexual Health	✓		
MSU Cooperative Extension 4-H office	✓		✓
National Alliance on Mental Illness		✓	✓
Our House	✓		
Ozone House	✓		
Packard Health	✓		
Scouts			✓
Stockbridge Chamber of Commerce			✓
Stockbridge Community Schools			✓
Stockbridge Police Department			✓
Stockbridge Wellness Coalition			✓
Student Advocacy Center			
UM School of Public Health	✓		
United Way of Washtenaw County	✓	✓	✓
Washtenaw Area Council on Children	✓	✓	✓
Washtenaw County Community Mental Health	✓	✓	✓
Washtenaw County Sheriff	✓	✓	✓
Washtenaw Health Initiative		✓	
Washtenaw Intermediate School District	✓	✓	✓
Washtenaw County Health Department	✓	✓	✓
Washtenaw County Office of Community and Economic Development		✓	
Washtenaw County Sheriff's Office		✓	
Washtenaw Success by Six	✓		
Great Start Collaborative			
Women's Center of Southeastern Michigan	✓		

CHNA IMPLEMENTATION STRATEGY
FISCAL YEARS 2022-2024

CHNA SIGNIFICANT HEALTH NEED:	Obesity and Related Illness
CHNA REFERENCE PAGE:	30

BRIEF DESCRIPTION OF NEED: The majority of adults and children in SJMAA, SJMC, and UMH service areas rates of overweight and obesity have remained steady. We have seen that the only group to decrease their previous rate was 5 to 7 years old's. This gives us an opportunity to continue to work toward helping adults and children reach a healthier weight. Overweight and obesity are indicators of potential chronic disease risk and can be indicative of lack of movement. Lack of access to healthy foods, low intake of vegetables and fruits, and limited movement can have huge impacts on both chronic disease risk and a person's ability to maintain a healthy weight.

Obesity has been shown to be a risk factor for severe COVID-19 illnesses. Although, this is not something that can be changed immediately. This has ramifications for helping our children to maintain a healthy weight so during future health crises they are at less risk of severe illnesses.
Further, social determinants such as poverty and incarceration have huge impacts on rates of overweight and obesity and chronic disease. Low-income communities often do not have safe neighborhoods to be active and do not have accessible and affordable healthy food, which puts them at a significant disadvantage in terms of managing their chronic disease risk. Further, those who are suffering from homelessness face barriers to managing their chronic illnesses and maintaining a healthy diet.

Finally, we know that eating whole and unprocessed foods and maintaining the recommended 150 minutes of moderate exercise can reduce risk of chronic disease such as cardiovascular disease (e.g. CHD & stroke). This is an opportunity for the hospitals and their collaborators to improve health behavior and reduce the overall burden of chronic disease on the system.

GOAL: Promote healthy lifestyle choices and reduce chronic disease prevalence & risk in greater Washtenaw County.

OBJECTIVE:

1. Increase healthy lifestyle choices among youth
    - 1.1. Percentage of students who were physically active for 60+ minutes per day on five or more days per week: 2020 county-wide HS rate is 59.2%, best sub-group rate is 73.5%
    - 1.2. Percentage of students who ate five or more servings of fruits and vegetables per day in the last seven days 2020 county-wide HS rate is 29.5%, (58.3% is best sub-group rate)
2. Increase healthy lifestyle choices among adults
    - 2.1. Increase by 10% the percentage of adults who report adequate physical activity, defined as "moderate physical activities for at least 150 minutes per week, vigorous physical activities for at least 75 minutes per week, or an equivalent combination of moderate and vigorous physical activities and also participate in muscle strengthening activities on two or more days per week". Baseline: 21.8% (Michigan BRFSS, 2017 and 2019 combined)
    - 2.2. Increase by 10% the percentage of adults who report eating at least 1 serving of fruits and vegetables a day. Baseline: 65.9% (Fruit) and 83.4% (Vegetables). (Michigan BRFSS, Retrieved via email from Yan Tian (Michigan DHHS).

ACTIONS THE HOSPITAL FACILITIES INTEND TO TAKE TO ADDRESS THE HEALTH NEED, FISCAL YEARS FY2020 - FY2022, unless otherwise noted:

Michigan Medicine:

1. Support, maintain and explore programs that target nutrition education/counseling:
    a. Regional Alliance for Healthy Schools (RAHS)
    b. MHealthy
    c. Project Healthy Schools
2. Support programs and policies that screen for food insecurity, provide referrals to reduce food insecurity, and/or directly provide food to reduce food insecurity:
    a. UMH Ann Arbor Meals on Wheels
    b. Patient Food and Nutrition Services meal provision to Ypsilanti Meals on Wheels
    c. Regional Alliance for Healthy Schools
    d. Food and resource drives for Food Gatherers.
3. Continue to support programs and policies that encourage more physical activity
    a. MHealthy
    b. Project Healthy Schools
    c. Regional Alliance for Healthy Schools
4. Support organizations and programs working to reduce food insecurity, obesity, and other related illnesses and weight related stigma through community-based funding.
    a. Support community and neighborhood gardens; increase access to local and nutritious foods.
    b. Advocate for reduced greenhouse gas emissions in order to prevent acute cardiac events.

St. Joseph Mercy Ann Arbor:

1. Expand food security support and nutrition education through The Farm at St. Joe's initiatives, Nutrition Buddies, Prescription for Health, Shapedown, and Community Health Workers to reduce chronic disease.
2. Advocate for policy change on food systems infrastructure through participation in Washtenaw Food Policy Council and other emerging policy efforts with a focus on food disparity.
3. Increase efforts to improve the safety and availability of fitness infrastructure options in the community, specifically 48197/48198.
4. Implement community-based walking groups.
5. Explore and apply programs and concepts of Lifestyle Medicine and the Blue Zone philosophy within Washtenaw County to improve overall health and reduce chronic disease.

St. Joseph Mercy Chelsea:

1. Continue to promote walking and running for all ages through activities and events.
2. Increase availability and connectivity of walking paths on the hospital campus.
3. Support the Chelsea Farmers Market and Farmers Market Food Assistance programs throughout the service area.
4. Provide nutrition education and technical assistance to individuals and organizations in the service area.
5. Support the development and expansion of area trail networks.

Joint Hospital Systems Actions:

1. Increase health system collaboration around healthy eating, physical activity, and chronic disease reduction as guided by the community.

