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

**** In person at the Learning Resource Center-Michigan Room**
4135 Washtenaw Ave, Ann Arbor
Or you may attend virtually at https://zoom.us/j/94013420152
February 25, 2022
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-12/17/21 (Attachment #1A)
- B. WCCMH Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions-12/13/21 (Attachment #1B)
- C. One Pager on Workforce Crisis (Attachment #1C)
- D. CMHPSM Performance Improvement Policy (Attachment #1D)
- E. CMHPSM Behavior Treatment Committee Policy (Attachment #1E)
- F. MILLAGE COMMITTEE: (reviewed/approved at the 2/14/22 MAC meeting)
  1. WCCMH Millage Advisory Committee Meeting Minutes and Actions-12/13/21 (Attachment #1F1)
  2. Millage Process, Investments and Progress Update (Attachment #1F2)
  3. Strategic Planning Update (Attachment #1F3)
  4. Funding Requests Reviewed and Approved for a total of $698,069.00 (Attachment #1F4)
     - a. Community, Leadership, Revolution (CLR) Academy-$45,000.00/1 year (Attachment #1F4a)
     - b. WCCMH Wraparound Position $85,305.00/Annual/Continuous (Attachment #1F4b)
     - c. Office of Community and Economic Development (OCED) Family Empowerment Program $69,573.00 Annually/3 years totaling $210,218.00(Attachment 1F4c)
     - d. Office of Community and Economic Development (OCED) Michigan Ability Partners (MAP) $357,546.00/1 year (Attachment 1F4d)
- G. WCCMH Consumer Advisory Council Meeting Minutes and Actions-12/8/21 (Attachment #1G)
- H. WCCMH Consumer Advisory Council Meeting Minutes and Actions-1/12/22 (Attachment #1H)
- I. Consumer Advisory December 2021 Newsletter (Attachment #1I)
- J. Recipient Rights Annual Report (Attachment #1J)
- K. Program Education Presentation on CMH Nursing (Attachment #1K)
- L. Program Dashboard FY21 Quarter 4 (Attachment #1L)

V. Treasurer's Report **ACTION** (20 minutes)
- WCCMH Financial Status Report (Attachment #2) **N. Phelps ACTION**
- WCCMH Millage and CCBHC Financial Status Report (Attachment #3) **N. Phelps ACTION**
- FY 2022 Budget Amendment (Attachment #4) **N. Phelps ACTION**

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

VII. CMHPSM Regional Update (10 minutes)
- February 9, 2022 Regional Meeting Update

VIII. New Business (15 minutes)
- Health Home Overview (Attachment #5) **T. Cortes/B. Hagaman**

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 (35 minutes)
- WCCMH 2022 Annual Board/Committee Meeting Schedule (Attachment #6) **ACTION**
- WCCMH 2022 Annual Board Calendar (Attachment #7) **ACTION**
- CCBHC Update **T. Cortes/M. Harding**
- Strategic Planning Update (Attachment #8) **T. Cortes/M. Harding**
- Update on One Pager on Workforce Crisis (Attachment 9) **T. Cortes**
- WCCMH Board members appointed by Board of Commissioners with terms of 4/1/22-3/31/25 (Attachment #10)
    - K. Scott-Secondary Consumer
    - A. LaBarre-Board of Commissioner Representative
    - A. Rooks-Community Member
    - B. King-Community Member

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

XI. Adjournment of Public Meeting

****Board members are encouraged to participate in person unless other arrangements have been made in advance.**

VIRTUAL MEETING LINK IS:

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. https://zoom.us/j/94013420152

Or One tap mobile:
+12678310333, 94013420152# US (Philadelphia)
+13126266799, 94013420152# 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: 940 1342 0152

International numbers available: https://zoom.us/u/aby0K1GiUE

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 AGENCY (WCCMH)
WCCMH BOARD MEETING MINUTES *DRAFT*

https://zoom.us/j/97998847993

December 17, 2021
9:30am

K. Walker called the meeting to order at 9:32 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 B. King attending remotely from Ann Arbor, Washtenaw County, MI A. LaBarre attending remotely from Ann Arbor, Washtenaw County, MI A. Rooks attending remotely from Chelsea, Washtenaw County, MI K. Scott attending remotely from 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, R. Jefferson
STAFF PRESENT:	T. Cortes, M. Harding, R. Dornbos, N. Phelps, H. Linky, K. Snay, S. Amos O'Neal, L. Gentz, S. Ray, M. Taylor, T. Florence, M. Tasker
OTHERS PRESENT:	L. Lutomski, T. Gavalier, G. Nelson, J. Osborn, L. Maharg, N. Heine

I. Introductions
- None

II. Audience Participation
- L. Maharg introduced themselves as the new board president from NAMI Washtenaw.

III. Board response to audience participation
-

IV. Consent Agenda Actions (Attachment #1)
- WCCMH Board Meeting Minutes and Actions-11/19/21
- WCCMH Budget-Finance Committee Meeting Minutes and Actions-11/8/21
- WCCMH Program-Quality Committee Meeting Minutes and Actions-11/8/21
- Wraparound and SED Waiver Presentation
- WCCMH Executive Committee Meeting Minutes and Actions-6/14/21
- Millage Committee:
    1. WCCMH Millage Advisory Committee Meeting Minutes and Actions-11/8/21
    2. Millage Process, Investments and Progress Update
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-11/10/21

MOTION BY A. LABARRE, SUPPORTED BY A. DUSBIBER TO ACCEPT AND APPROVE THE DECEMBER 17, 2021 WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**N/A**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**

JEFFERSON	**N/A**	**KING**	**Y**
LABARRE	**Y**	**ROOKS**	**Y**
SCOTT	**NOT PRESENT AT TIME OF VOTE**	**STRONG**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

K. Scott joined the meeting at 9:37am

V. Treasurer's Report

- WCCMH Financial Status Report
  - N. Phelps presented WCCMH Financial Status Report (Attachment #2) to the Board for the period ending October 31, 2021.

MOTION BY B. KING SUPPORTED BY A. DUSBIBER TO ACCEPT AND APPROVE THE WCCMH FINANCIAL STATUS REPORT ENDING OCTOBER 31, 2021.

ROLL CALL VOTE:

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

MOTION CARRIED

- 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 October 31, 2021.

MOTION BY B. HIGMAN SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT AND APPROVE THE WCCMH MILLAGE AND CCBHC FINANCIAL STATUS REPORT ENDING OCTOBER 31, 2021.

ROLL CALL VOTE:

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

MOTION CARRIED

- From Investment to Impact Presentation
  - N. Phelps presented the From Investment to Impact Presentation (Attachment #4) to the Board.
  - Integrate this presentation into the overall CMH funding in Strategic Planning. Suggestion to put in financial amounts for internal spending and external spending.
  - Show a breakdown of expansions taking place in 48197/48198 area…show amount raised and amount spent to expand services and deliver outcomes to these areas. Next steps for building on presentation is looking at impact of services in certain communities and populations.

VI. Executive Director report

- T. Cortes presented the Executive Director report to the WCCMH Board.
- State Level Update
  - Shirkey bill has not had any action on it.
  - House bill 5523-focusing on recruitment, retention and training on acute care providers as well as behavioral health providers.
  - Approached Washtenaw as one of the original health homes and T. Cortes agreed to participate again and this will bring in additional Medicaid funds.
  - Starting January 1, 2022 WCCMH will be the point of access for SUD services in Washtenaw County.

- Local Update
  - Recruitment and retention work is a continuing and a letter is being drafted to MDHHS for approval of the use of surplus general fund dollars for workforce stability.
  - Ongoing conversations with HR and labor leadership/partners about what matters to staff/providers and what could help them with this process.

VII. CMHPSM Regional Update

- The CMHPSM minutes (Attachment #5) from November 10, 2021 were reviewed.
- The December 8th Regional Meeting was cancelled.

VIII. New Business

- Washtenaw County Board Terms Expiring March 31, 2022
  - A. LaBarre-Board of Commissioners Representative
  - B. King-Community Member
  - A. Rooks-Community Member (University of Michigan)
  - K. Scott-Secondary Consumer
  - R. Dornbos will be contacting the identified members on their intent to continue with the WCCMH Board and what needs to be done.

- WCCMH Bylaw Changes
  - T. Cortes discussed the bylaw changes (Attachment #6) with the Board.
  - They are required to be approved by the Washtenaw County Board of Commissioners before they are finalized.
  - Combining Program-Quality and Budget-Finance into one committee called Quality-Finance Committee.
  - Insert comma in section vii.2-

MOTION BY A. LABARRE SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE BYLAW CHANGES AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- WCCMH Executive Director Evaluation Discussion

- K. Walker informed the board that the WCCMH Executive Director Evaluation is done annually. R. Dornbos will be sending out the goals from last year and he would like to do the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis again this year.
- The evaluation will be sent to all CMH Board members, direct report staff with a deadline of January 2022.
- Executive Committee will review returned documents and will make a recommendation to the CMH Board in February 2022.

IX. Old Business

- WCCMH 2022 Annual Board/Committee Meeting Schedule
  - T. Cortes presented the Annual Board/Committee Meeting Schedule (Attachment #7) to the Board.
  - The Executive Committee will meet bi-monthly for 1 hour starting in January 2022.
  - The Budget-Finance and Program-Quality Committees will be combined and called Quality-Finance Committee. Both Quality-Finance and Millage Advisory Committee will meet bi-monthly for 1.5 hours each staring in February 2022.
  - The WCCMH Board will meet bi-monthly for 2 hours starting in February 2022.
  - Request to not have Committee/Board meetings in the same week.
  - R. Dornbos will send out meeting notifications but will put TBD for location until something has been determined on in-person and virtual.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ADOPT THE MEETING SCHEDULE WITH THE PROVISION THAT WCCMH COMMITTEE AND BOARD MEETINGS NOT BE SCHEDULED IN THE SAME WEEK.

ROLL CALL VOTE:

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

MOTION CARRIED

- WCCMH 2022 Annual Board Calendar
  - The Board discussed the Annual Board Calendar (Attachment #8)

- CCBHC Update
  - M. Harding and T. Cortes provided an update on the CCBHC.

- Strategic Planning Update
  - M. Harding and T. Cortes provided the Strategic Planning Update (Attachment #9) to the Board.
  - CHRT report was gathered via interviews from CHRT staff and community members.
  - Unite report that is attached in the strategic planning update.
  - Gave information to staff for their responses.
  - Sending information for more feedback to MAC.
  - Next step is to have staff compile the information, look at recommendations, prioritize goals and bring to executive in February and then to full board.
  - M. Harding suggested that any feedback be sent to him and T. Cortes so that it can be incorporated into the document.

X. Items for future discussion

- Development of Reserve Capital at the CMHSP level
- COVID-19 Related Priorities Discussion
- Employee Engagement Survey

- Single Point of Access
- Strategic Planning Update
- SUD referral/call center data-calls/FTEs needed to make this happen

MOTION BY K. SCOTT, SUPPORTED BY M. UDOW-PHILLIPS TO ADJOURN THE WCCMH BOARD MEETING.

Meeting adjourned at 10:53 AM.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

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

DRAFT

December 18, 2021

https://zoom.us/j/95174458832

1:00 pm

ROLL CALL: S. Antonow attending remotely from Ann Arbor, Washtenaw County, MI
A. Dusbiber attending remotely from Ann Arbor, Washtenaw County, MI
N. Graebner-Sundling attending remotely from Chelsea, Washtenaw County, MI
B. Higman attending remotely from Ann Arbor, Washtenaw County, MI
R. Jefferson attending remotely from Ypsilanti Twp, Washtenaw County, MI
B. King attending remotely from Ann Arbor, Washtenaw County, MI
M. Udow-Phillips attending remotely from Ann Arbor, Washtenaw County, MI
K. Walker attending remotely Southgate, Wayne County, MI

MEMBERS ABSENT: K. Scott, D. Strong

STAFF PRESENT: T. Cortes, M. Harding, N. Phelps, R. Dornbos, H. Linky, S. Ray, K. Diebboll, S. Amos O'Neal, M. Taylor, K. Hoener, B. Brookens-Harvey, K. Snay, L. Gentz, T. Florence

OTHERS PRESENT: L. Lutomski, K. Homan, M. Creekmore, G. Nelson

N. Graebner-Sundling called the meeting to order at 1:03 pm.

I. Introductions
- T. Cortes introduced B. Brookens-Harvey from the Youth and Family Services who will be presenting at this meeting.

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Budget-Finance Committee Meeting Minutes and Actions from 11/8/21.
- The Budget-Finance Committee Meeting Minutes and Actions from 11/8/21 were reviewed. (Attachment #1A)

MOTION BY B. KING, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE MINUTES AND ACTIONS FROM THE NOVEMBER 8, 2021 BUDGET-FINANCE COMMITTEE MEETING.

ROLL CALL VOTE:

ANTONOW	**NOT ON BUDGET-FINANCE COMMITTEE**	**DUSBIBER**	**NOT ON BUDGET-FINANCE COMMITTEE**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**NOT ON BUDGET-FINANCE COMMITTEE**
JEFFERSON	**Y**	**KING**	**Y**

SCOTT	**N/A**	**STRONG**	**N/A**
UDOW-PHILLIPS	**Y**	**WALKER**	**NOT ON BUDGET-FINANCE COMMITTEE**

MOTION CARRIED

I. Program-Quality Committee Meeting Minutes and Actions from 11/8/21.

- The Program-Quality Committee Meeting Minutes and Actions from 11/8/21 were reviewed. (Attachment #1A)

MOTION BY K. WALKER, SUPPORTED BY S. ANTONOW TO APPROVE THE MINUTES AND ACTIONS FROM THE NOVEMBER 8, 2021 PROGRAM-QUALITY COMMITTEE MEETING.

ROLL CALL VOTE:

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

MOTION CARRIED

II. Financial Status Report

- N. Phelps presented the Financial Status Report for the period ending October 31, 2021 (Attachment #2).

MOTION BY B. KING SUPPORTED BY R. JEFFERSON TO APPROVE THE FINANCIAL STATUS REPORT ENDING OCTOBER 31, 2021 AS PRESENTED.

ROLL CALL VOTE:

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

III. Regional Finance Update

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

IV. Old Business

- CCBHC Update
  - M. Harding presented an update on the CCBHC.
  - The application is still being reviewed by the State.

- Received F. Brabec's notes from the listening sessions and the comments continually point towards CCBHC.
- Request to highlight the number of CCBHC people coming in, daily visits and look at reporting.

V. New Business

- Program Education Presentation-Wraparound and SED Waiver
  - B. Brookens-Harvey from the CMH Youth and Family Department presented the Wraparound and SED Waiver presentation to the committee (Attachment #3).
  - Outcome data would be beneficial to review at a future meeting.

A. Dusbiber left the meeting at 1:55pm

- General Fund Spending Opportunities Discussion
  - T. Cortes and N. Phelps discussed the Opportunities for General Fund spending.
  - The high priority is placed on Recruitment and Retention with the provider network and with staffing at WCCMH.
  - A communication has been drafted for the State and should be able to get something out to the state and board association in the next couple of weeks.

VI. Items for Future Discussions

- Accounts Receivable (Budget-Finance Committee)
- Cost Per Case Comparisons (Budget-Finance Committee)
- Looking at call data and how it affects CARES Team (Program-Quality after January 2022)
- Access Department comparison presentation from pre-CCBHC and with CCBHC (Program-Quality Committee)
- CCBHC Performance Measures (Program-Quality Committee)

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY K. WALKER TO ADJOURN THE WCCMH BUDGET-FINANCE MEETING.

VII. Meeting adjourned at 2:28 pm.

There's a behavioral health care staffing crisis in Michigan– here's how we can solve it.

Summary

The need and demand for mental health services has increased throughout the COVID-19 pandemic. Many community mental health agency staff members are overburdened, and open positions are going unfilled–both in Washtenaw County and across the state of Michigan. Increasing pay and providing more career opportunities for direct care mental health workers are both essential to help solve this problem. Governor Gretchen Whitmer's recommended budget contains important proposals to help with the state's mental health crisis. The Michigan State Legislature must consider these proposals and act quickly to avert a mounting crisis.

Background

Michigan's behavioral health care workforce provides a range of direct care services and responsibilities–from activities of daily living like dressing, bathing, and feeding, to household and social support and clinical tasks. Many of the behavioral health care workers who do this work are employed by the state's community mental health system, which serves adults with severe and persistent mental illness, children with serious emotional disturbances, and individuals with intellectual and developmental disabilities. However, Michigan is currently experiencing a staffing crisis with tens of thousands of unfilled jobs.

Data from the Community Mental Health Association of Michigan estimates that there are 50,000 vacant positions for behavioral health direct care workers–a 21 percent vacancy rate.[i] These jobs include case managers, social workers, peer support specialists, therapists, substance use specialists, nurse practitioners, and other mental health professionals. The positions remain empty during a time when services are in high demand due to the many negative effects of the COVID-19 pandemic–such as loss of family and friends, health conditions, job loss, financial issues, additional caregiving burdens, social isolation, and stress. For instance, during the pandemic, about four in ten adults reported symptoms of anxiety or depression – a 400 percent increase since 2019.[ii]

The COVID-19 pandemic can also be blamed for exacerbating behavioral health workforce recruitment and retention issues that existed prior to the pandemic. Many long-term behavioral health care workers report that they are exhausted, receive little appreciation for their contributions, and that the work has become too difficult for them to continue.[iii] Consequently, numerous seasoned professionals have left the field altogether, resulting in the loss of historical knowledge, relationships between staff, and mentoring. While women make up close to 70 percent of the mental health direct care workforce, many have chosen to stay at home to care for their own children due to unpredictable COVID-19 school and daycare closures. In addition, some direct care workers have expressed that a lack of specialized training prevents them from successfully fulfilling their responsibilities and is another barrier to retaining these workers long-term.[iv]

Other professional opportunities have also emerged for members of the behavioral health care workforce. With remote work becoming commonplace, some clinical workers have been "aggressively recruited" by companies that offer work from home options, such as telehealth services.[v] Furthermore, other industries are offering more competitive entry-level wages, with work that is less stressful–both physically and emotionally–and presents lower risk of COVID-19 exposure. The average starting wage of a direct care worker in Michigan is $11.44 per hour,[vi] while many fast food, grocery, retail, and clerical positions are now offering starting wages of at least $15 per hour.

In the fall of 2021, the Michigan legislature passed a permanent direct care worker wage increase of $2.35; however, this increase primarily affects direct care staff who work in nursing homes. Governor Gretchen Whitmer's upcoming budget proposes $135 million specifically for behavioral health care workers from the state's General Fund.[vii]

Recommendations

To address Michigan's behavioral health care staffing crisis:

- **The $2.35 increase in direct care worker wages should be extended to the behavioral health care workforce and made permanent.** Additional enhancements in wages beyond $2.35 should be considered, commensurate with the skill and important role severed by behavioral health staff.
- **Michigan DHHS should work with other state agencies to develop a specialized career pathway for direct care worker positions.** This includes a centralized recruitment and training center to elevate the profession, certification programs through the state's community colleges that provide a clear career pathing opportunity, and tiered levels of professional advancement based on job type, training, and experience.
- **Michigan DHHS should reduce provider administrative burdens**. This includes complicated new billing requirements for community living supports (CLS).

These steps are the minimum needed to address the state's behavioral health workforce shortage in the short-term. Longer term solutions are also needed to address the more fundamental issues resulting in a mismatch between capacity and need. Michigan should develop a statewide long-term strategic plan to expand mental health capacity. To accomplish this goal, the Governor should establish a state task force with bipartisan state legislators, government agency representatives, and those working in the field–to develop a cohesive, statewide strategy.

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[i] https://www.crainsdetroit.com/health-care/pandemic-caused-more-mental-illness-without-staff-industry-impasse
[ii] https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
[iii] https://cmham.org/wp-content/uploads/2021/04/Staff-Shortages-Client-Crises-Made-COVID-Hard-On-Mental-Health-Services.pdf
[iv] https://www.bridgemi.com/quality-life/michigan-ages-shortage-health-care-workers-explodes-crisis
[v] https://cmham.org/wp-content/uploads/2021/04/Staff-Shortages-Client-Crises-Made-COVID-Hard-On-Mental-Health-Services.pdf
[vi] https://arcmi.org/micarecrisis/
[vii] https://www.freep.com/story/news/politics/2022/02/07/whitmer-proposes-3-billion-extra-front-line-workers-police-other-heroes/6662322001/

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure Performance Improvement***
Department: Compliance and Clinical Performance Team ~~**Author:**~~	**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 and ensure an integrated region-wide Performance Improvement (PI) system is implemented and operating in accordance with applicable standards of the Community Mental Health Partnership of Southeastern Michigan (CMHPSM).

II. REVISION HISTORY

DATE	MODIFICATION
02/28/12	
6/16/14	Revised to reflect the new regional entity.
9/11/17	Due for regional review.
Will be Regional Approval Date	Due for regional 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 oversees the PI system and holds the overall responsibility for it. Each CMHSP Director assures implementation within their agency and involvement of leadership at the regional level. PIHP Performance Improvement initiatives will be

prioritized using decision making criteria covering high risk, high cost and problem prone areas and will be in alignment with the strategic plan.

The designated Quality/Compliance/Program Integrity Manager~~Director~~ is responsible for the implementation of this policy and ensuring the PI system operates in accordance with the Quality Assessment Performance Improvement Program (QAPIP) and other state/federal PI requirements. ~~PI Program Description/Plan.~~ Central to the PI system is the ~~PI committee/~~Clinical Performance Team (CPT) as the regional PI committee, with CMHSP representation, standing committees, workgroups, and ad hoc PI teams.

This PI system is responsible for overseeing and ensuring the quality of consumer/individual served care. The PI system shall address any issue in need of performance improvement, performance assurance and performance planning.

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.

Performance Improvement System: The CMHPSM is responsible for addressing, implementing and resolving Performance Improvement, Performance Assurance and Performance Planning initiatives.

Performance Improvement Process (PIP): 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.

Quality Assessment refers to a systematic evaluation process for ensuring compliance with specifications, requirements or standards and identifying indicators for performance monitoring and compliance with standards.

Quality Assessment and Performance Improvement Program (QAPIP) is an annual plan to establish goals for each fiscal year (FY) to meet the overall regional Quality Improvement (QI) framework for quality and accountability for consumer/individual served care. This occurs through the work of standing committees, ad hoc teams, and performance measures. The QAPIP establishes processes that promote ongoing systematic evaluation of important aspects of service delivery. The program promotes ongoing improvement and replication of strengths and focuses attention on ensuring that the safety of consumers/individuals served is addressed through the delivery of services while addressing the requirements of network providers and CMHPSM staff and programs.

Quality Assurance refers to a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards. The primary aim of quality assurance (QA) is to demonstrate that a service or product fulfills or meets a set of requirements or criteria. QA is identified as focusing on "outcomes," continuous quality improvement (CQI) identified as focusing on "processes" as well as "outcomes."

Quality/Compliance/Program Integrity Manager~~Director~~: The person responsible for ensuring that the implementation of the QAPIP is based on the agreed upon vision and values through the use of Learning Organization principles. The person is responsible for linking the activities of the CMHPSM committees with the QAPIP and providing oversight to CMHPSM performance improvement activities.

Quality Improvement refers to ongoing activities aimed at improving performance as it relates to efficiency, effectiveness, quality, performance of services, processes, capacities, and outcomes. It is the continuous study and improvement of the processes of providing services to meet the needs of the consumer/individual served and others.

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

VI. STANDARDS

A. Understanding root causes is the most effective means of ensuring lasting systemic change. When the need for such change has been identified, the use of qualitative and quantitative data will be reviewed to identify the specific areas that need improvement. These improvement efforts will ensure that high quality services are delivered across the entire CMHPSM.

B. The following values will be upheld in improvement processes based on the approved PI Program Description/Plan that include but are not limited to:
   - Organizational systems shared learning
   - Alignment with strategic planning
   - Stakeholder (consumers/individuals served, family members, providers, staff) involvement
   - Replication of s~~S~~uccesses by fostering and enabling both regional and local improvements.

C. The following outcomes shall be addressed:
   - The reductions of risk factors in service delivery.
   - The identification and resolution of specific service delivery and organizational opportunities for improvement.
   - Using established measures, evaluates specific program components. The data results will be used to modify, redesign, or otherwise improve that component.
   - Evidence of employee, consumer/individual served and community stakeholder involvement in needs assessment,

service planning and problem identification and resolutions.
- Evidence of service improvements and enhancements including innovative program designs based upon results of quality improvement activities.

D. The PI system shall adhere to all external and internal standards of governance, management and direct/support services.
E. The PI system shall be regularly monitored and evaluated to ensure quality components are being implemented along with any external or internal standards or regulation revisions are made.
F. The PI system program description/plan shall be approved annually by the PIHP board and be adopted by the CMHSPs.
G. The PI system shall operate within the annually approved PI program description/plan.
H. The PI system is a confidential peer review system where aggregate information is shared that is not subject to the Freedom of Information Act (FOIA) or other forms of disclosure.
I. The PI system shall include consumer/individual served and/or family representation, network provider representation, and have medical director consultation to assist the PI/CPT committee in addressing any medically significant related performance improvements.
J. The Clinical Performance Team shall serve as the regional Performance Improvement Committee. The Clinical Performance Team has representation from clinical and / or performance improvement staff from each of the four counties of the region as well as consumer/individual served representation from each county. The interim Medical Director or designee for the PIHP also sits on this committee as well as the PIHP Compliance/~~Director of~~ Quality Manager~~Improvement~~. Some members of the Clinical Performance Team serve as liaisons to other regional committees such as the Utilization Review Committee, Regional Consumer Advisory Committee, Network Management and various population specific administrators groups.
K. The PI system shall be responsible for approving, collecting, analyzing and monitoring organizational PI indicators to identify trends and reduce risk.
L. The PI system shall perform qualitative and quantitative improvement processes that obtain input from stakeholders to ensure high quality change efforts take place led by the Quality/Compliance/Program Integrity Director or other designated individual or body.
M. Led by the Quality/Compliance/Program Integrity Director or other designated individual or body, the PI system shall provide leadership, and will coordinate, collaborate, and or participate in CMHPSM or regional programs', boards' and stakeholders' improvement efforts for the purpose of building upon strengths and reducing the frequency of improvement opportunities.
N. The PI system shall communicate the results of improvement efforts made to necessary relevant stakeholders by the Quality/Compliance/Program Integrity Director or other designated individual or body.
O. The PI system shall obtain PI reports and data on time within time frames based upon the agreed upon reporting schedule and in the agreed format established by the Quality/Compliance/Program Integrity Manager ~~Director~~ or other designated individual or body.
P. All CMHPSM network providers, including both CMHSPs and other contract providers, shall report all PI data at the specified timeframes as specified in the

signed contract with the applicable CMHPSM led by the Quality/Compliance/Program Integrity Director or other designated individual or body.

Q. The CMHPSM shall withhold payment as outlined in the signed contract to a CMHSP and or CMHPSM network provider should PI reports and data not be submitted within the necessary required timeframe established by the Quality/Compliance/Program Integrity Manager~~Director~~ or other designated individual or body.

R. All CMHPSM network providers must operate within an approved performance improvement system as defined in the signed contract.

VII. EXHIBITS

A. CMHPSM PI Program Description/Plan

~~A.~~B. Quality Assessment Performance Improvement Program (QAPIP)

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	x	43 8.206, 43 8.236, 43 8.240
45 CFR Parts 160 & 164 (HIPAA)	x	
42 CFR Part 2 (Substance Abuse)	x	
Michigan Mental Health Code Act 258 of 1974	x	
The Joint Commission - Behavioral Health Standards	x	Performance Improvement
Michigan Department of Health and Human Services(MDHHS) Medicaid Contract	x	
MDHHS Substance Abuse Contract	x	
Michigan Medicaid Provider Manual	x	

IX. PROCEDURES

WHO	DOES WHAT

CMHPSM	1. Provides a written program description/plan. 2. Maintains and follows the guidelines as described in the program description and PI policy.
Clinical Performance Team	1. Makes recommendations for the Regional Operations Committee (ROC) to approve the functions/indicators and information for the PI system as described in the PI system Program Description/Plan. 2. Monitors the functions/indicators and information for the PI system as described in the PI system Program Description/Plan. 3. Assigns improvement activities to the appropriate standing committee, workgroup, local CMHSP or create an Ad Hoc PI team as needed to address areas in need of improvement. 4. Makes recommendations for the ROC to approve the Regional Committee/Workgroup PI Ad Hoc Teams charge. 5. Reviews and provides input on periodic reports to the ROC and the CMHPSM Regional Board.
Quality/Compliance/Program Integrity Manager~~Director~~	1. Participates in the PI/CPT Committee. 2. Communicates necessary information across the CMHPSM. 3. Establishes, maintains and adheres to a reporting schedule. 4. Generates periodic PI reports 5. Reports PI system initiatives to the CMHPSM Regional Board.
PI Committee/CPT Chair/Coach	1. Reports PI system initiatives to the ROC.
Standing Committees, workgroups, local CMHSPs and Ad Hoc PI teams	1. Aligns work plan and functions ~~to~~ with the CMHPSM strategic plan. 2. Use PI processes to implement

	functions and improvement efforts 3. Local CMHSPs use the PI processes to embed improvement efforts across the whole organization down to direct line staff. 4. Report periodically based on the reporting schedule and format to the PI Committee/CPT the work plan functions and indicators of performance and improvement activities. 5. Make recommendations to the PI committee/CPT for implementing PI processes to address areas needing improvement. 6. Relays information to and from committee, workgroups, or ad hoc teams.
CPT Members	1. Provide input and feedback on reports provided to the PI committee/CPT based on the roles of the members. 2. Relay information to and from the CMHSP.
Regional Operations Committee	1. Provides leadership across the CMHPSM and individual CMHSPs in promoting the values and principles of the PI system. 2. Reviews and provides input/feedback on the annual PI program description/Plan. 3. Reviews and provides input/feedback on periodic PI reports. 4. Reviews the PI reports prior to being presented to the CMHPSM Regional Board.
CMHSP	1. Receives and reviews reports and acts on any identified PI related issues. 2. Provides leadership for CMHSP the values and principles in promoting the PI system. 3. Approves local PI projects. 4. Provides feedback on regional PI projects

	5. Adopts the affiliation approved PI program description.
CMHPSM Regional Board	1. Provides input and feedback to Annual PI Program description/plan and periodic reports. 2. Approves the annual PI program description/plan and periodic reports.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	***Policy*** ***Behavior Treatment Committee***
Department: **Author:**	**Local Policy Number (if used)**
Regional Operations Committee **Regional Approval Date** ~~**6/4/2018**~~	**Implementation Date** ~~**7/18/2018**~~

I. PURPOSE

To establish policy for Behavior Treatment Committees (BTC) with the responsibility for reviewing restrictive and/or intrusive treatment plans and reviewing policies for the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
12/9/09	1	
8/28/13	2	Revised to reflect the new regional entity effective January 1, 2014.
7/30/14	3	Revisions to reflect the MDCH FY 14 Contract Attachment
9/21/17	4	3-year review/update
2021	5	3-year review

III. APPLICATION

All staff, students volunteers and/or contractual agencies within the CMHPSM. This policy does not apply to those external entities/providers that are not in a contractual relationship with the CMHPSM that may prescribe medications to consumers/individuals who receive services ~~served~~ in the CMHSPM system (i.e. dentists, primary care physicians).

