



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**

Virtually at <https://zoom.us/j/92255991728>

**June 24, 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-2/25/22 (Attachment #1A)
 - B. WCCMH Board Meeting Minutes and Actions-4/22/22 (Attachment #1B)
 - C. WCCMH Executive Committee Meeting Minutes and Actions-12/13/21 (Attachment #1C)
 - D. WCCMH Executive Committee Meeting Minutes and Actions-3/14/22 (Attachment #1D)
 - E. WCCMH Quality-Finance Committee Meeting Minutes and Actions-2/14/22 (Attachment #1E)
 - F. WCCMH Quality-Finance Committee Meeting Minutes and Actions-4/11/22 (Attachment #1F)
 - G. Millage Advisory Committee Meeting Minutes and Actions-2/14/22 (Attachment #1G)
 - H. Millage Advisory Committee Meeting Minutes and Actions-4/11/22 (Attachment #1H)
 - I. Contracts and Leases (approved by Executive Committee on 5/9/22) (Attachment #1I)
 - J. Contracts and Leases (recommended approval by Quality-Finance Committee on 6/13/22) (Attachment #1J)
 - K. Executive Director Authorizations (approved by Executive Committee on 5/9/22 (Attachment #1K)
 - L. Executive Director Authorizations (recommended approval by Quality-Finance Committee on 6/13/22) (Attachment #1L)
 - M. Millage Advisory Committee Funding Requests totaling \$835,790.00 (approved by Executive Committee on 5/9/22) (Attachment #1M)
 1. NAMI (Attachment #1M1)
 2. Public Health Anti-Stigma (Attachment #1M2)
 3. CHRT Communications Plan (Attachment #1M3)
 - N. Millage Advisory Committee Funding Requests Summary totaling \$268,180.00(recommended approval by MAC on 6/13/22)(Attachment #1N)
 1. YBMen Project Attachment #1N1)
 2. Voices of Youth (this was approved under Executive Director Authorizations on 6/13/22) (Attachment #1N2)
 3. Teen Turn Challenge (this was approved under Executive Director Authorizations on 6/13/22) (Attachment #1N3)
 - O. WCCMH Financial Status Report period ending 2/28/22 (approved by Executive Committee on 5/9/22) (Attachment #1O)
 - P. WCCMH Millage and CCBHC Financial Status Report ending 2/28/22 (reviewed by Executive Committee on 5/9/22) (Attachment #1P)
 - Q. Annual Performance Improvement Year End Report (Attachment #1Q)
 - R. Program Committee Dashboard FY2022, Quarter 1 (Attachment #1R)
 - S. Program Education Presentation-I/DD Overview (Attachment #1S)

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.

- T. CMHPSM Customer Services Policy (Attachment #1T)
 - U. CMHPSM County of Financial Responsibility within the CMHPSM PIHP Policy (Attachment #1U)
 - V. CMHPSM Notice of Privacy Practices and Consumer Complaints for Protected Health Information Policy (Attachment #1V)
 - W. CMHPSM Claims Policy (Attachment #1W)
 - X. CMHPSM Regional Consumer Appeals Policy (Attachment #1X)
 - Y. CMHPSM Culturally and Linguistically Relevant Services Policy (Attachment #1Y)
 - Z. CMHPSM Financial Fraud and Abuse Policy (Attachment #1Z)
 - AA. CMHPSM Service Verification Policy (Attachment #1AA)
 - BB. CMHPSM Utilization Management and Review Policy (Attachment #1BB)
 - CC. WCCMH Consumer Advisory Council Meeting Minutes and Actions-2/9/22 (Attachment #1CC)
 - DD. WCCMH Consumer Advisory Council Meeting Minutes and Actions-3/9/22 (Attachment #1DD)
 - EE. WCCMH Staff Spring Quarterly Newsletter (Attachment #1EE)
 - FF. Program Education Presentation on Crisis Negotiation Team (CNT) (Attachment #1FF)
 - GG. Millage Process, Investments, and Progress Update (from 4/22/22 Board packet) (Attachment #1GG)
 - HH. Millage Process, Investments, and Progress Update (reviewed by MAC on 6/13/22)(Attachment #1HH)
 - II. WCCMH CARES Report (from 4/22/22 Board packet) (Attachment #1II)
 - JJ. WCCMH CARES Report (reviewed by MAC on 6/13/22) (Attachment #1JJ)
 - KK. Washtenaw County Sheriff's Office Millage Update (Attachment #1KK)

 - V. Treasurer's Report **ACTION** (50 minutes)
 - WCCMH FY 2021 Financial Audit (Attachment #2) **N. Phelps/S. Blann ACTION**
 - WCCMH Financial Status Report (Attachment #3) **N. Phelps ACTION**
 - WCCMH Millage and CCBHC Financial Status Report (Attachment #4) **N. Phelps ACTION**

 - VI. Executive Director Report-**T. Cortes** (10 minutes)

 - VII. CMHPSM Regional Update (10 minutes)
 - June 8, 2022 Regional Meeting was cancelled
 - CMHPSM Board Meeting Minutes and Actions from 2/9/22 (Attachment #5)
 - CMHPSM Board Meeting Minutes and Actions from 5/11/22 (Attachment #5A)

 - VIII. New Business (10 minutes) (Attachment #6) **ACTION**
 - WCCMH Board Officers for 4/1/22-3/31/23
 - Chair
 - Vice-Chair
 - Secretary
 - Treasurer
 - WCCMH Committee assignments 4/1/22-3/31/23
 - WCCMH Quality-Finance Committee
 - WCCMH Millage Advisory Committee
 - WCCMH Executive Committee
 - CMHPSM Regional Board

 - IX. Old Business (15 minutes)
 - CCBHC Update **T. Cortes/M. Harding**
 - Strategic Planning Update (Attachment #7) **T. Cortes/M. Harding**
 - Annual WCCMH Board Training Reminder
 - Recipient Rights Training
 - Annual Conflict of Interest Policy
- 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.

- Annual Ethics Statement

- 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 required to participate in person to count towards a quorum**

VIRTUAL MEETING LINK IS:

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. <https://zoom.us/j/92255991728>

Or One tap mobile:
+12678310333, 92255991728# US (Philadelphia)
+13126266799, 92255991728# 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: 922 5599 1728

International numbers available: <https://zoom.us/j/92255991728>

Audience Participation Guidelines:

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



WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD

JUNE 24, 2022

CONSENT AGENDA

- A. WCCMH Board Meeting Minutes and Actions-2/25/22 (Attachment #1A)
- B. WCCMH Board Meeting Minutes and Actions-4/22/22 (Attachment #1B)
- C. WCCMH Executive Committee Meeting Minutes and Actions-12/13/21 (Attachment #1C)
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- R. Program Committee Dashboard FY2022, Quarter 1 (Attachment #1R)
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- KK. Washtenaw County Sheriff's Office Millage Update (Attachment #1KK)

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

***In Person: Learning Resource Center-Michigan & Huron Rooms
4135 Washtenaw Ave, Ann Arbor, MI***

Virtually: <https://zoom.us/j/94013420152>

February 25, 2022

9:30am

K. Walker called the meeting to order at 9:43am.

ROLL CALL:

S. Antonow attending remotely
A. Dusbiber attending remotely
N. Graebner-Sundling attending in person
B. Higman attending in-person
R. Jefferson attending in person
B. King attending remotely-does not count towards quorum
A. LaBarre attending in person
A. Rooks attending remotely-does not count towards quorum
D. Strong attending remotely-does not count towards quorum
M. Udow-Phillips attending in person
K. Walker attending in person

MEMBERS ABSENT:

K. Scott

STAFF PRESENT:

T. Cortes, M. Harding, N. Phelps, B. Hagaman, L. Gentz, K. Snay, S. Amos O'Neal,
L. Higle.

OTHERS PRESENT:

L. Lutomski, T. Gavalier, A. Anderson, K. Karpiak, A. Cisneros, K. Homan,
M. Creekmore, G. Nelson, C. Walsh, N. Heine, S. Swisher

- I. Introductions
- None
- II. Audience Participation
- None
- III. Board response to audience participation
- None
- IV. Consent Agenda Actions (Attachment #1)
- WCCMH Board Meeting Minutes and Actions-12/17/21
 - WCCMH Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions-12/13/21
 - One Pager on Workforce Crisis
 - CMHPSM Performance Improvement Policy
 - CMHPSM Behavior Treatment Committee Policy
 - Millage Committee:
 1. WCCMH Millage Advisory Committee Meeting Minutes and Actions-12/13/21
 2. Millage Process, Investments and Progress Update
 3. Strategic Planning Update
 4. Funding Requests totaling \$698,069.00

- a. Community, Leadership, Revolution (CLR) Academy-\$45,000.00/1 year
- b. WCCMH Wraparound Position \$85,305.00/Annual/Continuous
- c. Office of Community and Economic Development (OCED) Family Empowerment Program \$69,573.00 Annually/3 years totaling \$210,218.00
- d. Office of Community and Economic Development (OCED) Michigan Ability Partners (MAP) \$357,546.00/1 year
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-12/8/21
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-1/12/22
- Consumer Advisory December 2021 Newsletter
- Recipient Rights Annual Report
- Program Education Presentation on CMH Nursing
- Program Dashboard FY21 Quarter 4

MOTION BY A. LABARRE, SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT AND APPROVE THE FEBRUARY 25, 2022 WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	X	DUSBIBER	X
GRAEBNER-SUNDLING	X	HIGMAN	X
JEFFERSON	X	KING	NOT PRESENT FOR VOTE
LABARRE	X	ROOKS	NOT PRESENT FOR VOTE
SCOTT	N/A	STRONG	NOT PRESENT FOR VOTE
UDOW-PHILLIPS	X	WALKER	X

MOTION CARRIED

- V. Treasurer's Report
 - WCCMH Financial Status Report
 - o N. Phelps presented WCCMH Financial Status Report (Attachment #2) to the Board for the period ending December 31, 2021.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE WCCMH FINANCIAL STATUS REPORT ENDING DECEMBER 31, 2021.

ROLL CALL VOTE:

ANTONOW	X	DUSBIBER	X
GRAEBNER-SUNDLING	X	HIGMAN	X
JEFFERSON	X	KING	NOT PRESENT FOR VOTE
LABARRE	X	ROOKS	NOT PRESENT FOR VOTE
SCOTT	N/A	STRONG	NOT PRESENT FOR VOTE

UDOW-PHILLIPS	X	WALKER	X
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MOTION CARRIED

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

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE WCCMH MILLAGE AND CCBHC FINANCIAL STATUS REPORT ENDING DECEMBER 31, 2021.

ROLL CALL VOTE:

ANTONOW	X	DUSBIBER	X
GRAEBNER-SUNDLING	X	HIGMAN	X
JEFFERSON	X	KING	NOT PRESENT FOR VOTE
LABARRE	X	ROOKS	NOT PRESENT FOR VOTE
SCOTT	N/A	STRONG	NOT PRESENT FOR VOTE
UDOW-PHILLIPS	X	WALKER	X

MOTION CARRIED

- FY2022 Budget Amendment
 - o N. Phelps presented the F2022 Budget Amendment (Attachment #4) to the Board.
 - o A. LaBarre inquired about positive indications from Budget Amendment and financial status for F2022.
 - o N. Phelps reports next steps as paying down the deficit.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE WCCMH FY 2022 BUDGET AMENDMENT AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	X	DUSBIBER	X
GRAEBNER-SUNDLING	X	HIGMAN	X
JEFFERSON	X	KING	NOT PRESENT FOR VOTE
LABARRE	X	ROOKS	NOT PRESENT FOR VOTE
SCOTT	N/A	STRONG	NOT PRESENT FOR VOTE
UDOW-PHILLIPS	X	WALKER	X

MOTION CARRIED

- VI. Executive Director report
- T. Cortes presented the Executive Director report to the WCCMH Board.
 - State Level Update
 - o Governor's budget highlights:
 - The Health Home allocation which includes Washtenaw's participation, set to begin 4/1/22.
 - CCBHC allocation increased from \$22 million to \$101 million.
 - Supplemental budget allocations for hospital inpatient capacity increased at Walter Reuther and Hawthorne.
 - \$135 million for recruitment and retention workforce shortage in behavioral health.
 - Local Update
 - o Plans at the regional level to send a Provider stability payment to residential providers in the next few months.
 - o WCCMH recruitment efforts reviewed, to include working with a new recruiting firm.
 - o WCCMH retention efforts highlighted.
- VII. CMHPSM Regional Update
- The CMHPSM meeting from February 9, 2022 did not have a quorum so the January minutes will be reviewed at the next meeting.
- VIII. New Business
- Health Home Overview
 - o B. Hagaman and T. Cortes presented the Health Home Overview (Attachment #5) to the Board.
- IX. Old Business
- WCCMH 2022 Annual Board/Committee Meeting Schedule
 - o K. Walker and T. Cortes discussed the 2022 WCCMH Board/Committee meeting schedule (Attachment #6).
 - o R. Dornbos will be sending meeting invitations to the board/committee members
 - o The LRC has been reserved for the in person meetings and a virtual meeting link will be sent in the invitation.

MOTION BY A. LABARRE, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE WCCMH 2022 ANNUAL BOARD/COMMITTEE MEETING SCHEDULE AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	X	DUSBIBER	X
GRAEBNER-SUNDLING	X	HIGMAN	X
JEFFERSON	X	KING	NOT PRESENT FOR VOTE
LABARRE	X	ROOKS	NOT PRESENT FOR VOTE
SCOTT	N/A	STRONG	NOT PRESENT FOR VOTE
UDOW-PHILLIPS	X	WALKER	X

MOTION CARRIED

- WCCMH 2022 Annual Board Calendar
 - o K. Walker and T. Cortes discussed the revised 2022 Annual Board Calendar (Attachment #7).
 - o This was revised due to the meeting schedules to ensure that required documentation coordinated with the meeting months.

MOTION BY A. LABARRE, SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT THE WCCMH 2022 ANNUAL CALENDAR AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	X	DUSBIBER	X
GRAEBNER-SUNDLING	X	HIGMAN	X
JEFFERSON	X	KING	NOT PRESENT FOR VOTE
LABARRE	X	ROOKS	NOT PRESENT FOR VOTE
SCOTT	N/A	STRONG	NOT PRESENT FOR VOTE
UDOW-PHILLIPS	X	WALKER	X

MOTION CARRIED

- CCBHC Update
 - o T. Cortes and M. Harding gave an update on CCBHC.
- Strategic Planning Update
 - o T. Cortes and M. Harding presented the Strategic Planning Update(Attachment #8) to the Board.
 - o Black Lives Matter Task Force should be listed as a contributor.
 - o Measurable outcomes and goals will be coming soon.
 - o M. Udow-Phillips commented next step will begin to operationalize outcomes and measures.
 - o Feedback from this meeting will be consolidated into the document and brought back to the Board for action.
- Update on One Pager on Workforce Crisis
 - o T. Cortes discussed updates to the One Pager on Workforce Crisis (Attachment #9) to the Board.
 - o Consensus was received from the board to move forward with continued advocacy with GCSI and to share the document with MDHHS.
- Washtenaw County Board members appointed by Board of Commissioners with terms of 4/1/22-3/31/25
 - o K. Scott-Secondary Consumer
 - o A. LaBarre-Board of Commissioners Representative
 - o A. Rooks-Community Member (University of Michigan)
 - o B. King-Community Member
- R. Dornbos will be contacting the appointed members to swear them in prior to their appointments expiring

- 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 Plan

MOTION BY A. LABARRE, SUPPORTED BY R. JEFFERSON TO ADJOURN THE WCCMH BOARD MEETING.

Meeting adjourned at 10:46 AM.

DRAFT

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

In Person: Learning Resource Center-Michigan Room

4135 Washtenaw Ave, Ann Arbor, MI

Virtually: <https://zoom.us/j/98072275319>

April 22, 2022

9:30am

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

ROLL CALL: R. Jefferson attending in person
N. Graebner-Sundling attending remotely
B. King attending remotely
A. LaBarre attending remotely
A. Rooks attending remotely
D. Strong attending virtually
K. Walker attending in person

MEMBERS ABSENT: A. Dusbiber, B. Higman, K. Scott, M. Udow-Phillips

STAFF PRESENT: M. Harding, R. Dornbos, M. Taylor, L. Gentz, K. Snay, H. Linky, L. Hagle,
S. Amos O'Neal, S. Ray, M. Hershberger

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

K. Walker stated that Washtenaw CMH received a milestone notification this week and was certified as a CCBHC. Congratulations to the CMH Team and the hard work from M. Harding to make this happen. This opens the door to sustainable funding for CMH to provide services to the public.

There was not a quorum of WCCMH Board members present so no action was taken.

- I. Introductions
 - None
- II. Audience Participation
 - None
- III. Board response to audience participation
 - None
- IV. Consent Agenda Actions (Attachment #1)
 - WCCMH Board Meeting Minutes and Actions-2/25/22
 - CMHPSM Customer Services Policy
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 - WCCMH Consumer Advisory Council Meeting Minutes and Actions-2/9/22
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 - WCCMH Staff Spring Quarterly Newsletter
 - Program Education Presentation on Crisis Negotiation Team (CNT)
 - Millage Process, Investments and Progress Update
 - WCCMH CARES Report
 - Washtenaw County Sheriff's Office Millage Update

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THESE ITEMS WILL BE VOTED ON AT A FUTURE MEETING.

V. Treasurer's Report

- WCCMH Financial Status Report
 - M. Harding presented WCCMH Financial Status Report (Attachment #2) to the Board for the period ending February 28, 2022.

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THE WCCMH FINANCIAL STATUS REPORT WILL BE VOTED ON AT A FUTURE MEETING

- Millage and CCBHC Financial Status Report
 - M. Harding presented the Millage and CCBHC Financial Status Report (Attachment #3) to the Board for the period ending February 28, 2022.
- Contracts and Leases
 - M. Taylor presented the Contracts and Leases (Attachment #4) to the Board.

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THE CONTRACTS AND LEASES WILL BE VOTED ON AT A FUTURE MEETING

- Executive Director Authorizations
 - M. Taylor presented the Executive Director Authorizations (Attachment #5) to the Board.

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THE EXECUTIVE DIRECTOR AUTHORIZATIONS WILL BE VOTED ON AT A FUTURE MEETING

VI. Executive Director report

- M. Harding presented the Executive Director report to the WCCMH Board.
 - State Level Update
 - i. Director's Forum included a lot of discussion around CCBHC and Behavioral Health Home funding.
 - ii. Direct care wage was another hot topic and is awaiting State approval.
 - iii. Illinois and Ohio looked at redundancies in CMH system auditing. State of Michigan has committed to removing redundancies in auditing which would be a cost and resource savings.
 - iv. State is recognizing the lack of residential homes. Looking at the bill that will help to target homes for youth.
 - v. Statewide workforce crisis continues to be discussed and looking at potential solutions.

VII. CMHPSM Regional Update

- B. King discussed the April 13, 2022 Regional Board meeting
- The CMHPSM meeting minutes and actions from February 9, 2022 were reviewed.

VIII. New Business

- Consumer Advisory Council Quarterly Update
 - M. Hershberger presented the Consumer Advisory Council Quarterly update to the Board.
 - October's Celebration of Success will be in person this year after 2 years of virtual attendance.
 - September is the Walk-a-Mile event in Lansing.
 - Couple of new members that have joined the Consumer Advisory Council. Looking for Y&F or I/DD representatives for the committee.
 - M. Harding stated that the Consumer Advisory Council is a crucial part of the CCBHC requirements.
- Millage Advisory Committee Funding Requests Summary (Attachment #7)

- L. Gentz presented the Millage Advisory Committee Funding Requests to the Board.
 - NAMI funding request in the amount of \$225,900 for continuation of NAMI's Peer Support Services for 1 year.
 - Public Health Anti-Stigma funding request in the amount of \$340,000 for a 2 year contract
 - CHRT Communications Plan funding request in the amount of \$269,890 for 1 year

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THE MILLAGE FUNDING REQUESTS WILL BE VOTED ON AT A FUTURE MEETING

- Annual Recipient Rights Training for Board Members (Attachment #8)
 - K. Snay, Director of Recipient Rights, conducted the annual training for the board.
 - Recipient Rights Advisory Committee is looking for additional members. R. Dornbos will send the list of the committee members to the Board.
 - R. Dornbos will send out a signature sheet for the Board members not in attendance.
- Annual Conflict of Interest (Attachment #9)
 - The Annual Conflict of Interest policy was distributed to the board.
 - Board members will complete and return to R. Dornbos to fulfill their annual training requirements.
- Annual Ethics Statement (Attachment #10)
 - The Annual Ethics Statement was distributed to the board.
 - Board members will complete and return to R. Dornbos to fulfill their annual training requirements.
- WCCMH Board Officers for a term of 4/1/22-3/31/23
 - Chair-K. Walker
 - Vice-Chair-S. Antonow
 - Treasurer-N. Grabner-Sundling
 - Secretary-A. Dusbiber

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THE 2022-2023 WCCMH BOARD OFFICERS WILL BE VOTED ON AT A FUTURE MEETING

- WCCMH Committee assignments for a term of 4/1/22-3/31/23
 - K. Walker discussed the structure of the committee meetings when held virtually. He presented the proposed committee structure options for either virtually or in person and stated that we could not have a quorum of the board present for virtual committee meetings.
 - WCCMH Quality-Finance Committee
 - N. Graebner-Chair
 - S. Antonow
 - A. Dusbiber
 - B. Higman
 - D. Strong
 - M. Udow-Phillips
 - WCCMH Millage Advisory Committee
 - N. Graebner-Sundling-Chair
 - B. Higman
 - R. Jefferson
 - A. Rooks
 - M. Udow-Phillips
 - K. Walker
 - WCCH Executive Committee
 - K. Walker-Chair
 - S. Antonow

- A. Dusbiber
- N. Graebner-Sundling
- B. King
- A. LaBarre
- CMHPSM Regional Board
 - B. King
 - A. Rooks
 - K. Scott

THERE WAS NOT A QUORUM OF BOARD MEMBERS PRESENT SO THE 2022-2023 WCCMH BOARD COMMITTEE ASSIGNMENTS WILL BE VOTED ON AT A FUTURE MEETING

- IX. Old Business
 - CCBHC Update
 - M. Harding provided an update on CCBHC.
 - Strategic Planning Update
 - M. Harding updated the Board on the Strategic Plan.
 - Working on getting tactics to the board and looking to present to the board at the net meeting.
- 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

Meeting adjourned at 10:45 AM.

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

<https://zoom.us/j/93379257865>

December 13, 2021

2:30 pm

K. Walker called the meeting to order at 2:34 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. King attending remotely from Ann Arbor, Washtenaw County, MI
A. LaBarre attending remotely from City of Ann Arbor, Washtenaw County, MI
K. Walker attending remotely from Southgate, Wayne County, MI

MEMBERS ABSENT: None

STAFF PRESENT: T. Cortes, M. Harding, N. Phelps, R. Dornbos, S. Ray, H. Linky, K. Snay,
K. Diebboll, L. Gentz, S. Amos O'Neal

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

- I. Introductions
 - None
- II. Audience Participation
 - None
- III. Executive Committee Minutes and Actions
 - Executive Committee Minutes and Actions from 6/14/21 were reviewed (Attachment #1).

MOTION BY B. KING, SUPPORTED BY N. GRAEBNER-SUNDLING TO APPROVE THE MINUTES AND ACTIONS OF THE JUNE 14, 2021 WCCMH EXECUTIVE COMMITTEE MEETING.

ROLL CALL VOTE:

			NOT PRESENT AT TIME OF VOTE
ANTONOW	Y	DUSBIBER	
GRAEBNER-SUNDLING	Y	KING	Y
	NOT PRESENT AT TIME OF VOTE		
LABARRE		WALKER	Y

MOTION CARRIED

- IV. Discussion Items
 - None

A. LaBarre joined the meeting at 2:34pm
A. Dusbiber joined the meeting at 2:38pm

V. Old Business

- CCBHC Update
 - o M. Harding presented the CCBHC Update to the committee.

VI. New Business

- WCCMH 2022 Annual Board/Committee meeting schedule discussion (Attachment #2)
 - o T. Cortes discussed the proposed meeting schedule for the 2022 year.
 - o October meetings should be rescheduled due to October County holiday.
 - o The Program-Quality and Budget-Finance Committees will now be combined meetings for FY2022 and will be called Quality-Finance Committee.
- WCCMH 2022 Annual Board Calendar
 - o T. Cortes discussed the WCCMH 2022 Annual Board Calendar (Attachment #3).
- WCCMH Board Member terms expiring on March 31, 2022.
 - o K. Walker stated the following members will be up for reappointment. R. Dornbos will be contacting the members soon to work on their reappointments.
 - B. King-Community Member
 - A. LaBarre-Board of Commissioners Representative
 - A. Rooks-Community Member
 - K. Scott-Secondary Consumer
- WCCMH Executive Director Evaluation Discussion
 - o The process for the Executive Director evaluation was discussed.
 - o Request for R. Dornbos to send out the goals from last year to the WCCMH Board. Executive Committee would conduct the evaluation in January 2022 and make a recommendation to the full board.
 - o Suggestion to use the SWOT template for evaluation.
- Bylaw Changes
 - o The Bylaw Changes (Attachment #4) were discussed with the committee.
 - o This document will be brought to the December 17, 2021 WCCMH Board meeting for approval. Once the WCCMH Board approves then it goes to the Washtenaw County Board of Commissioners for final approval.

MOTION BY A. DUSBIBER, SUPPORTED BY S. ANTONOW TO APPROVE THE WCCMH BYLAWS AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	Y	DUSBIBER	Y
GRAEBNER-SUNDLING	Y	KING	Y
LABARRE	Y	WALKER	Y

MOTION CARRIED

- Strategic Planning Process Discussion (Attachment #5)
 - o M. Harding and T. Cortes discussed the Strategic Planning Process with the committee.
 - o The consolidated information will be reviewed by CMH staff and will bring back to Executive Committee to review at their next meeting.
 - o Suggestion to bring the CHRT and Unite documents to the WCCMH Board for the December meeting.

- VII. Items for Future Discussions
- Executive Director Evaluation
 - Strategic Planning

- VIII. Adjournment of Meeting

MOTION BY N. GRAEBNER-SUNDLING, SUPPORTED BY A. DUSBIBER TO ADJOURN THE WCCMH EXECUTIVE COMMITTEE MEETING.

MOTION CARRIED

The WCCMH Executive Committee Meeting was adjourned at 3:05 pm.

DRAFT

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

In person: Learning Resource Center-Michigan Room

4135 Washtenaw Ave, Ann Arbor

OR Virtually at <https://zoom.us/j/93652861382>

March 14, 2022

2:30 pm

K. Walker called the meeting to order at 4:10 pm.

ROLL CALL: N. Graebner-Sundling attending in person
B. King attending remotely
A. LaBarre attending remotely
K. Walker attending in person

MEMBERS ABSENT: S. Antonow, A. Dusbiber

STAFF PRESENT: T. Cortes, M. Harding, N. Phelps, R. Dornbos

OTHERS PRESENT: M. Billard

There was not a quorum of Executive Committee members present in person to conduct business at this meeting.

- I. Introductions
 - None
- II. Audience Participation
 - None
- III. Executive Committee Minutes and Actions
 - Executive Committee Minutes and Actions from 12/13/21 were reviewed (Attachment #1).

No action was taken. There was not a quorum for this meeting.

- IV. Executive Director Report
 - None
- V. Old Business
 - None
- VI. New Business
 - None
- VII. Items for Future Discussions
 - None
- VIII. Adjournment of Meeting

The WCCMH Executive Committee Meeting was adjourned at 4:12 pm.

**WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH QUALITY-FINANCE COMMITTEE MEETING MINUTES**

DRAFT

February 14, 2022

Learning Resource Center-Michigan and Huron Rooms (in person)

<https://zoom.us/j/94513867007> (virtual)

2:00 pm

ROLL CALL:

S. Antonow attending remotely
A. Dusbiber attending remotely
N. Graebner-Sundling attending in-person
B. Higman attending in person
D. Strong attending remotely-cannot count towards quorum
B. King attending remotely-cannot count towards quorum
M. Udow-Phillips attending in person
K. Walker attending in person

MEMBERS ABSENT:

R. Jefferson, K. Scott

STAFF PRESENT:

T. Cortes, M. Harding, N. Phelps, L. Hagle, S. Ray, H. Linky, k. Diebboll,
A. Igoe, B. Hagaman, T. Florence, C. O'Brien, K. Snay, S. Amos O'Neal,
M. Taylor, R. Dornbos

OTHERS PRESENT:

L. Lutomski, J. Martin, G. Nelson, K. Homan, T. Gavalier, M. Creekmore

N. Graebner-Sundling called the meeting to order at 2:05 pm.

I. Introductions

- None

II. Audience Participation

- None

III. Committee Response to Audience Participation

- None

A. Dusbiber joined the meeting virtually at 2:07pm

IV. Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions from 12/13/21.

- The Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions from 12/13/21 were reviewed. (Attachment #1)

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY B. HIGMAN TO APPROVE THE MINUTES AND ACTIONS FROM THE DECEMBER 13, 2021 BUDGET-FINANCE AND PROGRAM-QUALITY COMBINED COMMITTEE MEETING.

ROLL CALL VOTE:

ANTONOW	Y	DUSBIBER	Y
GRAEBNER-SUNDLING	Y	HIGMAN	Y

JEFFERSON	N/A	KING	N/A
SCOTT	N/A	STRONG	N/A
UDOW-PHILLIPS	Y	WALKER	Y

MOTION CARRIED

I. Financial Status Report

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

MOTION BY A. DUSBIBER SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE FINANCIAL STATUS REPORT ENDING DECEMBER 31, 2021 AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

II. Regional Finance Update

- N. Phelps presented the Regional Finance Update to the committee.
- The Regional budget amendment was not passed due to no quorum at the meeting.

III. Old Business

- CCBHC Update
 - o M. Harding presented an update on the CCBHC.
 - o Process is moving forward.

M. Udow Phillips joined the meeting at 2:16pm.

- General Fund Spending Update
 - o T. Cortes and N. Phelps presented an update on the General Fund Spending to date.
 - o Continuing to work with County Administration and Human Resources along with other external resources.
- One Pager on Workforce Crisis (Attachment #3)
 - o T. Cortes provided an update on the Workforce Crisis.
 - o K. Walker, M. Udow-Phillips and T. Cortes met with GCSI to look at other options.
 - o Suggestion to update the document to reflect the Governor's budget.
 - o This will come to the WCCMH Millage Advisory Committee and the Board meeting for final approval.

IV. New Business

- FY 2022 Budget Amendment (Attachment #4)
 - o N. Phelps presented the FY 2022 Budget Amendment to the committee.

o This budget amendment will be brought to the Washtenaw County Board of Commissioners meeting on March 2, 2022 for approval.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. DUSBIBER TO APPROVE THE FY 2022 BUDGET AMENDMENT AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- Program Education Presentation-CMH Nursing Program
 - o B. Hagaman, C. O'Brien and A. Igoe presented the CMH Nursing Program presentation to the committee (Attachment #5).
- Program Dashboard FY21 Quarter 4
 - o T. Florence and L. Higl presented the Program Dashboard FY21 Quarter 4 (Attachment #6) to the committee.
 - o There were no sentinel events for this period.

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY K. WALKER TO ACCEPT THE FY 2021 4TH QUARTER PROGRAM DASHBOARD AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- Annual Recipient Rights Report
 - o S. Thompson presented the Annual Recipient Rights Report (Attachment # 7) to the committee.
 - o The tri-annual assessment was completed virtually over a period of a month and WCCMH Recipient Rights Department received a full compliance rating.
 - o Request to see further information and benchmark data on providers recipient right's complaints/substantiations.

MOTION BY K. WALKER SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT THE FY 2021 ANNUAL RECIPIENT RIGHTS REPORT.

ROLL CALL VOTE:

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

MOTION CARRIED

- V. Items for Future Discussions
- Accounts Receivable
 - Cost Per Case Comparisons
 - Looking at call data and how it affects CARES Team
 - Access Department comparison presentation from pre-CCBHC and with CCBHC
 - CCBHC Performance Measures

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

- VI. Meeting adjourned at 3:28 pm.

**WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH QUALITY-FINANCE COMMITTEE MEETING MINUTES**

DRAFT

April 11, 2022

Learning Resource Center-Michigan Room (in person)

<https://zoom.us/j/95983442519> (virtual)

2:00 pm

ROLL CALL: S. Antonow attending remotely
A. Dusbiber attending remotely
B. Higman attending in person
B. King attending virtually-does not count as quorum
M. Udow-Phillips attending in person

MEMBERS ABSENT: N. Graebner-Sundling, K. Walker, K. Scott, D. Strong, R. Jefferson

STAFF PRESENT: T. Cortes, M. Harding, R. Dornbos, M. Taylor, L. Hagle, K. Hoener, L. Gentz, K. Snay, S. Amos O'Neal, S. Ray, M. Tasker, T. Florence, B. Hagaman

OTHERS PRESENT: L. Lutonski, D. Leahy, M. Creekmore, T. Gavalier, K. Snodgrass, K. Homan, M. Creekmore

S. Antonow called the meeting to order at 2:10 pm.

There was not a quorum of the Quality-Finance Committee present so no action was taken.

- I. Introductions
 - None
- II. Audience Participation
 - None
- III. Committee Response to Audience Participation
 - None
- IV. Quality-Finance Committee Meeting Minutes and Actions from 2/14/22.
 - The Quality-Finance Committee Meeting Minutes and Actions from 2/14/22 were reviewed. (Attachment #1)
 - There was not a quorum of the committee so this will be presented at the next Quality-Finance Committee meeting for approval.
- V. Financial Status Report
 - N. Phelps presented the Financial Status Report for the period ending February 28, 2022 (Attachment #2).
 - There was not a quorum of the Quality-Finance Committee so this will be presented at the April 22, 2022 WCCMH Board for approval.
- VI. Contracts and Leases
 - M. Taylor presented the Contracts and Leases to the committee (Attachment #3)

- There was not a quorum of the Quality-Finance Committee so this will be presented at the April 22, 2022 WCCMH Board for approval.
- VII. Executive Director Authorizations
- M. Taylor presented the Executive Director Authorizations to the committee (Attachment #4)
 - There was not a quorum of the Quality-Finance Committee so this will be presented at the April 22, 2022 WCCMH Board for approval.
- VIII. Regional Finance Update
- N. Phelps and T. Cortes presented the Regional Finance Update to the committee.
- IX. Old Business
- None
 - K. Walker stated that the Board will need to decide on what the committee membership is and whether they can allow virtual meetings under the current conditions. There cannot be a quorum of the Board present at Committee meetings so there will be 4-5 Board members on a committee and use recommendations instead of approval for motions.
 - R. Dornbos will be sending out an email to the Board asking what committee they would be interested in serving on.
 - If members need an ADA accommodation to attend the meetings virtually, please contact R. Dornbos.
- X. New Business
- Program Education Presentation on Crisis Negotiation Team (CNT) (Attachment #5)
 - K. Hoener and Sgt. J. Cratzenburg (WCSO) presented the Crisis Negotiation Team presentation to the committee.
 - CARES Report (Attachment #6)
 - L. Hagle and M. Tasker presented the CARES Report to the committee.
 - Chicago Lab Update
 - T. Cortes and L. Gentz provided an update on the Chicago Lab
- XI. Items for Future Discussions
- Accounts Receivable
 - Cost Per Case Comparisons
 - Looking at call data and how it affects CARES Team
 - CCBHC Performance Measures
 - Single point of entry for Substance Abuse Disorder
- XII. Meeting adjourned at 3:20 pm.

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

February 14, 2022

Learning Resource Center-Michigan and Huron Rooms (in person)

<https://zoom.us/j/95859718235> (virtual)

3:30 pm

N. Graebner-Sundling called the meeting to order at 3:40 pm.

ROLL CALL:

A. Carlisle attending remotely
N. Graebner-Sundling attending in person
H. Heaviland attending in person
B. Higman attending in person
D. Jackson attending remotely
J. Martin attending in person
R. Rion attending in person
G. Waddles, Jr. attending in person
M. Udow-Phillips attending in person
K. Walker attending in person

MEMBERS ABSENT:

R. Jefferson, B. King, A. LaBarre

STAFF PRESENT:

T. Cortes, L. Gentz, R. Dornbos, N. Phelps, T. Florence, E. Spring, K. Snay,
L. Higle, K. Diebboll

OTHERS PRESENT:

B. Saeed, S. Moffat, J. Bufford, T. Gillotti, M. Hammond, G. Nelson, K. Homan,
L. Lutomski, M. Creekmore

- I. Introductions
 - L. Gentz introduced E. Spring, M. Hammond, T. Gillotti, S. Moffat, J. Bufford, B. Saeed who will be available for questions on the funding requests portion of the agenda.
- II. Audience Participation
 - None
- III. Committee Response to Audience Participation
 - None
- IV. Millage Advisory Committee Minutes and Actions from 12/13/21 (Attachment #1)
 - Millage Advisory Committee Minutes and Actions of 12/13/21 were reviewed.

MOTION BY J. MARTIN, SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE MINUTES AND ACTIONS FROM THE DECEMBER 13, 2021 MILLAGE ADVISORY COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

CARLISLE	Y	GRAEBNER-SUNDLING	Y
HEAVILAND	Y	HIGMAN	Y
JACKSON	Y	JEFFERSON	N/A
KING	N/A	LABARRE	N/A

MARTIN	Y	RION	Y
UDOW-PHILLIPS	Y	WADDLES, JR.	Y
WALKER	Y		

MOTION CARRIED

V. Discussion Items

- Millage Process, Investments and Progress Update (Attachment #2)
 - L. Gentz presented the Millage Process, Investment and Progress Update (Attachment #2A) to the committee.

VI. Financial Budget Update (Attachment #3)

- N. Phelps presented the Financial Budget update ending December 31, 2021 to the committee.
- The FY2022 will show more funding being pushed out.
- Continuing to utilize the current funds as well as trying to spend down the fund balance.
- COVID has had a major impact on other projects but those should be going back soon.

VII. Old Business

- Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
 - D. Jackson presented the WCSO report for this month.
 - D. Jackson will forward the attachment to R. Dornbos for distribution to the committee.

VIII. New Business

- Strategic Planning Update
 - T. Cortes presented the Strategic Planning Update to the committee (Attachment #4).
- Funding Requests Summary
 - L. Gentz presented the following funding requests to the committee for approval (Attachment #5) totaling \$698,069.00.
 - Community, Leadership, Revolution (CLR) Academy in the amount of \$45,000.00 annual for 1 year (Attachment #5A).

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY H. HEAVILAND TO APPROVE THE COMMUNITY, LEADERSHIP, REVOLUTION ACADEMY FUNDING REQUESTS TOTALING \$45,000.00 FOR ONE YEAR AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- WCCMH Wraparound Position in the amount of \$85,305.00 annual continuous (Attachment #5B).

MOTION BY G. WADDLES, JR., SUPPORTED BY B. HIGMAN TO APPROVE THE WCCMH WRAPAROUND POSITON FUNDING REQUEST TOTALING \$85,305.00 ANNUALLY AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- Office of Community and Economic Development (OCED) Family Empowerment Program in the amount of \$69,576.00 annually for 3 years totaling \$210,218.00 (Attachment #5C)

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY J. MARTIN TO APPROVE THE OFFICE OF COMMUNITY AND ECONOMIC DEVELOPMENT FAMILY EMPOWERMENT PROGRAM FUNDING REQUEST IN THE AMOUNT OF \$69,576.00 ANNUALLY FOR 3 YEARS TOTALING \$210,218.00 AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- Office of Community and Economic Development (OCED) Michigan Ability Partners in the amount of \$347,546.00 annual for 1 year (Attachment #5D),
- A. Carlisle requested removal of the word CHRONIC from project criteria, board agreed. Proposal now reads:
The project will add leasing assistance and supportive services to 14 homeless, disabled 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.

MOTION BY K. WALKER , SUPPORTED BY M. UDOW-PHILLIPS TO APPROVE THE OFFICE OF COMMUNITY AND ECONOMIC DEVELOPMENT MICHIGAN ABILITY PARTNERS FUNDING REQUEST TOTALING \$347,546.00 FOR ONE YEAR WITH THE REMOVAL OF THE WORD CHRONIC FROM THE PROJECT CRITERIA.

ROLL CALL VOTE:

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

MOTION CARRIED

- Millage Advisory Committee members terms expiring on March 31, 2022.
 - The following Millage Advisory Committee members terms are set to expire:
 - B. King
 - A. LaBarre
 - A. Carlisle
 - G. Waddles, Jr.
 - Reminder that if the mentioned members are interested to continue on the committee to notify K. Walker in writing.
 - R. Dornbos will contact members for their intent to continue.

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 M. UDOW-PHILLIPS SUPPORTED BY H. HEAVILAND TO ADJOURN THE MEETING.

Meeting adjourned at **4:40** pm.

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

April 11, 2022

Learning Resource Center-Michigan Room (in person)

<https://zoom.us/j/93765775843> (virtual)

3:30 pm

A. Carlisle called the meeting to order at 3:37 pm.

ROLL CALL:

A. Carlisle attending in person
H. Heaviland attending in person
B. Higman attending in person
D. Jackson attending in person
B. King attending remotely (doesn't count as quorum)
R. Rion attending in person
G. Waddles, Jr. attending virtually (doesn't count as quorum)
M. Udow-Phillips attending in person

MEMBERS ABSENT:

N. Graebner-Sundling, R. Jefferson, A. LaBarre, J. Martin, K. Walker

STAFF PRESENT:

T. Cortes, L. Gentz, M. Harding, T. Florence, N. Phelps, M. Tasker, R. Dornbos, K. Snay

OTHERS PRESENT:

E. Spanier, J. Gardner, E. Serrano, G. Powers, L. Maharg, S. Ringler-Cerniglia, A. Rooks, L. Lutomski, K. Snodgrass, L. Lutomski, K. Homan, D. Leahy, M. Creekmore

There was not a quorum of Millage Advisory Committee members present so items will be brought to the April 22, 2022 WCCMH Board for approval.

- I. Introductions
 - L. Gentz introduced J. Gardner, L. Maharg, S. Ringer-Cerniglia, E. Spanier, G. Powers who will be available for questions on the funding requests portion of the agenda.
- II. Audience Participation
 - None
- III. Committee Response to Audience Participation
 - None
- IV. Millage Advisory Committee Minutes and Actions from 2/14/22 (Attachment #1)
 - Millage Advisory Committee Minutes and Actions of 2/14/22 were reviewed.
 - There was not a quorum of the committee so these items will be reviewed at the next Millage Advisory Committee meeting.
- V. Discussion Items
 - Millage Process, Investments and Progress Update (Attachment #2)
 - o L. Gentz presented the Millage Process, Investment and Progress Update the committee.
 - CARES Dashboard (Attachment #3)

- o M. Tasker presented the CARES Dashboard to the committee.

VI. Financial Budget Update (Attachment #4)

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

VII. Old Business

- Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
 - o D. Jackson presented the WCSO report for this month.
 - o D. Jackson will send the presentation from this meeting to R. Dornbos to distribute to the committee.
 - o This presentation will go to the County Board of Commissioners for approval.

VIII. New Business

- RFP Scope Discussion
 - o L. Gentz discussed the possibility of presenting another Housing RFP. Primary categories from previous RFP's-crisis housing/prevention and stabilization supports/youth crisis prevention and stabilization.
 - o Working with Office of Community and Economic Development (OCED) on categories and bringing this back to the committee.
- Funding Requests Summary (Attachment #5)
 - o L. Gentz presented the following funding requests to the committee for approval totaling \$835,790.00.
 - NAMI in the amount of \$225,900.00 annual for 1 year (Attachment #5A).
 - a. There was not a quorum of the Millage Advisory Committee present so this will be brought to the April 22, 2022 WCCMH Board meeting for approval.
 - Public Health Anti-Stigma Campaign in the amount of \$340,000.00 annual for 2 years. (Attachment #5B).
 - a. Arabic should be included on this proposal.
 - b. There was not a quorum of the Millage Advisory Committee present so this will be brought to the April 22, 2022 WCCMH Board meeting for approval.
 - CHRT Communications Strategy Plan in the amount of \$269,800.00 annual for 1 year. (Attachment #5C)
 - a. There was not a quorum of the Millage Advisory Committee present so this will be brought to the April 22, 2022 WCCMH Board meeting for approval.

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

Meeting adjourned at 4:40pm.

REQUEST: To approve recommendations to the board for the following contract(s) and lease(s):

BACKGROUND:

1. Vintage Specialized Services, LLC DBA Creekside Residential Services- West: will provide Licensed Residential Services.
2. Elite AFC: will provide Licensed Residential Services.
3. Rose Hill- will provide Licensed Residential Services.
4. Cliff Corp- group home lease.
5. Illuminate ABA, LLC- will provide Applied Behavior Analysis Services.
6. Ivyrehab Michigan, LLC- will provide Applied Behavior Analysis Services.
7. Maxim- will provide Private Duty Nursing Services.

Service Contracts

Contractor	Funding	Estimated Budget	Contract Term	Service Description
1. Vintage Specialized Services, LLC DBA Creekside Residential Services-West	Medicaid	Per Consumer Authorizations	March 1, 2022-September 30, 2022	Licensed Residential Services
2. Elite AFC	Medicaid	Per Consumer Authorizations	January 25, 2022-September 30, 2022	Licensed Residential Services
3. Rose Hill Center, Inc.	Medicaid	Per Consumer Authorizations	March 1, 2022-September 30, 2022	Licensed Residential Services
4. Cliff Corp	Medicaid	\$9,000	January 1, 2022-March 31, 2022	Group Home Lease
5. Illuminate	Medicaid	Per Consumer Authorizations	April 15, 2022-September 30, 2022	Applied Behavior Analysis Services
6. Ivyrehab Michigan, LLC	Medicaid	Per Consumer Authorizations	April 1, 2022-September 30, 2022	Applied Behavior Analysis Services
7. Maxim	Medicaid	Per Consumer Authorizations	April 1, 2022-September 30, 2022	Private Duty Nursing Services

REQUEST: To approve recommendations to the board for the following contract(s) and lease(s):

BACKGROUND:

1. E3 Achievement: will provide pre-vocational/skill building services for an out-of-county client.
2. Young Life: will provide summer respite camp services.
3. Tender Hearts, Inc.: will provide licensed residential services.
4. CLR Academy: will provide Beyond Sport Programming to young individuals who are incarcerated at Washtenaw County Youth Center, young individuals who reside in the Sycamore Meadows neighborhood, and young individuals who reside in the Parkridge neighborhood.

Service Contracts

Contractor	Funding	Estimated Budget	Contract Term	Service Description
1. E3 Achievement	Medicaid	Per Consumer Authorizations	June 15, 2022- September 30, 200	Pre-vocational/Skill Building Services
2. Young Life	Medicaid	Per Consumer Authorizations	June 1, 2022- September 30, 2022	Respite Camp Services
3. Tender Hearts, Inc.	Medicaid	Per Consumer Authorizations	June 1, 2022- September 30, 2022	Licensed Residential Services
4. CLR Academy	Millage	\$45,000	May 1, 2022- April 30, 2023	Beyond Sport Programming

**Executive Director Contract Authorizations
April 2022 Finance Committee Meeting**

REQUEST: Recommend acceptance of the Executive Director's signature on contracts with a value of less than \$25,000

Contractor	Amount	Term	Purpose	Approval Date
JCJ Contracting	\$3,438	9/10/21-9/30/21	Driveway Repair	11/19/2021
Michigan Theatre	\$2,320	2/16/2022	WCCMH Private Screening of "Summer of Soul"	
National Council for Mental Wellbeing	\$12,850	1/18/22-9/30/22	Daily Living Activities-20 Training Module	
Althea Wilson	\$5,000	1/1/22-9/30/22	Community Anti-Racism Education Trainings	
U.S. Transport Service	\$5,000	4/1/22-4/15/22	Coordinate and Provide Supervised Transportation from Out-of-State Residential Facility	
Shanna Kattari	\$5,000	6/1/22-9/30/22	Alphabet Soup & Treating Equality: inclusivity in Healthcare Trainings	

**Executive Director Contract Authorizations
June 2022 Finance Committee Meeting**

REQUEST: Recommend acceptance of the Executive Director's signature on contracts with a value of less than \$25,000

Contractor	Amount	Term	Purpose	Approval Date
JCJ Contracting	\$3,438	9/10/21-9/30/21	Driveway Repair	11/19/2021
Michigan Theatre	\$2,320	2/16/2022	WCCMH Private Screening of "Summer of Soul"	5/9/2022
National Council for Mental Wellbeing	\$12,850	1/18/22-9/30/22	Daily Living Activities-20 Training Module	5/9/2022
Althea Wilson	\$5,000	1/1/22-9/30/22	Community Anti-Racism Education Trainings	5/9/2022
U.S. Transport Service	\$5,000	4/1/22-4/15/22	Coordinate and Provide Supervised Transportation from Out-of-State Residential Facility	5/9/2022
Shanna Kattari	\$5,000	6/1/22-9/30/22	Alphabet Soup & Treating Equality: inclusivity in Healthcare Trainings	5/9/2022
Issue Media Group, LLC	\$12,000	6/1/22-5/31/23	Voices of Youth Programs	

DMH Coffee DBA Bearclaw Coffee Catering	\$5,000	5/12/22-9/30/22	Bimonthly mobile coffee services for WCCMH sites	
Teen Turn Challenge Program	\$6,180	6/1/22-5/31/23	Athletic, educational, and outreach events for youths	

Millage Funding Summary April 2022

NAMI:

Goals: Continuation of NAMI's Peer Support Services

What: Targeted populations are families and youth in communities with higher rates of mental health issues that currently are not being addressed. (Neighborhoods in Ypsilanti Township will include—but not be limited to—Parkridge, Sugarbrook, and Sycamore Meadows.) Expanding to include Saline and Milan.

- Complete development of a user-friendly, comprehensive booklet listing mental health services in Washtenaw County and informing the public on how to access care. We'll distribute copies to our partners, in community venues throughout the county, and at community events. A digital version will be available as well.
- Craft smart, concise online communications about mental health topics, including how to access services. These messages will be distributed via social media, YouTube, podcasts, and other online media used by our target populations.
- Continue offering presentations (Ending the Silence and Mental Health 101) focused on the need for early intervention, suicide prevention, reduction of stigma, and access to appropriate care. Preferred venues are schools, places of worship, and other community venues — in person, when possible.
- Conduct more NAMI Family and Friends programs, 4-hour seminars for people who have loved ones with a mental health condition. Participants will learn about diagnoses, treatment, recovery, communication strategies, crisis preparation and NAMI resources.
- Refer individuals in crisis and unable to gain immediate access to our services to NAMI Basics OnDemand, a free, 6-session online education program for parents, caregivers and other family members who provide care for youth experiencing mental health symptoms.
- Assemble a calendar of public (outdoor) events hosted by target area schools and communities and attend every event with our table, banner, and materials. NAMI volunteers will engage with event attendees on mental health topics and increase awareness of available resources, including NAMI's.
- Mount a Community Event for Families and Youth with our collaborating organizations.

Funding Amount: 1 year contract total \$225,900

Public Health Anti-Stigma Campaign:

Goals: Continuation of the Public Health Anti-Stigma Campaign for an additional 2 years.

What: Major elements of the work include:

- Work with target audiences to develop, refine, review messages and themes
- Review, revise, and expand existing themes for both youth and their trusted adults/parents/caregivers
 - Include more detailed content on seeking services, normalizing seeking help and navigating mental services and support
 - Develop messaging and content that resonates with and supports LGBTQ youth and their families
 - Incorporate Spanish content including developing messages/themes with community members who speak languages other than English
- Prioritize additional strategies for sharing messages (new artwork, formats, murals, merch, platforms, etc.)
- Continue connecting to CARES and promoting youth access

- Disseminate campaign resources through multiple channels, formats, partners, and community outreach
- Track visibility and impact

Funding Amount: 2 year contract total- \$340,000

CHRT Communication Strategy:

Goals: Continuation of the CHRT millage communications strategy

What:

1. **Vignettes.** Continue to produce a quarterly vignette series sharing information about the millage with new participant photos and artwork; create vignettes that resonate with specific audiences, such as youth and families; produce three vignettes per quarter. Due date: Quarterly.
2. **Communications.** Continue to develop and release announcements about newly funded services, staff spotlights, blog posts, Q&As, and press releases. Post original content on WCCMH website and social media accounts; disseminate quarterly newsletter; pitch stories to local news outlets, such as Groundcover News, Ann Arbor Observer, and Connected Magazine. Due date: Quarterly and ad hoc.
3. **Promotion.** Promote twelve vignettes as well as the vignettes, annual report, and video from CHRT's 2021-2022 millage communications contract through online ads, print ads, billboard ads, bus ads, social media platforms, e-newsletters, and more. Due date: Quarterly.
4. **Underwriting.** Continue underwriting contract with Second Wave Media (Concentrate) to publish three (3) stories per quarter on MHSUD concerns in local publications; ensure Concentrate credits the millage for underwriting all applicable MHSUD stories. Due date: Quarterly.
5. **Impact reporting.** Create and publish materials that describe the programs and services made available through millage funding; work with the WCCMH business team to develop and regularly update a data dashboard on millage investments and impacts. Due date: Quarterly and Q4.
6. **Community event.** Host a movie night at the Michigan Theater with a feature-length film about MHSUD concerns; show the millage video and distribute information about millage-funded programs and services. Due date: Prior to March 31, 2023.
7. **Materials.** Develop and distribute print materials to promote millage services, such as posters, flyers, postcards, magnets, brochures, and more. Due date: Q3 and Q4.
8. **Website maintenance.** Continue to post original content on millage microsite and monitor web metrics on a quarterly basis to evaluate success of advertising strategies. Manage news and announcement posts for WCCMH staff. Due date: Quarterly and ad hoc.

Funding Amount: 1 year contract total- \$269,890

NAMI Washtenaw County

DATE SUBMITTED	CMH – Contract Proposal 2022
SUBMITTED TO	WCCMH – Millage Advisory Committee
SUBMITTED BY	NAMI Washtenaw County (National Alliance on Mental Illness)

I. PROJECT DESCRIPTION

A. STATEMENT OF PROBLEM TO BE ADDRESSED	Awareness and utilization of services for people with mental health needs is not spread equally among Washtenaw County residents. Until 2019, NAMI Washtenaw County's peer services were not widely known of or utilized by residents outside the Ann Arbor/Dexter/Chelsea areas. However, with passage of the Mental Health and Public Safety Millage in 2017 and the expansion of our contract with WCCMH in 2019, NAMI Washtenaw engaged in a major effort to reach out to three underserved communities—Ypsilanti, Ypsilanti Township, and Whitmore Lake—to engage residents in conversations around mental health topics, ascertain mental health needs, and spread awareness of mental health resources throughout the county, including those offered by NAMI WC. Going forward, we will build on the outreach and education strategies we've developed over the past three years, spreading awareness of mental health concerns among youth and parents in underserved areas of the county: the importance of early assessment and intervention, service navigation, reduction of stigma, and the building and maintenance of social supports. Other underserved communities in Washtenaw County include (but are not limited to) Milan and Saline. NAMI WC will work with local school administrators and counselors to bring NAMI education to youth and parents in target schools and other districts by request.
B. GOALS & OBJECTIVES	NAMI WC provides peer services in partnership with 6 mental health service sectors: CMH, hospitals and community clinics, the criminal justice system, housing, schools, and faith organizations. We will continue working with service providers and community residents in these sectors to deepen our awareness of (a) existing mental health challenges in the populations they serve, (b) the barriers individuals face in accessing services, and (c) where the gaps in service are. NAMI will further develop outreach plans to facilitate learning about mental health conditions, resources, and supports available in Washtenaw County. Specific outreach activities will be developed according to the needs and situation of each targeted population. Activities will start with culturally competent conversations that result in specific action plans (involving education, support, and advocacy) that improve navigation through service systems and reduce stress and trauma. We aim to spread NAMI's message that recovery is possible with appropriate care and support as widely as possible throughout the county.
C. TARGET POPULATION	Targeted populations are families and youth in Ypsilanti, Ypsilanti Township, and Whitmore Lake. (Neighborhoods in Ypsilanti Township will include—but not be limited to—Parkridge, Sugarbrook, and Sycamore Meadows.) NAMI WC may also make educational presentations in other underserved school districts upon request by district administrators.
D. PROJECT ACTIVITIES	In broadening our reach to include communities such as Milan and Saline, we will conduct a series of key informant interviews to ascertain mental health needs. We will then take what we've learned in past focus groups, in the many key informant interviews we have conducted and will conduct, and from providers

about mental health challenges in all of our target communities and use it to implement further outreach and education activities. We will:

- Complete development of a user-friendly, comprehensive booklet listing mental health services in Washtenaw County and informing the public on how to access care. We'll distribute copies to our partners, in community venues throughout the county, and at community events. A digital version will be available as well.
- Craft smart, concise online communications about mental health topics, including how to access services. These messages will be distributed via social media, YouTube, podcasts, and other online media used by our target populations.
- Continue offering presentations (Ending the Silence and Mental Health 101) focused on the need for early intervention, suicide prevention, reduction of stigma, and access to appropriate care. Preferred venues are schools, places of worship, and other community venues — in person, when possible.
- Conduct more NAMI Family and Friends programs, 4-hour seminars for people who have loved ones with a mental health condition. Participants will learn about diagnoses, treatment, recovery, communication strategies, crisis preparation and NAMI resources.
- Provide the phone number (734-544-3050) for Washtenaw County Access and Crisis Services — a local, round-the-clock resource provided by CMH for individuals experiencing mental health symptoms — in all our publications and presentations.
- Refer individuals in crisis and unable to gain immediate access to our services to NAMI Basics OnDemand, a free, 6-session online education program for parents, caregivers and other family members who provide care for youth experiencing mental health symptoms.
- Assemble a calendar of public (outdoor) events hosted by target area schools and communities and attend every event with our table, banner, and materials. NAMI volunteers will engage with event attendees on mental health topics and increase awareness of available resources, including NAMI's.
- Mount a Community Event for Families and Youth with our collaborating organizations.

II. Measureable (Outputs) & Outcomes

Enrollment statistics from our Family Education series show that for the past several years, less than 10% of class participants have been from the 48197, 48198, and 48189 zip codes, our targeted communities in the past 3 years. Likewise, few class participants have been from communities to the south of Ann Arbor. Our experience with education, support, and advocacy has shown that change begins when communities understand and accept what mental health challenges “look like” and how stress and trauma exacerbate situations involving parents and youth. When affected individuals receive education and support and learn how to navigate service systems, some of the burden on service providers, emergency rooms, police, and hospitals is reduced.

Communities that understand the early signs of poor mental health in their youth and know where to find resources will be more likely get their sons and daughters the help they need early on, thereby improving mental health outcomes. And having similar conversations with families and youth at schools and community gatherings creates an atmosphere of shared learning, in turn reducing stigma.

Through this type of outreach, we would expect to see an increased demand for existing NAMI signature programs: Peer to Peer, Family to Family, Support Groups, and Ending the Silence. We would also expect increased demand for other NAMI programs offered by our affiliate: NAMI Faith Net; NAMI Family and Friends, a 4-hour seminar for people who have loved ones with a mental health condition; and Parents Together, a support group for parents of children with suicidal ideation. Finally, with the publication and wide distribution of our comprehensive resource guide, we would expect to see individuals and families with mental health needs have an easier time of navigating systems and accessing appropriate, quality care.

In addition, the NAMI Smarts program will assist target communities in learning how to advocate for themselves at the local level. Our aim is to develop knowledgeable and engaged groups of people who can guide health and wellness activities in the 6 mental health service sectors: CMH, hospitals and community clinics, the criminal justice system, housing, schools, and faith organizations.

III. Organization Mission and Goals and History of our accomplishments:

NAMI Washtenaw County is an affiliate of National Alliance on Mental Illness, the largest national grassroots organization dedicated to improving the lives of people living with mental health conditions and their loved ones, who live in support. We've been active in Washtenaw County as a resource for all those affected by mental health challenges for 38 years. NAMI WC has been presenting information about mental health in schools, faith organizations, and other community venues for over 9 years. In 2018, our team of over 70 trained volunteers reached over 2400 community members (over 1500 students under age 18) and logged over 5,000 volunteer hours. Early in 2020 when the pandemic struck, our team of 70+ volunteers quickly pivoted to conducting all of our classes and all but one of our support groups online. Enrollment in these online classes and support groups has continued at pre-pandemic levels, in some instances increasing due in part to the uptick in mental disorders attributable to the pandemic and in part to the ease of accessing online classes and groups from home.

NAMI Washtenaw County provides:

- Education about mental health via Peer-to-Peer classes (for people living with a mental health condition and taught by certified peers with similar lived experience); Family-to-Family classes (for people living in support of a loved one and taught by certified peers with similar lived experience); NAMI Family and Friends, a 4-hour seminar for people who have loved ones with a mental health condition; Ending the Silence presentations (for students, teachers, staff, and parents); and Mental Health 101 presentations (for the general public). Prior to the pandemic, NAMI volunteers attended bimonthly sessions of the Mental Health Treatment Court to talk with court participants and their families and acquaint them with NAMI resources they could turn to for help. NAMI volunteers also conducted Peer-to-Peer classes for court participants and other P2P classes in the jail. These activities will resume when social distancing is no longer necessary.
- Support groups for young adults, older adults, people living with a mental health condition, people living in support, parents of children with suicidal ideation, and people seeking a faith component in their journey toward mental health. Also, NAMI volunteers make weekly or biweekly visits to inpatient psychiatric units at Michigan Medicine and St. Joe Hospitals in Ypsilanti and Chelsea to offer support and share information about peer-support activities at NAMI WC with residents and their families. This Hospital Visitation program has existed since 2017.
- Advocacy activities to overcome stigma and discrimination and improve the visibility and quality of mental health care in our community.

History of NAMI Washtenaw County's experiences in support of youth mental health:

In 2017 and 2018, NAMI Washtenaw County's team of Ending the Silence presenters delivered information to over 1700 youth and over 200 teachers and parents in Saline, Ann Arbor, Dexter, Ypsilanti, and Howell school districts on the warning signs of mental health disorders in youth and how to respond to get them help. In-person presentations at schools around the county continued through 2019, but early in 2020, the pandemic necessitated a pivot to mostly online presentations of Ending the Silence. Despite the challenges of the new online format, in 2020 and 2021, our team of volunteers made 35 presentations of Ending the Silence, the majority aimed at individuals in our target zip codes, reaching over 600 students, teachers and parents. We have now trained 29 people in Washtenaw County to present Ending the Silence.

A NAMI WC support group for parents of suicidal children ages 12 – 25 was established in August 2017 with the support of Community Mental Health, Washtenaw County Public Health, and the University of Michigan Depression Center. It continues to meet twice a month, with 40 parents on the mailing list and an average of 10 – 11 participants per meeting.

Following are new youth-focused activities we've initiated in the past two years:

- We partnered with the Corner Health Center in Ypsilanti to launch a new Peer-to-Peer class for young adults (ages 18 – 25) in October 2020. Two months later, we formed a new support group, NAMI Young Adult, for adults ages 18 – 30.
- We partnered with Ypsilanti Community Schools in July 2021 to conduct "Boots on the Ground." This was a door-to-door outreach partnership with YCS and other local nonprofits in Ypsilanti neighborhoods to discuss NAMI WC's mental health resources along with YCS resources and enrollment.
- Mental health disorders often present for the first time in teens and young adults as a mental health crisis. We partnered with Michigan Medicine and Community Mental Health last fall to present a 3-part webinar, "Navigating a Mental Health

Crisis: Before, During, and After.” A total of 335 people registered for the event and, as of early 2022, nearly 1,000 people had visited the event landing page and about 240 had viewed the webinar on YouTube.

IV. AFFILIATIONS WITH SIMILAR ORGANIZATIONS

NAMI Washtenaw County is an affiliation of the NAMI State and NAMI National organizations.

TIMELINE

ACTIVITY	PROJECTED DATE
Outreach to partners and community via community events and key providers (existing service agencies) in 6 sectors	Fall 2022
Recruitment for and training of Peer Companions, Community Leaders	Ongoing
Development and implementation of strategic plan to train community peer companions, expand NAMI signature programs and provide information to (and advocate among) providers regarding policies and practices in underserved areas of the county.	Winter 2022 – Ongoing
Hold community-wide Youth and Family Mental Health Event (Generation Stigma Free), inviting families and youth to take part in presentations by local providers and professional associations.	Fall 2023

V. BUDGET

EXPENSE			
CATEGORY	AMOUNT		
Program Coordination/Staff	\$155,000	3.5 FTE's	
Outreach Supplies, Mileage, Swag, Food	\$10,000		
Social Media, Marketing, Web Support	\$8,000		
Volunteer Stipends for Community Leaders and Peer Companions	\$17,000		
Materials and Printing	\$7,000		
Youth and Family Conference	\$7,500		
Volunteer Training	\$4,500		
Office Support/Professional Fees	\$16,900		
TOTAL	\$225,900		

LONG-TERM SOURCES / STRATEGIES FOR FUNDING

Strengthen and collaborate with existing agencies and providers (in the 6 sectors) to continue education, support and advocacy around mental health conditions. Provide trained and experienced peer service providers (following NAMI signature peer programs) which can be incorporated into ongoing (expanded) agency budgets. Provide advocacy stories and information from key informant interviews which can improve and re-direct funding and improve policies and practices. Collaborate with existing data gathering and research organizations (WISD CHRT, WHI, WCCMH, Michigan Medicine-SJMHS) to ensure peer perspectives are represented. Conduct our own major fundraising event (rather than partnering and sharing half the proceeds with the state organization), a 5k walk at a park in Washtenaw County. Continue to reach out to and build relationships with potential major donors and grantors.

VI. EVALUATION

NAMI WC will develop an evaluation plan for a process and outcome evaluation that documents NAMI WC efforts and improved outcomes among the 6 service sectors and our targeted communities. Basic data will be gathered for NAMI WC program activities, including demographic information and attendance, training assessments by participants, follow-up assessments by participants, and evaluation assessments by key agency collaborators. Periodic progress reports will be provided to WCCMH Millage Advisory Board and WCCMH staff.



Wish You Knew Mental Health Campaign

Continuation Proposal – April 2022

Washtenaw County Health Department (WCHD) is pleased to propose continuing work on the Wish You Knew Mental Health Campaign ([#WishYouKnew](#)) in partnership with Washtenaw County Community Mental Health (CMH), area youth, community members and community partners. The goal is to provide a community-driven campaign focused on youth mental health and reducing stigma. Primary audiences include area youth and their trusted adults and caregivers.

Background

Driven by community conversations and feedback, the Wish You Knew Washtenaw campaign aims to spark honest and supportive conversations about mental health between youth and adults and to spread hope. If we can share our truth with trusted people in our lives, we can begin to heal. Wish You Knew was developed in 2019 and funded for two years through the Washtenaw County Mental Health and Public Safety Preservation Millage. It was extended through a third year during the pandemic (no-cost extension).

The COVID-19 pandemic reduced available staffing and interrupted planned activities. The Health Department requested a one-year extension and finished the initial implementation the end of March 2022. This included an additional round of paid advertising with campaign themes as well as continued distribution of resource materials and themed items like stickers with area youth and schools and ongoing social media content. In addition the COVID pandemic has undoubtedly exacerbated [mental health concerns](#) and stressors for youth.

Outcomes included developing a meaningful and recognizable framework for sharing mental health messages and resources. The voices of local youth and trusted adults were collected and shared with original artwork and through a variety of outlets and partners. The campaign successfully established an online and community presence and connected to community through partners, advertising, and resource materials. Platforms included social media, billboard and bus advertising, videos in movie theaters and streaming, and merchandising (stickers, magnets, art prints, etc.). Examples of reach included material distribution in 34 schools and counting (preK-12) and across 10 districts.

In 2021, paid advertising reach included: Spotify (1/6/21 – 2/5/21) 132,486 plays, about 10 clicks to webpage per day; Comcast streaming (2/1/21 – 5/30/21) 60,576 plays; and billboards (3/1/21 – 4/25/21) with an estimated reach of 900,000 based on locations and visibility. The Wish You Knew Instagram ended 2021 with 929 followers and 11,065 impressions for the year. The main Wish You Knew website page had 1,310 unique visitors in 2021.

In 2022, the Wish You Knew Instagram reached 79% more accounts (338) compared to the last three months of 2021. Total Instagram followers remained consistent in the first three months of 2022. To increase campaign recognition and visibility, additional bus and billboard advertising was launched in March 2022. The billboard campaign consists of three poster and two digital ads in the Ypsilanti/Ann Arbor area that together receive a total of over 360,000 weekly impressions.

COVID-19 impact

The COVID-19 pandemic has very likely exacerbated mental health needs and challenges, and Wish You Knew is more critical as a resource and framework for supporting conversations and access. Unfortunately, the demands of the pandemic response on the Health Department staff reduced staffing for Wish You Knew during 2020. Some planned work was postponed, especially interactive events and gatherings. The campaign has continued to share information and resources in the pandemic context. Staffing gaps have been filled and additional, permanent staffing is now in place moving forward.