2. Maintain the health system and community supported programs and policies that reduce chronic disease and increase healthy eating and physical activity.
3. Provide Diabetes prevention, education, and share group programming.
4. Provide and support the Prescription for Health Program
5. SJMC and SJMAA: Increase rates of screening and referral to healthy weight services for patients with BMI greater than 25.
6. SJMC and SJMAA: Expand the presence of Faith Community Nursing staff throughout the community to provide obesity and related illnesses education support through faith communities.
7. SJMC and SJMAA: Utilize Community Resource Directory to help support obesity and related illnesses initiatives

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Increase physical activity among participants.
2. Reduce prevalence of and complications associated with diabetes.
3. Increase walking among hospital patients, visitors, employees, and neighborhood residents.
4. Increase consumption of fruits and vegetables, and support the local farming economy.
5. Reduce the onset of diabetes through the Diabetes Prevention Program.
6. Increase understanding of healthy food choices. Reducing food insecurity among families and seniors living in Ann Arbor and Ypsilanti.
7. Increase access to support and resources to support reducing weight among middle and high school students within Washtenaw County.
8. Reduce prevalence of cardiovascular disease
9. Increase self-efficacy by providing educational classes that increase individual ability to cook healthy foods.
10. Community members will report a reduction in barriers to carrying out healthy behaviors (e.g. increased physical activity or increased access to healthy foods).
11. New policies to support reduction of food insecurity.

PLAN TO EVALUATE THE IMPACT:

Michigan Medicine:
The Community Health Coordinating Committee will monitor progress of community grant programs' impact. Community Health Services staff will collect various metrics from staff on ongoing community benefit programming. For data inquiries please contact Community Health Services: 734-998-2156 or email communitybenefit@med.umich.edu.

St. Joseph Mercy Ann Arbor
The SJMAA Community Health Council will monitor progress towards these outcomes by regularly collecting and analyzing program data. Each program has defined process and outcome measures to evaluate impact. This data is collected and reported at regular intervals. Data sources include surveys, focus groups, key stakeholder interviews and archival data from hospital, law enforcement, school, and other records.

For data inquiries, please contact SJMC/SJMAA staff through www.stjoeshealth.org/cbm 'Contact' icon at the bottom of the webpage

St. Joseph Mercy Chelsea
The SJMC Community Health Improvement Council will monitor progress towards these outcomes by regularly collecting and analyzing program data. Each program has defined process and outcome measures to evaluate impact. This data is collected and reported at regular intervals. Data sources include surveys, focus

groups, key stakeholder interviews and archival data from hospital, law enforcement, school, and other records.

For data inquiries, please contact: Reiley Curran, at (734) 593-5279, or reiley.curran@stjoeshealth.org.

PROGRAMS AND RESOURCES THE HOSPITALS PLANS TO COMMIT:

- Staff time to support the implementation of the actions listed above.
- Supplies and marketing for programs.
- Funding for programs, organizations, and advocacy.

COLLABORATIVE PARTNERS: Obesity and Related Illness

Collaborative Partner Name	Michigan Medicine	St. Joseph Mercy-Ann Arbor	St. Joseph Mercy-Chelsea
5 Healthy Towns Foundation			✓
American Heart Association		✓	
Ann Arbor Meals on Wheels	✓		
Ann Arbor Public Schools	✓	✓	
Barrier Busters		✓	
Carpenter Place	✓	✓	
Chelsea Ministerial Association			✓
Chelsea School District			✓
Chelsea Senior Center			✓
Chelsea Wellness Coalition			✓
Chelsea-area Chamber of Commerce			✓
City of Chelsea			✓
City of Dexter			✓
Community Family Life Center	✓		
Corner Health Center		✓	
Dexter Chamber of Commerce			✓
Dexter Community Schools			✓
Dexter Internal Medicine			✓
Dexter Ministerial Association			✓
Dexter Senior Center			✓
Dexter Wellness Coalition			✓
EMU Engage, Bright Futures		✓	
EMU School of Nutritional Sciences, Dietetic Interns		✓	
Faith in Action		✓	✓
Family Empowerment Program (Engage EMU)	✓	✓	
Food Gatherers	✓	✓	
Foster Grandparents	✓		
Grass Lake Community Wellness Initiative			✓
Grass Lake School District			✓
Grass Lake Senior Center			✓

Growing Hope		✓	
Hope Clinic		✓	
Jewish Family Services		✓	
Manchester Community Schools			✓
Manchester Wellness Coalition			✓
Michigan Islamic Academy	✓		
Ozone House		✓	
Packard Health		✓	
Parkridge Community Center		✓	
Parkway Meadows	✓		
Patient Food and Nutrition Services	✓		
SOS Community Services		✓	
Stockbridge Chamber of Commerce			✓
Stockbridge Community Schools			✓
Stockbridge Wellness Coalition			✓
UM School of Public Health, Nutrition Sciences, Dietetic Interns	✓	✓	
UM School of Public Health, Office of Public Health Practice	✓	✓	
United Way of Washtenaw County		✓	
Washtenaw Community College		✓	
Washtenaw County Commissioners		✓	
Washtenaw County Health Department	✓	✓	✓
Washtenaw Food Policy Council		✓	
Washtenaw Health Plan		✓	
Washtenaw Intermediate School District	✓	✓	✓
We the People Opportunity Farm		✓	
Ypsilanti Community Schools		✓	
Ypsilanti Heritage Festival	✓		
Ypsilanti Meals on Wheels	✓	✓	
Ypsilanti Public Library		✓	

CHNA IMPLEMENTATION STRATEGY
FISCAL YEARS 2022-2024

CHNA SIGNIFICANT HEALTH NEED:	Pre-conceptual and Perinatal Health
CHNA REFERENCE PAGE:	32

BRIEF DESCRIPTION OF NEED: Birth outcome disparities continue to persist among racial and ethnic minorities, largely due to institutional and systemic issues that inequitably distribute resources and opportunities. In Washtenaw County, babies born of Black/African American mothers are 4.3 times more likely to die in the first year of life than those of White/Caucasian mothers.

Research shows that babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those babies born to mothers who do get adequate prenatal care. It is essential to obtain early quality prenatal care to identify and treat health problems and health-compromising behaviors that can negatively impact fetal development. Increasing the number of women who receive early quality prenatal care can improve maternal and infant health outcomes and lower health care costs by reducing the likelihood of complications during pregnancy, childbirth, and postpartum.

GOAL: Increase positive outcomes for pre-conceptual and perinatal health. Improve the health and well-being of women, infants, children and families in greater Washtenaw County.

OBJECTIVE:

1. Reduce the infant mortality rate from 5.2 deaths per 1000 live births (2017-2019) to 4.5 deaths per 1000 live births (Source: MDHHS| Health for All).
    1.1. Reduce Black/African American Infant Mortality rates from 14 to 8 deaths per 1000 live births within Washtenaw County (Source: MDHHS| Health for All).
2. Increase the percentage of mothers who receive adequate prenatal care from 81.1% to 84% (Source: MDHHS| Health for All).