IV. POLICY

The Behavior Treatment Committee shall be a standing committee within each Community Mental Health Services Program (CMHSP) in the CMHPSM. The BTC shall review **and** approve or disapprove any treatment plans that propose to use any behavioral management techniques as defined in this policy.

V. DEFINITIONS

Applied Behavior Analysis - is the organized field of study which has, as its objective, the acquisition of knowledge about behavior using accepted principles of inquiry

based on operant and respondent conditioning theory and functional assessment of behavior. It also refers to a set of techniques for modifying behavior toward socially meaningful ends based on these conceptions of behavior.

Aversive Techniques - are those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, use of nausea-generating medication to establish a negative association with target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited.

Behavior Modification - is the systematic application of principles of general behavior theory to the development of adaptive and/or the elimination of maladaptive behavior consistent with therapeutic objectives through the use of a variety of recognized techniques including but not limited to shaping, positive reinforcement, and other techniques based on general behavior theory.

Community Mental Health Partnership of Southeast Michigan (CMHSPM) - the Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services through contract with the Michigan Department of Health and Human Services (MDHHS).

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.

Intrusive Techniques: - are those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug that is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Peer-Reviewed Literature: - Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered

authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

Physical Management: - A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is **prohibited under any circumstances.**

Positive Behavior Support: - A set of research-based strategies used to increase *quality of life* and decrease problem behavior by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce problem behaviors such as self-injury, aggression, property destruction, pica, defiance and disruption.

Practice or Treatment Guidelines: - Guidelines published by professional organizations such as the American Psychiatric Association (APA) or the federal government.

Restraint: - Any physical or mechanical device, material or equipment that immobilizes or reduces the ability of the ~~recipient~~consumer/individual served to move his or her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. This definition excludes anatomical or physical supports that are ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual's physical functioning. The definition also excludes safety devices required by law, such as car seat belts or child rear seats used while riding in vehicles. The use of physical or mechanical devices used as restraint is **prohibited** except in a state-operated facility or a licensed hospital.

Restrictive Techniques: - Those techniques which will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purpose ~~if~~of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Restrictive techniques include the use of a drug or medication when it is used as a restriction to manage, control or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of restrictive techniques requires the review and approval of the Committee.

Seclusion: - The placement of an individual in a room alone where egress is prevented by any means. Seclusion is **prohibited** except in a hospital or center operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Special Consent – Obtaining the prior written approval of the ~~recipient~~consumer/individual served, legal guardian, the parent with legal custody of a minor child or designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the ~~recipient~~consumer/individual served, guardian or parent of a minor ~~recipient~~consumer/individual served may only occur when the ~~recipient~~consumer/individual served has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518 or 519 of the Mental Health Code.

Time Out **–** A voluntary response to the therapeutic suggestion to a ~~recipient~~consumer/individual served to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome. (MDHHS) Admin Rules definition).
Therapeutic De-escalation – An intervention where the implementation is incorporated in the individualized written plan of service, wherein the ~~recipient~~consumer/individual served is placed in an area or room, accompanied by staff who shall therapeutically engage the ~~recipient~~consumer/individual served in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

VI. V. STANDARDS

A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. If the CMHSP delegates the functions of the BTC to a contracted mental health service provider, the CMHSP must monitor the BTC to assure compliance with this policy.

B. The BTC shall be comprised of at least three individuals, one of whom shall be a licensed psychologist with the specified training and experience in applied behavioral analysis; at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL330.1100c(10**).** Membership shall also include a person(s) external to the organization. A representative of the Office of Recipient Rights (ORR) shall participate on the Committee as non-voting member to provide consultation and technical assistance to the Committee for consideration of any rights related issues. Other non-voting members may be added at the BTC's discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

C. The BTC, and BTC chair, shall be appointed by the agency for a term of not more than two years. Members may be reappointed to consecutive terms.

D. The BTC shall meet as often as cases requiring review dictate. Plans with intrusive or restrictive techniques require minimally a quarterly review. (See G).

E. The BTC shall keep all its meeting minutes, and clearly delineate the actions of the BTC.

F. The BTC shall ask that a BTC member who has prepared a behavior treatment plan to be reviewed by the BTC recuse themselves from the final decision-making.

G. The functions of the BTC shall be:
   - Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management or seclusion or restraint in a setting where it is prohibited by law or regulations.
   - Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques (see definitions).
   - Determine whether causal analysis of the behavior has been performed; whether positive behavior supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
   - For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency determined by the BTC or more frequently if clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process.~~.~~ Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavioral treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary; the more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire behavior treatment plan should be reviewed by the BTC.
   - Ensure that inquiry has been made about any medical, psychological or **other** factors that the individual has which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
   - Once a decision to approve a behavior treatment plan has been made by the BTC and written special consent to the plan (see limitations in definition of special consent) has been obtained from the consumer/individual served or the legal representative it becomes part of the person's written Person-Centered Plan (PCP). The individual or legal representative has the right to request a review of the written PCP, including the right to request that person-centered planning be re-convened in order to revisit the behavior treatment plan. (MCL 330-1712(2)).

H. On a quarterly basis the BTC will track and analyze the use of all physical

management for emergencies and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:

- Dates and numbers of interventions used
- The settings (e.g., group home, day program) where behaviors and interventions occurred
- Behaviors that initiated the techniques
- Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention
- Description of positive behavioral supports used.
- Behaviors that resulted in termination of the interventions
- Length of time of each intervention
- Staff development and training and supervisory guidance to reduce the use of these interventions
- Review and modification or development, if needed, of the individual's behavior plan.

I. The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program and be available for MDHHS review. Physical management, permitted for intervention in emergencies only, is considered a critical incident that must be analyzed by the BTC and the QAPIP or QIP and reported to MDHHS on a quarterly basis per mutually-agreed upon data elements. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event that must be reported to MDHHS on a quarterly basis.

J. In addition, the BTC <u>may</u>:

- Advise and recommend to the agency the need for specific staff or home-specific training in a culture of gentleness, positive behavior supports and other individual-specific non-violent interventions
- Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm. In addition, the BTC might recommend a limit for the number of emergency interventions that can be used with an individual in a defined period before the mandatory initiation of a process that includes assessments and evaluations, and possible development of a behavior treatment plan, as described in this policy.
- At its discretion, review other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the agency's needs and approved in advance by the agency.
- Advise the agency regarding administrative and other policies affecting behavior treatment and modifications practices.
- Provide specific case consultation as requested by professional staff of the agency.
- Assist in assuring that other related standards are met, e.g., positive behavior supports.
- Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

K. Prohibited Program Plans:
   - Aversive techniques – Those techniques which require the deliberate infliction of painful stimulation (or stimuli which would be painful to the average person) to achieve their effectiveness. Aversive techniques are prohibited and not utilized by any staff or program providing services.
   - Procedures that deny any basic needs, such as nutritional diet, water, shelter, and essential, safe and appropriate clothing
   - Corporal punishment
   - Fear-eliciting procedures
   - Any behavior management and treatment intervention that is implemented by another client
   - Mechanical restraint, seclusion or time-outs
   - Any procedure that is a psychological risk to the ~~recipient~~consumer/individual served
   - Any technique that violates the dignity and respect of the ~~recipient~~consumer/individual served

BEHAVIOR TREATMENT PLAN STANDARDS

A. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that assessments have been conducted to rule out physical, medical or environmental causes of the behavior; and that there have been unsuccessful attempts, using positive behavior supports and interventions, to change the behavior.

B. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the individual or his/her legal representative prior to the implementation of the behavior plan.

C. Behavior treatment plans that propose to use physical management in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the BTC.
Utilization of physical management in emergency situations, or requesting law enforcement, may be evidence of treatment/supports failure. Should use occur more than 3 times within a 30-day period the individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. Inclusion of emergency interventions is prohibited as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

D. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the BTC.

E. Plans that are forwarded to the BTC for review shall be accompanied by:
   - Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior

- A functional assessment
- Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma
- Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.
- Evidence of continued efforts to find other options.
- Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention
- References to the literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available.
- The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

VII. REFERENCES

A. 1997 federal Balanced Budget Act at 42 CFR 438.100
B. MCL 330.1712, Michigan Mental Health Code
C. MCL 330.1740, Michigan Mental Health Code
D. MCL 330.1742 Michigan Mental Health Code
E. Michigan Department of Health and Human Services Administrative Rule 330.719(2)(g)
F. Standard of Care on Medications – CMHPSM Prescriber Group
~~F.~~ MDHHS/CMHSP Managed Mental Health Services and Supports Contract FY21 Attachment C.8.8.3.1

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH MILLAGE ADVISORY COMMITTEE MEETING MINUTES *DRAFT*
December 13, 2021
https://zoom.us/j/97458198985
3:30 pm

N. Graebner-Sundling called the meeting to order at 3:31 pm.

ROLL CALL:	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 R. Jefferson attending remotely from Ypsilanti Twp, Washtenaw County, MI B. King attending remotely from Ann Arbor , Washtenaw County, MI J. Martin attending remotely from Scio Twp, Washtenaw County MI G. Waddles, Jr. attending remotely from Ypsilanti, Washtenaw County, MI M. Udow-Phillips attending remotely from Superior Twp, Washtenaw County, MI K. Walker attending remotely from Southgate, Wayne County, MI
MEMBERS ABSENT:	A. Carlisle, D. Jackson, A. LaBarre, R. Rion
STAFF PRESENT:	T. Cortes, M. Harding, N. Phelps, L. Gentz, R. Dornbos. K. Diebboll, K. Snay
OTHERS PRESENT:	A. Rooks, B. Higman, K. Homan, G. Powers, L. Lutomski, G. Nelson, M. Creekmore

I. Introductions
- N,. Graebner-Sundling introduced A. Rooks who is a new member on the CMH Board and will be observing the meeting.

II. Audience Participation
- None

III. Committee Response to Audience Participation
- .None

IV. Millage Advisory Committee Minutes and Actions from 11/8/21 (Attachment #1)
- Millage Advisory Committee Minutes and Actions of 11/8/21 were reviewed.

MOTION BY B. KING, SUPPORTED BY H. HEAVILAND TO APPROVE THE MINUTES AND ACTIONS FROM THE NOVEMBER 8, 2021 MILLAGE ADVISORY COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

CARLISLE	**N/A**	**GRAEBNER-SUNDLING**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
JACKSON	**N/A**	**JEFFERSON**	**NOT PRESENT AT TIME OF VOTE**
KING	**Y**	**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 #2)
  - L. Gentz referred to the Millage Process, Investment and Progress Update (Attachment #2A) for the sake of time.

VI. Financial Budget Update (Attachment #3)

- N. Phelps presented the Financial Budget update ending September 30, 2021 to the committee.

VII. Old Business

- Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
  - There was not a WCSO report for this month.

R. Jefferson joined the meeting at 3:40 pm.

VIII. New Business

- Strategic Planning Update
  - T. Cortes presented the Strategic Planning Update to the committee (Attachment #4)
  - CMH Board had leaders from the State, contracted with CHRT to look at a needs assessment from 2019, joint community needs assessment, sent all information to cmh staff for input internally, ran information through the community advisory council and wanting input from this group on what may be missed.
  - Main concern from community is to continue to do more for the youths, supported housing, more services to the rural areas and hiring/retaining staff.
  - Next step will be for CMH staff to compile information and bring to Executive Committee meeting.
  - Share the previous strategic plan to millage advisory committee.
  - Develop a form on what the current community needs are that can be financed.
  - Suggestion for a Towner crisis center on the west side of county.
  - Cash bail system-possibly enter into some sort of bail bondsman system in conjunction with WCSO funding.

- From Investment to Impact Presentation
  - N. Phelps presented the From Investment to Impact Presentation (Attachment #5) to the committee.
  - Request to have the WCSO millage fund balance and County Millage funding combined in a report.
  - Looking for ideas to plan for in the budget.
  - Look at 2023-2027 and using $6.8 million as revenue streams-what expenses are committed through these years.

The 2022 Meeting Schedule was discussed. The Millage Advisory Committee would meet bi-monthly for 1.5 hours for 2022.

IX. Items for Future Discussions

- Youth Assessment Center
- Millage Investment Plan
- Youth Needs Discussion

- Updated Millage Commitments
- Survey regarding funding opportunities for FY2022
- Washtenaw Coordinated Funding Partnership Update

MOTION BY B. KING SUPPORTED BY H. HEAVILAND TO ADJOURN THE MEETING.

Meeting adjourned at 4:31 pm.

Plan and Integrate

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	✓					✓		✓	✓	✓	✓	✓	✓	✓	Implemented	January 2022
MAT in jail	✓					✓				✓		✓		✓	Implemented	January 2020
LEAD initiative	✓							✓		✓	✓	✓		✓	In progress	Ongoing
Housing RFP w/OCED	✓	✓	✓				✓			✓	✓	✓			In progress	January 2020
Washtenaw Health Plan	✓			✓				✓		✓					In progress	Ongoing
Student Advocacy Center	✓							✓			✓				In progress	Ongoing
Ozone Psychiatry Access	✓						✓				✓	✓			Implemented	June 2021
5 Healthy Towns										✓	✓	✓	✓		In progress	Ongoing

Initiative Descriptions

Initiative	*Status*	*Updates?*
LEAD	Staffing related issues with resolution identified. 1 position still posted. Engagement has begun with participants. 23 referrals already received.	
Youth Assessment Center	Additional conversations have started with key sector leaders and additional are being planned.	**No**
Community Response to MH Crisis	Working with University of Chicago's Health Lab to provide analytic support and conduct a process evaluation of the program. The program will deliver the most appropriate services, supports, and responses to persons involved in public situations (e.g., behavioral health-related crises). It will provide a full continuum of services, including behavioral health, public health, social services, and police services.	
Rethink Health/5 Healthy Towns	SJM Chelsea SAMSHA grant is up and running. We are coordinating MHFA trainings with their new program coordinator. NAMI presented a faith community workshop entitled *Faith Leaders Role as Shepherds Through a Mental Health.* One Big Connection achieved over 4700 users' interactions and over 100 community resources over the last 6 months.	
5HT Intergenerational Populations Project	Findings have been reviewed and next steps are being identified.	**No**
SUD System Transition	Implementation began on January 1, 2022.	

Expand Services

Initiative	*Status*	*Updates?*
CARES/Crisis/750/CCBHC	No report, new data report is being developed	**No**
Housing RFP	New housing RFP being developed with OCED to roll out in the spring offering continuation funds for currently funded projects but also to meet additional needs identified in the Unite and CHRT gaps analysis documents. Additionally, 2 OCED funding proposals coming during this meeting to support Family Empowerment Program and MAP (see additional attachments).	
31 N/ WISD Mini Grants	**Mini Grants**-19 mini grants have been awarded so far this year. Milan Middle School, Dexter High School, Saline Middle School, Slauson Middle School, and	

Initiative Descriptions

	Lincoln Middle School. Collectively they've been granted $64,520. One middle school has requested funds to create "Calming Kits" for each middle school classroom. Each kit will include a variety of items such as: healthy snacks, a foot rocker, aroma putty, weighted scarf, bubble timers, pea poppers and other sensory toys. **31N-** 37 students served from Oct.-Dec. providing over 60 hours of services including case management, crisis intervention and therapy.	
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	For this quarter WHP has connected 120 individuals to behavioral health services, they have contracted with 36 mental health providers. These providers are providing services in 7 different languages- Italian, French, Mandarin, Russian, Spanish, Farsi, and Arabic.	
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.	**No**
Shelter Association	Emergency covid crisis stabilization funds (under $50,000) were provided to the Shelter to provide emergency isolation quarantine staffing for Omicron Covid surge.	

Initiative Descriptions

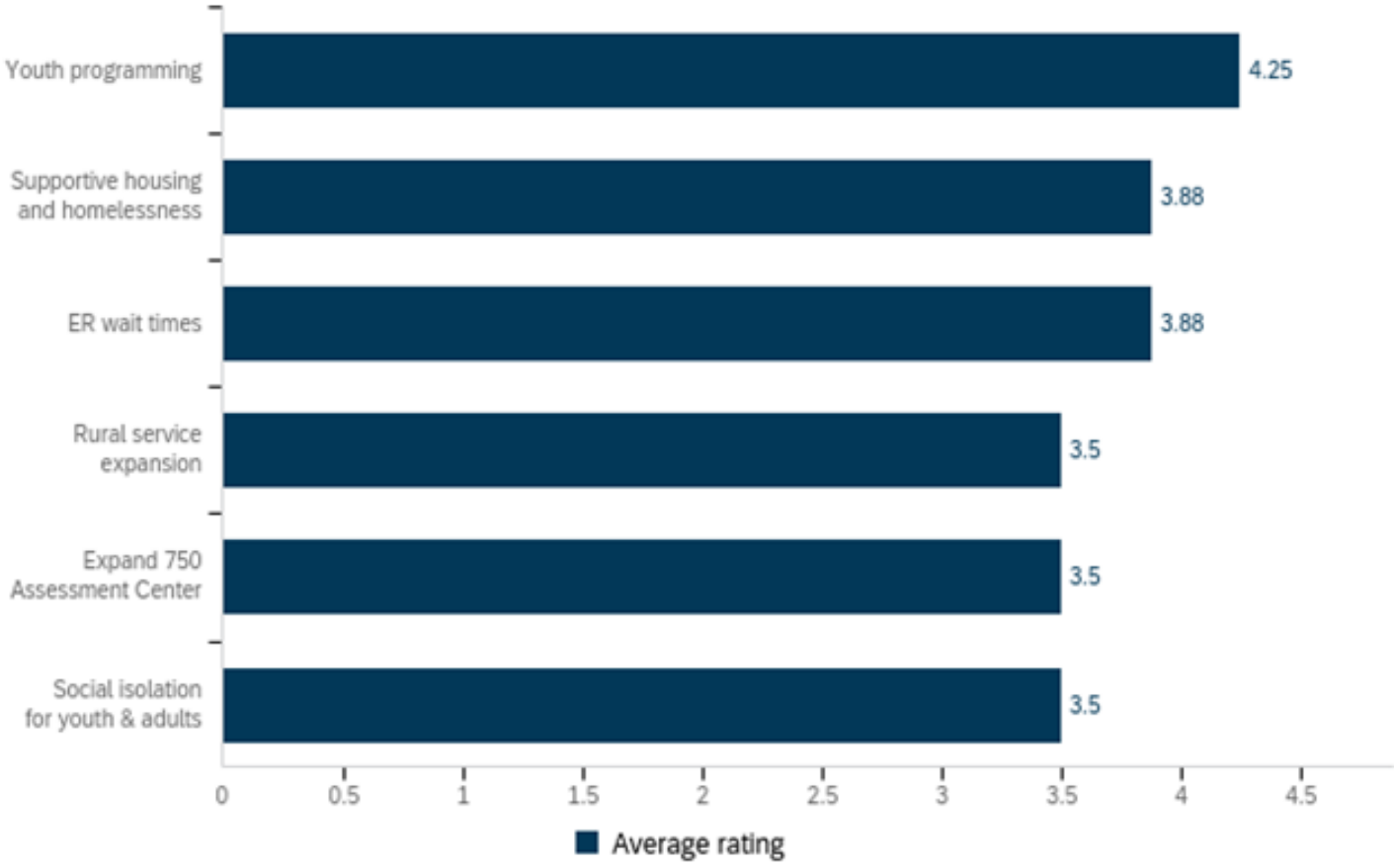
Communicate and Evaluate

Initiative	*Status*	*Updates?*
NAMI Peer Project	NAMI is currently developing a new funding proposal to continue and expand their efforts. This will be ready for review by the MAC at the April meeting.	
Anti-Stigma Campaign	Public Health 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.	**No**
MHFA/YMHFA Education initiatives	Two Trainings occurred in January and February and one training is scheduled monthly for the next few months.	
Millage Comms Strategy	New millage site enhancements have yielded significant outcomes with an increase of 22.3% traffic on the millage page. The bounce rate has also decreased with enhanced communication strategies meaning more people are engaging for longer periods of time on the site. The annual report is being distributed widely and the MAC's feedback on distribution was incorporated in the plan.	

MAC Survey Results – Identifying Priority Need Areas

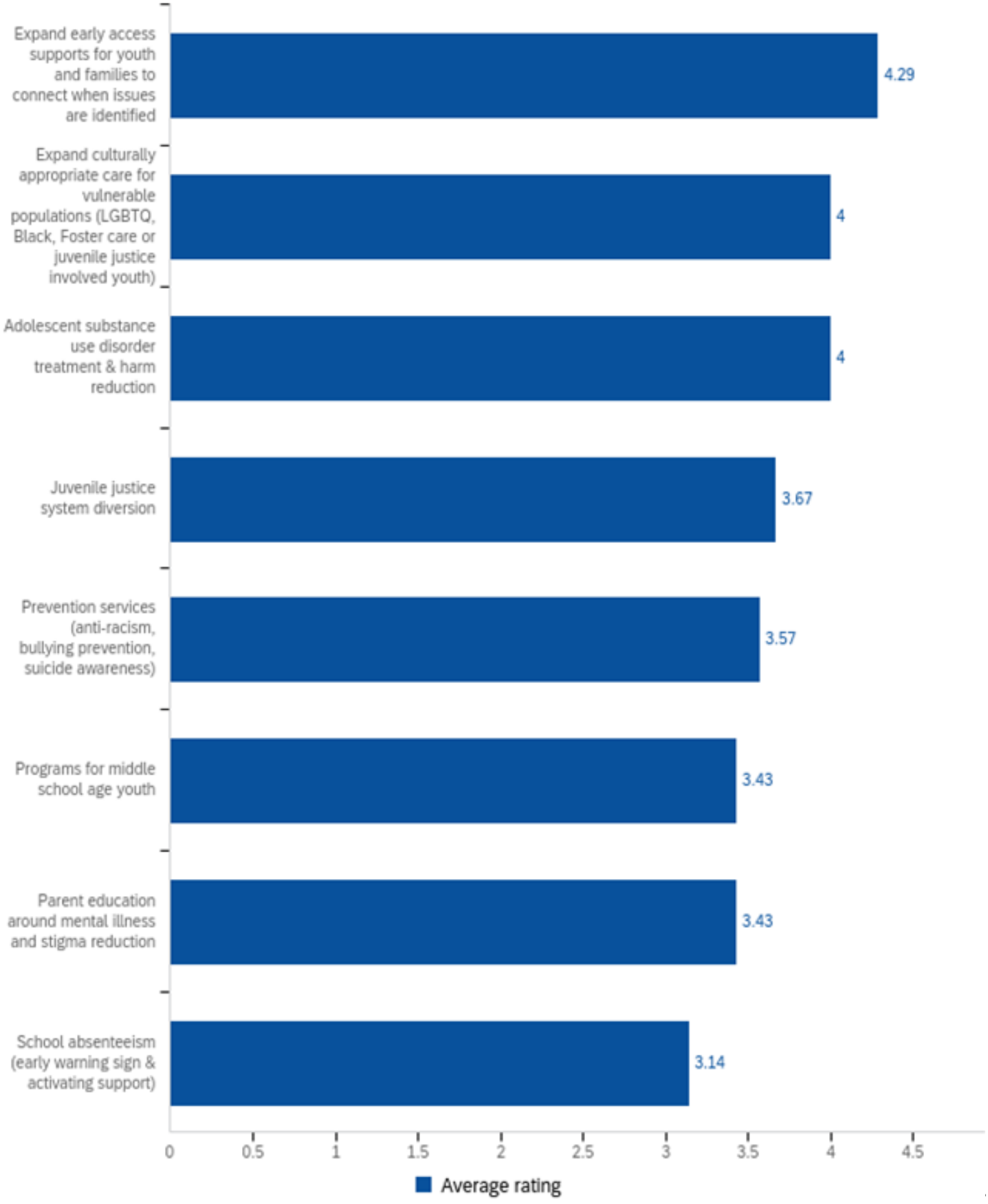
01/24/22

Q1. Below are identified priority need areas from the CHRT report and the UNITE CHNA. Please rate each general area on a scale of 1-5 (1 being less urgent need and 5 being most urgent need) to indicate where you believe the millage should focus their efforts.



Q2. Within **youth programming**, multiple focus areas have been identified as priority needs. Please indicate which youth programming priority areas you believe are most urgent for the millage to focus on by rating them on a scale of 1-5 (1 being least urgent, and 5 being most urgent).

ATTACHMENT #1F3
FEBRUARY 2022



Q3. Out of 7 responses, 5 said nothing was missing from **youth programming**. The two additional suggestions were:

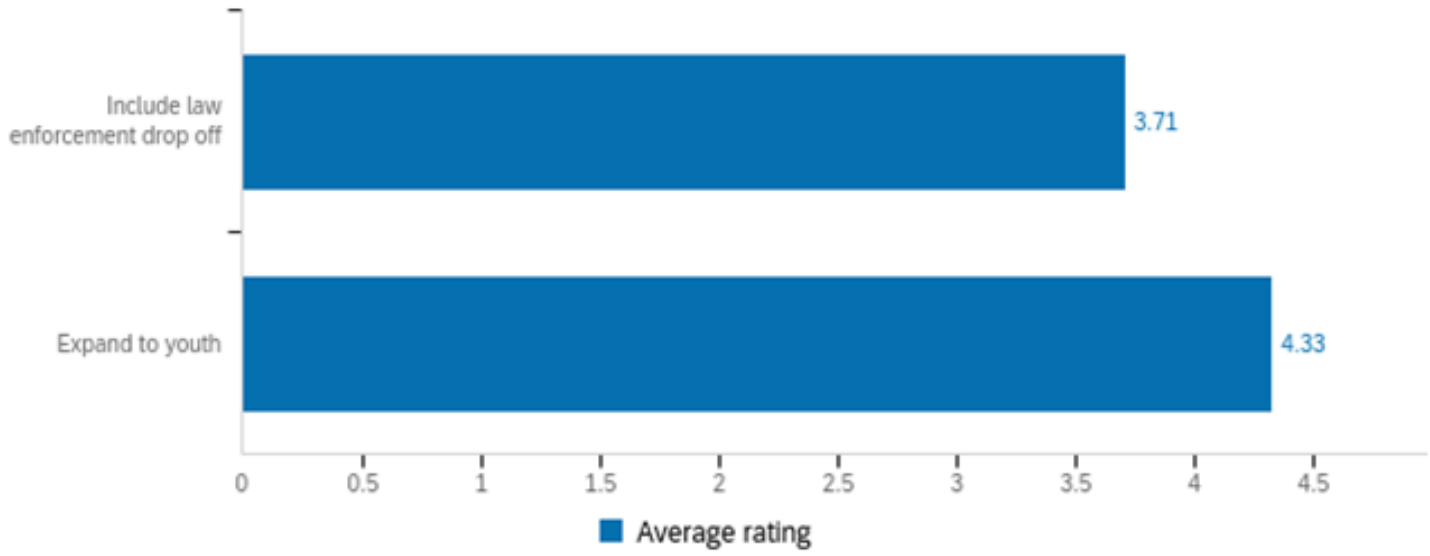
- Education programs for kindergarten and elementary school aged children about basic mental health
- Explicit, transparent work on gang intervention

Q4. **Manchester** and **Whitmore Lake** were given equal priority on average, both scoring 3.71/5.

Q5. Half of the respondents said a **rural community** was missing and the suggestions were to add:

- Dexter
- Chelsea
- Augusta Township in the far SE corner of the county

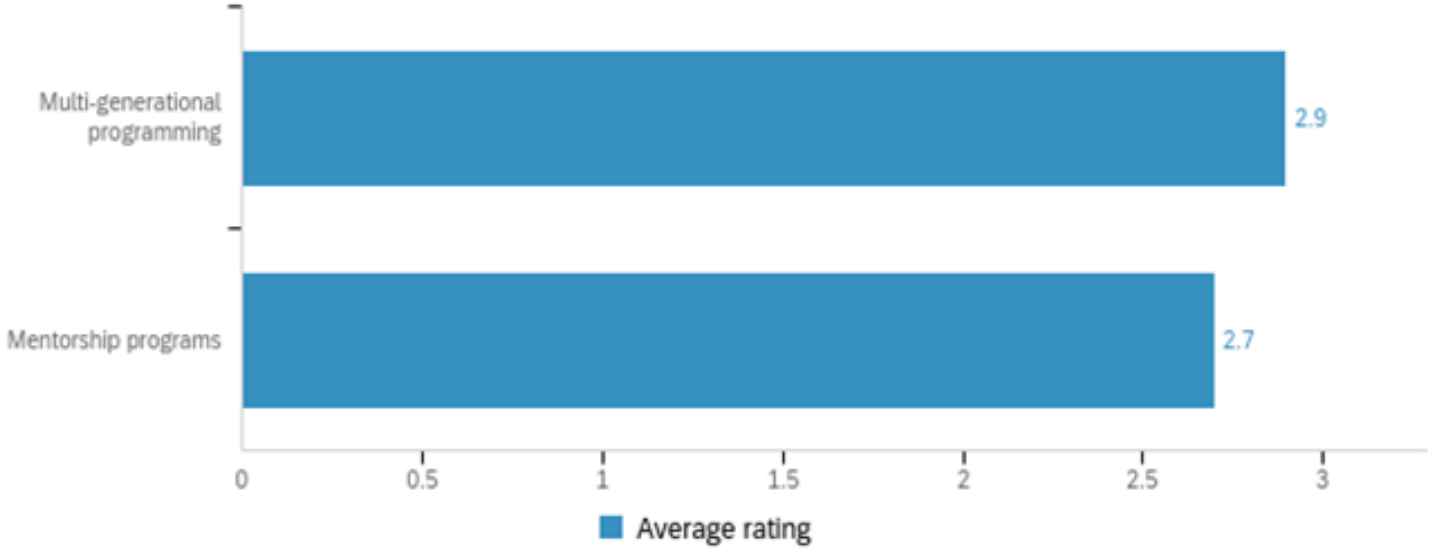
Q6. Within the need to **expand 750 Assessment Center**, two priority need areas were identified. Please indicate the urgency of each need on a scale of 1 to 5 (1 being less urgent and 5 being most urgent).



Q7. The majority of respondents (3/5) said nothing was missing from **expanding 750 assessment center**, but the two additional suggestions were to add:

- Social detox
- Sufficient beds to meet the demand

Q8. In **addressing social isolation for youth and adults**, two specific program types have been identified as a gap/need. Please indicate the level of urgency in implementing each program (1 being least urgent and 5 being most urgent).



Q9. The majority (4/7) of respondents indicated that they did not believe anything was missing from **addressing social isolation for youth and adults,** but the other respondents added the following:

- Healthy youth alternative after school programs – both social and athletic
- Day programs
- We actually have lots of mentioning programs locally. Our most complex youth and families refuse to participate in them. I don't see this as the answer for lots of financial investments.

Q10. When asked if there were **any missing priority areas**, the following items were added:

- Access points and crisis access in western Washtenaw County
- Unarmed safety response program; incorporation of 988 into existing program infrastructure
- Transitioning youth ages 17-25; very difficult period developmentally
- Family systems needs and housing solutions for youth ages 14+ hwo struggle to live in their homes. There are virtually nonexistent support opportunities for this age group

ATTACHMENT #1F4
FEBRUARY 2022

Millage Funding Summary February 2022

CLR (Community. Leadership. Revolution.) Academy: launched in 2021 in a partnership formed by *Washtenaw My Brother's Keeper* and *AFC Ann Arbor*. The founding partners included Jamall Bufford of WMBK, Bilal Saeed of AFC Ann Arbor and Justin Harper, the Director of CLR Academy.

