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/94254655041
December 12, 2022
3:00 – 5:00 PM

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-11/18/22 (Attachment #1A)

V. Treasurer's Report **ACTION** (10 minutes)
- Financial Status Report (Attachment #2) **N. Phelps ACTION**

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

VII. CMHPSM Regional Update (5 minutes)

VIII. New Business (60 minutes)
- Legislative Advocacy Discussion **T. Cortes**
  - Strengthening Partnerships between MDHHS and the Community Based Mental Health System (Attachment #3)
  - Proposals to Address Michigan's BH Workforce Shortage (Attachment #3A)

IX. Old Business (10 minutes)
- August 26, 2022, Closed Session Minutes (Distributed at the Meeting) **ACTION**
- November 18, 2022, Closed Session Minutes (Distributed at the Meeting) **ACTION**

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**

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.

VIRTUAL MEETING LINK IS:

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. https://zoom.us/j/94254655041

Or One tap mobile:
+19292056099, 94254655041# US (New York)
+12678310333, 94254655041# US (Philadelphia)

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

Webinar ID: 942 5465 5041

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

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

DECEMBER 12, 2022

CONSENT AGENDA

A. WCCMH Board Meeting Minutes and Actions-11/18/22 (Attachment #1A)

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/94232762360
November 18, 2022
9:30am

K. Walker called the meeting to order at 9:36 am.

ROLL CALL:	A. Dusbiber attending virtually N. Graebner-Sundling attending in person B. Higman attending in person B. King attending in person A. LaBarre attending in person A. Rooks attending virtually D. Strong attending virtually M. Udow-Phillips attending in person K. Walker attending in person
MEMBERS ABSENT:	S. Antonow; K. Scott; R. Jefferson
STAFF PRESENT:	T. Cortes, M. Harding, H. Linky, N. Phelps, R. Dornbos, K. Onyskin, S. Hungerford, N. Testorelli, D. Weston, M. Taylor, T. Gavalier, E. George, B. Hagaman, K. DeWeese, M. Hershberger, S. Ray
OTHERS PRESENT:	C. Reuben, L. Lutomski, K. Homan

I. Introductions
- None

II. Audience Participation
- K. Grahalva, addressed the Board regarding Washtenaw Lifespan, a new group organized by I/DD Families.
- C. Lirones addressed the Board requested that K. Walker attend the Washtenaw Lifespan meetings.

III. Board response to audience participation
- K. Walker responded to audience participation regarding the composition of the Board regarding primary and secondary consumers.
- A. LaBarre responded to audience participation noting the BOC will be making new appointments to the board in January.

IV. Consent Agenda Actions (Attachment #1)
- WCCMH Board Meeting Minutes and Actions-8/26/22 (Attachment #1A)
- WCCMH Quality-Finance Committee Meeting Minutes and Actions-8/8/22 (Attachment #1B)
- WCCMH Millage Advisory Committee Meeting Minutes and Actions-8/8/22 (Attachment #1C)
- WCCMH Executive Committee Meeting Minutes and Actions 5/9/22 (Attachment #1D)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-8/10/22 (Attachment #1E)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-9/14/22 (Attachment #1F)
- WCCMH Fall 2021 Staff Quarterly Newsletter (Attachment #1G)
- WCCMH 2023 Annual Board/Committee Meeting Schedule (Attachment #1H)
- CMHPSM Psychotropic Medication Orders and Consents Policy (Attachment #1I)
- CMHPSM Sanctions for Breaches of Security or Confidentiality Policy (Attachment #1J)

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE NOVEMBER 18, 2022, WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

V. Treasurer's Report

- WCCMH Financial Status Report
  - N. Phelps presented the Financial Status Report to the Board for the period ending August 31, 2022. (Attachment #2).