ACTIONS THE HOSPITAL FACILITIES INTEND TO TAKE TO ADDRESS THE HEALTH NEED, FISCAL YEARS 2022-2024, UNLESS OTHERWISE NOTED:

Michigan Medicine:

1. Train and educate providers, staff, and parents on safe sleep practices.
2. Continue the Maternal and Infant Health Program (MIHP) for pregnant women and infants up to one year of age.
3. Invest in community organizations, programs and advocacy that support mothers, infants, children, adolescents, and families in order to improve health.
4. Program for Multicultural Health will serve on the Region 9-Pre-conceptual and Perinatal Health Collaborative.
5. Regional Alliance for Healthy Schools will provide pre-conception and sexual activity risk reduction counseling, and offer confidential adolescent testing and treatment for sexually transmitted infection.
6. Regional Alliance for Healthy Schools will offer expectant parents' referrals to OBGYN, prescriptions for prenatal vitamins, referrals to local agencies for parenting and resource support, and vaccinations, including COVID vaccines.
7. Partner with community organizations to provide education and outreach related to pre-conceptual health and perinatal care.

St. Joseph Mercy Ann Arbor:

1. Launch St. Joe's Ann Arbor Perinatal Wellness Center which offers a safe, inclusive, and nonjudgmental space where women seek social, emotional, and physical support to help with their transition through pregnancy and the postpartum period.
2. Train and educate providers and staff on implicit bias.
3. Provide counseling and support groups for both mothers and fathers, specifically within 48197/48198.
4. Advocate for the provision of breastfeeding and prenatal education and support classes for free or greatly reduced rates for families in our community.
5. Support the Developmental Clinic (DAC) for Medicaid patients.
6. Launch a Diversity, Inclusion & Equity Committee within the Women's & Children Hospital Division to better collaborate, communicate, and support families and advance this work.

St. Joseph Mercy Chelsea:

1. Collect data on local needs related to prenatal care and education among expectant mothers in the service area.
2. Provide opportunities for learning, skill-building and social support for women and children.

Joint Hospital Systems Actions:

1. Explore opportunities to increase access to prenatal education and programs to support new mothers.
2. Partner with local Maternal and Infant Health Coalitions to advance the work
3. Invest in community organizations, programs and advocacy that support mothers, infants, children, adolescents, and families in order to improve health
4. Conduct regular community listening sessions to understand the experiences of minority mothers before, during and after pregnancy.
5. SJMC and SJMAA: Utilize Community Resource Directory to help support maternal and infant health initiatives
6. SJMC and SJMAA: Expand the presence of Faith Community Nursing staff throughout the community to provide maternal and infant health education support through faith communities.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Improve access to care and education for expectant mothers and fathers.
2. Reduction of infant mortality rates in Washtenaw County.
3. Reduction of maternal mortality rates in Washtenaw County or service area.
4. Increase in breastfeeding uptake and duration.
5. Improve patient experience.

PLAN TO EVALUATE THE IMPACT:

Michigan Medicine:
The Community Health Coordinating Committee will monitor progress of community grant programs' impact. Community Health Services staff will collect various metrics from staff on ongoing community benefit programming. For data inquiries please contact Community Health Services: 734-998-2156 or email communitybenefit@med.umich.edu.

St. Joseph Mercy Ann Arbor:
The SJMAA Community Benefit Ministry Council will monitor progress towards these outcomes by regularly collecting and analyzing program data. Each program has defined process and outcome measures to evaluate

impact. This data is collected and reported at regular intervals. Data sources include surveys, focus groups, key stakeholder interviews and archival data from hospital, law enforcement, school, and other records.

For data inquiries, please contact SJMC/SJMAA staff through www.stjoeshealth.org/cbm 'Contact' icon at the bottom of the webpage.

St. Joseph Mercy Chelsea
The SJMC Community Health Improvement Council will monitor progress towards these outcomes by regularly collecting and analyzing program data. Each program has defined process and outcome measures to evaluate impact. This data is collected and reported at regular intervals. Data sources include surveys, focus groups, key stakeholder interviews and archival data from hospital, law enforcement, school, and other records.

For data inquiries, please contact Reiley Curran, at (734) 593-5279, or reiley.curran@stjoeshealth.org.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Staff time to support the implementation of the actions listed above.
- Supplies and marketing for programs.
- Funding for programs, organizations, and advocacy.

COLLABORATIVE PARTNERS: Pre-conceptual and Perinatal Health

Collaborative Partner Name	Michigan Medicine	St. Joseph Mercy-Ann Arbor	St. Joseph Mercy-Chelsea
Catholic Social Services		✓	
Corner Health Center	✓	✓	
Michigan Prison Doula Initiative		✓	
Peace Neighborhood Center	✓		
Washtenaw Success by Six	✓		
Great Start Collaborative	✓		
Engage EMU	✓		
Region 9 Perinatal Quality Collaborative		✓	
USDA: Women, Infants, and Children (WIC)		✓	
United Way of Washtenaw County		✓	
SOS Community Services		✓	
Huron Valley Correctional Facility		✓	
Hope Clinic		✓	
Women's Center of Southeast Michigan	✓		

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2022-2024	
CHNA SIGNIFICANT HEALTH NEED:	Social Isolation
CHNA REFERENCE PAGE:	48

BRIEF DESCRIPTION OF NEED:

- A youth collaborative, based in Ypsilanti, evaluated health and safety concerns of young people (12-25) and found that 2 out of every 3 young people surveyed wish there were more opportunities to get to know their neighbors.
- Within Washtenaw County, the most positive social needs screened within primary care sites was the domain of Loneliness (as an equivalent to social isolation).
- Focus groups of pregnant women and mothers of young children in Washtenaw County revealed lack of social support and social isolation affect ability to return to work and had effects on mental health during the postpartum period.

GOAL: Increase social support and reduce the negative impacts of social isolation in greater Washtenaw County.

OBJECTIVE:

1. Reduce the proportion of patients who screen positive for social isolation by 1-2%. (Baseline: 6.3-15.4%) (*Source: UNITE member hospital and physician practice EMR)*

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED, FISCAL YEARS (FY) 20220-2024, UNLESS OTHERWISE NOTED:

Joint Hospital Systems Actions:

1. Screen patients for social needs at regular intervals. Refer those who screen positive to local resources or programs.
2. Review data collected and analyzed by the UM School of Public Health in 2018 and 2019. Identify additional data collection needs.
3. Develop, implement and evaluate a signature project to address social support over the next three years.
4. Develop a resource map of agencies, programs, services and policies that impact social support.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. A shared understanding of the current state of social support and social isolation in greater Washtenaw County, particularly among vulnerable populations
2. Increase investment in programs to address social isolation and social support.
3. Increase collaboration to create policy, systems and environmental changes to improve social support and decrease social isolation.