Goals: Create a program for the most underserved Black K-8th youth in our community that will create consistent role models and non-related adults involved in their lives while introducing wellness through sport sampling, nutrition, and mindfulness.

What: Partner with the county's Youth Center to support its high school age Day Treatment participants with its *Beyond Sport* programming. Many of the Day Treatment participants are dealing with mental health issues, in some cases stemming traumatic experiences in their households. To address this matter, CLR will use soccer, basketball, football, and other sports, along with a focus on mindfulness and wellness to help with the development of the participants. But *Beyond Sport* will expand the CLR programming to include exposure to the other side of sports as well. Roles such as sports agents, marketing and promotion, team ownership, training staff, and much more. All in hopes that it could spark possible career interests for the participants. The funding will also provide weekly summer programming in neighborhoods that experience higher rates of police presence and incarceration. Families and stakeholders have expressed a deep need for high-quality, engaging opportunities for young people.

Funding Amount: $45,000 Annual for 1 year

Wraparound Mental Health Professional Position: Wraparound is a structured planning process that aims to support youth and their families develop problem-solving, coping, and self-efficacy skills. The model emphasizes integrating youth into the community, as well as building the family's social support network.

Goals:

- Aid the prevention of youth cascading into the criminal justice system
- Interrupt the school-to-prison pipeline by providing services before youth are court involved
- Reduce the number of youth contained in the detention center and out-of-home placement
- Minimize trauma caused by involvement in the criminal legal system

What: The position will serve youth aged 12 to 18 years who have complex needs, have experienced prolonged adversity, including caregiver substance abuse and/or mental illness. This position will focus on preventing local youth from becoming involved in the juvenile justice system, as well as providing treatment for those who already have system involvement, especially those youth in the Day Treatment Program.

Funding Amount: $85,305 Annual, continuous

Office of Community and Economic Development: *The Family Empowerment Program (FEP*) launched in 2011 through an initial grant from the Kresge Foundation, the Family Empowerment Program housed at Eastern Michigan University and coordinated by community based social workers is the key point for social, health, and economic access, educational support, and community navigation for families in Ypsilanti Housing Commission communities.

Goals: Provide case management services to individuals, families, and New Parkridge community at large. The services will aim to ensure family housing security, stabilization, and growth with a key focus on addressing trauma and unmet mental health needs of New Parkridge residents.

What: Hire/retain a Residential Service Coordinator

Funding Amount: $69,573 Annually for 3 years ($210,218 total)

Office of Community and Economic Development: *Michigan Ability Partners (MAP)* has been passionately serving people who are homeless and disabled in Washtenaw County since 1985. MAP owns and operates 44 units of affordable housing in Washtenaw County and manages approximately 107 additional subsidy vouchers in scattered site settings. The agency works with over 30 local landlords and property managers to secure suitable housing for those with the most severe barriers, including criminal histories, past evictions, physical limitations, and mental health issues.

Goals: Expand leasing assistance and supportive housing services to chronically homeless, disabled, and low income individuals.

What: MAP's RASS Permanent Supported Housing (PSH) expansion project will add leasing assistance and supportive services to 14 homeless, disabled (mentally illness/chronic substance abuse, physical), and low-income individuals as well as supportive services only to an additional eight households already receiving a subsidy but who need the supportive services. In total, at full capacity, the project will serve 33 households with leasing vouchers and 44 total households will receive supportive services. This project allows affordability to tenants by providing funding for rental subsidy, while tenants pay 30% of their income toward rent. Rent will be at or below Fair Market Rent (FMR).

Funding Amounts: $357,546 Annual for 1 year

BEYOND SPORT

Powered by CLR Academy

What is Beyond Sport?

Beyond Sport is a holistic sport and wellness program that uses sport as a mechanism to create an engaging, educational curriculum that introduces students to the business and operations side of the sporting industry.

This high school aged curriculum created by CLR Academy ties in actual physical fitness with mindfulness, nutrition and an emphasis on academics by introducing them to opportunities within the sporting industry (other than being an athlete).

By exploring the societal and economic impact of sport through a mixture of classroom and fieldwork, students will learn about the intersection of sport and music, sport and race and sport and power. Visiting local universities and sports organizations will give the students first hand experiences of what goes into making a game day happen from the trainers, to the media, to the scouting, to the event management.

What is CLR Academy?

CLR Academy is a free youth sports academy that provides consistent mentorship, coaching and guidance for kids K-8 with ongoing summer programming directly in the neighborhoods of the most underserved Black and Brown youth. CLR (Community, Leadership, Revolution) uses restorative justice circle work, conflict resolution and mindfulness techniques such as yoga, journaling and meditation, while providing sports sampling, nutrition education and exposure to new activities all summer long. CLR Academy not only provides free sports equipment and snacks, but also free books along with author meet and greets and readings from community members. From breakdancing with their friends and parents to viewing artifacts from the Black Mobile History Museum, CLR Academy students are introduced to holistic healthy lifestyles and empowered with new opportunities.

BEYOND SPORT

Powered by CLR Academy

Instructors

Bilal Saeed brings over 15 years of experience in the sports and entertainment industry and has worked with youth for over 10 years. He holds a Masters in Sports Administration, is co-owner and Chair of AFC Ann Arbor (local semi-pro soccer club), founder and owner of PKMD Media Group, co-founder of CLR Academy, founder of Anti Racist Soccer Club and co-founder of The Mighty Oak Project. He is a sports market and community builder and also teaches Ethics in Sport at Wayne State University.

Jamall Bufford set out to pursue his music career as a Hip Hop recording artist, following his graduation from the University of Michigan. Music led Jamall to his current career of youth advocacy and empowerment. He has been making music for over 25 years and performed in 15 countries. Jamall wanted to share his love for Hip Hop with the young people in his community, which led to being Music Coordinator at the Neutral Zone teen center, later a Special Needs Paraprofessional in Ann Arbor Public Schools, and now his current role with Washtenaw My Brother's Keeper. Jamall is the Project Specialist for Washtenaw County My Brother's Keeper, which is a nonprofit initiative started by President Barack Obama in 2014. The initiative is focused on cradle to career pathways for Black and Brown boys and men of all ages, working to help counter some of the barriers they face. Barriers based on inequities in the criminal justice system, the education system, or economically.

Justin Harper has a heart for people in need, especially children. Harper brings twenty years of experience developing and mentoring youth through coaching, officiating and teaching in the classroom. Justin currently works as a paraeducator for Ann Arbor Public Schools and is pursuing his special education teaching degree from Eastern Michigan University. Some of his passions are improving communities, mentoring youth and engaging in sports. Justin is a steering committee member for Washtenaw My Brother’s Keeper, co-founder and director of CLR Academy, and board member for both We The People Opportunity Farm and The Mighty Oak Project.

BEYOND SPORT

Powered by CLR Academy

Problem Statement

Youth who lack access to sport, consistent adult mentors, healthy lifestyles and opportunity- lack structure, hope and guidance.

Attempts have been made to use sport as a tool to keep kids out of trouble, to improve attendance and even to improve relationships with police. What sport is used for can differ, but sport itself has become one of the most powerful tools of influence.

Access to sport is one of the biggest issues young children face today. Youth sports costs continue to increase creating larger gaps between marginalized communities and their ability to access youth sports. As professionalization of youth sports increases significantly year after year, other factors like travel and time commitment start to play significant roles as well. The kids who are being priced and pushed out of sport are oftentimes the ones who need it the most.

There is a lack of consistent, positive, adult role models, especially men and women of color, for this underserved population. Oftentimes we think about kids being able to turn to an adult if they have a problem or issue, and we see that is missing with many of the kids. Being able to provide what takes time to build genuine trusting relationships.

With many kids living in food deserts, the importance for nutrition education is even more important to break the cycle and systemic challenges around food in parts of the county. It begins by introducing healthy snacks and nutrition basics.

Without understanding what opportunities exist, how are we giving each kid a fair chance? Sport is viewed as one of the few opportunities as a way out, yet few have access to it. Even if access was available, the statistics of trying to “make it” are something we will study in our curriculum as we begin to explore new opportunities in the sports industry like coaching, physical therapists, nutritionist, event management, ticket and sponsorship sales, etc.

BEYOND SPORT

Powered by CLR Academy

Some young people involved in day treatment may have come from traumatic experiences. Knowing trauma causes the brain to get locked into an emotional space, bicameral movement can help unlock the emotionally traumatized brain. This is why sport/movement is so vital to healing the traumatized brain. Movement through sport, yoga, dance, etc. Doing it before academics in particular also unlocks the brain for learning.

Goals

- *Get students engaged in all aspects of sport from physical fitness to front office*
- *Create consistent, positive adult mentor relationships*
- *Create real opportunities for work after completing course (like partnership with AFCAA)*
- *Show kids the many opportunities that exist within sport and entertainment*
- *Use journaling, mediation and other mindfulness techniques to teach coping skills*
- *Use expertise of instructors to instill strong conflict-resolution skills taught through sport*
- *Use restorative justice practices like circle work as core part of curriculum*

Total requested funding per 12 week session: $10,000 (can offer up to 3 sessions per year)
**Includes, staffing, equipment, insurance, and some additional smaller overhead expenses*

Washtenaw County
Supporting Intergenerational Mental Health Through Sport & Wellness

Key Partners: WMBK**,** The Mighty Oak Project (AFC Ann Arbor), Hart & Tay Train Foundation (Mike Hart and Latavius Murray Foundation), Rob Murphy Foundation,

Key Community Relationships: Our Community Reads, Supreme Felons, Black Mobile History Museum 101, Trusted Parents Advisory Group, U of M Athletics, Eastern Michigan University Football, Youth Arts Alliance

Key Data

- For each location we are operating at, we can reach over 250 children, with a retention rate of no less than 30% which allows us to average anywhere from 25 to 50 kids per location per week
- Over 60% over of the funds are redistributed to local Black organizers and organizations that are programming support partners (yoga teachers, breakdancers, coaches, authors, artists, nutritionists, etc)
- A minimum of 10% of funds from each site are allocated to providing work opportunities for court involved teens

Outcomes of Investment:

- Strong intergenerational connections in community with key stakeholder involvement
- Collaborative leadership programming building trust, pathways for communication and prevention of community harm and system involvement
- Programming and participants responsive to expressed community needs and collective vision for healthier, more just community.
- Interdisciplinary support and resource network from several organizations; for example:
- Increased emotional self-efficacy, resilience to systemic and community conditions, intergenerational relationships and coping skills for improved mental health.

Necessity of Partnership/Collaborative Effort:

- Building network of relational and organizational support in community for young people who have inequitable access to recreation, positive youth engagement experiences
- Strengthening relationships harmed by system involvement and community violence;
- Building and sharing restorative practices for wellness

THE NEED:
Weekly programming at Washtenaw County Youth Center and weekly summer programming in neighborhoods that experience higher rates of police presence and incarceration. Families and stakeholders have expressed a deep need for high-quality, engaging opportunities for young people.

THE RESPONSE:
CLR seeks to provide, no-cost, place-based weekly programming to:

- Young people incarcerated at Washtenaw County Youth Center.
- Young people who reside in the Sycamore Meadows neighborhood
- Young people who reside in the Parkridge neighborhood

CLR operates in 8-12 week programming series in a myriad of skill-building, leadership, sports and expressive disciplines

Cost per location: $15,000 annually // $45,000 total per year

WHAT

Using sport to introduce underserved Black youth to wellness, mindfulness and opportunities beyond the neighborhood

CLR Academy *was launched in 2021 in a partnership formed by Washtenaw My Brother's Keeper and AFC Ann Arbor. The two brought in three additional partners with similar objectives. These included The Mighty Oak Project, Rob Murphy Foundation and Hart & Tay Train Foundation. AFC Ann Arbor became the acting fiduciary for the project with each partner chipping in $5,000 for a total operating budget of $25,000. The founding partners included Jamall Bufford of WMBK, Bilal Saeed of AFC Ann Arbor and Justin Harper, the Director of CLR Academy.*

GOALS

Create a program for the most underserved Black youth in our community that will create consistent role models and non-related adults involved in their lives while introducing wellness through sport sampling, nutrition and mindfulness. Remove all barriers to participate and give away everything for free. Build the program with the Black community, for the Black community while financially supporting the Black community.

PROGRAMMING

Every Saturday from 12 to 1:30PM; The day begins promptly at Noon with everyone including coaches, volunteers and participants in a circle (no one in the middle). We discuss the norms (rules) which are key to the foundation of making this a formal, yet fun program. (Program began on June 5th and ended August 28th; 3 consecutive months)

1. **One rapper, One mic**
2. **Don't Hate**
3. **Circle of Trust**
4. **Respect**
5. **Have fun!**

Word of the day: In the circle, we also discuss a word of the day such as **leadership, responsibility, trust, hard work, patience** and so on. We incorporate this word throughout the day with all of our coaches using it during their sessions.

Immediately from the circle we stretch and get into a dynamic warm up getting the kids active and moving together. We then break into three pods based on age and rotate between three stations of football, basketball and soccer for a total of 45 mins. Together the circle and these three sports take up one hour.

The sports are focused on getting kids active, having fun, while learning basic skills and rules through maximum touches on the ball and interactions with the coaches (playing with them).

The remaining half an hour is where we introduce different activities and things to the kids. We have done reading with local authors, yoga, community day (video game truck and inflatables), Black Mobile History museum, nutrition day, breakdancing and journaling.

We take a lot of breaks to encourage healthy snacks which are all provided free of charge. All of the snacks, books and sports equipment is free of charge for the kids to use and to take home with them.

VOLUNTEERS

The program included one paid director who is responsible for being there every Saturday. They are the main decision maker, the lead coach and the person who the program will rely on the most to function well. In addition, you will need a core of 6 to 8 consistent volunteers who will attend at least 80% of the Saturdays. Ideally, they will be connected to the partners (current athletes, ex-athletes, local coaches, parents, teachers, educators, etc).

Our program director, Justin Harper not only had 100% attendance through the summer for our events, but was the dynamic leader we needed to effectively bridge the gap between us and the residents of Sycamore Meadows.

Justin's partners in launching CLR Academy, Jamall Bufford and Bilal Saeed were in attendance for over 75% of the events and brought a wealth of knowledge and experience in restorative practices and youth development through sport, respectively.

Additional key volunteers included former Michigan State soccer standout Alex Warner and local soccer star Emily Eitzman.

Our core volunteers were diverse in many areas and consistent in their attendance. This representation was massive to building relationships quickly with the kids.

LAYERS

CLR stands for **community, leadership, revolution**. These are our key principles and we are able to weave these into who we are through different layers.

1. Use Black vendors, from the local community, whenever possible
2. Allocate $2,500 to $5,000 for local court involved teens who can earn a stipend for working every Saturday for the Academy
3. Connect with local sport organizations to create volunteer opportunities and special days for the kids (local Universities, semi-pro teams, etc)

CLR ACADEMY

ACCOMPLISHMENTS

- Distributed books from local Black authors such as Khalid and Khalida's ABCs of Black History and Young King Take Your Stand for free
- Appearances from local collegiate athletes from University of Michigan and EMU
- Provided healthy snacks and drinks each week while discussing nutrition with one week of programming specific to a deeper discussion on nutrition with sampling and more
- Introduced multiple sports and wellness activities from soccer to yoga to breakdancing
- Awarded $2,500 in stipends to multiple court involved teens
- Kept a core group of volunteers engaged with the kids building healthy adult/youth relationships
- Gave away over 500 soccer, football and basketballs plus yoga mats, soccer goals, t-shirts, snacks and multiple used and new books
- Over $12,000 reinvested into black organizers and organizations including authors, artists, entrepreneurs and activists

Wraparound Position January 2022

Community Need:
Racial and economic disparities exist in our community impacting who gets caught up in the juvenile justice system. WCCMH, Youth & Family Services is seeking to help address this concern by providing comprehensive, early intervention, community-based supports for at-risk youth to advance more equitable outcomes.

WCCMH Request:
We are seeking a new Wraparound MHP position to serve youth aged 12 to 18 years who have complex needs, have experienced prolonged adversity, including caregiver substance abuse and/or mental illness. This position will focus on preventing local youth from becoming involved in the juvenile justice system, as well as providing treatment for those who already have system involvement, especially those youth in the Day Treatment Program.

What is Wraparound?
Wraparound is a structured planning process that brings people together from different parts of the family's life and follows steps to help youth and their families realize their potential. The process aims to support youth and their families develop problem-solving, coping and self-efficacy skills. The model emphasizes integrating youth into the community, as well as building the family's social support network.

Staff trained in Wraparound follow a structured yet individualized team planning process that results in a holistic care plan. Wraparound is generally considered an intensive service that aims to address a range of life areas, as well as achieve positive outcomes. Services are tailored towards building strengths, promoting safety and permanency in the home, school and the community.

Referral Sources:
- WISD
- Ozone
- Juvenile Court

Services:
The Wraparound MPH will work directly with youth and their families to address their individual circumstances. This position would be trauma informed and strengths-based, emphasizing safe, healthy, and adaptive coping skills. Working directly with youth in the community, as opposed to an office setting, enables a range of services within the youth's everyday environment, including the familial residence.

Key Community Partners to Facilitate Linkages to:
Mental Health Services, Mentoring/tutoring, Vocational Training, Substance abuse treatment

Expected Benefits:
- Aid the prevention of youth cascading into the criminal justice system
- Interrupt the school-to-prison pipeline by providing services before youth are court involved
- Reduce the number of youth contained in the detention center and out-of-home placement
- Minimize trauma caused by involvement in the criminal legal system

Budget:

Salary	50,722
Fringe	34,583
Total	85,305

Summary

The Family Empowerment Program (FEP) requests $210,218 (~$69,573/yr) over the next three years from the Washtenaw County Racial Equity Office to continue supportive services for residents at New Parkridge (NP). The Family Empowerment Program's initial work conducted at New Parkridge was designed to allow the FEP to expand to meet the needs of a new community while simultaneously embarking on a new venture to gain a better understanding of mental health needs. The broad strokes of this initiative were, to provide resident service coordination to 86 New Parkridge families, measure attitudes regarding mental health, gauge the breadth of mental health need, discover ideal service delivery methods and models, and utilize this data to form the foundation of a mental health arm for the FEP. Unfortunately, the COVID-19 pandemic largely disrupted this work and the focus (appropriately) shifted to meeting basic needs. As current funding comes to a close, the program seeks to continue this vital work while enhancing service delivery by developing and adhering to practices designed to address the effects of Adverse Childhood Experiences, acknowledging and meeting mental health needs, and professionally developing staff in order to do so. Funding from the Racial Equity Office would allow the Program to continue providing services to one of Washtenaw County's most marginalized communities as well as another opportunity to establish a mental health component for the program.

History

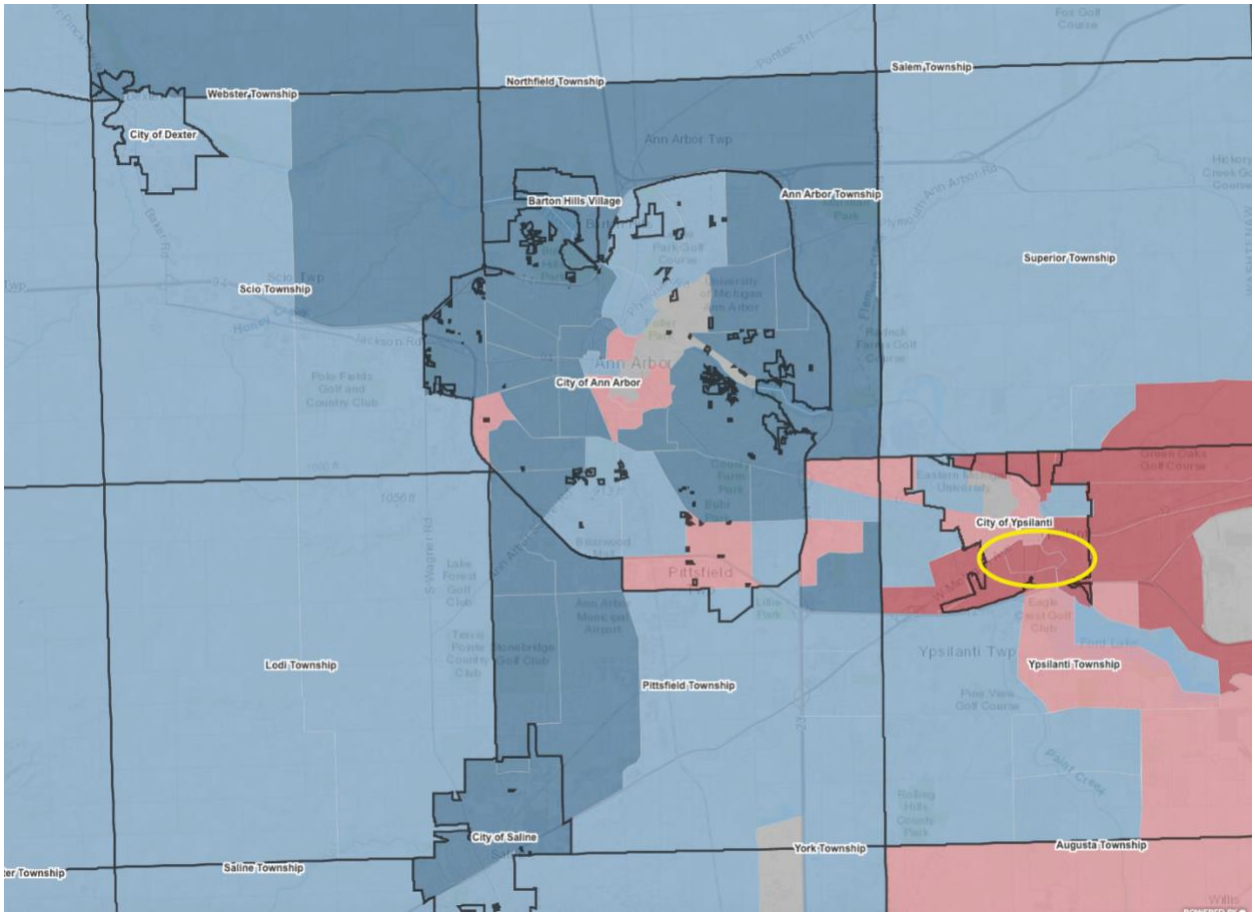
Launched in 2011 through an initial grant from the Kresge Foundation, the Family Empowerment Program housed at Eastern Michigan University and coordinated by community-based social workers is the key point for social, health, and economic access, educational support, and community navigation for families in Ypsilanti Housing Commission communities. Launched at Hamilton Crossing (serving 144 families), the program has steadily grown over the past decade, expanding to serve Strong Future Homes in 2016 and most recently New Parkridge in 2017 (112 and 86 families). As of the last community snapshot in 2019, the FEP serves 390 adults and over 500 children under 18. Residents are primarily single mothers (95%) of color (79%) and are between the ages 19-35 (79%).

Narrative

As Dr. Nadine Burke Harris notes in her exploration of child trauma, The Deepest Well (2018), there is a well-documented connection, particularly across the United States between poor communities and poor health – that it is not solely how one lives that affects one's health, but where. This is observed in Washtenaw County through the Opportunity Index (2020). The Opportunity Index is a granular examination of the County through an equity lens – measuring health, education, job access, and community stability/engagement. These sectors are rated individually and then combined to create opportunity scores based on census tract, ranging from 'Very Low Access to Opportunity' to 'Very High Access to Opportunity'.

As indicated in yellow below, all FEP communities fall within census tracts that are rated to have 'Low' or 'Very Low' Access to Opportunity (tracts 4106, 4107, and 4108). The Index

additionally details that the County is eighth most segregated in the United States, which is bore out through comparing 2020 Census data with demographic information collected by the FEP. African Americans comprise approximately 28% of Ypsilanti City and 33% of Ypsilanti



Township (US Census, 2020), while FEP communities are on average 79%. This reality continues to harm those with low access to power and opportunity - specifically minorities in Washtenaw County, which the FEP has sought to address since inception.

This structural inequity and resource disparity can be seen in data from the 2016 baseline survey conducted at New Parkridge, prior to service delivery by the FEP: 72% did not have a checking or savings account, 64% did not have access to a computer, 52% did not have a high school diploma or GED, and 95% had children. However, 42% said they never receive assistance from an agency or nonprofit, 60% reported not being able to afford balanced meals, and only 60% reported having a dentist they can see regularly.

The Family Empowerment Program was born out of a recognition of the inequity demonstrated by the Opportunity Index in addition to the idea that solely providing housing to oppressed, low-income, and traumatized families and individuals is not enough to break the cycle of poverty, overcome systemic injustice, and meet this plethora of need. As such, FEP services at NP are made available without qualification and designed to be flexible enough to meet the needs of a vulnerable individual or family: stable housing, food assistance, child care, transportation, access

to health and dental care, tutoring, homeownership programs, financial coaching and matched savings accounts. These services are provided or referred for while clients are encouraged to utilize the tools of self-empowerment, self-reliance, and agency with support and coaching from staff. This case management approach allows staff to become familiar with and honor each individual without being onerous or prescriptive, ensuring programming and services meet the needs of the individual or family (person-centered and two generation) as well as those of the YHC as a whole (community minded). This approach is supported as by the Corporation for Supportive Housing (CSH), a national supportive housing leader which notes that "Access to safe, quality, affordable houses *and the supports necessary* to maintain that housing – constitute one of the most basic and powerful social determinants of health." (Housing is the Best Medicine, 2014). Funding from the Washtenaw County Racial Equity Office would allow the Resident Service Coordinator at New Parkridge to continue to provide case management and services to a community that is demonstrated to be marginalized by County data.

However, continued service delivery at NP is a foundation from which the program seeks to build upon. As noted, the FEP was unable to make significant progress on proposed mental health work due to the COVID-19 pandemic. The program wishes to restart efforts on this front, an initiative that is supported by a long-documented need. FEP surveying in 2017 revealed that approximately 30% of respondents noted they have mental health concerns and wanted to address them (Attachment A). This trend has continued through the most recent annual survey (2020, Attachment B) which demonstrates that 24% of adults noted mental health concerns and wished to address them. Despite this statistic hovering between 1/4 and 1/3 of families, another body of information suggests a much larger portion of the community would benefit.

Additional assessments were conducted in the following years, which demonstrated that 47% of New Parkridge adults surveyed (n=53) scored higher than a 4 on the Adverse Childhood Experience (ACE) Survey (Attachment C). The initial ACE study of 17,000 participants demonstrated that only 12.5% of respondents scored a 4 or higher on the survey (Felitti et al., 1998). This indicates that the rate of FEP adults that have experienced significant trauma and adverse childhood experiences is nearly four times that of the general population. Why do 4 ACEs matter anyhow? Those that have experienced four or more ACEs are at significant increased risk for health outcomes compared to individuals with no ACEs (Hughes et al., 2017), in addition to a host of other potential issues.

As Dr. Burke Harris' nonprofit, The Center for Youth Wellness bluntly puts it, "Experiencing 4 or more ACEs is associated with significantly increased risk for 7 out of 10 leading adult causes of death, including heart disease, stroke, cancer, COPD, diabetes, Alzheimers and suicide." Cyclical, generational trauma is another consequence of higher ACEs, as other outcomes associated with having multiple ACEs as an adult (violence, mental illness, substance use) represent future ACE risks for children (Burke Harris, 2018 & Hughes et al., (2017). Without intervention – the cycle can continue, solely due to the existence of unaddressed ACEs.

Continued support for FEP families is of urgent importance when taking this into account in addition to the findings of the Opportunity Index. Certain social determinants of health (SDoH), when combined with Adverse Childhood Experiences can lead to even worse outcomes (Shonkoff & Phillips, 2000). Some of these SDoH include, living in under-resourced

neighborhoods, neighborhoods segregated by race, experiencing food insecurity, and frequently moving – nearly all of which affect or have affected FEP families, as detailed by the Opportunity Index and supported by internal data (attachment D). These negative components of SDoH, when combined with a significant number of ACEs (both criteria many FEP families fit), can lead to toxic stress.

As Houry and Mercy note in Preventing Adverse Childhood Experiences (2019), a growing body of research indicates toxic stress during childhood can have disastrous consequences. Changes to the brain due to toxic stress can affect attention, impulse behavior, decision making, emotion, learning, and stress response. Without the presence or introduction of protective factors, children struggle to complete their schooling and learn. They are at increased risk of becoming involved in crime and violence, using alcohol or drugs and suicide. As adults, they have unstable employment histories and financial struggles, have difficulty maintaining relationships with friends and family, and often suffer from depression – the effects of which can be passed on to their own children (Chapman et al., 2004).

While this sounds grim and hopeless, there has been significant research in what is effective in counterbalancing lives when SDoH are negative and ACEs are present. One such finding is the development of resilience, which can be strengthened at any age and any time (Center for the Developing Child, 2020). This can be accomplished through maintaining a stable and committed relationship with a supportive parent, caregiver, or other adult. Other positive experiences that build resilience and 'counterbalance' the effects of ACEs and SDoH are building a sense of self-efficacy and self-control, and providing opportunities to strengthen self-regulation and adaptive skill capacities (Center on the Developing Child, 2020). In Preventing ACEs (Houry & Mercy, 2019), it is noted that mentoring programs, after school programs, and coordination with schools can improve outcomes. These programs in addition to high-quality childcare, preschool, and enrichment programs can be part of the positive counterbalance, too. Families can be stabilized by preventing frequent moving or eviction, utility disruption, and by building a sense of community. Adults can specifically be engaged in therapy – in victim-centered services, trauma-focused cognitive behavioral therapy (TF-CBT), and Multisystemic Therapy (MST) – all of which have been proven to be effective for adults with ACEs and in building protective factors. This engagement can continue in the form of skills-based parenting, strengthening financial acumen, and in building relationships within community. It has also been demonstrated to be effective when parents are connected for regular care with primary care physicians for themselves and their children to identify and address ACE exposures.

The FEP utilizes a two generation (parent and child), person-centered, and client-driven model of engagement, allowing the program to provide stability and a sense of control through empowerment, resource navigation, and provision. The programs holistic treatment of individuals and families is in line with much of what Houry and Mercy (2019) recommend in 'Preventing ACEs'. The program provides afterschool tutoring opportunities, connections to mentoring programs and early education opportunities, and has helped establish an accredited child care center where FEP families can enroll free of charge. The program has partnered each year with local camps to provide educational support and enrichment for children. While the FEP has always sought to assist families with utilities and rental assistance, demand skyrocketed during the pandemic. The program has allowed families to remain stably housed by securing

over $200,000 in utility and rental assistance since the pandemic began. This has been accomplished by working cooperatively with residents to navigate and apply for programs through the Barrier Busters network, Michigan State Housing Development Authority's Covid Emergency Rental Assistance Program (CERA), and Cinnaire's Rental Relief Fund.

While the FEP is on the right track in terms of being in line when it comes to combating the effects of ACEs and negative SDoH, there is certainly room to grow. Additional emphasis could be placed on coordinating adult and child primary care, ensuring families have barrier free access to their provider. The program helps participants understand insurance benefits and identify a PCP, but this additional step is in line with recommendations. While most workshops are held in response to needs identified by participants and staff, additional activities could be held that are in line with Houry and Mercy's (2019) document: skills-based parenting classes, victim-centered support groups, integrated and evidence-based treatments for substance use disorders, and an open house for mentoring programs (My Brother's Keeper, Big Brothers Big Sisters Washtenaw, Girls on the Run, etc..). In line with CDC recommendations, program staff would become proficient in trauma informed care approaches, starting with completing training through Dr. Burke Harris' Center for Youth Wellness and eventually Multisystemic therapy to meet the needs of families from an additional evidence base.