Moving Forward

Washtenaw County Health Department proposes continuing the campaign for an additional two-year period at a total cost of \$340,000. The proposed project period is May 1, 2022-April 30, 2024, or two years starting as soon as a contract is finalized.

Staffing resources include time from our communications coordinator(s), administrator, and temporary staff (either masters-level intern(s) or a community health worker). As with the initial development of the campaign, the support, expertise, and collaboration of CMH staff, community partners, service providers and community members are critical to forming, reviewing, and carrying out planned activities. Notably, when Wish You Knew was originally developed and launched, the Washtenaw County Racial Equity Office and the BLM Taskforce were not yet established but will now be included.

Funds and incentives are budgeted to support community involvement and participation. Additional funding will provide for contracts with vendors, such as artists, video production, advertising platforms and to support community engagement or activities in response to input gathered.

Major elements of the work include:

- **Work with target audiences to develop, refine, review messages and themes**
 - Target audiences will continue to focus on youth and their trusted adults with a primary focus on communities of color, Ypsilanti youth, and [prioritized communities and populations](#)
 - Review, revise, and expand existing themes for both youth and their trusted adults/parents/caregivers
 - Include more detailed content on seeking services, normalizing seeking help and navigating mental services and support
 - Develop messaging and content that resonates with and supports LGBTQ youth and their families
 - Incorporate Spanish, Arabic or other non-English language content. including developing messages/themes with community members who speak languages other than English
 - Prioritize additional strategies for sharing messages (new artwork, formats, murals, merch, platforms, etc.)
 - Continue connecting to CARES and promoting youth access
- **Disseminate campaign resources through multiple channels, formats, partners, and community outreach**
- **Track visibility and impact**

More information about how implementing the proposed work is outlined below.

Campaign Elements	Resources Needed	Non-staff Costs
<u>Message development/revision:</u> Work with stakeholders to refine, check or expand campaign messages, elements, activities, images, etc. Methods include focus group discussions, key informant interviews, surveys, existing listserv (~250).	Staff time with intern or temporary staff support Access to stakeholders (partners, advocates, clients, youth, target audiences, youth leaders, community organizations, etc.)	Gift cards, incentives for youth, community members ~\$25 per participant, for participant raffles, refreshments, etc.
<u>Advertising (paid):</u> Make sure campaign messages reach target audiences ideally from multiple places and through multiple channels. Can be targeted (specific publications, social platforms, events) or broad (bus ads, billboards). Paid ads on social media can be affordable, ongoing and targeted (if audience is using platform).	Staff time or consultation for photography, graphic design, and contract execution Ongoing staff time to keep messages/materials circulating and tie to timely events, news, observances, program activities, etc.	Ad placement. Costs vary greatly depending on length and type (billboard, bus, online or print)
<u>Networking/implementation:</u> Work with partners, leaders, groups to utilize, adapt, disseminate messaging/tools. Develop or enhance additional resources as appropriate (e.g. school campaigns).	Partners, community members, leaders Targeted settings	Supportive materials, resources, or merchandise
<u>Campaign materials/resources:</u> Expand message reach with print materials or “SWAG” carrying messages/images and promoting resources. “Merch” for youth audiences. Examples art posters, magnets, referral cards, stickers, buttons, clothing, fidget toys, stress relievers, etc.	Staff time for design, artwork, photography, ordering. Translation into multiple languages, as appropriate. Staff time to distribute directly to partners, community members, etc.	Cost vary by item, quantity, design Translation costs, as needed
<u>Tracking and evaluation:</u> Reach of ads and messages can be tracked (i.e. impressions, social media insights or interactions, web hits). If the campaign format requests an action, such as visiting a website or getting vaccination, actions can be tracked. Focus groups or surveys can be used to ask members of targeted audiences if they saw messages and to provide feedback.	Staff time to develop or carry out strategies. Analyze and report or share results.	Incentives/gift cards if focus groups or surveys are used.

Washtenaw County Health Department prepared this information as of March 24, 2022.



CHRT

15 years of
Improving Health. Informing Policy

WASHTENAW COUNTY PUBLIC SAFETY AND MENTAL HEALTH
PRESERVATION MILLAGE ADVISORY COMMITTEE

Improving access to millage-funded programs and services

MARCH 31, 2022

CENTER FOR HEALTH AND
RESEARCH TRANSFORMATION
4251 Plymouth Road,
Arbor Lakes 1, Suite 2000,
Ann Arbor, MI 48105-3640
chrt-info@umich.edu

COMMUNICATIONS REPORT / PROPOSAL

CHRT

Improving awareness of millage-funded programs and services

From April 2021 – March 2022, the communications team at the Center for Health and Research Transformation (CHRT) has worked to ensure that Washtenaw County residents understand how to access the many new programs and services funded by the county's Public Safety and Mental Health Preservation Millage.

Thanks to Washtenaw County voters, who passed the eight-year millage in 2017, Washtenaw County Community Mental Health has been able to offer mental health and substance use treatment and recovery services to all Washtenaw County residents, regardless of their insurance status or ability to pay for services, since the spring of 2019 (millage funding became available on January 1, 2019).

Last spring, Washtenaw County Community Mental Health and the Public Safety and Mental Health Preservation Millage Advisory Committee set aside funding to allow CHRT, a non-profit health policy center at the University of Michigan, to announce new millage-funded services, describe and promote them to key stakeholders and the public, and ensure that Washtenaw County residents know how to access these services.

CHRT's work was commissioned by the Millage Advisory Committee for the sum of \$282,888 with the understanding that a large portion of these funds would support businesses, creators, and entrepreneurs. The money has been used for this purpose and within these constraints.

In the pages that follow, CHRT:

- describes the strategic communications activities undertaken during CHRT's 2021 – 2022 millage communications contract;
- reports on the known impact of these communications activities, as of March 31, 2022;
- provides samples of several communications deliverables from CHRT's 2021 – 2022 millage communications contract; and
- describes additional communications activities that would be undertaken in the April 2022 – March 2023 timeframe with a new \$269,890 contract to CHRT to build awareness about millage-funded programs and services.

Communicating with residents (2021 – 2022)

From March 1st, 2021 - March 31st, 2022, the Center for Health and Research Transformation:

Met with 24 community leaders to better understand millage communication needs and opportunities

Impact. Learned from community leaders about how to inform residents across Washtenaw County about millage-funded services and initiatives. Disseminated a millage communications toolkit to these and other community partners; the toolkit includes stories and social media assets that partners can share with their clients and colleagues.

Developed and disseminated 24 stories about millage-funded programs and services

Impact: 850 MHSUD stakeholders—including residents (self-identified), elected and appointed officials, local media outlets, and mental health and substance use disorder professionals—received quarterly updates about millage-funded services. Many stories were published by local media outlets describing millage-funded programs and services.

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Developed and disseminated 24 vignettes about millage-funded programs and services

Impact: Five local artists contributed to the MHSUD campaign, including artists Gary Horton and Avery Williamson, photographers Heather Nash and William Watson, and designer Daina Fuson. These vignettes were shared through WCCMH social media accounts (Facebook, Instagram) and advertised on billboards (Chelsea, Whitmore Lake, and Ypsilanti), bus signs and wraps, websites, and news outlets across the county.

Developed and published an impact report to describe millage investments in 2020

Impact: Disseminated 3,000 copies to over 250 community-based organizations, including libraries, schools, health centers, food pantries, housing organizations, faith-based organizations, senior organizations, law enforcement, courts, and local businesses. Developed a digital impact report and shared it widely through email lists, social media, and millage newsletter. Worked with the WCCMH business office to report on millage-funded initiatives during the first three years of the eight-year millage.

Analyzed the WCCMH website for usability and accessibility

Impact: Gathered feedback and suggestions from five-dozen individuals through interviews, surveys, and usability studies and conducted a comparative analysis of other CMH websites. Developed a usability report to guide website improvements.

Designed and distributed postcards to promote the 24/7 access line

Impact: Sent 14,500 postcards with refrigerator magnets to promote the millage-funded access line in Dexter and Saline as an initial run. Delivered 500 postcards with refrigerator magnets to Avalon Housing and Washtenaw County Community Mental Health. Printed 3,000 postcards for the millage-funded crisis team to leave with a note when field visits are unanswered.

Developed a ten-minute video highlighting millage-funded initiatives and partnerships

Impact: Worked with Reel Clever, a southeast Michigan production company, to develop a ten-minute video that describes and promotes millage-funded programs and services. This video has not yet been distributed; however local distribution is part of CHRT's proposed 2022 – 2023 communications contract.

Refreshed the WCCMH website based on usability analysis findings

Impact: Revisions include adaptations to the navigation bar to improve accessibility; simplifying website language; making the site more visually appealing; adding new content about eligibility for and cost of services, and more. The new design is being shared with WCCMH on a sandbox site before the changes are released on the WCCMH site.

During the second and third quarters of 2021, while the key messages, stories, and vignettes were being developed, millage microsite visitors were only 1,538 (Q2) and 2,345 (Q3), respectively. In the fourth quarter of 2021, when the campaign was fully launched, millage page visitors more than tripled, to 8,256.

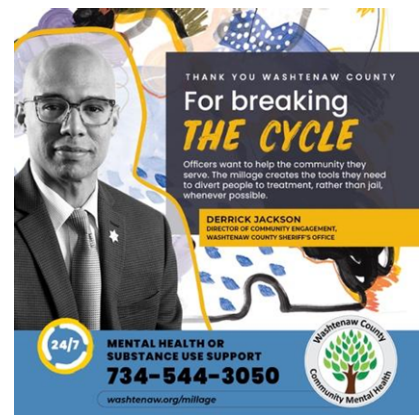
Additionally, between March and November, the bounce rate for WCCMH pages declined from 77.2% to 62.6% as of December 15, 2021. WCCMH's unique page visitors are also increasing. WCCMH had 24,711 unique page visitors between March 1 and July 31. Between August 1 and December 28, 944 unique visitors.

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Sample communications (2021 – 2022)

I. Vignettes

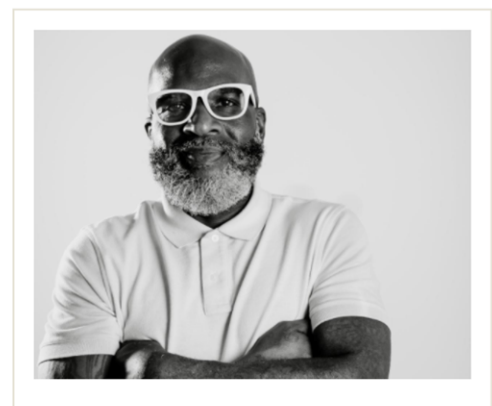


II. Stories

Fostering hope, peer support specialists are helping people on their journey to recovery

There aren't too many job applications where checking the box for a criminal history or a mental illness or a history of addiction would give you an edge. But for [peer-support specialists](#), it's a decided advantage.

Valerie Bass, who has navigated homelessness, addiction, depression, and incarceration checked those boxes to become trained as a peer support specialist. Artie Tomlin did the same. And today, thanks to funding from [Washtenaw County's Public Safety and Mental](#)



CHRT

Millage funding and partnerships are reforming how Washtenaw County responds to public safety

Beginning in 2019, the Washtenaw County Sheriff's Office (WCSO) and Washtenaw County Community Mental Health (WCCMH)—with funding from the [Public Safety and Mental Health Preservation Millage](#)—came together to adopt a set of police reforms.

The reforms allow the two agencies to “work better together, so we can respond more effectively to individuals living with behavioral health conditions—not only in the jail, but also in the community,” says Washtenaw County Sheriff Jerry Clayton, a nationally regarded police reform leader who has been serving as the county's sheriff since



Millage funds help Ozone House youth with housing and supportive services

For over 50 years, [Ozone House](#) has played a pivotal role in Washtenaw County—assisting runaway, homeless, and high-risk youth and their families.

While stable housing is a primary focus, the organization has expanded its mission to provide a holistic range of support services—food, job training, life skills, therapy, and more—that help clients meet their full potential. And beyond homelessness, many young people are also struggling with mental health issues.



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III. Billboard



IV. Bus wrap

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V. Annual report



CARES

In 2019, WCCMH expanded its services to all county residents regardless of insurance, ability to pay, or crisis severity. The expansion, known as CARES, provides short-term care and ultimately connects clients to long-term, sustainable care. The CARES team served, on average, 278 active cases per month in 2020. For assistance with a crisis situation, or guidance on how to get connected to services or how to help a loved one, anyone can call the CARES hotline at 734-544-3050.



24/7 Crisis Center

In 2020, through millage funding, WCCMH opened a 24/7 crisis center—providing an alternative space to emergency rooms and jail for individuals experiencing a crisis. 750 Townner provides after-hours medical care, peer support, and services to meet basic needs—such as food and a safe place to sleep—to stabilize individuals, then connects them to sustainable community care. Between July and September 2020, the center served 30 people. It will continue to serve many more in the years ahead.

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\$3.2 million

For service expansion

Funds that expand the reach of WCCMH to provide 24/7 support, further services and access to more residents and geographic areas in Washtenaw County.

9,326

Services by CARES

Services such as case management, medication reviews, nursing services, peer services, intake assessments, psychiatric evaluations, injections, and more.

\$1.1 million

For community partners

Funds for local organizations to provide important programming and services that improve community mental health and create stronger linkages to WCCMH.

2020: INVESTMENT CATEGORIES



2020: SERVICES PROVIDED

Service Category	Number of services	Number of clients
Case management	5,813	607
Psychiatric medication reviews	1,165	277
Nursing services	785	256
Peer support	674	100
Intake assessments	341	320
Psychiatric evaluations	292	248
Injections	166	31
Wellness notes	71	59
Nursing assessments	19	18
Total	9,326	1,916

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Prevention and Education

Prevention and education are essential for improving and maintaining the health and wellness of our community. These initiatives tackle root causes and upstream issues, which ultimately reduce costs and prevent adverse health outcomes by reaching those in need early. WCCMH values educating community members about how to recognize and respond to mental health crises and needs, as well as destigmatizing reaching out for help.

[Learn more →](#)



Diversion

A key millage goal is connecting individuals in need to the right resources at the right time. Diversion efforts consist of moving

VI. Toolkit samples

News to share with your clients

Here's what happens when you call Washtenaw's 24/7 hotline for mental health and substance use support

Anyone can call Washtenaw County's 24/7 mental health and substance use treatment access line at 734-544-3050. The line is staffed around the clock by mental health experts who ask a series of questions to understand caller needs, then provide callers with the information they request or links to the services they require.

First, call center staff will ask who needs assistance—the caller, or the caller's child, parent, grandparent, student, parishioner, patient, or friend. All calls and callers are welcome.

Second, call center staff need to quickly determine the urgency of the need. This allows them to immediately route crisis calls to the agency's 24/7 crisis response team, a group of mental health experts, with advanced training in crisis situations, that is available to respond to community needs at any time of the day or night.

Staff then ask callers for some basic information about the person who needs assistance, including name, age, and location. This allows hotline staff to begin a confidential health record, which is required for program and service referrals.

To best help callers, staff may also ask about symptoms and mood, history of mental health or substance use concerns, and more. This allows staff to provide relevant information and resources and to refer callers to the community or agency resources they need, such as peer-support specialists, group or individual counseling, or licensed psychiatrists who can prescribe medications.

Call center staff are required to ask about insurance status, *but no Washtenaw County resident will be denied service based on insurance status, ability to pay, or immigration status*. Callers do not need insurance, citizenship, or money to access mental health or substance use treatment services.

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“Plug and play” social media posts

Post 1

Problems with your #mentalhealth are really hard to handle. But you're not alone. Contact #WashtenawCounty Community Mental Health. <https://bit.ly/35OdU3G>
Add 140 characters of tags, e.g.,
@WashtenawHI @NAMIWC @washtenawCMH [ID possible other tags]



Post 2

Insured or not, anyone can call #WashtenawCounty Community Mental Health for support services. Any time, 24/7. <https://bit.ly/35OdU3G>
Add 140 characters of tags, e.g.,
@WashtenawHI @NAMIWC @washtenawCMH [ID possible other tags]



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Proposal for 2022 – 2023 communications

There is a significant need to share millage impact for two reasons: first, to be transparent about the use of millage funds, and second, to ensure that residents are aware of services available to them due to millage funding. CHRT's proposed contract for 2022-23 addresses both needs and will serve to highlight the commendable new programs and initiatives made possible by the millage.

Proposed deliverables

1. **Vignettes.** Continue to produce a quarterly vignette series sharing information about the millage with new participant photos and artwork; create vignettes that resonate with specific audiences, such as youth and families; produce three vignettes per quarter. Due date: Quarterly.
2. **Communications.** Continue to develop and release announcements about newly funded services, staff spotlights, blog posts, Q&As, and press releases. Post original content on WCCMH website and social media accounts; disseminate quarterly newsletter; pitch stories to local news outlets, such as Groundcover News, Ann Arbor Observer, and Connected Magazine. Due date: Quarterly and ad hoc.
3. **Promotion.** Promote twelve vignettes as well as the vignettes, annual report, and video from CHRT's 2021-2022 millage communications contract through online ads, print ads, billboard ads, bus ads, social media platforms, e-newsletters, and more. Due date: Quarterly.
4. **Underwriting.** Continue underwriting contract with Second Wave Media (Concentrate) to publish three (3) stories per quarter on MHSUD concerns in local publications; ensure Concentrate credits the millage for underwriting all applicable MHSUD stories. Due date: Quarterly.
5. **Impact reporting.** Create and publish materials that describe the programs and services made available through millage funding; work with the WCCMH business team to develop and regularly update a data dashboard on millage investments and impacts. Due date: Quarterly and Q4.
6. **Community event.** Host a movie night at the Michigan Theater with a feature-length film about MHSUD concerns; show the millage video and distribute information about millage-funded programs and services. Due date: Prior to March 31, 2023.
7. **Materials.** Develop and distribute print materials to promote millage services, such as posters, flyers, postcards, magnets, brochures, and more. Due date: Q3 and Q4.
8. **Website maintenance.** Continue to post original content on millage microsite and monitor web metrics on a quarterly basis to evaluate success of advertising strategies. Manage news and announcement posts for WCCMH staff. Due date: Quarterly and ad hoc.

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Proposed timeline

Deliverable	Q1 (Apr-Jun 22)	Q2 (Jul-Sep 22)	Q3 (Oct-Dec 22)	Q4 (Jan-Mar 23)
Vignettes	X	X	X	X
Promotion	X	X	X	X
Underwriting	X	X	X	X
Stories & newsletters	X	X	X	X
Impacting reporting	X	X	X	X
Community event				X
Materials			X	X
Website maintenance	X	X	X	X

Millage Funding Summary June 2022

YBMen Project (Attachment #5A):

Goals: The Young Black Men, Masculinities, and Mental Health (YBMen) Project at the University of Michigan is a behavioral health intervention for Black males that provides psychoeducation about mental health, race and gender development, and sustainable social support through innovative technology. The proposed project is a collaboration between Packard Health, the Corner, and the YBMen project to adapt and implement the YBMen program for 200 Black adolescent boys in Washtenaw County, train a workforce to address the needs of this vulnerable population through integrated models of coordinated care, and expand workforce development in Michigan.

What:

- Adapt YBMen for Black adolescent boys and train behavioral health professionals.
- Deliver the YBMen program to Black adolescent boys in Washtenaw County and explore coordinated care models to address the specific needs of Black boys.
- Update the YBMen Technical Assistance Package and launch statewide outreach to other federally qualified health centers in Michigan.

Funding Amount: 2-year contract total- \$250,000

Voices of Youth (Issue Media Group (Attachment #5B)):

Goals: Increase youth voice and civic engagement on critical local issues in Washtenaw County with a focus on youth of color

What: Provide paid journalism opportunities to local youth to learn about and participate in editorial content, focused on mental health stigma reduction, while increasing civic engagement in their own communities. Major elements of the work include:

- Voices of Youth will be offered to youth in two cohorts: spring/summer 2022 and fall 2022.
- IMG will attend youth development/serving organizations meetings to share the VOY program with and invite youth to sign up. There is a focus on youth development organizations that serve youth of color in Washtenaw County.
- IMG facilitates listening sessions with youth to determine youth identified issues/themes. Many youth-identified themes include but are not limited to: destigmatizing mental health, addiction and recovery, food access, etc.
- IMG's youth workshops and mentors will include professional journalists and near-peer mentors of color to ensure representation to support the youth in their work. All adult mentors and staff are paid (not volunteers).
- IMG will also have youth work with professional journalists as story subjects and collaborators on publishable stories.
- IMG will also offer the opportunity (not required) for youth to present their work to elected officials, public sector leaders, nonprofits, and foundations with the intent to increase civic engagement, awareness, and change.
- 10 published stories produced by a team of youth-writers and researchers

- Youth are paid for each activity including:
 - Participating in listening sessions to identify themes and story subjects
 - Participating in multi-part solutions journalism workshops with mentors
 - Publishing their work (writing, research, photography, etc.) and helping it reach targeted audiences (social media)

Funding Amount: One time funding request of \$12,000 was approved under Executive Director authority.

Teen Turn Challenge (Attachment #5C):

Goals: Mentorship and Support for 10–18-year-old males in the Ypsilanti community.

What: Major elements of the funding include:

- Workbooks and group materials
- Food and beverages for groups
- 3 group outings

Funding Amount: One time funding request of \$6,180 was approved under Executive Director authority.

A Proposal to
Expand Behavioral
Health Resources
for Black Adolescent
Boys in Washtenaw
County

The Young Black
Men, Masculinities,
and Mental Health
(YBMen) Project



A PROPOSAL

Expanding Behavioral Health Resources for Black Adolescent Boys in Washtenaw County

Daphne C. Watkins, Ph.D.
Professor of Social Work
University of Michigan

EXECUTIVE SUMMARY

Packard Health and the Corner are health centers that value their connections to partner organizations to meet health care needs, build their workforce, and engage in coordinated care services for children and families across Washtenaw County. The Young Black Men, Masculinities, and Mental Health (YBMen) Project at the University of Michigan is a behavioral health intervention for Black males that provides psychoeducation about mental health, race and gender development, and sustainable social support through innovative technology. The proposed project is a collaboration between Packard Health, the Corner, and the YBMen project to adapt and implement the YBMen program for 200 Black adolescent boys in Washtenaw County, train a workforce to address the needs of this vulnerable population through integrated models of coordinated care, and expand workforce development in Michigan.

Key Issue: In one sentence, what is the key issue you are trying to address?

We are requesting \$250,000 to develop a workforce equipped to address the behavioral health out-comes and coordinated care needs of Black adolescent boys in Washtenaw County.

Defined Need: What data support the need for this initiative/intervention?

Though our region has been named the best provider of behavioral health services in the state, challenges exist when engaging Black adolescent boys in behavioral health programs in Washtenaw County.¹ Traditional definitions of manhood, the stigma surrounding mental illness, and a lack of social support create barriers to mental health, behavioral health services, and coordinated care for Black males.² Targeted behavioral health interventions sensitive to race, culture, social norms, and gender that circumvent these barriers are urgently needed to improve access and coordinated care for Black adolescent boys.² We need more health professionals trained to work with – and coordinate services for -- Black adolescent boys susceptible to stress, depression and anxiety, and trauma as they transition to early adulthood. A behavioral health intervention delivered online by a trained workforce (with optional face-to-face segments) offers a promising way to engage Black adolescent boys in Washtenaw County so their behavioral health needs can *a/so* be met by local health and community services.

In Michigan, Black adolescent boys face numerous barriers to obtaining behavioral health resources. These barriers are complicated by Black adolescent boys' access, or lack thereof, to health resources and lack of coordinated care due to their family's socioeconomic level, geographic region, and transportation issues.³ For instance, mental health illiteracy and limited access to healthcare are two primary indicators that influence behavioral health for marginalized communities. A September 2020 report suggested approximately 2200 Black adolescent boys live in Washtenaw County.⁴ According to recent data from the Washtenaw County Health Department, Black adolescent boys are at risk for poor health due to the cultural/political climate, hate crimes, cyberbullying, adverse childhood events (ACES), child abuse rates, poverty, and lack of parental support.²⁻⁷ Black adolescent boys in Washtenaw County could benefit from more outreach, coordinated services, and behavioral health resources tailored to

them. Since Black boys and young men already confront challenges to success and have fewer encounters with health professionals than their female counterparts, our team will (1) develop behavioral health resources that can help improve the health of Black adolescent boys; and (2) create workforce and integration models that can be sustained in the county and disseminated across the state.

Washtenaw County health professionals have confirmed the value of community-anchored behavioral health resources explicitly aimed at Black adolescent boys. There is value to culturally relevant, age-appropriate, and gender-specific mental health resources for Black boys. There are also benefits to online interventions and social support groups when addressing mental health. This includes anonymity and confidentiality, increasing the potential of self-disclosure, and encouraging honesty and intimacy among participants when discussing stigmatizing topics, such as mental health.^{7,8} Participation in culturally relevant, age-appropriate, and gender-specific interventions can serve as preventative mechanisms for poor mental health over the life span.^{8,9} The use of online support groups has quadrupled in the past decade¹⁰ and the YBMen program provides Black boys with a safe, online community space^{11,12} accessible 24 hours a day. Furthermore, the online programming can be supplemented with face-to-face groups so Black boys can further develop their sense of support and community.

Target Group: Please include the number of individuals served by the proposed activities.

We will serve approximately 200 Black adolescent boys (ages 13-18) in Washtenaw County.

Mission: Provide a statement of how this project aligns with your mission.

Packard Health is a federally qualified health center that provides high-quality, affordable primary care, mental health care, and a complementary range of fully integrated services for patients at every stage of life. In addition to comprehensive family medical care, Packard Health offers patients mental and behavioral health care, chronic disease case management, health promotion, nutrition counseling, and support and assistance with enrollment in public health plans and drug assistance programs. Adapting the YBMen program for Black boys, activating a behavioral health workforce, and exploring coordinated care models to address the specific needs of Black boys aligns with our mission. It allows us to provide the best possible care to our community, including people whose economic, social, or cultural conditions might otherwise prevent them from accessing health care. By focusing on the behavioral health needs of Black boys, we can provide services to an underrepresented group in need.

PURPOSE OF GRANT

Details: What health problem(s), challenge(s) or need(s) will you address and how?

Packard Health's partnership with the YBMen program and the Corner aims to improve short- and long-term mental health, promote healthy definitions of race and gender development, and encourage sustainable social support among Black males.^{10,11} To date, the YBMen program has been successfully implemented with 150+ young adult Black men (ages 18-30) and 25 Black adolescent boys (ages 13 - 15) in Michigan and Ohio. Findings have demonstrated improved mental health outcomes; healthy, more progressive definitions of Black manhood; and healthy relationships among participants. For example, previous iterations of the intervention resulted in a *decrease* in PHQ-9 depression scores (M= 6.77 at baseline; M= 5.50 at follow up), a *reduction* in traditional, toxic definitions of masculinity (M= 9.62 at baseline; M=9.21 at follow-up), and an *increase* in social support (M= 4.88 at baseline; M=5.35 at follow up) for YBMen participants across sites. Participants also reported feeling more comfortable seeking professional health services. The YBMen program has not been adapted and delivered to Black adolescent boys in Washtenaw County. Drawing on our current resources, we are requesting \$250,000 to achieve the three aims described below.

AIM 1: Adapt YBMen for Black adolescent boys and train behavioral health professionals.

Aim 1.1. Adapt the YBMen program for Black adolescent boys. Our adaptation team, led by Dr. Rion and Dr. Watkins, will begin by working with our partners to recruit six Black adolescent boys in Washtenaw County to serve as Ambassadors for the Community Advisory Board (CAB). The CAB will meet eight times over the two-year project period to help our team adapt the low-cost, high-return YBMen program to Black adolescent boys in Washtenaw County. To engage community leaders in decision-making, the CAB will also include volunteers identified by each of our community partners (Amplify Colectivo, Neutral Zone, Pioneer High School, TRAILS, Washtenaw County My Brother's Keeper, Washtenaw International High School, and Ypsilanti Community Schools).

The CAB will adapt the current YBMen manual, tailoring the content and delivery style recommended by the Black adolescent male ambassadors. This will allow the adapted YBMen program to align with the needs and requests of Black adolescent boys in the county. Partners at YBMen, the Corner, volunteers from our partnering agencies, and Black adolescent boys from the CAB will be involved in the team-based adaptation process. The YBMen program is based on popular culture content. Therefore, we will gauge the CAB's preferences for the kinds of popular culture references they want to see in the adapted program (to date, the YBMen project has used movies, sports, songs, and news headlines/stories), as well as their preferred social media platform (e.g., Facebook, Instagram, TikTok, etc.). Finally, we will discuss the desired program length and the appropriate ratio of online to face-to-face time (considering the pandemic) and build these responses into the adapted YBMen program. The YBMen program length is adaptable and occurs between two and twelve weeks. Program adaptation will be an iterative process. We will review and adapt the current YBMen manual, pay close attention to how we work with all stakeholders, and note these processes in the updated project materials. *By achieving Aim 1.1, we will have guidelines for adapting and delivering the YBMen program to Black adolescent boys in Washtenaw County and, eventually, to other counties in Michigan.*

Aim 1.2. Train behavioral professionals in Washtenaw County. Members of the YBMen team, led by Dr. Watkins, will train behavioral health staff from Packard Health and the Corner on adapting and delivering the YBMen program during the project period. Two "YBMen Program Specialists" will be hired and housed at Packard and the Corner (4 total) and responsible for the YBMen program adaptation and delivery processes at their respective health centers. Through the training, the behavioral health staff at Packard and The Corner will undergo a YBMen certification process on curriculum adaptation and program delivery to their Black adolescent male clients. We will refer to this newly trained behavioral health staff as "Certified YBMen Professionals," or CYPs. We will host three one-day meetings (via Zoom or in-person pending covid regulations) for the CYPs from Packard and the Corner. During this training, participants will receive the YBMen manual, review the adaptation guidelines provided by the CAB and adaptation team (see Aim 1.1. above), review the YBMen Technical Assistance Package (housed at the University of Michigan), adapt the curriculum, and develop the plans and timeline for the upcoming YBMen program period. CYPs will work alongside members of the YBMen team (or "YBMen coaches") to deliver the YBMen program to groups of Black adolescent boys during the two-year project period. The training process will be team-based, as CYPs from Packard and Corner will be paired with experienced YBMen coaches to deliver the YBMen intervention to Black adolescent boys effectively. During this time, Drs. Rion and Watkins will initiate outreach and expansion to FQHC partners and other health care providers (e.g., the School-Community Health Alliance of Michigan) across the county. *By achieving Aim 1.2. we will train and support a workforce of behavioral health professionals equipped to (a) work with Black adolescent boys on matters involving their mental health, racial and gender development, and social support; and (b) deliver the adapted YBMen program to Black boys in the county.*

AIM 2: Deliver the YBMen program to Black adolescent boys in Washtenaw County and explore coordinated care models to address the specific needs of Black boys.

Aim 2.1. Deliver the YBMen program to Black adolescent boys in the county. We will work with our partners to recruit 200 Black adolescent boys in Washtenaw County who will receive the adapted YBMen program. Packard Health and the Corner will serve as our primary sites for delivering the YBMen program to Black adolescent boys. Behavioral health professionals at Packard and the Corner (i.e., Certified YBMen Professionals; CYPs) will be trained on how to deliver the YBMen program (see Aim 1.2) and, therefore, will co-facilitate the YBMen program, build rapport, and sustain the YBMen program with experienced members from the YBMen Project team (i.e., YBMen coaches). As 200 is our target number of Black adolescent boys to reach with the YBMen program, we will have a rolling recruitment and enrollment process beginning the second half of year one of the project. Previous YBMen groups have included between 12 to 15 members, so we may have up to 17 groups of Black adolescent boys in the YBMen program over the two years. We will work with the Corner, the YBMen team, and the CAB to decide on the appropriate length of the YBMen program for this project period. In previous iterations of the program, we have had as many as ten groups running simultaneously over a two-to-twelve-week period. So, given the additional support from the CYPs and the YBMen team, our project team will manage the workload associated with this project over the grant period. Black adolescent boys will be screened for eligibility, enrolled, and assigned to specific groups based on their ages (e.g., 13-15 vs. 16-18), and locations in the county (east, west, north, south), and mental health needs.

After we make group assignments, but before they begin the YBMen program, all the boys will participate in one focus group (either virtual or in-person, pending COVID restrictions) and complete one survey. This will serve as their pretest and will include measures of mental health (i.e., depressive symptoms, PHQ-9 and Gotland Male Depression Scale; anxiety symptoms GAD-7); mental health stigma (3 Stop Stigma Items); mental health literacy (MHLS); masculine norms (CMNI); social support (ISEL); and participant demographics. After the boys complete the YBMen program, they will participate in another round of focus groups and surveys, which will serve as their post-test. The pretest and post-test quantitative assessments will include the same measures, delivered via Qualtrics. We have used Qualtrics to collect pretest and post-test data in previous YBMen trials. We will follow the same protocols for this project. All pretest and post-test data, and the YBMen program data, will inform the overall program evaluation and dissemination plan. *By achieving Aim 2.1, we will gather a broad range of mental and behavioral health data on approximately 200 Black adolescent boys in Washtenaw County, which will help with future programs and policies to improve their services, inform a workforce ready to serve them, and coordinate care to address their specific needs.*

Aim 2.2. Explore coordinated care models to address the specific needs of Black boys. The CYPs and YBMen coaches will develop and document strategies for sustainability and expansion of the YBMen program beyond the project period (to achieve Aim 3.2). This includes exploring coordinated care models that health centers and community resources can address. By working together to co-facilitate the YBMen program, behavioral health professionals at Packard and the Corner will have first-hand experience working with Black adolescent boys and can help guide the project leaders on better ways to coordinate behavioral care across various agencies that engage and do not engage with Black boys. Furthermore, pretest and post-test data, YBMen program data, and strategies used to engage participants will inform our exploration of coordinated care models best suited for Black adolescent boys in the county. *By achieving Aim 2.2, we will engage health, education, and community leaders in the shared decision-making on culturally appropriate coordinated care to address the needs of Black boys.*

AIM 3: Update the YBMen Technical Assistance Package and launch statewide outreach to other federally qualified health centers in Michigan.

Aim 3.1. Update the YBMen Technical Assistant Package. As in previous iterations of the YBMen project, we will maintain cloud-based communication and tracking systems to ensure the CAB, YBMen coaches, and CYPs maintain contact over the project period. These files will help inform the evaluation and update the YBMen Technical Assistance Package for future expansion and dissemination. While the CYPs and YBMen coaches deliver the YBMen intervention to 200 Black adolescent boys, they will also assist the YBMen team with updating various components of the YBMen Technical Assistance Package (TAP). The current YBMen TAP consists of (a) the YBMen manual, (b) access to the virtual YBMen Library of Program Content, (c) the YBMen Implementation Guide, (d) the YBMen Media Kit, and (e) Consultation sessions with YBMen Coaches. The YBMen TAP also includes recommendations for sustainability and best practices for providing care to Black adolescent boys with mental health conditions. The YBMen TAP is housed on a secure website through the University of Michigan School of Social Work. *By achieving Aim 3.1, our team will update protocols for engaging Black adolescent boys in a behavioral health program, develop recommendations for sustainability, and explore coordinated care models to address the specific needs of Black adolescent boys.*

Aim 3.2. Launch statewide outreach and expansion. Our final aim involves launching statewide outreach to federally qualified health centers and other health centers that serve Black adolescent boys. We will work with our Michigan Primary Care Association (MPCA) partners to initiate outreach for learning and knowledge dissemination to other federally qualified health centers that serve Black boys across the state. Our experienced team has worked with organizations to facilitate and empower them to implement and use behavioral health resources in their work, develop information that can be used for program improvement, and document outcomes, specifically for programs aimed at improving the health of Black males. We have written extensively and have led workshops on health equity, gender and race in behavioral health for youth of color, and the social determinants of health for Black men and boys. Drs. Rion and Watkins will lead our YBMen TAPs outreach and expansion to FQHC partners and health care providers (e.g., the School-Community Health Alliance of Michigan) across the county.

In addition to the YBMen TAP, our team is prepared to offer our statewide partners and providers training and workshops on the following topics: logic models, evaluation, data collection, data interpretation, reporting results, and cultural sensitivity. We are also comfortable working with other evaluators, federally qualified health centers, and community partners to coordinate our research team, CYPs, partners and providers, and other county representatives and constituents. We will support the YBMen TAP recipients by creating and maintaining a directory of behavioral health professionals working to improve the behavioral health of Black boys across Michigan. This network will participate in a moderated online community for all adapters of the YBMen manual. The online community will offer quarterly program updates, webinars, newsletters, direct contact with the YBMen team, and supplemental information to support the workforce in addressing the behavioral health needs of Black adolescent boys in the state. We plan to initiate statewide outreach during the first year and continue throughout the project. *By achieving Aim 3.2. we will launch statewide outreach to other federally qualified health centers in Michigan and assess the feasibility of the statewide rollout of our efforts in Washtenaw County.*

Collaboration: Describe your collaborators on this specific project and their role(s).

We are requesting \$250,000 from the MHEF for this unique opportunity to enhance behavioral health services, train a workforce to address behavioral health needs, and explore coordinated care models that address the specific needs of Black boys in Washtenaw County. Our team at Packard Health will partner with the YBMen Project at the University of Michigan and the Corner Health Center, Amplify

Colectivo, Neutral Zone, Pioneer High School, TRAILS, Washtenaw County My Brother's Keeper, Washtenaw International High School, and Ypsilanti Community Schools, and the University of Michigan School of Social Work Program Evaluation Group (PEG). Packard Health is a federally qualified health center that has served 11,000 patients across its three locations and will be the leader and primary site for our project. Packard Health will host the CAB meetings and team training. Packard will also help with recruitment, host any face-to-face YBMen groups, and support Packard staff in adapting the YBMen program and delivering it to Black adolescent boys during the grant period and beyond. The YBMen Project team will work with Packard, the Corner, and the CAB to adapt the YBMen manual. The YBMen team will also provide coaches to accompany the CYPs from Packard and the Corner to deliver the YBMen program. The YBMen team will also lead data collection and analysis for this project. The Corner will help with recruitment, host YBMen groups, and support Corner staff in adapting the YBMen program and delivering it to Black adolescent boys during the grant period and beyond. Our other partners (e.g., Amplify Colectivo, Neutral Zone, Pioneer High School, TRAILS, Washtenaw County My Brother's Keeper, Washtenaw International High School, and Ypsilanti Community Schools) will help recruit Black adolescent boys into the YBMen program; help explore coordinated care services and community resources to promote the health of Black adolescent boys; and identify individuals to serve on the CAB. The University of Michigan School of Social Work Program Evaluation Group (UM-SSW PEG) will evaluate our short-term and long-term project outcomes.

Cross-cutting Goal: Which of the MHEF's two cross-cutting goals does this project address?

Our cross-cutting goal is two-fold. First, we will provide training, support, and workforce development to behavioral health professionals at Packard Health, the Corner and, eventually, centers. Second, we will explore innovative and cost-effective integration models that coordinate care, services, and community resources to support behavioral health for Black adolescent boys. This project will strengthen the capacity for a network of professionals who can improve and maintain behavioral health for Black adolescent boys and initiate steps to what kind of coordinated care models can be put in place for healthcare providers and communities to promote the health of Black boys. We define "workforce" as the professionals who work with Black boys at health centers and community agencies (e.g., Packard Health and the Corner Health). "Integration" is the coordination of care and services between health centers, educational institutions, and community agencies to promote the health of Black adolescent boys.

POTENTIAL IMPACT

Outcomes: What are your project's intended short-term and long-term outcomes? How do you intend to measure these outcomes and why are those measures good indicators?

Short-term outcomes of the project are to: increase the use of health and behavioral health services at Packard Health and the Corner by Black boys, improve mental health, reduce mental health stigma, increase mental health literacy, expand definitions of race and gender development, and increase boys' engagement in social support. We anticipate having Packard and the Corner staff trained to deliver the YBMen program to Black boys using an updated YBMen manual in the short term. By the end of the project, we will have expanded behavioral health resources for Black boys, updated the YBMen manual, and updated our partners' YBMen Technical Assistance Package. In the short term, we will focus on the process evaluation, which will examine the steps associated with achieving our aims. For example, we will critically assess our procedures for adapting and delivering the YBMen program for Black adolescent boys, building and maintaining communication with our partners, training the staff at Packard Health and the Corner, and indicate which aspects are working as planned and which might need to be revised to meet the project's goals and objectives.

Long-term outcomes of the project are to: sustain services at Packard Health and the Corner for Black boys; have Black adolescent boys experience less depression, distress, and anxiety; help ensure Black adolescent boys develop healthy masculine norms/manhood, and positive and meaningful social relationships. We also anticipate, in the long-term, having Packard and Corner staff using the YBMen TAP, sustaining a workforce equipped with the tools to address behavioral health challenges among Black adolescent boys, and working toward coordinated care. In the long-term, we will establish models for behavioral health resources to disseminate healthy living, learning, and thriving for Black boys across Michigan. We will measure outcomes by collecting administrative data to assess: (1) the number of Black adolescent boys served; (2) the number of current resources offered to adolescent boys across the county; (3) the number of Packard Health and Corner Health staff involved in the project; and (4) the number of YBMen partners and providers. To measure health outcomes, we will assess (1) mental health (using PHQ-9 for depression and the Gotland Male Depression Scale [GMDS]) and anxiety scores (using GAD-7); (2) gender scores on the Conformity to Masculine Norms Inventory (CMNI); (3) perceptions of social support using three domains from the Interpersonal Support Evaluation List (ISEL-12): appraisal, belonging, and tangible support; and (4) additional measures such as mental health stigma (Stop Stigma Items); mental health literacy (MHLS); and participant demographics.

We will assess the above indicators for Black adolescent boys by administering a pretest when they enroll in the YBMen program and at post-test one month after the YBMen program is completed. These data will be shared with the UM-SSW PEG for evaluation. We will use the evaluation results to modify program components, including refining the YBMen manual to bring it to scale. We will also use the Integrated Practice Assessment Tool (IPAT) © to determine the level of collaboration/integration of the YBMen manual into the service delivery model at Packard Health and The Corner. Using the IPAT in this manner with Packard Health and The Corner with help with future expansion and dissemination to other FQHCs and other health centers across the state. The UM-SSW PEG will determine our project's effectiveness and potential impact based on our evaluation plan and logic model. Our evaluation by UM-SSW PEG will evaluate hopes and concerns through reciprocal relationships and overarching success indicators, strategies for communication, and working relationships.

Evaluation: Visually present the evaluation approach and connect project activities with measurable outputs, intended short-and long-term outcomes, and the ultimate impact(s).

See Evaluation Plan (Attachment 1) and Logic Model (Attachment 2)

Learning: At the end of this project, what do you expect to have learned? How will what you learn help advance work on this issue area? How might you share what you've learned?

By the end of this project, we would have learned about: (1) the behavioral health needs of Black adolescent boys in Washtenaw County; (2) the needs of a workforce passionate about working with Black adolescent boys in integrated care settings; (3) preliminary integration models of coordinated care, services, and community resources; and (4) the feasibility of statewide dissemination through federally qualified health centers. Health promotion interventions for Black boys at early developmental stages provide a unique opportunity to intervene when they are susceptible to stress, mental health concerns, and risky health behaviors (e.g., substance misuse). The YBMen project helps us learn how Black boys define their mental health and conceptualize their race and gender development, and social relationships. Similarly, we will learn about the effectiveness of behavioral health resources at Packard Health and the Corner that are culturally sensitive, age-appropriate, and gender-specific for Black boys.

We know challenges exist when engaging Black adolescent boys in traditional health interventions. The social and economic hardship young men of color face -- and marginalized roles within their families and communities -- restrict their ability to establish and maintain positive mental health and wellbeing

as they age.^{1,2,7,8,13} What we will learn through this project will help advance research, practice, and policy for Internet-based health programs for Black adolescent boys. Online programs for youth are promising, as members of this group tend to report high rates of social media use and are more receptive to these interventions. The Packard Health partnerships with the YBMen Project, Corner Health, and other constituents will serve as a pipeline for Black adolescent boys. This partnership will help bridge gaps across individuals, communities, organizations, and generations, expand behavioral health resources, and leverage help-seeking among Black adolescent boys.

Given our successful track record of community-grounded projects with Black boys and men, we look forward to sharing what we have learned in several ways and across several audiences. First, we will disseminate the lessons we learn and the project results to key stakeholders via a consolidated report. Next, we will present what we have learned to potential stakeholders through the revised YBMen manual, the Technical Assistance Package, and a special invitation-only symposium in Washtenaw County, sponsored by Packard, the Corner, and the YBMen project. Finally, we will develop a series of conference presentations, peer-reviewed publications, and policy briefs to share what we have learned with broader academic and professional audiences. We will also share lessons learned with Michigan policymakers to inform their decisions and future programming on mental health and suicide prevention among the youth of color. The lessons we learn will help state officials and leaders expand existing programs and create new programs for youth of color. Our project will provide a blueprint for intervention researchers and practitioners who may not be familiar with race- and gender- norms and behaviors, providing them with best practices for identifying and reaching subgroups of marginalized youth, such as Black adolescent boys. Further dissemination efforts will involve social media platforms such as Facebook, Twitter, and Instagram. Furthermore, we will create and monitor a webpage dedicated to the YBMen project in Washtenaw County and across Michigan for our YBMen partners and providers.

Systems Change: What system or systems is this project trying to impact or change? How might this project change existing systems or structures to improve service delivery?

Our team is proposing to model a partnership between a Federally Qualified Health Center (Packard Health), a community-anchored, evidence-based intervention (YBMen), and a member of the School-Community Health Alliance of Michigan (The Corner) to expand the behavioral health resources offered to Black adolescent boys. A culturally sensitive, age-appropriate, and gender-specific intervention adapted and delivered through health centers, specifically for Black adolescent boys, will change the current way services are delivered. This project will change existing systems by providing a model through which collaboration and connectivity of behavioral health services, driven by community-based researchers and practitioners, can dive into existing mental health and social support experiences of Black adolescent boys. We are proposing a model of expanding behavioral health services that will strengthen a workforce capable of addressing the behavioral health needs of Black adolescent boys to improve their health and wellbeing overall. Our project's healthcare integration model will be impacted by how services are currently provided to Black adolescent boys. The YBMen program, manual, Technical Assistance Package, and ongoing connectivity of the stakeholders will improve service delivery for Black adolescent boys in the long term. This application prioritizes a multi-sector response for developing and strengthening local care systems for mental health, supporting efficient treatment, and seamless transitions to community treatment settings.

Healthcare Savings: Does your project lead to potential or actual healthcare cost savings?

An April 2019 report from the Commonwealth Fund National Survey of Federally Qualified Health Centers¹³ found community health centers that expanded Medicaid in their states (i.e., Michigan) are more likely to provide behavioral health services and coordinate care with social service providers. Our project will support these outcomes and will align with the other ways federally qualified health centers

currently benefit Michigan residents, which are by: (1) reducing tertiary care due to the preventive nature of the project; (2) lowering overall health care costs; (3) employing thousands of people; and (4) generating billions of dollars in economic activity through job creation and the purchase of goods and services.¹³ The YBMen program is a low-cost, high-return program that can be integrated into the behavioral health resources currently offered by federally qualified health centers across the state. Given the nature of federally qualified health centers and their communities, delivering the YBMen program in these health centers means it has a better chance of reaching Black adolescent boys most at risk and in dire need of behavioral health resources. Delivering the YBMen program requires minimum time and effort for YBMen partners and providers, making it less burdensome for health center staff. Healthcare savings for providing the YBMen program and equipping a workforce to address the behavioral health needs of Black adolescent boys will be accrued by the state, the health centers themselves, and Black families and communities. These savings can be measured by assessing the short- and long-term effects of our project goals. Supporting behavioral health, positive development, and social relationships of Black boys transforms into positive families and communities that thrive over the life course.

Sustainability: Describe how the proposed activities will be sustained after the grant.

We have a strong sustainability plan, which includes our long-term goals to (1) support the complete adoption and integration of the YBMen program into behavioral health services at Packard and the Corner after the grant period has ended, (2) disseminate an updated YBMen manual for Black adolescent boys in Washtenaw County, and (3) build and support a YBMen Technical Assistance Package (TAP) for behavioral health professionals across the state. By the end of the project period, Packard and Corner staff would have participated in the adaptation and delivery of the YBMen program. Also, the staff would have been trained on how to integrate the YBMen program into their practice and received a YBMen TAP for support and sustainability. The models we use at Packard and the Corner will be sustained within their current service delivery model, allowing their staff to participate in low-cost training opportunities for working with Black adolescent boys.

As a federally qualified health center (Packard Health) and a member of the School-Community Health Alliance of Michigan (The Corner), these health centers will serve as models for other health centers in the state that want to expand their behavioral health programming for Black adolescent boys. We have generated interest in our efforts from the Michigan Primary Care Association (MPCA), the membership organization for federally qualified health centers. We are currently in conversations with them about the feasibility of a statewide rollout of our initiatives. We recognize the activities proposed here are designed to be inexpensive for wide dissemination, and the support for occasional updates to program materials will be in kind. The YBMen team is fully committed to updating the YBMen TAP as needed, basing it on clinical and community-anchored research and informing evidence-based practice with Black adolescent boys. All training materials and the updated YBMen TAP will be available online. We have secured funding from the Vivian A. and James L. Curtis Center for Health Equity Research and Training at the University of Michigan School of Social Work to maintain these online resources. Given the direction of our current conversations, we anticipate full commitment from MPCA for promoting the complete YBMen TAP across federally qualified health centers, allowing for the expansion of much-needed behavioral health resources for Black adolescent boys in the state of Michigan.

EVALUATION PLAN***Expanding Behavioral Health Resources for Black Adolescent Boys in Washtenaw County***

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Professor of Social Work

University of Michigan

Our team will work with the University of Michigan School of Social Work Program Evaluation Group (UM-SSW PEG) to achieve our evaluation goals. The UM-SSW PEG is accomplished in the area of program evaluation. The PEG has worked with over 55 clients to conduct needs assessments, process evaluations, and outcome evaluations using qualitative and quantitative methods. The PEG staff brings decades of expertise in evaluation best practices to further enhance the feasibility of the proposed activities. The proposed work builds on the strong collaborations between Packard Health, the Corner, the YBMen project, the UM-SSW, and other county agencies. The evaluation approach for this project considers these strong collaborations. Dr. Shawna Lee, Director at the UM-SSW PEG, will establish precise, rigorous, and consistent program evaluation procedures for the project.

We will develop a detailed evaluation plan employing a one-group, pretest-posttest study design to assess short-term and long-term indicators of key outcomes. This project tests the core tenants of our logic model (Attachment 2). It also advances theory by testing the YBMen program's main effects in improving behavioral health for Black adolescent boys. Targeted programs are ideal for some Black adolescent boys. They offer anonymity and increase the potential of self-disclosure, honesty, and intimacy among participants when discussing stigmatizing topics, such as those related to mental health and stigma. The logic model for this project outlines the program and goal, inputs, outputs, mechanisms of change, and outcomes. Each is described below.

The Situation: Our evaluation will be based on our logic model (See Attachment 2), which provides fundamental reasoning that change is dynamic and not linear. This proposal was developed to address a specific problem: According to recent data, Black boys living in Washtenaw County¹ are at high risk for poor health as a result of cultural/political climate; hate crimes; cyberbullying; adverse childhood events (ACES); child abuse rates; poverty; and lack of parental support. Black boys in Washtenaw county could benefit from more outreach, services, and behavioral health resources tailored to them.

Activities, Inputs, and Outputs: To address the situation, we need to adapt the YBMen program for Black boys in Washtenaw County, deliver YBMen to Black adolescent boys ages 13-18 in the county, train Packard and Corner staff to adapt and deliver the YBMen program, revise the YBMen program manual, build partnerships with groups and agencies across the county, evaluate our efforts, facilitate dialogue about the behavioral health needs of Black boys, and update the YBMen Technical Assistance Package (TAP). To accomplish these activities, we need to invest in (i.e., Inputs): 4 Packard Staff, 2 Corner staff, 9 YBMen staff, approximately 200 Black boys, 10 Community Partners, time, money, meeting space, transportation, evaluation materials (e.g., video recorder, etc.), and intervention technology (e.g., Internet, Wi-Fi, social media, etc.). We must also (i.e., Outputs) monitor the activities by recording (*for Aim 1*) the number of Black boys served by Packard and Corner, the amount of time Black boys participate in the YBMen program, scores on health assessments, the number of YBMen modules for Black boys, and the number of meetings for Black boys. Additionally, we must record (*for Aim 2*) the number of Packard & Corner staff/ county partners trained, the number of training resources (YBMen TAP), and (*for Aim 3*) the number of behavioral health resources, number of YBMen partners and providers, and number of TAPs distributed. Upon completing the program activities, we expect to achieve specific short- and long-term outcomes, below.

¹ Washtenaw County Health Department, Internal Communication. Waller, A. April 2017.

Short-Term and Long-Term Outcomes: In the **short-term**, we expect the program will increase service use by Black boys at Packard and the Corner by 50%, 50% improvement in mental health education/literacy, 60% expanded definitions of race and gender development, 60% engaged social support/healthy relationships. We also anticipate the program will result in two Packard staff and two Corner staff trained to deliver YBMen to Black boys, an updated YBMen manual, as well as increased behavioral health resources for boys by 50%, 10 TAPs developed and delivered across the state, 10 YBMen providers using TAP across the state. Our short-term outcomes will lead to **long-term** outcomes such as sustaining 60% of programming at Packard and Corner for Black boys; 70% of Black boys experiencing less depression, distress, and anxiety; 70% of Black boys having healthy race and gender norms/development, and 70% of Black boys having positive relationships. We also anticipate using YBMen TAP resources in 50% of their interactions with Black boys and an increased workforce for behavioral health with Black adolescent boys by 40%. Furthermore, we anticipate having behavioral health resources and service integration models (e.g., coordinated care and resources) to expand across the state and healthy living, learning, and thriving for Black boys in Michigan.

Our project affirms that upon operationalizing the program activities, inputs, and outputs, there will be outcomes (short- and long-term) that lead to behavioral health resources that improve the health of Black adolescent boys and workforce and service integration models that can be sustained in Washtenaw County and disseminated across the state. We have a strong sustainability plan, which includes our long-term goals to (1) support the complete adoption and integration of the YBMen program into behavioral health services at Packard and the Corner after the grant period has ended, (2) disseminate an updated YBMen manual for Black adolescent boys in Washtenaw County, and (3) build and support a YBMen Technical Assistance Package (TAP) for behavioral health professionals across the state. The health centers in Washtenaw County will serve as a model for other health centers across the state and across the country that want to expand their behavioral health programming for Black adolescent boys. Involvement in this process will also contribute to developing a network of YBMen partners and providers who can provide iterative feedback on the adaptation and delivery of the YBMen intervention, training the workforce to address behavioral health among Black adolescent boys, and the YBMen manual and TAP. Here we outline the markers of success associated with our process and outcome evaluations.

The process evaluation will examine the steps associated with achieving our project aims. For example, we will critically assess our procedures for adapting and delivering the YBMen program for Black adolescent boys, building and maintaining communication with our partners, training the staff at Packard Health and the Corner, and indicate which aspects are working as planned and which might need to be revised to meet the project's goals and objectives. We will track this by assessing meeting frequency and communication between the research team and our partners. We will measure success based on standards determined through personnel review of the process; quality control standards; review of the project materials; and careful audit of each phase by the research team and partners. Intended impacts for our process evaluation will be defined by our ability to convene meetings, achieve process objectives, stay on track with our timeline and work plan, and our ability to adapt and deliver the YBMen program, recruit Black adolescent boys to participate, and train the staff at Packard Health and the Corner on how to deliver the YBMen program to Black adolescent boys in the county.

The outcome evaluation will determine whether the overall objectives have been achieved. Research findings underscore the gaps in mental health knowledge, problematic conceptions of manhood, and inadequate social support among Black adolescent boys. The proposed study aims to address these gaps by providing behavioral health resources (e.g., the YBMen intervention) for Black adolescent boys in Washtenaw County and training a workforce capable of handling their short- and long-term

behavioral health needs. *Intended impacts* for our outcome evaluation include notable changes among YBMen intervention participants between the pretest (before the intervention begins) and the posttest (after the intervention ends). This is indicated by decreased depressive and anxiety symptoms (PHQ-9, GMDS, and GAD-7 scores); expanded definitions of manhood (CMNI scores and focus group data); increased social support (ISEL scores) and connectedness (measured using focus group data); demographics; help-seeking; and increased dialogue about connections between mental health, manhood, and social support (determined by focus group data). We will also use the IPAT® to assess the level of collaboration/integration of the YBMen manual into the service delivery model at Packard Health and the potential for expansion to other FQHCs across the state.

Our team will use data to strengthen the project. Evaluation will be an engaged learning process that will provide all stakeholders with an opportunity to: reflect on their efforts, document what works and what does not work in different contexts, identify and address challenges, assess types of technical assistance that might support their work, and share what is learned with others. Steps for our evaluation process are to (1) assemble the project team; (2) review our vision for change (i.e., logic model) and use it to assess how change occurs; (3) implement community activities and mobilize resources; (4) provide evaluation feedback about what is and is not working, opportunities and obstacles, and what types of technical assistance might support our efforts; (5) make changes to the work based on the evaluation feedback; (6) document initial intended and unintended outcomes and context; and (7) return to step 2 and repeat the process as necessary. Below is our work plan for the two-year project period.

Work Plan and Timeline	Sept-Dec 2022				Jan-Apr 2023				May-Aug 2023				Sept-Dec 2023				Jan-Apr 2024				May-Aug 2024			
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
<i>Project planning/Team training</i>																								
<i>Bi-weekly team meetings with the team</i>																								
Aim 1: Adapt YBMen for Black boys in the county																								
Aim 1: Train behavioral health staff																								
Aim 2: Deliver the YBMen program																								
Aim 2: Explore coordinated care models																								
Aim 3: Update Technical Assistance Package																								
Aim 3: Launch statewide outreach																								
<i>Write final report/Report results to partners</i>																								

We will analyze pretest and posttest quantitative and qualitative data to determine the project's intended outcome. Quantitative data collection will include mental health (i.e., depressive symptoms, PHQ-9 and GMDS; anxiety, GAD-7); mental health stigma (3 Stop Stigma Items); mental health literacy (MHLS); masculine norms (CMNI); social support (ISEL); help-seeking behaviors; and participant demographics. The pretest and posttest quantitative assessments will include the same measures, delivered via Qualtrics. We have successfully used Qualtrics to collect pretest and posttest survey data in previous YBMen trials and will follow the same protocols for this project. Qualitative data collection will include a focus group protocol used in previous YBMen trials with questions about mental health, depression, masculinity, social support, and the YBMen intervention (posttest only). Additional interview questions about mental health stigma, mental health literacy, and help-seeking behavior will be added for this study. Participants will participate in 60-minute video focus groups (via Zoom) at pretest and posttest.

The Logic Model: “Expanding Behavioral Health Resources for Black Boys”

The Goal: To develop behavioral health resources that improve the health of Black adolescent boys and create workforce and service integration models that can be sustained in Washtenaw County and disseminated across the state.

SITUATION	ACTIVITIES	INPUTS	Project Aims	OUTPUTS	SHORT-TERM OUTCOMES	LONG-TERM OUTCOMES
<i>The current state of Black boys in Washtenaw County:</i>	<i>To address the situation we need to:</i>	<i>To accomplish the activities we need:</i>		<i>We will monitor the activities by recording:</i>	<i>In the short-term, we expect the program will lead to:</i>	<i>In the long-term, we expect the program will lead to:</i>
According to recent data, Black boys living in Washtenaw County¹ are at high risk for poor health as a result of: • Cultural/political climate; • Hate crimes; • Cyberbullying; • Adverse childhood events (ACES); • Child abuse rates; • Poverty; and • Lack of parental support Black boys in Washtenaw county could benefit from more outreach, services, and behavioral health resources tailored to them.	• Adapt YBMen for Black boys in Washtenaw County • Deliver YBMen to Black boys ages 13-18 in the county • Train Packard and Corner staff to adapt and deliver YBMen program • Revise YBMen program manual • Build partnerships with groups and agencies in county • Evaluate our efforts • Facilitate dialogue re: behavioral health needs of Black boys • Update YBMen TAP² • Outreach across the state	• 2+ Packard Staff • 2 Corner staff • 9 YBMen staff • ~200 Black boys • 10 Community Partners • Time • Money • Meeting space • Transportation • Evaluation equipment (e.g., video recorder, etc.) • Intervention technology (e.g., Internet, Wi-Fi, social media, etc.)	AIM 1	• # of Black boys served by Packard & Corner • Time in YBMen program (dose) • Scores on health assessments • # of YBMen modules for Black boys • # of meetings for Black boys	• Increase service use by Black boys at Packard and the Corner by 50% • 50% improvement in mental health education/ literacy • 60% expanded definitions of race and gender develop. • 60% engaged social support/ healthy relationships	• Sustain 60% services at Packard & Corner for Black boys • 70% Black boys experience less depression/distress/ anxiety • 70% Black boys increase in healthy masculine norms/manhood • 70% Black boys have positive relationships
			AIM 2	• # of Packard & Corner staff/ county partners trained • # of training resources (YBMen TAP)	• 4 Packard & Corner staff trained to deliver YBMen to Black boys • Updated YBMen program manual	• Packard & Corner using YBMen TAP resources in 50% of their interactions with Black boys • Increase workforce for behavioral health with Black boys by 40%
			AIM 3	• # of behavioral health resources • # of YBMen partners and providers • # of TAPs² distributed	• Increase behavioral health resources for boys by 50% • 10 TAPs² developed and delivered across the state • 10 YBMen providers using TAP across the state	• Models for behavioral health resources and service integration models to expand across the state • Healthy living, learning, and thriving for Black boys in Michigan

Assumptions:

- Commitment from staff at Packard Health and The Corner
- Commitment from other county partners (YBMen Project, schools, groups, etc.)
- Interest and involvement by Black boys in the county

External Factors:

- Political environment
- Economic situation
- Sociocultural context
- Geographic conditions

¹ Washtenaw County Health Department, Internal Communication. Waller, A. April 2017.

² Technical Assistance Package (TAP)

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Voices of Youth Proposal for Washtenaw
County CMH

Objective

Increase youth voice and civic engagement on critical local issues in Washtenaw County with a focus on youth of color.

Strategy – Voices of Youth Program

There is a significant risk that **youth are becoming disconnected from local media** and the issues that impact them most in their own communities. As a result, youth are left with national news narratives of division and apathy that **may result in a lack of local civic engagement**.

IMG is implementing the Voices of Youth (VOY) program to **provides paid journalism opportunities for local youth** to learn about and participate in editorial content while increasing civic engagement in their own communities.

VOY provides paid journalism opportunities to:

- Write and research
- Photograph, video, illustrate and/or podcast
- Reach targeted audiences with the content using social media

IMG **facilitates listening sessions to determine youth identified issued/themes**, in addition to peers that may be experiencing challenges, nonprofits/youth service organizations that are working to address these challenges. Many youth-identified themes include but are not limited to: **Destigmatizing mental health**, addiction and recovery, food access, art, music, youth experiencing houselessness and many other topics. All themes and articles published are to be addressed through a racial equity lens and anti-racism principles.

VOY is delivered in partnership with local youth-serving organizations and youth advisory councils with adult supports. Our current partners include WMBK/Formula 734, EMU Upward Bound and WISD's Youth Council. We are seeking additional youth development partners with an emphasis on youth of color and themes rooted in racial equity and justice.

Youth workshops and mentors will include professional journalists and near-peer mentors of color to ensure representation.

Youth are paid for each activity including:

- Listening sessions to identify themes and story subjects
- Multi-part **solutions journalism** workshops with mentors
- Publishing their work and helping it reach targeted audiences

The primary **purpose of the program is to lift up youth voice** and help the community see issues with their point of view. We also believe it is important to **expose youth to the power of journalism** and how it can create real change.

All stories will include youth voices and youth contributed content in a variety of forms such as interviews, photography, art, data, etc.

The reporting will lift-up youth voice using one of these different types of content being published:

- Stories written by youth with a youth byline
- Stories written in collaboration with a professional journalist with a shared byline.
- Stories written by a professional journalist with youth voice and lived experiences as the primary focus of the article.

Upon publication of the stories and content, youth are offered the opportunity to **present their work to elected officials, public sector leaders, nonprofits, and foundations** with the intent to increase civic engagement, awareness, and change.

The program is designed to run over a 3-month period but can be tailored to align with youth serving organization partner schedules.

VOY is designed to increase outcomes for youth including:

- Published professional work to share for future employment/internship opportunities and strengthen college applications and/or essays.
- Increased civic engagement and working to advance issues they care about
- Increased social capital – access to community leaders, elected officials and funders

Youth Participation opportunities:

110 paid youth participation opportunities per year.

- 10 stories produced by a team of
 - writers
 - researchers and social media coordinators
 - photographers, artists, videographers, etc.
 - youth listening session participants
 - solutions journalism workshop participants
 - interviewees (unpaid)

2022 Voices of Youth Washtenaw Scope

- Voices of Youth will be offered to youth in two cohorts: spring/summer 2022 and fall 2022.
- IMG will attend youth development/serving organizations meetings to share the VOY program with and invite youth to sign up. There is a focus on youth development organizations that serve youth of color in Washtenaw County.
- IMG facilitates listening sessions with youth to determine youth identified issues/themes. Many youth-identified themes include but are not limited to: **destigmatizing mental health**, addiction and recovery, food access, etc.
- IMG's youth workshops and mentors will include professional journalists and near-peer mentors of color to ensure representation to support the youth in their work. All adult mentors and staff are paid (not volunteers).
- Youth are paid for each activity including:
 - Participating in listening sessions to identify themes and story subjects
 - Participating in multi-part solutions journalism workshops with mentors
 - Publishing their work (writing, research, photography, etc.) and helping it reach targeted audiences (social media)
- IMG will also have youth work with professional journalists as story subjects and collaborators on publishable stories.
- IMG will also offer the opportunity (not required) for youth to present their work to elected officials, public sector leaders, nonprofits, and foundations with the intent to increase civic engagement, awareness, and change.
- 10 published stories produced by a team of youth
 - o writers
 - o researchers and social media coordinators
 - o photographers, artists, videographers, etc.
 - o interviewees (unpaid)

Reporting requirements

- Names of youth development/serving organization and the number of youth offered the opportunity to participate.
- Number of youth participating in listening sessions and solutions journalism workshops
- Number of adult hours invested in serving the youth throughout the program.
- Number of adult mentors and support staff

- Links to the published stories including youth participation in each piece.
- Story analytics including reach and engagement for each piece

Teen Turn Challenge Program

The Teen Turn Challenge is designed to be a faith based comprehensive study course and interaction with teens and mentors from every walk of life. It is designed to teach young men the influence of Fatherhood and responsible teen and young adulthood and how to actualize a young person's potential.

This is accomplished with the care and concern demonstrated by the volunteers and male mentors. We feel the Teen Turn Challenge is the solution to help shape the identity of a young man or woman and have them understand how God as Father created them. Through this course, 3 topics in detail will be explained: Intimacy; Knowing God as Father and how that effects our relationships. Identity" Knowing who we are as men and who we are in Christ. Destiny: Knowing what you have in you and what you are here for, i.e., Purpose. All of these will be explained from a biblical perspective. The youth will be using the workbook entitled the Blueprint which provides topics geared to help developing boys into men.

We encourage all members of society to attend and participate. There is no exclusion based on sexual orientation, religion, or ethnicity The program is geared for males ages 10 to 18 years of age. The program is located at 2146 Moeller in Ypsilanti Michigan on the campus of Christian Life Center church. The program will also include matching youth with an individual mentor, providing athletic and educational events throughout the year and an opportunity to participate in a community outreach (food pantry) to volunteer their services which can be applied to community service if a youth needs community services in fulfilling requirements if a youth is court involved. Our objective is to effectuate change, starting with our younger generation of young males, shaping them to be successful productive young men and reduce the recidivism rate of delinquency and at-risk youth and those who have mental health disorders The program is slated for 3 months meeting weekly for one hour.