PLAN TO EVALUATE THE IMPACT:

The UNITE team will define outcome and impact measures to be tracked at regular intervals over the next three years. The results of this evaluation will be shared with the communities via internal and external methods.

PROGRAMS AND RESOURCES THE HOSPITALS PLANS TO COMMIT:

- Staff time to support the implementation of the actions listed above.
- Supplies and marketing for programs.
- Funding for programs, organizations, and advocacy.

COLLABORATIVE PARTNERS: Social Isolation

Collaborative Partner Name	Michigan Medicine	St. Joseph Mercy-Ann Arbor	St. Joseph Mercy-Chelsea
UM School of Public Health	✓	✓	✓
5 Healthy Towns Foundation	✓	✓	✓
Chelsea Ministerial Association			✓
Chelsea Police Department			✓
Chelsea School District			✓
Chelsea Senior Center			✓
Chelsea Wellness Coalition			✓
Chelsea-area Chamber of Commerce			✓
City of Chelsea			✓
City of Dexter			✓
Dexter Chamber of Commerce			✓
Dexter Community Schools			✓
Dexter Internal Medicine			✓
Dexter Ministerial Association			✓
Dexter Senior Center			✓
Dexter Wellness Coalition			✓
Faith in Action			✓
Grass Lake Community Wellness Initiative			✓
Grass Lake School District			✓
Grass Lake Senior Center			✓
Manchester Community Schools			✓
Manchester Wellness Coalition			✓
MSU Cooperative Extension 4-H office			✓
National Alliance on Mental Illness	✓	✓	✓
Scouts			✓
Stockbridge Chamber of Commerce			✓
Stockbridge Community Schools			✓
Stockbridge Police Department			✓
Stockbridge Wellness Coalition			✓
Washtenaw Area Council on Children	✓	✓	✓
Washtenaw County Community Mental Health	✓	✓	✓
Washtenaw County Sheriff	✓	✓	✓
Washtenaw Intermediate School District	✓	✓	✓
Washtenaw County Health Department	✓	✓	✓

Social Determinants of Health

Social Determinants of Health (SDOH) have always been a lens which UNITE has utilized in order to impact the three health priority areas of (1) Mental Health and Substance Use Disorders, (2) Obesity and Related Illnesses and (3) Pre-conceptual and Perinatal Health. According to the Centers for Disease Control (CDC), SDOH are "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." For more information about Social Determinants of Health, please see https://www.cdc.gov/socialdeterminants/about.html.

UNITE's Community Health Needs Assessment published in June, 2021, identified six key Social Determinants of Health (SDOH) that impact each of the identified health priority areas. The SDOH identified by UNITE include three primary SDOH:

1. Housing/Homelessness
2. Poverty
3. Social Isolation

And three emerging SDOH:

1. Climate Change
2. Incarceration
3. Medical Debt

UNITE will be addressing Social Isolation collaboratively (see table above). Recognizing the importance of six named Social Determinants of Health (SDOH), each hospital will engage in some level of programming/tactics related to addressing one or more of the remaining SDOH. These activities are summarized below.

Michigan Medicine
Michigan Medicine will continue community-based funding related to health equity and Social Determinants of Health, including the below:

Housing/Homelessness:
- Collaborate, support and/or fund training for parents, families, and residents that equip them with the skills to organize and advocate around issues related to poverty, housing, and more.
- Partner with community organizations to support housing and shelter opportunities for unhoused individuals exiting the hospital, and ensure adequate housing resources for people with mental illness and substance use disorders.
- Provide tax filing support to older adults to support continuation of stable housing.

Poverty:
- Engage in Healthcare Anchor Network activities to develop strategies for improving local hiring practices.
- Partner with, support, and or advocate for anti-poverty efforts.

Climate Change:
The University of Michigan has committed to the following:
- Eliminate Scope 1 emissions (resulting from direct, on-campus sources) by 2040.
- Achieve carbon neutrality for Scope 2 emissions (resulting from purchased electricity) by 2025.

- Establish net-zero goals for Scope 3 emissions categories (resulting from indirect sources like commuting, food procurement, and university-sponsored travel) by 2025.

For more information about these commitments, please see
http://sustainability.umich.edu/carbonneutrality#scope-1-emissions-initial-reduction-strategies

Additionally, Michigan Medicine will explore

- Support of programs that improve resilience and reduce the impact of climate change on vulnerable communities within the Michigan Medicine service area.
- Support of programs that reduce the impact of toxins/environmental injustice.

Incarceration:

- Partner with, support, and/or advocate for restorative justice programs and practices, social supports, prevention, and alternatives to police and organizations that support people experiencing and exiting incarceration.
- Explore programs for youth that disrupt the school to prison pipeline.
- The Trauma/Burn program will provide programming to youth involved in fire-setting to reduce arrest and recidivism.

Medical Debt:

- Michigan Medicine will continue to provide Financial Assistance through the MSupport program.
- Support the Washtenaw Health Plan (WHP) to ensure health coverage for individuals who are ineligible for Medicaid.

St. Joseph Mercy Ann Arbor

St. Joseph Mercy Ann Arbor's Community Health & Well-Being strategy includes impacting Social Determinants of Health as a key pillar of our work. Through advocacy and anchor strategy initiatives, SJMAA will augment our effort to address the root cause of SDOH and devise a more robust plan to address these topic areas. Below are initiatives SJMAA is or will be engaged in.

Housing/Homelessness:

- Explore how St. Joseph Mercy Ann Arbor can utilize campus land to support workforce housing
- Continue to offer free or subsidized rent to community-based organizations (Washtenaw Housing Alliance, Alpha House, Catherine's House and HouseN2 Home) to support shelters, transitional housing, furnishing homes, and assisting clients with obtaining jobs.

Poverty:

- Engage in Healthcare Anchor Network activities to develop strategies for improving local hiring practices and workforce development
- Continue to offer free or subsidized rent to community-based organizations (i.e. Dress for Success) to support the distribution of professional attire for work and development tools to help women thrive at work and in life.
- Continue to provide charitable contributions to community-based organizations to address poverty and other social determinants of health.

Climate Change:

- Continue initiatives related to energy conservation, waste reduction, decreasing dependency on plastic products, increasing recycling efforts, and overall efforts to reduce our carbon footprint as a healthcare institution.

- Leverage the power of stock ownership in publicly-traded companies to promote environmental change such as reducing greenhouse gas emissions and encouraging the development of sustainability reports.

Incarceration:
- Support efforts through the Washtenaw County Mental Health and Safety Millage.
- Partner with the Washtenaw Sheriff's Department to explore collaboration opportunities.