MOTION BY A. LABARRE, SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT AND APPROVE THE WCCMH FINANCIAL STATUS REPORT AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- WCCMH Millage and CCBHC Financial Status Report
  - N. Phelps presented the Millage and CCBHC financial status reports for FY22 (Attachment #3)

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE WCCMH MILLAGE AND CCBHC FINANCIAL STATUS REPORT FOR FY22 AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

VI. Executive Director report

- T. Cortes presented the Executive Director report to the WCCMH Board.
  - Conversations around establishing behavioral health policy committee at the state level. Suggestion to work on a strategy for what Washtenaw County might be interested in contributing to this group. Future agenda item for Executive and/or full board meeting to discuss the behavioral health policy committee at the state level.
  - Consumer Celebration of Success was a phenomenal event with all populations represented. S. Amos-O'Neal and M. Hershberger along with the CAC group did a great job putting on this event.

VII. CMHPSM Regional Update

- T. Cortes presented the CMHPSM Regional Update to the Board.
  - B. King is now chair of the PIHP Board

VIII. New Business

- Recruitment Pilot for Direct Care Workers
  - H. Linky presented the update on the Recruitment Pilot for Direct Care Workers.
  - WCCMH and the Provider Advisory Group have been collaborating on the pilot.

- WCCMH Recruitment and Retention (Attachment #4)
  - T. Cortes presented the WCCMH Recruitment and Retention presentation.
-
- Consumer Advisory Council Update
  - M. Hershberger and B. Higman presented the Consumer Advisory Council Update to the Board.

IX. Old Business

- None

X. Items for future discussion

- Behavioral health policy committee discussion.
- Youth Assessment Center

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY N. GRAEBNER-SUNDLING TO MOVE THE WCCMH BOARD MEETING TO CLOSED SESSION.

ROLL CALL VOTE:

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

MEETING MOVED TO CLOSED SESSION AT 11:10 AM.

MOTION BY A. LABARRE SUPPORTED BY M. UDOW-PHILLIPS TO ADJOURN CLOSED SESSION
Closed session ended at 11:45AM.

PUBLIC MEETING RESUMED AT 11:46 AM

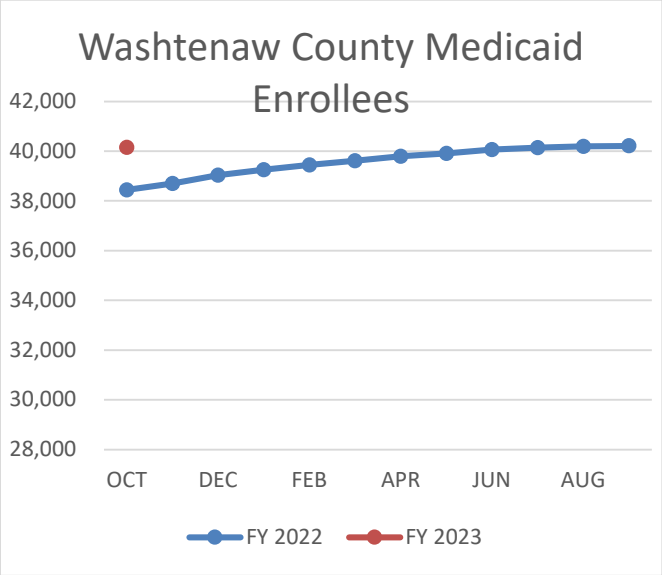
MOTION BY K. WALKER SUPPORTED BY M. UDOW-PHILLIPS TO ADJOURN THE WCCMH BOARD MEETING.