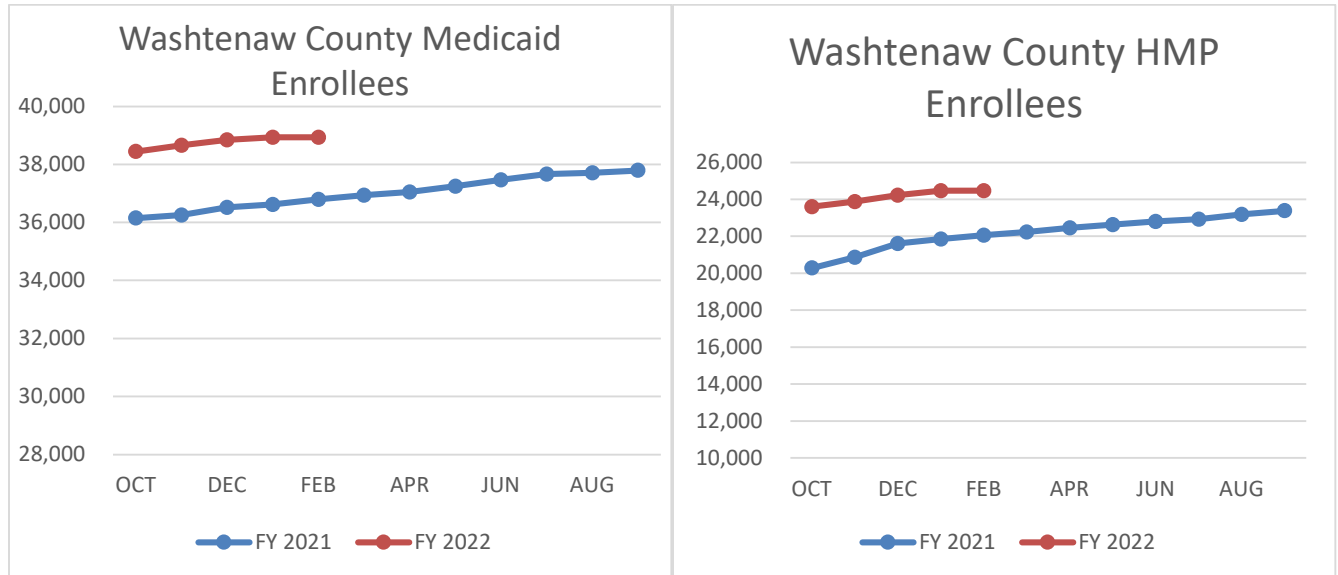
Dr. Vernon Stevenson

Coordinator of Teen Turn Challenge Program

**WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2022: For the period ending February 28, 2022
Prepared: April 5, 2022**

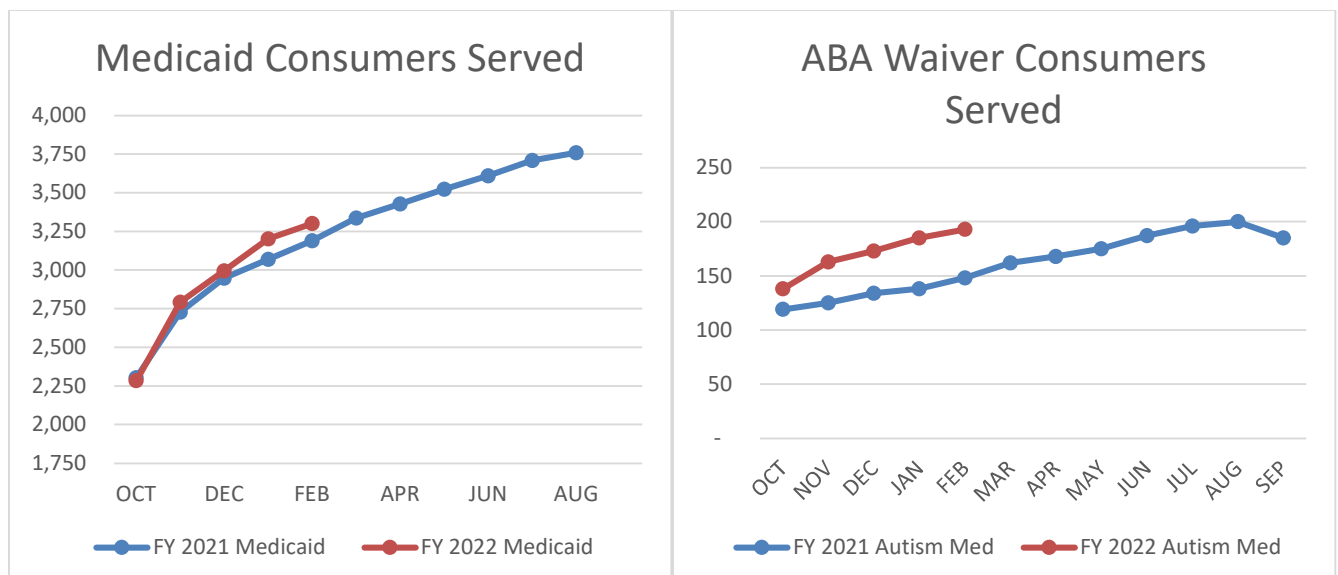
1. Washtenaw County Enrollees

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



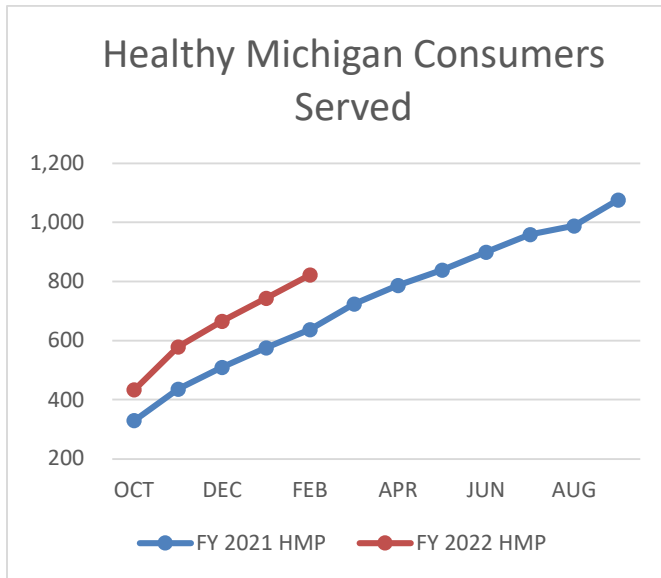
Washtenaw County Medicaid Enrollees were 38,932 in February 2022. This is a 5.81% increase from the same time last year (2,137 more enrollees than in February 2021). Healthy Michigan enrollment in February 2022 was 24,466. This is a 10.95% increase from the same time last year (2,415 more enrollees than in February 2021).

2. WCCMH Consumers Served to Date



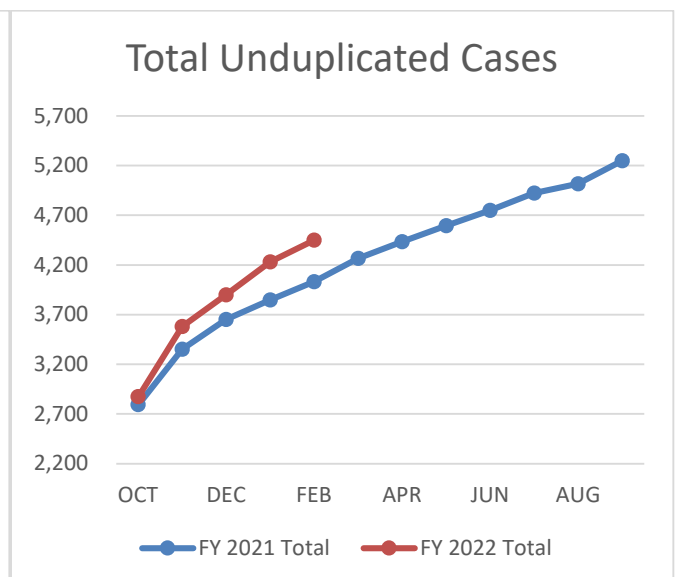
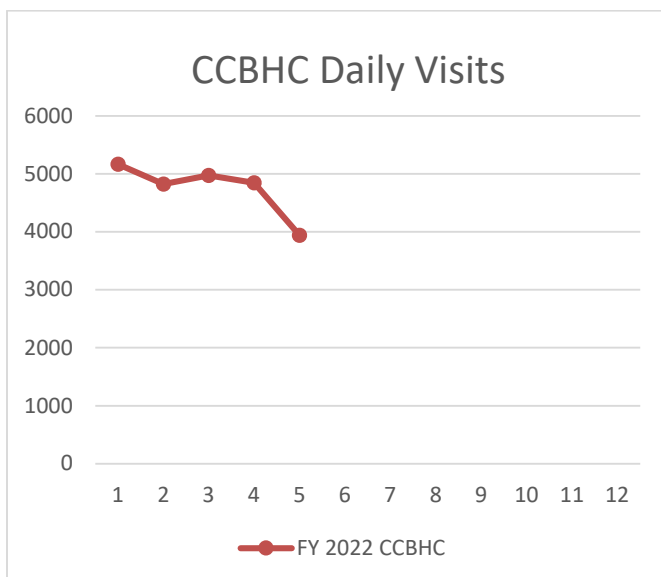
Medicaid consumers served through February 2022 are 3,302. This is 112 more consumers than the prior year (3,190 consumers were served through February 2021).

ABA Waiver consumers served through February 2022 are 193. This is 45 more consumers than prior year (148 consumers were served through February 2021).



Healthy Michigan consumers served through February 2022 were 823. This is 185 more consumers than the same period last year.

General Fund consumers served is not available this month due to reporting errors.



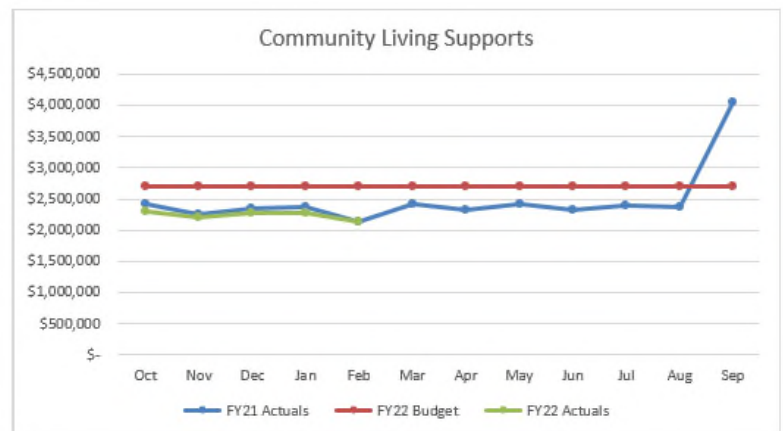
The CCBHC daily visit count for February 2022 were 3,939.

The total unduplicated consumers served through February 2022 were 4,451. This is 421 more consumers than served last year.

3. Financial Statement Highlights

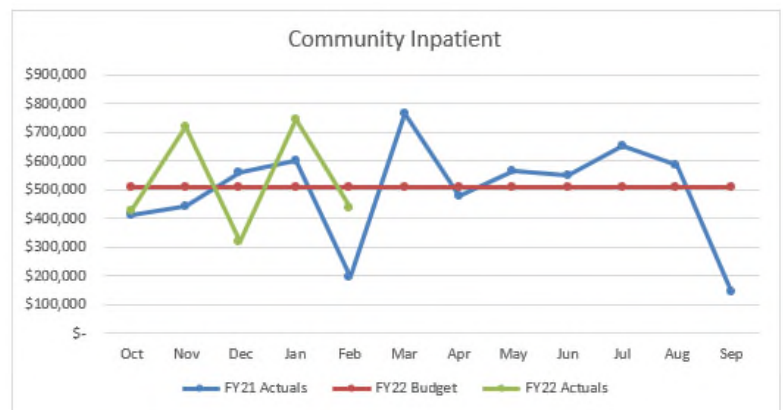
- a. CLS service costs to date are estimated to be \$11.3 Million and \$2.4 Million under budget. The costs year to date are 2.5% less than this time last year. At the end of FY21 there were additional provider stability payments made to CLS providers and are reflected in the graph below. The temporary 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	\$ 2,307,044	-4.90%
Nov	2,264,769	2,711,968	2,217,838	-3.53%
Dec	2,346,049	2,711,968	2,284,691	-3.23%
Jan	2,365,368	2,711,968	2,286,246	-3.26%
Feb	2,135,096	2,711,968	2,147,479	-2.55%
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		



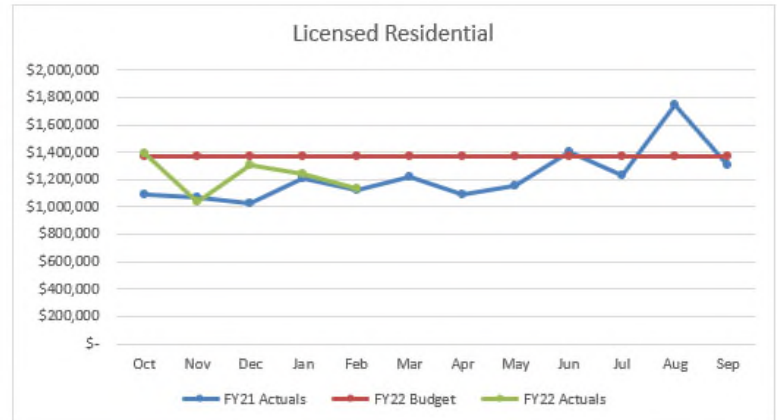
- b. Community Inpatient costs to date are \$2.6 Million. The costs year to date are 19.81% more than this time last year and \$110,000 over budget.

	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	745,851	9.64%
Feb	194,823	508,333	438,634	19.81%
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		



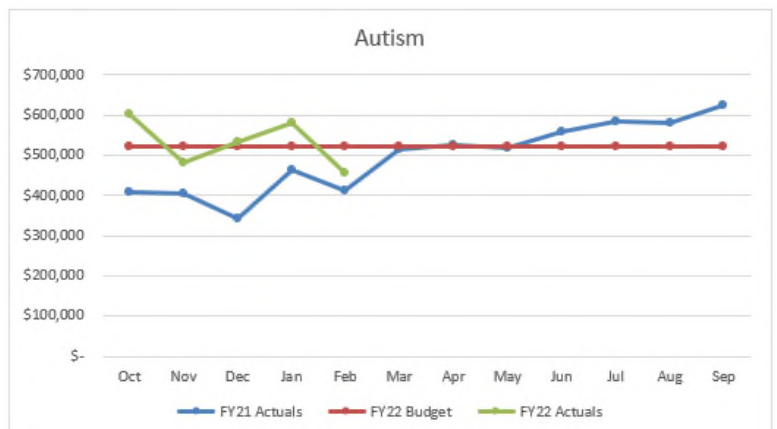
- c. Licensed Residential costs to date are \$6.1 Million and \$774,000 under budget. The costs year to date are 10.45% more than this time last year. At the end of FY21 there were additional provider stability payments made to CLS providers and are reflected in the graph below. The temporary direct 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	1,238,132	12.75%
Feb	1,118,469	1,375,450	1,134,181	10.45%
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 \$2.6 Million. The costs year to date are 30.49% more than this time last year and \$46,000 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	580,372	35.56%
Feb	410,998	520,861	453,979	30.48%
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 \$3.6 Million through February.
- c. By funding source, HMP is showing a deficit of \$258,000 through February.
- d. Overall, the PIHP surplus is \$5.0 Million through February.
- 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 \$954,000.

6. Local Key Points

- a. The majority of Local Funding comes from Washtenaw County.
- b. Local Funds are showing a deficit of \$141,000 through February.
- 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
 FEBRUARY 2022 FYTD

ATTACHMENT #10
JUNE 2022

	<u>Total</u>
Medicaid **	
Revenue	
B & B3	\$ 18,570,497
HSW	10,914,109
DCW	3,341,805
Child Waiver/SED Waiver	737,900
Autism	2,452,801
Prior Year Adjustments	-
Care for Caïd	27,694
Total Medicaid Revenue	<u>\$ 36,044,805</u>
Total Medicaid Expense	\$ 32,437,216
Medicaid Surplus/(Deficit)	<u><u>\$ 3,607,590</u></u>

CCBHC **	
Revenue	\$ 1,709,083
Expense	-
CCBHC Surplus/(Deficit)	<u><u>\$ 1,709,083</u></u>

Healthy Michigan **	
Revenue	\$ 2,618,701
Expense	2,876,740
Healthy MI Surplus/(Deficit)	<u><u>\$ (258,039)</u></u>

General Fund	
Revenue	
CMH Operations	\$ 1,764,601
CMH Operations Contra	-
GF Carryforward	-
Categorical	-
Redirect To Injectable Meds.	-
Funding Fr. Other Local Sources	5,745
Total General Fund Revenue	<u>\$ 1,770,346</u>
Total General Fund Expense	\$ 815,895
General Fund Surplus/(Deficit)	<u><u>\$ 954,451</u></u>

Injectable Meds	
Revenue	\$ 45,599
Expense	<u>40,406</u>

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
 FEBRUARY 2022 FYTD

ATTACHMENT #10
JUNE 2022

	Total
Inj. Meds. Surplus/(Deficit)	\$ 5,193
Grants And Contracts	
Revenue	\$ 602,782
Expense	602,782
Grants & Cont. Surplus/(Deficit)	\$ -
CMHSP To CMHSP	
Revenue	\$ 219,584
Redirect to GF	(5,745)
Expense	213,840
CMHSP to CMHSP Surplus/(Deficit)	\$ -
Local	
Revenue	\$ 643,040
Expense	784,958
Local Surplus/(Deficit)	\$ (141,918)
Private Grant & All NOR	
Revenue	\$ 70,251
Expense	70,251
Priv. Grant & NOR Surplus/(Deficit)	\$ -
Grand Total	
Revenue	\$ 43,818,877
Expense	37,942,518
Grand Total Surplus/(Deficit)	\$ 5,876,360

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	\$ 5,063,826
WCCMH Surplus/(Deficit)	812,534
	\$ 5,876,360

**Washtenaw County Community Mental Health
Budget to Actuals
For Five Months Ending February 28, 2022**

Current Fiscal Year					
	FY 2022 Amended Budget	FY 2022 Amended Budget YTD	FY 2022 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
<u>Operating Revenue</u>					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	\$ 46,276,405	\$ 19,281,835	\$ 18,570,497	\$ (711,338)	-3.69%
HSW	27,372,824	11,405,343	10,914,109	(491,234)	-4.31%
Children & SED Waivers	1,044,210	435,088	737,900	302,813	69.60%
Healthy Michigan Capitation	6,284,880	2,618,700	2,618,701	1	0.00%
Autism Capitation	5,886,723	2,452,801	2,452,801	(0)	0.00%
Direct Care Worker Pass-Through	8,421,349	3,508,895	3,341,805	(167,090)	-4.76%
CCBHC Supplementary	4,059,000	1,691,250	1,709,083	17,833	1.05%
TOTAL PIHP Revenue	\$ 99,345,391	\$ 41,393,913	\$ 40,344,896	\$ (1,049,017)	-2.53%
MDHHS Revenue					
State General Funds	\$ 4,235,050	\$ 1,764,604	\$ 1,764,601	\$ (3)	0.00%
Grants & Earned Contracts	1,790,168	745,903	628,858	(117,045)	-15.69%
All Other Revenue					
County Appropriation	\$ 1,751,761	\$ 729,900	\$ 313,636	\$ (416,264)	-57.03%
Project Revenue	847,984	353,327	303,343	(49,984)	-14.15%
All Other	1,917,652	799,022	932,209	133,187	16.67%
TOTAL Operating Revenue	\$ 109,888,006	\$ 45,786,669	\$ 44,287,543	\$ (1,499,126)	-3.27%
<u>Operating Expenses</u>					
Administrative Expenses					
General Administration	\$ 6,598,359	\$ 2,749,316	\$ 2,417,474	\$ (331,842)	-12.07%
Program Administration	3,355,568	1,398,153	1,280,592	(117,561)	-8.41%
Residential Services					
Community Living Supports	\$ 32,543,612	\$ 13,559,838	\$ 11,335,492	\$ (2,224,346)	-16.40%
Licensed Residential	16,505,397	6,877,249	6,102,371	(774,878)	-11.27%
Outpatient Services					
Autism Services	\$ 6,250,336	\$ 2,604,307	\$ 2,650,555	\$ 46,248	1.78%
Case Management	5,000,662	2,083,609	1,703,376	(380,233)	-18.25%
Supports Coordination	2,948,825	1,228,677	863,197	(365,480)	-29.75%
Skill Building	4,688,790	1,953,663	1,332,933	(620,730)	-31.77%
Supported Employment	1,538,321	640,967	607,831	(33,136)	-5.17%
Psychiatry	3,307,258	1,378,024	1,271,673	(106,351)	-7.72%
Nursing Services	2,397,642	999,018	880,644	(118,374)	-11.85%
Therapy Services	2,194,098	914,208	739,438	(174,770)	-19.12%
All Other	9,327,130	3,886,304	3,250,899	(635,405)	-16.35%
CCBHC Services	4,059,000	1,691,250	-	(1,691,250)	-100.00%
Other Expenses					
Community Inpatient	\$ 6,100,000	\$ 2,541,667	\$ 2,651,808	\$ 110,141	4.33%
Local Matches & Shelter	1,282,838	534,516	699,787	165,271	30.92%
Grants & Earned Contracts	1,790,168	745,903	623,113	(122,790)	-16.46%
TOTAL Operating Expenses	\$ 109,888,006	\$ 45,786,669	\$ 38,411,183	\$ (7,375,486)	-16.11%
Revenue Over/(Under) Expenses	-	-	5,876,360	5,876,360	

**Washtenaw County Community Mental Health
Budget to Actuals
For Five Months Ending February 28, 2022**

Prior Year Comparison				
	FY 2022 YTD Actuals	FY 2021 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
<u>Operating Revenue</u>				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	\$ 18,570,497	\$ 17,768,854	\$ 801,643	4.51%
HSW	10,914,109	10,801,489	112,620	1.04%
Children & SED Waivers	737,900	398,585	339,315	85.13%
Healthy Michigan Capitation	2,618,701	2,405,741	212,960	8.85%
Autism Capitation	2,452,801	1,996,658	456,143	22.85%
Direct Care Worker Pass-Through	3,341,805	1,782,296	1,559,509	0.00%
CCBHC Supplementary	1,709,083	-	1,709,083	0.00%
TOTAL PIHP Revenue	\$ 40,344,896	\$ 35,153,623	\$ 5,191,273	14.77%
MDHHS Revenue				
State General Funds	\$ 1,764,601	\$ 1,789,001	\$ (24,400)	-1.36%
Grants & Earned Contracts	628,858	535,153	93,705	17.51%
All Other Revenue				
County Appropriation	\$ 313,636	\$ 372,540	\$ (58,904)	-15.81%
Project Revenue	303,343	278,941	24,402	8.75%
All Other	932,209	792,080	140,129	17.69%
TOTAL Operating Revenue	\$ 44,287,543	\$ 38,921,338	\$ 5,366,205	13.79%
<u>Operating Expenses</u>				
Administrative Expenses				
General Administration	\$ 2,417,474	\$ 2,048,036	\$ 369,438	18.04%
Program Administration	1,280,592	1,133,948	146,644	12.93%
Residential Services				
Community Living Supports	\$ 11,335,492	\$ 11,809,643	\$ (474,151)	-4.01%
Licensed Residential	6,102,371	5,524,817	577,554	10.45%
Outpatient Services				
Autism Services	\$ 2,650,555	\$ 2,031,262	\$ 619,293	30.49%
Case Management	1,703,376	1,705,598	(2,222)	-0.13%
Supports Coordination	863,197	896,368	(33,171)	-3.70%
Skill Building	1,332,933	935,869	397,064	42.43%
Supported Employment	607,831	577,212	30,619	5.30%
Psychiatry	1,271,673	1,065,162	206,511	19.39%
Nursing Services	880,644	789,739	90,905	11.51%
Therapy Services	739,438	688,253	51,185	7.44%
All Other	3,250,899	2,753,215	497,684	18.08%
CCBHC Services	-	-	-	0.00%
Other Expenses				
Community Inpatient	\$ 2,651,808	\$ 2,213,354	\$ 438,454	19.81%
Local Matches & Shelter	699,787	603,581	96,206	15.94%
Grants & Earned Contracts	623,113	535,153	87,960	16.44%
TOTAL Operating Expenses	\$ 38,411,183	\$ 35,311,210	\$ 3,099,973	8.78%
Revenue Over/(Under) Expenses	5,876,360	3,610,128	2,266,232	

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

Prior Year FY 2021	<u>October</u>	<u>November</u>	<u>December</u>	<u>January</u>	<u>February</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>September</u>
Total Revenue	\$ 7,755,401	\$ 15,310,244	\$ 23,580,591	\$ 31,333,092	\$ 38,921,338	\$ 47,115,196	\$ 56,134,326	\$ 64,236,863	\$ 72,980,573	\$ 81,144,669	\$ 90,818,496	\$ 99,945,774
Total Expense	\$ 6,390,300	\$ 13,468,771	\$ 20,308,564	\$ 28,129,172	\$ 35,311,210	\$ 42,743,574	\$ 50,665,179	\$ 58,492,671	\$ 66,459,411	\$ 75,089,495	\$ 84,875,262	\$ 90,335,121
Surplus / (Deficit)	\$ 1,365,101	\$ 1,841,473	\$ 3,272,027	\$ 3,203,920	\$ 3,610,128	\$ 4,371,622	\$ 5,469,147	\$ 5,744,192	\$ 6,521,162	\$ 6,055,174	\$ 5,943,234	\$ 9,610,653 (a)
Current Year FY 2022	<u>October</u>	<u>November</u>	<u>December</u>	<u>January</u>	<u>February</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>September</u>
Total Revenue	\$ 9,108,033	\$ 17,714,521	\$ 26,486,887	\$ 35,542,274	\$ 44,287,543							
Total Expense	\$ 7,658,696	\$ 14,955,417	\$ 22,766,179	\$ 30,490,909	\$ 38,411,183							
Surplus / (Deficit)	\$ 1,449,337	\$ 2,759,104	\$ 3,720,708	\$ 5,051,365	\$ 5,876,360	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

(a) Includes PIHP Medicaid Surplus of \$4,639,734 which is returned to PIHP
Includes General Fund Surplus of \$2,682,639 which is returned to MDHHS
Includes Local Funds Surplus of \$2,288,280 (County \$2,013,517 deficit elimination plan contribution & \$274,763 local surplus) which offsets Fund Deficit

Washtenaw County Community Mental Health
Millage and CCBHC Grants Budget to Actuals
For One Month Ending February 28, 2022

Millage Budget

	<u>Annual Budget</u>	<u>Budget YTD</u>	<u>YTD Actual</u>	<u>YTD Actual O/(U) YTD Budget</u>
Millage Revenue				
Millage	\$ 6,565,388	\$ 1,094,231	\$ 4,448,913	\$ 3,354,682
Millage Interest Revenue	-	-	-	-
Millage GASB31 Adjustment	-	-	3,142	3,142
	<u>\$ 6,565,388</u>	<u>\$ 1,094,231</u>	<u>\$ 4,452,055</u>	<u>\$ 3,357,824</u>
Millage Expenses				
Salary	\$ 2,395,000	\$ 399,167	\$ 241,785	\$ (157,382)
Fringe	1,339,513	223,252	136,694	(86,558)
Contractors	1,500,000	250,000	75,806	(174,194)
Trainings	140,000	23,333	80	(23,253)
Operating Expenses	782,500	130,417	57,692	(72,725)
Fleet Charges	60,000	10,000	963	(9,037)
Client Care	78,500	13,083	50,617	37,534
Cost Allocation Plan	70,875	11,813	46,869	35,057
Furniture & Equipment	100,000	16,667	-	(16,667)
Depreciation Expense	10,000	1,667	-	(1,667)
Telephone	50,000	8,333	2,175	(6,158)
All Other Expenses	39,000	6,500	263	(6,237)
Total Millage Expenses	<u>\$ 6,565,388</u>	<u>\$ 1,094,231</u>	<u>\$ 612,944</u>	<u>\$ (481,287)</u>
Revenue Over/(Under) Expenses		-	3,839,111	3,839,111

*** Millage Fund Balance at the close of 2021 is \$6,883,265

CCBHC Grant

January 2022 - April 2022

CCBHC #2 - Year 2 Grant Revenue	\$ 960,000	\$ 480,000	\$ 442,572	\$ (37,428)
CCBHC #2 - Year 2 Grant Expenses				
Salary	\$ 549,300	\$ 274,650	\$ 248,248	\$ (26,402)
Fringe	315,000	157,500	150,157	(7,343)
Trainings	-	-	-	-
Telephone	7,500	3,750	3,569	(181)
Operating Supplies	1,000	500	-	(500)
Client Care	2,500	1,250	364	(886)
Indirect Costs	84,700	42,350	40,234	(2,116)
Total Expenses	<u>\$ 960,000</u>	<u>\$ 480,000</u>	<u>\$ 442,572</u>	<u>\$ (37,428)</u>
Revenue Over/(Under) Expenses	-	-	-	-

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

Millage Budget

	<u>Annual Budget</u>	<u>Budget YTD</u>	<u>YTD Actual</u>	<u>YTD Actual O/(U) YTD Budget</u>
Millage Revenue				
Millage	\$ 6,565,388	\$ 6,565,388	\$ 6,824,906	\$ 259,518
Millage Interest Revenue	-	-	44,919	44,919
Millage GASB31 Adjustment	-	-	(77,053)	(77,053)
	<u>\$ 6,565,388</u>	<u>\$ 6,565,388</u>	<u>\$ 6,792,772</u>	<u>\$ 227,384</u>
Millage Expenses				
Salary	\$ 2,395,000	\$ 2,395,000	\$ 1,762,941	\$ (632,059)
Fringe	1,339,513	1,339,513	892,930	(446,583)
Contractors	1,500,000	1,500,000	1,471,320	(28,680)
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	92,298	13,798
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	<u>\$ 6,565,388</u>	<u>\$ 6,565,388</u>	<u>\$ 4,965,686</u>	<u>\$ (1,599,702)</u>
Revenue Over/(Under) Expenses		-	1,827,086	1,827,086

*** Millage Fund Balance at the close of 2021 is \$6,883,265

CCBHC Grant

January 2022 - December 2022

CCBHC #2 - Year 2 Grant Revenue	\$ 2,250,971	\$ 2,250,971	\$ 2,031,585	\$ (219,386)
CCBHC #2 - Year 2 Grant Expenses				
Salary	\$ 1,166,672	\$ 1,166,672	\$ 1,176,594	\$ 9,922
Fringe	765,442	765,442	654,002	(111,440)
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	567	(65,683)
Indirect Costs	204,634	204,634	184,082	(20,552)
Total Expenses	<u>\$ 2,250,971</u>	<u>\$ 2,250,971</u>	<u>\$ 2,031,585</u>	<u>\$ (219,386)</u>
Revenue Over/(Under) Expenses	-	-	-	-

**Washtenaw County Community Mental Health (WCCMH)
Annual Year End Performance Improvement Report
Fiscal Year 21 (October 1, 2020 – September 30, 2021)**

Organizational Focus FY 21

- ❖ FY 21 required ongoing adjustments as COVID-19 pandemic continued. These adjustments included responding to mandates, focusing on individuals served, and managing impacts on employees' health and safety. Categorized and individualized adjustments included the following:
 - Response to mandates:
 - Monitored and responded to Centers for Disease Control and Prevention (CDC) Guidelines and Michigan Occupational Safety and Health Administration (MI-OSHA) standards regarding COVID-19 and healthcare settings.
 - Worked with Washtenaw County Public Health Department for assistance interpreting CDC guidelines and ongoing changes.
 - Developed and continually updated COVID-19 screening process for those entering our buildings (including on-site staff members and individuals served).
 - Monitored ongoing feedback and changes from accrediting organization (Joint Commission) regarding Infection Control Standards.
 - Worked with County Human Resources Department to manage privacy issues related to employee vaccinations while managing employee safety and minimizing risk.
 - Focus on systems to minimize COVID-19 risk from and to individuals served:
 - Continued to implement COVID-19 screening for individuals served as they entered our service buildings.
 - Monitored vaccination status of all clients and entered relevant information into the electronic health record (EHR) also known as "Confidential Record of Consumer Treatment" (CRCT).
 - Offered Johnson and Johnson vaccinations via vaccination clinics twice in all service buildings (Towner, Annex and Ellsworth).
 - Offered Pfizer vaccination to youth via two clinics at the Youth and Family program (Ellsworth).
 - Began offering services either in person or via telehealth or telephone based on the individual's choice.
 - Collaborated with the County administration and the Delonis Center to assist the homeless population during the pandemic. Emphasis on:
 - Working with a local area hotel which provided housing to the homeless to help them avoid COVID exposure. These services then switched to another local hotel and then ended in July 2021.
 - While individuals received this temporary shelter, we helped house twenty two individuals through our PATH program.
 - For those who required a higher level of care in an emergent situation, a policy and procedure for rapid COVID testing was developed which minimized barriers to individuals receiving the most appropriate level of care.
 - Worked with the Health Department as consumers were exposed to or tested positive with COVID-19 and required contact tracing.
 - Focus on employees:
 - Collaborated with the Washtenaw County Public Health Department to allow WCCMH staff members to gain access to vaccinations as members of the priority population.

- Continued to obtain, maintain, and monitor the supply and distribution of Personal Protective Equipment (PPE) for our staff members and providers.
 - Regular and ongoing reminders regarding the required use of PPE and COVID screening for our staff members.
 - Worked with the County Human Resources and Public Health Department as employees were impacted by COVID-19 (exposure, testing positive, contact tracing, requirements for isolation, when to return to work, etc.).
 - Assisted employees with understanding CDC guidelines if they were exposed or tested positive.
 - Updated screening and testing protocol when a widespread community outbreak occurred.
- Administrative focus:
 - Developed and implemented rotating schedule for onsite and offsite staff members to minimize possible COVID-19 virus exposure by maintaining social distancing while maximizing services to individuals. This schedule required constant attention and revision as staff needs and/or requests changed.
 - Navigated and created solutions that pertained to reopening buildings to the public.
 - Monitored overall compliance with mandates and opportunities to assist our community.
 - Improved our telehealth processes.
- ❖ FY 19 and FY 20 were impacted by changes in the capitated funding model resulting in revenue changes and subsequent actions to minimize that impact. Continuing to work with the WCCMH Board, Washtenaw County's Board of Commissioners, and County Administration, WCCMH's hiring freeze (implemented in FY 19) resulted in continued clinical and non-clinical administrative positions remaining vacant. Due to positive revenue changes, the hiring freeze was lifted in the summer of FY 21. Then, starting in late spring of FY 21, "The Great Resignation" impacted much of the nation including a statewide impact on available and willing individuals applying for clinical positions in the Community Mental Health service arena. The number of position vacancies at the beginning and end of the FY 21 are as follows:
 - FY 21 began with the following vacancies:
 - 58 total vacancies
 - 48 vacant program positions
 - 10 vacant administrative positions
 - FY 21 end of fiscal year vacancies:
 - 85 total vacancies
 - 72 vacant program positions
 - 13 vacant administrative positions
- ❖ Additionally, management resources were also impacted due to various leave of absences resulting in:
 - Upper management managing significant leave of absences without disruption of employee management and service implementation.
 - During the third and fourth quarter WCCMH saw an increase in resignations and a significant decrease in individuals applying to work with CMH. Program Administrators, Supervisors and frontline staff members had to respond to the intense pressure of increased caseloads knowing that:
 - Increased caseloads forces the clinician's time to be spread across more cases which lowers the amount of time the clinician has for each case.
 - The lack of available time impacts the development of a therapeutic rapport with the consumer which research identifies as the best predictor of good outcomes.
 - A lack of time impacts the ability to engage and discover the consumer which helps reveal additional needs and/or symptoms the consumer/family may be experiencing.

- The lack of time could result in 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 know or understand issues the consumer or family are facing.
- Less time to spend on evidence-based practices with the consumer and their family will impact the ability to achieve the outcomes we are striving for.
- A lack of time is available to spend completing the arduous volume and processes of the Medicaid guidelines.
- The lack of time impacts the ability to implement steps toward improving processes identified in audits leading to higher expectations of staff who struggle with a large caseload and continued additional compliance expectations.
- The limited time requires Supervisors to cover additional duties including carrying caseloads, being senior staff on call for other programs when no other staff were available as well as a constant and intense demand for their time.
- The caseloads and constant shifting required staff members to assist consumers in other programs due to the ongoing vacancies and increased caseloads.
- The highest priority amongst all the expectations is to provide the needed services to the client.

Additional foci for FY 21 included the following:

- ❖ Developed and prepared for full implementation of a Certified Community Behavioral Health Clinic (CCBHC).
- ❖ Deployed a survey of telehealth utilization to identify future improvement opportunities.
- ❖ Reviewed and implemented new code procedure transactions as mandated by the Michigan Department of Health and Human Services (MDHHS).
- ❖ Continued to implement a process to help manage and monitor virtual/hybrid work processes and productivity to replace previous “in person” processes.
- ❖ Implemented the Black Lives Matter (BLM) Taskforce:
 - June 2020, WCCMH Board approved the WCCMH BLM statement.
 - September 2020 – a taskforce was identified to develop and implement the BLM activities.
 - Taskforce comprised of organization employees as well as community members.
 - Internal focus of BLM included developing a more culturally sensitive and aware workforce to help improve therapeutic rapport and effectiveness of our services.
 - External focus of BLM to increase exposure to WCCMH and help minimize stigma associated with mental health services.
 - Externally, in addition to reducing stigma in the African American Community as it relates to mental health but also look at some issues dealing with gun violence, voting rights, and health disparities.
 - Task force met Bi-weekly (2x/month).
 - Taskforce activities built upon the theme: “The Indirect Effect of Injustice”.
 - Regular meetings of a Book Club.
 - Offered “Chat and Chew” with the following topics:
 - Black History Moments
 - KKK and Law Enforcement
 - Black Wall Street
 - Social Workers Role in Undoing Racism
 - Modern Day Lynching
 - Voting Laws
 - The Racist Roots of American Policing
 - Presented film “Love is the Answer”
 - Set up a booth at Juneteenth celebration in downtown Ypsilanti.

- Sponsored Jazz Festival in downtown Ypsilanti.
- Facilitated required training for WCCMH employees – “Death by a Million Cuts”

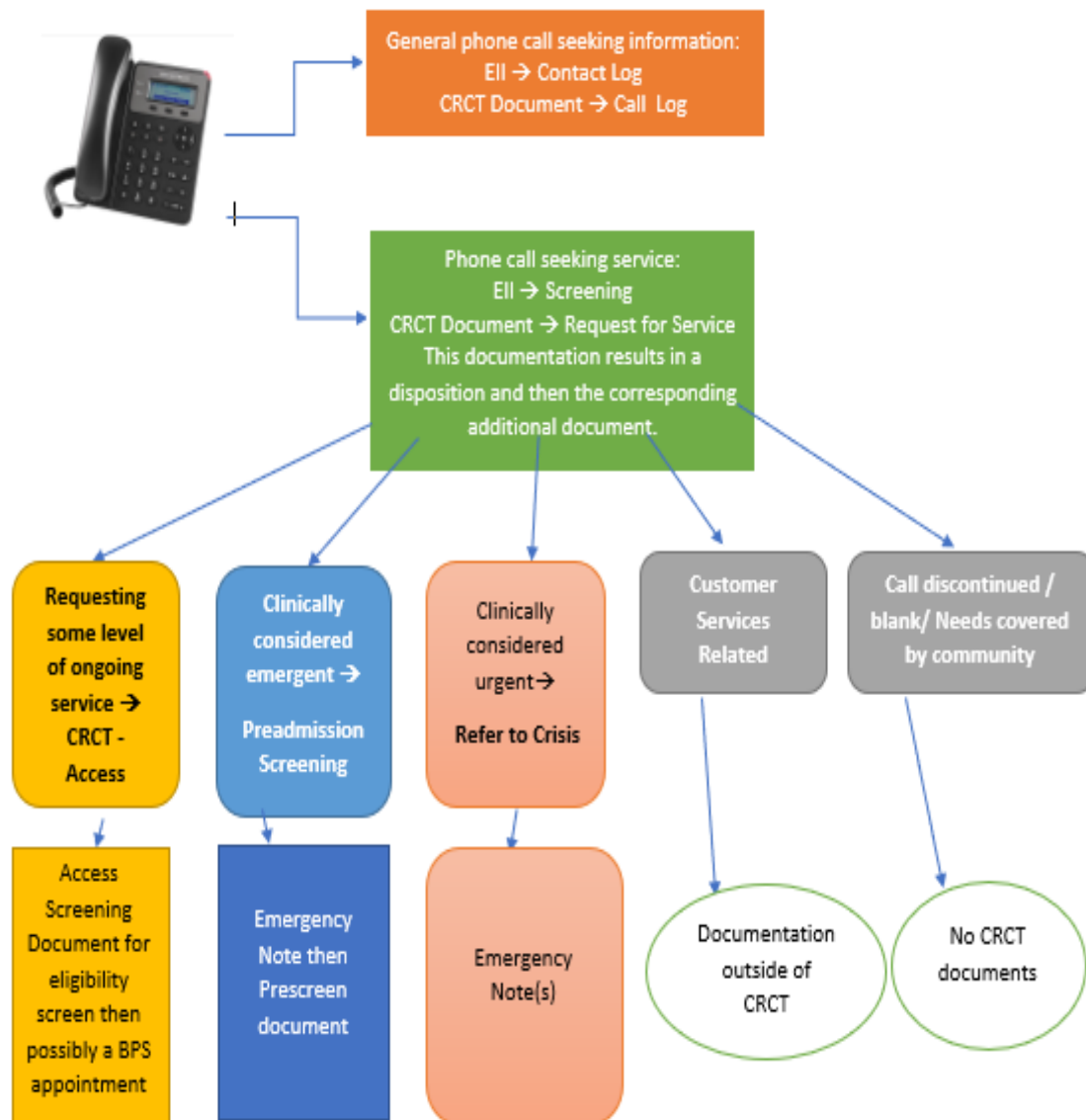
Initiative	Crisis services	Stabilization services	Peer support services	SUD services	Housing services	Education & prevention	Reducing stigma	Needs assessment & planning	Grants: supplements millage \$	Status	Date Implemented, Expected, or Completed
CARES	✓	✓	✓	✓	✓	✓				Implemented	May 2019
CCBHC	✓	✓	✓	✓		✓			✓	Implemented	May 2019
750 Towner	✓	✓								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										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 Health psychiatry access	✓	✓								Implemented	November 2019
SUD system transformation				✓		✓	✓	✓	✓	In progress	Ongoing
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 House Psychiatry Access					✓					Implemented	June 2021
5 Healthy Towns								✓		In progress	Ongoing

- ❖ Continued to advocate and respond to direct care worker staffing shortage through the implementation of \$2.25/hour as well as additional stability payments to support residential service providers with workforce challenges.
- ❖ Washtenaw County’s Public Safety and Mental Health Preservation Millage of 2018 (Millage) – below is the Dashboard which reflects the progress on various millage funded projects.

This concludes a narrative overview of various activities conducted during the FY 21. Additional information follows which includes WCCMH’s performance in some areas of efficiency and effectiveness as indicated by presenting various indicators monitored throughout the year. These indicators may reveal trends and patterns which assist our future foci. This is a summary review of our status in FY 21.

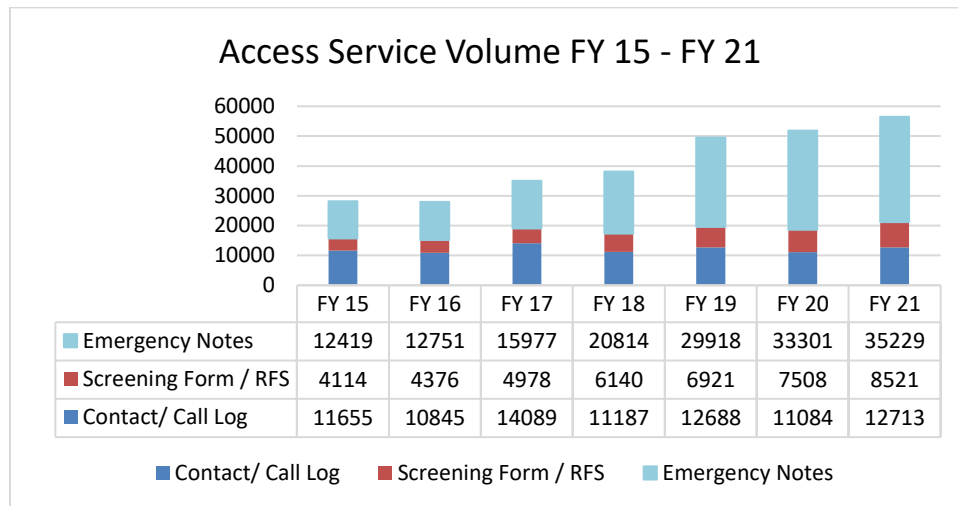
Access, Triage and Crises

Our indicator monitoring will begin with our front door and access to our services. Typically, the process starts with a phone call (though we also respond to those who walk in to our locations). Below is a graphic to help understand the flow of a phone call to our organization regarding a consumer or a potential consumer and the subsequent document in the electronic health records (EHR). The EHR “EII” was in place until April 1, 2018 at which time “CRCT” became the new EHR.



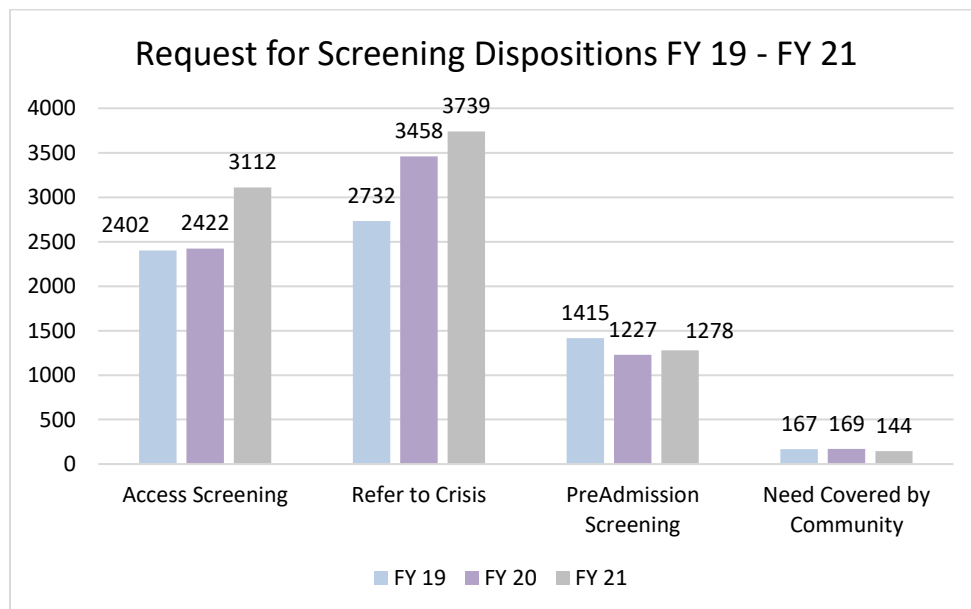
The following describes the process as well as documentation in the current electronic health record, “CRCT”. The phone call may result in a Call Log or Request for Services (RFS) when services are being requested. If the call is considered routine, the RFS will route to an Access Screening to complete the screening of, and scheduling for, a Biopsychosocial (BPS). If the phone call is considered urgent, the call will be routed to the Crisis Team which results in an Emergency Note. If the situation is considered emergent, the call will be routed for a Prescreen evaluation to determine the necessary level of care and subsequent follow up.

Below is a graph of Access Services from FY 15 – FY 21. The data is from “EII” (FY 15 – 2nd qtr FY 18) and “CRCT” (3rd qtr FY 18 – FY 21).



Monitoring the total number of services over seven fiscal years show a steady increase most likely attributed to marketing based on millage funded expansion of services and therefore increased penetration by WCCMH, increased need in the community, and increased collaborations with various law enforcement departments.

Below is a graph for a three-year time period reflecting RFS dispositions. The RFS document produces dispositions that can help understand the type of requests that are being fielded. (The CRCT document RFS dispositions are very different than the EII document “Screening Form”, therefore the graph below displays only the CRCT RFS dispositions.) When an individual requests a service, the caller can be routed to an Access Screening, referred to the crisis team if there is an urgent issue, can be routed for a preadmission screening if there is an emergent situation or can be given information of options in the community. The graph below includes FY 19 – FY 21 RFS disposition data that pertain to a service request.

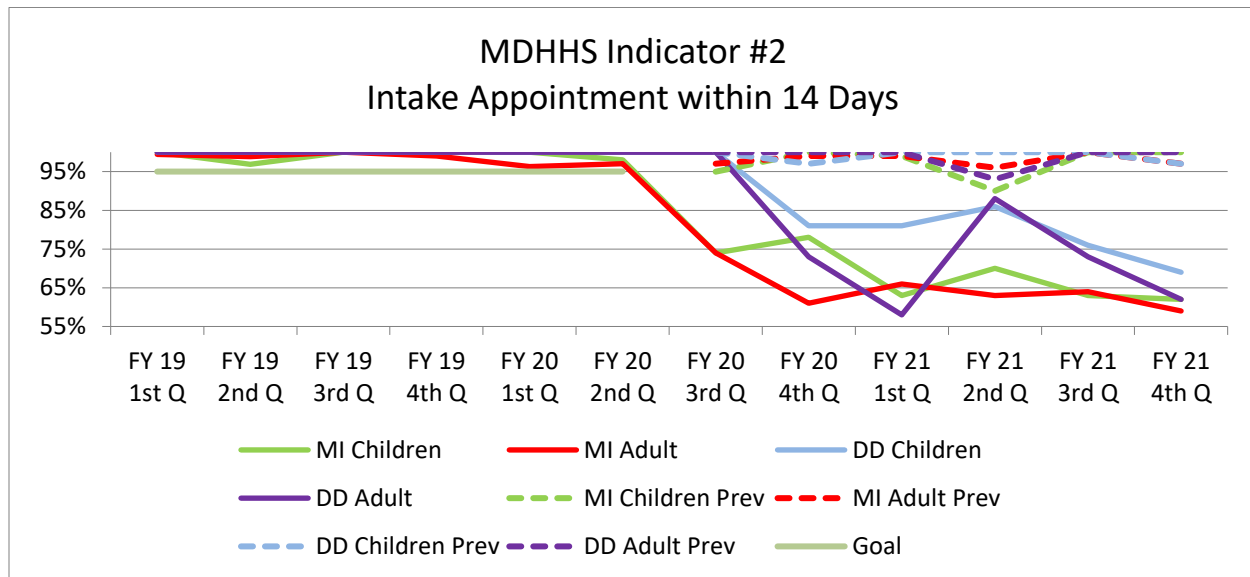


Over the past three years, there is a significant increase in request for service calls resulting in a disposition of Access Screenings and referrals to our Crisis Team. Conversely, we see a decrease in the number of calls that resulted in a preadmission screening and where the needs were met by the community. This suggests the Millage funded services (CARES) may be resulting in:

- More individuals contacting us for service and proceeding to the intake process.
- More individuals being aware of our services and calling us for assistance with their urgent situation, resulting in Crisis Team engagement (Refer to Crisis).
- Decreasing the number of emergent situations since WCCMH may have more options to respond to situations when they are urgent.
- Providing services for individuals (CARES team) rather than referring them elsewhere in the community (where often there are wait lists).

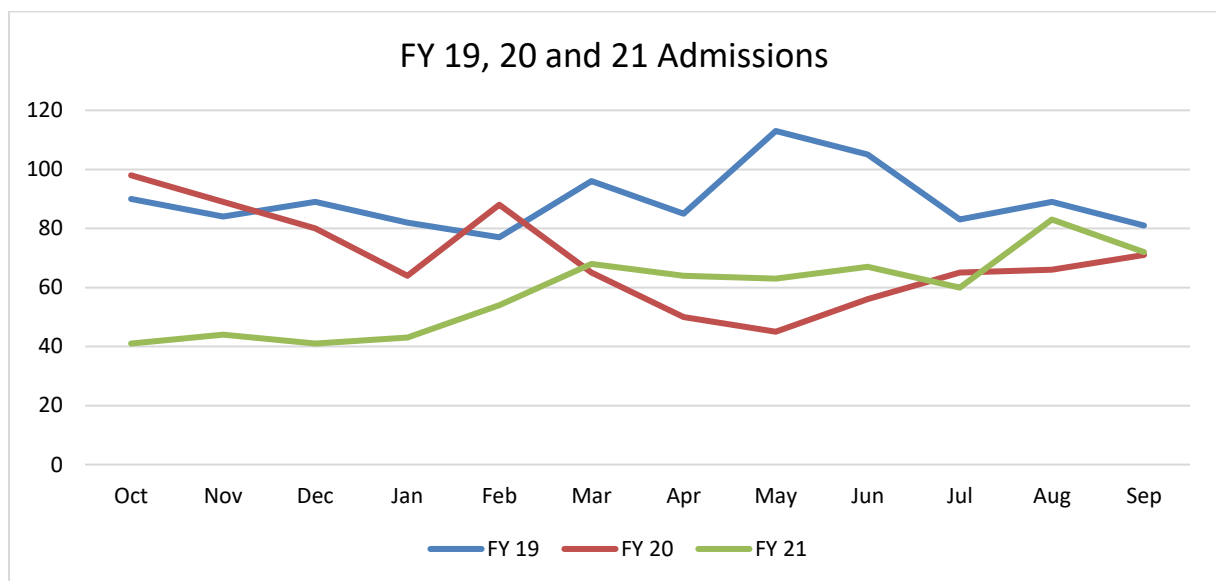
RFS dispositions, resulting in “Access Screening” leads to the Access department determining if the individual is eligible for and continuing to seek out an intake and then scheduling the Biopsychosocial (BPS) appointment. (Please note, callers seeking substance use services may be routed elsewhere.) The individual receiving their BPS/intake appointment within fourteen days of the request is one of the Michigan Department of Health and Human Services (MDHHS) performance indicators (specifically indicator #2). As of April 1, 2020, the MDHHS changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to ongoing service) and removed the historical goal of 95% compliance. The major change in the operational definition does not allow accounting for individual choice. Individual choice is indicated when the individual requests an appointment outside of the 14-day window, reschedules, cancels and/or does not attend an appointment. Because of these changes, the number of out of compliance cases has increased statewide. MDHHS is requiring each Prepaid Inpatient Health Plan (PIHP) to have each Community Mental Health Service Provider (CMHSP) develop a quality improvement plan to address one of these indicators beginning January 2022.

The graph below shows our historical compliance rate for Indicator #2 (14 days to intake) under the previous definition and the new definition starting third quarter FY 20 (April 1, 2020). The “dashed lines” indicate where our compliance would have been under previous definitions. (Please note, for State Performance Indicators, all population naming follows the MDHHS population naming convention. MDHHS continues to identify adults who experience a developmental disability as “DD Adult” while our internal programming describes these individuals as experiencing an Intellectual and/or Developmental Disability (IDD)).



The individual's preference has a significant impact on the intake occurring within 14 days. Our Access Department offers appointments as close to the request as possible hoping this will help the individual keep the appointment as a priority. However, as indicated in the third and fourth quarters, individuals seeking services often have competing priorities or other variables that prohibit them from attending appointments within 14 days. As stated earlier, there is no MDHHS goal for quarters 3 and 4 as this is considered a statewide baseline collection period.

The BPS results in identifying eligibility. Tracking admissions into WCCMH reveals the following graph:

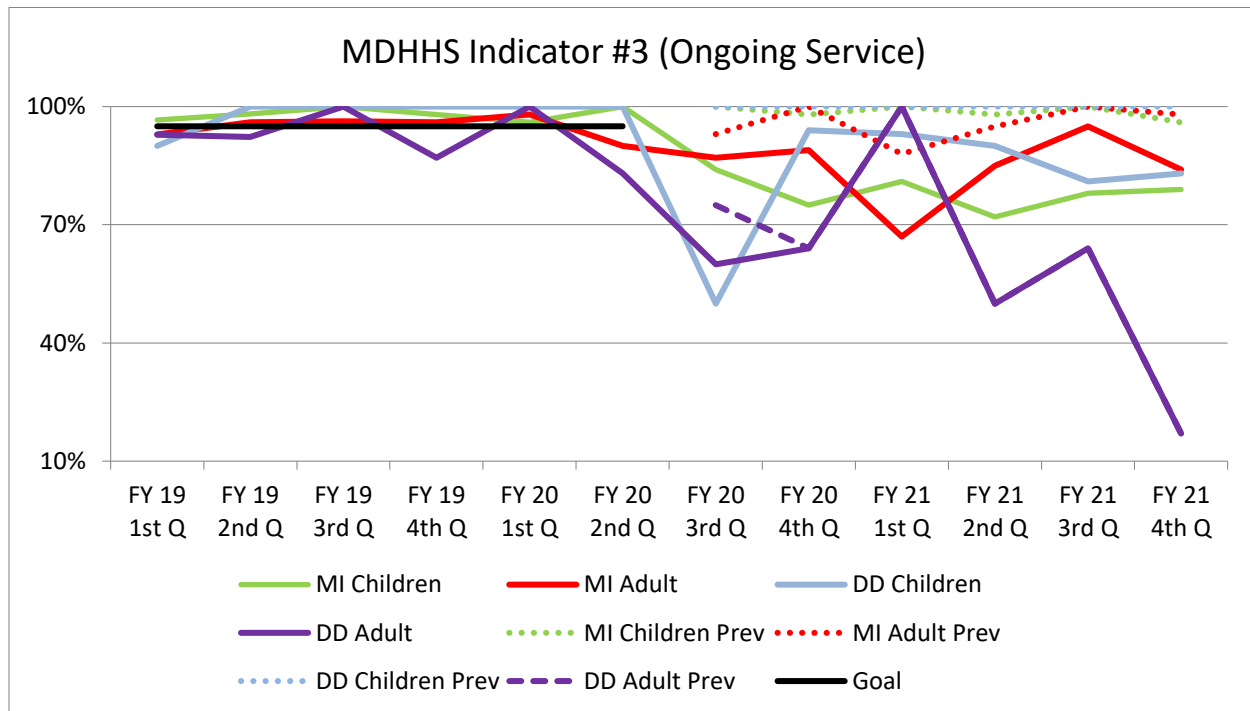


The FY 21 admission rate for WCCMH core programs continues to be lower than admissions in FY 19 though steadily increased over the fiscal year.

After the individual is found eligible to receive services, it is expected that ongoing services occur within 14 days. This is monitored via the MDHHS performance indicator (#3). (Again, the MDHHS operational definition changed for this indicator and does not account for individual choice when

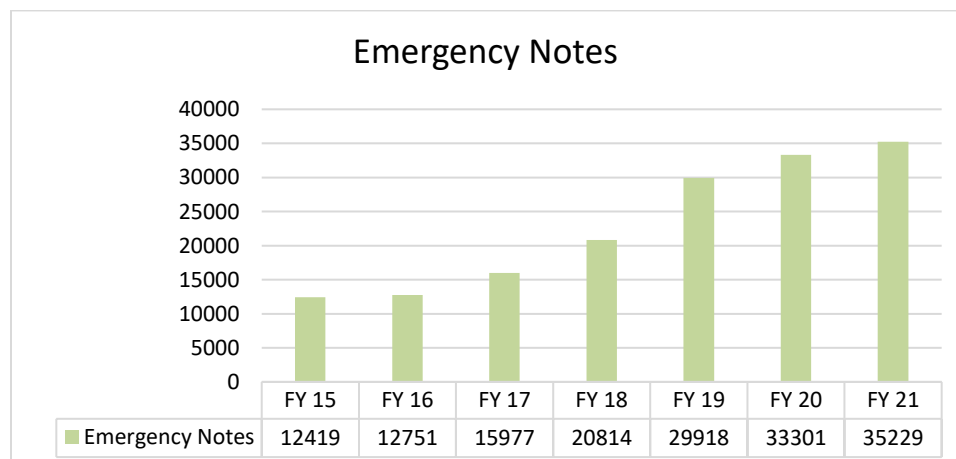
JUNE 2022

determining compliance. An additional change that impacts indicator #3 includes eligible individuals declining our services would still be out of compliance.) The dotted line indicates where compliance would have been under the previous definitions.



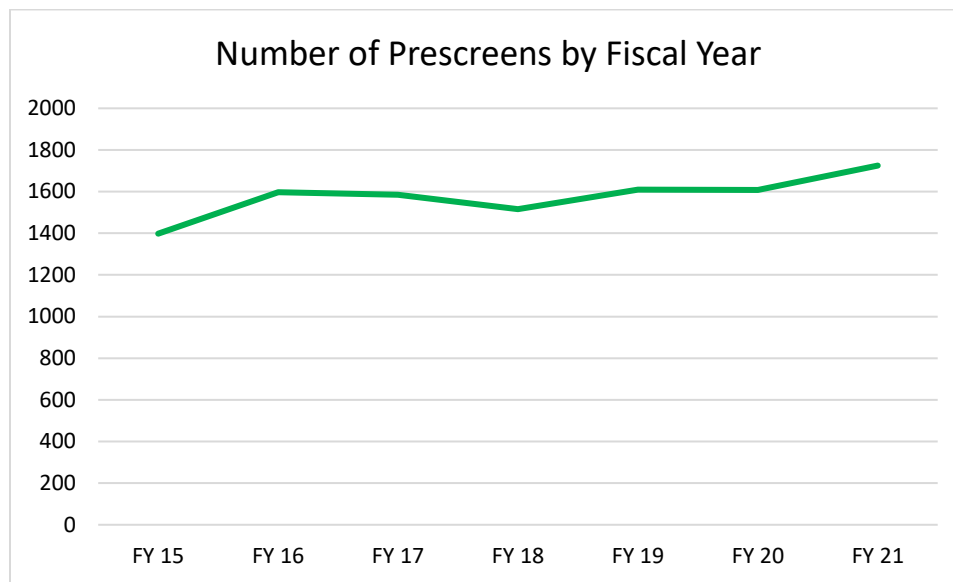
The DD Adult dashed line merges with the solid line of actual compliance indicating the individual's preference is not impacting on overall compliance. There have been programmatic changes to help the adults with an intellectual disability receive their ongoing service quicker.

Continuing to monitor the flow of a request for service, individuals who contact us for services and present with an urgent situation are referred to the Crisis Team which then results in an emergency note. (Please note, there may be multiple emergency notes connected to each issue referred and there may be Crisis Team involvement that was not initiated via the Request for Service process.) The emergency note will also occur when a Prescreen is needed. Monitoring the volume of emergency notes (which indicate an urgent issue) by fiscal years reveals a significant trend:



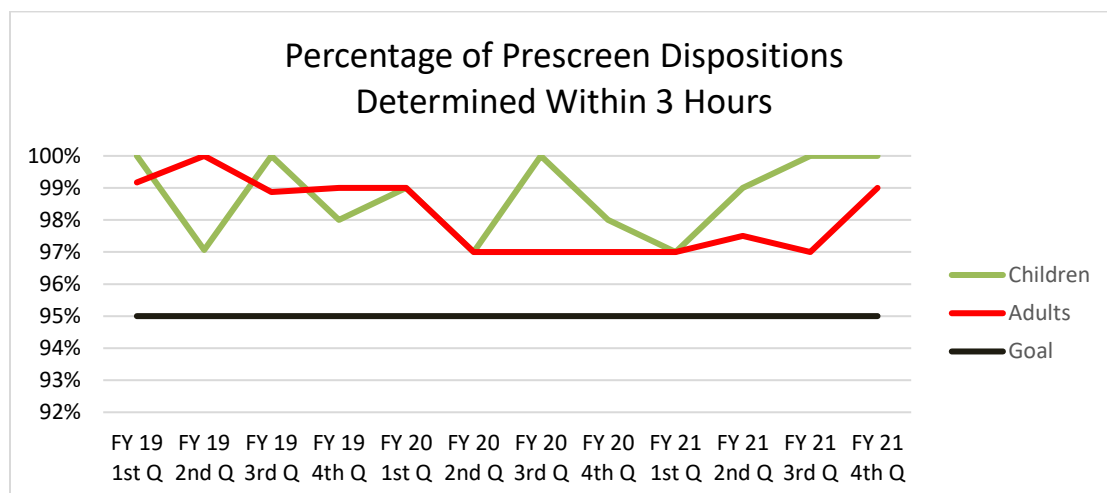
It is clear the urgent services of the Crisis Team have significantly increased over the years. The volume is almost three times higher than the volume of urgent services in FY 15.

When the RFS is of an emergent nature, the RFS can result in a direct request for a Preadmission Screening. It should be noted, sometimes preadmission screens can occur without a RFS (typically these are internal cases that require preadmission screen). The Preadmission Screen evaluates the emergent situation to identify the appropriate level of care. The preadmission screen is implemented in either a face to face or telephonic evaluation of the individual's emergent needs. Below are the total number of Crisis Hospital Prescreens over a seven-year period:

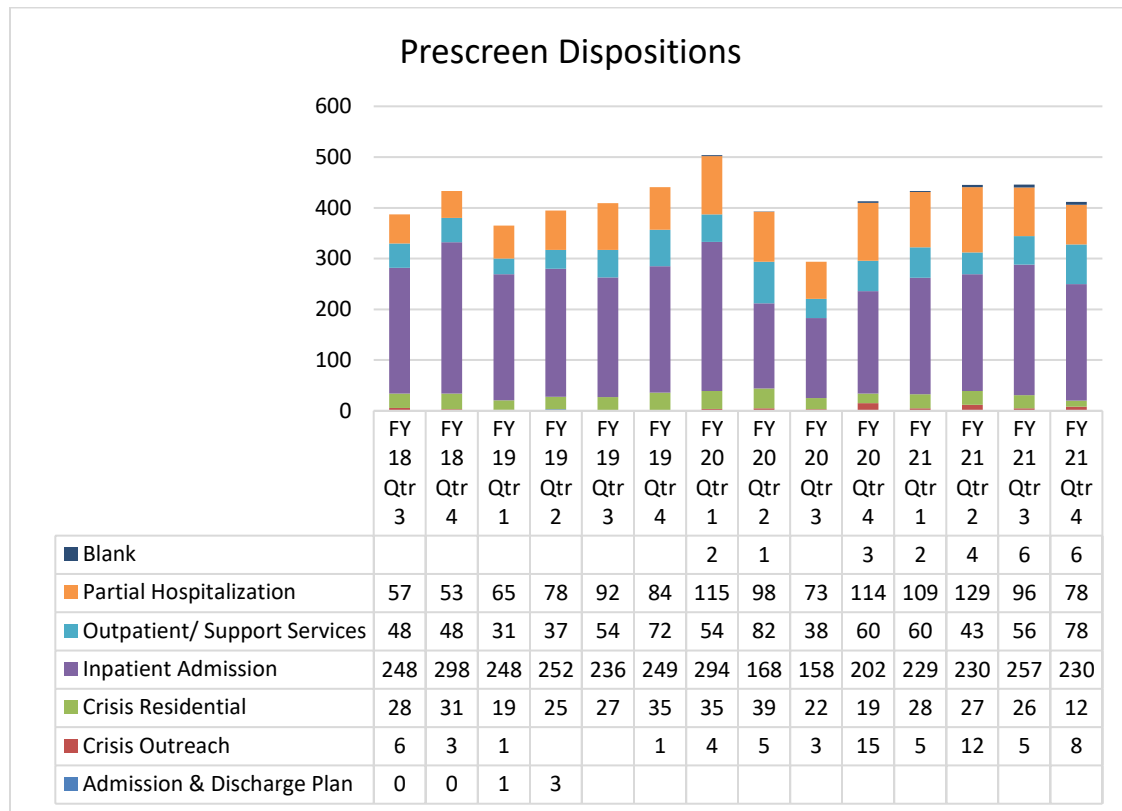


Overall, the number of Crisis prescreens in FY 21 continued the increased trend as seen over the past years. This continues to suggest possibly higher acuity in our communities and/or perhaps deeper penetration by WCCMH.

During the hospital prescreen, the organization has three hours from the moment the individual is medically cleared to complete the disposition which includes identifying the level of service needed to address the emergent issue. This is another performance indicator monitored by MDHHS (Indicator #1). Our ability to achieve higher than the expected 95% compliance is depicted below:

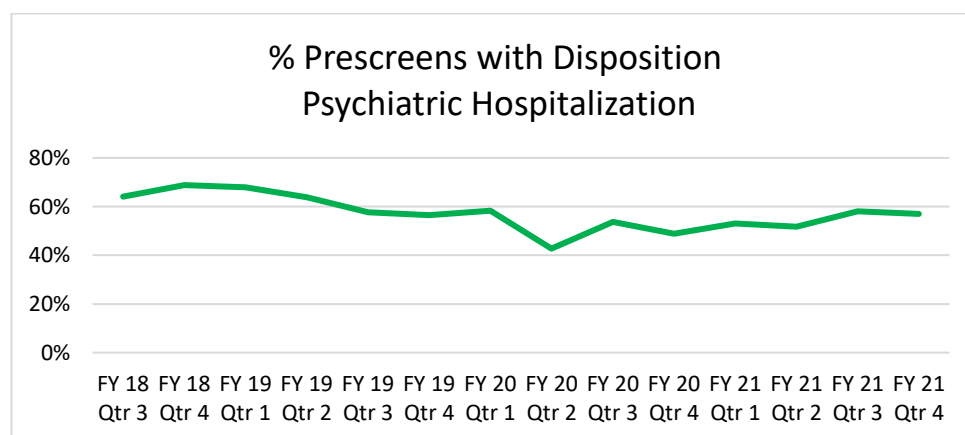


We continue to excel beyond expectations. When an individual is in a psychiatric crisis, our crisis team evaluates the individual to determine their needs and assist with appropriate treatment in the medically necessary level of care. Of the Crisis Prescreens, it is useful to look at all disposition categories that resulted from the screening. The following graph helps to pictorially represent these dispositions.