Goals and Objectives

Goals / Objective	Intervention	Outcome / *Measurement Tool*	Associated Date(s)
G1: Resident Service Coordinator provides case management services to individuals, families, and NP community at large O1: RSC develops 'Community Plan' in coordination with residents, FEP staff, community stakeholders O2: RSC engages, motivates, and encourages active participation in voluntary services O3: RSC develops empowerment plans with individuals and families with focus on protective measures: food security, childcare connections, preschool enrollment, mentoring services, PCP connections, therapy engagement	Proactive engagement, outreach, and service provision Development of workshops in coordination w/ community partners based off site plan	O1: Production of Community Plan during of Q1 each program year O2+3: Individuals and families identify the FEP&RSC as a resource, participation ideally increasing year over year/ *Annual Survey Count, Empowerment Plan documentation*	G1: Ongoing O1: Quarter 1, 2022, 2023, 2024 O2/O3: Ongoing
G2: RSC ensures family housing security, stabilization, and growth	Continued case management, coordination	O1: Families remain stably housed, eviction being a last resort after	O1/O2/O3: Ongoing

O1: RSC completes eviction prevention plans with at risk households in coordination with property management O2: RSC pursues local resources to reduce or eliminate barriers, obtain rental assistance, utility assistance, transportation, internet subsidy, etc… O3: RSC refers residents to service providers, or coordinates services based on individual empowerment plans	with property management and local safety net, transportation partner GDI	EPP implementation and amendments/ *Eviction Prevention Plan Records* O2: Families do not experience utility shutoff, lapse in rent payments, unnecessary disruption in school or work/ *Barrier Buster request records, CERA/addtl. Rental assistance records, GDI referral records*	
G3: NP residents participate in mental health services, eventually demonstrate a reduction in unmet mental health needs O1: RSC increases participation in mental health services Y1-3	Continued case management	O1: Year over year reduction in immediate and long-term unmet mental health needs after Y1/ Annual survey, *resident self-report*	O1: Quarter 1, 2023 and 2024

Program Budget

Projected Yearly Expenses	
Line Items	**Amount**
FEP Staff (New Parkridge Resident Service Coordinator, 3% increase/yr)	$45,000
EMU Staff Fringe Rate, 8%	$3,600
Professional Development	$2,000
Intern Stipend ($500/student)	$1,000
Workshops, Community Events, Programming	$9,000
Computers, Computer Repair	$1,500
Office Supplies	$850
Summer Camp Scholarships	$3,000
Resident Incentives	$2,150
Total Projected Expenses, Y1	**$68,100**

Budget Narrative

This funding will primarily allow the FEP to continue employing Christa Hughbanks, who serves as the Resident Service Coordinator for the 86 residents of the New Parkridge community. A native of Ypsilanti and a graduate of EMU's undergraduate Social Work Program, Ms.

Hughbanks has assisted the FEP in previous research efforts and contributed to collecting annual surveys at both Hamilton Crossing and Strong Housing. She went on to receive her Masters from the University of Michigan with a concentration in mental health and since has assisted the program in starting its Permanent Supportive Housing (PSH) certification, worked as a substance use counselor at Women's Huron Valley Correctional Facility, and is a therapist for Catholic Social Services. Her commitment to FEP families is unmatched and expertise in providing care with cultural humility is of the utmost importance. 3% increase in staff expense accounts for inflation and yearly raises, ensuring her position provides a living wage year over year and remains competitive: Annual increase, $45,000 @ 3%: ($46,350/Y2, $47,741/Y3). Eastern Michigan University has a fringe rate of 8% for employee consultants which would result in a total of $11,127 over the three-year period.

To ensure the FEP can continue to invest in Ms. Hughbanks and she is able to attend relevant trainings while remaining abreast to best practices associated with trauma-informed care; expenses related to staff training, conference registration, and travel are included under professional development. This would include training through the Center for Youth Wellness and in Multisystemic Therapy. Since inception, the Family Empowerment Program has a history of partnering with local Colleges and Universities. To honor the contributions, time commitment, and expenses associated with completing an internship, the FEP provides a stipend of $500 to each intern.

Workshops and associated expenses, facilitation fees, catering, materials, etc… are all expenses associated with partner organizations and agencies. For example, payment for women's empowerment group facilitator, food for attendees, and craft materials for associated activities. Lastly, the program has a partnership with Digital Inclusion to provide residents with affordable computers, productivity software, and repairs. Access to computers, subsidized internet, and computer repair specialists during the pandemic was crucial to residents staying connected to the FEP, local and state resources, and ensured access to distance learning. The FEP wishes to continue to offer this resource to families.

The FEP typically provides scholarships to families that can be used at any number of local summer camps, including Salvation Army, United Way, and Parkridge Community Center. These are typically combined with scholarships already provided by the camp to maximize funds so as many families as possible can attend. Lastly, the program wishes to honor the time and contributions of participants with equitable compensation. As such, Resident Incentives include a $25 gift card per household per year that contribute to the program's annual survey or assessments.

Proposed Reporting

Reporting would be conducted biannually. A short form report containing an executive summary, including: project goals and objectives progress, impact, and challenges. The first such report would include baseline data used to develop the New Parkridge 'community plan' and input from community partners and residents. Long form submissions would include the above

executive summary, year over year data reporting, SWOT analysis, lessons learned and in the final report, plans for sustaining the program.

Reporting Activity	Date
Biannual Check-in, Short Report	August 2022, 2023, 2024
Annual Check-in, Long Report	February 2022, 2023
Final Report	February 2024

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NEW/EXPANSION PROJECT APPLICATION

2021 CoC Funding Competition

- **All information is required, including attachments. The Funding Review Team reserves the right not to review incomplete applications or projects that don't meet eligibility requirements.**
- **Applications are due by Friday, October 15, 2021 and should be sent to Andrew Kraemer at kraemera@washtenaw.org. Late submissions will not be reviewed.**
- Please contact kraemera@washtenaw.org with any questions about the form or process.
- Please save your document with the following naming convention:
  - **New Projects**
    <Agency name –Program name- Program Type-NEW CoC21>.doc
    Example: ABC Services-Home to Stay-PSH-NEW CoC21.doc
  - **Expansion Projects**
    <Agency name –Existing Program name- EXPANSION_CoC21>.doc
    Example: ABC Services-Home to Stay-EXPANSION_CoC21.doc

I. GENERAL INFORMATION (not scored)

1. **Agency Contact Information:**
   a. Name of Organization: Michigan Ability Partners_____
   b. Organization Type
   ☐ Units of Local Government X☐ Non-profit 501(c)(3) ☐ PHA
   ☐ State Government ☐ Other: Describe_____
   c. DUNS Number: _181258021_____
   d. Is the agency a current HUD CoC grantee? X☐ Yes ☐ No

2. **If application is for a project expansion, please answer the following:**
   a. **Existing Project to be expanded:**
   Name: __: MAP RASS PSH _____
   Project grant number: __ MI0508L5F091904_____
   Project component type: __PSH- Leasing and Supportive Services_____
   b. **Activities that describe expansion project:**
   X☐ Increase number of homeless persons served
   X☐ Provide additional supportive services to homeless persons
   ☐ Bring existing facilities up to state/local government health and safety standards
   ☐ Replace the loss of nonrenewal funding (private, federal, other excluding state/local government)

3. **Sub-Recipient Organization (if applicable):**
   a. Name of Organization: _____N/A_____
   b. Organization Type
   ☐ Units of Local Government ☐ Non-profit 501(c)(3) ☐ PHA
   ☐ State Government ☐ Other: Describe_____
   c. DUNS Number: _____

4. **Contact person for this project:**
   Name: ___Jan Little_____ Title: _____CEO_____
   Phone: __734-975-6880 ext.212_____ Email: __jlittle@mapagency.org_____

5. **Proposed HUD Request ($): ___321,249_____**
6. **Proposed Total Budget $ (Total HUD Requested + at least 25% Match) *:_357,546_____**
7. **Proposed Number of Units:**
   a. **New Projects:** # Units Projected: _____
   b. **Expansion Projects:** Existing Project # Units: __**22**__ Expansion Project # Units __**44**___
8. **Proposed number of beds (choose applicable designation only):**

   # Dedicated___22_____ # DedicatedPLUS _____
9. **Proposed Project Type** (Expansion Projects must be the same project type as the current project)**:**

   X☐ **PSH** ☐ **RRH**
10. **Proposed Population to be served:** __Chronically Homeless Individuals_____
11. **Proposed Grant Term: _____One Year_____**
12. **Proposed Project Budget:**

Activities	Total Assistance Requested	Total Project Budget
Rental Assistance **Leasing**	176,064	176,064
Supportive Services	116,050	116,050
Operations		
HMIS		
Sub-total Request	292,114	292,114
Administrative costs (Up to 10%)	29,135	29,135
Cash Match		
In-kind Match	36,297	36,297
Total Match – 25% for all categories	Leasing does not require match	
Total Budget		$357,546

13. If the FRT decides to scale down projects, what is the **Minimum HUD Funding** needed to make this project or expansion viable? _____$225,500_____
14. The following **required attachments** are included:
    X☐ Most recent independent audit and submission of SAS114, and 115, if applicable
    X☐ Current year Board-approved agency budget

APPLICANTS SHOULD FULLY RESPOND TO THE FOLLOWING NARRATIVE QUESTIONS.
APPLICANTS ARE ENCOURAGED TO ANSWER AS SUCCINCTLY AS POSSIBLE.

II. APPLICANT/SPONSOR EXPERIENCE AND CAPACITY (15 points)

A. Describe the experience of the project applicant, sub-recipients (if any), and partner organizations (e.g., key contractors, service providers if applicable) as it relates to providing supportive services and housing for homeless persons, & carrying out the activities of the project. Be sure to provide concrete examples that illustrate

1) experience/expertise with renting units, operating rental assistance, & providing supportive services similar to the activities proposed in the applications &
2) working with & addressing the target population's identified housing & service needs.

Response:

Michigan Ability Partners (MAP) is a current HUD CoC grantee with six current Permanent Supported Housing (PSH) grants totaling $1,649,356. Additionally, since 2014, MAP has operated a Supported Service for Veteran Families Rapid Re-housing Program providing rental assistance and supportive services to homeless Veteran families. This proposed bonus project proposes to expand the RASS PSH grant that is in its fifth year of operation. MAP has been passionately serving people who are homeless and disabled in Washtenaw County since 1985. MAP owns and operates 44 units of affordable housing in Washtenaw County, and manages approximately 107 additional subsidy vouchers in scattered site settings. The agency works with over 30 local landlords and property managers to secure suitable housing for those with the most severe barriers, including criminal histories, past evictions, physical limitations, and mental health issues. Because each voucher comes with unique regulations, MAP's experience in operating a variety of subsidy programs, make the expansion a natural fit. MAP's housing team provides excellent supportive services to help each participant obtain housing quickly and maintain housing. The team works to meet the individual needs of each participant by providing onsite services, assessing what is needed for stability and making referral for representative payee services, income benefits, health care, employment, utility payments and basic needs. Additionally, MAP offers a food bank that supports all housing participants that want it.

B. Describe the experience of the applicant and potential subrecipients (if any) in leveraging other Federal, State, local, and private sectors. Be sure to include a description of experience with delivering or securing Medicaid funded services for participants in the agency's programs.

Response:

MAP receives funding from Housing and Urban Development, Veterans Affairs, U.S. Dept. of Labor, Michigan Rehabilitation Services, Washtenaw County and a variety of private foundations to support the work we do with participants with disabilities, veterans, and those experiencing homelessness. Packard Health serves a large portion of agency participants for physical health. Medicaid funded services might include physical health care, mental health care, etc. It can be difficult to find client resources for mental health care outside of CMH that will accept Medicaid. There are also barriers related to dental care, as there is a lack of providers in the area that accept Medicaid, and certain dental care such as dentures are not covered.

C. Describe the basic organization & management structure of the applicant & subrecipients (if any). Include description of internal & external coordination, structures for managing basic organization operations, & an adequate financial accounting system that will be used to administer the grant.

Response:
MAP's PSH team consists of Housing Supports Coordinators, a SOAR specialist, Rental Assistance Coordinator, and Clinical Housing Team Leader. The Housing Supports Coordinators who assist in ensuring that all homeless, disability and income documentation necessary for establishing eligibility are obtained. They perform the housing search with participants, and offer long-term supports such as frequent check-ins and connections to other resources to maintain stability. All report to the Clinical Team Leader, who is the HMIS admin and represents MAP at the Community Housing Prioritization (CHP) meeting, presenting voucher openings at meetings, and offering clinical support to the entire team. The SOAR specialist works to help participants apply for Social Security income and disability benefits. The Rental Assistance Coordinator works closely with the housing supports and the accounting team to ensure timely rental payments, completing inspections, renewing leases and collecting tenant portions of rent as needed. The accounting team completes the monthly funding draws from HUD and integrates the rental assistance data into the agency's accounting system (Abila). Monthly financial reviews of the grants with the leadership team determine availability of funds for services and leasing units.

D. Describe the experience of the applicant & potential subrecipients (if any), in effectively utilizing federal funds & performing the activities proposed in the application, given funding & time limitations.

Response:
MAP is a current CoC funding recipient and this is an expansion project of an existing grant, therefore the timeline would not be a barrier. MAP would work with the Community Housing Prioritization committee to ensure all vouchers would be leased up within the first six months of the grant. Additional Housing Supports Coordinators would be hired upon award notification and be ready to start on the proposed grant start date of July 1, 2022. (existing grant operating year is July1st-June30th.

E. Have any of your agency's HUD funded programs (including ESG) received a HUD audit in the last 12 months? X☐ Yes ☐ No

If yes, were there any findings from the audit? **X**☐ Yes ☐ No

If yes, please describe the findings & your agency's corrective actions to satisfy the findings & attach a copy of the corrective action plan that you submitted to HUD or OCED.

Response: There was one finding from the HUD audit, related to failure to make a quarterly draw of funding on one of the grants. A procedure has been added to the monthly financial closing process, which ensures the accounting team makes a monthly draw at month end. From May 2021 to August 2021, MAP notified the appropriate HUD personnel of every draw made. The finding has been resolved and closed.

F. Are there any unresolved monitoring or audit findings for any HUD grants (including ESG) operated by the applicant or potential subrecipients (if any)?
☐ Yes X☐ No

If Yes, describe the details of unresolved monitoring or audit findings & steps that will be taken to resolve.

G. Have you returned any funds to HUD on any existing grants in the last two years?

X☐ Yes ☐ No

If yes, how much has been returned?

PASS- $5,585

SRA- 2019- $18,965 2020- $10,116

TRA- 2019-$13,200 2020-$7,289

What is the reason that the funds have been returned?

Response:

The rental assistance grants did not have enough funding for a full year of rental assistance at Fair Market Rate ($1,029X12mo.=$12,348) for an additional voucher. The 2019 SRA rental assistance grant had several vacancies and a slow community process to fill them. The process has since improved with providing documentation to move participants into housing more quickly.

H. Do you have any outstanding obligation to HUD that is in arrears or for which a payment schedule has not been agreed upon? ☐ Yes X☐ No

If yes, how much is owed?

What is the reason for the obligation to HUD?

What is preventing establishing a payment schedule?

III. PROJECT DESCRIPTION (20 points)

A. Provide a description (**limit 2000 characters**) that addresses the entire scope of the proposed project. The project description should be complete & concise. It must address the entire scope of the project, including a clear picture of the community/target population(s) to be served, the plan for addressing the identified needs/issues of the CoC community/target population(s), projected outcome(s), & any coordination with other source(s)/partner(s).The description must be consistent with other parts of this application & identify **in 2000 characters or less (spaces included)**:

- If expansion project, how the application will expand units, beds, services, persons served
- The target population including the number of single adults & the number of families with children to be served when the project is at full capacity
- Address & location of units (current & expansion units for expansion projects)
- Type & number of units – scatter site or single site, single or multi-family homes, etc
- How the type, scale & location of the housing fit the needs of program participants
- The specific services that will be provided & outreach methods to be used to serve the long-term homeless population
- Projected outcomes
- Coordination with partners

- Project timeline – when units will be developed or leased-up
- HMIS implementation
- How the project will leverage or deliver Medicaid services to participants

Response:

MAP's RASS Permanent Supported Housing (PSH) expansion project will ***add*** leasing assistance and supportive services to 14 chronically homeless, disabled (mentally illness/chronic substance abuse, physical), and low-income individuals as well as supportive services only to an additional eight households already receiving a subsidy but who need the supportive services . In total, at full capacity, the project will serve 33 households with leasing vouchers and 44 total households will receive supportive services. This project allows affordability to tenants by providing funding for rental subsidy, while tenants pay 30% of their income toward rent. Rent will be at or below Fair Market Rent (FMR). MAP will sign the leases for units and sublease to participants. This allows for individuals who have difficulty leasing in their own name to have safe and affordable housing. There will be/are 33 1-bedroom scattered site units throughout the county. The 11 supportive services only units are units at a MAP owned clustered site in Ann Arbor and at other sites in the community. MAP works with landlords to ensure that units are safe (HQS inspected), and affordable. MAP provides services in the most integrated setting and structures this program as a Housing First model, to be inclusive, low barrier and without preconditions of sobriety, treatment, service participation or criminal background checks. MAP uses a harm reduction model of supportive services, supporting clients without passing judgment on their use of drugs and alcohol. Those most in need are determined by the CHP Committee that meets along with community providers to place participants into housing. MAP also participates in HMIS. MAP's case management includes creating a plan with each participant for housing and service needs, job training services, food and nutrition (with Food Gatherers), transportation, referrals to community providers, and assistance accessing mainstream services. These services will be extended to all of the households in this project. Projected outcomes are for individuals to remain housed and if exited, will exit to other permanent housing (95%), obtain employment income (20%), maintain or increase their income (75%), and will obtain health insurance (80%).

B. Describe the estimated schedule for the proposed activities, the management plan, & the method for assuring effective & timely completion of all work.

Response:

The Clinical Team Leader, will begin the hiring process for the Housing Supports Coordinator(s) upon notification of the award. The staff will be on boarded prior to the July1, 2022 grant start date. The members of the CHP committee will be notified upon award announcement to begin the process of assigning the new vouchers to those determined most in need by the committee. Fourteen vouchers will be assigned and participants will be housed within six months (by December 31, 2022.) The additional 11 participants needing supportive services will be transferred to the Housing Supports Coordinator for case management at grant start date.

C. If project is designated as DedicatedPLUS, please explain the reasoning for this designation and how this project will use this expanded criteria.

D. For expansion projects ONLY, please detail why the proposed expanded activity is needed & how it would be implemented. *Only answer the expanded activities that apply to your project as answered in part I.2.b of this application.*

1. **Increase the number of homeless persons served:** Indicate why & how your project is proposing to increase the number of served

Response:

In an effort to decrease the number of chronically homeless people on the by-name list, and work toward ending homelessness in Washtenaw County, this project will assist fourteen people with housing and services and an additional eleven that need supports to maintain their housing.

2. **Provide additional supportive services to homeless persons:** Which supportive services would this project increase and how they will be increased (e.g. increased service; increased frequency, etc)? Describe the reason & identify how you will be providing additional services

   Response:

   With additional supports available, including assisting those in the program to obtain Social Security Disability benefits, and mental health treatment, along with increased frequency of onsite case management, participants in this program will become stable and maintain housing. This will take the burden off other emergency systems, including jails and hospital emergency rooms.

3. **Bring existing facilities up to state/local gov. health & safety standards:** Describe how the project is proposing to bring the existing facility or facilities up to state/local government health & safety standards

4. **Replace the loss of non-renewable funding:** Indicate how the project is proposing to replace the loss of nonrenewable funding from private, federal, &/or other (excluding state/local government). List the source of nonrenewable funding, why funds are non-renewable, & when funds expire. Identify any steps already taken to identify other funding sources.

E. Describe a plan for executing the grant agreement and beginning rental assistance within 12 months of the award. Describe how full capacity will be achieved over the term being requested. If any project site is not currently owned or under a lease agreement, provide a summary of relevant contracts & agreements (e.g., with local landlords, housing locator specialists, public housing authority, other partner organizations) needed for the achievement of project operation. The narrative must provide evidence that ensures there will be no delay in service provision to participants, operation of CoC management systems, or the leasing of units for reasonable rents.

Response:

The Clinical Team Leader will begin the hiring process for the Housing Supports Coordinator(s) upon notification of the award. The staff will be on boarded prior to the July1, 2022 grant start date. The members of the CHP committee will be notified upon award announcement to begin the process of assigning the new vouchers to those determined most in need by the committee. Fourteen vouchers will be assigned and participants will be housed within six months (by December 31, 2022.) The additional 11 participants needing supportive services will be transferred to the Housing Supports Coordinator for case management at grant start date. Full capacity will be achieved at six months. Prior experience working with landlords has proven that we can place approximately three people per month into housing. Because MAP staff have well-established relationships with landlords who understand the process involved with rent reasonableness, Housing Quality Standard (HQS) inspections, and other unique aspects

of subsidy vouchers, this process will go more smoothly. CoC PSH policies and procedures are already in place to ensure compliance with HUD standards.

F. Describe recipient/subrecipient capacity for assessing need, prioritizing persons with the most severe needs & outreach to the chronically homeless & the specific plan for how the project will first serve the chronically homeless according to the order of priority established in *Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness & Other Vulnerable Homeless Persons (SEE APPENDIX)*.

Response:

At the CHP committee, MAP works with the community on reviewing assessments of the participants to determine:1. Literal homelessness 2. Medical, physical and mental health vulnerabilities 3. Current living situation risks, and make recommendations to determine who is most in need of PSH.

G. If applying for Rental Assistance, describe the method for determining the type & amount of rental assistance that participants can receive.

Response:

Rental assistance is determined by completion of the Tenant Income Certification at the time of lease up , when income changes and annually. Income source documents are collected from the participant and rent subsidy and tenant rent portion are calculated using this form.

IV. COMMITMENT TO HOUSING FIRST (10 points)

Housing First is an approach to homeless assistance that prioritizes rapid placement & stabilization in permanent housing & does not have service participation requirements or preconditions such as sobriety or a minimum income threshold. See Appendix A for a list of Housing First principles.

Describe recipient/subrecipient experience with & a description of the program design for implementing housing first.

Response:

MAP structures this housing program around a Housing First model, to be inclusive and does not impose preconditions of sobriety, treatment, service participation or criminal background checks. Income is not required to be in the program. Knowing that the behaviors and habits are ingrained and even with desire are difficult to change, MAP uses a harm reduction model of supportive services, educating participants on natural consequences of their choices and supporting them without passing judgment on their behavior or use of drugs and alcohol. Stability and safety are the priority. In MAP 35 year history, there have been only a few terminations from the PSH program.

V. SUPPORTIVE SERVICES FOR PARTICIPANTS (25 points)

A. For projects serving **families**, does the applicant/sponsor have policies & practices that are consistent with, & do not restrict the exercise of rights provided by the education subtitle of the McKinney-Vento Act, & other laws relating to the provision of educational & related services to individuals & families experiencing homelessness?

☐Yes ☐No X ☐ N/A (project not serving families)

B. For projects serving **families**, does the applicant/sponsor have a designated staff person responsible for ensuring that children are enrolled in school & connected to the appropriate services within the community, including early childhood education programs such as Head Start, Part C of the Individuals with Disabilities Act, & McKinney-Vento education services?

☐Yes ☐No X☐ N/A (project not serving families)

C. Describe the manner in which the project applicant will take into account the educational needs of children when youth and/or families are placed in housing.

MAP works with individuals and not families, however, if an individual's status changes and a child is brought into the program, MAP would work with the participant to ensure the child is enrolled in school and has the needed resources available to them.

D. Describe how participants will be assisted to obtain & remain in permanent housing and what supportive services will be provided.

Response:

MAP's case management includes creating a plan with each participant for housing and service needs, job training services, food and nutrition (with Food Gatherers), transportation, referrals to community providers, and assistance accessing mainstream services such as SNAP benefits, Social Security Disability Benefits, and Healthcare. MAP provides referrals for Substance Use treatment. MAP does everything possible to engage clients and keep them housed, advocating with landlords to call us first if there is a problem. MAP has staff on-call 24/7/365. MAP provides basic Life Skills training to learn cooking, cleaning, strategies to get along with neighbors and landlords. MAP assists participants in gaining a reduced fare or free bus card to enable safe transportation.

E. Describe your plan for ensuring program participants will be individually assisted to obtain benefits of the mainstream health, social, & employment programs for which they are eligible.

Response:

Upon intake into the program, a thorough assessment is completed to determine assistance needed and eligibility for mainstream benefits. Applications for health insurance are completed with the participant, a referral to the MAP SOAR Coordinator for disability benefits and referral to Michigan Rehabilitation Services and/or Michigan Works for employment are completed. These are all based on needs and requests from the participant.

F. Describe how participants will be assisted to increase employment &/or income using mainstream housing & service programs.

Response:

The MAP SOAR Coordinator will help the participant apply for disability benefits. Referral to Michigan Rehabilitation Services and/or Michigan Works for employment are completed. MAP's employment program can offer supports as well to complete resumes and apply for jobs. A jobs board is posted in the resource room at MAP and all participants have access to this.

G. Describe how participants will be assisted to maximize ability to live independently & increase self-sufficiency using mainstream housing & service programs.

Response:

Each participant has a housing stability plan created with them that focuses on what is needed to be self-sufficient and stable. Resources through DHS such as personal assistance can be helpful in keeping someone housed. Referrals to Center for Independent Living can benefit participants with a physical disability. Life skills training on basic chores such as cooking simple meals and cleaning the unit are offered by MAP and other mainstream providers.

H. Describe how the type, scale, & location of the supportive services & the mode of transportation to those services fit the needs of program participants.

Response:

At the CHP meeting, at referral and during intake, MAP staff assess needs for size (number of bedrooms), first floor access due to disability or other needs, location i.e., near a bus line and amenities, whether shared housing will work, if a house or larger apartment will work based on the needs and desires of the applicant, although being realistic about available units.

Supportive Services Type & Frequency Chart:

For all supportive services available to participants, indicate who will provide, how they will be accessed & how often they will be provided **regardless of the resources that will be used to pay for the services**. Please include all Medicaid services whether provider by the applicant or through partnerships with other organizations that provide Medicaid funded services.

For Provider, indicate: "Applicant" if the applicant will provide the service directly; "Subrecipient" if a subrecipient will provide the service directly; "Partner" if an organization that is not a subrecipient of project funds but with whom a formal agreement or memorandum of understanding (MOU) has been signed will provide the service directly; or, "Non-Partner" to if a specific organization with whom no formal agreement has been established regularly provides the service to clients.

		Frequency – select one per service type				
Supportive Service	**Provider**	**Daily**	**Weekly**	**Bi-monthly**	**Monthly**	**Does not Apply**
Assessment of Service Needs	Applicant				X	
Assistance with Moving Costs	Applicant as needed					
Case Management	Applicant			X		
Child Care						X
Education Services						X
Employment Assistance/Job Training	Applicant				X	
Food	Applicant				X	
Housing Search/Counseling Services	Applicant as needed					
Legal Services	Non-partner				X	
Life Skills	Applicant				X	
Mental Health Services	Partner				X	
Outpatient Health Services	Non-partner				X	
Outreach Services	Partner-as needed					
Substance Abuse Treatment Services	Non-partner			X		
Transportation	Applicant As needed					
Utility Deposits	Non-partner as needed					

l. How accessible are basic community amenities (e.g. medical facilities, grocery store, recreation facilities, schools, etc) to the projects?

X☐ Yes, very accessible
☐ Somewhat accessible
☐ Not accessible

VI. LANDLORD ENGAGEMENT (scattered-site projects only) (5 points)

A. Describe how your organization reaches out to, & engages with local landlords to recruit their participation in making their units available to program participants. In your description, explain how your organization maintains an on-going positive relationship & communication with landlords renting to your organization's program participants.

Response:

MAP staff have well-established relationships with landlords who understand the process involved with leasing units rent. MAP has an extensive landlord list identifying unique features of each landlord for example, who will lease to someone with past evictions, criminal history etc. Because this program is a leasing program all units will be in MAP's name. This give reassurance to the landlord that rent payments will be made in full, and on time. Rent reasonableness, Housing Quality Standard (HQS) inspections, and other unique aspects of subsidy vouchers are explained by staff and this makes the process go more smoothly. Lanlords often call MAP when they have openings. MAP values our landlord relationships, we often publicly thank them and acknowledge their support and work with us.

VII. COMMITMENT TO AFFORDABLE HOUSING PLAN (project-based projects only) (5 points)

A. If a project-based voucher, please indicate alignment to the *Housing Affordability & Economic Equity Analysis.*

N/A

VIII. PARTNERING & COMMITMENT TO COORDINATED ENTRY (5 points)

A. Describe how your organization will or currently works with OCED, Washtenaw Housing Alliance, coordinated entry, & other organizations to coordinate services & reduce duplication of services.

Michigan Ability Partners has consistently worked as a team member of Coordinated Entry. All MAP-owned units of Permanent Supported Housing are filled through the Community Housing Prioritization Committee process. All MAP subsidy vouchers are assigned through this process as well. MAP is a long-time contributing member of the Washtenaw Housing Alliance Operations Committee, and MAP has been at the table during important transitions and new initiatives to reduce duplication of services. MAP's Executive Director serves on the CoC Board and as been a partner in the Built for Zero initiative to end homelessness in Washtenaw Co. since its inception in 2015.

IX. BUDGET DETAIL (20 points)

Rental Assistance: Enter number of units by unit type; the applicable Fair Market Rent (FMR) level; the term (1 year grant); and enter total amounts.

Indicate the Type of Rental Assistance:

☐ Project Based ☐ Sponsor Based ☐ Tenant Based **X**☐ Leasing ☐ Other _____

Unit Size	No. of Units	FMR	Term	Total
Efficiency		$		
1 Bedroom	14	$1048	12 months	176,064
2 Bedroom		$		
3 Bedroom		$		
4 Bedroom		$		
Total				**$176,064**

Operating Costs: Enter the quantity & total budget request for each operating cost. The request entered should be equivalent to the cost of one year of the relevant operating costs. When including staff costs, please include title, salary & FTE.

Operating Costs	Quantity Description (max 400 characters)	Annual Assistance Requested
Maintenance & repair		
Electricity		
Gas & Water		
Property Tax & Insurance		
Furniture		
Replacement Reserve		
Equipment		
Building Security		
Total		**$0**

Supportive Services: Enter the quantity & total budget request for each supportive services cost. The request entered should be equivalent to the cost of one year of the relevant supportive service. When including staff costs, please include title, salary & FTE.

Eligible Costs	Quantity Description (max 400 characters)	Annual Assistance Requested
Assistance with Moving Costs		
Case Management	**Salaries and benefits -1.5 FTE Case Mgr@$48,750, .20FTE Clinical support @ $62,500, .10FTE Supervisor @$100,000 phones, equipment & internet($3,655)**	**$107,450**
Food		
Housing Search/Counseling Services		
Life Skills	**salary & benefits -.3 FTE Income and Employment Specialist @ $50,000**	**$6,500**
Outreach Services		
Transportation	**5 bus passes @$29/ea x12 mo. 96.47 miles/mo. @$.52/mile x 12 mo.**	**$2,100**
Utility Deposits		
Total Annual Assistance Requested		**$116,050**

Other Funding: What additional funding sources are committed to this project (e.g. NSP, VASH, HOME)?