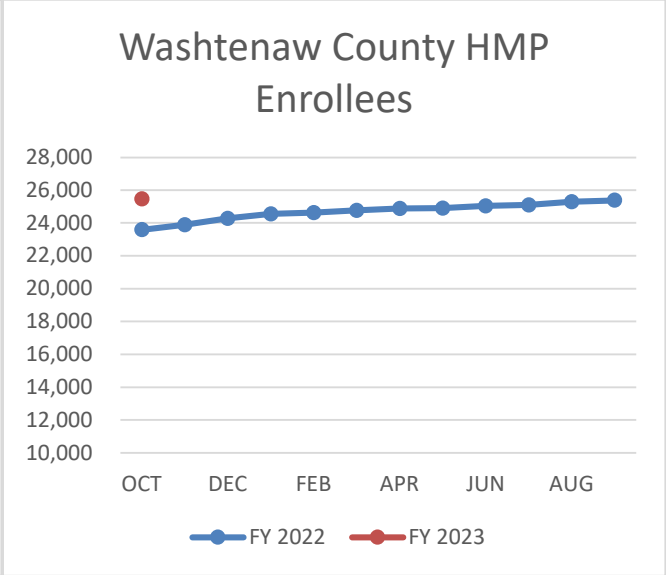
Meeting adjourned at 11:49 AM.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2023: For the period ending October 31, 2022
Prepared: December 9, 2022

1. Washtenaw County Enrollees

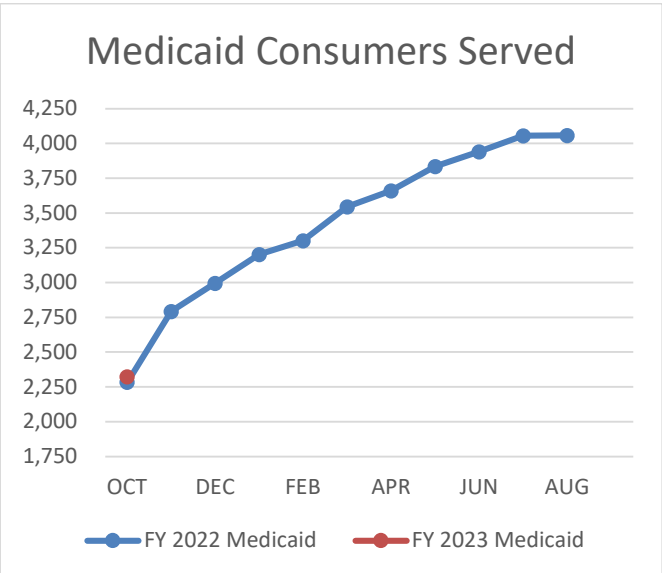
A summary of FY 2023 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

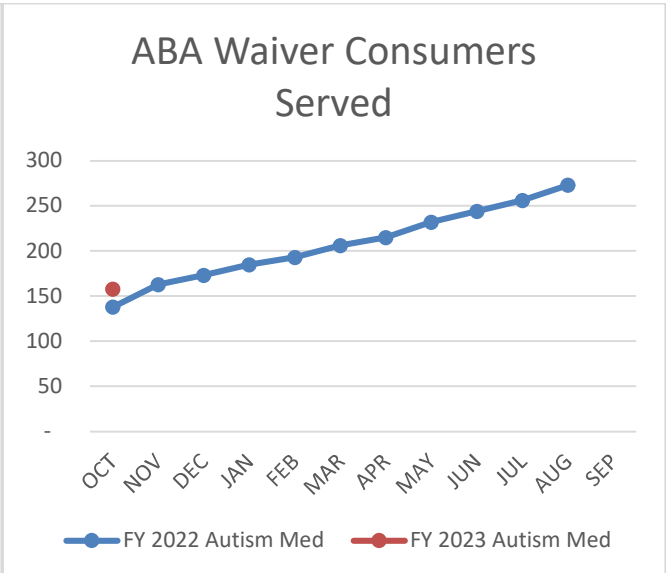




Washtenaw County Medicaid Enrollees were 40,154 in October 2022. This is a 4.44% increase from the same time last year (1,707 more enrollees than in October 2021). Healthy Michigan enrollment in October 2022 was 25,467. This is a 7.93% increase from the same time last year (1,871 more enrollees than in October 2021).