There was a higher use of Partial Hospitalization until quarter three and four. Inpatient admissions are higher than in FY 20 though overall lower than in FY 19.

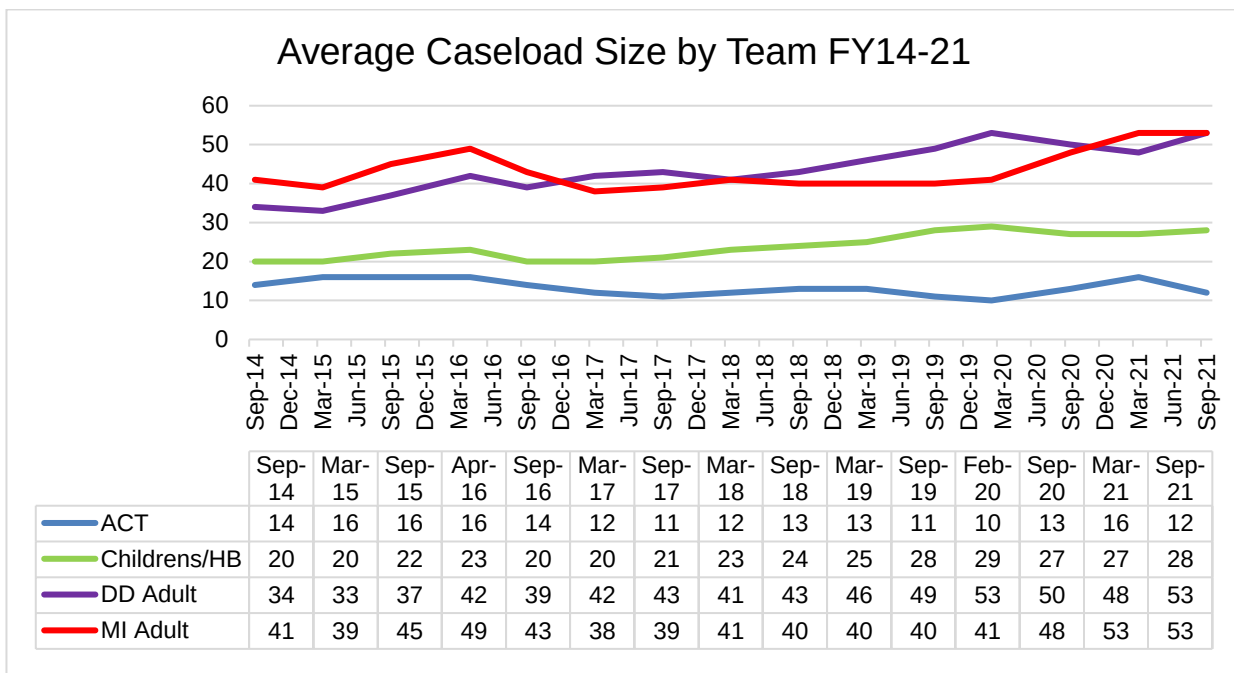
Monitoring the percentage of prescreens that result in dispositions of psychiatric hospitalizations reveals the following:



FY 21 dispositions increased in quarters 3 and 4 and seem to be at the same level as FY 19.

Caseloads vary depending on increased demand for services, turnover in staffing, the hiring freeze from FY 19 and the “Great Resignation” which resulted in higher vacancies and very few applicants for open

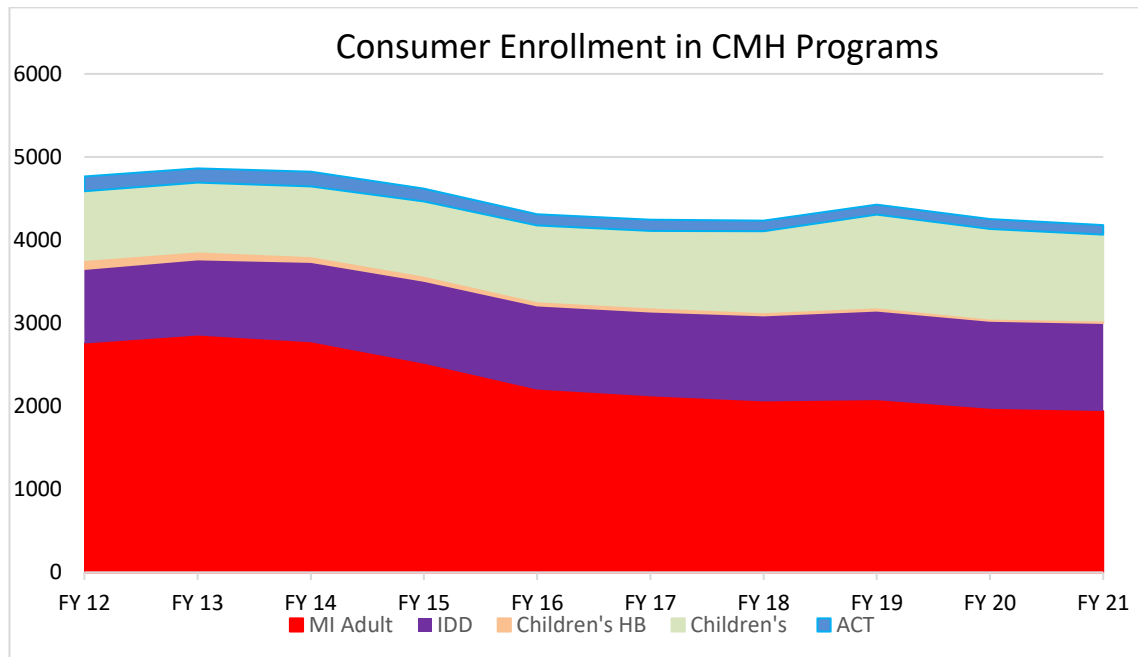
positions. The “Great Resignation” is not limited to Washtenaw County but is impacting Community Mental Health centers throughout the state and is also reported to have a nationwide impact as well. An increase in the caseload size began in FY 19 (except for the ACT program which has a mandated caseload limit) when there were several position on hold due to the financial status of the organization at that time. The number of primary staff members assigned to the cases are captured every month by the PI processes as part of the monthly management data sharing and review process. For this particular review, we captured caseload sizes at two points in time for every fiscal year and averaged those caseload sizes for their respective programs.



*Children's/ Home Based and Assertive Community Treatment (ACT) have much lower caseload sizes due to MDHHS and/or Medicaid mandates.

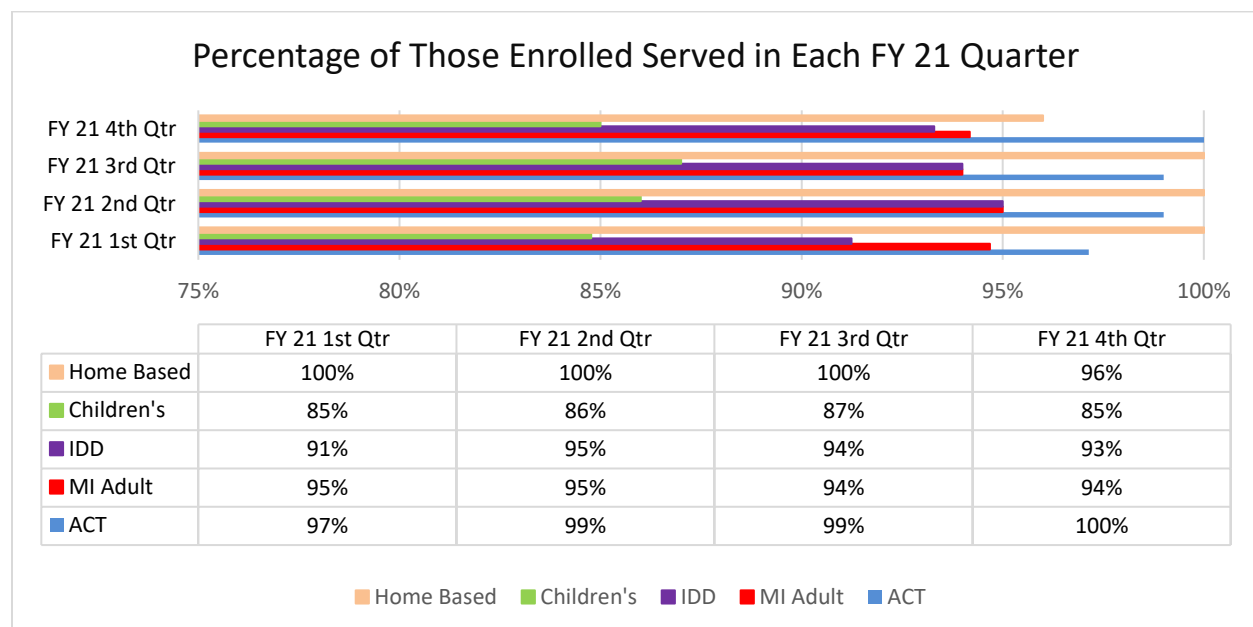
MI Adult has experienced a continued significant increase in caseload size and leveled out (as an average) in the last six months of FY 2021 (though the increased trend is anticipated to continue into FY 22). IDD also experienced an overall increase in caseload sizes which leveled out to the the same size as MI Adult.

The following graph identifies the cumulative enrollment in each of the WCCMH core programs by fiscal year.



Cumulative enrollment shows overall decrease in admission to WCCMH services. (Note – data is specific to services in the Community Mental Health programs and does not include the Cares program at this time.)

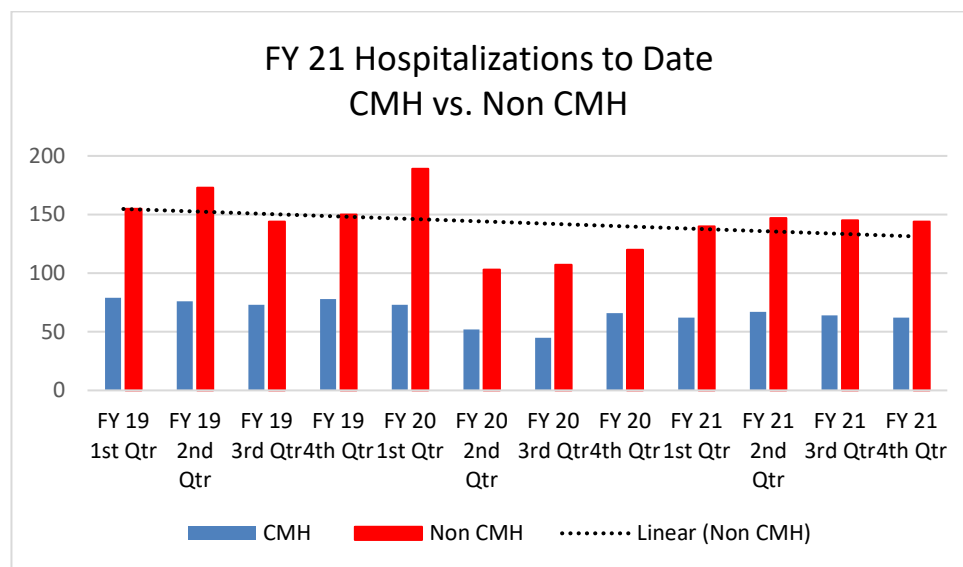
The organization's priority during this challenging time is to be sure the individual is receiving their services and that we remain in contact with them. Of those enrolled, it is helpful to monitor the percentage receiving a service in the designated time period as indicated below:



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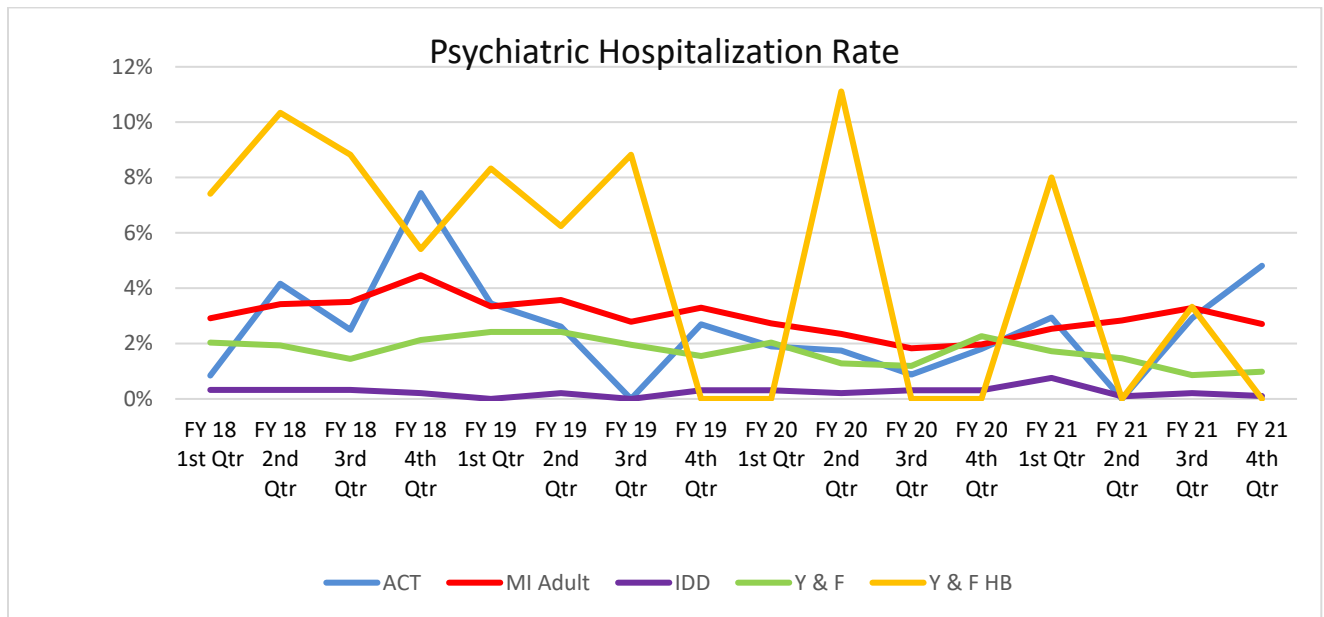
This graph displays the percentage of individuals receiving at least one service in the corresponding time period. It should be noted, engaging those enrolled in the Children's program can be quite challenging due to the competing priorities in the family's life.

Monitoring a trend of how many individuals end up in a level of care that is very restrictive helps to identify how well we are helping people remain in the community. This very restrictive setting occurs when one receives a psychiatric hospitalization. Cases receiving ongoing services from WCCMH core services may be psychiatrically hospitalized. Additionally, those who are in the community and do not have insurance or are underinsured may be psychiatrically hospitalized and funded by the WCCMH system. Of those who are psychiatrically hospitalized, some are already enrolled and active in our WCCMH service system (CMH) while some are county residents who are not enrolled in one of our core programs (Non CMH). Data regarding the hospitalization trends over three fiscal years between these two categories is depicted below:



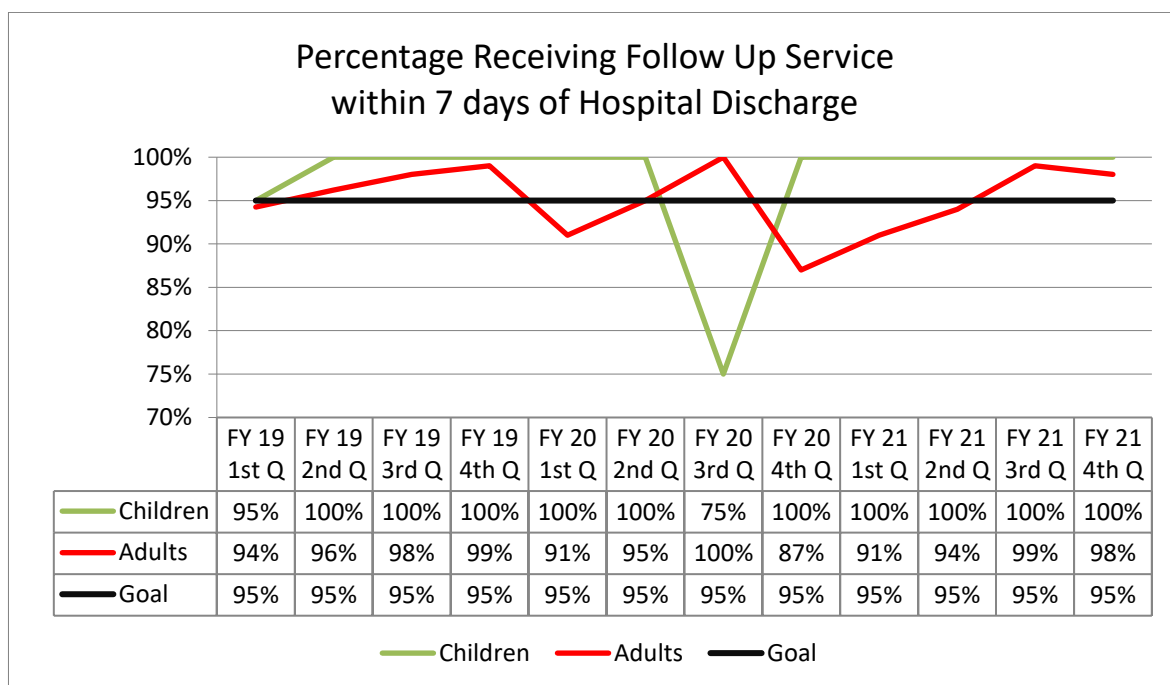
Psychiatric hospitalizations of CMH-served individuals (open CMH cases) overall have a decreasing trend from FY 19. Non-CMH individuals (not open to CMH but may be open to CARES) also show a decrease in hospitalizations. This may be due to the full implementation of the millage-funded CARES program and the 750 Towner crisis center, which opened in the Spring of 2020. It is important to note level of care recommendations are always the least restrictive service while addressing the medical necessity of the individual's presenting symptoms. Having less restrictive options for medically necessary services is recovery focused and less traumatic for the individuals we serve.

Considering a psychiatric hospitalization rate (number of individuals hospitalized compared to number of individuals served as an open case) can be a very useful measure to monitor as it helps identify the percentage of admissions per those served. The following graph helps depict these rates and possible trends:



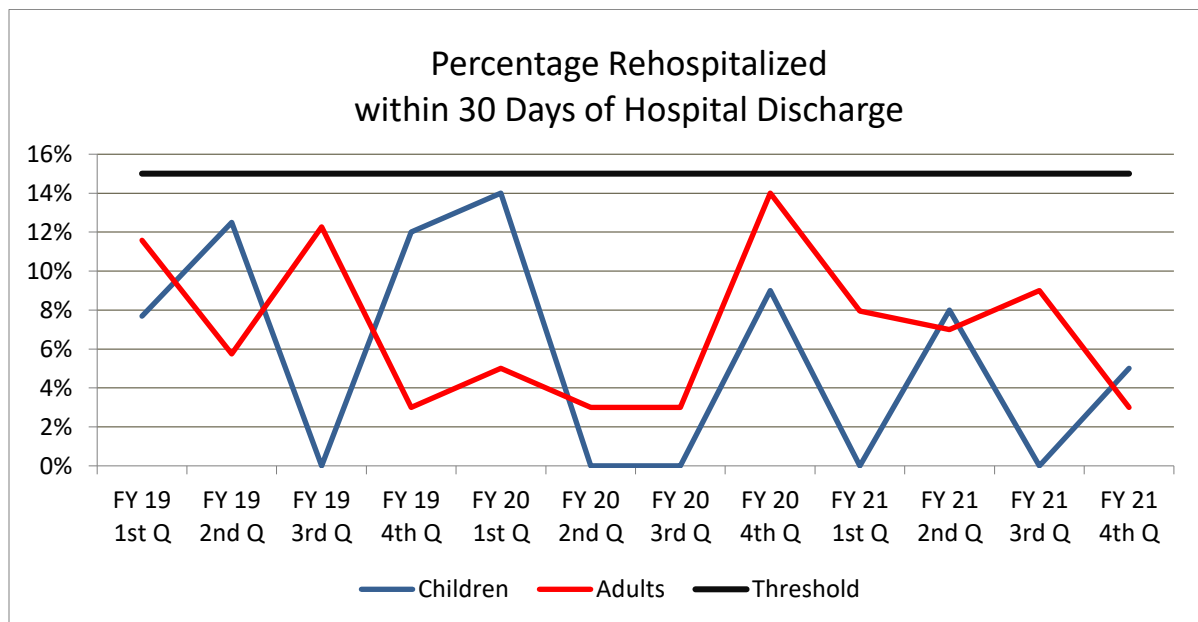
ACT has seen a slow increase in the percentage of hospitalizations and in FY 21 saw an increase in hospitalization except for the second quarter. The MI Adult Team experienced a steady increase except for the fourth quarter though overall still higher than in FY 20 but lower than in FY 19 and FY 18.

When an individual is psychiatrically discharged, they should receive a service within 7 days of their discharge. Below are graphs of the MDHHS Performance Indicator monitoring open WCCMH cases of children and adults who were psychiatrically hospitalized and received a face-to-face service within 7 days of their discharge.



Children's services did an outstanding job offering and providing the service within 7 days. The MI Adult program was impacted by caseload sizes and required an adjustment which impacted the resulting three quarters and is now appearing to do a very good job offering and providing this service.

The following MDHHS Performance indicator helps to monitor our effectiveness of avoiding repeat hospitalization within 30 days of discharge from the hospital. This graph is comprised of adults and children who are enrolled in and receive services from WCCMH, were hospitalized and then re-hospitalized within 30 days of discharge.



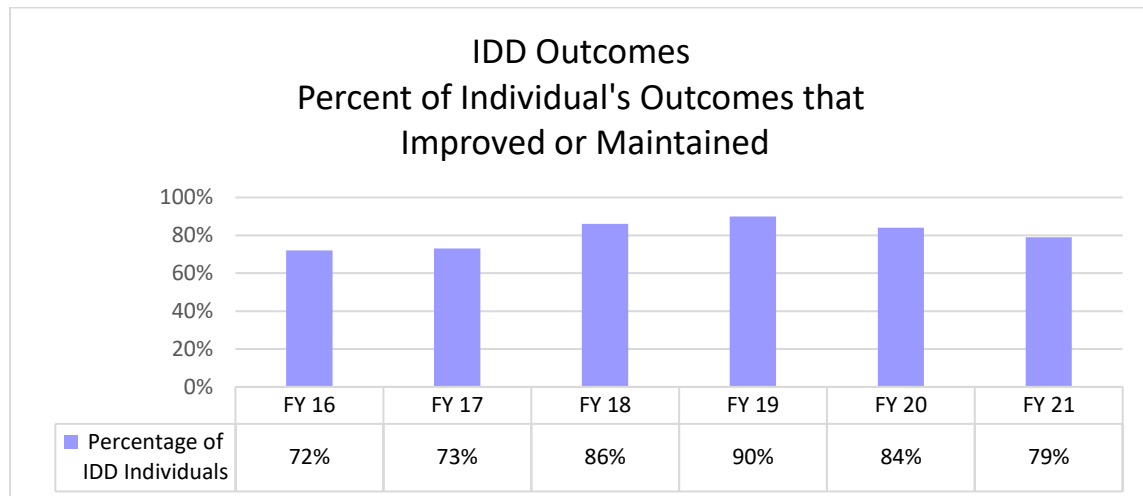
The organization continues to remain below the MDHHS threshold of 15%.

Program Outcomes

IDD Program Outcomes

Adults with an Intellectual Developmental Disability are continually assessed with the standardized “DD Outcome” tool. The tool was developed in 2007 to quantify the status of an individual’s life domains and needs. The tool was then implemented to achieve a standardized manner of collecting outcome data. The tool focuses on the individual’s status and/or level of independence in factors of Self Determination (Work, Community Living, Choice & Decision Making, Relationships, Housing) and Health and Welfare (Safety, Safety Education, Health Access, and Wellness). Their status in each of these items is assigned a quantitative designation. The range of assigned number is from 1 – 5. “1” reflects extreme need while “5” reflects that specific area is addressed and in place. Based on the sum of completed items, an average for all items is determined. This tool continues to be used in a standardized manner by WCCMH.

Identifying aggregated results of maintaining status or improving are developed based on calculating differences between the average scores of the most recent assessment and the initial assessment.



IDD shows an overall decrease in the percentage of individuals who improved or maintained their outcome values.

Youth and Family Program Outcomes

The Youth and Family program uses the Child, Adolescent Functional Assessment System (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) as valid and reliable outcome measures for children who experience a serious emotional disorder. The CAFAS is used for children who are in school and are between 7 and 18 years old. The PECFAS is used for children 3 years old and under 7 years old.

The CAFAS Total Score is the sum of the impairment ratings for the 8 subscales for the youth. For each subscale, the rater selects the item(s), which are true for the youth, which in turn, determines the youth's level of impairment for that subscale. There are 4 levels of impairment based on the score (indicated parenthetically): Severe Impairment (30), Moderate (20), Mild (10), and No or Minimal (0) Impairment.

Reviewing this outcome for FY 20 indicates the program has made a significant difference in the individuals they serve. For this administrative report, CAFAS Total Scores are aggregated across youths and a comparison is made between the scores for the initial and most recent assessments. A lower score at the most recent assessment indicates a positive change. The difference in scores is also calculated: a positive number indicates improvement in functioning, 0 indicates no change, and a negative number indicates greater functional impairment. The findings are broken down between inactive episodes of care (closed cases) and for both inactive and active episodes of care (closed and open cases).

FY 21 Child and Adolescent Functional Assessment Scale (CAFAS)

Difference Between Average CAFAS Youth Total Score for Initial and Most Recent Assessments (for inactive episodes of care with a sample size of 188): **24**

Average CAFAS Youth Total Score on Initial Assessment: **102**

Average CAFAS Youth Total Score on Most Recent Assessment: **78**

Difference Between Average CAFAS Youth Total Score for Initial and Most Recent Assessments (for both active and inactive episodes of care with a sample size of 521): **19**

Average CAFAS Youth Total Score on Initial Assessment: **101**

Average CAFAS Youth Total Score on Most Recent Assessment: **82**

The finding for inactive cases identifies a significant improvement (a score greater than 20 indicates a statistically significant change) and an impressive difference between initial and most recent assessment. The significant improvement is consistent with previous year's findings.

The finding that includes both active and inactive cases indicate a change just below what is considered statistically significant (20) though still reflects positive improvement for the children suggesting the program model is effective. Typically, we do not see a statistically significant change in this category because the active cases are still receiving interventions and may not have experienced a significant change yet.

The PECFAS is a "preschool" version of the CAFAS that assesses the child's functioning over relevant life domains and overall improvement. The PECFAS Total Score is based on the same subscales as the CAFAS and also includes information from the Caregiver (Material Needs, Family/Social Support). The four levels of impairment are the same as the CAFAS.

For this administrative report, PECFAS Total Scores are aggregated across youths and a comparison is made between the scores for the initial and most recent assessments. A lower score of the most recent assessment indicates a positive change. The difference score is also calculated: a positive number indicates improvement in functioning, 0 indicates no change, and a negative number indicates greater functional impairment. The findings are broken down between inactive episodes of care (closed cases) and for both inactive and active episodes of care (closed and open cases).

FY 21 Preschool and Early Childhood Functional Assessment Scale (PECFAS)

Difference Between Average PECFAS Youth Total Score for Initial and Most Recent Assessments (for inactive episodes of care with a sample size of 22): **13**

Average PECFAS Youth Total Score on Initial Assessment: **78**

Average PECFAS Youth Total Score on Most Recent Assessment: **65**

Difference Between Average PECFAS Youth Total Score for Initial and Most Recent Assessments (for both active and inactive episodes of care with a sample size of 56): **14**

Average PECFAS Youth Total Score on Initial Assessment: **82**

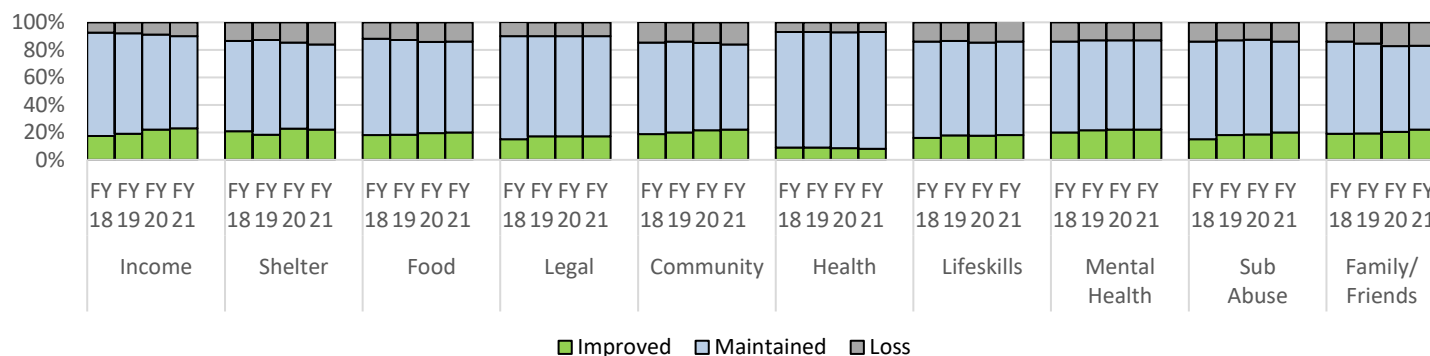
Average PECFAS Youth Total Score on Most Recent Assessment: **68**

Reviewing the outcome for FY 21 indicates the program is having a positive impact on the child (and their family) though has not achieved the significant criteria (20).

MI Adult and ACT Program Outcomes

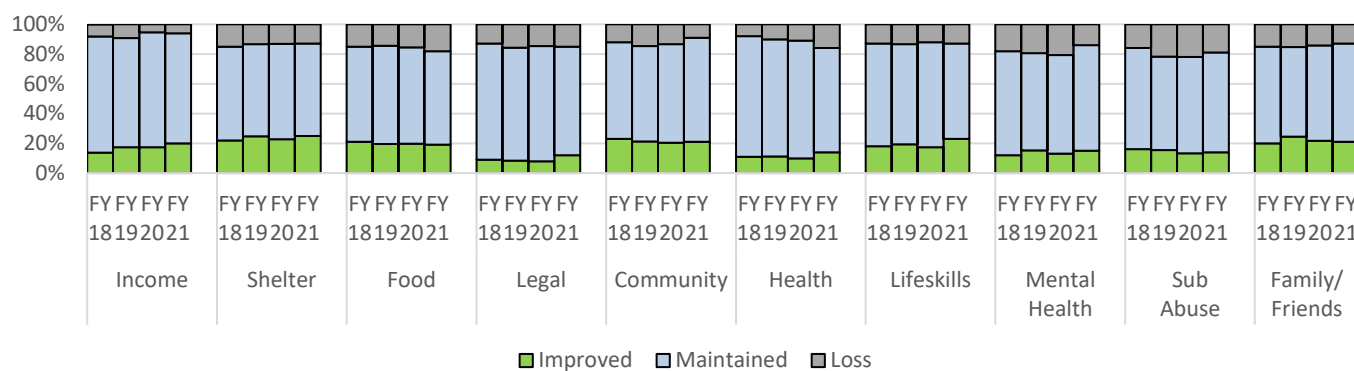
Adults with a Mental Illness are continually assessed with the standardized outcome tool called the Self Sufficiency Matrix. The Self Sufficiency tool reviews an individual's status on 13 indicators (Income, Shelter, Education, Healthcare, Mental Health, Family/ Friends, Community, Employment, Food, Legal, Life Skills, Substance Abuse and Mobility). However, for purposes of efficient display, education, employment, and mobility are not included in the graph. Values can include In Crisis, Vulnerable, Safe, Building Capacity or Empowered. Aggregated results of improving, maintaining or loss of status are developed based on calculating differences between the initial and most recent item score, categorizing for each item and each case if there was an improvement, loss or maintained and then subsequent percentages for the overall program.

MI Adult Self Sufficiency Outcome Categories



The graphs identify percentages of Improvement, Maintained, and Loss over a four-year time period. Sometimes there will be a percentage that Improved and a percentage that experienced Loss, sometimes on the same domain. This can occur because the aggregated data may reflect individuals who moved from “Maintained” and either moved to “Improved” or “Loss.” MI Adult continued to improve or maintain in six of the ten categories (Income, Food, Community, Mental Health, Substance Abuse and Family/Friends) while a higher percentage show increased loss in four categories (Income, Shelter, Community, and Life Skills). Again, the aggregated findings can show a higher improvement and loss in the same category, and which indicate the aggregated percentage of those who maintained a lower number.

ACT Self Sufficiency Outcome Categories



ACT had a higher improvement from FY 20 in eight of the ten categories (Income, Shelter, Legal, Community, Health, Life Skills, Mental Health, and Substance Abuse). Aggregated losses occurred in four of the ten categories (Food, Legal, Health and Life Skills). Again, the aggregated findings can show a higher improvement and higher loss in the same category, which indicates the aggregated percentage of those who maintained is a lower number.

Integrated Care

WCCMH continues to maintain a strong focus of integrated care. We monitor indicators of Hypertension (HTN), Smoking, Diabetes and Body Mass Index (BMI) for improvements. These definitions are:

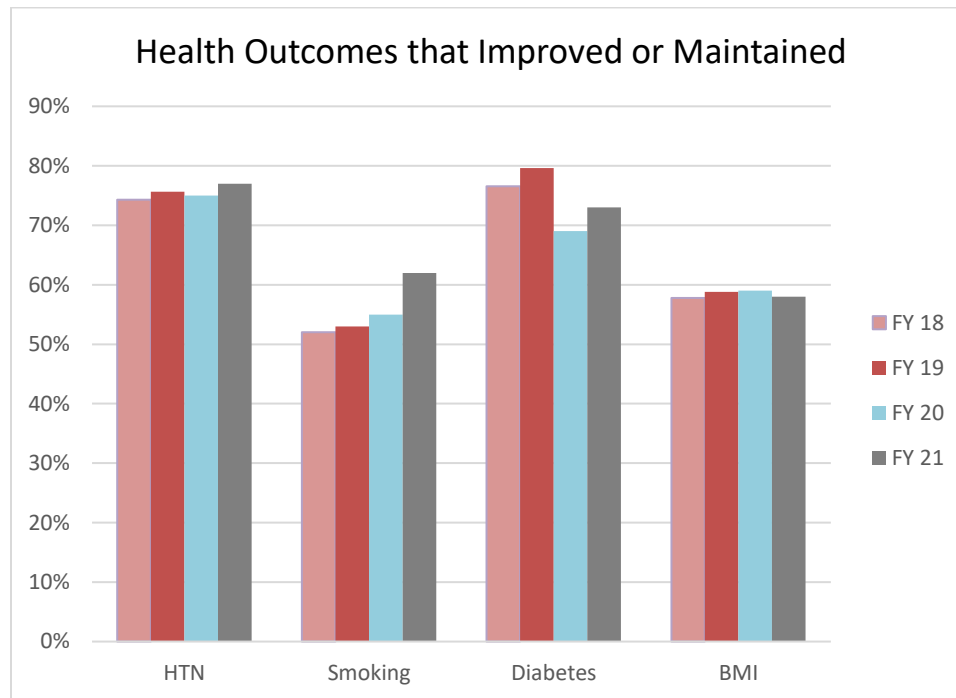
Hypertension: the percentage of individuals diagnosed with Hypertension who either improved or maintained their health based on their blood pressure.

Smoking: the percentage of individuals who either smoked in the past or currently smoke who either improved or maintained their health based on their smoking status.

Diabetes: the percentage of individuals who have a Diabetes diagnoses and a current laboratory value (within 12 months of the end of the fiscal year) who either improved or maintained their health as indicated by an improvement or maintained level of their A1C.

BMI: the percentage of individuals who either improved or maintained their health by a static or decrease in their BMI.

The graph below depicts the percentage of individuals who either improved or maintained on measures of health:



HTN, Smoking and Diabetes improved or maintained from FY 20. BMI is slightly lower in the number who improved or maintained.

Health and Mortality

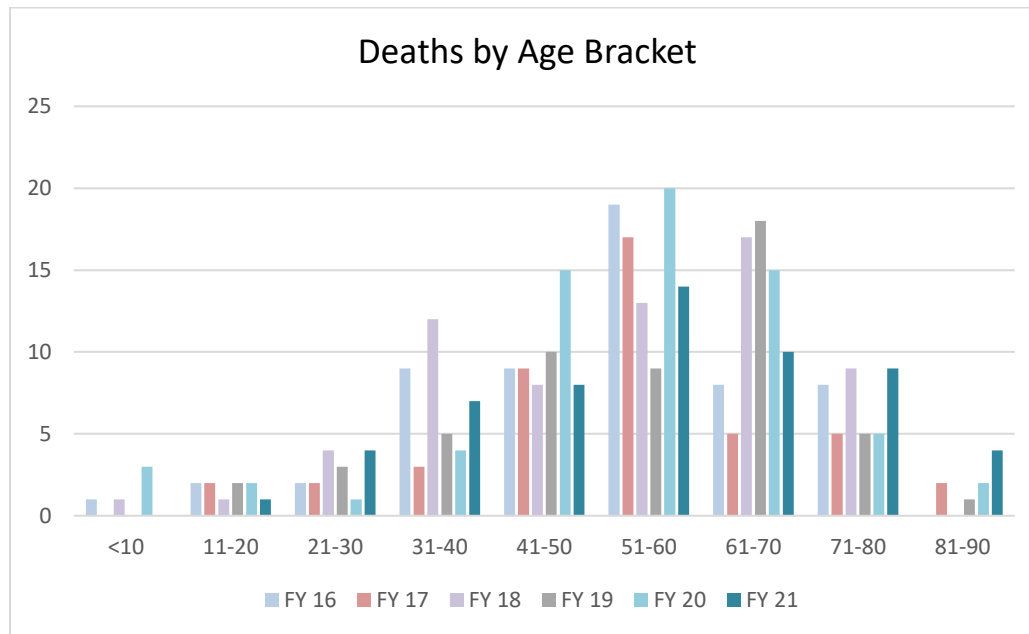
Research and industry trends identify those individuals who experience a severe mental illness tend to die much younger than their counterparts. WCCMH monitors our mortality rate, as well as the average age of the individual at the time of death. The data below are commensurate with research identified trends. For every reported individual death, WCCMH process includes reviewing the chart, obtaining the death certificate (if available) and presenting this information and the death report to the Medical Director. The Medical Director then classifies the cause of death. Below are the aggregated categories of cause of death and the average age at the time of death for each category.

Mortality

Cause of Death	FY 17	<i>Age FY 17</i>	FY 18	<i>Age FY 18</i>	FY 19	<i>Age FY 19</i>	FY 20	<i>Age FY 20</i>	FY 21	<i>Age FY 21</i>
Aspiration Pneumonia		26			1		2		2	77
Cancer	10	54	8	63	9	57	7	57	10	63
Cardiovascular	8	76	13	59	14	61	14	60	6	69
Dehydration			1	76						
Drug Abuse	6	47	12	39	5	40	8	45	2	37
Endocrine System (Diabetes)									1	50
Environmental Hypothermia					1	51		60		
Gastrointestinal							3		1	66
Hip Fracture Complications			1	60				60		
Homicide	1	33	3	30						
Inanition							2	70		
Infection		61		72		61	4 (2 - COVI D19)	80	5 (4 - COVID 19)	66
Kidney Disease	1	42	1	62			1	49		
Liver Disease	1	57	2	63			2		3	52
Metabolic					1	61				
Muscular Dystrophy										
Natural/Other	3	47	1	38				50		
Neurological	2	47	2	34	1	81	3	51	7	60
Respiratory	4	61	5	66	9	52	10		4	41
Sturge Weber Syndrome								45		
Suicide	3	47	2	44	2	22	5		2	24
Trauma			1	53	2	68		44	2	40
Unknown	3	51	9	52	10	52	8		12	57
Grand Total	# of Deaths 47	Avg Age 52	# of Deaths 65	Avg Age 56	# of Deaths 55	Avg Age 53	# of Deaths 67	Ave Age 54	# of Deaths 57	Avg Age 57

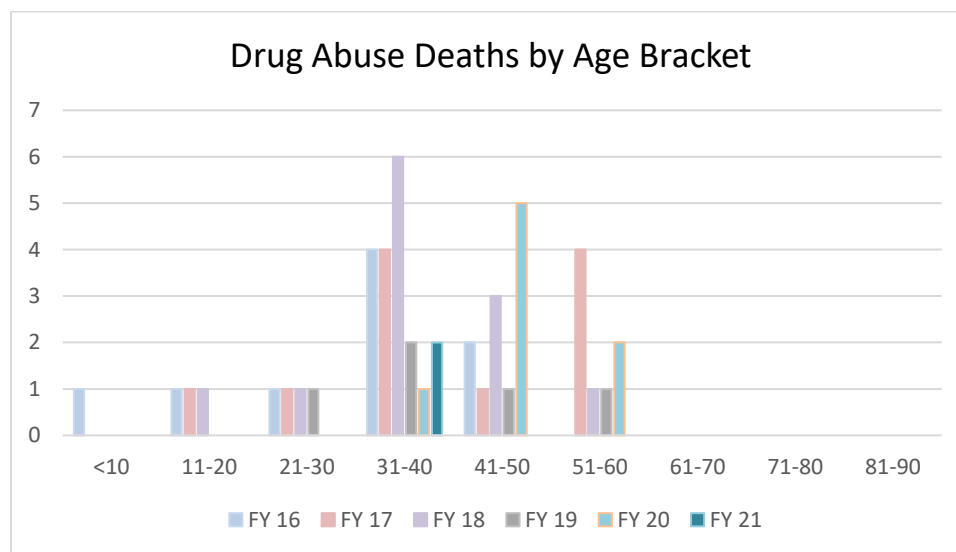
Mortality data is based on death certificates from the Washtenaw County Medical Examiner. If an individual dies out of county, we do not receive that death certificate. The number of deaths tend to vary as indicated by the six-year dataset.

Reviewing the number of individuals who were receiving services and passed away in Fiscal Year 2021 between frequency of deaths per bracketed age categories helps monitor and review baseline data and possible trends/ patterns.



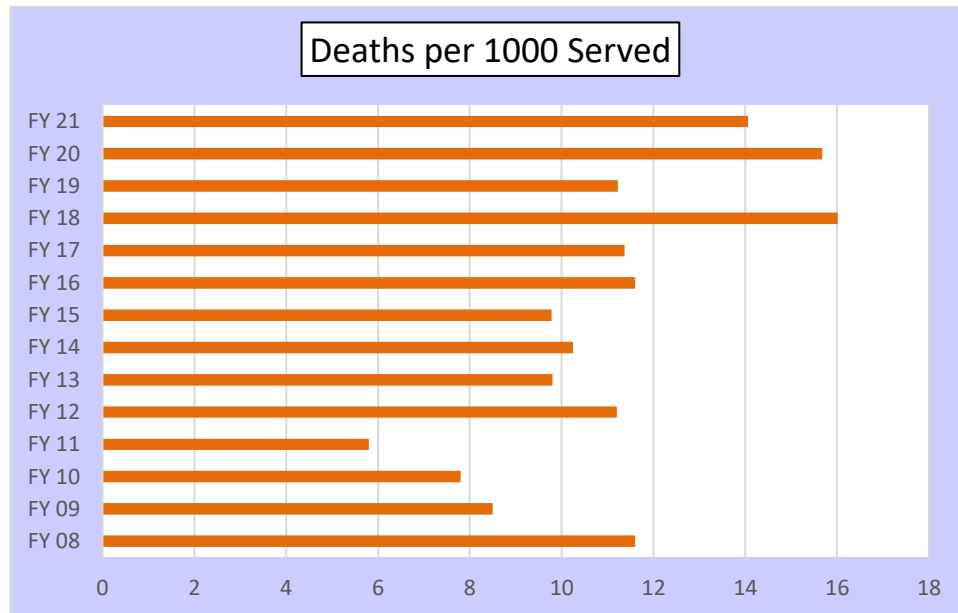
Not surprisingly, a higher frequency of deaths occurs in the older decades. We hope that helping individuals with their health will result in the frequency of deaths moving to the right on the graph, i.e., occurring in older age. The bracketed age group 81-90 continues to show an increased number of individuals which may indicate a trend toward living longer. The age groups 61-70 and 71-80 are both showing higher numbers over time.

Deaths that occurred due to accidental overdose (Drug Abuse) are much lower than in years previous. These deaths from FY 21 and their bracketed age group are depicted below:



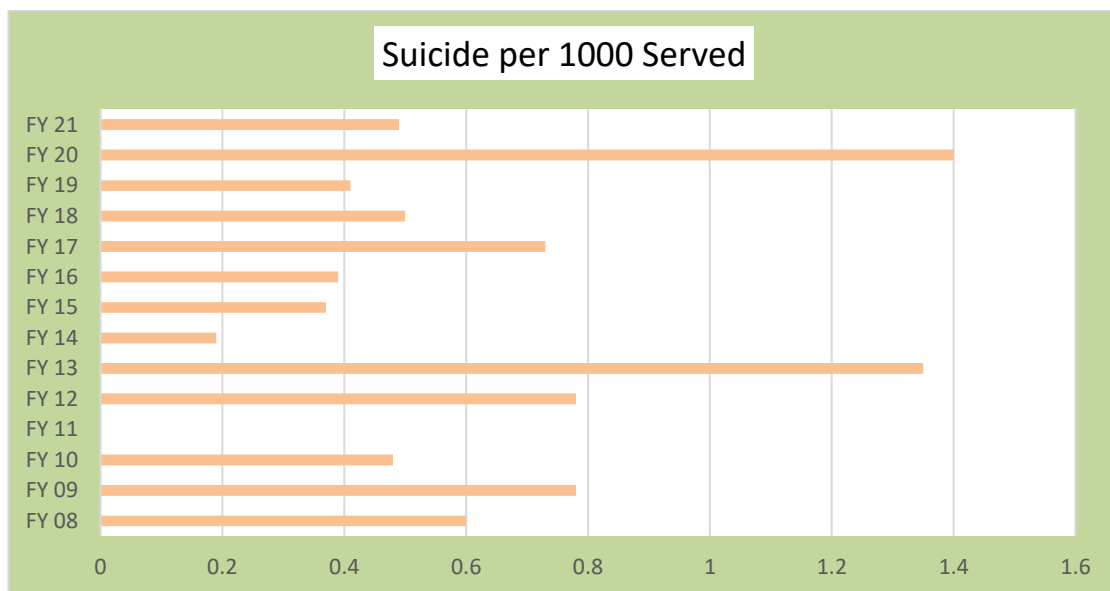
Unusually, there were only two deaths attributed to “drug abuse” in FY 21 and both occurred in the age bracket of 31-40.

Reviewing deaths over the past fourteen years has helped us identify the number of deaths compared to the number of individuals served. Please note, the accuracy and robustness of deaths in fiscal years 2008 – 2011 is unknown due to concerns about reporting processes in that time frame. Reporting processes are much more robust and monitored so there is credibility to the number of deaths from 2012 – 2021.



The ratio of deaths / individuals served this past year is lower than last year though is still higher than what might be considered an average. There are no identified systemic mental health treatment factors contributing to these deaths. To the best of the organization's ability, we know of only four deaths of an individual whose COVID-19 test results was positive in FY 21 and two deaths from FY 20.

Monitoring the ratio of suicides per 1,000 individuals served is also important. Again, it is not known how robust or accurate our historical death reporting process was. That is, there may have been more historical suicides than are listed in the following chart. This is the data trend over the past thirteen fiscal years:



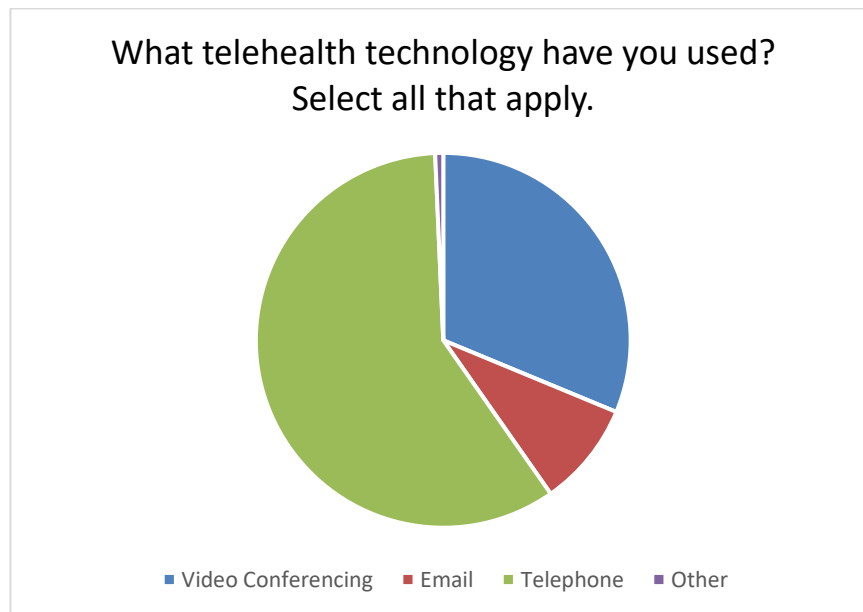
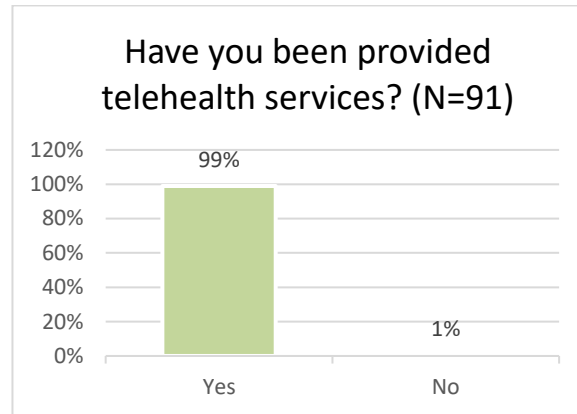
The ratio for FY 21 is one of the lowest ratios in the evaluated time period. It should also be noted that all suicides are reviewed with a root cause analysis. This is a very thorough and thoughtful review process beyond

the normal death review process. There were no practice-of-care issues in these suicides and no systemic patterns or trends identified.

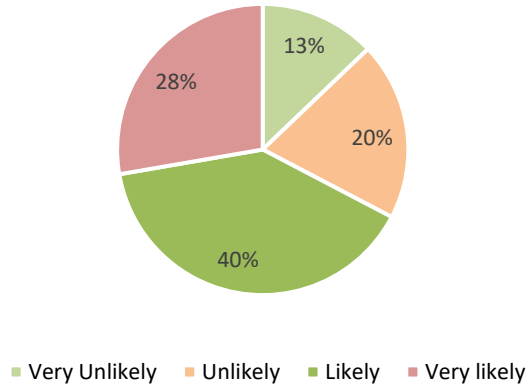
Satisfaction Survey Results

Due to the change in service delivery, the Regional Customer Service Committee did not survey all populations with the satisfaction surveys as in the past. Instead, early in the pandemic, WCCMH participated with 19 other state wide Community Mental Health Service Providers and implemented a standardized Telehealth Satisfaction Survey. This process continued for FY 2021. The FY 2021 results are below.

Survey Results from Those Who Receive Services



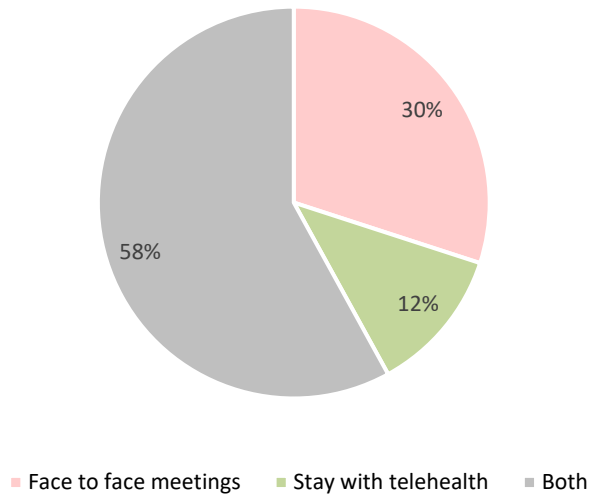
FY 21 - If available, how likely would you be to use telehealth services instead of in-person services? (N = 87)



FY 21 - What part of telehealth do you wish could remain even after COVID - 19 is no longer a concern? Select all that apply. (N = 89)



When face to face appointments are available again, would you like to resume face to face appointments, or choose to stay with telehealth, or do both? (N=91)



Summary

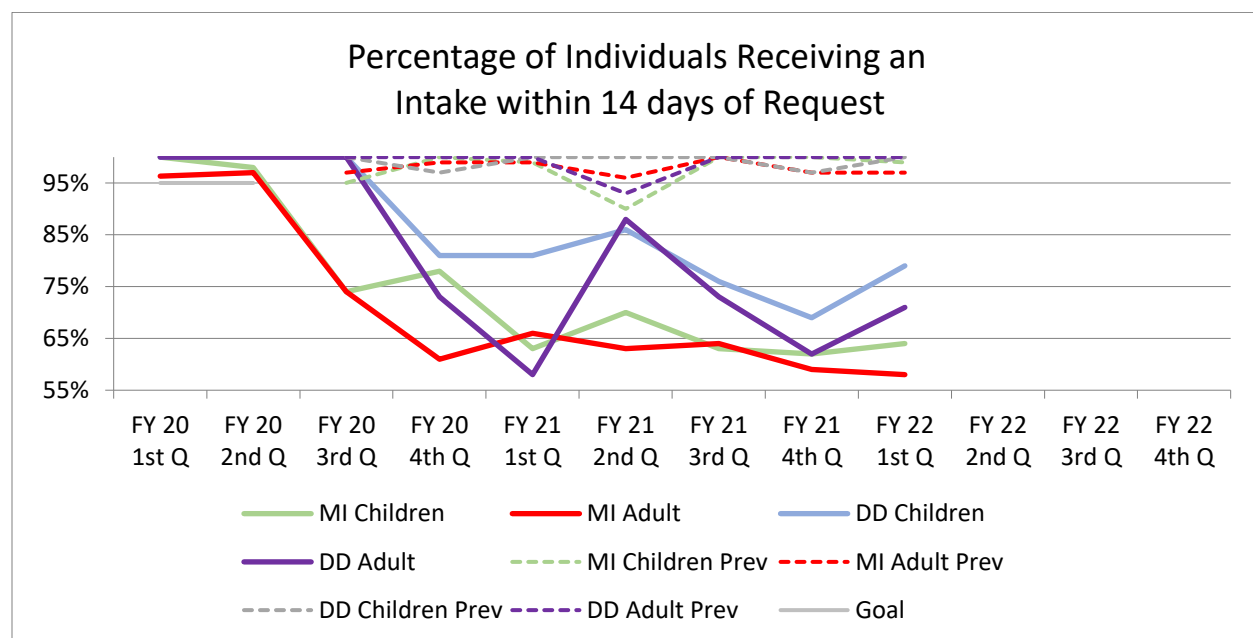
The industry of Community Mental Health services is a complex, demanding and high-risk environment seeking to service individuals who experience functional impairment, poverty, disabilities and severe symptoms in a limited resourced environment. CMH Organizations must manage this complexity while also improving lives and families as an important component of community responsibility. We continue to seek out ways to strengthen our organization in a manner that will help to improve the lives of those we are honored to serve.

Program and Quality Board Committee
Dashboard Data FY 2022 1st Qtr (Oct - Dec 2021)

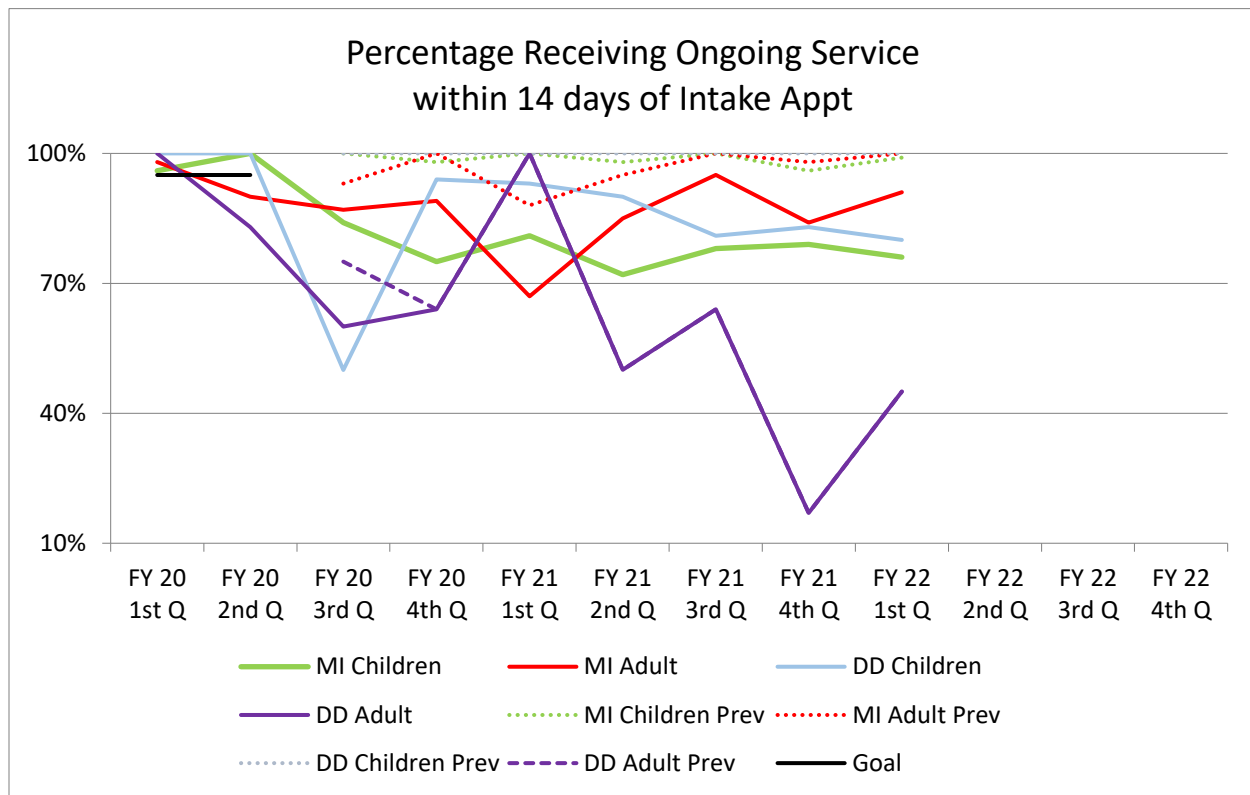
As of April 1 2020, the Michigan Department of Health and Human Service (MDHHS) changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to Ongoing Service) and removed the 95% historical expected goal.

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.