(In Whole Numbers)

MAP Budget FY 20-21	Total
Revenues	
Federal Grants	1,961,065
Local Grants	48,223
Private Grants	229,114
Fees For Service	611,785
Donations	135,000
Investment Income	1,156
Other Revenues	34,479
Total Revenues	3,020,821
Direct Expenses	
Salaries & Fringe Benefit Expenses	1,360,179
Consumer Payroll	39,003
Professional Fees/Services	110,149
Non-Housing Client Care	62,862
Client Housing	1,075,727
Furniture, Fixtures & Equipment	23,729
Supplies	13,582
Communications	84,903
Insurance	32,942
Facilities	111,227
Staff Development	10,245
Dues & Subscriptions	12,487
Travel & Fleet	31,986
Interest Expense	8
Miscellaneous Expenses	9,896
Total Direct Expenses	2,978,924
Operational Profit/Loss	41,897

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

December 8, 2021

Members possibly Present on the Call: Pam Rathbun (president), Jason Zurawski (secretary), Leo Hanifin, Barb Higman, Ed Howlett, Alayna Manzanares, Melissa Vaden.
Staff: Mert Hershberger (Liaison)
Members Absent: Lisa Porzondek.

I. **Meeting called to order at: _ 12:35 _ pm _.**

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

II. **Shirkey legislation & opportunity to advocate**: Senator Shirkey is pushing legislation that moves responsibility for Mental Health care decision making from the state of Michigan & respective CMH agencies and networks to private insurance agencies outside the state of Michigan. The major concern is that private insurance agencies don't have the same commitment to the individuals served. An email was sent to all CAC members with a link for advocacy.

III. **Story Jam with NAMI & Speaker's Bureau & Avalon (Formally led by the WC-CMH-CAC)**: Barb reported that Mark Creekmore is responsible for facilitating Story Jam in Washtenaw based on a NAMI program. The CAC continues to use this process to feed into the strategic planning process. The writing group also was invited to share with Mert's help. Anyone with a mental health person who wants to share their story with the CAC via this process. This is a private, confidential process and will be ongoing. Melissa expressed interest in participating.

IV. Newsletter: Barb and Lisa have submitted articles. Mert hopes to send this out in December. Leo will deliver to Annex; Mert to Towner; Pam to Ellsworth.

V. **Art Show plans**: Still collecting artwork. In January we will share these with the region for judging. We will try to contact folks from UM or EMU-Psychology department, St.Joes, and UM-PES.

VI. **Celebration of Success**: Alayna thought it would be good to consider the need for more participation for next year before committing to doing it virtually in the fall. Melissa thinks people should be recognized and was for cultivating further participation. People would really prefer an in-person event. However, they did think something was better than nothing for now.

VII. **Additional members to suggest**: … April? Via Fresh Start? Leo may have someone?

VIII. **Alayna suggested people consider what our plans and purposes should be for the new year**. Mert will receive email suggestions for topics to be added to the agenda. **Mert mentioned Mike Harding's ongoing reporting on the CCBHC**, and will coordinate legislative visits around his reporting requirements.

IX. **Holiday Plans**: Different people shared about the presents given & plans. Greetings were exchanged by all.

X. **Meeting adjourned at _ 1:24 pm_ motion by _ Alayna _ supported by _ Pam _ .**

The next meeting will be January 12, 2022 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

January 12, 2022

Members Present on the Call: Pam Rathbun (president), Jason Zurawski (secretary), Leo Hanifin, Barb Higman, Ed Howlett, Alayna Manzanares, Lisa Porzondek, Melissa Vaden.
Staff: Mert Hershberger (Liaison).
Guest: Laura Higle (CMH-Performance Improvement). May be reached via email: HigleL@Washtenaw.org

12:00: Premeeting: Personal Holiday Happenings & plans for New Year: Several joined early for this.

I. **Meeting called to order at: _ 12:31 _ pm _.**

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

II. **Consumer Engagement: Laura Higle, performance improvement**: Laura addressed initial engagements with CMH services through the first assessment, intake and financial determination in 14 days. She took note of various suggestions on how to improve engagement through immediate turnaround or better outreach or engaging with churches who might support the Mental Health & Wellbeing of their members. Questions about stigma, poverty and complexities related to diverse demands on the individuals' time & schedule were also addressed. Barb asked about a mobile clinic model. Leo asked about getting as much done at time of first call. Laura also invited comments after the meeting if anyone thinks of any further ways to improve engagement.

III. **Questions and Suggestions for Legislators for the year**: We've had Felicia Brabec, Jeff Irwin, Yousef Rabhi and are in communication with Ron Peterson and Dana Lasinski and Lisa Thiel (Rep Sen). Some legislative sessions are set for Noon on Wednesdays. Questions: What are you doing for mental health? How to maintain stability of services for those served should Republican proposals go forward? Federal Legislation: 988 – national crisis line number for mental health crises/suicide lifelines – Launching July 2022. Leo asked for a week advance notice when someone confirms that they will come; though Barb noted the variability of legislative schedules.

IV. **Suggestions for new Chair:** By default, Pam will continue.

V. **Art Show plans**: Collecting art from other counties. Art to be chosen at the end of January/Start of February. Livingston, Lenawee & Washtenaw all 3 have art for the judging in February.

VI. **Story Jam with NAMI & Speaker's Bureau & Avalon (Formally led by the WC-CMH-CAC)**: Barb mentioned the need to continue to engage with folks and that the person in charge of ensuring the process advances smoothly has been in high demand and has been busy lately.

VII. Newsletter: End of year edition sent out in December. Next one in April/May? Article submissions by late March. Leo, Barb, and Lisa are thinking about it.

VIII. **Celebration of Success**: table this till we see how the pandemic pans out this year.

IX. **Additional members to suggest?**: Alayna suggested maybe we could send a note around to CMH case managers to get their input; Mert suggested reaching to CMH group/class leaders; Pam will email teams at Ellsworth seeking new members.

X. **Our plans and purposes should be for the new year as the WC-CMH-CAC**: Admin functions: Mike Harding & Laura Higle; Art Show; Newsletter; Story Jam; speaking with Legislators; … Alayna Suggested getting input from the Regional meeting.

XI. **Meeting adjourned at _1:33pm_ motion by _ Lisa _ supported by _Leo & Jason_ .**

The next meeting will be February 9, 2022 via Zoom at 12:30pm. (Please log in by 12:20pm to make sure we are all ready to participate by 12:30pm.)

Consumer Advisory Council 2021 — End of Summer Newsletter

The MiABLE Account

By Lisa Porzondek

In 2014, the "Federal Stephen Beck Jr. Achieving A Better Life Experience" (ABLE) Act passed which authorized states to establish tax-advantaged saving programs for individuals with disabilities. The Michigan ABLE Act was signed into law on October, 2015. It assists individuals and families to save funds that help individuals with disabilities to maintain health, independence and quality of life without jeopardizing benefits from private insurance, supplemental security income, Medicaid, the beneficiary's employment and other sources.

The account is tax-free if used for *qualifying expenses*. You must have been disabled before age 26. The MiABLE Program is administered by the Michigan Department of Treasury and Investment Services managed by a TSA consulting group. You can deposit up to $15,000 annually. If the total in the account exceeds $100,000, you could lose monthly SSI benefits.

The debit card is free, but there's a $10 processing fee for each check. There's a $45.00 charge per year taken out quarterly, and .5% taken out quarterly. You can transfer from MiABLE to a checking account for free and you are not required to submit documentation showing whether withdrawals are qualified, although the IRS may audit it. It's a good idea to retain documentation.

Qualifying expenses include education, housing, technology, personal support services, health, illness, prevention and wellness, dental, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses. Money withdrawn for an unqualified expense may result in tax consequences. MiABLE Account is worth considering, and this account can be very useful in saving money for future expenses, both expected and unexpected.

Q. What is the Consumer Advisory Council?

A. The Consumer Advisory Council members work as advocates to promote services, supports, communication, opportunities and legislation for all individuals recovering from mental illness and develop-mental and intellectual disabilities and emotional impairments, who are Community Mental Health (CMH) consumers. The Council also works to create an awareness of mental health issues for all people recovering from these issues. Through education & advocacy, the Council combats stigma.

B. To share your thoughts with the council, you may contact Mert Hershberger via email: HershbergerM@washtenaw.org or call: 734-796-6944.

Before you start a new journey, make preparations for the exploration ahead.
While you journey, enjoy each step and each day of your adventure.
Once you have journeyed, look back, reflect, and treasure time well spent.

Whence We Came

Part 3 — by Barb Higman.

Part 2 ended on a lament about the Deranged Haunt scheduled to occur starting September 24h, 2021 in Romulus in honor of Halloween. I checked to see if it is actually happening, and it is. if you are into haunted houses, I ask that you make sure you are not contributing to the perpetuation of misguided misunderstanding of mental health conditions by paying to visit a haunted lunatic asylum.

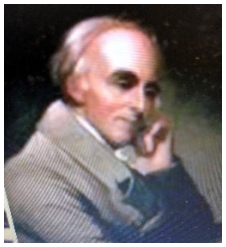
If we look back in history, we can perhaps determine where some of our current misconceptions about mental illness come from and how they persist to this day. Before the time of the ancient Greeks, mental illness was considered to be a form of religious punishment or demonic possession. In the 5th century BC, our father of modern medicine, Hippocrates, was well before his time in treating those with mental health conditions using techniques that were not rooted in religion or superstition such as changing a person's environment and/or occupation and using small amounts of different substances as medication. However, like buckthorn roots and roots of molars requiring extraction, false beliefs about people whose behavior we do not understand can be very difficult to eradicate. Throughout the middle ages the idea that people with mental health conditions were possessed by the devil and deserved the punishment bestowed upon them held sway in European culture… not that many years ago I heard a judge in the Washtenaw County Circuit Court say she hoped a young woman struggling with a mental health condition would tame the demons in her mind… people were put in chains, beaten and otherwise tortured; after all, it was thought, like wild animals the insane do not feel pain or the cold.

Treating individuals afflicted with mental illness with kindness only re-emerged as a medical precept during the Age of Enlightenment or Reason in the 18th century when the French physician, Philippe Pinel promulgated his traitement moral approach based on humane psychosocial care. Inspired by the observed efficacy of reforms in mental health care abroad, the Moral Treatment movement took off in the United States in the early 1800s under the guidance of Benjamin Rush, our father of American psychiatry. Rush was instrumental in turning the tide when it came to the brutal treatment of individuals with mental health conditions in this country. His efforts to change how people were treated were largely responsible for the construction, in 1813, of The Friends Asylum for the Relief of Persons Deprived of the Use of Their Reason, the first private nonprofit mental hospital in the U.S. devoted to humane psychiatric treatment. Located in Frankford, PA, the asylum was renamed the Frankford Asylum for the Insane and continues in operation to this day… although it is now known as Friend's Hospital.

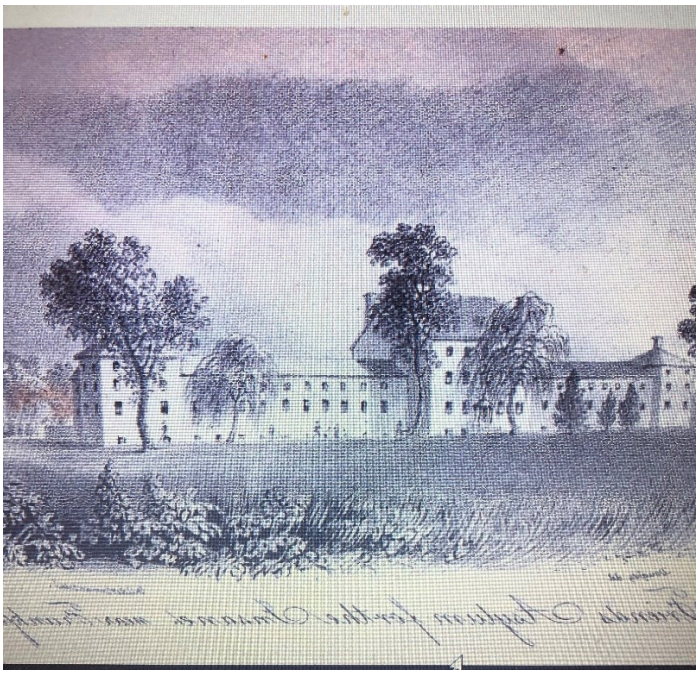
In 1841, four years after Michigan became a state and the University of Michigan moved from Detroit to Ann Arbor and some 28 years after Rush's death in 1813, Dorothea Dix began to advocate for compassionate care of people who were still referred to as "the insane." Herself a recipient of moral treatment, Dix was a proponent of the psychosocial tenets espoused by practitioners. She demanded that hospitals for the insane be situated on expansive grounds away from the hustle and bustle of urban settings and that the buildings be airy and spacious and let the sun shine in. There was hope for a cure… … To be continued.

Illustrations:

Phillppe Pinel



Benjamin Rush



The Friends Asylum for the Relief of Persons Deprived of Their Use of Reason

To be continued…

WCCMH - Office of Recipient Rights

Quarter IV- FY 20/21

Executive Summary

ORR Program Overview:

- The Rights Office attended the Annual Recipient Rights Conference (virtually) in September 2020.
- We are excited to introduce you to our new Rights Director, Katie Snay and new Rights Officer Sarah Smith.
- The Rights Office received a full compliance score on their tri-annual audit by MDHHS ORR.

Report Complaint Data:

- In addition to the complaint data below, the Rights Office follow up with or referred 32 issues to customer service.

Aggregate Summary

Fiscal Year	20/21	19/20	18/19	17/18
Complaints Received	123	142	233	246
Allegations Involved	164	206	337	375
Allegations Investigated	157	190	324	371
Allegations Resolved by Intervention	0	0	0	0
Allegations Substantiated	63	65	116	122
Percentage of allegations substantiated	40.12%	34.21%	33.64%	32.88%

The following is a four year comparison of **abuse and neglect cases**. Please note that the Abuse Class II data includes *all types* of Abuse II. Additionally, the Neglect data *does not* include Neglect-Failure to Report allegations.

	FY 20/21		FY 19/20		FY 18/19		FY 17/18	
	Received	**Substantiated**	**Received**	**Substantiated**	**Received**	**Substantiated**	**Received**	**Substantiated**
Abuse:								
Class I	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Class II	**19**	**5**	**23**	**3**	**28**	**7**	**38**	**8**
Class III	**13**	**4**	**18**	**1**	**23**	**8**	**26**	**5**
Sexual Abuse	**0**	**0**	**2**	**0**	**1**	**0**	**3**	**0**
Neglect:								
Class I	**0**	**0**	**1**	**1**	**1**	**0**	**1**	**0**
Class II	**3**	**1**	**3**	**1**	**2**	**1**	**5**	**0**
Class III	**45**	**26**	**60**	**33**	**75**	**36**	**66**	**31**

The following is a four year comparison of **the top three complaint substantiation cases,** all categories.

FY 20/21	(Received) **Substantiated**	**FY 19/20**	(Received) **Substantiated**	**FY 18/19**	(Received) **Substantiated**	**FY 17/18**	(Received) **Substantiated**
Neglect Class III	(45) **26**	Neglect Class III	(60) **33**	Neglect Class III	(75) **36**	Neglect Class III	(66) **31**
Dignity and Respect	(31) **8**	Neglect Class III: Failure to Report	(8) **8**	Mental Health Services Suited to Condition	(70) **26**	Mental Health Services Suited to Condition	(58) **24**
Mental Health Services Suited to Condition *and* Abuse Class II	(20) **5** (19) **5**	Mental Health Services Suited to Condition	(19) **6**	Dignity and Respect	(68) **15**	Dignity and Respect	(93) **19**

Neglect Class III

Staff fail to follow a written standard AND caused or contributed to:
Harm
Risk of Harm
Failure to report Abuse/Neglect

Dignity and Respect

Treat recipients with consideration, politeness, appreciation
Provide recipients with privacy & choices
Examples:

- Use preferred name
- Give personal space & privacy
- Use positive and kind language
- Honor cultural/other differences
- Let recipients speak for themselves
- Actively listen and respond
- Put recipient's interest and needs first

Mental Health Services Suited to Condition

Staff fail to follow a written standard
(ex: IPOS, doctor's order, policy, etc.)

- No harm or risk of harm

Abuse Class II

<u>Staff caused/contributed to</u>:

- Physical (non-serious)/emotional harm
  - Nonserious physical harm means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions
- Exploitation
- Unreasonable force

The following chart is an explanation of **substantiations by service location**:

Service location type/Code	Number of substantiations
Outpatient services (01)	0
Residential Group home – MI (02)	1
Residential Group Home – DD (03)	9
Mixed Residence (02,03)	0
Inpatient (5)	0
Day Program MI (6)	0
Day Program DD (7)	0
Workshop (Prevocational)	1
Supported Employment (08)	0
Assertive Community Treatment (09)	2
Case Management (10)	5
Psychosocial Rehabilitation	0
Partial Hospitalization (12)	0
Supported Living (13)	45
Other (14)	0
Residential MI/DD (15)	0

Annual Appeals Data for: WCCMH

APPEALS INFORMATION (if agency has local appeals committee)

Number of Appeal Requests Received	3
Number of Appeals Accepted	3
Number Number of Appeals Upheld	3
Number of Appeals Sent Back for Reinvestigation	0
Number of Appeals Requesting External Investigation by DHHS	0
Number of Appeals Sent Back for Further Action	0
Total Number of Appeals Reviewed by the Appeals Committee	3

Complaint Data for: Washtenaw County Community Mental Health

Rights Office Director: Katie Snay

Reporting Period: 2020-10-01 to 2021-09-30

CMH: 4553 # of Consumers Served (unduplicated count) CMH

3 Rights Office FTEs

LPH: Number of Admissions LPH

Hours/40

Section I: Complaint Data Summary

Part A: Agency Totals

Allegations	164
Interventions	0
Investigations	157
Interventions Substantiated	0
Investigations Substantiated	63

DO NOT TYPE HERE - IT WILL AUTO FILL

COMPLAINT SOURCE

Recipient	17
Staff	34
ORR	47
Guardian/Family	16
Anonymous	2
Community/General Public	7
Total Complaints Received	123

Number of Complainants (unduplicated count): 65

TIMEFRAMES OF COMPLETED INVESTIGATIONS

Category	Total	≤30	≤60	≤90	>90
Abuse I, II, III & Neglect I, II, III	85	21	16	40	3
All others	72	15	12	35	7

Part B: Detailed Summary

1. Freedom from Abuse

Code	Category	Received	Investigations	Investigations Substantiated	Recipient Population		
					MI	DD	SED
7221	Abuse class I	0	0	0	0	0	0
72221	Abuse class II - nonaccidential act	4	4	1	0	4	0
72222	Abuse class II - unreasonable force	8	8	1	0	9	0
72223	Abuse class II - emotional harm	0	0	0	0	0	0
72224	Abuse class II - treating as incompetent	0	0	0	0	0	0
72225	Abuse class II - exploitation	7	7	3	1	6	0
7223	Abuse - class III	13	13	4	3	13	0
7224	Abuse class I - sexual abuse	0	0	0	0	0	0

2. Freedom from Neglect

Code	Category	Received	Investigations	Investigations Substantiated	Recipient Population		
					MI	DD	SED
72251	Neglect class I	0	0	0	0	0	0
72252	Neglect class I - failure to report	0	0	0	0	0	0
72261	Neglect class II	3	3	1	0	3	0
72262	Neglect class II - failure to report	2	2	1	0	2	0
72271	Neglect class III	45	45	26	8	62	0
72272	Neglect class III - failure to report	3	3	3	0	4	0

3. Rights Protection System

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7060	Notice/explanation of rights	0	0	0	0	0	0	0	0
7520	Failure to report	0	0	0	0	0	0	0	0
7545	Retaliation/harassment	0			0	0	0	0	0
7760	Access to rights system	0	0	0	0	0	0	0	0
7780	Complaint investigation process	0	0	0	0	0	0	0	0
7840	Appeal process/mediation	0	0	0	0	0	0	0	0

4. Admission/Discharge/Second Opinion

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
4090	Second opinion - denial of hospitalization	0	0	0	0	0	0	0	0
4190	Termination of voluntary hospitalization (adult)	0	0	0	0	0	0	0	0
4510	admission process	0	0	0	0	0	0	0	0
4630	Independent clinical examination	0	0	0	0	0	0	0	0
4980	Objection to hospitalization (minor)	0	0	0	0	0	0	0	0
7050	Second opinion - denial of services	0	0	0	0	0	0	0	0

5. Civil Rights

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7041	Civil rights: discrimination, accessibility, accommodation, etc	0	0	0	0	0	0	0	0
7044	Religious practice	0	0	0	0	0	0	0	0
7045	Voting	0	0	0	0	0	0	0	0
7047	Presumption of competency	0	0	0	0	0	0	0	0
7284	Search/seizure	1	0	0	1	1	0	1	0

6. Family Rights

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7111	Family dignity & respect	4	0	0	4	1	1	3	0
7112	Receipt of general education information	0	0	0	0	0	0	0	0
7113	Opportunity to provide information	0	0	0	0	0	0	0	0

7. Communication & Visits

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7261	Visits	0	0	0	0	0	0	0	0
7262	Contact with attorneys or others regarding legal matters	0	0	0	0	0	0	0	0
7263	Access to telephone, mail	0	0	0	0	0	0	0	0
7264	Funds for postage, stationery, telephone usage	0	0	0	0	0	0	0	0
7265	Written and posted limitations, if established	0	0	0	0	0	0	0	0
7266	Uncensored mail	0	0	0	0	0	0	0	0

8. Confidentiality/Privileged Communications/Disclosure

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7481	Disclosure of confidential information	2	0	0	2	2	1	1	0
7485	Withholding of information (includes recipient access to records)	0	0	0	0	0	0	0	0
7486	Correction of record	0	0	0	0	0	0	0	0
7487	Access by p & a to records	0	0	0	0	0	0	0	0
7501	Privileged communication	0	0	0	0	0	0	0	0

9. Treatment Environment

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7081	Safe environment	5	0	0	5	1	1	5	0
7082	Sanitary/humane environment	7	0	0	7	4	0	8	0
7086	Least restrictive setting	0	0	0	0	0	0	0	0

10. Freedom of Movement

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7441	Restrictions/limitations	1	0	0	1	1	0	4	0
7400	Restraint	0	0	0	0	0	0	0	0
7420	Seclusion	0	0	0	0	0	0	0	0

11. Financial Rights

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7301	Safeguarding money	0	0	0	0	0	0	0	0
7302	Facility account	0	0	0	0	0	0	0	0
7303	Easy access to money in account	0	0	0	0	0	0	0	0
7304	Ability to spend or use as desired	0	0	0	0	0	0	0	0
7305	Delivery of money upon release	0	0	0	0	0	0	0	0
7360	Labor & Compensation	0	0	0	0	0	0	0	0

12. Personal Property

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7267	Access to entertainment materials, information, news	0	0	0	0	0	0	0	0
7281	Possession and use	0	0	0	0	0	0	0	0
7282	Storage space	0	0	0	0	0	0	0	0
7283	Inspection at reasonable times	0	0	0	0	0	0	0	0
7285	Exclusions	0	0	0	0	0	0	0	0
7286	Limitations	0	0	0	0	0	0	0	0
7287	Receipts to recipient and to designated individual	0	0	0	0	0	0	0	0
7288	Waiver	0	0	0	0	0	0	0	0
7289	Protection	0	0	0	0	0	0	0	0

13. Suitable Services

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
1708	Dignity and Respect	31	0	0	31	8	10	26	2
7003	Informed consent	0	0	0	0	0	0	0	0
7029	Information on family planning	0	0	0	0	0	0	0	0
7049	Treatment by spiritual means	0	0	0	0	0	0	0	0
7080	Mental health services suited to condition	20	0	0	20	5	6	18	0
7100	Physical and mental exams	0	0	0	0	0	0	0	0
7130	Choice of physician/mental health professional	0	0	0	0	0	0	0	0
7140	Notice of clinical status/progress	0	0	0	0	0	0	0	0
7150	Services of mental health professional	0	0	0	0	0	0	0	0
7160	Surgery	0	0	0	0	0	0	0	0
7170	Electro convulsive therapy (ect)	0	0	0	0	0	0	0	0
7180	Psychotropic drugs	0	0	0	0	0	0	0	0
7190	Notice of medication side effects	0	0	0	0	0	0	0	0

14. Treatment Planning

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7121	Person-centered process	1	0	0	1	0	0	1	0
7122	Timely development	0	0	0	0	0	0	0	0
7123	Requests for review	0	0	0	0	0	0	0	0
7124	Participation by individual(s) of choice	0	0	0	0	0	0	0	0
7125	Assessment of needs	0	0	0	0	0	0	0	0

15. Photographs, Fingerprints, Audiotapes, One-way Glass

Code	Category	Received	Interventions	Interventions Substantiated	Investigations	Investigations Substantiated	Recipient Population		
							MI	DD	SED
7241	Prior consent	0	0	0	0	0	0	0	0
7242	Identification	0	0	0	0	0	0	0	0
7243	Objection								
7244	Release to others/return	0	0	0	0	0	0	0	0
7245	Storage/destruction	0	0	0	0	0	0	0	0
	TOTALS	**157**	**0**	**0**	**157**	**63**	**31**	**170**	**2**

17. No Right Involved

Code	Category	Received
0000	No right involved	4

18. Outside Provider Jurisdiction

Code	Category	Received
0001	Outside provider jurisdiction	3

ATTACHMENT #1J
FEBRUARY 2022

Section II: intervention & investigation substantiation data for: WCCMH

Category (from Complaint Data)	Specific Provider Type	Specific Remedial Action	Specific Remedial Action	Specific Remedial Action	MI	DD	SED	SED-W	DD-CWP	HSW
Neglect class III	ACT	Written Reprimand	Training	Suspension	0	1	0			
Neglect class III	SIP	Suspension	Staff Transfer		0	1	0			
Abuse class II - exploitation	SIP	Employee left the agency, but substantiated	Policy Revision/Development	Other	0	1	0			
Neglect class II - failure to report	SIP	Employee left the agency, but substantiated	Policy Revision/Development	Other	0	1	0			
Abuse class III	SIP	Employee left the agency, but substantiated			0	3	0			
Neglect class III	SIP	Employee left the agency, but substantiated			0	3	0			
Abuse class III	Residential DD	Written Reprimand	Training		0	1	0			
Abuse class III	Residential DD	Written Reprimand	Training		0	1	0			
Disclosure of confidential information	Case Management	Training			0	1	0			
Abuse class II - exploitation	SIP	Written Reprimand	Training	Other	0	1	0			1
Neglect class III	Residential DD	Employee left the agency, but substantiated			0	6	0			5
Neglect class III	SIP	Employee left the agency, but substantiated			0	1	0			
Neglect class III	SIP	Suspension			0	3	0			1
Neglect class III	SIP	Employee left the agency, but substantiated			0	4	0			4
Restrictions/limitations	SIP	Employee left the agency, but substantiated			0	4	0			4
Neglect class III	SIP	Employee left the agency, but substantiated			0	1	0			
Sanitary/humane environment	Residential DD	Employment Termination			0	1	0			
Sanitary/humane environment	SIP	Employment Termination			0	1	0			1
Neglect class III	SIP	Written Reprimand			0	2	0			2
Neglect class III	ACT	Written Reprimand	Training		1	0	0			
Neglect class III	SIP	Written Reprimand	Training		0	2	0			2
Neglect class III	Residential DD	Verbal Counseling	Written Reprimand	Employee left the agency, but	0	1	0			1
Neglect class III - failure to report	Case Management	Written Reprimand			0	1	0			1
Neglect class III - failure to report	SIP	Written Reprimand			0	2	0			2
Sanitary/humane environment	SIP	Employee left the agency, but substantiated			0	2	0			1
Neglect class III	SIP	Suspension	Written Reprimand		0	1	0			1
Dignity and respect	Case Management	Other			0	0	1			
Dignity and respect	Residential DD	Employee left the agency, but substantiated			0	1	0			
Search/seizure	Residential DD	Employee left the agency, but substantiated			0	1	0			
Dignity and respect	SIP	Employee left the agency, but substantiated			1	0	0			
Mh services suited to condition	SIP	Written Reprimand	Training		0	1	0			1
Neglect class III	SIP	Written Reprimand	Training		0	1	0			1
Mh services suited to condition	SIP	Written Reprimand	Staff Transfer		0	1	0			
Neglect class III	SIP	Written Reprimand	Staff Transfer		0	1	0			
Disclosure of confidential information	Case Management	Training			1	0	0			
Neglect class III	SIP	Written Reprimand	Training		0	1	0			1
Dignity and respect	SIP	Employment Termination			0	3	0			1
Abuse class II - exploitation	Residential DD	Employment Termination	Other		0	1	0			
Dignity and respect	SIP	Employment Termination			0	2	0			2
Safe environment	SIP	Employee left the agency, but substantiated			0	2	0			2
Abuse class III	SIP	Employee left the agency, but substantiated			0	2	0			2
Neglect class III	SIP	Employee left the agency, but substantiated			1	0	0			
Mh services suited to condition	SIP	Written Counseling	Training		0	1	0			1
Neglect class III	SIP	Other			0	3	0			3
Neglect class III	SIP	Written Reprimand	Training		0	1	0			
Dignity and respect	SIP	Employee left the agency, but substantiated	Staff Transfer		0	3	0			
Neglect class III	Residential MI	Written Reprimand	Training		1	0	0			
Neglect class III	SIP	Employee left the agency, but substantiated			0	1	0			
Neglect class III - failure to report	SIP	Written Reprimand	Training		0	1	0			
Abuse class II - nonaccidential act	SIP	Written Reprimand	Verbal Counseling		0	1	0			1
Abuse class II - unreasonable force	SIP	Written Reprimand	Verbal Counseling		0	1	0			1
Neglect class III	SIP	Suspension	Staff Transfer	Other	0	1	0			1
Neglect class III	SIP	Suspension	Training	Other	0	1	0			1
Dignity and respect	SIP	Employee left the agency, but substantiated			1	0	0			
Neglect class III	SIP	Written Reprimand	Training		2	0	0			
Dignity and respect	SIP	Written Reprimand	Training		0	1	0			1
Sanitary/humane environment	SIP	Written Reprimand	Training		0	1	0			1
Mh services suited to condition	Residential DD	Written Reprimand			0	1	0			
Neglect class III	SIP	Written Reprimand	Training		0	1	0			
Mh services suited to condition	SIP	Training	Verbal Counseling		0	3	0			3
Family dignity & respect	Case Management	Training			1	0	0			
Neglect class III	SIP	Employee left the agency, but substantiated			0	3	0			1
Neglect class II	Day Program DD	Training	Employment Termination		0	1	0			1

REMEDIATION TOTALS	
Verbal Counseling	4
Written Counseling	1
Verbal Reprimand	0
Written Reprimand	26
Suspension	6
Demotion	0
Staff Transfer	5
Training	23
Employment Termination	6
Employee left the agency, but substantiated	21
Contract Action	0
Policy Revision/Development	2
Environmental Repair/Enhancement	0
Plan of Service Revision	0
Recipient Transfer to Another Provider/Site	0
Other	8
Pending	0
None	0