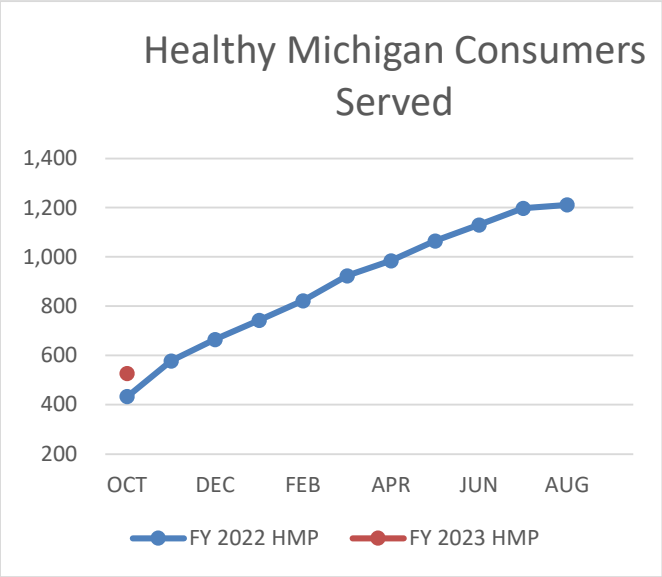
2. WCCMH Consumers Served to Date

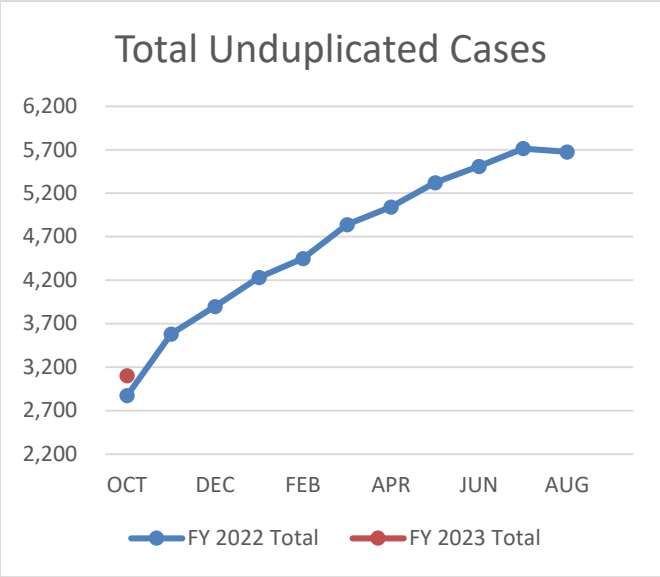




Medicaid consumers served through October 2022 are 2,324. This is 40 more consumers than the prior year (2,284 consumers were served through October 2021).

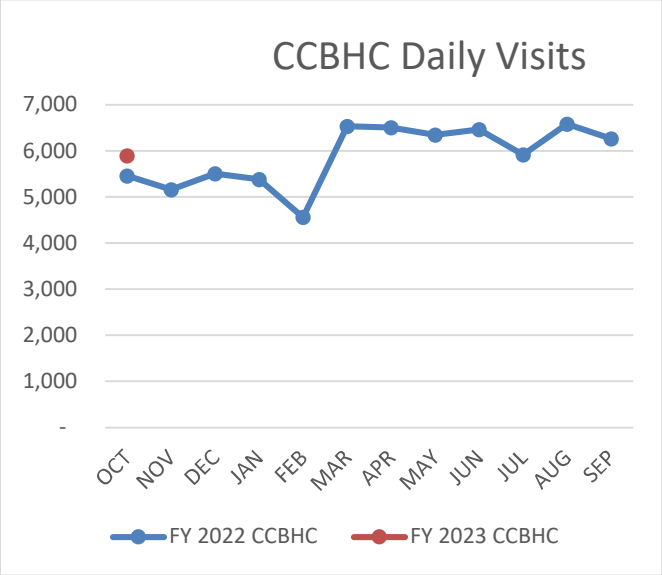
ABA Waiver consumers served through October 2022 are 158. This is 20 more consumers than prior year (138 consumers were served through October 2021).