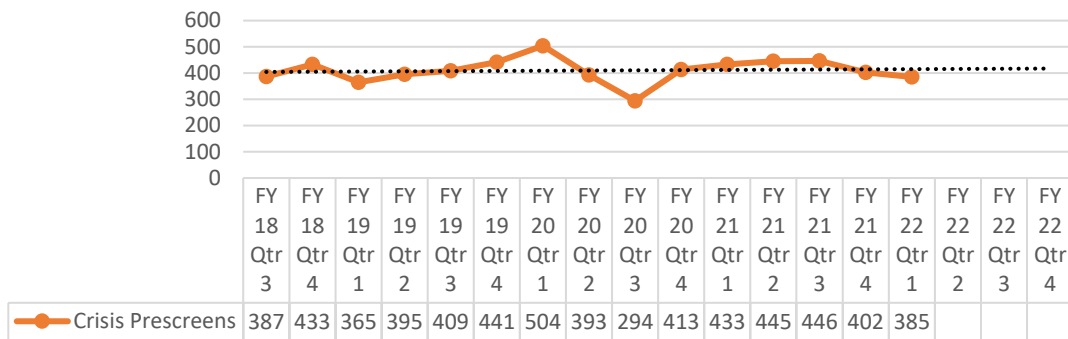


FY 22 1st Qtr Intake Appt within 14 days Detail						
Population	Total # of new persons requesting service	Number receiving appt. within 14 days of request	State defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- was formerly removed from the denominator	Percent Compliant by new State definition	Percent Compliant in previous definition
MI Child	133	85	48	47	64%	99%
MI Adult	178	104	74	71	58%	97%
DD Child	39	31	8	8	79%	100%
DD Adult	14	10	4	4	71%	100%

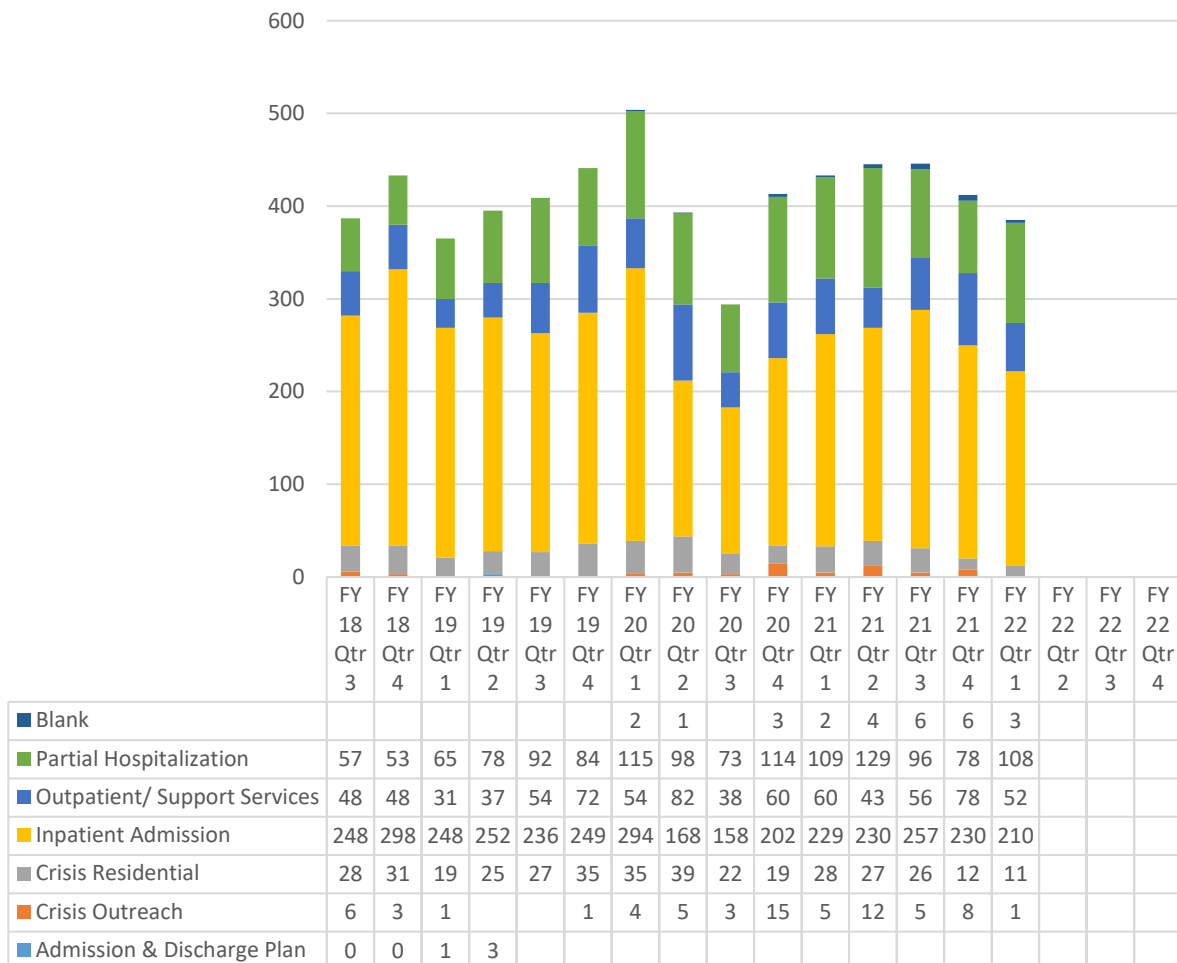


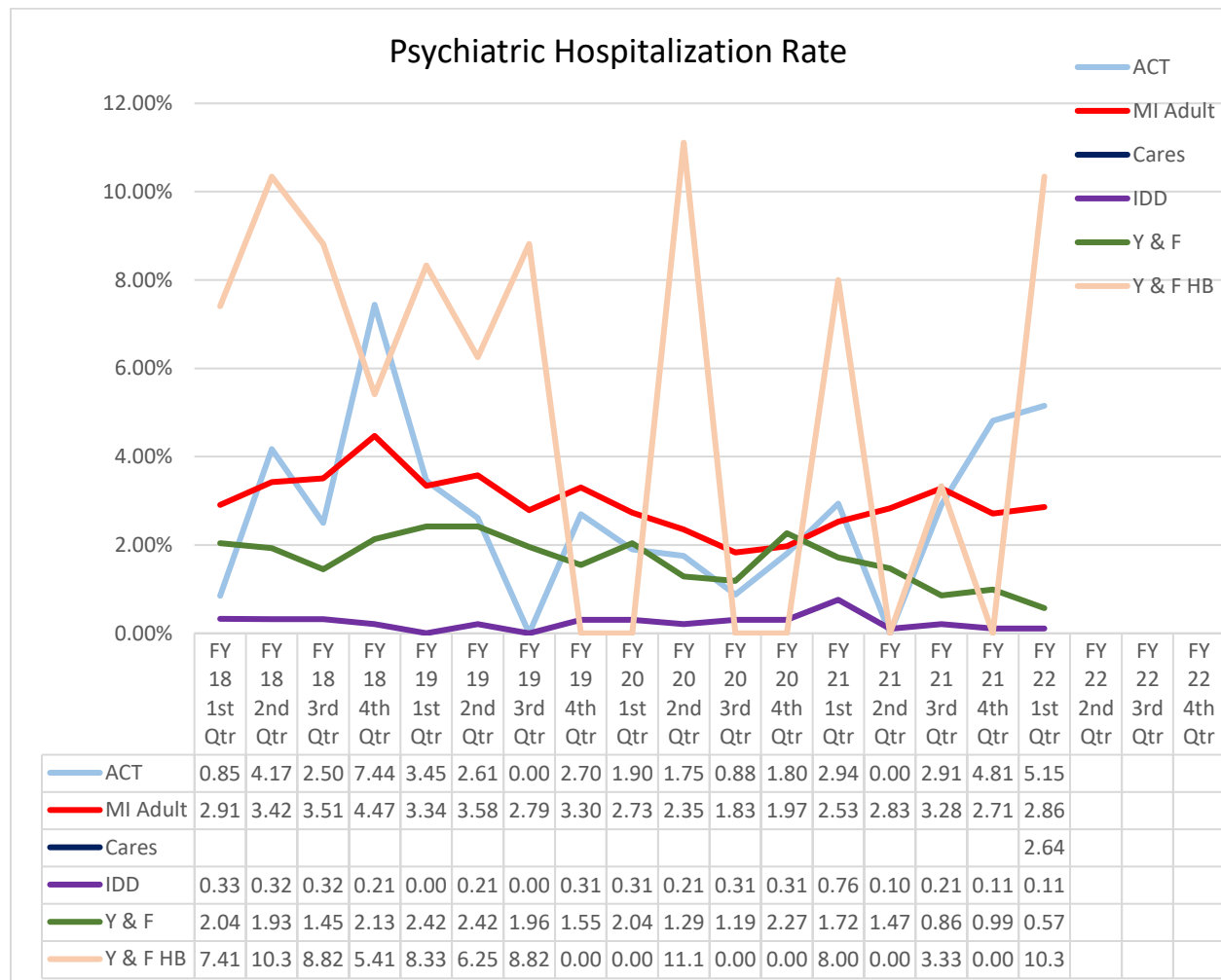
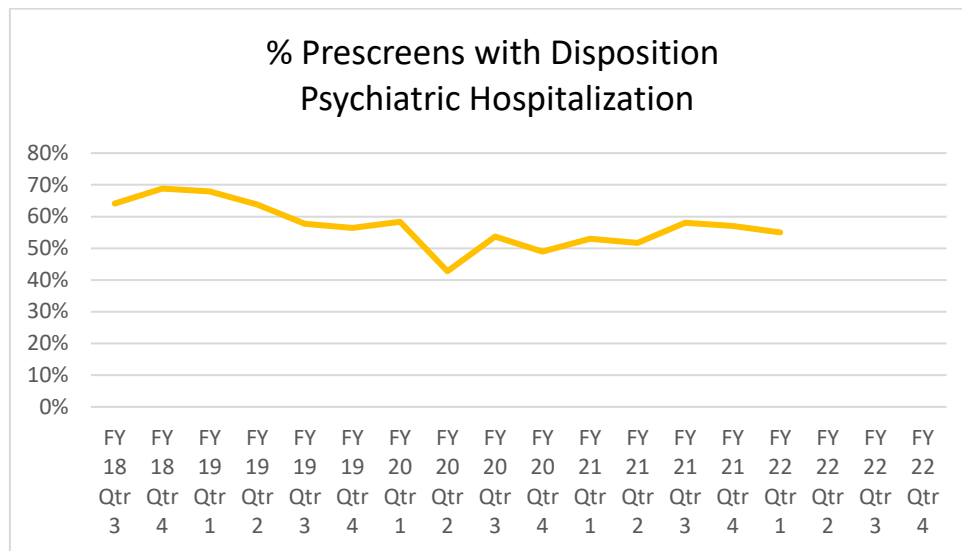
FY 22 1st Qtr Detail Ongoing Service						
Population	# of New Persons Eligible for Service	# of New Persons who started a new service within 14 days of eligibility	State Defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- used to be removed from the denominator	Percent Compliant under new definition	Percent Compliant under previous definition
MI Child	91	69	22	22	76%	100%
MI Adult	87	79	8	8	91%	100%
DD Child	46	37	9	9	80%	100%
DD Adult	11	5	6	0	45%	45%

Number of Crisis Prescreens

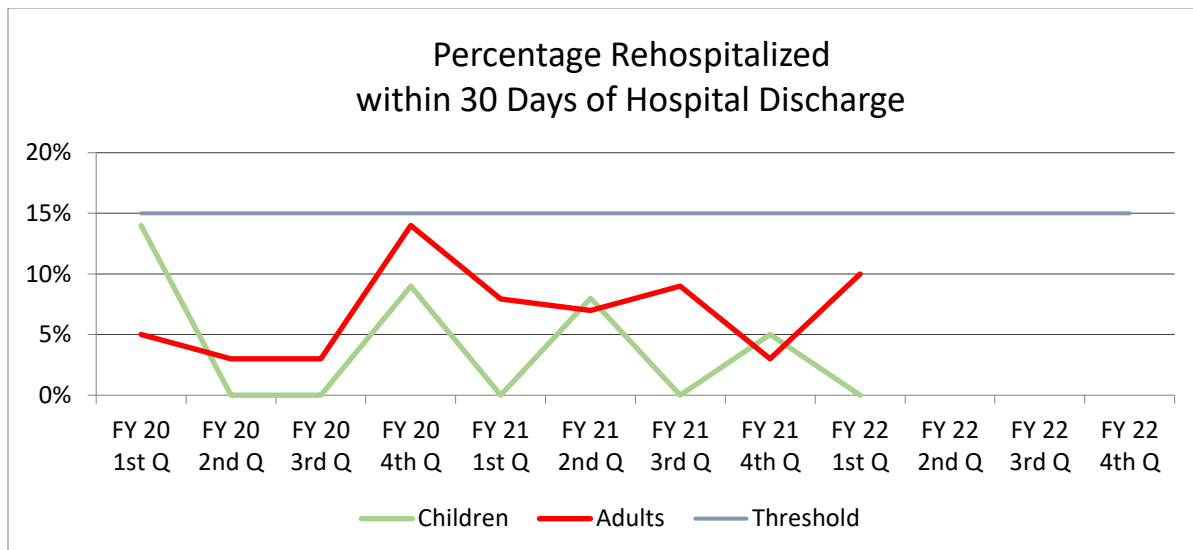
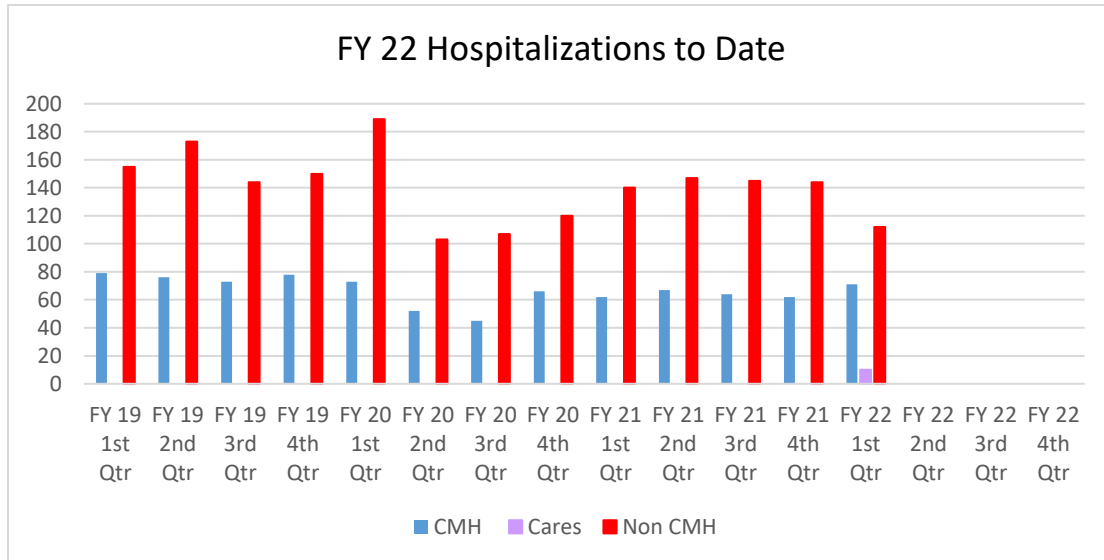


Prescreen Dispositions

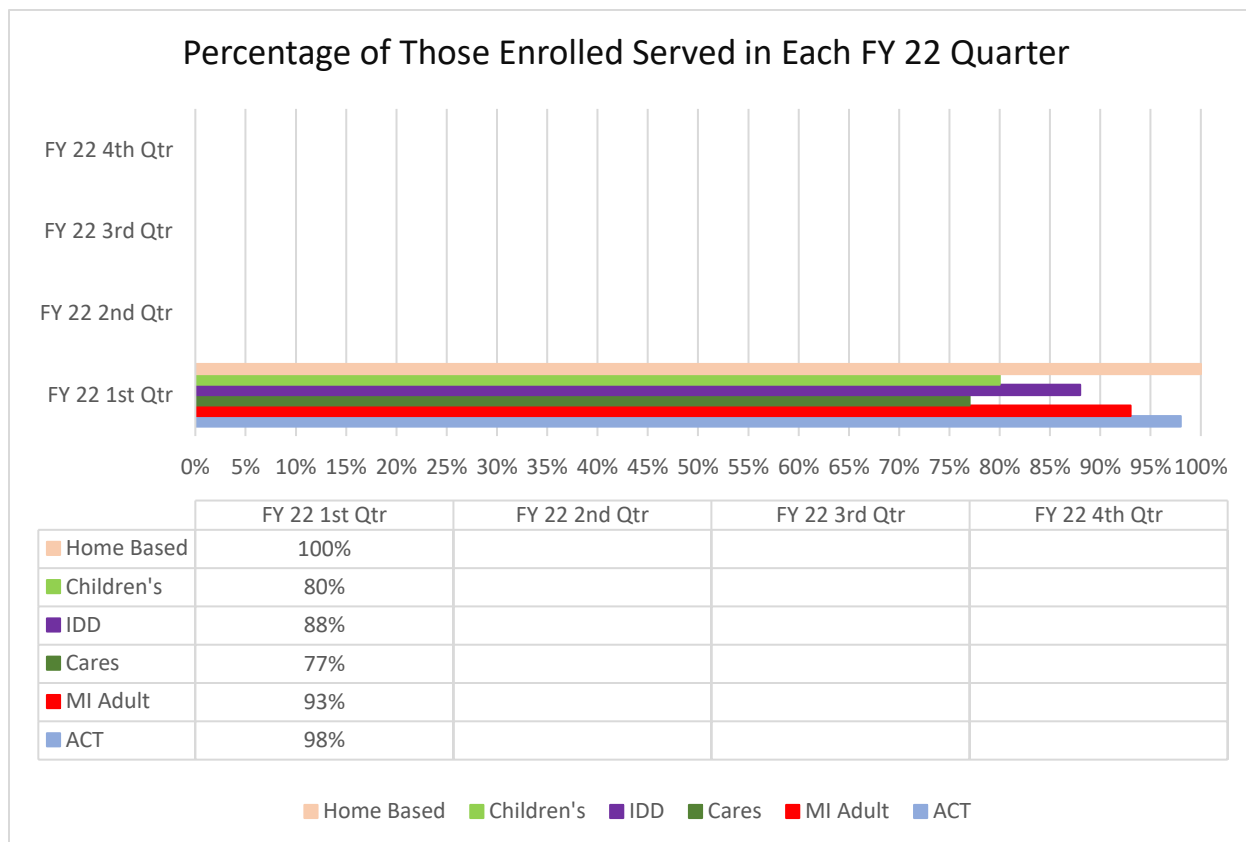




FY 22 1st Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	97	6 (1)	5.15%
MI Adult	1572	54 (9)	2.86%
Cares	341	9 (1)	2.63%
IDD	891	1 (0)	0.11%
Y & F	707	4 (0)	0.57%
Y & F Home Based	29	3 (0)	10.34%



FY 22 1st Qtr Detail Readmit within 30 days of Discharge			
Population	# Discharged and Core Team Assignment	# Readmitted within 30 days of Discharge	% Readmit
Child	9	0	0%
Adult	98	10	10%



Critical Event Data Reported Thru Qtr 1 FY 2022

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	Non Suicide Death	8
	MI Adult	Non Suicide Death	5
		Suicide	1
Qtr 1 Total			14

Mortality Data Thru Qtr 1 FY 2022

Cause of Death	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	Number of Deaths FY 22
Aspiration Pneumonia			1	2	2	2
Cancer	10	8	9	7	10	
Cardiovascular	8	13	14	14	5	2
Dehydration		1				
Drug Abuse	6	12	5	8	2	
Endocrine System (Diabetes)					1	
Environmental Hypothermia			1			
Gastrointestinal				3	1	
Hip Fracture Complications		1				
Homicide	1	3				
Inanition				2		
Infection				4	5 (4 - COVID 19)	3 (2 - COVID 19)
Kidney Disease	1	1		1		
Liver Disease	1	2		2	3	1
Metabolic			1			
Muscular Dystrophy						
Natural/Other	3	1				
Neurological	2	2	1	3	7	2
Respiratory	4	5	9	10	4	
Sturge Weber Syndrome						
Suicide	3	2	2	5	2	1
Trauma		1	2		2	1
Unknown	3	9	10	8	10	2
Grand Total	47	65	55	67	54	14

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



WCCMH **Adult I/DD Program**

WCCMH Board Meeting, June 2022

Service Population Includes:

ATTACHMENT #1S
JUNE 2022

- ▶ I/DD = Intellectual and Developmental Disability
- ▶ Adults - 18 years and older that have a diagnosed developmental disability. This includes; A Cognitive or Physical Disability that is acquired prior to the age of 22 and is deemed to be life long, resulting in substantial functional limitations. Substantial functional limitations in 3 or more of the following areas: receptive and expressive communication; mobility; self-care; self direction; learning; economic self-sufficiency; capacity for independent living.



What do services look like?

**ATTACHMENT #1S
JUNE 2022**

Services for I/DD Individuals Include:

- ▶ Supports Coordination
- ▶ Therapy - individual and group
- ▶ Psychiatry
- ▶ Psychology
- ▶ Occupational Therapy
- ▶ Dietician
- ▶ Nursing
- ▶ Housing - CLS, Specialized Residential
- ▶ Vocational (Skill Building & Supported Employment)
- ▶ Respite



Numbers Served

**ATTACHMENT #1S
JUNE 2022**

- ▶ Total served in I/DD program - 973
- ▶ Number of enrolled Habilitation Supports Waiver (HSW) individuals - 386
- ▶ Total individuals receiving unlicensed Community Living Support (CLS) - 433
- ▶ Total individuals living in licensed residential settings - 98



The Current CMH I/DD Team

**ATTACHMENT #1S
JUNE 2022**

- ▶ 4 Clinical Supervisors
- ▶ 2 Vocational Supervisors
- ▶ 2 Service Coordinators
- ▶ 1 MHP
- ▶ 19 Supports Coordinators
- ▶ 3 Psychologists
- ▶ 1 Nurse
- ▶ 1 OT



Who do we partner with?

**ATTACHMENT #1S
JUNE 2022**

- ▶ WISD
- ▶ Guardians
- ▶ Families
- ▶ Advocates
- ▶ Legal teams
- ▶ Hospitals
- ▶ Primary/Integrated Care Coordination
- ▶ Provider agencies
- ▶ Payees
- ▶ Community agencies
- ▶ MDHHS



What is a Habilitation Support Wavier(HSW) and how do you obtain one?

**ATTACHMENT #1S
JUNE 2022**

- ▶ HSW is a waiver program that deviates from the State Plan and allows for more/different services
- ▶ This program is specific for individuals with developmental disabilities
- ▶ An initial application is needed to determine eligibility
- ▶ Annual re-certification is completed for continuing eligibility
- ▶ Audits of HSW services happen every other year, with plans of corrections reviewed by the State on the off year



Eligibility Criteria

ATTACHMENT #1S
JUNE 2022

- ▶ Individual has a developmental disability (per MMHC)
- ▶ Is an active Medicaid recipient
- ▶ Is residing in a community setting; cannot live in licensed setting with more than 12 beds
- ▶ If not for HSW services, would require ICF/IDD level of care services; and is receiving habilitative services. MDHHS has not defined an exact number of hours needed for services, but it should be substantial per MDHHS.
- ▶ Individual choose to participate in the HSW program

An individual must have CLS, out of home non-vocational, Prevocational or Supported Employment in order to be considered for HSW. These are described as “habilitative services” and the consumer must be working on a habilitative skill to qualify for HSW.



Initial Referral Packet Process

**ATTACHMENT #1S
JUNE 2022**

- ▶ Initial conversations occur with consumers/families to see if they are interested. Individuals/guardians must consent to HSW every 3 years. Professionals must recertify annually.
- ▶ If interested, SC's receive and prepare the following documentation: Initial Certification form, ensure BH Teds has been update for accurate living arrangement, signed copy of IPOS (including clear goals around habilitative skill development with at least 3 highlighted skill development, a signed signature page, all supporting documentation - health care guidelines, behavioral plans, etc) and an IEP for all individuals under the age of 26.
- ▶ This is all submitted to our HSW Coordinator. HSW Coordinator will review and complete the new client worksheet and performance of Major Life Activities documents. HSW coordinator will also contact the PIHP HSW Lead with the CRCT Identification so that a WSA (State system) can be created for the new HSW candidate.
- ▶ HSW Coordinator will add all the above information and uploads the relevant documents into the WSA and submit to the PIHP.
- ▶ PIHP will then review for eligibility and submit to the State for review.
- ▶ The State will then review and approve or send back with comments or deny.



Annual Recertification Process

**ATTACHMENT #1S
JUNE 2022**

- ▶ Within 90 days of the HSW consumer recertification end date (365 days from initial approval), the CMH will be able to add information for recertification. This is completed through the WSA system.
- ▶ All supporting documentation that was sent for the initial certification must be sent again for review to ensure continued eligibility. The only document that is not needed after the initial packet is the IEP.
- ▶ This acts as a mini-audit of the chart to ensure continued eligibility. If there are pending documents or any document that is out of date, the packet will not be accepted. Packets have not been accepted if the State does not feel that the habilitative goals are not strong enough, not enough skills are being worked on, no signed signature page, etc.
- ▶ Larger state audits then occur every other year to review that services are provided as intended. This also includes review of staff providing HSW services including our contract providers.



Questions?

**ATTACHMENT #1S
JUNE 2022**

- ▶ Krista DeWeese
 - ▶ Program Administrator for Adult I/DD Services
 - ▶ deweeseek@washtenaw.org
 - ▶ 734-222-3412



Community Mental Health Partnership of Southeast Michigan/PIHP	Policy Customer Services Policy
Committee/Department: Regional Customer Services and Compliance Committees	Local Policy Number (if used)
Implementation Date	Regional Approval Date

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

I. PURPOSE

To ensure consumer/individual satisfaction with services and to enhance the relationship between consumers/individuals served and the community.

II. REVISION HISTORY

DATE	MODIFICATION
1/14/2009	
2013	Updated process to remove references to PRU and disbanded committees. Also included language on barrier free services.
2014	Revised to reflect the new regional entity
6/5/2015	Revised to include recommendations made by the External Quality Review (EQR) audit.
2017	Revised to reflect Medicaid Managed Care Regulations Final Rule 2016
8/12/2020	Revisions related to HSAG CAP on significant change timeframes
<u>12/08/2021</u>	<u>Revisions related to HSAG Compliance review on</u>

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) who are responsible for customer service functions.

IV. POLICY

The focus of Customer Services includes problem prevention, removal of barriers to consumers/individuals served, grievance resolution, and advocacy for consumers/individuals served so that their voices are heard, respected, and included in organizational decisions and service provision. It is the responsibility of Customer

Services to ensure that the community mental health system provides care that is respectful, available to all consumers/individuals served, informs consumers/individuals served of their choices in the system, and is free of stigma.

V. DEFINITIONS

Accessible – Services are located near the population group likely to utilize the service(s) and on/near public transportation routes where available.

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.

CMHPSM Confidential Record of Consumer Treatment (CRCT) – the electronic health record used by the PIHP and CMHSP partners in the CMHPSM region.

Consumer/Individual Served – An individual who is receiving Community Mental Health or Substance Use Disorder services, including services provided by mental health service providers and substance use disorder agencies under contract with the PIHP.

Customer Services – The department or staff members who provide a link between consumers, their service network, and their community. The Customer Services staff respond to any inquiries made by consumers/individuals served/potential consumers/family members/legal representatives/community members/staff, and responds to grievances made by consumers/individuals served/legal representatives. Customer Services staff orient consumers to the Service Network, provides information on benefits and availability of services, and assists consumers in pursuing services as needed.

Grievance – An expression of dissatisfaction about any matter related to services, other than an adverse action or a rights complaint. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer/individual served.

Grievance System – Processes in place to handle appeals, grievances and the collecting and tracking of appeal and grievance information.

Inquiry – a contact made to the Customer Services department (via phone, mail, e-mail or in person) from consumers/individuals served, legal representatives, family members, providers, or anyone in the community seeking information and assistance. Inquiries can include (but are not limited to): information on benefits, services, providers, transportation, and reasonable accommodations available to consumers/individuals served.

Legal Representative – Legal Representative - A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Local Dispute Resolution Committee – (LDRC) An ad hoc committee, convened by the local entity (either the CMHSP or the ROSC Core Provider). The LDRC for mental health services is chaired by the designee of the CMHSP Director; the LDRC for substance use disorder services is chaired by the SUD Director. The LDRC has the responsibility for reviewing local appeals regarding mental health or substance use disorder services of the CMHPSM/Core Provider and those of its contract agencies.

Mediation – a process wherein parties meet with an impartial and neutral person (mediator) that assists them in the negotiation of their differences. For the purposes of this policy, MDHHS has contracted with a specific entity to provide facilitative mediation when disagreements occur between a consumer/individual served/legal representative and the CMHSP/PIHP about the consumer/individual's services and supports. A mediator guides the parties through a confidential information-sharing and decision-making process, ensuring there is a power balance and that all parties have a voice. If a settlement is reached the mediator assists in writing an enforceable agreement created by the parties. A consumer/individual served/legal representative does not lose any due process rights (i.e. a grievance or an appeal) by participating in mediation.

Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution Process - A program of the Michigan Department of Health & Human Services with responsibility for conducting hearings for an appeal which was not resolved at the local level through the Local Dispute Resolution Committee. This process may occur after the LDRC review has been exhausted and Community Mental Health upholds the adverse benefit determination. A hearing may also be requested, if Community Mental Health does not adhere to the notice and timing requirements in 438.408. (This is also available to non-Medicaid consumers).

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

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.

Rights Complaint – A written or verbal statement by a consumer or anyone acting on behalf of a consumer alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Network – The group of providers and practitioners with which the CMHPSM contracts or makes arrangements to furnish specialty support services to consumers through the CMHPSM network panel.

Significant Change - expected and unexpected changes in services received by consumers that dictate the need for consumers/families to be formally notified of these changes, including changes in: all types of provider/contractual arrangements, program, law and/or compliance requirements, staff, and other changes deemed by Customer Service staff as meeting the criteria.

VI. STANDARDS

In order to achieve the goals of this policy, Customer Service staff shall:

- A. Orient new consumers/individuals served to the services and benefits available to them, including how to access services, also any fees and co-pays for which they are responsible.
- B. Provide consumers/individuals served with information on accessing services, service authorization, and the provider network, including providers who are accepting new consumers. Additionally, provides information on how to access primary health and other community services.
- C. Provide consumers/individuals served with information on the recipient rights protection processes and how to file a rights complaint.
- D. Provide consumers/individuals served with information on other rights to which they are entitled, including freedom to exercise those rights without retaliation, harassment, or discrimination.
- E. Help consumers/individuals served/applicants with problems and inquiries regarding benefits.
- F. Oversee and assist consumers/individuals served/legal representatives with the grievance process, including assuring the grievance process is conducted in a timely manner in accordance with the Balanced Budget Act requirements and the Regional Consumer Appeals policy.
- G. Ensure translator services will be provided to consumers/individuals served/applicants in accordance with the Culturally and Linguistically Relevant Services Policy at no charge to the consumer/individual served/legal representative.
- H. Notify and ensure a consumer/individual served that written information is available in alternative formats and in an appropriate manner that considers special needs. Ensure that available resources include oral interpretation services; that written information is available in prevalent languages in the region's service area; and that such services will be free of charge to the consumer. Ensure that consumers are given an explanation of how to access these services or information.
- I. Ensure that all notices and written communication provided to consumers/individuals served/applicants (12-point font) are available in an easily understood format, including large print (minimum 18-point font) when needed.
- J. Written materials for potential applicants/consumers require taglines in all prevalent languages in Michigan (top 15 languages). Ensure written materials for potential applicants/consumers/individuals served that are critical to obtaining services must also be made available in alternative formats upon request at no cost, that they include taglines in the prevalent non-English languages in Michigan, are in a conspicuously visible font size explaining the availability of

written translation or oral interpretation to understand the information provided, provide information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the PIHP's member/customer service unit.

- K. Ensure that consumers/individuals served/applicants are informed that electronic information (i.e. Guide to Services, etc.) is available in paper format without charge. Paper information must be provided within 5 business days of the request. Requests will be tracked in the CRCT Customer Service and Grievance system.
- L. Address needs or barriers related to cultural sensitivity, reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communication.
- M. Track and report trends and problem areas to the organization locally and regionally.
- N. Provide a readily available system of customer services that quickly assists consumers.
- O. Address the need for cultural sensitivity and reasonable accommodation for persons with physical disabilities, hearing and/or visual impairments.
- P. Track the effectiveness and efficiency of Customer Services functions through documented and periodic reports that show performance.
- Q. Assist consumers/individuals served and family members to find mechanisms within the CMHPSM to provide their input and insight into the operation of the CMHPSM. These mechanisms include soliciting membership and participation on advisory councils and Performance Improvement (PI) activities, development of new service programs and community awareness outreach initiatives, or provision or facilitation of arrangements for advocacy when requested, such as mentoring or developing informational material, newsletters, and customer satisfaction inquiries.
- R. Maintain and make available to consumers/individuals served/applicants/legal representatives written information on benefits, access to services, services available, service authorization, provider network information, the grievance system, and Customer Services functions. This shall include annual review and revision of this information.
- S. Ensure that consumers/individuals served/applicants are provided with the information described above at the time they enter services and are informed of their right to request and obtain this information at least once a year, in accordance with the Balanced Budget Act of 1997.
- T. Be available to consumers/individuals served during normal business hours and assist consumers/individuals served on the first contact.
- U. Clearly identify hours of operation.
- V. Ensure facilitation of phone access from the consumer/individual served, legal representatives, the community, and service providers throughout normal business hours (voice mail and answering machines are not considered phone access). It is expected that the customer services unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized.
- W. Enhance the relationship between the community mental health service provider/agency and the community.

- X. Ensure information about mediation is available to consumers/individuals served/legal representatives and assist them in how to contact mediation services upon request.
- w.Y. Include requests/referrals to mediations services in all inquiry and grievance data where applicable.
- x.Z. Ensure that consumers/individuals served are notified of any Significant Changes within the required time frame of at least 30 days before the intended effective date of change and by ~~by~~ means of the Regional process (see Exhibit A). All staff shall inform their local Customer Services representative immediately if they become aware of a potential Significant Change for consumers/individuals served. Such communication will include taglines for any potential language assistance needed.
- y.AA. Ensure consumers/individuals served are ~~notified in writing within 15 days of when provider services have been terminated or when a provider terminates its contract.~~ Given written notice of termination of a contracted provider to each consumer who received his or her primary care from, or was seen regularly by, the terminated provider. Notice must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. ~~Notification will be given to consumers receiving services from said provider.~~ Such communication will include taglines for any potential language assistance needed.
- z.BB. Ensure that written notice will be provided to consumers/individuals served and guardians as applicable when a contracted provider's services are terminated for whatever reason.
- aa.CC. Assist consumers/individuals served in accessing transportation services needed for medically necessary services, including specialty services identified by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
- bb.DD. Inform consumers/individuals served of any Significant Change in providers or benefits.
- cc.EE. Ensure that a copy of the Bill of Rights and Responsibilities shall be posted at each Community Mental Health Service Provider (CMHSP) network site in a location where it is easily visible to all people coming to the site, and update the Consumer Bill of Rights and Responsibilities periodically to ensure that the document continues to reflect state/federal standards, and the values of consumers/individuals served and the CMHPSM. All consumers/individuals served shall receive a brochure version of the Bill of Rights and Responsibilities, along with an explanation of the contents, at the time that services begin.
- dd.FF. Ensure there is annual review and update of all Customer Service brochures to ensure documents continue to reflect the values of recovery/resiliency, provide value to consumers/individuals served, as well as those of network staff members and members of the Community Mental Health Service Provider (CMH)SP Board. Ensure that these materials are available in the prevalent language in the region's service area. Tag lines will be provided in the Guide to Services.

Customer Services shall coordinate efforts locally with the Office of Recipient Rights (ORR) to ensure that ORR is informed of potential rights violations, and Customer Services is informed of grievances in the course of daily operations.

All consumers/individuals served shall receive a brochure version of the Bill of Rights and Responsibilities, along with an explanation of the contents, at the time that services begin.

Customer Service staff shall be knowledgeable regarding different methods used per population served for orienting consumers/individuals served into the general community based on the eligibility criteria and availability of services offered through the network.

Customer Service staff shall have up-to-date knowledge regarding benefits, the provider network, applicant and network policies/procedures regarding access, service authorization, and grievance/appeal procedures and are skilled in customer relations. Customer Services staff shall be trained on this information at the time of hire and refresher training therein annually.

Customer Services staff shall ensure compliance with any applicable Federal or State laws that pertain to consumers/individuals' informational ~~rights, and~~ rights and ensure that information is disseminated through the region on how staff and subcontract providers need to include those rights in the provision of services to consumers/individuals served. The CMHSP shall review any areas of need with applicable state and federal laws on a regular basis, and report these needs and any recommendations to the Clinical Performance Team (CPT) when needed.

VII. EXHIBITS

- A. Procedures
- B. Significant Change Process Flowchart

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 Code of Federal Regulation, Parts 400 et al. (Balanced Budget Act of 1997)	X	42CFR438.100 & 42CFR438.10
Michigan Department of Health and Human Services (MDHHS) "PIHP" Medicaid Contract	X	
MDHHS Community Mental Health Authority (CMHA) Medicaid Contract	X	
MDHHS CMHA General Funds Contract	X	
CMHPSM Consumer Appeals Policy	X	
CMHPSM Culturally Linguistically Relevant Services Policy	X	
Health Insurance Portability and Accountability Act of 1996	X	
CMHPSM Office of Recipient Rights Policy	X	
CMHPSM Organization Credentialing and	X	

Monitoring Policy		
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EXHIBIT A

IX. ~~IX.~~ PROCEDURES

GRIEVANCES

The grievance process is for any expression of dissatisfaction with service provision that is not related to an adverse action and is not a Rights complaint. A grievance may be filed by a consumer/individual served or the consumer/individual's legal representative. If the consumer/individual served requires assistance in filing a grievance, the Customer Services or Office of Recipient Rights will assist as needed. Grievances may be filed orally or in writing.

WHO	DOES WHAT
Consumer/ <u>Individual Served</u> or Legal Representative	May contact the community mental health agency or Customer Service department directly to file a grievance orally or in writing
Customer Services Staff	Logs receipt of oral or written grievance and enters relevant information In CRCT Customer Service and Grievance system. Consults with the Office of Recipient Rights (ORR) to determine if the grievance is a legally protected right (Rights Complaint). If so, informs consumer/<u>individual served</u>/legal representative filing grievance of the need to refer the matter to ORR; refers person to the local ORR for follow-up, and logs ORR referral on Grievance Report Form. (Skip to "Office of Recipient Rights Staff" under "Who" to follow this procedure.) If the grievance is not a legally protected right, sends written acknowledgement of receipt of the grievance within five days and explains the process to consumer/<u>individual served</u>/legal representative <u>and includes taglines in this communication</u>. Contacts consumer/<u>individual served</u>/legal representative by phone, if needed, to review the grievance. Completes the Grievance Report in CRCT and works with the appropriate staff and local/PIHP administrator(s) who was not involved in the initial determination that led to the grievance and who has the authority to require corrective action. Any grievances that Customer Services staff have the authority to respond to will be signed off by the Customer Services Supervisor prior to the disposition notification being sent to the consumer/<u>individual served</u>.
Assigned Administrator or Customer Services Staff	Takes necessary action to ensure the grievance is resolved as expeditiously as the consumer/<u>individual</u>'s health condition requires, but no later than sixty calendar days of the receipt of the grievance. Ensures corrective action is taken, when necessary. If the grievance involves clinical issues or issues of medical necessity, ensures that professional(s) who have the appropriate clinical expertise in treating the consumer/<u>individual</u>'s condition or disease are involved in review of the grievance. Ensures all grievances are disposed of within ten calendar days whenever possible. Whether or not the disposition is in favor of the consumer/<u>individual served</u>, the grievance must be addressed within the

	required time frame. If the grievance is filed by a Medicaid recipient and is not disposed of within sixty calendar days, on the sixty first day, notifies the consumer/<u>individual served</u>/legal representative of applicable appeal rights. Ensures the consumer/<u>individual served</u>, guardian or parent of a minor child receives written notification of the disposition within sixty calendar days from the date of the request for a grievance. The notice of the disposition shall include the results of the grievance process; the date the grievance process was conducted; the consumer/<u>individual</u>'s right to request a fair hearing, if the notice is more than sixty calendar days from the date of the request for a grievance; and how to access the fair hearings process. <u>Ensures taglines are included in this this communication</u> Ensures the Grievance Report in CRCT is completed. Provides quarterly grievance summary data to the CMHPSM QI Program and Regional Customer Services Committee
Office of Recipient Rights Staff	When providing consultation to Customer Services, or when triaging a call to the ORR, makes the final determination whether: A received rights complaint involves a grievance. A grievance involves a legally protected right. Follows ORR policies and procedures for a rights complaint when ORR staff determines that a grievance also involves a legally protected right. Refers any grievance portion of rights complaint to Customer Services department.
Regional Customer Services Committee	Staff follows the "Grievance Process Instructions for Regional Staff." Maintains grievance report database in CRCT regionally. Reviews data on a quarterly basis and reports regional summary of grievance data to the Clinical Performance. Identifies any trends from grievance data and makes recommendations to the Clinical Performance where needed.

INQUIRIES

The inquiry process is used for contacts made to the Customer Services Department (via phone, mail, e-mail or in person) from consumers/individuals served, legal representatives, family members, providers or anyone in the community seeking information and assistance. Inquiries can include but are not limited to: information on benefits, services, providers, transportation, and reasonable accommodations available to consumers/individuals served.

WHO	DOES WHAT
Consumer/ <u>Individual Served</u> , Legal Representative, Family Member, Provider, or other Community Member, or staff	Contacts Customer Services for information or assistance.
Customer Services	Takes contact (including inquiries and suggestions).

Staff	Logs receipt of inquiry in CRCT Customer Service and Grievance system. Consults with ORR as needed to clarify whether an inquiry may be a legally protected right (Rights Complaint) or a grievance. If ORR determines the contact is a potential rights issue, refers to ORR and logs in CRCT Customer Service and Grievance system. If a grievance, follows the grievance procedure above. Determines if contact is a suggestion that would be relevant feedback to provide to the PIHP via the Clinical Performance Team in the Customer Service Quarterly Report. Determines if contact is a request for information or assistance. If so, provides information or assistance to contact or refers contact person to other resources, when appropriate. Ensures the Customer Service Form Letter is completed in CRCT. Maintains local Customer Service database in CRCT. Reports local data, including relevant suggestions to Regional Customer Services Committee.
Regional Customer Services Committee	Maintains inquiry and grievance report database regionally. Reviews data on a quarterly basis and reports regional summary of inquiry data to the Clinical Performance Team. Identifies any trends from inquiry data, including relevant suggestions, and makes recommendations to the Clinical Performance Team when needed.

NOTIFYING CONSUMERS/INDIVIDUALS SERVED OF SIGNIFICANT CHANGES

The significant change process allows Customer Services to proactively respond to expected and unexpected changes in services received by consumers/individuals served. Utilization of the significant change process facilitates the prevention of consumer grievances and inquiries, a way for Customer Service to work collaboratively and systematically to ensure service delivery is provided in the best means possible for consumers/individuals served and families.

WHO	DOES WHAT
All Staff/Providers	Notifies Customer Services staff of potential or actual significant change.
Customer Services Staff	Checks definition of "Significant Change" to be sure the reported change meets the parameters of a Significant Change. Ensures consumers/individuals served are notified of any Significant Changes at least 30 days before the intended effective date of change, <u>and that taglines are included with the communication.</u> Ensures appropriate Administrative Staff is informed of Significant Change. Informs Chairperson of Regional Customer Services Committee of Significant Change. Works with core team to determine impact of change including: Whether change will have a local or regional impact. Whether a local or regional process needs to be implemented.
Customer Services Staff	Contacts key Department Heads and Administrative Staff of upcoming change. Ensures a Core Team is identified that will work on the development and implementation of notifying consumers/individuals served of the Significant Change (will vary depending on the type and scope of change).
Identified Core Team	Develops and executes plan to notify consumers/individuals served of

	Significant Change using parameters identified in Exhibit C. Develops and executes a communication/public relations plan for staff and consumers/ <u>individuals served</u> using parameters identified in Exhibit C Assures Customer Services staff (local or the Regional Chairperson depending on the type of change) is informed of the plan and the outcome of the plan.
Local Customer Services Staff	If the notification of a Significant Change was local, assures that the Regional Customer Services Committee is informed of the plan and its outcome.
Regional Customer Services Committee	Maintains data across the region on Significant Changes that occurred and their resolution.

EXHIBIT B

Process Flow to Notify Consumers of Significant Changes

This process flow identifies standard parameters to be followed when developing and implementing a plan to notify consumers/family members of a Significant Change. The specifics of the plan and implementation will be led by the Identified Core Team and will depend on the type and scope of the change involved.

Customer Services will be the lead in assuring the appropriate local or regional entities are made aware of a Significant Change that will require this process.

Customer Services may or may not be members of the Identified Core Team for the actual development and implementation of a notification plan (as per the process flow), depending on the type of Significant Change involved

1. The Definition of Significant Change Process for Consumers

Significant Changes that would require staff to notify Customer Services include:

a. All Types of Potential Provider/Contractual Changes

CMH staff needs to be notified of any of these changes. Consumers need to be notified in writing within 15 days of any of the changes below with an asterisk (*) next to them.

- i. Contract added
- ii. Provider in provisional status
- iii. Service added in provider contract*
- iv. Service removed from provider contract*
- v. Contract terminated by CMH or by the provider*

b. Program Changes

CMH staff and consumers need to be notified of any of these changes.

- i. New program and services
- ii. Removed program
- iii. Changes in Medicaid Provider Manual (changes in services covered)
- iv. Change in programming (change in location, change in how service provided and scope of service)
- v. Reduction in services or a particular service (due to budget cuts)

c. Law/Compliance Change

CMH staff, consumers and providers need to be notified of any of these changes.

- i. Advance Directives (within 90 days of change in law)
- ii. Michigan Mental Health Code
- iii. 42 CFR (including the Balanced Budget Act and other Medicaid law that affects consumers)
- iv. HIPAA/Privacy Changes – either in the law or in our privacy practices

d. Other

Customer Service staff will determine notification of any of these changes.

- i. Change in leadership (from Program Administrators/Department Heads to Executive Directors)
- ii. Change with clinical staff (the level of communication to be determined by the process)

2. Significant Change Notification of Identified Stakeholders

Identified Stakeholders that need to be considered, notified, and/or involved in the process of notifying consumer of significant change include:

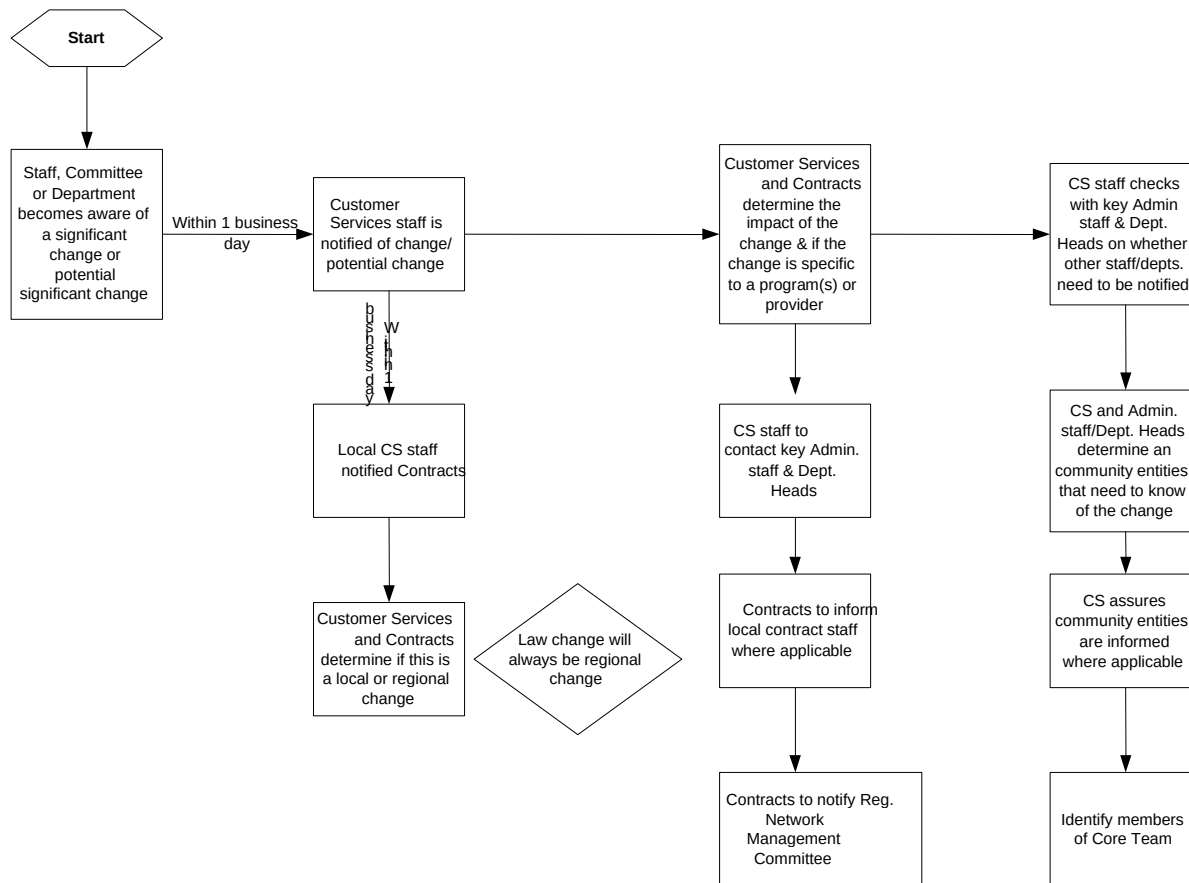
- a. Consumers/families/guardians
- b. Clinical/case management staff
- c. Customer Services Department (CMHSP and Regional Committee)
- d. Providers affected by the change
- e. Regional Network Management Committee
- f. Contract Holder in individual CMHSP
- g. Office of Recipient Rights
- h. Administrative/Fair Hearings Officer
- i. CMHPSM Regional Substance Use Disorder Services
- j. CMHSP's Finance Departments, Regional Finance Committee
- k. Regional Operations Committee
- l. Community Mental Health Service Provider (CMHSP) Administrative Teams
- m. Board (Regional, CMHSP Boards)
- n. Community (Association for Community Advocacy, Intermediate School District, etc.)
- o. Partners (i.e. National Alliance on Mental Illness, Friends of Developmentally Disabled, Michigan Rehabilitative Services, Association for Retarded Citizens, Housing Authorities)
- p. Reception and Clerical staff in the CMHSPs and CMHPSM
- q. MDHHS (when applicable)
- r. Consumer Advisory Committees (local & regional)

3. Minimum Standards for a Written Communication Plan (Specifically for Consumers/Families)

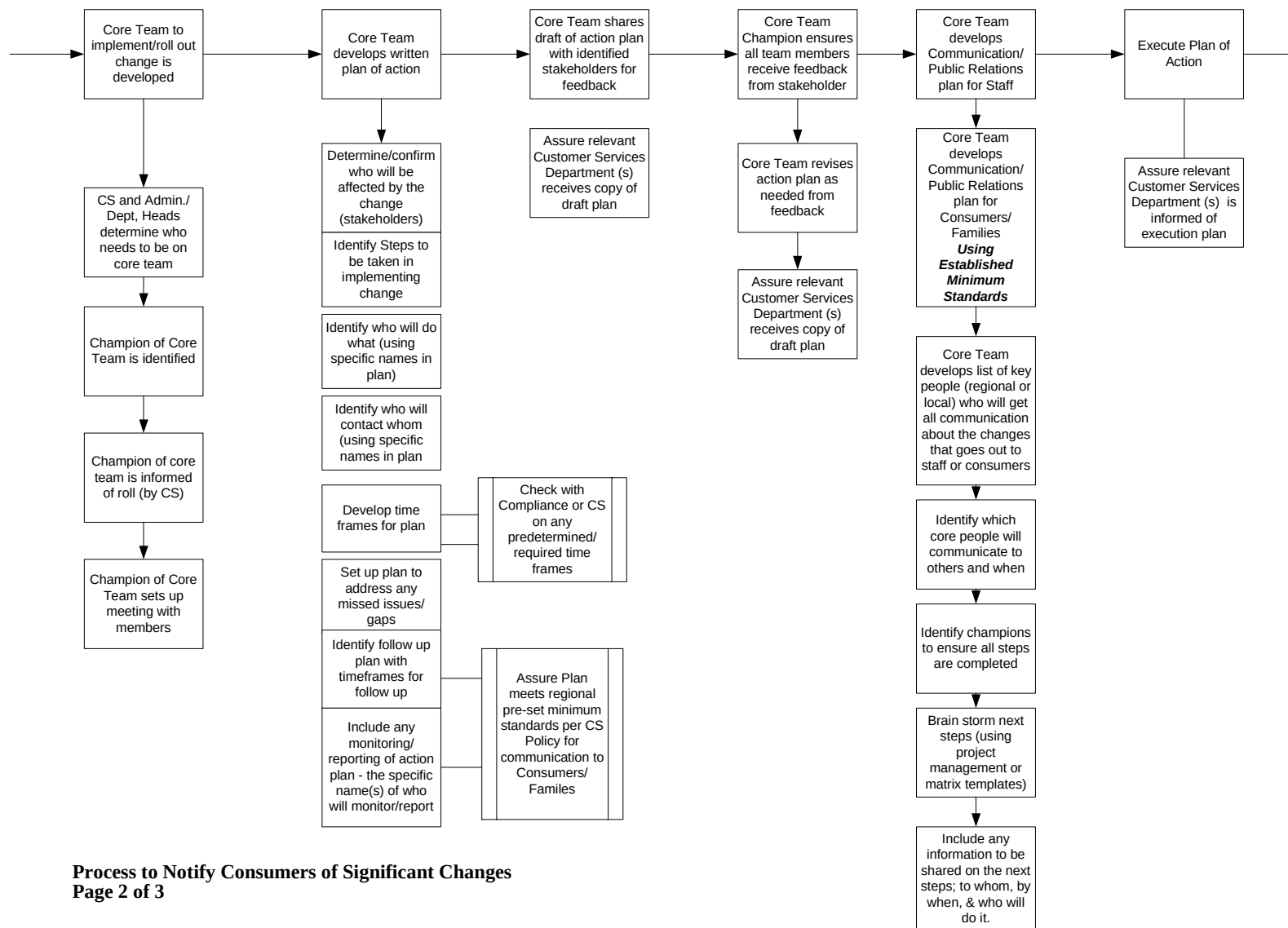
- a. Impact Assessment - Make a thorough assessment of which consumers and other identified stakeholders* will be affected by this change.
 - i. Is it all consumers we serve?
 - ii. Is it consumers in a specific program/department?
 - iii. Is it consumers who receive a particular service?
 - iv. Is it consumers receiving service from a particular provider?
- b. Get consumer involvement and feedback before notice goes out if possible.
- c. Notify consumers/families to clinical/case management staff involved.
- d. Explain what the Significant Change is using parameters of definitions of Significant Change above.
 - i. Give the most direct information possible in the least complicated language.
 - ii. Explain clearly what is expected of consumers/families and any timeframes they need to commit to in order to make the change/transition successful.
 - iii. Explain simply and clearly what it means for consumers/guardians/family - how will it affect them
 - iv. Plan for any continuity of care needs – clarify whether it will or will not be a change in service.
- e. Provide a letter with information on any meetings that are happening related to this change consumers/families can attend. Include the date, location, and time of meeting. If the meeting is a standing meeting and there is a schedule (i.e. a Board meeting), provide a copy of that schedule.

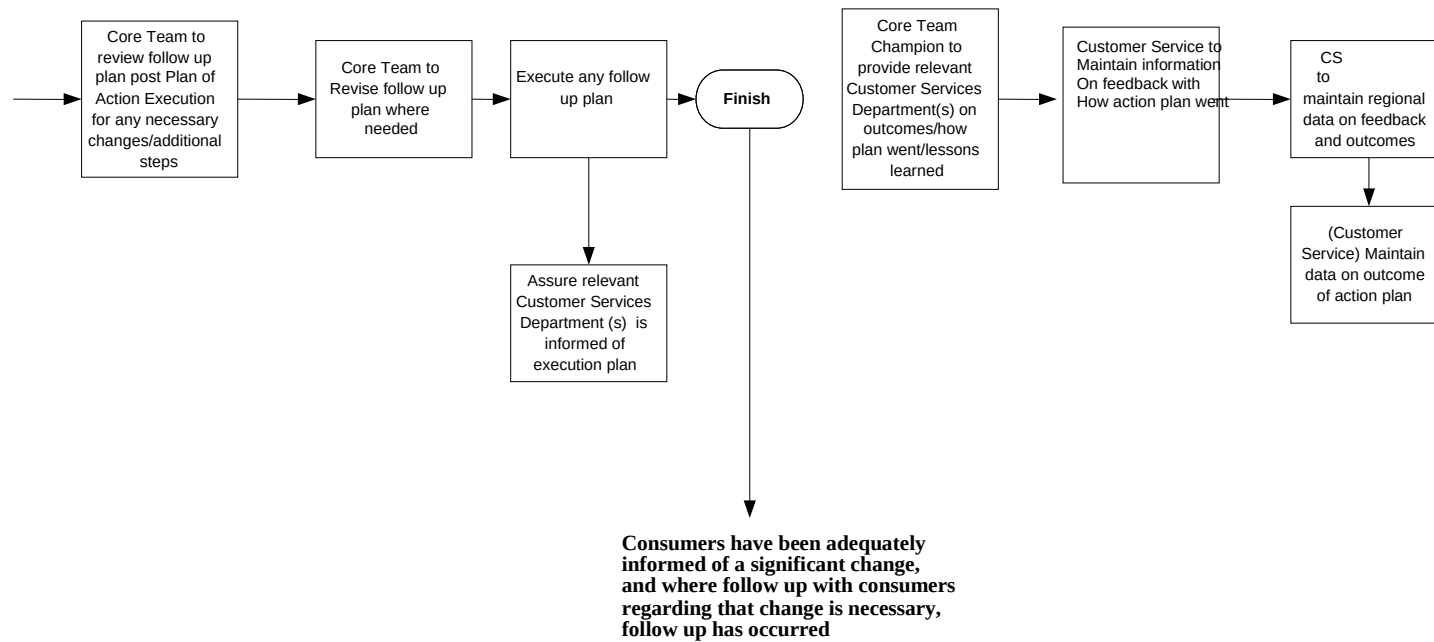
- i. Double check the correct addresses of the consumers/family members receiving a letter.
 - ii. Give clinical/case management staff lead time (two weeks) to make sure the correct address is in the system.
 - iii. Include staff names and contact numbers that consumers/families can access in the letter.
 - iv. Make sure guardian gets copy if they are not in the same home as consumer;
 - v. Make sure family members get a copy even if they are not the guardian when there is a return on investment that allows it.
 - vi. Include any information (copies of documents) consumers/families may need to explain the change, when possible.
 - vii. If information can't be included in the communication then explain where consumers/families can access it.
 - viii. Provide a chronology of how the change happened/how we got here, whenever appropriate.
 - ix. Note any changes/alterations in the change or the plan for change will be communicated as soon as possible.
- f. Consider alternate forms of communication for general changes such as newsletters, web, multimedia information at different locations, etc.
 - i. General changes are changes that do not adversely affect consumers.
 - ii. The timeframe would be longer, i.e. Advance Directives.
- g. Include any information (copies of documents) they may need to explain the change, when possible. [Ensure taglines are included in the communication.](#)
- h. Ensure follow up post letter is created and distributed.
- i. Explain what we are doing about the change (our action plan) to the extent we can share this information.

* Notification of other identified stakeholders who could or could not follow this communication plan depending on what the identified core team decided. These standards were set to note what minimally needs to be included about a Significant Change as a requirement for the region in how communication to consumers/families occurred, but it could be used for other identified stakeholders when applicable.



Process to Notify Consumers of Significant Changes
Page 1 of 3





Process to Notify Consumers of Significant Changes
Page 3 of 3

Figure 1

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	<i>Policy</i> <i>County of Financial Responsibility within the CMHPSM PIHP</i>
Committee/Department: Network Management	Local Policy Number:
Implementation Date (2 weeks from Regional Approval Date)	Regional Approval Date (date of last CMH board's approval)

Reviewed by:	Recommendation Date:
ROC	03/09/2022
CMH Board:	Approval Date:
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish guidelines relating to the Community Mental Health Service Program (CMHSP) service and financial responsibility for ~~consumer~~consumers/individuals serveds that the Community Mental Health Partnership of Southeast Michigan (CMHPSM), the Pre-Paid Health Plan (PIHP) for the four-county region comprised of Lenawee, Livingston, Monroe, and Washtenaw counties. ~~CMHPSM PIHP receives capitated payments for, whom live within the four-county region comprised of Lenawee, Livingston, Monroe and Washtenaw counties~~

II. REVISION HISTORY

DATE	MODIFICATION
3/1/2019	Reviewed and revised for clarity
Will be regional approval date	<u>Reviewed and revised for clarity</u>

III. APPLICATION

This policy only applies to consumers/individuals served by one of the four CMHSPs within our PIHP region, who are also eligible for a capitated payment that is received by the CMHPSM PIHP for the four-county region comprised of Lenawee, Livingston, Monroe, and Washtenaw counties.

Consumers/individuals served residing within the CMHPSM region receiving solely general fund supported services are not covered by this policy as local funding is not managed by the CMHPSM regionally.

Consumers/individuals residing within the CMHPSM region with an out of region County of Financial Responsibility (COFR) status are not covered by this policy; an out of region COFR is an individual served by a CMHSP within the CMHPSM four-county region with capitated funding received from outside our PIHP region; or an individual served by a CMHSP outside our four-county region when one of our in-region CMHSPs is identified as the COFR.

This policy only applies to consumers the CMHSPs serve that are covered by a capitated payment source received by the Community Mental Health Partnership of Southeast Michigan (CMHPSM), the Pre-Paid Health Plan (PIHP) for the four-county region comprised of Lenawee, Livingston, Monroe, and Washtenaw counties.

Individuals residing within the CMHPSM region receiving solely general fund supported services are not covered by this policy as local funding is not managed by the CMHPSM.

Individuals residing within the CMHPSM region with an out of region County of Financial Responsibility (COFR) status are not covered by this policy; an out of region COFR is any individual where a county outside of the CMHPSM four county region is identified as COFR.

IV. POLICY

It is the policy of the CMHPSM that the four regional CMHSPs will not enter in-to a County of Financial Responsibility (COFR) arrangement with each other related to any consumer/individual served whose services are covered by a CMHPSM PIHP capitated funding source. The CMHSP that provides services within the county where a consumerconsumer/individual served covered by this policy is currently residing is responsible for the delivery of all PIHP covered services regardless of the location of the consumerconsumer/individual's last residence in an independent arrangement. The CMHPSM will cost settle at the end of each fiscal year with CMHSPs related to all PIHP covered services for consumerconsumers/individuals serveds served within its PIHP region, including consumerconsumers/individuals serveds covered by this policy.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): -The Regional Entity that serves and is comprised of the four-county affiliation of Lenawee, Livingston, Monroe, and Washtenaw to provide specialty services and supports for people with mental health, developmental/intellectual/developmental disabilities, and substance use disorder.

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.

County of Financial Responsibility (COFR): -CMHSP who last served a ~~consumer~~consumer/individual served in the county where they last lived independently.

Electronic Health Record (EHR): -The software platform used across the CMHPSM region in which ~~consumer~~consumer/individual served medical, behavioral health, demographic, utilization management, and claims payment data are entered and used in the management and provision of services.

Independent Living Arrangement: -A living arrangement that,

- for an adult, is either an unlicensed setting or a setting in which the ~~consumer~~consumer/individual served required less than eight hours of specialized service/supports in the residence each day ~~in order to~~ maintain their health and safety in the least restrictive environment.
- for a child, is either the county in which the child/youth last resided with parents (birth or adoptive) prior to an out of home placement or if the child/youth is a temporary or permanent ward of the court, it is the county ~~served by the "court of record"~~. where the child currently resides in the community (i.e., licensed foster care home, relative placement or independent living) as long as the foster care case remains open.

Individual Plan of Service (IPOS): -The plan for the services and supports a ~~consumer~~consumer/individual served will be provided that is developed using the principles of person centered/family centered planning as required by the Medicaid contract with the CMHPSM.

Originating CMHSP: -Within the CMHPSM region, the CMHSP for the county in which a ~~consumer~~consumer/individual served last resided in an independent living arrangement.

Serving CMHSP: -Within the CMHPSM region, the CMHSP for the county in which a ~~consumer~~consumer/individual served currently resides and is determined eligible to receive Medicaid services or is receiving Medicaid covered services.

VI. STANDARDS

- ~~Consumer~~Consumers/individuals serveds must be provided appropriate services without delay resulting from issues of determining financial responsibility.
- CMHSPs are responsible to ensure all medically necessary services are provided to a ~~consumer~~consumer/individual served residing within the CMHPSM four county region that is currently and continually eligible for Medicaid, Healthy Michigan or any other capitated funding source managed through the CMHPSM PIHP. -The CMHSP delivering services to any ~~consumer~~consumer/individual covered by this policy will be recognized as the serving CMHSP, in relation to this policy.

- C. The Serving CMHSP, where a ~~consumer~~ consumer/individual served is determined eligible to receive or is receiving services, develops the Individual Plan of Service (IPOS), authorizes all medically necessary services, and enters all relevant service and claim documentation into the Electronic Health Record (EHR).
- ~~D.~~ The Serving CMHSP is responsible to manage crisis and emergency services for inpatient hospitalization.
- ~~E.~~
- F. The CMHSP serving the County where an ~~an~~ consumer/individual served last resided, in an independent living arrangement, will still be tracked in relation to ~~consumer~~ consumers/individuals served covered by this policy. That CMHSP will be referred to as the originating CMHSP in relation to this policy.
- ~~D.~~
- ~~G-E.~~ If an ~~an individual~~ consumer/individual served, covered by this policy, moves to a dependent setting, in a County outside of the CMHPSM four County region, the originating CMHSP will be recognized as the COFR, where appropriate, related to any out of region COFR arrangement. The serving CMHSP will notify the ~~o~~ Originating CMHSP when such an event occurs.
- ~~H-F.~~ At the time a ~~consumer~~ consumer/individual served moves outside the CMHPSM, the serving CMHSP will terminate services and the originating CMHSP becomes responsible for coordinating and funding services if an out of region COFR arrangement is required.

VII. EXHIBITS

 None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
MDHHS/PIHP Managed Mental Health Supports and Services Contract	X	
42 CFR Parts 400 et al. (Balanced Budget Act)		
45 CFR Parts 160 & 164 (HIPAA)		
42 CFR Part 2 (Substance Abuse)		
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission - Behavioral Health Standards		
Michigan Department of Community Health (MDHHS) Medicaid Contract	X	
Michigan Medicaid Provider Manual	X	

ATTACHMENT #1V
JUNE 2022

Community Mental Health Partnership of Southeastern Michigan/PIHP	<i>Policy</i> <i>Notice of Privacy Practices and Consumer Complaints for Protected Health Information</i>
Committee/Department:	Local Policy Number (if used)
Implementation Date	Regional Approval Date

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

I. PURPOSE

To establish guidelines for informing ~~recipient~~consumers/individuals serveds of the circumstances under which Protected Health Information will be used and disclosed, and their rights regarding their protected health information

II. REVISION HISTORY

DATE	MODIFICATION
1/12/2015	Revised to reflect the new regional entity effective January 1, 2014.
5/17/2018	Revised to reflect updates to the Mental Health Code (330.1748)
6/09/2021	Revised to reflect EQR requirements, regulations, and updates to notification requirements.

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

All ~~recipient~~consumers/individuals serveds of CMHPSM services have the right to notice of the uses and disclosures of protected health information that may be made in the course of providing services to the ~~recipient~~consumer/individual served. Furthermore, a ~~recipient~~consumer/individual served has the right to know the CMHPSM and service provider's legal duties with respect to the use and disclosure of confidential information.

V. **DEFINITIONS**

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves and is comprised of the four-county affiliation of 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.

Complaint: Any written documentation received that expresses concern that a ~~consumer~~consumer/individual's right to confidentiality and security of protected information has been violated.

Complainant: A ~~consumer~~consumer/individual served or anyone acting on behalf of a ~~consumer~~consumer/individual served, who files a complaint that the ~~consumer~~consumer/individual's right to confidentiality and security of protected information has been violated.

Protected Health Information: Medical, mental health, and substance abuse information that is individually identifiable and that is transmitted in any form or medium.

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. All CMHPSM Board members, employees, students and volunteers shall be apprised of its policies and procedures protecting the confidentiality and integrity of its ~~consumer~~consumer/individuals' protected health information and be required to sign a Confidentiality Statement.
- B. Each CMHSP will designate a Privacy Officer/designee at each CMHSP to receive complaints concerning the Community Mental Health's (CMH) compliance with policies and procedures related to protecting the confidentiality and security of protected health information.
- C. The CMHPSM will designate a Privacy Officer at the regional entity level to receive complaints concerning substance use disorder (SUD) providers' compliance with policies and procedures related to protecting the confidentiality and security of protected health information.

NOTICE OF PRIVACY

ATTACHMENT #1V

JUNE 2022

- D. All Notice of Privacy Practices shall comply with section 164.520 of the Health Insurance Portability and Accountability Act of 1996, the Michigan Mental Health Code, 42 C.F.R. (Code of Federal Regulations) Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records; Final Rule, and any other applicable laws, explaining the allowable uses of protected health information
- E. A Notice of Privacy Practices (see exhibit A) shall be posted at all CMHPSM service delivery sites, and the service delivery sites of all contractual providers. Notice must be posted in a clear and prominent location where it is reasonable to expect ~~consumer~~consumers/individuals serveds and those seeking services from the CMHPSM to be able to read it.
- F. Copies of the Notice of Privacy Practices shall be available at each service delivery location to be given to ~~consumer~~consumers/individuals serveds or others upon their request.
- G. A Notice of Privacy Practices shall be given to each new ~~consumer~~consumer/individual served, guardian, or parent of a minor during his or her initial visit along with a brief explanation of the Notice and an opportunity for the ~~consumer~~consumer/individual served to have questions answered.
- H. If services are provided in an emergency situation, a good faith effort must be made to provide the ~~consumer~~consumer/individual served with a copy of the Notice Privacy Practices; such efforts must be documented in the ~~recipient~~consumer/individual's record. A copy of the Notice of Privacy Practices shall be given to the ~~recipient~~consumer/individual served as soon as reasonably practical after treatment of the emergency situation.
- I. Each ~~consumer~~consumer/individual served who receives a Notice of Privacy Practices shall be asked to sign an Acknowledgement of Receipt (see exhibit A), which will be made a part of the ~~consumer~~consumer/individual's record. If the ~~recipient~~consumer/individual served cannot or will not sign the Acknowledgment of Receipt, a good faith effort to obtain such signature must be documented in the ~~recipient~~consumer/individual's record, as well as the reason why the acknowledgement was not obtained.
- J. Whenever the Notice of Privacy Practices is revised, the revised Notice of Privacy Practices must be promptly posted at all CMHPSM service delivery sites and made available upon request on or after the effective date of the revision.
- K. The Notice of Privacy Practices and policy shall be reviewed annually at a minimum or otherwise updated as needed.
- L. In the CMHPSM, the Rights Office appoints a local Privacy Officer for each county. The Rights Office Contact will ensure that the Privacy

Officer is informed and begins necessary follow-up and/or actions as needed.

- M. The CMHPSM Compliance Officer shall oversee any regulatory changes with notice of privacy practices, and ensure the regional notice is revised and redistributed to the local CMHSPs.

CONSUMER/INDIVIDUAL SERVED COMPLAINTS

- N. A ~~consumer~~consumer/individual served, who feels that his /her confidentiality has been violated, or his /her protected health information has been improperly used, has the right to a thorough and confidential investigation.
- O. A ~~consumer~~consumer/individual served, or anyone acting on behalf of a ~~consumer~~consumer/individual served, who feels that any Board member, employee, student, volunteer or those of organizations under contract with the CMHPSM, has violated the confidentiality and security of their protected health information should contact the Privacy Officer to file a complaint.
- P. There shall not be any retaliation or reprisals against any ~~consumer~~consumer/individual served, or any person acting on behalf of a ~~consumer~~consumer/individual served, who reports a suspected violation of its policies protecting the confidentiality and integrity of protected health information. Nor will the CMH require ~~consumer~~consumers/individuals served to waive their right to a complaint to the Secretary of Health and Human Services as a condition of receiving treatment.
- Q. The Privacy Officer/designee will conduct a thorough and confidential investigation of the allegation in a timely manner and will recommend corrective action to the CMHSP Executive Director. Investigations will be conducted in a manner that will not violate employee rights, e.g. the Bullard-Plawecki Employee Right to Know Act.
- R. The Privacy Officer will inform their CMHSP Risk Manager and/or Compliance Officer at the time a complaint is received and notifies the Risk Manager and/or Compliance Officer of the results of the investigation and any corrective action taken.
- S. The Privacy Officer/designee will inform the complainant in writing of the results of the investigation and any corrective action taken and will ensure the complainant understands that he/she also has the option of contacting the Office of Civil Rights to file a complaint against the CMH.
- T. The Privacy Officer/designee will maintain a system for logging all complaints received and for the secure storage of all investigative documents and evidence.

ATTACHMENT #1V**JUNE 2022**

U. The Privacy Officer will provide a quarterly aggregate report of complaints and investigations to the Regional Compliance Committee for the purpose of trend analysis.

V. The Privacy Officer will maintain documentation related to an investigation, and any corrective action taken, for a minimum of six years from the date of its creation or the date it was last in effect, whichever is later.

W. The CMHSP Compliance Liaison will ensure compliance with all notification requirements made to consumers/individuals served and collaborate with the CMHPSM Compliance Officer to ensure all notification requirements are provided to the media, HHS, and legal entities where applicable.

Commented [VA1]: Not sure if we really want/need to include this here since it is already in the "Confidentiality and access to Consumer/individual served records policy" and the "Compliance Plan":

The Privacy Officer at each CMHSP notifies the relevant individuals and entities of a HIPAA breach in accordance with the notification Rule 45 CFR §§ 164.400-414 and the regional Confidentiality and Access to Consumer/individual served Records Policy.

The Privacy officer also provides the PIHP notice of breaches in accordance with the Compliance Plan (i.e. Annually, on January 15th, for breaches affecting less than 500 people. And within 10 days of discovery of a breach for those breaches affecting more than 500 people). The PIHP reports these breaches to HHS.

VII. EXHIBITS

Notice of Privacy Practices and Acknowledgement of Receipt, effective date 4/13/03.

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPPA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974	X	
CMHPSM Confidentiality and Access to Records Policy	X	
CMHPSM Sanctions for Breaches of Security or Confidentiality Policy		
CMHPSM Ethics and Conduct Policy	X	
CMHPSM Corporate Compliance Policy	X	

Exhibit A
Notice of Privacy Practices and Consumer Complaints for PHI

NOTICE OF PRIVACY PRACTICES
(Insert Name of Organization)

This notice describes how medical, mental health and substance use information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

We understand that health information about you is personal. We are committed to protecting it. We refer to this information as “Protected Health Information” or “PHI.” We created a record of the care you receive from (insert name of organization). We need this record to provide you with quality care and to comply with certain legal and payment requirements.

This notice will tell you about the ways in which we may use and disclose your PHI. It also describes your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

- make sure that PHI that identifies you is kept private,
- **notify you if there is a breach of your PHI,**
- give you this notice or our legal duties and privacy policies concerning your PHI and
- follow the terms of the notice that are currently in effect.

The privacy practices in this notice apply to all staff, students and volunteers and to all contract providers in our region, the Community Mental Health Partnership of Southeast Michigan (CMHPSM)

We reserve the right to change the terms of this notice and will post the revised notice. Upon your request, we will give you a copy of the revised notice. The new notice would be effective for any health information that we hold at that time or receive from that time on.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- **Confidential Communications.** You may ask that we communicate with you in a particular way or at a certain location, such as calling you at work rather than at home, to maintain confidentiality.
- **Inspect and Copy.** You have the right to review and/or receive a copy of the information in your record. Under very limited circumstances we may deny access to the record or to portions of the record. For instance, if disclosing this information would endanger you or someone else. If any access is denied, you can request a review of this decision by contacting your local customer services staff.

Notice of Privacy Practices and Consumer Complaints
for Protected Health Information

Commented [VA2]:
45 CFR §164.520

(b)- Implementation-Content of Notice
(1) Required Elements

(v) Covered entity's duties. The notice must contain:

(A) A statement that the covered entity is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information;

<https://www.law.cornell.edu/cfr/text/45/164.520>

ATTACHMENT #1V
JUNE 2022

- **Addendum.** You may ask us to include an addendum to the information in your record if you feel it is incorrect or incomplete. You may prepare a correcting statement that will be included in your record.
- **Accounting of Disclosures.** You may request a list of disclosures that we have made ~~with your authorization~~ of your protected health information. We are not required to track certain disclosures such as those made with the exception of for treatment, payment and coordination of care described in this notice below, or disclosures, or information that was released made without your signed authorization, also described below.
- **Reporting Restrictions.** You may ask us to limit our use or disclosure of your health information. We are not required to agree to your request, but if we do agree to it, we will honor your request unless the information is needed to provide emergency treatment to you.
- **Receiving a Copy.** You may receive a paper copy of this notice at any time upon request.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Uses and Disclosures for Treatment, Payment and Coordination of Care

- **For Treatment.** We may use and disclose your protected health information to provide your services. Information about you may be shared with staff, students or volunteers, and with contract providers or regional staff who may be involved in your or your family's treatment. For example, a staff person may need to review your record in order to respond to your emergency. We may also use your health information to remind you about an appointment or to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **For Payment.** Your health information will be used and disclosed as needed to obtain payment for your services. For example, a bill for services sent to you or to a third-party payer such as Medicaid might include identifying information about you, such as your name, your diagnosis and services received.
- **For Healthcare Operations and Quality Improvement.** We will use or disclose, as needed, your health information to support and improve the activities of our community mental health services. For example, staff may use information in your clinical record to evaluate the care you received.
- **Coordination of Care.** Your health information may be used and disclosed, as needed, to coordinate and manage your mental health and related services by one or more providers involved in your treatment. For example, a staff of community mental health may provide information about you when submitting referrals to providers related to your services.