POPULATION TOTALS	
MI	9
DD	88
SED	1
SED-W	0
DD-CWP	0
HSW	51

PROVIDER TOTALS	
Out Patient	0
Residential MI	1
Residential DD	9
Residential MI & DD	0
Inpatient	0
Day Program MI	0
Day Program DD	1
Workshop (prevocational)	0
Supported Employment	0
ACT	2
Case Management	5
Psychosocial Rehabilitation	0
Partial Hospitalization	0
SIP	45
Crisis Center	0
Children's Foster Care	0
Clubhouse/Drop-in Center	0
Respite Homes	0
Other	0

WCCMH

SECTION II: ANNUAL TRAINING ACTIVITY

Part A: Training Received by Office Staff (Please only list trainings related to rights protection)

LIST THE NAMES OF ALL STAFF HERE
Evan George
Leah Raehtz
Shaun Thompson

Staff Name (drop down: you have to scroll up to see the names)	MDHHS-ORR Course Number	Topic of Training Received	CEU Type (drop down)	# Hours
Evan George	RC21-GS1	Detecting Deception in a Verbal and Written Statement	I - Operations	1.50
Evan George	RC21-02	What's New in Lansing	I - Operations	1.50
Evan George	RC21-07	BHDDA Updates	IV -Augmented Training	1.50
Evan George	RC21-LPHRT	LPH Roundtable	I - Operations	1.50
Evan George	RC21-10	Moving from Challenging to Rewarding Conversations	IV -Augmented Training	1.50
Evan George	RC21-13	Behavioral Health Mediation Program with the Community Dispute Resolution Program	II - Legal Foundations	1.50
Evan George	RC21-18	Guardianship Reform: Kicking the Can Down the Road	II - Legal Foundations	1.50
Evan George	RC21-GSII	Velvet Covered Steel: How to Think Communicate and Act with Resilience	IV -Augmented Training	1.50
Leah Raehtz	RC21-GS1	Detecting Deception in a Verbal and Written Statement	I - Operations	1.50
Leah Raehtz	RC21-01	Evidence Analysis	I - Operations	1.50
Leah Raehtz	RC21-05	SUD Recipient Rights	I - Operations	1.50
Leah Raehtz	RC21-07	BHDDA Updates	IV -Augmented Training	1.50
Leah Raehtz	RC21-LPHRT	LPH Roundtable	I - Operations	1.50
Leah Raehtz	RC21-10	Moving from Challenging to Rewarding Conversations	IV -Augmented Training	1.50
Leah Raehtz	RC21-15	NGRI Policy Updates	II - Legal Foundations	1.50
Leah Raehtz	RC21-CMHRT	CMH Roundtable	I - Operations	1.50
Leah Raehtz	RC21-18	Guardianship Reform: Kicking the Can Down the Road	II - Legal Foundations	1.50
Leah Raehtz	RC21-GSII	Velvet Covered Steel: How to Think Communicate and Act with Resilience	IV -Augmented Training	1.50
Shaun Thompson	RC21-GS1	Detecting Deception in a Verbal and Written Statement	I - Operations	1.50
Shaun Thompson	RC21-02	What's New in Lansing	I - Operations	1.50
Shaun Thompson	RC21-05	SUD Recipient Rights	I - Operations	1.50
Shaun Thompson	RC21-09	Practicing Effective Management	IV -Augmented Training	1.50
Shaun Thompson	RC21-LPHRT	LPH Roundtable	I - Operations	1.50
Shaun Thompson	RC21-12	Disrupting the Impacts of Implicit Bias and Micro-Aggressions: Being Respectful and Professional is not Enough	IV -Augmented Training	1.50
Shaun Thompson	RC21-15	NGRI Policy Updates	II - Legal Foundations	1.50
Shaun Thompson	RC21-CMHRT	CMH Roundtable	I - Operations	1.50
Shaun Thompson	RC21-16	Medication Over Objection: Rights and Responsibilities	II - Legal Foundations	1.50
Shaun Thompson	RC21-GSII	Velvet Covered Steel: How to Think Communicate and Act with Resilience	IV -Augmented Training	1.50

CATEGORY TOTALS	
I - Operations	19.50
II - Legal Foundations	9.00
III - Leadership	0.00
IV -Augmented Training	13.50
Non-CEU	0.00

THESE NUMBERS WILL AUTO-FILL

WCCMH

SECTION II: ANNUAL TRAINING ACTIVITY

Part B: Training Provided by Rights Office

Is Update Training Required?	Yes
If Yes, how often: (Annual, Every 2 years, etc.)	Annual

Topic of Training Provided	How long is the training? # Hours	# Agency Staff	# Contractual Staff	# of Consumers	# Other Staff	Type of Other Staff	Method of Training Provided	Description (If Needed)
		75	700					
Recipient Rights Online Training	3.00	75	700				Computer	# estimated for contractual due to use of online training
RRAC Training	1.00					6	Face-to-Face	
WCCMH Board Training	0.50					8	Face-to-Face	

Type of Training Totals		Agency Staff	Contractual Staff	Consumers	Other Staff
Face-to-Face	2	0	0	0	0
Video	0	0	0	0	0
Computer	1	75	700	0	0
Paper	0	0	0	0	0
Video & Face-to-Face	0	0	0	0	0
Computer & Face-to-Face	0	0	0	0	0
Paper & Face-to-Face	0	0	0	0	0
Other (please describe)	0	0	0	0	0
These Numbers will self-fill					

WCCMH

SECTION III: DESIRED OUTCOMES FOR THE OFFICE & PROGRESS OF PREVIOUS OUTCOMES

Progress on Outcomes established by the office for FY 20/21. Pick from the drop-down in Outcome and indicate if goal was accomplished, was discontinued, or remains ongoing. Checking ongoing will result in that outcome being self-populated in the FY 21/22 goal section below.

1 **Invite someone from WCCMH to explain priority setting regarding recipients during the pandemic and to speak about WCCMH staff furloughs, and what staffing changes have/will be made to WCCMH due to the pandemic.**

Outcome: Accomplished

2 **Invite someone to speak or gather information regarding how St. Joseph Hospital Recipient Rights is providing rights protection with their Rights Officer furloughed.**

Outcome: Accomplished

3 **In addition to rights investigation statistics, RRAC members would like the WCCMH Rights Office to present the WCCMH Board with the full spectrum of the responsibilities handled by the Rights Office (this can occur during the WCCMH Board**

Outcome: Accomplished

4 **RRAC members would like to invite people to share their personal stories regarding recipient rights during the public comment portion at the WCCMH Board meeting.**

Outcome: Ongoing

5 **Recruit new/additional committee members.**

Outcome: Ongoing

Outcomes established by the office for FY 21/22:

1 **The RRAC would like to review the technical requirement for appeals and find an appropriate way to request WCCMH follow up from concerns that are expressed during appeals.**

2 **The RRAC would like to invite Michigan Medicine Rights Officer Matt Zugel and his RRAC chair, David, to speak about their RRAC, appeals and hospital rights perspective.**

3 **The RRAC would like to hear Katie Snay's goals as the new rights director and have her share new initiatives she and the Rights Officers will create through work plans.**

4 **RRAC members would like to invite people to share their personal stories regarding recipient rights during the public comment portion at the WCCMH Board meeting.**

5 **Recruit new/additional committee members.**

WCCMH

SECTION IV: RECOMMENDATIONS TO THE GOVERNING BOARD

The ORR & Advisory Committee recommends the following:

1.	**The RRAC recommends that the WCCMH Board supports the 2020/2021 outcomes for the WCCMH Rights Office and continues to support and fund the WCCMH Rights Office at the level it needs to be effective.**
2.	None

WCCMH						
STAFF CEU TRAINING HOURS TOTALS						
THIS DATA WILL SELF-FILL						
Staff Name	Operations	Legal Foundations	Leadership	Augmented Training	Non-CEU	Total Training for Staff
Evan George	4.50	3.00	0.00	4.50	0.00	12.00
Leah Raehtz	7.50	3.00	0.00	4.50	0.00	15.00
Shaun Thompson	7.50	3.00	0.00	4.50	0.00	15.00

ATTACHMENT #1K
FEBRUARY 2022

WCCMH Nursing Services

BRANDIE HAGAMAN, MPH, PROGRAM ADMINISTRATOR

COLLEEN O'BRIEN, RN, NURSING SUPERVISOR

ANN IGOE, RN, BSN, DNP CANDIDATE

Teams with nursing services

** will have a separate presentation at a later date.

- ACT
- Residential
- MI- Core
- Intellectual and Developmentally Disabled (I/DD)
- Youth and Family (YF)
- 750
- CARES
- CRS
- OBRA**
- Health and Wellness Program (HWP)**

Team descriptions

ACT team- high intensity group that live in the community that are seen anywhere from multiple times a day or a week, nurses go out on “grid” a few times a week, coordinates with psychiatrist, helps with medication delivery and monitoring

Residential team- consumer that lives in a community setting with assistance (group home, supported apartment, etc.) generally older, nurses interact with the providers staff for medication, education. Services are both in the community and at the clinics.

MI-Core teams- largest group at WCCMH, consumers live more independently, and some are significantly ill. Services are more clinic based and works closely with psychiatrist and treatment team.

CARES – stabilization team that works with consumers that have insurance or no insurance. Works with psychiatry and treatment team to coordinate care after treatment provided.

Team descriptions

I/DD- DD diagnosis and DD/MI, consumers live in a variety of settings that can include group homes, supported living sites, living with family, living independently. Quite a few have high medical acuity, services are community based as well as some clinical services that are coordinated with the prescriber team and treatment team.

YF- Serves 0-18 years old with SED, or I/DD. Services are clinic based, coordination with pediatricians and other community programs that include schools, therapy team and providers, works with multiple teams/ programs within YF services.

CRS- on site nursing 7 days a week, step down house that has consumers that might be discharged from the hospital, need medication monitoring or psychiatric monitoring for short term. Nursing works with all adults' teams across WCCMH and community providers (physicians).

750- Staffed by a medical assistant (MA) and other treatment team staff for a 23-hour setting. The MA completes a health assessment, provides medication monitoring and monitoring for the consumers stay.

Why Nurses?

Psychiatric nursing is defined as a specialty within the field of nursing that **provides holistic care to individuals with mental disorders or behavioral problems** so as to **promote their physical and psychosocial well-being**. It emphasizes the use of **interpersonal relationships as a therapeutic agent** and considers the environmental factors that influence mental health – *American Psychological Association, 2020*

The four metaparadigms of nursing align well with the CMH bio-psycho-social approach:

Person – receiver of care, a multifaceted human being with individual experiences

Environment – internal and external influences which affect a person's health

Health – physical, emotional, intellectual, social and spiritual well-being

Nursing - delivery of optimal health outcomes for the patient through a mutual relationship in a safe and caring environment

Daily Activities of Nursing

- Take vitals
- Give injections
- Refills/verbal orders
- Provide medication education
- Participate in interdisciplinary communication
- Gather information for the annual health risk assessment (PHRs)
- Provide care coordination between CMH, hospitals, and community providers
- Assessment and support during medical and psychiatric emergencies

Committees:

Medication Management – this committee reviews, develops and monitors processes that involve medications at WCCMH. This committee also reviews the Joint Commission standards around medication control.

Infection Control – this committee ensures that WCCMH is following the infection control standards set forth by the Joint Commission. This committee also encourages methods to decrease the spread of diseases and promotes vaccinations.

New staff training – this training is provided monthly to all new WCCMH staff that covers many of the medication management, infection control and other safety standards that are required of staff.

Provider medication training- nursing staff develop and implement the medication training and testing for provider's staff. This testing takes place multiple times a month.

Safety – nursing staff participate on the safety committee to ensure processes and protocols are being followed at the sites.

Committees/ Coverage :

Staff Development – Sit on the staff development to provide input on staff development and trainings from the nursing perspective

Employee Activities Committee (EAT)- this committee promotes staff morale and recognition by planning activities, theme weeks, staff goodie bags and acknowledgement boards across all the sites.

Team Trainings- On a quarterly basis all nurses are required to provide trainings at their treatment team meetings. This includes training on medication management, naloxone, flu shot and handwashing, Waived testing (for designated teams)

On call- nursing staff provide on-call services during nonbusiness hours and throughout the weekends/holidays. They work with the crisis team, CRS, on call prescribing to help answer questions and solve medication related issues.

CRS weekend/holiday coverage- nurses provide coverage every day at CRS on a volunteer (paid basis) on the weekends and on holidays

Post hospitalization process- nursing staff meet with consumers within 7 days post hospitalizations in order to reconcile medications, coordinate with the prescriber and treatment team with any follow up needs.

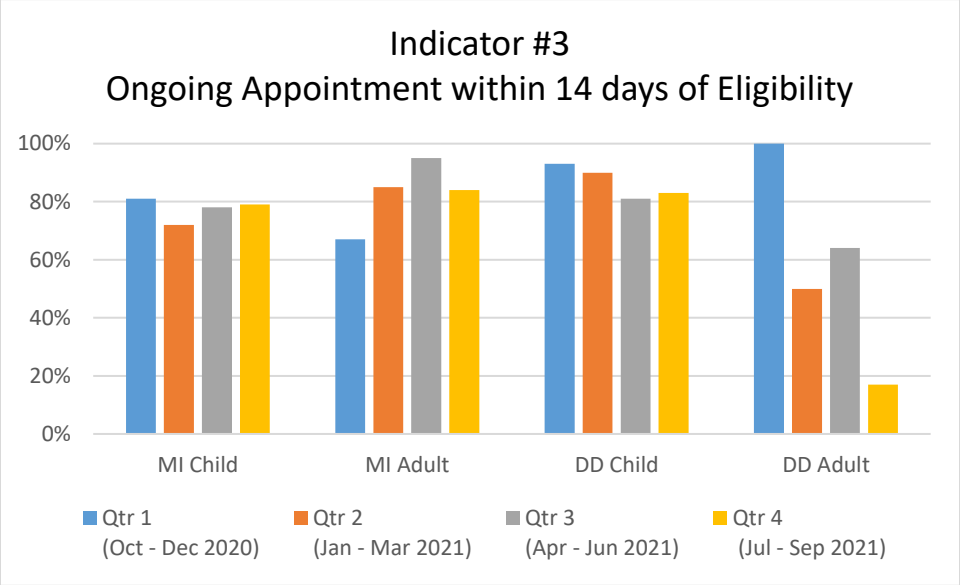
Pandemic changes:

- Nursing staff were on a rotating schedule so that there was minimum nursing staffing as well as being able to socially distance. Services included:
  - Provided injections in office and in the community
  - Covered CRS
  - ACT medications ordering and monitoring
  - Virtual visits prior to prescriber appointments
  - Virtual post hospital discharge appts
- COVID screening/testing- nursing staff provide onsite treatment determination (in conjunction with the treatment team) when a consumer presents with symptoms/exposure concerns. Nursing staff also provide rapid COVID testing for those that are transition to different levels of care when at WCCMH.
- COVID vaccine clinics- Nursing staff helped plan and execute multiple Johnson and Johnson vaccine clinics for WCCMH consumers.
- Currently all nursing services staff are onsite

Washtenaw Community Mental Health
Impact of Staffing Crisis

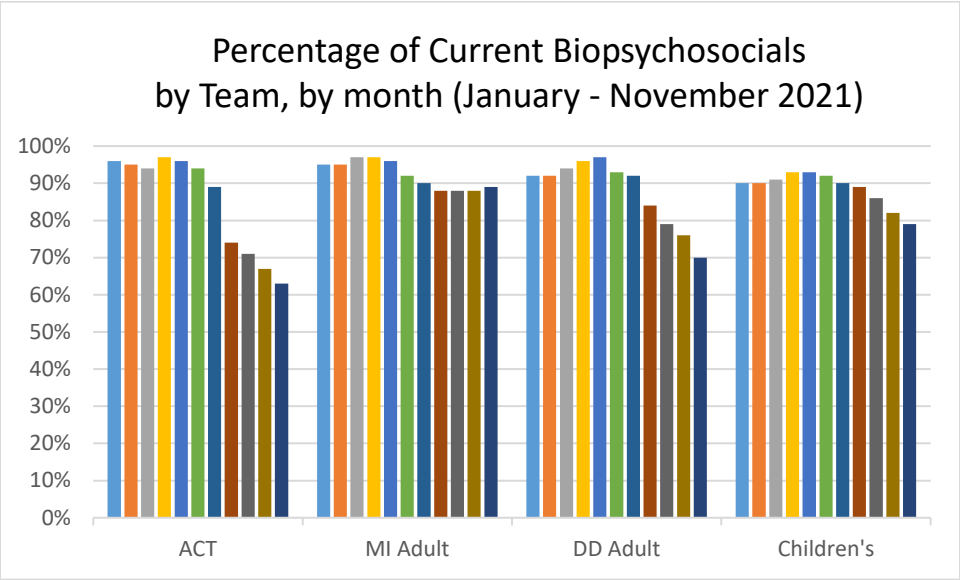
Michigan Department of Health and Human Services (MDHHS) performance indicators include monitoring status of a Community Mental Health Service Provider's (CMHSP) ability to initiate ongoing services to consumers within 14 days of their eligibility assessment.

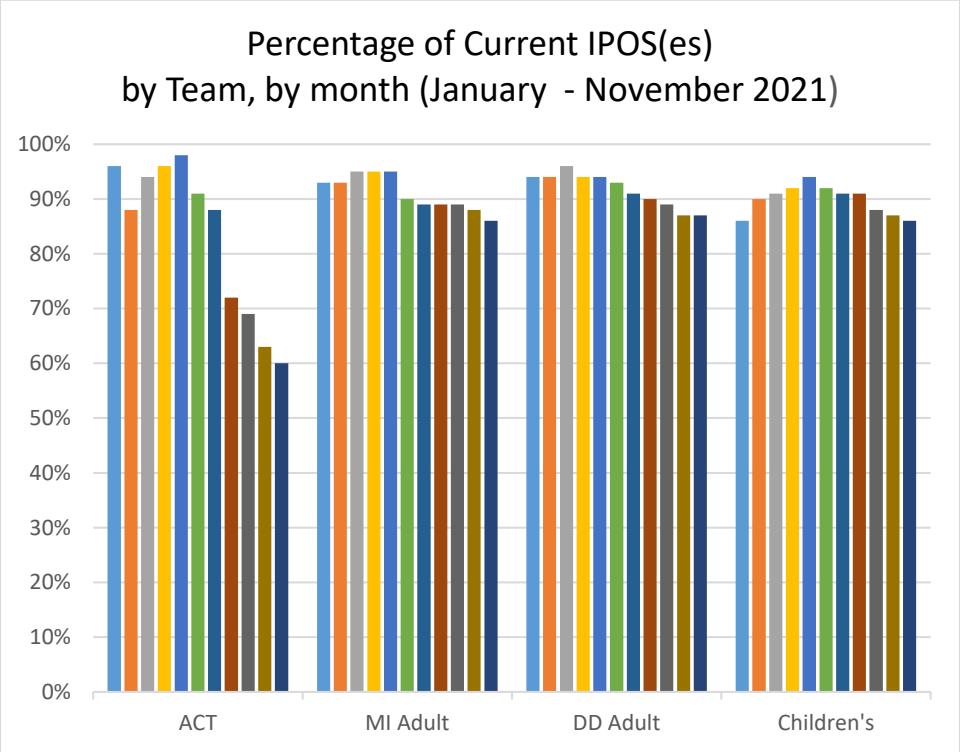
Below shows our ability to do this as indicated by the percentage of cases that received their ongoing service within 14 days. Some of the reasons for not receiving the service may be due to consumer choice (e.g. no show appointment, scheduling outside of the 14 day area, moving out of the area, etc.). However, Program has reported the staffing shortage has made it very difficult to establish service for new cases within the 14 days thereby impacting accessibility to our services. Below is a chart showing MI Adult and DD Adults performance on this indicator for three quarters (Jan – Mar, Apr – Jun and July – Sep 2021).



The staffing shortage has also impacted our ability to complete two significant documents in the treatment process. These documents guide our individualized consumer care. They are the Biopsychosocial and the Individual Plan of Service (IPOS). Both of these must be updated every year or they are considered expired. The Individual Plan of Service must be based on current information which is gathered through the completion of the Biopsychosocial process. If these documents are expired, we are not meeting Medicaid mandates and this also impacts other parts of the operations chain (e.g. services identified and subsequently authorized to support claims, information in the electronic health record that assists other aspects of services such as prescribers, etc.).

Through our Performance Improvement Department monthly management reports, we monitor how well we are keeping up with these mandates on a monthly basis. Below are two graphs which initially show relatively strong compliance (with some variance) which can be considered our baseline. However, they also display a significant drop off in our ability to stay compliant with the expectations and mandates.





The IPOS has a higher compliance rate because it is required to be current to support all services and claims but really should be informed by a current BPS which is a Joint Commission Standard, a Medicaid mandate and a regional policy.

The staffing shortage is impacting access to care in a timely way, proper and timely assessment process and the development of the treatment plan which impacts service and overall quality.

Another factor whose effect is not able to be measured at this time is the impact from a burgeoning caseload which requires the clinician to spread their available time amongst more consumers which means less time for each consumer. This lack of time impacts:

a) The time available to develop of a therapeutic rapport with the consumer which research identifies as the best predictor of good outcomes,
b) The clinician's available time to engage and discover the consumer which helps reveal additional needs and/ or symptoms the consumer / family may be experiencing,
c) A possible increase in adverse events since we do not know the consumer as well as we have in the past and therefore may not understand issues the consumer or family are facing,
d) The available time to spend on evidence based practices with the consumer and their family in order to achieve the outcomes we wish to achieve and
e) The ability to implement steps toward improving processes identified in audits. (A recent MDHHS audit will require the implementation of a corrective action plan which will require training, monitoring and higher expectations of an already beleaguered staff who struggle with a large caseload and continued additional compliance expectations. It is feared that this may further stress our system and could also impact additional turnover.)

To summarize, all of these issues are significantly impacted when the clinician is spread too thin with their large caseload and the added documentation requirements that come with each case assigned to them. This has a significant impact in our quality of care.

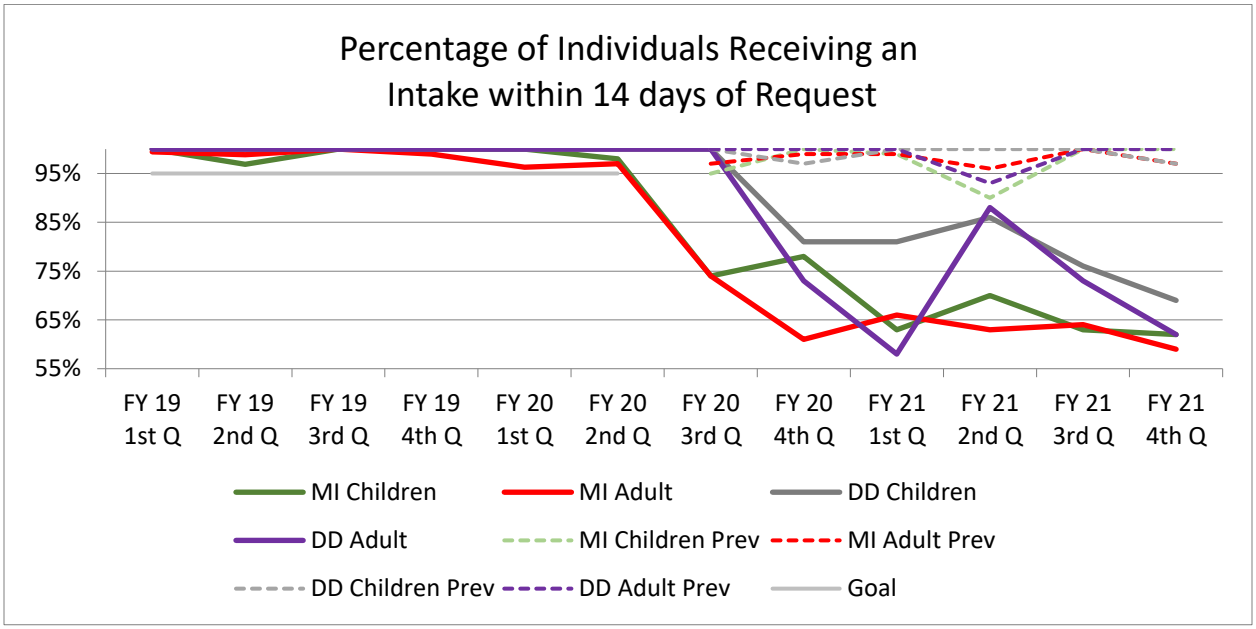
Prepared and submitted by:
WCCMH Performance Improvement
Division Manager Laura Higle

Program and Quality Board Committee
Dashboard Data FY 2021 4th Qtr (July - Sept 2021)

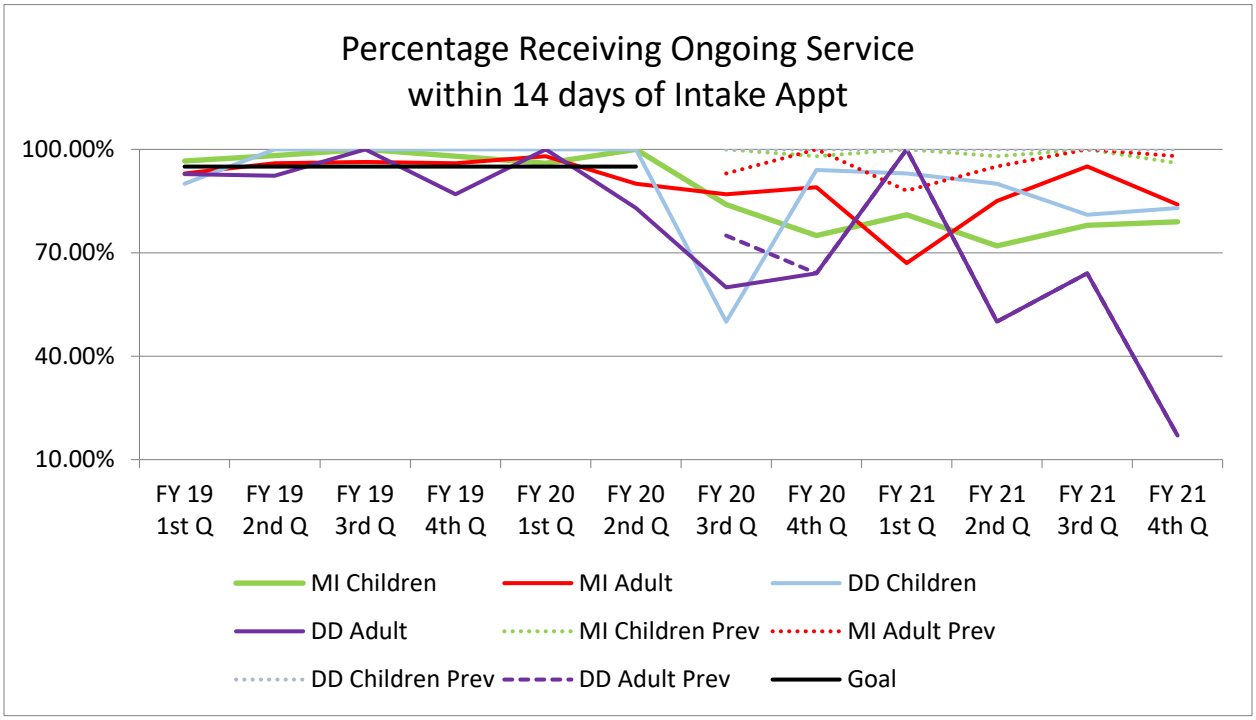
As of April 1 2020, the Michigan Department of Health and Human Service (MDHHS) changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to Ongoing Service) and removed the 95% historical expected goal.

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.

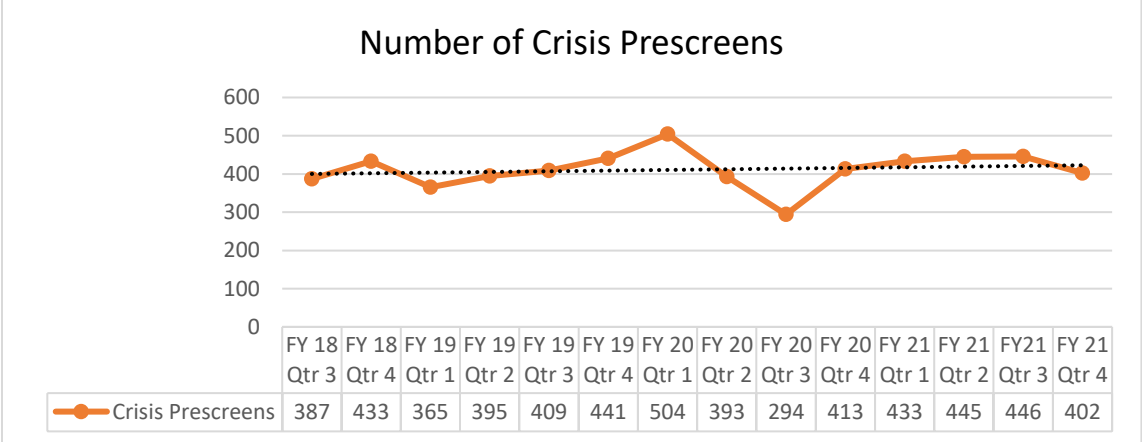
The "dashed lines" indicate where our compliance would have been under previous definitions. The data points are detailed in the tables below the graphs.