Medical Debt:
- St. Joseph Mercy Ann Arbor will provide Financial Assistance to patients in need.
- Support the Washtenaw Health Plan (WHP) to ensure health coverage for individuals who are ineligible for Medicaid.

St Joseph Mercy Chelsea
St. Joseph Mercy Chelsea will continue community-based funding related to health equity and Social Determinants of Health, including the below:

Housing/Homelessness:
- Collaborate, support and/or fund training for parents, families, and residents that equip them with the skills to organize and advocate around issues related to poverty, housing, and more.
- Partner with community organizations to support housing and shelter opportunities for unhoused individuals exiting the hospital, and ensure adequate housing resources for people with mental illness and substance use disorders.

Poverty:
- Engage in Healthcare Anchor Network activities to develop strategies for improving local hiring practices.
- Partner with, support, and or advocate for anti-poverty efforts.

Climate Change:
- Continue initiatives related to energy conservation, waste reduction, decreasing dependency on plastic products, increasing recycling efforts, and overall efforts to reduce our carbon footprint as a healthcare institution.
- Leverage the power of stock ownership in publicly-traded companies to promote environmental change such as reducing greenhouse gas emissions and encouraging the development of sustainability reports.

Incarceration:
- Support efforts through the Washtenaw County Mental Health and Safety Millage.
- Partner with the Washtenaw Sheriff's Department to explore collaboration opportunities.

Medical Debt:
- St. Joseph Mercy Chelsea will continue to provide Financial Assistance through the McAuley Support program.
- Support the Washtenaw Health Plan (WHP) to ensure health coverage for individuals who are ineligible for Medicaid.
- Provide enrollment assistance in partnership with local safety net organizations, to help uninsured people access health insurance.

Conclusion

On October 26, 2021, the local Board of Trustees for St. Joseph Mercy Chelsea met to discuss the 2022-2024 Implementation Strategy for addressing the community health needs identified in the 2021 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget. Subsequently, the Joint Venture Board of Trustees for St. Joseph Mercy Chelsea reviewed and approved this Implementation Strategy on October XX, 2021.

On October 27, 2021, the local board for St. Joseph Mercy Ann Arbor met to discuss the 2022-2024 Implementation Strategy for addressing the community health needs identified in the 2021 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy.

On November 4, 2021, the Michigan Medicine health system executive committee met to discuss the 2022-2024 Implementation Strategy for addressing community health needs identified in the Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy.

Acknowledgements

The work of the UNITE collaborative would not have been possible without the commitment of numerous partners. We wish to thank Washtenaw County Public Health, the Washtenaw Health Initiative, the University of Michigan School of Public Health Office of Public Health Practice for their support of this work. We are grateful to the members of our internal committees for their contributions to the plan.

We also want to thank our executive leadership for their support of the work. Without their support we would not be able to continue doing this good work in the community.

We are especially thankful to community organizations, members and groups for helping us shape our understanding of the community's needs and how to best respond to priorities and the existing gaps.

WASHTENAW HEALTH INITIATIVE

2021

IMPACT REPORT

WASHTENAW HEALTH INITIATIVE

ATTACHMENT #9
NOVEMBER 2021

WASHTENAW HEALTH INITIATIVE

2021 IMPACT REPORT

In 2021, the Washtenaw Health Initiative celebrated its 10th anniversary.

During this anniversary year, the Washtenaw Health Initiative:

- advanced the critcally important goals of the WHI's active workgroups;
- focused on integrating diversity, equity, and inclusion objectives in WHI programs and operations;
- developed new programs, and new sources of support, that show tremendous promise for addressing inequities and improving health;
- enhanced communications to address information needs during the COVID-19 pandemic;
- documented the WHI's impact over the last 10 years;
- and implemented a series of improvements to ensure that the WHI is positioned to have a greater impact in the years ahead.

To improve health, health equity, and health care for low-income, uninsured, underinsured, and underrepresented populations across Washtenaw County.

WASHTENAW HEALTH INITIATIVE

2021 IMPACT

CONTENTS

CHRT

FACILITATED BY THE CENTER FOR HEALTH AND RESEARCH TRANSFORMATION

WASHTENAW HEALTH INITIATIVE

Advance active work

The investments that the Washtenaw Health Initiative receives from Michigan Medicine and the St. Joseph Mercy Health System are critical. They primarily fund staff time--roughly three full-time equivalent positions--to support the WHI's active work groups.

Workgroup highlights in 2021 included:

Healthy Aging Collaborative. In an effort to identify the needs of seniors, and to improve the county's services for this growing population, the Washtenaw County Board of Commissioners established a new Commission on Aging. The new commision needed local experts to support its work—providing guidance on existing aging services, as well as gaps in services as they relate to the needs of seniors and their families.

- **Impact:** The Washtenaw County Healthy Aging Collaborative was formed to offer guidance to the county commission. It includes local representatives from a dozen critical aging service sectors.

Opioid Project. Several Opioid Project members were invited to join the transition team for Washtenaw County's new prosecutor, Eli Savit. They provided input on medications used to effectively treat Opioid Use Disorder and challenges around implementing and participating in medication assisted treatment.

- **Impact:** Two new policies were announced by the prosecutor's office. The first allows possession of personal-use amounts of Buprenorphine, a medication regularly used to treat Opioid Use Disorder. The second allows possession of personal-use amounts of Methadone, which is more often prescribed for people of color. Together, these policies ensure that individuals with opioid use disorder are able to use gold standard treatments, and that justice is dispensed evenhandedly.

Vital Seniors Network. Launched and led a successful Home Nutrition+ pilot, providing home-based social needs assessments, medically-friendly meals, and referrals to community-based services, to more than 100 seniors and individuals with disabilities.

- **Impact:** The pilot program was shown to improve health, reduce falls, and reduce unnecessary hospitalizations. Based on these results, we secured outside grants that will allow us to expand the network in southeastern Michigan, and perhaps beyond.

WASHTENAW HEALTH INITIATIVE

Advance active work

Workgroup highlights in 2021 continued:

MI Community Care (MiCC). The MiCC group continued to convene local health and human service organizations to provide patient-centered, coordinated care to individuals with complex medical, behavioral and social needs. While funding for this program was uncertain for the first few months of 2021, since April the program has expanded dramatically.

- **Impact:** In July alone, MiCC supported 122 residents. Most of these individuals (78.7 percent) had Medicaid or Medicare coverage, or were initially uninsured. Twenty-four percent identified as Black or African American; 2.3 percent as Arab or Middle Eastern; and 2.3 percent as Hispanic or Latino. With new funding secured in 2021, the MiCC program will continue to expand in service and impact.