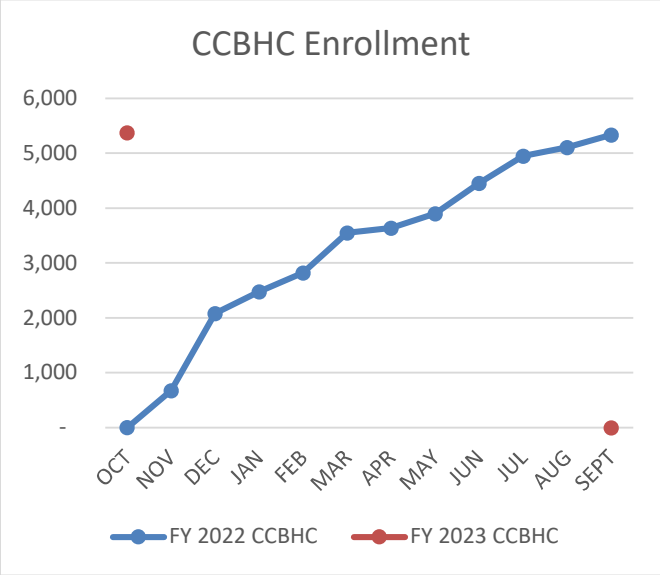




Healthy Michigan consumers served through October 2022 were 528. This is 94 more consumers than the same period last year.

The total unduplicated consumers served by WCCMH through October 2022 were 3,103. This is 228 more consumers than served last year.





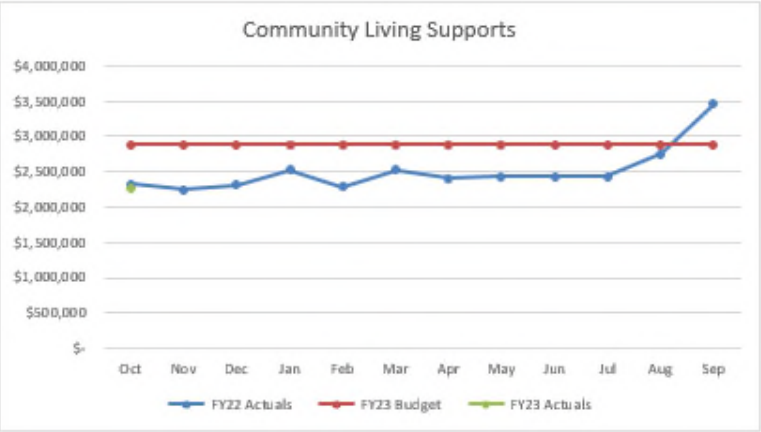
The CCBHC daily visit count for October 2022 were 5,895.

The YTD CCBHC Enrollment for FY 2023 as of October 2022 was 5,376.

3. Financial Statement Highlights

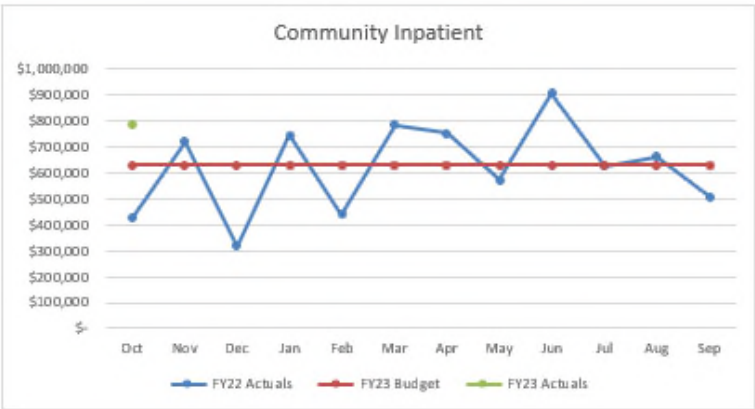
a. CLS service costs to date are estimated to be $2.2 Million. The costs year to date are 3% less than this time last year. A 5% increase to CLS rates has been implemented as of 10/1/2022.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 2,325,336	2,883,333	$ 2,259,224	-2.84%
Nov	2,240,096	2,883,333		
Dec	2,317,212	2,883,333		
Jan	2,524,996	2,883,333		
Feb	2,285,682	2,883,333		
Mar	2,529,180	2,883,333		
Apr	2,406,148	2,883,333		
May	2,431,396	2,883,333		
Jun	2,431,870	2,883,333		
Jul	2,436,133	2,883,333		
Aug	2,746,122	2,883,333		
Sep	3,451,817	2,883,333		