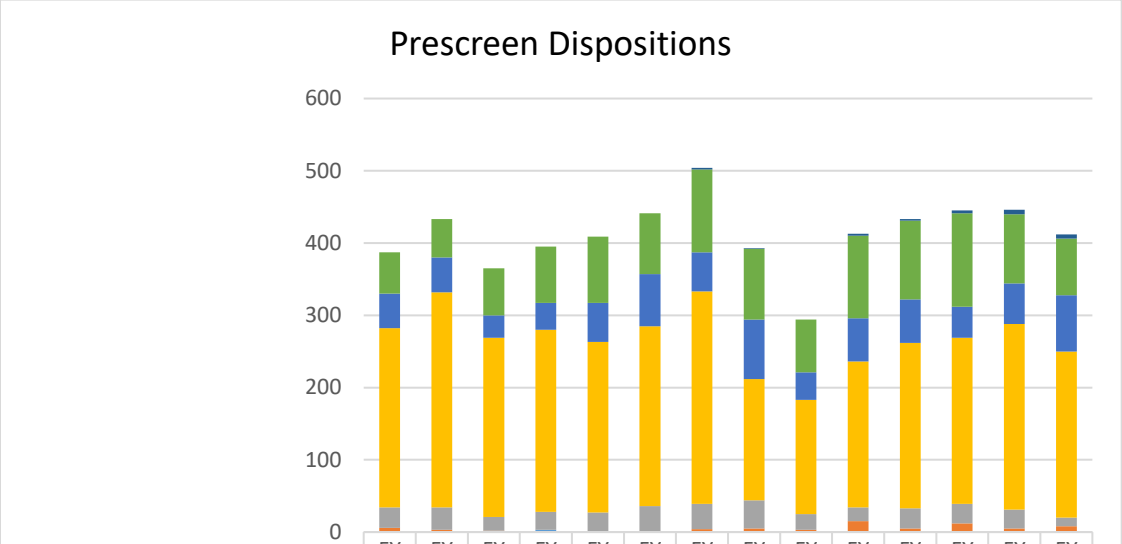


FY 21 4th Qtr Intake Appt within 14 days Detail						
Population	Total # of new persons requesting service	Number receiving appt. within 14 days of request	State defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- was formerly removed from the denominator	Percent Compliant by new State definition	Percent Compliant in previous definition
MI Child	101	63	38	38	63%	100%
MI Adult	179	106	73	70	59%	97%
DD Child	48	33	15	14	69%	97%
DD Adult	21	13	8	8	62%	100%

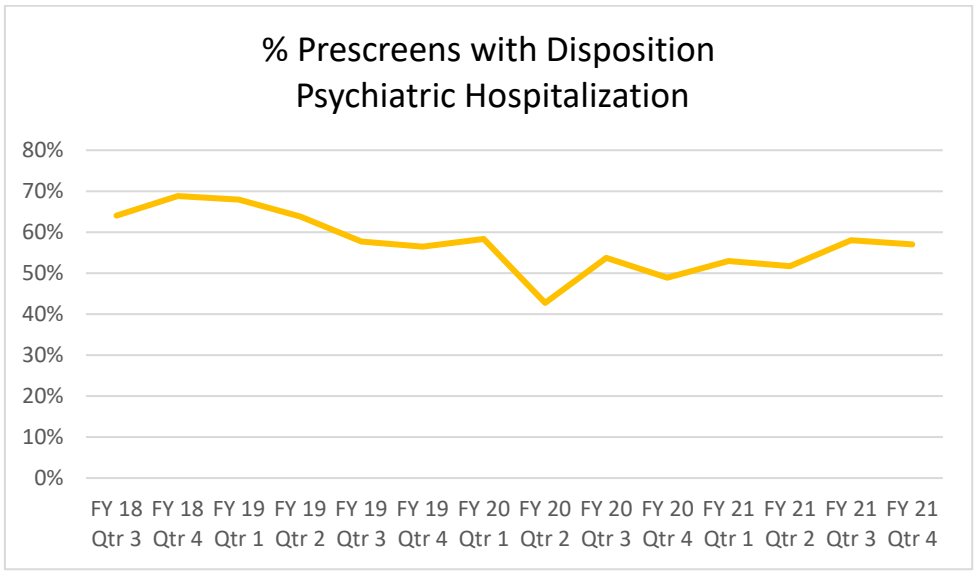


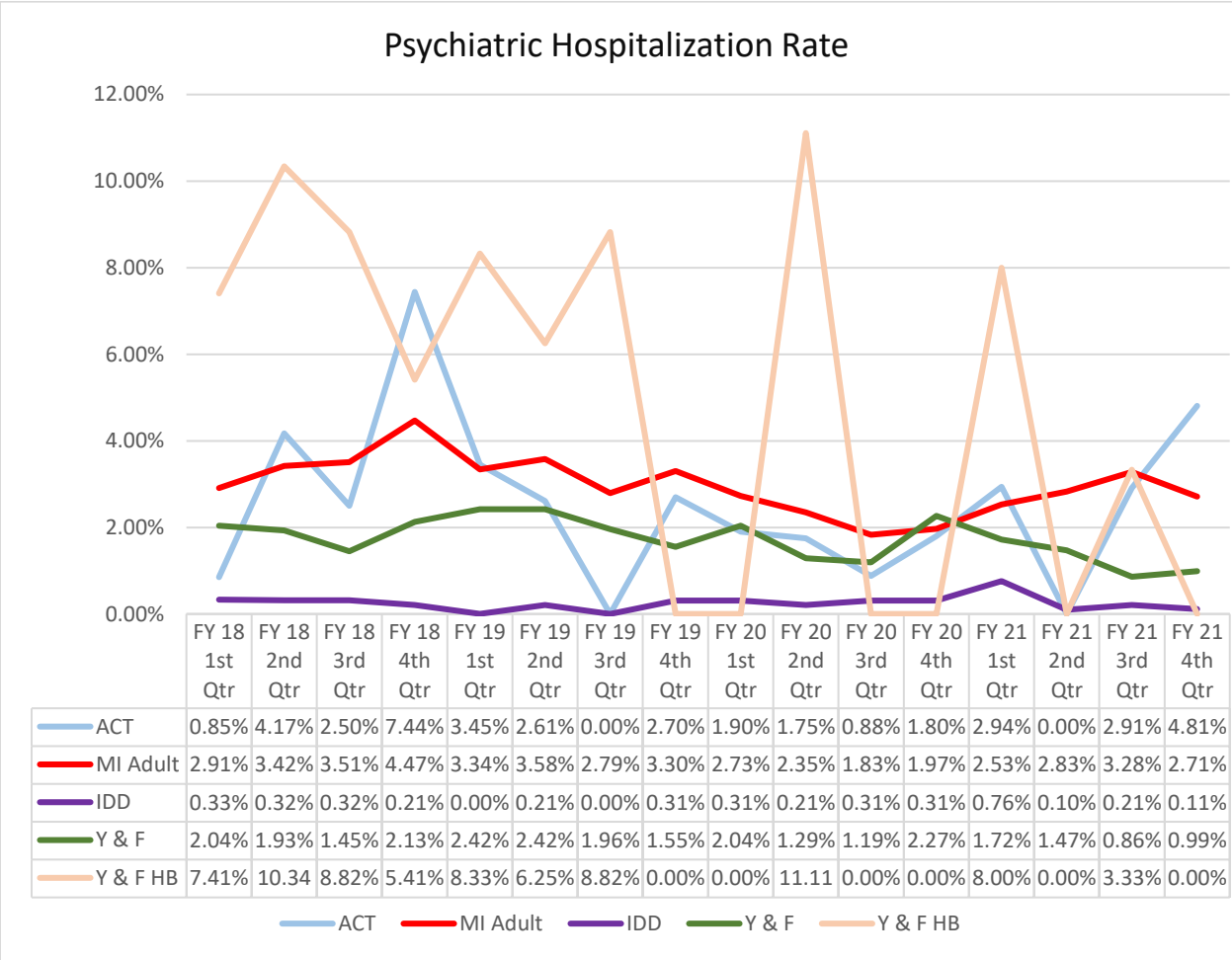
FY 21 4th Qtr Detail Ongoing Service						
Population	# of New Persons Eligible for Service	# of New Persons who started a new service within 14 days of eligibility	State Defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- used to be removed from the denominator	Percent Compliant under new definition	Percent Compliant under previous definition
MI Child	70	55	15	13	79%	96%
MI Adult	105	88	17	15	84%	98%
DD Child	36	30	6	6	83%	100%
DD Adult	12	2	10	2	17%	20%





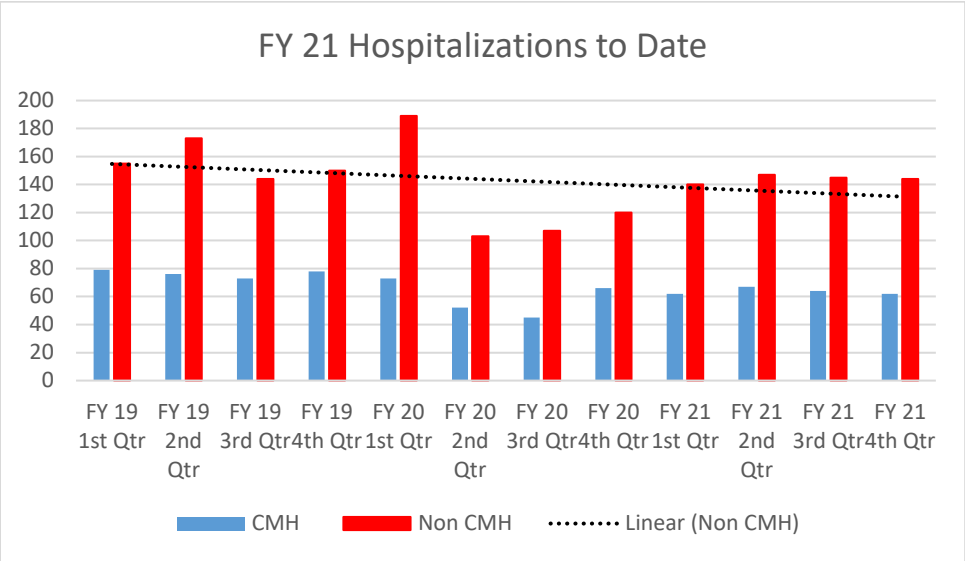
	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4
Blank							2	1		3	2	4	6	6
Partial Hospitalization	57	53	65	78	92	84	115	98	73	114	109	129	96	78
Outpatient/ Support Services	48	48	31	37	54	72	54	82	38	60	60	43	56	78
Inpatient Admission	248	298	248	252	236	249	294	168	158	202	229	230	257	230
Crisis Residential	28	31	19	25	27	35	35	39	22	19	28	27	26	12
Crisis Outreach	6	3	1			1	4	5	3	15	5	12	5	8
Admission & Discharge Plan	0	0	1	3										

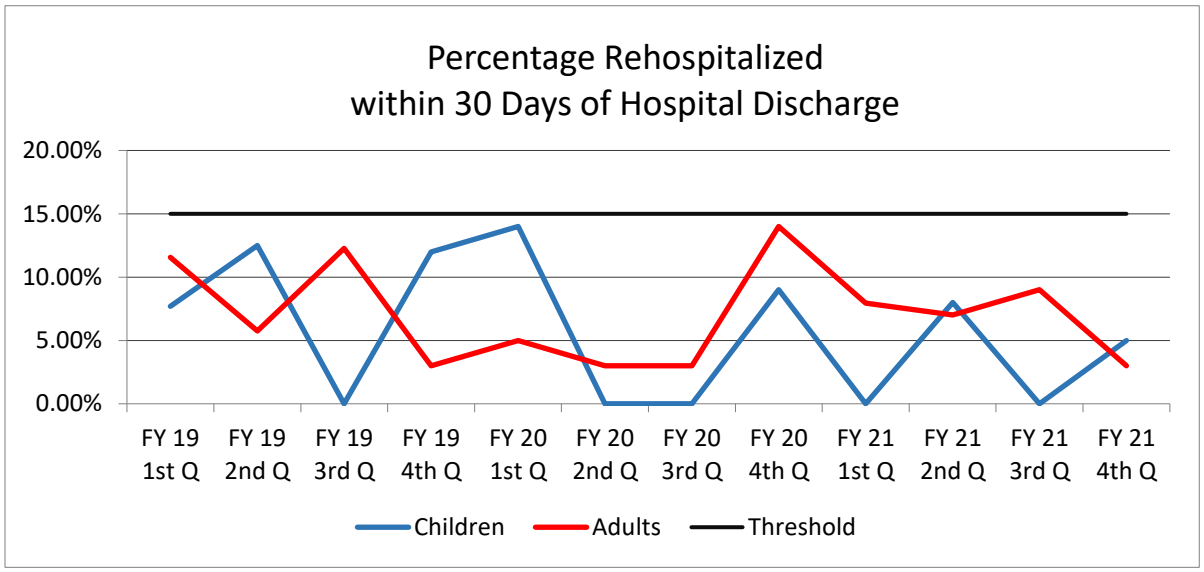




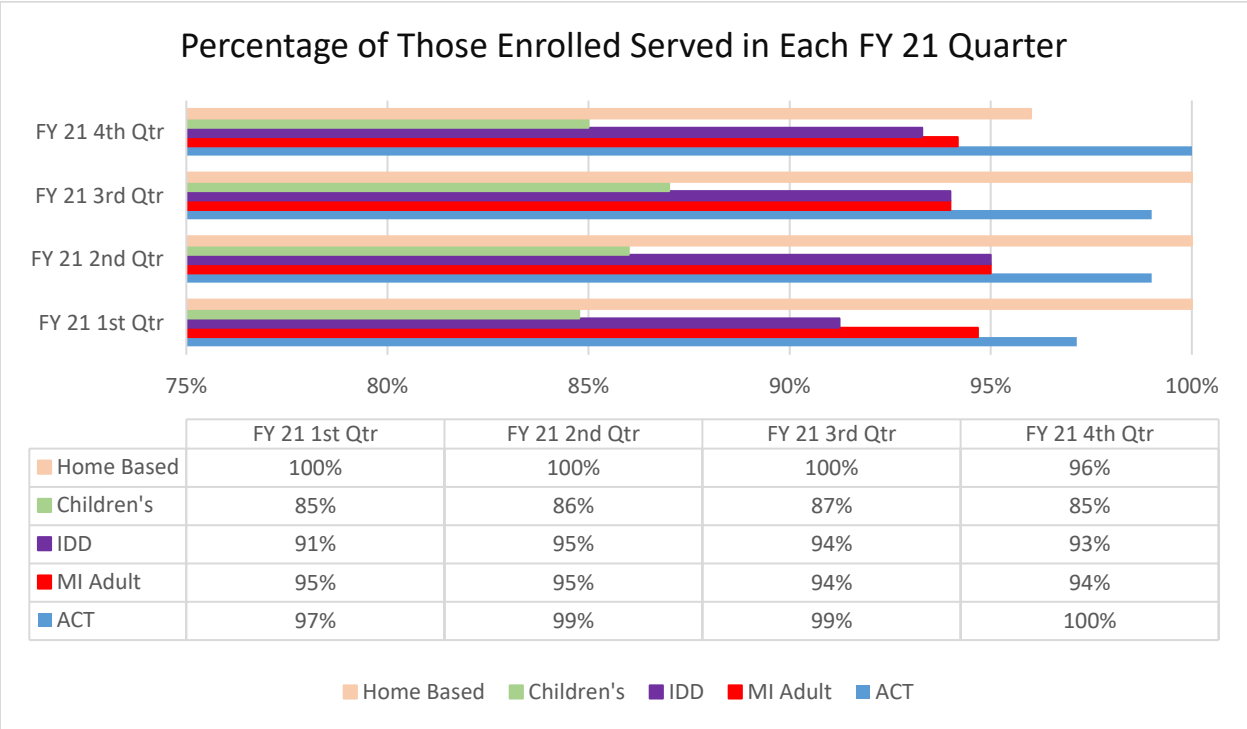
	FY 18 1st Qtr	FY 18 2nd Qtr	FY 18 3rd Qtr	FY 18 4th Qtr	FY 19 1st Qtr	FY 19 2nd Qtr	FY 19 3rd Qtr	FY 19 4th Qtr	FY 20 1st Qtr	FY 20 2nd Qtr	FY 20 3rd Qtr	FY 20 4th Qtr	FY 21 1st Qtr	FY 21 2nd Qtr	FY 21 3rd Qtr	FY 21 4th Qtr
ACT	0.85%	4.17%	2.50%	7.44%	3.45%	2.61%	0.00%	2.70%	1.90%	1.75%	0.88%	1.80%	2.94%	0.00%	2.91%	4.81%
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%	2.71%
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%	0.11%
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%	0.99%
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%	0.00%

FY 21 4th Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	104	6 (1)	4.81%
MI Adult	1587	47 (4)	2.71%
IDD	947	1 (0)	0.11%
Y & F	707	8 (1)	0.99%
Y & F Home Based	26	0 (0)	0





FY 21 4th Qtr Detail Readmit within 30 days of Discharge			
Population	# Discharged and Core Team Assignment	# Readmitted within 30 days of Discharge	% Readmit
Child	22	1	4.55%
Adult	92	3	3.26%



	FY 21 1st Qtr	FY 21 2nd Qtr	FY 21 3rd Qtr	FY 21 4th Qtr
Home Based	100%	100%	100%	96%
Children's	85%	86%	87%	85%
IDD	91%	95%	94%	93%
MI Adult	95%	95%	94%	94%
ACT	97%	99%	99%	100%

Critical Event Data Reported Thru Qtr 4 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
Qtr 4	DD Adult	Non Suicide Death	3
	MI Adult	Non Suicide Death	3
Qtr 4 Total			6

Mortality Data Thru Qtr 4 FY 2021

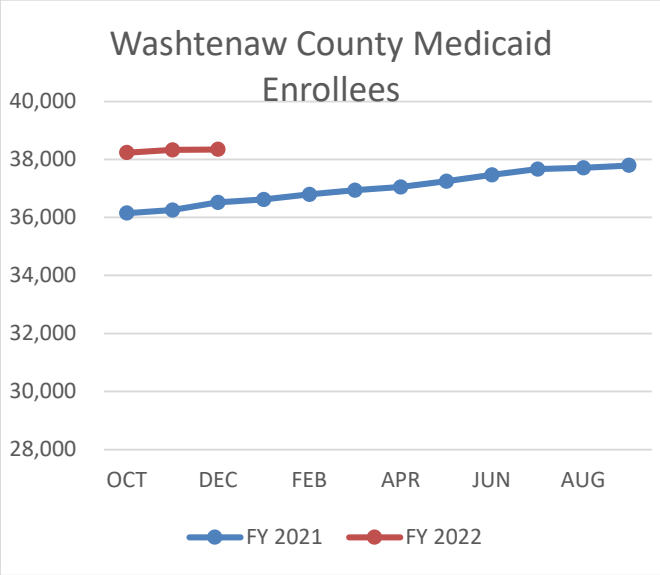
Cause of Death	Number of Deaths FY 16	Number of Deaths FY 17	Number of Deaths FY 18	Number of Deaths FY 19	Number of Deaths FY 20	Number of Deaths FY 21
Aspiration Pneumonia				1	2	2
Cancer	10	10	8	9	7	10
Cardiovascular	16	8	13	14	14	5
Dehydration			1			
Drug Abuse	8	6	12	5	8	2
Endocrine System (Diabetes)						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	7
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	10
Grand Total	**58**	**47**	**65**	**55**	**67**	**54**

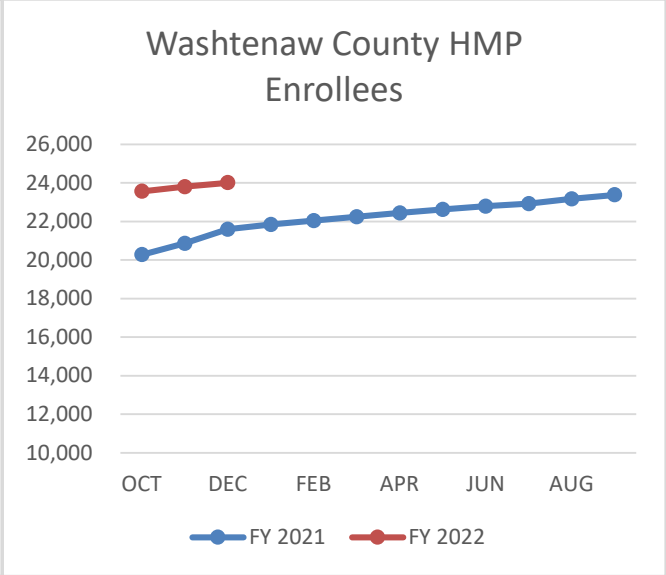
Sentinel Events: There were no sentinel events in the fourth quarter.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2022: For the period ending December 31, 2021
Prepared: February 8, 2022

1. Washtenaw County Enrollees

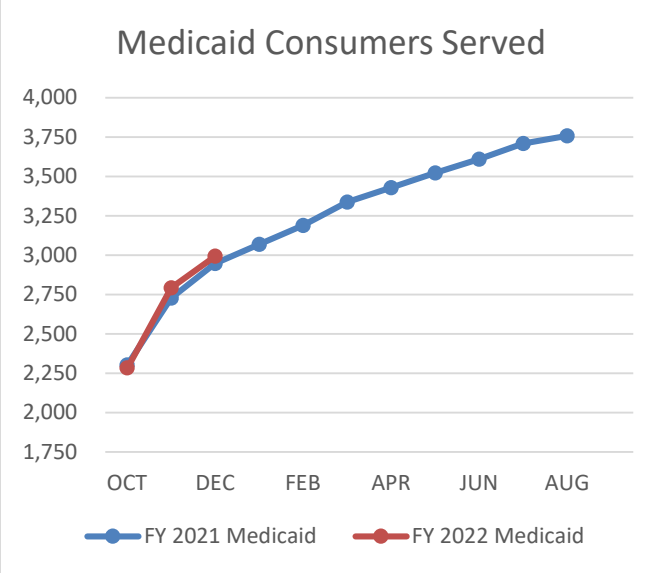
A summary of FY 2022 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

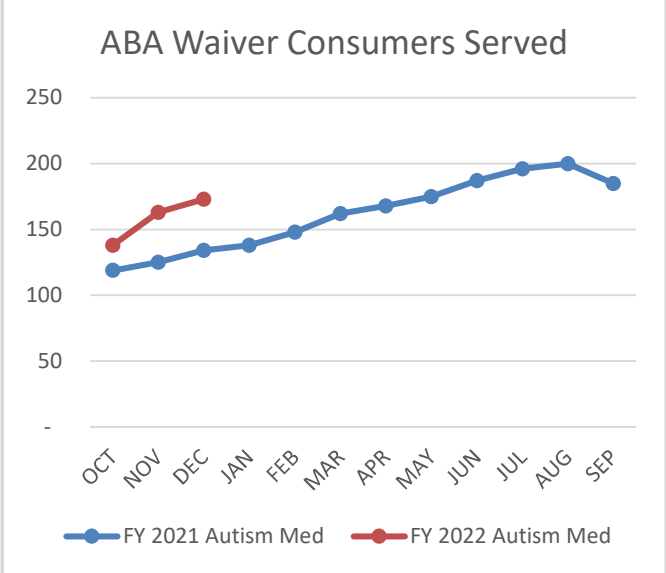




Washtenaw County Medicaid Enrollees were 38,351 in December 2021. This is a 5.00% increase from the same time last year (1,826 more enrollees than in December 2020). Healthy Michigan enrollment in December 2021 was 24,016. This is a 11.18% increase from the same time last year (2,415 more enrollees than in December 2020).

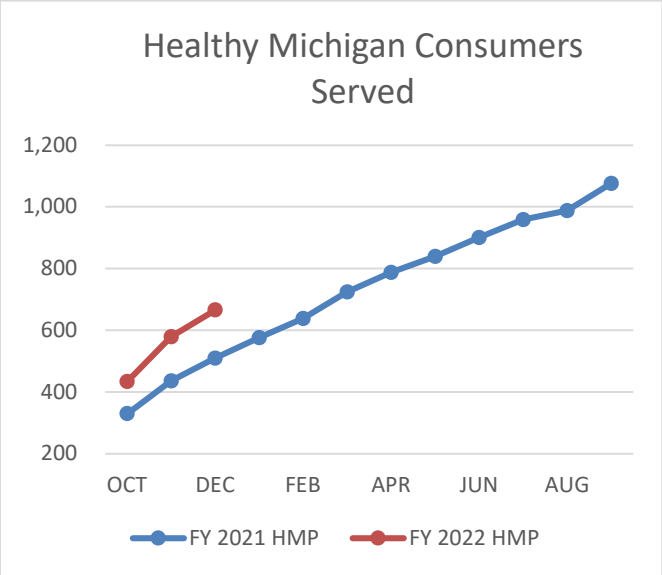
2. WCCMH Consumers Served to Date

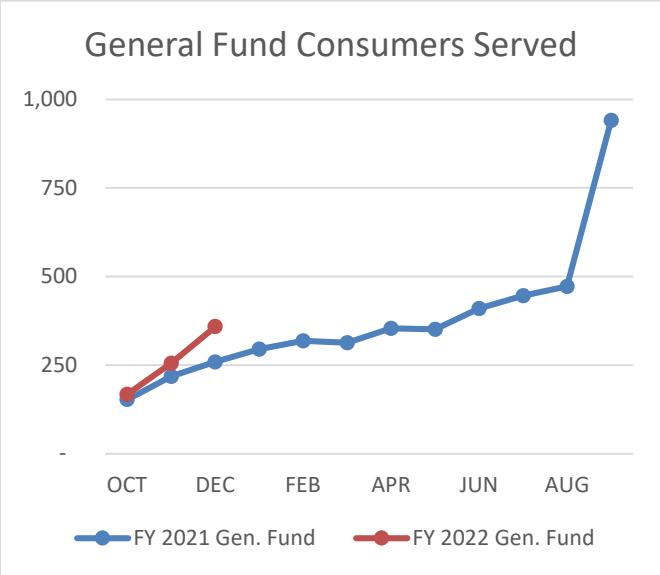




Medicaid consumers served through December 2021 are 2,994. This is 47 more consumers than the prior year (2,947 consumers were served through December 2020).

ABA Waiver consumers served through December 2021 are 173. This is 39 more consumers than prior year (134 consumers were served through December 2020).





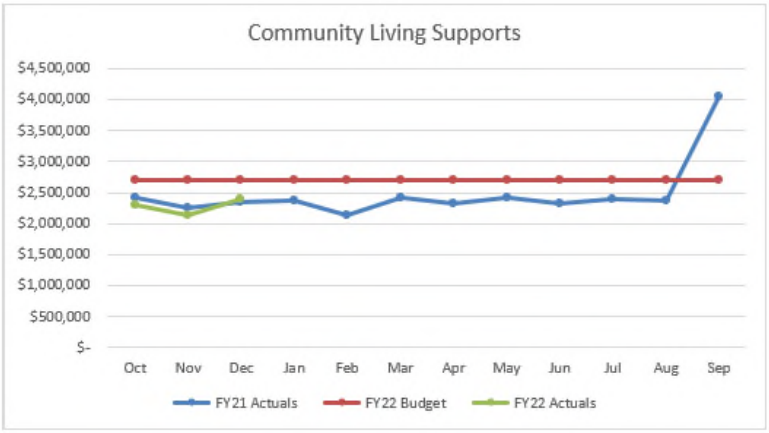
Healthy Michigan consumers served through December 2021 were 666. This is 156 more consumers than the same period last year.

General Fund consumers served through December 2021 were 359. This is 100 more consumers than the same period last year.

3. Financial Statement Highlights

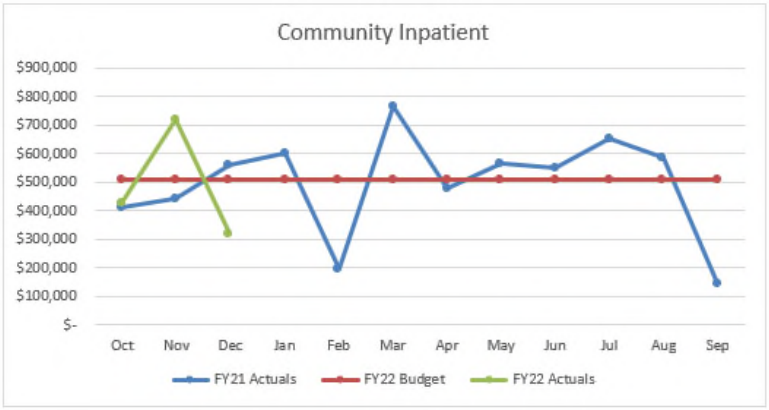
a. CLS service costs to date are estimated to be $6.8 Million and $1.3 Million under budget. The costs year to date are 6% less than this time last year. At the end of FY21 there were additional provider stability payments made to CLS providers and are reflected in the graph below. The temporary direct care worker pass-through funds for FY22 have been incorporated in the FY22 Budget and FY22 Actuals.

	FY21 Actuals	FY22 Budget	FY22 Actuals	YTD % Change
Oct	$ 2,425,825	2,711,968	$ 2,291,232	-5.55%
Nov	2,264,769	2,711,968	2,134,739	-5.64%
Dec	2,346,049	2,711,968	2,405,193	-2.92%
Jan	2,365,368	2,711,968		
Feb	2,135,096	2,711,968		
Mar	2,408,780	2,711,968		
Apr	2,328,718	2,711,968		
May	2,410,288	2,711,968		
Jun	2,316,806	2,711,968		
Jul	2,393,966	2,711,968		
Aug	2,377,568	2,711,968		
Sep	4,042,059	2,711,968		



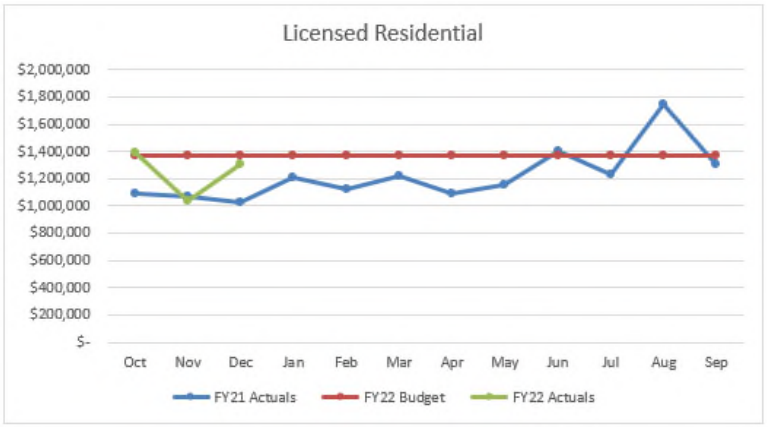
b. Community Inpatient costs to date are $1.4 Million. The costs year to date are 3.58% more than this time last year and $57,000 under budget.

	FY21 Actuals	FY22 Budget	FY22 Actuals	YTD % Change
Oct	$ 411,150	$ 508,333	$ 428,747	4.28%
Nov	444,907	508,333	719,608	34.14%
Dec	560,543	508,333	318,967	3.58%
Jan	601,931	508,333		
Feb	194,823	508,333		
Mar	767,313	508,333		
Apr	480,817	508,333		
May	567,208	508,333		
Jun	548,208	508,333		
Jul	653,771	508,333		
Aug	584,676	508,333		
Sep	146,525	508,333		



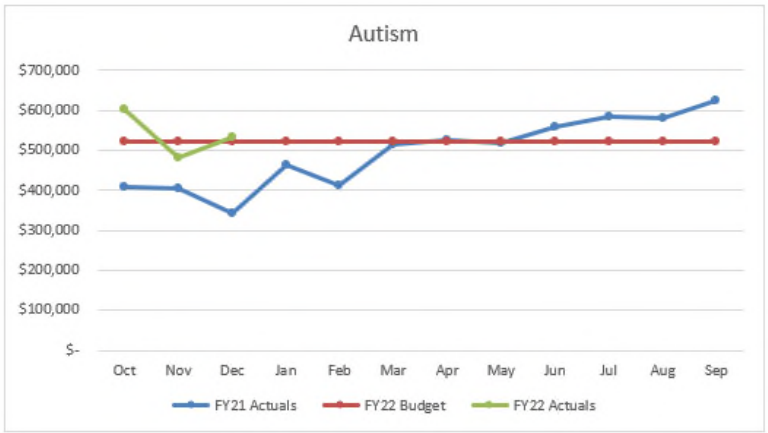
c. Licensed Residential costs to date are $3.7 Million and $396,000 under budget. The costs year to date are 16.74% more than this time last year. At the end of FY21 there were additional provider stability payments made to CLS providers and are reflected in the graph below. The temporary direct care worker pass-through funds for FY22 have been incorporated in the FY22 Budget and FY22 Actuals.

	FY21 Actuals	FY22 Budget	FY22 Actuals	YTD % Change
Oct	$ 1,093,095	$ 1,375,450	$ 1,386,550	26.85%
Nov	1,073,263	1,375,450	1,038,733	11.95%
Dec	1,028,927	1,375,450	1,304,777	16.74%
Jan	1,211,062	1,375,450		
Feb	1,118,469	1,375,450		
Mar	1,225,127	1,375,450		
Apr	1,093,521	1,375,450		
May	1,159,115	1,375,450		
Jun	1,399,305	1,375,450		
Jul	1,228,220	1,375,450		
Aug	1,742,223	1,375,450		
Sep	1,304,444	1,375,450		



d. Applied Behavior Analysis/Autism service costs to date are $1.6 Million. The costs year to date are 39.84% more than this time last year and $53,000 over budget. The temporary direct care worker pass-through funds for FY22 have been incorporated in the FY22 Budget and FY22 Actuals.