Unified Needs Assessment Implementation Plan Team Engagement Group (UNITE). The UNITE group, comprised of Washtenaw County's non-profit hospitals and health department, once again worked on a collaborative community health needs assessment, and community investment plans, to magnify the impact of hospital investments on community health. This year, the group completed its community health needs assessment one year early to reflect on the impact of COVID-19 on previously identified priority focus areas.

- **Impact:** COVID-19 created new challenges for these health systems as their priorities shifted to combat the pandemic. UNITE members still managed to find time to prioritize collaboration and partnership throughout the pandemic.

Mental Health and Substance Use Disorders (MHSUD). After an intensive systems change effort in 2020, the MHSUD workgroup met quarterly in 2021 to solicit feedback from group members and develop recommendations for future work. Topics of discussion this year included the impact of COVID-19 on MHSUD services, proposed changes to that state's Medicaid behavioral health policies, and ways in which the public behavioral health system can better address racial disparities in health outcomes.

WASHTENAW HEALTH INITIATIVE

Advance active work

Workgroup highlights in 2021 continued:

- **Impact:** In 2020, the MHSUD group was heavily engaged in a systems change process designed to improve SUD treatment access and quality across the county. Very soon, one of the key goals outlined by the group will be implemented, leading to 24/7 access to SUD support.

Medicaid and Marketplace Outreach and Enrollment (MMOE). As in previous years, more than 10,000 English and Spanish flyers were distributed across Washtenaw County to raise awareness about trustworthy counselors who provide free support with Medicaid and Marketplace health insurance applications.

- **Impact:** This year, electronic and paper flyers were also delivered to K-12 schools, colleges, faith -based organizations, healthcare clinics, county offices, COVID-19 testing centers, EMS providers, food pantries, and employment organizations. These community partners distributed even more flyers to their clients.

WASHTENAW HEALTH INITIATIVE

Emphasize equity

Recruited new Steering Committee members with DEI experience:

- Sharon Moore, a retired UAW / Ford auto worker and a Packard Health Steering Committee member;
- Dr. Tendai Thomas, chair of the diversity, equity, and inclusion advisory council for Integrated Health Associates (IHA);
- Pastor Mashod Evans, an itinerant elder in the African Methodist Episcopal Church and senior pastor of Bethel AME Church in Ann Arbor; and
- Angela Moore, a lifelong Washtenaw County resident with lived experience that is of direct relevance to the WHI mission.

Hired new staff with DEI experience:

- Erin Horne, MSW, community engagement project manager, provides strategic support focused on health care equity and justice for underrepresented minorities, vulnerable elders, and others

Improved policies and procedures:

- Embarked on a listening campaign to understand member perspectives on diversity, equity, and inclusion
- Updated the WHI's mission statement to include health equity
- Updated the WHI's operational principles to include health equity and relevant focus areas
- Updated the WHI's member commitment statement to request that members demonstrate an explicit focus on DEI
- Implemented a biannual work group reporting requirement, with an explicit focus on equity
- Conducted a self-assessment for diversity, equity, and inclusion to collect benchmark data
- Developed an inventory of grassroots organizations and community groups to learn how their work may connect with the WHI and to prepare for outreach.

WASHTENAW HEALTH INITIATIVE

Launch new initiatives

Launched an Annual Wellness Visit improvement initiative

The need: Annual Wellness Visits (AWVs) give patients an opportunity to speak with physicians about their health, mental health, and social concerns. AWVs give providers an opportunity to offer preventive care, screenings, and chronic disease management. But while AWVs are beneficial for both patients and providers, the use of AWVs is low nationwide, especially among individuals with low incomes and ethnoracial minorities. The persistence of low AWV utilization rates among communities of color is of particular concern.

- **Intended impact:** The WHI and its partners, Michigan Medicine and IHA, hope to identify which patients are absent in care for Annual Wellness Visits and the root causes that may be contributing to disparities. To do so, partners will provide aggregated Medicare AWV data for the last three years and the WHI will analyze the data by race, disability, age, and zip code. With this data, the WHI will facilitate conversations about health and racial disparities, potential root causes, and strategies for closing the gaps.

Launched community integrated health network pilot

The need: During the COVID-19 pandemic, many Washtenaw County seniors and vulnerable populations with chronic conditions found themselves homebound, with limited access to groceries, increasing social isolation, and mounting social needs. Local senior service leaders wanted to become a community integrated health network, so they could contract with health insurers and systems to provide medically-friendly meals to this population. The pilot design built on evidence that links medically tailored meals to improvements in health and wellness.

- **Intended impact:** With support from the WHI and its backbone organization, CHRT, these senior service leaders became a community integrated health network and partnered with Priority Health to conduct a pilot, visiting dual-eligible Medicare and Medicaid clients with specific chronic conditions, screening them for social needs, delivering medically-friendly meals, and providing community-based service referrals. The pilot program participants experienced improvements in overall health and wellness, reductions in falls and unnecessary hospitalizations, and more.

WASHTENAW HEALTH INITIATIVE

Leverage investments

Whenever possible, health system-funded Washtenaw Health Initiative staff members leverage Michigan Medicine and St. Joseph Mercy Health System investmets to attract outside grants to advance high-impact WHI activities.

This year, five commitments in the range of $2.3 million were made to support and expand programs that were launched and nurtured in the WHI.

Promotion of Health Equity **$1.3 million**

The U.S. Centers for Medicare and Medicaid Services have pledged to provide a 90/10 Medicaid match in support of a Promotion of Health Equity project. Over the next two years, CHRT will facilitate the delivery of social services provided by the state's former Community Health Innovation Regions (CHIRs) in Genesee, Jackson, and Kent Counties. In Livingston and Washtenaw Counties, the grant will support the WHI's MI Community Care program.

MI Community Care **$507,000**

The U.S. Centers for Disease Control has made a $507,000 commitment to support the work of Michigan's former Community Health Innovation Regions, including the MI Community Care program in Livingston and Washtenaw Counties.

Home Nutrition+ **$401,564**

Three new grants from the Thome Foundation ($50,000) Ann Arbor Area Community Foundation ($60,000) and U.S. Administration for Community Living ($291,564) support the development of the local network of social service providers that launched the Home Nutrition+ pilot, which emerged from the WHI's Vital Seniors Project. CHRT will function as a Network Lead Entity (NLE) to help these providers become a formal community integrated health network so they can contract with health plans to address key social determinants of health related to food insecurity, and other needs, for adults aged 60+ and those with disabilities under the age of 60. The program will expand through southeastern Michigan, and perhaps beyond.

WASHTENAW HEALTH INITIATIVE

Enhance communications

The Washtenaw Health Initiative Communications Committee, co-chaired by Liz Conlin and Maria Alfonso, set ambitious goals for 2021 communications.