Uses and Disclosures That May Be Made Only with Your Authorization

ATTACHMENT #1V
JUNE 2022

- **Individuals Involved in Your Life.** We may disclose PHI about you to a family member or other persons you designate if you give permission to do so. There may be other service providers/agencies not directly involved in your care for whom we would require your permission to share PHI.
- **For Health Information Exchanges (HIE).** Along with other healthcare providers in our area, we may participate in a health information exchange. An HIE is a community-wide information system used by participating healthcare providers to share health information about you for treatment coordination purposes. Should you require treatment from a participating healthcare provider who does not have your medical records or health information, that healthcare provider can use the system to gather needed health information to treat you. For example, he or she may be able to get laboratory or other test results that have already been performed or find out about the treatment that you have already received. We will include your PHI in this system only if you give us special written permission to do so.
- **Psychotherapy Notes.** We may disclose psychotherapy notes only with your permission unless an exception applies. For example, we may disclose these notes without your permission if required or permitted by law for reasons such as preventing or lessening an imminent threat to someone's health and safety, a state or federal audit of our organization, to defend a legal action brought by you, or to provide training to mental health practitioners.
- **Marketing.** The PIHP does not engage in marketing. We may disclose PHI for marketing purposes only with your authorization. Marketing does not include our communication to you about our own products and services, or communication for treatment or case management purposes. An authorization for marketing purposes must include a statement on whether payment is involved.
- **Sale of PHI.** The PIHP will not sell your "Protected Health Information" (PHI). We are prohibited from selling your PHI unless authorized by you. An authorization that allows us to sell PHI must include a statement that the disclosure will result in payment to our organization.
- **Other Uses and Disclosures.** These will happen only with your written authorization, unless otherwise permitted by law as described below.

Uses and Disclosures That May Be Made without Your Authorization

- **As Required by Law.** We may be required by federal, state or local law to disclose your health information.
- **Organizations Involved in Your Care.** If you are a Medicaid enrollee, we may disclose PHI about you to another service provider involved in your care. This would include healthcare data available to providers through the state database.
- **For Public Health Activities.** We may need to disclose your health information to a public health authority that is required by law to receive the information. Such disclosures would be made for the purpose of controlling disease, injury or disability.

Commented [VA3]: for which Authorization is required:
(E) A description of the types of [uses](#) and [disclosures](#) that require an authorization under [§ 164.508\(a\)\(2\)-\(a\)\(4\)](#), a statement that other [uses](#) and [disclosures](#) not described in the notice will be made only with the [individual's](#) written authorization, and a statement that the [individual](#) may revoke an authorization as provided by [§ 164.508\(b\)\(5\)](#).

§ 164.508(a)(2)-(a)(4):
a(2)- Psychotherapy Notes
a(3)- Marketing
a(4)- Sale of PHI

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- **Abuse or Neglect.** We may be required to disclose your health information if we suspect that you or another person has been abused or neglected.
- **Health Oversight.** We may be required to disclose your health information for an audit, inspection, investigation or other healthcare oversight activity.
- **Judicial or Administrative Proceedings.** We may have to disclose your health information if we receive a court order or subpoena or for risk management purposes.
- **Law Enforcement.** We may have to disclose your health information in connection with a criminal investigation by a federal, state or local law enforcement agency or disclose it to authorized federal officials who provide protective services for the President or other persons.
- **Serious Threat to Health or Safety.** We may be required to disclose information about you to prevent a serious threat to your health and safety or that of another person or of the public.
- **Coroner or Medical Examiner.** We may need to disclose your health information to help identify a deceased person or to determine the cause of death.
- **Research.** We may disclose your health information to researchers only if their research proposal includes protocols to hide your identify and to ensure the privacy of your health information. The research project and its procedures must be approved by a CMHPSM review board.
- **Business Associates.** There are some services provided in our organization through contracts with business associates. To protect your health information, however, we require these business associates to appropriately safeguard your information.
- **Food and Drug Administration (FDA).** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- **Special Situations.** Consistent with applicable law, we may disclose health information to funeral directors, coroners and medical examiners, as required by military command authorities, and for national security activities. A mental health services recipient's information will be disclosed only as allowed by law.

If you believe your rights have been violated, contact the (insert name of your organization) Privacy Officer or the Office of Civil Rights. Your services will not be affected in any way if you file a complaint.

- To file a complaint with (insert name of organization) or if you have any questions or want more information, call or write: Privacy Officer, (insert name, address and phone number of your organization).
- To file a complaint with the Office of Civil Rights, call or write:

Office for Civil Rights, U.S. Department of Health and Human Services, 233 N.

**ATTACHMENT #1V
JUNE 2022**

Michigan Ave., Suite 240, Chicago, IL 60601
Voice Phone (800) 368-1019, FAX (202) 619-3818, TDD (800) 537-7697
OCRComplaint@hhs.gov

HHS OCR Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
HHS OCR website for complaints
<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

(Insert name of organization)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices.

My signature below indicates that I have received the notice, that I have been provided an opportunity to ask questions, and that I understand the organization's privacy practices as they pertain to my protected health information.

Signature

Date

Witness

Date

(Insert name of organization)

Documentation of Good Faith Efforts

Consumer Name: _____

Date: _____

The consumer presented for services on this date and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice, however, an acknowledgement was not obtained because:

_____ Consumer refused to sign

_____ Consumer was unable to sign or initial because:

_____ There was a medical emergency. Staff will attempt to obtain acknowledgement at the next available opportunity.

_____ Other reason:

Signature of Employee completing form:

(Insert name of organization)

SECURITY AND CONFIDENTIALITY AGREEMENT

As an employee of (Insert name of organization) and as a condition of my employment, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies which were provided to me.
2. I will treat all information received in the course of my employment with (Insert name of organization), related to the consumers of services, as confidential and privileged information.
3. I will not access consumer information unless I have a need to know this information in order to perform my job.
4. I will not disclose information regarding (insert name of organization) consumers to any person or entity other than as necessary to perform my job and as permitted under the Community Mental Health Partnership of Southeast Michigan (CMHSPM) HIPAA/Confidentiality policies.
5. I will not log on to any of the computer systems that currently exist or may exist in the future using a password other than my own.
6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my ID badge.
7. I will not allow anyone, including other employees, to use my password to log on to the computer.
8. I will log off of the computer as soon as I have finished using it.
9. I will not use e-mail to transmit consumer information outside of the CMHPSM, unless I am instructed to do so by the Privacy Officer.
10. I will not take consumer information from the premises in paper or electronic form without first receiving permission from my supervisor and ensuring it is secure.
11. Upon cessation of my employment, I agree to continue to maintain the confidentiality of any information I learned while an employee, and agree to turn over any keys, key fobs, or any other device that would provide access to the agency or its information.

I understand that violation of this agreement could result in disciplinary actions.

Employee Printed Name

Date

Employee Signature

Supervisor Signature

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy Claims Payment and Appeal</i>
Committee/Department: Regional Finance	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	<u>05/02/2022</u>
CMH Board:	Approval Date:
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish the standards by which behavioral health (Mental Health and Substance Use Disorder) service claims, submitted by service providers, are reviewed for accuracy, conformance to authorizations, and paid within the requirements stated in the current contract between the State of Michigan-Department of Health and Human (MDHHS) and the CMHPSM or the regional CMHSPs.

II. REVISION HISTORY

DATE	MODIFICATION
10/01/2018	Language revisions
<u>Will be Regional Approval Date</u>	<u>3-year review by Regional Finance</u>

III. APPLICATION

This policy shall apply to the CMHPSM as the PIHP, the CMHSPs within the CMHPSM region (herein after referred to as CMHPSM payers) and all service providers submitting service claims.

IV. POLICY

It is the policy of the CMHPSM that service claims submitted directly to the CMHPSM, or to one of its regional CMHSPs will be appropriately adjudicated and processed according to this policy, MDHHS rules and all applicable federal regulations. Service providers serving CMHPSM consumers individuals will follow this policy related to claims payment.

V. DEFINITIONS

- Adjudication- claims payment process that involves paying clean claims or denying claims after comparing claim information to payer coverage requirements and system edits.

- Claim- formal request for payment related to mental health or substance use disorder service delivery based upon service rates.
- Clean Claim- a claim that does not contain a defect related to adjudication rules or other CMHPSM claim requirements.
- Denied Claim – a claim that did not meet the CMHPSM adjudication rules and/or claim requirements.
- CMHPSM Payers - The CMHPSM itself as the PIHP, or one of the CMHSP entities within the CMHPSM region that pay service claims to their contracted service providers.
- HIPAA - Health Insurance Portability and Accountability Act, law designed to protect patients' health and treatment information.
- Service Provider – Any entity authorized to provide specialty services on behalf of the CMHPSM payers (PIHP or CMHSP).
- Electronic Health Record (EHR) - a digital version of a patient centered health record.

VI. STANDARDS

A. Claims Payment Process

The CMHPSM payers (CMHPSM and its partner CMHSPs) will adjudicate all claims and pay valid clean claims based on the following standards.

1. Service provider Claim Submission

Claims will be submitted by direct entry into the CMHPSM web-based electronic health record (EHR). Service providers may also submit claims electronically through a CMHPSM approved format, such as an 837 file transfer. Service providers submitting paper claims must use a HIPPA compliant HCFA 1500, CMS 1450 (UB04) or a CMHPSM approved format. Service providers must submit claims within the following prescribed timeframes:

- a. 60 calendar days of providing a service
- b. 60 calendar days from date of discharge for all inpatient hospital stays
- c. 90 calendar days of providing service where the CMHPSM payer is a secondary payer.

2. Adjudication

The CMHPSM payer staff will perform adjudication activities on service claims, included but not limited to: system edits, manual edits, claim documentation reviews, primary insurance validation, and/or Medicaid Service Verification sample audits. Service providers may be required to submit additional information to CMHPSM payers upon request including service documentation, copies of primary insurance EOB's, etc.

3. Clean Claims

All clean claims submitted electronically to the CMHPSM payer will be paid within 30 calendar days of the submission date by the CMHPSM payer. Claims not submitted electronically will be processed within 90 calendar days of receipt.

4. Pended Claims

Claims may be pended for multiple reasons during the claims adjudication process. These claims may be denied or returned to the service provider for correction. Batches that have been returned to

service providers must be corrected and resubmitted within 30 calendar days of the date it was returned to the service provider. CMHPSM payers will assist service providers upon request.

5. Denied Claims

A denied claim may be rebilled. A corrected clean claim must be entered and resubmitted for payment within 30 calendar days of the original denial or the EOB/Remittance advice date the original claim appeared. If a rebilled claim is denied for a second time, service provider must follow appeal process for final determination.

6. Reconsidered Claims

Previously paid claims may need to be reconsidered by the CMHPSM payer for multiple reasons. The reconsideration process may result in an increase or decrease in the payment to the service provider which would be reconciled in a future payment to the service provider.

7. Claim Data Layout

Service providers follow the current data claim layout, data fields requirements, etc. as prescribed by the CMHPSM to ensure claims meet all CMHPSM, MDHHS, and/or federal field requirements.

8. HIPAA

Service providers must follow all HIPAA regulations when submitting claims.

9. Other Claim Information

Service provider must maintain documentation supporting claims in a format that provides evidence that service was provided as billed. CMHPSM payer may review supporting documentation in its determination of appropriateness of claims.

10. Fiscal Year End Claims Submission

Service provider must submit all claims for the previous fiscal year (October-September) no later than October 15th. Batches received with different fiscal year claims will be denied and no additional Fiscal Year end submission time will be allotted. Due to the end of the year reporting requirements set by MDHHS, the CMHPSM payer may shorten submission days for Pending, Denied and Appealed claims after October 15th. Failure to follow the Fiscal year End Claims Submission process may result in payment denial. Exceptions to the process must be approved by the CMHPSM payer.

If October 15th falls on a Saturday, Sunday or federally recognized holiday, the due date will be the next business date.

B. Service Provider Appeals

1. Service Provider Right to Appeal

Service providers may appeal CMHPSM payer decisions related to service claim payment denials. The CMHPSM payer and service provider should first communicate so each party understands the reason for denial. If communication between the parties does not resolve the situation, service providers shall follow the Service Provider Appeal Process as outlined in this standard.

2. Service Provider Appeal Process

Service providers will utilize the CMHPSM appeal form which can be found on the CMHPSM website www.cmhpsm.org or through your local CMHPSM payer contact.

- a. Service provider submits appeal form, with all relevant documentation attached, to the CMHPSM Payer that denied

- the claim, within 30 calendar days of the most recent denial or the EOB/Remittance advice date the original claim appeared.
- b. The CMHPSM payer designee reviews the appeal form and attached documentation to make a determination within 15 business days of receiving the appeal.
 - c. CMHPSM payer will provide the appeal determination to the service provider. Services approved in the appeal must be re-entered in EHR and submitted to CMHPSM payer by the service provider within 15 business days of receiving the appeal determination.
 - d. If the service provider disagrees with the determination, they have the right to file a second appeal within 15 business days of receiving the appeal determination.
 - e. Service provider submits a written appeal and includes any additional information to the CMHPSM payer's Executive Director or their designee.
 - f. CMHPSM payer's Executive Director or their designee makes determination on 2nd appeal and returns final determination to the service provider within 15 business days of receiving the appeal. Services approved in the appeal must be re-entered in the EHR and submitted to CMHPSM payer within 15 business days of receipt of final determination.

C. Provider Compliance with Medicaid Service Verification Activities

Regional service provider claims are constantly monitored through the adjudication rules and edits described in this policy. Regional service providers may be selected by CMHPSM payers for additional service verification activities related to claims that have been submitted. Additional service verification activities include but are not limited to random or targeted service claim reviews.

VII. EXHIBITS

- A. Attachment #1: HCFA 1500 Form Example
- B. Attachment #2: CMS1450 (UB04) Form Example
- C. Attachment #3: Appeal Form (Form found at www.cmhpsm.org)

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
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	
Michigan Department of Community Health (MDHHS) Medicaid Contract	X	
Current Michigan Medicaid Provider Manual	X	
Current Michigan Provider Qualifications Chart	X	

Current PIHP/CMHSP Encounter Reporting Costing Per Code and Code Chart	X	
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Attachment #1 HCFA 1500 Form

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05										CARRIER																																																																																																
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																															
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()					6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ 8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐						7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()																																																																																															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐ b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) _____ c. OTHER ACCIDENT? YES ☐ NO ☐ 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.																																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																					
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. 17b. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																															
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER																																																																																																					
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # () a. NPI b.																																																																																																			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Attachment #2 CMS1450 (UB04) Form Example

1		2		3a PAT. CNTRL. # b. MED. REC. #		4 TYPE OF BILL	
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		9 PATIENT ADDRESS					
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC	
16 DHR		17 STAT		18		19	
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**Attachment #3
Appeal Form**

Regional Service Provider Claim Payment Appeal Form

Providers must use this form to appeal service claims denied by Lenawee, Livingston,
Monroe, Washtenaw or CMHPSM SUD payers.

Provider Name:		Appeal Date:	
Contact Person:		Contact Email:	
Contact Phone:		Contact Fax:	

CMHPSM Payer

☐ Lenawee	☐ Livingston	☐ Monroe	☐ Washtenaw	☐ CMHPSM SUD
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EHR Claim ID Number(s)

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EHR Batch Number(s)

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Denial Date and Reason for Denial

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Basis of Appeal

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Resolution Requested

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Service Provider Authorized Signature

Date

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Completed appeal form, including supporting documentation, should be faxed or e-mailed directly to the appropriate CMHPSM Payer department (i.e. Appeal of Lenawee CMH denial of payment sent to Lenawee CMH, appeal of CMHPSM-SUD sent to CMHPSM, etc.)

Received by CMHPSM Payer

Date

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Determination / Outcome

Date

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COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	<i>Policy and Procedure Consumer Appeals Policy</i>
Committee /Department: Regional UM Committee	Local Policy Number (if used)
Implementation Date 12/31/2021	Regional Approval Date 12/17/2021

Reviewed by:	Recommendation Date:
ROC	9/27/2021 05/11/2022
CMH Board:	Approval Date:
Lenawee	11/17/2021
Livingston	11/30/2021
Monroe	11/17/2021
Washtenaw	12/17/2021

I. PURPOSE

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

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
06/05/2015	Revised to reflect the External Quality Review recommendations.
02/24/2017	Revised to reflect Section 942 of P A 268 of 2016 Revised Memo 12 15 16
10/01/2017	Revised to reflect the revised Managed Care Rules.
01/28/2019	Revised to reflect corrections from EQR review
12/17/2021	Revised to reflect new ABD language that provides grievance rights only.
1/26/2022 Will be the Regional Approval Date	Revised to clarify local appeal roles; add state mediation option, notification requirements for extension of service authorization decisions, clarification of 2nd opinion, SUD provider roles; updated reporting requirements

III. APPLICATION

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

IV. POLICY

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

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

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

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

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

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

These processes shall:

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

V. DEFINITIONS

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

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

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

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

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

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

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

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

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

Alternative Dispute Resolution Process - A program of the Michigan Department of Health & Human Services with responsibility for conducting an appeal which was not resolved at the local level through the LDRP. This process may occur after the LDRP review has

been exhausted and Community Mental Health (CMH) upholds the adverse action at the local appeal.

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

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

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

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

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

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

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

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

1. A delay in making a standard/routine service authorization decision of a service request within 14 calendar days from the date of receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
2. A delay in making a decision regarding a request for an expedited service authorization decision within 72 hours from the receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
3. A delay in resolving standard internal appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. The resolution timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.

4. A denial of a request for an expedited appeal. The request for an expedited appeal within 72 hours can be denied and extended (hence delayed) to the standard 30-day appeal time frame if the consumer/individual served is notified of the right to file a grievance.
5. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. STANDARDS

A. General Standards

1. Both grievance and appeals systems shall have a Grievance and Appeal System: Processes ~~shall be~~ in place for consumers/individuals served, ~~and~~ promote the resolution of concerns, ~~and as well as~~ support and enhance the goal of improving the quality of services.
2. Consumers/individuals served/legal representatives shall be informed of their right to access ~~the~~ grievance and appeal processes, if they are dissatisfied or concerned at any point during the delivery of mental health services or supports.
3. Customer Services and the Office of Recipient Rights (ORR) shall assist

applicants/consumers/individuals served/legal representatives of their legal rights to access all grievance and/or appeal processes which they are eligible.

4. Providers shall be informed of their right to access the [provider](#) appeal process when they are denied or limited authorization for services, or when they wish to file an expedited appeal on behalf of a consumer/individual served.
5. Providers, acting on behalf of a consumer/individual served/applicant and with the consumer/individual's/legal representative's written consent, may file an appeal as the consumer/individual's Authorized Hearing Representative (AHR).
6. If an external/contractual provider makes a service request on behalf of a consumer/individual served, and that request results in an adverse benefit determination/action, both the provider and the consumer/individual served/guardian will be notified of the adverse benefit determination/action. Notice to the provider can be verbally or in writing. Notice to the consumer/individual served/guardian shall follow written notice requirements as outlined in this policy.
7. If the consumer/individual served/legal representative is not aware of the provider's service request, and the matter warrants involving the consumer/individual served/legal guardian in the request process (i.e., will warrant a change in the Individual Plan of Service (IPOS) that the consumer/individual served/legal representative would need to agree to), CMHSP staff will inform the consumer/individual served/legal representative regarding the request.
- ~~8. [Level of Appeals](#):~~ The PIHP/CMHSP may only have one [local](#) level of appeal for consumers/individuals served.
- ~~8-9. [Individuals served/legal representatives will be informed of their right to request mediation services per MDHHS requirements](#)~~

B. Timeliness of Authorization/Service Decisions

1. State and federal regulations require that specific service decisions shall be made within certain time frames. If these time frames (described below) are not met they are considered [appealable](#) denials/Adverse Benefit Determinations ([ABD](#)) or decisions with grievance rights, and staff shall follow the same processes for providing consumers/individuals served/legal representatives with notices of their appeal or grievance rights as outlined in this policy.
2. Authorization decisions at the initial request for services, or request for hospitalization shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent.
3. Authorization decisions for Medicaid consumers/individuals served currently receiving services shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance for this delay.
4. A standard service authorization decision may be extended an additional 14 calendar days if the consumer/individual served or legal representative requests an extension or if the PIHP/CMHSP/Core Provider justifies a need for additional information and the extension is in the consumer/individual's interest.
5. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ROSC Core Provider must:

- i. ~~make reasonable efforts to give the member~~ make attempts to give prompt oral/verbal notification of the delay to the individual served/legal representative ~~oral notice of the delay~~;
 - ii. Within two calendar days, provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a grievance if he ~~or~~ she disagrees with that decision;
 - iii. ~~Within two calendar days, provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision~~;
 - iv. issue and carry out ~~the its~~ determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).
6. Medicaid covered services shall begin within 14 days from when the authorization was completed, except in cases where the consumer/individual served agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14-day time frame and the consumer/individual served does not agree to an extension, this shall be considered an ABD and staff shall provide the consumer/individual served/legal representative with notice of the denial and their appeal rights.
7. Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/individual served/legal guardian requests, or the PIHP/CMHSP determines that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life or health or ability to attain, maintain, or regain maximum function. In these cases, a decision must be made, and written/electronic notice provided no later than 72 hours from receipt of the request for service.
8. The PIHP/CMHSP may extend the 72-hour time period by up to 14 calendar days if the consumer/individual served/legal representative requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer/individual's interest. If the PIHP/CMHSP extends the timeframe, it must:
 - i. give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe,
 - ii. inform the consumer/individual served/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and
 - iii. make a determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.
- ~~9.~~ 9. ~~Consumer/individual served requests for an expedited review of an authorization decision can be denied. If it is denied the consumer/individual served shall receive notice of denial for an expedited review, including the right to file a grievance, and standard 14-day timeframes for an authorization decision shall still be met.~~
- ~~9-10.~~ 10. ~~If a provider requests an expedited review of an authorization decision, such a request from a provider cannot be denied;~~ the review shall follow the expedited process and the provider shall be informed within 72 hours on whether the service request will be approved or denied.

C. Filing and Timeliness Requirements

1. Grievances: A consumer/individual served/legal representative may file a grievance at any time. The PIHP/CMHSP/SUD Core Provider shall resolve grievances and send written notice of the grievance outcome within 60 days of receipt.
2. Appeals:
 - a) Medicaid Appeals: Following receipt of notification of an Adverse Benefit Determination (ABD) by a PIHP/CMHSP/ROSC Core Provider/SUD provider, a consumer/individual served/legal representative has 60 calendar days to request an internal appeal with the entity that provided the ABD, PIHP/CMHSP. An internal appeal must be resolved within 30 days of receipt.
 - i. The 30-day timeframe for an internal appeal may be extended by up to 14 calendar days if a consumer/individual served/legal representative requests an extension or if the CMHSP/PIHP/ROSC Core Provider/SUD provider finds that there is a need for additional information that would be in the best interest of the consumer/individual served. If the timeframe for an internal appeal is extended, notice of the consumer/individual/legal representative must be given notice of the right to file a grievance about the on this decision, must be provided.
 - ii. A consumer/individual served/legal representative may request a State Fair Hearing within 120 calendar days after receiving notice that the ABD was upheld by the internal appeal.
 - iii. If the PIHP/CMHSP does not meet the notice or internal appeal timing requirements, the consumer/individual served has the immediate right to file a State Fair Hearing.
 - b) Non-Medicaid/General Fund Appeals: Following receipt of an action by the PIHP/CMHSP/ROSC Core Provider, a consumer/individual served/legal representative has 30 calendar days to request a local appeal with the CMHSP. A consumer/individual served/legal representative may request an Alternative Dispute Resolution Process with the state within 10 calendar days after receiving notice that the action was upheld by the local appeal/LDRP.

D. ~~Notice of~~ Approved Services

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

E. Second Opinion Process

1. All applicants/consumers/individuals served/legal representatives may request a second opinion for a denial of access to services and/or denial of an inpatient psychiatric of access to hospitalization within 30 days of the denial. A second opinion will be provided within the PIHP/CMHSP, at no extra cost to applicants/consumers/individuals served, by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.
- 1-2. All consumers/individuals served may request a second opinion when denied a request for routine/non-urgent/non-emergent service. The CMHSP/PIHP/ROSC Core Provider/contractual provider will ensure a second opinion is provided at no cost to the consumer/individual served, and by a clinical staff that meets the MDHHS criteria

[for the service in question.](#)

- ~~2-3.~~ Non-urgent requests for a second opinion will be completed for applicants/consumers/individuals served within five (5) business days from the receipt of the request.
- ~~3-4.~~ Upon completion of the second opinion, the applicant/consumer/individual served will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion, ~~and ; this notification will be followed by a~~ written notification [provided](#) within five (5) business days from the completion of the second opinion.
- ~~4-5.~~ Urgent requests for a second opinion will be provided to consumer/individual served with Medicaid within 72 hours.
- ~~5-6.~~ Urgent requests for a second opinion will be provided to Non-Medicaid consumer/individual served within three (3) business days.
- ~~6-7.~~ Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer/individual served clinical need, and no later than 24 hours of when the service was requested.
- ~~7-8.~~ If the second opinion upholds the original denial, the notification to the applicant/consumer/individual served shall include the next steps available to them, including filing a [grievance, and appeal, and/or a](#) recipient rights complaint.
- ~~8-9.~~ If the second opinion reverses the original denial, staff (Access, Psychiatric Emergency Services, or the local designee) shall arrange for services to be provided per the appropriate required timeframes for authorization decisions.

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

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

1. Timeliness of Notice for Medicaid Beneficiaries:

- a. For a Service Authorization decision that denies or limits services, notice must be provided to the consumer/individual served within 14 days following receipt of the request for service for standard authorization decisions, or within 72 hours after receipt of a request for an expedited authorization decision.
- b. The CMHSP/PIHP/ROSC Core Provider may be able to extend the standard Service Authorization timeframe up to 14 additional calendar days, if:
 - (i) The consumer/individual served, or the provider, requests extension; or
 - (ii) The CMHSP/PIHP/ROSC Core Provider justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer/individual's interest.
- c. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ROSC Core Provider must:
 - (iii) provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a Grievance if he or she disagrees with that decision; and
 - (vi) issue and carry out its determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

- d. Advance Notice of Adverse Benefit Determination is required for service authorization decisions that are reductions, suspensions or terminations of previously authorized/currently provided Medicaid Services. Advance Notice of an ABD must be provided to the consumer/individual served/legal representative at least ten (10) calendar days prior to the proposed effective date.
- e. If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP/[ROSC Core Provider/SUD provider provider](#) must reinstate services to the level before the action if services have been reduced, terminated, or suspended.
- f. Limited Exceptions to Advance Action Notice of an ABD:
The PIHP may mail an adequate notice of action instead of advance action notice, not later than the date of action to terminate, suspend or reduce previously authorized services, if:
 - i. The [entity providing notice -CMHSP/PIHP](#) has factual information confirming the death of a consumer/individual served/applicant;
 - ii. The [entity providing notice CMHSP/PIHP](#) receives a clear written statement signed by a consumer/individual served/legal representative that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the consumer/individual served/legal representative understands that this must be the result of supplying that information;
 - iii. The consumer/individual served has been admitted to an institution where he/she is ineligible under the plan for further services;
 - iv. The consumer/individual's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address;
 - v. The [entity providing notice CMHSP/PIHP](#) establishes that the consumer/individual served/applicant has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
 - vi. A change in the level of medical care is prescribed by the consumer/individual's physician;
 - vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the [Social Security](#) Act;
 - viii. The date of action will occur in less than 10 calendar days.
 - ix. The [entity providing notice PIHP](#) has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the consumer/individual served (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).
- g. If the PIHP/CMHSP/[ROSC Core Provider/SUD Provider](#) does not meet the requirements of providing notice or of internal appeal timing requirements, the consumer/individual served [with Medicaid](#) has the immediate right to file a State Fair Hearing.

2. Timeliness of Notice for Non-Medicaid/General Funds Consumers

Beneficiaries:

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

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

G. Content of Notice

1. Consumers/individuals served/legal representatives shall receive written notice of an ABD/action with content that meets federal and state requirements.
 - a. **Content of a Medicaid Notice shall explain the following:**
 - i. The ABD the PIHP/CMHSP intends to make or has already made.
 - ii. The reasons for the ABD.
 - iii. The consumer/individual's right to request an appeal of the PIHP's/CMHSP's ABD, including information on exhausting the PIHP's/CMHSP's one level of appeal and the right to request a State Fair Hearing.
 - iv. The right for consumers/individuals served/legal representatives to have an AHR and the timeframes for requesting appeals.
 - v. Before and during the appeal, the right of the consumer/individual served/legal representative and/or AHR to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the consumer/individual's ABD. This shall occur in a timely manner sufficient for preparation of their case for the appeal.
 - vi. How to submit written comments or information relevant to the appeal.
 - vii. The procedure for exercising their appeal rights.
 - viii. The circumstances under which an appeal process can be expedited and how to request it.
 - ix. The consumer/individual's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the consumer/individual served may be required to pay the cost of these services. A consumer/individual served may be required to pay the cost of the services if:
 - 1) The decision was upheld.
 - 2) The consumer/individual served/legal representative/AHR withdraws their appeal request.
 - 3) The consumer/individual served/legal representative/AHR does not attend the appeal.
 - x. Notice of denials given to providers/practitioners shall include information on the opportunity for providers to discuss any denial decision with the reviewer and how to contact the reviewer.

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

H. Handling of Appeals:

- All PIHP/CMHSP/Provider entities [handling appeals](#) will:
 - Ensure that written materials will be provided to consumers/individuals served, legal representatives and AHRs in a language and format that is easily understood.
 - If an applicant/consumer/individual served requires written materials in alternative formats (i.e., visual/hearing impairments or limited English proficiency), materials will be provided free of charge and in ways to meet their needs. Large print materials must be typed in a font large enough and no less than an 18-point font for the individual to read. (See the Regional Customer Services Policy for further information about written materials).
 - Give consumers/individuals served/legal representatives reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes but is not limited to auxiliary aids and services upon request, such as providing free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. This shall occur in accordance with PIHP policies on interpreters and/or limited English proficiency.

- Any staff/designee handling appeals of ABDs/actions shall:

- Acknowledge the receipt of each internal/local appeal in writing within 5 calendar days to the consumer/individual served/legal representative and when applicable, the AHR.

Requests for internal/local appeals received orally will be treated as a formal appeal request to establish the earliest possible filing date for a local appeal. [Staff receiving oral requests for an appeal will ensure this is documented in consumer and appeals records to ensure compliance with required timeframes are met in both responding to the appeal request and data reporting of appeals. An oral appeal must be confirmed in writing unless the applicant/consumer/individual served, legal representative/provider requests expedited resolution of an appeal.](#)

- Ensure that the individuals who make decisions on appeals are individuals who:
 - Were not involved in any previous level of review or decision making nor a subordinate of any such individual.
 - If deciding any of the following, are individuals who have the appropriate clinical expertise in treating the consumer/individual's condition:
 - An appeal of a denial that is based on lack of medical necessity.
 - A grievance regarding denial of expedited resolution of an appeal
 - A grievance or appeal that involves clinical issues.

- Take into account all comments, documents, records and other information

Commented [CW1]: Check if this is still accurate

Commented [CW2R1]: § 438.406 Handling of grievances and appeals.
(b) Special requirements. An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:
(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.

submitted by the consumer/individual served/legal representative without regard to whether such information was submitted or considered in the initial ABD/action.

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

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

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

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

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

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

- i. The consumer/individual served/legal representative withdraws the internal appeal or request for State Fair Hearing.
- ii. The consumer/individual served/legal representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the

PIHP/CMHSP sends the consumer/individual served notice of an adverse resolution to the consumer/individual's/legal representative's internal appeal.

- iii. A State Fair Hearing office issues a decision adverse to the consumer/individual served/legal representative.

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

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

l. Ensure that staff provide notice of appeal rights through the use of/entry into the Consumer Notice Module in the regional electronic record, which will generate the appropriate forms as described in this policy, or use of notice of grievance rights in the Letters module of the regional electronic record. The only exception to this standard is in cases where staff/providers do not have access to the electronic record. In these cases, staff will provide paper/manual notice that meets current state and federal requirements. Resources are available at the PIHP website <https://www.cmhpsm.org/sudtraining>.

k.

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I. Resolution and Notification: General Standards

1. The Internal/Local Appeal Coordinator will follow the receipt process for requests for internal/local appeals.
2. PIHP/CMHSP/Provider person(s) reviewing internal/local appeals will follow processes for conducting internal/local appeals.
3. Review of all internal/local appeals will include:
 - a. A full investigation of the substance for the appeal and any aspects of clinical care involved.
 - b. The opportunity for the consumer/individual served/legal representative/Authorized Hearing Representative to be present at the internal/local appeal and bring anyone they wish to testify on their behalf.
 - c. The opportunity for the consumer/individual served/legal representative to submit written comments, documents, or other information before or during the internal/local appeal meeting.
4. Expedited resolution of internal/local appeals shall be carried out in cases when, by request from the consumer/individual served/legal representative, the PIHP/CMHSP determines or the provider indicates (in making the request on the consumer/individual's behalf or supporting the consumer/individual's request) that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life, physical or mental health or ability to attain, maintain, or regain

maximum function.

5. A consumer/individual's request for an expedited appeal can be denied by the PIHP/CMHSP in cases that do not meet the criteria for an expedited appeal.
6. A provider's request for an expedited appeal cannot be denied by the PIHP/CMHSP. In cases where the provider is requesting an expedited appeal the appeal review must be expedited.

H. Medicaid Internal/ Appeal Process:

1. Medicaid internal appeals shall be completed (including the disposition sent out) within 30 calendar days of receipt of the request for an internal appeal with exception of expedited appeals. The 30-day timeframe may be extended by up to 14 calendar days if the consumer/individual served/legal representative request the extension or the PIHP shows that there is need for additional information and the delay is in the consumer/individual's best interest. If the PIHP extends the timeframe not at the request of the consumer/individual served, it must:
 - A. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the delay,
 - B. Within 2 calendar days give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served/legal representative of the right to file a grievance if he or she disagrees with that decision, and
 - C. Resolve the appeal as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.
2. **Medicaid Expedited Appeals:** The expedited internal appeals for Medicaid beneficiaries must be resolved and notice of disposition given no later than 72 hours from the request. In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable, based on clinical judgment of a consumer/individual's needs. As with appeals of reductions, suspensions or terminations, the consumer/individual's services will continue until a decision is made, if requested within 10 days of ABD.

A. For expedited resolution of Medicaid internal/local appeals, the PIHP/CMHSP may extend the 72-hour notice of disposition time frame by up to 14 calendar days if the consumer/individual served/legal representative requests an extension or, if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the consumer/individual's best interest. (Justification for the extension must be documented).

B. If PIHP, CMHSP, or ROSC Core Provider extends the timeframes not at the request of the enrollee, it must complete all of the following:

- i. Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- ii. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- iii. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

C. If the request for an expedited resolution of a Medicaid internal appeal is denied, the PIHP/CMHSP must:

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- A. Transfer the internal appeal to the timeframe for standard resolution or no longer than 30 calendar days from the date the PIHP/ CMHSP received the appeal;
- B. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/individual served/legal representative written notice of the denial for an expedited appeal within two (2) calendar days;
- C. Inform the consumer/individual served/legal representative of their right to file a grievance for denial of an expedited appeal.

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

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

- A. The results of the resolution and the date it was completed.
- B. When the appeal is not resolved wholly in favor of the consumer/individual served, the notice of disposition must also include notice of the following:
 - i. The consumer/individual's right to request a State Fair Hearing and how to do so.
 - ii. The Right to request to receive benefits while the State Fair Hearing is pending and how to make the request.
 - iii. The potential liability for the cost of those benefits, if the hearing decision upholds the PIHP's ABD.
 - iv. The right to contact Customer Services or the Office of Recipients Rights.
- C. If the consumer/individual served/legal representative continues to receive the service pending the appeal, the consumer/individual served may have to repay the cost of the service. This may happen if:
 - i. The proposed suspension, reduction or termination of services is upheld in the appeal decision.
 - ii. The consumer/individual served/legal representative/AHR withdraws their appeal request.
 - iii. The consumer/individual served/legal representative/AHR does not attend the appeal.

I. Non-Medicaid Local Appeal Process:

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

2. Non-Medicaid/General Fund Expedited Appeal

- a. If psychiatric inpatient services are denied for Non-Medicaid/General Fund consumers/individuals served, the consumer/individual served/legal representative must be informed of their right to the LDRP, with the decision from that process to be reached within 3 business days.

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

1. Non-Medicaid/General Fund Local Appeal – Notice of Resolution:

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

J. State Level Appeal Process:

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

2. State Medicaid Fair Hearings:

- a. After the internal appeal has been exhausted, a Medicaid consumer/individual served may request a State Fair Hearing, if the PIHP/CMHSP upholds the ABD. If the PIHP/CMHSP does not adhere to the notice and timing requirements in 42CFR 438.408, the consumer/individual served is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.
- b. A consumer/individual served must request a State fair hearing not later than 120 calendar days from the date of the PIHP's/CMHSP's notice of resolution.
- c. The parties to the State Fair Hearing include the PIHP/CMHSP as well as the consumer/individual served/legal representative or the representative of a deceased consumer/individual's estate.
- d. If ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP may recover against the consumer/individual served for services provided during the internal appeal and State Fair Hearing.
- e. If the Administrative Law Judge at the State Fair Hearing level reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMHSP/PIHP must authorize, pay for, and/or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

3. Non-Medicaid State Appeals:

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

- b. A consumer/individual served must request the MDHHS ADRP within 10 days from the written notice of the LDRP outcome.
- c. MDHHS shall review all requests within two business days of receipt.
- d. If MDHHS agrees with the CMHSP/PIHP/Provider decision, the consumer/individual served may be required to pay for the extended services.

K. Family Support Subsidy Appeals

1. All Family Support Subsidy appeals are handled by the local CMHSP.
2. If a Family Support Subsidy Application is denied or services are terminated, the CMHSP will send the consumer/individual's parent or legal representative a memorandum stating the reason for ineligibility and timeline for an appeal.
3. If the parent or representative had an income increase that resulted in the family exceeding the statutory limit, and the parent or representative did not notify the CMH within two weeks of the change, the CMHSP shall send the parent or representative a memorandum explaining that the subsidy will be terminated, and any amount illegally received will be repaid together with interest as provided in Administrative Rule 330.1621. Repayment of these services will be arranged through the state FSS program.
4. The parent/legal representative has 60 days to file an appeal from the date of the notice of ineligibility or termination. This may be done by letter or by a local Non-Medicaid appeal form available from the local CMHSP.
If the parent/legal representative requests an FSS appeal within 60 days, the CMHSP shall conduct an FSS hearing in the manner provided for a contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969
5. Using a "reasonable person" standard, the CMHSP determines if the denial or termination of the subsidy will pose an immediate and adverse impact upon the consumer/individual's health and safety. If so, the CMHSP hears the appeal within one business day. If not, the CMHSP follows the steps below.
 - a. Sends parent or legal representative notice of receipt of appeal, indicating the following information about the scheduled hearing:
 - i. Date, hour, place, and nature of hearing.
 - ii. Statement of legal authority and jurisdiction under which the hearing is to be held.
 - iii. Reference to statutes and rules involved, and
 - iv. Short and plain statement of the matters asserted.
 - v. If the timeline for an appeal was exceeded, sends a response indicating that the appeal was not received within two months of the action, and no further appeal rights are warranted.

L. Record Keeping Requirements:

- a. PIHPs shall ensure the maintenance of records for second opinions, local appeals, and copies of State appeals. The PIHP must review the information as part of its ongoing monitoring procedures. The record of each appeal must contain, at a minimum, all of the following information:
 - i. If the individual is a Medicaid beneficiary or is served with Non-Medicaid/General Funds.
 - ~~ii.~~ A general description of the reason for the appeal.
 - ~~iii.~~ The date and time the appeal was received.

- ~~iii-iv.~~ Date and type of adverse benefit determination associated with the appeal.
 - ~~iv-v.~~ Whether ABD timeframes were met in providing notice
 - ~~vi.~~ Service(s) related to the appeal.
 - ~~v-vii.~~ Date of the service request; if an expedited appeal is request the time of the request needs to also be included.
 - ~~vi-viii.~~ Whether an expedited appeal review was requested
 - ~~vii-ix.~~ Whether and expedited appeal request was approved or denied.
 - ~~viii-x.~~ Whether expedited appeal timeframes were met (where applicable)
 - ~~ix-xi.~~ The date of each review or, if applicable, review meeting.
 - ~~x-xii.~~ Evidence that individuals who made the decisions on appeals were not involved in any previous level of review or decision making, nor are subordinates of any such individual.
 - ~~xi-xiii.~~ Resolution at each level of the appeal, if applicable, including whether original ABD was upheld or not, in full or in part.
 - ~~xii-xiv.~~ Date and time of resolution at each level, where applicable.
 - ~~xiii-xv.~~ Name of the covered person for whom the appeal was filed.
 - ~~xvi.~~ If the person had an AHR, and the name of the AHR where applicable.
 - ~~xvii.~~ Whether the Medicaid beneficiary involved is using or has used at least one LTSS service at any point during the reporting year.
 - ~~xiv-xviii.~~ Whether the Medicaid beneficiary is enrolled in a health home.
- b. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

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M. Performance Improvement

1. Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, LDRC requests/resolutions, MOAHR Administrative Hearing requests/resolutions, and MDHHS Alternative Dispute Resolution requests/resolutions. This information will be reported and reviewed by the PIHP UM Committee quarterly and maintained by the provided to the PIHP Director of Quality and Compliance/Quality Manager-Compliance quarterly.
2. Quarterly aggregate reports of appeals data shall be provided by the PIHP Compliance Manager /PIHP Utilization Management Committee Chair to the PIHP Clinical Performance Team and the PIHP Customer Services Committee as the PIHP Quality Assurance and Performance Improvement Program (QAPI) entity for their review and recommendations on any trends or improvement opportunities.
- 2-3. The PIHP Compliance/Quality Manager will ensure PIHP reporting of service denial decisions, local/internal appeals, and grievances to MDHHS in accordance with the current MDHHS/PIHP contract.

VII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Medicaid Managed Care Rule 42 CFR Parts 432, 433, 438 et al.	X	
Michigan Mental Health Code Act 258 of 1974 as amended	X	Section 100b,409(4),705

MDHHS/PIHP Medicaid Contract and Attachments	X	4.4.1.1 Person Centered Planning Practice Guideline; 6.3.1.1 Grievance & Appeal Technical Requirement Process
MDHHS Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings.	X	
MDHHS/CMHSP General Funds Contract	X	3.1.1 Access System Standards; 6.3.2.1 CMHSP Local Dispute Resolution Process; 6.3.2.2 Family Support Subsidy Program
Family Support Subsidy Act, Public Act 249 of 1983, as amended.	X	
Administrative Procedures Act of 1969, Public Act 306 of 1969	X	Sec. 24.271-24.287.
MDHHS Administrative Rules	X	
MDHHS Policy Hearing Authority Decision #01-0358CMH, and subsequent MDHHS clarifications	X	
CMHPSM Office of Recipient Rights Policy	X	
CMHPSM Culturally and Linguistically Relevant Services Policy	X	
CMHPSM /Limited English Proficiency Policy	X	
CMHPSM Utilization Management Policy	X	
CMHPSM Customer Services Policy	X	
MI Medicaid Provider Manual	X	Coordination of Benefits Chapter; Behavioral Health and Intellectual and Developmental Disabilities Supports & Services Chapter
MOAHR Administrative Hearings Pamphlet	X	
Section 942 of PA 268 of 2016	X	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	<i>Policy and Procedure Culturally and Linguistically Relevant Services</i>
Committee/Department: Regional Customer Services and Compliance	Local Policy Number (if used)
Implementation Date (2 weeks from Regional Approval Date)	Regional Approval Date (date of last CMH board's approval)

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

I. PURPOSE

To ensure that consumers/individuals served and families with culturally diverse backgrounds and/or linguistically different needs have access to needed translation services so that planning and service delivery can be conducted in a way that facilitates the consumer/individual's desired outcomes.

Behavioral health services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. Present and projected changes in America's ethnic composition should be reflected in the care system which serves its people (National Research Center for Hispanic Mental Health).

II. REVISION HISTORY

DATE	MODIFICATION
12/06/2011	
2014	Revised to reflect the new regional entity. Changed policy name to replace "Appropriate Services" with "Relevant Services"
2017	Revised to reflect Medicaid Managed Care Regulations Final Rule 2016
Will be Regional Approval Date	<u>3-year review</u>

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 and all contractual network service providers shall effectively and efficiently address the treatment and psychosocial needs of consumers/individuals served and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, abilities, and language. Every effort shall be made to ensure that services and staff are participating in the ongoing process of achieving cultural competence.

This includes ensuring that consumers/individuals served with Limited English Proficiency (LEP) are given, free of charge, accurate and timely assistance to obtain effective and meaningful access to services. All individuals seeking services will be given adequate information to be able to understand their rights and the services and benefits available. This policy also establishes guidelines for the provision of interpreters for consumers/individuals served with hearing impairment, and assures that speech, language, and hearing services are available free of charge.

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.

Cultural Competency - An ongoing process by which individuals and systems respond respectfully and effectively to all people in a manner that recognizes, affirms and values the worth of individuals, families, and communities and protects and preserves the dignity of each. It is an ability to honor and respect others' beliefs, interpersonal styles, and behaviors that leads to an ability to respond well to the challenges and opportunities of social and cultural diversity. "Competency" refers to the ability of staff to acknowledge and understand the influence of cultural histories (including oppressive histories), life experiences, language differences, beliefs, values, formal and informal help-seeking pathways, and traditional healing practices on an individual's recovery (NY Office of Mental Health). Culturally competent organizations have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to the diversity and cultural contexts of individuals and communities served (National Center for Cultural Competence).

Cultural Relevance - The understanding and application of the concept that all individuals' values and beliefs will be honored and respected in all interactions.

Culture- An integrated pattern of human behavior, which includes but is not limited to

thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; dynamic in nature (National Center for Cultural Competence).

Deaf Person - a person whose hearing is totally impaired or whose hearing, with or without amplifications, is so seriously impaired that the primary means of receiving spoken language is through visual or other sensory input including, but not limited to, lip reading, sign language, finger spelling or reading, gestures or tactile signs.

Foreign Language Interpreters/Translators- Individuals who have a bachelor's degree from an accredited institution, preferably in languages or linguistics and possess at least one year of specialized experience in interpreting, translating or other work requiring the use of English and the foreign language from (to) which the interpretation/translation is being provided.

I-Speak Cards – Laminated cards that have examples of various languages illustrated for consumers/individuals served to point to so staff are able to secure appropriate translation/interpretation services.

Limited English Proficiency (LEP) – a limited ability to speak, read, write, or understand the English language at a level that permits him or her to interact effectively with health and social service agencies and providers.

Qualified Interpreter in Mental Health - a qualified foreign language interpreter/translator who is also familiar with behavioral health terminology and practices.

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

Sign Language Interpreters – an individual who has a bachelor's degree from an accredited institution, preferably in Humanities or related fields and certified by the Registry of Interpreters for the Deaf (RID) assessed by the National Association for the Deaf (NAD) or qualified as per the state quality assurance (QA) Levels Descriptions as a QA Level III and possesses at least one year of experience working with deaf and hearing impaired individuals.

Tactile Interpreter - an individual who uses sign language applied to the deaf/blind person's hand to convey information.

Translator – an individual or device that translates, in writing or speech, from one language into another. (Encarta® World English Dictionary [North American Edition] © & (P) 2006)

VI. STANDARDS

- A. CMHSP's shall maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to plan accurately and implement services and materials that correspond to the cultural and linguistic characteristics of

- the service area. Identify any populations whose needs are not being appropriately met, and create plans for outreach and engagement.
- B. A designated CMH staff will ensure language posters and “I Speak” cards are posted and accessible.
- C. A designated CMH staff will ensure a panel of providers for translator, speech, and interpreter services.
- D. To ensure consumer/individuals’ cultural and linguistic needs are met, CMHSP staff shall do the following when assessing, recommending, or making referrals:
- Ensure cultural and language needs are discussed with the client in a respectful manner and assessed initially and annually.
 - Ensure that the Person-Centered Planning process and the Individual Plans of Service address cultural issues and any language assistance needs.
 - Identify any speech, language, and hearing service needs, cultural needs and language assistance needs, and authorize related specialty services within the initial authorization of care.
 - Make recommendations for obtaining speech, hearing or language, cultural needs and language assistance services for a client. The recommendations may be based on a physician referral, assessment, or other sources of information indicating client need. CMH staff will obtain necessary releases from the client or guardian.
 - Identify and contact potential interpretive service providers.
 - Assure the objectives of the referral are clear and relevant and that relevant background information is exchanged with the service provider.
 - Monitor and address follow-up with the referral.
 - Obtain all follow-up reports and information as a result of the referral, share information with other team members, and make the information available in the clinical record.
 - Evaluate the effectiveness of the referral and client satisfaction with the services. This will include determination of whether services were respectful, culturally and linguistically relevant, and reasonably accessible to the client.
- E. To ensure that services are culturally competent and relevant, CMHSPs and contract service providers shall:
- Promote awareness of cultural differences and concerns, develop knowledge of cultural issues, develop skills to work well with differences, and embed cultural experiences within all levels of the organization.

- Make every effort to implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership team that are representative of the demographic characteristics of the service area.
- Incorporate a management strategy that addresses culturally and linguistically relevant services and incorporates community and consumer individuals served involvement in the design, execution, and service delivery.
- Conduct annual organizational self-assessments of culturally and linguistically relevant services to identify further opportunities to integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, satisfaction assessments and outcomes-based evaluations.
- Ensure that service for all consumers individuals served shall be relevant to their culture and life experiences.
- Ensure that individual plans of service/treatment plans have documented evidence of cultural/LEP issues and values.
- Ensure that culturally and linguistically competent literature is made available on prevalent psychiatric disorders, medical treatment options, and pharmacological interventions.
- Develop participatory, collaborative partnerships and outreach activities with communities to facilitate community and consumer individual served involvement to improve cultural and linguistic related activities. Make available to the public information about progress and successful innovations of cultural and linguistic relevant activities.
- Ensure that the physical environment uses visual images that reflect the diversity of the community. Artwork, photographs, colors, and decorations will be utilized that reflect this cultural diversity.
- Ensure training of all employees during orientation and as required by the Regional Training Grid regarding core Cultural Competency and LEP policies and procedures. Components of the training shall include:
 - Overall awareness of cultural competency/LEP and issues involved, including ethnic/ racial backgrounds, gender culture, socioeconomic/education status, sexual orientation, physical capacity, age/generation, personality type, spiritual/ religious beliefs, regional perspectives, multi-cultural influences, and LEP.
 - Completion of the cultural competency and LEP training will be required as part of the initial and on-going credentialing process. Documentation of the training will be maintained that includes the employees' names and dates of training.
 - Ensure that any person receiving services within the CMHPSM who believes that he or she has been excluded from the participation in, denied the benefits of, or subjected to discrimination under any program or activity within the CMHPSM,

understands that they may file a Recipient Rights Complaint with the CMHPSM designated Recipient Rights Officer or Customer Services.

- Ensure that conflict resolution, grievance, and appeals processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by consumers /individuals served

F. To ensure linguistically relevant services, CMHSPs shall also:

- Offer and provide language assistance services, at no cost for persons with Limited English Proficiency, at all points of contact, and in a timely manner during all hours of operation.
- Work in the consumer /individual's preferred language and provide both verbal offers and written notices informing consumers /individuals served of their right to receive language assistance services.
- Ensure the competence of language assistance provided to consumers /individuals served with LEP by interpreters and bilingual staff.
- Ensure that family and friends are not used to provide interpretation services, except by request of the consumer /individual served. The request and relevant releases of information shall be documented in the clinical record.
- Ensure that children are not used for interpretation services.
- Create and maintain a list of languages spoken by CMHSP and provider staff.
- Ensure that sign language and/or oral interpreters for persons with hearing impairment shall be provided to persons who are authorized for services.
- Ensure that speech, language and hearing services are available to clients as identified in their Treatment Plans.
- Make available easily understood materials and post signage in the languages of commonly encountered cultural groups and/or cultural groups represented in the service area.
- Ensure that notices of available interpreter services are posted in all public areas.
- Monitor to ensure that individual consumer /individual's race, ethnicity, spoken and written languages are collected in health records, integrated into management information systems, and periodically updated so accurate data may be obtained.

G. Contract Service Providers shall:

- Have a procedure in place for identifying and requesting the need for sign language and/or interpretive services.

- Have a procedure to request written materials or other supports that meets the cultural, linguistic and ethnic needs for delivery of services as outlined in the consumer/individual's individual plan of service or treatment plan.

VII. **EXHIBITS**
None

VIII. **REFERENCES**

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	x	45 CFR 438.10(c)
45 CFR Parts 160 & 164 (HIPAA)		
42 CFR Part 2 (Substance Abuse)		
Michigan Mental Health Code Act 258 of 1974	x	330.1748, 330.1749, 330.1750, 330.1946
The Joint Commission - Behavioral Health Standards		
Michigan Department of Community Health (MDCH) Medicaid Contract		
MDCH Substance Abuse Contract		
Michigan Medicaid Provider Manual		
PIHP Policy Review Schedule		
Policy Tracking Form		
Section 601 of Title VI of the Civil Rights Act of 1964	x	A42 USC Section 20000d et. Seq.
US Department of Transportation (DOT)	x	Title VI regulations at 49CFR, Part 21

National Center for Cultural Competence - Georgetown http://nccc.georgetown.edu/foundations/assessment.html	x	
National Research Center for Hispanic Mental Health http://nrchmh.org/ResourcesMHAdminsLeaders/Cultural%20Competence%20Standards%20SAMHSA.pdf	x	
NY Office of Mental Health http://www.omh.ny.gov/omhweb/cultural_competence/guidance/agency_plan.html	x	
CMHPSM Organization Credentialing and Monitoring Policy	x	
CMHPSM Customer Services Policy	x	

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy and Procedure Financial Fraud and Abuse</i>
Committee/Department: Regional Finance Committee	Local Policy Number (if used)
Implementation Date (2 weeks from Regional Approval Date)	Regional Approval Date (date of last CMH board's approval)

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

I. PURPOSE

To establish a process to investigate, document and report alleged financial fraud and abuse.

II. REVISION HISTORY

DATE	MODIFICATION
3/16/15	Revised to reflect the new regional entity effective January 1, 2014.
Will be Regional Approval Date	<u>3-year review by Regional Finance</u>

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. DEFINITIONS

Abuse: Describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing consumers with services that are medically necessary, meet professionally recognized standards, and priced fairly.

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.

Exploitation – Any action by an employee, contract employee, or volunteer that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Financial Fraud: Intentional or unintentional failure to comply with any professional standards for health care, standards for medical necessity, or standards for billing/business operations that could result in potential false claims/overpayment. These include claims for services not delivered, for services delivered that are not in accordance with the service code definitions included in the CPT (Current Procedural Terminology) manual and the Healthcare Common Procedure Coding System (HCPCS) manual, both issued by the American Medical Association.

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.

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.

V. POLICY

It is the policy of the CMHPSM to report and document suspected financial fraud and financial abuse to the proper state and federal authorities, to maintain a database of all alleged fraud instances, and to provide to [MDCH-MDHHS](#) an aggregated report of all cases reported.

VI. STANDARDS

- A. All entities shall ensure that staff receives training about fraud, abuse and reporting requirements.
- B. All staff, students and volunteers shall report possible financial fraud or financial abuse to the CMHSP designee or CMHPSM [Finance Director or Finance Director/Chief Financial Officer](#); and submit an incident report to the Office of Recipient Rights if it is a consumer-related matter, such as exploitation.
- C. The CMHSP [or CMHPSM as appropriate](#) shall gather preliminary information regarding the suspected fraud and/or abuse situation. Preliminary information shall include Who, What, Where, and When.

- D. The CMHSP shall notify the CMHPSM of suspected fraud and/or abuse within 48 hours of gathering the preliminary information.
- E. The CMHPSM shall ensure that the Office of the Inspector General (OIG) is notified of suspected fraud and/or abuse cases at the onset of the investigation process as applicable.
- F. When there is suspected financial fraud and/or abuse, the CMHSP and the CMHPSM shall ensure that a thorough audit is conducted, and shall determine whether it will be conducted by the local CMHSP/CMHPSM Finance Director or Finance Director/Chief Financial Officer or designee.
- G. The financial audit shall include the following:
1. A review of the provider's documentation and operational controls in accordance with the Service Verification Policy.
 2. When the suspected abuse occurred, including:
 - a. Dates of reported service whether actually provided or only reported to have been provided.
 - b. Dates of suspected financial abuse. Include summary of details; e.g., nature of financial abuse, amount in question, etc.
 3. Where the service took place; or where it was claimed to have been provided.
 4. Who reported the service
 - a. The provider agency name and address
 - b. The staff person who reported providing the service
 5. What services were reported
 - a. Actual service provided
 - b. Services billed
 - c. Non-authorized services billed
 6. Obtain copies of any backup documentation
 - a. Obtain copies of the Provider's backup whether or not thought to be falsified.
 - b. Document the lack of evidence supporting the claims/invoice.
 - c. Obtain copies of documentation that contradict Provider backup; e.g., hospital stay documentation for a date billed by Provider.
- H. Finance Director, Finance Director/Chief Financial Officer or Designee is responsible for the following:
1. Review documentation compiled from the internal financial audit.
 2. Consults with CMHPSM Managing Director and/or, CMHPSM Compliance Officer, CMHPSM Director of Operations, and the Director of Recipient Rights and provides them with regular status updates.
 3. Determines if independent audit is warranted. If warranted, obtains services of an independent audit firm to conduct special audit of provider.
 4. Consults with independent auditor regarding any special audit prepared.
 5. Maintains Fraud Incidents Database.
 6. Submits annual report to the Department of Community Health that includes the following aggregate data:
 - a. Number of complaints of financial fraud and financial abuse made to agency
 - b. Source of complaint
 - c. Type of Provider Nature of complaint
 - d. Approximate range of dollars involved

- e. Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred
- I. The CMHPSM ~~Managing Director~~Chief Executive Officer determines if and when local, state and/or federal authorities should be notified. If warranted, the ~~Managing Director~~Chief Executive Officer files Medicaid Fraud Complaint Form with the Health Services Office of the Inspector General.
- J. The CMHPSM ~~Director of Operations~~Chief Operation Officer notifies the CMHSP Provider Network Manager of the need to notify the provider of its placement on Provisional Status until outcome of investigation is reached.
- K. The CMHSP or CMHPSM will terminate the contract with cause if full investigation results in affirmation of fraudulent act(s).
- L. The local ORR officer shall follow relevant ORR policies relating to consumer rights and protections around the financial fraud investigation,

VII. EXHIBITS

VIII. REFERENCES

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy Service Verification</i>
Committee/Department: Regional Finance Committee	Local Policy Number (if used)
Implementation Date (2 weeks from Regional Approval Date)	Regional Approval Date (date of last CMH board's approval)

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

I. PURPOSE

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) process for conducting the monitoring and oversight of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the CMHPSM Provider Network. To assess for conflict-of-interest situations across the Provider Network and remove them. To ensure compliance with federal and state regulations and to establish a standardized process for the review of claims/encounters submitted for Medicaid and Healthy Michigan Plan beneficiaries in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program Medicaid services Verification Technical Requirements.

II. REVISION HISTORY

6/11/2014	Revised to reflect the new regional entity effective
2019	Language updated to reflect PIHP/state contract
<u>Will be Regional Approval Date</u>	<u>3-year review by Regional Finance</u>

III. APPLICATION

This policy applies to all staff, students, volunteers, individual contractors, and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that submit claims/encounters for services provided to Medicaid and Healthy Michigan Plan beneficiaries.

IV. POLICY

The CMHPSM shall create, implement and maintain a published process to monitor and evaluate its Provider Network to ensure compliance with federal and state regulations. This includes protocol for monitoring and oversight of any claims/encounter provided to beneficiaries of Medicaid or Healthy Michigan services will be completed.

V. DEFINITIONS

Authorization: The documented formal approval of a service(s), with a designated CPT code(s) and specified amount scope and duration.

Beneficiary: An individual who has been determined eligible by the MDHHS according to state and federal rules and regulations for medical and behavioral healthcare coverage under Medicaid or Healthy Michigan Plan programs.

Claim: Invoice submitted for payment in accordance with the authorization issued to the particular contract provider.

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.

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

CPT Code: A standardized service code as listed in the Current Procedural Terminology manual issued by the American Medical Association. This manual is updated annually.

Encounter Data: An electronic submission of services directly provided by a CMHSP in accordance with the related authorization.

HCPCs Code: A standardized service code as listed in the Healthcare Common Procedure Coding System manual issued by the American Medical Association. This manual is updated annually.

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.

Service Verification: Confirmation that services are medically necessary, provided by qualified staff, documented in accordance with the service definition (CPT code),

connected to the consumer's IPOS goals, and meet timeliness standards.

VI. STANDARDS

- A. The CMHPSM shall conduct a full monitoring and verification process on a selected sample of claims/encounters. The reviews will be completed bi-annually. CMHPSM reserves the right to conduct further reviews of the Provider Network on an as needed basis.
- B. Each CMHSP and ROSC Core Provider shall ensure services provided to consumers are documented in formats that provide sufficient support to assure accurate submissions of claims/encounters.
- C. The Medicaid/Healthy Michigan claim/encounter review process may consist of the following components:
 1. Desk Audit: consists of a pre-review of select policies, protocols, and documents and other resource material submitted by the Provider Network to the CMHPSM for review prior to the on-site visit. In addition, a review of whether the provider meets state and federal, standards for staff training requirements and for ongoing status as a provider with which the CMHSP/PIHP can maintain a contractual relationship
 2. On-Site Audit: consists of an on-site visit to the Provider Network to review and validate process requirements as needed.
 3. Claim/Encounter Review: the PIHP shall pull a random sample of Medicaid and Healthy Michigan Plan participants to complete verification of submitted claims/encounters
 4. Data Review and Analysis includes analysis of the Provider Network
- D. The overall responsibility for the verification of Medicaid and Healthy Michigan Plan claim/encounter verification and updating of the monitoring evaluation tool shall rest with the CMHPSM as the PIHP. The tool shall be reviewed on an annual basis to ensure functional utility and updated as necessary due to changing regulations, new contract terms and operational feedback received.
- E. Each CMHSP and ROSC core providers shall submit encounters and/or claims within timeframe outlined in contracts (60 days from date of service: from date of discharge for hospitals). Submission of claims for consumers on the Habilitation Supports Waiver is within 30 days of service.
- F. Each CMHSP and ROSC core providers shall have a service verification system in place to validate that services are provided to consumers according to their IPOS.
- G. Each CMHSP and ROSC core providers shall adjudicate and pay claims timely; clean claims (i.e., error-free) are to be paid within 30 days of submission.
- H. Any electronic claims payment system used by the CMHSPM shall have the following automatic integrity checks:
 - when a claim is submitted the system verifies that the claim information matches

- the authorization information
 - the claim submitted is within the allowed time period
 - the provider contract is active
 - the system verifies that the code(s) submitted in the claim match the code(s) on the authorization and that there is a sufficient number of authorized units still available
 - the system identifies the insurance type/funding source and verifies it was in effect at the time the service was provided
 - the system provides information to retrospectively adjust for any retroactive changes to the fund source that were in effect at the time of the services
 - a report is run monthly to retroactively adjust payments to the proper funding source. If the report indicates a correction to a fund source, journal entries are completed.
- I. Each CMHSP shall conduct service verification activities of their contractual providers separately from the Medicaid Event Verification review by the CMHPSM.
- J. Following the review, the CMHPSM shall develop a Medicaid Event Verification Report detailing the results of its verification review. Copies of this report shall be provided to the CMHSPs and all other Network Providers whose claims/encounters were included in the verification review. This report will include any corrective action plans (CAPS) that are required and the date the CAP is due back to the CMHPSM.
- 1) A summary detailing the PIHP's overall review process and findings;
 - 2) Detailed findings pertaining to each claim/encounter reviewed
 - 3) "Recommendations" (if applicable) pertaining to any finding that will require corrective action for claims/encounters that are found not to be in substantial compliance with Medicaid verification scores
 - 4) All claims/encounters found to be invalid will require correction either by resubmission or voiding.
 - 5) Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.
- K. Any suspected fraud or abuse discovered during the Medicaid Event Verification Process will be reported to MDHHS and a required to the Office of the Inspector General (OIG).
- L. Summary findings of the Medicaid Event Verification audits shall be shared with the CMHPSM Regional Operations Committee and other regional committees as appropriate.

VII. REFERENCES

- A. Balanced Budget Act: 438.608; 447.46
- B. The Deficit Reduction Act of 2005

- C. Affordable Care Act of 2010
- D. MDCH PIHP Contract
- E. MDCH CMHSP Contract
- F. Whistleblowers Protection Act of 1989
- G. Title 42—Public Health; Part 455—Program Integrity; Subpart A—Medicaid Fraud Detection and Investigation Program [cite: 42CFR455.17]
- H. Current Procedural Terminology (CPT) manual issued by the American Medical Association
- I. Healthcare Common Procedure Coding System (HCPCS) issued by the American Medical Association
- J. Person Centered Plan Policy
- K. Service Authorization Policy

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy and Procedure</i> Utilization Management and Review
Committee/Department: Utilization <u>Management Committee</u> 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	<u>05/11/2022</u>
CMH Board:	Approval Date:
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish consistent utilization management and review standards, requirements, structures and activities to be used by Community Mental Health Service Providers (CMHSPs), [Substance Use Disorder \(SUD\) Core Providers](#), primary contracted providers, and substance use disorder (SUD) provider systems; and to be monitored by the regional entity of Community Mental Health Partnership of Southeast Michigan (CMHPSM) as the Pre-Paid Inpatient Health Plan (PIHP), [and the Substance Abuse Coordinating Agency \(CA\)](#).

II. REVISION HISTORY

DATE	MODIFICATION
12/20/05	Revised to meet EQR CAP
6/21/13	Revised for new regional entity and language/role clarity
12/10/17	Revised to comply with Managed Care Rule of 2017
Will be Regional Approval Date	<u>3-year review; Language updates from Substance Abuse Coordinating Agency to SUD Core Providers; updated ABD and delay definitions to reflect state and federal requirements; addition of LTSS definition and requirements per state requirements and HSAG finding; updated state definitions of medical necessity; addition of state/federal parity requirements; clarification of review type definitions; addition of SUD specific UM practices, conflict of interest language (HSAG finding); committee role language update; updated references.</u>

III. APPLICATION

This policy applies to:

- All regional entity, CMHSP, and primary contracted provider staff responsible for provision of and/or oversight of access system services within the CMHPSM.

- All Staff representing the [ROSC SUD Core Provider CA](#) for oversight of access to substance use disorder (SUD) services through the Recovery Oriented System of Care (ROSC) [SUD Core Provider](#) network.
- CMHSP staff, SUD [pProvider](#) staff, and all contractual provider staff responsible for service authorization decisions or adverse actions, and their oversight.
- Staff responsible for the development, implementation, and updating of service eligibility, continuing stay, and discharge criteria.
- Members of the regional entity Utilization Review Committee and others involved in studying data-based service utilization patterns.

IV. POLICY

It is the policy of CMHPSM as the regional entity that utilization management and review standards, requirements, structures and activities will be implemented and practiced in a way that ensures the efficient and effective use of resources. This includes ensuring service decisions are made consistently and based on medical necessity, [and](#) that ~~consumer~~[consumers/individuals served](#) with comparable needs receive comparable ~~services,~~ [and services and](#) those decisions are made based on medical necessity.

V. DEFINITIONS

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

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

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

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

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

8. The failure of the PIHP/CMHSP to act within the required timeframes regarding standard resolution of appeals.

Concurrent Review - part of a utilization management program in which health care is reviewed as it is provided. Reviewers monitor appropriateness of the care, the setting, and the progress of discharge plans. The ongoing review is directed at keeping costs as low as possible and maintaining effectiveness of care.