	FY21 Actuals	FY22 Budget	FY22 Actuals	YTD % Change
Oct	$ 408,109	$ 520,861	$ 602,553	47.64%
Nov	404,662	520,861	479,479	33.13%
Dec	342,956	520,861	534,172	39.84%
Jan	464,654	520,861		
Feb	410,998	520,861		
Mar	512,641	520,861		
Apr	525,526	520,861		
May	518,865	520,861		
Jun	558,191	520,861		
Jul	584,957	520,861		
Aug	578,244	520,861		
Sep	624,950	520,861		



e. Internal staffing expenses are trending under budget due to the difficulty recruiting for budgeted vacant positions.

4. PIHP Revenue Key Points

a. Medicaid and Healthy Michigan Plan revenues are collected from the PIHP.
b. By funding source, Medicaid is showing a surplus of $2.2 Million through December.
c. By funding source, HMP is showing a deficit of $108,000 through December.
d. Overall, the PIHP surplus is $3.1 Million through December.
e. At this time, funding related to temporary direct care worker wage increases will be cost settled separately and any unspent funds must be returned to the State and cannot be retained by the PIHP.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a surplus of $514,000.

6. Local Key Points

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

b. Local Funds are showing a surplus of $64,000 through December 2021.

c. Uses of Local Funding include:

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

7. Fund Balance

WCCMH currently has no fund balance available for fiscal year 2022.

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

		Total
Medicaid **		
Revenue		
B & B3	$	11,142,546
HSW		6,650,331
DCW		2,005,083
Child Waiver/SED Waiver		453,928
Autism		1,471,681
Prior Year Adjustments		-
Care for Caid		27,694
Total Medicaid Revenue	$	21,751,262
Total Medicaid Expense	$	19,538,482
Medicaid Surplus/(Deficit)	$	2,212,780
CCBHC **		
Revenue	$	1,032,500
Expense		-
CCBHC Surplus/(Deficit)	$	1,032,500
Healthy Michigan **		
Revenue	$	1,571,221
Expense		1,679,543
Healthy MI Surplus/(Deficit)	$	(108,322)
General Fund		
Revenue		
CMH Operations	$	1,058,761
CMH Operations Contra		-
GF Carryforward		-
Categorical		-
Redirect To Injectable Meds.		-
Funding Fr. Other Local Sources		394
Total General Fund Revenue	$	1,059,155
Total General Fund Expense	$	544,833
General Fund Surplus/(Deficit)	$	514,322
Injectable Meds		
Revenue	$	20,621
Expense		15,216

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

		Total
Inj. Meds. Surplus/(Deficit)	$	5,405
Grants And Contracts		
Revenue	$	385,541
Expense		385,541
Grants & Cont. Surplus/(Deficit)	$	-
CMHSP To CMHSP		
Revenue	$	161,121
Redirect to GF		(394)
Expense		160,726
CMHSP to CMHSP Surplus/(Deficit)	$	-
Local		
Revenue	$	386,775
Expense		322,752
Local Surplus/(Deficit)	$	64,023
Private Grant & All NOR		
Revenue	$	60,297
Expense		60,297
Priv. Grant & NOR Surplus/(Deficit)	$	-
Grand Total		
Revenue	$	26,486,887
Expense		22,766,179
Grand Total Surplus/(Deficit)	$	3,720,708

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	3,142,363
WCCMH Surplus/(Deficit)		578,345
	$	3,720,708

Washtenaw County Community Mental Health
Budget to Actuals
For Three Months Ending December 31, 2021

	Current Fiscal Year				
	FY 2022 Amended Budget	FY 2022 Amended Budget YTD	FY 2022 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 46,276,405	$ 11,569,101	$ 10,869,833	$ (699,268)	-6.04%
HSW	27,372,824	6,843,206	6,650,331	(192,875)	-2.82%
Children & SED Waivers	1,044,210	261,053	453,928	192,876	73.88%
Healthy Michigan Capitation	6,284,880	1,571,220	1,571,221	1	0.00%
Autism Capitation	5,886,723	1,471,681	1,471,681	0	0.00%
Direct Care Worker Pass-Through	8,421,349	2,105,337	2,005,083	(100,254)	-4.76%
CCBHC Supplementary	4,059,000	1,014,750	1,032,500	17,750	1.75%
TOTAL PIHP Revenue	$ 99,345,391	$ 24,836,348	$ 24,054,577	$ (781,771)	-3.15%
MDHHS Revenue					
State General Funds	$ 4,235,050	$ 1,058,763	$ 1,058,761	$ (2)	0.00%
Grants & Earned Contracts	1,790,168	447,542	408,670	(38,872)	-8.69%
All Other Revenue					
County Appropriation	$ 1,751,761	$ 437,940	$ 220,488	$ (217,452)	-49.65%
Project Revenue	847,984	211,996	181,974	(30,022)	-14.16%
All Other	1,917,652	479,413	562,417	83,004	17.31%
TOTAL Operating Revenue	**$ 109,888,006**	**$ 27,472,002**	**$ 26,486,887**	**$ (985,115)**	-3.59%
Operating Expenses					
Administrative Expenses					
General Administration	$ 6,598,359	$ 1,649,590	$ 1,506,797	$ (142,793)	-8.66%
Program Administration	3,355,568	838,892	827,012	(11,880)	-1.42%
Residential Services					
Community Living Supports	$ 32,543,612	$ 8,135,903	$ 6,831,163	$ (1,304,740)	-16.04%
Licensed Residential	16,505,397	4,126,349	3,730,060	(396,289)	-9.60%
Outpatient Services					
Autism Services	$ 6,250,336	$ 1,562,584	$ 1,616,204	$ 53,620	3.43%
Case Management	5,000,662	1,250,166	1,044,238	(205,928)	-16.47%
Supports Coordination	2,948,825	737,206	502,277	(234,929)	-31.87%
Skill Building	4,688,790	1,172,198	633,456	(538,742)	-45.96%
Supported Employment	1,538,321	384,580	368,241	(16,339)	-4.25%
Psychiatry	3,307,258	826,815	789,552	(37,263)	-4.51%
Nursing Services	2,397,642	599,411	539,654	(59,757)	-9.97%
Therapy Services	2,194,098	548,525	450,370	(98,155)	-17.89%
All Other	9,327,130	2,331,783	1,702,237	(629,546)	-27.00%
CCBHC Services	4,059,000	1,014,750	-	(1,014,750)	-100.00%
Other Expenses					
Community Inpatient	$ 6,100,000	$ 1,525,000	$ 1,467,322	$ (57,678)	-3.78%
Local Matches & Shelter	1,282,838	320,710	349,321	28,612	8.92%
Grants & Earned Contracts	1,790,168	447,542	408,275	(39,267)	-8.77%
TOTAL Operating Expenses	**$ 109,888,006**	**$ 27,472,002**	**$ 22,766,179**	**$ (4,705,823)**	-17.13%
Revenue Over/(Under) Expenses	-	-	3,720,708	3,720,708	

Washtenaw County Community Mental Health
Budget to Actuals
For Three Months Ending December 31, 2021

	Prior Year Comparison			
	FY 2022 YTD Actuals	FY 2021 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 10,869,833	$ 10,816,488	$ 53,345	0.49%
HSW	6,650,331	6,148,615	501,716	8.16%
Children & SED Waivers	453,928	231,483	222,445	96.10%
Healthy Michigan Capitation	1,571,221	1,439,000	132,222	9.19%
Autism Capitation	1,471,681	1,164,460	307,221	26.38%
Direct Care Worker Pass-Through	2,005,083	1,679,127	325,956	0.00%
CCBHC Supplementary	1,032,500	-	1,032,500	0.00%
TOTAL PIHP Revenue	$ 24,054,577	$ 21,479,171	$ 2,575,406	11.99%
MDHHS Revenue				
State General Funds	$ 1,058,761	$ 968,106	$ 90,655	9.36%
Grants & Earned Contracts	408,670	284,205	124,465	43.79%
All Other Revenue				
County Appropriation	$ 220,488	$ 223,524	$ (3,036)	-1.36%
Project Revenue	181,974	158,947	23,027	14.49%
All Other	562,417	466,637	95,780	20.53%
TOTAL Operating Revenue	**$ 26,486,887**	**$ 23,580,591**	**$ 2,906,296**	12.32%
Operating Expenses				
Administrative Expenses				
General Administration	$ 1,506,797	$ 1,129,105	$ 377,692	33.45%
Program Administration	827,012	591,527	235,485	39.81%
Residential Services				
Community Living Supports	$ 6,831,163	$ 7,287,064	$ (455,901)	-6.26%
Licensed Residential	3,730,060	3,195,285	534,775	16.74%
Outpatient Services				
Autism Services	$ 1,616,204	$ 1,155,728	$ 460,476	39.84%
Case Management	1,044,238	912,034	132,204	14.50%
Supports Coordination	502,277	466,314	35,963	7.71%
Skill Building	633,456	458,923	174,533	38.03%
Supported Employment	368,241	311,338	56,903	18.28%
Psychiatry	789,552	547,822	241,730	44.13%
Nursing Services	539,654	415,659	123,995	29.83%
Therapy Services	450,370	358,620	91,750	25.58%
All Other	1,702,237	1,423,042	279,195	19.62%
CCBHC Services	-	-	-	0.00%
Other Expenses				
Community Inpatient	$ 1,467,322	$ 1,416,600	$ 50,722	3.58%
Local Matches & Shelter	349,321	355,299	(5,978)	-1.68%
Grants & Earned Contracts	408,275	284,205	124,070	43.66%
TOTAL Operating Expenses	**$ 22,766,179**	**$ 20,308,564**	**$ 2,457,615**	12.10%
Revenue Over/(Under) Expenses	3,720,708	3,272,027	448,681	

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

Millage Budget

	Annual Budget	Budget YTD	YTD Actual	YTD Actual O/(U) YTD Budget
Millage Revenue				
Millage	$ 6,565,388	$ 6,565,388	$ 6,824,906	$ 259,518
Millage Interest Revenue	-	-	44,919	44,919
Millage GASB31 Adjustment	-	-	(73,911)	(73,911)
	$ 6,565,388	$ 6,565,388	$ 6,795,914	$ 230,526
Millage Expenses				
Salary	$ 2,395,000	$ 2,395,000	$ 1,762,586	$ (632,414)
Fringe	1,339,513	1,339,513	892,930	(446,583)
Contractors	1,500,000	1,500,000	1,379,468	(120,532)
Trainings	140,000	140,000	5,151	(134,849)
Operating Expenses	782,500	782,500	417,326	(365,174)
Fleet Charges	60,000	60,000	10,196	(49,804)
Client Care	78,500	78,500	91,513	13,013
Cost Allocation Plan	70,875	70,875	280,709	209,834
Furniture & Equipment	100,000	100,000	-	(100,000)
Depreciation Expense	10,000	10,000	-	(10,000)
Telephone	50,000	50,000	23,495	(26,505)
All Other Expenses	39,000	39,000	9,320	(29,680)
Total Millage Expenses	$ 6,565,388	$ 6,565,388	$ 4,872,694	$ (1,692,694)
Revenue Over/(Under) Expenses		-	1,923,220	1,923,220
	-			

*** 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	$ 2,250,971	$ 2,032,724	$ (218,247)
CCBHC #2 - Year 2 Grant Expenses				
Salary	$ 1,166,672	$ 1,166,672	$ 1,176,949	$ 10,277
Fringe	765,442	765,442	654,001	(111,441)
Trainings	9,660	9,660	850	(8,810)
Telephone	16,050	16,050	13,621	(2,429)
Operating Supplies	22,263	22,263	1,869	(20,394)
Client Care	66,250	66,250	1,352	(64,898)
Indirect Costs	204,634	204,634	184,082	(20,552)
Total Expenses	$ 2,250,971	$ 2,250,971	$ 2,032,724	$ (218,247)
Revenue Over/(Under) Expenses	(0)	-	-	-

Washtenaw County Community Mental Health

Fiscal Year 2022 Budget Amendment Details

February 2022

REVENUES:

Medicaid:

- PIHP Revenue has been updated to reflect the budgeted amounts included in the FY22 PIHP Budget.
- Overall, the capitation categories reflect a $2,615,042 increase over the original WCCMH FY22 Budget as well as an additional $1,750,000 as a direct pass through for provider workforce stability.
- The "Direct Care Worker Pass-Through" amount has been updated to reflect the increased funding needed to support the $2.35 per hour wage increase.
- The "CCBHC Supplementary" has been updated to reflect the projected revenue with all the information known at this time.
- In total, the PIHP Revenue has increased $16,845,391 from the FY22 Original Budget.

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. As a placeholder, a separate expense category "CCBHC Services" is included in the Outpatient Services section.

Contracted Services:

- Updates to contracted services to reflect the anticipated cost of the "Direct Care Worker Pass-Through" effort as well as provider workforce stability payment for residential services.

ATTACHMENT #4
FEBRUARY 2022

Washtenaw County Community Mental Health
Fiscal Year 2022
Proposed Second Budget Amendment

	FY 2022 Original Budget	FY 2022 1st Budget Amendment	FY 2022 2nd Budget Amendment	2nd Amendment Over/(Under) Original Budget
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 43,503,203	$ 44,526,405	$ 46,276,405	$ 2,773,202
HSW	25,102,700	25,368,146	27,372,824	2,270,124
Children & SED Waivers	894,097	1,044,210	1,044,210	150,113
Direct Care Worker Pass-Through	-	8,020,332	8,421,349	8,421,349
CCBHC Supplmentary	-	2,000,000	4,059,000	4,059,000
Healthy Michigan Capitation	7,000,000	6,284,882	6,284,880	(715,120)
Autism Capitation	6,000,000	5,886,723	5,886,723	(113,277)
TOTAL PIHP Revenue	$ 82,500,000	$ 93,130,698	$ 99,345,391	$ 16,845,391
MDHHS Revenue				
State General Funds	$ 4,235,050	$ 4,235,050	$ 4,235,050	$ -
Grants & Earned Contracts	1,779,812	1,790,168	1,790,168	10,356
All Other Revenue				
County Appropriation	$ 1,748,770	$ 1,751,761	$ 1,751,761	$ 2,991
Project Revenue	847,984	847,984	847,984	-
All Other	1,917,652	1,917,652	1,917,652	-
TOTAL Operating Revenue	**$ 93,029,268**	**$ 103,673,313**	**$ 109,888,006**	**$ 16,858,738**
Operating Expenses				
Administrative Expenses				
General Administration	$ 6,279,421	$ 6,279,421	$ 6,598,359	$ 318,938
Program Administration	3,304,826	3,304,826	3,355,568	50,742
Residential Services				
Community Living Supports	$ 26,750,000	$ 31,543,612	$ 32,543,612	$ 5,793,612
Licensed Residential	13,000,000	15,755,397	16,505,397	3,505,397
Outpatient Services				
Autism Services	$ 5,520,000	$ 5,732,206	$ 6,250,336	$ 730,336
Case Management	4,758,950	4,758,950	5,000,662	241,712
Supports Coordination	2,806,291	2,806,291	2,948,825	142,534
Skill Building	4,294,135	4,462,153	4,688,790	394,655
Supported Employment	1,463,965	1,463,965	1,538,321	74,356
Psychiatry	2,861,899	2,861,899	3,307,258	445,359
Nursing Services	2,281,750	2,281,750	2,397,642	115,892
Therapy Services	2,088,044	2,088,044	2,194,098	106,054
All Other	8,457,337	9,161,793	9,327,130	869,793
CCBHC Services	-	2,000,000	4,059,000	4,059,000
Other Expenses				
Community Inpatient	$ 6,100,000	$ 6,100,000	$ 6,100,000	$ -
Local Matches & Shelter	1,282,838	1,282,838	1,282,838	-
Grants & Earned Contracts	1,779,812	1,790,168	1,790,168	10,356
TOTAL Operating Expenses	**$ 93,029,268**	**$ 103,673,313**	**$ 109,888,006**	**$ 16,858,738**
Revenue Over/(Under) Expenses	$ -	$ -	$ -	$ -

ATTACHMENT #5
FEBRUARY 2022

WCCMH Health Home

Brandie Hagaman, MPH, Program Administrator

February 25, 2022

Brief WCCMH history

Disease Management pilot

MDHHS Pilot Disease Management

SAMHSA PBHCI grant

MDHHS Health Home (Paid to play)

MDHHS Health Home (starts April 1, 2022)

MDHHS Health Home criteria

Medicaid beneficiaries with the following ICD-10 codes for Serious Mental Illness or Serious Emotional Disturbances

- F06- Other mental disorders due to know physiological condition
- F20 –Schizophrenia
- F25- Schizoaffective Disorders
- F31- Bipolar disorder
- F32- Major depressive disorder, single episode
- F33- Major depressive disorder, recurrent
- F43- Reaction to server stress, and adjustment disorders
- F41- other anxiety disorders
- F90- Attention- deficit hyperactivity disorders

6 activities of the Health Home

- Comprehensive Case Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services

All enrollees will have a BHH care plan that includes these 6 activities

Payment is based on a monthly service

Staffing Model

Lead Entity- PIHP (per 100 enrollees)

- Health Home Director (.5 FTE)

Health Home Partner- WCCMH (per 100 enrollees)

- Behavioral Health Specialist (.25 FTE)
- Nurse Care Manager (1.0 FTE)
- Peer Support Specialist, Community Health Worker, Medical Assistant (3.00-4.00 FTE)
- Medical Consultant (.10 FTE)
- Psychiatric Consultant (.10 FTE)

Administrative and Next Steps

- WSA Enrollment component
  - Mimics CCBHC enrollment
- Anticipating 200 individuals by 9/30/22
- PMPM is $389.97 (less 20% for PIHP)
  - For those enrolled in both CCBHC and HH additional to CCBHC payment

- MDHHS BHH training March 1st and 2nd
- Kick off April 1st

2022 WCCMH BOARD AND BOARD COMMITTEE MEETING SCHEDULE

ATTACHMENT #6
FEBRUARY 2022

WCCMH Board	Executive Committee	Millage Advisory Committee	Quality-Finance Committee
NO MEETING SCHEDULED FOR JANUARY 2022	**January 10, 2022** **CANCELLED**	**NO MEETING SCHEDULED FOR JANUARY 2022**	**NO MEETING SCHEDULED FOR JANUARY 2022**
February 25, 2022 Learning Resource Center-Michigan & Huron 4135 Washtenaw Ave 9:30-11:30am	**NO MEETING SCHEDULED FOR FEBRUARY 2022**	**February 14, 2022** Learning Resource Center-Michigan & Huron 4135 Washtenaw Ave 3:30-5:00pm	**February 14, 2022** Learning Resource Center-Michigan & Huron 4135 Washtenaw Ave 2:00-3:30pm
NO MEETING SCHEDULED FOR MARCH 2022	**March 14, 2022** TBD 4:00-5:00pm	**NO MEETING SCHEDULED FOR MARCH 2022**	**NO MEETING SCHEDULED FOR MARCH 2022**
April 22, 2022 TBD 9:30-11:30am	**NO MEETING SCHEDULED FOR APRIL 2022**	**April 11, 2022** TBD 3:30-5:00pm	**April 11, 2022** TBD 2:00-3:30pm
NO MEETING SCHEDULED FOR MAY 2022	May 9, 2022 TBD 4:00-5:00pm	**NO MEETING SCHEDULED FOR MAY 2022**	**NO MEETING SCHEDULED FOR MAY 2022**
June 24, 2022 TBD 9:30-11:30am	**NO MEETING SCHEDULED FOR JUNE 2022**	**June 13, 2022** TBD 3:30-5:00pm	**June 13, 2022** TBD 2:00-3:30pm
NO MEETING SCHEDULED FOR JULY 2022	July 11, 2022 TBD 4:00-5:00pm	**NO MEETING SCHEDULED FOR JULY 2022**	**NO MEETING SCHEDULED FOR JULY 2022**
August 26, 2022 TBD 9:30-11:30am	**NO MEETING SCHEDULED FOR AUGUST 2022**	**August 8, 2022** TBD 3:30-5:00pm	**August 8, 2022** TBD 2:00-3:30pm
NO MEETING SCHEDULED FOR SEPTEMBER 2022	September 12, 2022 TBD 4:00-5:00pm	**NO MEETING SCHEDULED FOR SEPTEMBER 2022**	**NO MEETING SCHEDULED FOR SEPTEMBER 2022**
October 21, 2022 TBD 9:30-11:30am	**NO MEETING SCHEDULED FOR OCTOBER 2022**	**October 17, 2022** TBD 3:30-5:00pm	**October 17, 2022** TBD 2:00-3:30pm
NO MEETING SCHEDULED FOR NOVEMBER 2022	November 14, 2022 TBD 4:00-5:00pm	**NO MEETING SCHEDULED FOR NOVEMBER 2022**	**NO MEETING SCHEDULED FOR NOVEMBER 2022**
December 23, 2022 TBD 9:30-11:30am	**NO MEETING SCHEDULED FOR DECEMBER 2022**	**December 12, 2022** TBD 3:30-5:00pm	**December 12, 2022** TBD 2:00-3:30pm

ZOOM LINKS WILL BE POSTED TO THE WCCMH WEBSITE FOR ALL MEETINGS IN ORDER TO ASSIST IN ADHERING TO SOCIAL DISTANCING GUIDELINES

2/14/22 rld

ATTACHMENT #7
FEBRUARY 2022

Washtenaw County Community Mental Health (WCCMH) Board
2022 Annual Calendar

January ▪ BOC review CMH Board applications	**February** ▪ BOC will appoint new/re-appointed board members and notify WCCMH Executive Director or designee ▪ Identify WCCMH Board Officers effective April 1st ▪ Program Committee Dashboard due to Program-Finance Committee (Quarters 3 and 4) ▪ Annual Recipient Rights Reports due to Program-Finance Committee ▪ Consumer Advisory Council quarterly update to WCCMH Board ▪ WCCMH Board will identify Millage Advisory Committee members with terms expiring ▪ Annual WCCMH Board meeting (election of officers and assign committee membership) terms effective April 1st
March ▪ Swear in new/re-appointed WCCMH Board member (terms effective April 1st) ▪ Swear in new/re-appointed Millage Advisory Committee members (terms effective April 1st) ▪ Executive Committee begin working on WCCMH Board Evaluation process	**April** ▪ Annual Conflict of Interest and Ethics statement from Board members due ▪ Annual Recipient Rights Training for all board members ▪ Annual WCCMH Board evaluation ▪ Consumer Advisory Council quarterly update to WCCMH Board ▪ Annual Performance Improvement Year End Report due to Program-Finance Committee then to Full Board on the Consent Agenda
May	**June** ▪ Board Development (training/education) ▪ Annual Finance Audit Report due to WCCMH Board ▪ Draft budget to WCCMH Board ▪ Consumer Advisory Council quarterly update to WCCMH Board ▪ Program Committee Dashboard due to Program-Finance Committee (Quarter 1)
July	**August** ▪ Final Budget Approval due to WCCMH Board ▪ Program Committee Dashboard due to Program-Finance Committee (Quarter 2) ▪ Semi-Annual Recipient Rights Reports due to Program-Finance Committee
September ▪ Executive Committee begin working on WCCMH Executive Director Evaluation ▪ Budget Review to Washtenaw County BOC ▪ End of fiscal year ▪ Executive Committee review Annual Board calendar	**October** ▪ WCCMH Board review next year's meeting schedule ▪ Begin new fiscal year ▪ Consumer Advisory Council quarterly update to WCCMH Board ▪ WCCMH will identify expiring Board member terms ▪ Annual Board Calendar to WCCMH Board
November ▪ Staff schedule annual Board and Board Committee meetings on member's calendars. ▪ WCCMH will Identify new/reappointed board members (terms expiring) and submit to BOC. ▪ Executive Committee finalize WCCMH Executive Director evaluation (moved from	**December** ▪ BOC will post for expiring WCCMH Board terms expiring on March 31st.

BOC=Board of Commissioners

2/14/22 rld

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

WASHTENAW COUNTY BOARD OF COMMISSIONERS

February 16, 2022

Prepared by: Commissioner Sue Shink

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, a secondary consumer is a family member of a primary consumer that is/was receiving services from CMH; and

WHEREAS, four vacancies exist from the following sectors: one (1) Secondary Consumer, two (2) General Public members (preference for one member affiliated with Michigan Medicine), and one (1) BOC Representative; and

WHEREAS, this item has been reviewed by Corporation Counsel and County Administration.

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
Katie Scott	Secondary Consumer	March 31, 2025	N/A – Incumbent
Alfreda Rooks	General Public (Michigan Medicine)	March 31, 2025	N/A – Incumbent
Bob King	General Public	March 31, 2025	N/A – Incumbent
Andy LaBarre	BOC Representative	March 31, 2025	N/A – Incumbent

WASHTENAW COUNTY
BOARD OF COMMISSIONERS
February 16, 2022

7:00 PM
Board Room
Washtenaw County Administration Building
220 N. Main Street
Ann Arbor, Michigan

Action Minutes

I. PLEDGE OF ALLEGIANCE

II. ROLL CALL

III. PUBLIC PARTICIPATION

1. Written Public Comment

IV. COMMISSIONER FOLLOW-UP TO PUBLIC PARTICIPATION

V. LIAISON REPORTS

VI. SPECIAL ORDER OF BUSINESS

VII. APPOINTMENTS

1. A resolution appointing a member to the Building Authority – **Passed, Resolution #22-009**

2. A resolution appointing members to the Community Mental Health (CMH) Board - **Passed, Resolution #22-010**

VIII. CONSENT AGENDA - **Passed**

1. Approval of Minutes of Previous Meeting (January 5, 2022)

2. Communications

3. Report of Standing Committees

4. Report of Special Committees: Washtenaw County Parks and Recreation Commission and Washtenaw County Board of County Road Commissioners

5. Other Reports

   A. A report on contracts in the amount of $25,000 and under from November 26, 2021 through December 30, 2021

   B. A report on contracts in the amount of $25,000 and under from December 30, 2021 through January 14, 2022

C. A report on contracts in the amount of $25,000 and under from January 14, 2022 through January 28, 2022

D. A report on contracts in the amount of $25,000 and under from January 28, 2022 through February 11, 2022

E. A report from the Washtenaw County Road Commission on the summary of service requests for the month of November, 2021

F. A report from the Washtenaw County Road Commission on the summary of service requests for the month of December, 2021

G. A report from the Washtenaw County Road Commission on the summary of service requests for the month of January, 2022

6. Report of the Treasurer

IX. RESOLUTIONS

1. First Reading

A. A resolution approving the acceptance of the Weatherization Assistance Program Deferral Reduction Grant in the amount of $97,080 for the period of January 1, 2022 through September 30, 2022 from the Office of Community and Economic Development – **Passed, Moving to 3/2 BOC Agenda for Final Reading**

B. A resolution to approve all formula grants received by the Office of Community and Economic Development with a fiscal year starting during the 2022 calendar year - **Passed, Moving to 3/2 BOC Agenda for Final Reading**

C. A resolution authorizing the County Administrator to sign the 2020 Homeland Security Grant program interlocal fiduciary agreement with Macomb County for the period of September 1, 2020 through May 31, 2023 in the amount of $340,914 from the Sheriff's Office - **Passed, Moving to 3/2 BOC Agenda for Final Reading**

D. A resolution authorizing the pause of the Washtenaw County Pollution Prevention Regulation to review, engage and update the regulation for a time effective immediately and for not more than 2 years from the effective date from the Health Department - **Passed, Moving to 3/2 BOC Agenda for Final Reading**

E. A resolution to encourage generational success and invest in our community's health and wellbeing through a series of targeted investments in under-resourced communities as part of the Washtenaw County Rescue Plan and allocate up to $11,299,007 in ARPA funds - **Passed, Moving to 3/2 BOC Agenda for Final Reading**

2. Single Reading

A. A resolution ratifying the approval of the Low Income Household Water Assistance Program in the amount of $867,938 for the period of November 1, 2021 through September 30, 2023 and creating a grant-status Human Service Program Aide position from the Office of Community and Economic Development - **Passed, Resolution #22-011**

B. A resolution approving the contract for the Michigan State Housing Development Authority COVID Emergency Rental Assistance Program II in the amount of $4,502,461 for the period of January 1, 2022 through March 31, 2022 to the Office of Community and Economic Development - **Passed, Resolution #22-012**

C. A resolution to ratify the submission of the grant extension to the Michigan State Police Coronavirus Emergency Supplemental Funding Program for the period of June 2021 to December 2022 in the amount of $131,452 from the Washtenaw County Prosecutor's Office - **Passed, Resolution #22-013**

D. A resolution ratifying the amended 2021-2022 Secondary Road Patrol (SRP) grant amendment to the state to include additional funding awarded by the state in the amount of $145,661 from the Sheriff's Office - **Passed, Resolution #22-014**

E. A resolution accepting the AAA Driver's Education grant in the amount of $33,000 and authorizing the County Administrator to sign the grant agreement from the Sheriff's Office - **Passed, Resolution #22-015**

F. A resolution authorizing the County Administrator to sign the 2021 Emergency Management Performance Grant - American Rescue Plan Act grant agreement in the amount of $30,823 from the Sheriff's Office - **Passed, Resolution #22-016**

G. A resolution affirming the appointment of Benjamin Curtiss Pinette as Washtenaw County Emergency Management Coordinator from the Sheriff's Office - **Passed, Resolution #22-017**

H. A resolution amending the by-laws for the Washtenaw County Food Policy Council from the Health Department - **Passed, Resolution #22-018**

I. A resolution amending the by-laws for the Washtenaw County Board of Health from the Health Department – **Chair Shink pulled this item from the agenda.**

J. A resolution to authorize tax and continuing disclosure post issuance compliance procedures from the Finance Department - **Passed, Resolution #22-019**

K. A resolution to support State Legislators working to protect those in our community from sexual violence - **Passed, Resolution #22-020**

L. A resolution to support Senator Irwin's request for a hearing on prison conditions at Women's Huron Valley Correctional Facility - **Passed, Resolution #22-021**

3. Approval of Claims

A. A resolution authorizing the payment of claims commencing with the last previously approved claim and continuing through the date of January 13, 2022 - **Passed, Resolution #22-022**

B. A resolution authorizing the payment of claims commencing with the last previously approved claim and continuing through the date of January 27, 2022 - **Passed, Resolution #22-023**

C. A resolution authorizing the payment of claims commencing with the last previously approved claim and continuing through the date of February 10, 2022 - **Passed, Resolution #22-024**

X. REPORT FROM THE COUNTY ADMINISTRATOR

1. A report from Jimena Loveluck, Health Officer, on COVID cases and prevention measures in the County

2. A report on the status of Domestic Violence Survivor services

XI. REPORT OF THE CHAIR OF THE BOARD OF COMMISSIONERS

XII. ITEMS FOR CURRENT/FUTURE DISCUSSION

XIII. PENDING

XIV. ADJOURN TO NEXT SESSION

Next Board Meeting
March 2, 2022
Board Room, Administration Building *and* Remote via Zoom
7:00 PM