Due to the pandemic, and urgent, unmet community information and support needs, the committee set a goal of sending monthly e-newsletters with COVID-19 information, free and low-cost community resources, and grant opportunities. These e-newsletters achieved a 37 percent open rate and 28 percent click-through rate, well above industry standards.

In addition to the items referenced above, the e-newsletters included:

- WHI member organization spotlights for Integrated Health Associates (IHA), Dawn Farm, Huron Valley Ambulance (HVA), and others.
- Voice of the WHI interviews with longstanding WHI stakeholders, including Margy Long, director of Washtenaw Success by 6, Versell Smith, director of the Corner Health Center in Ypsilanti, and Jack Billi, professor of internal medicine.
- Stories about the WHI's new collaborative impact award, annual wellness visit initiative, and health insurance outreach opportunities.

In addition, the WHI Communications Committee developed:

- a new award to recognize high-impact community health collaborations;
- an interactive, historical timeline of WHI accomplishments;
- an enhanced website to showcase workgroup activities and attract partners; and
- a 10th anniversary stakeholders meeting with panel to discuss unmet health needs.

Finally, the WHI communications team supported WHI workgroup initiatives. Materials developed to serve this need in 2021 included:

- For free and low-cost insurance, seek new health care coverage during this year's special enrollment period, requested by the WHI's Medicaid and Marketplace Outreach and Enrollment (MMOE) workgroup. Packard Clinic shared this with hundreds of patients.
- American Rescue Plan benefits, a two-page overview for clients, requested by a former member of the MMOE group. Document shared with thousands of low-income residents.
- Health insurance myths, a two-page overview for clients, requested by members of the MMOE workgroup to explain why health insurance is valuable, even when you're healthy.

WASHTENAW HEALTH INITIATIVE

Plan for 2022

Plans for calendar year 2022 include:

- Expand the senior services network behind the Home Nurition+ pilot to additional southeastern Michigan counties, and perhaps beyond, by formalizing a regional community integrated health network that allows payers and health systems to reimburse social service agencies for addressing social needs.
- Facilitate Health Equity Project rollout in five Michigan counties, including Genesee, Jackson, Kent, Livingston, and Washtenaw; collect racial, ethnic, and socioeconomic data from regional partners; collect service data from regional partners; support researchers as they analyze data to identify best practices for addressing inequities.
- Analyze and report on Medicare Annual Wellness Visit data from IHA and Michigan Medicine. Provide research and support to partners as they plan policies and procedures to encourage more equitable use of these critically important preventive benefits.
- Develop one new MI Community Care pilot initiative, with funding from the U.S. Centers for Disease Control and Prevention grant, that is designed to improve access to care for individuals with complex lives and medical conditions.
- Find ways to engage more diverse community partners--including grassroots organizations and community groups--in the work of the Washtenaw Health Initiative through Steering Commitee membership, work group participation, and other mechanisms.
- Solidify an organization-wide commitment to diversity, equity, and inclusion by having all WHI member organizations resign our revised membership charter.
- Explore community information exchange needs in Washtenaw County, including the data systems used by community partners, interoperability between these systems, and more.

WASHTENAW HEALTH INITIATIVE

Document historic impact

In 2012

- Developed and disseminated a county-wide detox protocol for those who would benefit from medically supported detox services
- Informed the development of a dental pilot, which would serve patients without dental coverage at a reduced fee based on their income, a significant need in Washtenaw County

In 2013

- Facilitated a BlueCaid pilot at Michigan Medicine's Ypsilanti Family Medicine health care center, connecting new Medicaid enrollees to primary care physicians and social services within 90 days of enrollment
- Hosted monthly meetings of care managers, designed to strengthen the network between care managers and provide educational opportunities to improve their knowledge base
- Assessed the needs of local safety net clinics and identified priority focus areas for improving capacity and services (informed clinic advancements)

In 2014

- Assessed mild and moderate mental health capacity at community-based primary care safety net clinics (informed future programs)
- Met with the Snyder Administration to share evidence and findings pertinent to expanding Medicaid eligibility in the state (informed decision to expand Medicaid)
- Coordinated community-wide education, outreach, and enrollment efforts for Medicaid and Marketplace enrollment (have continued to do this every year since)
- Supported an acute dental care pilot including a referral process for patients presenting at hospitals with abscess-related diagnoses
- Helped MHSUD workgroup co-chairs develop a Tailored Mental Health Management and Support (TaMMS) project to manage the treatment of depression and anxiety for patients served by safety net clinics

In 2015

- Facilitated conversations between the St. Joseph Mercy Health System and the Michigan Medicine Health System to devlop a joint hospital community health needs assessment (the two have continued to build on and expand this collaboration, with WHI support, in the intervening years)

WASHTENAW HEALTH INITIATIVE

Document historic impact

In 2015, continued

- Submitted a proposal to serve as the backbone organization for the Livingston Washenaw Community Health Innovation Region, a critical part of Michigan's Sate Innovation Model
- Published a County Dental Assessment, offering history and context surrounding county dental care, analyzing access and cost issues for different populations, and illustrating the impact of oral health on physical health
- Hosted a film and panel discussion at the Michigan Theatre in downtown Ann Arbor about communicating about and preparing for end-of-life care
- Hosted a substance use disorder harm reduction training program, sharing tools and best practices

In 2016

- Completed assessment of acute dental pilot - 71 percent of qualifying patients were treated
- Selected as the coordinating organization for the Livingston-Washtenaw Community Health Innovation Region SIM project
- Educated hundreds of Washtenaw County teens about substance use and opioid use disorders
- Completed a Mental Health and Substance Use Service Gaps Assessment - later used to inform the development of the successful Public Safety and Mental Health Preservation Millage ballot initiative

In 2017

- Received approval for SIM operational plan at the LIvingston Washtenaw Community Health Innovation Region (plan included community health needs assessment, intervention designed to link frequent ED users with clinical and social services)
- Applied for a grant from the Community Foundation for Southeast Michigan to research the impact of the Livingston Washtenaw SIM care coordination program; began pilot testing for associated care coordination intervention

WASHTENAW HEALTH INITIATIVE

Document historic impact

In 2017, continued

- Completed first SIM social needs assessment report, reporting social needs screening results, to show a snapshot of social needs in Washtenaw County
- Published "Making Your Health Care Wishes Known" advance care planning conversation guide

In 2018

- Celebrated the TaMMS pilot, which the WHI helped get off the ground, which served 585 participants during its six years of operation (showed statistically significant decreases in depression and anxiety symptoms among participants; the data was instrumental in Michigan's decision to expand coverage for mental health services)
- Hosted first Washenaw County Opioid Summit, atracting more than 400 attendees including numerous government officials and community-based organizations
- Hosted the first of several convenings designed to improve the county's substance use disorder treatment system (participants identified a common vision and goals)