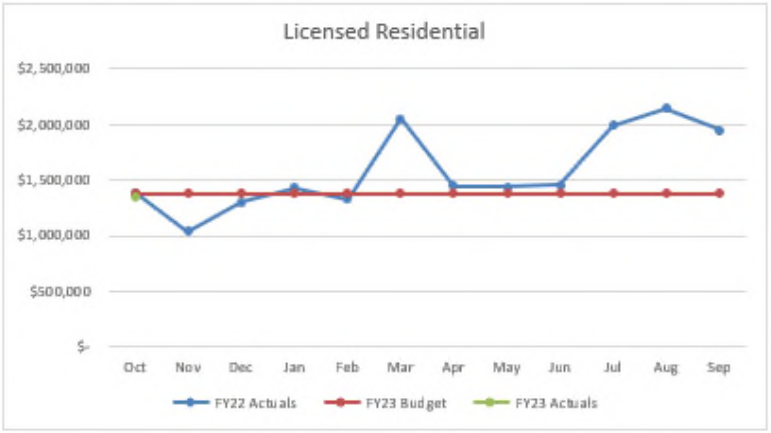
b. Community Inpatient costs to date are $783,000. The costs year to date are 82.82% more than this time last year and $154,000 over budget.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 428,747	$ 629,167	$ 783,838	82.82%
Nov	719,608	629,167		
Dec	318,967	629,167		
Jan	745,851	629,167		
Feb	438,634	629,167		
Mar	785,399	629,167		
Apr	751,136	629,167		
May	572,488	629,167		
Jun	904,625	629,167		
Jul	624,231	629,167		
Aug	661,279	629,167		
Sep	508,767	629,167		



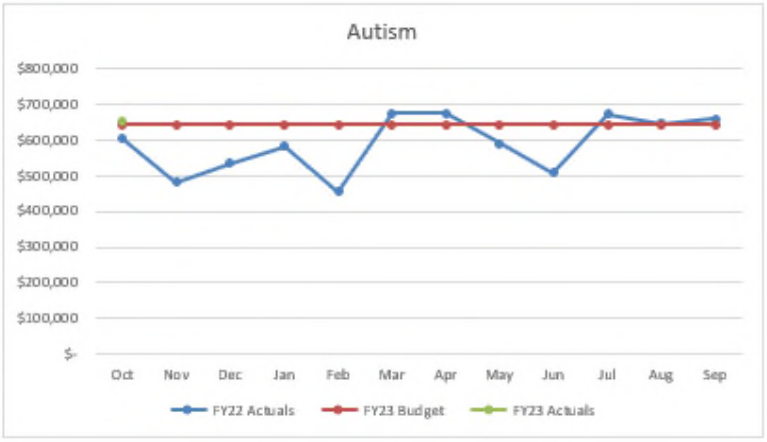
c. Licensed Residential costs to date are $1.34 Million and $34,000 under budget. The costs year to date are 2.74% less than this time last year. A 5% increase was implemented as of 10/1/2022 for local providers.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 1,386,550	$ 1,383,333	$ 1,348,498	-2.74%
Nov	1,038,733	1,383,333		
Dec	1,304,777	1,383,333		
Jan	1,429,675	1,383,333		
Feb	1,325,725	1,383,333		
Mar	2,048,936	1,383,333		
Apr	1,451,576	1,383,333		
May	1,437,448	1,383,333		
Jun	1,454,128	1,383,333		
Jul	1,995,132	1,383,333		
Aug	2,141,085	1,383,333		
Sep	1,952,399	1,383,333		