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

1. A delay in making a standard/routine service authorization decision of a service request within 14 calendar days from the date of receipt of the request. The decision timeframe can be extended another 14 days if the ~~consumer~~consumer/individual served is notified of the right to file a grievance.
2. A delay in making a decision regarding a request for an expedited service authorization decision within 72 hours from the receipt of the request. The decision timeframe can be extended another 14 days if the ~~consumer~~consumer/individual served is notified of the right to file a grievance.
3. A delay in resolving standard internal appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. The resolution timeframe can be extended another 14 days if the ~~consumer~~consumer/individual served is notified of the right to file a grievance.
4. A denial of a request for an expedited appeal. The request for an expedited appeal within 72 hours can be ~~deniesd~~ and extended (hence delayed) to the standard 30-day appeal time frame if the ~~consumer~~consumer/individual served is notified of the right to file a grievance.
- 1-5. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal

Denial – A term used in this policy that includes the definition of an Action or an Adverse Benefit Determination.

Long-Term Services and Supports (LTSS) - services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the ~~consumer~~consumer/individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Medical Necessity – The basis by which service decisions are made for mental health, developmental disabilities, and substance abuse supports and services. Criteria are based on state law/policy and the Medicaid Provider Manual. For the purposes of this policy keys aspects of medical necessity are described below. For a complete definition of medical necessity, see the current version of the Medicaid Provider Manual (Mental Health/Substance Abuse Services Chapter, Section 2.5) and the MI Mental Health Code, Chapter 1, Definitions Services must be:

- Necessary for screening, assessing, identifying, evaluating; and/or Intended to treat, ameliorate, diminish or stabilize the symptoms; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability or substance use disorder

- Designed for the prevention, diagnosis, and treatment of a ~~consumer~~consumer/individual's condition, and/or disorder that results in behavioral health and health impairments and/or disability.
- The ability for a member to achieve age-appropriate growth and development.
- Designed to assist the beneficiary to attain, ~~or~~ maintain, or regain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Service determinations must be:

- No more restrictive than that used in the MDHHS Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in MDHHS statutes and regulations, the MDHHS Plan, and other MDHHS policy and procedure
- Based on information provided by the individual, his/her family, and/or other individuals who know the individual and clinical information from the individual's primary care physician/health care professionals
- Based person centered planning or individualized treatment planning and documented in the plan
- Made by appropriately trained professionals with sufficient clinical experience;
- Accessible to the individual, and responsive to any cultural, sensory, or mobility needs
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Provided in the least restrictive, most integrated setting.
- Consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.
- Provide the opportunity for a ~~consumer~~consumer/individual served receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

For substance use/abuse services, ASAM (American Society of Addiction Medicine) Placement Criteria shall also be used when determining the medical necessity of placement, continued stay and transfer/discharge of consumers/individuals served with addiction and co-occurring conditions.

Parity – Based on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prevents group health plans and health insurance issuers providing mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. Parity includes that financial cost-sharing requirements for mental health/substance use disorder benefits (such as deductibles, copayments, coinsurance, and out-of-pocket limitations) must be comparable to those for medical surgical benefits. Parity rules also apply to rules regarding authorization for treatment and treatment limitations. Key measures of mental health parity are “quantitative treatment limitations” (QTLs) and non-quantitative treatment limitations” (NQTLs). This policy refers to NQTLs when addressing the concept of parity.

Non-Quantitative Treatment Limitations” (NQTLs) - Processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Certain utilization reviews, prior authorization, and plan provisions may only be applied to mental health/substance use disorder benefits if they are comparable to or less restrictive than those for medical surgical services. NQTL provisions are not prohibited outright;

but are prohibited if they are applied more stringently to mental health/substance use disorder benefits than to medical surgical benefits.

Primary Contracted/Core Provider – a provider contracted by the CMHSP to provide primary community mental health services that would otherwise be directly operated by a CMHSP.

Prospective Review - (also known as **Preauthorization**) the prior assessment by a payer or payer's agent that proposed services are appropriate for a particular consumer/individual served, or that the consumer/individual served and the categories of service are covered by a benefits plan. Preauthorization includes and Individual Plan of Service (IPOS) developed through the person- centered planning process, whereby a CMHSP/SUD provider staff proposes t~~he approval of or concurrence with the covered services in individual plan of service (IPOS), and those services are approved or denied by staff with the authority to make service authorization decisions proposed by a CMHSP professional prior to before~~ the provision of service. In most cases, with the exception of some crisis services, Under some plans, preauthorization by the carrier is required before certain services can be provided.

Recovery Oriented System of Care (ROSC) – is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of consumers/individuals served, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Retrospective Review - a post-treatment assessment of service utilization on a case-by-case or aggregate basis after the services have been performed. A retrospective review can include a review of whether payment of services will be authorized/_reimbursed when a provider requests retrospective payment of an inpatient psychiatric hospital stay, and/or whether payment of services found to be out of compliance with medical necessity would be recouped.

Utilization Management (UM) - Procedures and clinical decisions intended to ensure that the services provided to a specific consumerconsumer/individual served at a given time are appropriate, medically necessary, and cost effective.

Utilization Review (UR) - Analysis of the patterns of service authorization decisions and service usage in order to determine the means for increasing the value of services provided that include minimizing cost and maximizing effectiveness/appropriateness.

VI. STANDARDS

- A. Utilization management decisions will be conducted as a delegated function by the regional entity to the CMHSPs, ROSC Core Providers, and primary contracted providers, and occur as close as possible to local provision of services. Concurrent or continued care reviews of SUD services will be conducted by CMHSP SUD Core Provider staff or CMHPSM SUD UM staff, where indicated in CMHPSM contract language.
- B. The basis by which service determinations are made is founded on state and regional entity policy and will be in compliance with medical necessity and all state/federal rules. The regional entity will include this basis in its delegation of UM functions to CMHSPs, primary contractual providers, and ROSC Core Providers. Any relevant updates to standards on service determinations will be communicated by the regional entity and

implemented locally by the CMHSPs, primary contractual providers, and ROSC Core Providers.

- C. The CMHSPs, primary contractual providers, and ROSC Core Providers are delegated by the regional entity to be responsible for local implementation, evaluation and updating of service-specific entry, continuing stay and discharge criteria.
- D. The regional entity shall have auditing and monitoring mechanisms in place to ensure utilization management standards and delegated functions are met by the CMHSPs, primary contractual providers, and ROSC Core Providers. The regional entity shall also enact and oversee any corrective action for areas of non-compliance.
- E. Decisions regarding the type, frequency, intensity and duration of services to authorize or deny must be:
 - 1. Furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21.
 - 2. Include mechanisms that comprehensively assess each ~~consumer~~/individual served identified (per MDHHS definitions) as needing LTSS or having special health care needs, to identify any ongoing special conditions of the ~~consumer~~/individual served that require a course of treatment or regular care monitoring for members with special health care needs. Decisions to authorize LTSS shall be based on a ~~consumer~~consumer/individual's current needs assessment and consistent with the person-centered service planning process.
 - 3. Accurate and consistent with state and federal medical necessity criteria, including relevant to goals developed through the person-centered planning process, and sufficient in amount, duration, and scope to reasonably achieve its purpose.
 - 1-4. Made in accordance with state requirements with Long Term Supports and Services, based on the ~~consumer~~consumer/individual's current needs assessment(s), and consistent with the person-centered service plan
 - 5. Consistent with Medicaid Provider Manual eligibility, entry, continuing stays and discharge criteria as applicable, and state law/policy as defined by MDHHS.
 - 2-6. Consistent with federal standards and state standards for meeting the Mental Health Parity and Addiction Equity Act (MHPAEA)
 - 3-7. Consistent with formal assessments of need and ~~consumer~~consumer/individuals' desired outcomes,
 - 4-8. Conducted with an effort to obtain all necessary information including pertinent clinical information and consultation with treating physicians/ clinicians as appropriate.
 - 5-9. Adjusted appropriately as ~~consumer~~consumer/individuals' needs, status, and/or service requests change,
 - 6-10. Timely,
 - 7-11. Provided to the ~~consumer~~consumer/individual served in writing, including reasons for the decision that are clearly documented,
 - 8-12. As applicable, shared with affected service providers in writing as to the specific nature of the decision and its reasons, (refer to the CMHPSM Provider Appeals Policy) if there are any concerns with decisions made,

9. Documented in the clinical case record as to the specific nature of the services authorized or denied and its reasons and
13. Accompanied by the appropriate notice to ~~consumer~~consumers/individuals regarding their appeal rights with a copy of the notice placed in the ~~consumer~~consumer/individual's clinical case record. (refer to the CMHPSM Consumer ~~Grievance &~~ Appeals Policy)
14. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the ~~consumer~~consumer/individual served.

F. The above utilization management / service authorization decisions and their associated procedures are required at numerous points during the course of service provision:

1. The completion of the Initial Assessment or Pre-Screen to assess initial CMH eligibility and medical necessity.
- 1.2. The completion of assessments related to specific services, specialties, or parity programs.
- 2.3. The completion of the Initial Individual Plan of Service through the Person-Centered Planning Process
- 3.4. The ~~consumer~~consumer/individual served requires, or a ~~consumer~~consumer/individual served or provider requests, a more intensive or less intensive level of a current service
- 4.5. The ~~consumer~~consumer/individual served requires, or a ~~consumer~~consumer/individual served or provider requests, the addition of a new service
- 5.6. The ~~consumer~~consumer/individual served requires or requests the termination of a current service
- 6.7. The expiration of a service authorization
- 7.8. The completion of the annual review of need/periodic review or other assessment including assessment of ongoing CMH eligibility and medical necessity of supports and services
- 8.9. The completion of the annual Individual Plan of Service (IPOS)-through the Person- Centered Planning Process
10. The need to modify a current IPOS due to a significant change in a ~~consumer~~consumer/individual's needs or change in level of care
- 9.11. Review of services that may be denied, suspended, reduced, or terminated

G. Utilization management decisions (both service authorization and denials) will be made by staff with appropriate clinical competencies as defined at minimum by state policy and will possess the required competencies and clinical expertise to treat the conditions relevant to the decisions being reviewed. —Where necessary, review decisions are supervised by qualified medical professionals.

H. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.

I. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any ~~consumer~~consumer/individual served.

J. Any decision to deny a service authorization request in whole or in part shall follow state and federal notification requirements where applicable to providers and ~~consumer~~consumers/individuals serveds as outlined in the CMHPSM Consumer Appeals Policy.

G.K. Utilization management decisions may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the ~~consumer~~consumer/individual served.

H.L. Utilization management decisions shall not be made by case managers, supports coordinators, or supports brokers. Case managers, supports coordinators, and other professional staff responsible for treatment planning will assess need and make treatment recommendations per their function in the development of Individualized Plans of Service, including requesting services, and as a way to inform the utilization management process. This information will be reviewed at minimum by qualified UM staff or supervisors with the appropriate clinical expertise or who will make the relevant service authorization decisions.

I.M. Each local CMHSP, primary contractual provider, and ROSC Core Provider will have a written internal process to oversee and review compliance with utilization management practices, including, eligibility, medical necessity, service authorization, service denial, and service verification.

J.N. Each local CMHSP primary contractual provider, and ROSC Core Provider will have a local UM/UR review processes to monitor the accuracy of service decisions.

K.O. The Utilization Review Committee for the regional entity will provide the following functions:

- Evaluate the success of utilization management processes used in the affiliationregion and ensure the accuracy, appropriateness and consistency of utilization management decisions.
- Coordinate ongoing utilization review activities and projects recommended by the committee or assigned by the CMHPSM on behalf of the affiliationregion
- Conduct UM/UR studies on behalf of the affiliationregion or local CMHSP/core provider as requested by the local CMHSP/core provider or regional entity.
- Report findings/results of committee activities/ studies to the regional entity, including any areas of trending, performance improvement projects, or compliance that requires follow-up or oversight by the regional entity
- Make recommendations and suggestions to the regional entity on local or regional performance improvements related to UM/UR functions
- Serve as a reporting body to the regional entity. Where compliance issues or trends arise during committee work, the committee will report issues/trends to the regional entity for CMHPSM action or oversight; the responsibility of monitoring CMHSP/core provider compliance with UM/UR standards and auditing UM/UR

functions delegated to CMHSPs/core provider will remain in the jurisdiction of the CMHSPM as the regional entity.

- Any activity the regional entity would delegate or assign to the Utilization Review Committee as a regional entity function, or on behalf of the regional entity will be determined and assigned by the CMHPSM.

L.P. In evaluating the success of utilization management processes and to ensure the accuracy, appropriateness and consistency of utilization management decisions, priority should be given to:

- high cost services,
- highly utilized services,
- services associated with a high number of ~~consumer~~consumer/individual served grievances and appeals,
- services for which there are large differences in cost per case and/or cost per unit among individual affiliates,
- services which are under and/or over utilized and,
- PIHP studies/assignments priorities.

M.Q. Consideration should be given to the following utilization review methods in evaluating the effectiveness of UM decisions:

- Analyzing aggregated case record review data reflecting the degree to which ~~consumer~~consumers/individuals serveds meet service eligibility criteria
- Analyzing aggregated case record review data to determine the degree to which ~~consumer~~consumers/individuals serveds meet entry criteria for a specific service
- Analyzing aggregated case record review data to determine the degree to which frequency and intensity of services are consistent with medical necessity criteria
- Data collection and analysis of cost per unit or cost per case for a service or program type
- Data collection of average length of stay for a specified service
- Data collection and analysis of ~~consumer~~consumer/individual served and provider satisfaction with the Utilization Management/ Utilization Review process
- Studies of under and over-utilization of services
- Studies of inpatient admissions per capita
- Studies of utilization of alternatives to high cost care

VII. EXHIBITS

None

VIII. REFERENCES

Medicaid and CHIP Managed Care Final Rule, April 2016 42 CFR 431, 42 CFR 433, 42 CFR 438 42 CFR 440, 42 CFR 457, 42 CFR 495 (Replaces Balanced Budget Act of 1998 (42 CFR 438; 438.210, 438.240)		
Michigan Mental Health Code, Act 258 of 1974 (most recently revised November 2017)		
Mental Health Parity and Addiction Equity Act		

of 2008; 45 CFR Parts 146 and 147		
MDHHS Medicaid Provider Manual (current version)		
The Joint Commission Behavioral Health Standards		
CMHPSM Consumer Grievance and Appeal Policy		
CMHPSM Service Verification Policy		
MDHHS CMHSP Managed Mental Health Supports and Services Contract (current version)		
MDHHS PIHP Medicaid Managed Specialty Supports and Services Contract (current version)		

IX. PROCEDURES

None

**WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH CONSUMER ADVISORY COUNCIL MEETING – Minutes
February 9, 2022**

Present on the Call: Pam Rathbun (president), Jason Zurawski (secretary), Leo Hanifin, Barb Higman, Alayna Manzanares, Lisa Porzondek, Melissa Vaden.

Staff: Mert Hershberger (Liaison).

Absent: Ed Howlett.

12:00: Premeeting: How are you dealing with the cold & the snow?

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

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

II. Report from the RCAC:

- a. **CJ Witherow** talked about the appeals process and disparities in accessing services. We summarized: the troubles many have with transportation; COVID; the struggles just to live from day to day; the lack of childcare.
- b. Possible training in November over 2 days (for the CAC's).
- c. Pam is the new (RCAC?) Vice Chair.
- d. Livingston had both art show winners. <https://bit.ly/2022-ArtShow> **Art Show plans:** Two pieces of art from Livingston: "Spring" by Danielle Garber and "Waves" by Austin were chosen. Sally Amos had asked Leo Hanifin about being a judge for the event in the future.

III. Parliamentary: Lisa offered to serve as co-chair of WC-CMH-CAC and will be the chair next year.

IV. Questions and Suggestions for Legislators: Pam suggested we work on writing legislators about our concerns. We discussed the problems with private insurances running mental health care and trying to replace CMH's in the decision-making role. We drafted a template for the letter below. Barb suggested inviting Felicia Brabec back. Barb mentioned Felicia's monthly Saturday morning coffee hour. Melissa is interested in her legislator's coffee hour.

Find your legislator here: <https://www.washtenaw.org/1247/State-Representatives-Senators>

V. Story Jam with NAMI & Speaker's Bureau & Avalon (Formally led by the WC-CMH-CAC): This will be happening virtually soon. The goal is to learn how to share your story and then to get a group of folks who can share their stories and speak to future questions and concerns in days to come. Currently: What helped and what didn't help and what you would like legislators to do. Barb gave examples of an advocacy story.

VI. Speaker's Bureau: Possible training in August. Mert will incorporate some principles from Story Jam: helping all have two types of speeches by all: an anti-stigma speech & a story with an ask.

VII. Newsletter: Next one in April/May? Article submissions by late March. Barb will continue the history of mental care in Washtenaw County saga. Melissa or Lisa may write. Leo may write an article on Homelessness in Ann Arbor & park evictions.

VIII. New Business:

The Point in Time Count went well per Leo, though he doesn't know the final count.

Headsets received were put into good use and everyone was grateful. Alayna reminded the peer that she needed a USB headset.

Fresh Start delivers crafting supplies to participants for the virtual.

IX. Meeting adjourned at _1:27 pm_ motion by _Barb_ supported by _Leo .

JUNE 2022

The next meeting will be March 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.)

Template for a letter to your legislator (adapt to your liking):

Your name

Street,

City, MI ZIP

DATE:

“LEGISLATOR’s Name”

Lansing, MI

RE: Senate Bills 597 and 598 submitted by Sen Shirkey

Introduction of self. (Share a bit about your connection to CMHs and how they have served you well.)

Prospective Problems with privatization:

- Profit motivation & distance of headquarters from Michigan of insurance companies diminishes their inherent interest in the well-being of our residents.
- Denial of eligibility for some consumers. Lack of adjudication process at this point.
- Insurance companies have a proven history of poorly managing care for individuals and not actively intervening as current nurses and case managers do.
- Micro-managing medications in conflict with doctors’ orders.
- Lack of experience as the primary resource for mental health care.
- Actuaries estimate that there would be minimal if any savings. The savings would mostly come out of the care of individual’s treatment.

If you have suggestions on what could be improved to the current system, make those suggestions appropriately.

Thanks the legislators for their time.

Sincerely,

Signature

Name

(No need to slam or slander insurance companies. Courtesy & civility are important, even as you intensely disagree with the efforts underway.)

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

March 9, 2022

Members Present on the Call: Pam Rathbun (president), Jason Zurawski (secretary), Leo Hanifin, Barb Higman, Ed Howlett, Lisa Porzondek (vicePres), Melissa Vaden.

Staff: Mike Harding (Administration); Mert Hershberger (Liaison).

Absent: Alayna Manzanares

12:00: Premeeting: What are your plans for Spring?

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

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

- II. **Mike Harding update:** Reporting for accountability and structural purposes for the board. Questions & Updates from last year's initial presentation: CCBHC ability to receive service regardless of ability to pay & regardless of insurance if & regardless of diagnoses: Mental Illness of any variety or Substance Use Disorder. WC-CMH is now a CCBHC now; all consumers are rolled into this new model. Provide Array of services very similar to traditional CMH, minus CLS and licensed residential & hospitalizations, which traditional CMH would provide. WC-CMH partners with Packard Health & others. WC-CMH is largely a referring agency for those whose diagnoses are mild to moderate in severity. ...Phone number 988 is a currently a number that is being tested in some areas for serving as a referring phone number for a mental health hub in Michigan, but Washtenaw is not yet part of that. There are still changes underway, but some things are slowing down implementation due to lack of staff. CARES is looking like the proposed mild to moderate services. Goal: to treat people before they have a crisis to reduce hospitalizations. Corner Health might be a referring agency for youth. CARES is located at 555 Towner, the Annex, and somewhat at the 750 Towner building where someone can stay for up to 23 hours. CRS is not fully back in service yet due to staffing issues. "We are building a bike while riding it. ... Not perfect yet." Administration is exploring funding for staff which should help with staffing.
- III. **Report from the RCAC: Texting & email policy to be looked at:** Texting is a necessity for some people (LH). Texting and email would be more convenient. I don't put out there what I don't want out there. (MV) Texting is probably easier than email for most people (EH). Some other staff report that sometimes texting is the only way to get ahold of folks (MH).
- IV. **Questions and Suggestions for Legislators:** The SB 598 and 597 bills were pulled from the Senate last week as there are a few Senators still on the fence. Shirkey didn't have the votes he needed to push the bills through. We need to tell our Senators to vote No on the bills. (BG) Barb is trying to get Senator Theil (R) from the western part of the county to come to the next meeting, but not response yet. Mert suggested coordinating this with CMH board members from the Western side of the county. <https://www.washtenaw.org/1247/State-Representatives-Senators>
- V. **Story Jam with NAMI & Speaker's Bureau & Avalon (Formally led by the WC-CMH-CAC):** Mert is planning to hold a **Speaker's Bureau** training in August with elements of the Story Jam process.. Barb: still working on a schedule for the sessions.
- VI. **Walk-A-Mile -** <https://cmham.org/education-events/walk-a-mile-rally/> September 15, 2022. Highly likely to be able to send in person representation.

- VII. **Newsletter:** Article submissions by late March. Barb will continue the history of mental care in Washtenaw County saga. Melissa or Lisa may write. Leo may write an article on Homelessness in Ann Arbor & park evictions (Still planned, but not in print yet.) since the Warming Center will end at the end of March. He is seeking to advocate for tolerance for those who sleep in the park. HE said that it is a long process to set folks up with Section 8 Housing Vouchers. He may also try to run this by the folks at GroundCover News.
- VIII. **Celebration Of Success** – Sally Amos-ONeal said we might start looking at having the Celebration in person in October. The sanctuary we have usually used seems large enough to accommodate socially distance in the space. The evenings that would work best for folks seems to be Wednesdays. Dates available in October in order of preference: October 19th, 26th, 5th in 2022.
- IX. **New Business/Agenda Items** for next month:
- X. **Meeting adjourned at _1:32 pm_: motion by _Barb_ supported by _Melissa_.**
The next meeting will be April 13, 2022 via Zoom at 12:30pm. (Please log in by 12:20pm to make sure we are all ready to participate by 12:30pm.)

CMH QUARTERLY

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH, SPRING 2022

THE UPDATE FORMERLY KNOWN AS TRISH'S

If you read the last newsletter or have been checking your email you know that Trish will no longer share a written update in the Quarterly. Instead you are welcome to join a monthly live update currently scheduled on the third Thursday of the month at 12noon via Zoom.



Simply watch for the announcement via Outlook and accept the appointment if you wish to attend. The Zoom link is included in the Outlook appointment. Your attendance at these updates is not mandatory but most find them to be helpful and informative. ... *And* most of the technical bugs have been worked out, too! So check in and find out what's new.

If there are questions or particular topics you would like to hear more about you can email Trish or your PA directly, and we'll do our best to work it into the 30-minute update.

Always looking forward!



HELLO! & HOORAY!

{December 1 - February 28}

WELCOME! - New Hires:

Barbara S
Carmen M
Catherine M
Jade F
Jessica G
Joseph F
Katherine L

Kendra C
Kertina K
LaRita B
Laura T
Margaret C
Michelle D
Nickole C
Preston R
Rachel B
Rebecca K
Riya W

CONGRATS! - Transfers/Promotions:

Jeff G
Jerry G
Rachel R
Sara H
Steve P



YEARS OF SERVICE

{Years of Service July 1, 2021 through December 31, 2021}

5 YEARS

- Christina C
- Alexandria E
- Joseph G
- Evan G
- Jade M
- Leah M
- Angela P
- Heather P
- Sara S
- Staci S
- Mackenzie T
- Kimberly V

10 Years

- Jessica H
- Coy H
- Elizabeth L
- Sharon S
- Melisa T
- Shaun T

- Judith T
- Cherie W
- William W

15 Years

- Christina B
- John D
- Matthew Z

20 years

- Tara F
- Barbara F
- Michael H
- Shad J
- Cari L
- Julie L

25 Years

- Kristian M
- Nancy S

30 Years

- Caryette F

RECRUITMENT & RETENTION UPDATE

WCCMH has been working to recruit and hire staff in a variety of positions. Recent efforts include:

Updated Job Descriptions

WCCMH and the County have recently made changes to the requirements for our Client Service Manager and Supports Coordinator job descriptions to reflect changes made by the State to the provider qualifications to provide targeted case management.

These changes allow providers with QIDP, QMHP or CMHP status to provide targeted case management to their respected populations. These changes will open up these positions to candidates with a wider array of qualifications and experience. These changes have also been implemented at other CMHs and behavioral health systems throughout the State.

Please contact Nick Testorelli with WCCMH Human Resources if you have additional questions or would like a further breakdown of the new qualifications. The updated job descriptions for these positions can be found on eCentral, under the Business Services section.

Arrow Strategies

Washtenaw County and WCCMH have entered into partnership with Arrow Strategies to provide recruitment services for WCCMH positions. Arrow is currently assisting WCCMH with identifying potential candidates for our high need and difficult to recruit for vacancies. Within

our first few weeks of working with Arrow, we've interviewed close to a dozen candidates and have made offers to four.

Workforce Stabilization Retention Bonus

All CMH Staff actively employed prior to 3/27/2022 will be receiving a bonus on April 15th to recognize the extraordinary work and sacrifice that has been made during the pandemic. MDHHS has agreed to allow CMH to use our State General Fund dollars to fund this effort, as they also acknowledge the challenges staff have endured and the State-wide staffing shortages taxing the healthcare industry.

UPDATE ON CMH AS A HEALTH HOME

WCCMH is happy to announce that Region 6 (Washtenaw, Livingston, Lenawee, Monroe) counties will be participating in the MDHHS Health Home starting April 1, 2022.

Are we moving? Is this a real home? No, this is not an actual home, it's a program that enhances care coordination services for Medicaid beneficiaries.

What does this mean? It means that for those enrolled in the Health Home program they receive a particular service (comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support and referral to community and social support services) every month and that WCCMH receives a PMPM (per member per month) payment for these enhanced care coordination services. These services will be provided by the Health and Wellness team in addition to other identified staff.

Does everyone qualify? Unfortunately, no, only Medicaid beneficiaries that meet the criteria established by MDHHS are eligible. There are a total of 9 SMI or SED ICD-10 diagnosis codes that meet the criteria.

What if I have a consumer who doesn't have Medicaid but needs more support coordinating care for chronic health conditions? Refer them to the Health and Wellness program. You can find the referral form on the M-drive.

What does this mean to me as WCCMH staff? It means there are potentially additional services that can be provided to consumers that qualify and that these services could have a tremendous impact on their chronic disease management, care coordination and other health education services.

As a WCCMH clinician do I need to change anything? Not at this time, but more to come on this. If you are interested in the above listed services check out the health integration tab in progress notes, wellness notes and/or medication reviews to learn more about each of these activities.

Wait, didn't we already do this? Yes, WCCMH participated in the first version of the MDHHS health home back in 2014. This is an updated version of the Health Home that has some similarities to the 2014 version but has some substantial differences as well.

When will I learn more: There will be a health home road show that will come to all team meetings to explain in more detail what this means.

What if I have questions? Please send your questions to Brandie H

ORR STILL RECRUITING FOR RRAC

The Rights Office is recruiting recipients, family members, and community members to participate in the Recipient Rights Advisory and Appeals Committee (RRAC). Participating with RRAC is a great way to learn more about Recipient Rights and play an integral role in the Rights system.

Members of this committee serve in an advisory capacity to the Washtenaw County CMH Executive Director as well as the Director of the Office of Recipient Rights. This includes reviewing and commenting on quarterly Recipient Rights data reports, establishing outcomes for the Office of Recipient Rights, and making recommendations to the governing CMH Board. In its advisory capacity, RRAC also protects the impartiality of the Rights Office.

The appeals component of the committee involves hearing and reviewing appeals of complaints that were investigated by Recipient Rights staff. This entails reviewing staff's investigative findings and conclusions, as well as any additional information from the appellant, and voting on whether to uphold the Rights Office's decision.

If you or your team members know of recipients, family members, and community members who would be a good fit to serve with RRAC, please share this information with them. Please contact the Rights Office at 734-219-8519. Thank you!

SDC QUARTERLY UPDATE

Most Popular Relias Question (or Complaint) this Quarter:

"I can't find the class I want to register for"

Most Popular Solution:

You already registered for it.

- Classes drop off the listing once your registration is complete. Class information is now available on your front page underneath any unread policies. (The same ones that don't go away and clutter up your page until you read them)
- If you need to cancel or change dates, scroll down below to the class information and use the "Withdraw" or "Change sessions" accordingly.

A few quick reminders:



- March 31 is your last chance to complete the PCP refresher for 2022. This training is not available once the current quarter ends.
- April 1 starts Bloodborne Infectious Disease refresher. This is a COUNTY requirement and therefore *cannot* be completed as a team. Watch your email for a link to the training and *Follow the Instructions CAREFULLY*.
- Most trainings are still being conducted online. Always read the description for links and details to make sure you get credit for attending.
- The M drive contains a "**Resources for Staff Development**" folder with a number of useful documents including carefully crafted cheat sheets and instruction booklets for using Relias, for using PD Made EZ, and for understanding requirements. More times than not - whatever the question - you'll find the answer there for all things Staff Development. (Including what to do if you can't find the training you wish to register for)



KUDOS TO PATH!

PATH Team members were recently recognized with a WHI Collaborative Award for their work in coming together with other organizations to help house Washtenaw's homeless population during the COVID-19 pandemic.

No easy feat when following guidelines for safety can mean a reduction of physical space and health services resources available. But through good collaboration, determination, and much effort we were able to safely house individuals with need, and reduce the spread of COVID.

Awesome work! Congratulations to the PATH program.

SAVE THE DATE! – WALK A MILE RALLY RETURNS ON SEPTEMBER 15

WHEN

THURSDAY, SEP. 15TH, 10AM

WHERE

100 NORTH CAPITOL AVENUE
LANSING, MI

MORE INFORMATION

This Year's Event will be IN PERSON (with a few restrictions)

More Details to Come - - [Check in Here](#) for the Most Up to Date Information



IT'S OUR BIRTHDAY

The CMH Quarterly Celebrates Five years with this Spring edition,
and we Thank You for your readership, contributions and feedback through the years.



THANKS TO OUR CONTRIBUTORS

Brandie H

Leah R

Matt H

Rhonda D

Sally O

The Artist Formerly Known as the Editor

THANKS FOR READING!





WASHTENAW COUNTY CRISIS NEGOTIATION TEAM

BOARD PRESENTATION APRIL 2022

Mental health professionals joining SWAT's crisis negotiation team

Published: Oct. 23, 2019, 5:04 p.m.



HISTORY OF TEAM

- POLICE INCIDENTS IN 2018-2019 INVOLVING SWAT INTERVENTION FOR INDIVIDUALS WITH A SEVERE MENTAL ILLNESS
- RECOGNITION BY WCSO AND WCCMH OF BENEFIT OF HAVING MENTAL HEALTH PROFESSIONALS EMBEDDED IN TEAM
- INTERVIEWS HAPPENED IN AUGUST 2019
- PARTICIPATION IN TRAININGS AND TEAM BEGAN IN OCTOBER 2019

TEAM MAKEUP

- WCSO, AAPD, EMU AND UOFM PD :
14 LAW ENFORCEMENT OFFICERS
- WCCMH 5 STAFF:
 - 1 ADULT MI PROGRAM
ADMINISTRATOR: KATIE HOENER
 - 1 CRISIS TEAM SUPERVISOR: NICOLE
MURACA
 - 1 JAIL SERVICES SUPERVISOR: SARAH
STEWART
 - 1 ADULT MI SUPERVISOR: JESSICA
HALLIDAY
 - 1 CRISIS SERVICES PROFESSIONAL:
CHRISTINE HOLSTON

WCCMH ONBOARDING

- MICHIGAN HOSTAGE NEGOTIATION CONFERENCE – OCTOBER 2019
- FBI NEGOTIATOR SCHOOL – DECEMBER 2019
- TRAININGS WITH TEAM 8 TIMES PER YEAR (PRIOR STANDARD)
 - EQUIPMENT
 - VA HOSPITAL
 - MSP BOMB SQUAD
 - WESTERN WAYNE
 - SWAT SCENARIO

WCCMH ROLES

- GATHER INFORMATION ON SUBJECT
- GATHER INFORMATION ON AFFILIATED INDIVIDUALS
- ASSIST IN DEVELOPING CLINICAL PICTURE
- PRESENTATION OF NEGOTIATION STRATEGIES BASES ON CLINICAL EVIDENCE
- INTERVIEW FRIENDS/FAMILY/ASSOCIATES OF SUBJECT
- SCENE MANAGEMENT (AS REQUESTED)
- OBSERVATION OF OFFICER WELLNESS, AND DISCUSSIONS WITH LEADERSHIP

TYPES OF CALL OUTS (RESPONSES)

- FULL CALLOUT: CAN ORIGINATE FROM ANY LAW ENFORCEMENT AGENCY IN WASHTENAW COUNTY, AND INVOLVES THE DEPLOYMENT OF BOTH THE CRISIS NEGOTIATION TEAM (CNT) AS WELL AS THE SPECIALIZED WEAPONS AND TACTICS (SWAT) TEAMS.
- PARTIAL CALLOUT: CAN ORIGINATE FROM ANY LAW ENFORCEMENT AGENCY IN WASHTENAW COUNTY AND INVOLVES AT LEAST 3 MEMBERS OF THE CNT LAW ENFORCEMENT TEAM, AND AT TIMES THE CMH STAFF AS WELL. CMH ARE NOT INITIALLY DEPLOYED FOR HIGH-RISK WARRANTS, THOUGH MAY BE BROUGHT IN AT POINT DEEMED NECESSARY, AND AS OUTLINED IN POLICY/PROCEDURE.

Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Full	1	1	1	2
Partial	0	1	0	6

FY 22 DATA

Washtenaw County Mental Health and Public Safety Millage Initiative Dashboard

Initiative	New or expanded services	Crisis services	Stabilization services	Integrated & coordinated	Peer support services	SUD services	Housing services	Education & prevention	Reducing stigma	Adult-focused	Youth-focused	Cross-sector collaboration	Needs assessment &	Grants: supplements millage	Status	Date Implemented, Expected, or Completed
Washtenaw CARES	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			Implemented	May 2019
CCBHC	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓	Implemented	May 2019
750 Towner assessment center	✓	✓	✓	✓						✓		✓			Implemented	March 2020
NAMI peer project	✓				✓					✓		✓			In progress	2020
Mental Health First Aid training								✓	✓	✓	✓	✓			In progress	2020
Youth assessment center	✓							✓			✓	✓	✓	✓	In progress	Ongoing
Youth court therapeutic CSM position	✓										✓	✓			Implemented	December 2020
31N WISD school MH project	✓							✓	✓		✓	✓			In progress	Ongoing
Mini-grant Anti-stigma campaign w/WISD								✓	✓		✓	✓			In progress	Ongoing
Anti-stigma campaign w/public health								✓	✓	✓	✓	✓			In progress	Ongoing
Corner psychiatry access	✓	✓	✓	✓							✓	✓			Implemented	November 2019
SUD system transformation	✓					✓		✓	✓	✓	✓	✓	✓	✓	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

Plan and Integrate

<i>Initiative</i>	<i>Status</i>	<i>Updates?</i>
LEAD	Case manager hired, 1 position still posted. Engagement has begun with participants. 23 referrals received.	
Youth Assessment Center	Working with Commissioners and NAC to put together a implementation team to make recommendations to BOC and County Administration on implementation of youth assessment center.	
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.	No
Rethink Health/5 Healthy Towns	Core group has been working to develop a logic model to guide upcoming joint activities and track key metrics related to negative outcomes of mental health and substance use in the 5 towns region. Key focus areas include social isolation, lack of sense of purpose, housing, food access, transportation, ease of service access and barriers to service access.	
5HT Intergenerational Populations Project	Findings have been reviewed and next steps are being identified.	No
SUD System Transition	Implementation began on January 1, 2022.	No

Initiative Descriptions

Expand Services

<i>Initiative</i>	<i>Status</i>	<i>Updates?</i>
CARES/Crisis/750/CCBHC	M. Tasker to report	
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. Focus populations are being identified for this upcoming round of funding.	
31 N/ WISD Mini Grants	Mini Grants -20 total mini grants have been awarded so far this year. Milan Middle School, Dexter High School, Saline Middle School, Slauson Middle School, and Lincoln Middle School. ACCE hosted a mental health day for students and is doing a Pride Prom in May in partnership with Ypsilanti high school. Saline middle school is developing a black student union to promote connection and social emotional wellness for minority students. 31N - 37 students served from Oct.-Dec. providing over 60 hours of services including case management, crisis intervention and therapy. No Update	
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.	No

Initiative Descriptions

Student Advocacy Center	Ed Advocacy- 55 students served fall semester, majority students have been black males from 48197, 98 and 48108. 100% of students served had no further behavioral referrals, 71% increased attendance and 91% increased grades. Check and Connect-61 students served this semester with majority students being black males all from Ypsi and Lincoln schools. They served students from 2 nd grade to 12 th grade and saw 63% increase in attendance and 66% improvement on CAFAS scores.
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.

No

Communicate and Evaluate

<i>Initiative</i>	<i>Status</i>	<i>Updates?</i>
NAMI Peer Project	Funding proposal attached for MAC review	
Anti-Stigma Campaign	Funding proposal attached for MAC review	
MHFA/YMHFA Education initiatives	Trainings occurring monthly for MHFA and WISD is developing their summer training schedule to include 20 YMHFA trainings.	
Millage Comms Strategy	Funding proposal attached for MAC review	

Washtenaw County Mental Health and Public Safety Millage Initiative Dashboard

Initiative	New or expanded services	Crisis services	Stabilization services	Integrated & coordinated	Peer support services	SUD services	Housing services	Education & prevention	Reducing stigma	Adult-focused	Youth-focused	Cross-sector collaboration	Needs assessment &	Grants: supplements millage	Status	Date Implemented, Expected, or Completed
Washtenaw CARES	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			Implemented	May 2019
CCBHC	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓	Implemented	May 2019
750 Towner assessment center	✓	✓	✓	✓						✓		✓			Implemented	March 2020
NAMI peer project	✓				✓					✓		✓			In progress	2020
Mental Health First Aid training								✓	✓	✓	✓	✓			In progress	2020
Youth assessment center	✓							✓			✓	✓	✓	✓	In progress	Ongoing
Youth court therapeutic CSM position	✓										✓	✓			Implemented	December 2020
31N WISD school MH project	✓							✓	✓		✓	✓			In progress	Ongoing
Mini-grant Anti-stigma campaign w/WISD								✓	✓		✓	✓			In progress	Ongoing
Anti-stigma campaign w/public health								✓	✓	✓	✓	✓			In progress	Ongoing
Corner psychiatry access	✓	✓	✓	✓							✓	✓			Implemented	November 2019
SUD system transformation	✓					✓		✓	✓	✓	✓	✓	✓	✓	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

Plan and Integrate

<i>Initiative</i>	<i>Status</i>	<i>Updates?</i>
LEAD	2 nd Case manager hired. Co-response with law enforcement beginning this week.	
Youth Assessment Center	Implementation team identified and kickoff meeting happening middle of June.	
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.	No
Rethink Health/5 Healthy Towns	Logic model created and will be reviewed with the Stewardship Council on June 7 th . New members and action teams will be developed to assist with completing strategies identified in the logic model. Key focus areas include social isolation, lack of sense of purpose, housing, food access, transportation, ease of service access and barriers to service access.	
5HT Intergenerational Populations Project	Findings have been reviewed and next steps are being identified.	No
SUD System Transition	Implementation began on January 1, 2022.	No

Expand Services

<i>Initiative</i>	<i>Status</i>	<i>Updates?</i>
CARES/Crisis/750/CCBHC	M. Tasker to report	
Housing RFP	New housing RFP continues to be developed with OCED. Two new supportive housing projects supported by the Millage include MAP and FEP.	
31 N/ WISD Mini Grants	Mini Grants -Mini grant work is wrapping up for the school year. WISD will be providing an update to the MAC in August highlighting the different youth led campaigns.	

Initiative Descriptions

	31N- 63 students served from January- March with over 190 service hours provided 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 conducted 131 visits serving 26 unique individuals. They have contracted with 36 mental health providers but waiting lists remain long, so they are hoping to contract with 3 additional providers. The behavioral health workforce shortage is impacting their ability to contract with additional providers. These providers are providing services in 7 different languages- Italian, French, Mandarin, Russian, Spanish, Farsi, and Arabic.	
Student Advocacy Center	Ed Advocacy- 55 students served fall semester, majority students have been black males from 48197, 98 and 48108. 100% of students served had no further behavioral referrals, 71% increased attendance and 91% increased grades. Check and Connect-61 students served this semester with majority students being black males all from Ypsi and Lincoln schools. They served students from 2 nd grade to 12 th grade and saw 63% increase in attendance and 66% improvement on CAFAS scores.	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.	No

Initiative Descriptions

Communicate and Evaluate

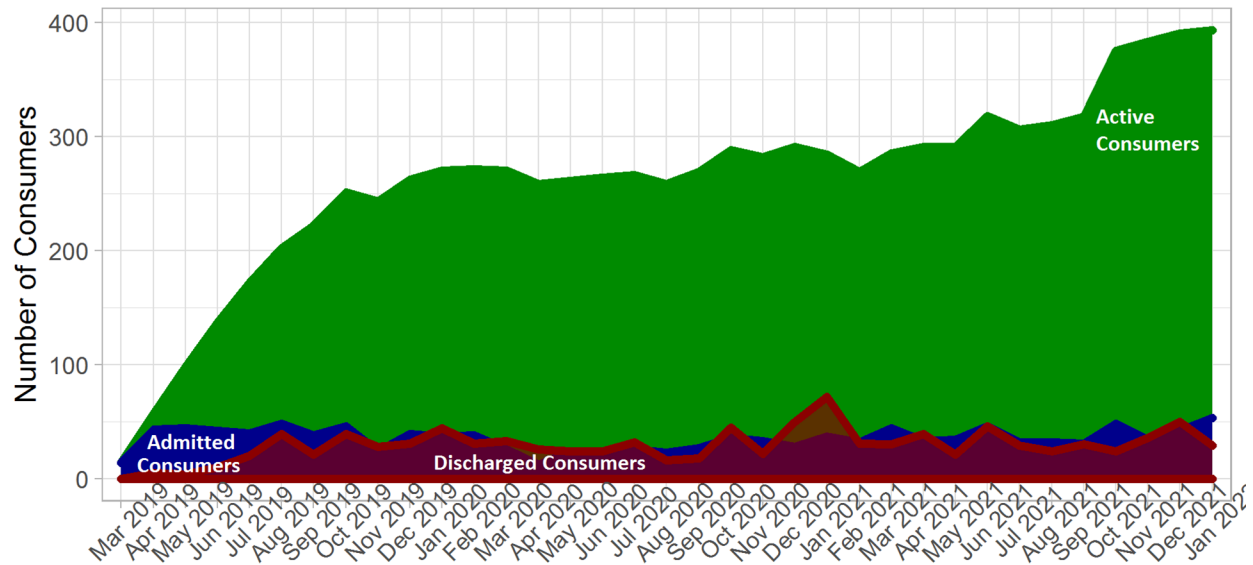
<i>Initiative</i>	<i>Status</i>	<i>Updates?</i>
<i>NAMI Peer Project</i>	Contract renewal will be occurring in the fall. Funding will allow for expansion of efforts.	
<i>Anti-Stigma Campaign</i>	Contract renewal process underway.	
<i>MHFA/YMHFA Education initiatives</i>	Trainings occurring monthly for MHFA and WISD is developing their summer training schedule to include 20 YMHFA trainings.	No
<i>Millage Comms Strategy</i>	Contract renewal process underway.	

Washtenaw County Community Mental Health – CARES Report January 2022

Last Updated: 02/22/2022

CARES THROUGHPUT

Cares Throughput is about consumers entering, leaving, and remaining active in the program. There are more consumers in CARES since October 2022 which may be a result of increased admissions relative to discharges.

Oct 2021 - Jan 2022: CARES Throughput

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

Jul-20	267	26	32
Aug-20	259	23	16
Sep-20	270	27	18
Oct-20	290	37	45
Nov-20	285	34	22
Dec-20	293	28	50
Jan-21	284	37	72
Feb-21	269	32	31
Mar-21	285	44	30
Apr-21	291	33	39
May-21	291	34	21
Jun-21	318	46	46
Jul-21	306	32	29
Aug-21	310	32	24
Sep-21	317	31	30
Oct-21	375	48	24
Nov-21	383	34	36
Dec-21	390	42	50
Jan-22	393	53	29

Referrals to CARES by Month

Also known as automatic enrollment in CARES

Note that when there are less automatic enrollment/referrals this generally leads to a decrease in the number of current (or active) CARES Admissions. This ceased starting 10/1/2022 – we could replace this with [CARES Adm Cases] from the above table if desired, but it is not a perfect replacement either.

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

Mar-20	40
Apr-20	21
May-20	39
Jun-20	44
Jul-20	40
Aug-20	33
Sep-20	45
Oct-20	72
Nov-20	61
Dec-20	48
Jan-21	52
Feb-21	48
Mar-21	73
Apr-21	72
May-21	68
Jun-21	58
Jul-21	57
Aug-21	77
Sep-21	67

Emergency Contact Notes by Month

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

ER_Note_Month	Yr	Mon	Num_ER_Notes	num_CRCT_cases	num_Cares_cases
Mar-18	2018	3	1	1	0
Apr-18	2018	4	100	76	2
May-18	2018	5	97	82	1
Jun-18	2018	6	124	100	1
Jul-18	2018	7	123	90	5
Aug-18	2018	8	118	96	3
Sep-18	2018	9	147	101	3
Oct-18	2018	10	183	102	3
Nov-18	2018	11	182	83	3
Dec-18	2018	12	205	102	1
Jan-19	2019	1	173	86	5
Feb-19	2019	2	200	106	8
Mar-19	2019	3	253	125	14
Apr 2019	2019	4	229	133	9
May 2019	2019	5	237	130	9
Jun 2019	2019	6	245	130	22
Jul 2019	2019	7	229	126	22
Aug 2019	2019	8	210	128	21
Sep 2019	2019	9	245	131	5
Oct 2019	2019	10	305	157	15
Nov 2019	2019	11	242	131	9
Dec 2019	2019	12	268	138	15
Jan 2020	2020	1	230	130	15
Feb 2020	2020	2	223	134	5
Mar 2020	2020	3	121	82	5
Apr 2020	2020	4	57	51	6
May 2020	2020	5	66	55	3
Jun 2020	2020	6	168	94	7
Jul 2020	2020	7	312	110	10
Aug 2020	2020	8	206	98	7
Sep 2020	2020	9	248	95	3
Oct 2020	2020	10	227	88	5
Nov 2020	2020	11	209	87	3
Dec 2020	2020	12	104	55	5
Jan 2021	2021	01	158	79	7

Feb 2021	2021	02	107	65	5
Mar 2021	2021	03	171	99	6
Apr 2021	2021	04	258	124	12
May 2021	2021	05	221	126	8
Jun 2021	2021	06	202	115	5
Jul 2021	2021	07	261	80	1
Aug 2021	2021	08	252	111	6
Sep 2021	2021	09	160	83	2
Oct 2021	2021	10	142	99	0
Nov 2021	2021	11	135	67	0
Dec 2021	2021	12	119	78	0
Jan 2022	2022	01	77	56	0

Gender

Gender data is from CRCT electronic medical record using any consumers at least one day active on the CARES Program between 3/1/2019 and the report run date.

# Consumers	Gender
742	F
645	M
1387	Total

# Consumers	Gender Identity
831	
4	Chose not to disclose
262	Man/Cisgender Man
5	Non-binary/Genderqueer
6	Not collected-Full Rec Exception
3	Other, please specify
3	Transgender Man
1	Transgender Woman
4	Unknown for this Crisis Event
268	Woman/Cisgender Woman
1387	Total

Race

Race data is from CRCT electronic medical record using any consumers at least one day active on the CARES Program between 3/1/2019 and the report run date.

Race	# Consumers
White	786
Black or African American	383
-missing data-	88
Other race	64
Asian	27
Refused to Provide	16
Two or more races	13
American Indian (non-Alaskan)	6
Native Hawaiian or other Pacific	4

Typical Length of Stay for Cases that Already Closed

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

	Days
Median	153
Mean	195.7
Min	1
Max	964

City/Zip Code for Open Cases

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

City	# Consumers
YPSILANTI	658
ANN ARBOR	462
Whitmore Lake	57
Saline	37
Chelsea	20
Dexter	18
MILAN	18
	14
Manchester	12
Willis	12
Northville	7
BELLEVILLE	6
Detroit	5
GRASS LAKE	5
Pinckney	5
Westland	4
Adrian	3
Brighton	3
Canton	3
Clinton	2
Gregory	2
Monroe	2
Plymouth	2
South Lyon	2
Superior Township	2
Taylor	2
Wayne	2
White Lake	2
Beaverton	1
Berkley	1
Clarkston	1
Clinton Twp	1
Corbin	1
Dearborn	1

Dundee	1
Florence	1
Fountain Hill	1
Gaylord	1
Ida	1
Idaho Falls	1
Inkster	1
Redford	1
Romulus	1
South Gate	1
Southfield	1
Standish	1
Van Buren Twp	1
Whittaker	1
Total	1387

Zip_Code	# Consumers
48197	347
48198	310
48103	171
48108	107
48104	98
48105	71
48189	57
48176	36
	25
48118	20
48130	18
48160	18
48158	12
48191	12
48111	7
48107	6
48167	6
48169	5
49240	5
48185	4
48109	3
49221	3
48114	2
48137	2

48161	2
48170	2
48178	2
48184	2
48188	2
49236	2
18015	1
40701	1
41042	1
48036	1
48072	1
48106	1
48116	1
48126	1
48131	1
48140	1
48141	1
48168	1
48174	1
48180	1
48187	1
48190	1
48202	1
48204	1
48209	1
48215	1
48224	1
48240	1
48348	1
48383	1
48386	1
48612	1
48658	1
49735	1
83401	1
90280	1
Total	1387

Age Groups for Consumers Active at least 1 Day in CARES

Age Category	# CARES Adm Cases
	1
0-16	75
17-19	62
20-24	189
25-29	172
30-34	183
35-39	152
40-44	120
45-49	98
50-54	101
55-59	81
60-64	67
65-69	49
70+	37
Total	1387

Funding Sources for Open CARES Consumers

Funding Sources	Medicare	# CARES cases
	N	96
	Y	8
HMP	N	205
Medicaid	N	133
Medicaid	Y	30
S/D	N	5
S/D	Y	5
	Total	482

Commercial Insurance

This provides a glimpse of the top priority insurance types that clients have in CARES, first excluding the following insurance names: (1) anything including the word 'Medicare', (2) 'CCBHC Demonstration', (3) 'Financial Determination', (4) 'Assessed for Medicaid Expansion - Not Eligible', (5) 'Assessed for Medicaid Expansion - Eligible', (6) no insurance listed whatsoever.

Insurance_Name	Open_Cares_Cases
BLUE CROSS BLUE SHIELD OF MI	12
SDA,SSI,SSDI	6
Medicaid Deductible	5
BLUE CARE NETWORK OF MICHIGAN	2
MERIDIAN CARE EXTRA HMO SNP	2
MOLINA MARKETPLACE MI	2
United Healthcare	2
WELLCARE HEALTH PLANS	2
BLUE CARE NETWORK (PO 68710)	1
BLUE CARE NETWORK PILOT	1
Blue Care Network Advantage	1
CIGNA MEDICAL	1
COFINITY	1
Physician Health Plan/PHPOFSM	1
SED Waiver	1
UNITED HEALTH CARE	1
United Healthcare Community Plan	1

CPT Categories from CARES and CRCT EMR. CPT Codes not categorized are lacking a category and are largely a result of new CPT codes.

CPT_Category	num_SAL_Documents	num_cases
Targeted Case Management	21108	1371
Med Reviews	3864	669
Peer Services	3573	447
H2011	2524	282
RN Services	1622	499
Psych Evals	1152	903
Intake Assessments	1077	865
Injections	565	85
Wellness Note	339	191
T1023	107	78
H0039	78	4
Therapy Group Notes	54	11
Nursing Assessments	47	46
IND02	41	25
S5111	21	1
H2023	20	1
S9470	18	3

S9446	17	3
H2022	17	1
90834	15	8
S0316	15	7
97165	6	1
99211	4	3
90846	3	1
90847	3	1
J2426	3	1
J3490	3	2
H2014	2	1
99212	2	2
S9445	2	1
T1040	2	247
99213	1	1
H0002	1	1
IND01	1	1

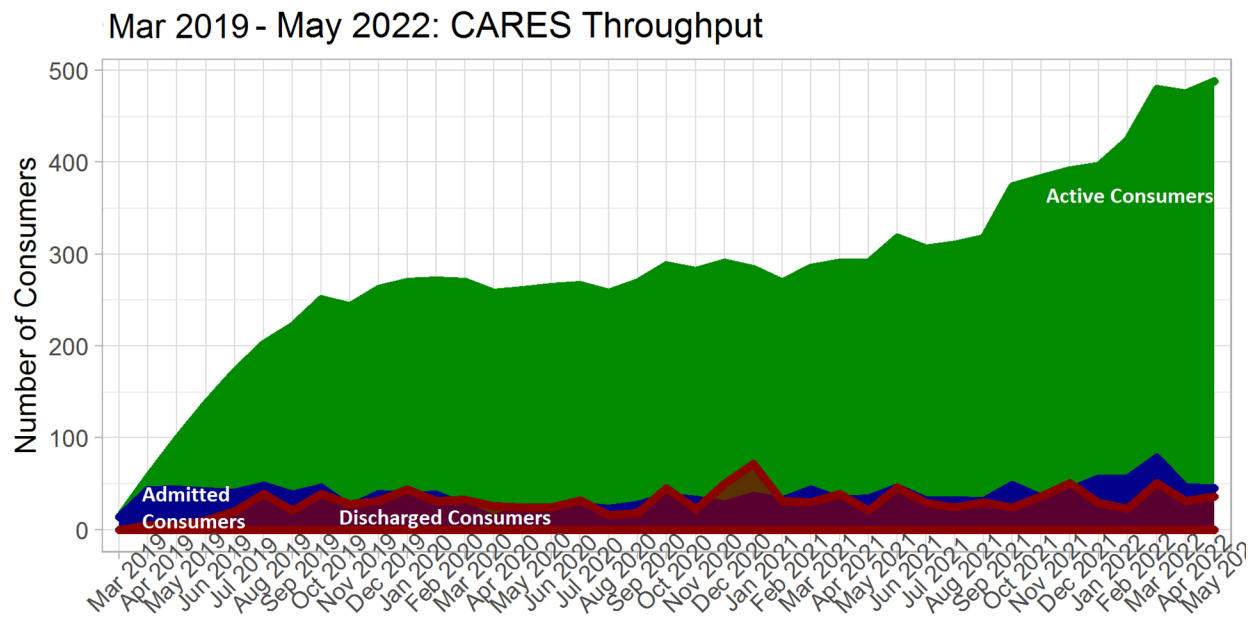
<u>Type of Service</u>	<u># CARES cases</u>	<u>Percent</u>
Mood disorders	1588	83.1%
Personality Disorders	718	12.8%
Psychosis	282	12.5%
SED	247	10.5%
SUD	238	33.2%
Total duplicate count	3073	100%
(Total unique count)	(1880)	

Washtenaw County Community Mental Health – CARES Report May 2022

Last Updated: 06/01/2022

CARES THROUGHPUT

Cares Throughput is about consumers entering, leaving, and remaining active in the program. There are substantially more consumers in CARES since October 2022 is a result of increased admissions with discharges remaining relatively stable.



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

Jul-20	267	26	32
Aug-20	259	23	16
Sep-20	270	27	18
Oct-20	290	37	45
Nov-20	285	34	22
Dec-20	293	28	50
Jan-21	284	37	72
Feb-21	269	32	31
Mar-21	285	44	30
Apr-21	291	33	39
May-21	291	34	21
Jun-21	318	46	46
Jul-21	306	32	29
Aug-21	310	32	24
Sep-22	317	31	30
Oct-21	374	49	24
Nov-21	383	35	36
Dec-21	391	43	51
Jan-22	396	56	29
Feb-22	424	56	23
Mar-22	480	79	51
Apr-22	475	46	31
May-22	488	45	36

Referrals to CARES by Month

Also known as automatic enrollment in CARES

Note that when there are less automatic enrollment/referrals this generally leads to a decrease in the number of current (or active) CARES Admissions. This ceased starting 10/1/2022 – we could replace this with [CARES Adm Cases] from the above table if desired, but it is not a perfect replacement either.

Referral Month	# New CARES Referrals
Mar-19	37
Apr-19	77
May-19	80
Jun-19	62
Jul-19	58
Aug-19	70
Sep-19	67
Oct-19	71

Nov-19	67
Dec-19	62
Jan-20	77
Feb-20	59
Mar-20	40
Apr-20	21
May-20	39
Jun-20	44
Jul-20	40
Aug-20	33
Sep-20	45
Oct-20	72
Nov-20	61
Dec-20	48
Jan-21	52
Feb-21	48
Mar-21	73
Apr-21	72
May-21	68
Jun-21	58
Jul-21	57
Aug-21	77
Sep-21	67

Emergency Contact Notes by Month

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

ER_Note_Month	Yr	Mon	Num_ER_Notes	num_CRCT_cases	num_Cares_cases
Mar-18	2018	3	1	1	0
Apr-18	2018	4	100	76	2
May-18	2018	5	97	82	1
Jun-18	2018	6	124	100	1
Jul-18	2018	7	123	90	5
Aug-18	2018	8	118	96	3
Sep-18	2018	9	147	101	3
Oct-18	2018	10	183	102	3
Nov-18	2018	11	182	83	3
Dec-18	2018	12	205	102	1

Jan-19	2019	1	173	86	5
Feb-19	2019	2	200	106	8
Mar-19	2019	3	253	125	14
Apr 2019	2019	4	229	133	9
May 2019	2019	5	237	130	9
Jun 2019	2019	6	245	130	22
Jul 2019	2019	7	229	126	22
Aug 2019	2019	8	210	128	21
Sep 2019	2019	9	245	131	5
Oct 2019	2019	10	305	157	15
Nov 2019	2019	11	242	131	9
Dec 2019	2019	12	268	138	15
Jan 2020	2020	1	230	130	15
Feb 2020	2020	2	223	134	5
Mar 2020	2020	3	121	82	5
Apr 2020	2020	4	57	51	6
May 2020	2020	5	66	55	3
Jun 2020	2020	6	168	94	7
Jul 2020	2020	7	312	110	10
Aug 2020	2020	8	206	98	7
Sep 2020	2020	9	248	95	3
Oct 2020	2020	10	227	88	5
Nov 2020	2020	11	209	87	3
Dec 2020	2020	12	104	55	5
Jan 2021	2021	01	158	79	7
Feb 2021	2021	02	107	65	5
Mar 2021	2021	03	171	99	6
Apr 2021	2021	04	258	124	12
May 2021	2021	05	221	126	8
Jun 2021	2021	06	202	115	5
Jul 2021	2021	07	261	80	1
Aug 2021	2021	08	252	111	6
Sep 2021	2021	09	160	83	2
Oct 2021	2021	10	142	99	0
Nov 2021	2021	11	135	67	0
Dec 2021	2021	12	119	78	0
Jan 2022	2022	01	77	56	0
Feb 2022	2022	2	103	69	0
Mar 2022	2022	3	102	59	0
Apr 2022	2022	4	89	67	0
May 2022	2022	5	84	70	0

Gender

Gender data is from CRCT electronic medical record using any consumers at least one day active on the CARES Program between 3/1/2019 and the report run date.

# Consumers	Gender
849	F
727	M
1576	Total

Gender Identity	# Consumers
	614
Woman/Cisgender Woman	483
Man/Cisgender Man	438
Non-binary/Genderqueer	10
Not collected-Full Rec Exception	9
Transgender Man	6
Transgender Woman	5
Other, please specify	4
Chose not to disclose	4
Unknown for this Crisis Event	2
Genderfluid	1

Race

Race data is from CRCT electronic medical record using any consumers at least one day active on the CARES Program between 3/1/2019 and the report run date.

Race	# Consumers
White	917
Black or African American	432
-missing data-	77
Other race	75
Asian	30
Refused to Provide	20
Two or more races	14
American Indian (non-Alaskan)	6
Native Hawaiian or other Pacific	5

Typical Length of Stay for Cases that Already Closed

We expect the mean and median to continue to grow as time continues and to fully stabilize after CARES has been fully functioning for two years. We are past the two year mark since the start of CARES at this time.

	Days
Median	155
Mean	200.6
Min	1
Max	1091

City/Zip Code for Open Cases

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

City	# Consumers
Ypsilanti	755
ANN ARBOR	511
Whitmore Lake	59
Saline	45
Chelsea	21
Dexter	20
Milan	20
	16
Manchester	15
Willis	13
Belleville	9
Northville	9
Detroit	7
Pinckney	7
Canton	6
GRASS LAKE	6
Adrian	3
Brighton	3
Monroe	3
Plymouth	3
South Lyon	3

Superior Township	3
Westland	3
Clinton	2
Gregory	2
Taylor	2
White Lake	2
Whittaker	2
Beaverton	1
Berkley	1
Clarkston	1
Clinton Twp	1
Corbin	1
Dearborn	1
Dundee	1
East Lansing	1
Florence	1
Fountain Hill	1
Gaylord	1
Ida	1
Idaho Falls	1
Inkster	1
Ludington	1
Mesick	1
Redford	1
Romulus	1
San Francisco	1
South Gate	1
Standish	1
Tecumseh	1
Toledo	1
Van Buren Twp	1
Washington	1
Wayne	1

Zip_Code	# Consumers
48197	405
48198	352
48103	186
48108	118
48104	111

48105	77
48189	59
48176	44
	29
48118	21
48130	20
48160	20
48158	15
48191	13
48111	10
48167	8
48169	7
48107	6
49240	6
48188	4
48109	3
48170	3
48178	3
48185	3
49221	3
48116	2
48137	2
48161	2
48187	2
48190	2
48224	2
49236	2
18015	1
20002	1
40701	1
41042	1
43614	1
48036	1
48072	1
48114	1
48126	1
48131	1
48140	1
48141	1
48162	1
48168	1

48174	1
48180	1
48184	1
48202	1
48204	1
48205	1
48209	1
48215	1
48240	1
48348	1
48383	1
48386	1
48612	1
48658	1
48823	1
49286	1
49431	1
49668	1
49735	1
83401	1
90280	1
94114	1

Age Groups for Consumers Active at least 1 Day in CARES

Age_Category	# CARES Adm Cases
-missing-	1
0-16	71
17-19	65
20-24	220
25-29	196
30-34	221
35-39	169
40-44	149
45-49	110
50-54	109
55-59	88
60-64	81
65-69	48
70+	48

Funding Sources for Open CARES Consumers

Funding Sources	Medicare	# CARES Cases
	N	121
	Y	12
HMP	N	247
Medicaid	N	156
Medicaid	Y	28
S/D/N	N	7
S/D/N	Y	6
S/D/Y (1)	Y	1

Commercial Insurance

This provides a glimpse of the top priority insurance types that clients have in CARES, first excluding the following insurance names: (1) anything including the word 'Medicare', (2) 'CCBHC Demonstration', (3) 'Financial Determination', (4) 'Assessed for Medicaid Expansion - Not Eligible', (5) 'Assessed for Medicaid Expansion - Eligible', (6) no insurance listed whatsoever.

Insurance Name	Open Cares Cases
BLUE CROSS BLUE SHIELD OF MI	9
SDA,SSI,SSDI	8
Medicaid Deductible	7
BLUE CARE NETWORK OF MICHIGAN	5
BLUE CARE NETWORK PILOT	2
MERIDIAN CARE EXTRA HMO SNP	2
WELLCARE HEALTH PLANS	2
BLUE CARE NETWORK (PO 68710)	1
Blue Care Network Advantage	1
CIGNA MEDICAL	1
COFINITY	1
MOLINA MARKETPLACE MI	1
PRIORITY HEALTH (MI)	1
SED Waiver	1
UNITED HEALTH CARE	1
United Healthcare	1
United Healthcare Community Plan	1

CPT Categories from CARES and CRCT EMR. CPT Codes not categorized are lacking a category and are largely a result of new CPT codes.

CPT Category	# SALs	# Cares Consumers
Targeted Case Management	26522	1565
Med Reviews	4689	772
Peer Services	4426	526
H2011	4260	439
RN Services	1854	547
Psych Evals	1503	1099
Intake Assessments	1095	869
Injections	729	97
Wellness Note	358	200
T1023	194	127
H0039	142	4
Therapy Group Notes	75	13
Nursing Assessments	68	66
IND02	60	29
90834	40	14
S9470	32	4
S5111	31	1
H2022	29	1
S9446	23	3
H2023	20	1
S0316	16	8
90847	7	2
99211	7	6
97165	6	1
90846	4	2
J3490	4	2
S9445	3	1
H0002	3	3
J2426	3	1
H2014	2	1
99212	2	2
T1040	2	559
99213	1	1
IND01	1	1

Types of Diagnoses	# Cares Consumers	Percent
Mood disorders	1763	85.3%
SUD	781	37.8%
Psychosis	305	14.7%
Personality Disorders	266	12.9%
SED	260	12.6%
Total unduplicated	2068	N/A
Total duplicated	3375	N/A

Community Violence Intervention Team (CVIT)

RECOMMENDATION REPORT

In the summer of 2021, in the midst of several violent altercations resulting in the shooting deaths of Antonio Bishop (24yo), Arthur Ellerson (18yo), Arshon Evans (17yo), and Ziair Willis-Wilson (21yo), Ypsilanti Mayor, Lois Richardson convened a diverse group of community members with a singular focus of addressing community violence and saving the lives of our young people.

It is believed 80% to 85% of gun violence in our community is retaliatory in nature. This means that violence in our neighborhoods is predictable therefore it is also preventable. Although the disease of violence is deep-rooted and complex, there are solutions if we are committed to understanding the true nature of the problem and commit ourselves to taking the necessary steps to save lives by stopping violence.

The CVIT was only convened in recent months, however the recommendations below come from the years of lived experience members have in navigating, surviving, and in some cases perpetuating violence in our community. It is this lived experience combined with the expertise brought forth by team members representing government and the real-world experience by team members representing service providers that has brought this plan forward.

For our purposes, when we reference violence, we are focused on intentional violent trauma that is a result of shootings, stabbings, and serious assaults. This is not meant to diminish the impact of other violence related categories. However, by maintaining our narrow focus our intention is to save lives by finally impacting street violence.

We know that violence is a public health issue. The three leading causes of death in the United States for people ages 15-24 are unintentional injury, homicide, and suicide¹. Most of these violent deaths are directly associated with firearms. We also know that exposure to firearm violence approximately doubles the probability that a young person will commit violence within two years². It is also true that hospitalization for violence-related injuries is recurrent, with hospital readmission rates for subsequent assaults as high as 44% and subsequent homicide rates as high as 20%³.

What does all this mean? If a young person in Washtenaw County is impacted by violence, there is a high probability they will either wind up injured a second time or involved in a homicide the next time.

RECOMMENDATIONS

1 – Set a clear goal: commit to saving lives by stopping violence CCJ 1

Violence is not a police problem or a specific neighborhoods issue. It is a public health crisis and requires a commitment by individuals, governing bodies, service providers, and business alike.

2 – Identify key people and places driving violence CCJ 2

In every community, including our county, violence concentrates among a small group of people and places. To effectively reduce violent crime, communities must begin with a rigorous problem analysis. These analyses draw on incident reviews, shooting data, law enforcement intelligence, and social network mapping to identify the people and groups most likely to become involved in a violent incident. **We must fund an in-depth problem analysis and asset mapping process.** These analyses should then be reviewed by trained street outreach workers and other non-police individuals with relevant experience. This foundational work is critical to creating a shared understanding of a city's violence and guiding collaborative efforts.

3 – Create a plan for engaging key people and places CCJ 3

Commit to building an ecosystems approach to addressing violence. No program or organization can solve this complex problem alone. Compassionate enforcement, street outreach, violence interrupters, and a whole host of services are required for any successful anti-violence initiative. Addressing violence demands a multi-disciplinary response and a strategic plan to effectively organize these efforts. Most critically, leaders must coordinate stakeholder activities focused on the highest risk people and places. Plans should be practical and actionable, detailing concrete commitments: for key people and in key places, who will do what, by when?

4 – Engage key people with empathy and accountability CCJ 4

Those individuals and groups at the highest risk of violence must be placed on notice that they are in great danger of being injured, killed, arrested, and/or incarcerated. This message must be delivered with a combination of empathy and accountability. Supports and services must be offered so people have something better to say "yes" to, but it must be made clear that further violence will not be tolerated.

Outreach workers in neighborhoods and hospitals where shooting victims are recovering can defuse conflicts, connect people to services, and serve as crucial go-betweens for a city and some of its most disconnected citizens, as they do in Detroit with the DLIVE program.

5 – Address key locations using place-based policing and investment CCJ 5

A combination of place-based policing and investment can calm violent spaces. Police are necessary to disrupt existing cycles of violence and stop others from starting. But such short-term actions must be supplemented and quickly replaced by place-based interventions and investments to change the nature of violent micro-locations and the communities in which they are located. Problem-oriented policing, conducted in collaboration with residents can be an effective strategy to begin the process of disrupting violence.