In 2019

- Completed two more substance use disorder system improvement convenings (developed an action plan including what to do, how to fund it, and how to see it through)
- Began to provide support for Vital Seniors Initiative grantees as they worked to improve the county's senior service system in preparation for Washtenaw's coming age wave
- Helped to prepare Washenaw County's Medicaid enrollees understand and conform to the state's new work requirements for Medicaid (these were eventually overturned)
- Helped community partners develop a strategic plan to improve the homeless response system in Livingston and Washtenaw Counties

In 2020

- Worked with community partners to implement strategic plan for the county's homeless response systems with a special focus on diversion (this has shown impressive results)

WASHTENAW HEALTH INITIATIVE

To Washtenaw Health Initiative Steering Committee Members and Workgroup Co-Chairs
From Elizabeth Jahn, Business & Finance Director, Center for Health and Research Transformation
Date November 5, 2021
Re 2022 Budget

FY21 Year-End projection

A financial report through September 30th and a year-end projection is attached. Overall, expenses are in line with budget. Since plans for an in-person WHI 10th Anniversary were changed due to the pandemic, funds were redirected to cover additional staffing, communications expense, and WHI data dashboard training.

FY22 Proposed Budget

The proposed FY22 budget is attached for your review. It has been developed using a focus on each work group area and the plan that has been set for next year, with a continued focus on racial equity work. The table below shows the breakdown of proposed FTE, salaries, and benefits, as well as direct expenses for each area of the WHI.

The budget assumes funding at continued levels of support from Michigan Medicine ($250,000), St Joseph Mercy ($80,000), Washtenaw County ($10,000) and the City of Ann Arbor ($10,000).

	Budget FY21 FTE	Actual FY21 FTE	Budget FY22 FTE	Salaries + Benefits	Direct Expenses
Operations (1.62 FTE) and Comms (.5 FTE)	1.87	2.03	2.12	$214,163	$31,150
Healthy Aging Collaborative	.15	.24	.15	$15,935	
UNITE Group	.25	.23	.2	$16,432	
MMOE	.25	.22	.2	$21,778	$5,000
Mental Health and Substance Use Disorder	.6	.6	.5	$48,347	
SUBTOTAL	**3.12**	**3.32**	**3.17**	**$316,655**	**$36,150**
Occupancy Recharge					$12,500
TOTAL					**$365,305**

Facilitated by:

CHRT
Center for Health and Research Transformation

FY22 Proposed Budget Detail

The WHI Finance Committee met on November 4th to review two budget scenarios, a break-even budget and this proposed budget that would tap into approximately $15,000 from the operating reserve to cover several communications initiatives including:

$10,000	Professional development for advanced data dashboard training and collective action training for staff serving WHI workgroups and workgroup members
$5,000	Website enhancements (design and development of dynamic pages for workgroups, a healthy aging microsite, a mechanism to better showcase member organizations, and a mechanism to showcase Voice of the WHI interviews with longstanding members)
$2,500	2022 WHI impact report
$2,500	Promotion of the Washtenaw Health Initiative and its workgroups
$750	2022 Collaborative Health Impact Awards

The budget also includes stipends for 2 Community Ambassadors to serve on the WHI Steering Committee.

Recommendation for Approval and Reserve Fund Implications

The WHI Finance Committee unanimously supported the proposed budget of $365,305, drawing upon $15,305 from the WHI's reserve fund, which would leave a reserve fund balance of approximately $150,000.

ATTACHMENT #9
NOVEMBER 2021

Washtenaw Health Initiative (WHI)
FY21 Year-End Projection and FY22 Proposed Budget

	2019 Actual	2020 Budget	2020 Actual	2021 Budget	2021 YTD (Jan-Sep)	2021 Projection	2022 Proposed Budget
Operating Revenue							
Grants & Contributions	337,400	330,000	320,000	350,000	340,000	350,000	350,000
Opioid Project	48,441	56,764	38,555	-			
Millage		25,000		-			
Total Revenue	**$ 385,841**	**$ 411,764**	**$ 358,555**	**$ 350,000**	**$ 340,000**	**$ 350,000**	**$ 350,000**
Operating Expenses - Administrative							
Staffing							
Salaries	231,593	238,381	229,868	223,403	168,984	246,001	249,527
Benefits/FICA	59,033	66,804	57,138	65,814	42,550	60,720	67,128
Subtotal	**$ 290,626**	**$ 305,185**	**$ 287,005**	**$ 289,218**	**$ 211,534**	**$ 306,720**	**$ 316,655**
Direct Expenses - Administrative							
Travel	2,347.59	5,500.00	626	3,000			2,000
Professional Development	381.17	500.00	380	500	1,126	6,076 [2]	12,000
Communication	6,235.00	7,000.00	4,372	12,500	13,691	14,555	10,750
Racial Equity / Other				10,000 [1]		-	
Community Ambassadors							2,400
Supplies & Misc	203.80	1,000.00	116	500	1,389	1,128	1,000
Legal Expense	1,748.00	2,500.00	-	2,000	-	-	1,000
Hospitality/Meeting Expenses	3,202.84	5,000.00	751	2,000	227	227	2,000
Subtotal	**14,118.40**	**21,500.00**	**$ 6,245**	**$ 30,500**	**$ 16,433**	**$ 21,986**	**$ 31,150**
Direct Expenses - Program							
CHRT Policy Brief	-	15,000.00	-				
MMOE	4,311.40	4,500.00	2,572	4,500	501	3,001	5,000
Opioid Summit	9,328.91	10,342.00	3,695				
Subtotal	**$ 13,640**	**29,842.00**	**$ 6,267**	**$ 4,500**	**$ 501**	**$ 3,001**	**$ 5,000**
Occupancy Recharge	25,153	33,500	19,923	25,000	14,798	18,000	12,500
Total Operating Costs	**$ 343,538**	**$ 390,027**	**$ 319,441**	**$ 349,218**	**$ 243,266**	**$ 349,707**	**$ 365,305**
Net Income (Loss)	**$ 42,302**	**$ 21,737**	**$ 39,114**	**$ 782**	**$ 96,734**	**$ 293**	**$ (15,305)**
WHI Fund Balance	**$ 124,823**	**$ 146,560**	**$ 163,938**	**$ 164,720**		**$ 165,012**	**$ 149,708**

[1] Racial Equity direct expense budget was reallocated to cover staffing focused on development of a deliverable that will be done in-house.
[2] WHI data dashboard training for CHRT staff assigned to WHI workgroups.
[3] WHI Finance Committee supportive of proposed use of reserve funds to support planned work.