6 – Place responsibility for violence reduction efforts at the top CCJ 6

Every community suffering from high rates of violent crime should have a permanent unit dedicated to violence reduction, with senior leadership reporting directly to the mayor, supervisor, administrator, or sheriff. These units can provide direct services as well as administer funding and should act as a hub for anti-violence efforts.

7 – Emphasize healing with trauma-informed approaches CCI 7

Agencies working with victims and survivors of violent crime should use a trauma-informed approach. This means acknowledging and recognizing the impacts and symptoms of trauma and ensuring that supports and services are delivered in a way that does not retraumatize survivors. Police also experience trauma and benefit from such approaches as well.

8 – Invest in anti-violence workforce development CCI 8

Violence intervention work happens because someone has attempted to or is planning to kill someone else. This work is difficult, dangerous, and requires an expertise that can't be learned in a book. Investing in and building up those who do this work and investing in violence prevention and retaliation mitigation programs are essential to saving lives.

9 – Set aside funding for new stakeholders and strategies CCI 9

There is a large base of rigorous evidence about what works, and what doesn't, when it comes to violence reduction. That said, there is still room for learning and improvement. While most funding should be reserved for strategies with demonstrated track records of success, some portion of anti-violence dollars should be set aside to promote innovation. Development funds should be created to nurture new leaders and organizations with small grants, training, and technical assistance.

10 – Create the Washtenaw County Violence Commission CCI 6 & 10

A new body is needed to continue and expand this work. [Committing to continuous improvement](#) by understanding violence in Washtenaw, recommending strategies, evaluating the effectiveness of strategies, reporting on progress made, and raising awareness are all important components of a violence commission. Strategies must be tested to see if they stop violence and save lives. Plans must be reviewed and, if necessary, revised. Leaders should embrace a learning culture that is able to recognize when strategies are not working and shift course – without starting over from scratch.

11 – Build a community center in eastern Washtenaw County

Whether it is the *science* behind successful violence intervention strategies or simply listening to what the young people in our community are telling us, safe spaces for young people are essential to stopping violence and saving lives.

12 – Build community mural/safe grieving community space

When listening to those directly impacted by violence, a mural of remembrance and safe space to grieve is needed. This allows us to begin the healing process, release the pain of loss, allow our community to grieve, unify those perpetuating violence, honor those lost, call attention to the issue of violence, and share the reality of violence in our community.

13 – Establish grief and loss community response protocol for violent deaths

When a young person dies from a drug overdose or suicide there are clear steps we take to wrap around their friends and loved ones. We do this because we understand the impact that a traumatic sudden loss can have. Why do we not provide the same support for those who lose a loved one to street violence?

14 – Establish Communication Alert System

For community responders to engage they must be alerted when instances of violence occur. Community responder is used in the broadest terms possible and include all working to cure violence.

CCI - Those local recommendations marked CCI are aligned with the CCI 10 Essential Actions to Save Lives plan⁴

REMEMBERANCE

Since 2008, the following individuals have been lost to violence in Washtenaw County. In their memory we commit to action in order to save the lives of future generations.

Donald Ray Hall – 19yo	Kenneth Jackson – 17yo	Anna List – 17yo
Jamar Gardner – 31yo	Chris King – 20yo	Brandon Charles – 28yo
Demarius Reed – 20yo	Edward Gwinner – 29yo	Keon Washington – 17yo
Derrick Allen – 29yo	Keandre Duff – 20yo	Derius James – 25yo
Eric Hargrove – 38yo	Allysha Tomlin – 23yo	Wesley Skinner – 44yo
Zachary Currie – 18yo	Jordan Klee – 18yo	Nina Battle - 32yo
Deshawn Jones – 30yo	Allen Shevrovich – 25yo	Deandre Willingham – 20yo
Domonique Lee – 28yo	David Sloss – 66yo	Kevin Hughbanks – 50yo
Luis Rivera-Estrada – 41yo	Brandon Cross – 19yo	Keifer Johnson – 26yo
Kelly Campbell-Brown – 53yo	Garland Johnson – 23yo	Robert Powell – 38yo
Chris Marsh – 18yo	Kevin Hughbanks Jr – 29yo	Marquis Gillespy – 16yo
Brian Matthews – 21yo	Aundre Smith – 22yo	Soloman Brown – 31yo
Marcus Mackey Jr. – 22yo	Sonni Green – 20yo	Reed Carter – 22yo
Henry Ross – 32yo	Arthur Ellerson – 18yo	Antonio Bishop – 24yo
Von Cratic – 22yo	Arshon Evans – 17yo	Ziair Willis-Wilson – 21yo
Laronte Binion-Phillips – 18yo		

The purpose of this list is to honor those lost. Any errors or omissions were unintentional and can be updated.

COMMUNITY VIOLENCE INTERVENTION TEAM MEMBERS

Cherisa Allen Ypsilanti Community Schools	Jamall Bufford Washtenaw My Brother's Keeper	Billy Cole WCSO Outreach, Supreme Felons
Drew Crosby Frech & Wang	Gregory Dill Washtenaw County Administration	Stacey Doyle Washtenaw ISD
Alyshia Dyer Community Member	Zachary Fosler Ypsilanti Housing Commission	Marv Gundy WCSO Community Outreach
Justin Hodge Washtenaw Co. Board of Commissioners	Jeannette Hadden Community Member	Derrick Jackson Washtenaw County Sheriff's Office
Darryl Johnson Mentor 2 Youth	Brian Jones-Chance City of Ypsilanti	Akintunde Oluwadre Community Member
Chuck Peterson-Bey Community Member	Lois Richardson City of Ypsilanti	Sue Shink Washtenaw Co. Board of Commissioners
Florence Roberson SURE moms, Sheriff's Office	Gail Wolkoff Educate Youth	Jimmy Wilson Ypsilanti Township Board of Trustees

END NOTES

1. Centers for Disease Control and Prevention. [10 leading causes of death by age group, United States—2020](#). Accessed February 20, 2022.
2. Bingenheimer JB, Brennan RT, Earls FJ. Firearm violence exposure and serious violent behavior. *Science*. May 27 2005;308(5726):1323-1326.
3. Bonderman J. Working with Victims of Gun Violence. Washington, DC: U.S. Department of Justice, Office for Victims of Crime; 2001.
4. CCJ: As communities around the country confront an ongoing surge in violent crime, particularly homicide, the Council on Criminal Justice launched the Violent Crime Working Group. Composed of a diverse range of leaders, the Group dedicated itself to saving lives by producing anti-violence guidance that is timely, relevant, and reliable. The result was the identification of Ten Essential Actions that communities can take now to reduce community gun violence. Those recommendations listed with CCJ are in alignment with the CCJ recommendations. The list focuses on the actions most likely to make the greatest immediate impact on violence and can be carried out within a year. The full plan can be found here. <https://counciloncj.org/10-essential-actions/>

Washtenaw County Community Mental Health Fund

Year Ended
September 30,
2021

Financial
Statements

Rehmann

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WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

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INDEPENDENT AUDITORS' REPORT

April 25, 2022

To the Washtenaw County Board
of Commissioners
Ann Arbor, Michigan

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of the ***Washtenaw County Community Mental Health Fund (WCCMH)***, a special revenue fund of Washtenaw County, Michigan, as of and for the year ended September 30, 2021, and the related notes to the financial statements, which collectively comprise WCCMH's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Washtenaw County Community Mental Health Fund, a special revenue fund of Washtenaw County, Michigan, as of September 30, 2021, and the changes in financial position and the budgetary comparison of the special revenue fund for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Independent Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of WCCMH and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.



In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about WCCMH's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Independent Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- exercise professional judgment and maintain professional skepticism throughout the audit.
- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of WCCMH's internal control. Accordingly, no such opinion is expressed.
- evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about WCCMH's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Reporting Entity

As discussed in Note 1, the financial statements present only the Washtenaw County Community Mental Health Fund and do not purport to, and do not, present fairly the financial position of Washtenaw County as of September 30, 2021, and the changes in its financial position for the year then ended in accordance with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Information

Our audit was conducted for the purpose of forming an opinion on the basic financial statements that collectively comprise the Washtenaw County Community Mental Health Fund's basic financial statements. The supplementary information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated April 25, 2022, on our consideration of WCCMH's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering WCCMH's internal control over financial reporting and compliance.

Rehmann Lobach LLC

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FINANCIAL STATEMENTS

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Balance Sheet

September 30, 2021

Assets

Cash and pooled investments	\$ 12,394,423
Receivables, net	1,176,646
Due from other governments:	
Community Mental Health Partnership of Southeast Michigan	13,498,489
Michigan Department of Health and Human Services	<u>360,584</u>

Total assets

\$ 27,430,142

Liabilities

Accounts payable	\$ 4,622,978
Accrued payroll	2,490,880
Due to other governments:	
Community Mental Health Partnership of Southeast Michigan	10,235,324
Michigan Department of Health and Human Services	912,908
Unearned revenue	<u>11,572,768</u>

Total liabilities

29,834,858

Fund balance

Unassigned (deficit)	<u>(2,404,716)</u>
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Total liabilities and fund balance

\$ 27,430,142

The accompanying notes are an integral part of these financial statements.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Statement of Revenues, Expenditures and Changes in Fund Balance

Budget and Actual

For the Year Ended September 30, 2021

	Original Budget	Final Budget	Actual	Actual Over (Under) Final Budget
Revenues				
Intergovernmental	\$ 84,972,467	\$ 85,955,434	\$ 88,837,035	\$ 2,881,601
Charges for services	824,821	824,821	307,270	(517,551)
Other revenue and reimbursements	1,555,190	1,555,190	1,945,211	390,021
Total revenues	<u>87,352,478</u>	<u>88,335,445</u>	<u>91,089,516</u>	<u>2,754,071</u>
Expenditures				
Health:				
Administration	5,624,552	5,624,552	5,650,014	25,462
Access and crisis services	1,578,213	1,578,213	1,336,589	(241,624)
Comprehensive supports and services	35,017,681	31,325,358	32,564,779	1,239,421
Residential and supported living	39,213,100	43,888,390	44,495,207	606,817
Inpatient services	5,887,890	5,887,890	5,909,050	21,160
Grants and contracts	1,779,812	1,779,812	1,473,705	(306,107)
Total expenditures	<u>89,101,248</u>	<u>90,084,215</u>	<u>91,429,344</u>	<u>1,345,129</u>
Revenues under expenditures	(1,748,770)	(1,748,770)	(339,828)	1,408,942
Other financing sources				
Transfers from Washtenaw County	1,748,770	1,748,770	3,781,137	2,032,367
Net change in fund balance	-	-	3,441,309	3,441,309
Fund balance (deficit), beginning of year	<u>(5,846,025)</u>	<u>(5,846,025)</u>	<u>(5,846,025)</u>	-
Fund balance (deficit), end of year	<u>\$ (5,846,025)</u>	<u>\$ (5,846,025)</u>	<u>\$ (2,404,716)</u>	<u>\$ 3,441,309</u>

The accompanying notes are an integral part of these financial statements.

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NOTES TO FINANCIAL STATEMENTS

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Notes To Financial Statements

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These financial statements represent the financial condition and the results of operations of a special revenue fund of Washtenaw County, Michigan (the "County") and are an integral part of that reporting entity. The Washtenaw County Community Mental Health fund (WCCMH) is not a legal entity and, therefore, is not a component unit of Washtenaw County or any other reporting entity, as defined by the Governmental Accounting Standards Board (GASB).

WCCMH is used to account for the provision of services to individuals with mental illnesses, developmental disabilities and substance abuse disorders under contracts with the Michigan Department of Health and Human Services (MDHHS) and the Community Mental Health Partnership of Southeast Michigan (CMHPSM, the regional administrator of federal Medicaid funds).

Under these managed specialty supports and services contracts, WCCMH receives monthly capitation payments based on the number of eligible participants, regardless of services actually performed. In addition, the MDHHS makes fee-for-service payments to WCCMH for certain covered services. WCCMH receives funding for Medicaid eligible consumers through CMHPSM.

Basis of Accounting

The County uses a special revenue fund (i.e., a separate accounting entity with a self-balancing set of accounts, using the modified-accrual basis of accounting) to report the financial position and the results of its community mental health operations. Fund accounting is designed to demonstrate legal compliance and to aid financial management by segregating transactions related to certain governmental functions and activities.

Receivables

Receivables consist primarily of fees and other such charges for services to first or third party payors, and are shown net of an allowance for uncollectible accounts, in the amount of \$1,226,807, based on an estimate of collectability by management.

Interfund Transfers

During the course of operations, numerous transactions occur between WCCMH and the County for goods provided, services rendered or the transfer of County appropriations. These receivables and payables are classified as interfund transfers on the statement of revenues, expenditures and changes in fund balance.

Contracts with Other Governments

WCCMH has several account balances that relate to the County's contracts with MDHHS and CMHPSM. The amounts reported as "Due from MDHHS" and "Due from CMHPSM" represent receivables from those agencies for services provided under the respective contracts for the year ended September 30, 2021. "Due to MDHHS" and "Due to CMHPSM" are amounts due to those entities as a result of year end financial reporting and cost settlements.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Notes To Financial Statements

Budgetary Accounting

WCCMH is under formal budgetary control and follows the County's annual budget process in establishing the budgetary data presented in the financial statements. The annual fiscal budget is adopted on a basis consistent with generally accepted accounting principles and the requirements of MDHHS. The legal level of budgetary control (i.e., the level at which expenditures may not legally exceed appropriations) is the function level for the County's special revenue funds.

Concentration

WCCMH derives substantially all of its revenue from contracts with the State of Michigan and/or regional PIHP (prepaid inpatient health plan), which is the CMHPSM. Accordingly, discontinuation of these contracts could adversely affect the fund's operating results.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenditures during the reporting period. Actual results could differ from those estimates.

2. EXCESS OF EXPENDITURES OVER APPROPRIATIONS

State statutes provide that a local unit shall not incur expenditures in excess of the amount appropriated. The legal level of budgetary control is at the functional level.

Excess of expenditures over appropriations are as follows:

	Final Budget	Actual	Excess
Health	\$ 90,084,215	\$ 91,429,344	\$ 1,345,129

This excess was funded by current year appropriations from the County.

3. CASH

WCCMH, along with the various other funds and component units of the County, participates in the County's pooled cash management accounts. Information regarding this cash management pool is presented in the County's annual comprehensive financial report.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Notes To Financial Statements

4. FUND BALANCE DEFICIT

WCCMH has a fund balance deficit of \$2,404,716 at September 30, 2021, substantially due to unearned revenue of approximately \$11.6 million related to the State of Michigan's Medicaid shared risk program, for which final cost settlement has not yet occurred.

5. CORONAVIRUS (COVID-19)

In March 2020, the World Health Organization declared the novel coronavirus outbreak (COVID-19) to be a global pandemic. The pandemic has resulted in operational challenges for WCCMH as it determines the impact on employees, vendors, and taxpayers, and the appropriate method for providing services. At this time, management does not believe that the ongoing negative financial impact related to the pandemic, if any, would be material to WCCMH.

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SUPPLEMENTARY INFORMATION

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Schedule of Mental Health Service Program Expenditures

For the Year Ended September 30, 2021

	Administration	Access and Crisis Services	Comprehensive Supports and Services	Residential and Supported Living
Expenditures				
Personnel services	\$ 4,450,894	\$ 1,082,502	\$ 18,908,373	\$ -
Supplies	51,600	2,048	91,641	-
Other services and charges	447,970	1,612	9,641,662	44,495,207
Inpatient services - community	-	-	-	-
Inpatient services - local	-	-	-	-
Internal service charges	699,550	250,427	3,923,103	-
Total expenditures	<u>\$ 5,650,014</u>	<u>\$ 1,336,589</u>	<u>\$ 32,564,779</u>	<u>\$ 44,495,207</u>

Inpatient Services	Grants and Contracts	Total
\$ -	\$ 1,264,035	\$ 25,705,804
-	8,763	154,052
-	173,008	54,759,459
5,240,444	-	5,240,444
668,606	-	668,606
-	27,899	4,900,979
<u>\$ 5,909,050</u>	<u>\$ 1,473,705</u>	<u>\$ 91,429,344</u>

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**INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING
AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS
PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS***

April 25, 2022

To the Washtenaw County Board
of Commissioners
Ann Arbor, Michigan

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the **Washtenaw County Community Mental Health Fund** (WCCMH), *a special revenue fund of Washtenaw County, Michigan*, as of and for the year ended September 30, 2021, and the related notes to the financial statements, which collectively comprise WCCMH's basic financial statements as listed in the table of contents, and have issued our report thereon dated April 25, 2022.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered WCCMH's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of WCCMH's internal control. Accordingly, we do not express an opinion on the effectiveness of WCCMH's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify a certain deficiency in internal control, described in the accompanying schedule of findings and responses, as item 2021-001 that we consider to be a significant deficiency.



Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether WCCMH's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The WCCMH's Response to Finding

WCCMH's response to the finding identified in our audit is described in the accompanying schedule of findings and responses. WCCMH's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of WCCMH's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Rehmann Loborn LLC

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Schedule of Findings and Responses

For the Year Ended September 30, 2021

2021-001 – Significant Audit Adjustments

Finding Type. Significant Deficiency in Internal Control over Financial Reporting.

Criteria. Management is responsible for maintaining its accounting records in accordance with generally accepted accounting principles (GAAP).

Condition. During our audit, we identified and proposed certain adjustments (which were approved and posted by management) that were significant to WCCMH's financial statements. Specifically, revenue was initially understated by approximately \$198,000 and liabilities were overstated by \$198,000.

Cause. Internal controls did not detect all adjustments necessary to properly record year-end balances.

Effect. As a result of this condition, WCCMH's financial statements were initially misstated by amounts that were significant to the financial statements.

Recommendation. Management has already taken appropriate corrective action by reviewing and approving the proposed audit adjustments.

View of Responsible Officials. The WCCMH Finance Director and Accounting Manager will review general ledger accounts in detail to ensure the accounts are reconciled.

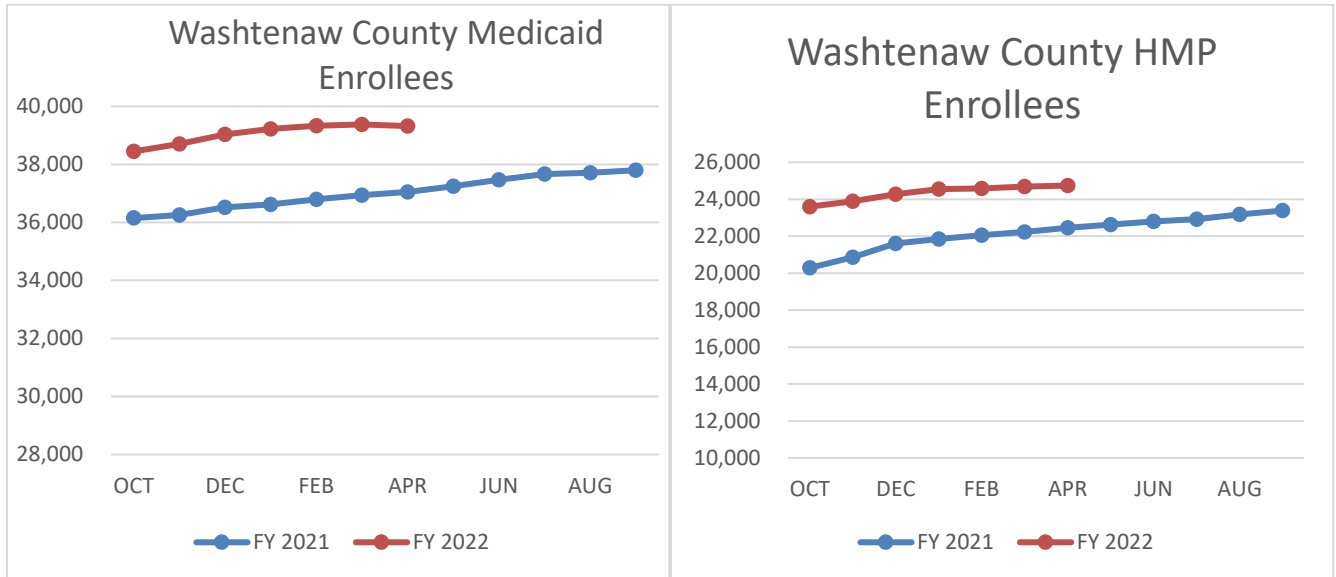
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**WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2022: For the period ending April 30, 2022
Prepared: June 6, 2022**

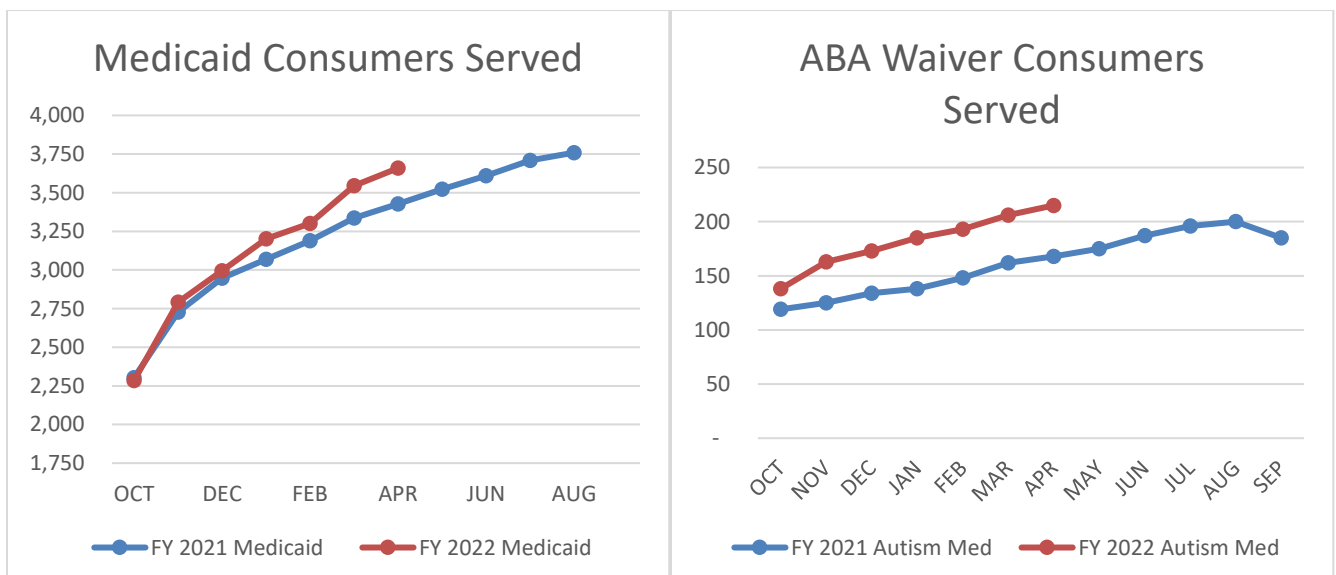
1. Washtenaw County Enrollees

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



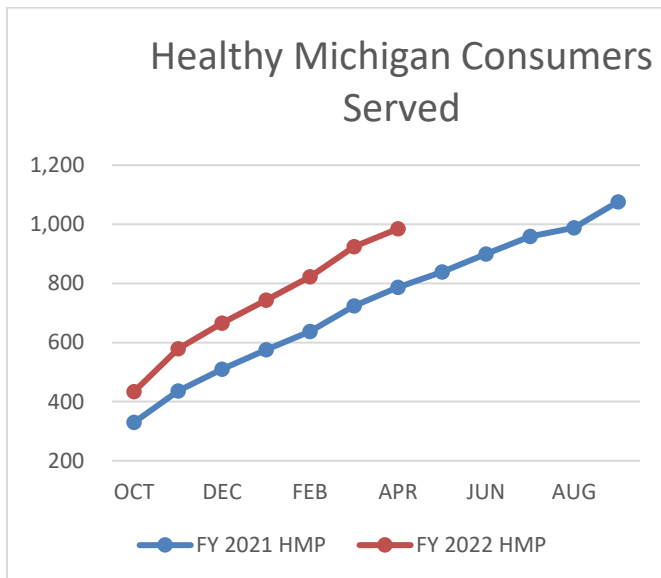
Washtenaw County Medicaid Enrollees were 39,327 in April 2022. This is a 6.14% increase from the same time last year (2,275 more enrollees than in April 2021). Healthy Michigan enrollment in April 2022 was 24,737. This is a 10.20% increase from the same time last year (2,290 more enrollees than in April 2021).

2. WCCMH Consumers Served to Date



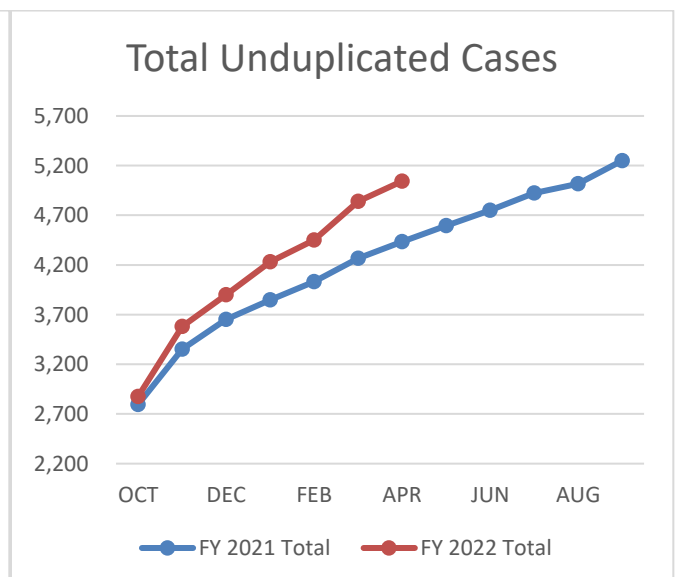
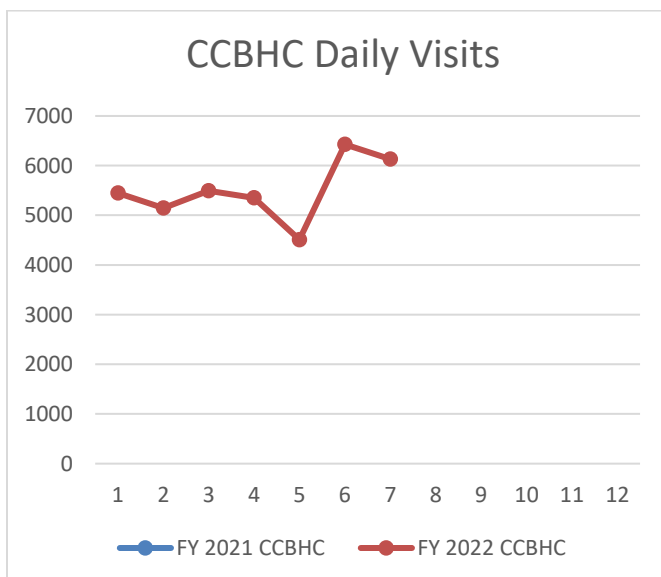
Medicaid consumers served through April 2022 are 3,659. This is 231 more consumers than the prior year (3,428 consumers were served through April 2021).

ABA Waiver consumers served through April 2022 are 215. This is 47 more consumers than prior year (168 consumers were served through April 2021).



Healthy Michigan consumers served through April 2022 were 985. This is 198 more consumers than the same period last year.

General Fund consumers served is not available this month due to reporting errors.



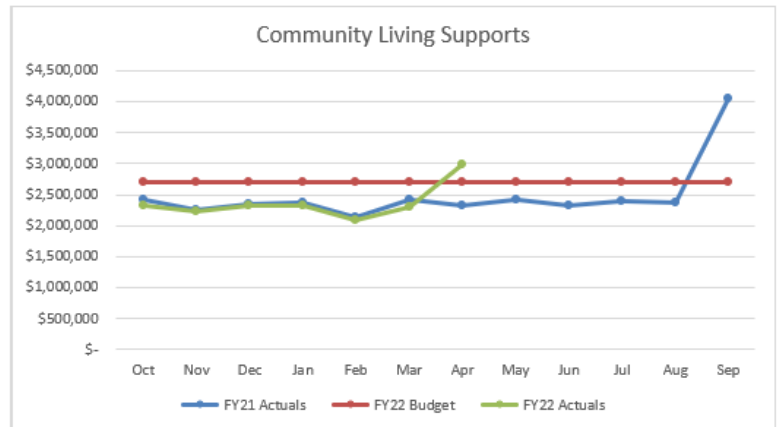
The CCBHC daily visit count for April 2022 were 6,132.

The total unduplicated consumers served by WCCMH through April 2022 were 5,043. This is 609 more consumers than served last year.

3. Financial Statement Highlights

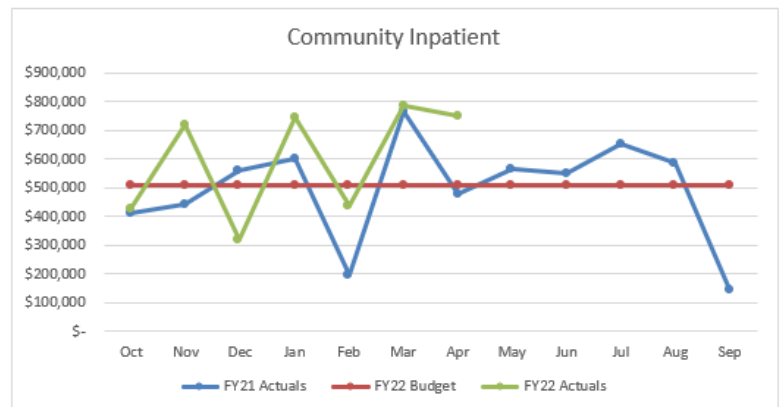
- a. CLS service costs to date are estimated to be \$16.6 Million and \$2.3 Million under budget. The costs year to date are 2% more than this time last year. At the end of FY21 and in April FY22 there were additional provider stability payments made to CLS providers and are reflected in the graph below. 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	\$ 2,323,772	-4.21%
Nov	2,264,769	2,711,968	2,239,357	-2.72%
Dec	2,346,049	2,711,968	2,317,212	-2.22%
Jan	2,365,368	2,711,968	2,329,070	-2.05%
Feb	2,135,096	2,711,968	2,086,644	-2.09%
Mar	2,408,780	2,711,968	2,312,469	-2.42%
Apr	2,328,718	2,711,968	2,997,213	2.03%
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		



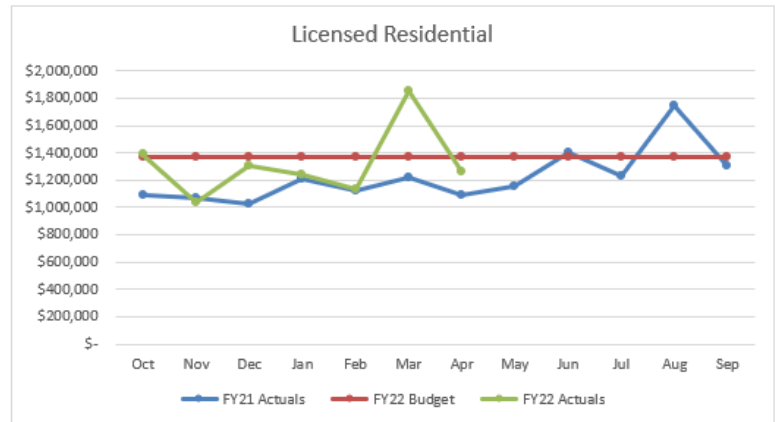
- b. Community Inpatient costs to date are \$4.1 Million. The costs year to date are 21.00% more than this time last year and \$110,000 over budget.

	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	745,851	9.64%
Feb	194,823	508,333	438,634	19.81%
Mar	767,313	508,333	785,399	15.32%
Apr	480,817	508,333	751,136	21.00%
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		



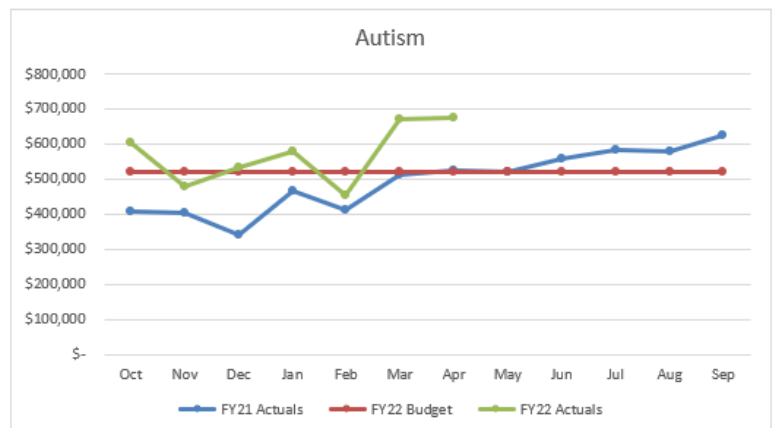
- c. Licensed Residential costs to date are \$9.2 Million and \$400,000 under budget. The costs year to date are 17.55% more than this time last year. At the end of FY21 and March FY22 there were additional provider stability payments made to CLS providers and are reflected in the graph below. The temporary 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	1,238,132	12.75%
Feb	1,118,469	1,375,450	1,134,181	10.45%
Mar	1,225,127	1,375,450	1,857,393	17.92%
Apr	1,093,521	1,375,450	1,260,033	17.55%
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 \$3.9 Million. The costs year to date are 30.21% more than this time last year and \$351,000 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	580,372	35.56%
Feb	410,998	520,861	453,979	30.48%
Mar	512,641	520,861	672,143	30.61%
Apr	525,526	520,861	674,225	30.21%
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 \$4.7 Million through April.
- c. By funding source, HMP is showing a deficit of \$665,000 through April.
- d. Overall, the PIHP surplus is \$4.1 Million through April.
- 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 \$738,000.

6. Local Key Points

- a. The majority of Local Funding comes from Washtenaw County.
- b. Local Funds are showing a surplus of \$27,000 through April.
- 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
 APRIL 2022 FYTD

ATTACHMENT #3
JUNE 2022

	<u>Total</u>
Medicaid **	
<u>Revenue</u>	
B & B3	\$ 27,697,869
HSW	15,171,189
DCW	4,678,527
Child Waiver/SED Waiver	1,075,142
Autism	3,433,922
Prior Year Adjustments	-
Care for Caïd	27,694
Total Medicaid Revenue	<u>\$ 52,084,342</u>
Total Medicaid Expense	\$ 47,346,429
Medicaid Surplus/(Deficit)	<u><u>\$ 4,737,913</u></u>

CCBHC **	
Revenue	\$ 2,365,438
Expense	-
CCBHC Surplus/(Deficit)	<u><u>\$ 2,365,438</u></u>

Healthy Michigan **	
Revenue	\$ 3,666,181
Expense	4,331,448
Healthy MI Surplus/(Deficit)	<u><u>\$ (665,267)</u></u>

General Fund	
<u>Revenue</u>	
CMH Operations	\$ 2,470,445
CMH Operations Contra	-
GF Carryforward	-
Categorical	-
Redirect To Injectable Meds.	-
Funding Fr. Other Local Sources	15,961
Total General Fund Revenue	<u>\$ 2,486,406</u>
Total General Fund Expense	\$ 1,748,629
General Fund Surplus/(Deficit)	<u><u>\$ 737,776</u></u>

Injectable Meds	
Revenue	\$ 70,702
Expense	<u>51,192</u>

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
 APRIL 2022 FYTD

ATTACHMENT #3
JUNE 2022

	Total
Inj. Meds. Surplus/(Deficit)	\$ 19,510
Grants And Contracts	
Revenue	\$ 930,136
Expense	930,136
Grants & Cont. Surplus/(Deficit)	\$ (0)
CMHSP To CMHSP	
Revenue	\$ 376,368
Redirect to GF	(15,961)
Expense	360,407
CMHSP to CMHSP Surplus/(Deficit)	\$ -
Local	
Revenue	\$ 1,029,815
Expense	990,938
Local Surplus/(Deficit)	\$ 38,877
Private Grant & All NOR	
Revenue	\$ 110,530
Expense	110,530
Priv. Grant & NOR Surplus/(Deficit)	\$ -
Grand Total	
Revenue	\$ 63,243,595
Expense	56,009,348
Grand Total Surplus/(Deficit)	\$ 7,234,248

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	\$ 6,457,594
WCCMH Surplus/(Deficit)	776,654
	\$ 7,234,248

Washtenaw County Community Mental Health
Budget to Actuals
For Seven Months Ending April 30, 2022

Current Fiscal Year					
	FY 2022 Amended Budget	FY 2022 Amended Budget YTD	FY 2022 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
<u>Operating Revenue</u>					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	\$ 46,276,405	\$ 26,994,570	\$ 27,697,869	\$ 703,299	2.61%
HSW	27,372,824	15,967,481	15,171,189	(796,291)	-4.99%
Children & SED Waivers	1,044,210	609,123	1,075,142	466,020	76.51%
Healthy Michigan Capitation	6,284,880	3,666,180	3,666,181	1	0.00%
Autism Capitation	5,886,723	3,433,922	3,433,922	0	0.00%
Direct Care Worker Pass-Through	8,421,349	4,912,454	4,678,527	(233,927)	-4.76%
CCBHC Supplementary	4,059,000	2,367,750	2,365,438	(2,312)	-0.10%
TOTAL PIHP Revenue	\$ 99,345,391	\$ 57,951,478	\$ 58,088,268	\$ 136,790	0.24%
MDHHS Revenue					
State General Funds	\$ 4,235,050	\$ 2,470,446	\$ 2,470,445	\$ (1)	0.00%
Grants & Earned Contracts	1,790,168	1,044,265	905,146	(139,119)	-13.32%
All Other Revenue					
County Appropriation	\$ 1,751,761	\$ 1,021,861	\$ 695,656	\$ (326,205)	-31.92%
Project Revenue	847,984	494,657	432,372	(62,285)	-12.59%
All Other	1,917,652	1,118,630	1,389,897	271,267	24.25%
TOTAL Operating Revenue	\$ 109,888,006	\$ 64,101,337	\$ 63,981,784	\$ (119,553)	-0.19%
<u>Operating Expenses</u>					
Administrative Expenses					
General Administration	\$ 6,598,359	\$ 3,849,043	\$ 3,349,468	\$ (499,575)	-12.98%
Program Administration	3,355,568	1,957,415	2,554,377	596,962	30.50%
Residential Services					
Community Living Supports	\$ 32,543,612	\$ 18,983,774	\$ 16,605,739	\$ (2,378,035)	-12.53%
Licensed Residential	16,505,397	9,628,148	9,219,797	(408,351)	-4.24%
Outpatient Services					
Autism Services	\$ 6,250,336	\$ 3,646,030	\$ 3,996,922	\$ 350,892	9.62%
Case Management	5,000,662	2,917,053	2,402,208	(514,845)	-17.65%
Supports Coordination	2,948,825	1,720,148	1,266,780	(453,368)	-26.36%
Skill Building	4,688,790	2,735,128	2,055,267	(679,861)	-24.86%
Supported Employment	1,538,321	897,354	848,094	(49,260)	-5.49%
Psychiatry	3,307,258	1,929,234	1,757,663	(171,571)	-8.89%
Nursing Services	2,397,642	1,398,625	1,231,484	(167,141)	-11.95%
Therapy Services	2,194,098	1,279,891	1,051,847	(228,044)	-17.82%
All Other	9,327,130	5,440,826	4,519,703	(921,123)	-16.93%
CCBHC Services	4,059,000	2,367,750	-	(2,367,750)	-100.00%
Other Expenses					
Community Inpatient	\$ 6,100,000	\$ 3,558,333	\$ 4,188,342	\$ 630,009	17.71%
Local Matches & Shelter	1,282,838	748,322	811,057	62,735	8.38%
Grants & Earned Contracts	1,790,168	1,044,265	889,185	(155,080)	-14.85%
TOTAL Operating Expenses	\$ 109,888,006	\$ 64,101,337	\$ 56,747,933	\$ (7,353,403)	-11.47%
Revenue Over/(Under) Expenses	-	-	7,233,851	7,233,851	

Washtenaw County Community Mental Health
Budget to Actuals
For Seven Months Ending April 30, 2022

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	\$ 27,697,869	\$ 24,848,384	\$ 2,849,484	11.47%
HSW	15,171,189	14,882,417	288,773	1.94%
Children & SED Waivers	1,075,142	565,308	509,834	90.19%
Healthy Michigan Capitation	3,666,181	3,385,074	281,107	8.30%
Autism Capitation	3,433,922	2,810,826	623,096	22.17%
Direct Care Worker Pass-Through	4,678,527	4,167,161	511,366	0.00%
CCBHC Supplementary	2,365,438	-	2,365,438	0.00%
TOTAL PIHP Revenue	\$ 58,088,268	\$ 50,659,169	\$ 7,429,099	14.66%
MDHHS Revenue				
State General Funds	\$ 2,470,445	\$ 2,434,407	\$ 36,038	1.48%
Grants & Earned Contracts	905,146	820,101	85,045	10.37%
All Other Revenue				
County Appropriation	\$ 695,656	\$ 521,556	\$ 174,100	33.38%
Project Revenue	432,372	391,807	40,565	10.35%
All Other	1,389,897	1,307,285	82,612	6.32%
TOTAL Operating Revenue	\$ 63,981,784	\$ 56,134,325	\$ 7,847,459	13.98%
Operating Expenses				
Administrative Expenses				
General Administration	\$ 3,349,468	\$ 2,857,544	\$ 491,924	17.21%
Program Administration	2,554,377	1,619,060	935,317	57.77%
Residential Services				
Community Living Supports	\$ 16,605,739	\$ 16,439,683	\$ 166,056	1.01%
Licensed Residential	9,219,797	7,843,464	1,376,333	17.55%
Outpatient Services				
Autism Services	\$ 3,996,922	\$ 3,069,546	\$ 927,376	30.21%
Case Management	2,402,208	2,443,981	(41,773)	-1.71%
Supports Coordination	1,266,780	1,304,617	(37,837)	-2.90%
Skill Building	2,055,267	1,386,903	668,364	48.19%
Supported Employment	848,094	794,017	54,077	6.81%
Psychiatry	1,757,663	1,548,785	208,878	13.49%
Nursing Services	1,231,484	1,140,570	90,914	7.97%
Therapy Services	1,051,847	985,757	66,090	6.70%
All Other	4,519,703	3,905,320	614,383	15.73%
CCBHC Services	-	-	-	0.00%
Other Expenses				
Community Inpatient	\$ 4,188,342	\$ 3,461,483	\$ 726,859	21.00%
Local Matches & Shelter	811,057	844,347	(33,290)	-3.94%
Grants & Earned Contracts	889,185	780,564	108,621	13.92%
TOTAL Operating Expenses	\$ 56,747,933	\$ 50,425,641	\$ 6,322,293	12.54%
Revenue Over/(Under) Expenses	7,233,851	5,708,685	1,525,166	

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

Prior Year FY 2021	<u>October</u>	<u>November</u>	<u>December</u>	<u>January</u>	<u>February</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>September</u>
Total Revenue	\$ 7,755,401	\$ 15,310,244	\$ 23,580,591	\$ 31,333,092	\$ 38,921,338	\$ 47,115,196	\$ 56,134,326	\$ 64,236,863	\$ 72,980,573	\$ 81,144,669	\$ 90,818,496	\$ 99,945,774
Total Expense	\$ 6,390,300	\$ 13,468,771	\$ 20,308,564	\$ 28,129,172	\$ 35,311,210	\$ 42,743,574	\$ 50,665,179	\$ 58,492,671	\$ 66,459,411	\$ 75,089,495	\$ 84,875,262	\$ 90,335,121
Surplus / (Deficit)	\$ 1,365,101	\$ 1,841,473	\$ 3,272,027	\$ 3,203,920	\$ 3,610,128	\$ 4,371,622	\$ 5,469,147	\$ 5,744,192	\$ 6,521,162	\$ 6,055,174	\$ 5,943,234	\$ 9,610,653 (a)
Current Year FY 2022	<u>October</u>	<u>November</u>	<u>December</u>	<u>January</u>	<u>February</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>September</u>
Total Revenue	\$ 9,108,033	\$ 17,714,521	\$ 26,486,887	\$ 35,542,274	\$ 44,287,543	\$ 55,120,090	\$ 63,981,784					
Total Expense	\$ 7,658,696	\$ 14,955,417	\$ 22,766,179	\$ 30,490,909	\$ 38,411,183	\$ 48,890,967	\$ 56,747,933					
Surplus / (Deficit)	\$ 1,449,337	\$ 2,759,104	\$ 3,720,708	\$ 5,051,365	\$ 5,876,360	\$ 6,229,123	\$ 7,233,851	\$ -	\$ -	\$ -	\$ -	\$ -

(a) Includes PIHP Medicaid Surplus of \$4,639,734 which is returned to PIHP
Includes General Fund Surplus of \$2,682,639 which is returned to MDHHS
Includes Local Funds Surplus of \$2,288,280 (County \$2,013,517 deficit elimination plan contribution & \$274,763 local surplus) which offsets Fund Deficit

Washtenaw County Community Mental Health - Millage Advisory Committee
Millage Financial Update - For the Month Ending April 30, 2022

	Budget to Actuals				Commitments		
	Annual Budget	Budget YTD	Actuals YTD	Actuals YTD Over/(Under) Budget YTD	Committed Current Fiscal Year	Remaining Uncommitted Current Fiscal Year	Committed FY 2023
Community Wide Service Expansion							
<u>CARES Team</u>							
Access & Triage	\$ 550,000	\$ 183,333	\$ 179,012	\$ (4,321)	\$ 550,000	\$ -	\$ 577,500
Treatment & Stabilization Services	550,000	183,333	168,448	(14,885)	550,000	-	577,500
Crisis Response	750,000	250,000	235,787	(14,213)	750,000	-	787,500
Crisis Stabilization Center	350,000	116,667	93,738	(22,929)	350,000	-	367,500
Other CARES Team	397,600	132,533	132,938	405	397,600	-	417,480
<u>Criminal Justice Diversion & Deflection</u>							
WCCMH Staffing - LEADD/Jail Services	\$ 450,000	\$ 150,000	\$ 78,119	\$ (71,881)	\$ 240,000	\$ -	\$ 252,000
<u>Supportive Housing</u>							
Supportive Housing RFP	\$ 400,000	\$ 133,333	\$ 67,081	\$ (66,252)	\$ 400,000	\$ -	\$ -
Supportive Housing Other	460,000	153,333	-	(153,333)	460,000	-	70,000
Avalon - Permanent Supportive Housing	180,000	60,000	45,000	(15,000)	180,000	-	180,000
Emergency Housing	50,000	16,667	13,247	(3,420)	50,000	-	50,000
<u>Youth Initiatives and Support</u>							
Washtenaw Intermediate School District	\$ 227,780	\$ 75,927	\$ -	\$ (75,927)	\$ 227,780	\$ -	\$ -
Student Advocacy Center	190,195	63,398	-	(63,398)	190,195	-	-
Health Dept - Anti Stigma Campaign	170,000	56,667	-	(56,667)	170,000	-	170,000
WCCMH - Wraparound Staff	95,000	31,667	-	(31,667)	95,000	-	100,000
Other Youth Initiatives and Support	350,000	116,667	-	(116,667)	20,000	330,000	-
<u>Other Service Expansion</u>							
Washtenaw Health Plan	\$ 165,000	\$ 55,000	\$ 55,000	\$ -	\$ 165,000	\$ -	\$ 165,000
Other	250,000	83,333	-	(83,333)	-	250,000	-
TOTAL Community Wide Service Expansion	\$ 5,585,575	\$ 1,861,858	\$ 1,068,370	\$ (793,488)	\$ 4,795,575	\$ 580,000	\$ 3,714,480

	Budget to Actuals				Commitments		
	Annual Budget	Budget YTD	Actuals YTD	Actuals YTD Over/(Under) Budget YTD	Committed Current Fiscal Year	Remaining Uncommitted Current Fiscal Year	Committed FY 2023
Education & Prevention							
<u>Education & Outreach</u>							
NAMI Contract	\$ 193,725	\$ 64,575	\$ 52,800	\$ (11,775)	\$ 193,725	\$ -	\$ 169,425
MHFA Trainings	25,000	8,333	-	(8,333)	-	-	-
TOTAL Education & Prevention	\$ 218,725	\$ 72,908	\$ 52,800	\$ (20,108)	\$ 193,725	\$ -	\$ 169,425
Evaluate & Communicate							
<u>Evaluate</u>							
CHRT Contract	\$ 60,000	\$ 20,000	\$ -	\$ (20,000)	\$ 60,000	\$ -	\$ -
<u>Communicate</u>							
CHRT Contract	\$ 300,000	\$ 100,000	\$ 6,434	(93,566)	\$ 300,000	\$ -	\$ -
TOTAL Evaluation & Communication	\$ 360,000	\$ 120,000	\$ 6,434	\$ (113,566)	\$ 360,000	\$ -	\$ -
Administration of the Millage							
WCCMH	\$ 540,000	\$ 180,000	\$ 164,000	\$ (16,000)	\$ 540,000	\$ -	\$ 555,000
CHRT Contract	140,000	46,667	1,858	(44,809)	140,000	-	150,000
Grand Totals	\$ 6,844,300	\$ 2,054,767	\$ 1,127,604	\$ (927,162)	\$ 5,349,300	\$ 580,000	\$ 3,883,905

Washtenaw County Community Mental Health - Millage Advisory Committee
Millage Partner Commitments Update - as of April 30, 2022

<u>Partner Commitments</u>	<u>Budget Category(s)</u>	<u>Service Description</u>	<u>Total Amount</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>FY22 Amount</u>	<u>FY23 Amount</u>
Avalon Housing	Supportive Housing	Permanent Supported Housing	\$180,000	10/1/2020	9/30/2022	\$180,000	\$180,000
Center for Healthcare Research and Transformation (CHRT)	Evaluate & Administer	Millage Staff Activities	\$106,640	4/1/2022	12/31/2022	\$106,640	
Center for Healthcare Research and Transformation (CHRT)	Communicate	Millage Communications Plan	\$282,888	4/1/2022	12/31/2022	\$282,888	
CLR Academy	Youth Initiatives & Support	Beyond Sports Programming	\$45,000	5/1/2022	4/30/2023	\$30,000	\$15,000
Corner Health	Other CARES Team	Psychiatry Time	remaining balance of psych time (7hrs/wk)			\$70,000	
Full Circle Community Center	Other CARES Team	Drop In Center, referral w/CARES	\$25,000	10/1/2020	9/30/2022	\$25,000	
Issue Media Group, LLC (Voices of Youth)	Youth Initiatives & Support	Youth development, mentors, supports	\$12,000	6/1/2022	5/31/2022	\$7,000	\$5,000
NAMI of Washtenaw County	Education & Outreach	Outreach, Social media campaigns, family groups	\$183,000	10/1/2021	9/30/2022	\$137,250	
NAMI of Washtenaw County	Education & Outreach	Outreach, Social media campaigns, family groups	\$225,900	10/1/2022	9/30/2023	\$56,475	\$169,425
National Assessment Center Association	CARES Team	Remote support for assessment center	\$20,650	10/1/2021	9/30/2022	\$20,650	
National Council for Behavioral Health	CARES Team	DLA-20 Training	\$12,800	10/1/2021	9/30/2022	\$12,800	
Ozone House	Youth Initiatives & Support	Psychiatry services	full balance of psych time (4hrs/wk)			\$40,000	
PCE Systems	Other CARES Team	Server for data reporting and CARES	\$117,600	10/1/2020	9/30/2022	\$88,200	
Shelter Association of Washtenaw County	Supportive Housing	COVID Crisis Stabilization - one time assistance	\$50,000	10/1/2021	9/30/2022	\$50,000	
Student Advocacy Center	Youth Initiatives & Support	Check and Connect	\$139,695	10/1/2021	9/30/2022	\$139,695	
Student Advocacy Center	Youth Initiatives & Support	Educational Advocate	\$50,500	10/1/2021	9/30/2022	\$50,500	
Teen Turn Challenge	Youth Initiatives & Support	Youth mentors and activities	\$6,180	6/1/2022	5/31/2023	\$6,180	
Washtenaw County Health Department	Youth Initiatives & Support	Anti-stigma campaign	\$340,000	5/1/2022	4/30/2024	\$113,333	\$170,000
Washtenaw County Trial Court	Criminal Justice Diversion	Trauma Therapist	remaining balance after \$85,000/yr.			\$10,000	
Washtenaw County - OCED - Homeless Diversion	Supportive Housing	One time assistance	\$30,000	1/1/2022	12/31/2022	\$30,000	
Washtenaw County - OCED - Family Empowerment	Supportive Housing	Supports Coordinator position for East side	\$210,218	1/1/2022	12/31/2022	\$69,573	\$69,573
Washtenaw County - OCED - Michigan Ability Partners	Supportive Housing	Leasing assistance and supportive services for low income, homeless,	\$357,546	1/1/2022	12/31/2022	\$357,546	
Washtenaw County - OCED - Supportive Housing RFP	Supportive Housing	Avalon, Shelter, Ozone House, Salvation Army, Ypsi Housing	\$1,200,000			\$400,000	
Washtenaw Health Plan	Other Service Expansion	Expand services in native language, outreach Latinx and youth	\$330,000	10/1/2021	9/30/2023	\$165,000	\$165,000
Washtenaw Intermediate School District	Youth Initiatives & Support	Anti-Stigma Mini Grants	\$132,000	10/1/2021	9/30/2022	\$99,000	
Washtenaw Intermediate School District	Youth Initiatives & Support	31n Match	\$81,780	10/1/2021	9/30/2022	\$61,335	
Washtenaw Intermediate School District	Youth Initiatives & Support	YMHFA Training	\$14,000	10/1/2021	9/30/2022	\$10,500	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN REGULAR BOARD MEETING MINUTES

February 9, 2022

*Meeting held electronically via Zoom



Members Present: Judy Ackley, Susan Fortney, Roxanne Garber, Molly Welch Marahar (phone), Randy Richardville (phone), Mary Serio, Sharon Slaton, Holly Terrill, Ralph Tillotson (phone)

Members Absent: Bob King, Sandy Libstorff, Katie Scott

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

Guests Present:

- I. Call to Order
Meeting called to order at 6:05 p.m. by Board Chair S. Slaton.
- II. Roll Call
 - No quorum confirmed, less than the required 7 members in attendance in person.
- III. Consideration to Adopt the Agenda as Presented
 - Tabled due to the lack of a quorum.
- IV. Consideration to Approve the Minutes of the November 10, 2021 Regular Meeting and Waive the Reading Thereof
 - Tabled due to the lack of a quorum.
- V. Audience Participation
None
- VI. Old Business
 - a. Board Review – February Finance Report – FY2022 as of December 31st
 - M. Berg presented.
- VII. New Business
 - a. Board Action – Proclamation for Greg Adams
 - K. Szewczuk provided an update on G. Adams.
 - b. Board Action – FY2022 Budget Revision
 - Tabled due to the lack of a quorum.
 - c. Board Action – FY2022 Q1 Provider Rate Adjuster Revenue
 - Tabled due to the lack of a quorum.
 - d. Board Action – FY2021 QAPIP Evaluation Summary

CMHPSM Mission Statement

Through effective partnerships, the CMHPSM shall ensure and support the provision of quality integrated care that focuses on improving the health and wellness of people living in our region.

- Tabled due to the lack of a quorum.
- e. Board Action – FY2022 QAPIP Plan Summary
 - Tabled due to the lack of a quorum.
- f. Board Action – Contracts
 - Tabled due to the lack of a quorum.
- g. Board Action – SIS Position Request
 - Tabled due to the lack of a quorum.
- h. Board Action – Operations Specialist
 - Tabled due to the lack of a quorum.
- i. Board Action – Establish CEO Review Committee
 - CEO Review Committee volunteers:
 - R. Garber. R. Tillotson and M. Serio.
 - M. Serio will chair the committee.
 - Committee will report back in March.

VIII. Reports to the CMHPSM Board

- a. Board Information – CEO Contract Authority
 - J. Colaianne provided an overview on the recent MORC contract that provides SIS training the region's newly hired SIS Assessor.
- b. Board Information - CEO Report to the Board
 - Washtenaw CMH now manages SUD access, joining Monroe, Lenawee, and Livingston CMHs in that function. Per T. Cortes, the transition has gone very well.
 - The Regional Network Management Committee has a training site that's been live since 12/1/22 that allows providers to do all of their training online. The PIHP pays less than \$100/month for the platform. J. Colaianne will send the board the link. S. Slaton requested that Mental Health First Aid be considered for the platform.

IX. Adjournment

Meeting adjourned at 6:43 p.m.

Sandra Libstorff, CMHPSM Board Secretary



**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
May 11, 2022**

Members Present: Susan Fortney, Roxanne Garber, Sandra Libstorff, Molly Welch Marahar, Mary Serio, Sharon Slaton, Holly Terrill, Ralph Tillotson

Members Absent: Judy Ackley, Bob King, Randy Richardville, Katie Scott

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

Guests Present: Derek Miller

I. Call to Order

Meeting called to order at 6:10 p.m. by Board Chair S. Slaton.

II. Roll Call

- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented

**Motion by S. Fortney, supported by R. Tillotson, to approve the agenda
Motion carried**

IV. Consideration to Approve the Minutes of the 4-13-2022 Regular Meeting and Waive the Reading Thereof

**Motion by R. Garber, supported by M. Welch Marahar, to approve the minutes of the 4-13-2022 regular meeting and waive the reading thereof
Motion carried**

V. Audience Participation

None

VI. FY2021 Audit Presentation

- Derek Miller presented the results of the FY2021 audit.

**Motion by R. Tillotson, supported by M. Serio, to accept the audit results as presented
Motion carried**

VII. Old Business

a. Board Information: April Finance Report – FY2022 as of March 31st

- M. Berg presented. Discussion followed.

b. CEO Review Committee Update

- M. Serio provided a written summary of the responses received for the CEO performance review.
- J. Colaianne will provide additional follow up as requested by the Board.

Motion by M. Serio, supported by R. Tillotson, to accept the Summary of Input for J. Colaianne's Performance Review for 2022

Motion carried

Roll Call Vote

Yes: Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill, Tillotson

No:

Absent: Ackley, King, Richardville, Scott

Motion by M. Serio, supported by R. Tillotson, to authorize S. Slaton to work with J. Colaianne on terms for the next CEO contract, with consultation from the PIHP's attorney, and to extend the contract term from 3 years to 5 years.

Motion carried

Roll Call Vote

Yes: Garber, Welch Marahar, Serio, Slaton, Terrill, Tillotson

No: Fortney, Libstorff

Absent: Ackley, King, Richardville, Scott

- S. Fortney and S. Libstorff noted that their vote was due to the 5-year term and was not a vote of opposition to offering J. Colaianne a new contract.

c. Bylaws Committee Update

- The process to revise the bylaws involves going to CMH boards for approvals.
- Rather than updating the bylaws, the Regional Board will define "attendance" in the Board Policy Manual instead. Updated language will state that a board member will only be counted as present at a meeting if they meet the Open Meetings Act quorum requirement.
- Only board members attending in person are able to participate in discussions and vote, per the Open Meetings Act. Board members attending a meeting remotely will only be able to offer comments during the Audience Participation portion of the meeting.
- The revised Board Policy Manual will be reviewed at the July Regional Board meeting.

d. Board Action: Renew Board Governance Policies

Motion by M. Welch Marahar, supported by S. Fortney, to approve the renewal of the Board Governance Policies:

- CMHPSM CEO Authority – Employee Position, Control and Compensation
- CMHPSM CEO General Scope of Authority
- Procurement
- Conflict of Interest Policy
- Investing

Motion carried

Roll Call Vote

Yes: Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill, Tillotson

No:

Absent: Ackley, King, Richardville, Scott

e. Board Information: Revised Strategic Plan Metrics

- J. Colaianne presented the revised Strategic Plan Goal metrics. Discussion followed.
- Board requested that a definition of quadruple aim be added to the document.
- M. Welch Marahar expressed some concern about the success of the change to the SUD access model in Washtenaw County, would like it to stay on the region's radar.

VIII. New Business

a. Board Action: Provider Stabilization Funding

Motion by R. Garber, supported by M. Serio, to approve the proposed allocation of funding to the CMHSPs to assist the regional provider network in delivering essential face-to-face services.

Motion carried

Roll Call Vote

Yes: Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill, Tillotson

No:

Absent: Ackley, King, Richardville, Scott

b. Board Action: Contracts

Motion by R. Tillotson, supported by R. Garber, to authorize the CEO to execute the contracts/amendments as presented

Motion carried

Roll Call Vote

Yes: Fortney, Garber, Libstorff, Welch Marahar, Serio, Slaton, Terrill, Tillotson

No:

Absent: Ackley, King, Richardville, Scott

c. Board Information: Discussion around Open Meetings Act

- Board discussed and declined to add a second opportunity for public comment to the board agendas going forward.

IX. Reports to the CMHPSM Board

a. No report from the SUD Oversight Policy Board, which didn't meet in April.

b. Board Information: CEO Report to the Board

- The office will move to the fully open phase on May 30.
- A Request for Quotes (RFQ) has been released for auditing services.
- Legislation: any movement on the proposed bills related to the public mental health system will probably not have any movement before fall.

X. Adjournment

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

Motion carried

Meeting adjourned at 7:26 p.m.

Sandra Libstorff, CMHPSM Board Secretary

2022 WCCMH Board and Board Committees/Officers

4/1/22-3/31/23

ATTACHMENT #6

JUNE 2022

	term expires	Executive (meets bi-monthly)	Quality-Finance (meets bi-monthly)	CMHPSM (meets monthly)	Officers
Suzie Antonow	3/31/2023	X	X		Board Vice-Chair/Quality-Finance Committee Chair
Anna Dusbiber	3/31/2024	X	X		Board Secretary
Nancy Graebner-Sundling	3/31/2024	X	X		Board Treasurer/Quality-Finance Committee Co-Chair & Millage Advisory Committee Chair
Barbara Higman	3/31/2023		X		
Ricky Jefferson	3/31/2023				
Bob King	3/31/2025	X		X	
Andy LaBarre	3/31/2025	X			
Alfreda Rooks	3/31/2025			X	
Katie Scott	3/31/2025			X	
Douglas Strong	3/31/2023		X		
Marianne Udow-Phillips	3/31/2024		X		
Kari Walker	3/31/2024	X			Board Chair/Executive Committee Chair

total CMH Board members assigned to Committees	6	6	3
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# members required for committee-per Bylaws		6 (4 officers, 2 additional board members and immediate past board chair) (Executive Director is an ex-officio member)	5 (Vice Chair & Treasurer and not less than 3 other Board members)	3 (per PIHP)
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Quorum for committees		4/6	4/6
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Quorum for Board is 7/12

2022 WCCMH Board and Board Committees/Officers
4/1/22-3/31/23

ATTACHMENT #6
JUNE 2022

Millage Advisory Committee (MAC) (meets monthly)		
Nancy Graebner-Sundling (Chair)	3/31/2024	WCCMH Board (St. Joseph Mercy Hospital)
Barb Higman	3/31/2023	WCCMH Board (Primary Consumer)
Ricky Jefferson	3/31/2023	WCCMH Board (Board of Commissioners)
Alfreda Rooks	3/31/2025	WCCMH Board (University of Michigan)
Marianne Udow-Phillips	3/31/2024	WCCMH Board (Community Member)
Kari Walker	3/31/2024	WCCMH Board (Secondary Consumer)
Amanda Carlisle	3/31/2025	Washtenaw Housing Alliance
Holly Heaviland	3/31/2024	Washtenaw Intermediate School District
Derrick Jackson	3/31/2023	Washtenaw County Sheriff's Office Liaison
Ray Rion	3/31/2023	Packard Health
George Waddles, Jr.	3/31/2025	Community Member

Quorum for Millage Advisory Committee		6/11
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Please email wccmhboard@washtenaw.org for questions and/or concerns



Washtenaw County Community Mental Health Strategic Plan 2022- 2027

Draft

MISSION

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

VISION

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

VALUES

Excellence

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

Growth

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

Well-being

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

Inclusion

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

Community

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

Accountability

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

Equity

Services will be delivered with a focus on eliminating health inequities by addressing and reducing the racial and economic disparities frequently impacting Black, Indigenous and People of Colors' health status, access, and outcomes.

Environmental Drivers

Access to Care

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

Performance/Quality

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

Expansion of Services

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

Other Drivers

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

STRATEGIC GOALS

Ensure availability of behavioral health services through a single point of entry.

Tactic:

- Create a single point of entry for behavioral health services for individuals with substance use disorder, mental illness, or intellectual/developmental disabilities
Completed by: January 2023
Responsible Party: Melisa Tasker
Measurement: TBD work PIHP on evaluation criteria
- Establish and strengthen care coordination agreements to develop a behavioral health network of safety net providers in Washtenaw County
Completed by: January 2025
Responsible Party: Trish Cortes, Heather Linky, Dr. Florence
Measurement: Care Coordination with key stakeholders. Examples may include Packard Health, Corner Health, Ozone, Catholic Social Services, Jewish Family Services, etc.

Promote wellness through the integration of physical and behavioral health.

Tactic:

- Achieve successful implementation of State of Michigan Behavioral Health Home
Completed by: October 2023
Responsible Party: Brandie Hagaman, Michael Harding
Measurement: 200 Washtenaw County individuals enrolled through the State of Michigan. Ongoing qualitative measure TBD in partnership with the State of Michigan.
- Complete and successfully implement State of Michigan Certified Community Behavioral Health Clinic (CCBHC)
Completed by: October 2023
Responsible Party: Michael Harding
Measurement:
 1. Successful State certification
 2. 95% of individuals receiving qualified CCBHC services are enrolled in in the State Demonstration.
 3. xx% of the number of individuals requesting services that are assessed for medical necessity are provided services either through community partnerships or directly

Provide an array of crisis services that promotes care in the least restrictive setting.

Tactic:

- Complete full implementation of crisis 23 Hour Observation site
Completed by: January 2023
Responsible Party: Melisa Tasker
Measurement: Maintain monthly capacity of 80%
- Partner in the development of a community plan to establish a youth assessment center
Completed by: January 2024
Responsible Party: Trish Cortes, Lisa Gentz
Measurement: Presentation of the community plan to the WCCMH board
- Implementation of Law Enforcement Assisted Diversion/Deflection (LEADD) in partnership with community stakeholders
Completed by: January 2022
Responsible Party: Trish Cortes, Lisa Gentz
Measurement: TBD CHRT Evaluation
- In partnership with Washtenaw County Sherriff's office, develop protocols for metro dispatch to deploy a mobile mental health crisis team as an alternative to law enforcement response.
Completed by: January 2024
Responsible Party: Trish Cortes, Lisa Gentz
Measurement: TBD Chicago Health Labs evaluation

Braid diversified revenue streams to support prevention, treatment, outreach, and equitable access to behavioral health services.

Tactic:

- Expand youth services through outreach and partnerships by leveraging all funding streams
Completed by: January 2025
Responsible Party: Trish Cortes, Lisa Gentz
Measurement: Either directly or through agreements increase youths served by 25%
- Expand the adult service array through primary care agreements
Completed by: January 2024
Responsible Party: Trish Cortes, Dr. Florence
Measurement: Agreements with primary care safety net clinics.
- Implement 31N WISD School Mental Health Project to expand services within Washtenaw School districts.
Completed by: January 2023
Responsible Party: Trish Cortes, Lisa Gentz
Measurement: Number of schools receiving mental health resources
- Prioritize available resources to broaden outreach, education, and prevention efforts to address health inequities
Completed by: January 2025

Responsible Party: Trish Cortes, Lisa Gentz

Measurement: Number of community events and trainings in geographic areas of need. No show rates for African Americans

Improve recruitment and retention of the behavioral health workforce.

Tactic:

- Advocate with MDHHS leadership and legislators to address behavioral health workforce shortages
Completed by: January 2025
Responsible Party: Trish Cortes
Measurement: Additional funding allocated from the State for behavioral health staffing or decrease vacancies from 10% to 5%.
- Collaborate with Washtenaw County administration and labor partners to strategize local efforts
Completed by: January 2025
Responsible Party: Trish Cortes, Nicole Phelps, Sally Amos O'Neal
Measurement: County Implementation of MAG Study
- Partner with provider network to address direct care workforce challenges
Completed by: January 2022
Responsible Party: Heather Linky
Measurement: Implementation of direct care worker training reciprocity and/or increased funding for direct care workers.

Thank you to the following groups that contributed to the WCCMH Strategic Plan:

Consumer Advisory Group
WCCMH All Staff
WCCMH Board
WCCMH Millage Advisory Group
WCCMH Black Lives Matter Taskforce
WCCMH Recipient Rights Committee
WCCMH Provider Network

The Following reports informed the WCCMH Strategic Plan:

CHRT Behavioral Health Environmental Analysis
Unite Report
WCCMH Staff Survey
Millage Advisory Committee Survey Results