d. Applied Behavior Analysis/Autism service costs to date are $648,000. The costs year to date are 29.10% more than this time last year and $7,100 over budget.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 602,553	$ 641,667	$ 648,805	7.68%
Nov	479,479	641,667		
Dec	534,172	641,667		
Jan	580,372	641,667		
Feb	453,979	641,667		
Mar	672,143	641,667		
Apr	674,225	641,667		
May	587,988	641,667		
Jun	508,069	641,667		
Jul	670,422	641,667		
Aug	643,331	641,667		
Sep	658,111	641,667		



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 $1.8 Million through October.
c. By funding source, HMP is showing a deficit of $5,900 through October.
d. Overall, the PIHP surplus is $1.2 Million through October.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a surplus of $271,000.

6. Local Key Points

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

b. Local Funds are showing a surplus of $381 through October.

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 2023.

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

		Total
Medicaid **		
Revenue		
B & B3	$	4,826,845
HSW		2,238,219
DCW		-
Behavioral Health Home		1,872
Child Waiver/SED Waiver		85,962
Autism		539,616
Prior Year Adjustments		-
Care for Caid		-
Total Medicaid Revenue	$	7,692,513
Total Medicaid Expense	$	5,851,644
Medicaid Surplus/(Deficit)	$	1,840,869
CCBHC **		
Revenue	$	752,290
Expense		1,356,059
CCBHC Surplus/(Deficit)	$	(603,769)
Healthy Michigan **		
Revenue	$	576,114
Expense		582,024
Healthy MI Surplus/(Deficit)	$	(5,910)
General Fund		
Revenue		
CMH Operations	$	383,139
CMH Operations Contra		-
GF Carryforward		-
Categorical		-
Redirect To Injectable Meds.		-
Funding Fr. Other Local Sources		743
Total General Fund Revenue	$	383,882
Total General Fund Expense	$	112,456
General Fund Surplus/(Deficit)	$	271,426
Injectable Meds		
Revenue	$	22,754

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

		Total
Expense		16,539
Inj. Meds. Surplus/(Deficit)	$	6,215
Grants And Contracts		
Revenue	$	179,038
Expense		179,038
Grants & Cont. Surplus/(Deficit)	$	-
CMHSP To CMHSP		
Revenue	$	69,998
Redirect to GF		(743)
Expense		69,256
CMHSP to CMHSP Surplus/(Deficit)	$	-
Local		
Revenue	$	128,925
Expense		128,544
Local Surplus/(Deficit)	$	381
Private Grant & All NOR		
Revenue	$	927
Expense		-
Priv. Grant & NOR Surplus/(Deficit)	$	927
Grand Total		
Revenue	$	9,814,574
Expense		8,304,435
Grand Total Surplus/(Deficit)	$	1,510,138

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	1,237,404
WCCMH Surplus/(Deficit)		272,734
	$	1,510,138

Washtenaw County Community Mental Health
Budget to Actuals
For One Month Ending October 31, 2022

	Current Fiscal Year				
	FY 2023 Approved Budget	FY 2023 Approved Budget YTD	FY 2023 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 48,979,046	$ 4,081,587	$ 4,826,845	$ 745,258	18.26%
HSW	30,058,737	2,504,895	2,238,219	(266,676)	-10.65%
Children & SED Waivers	1,200,000	100,000	85,962	(14,038)	-14.04%
Healthy Michigan Capitation	6,913,368	576,114	576,114	-	0.00%
Autism Capitation	6,475,395	539,616	539,616	(0)	0.00%
Direct Care Worker Pass-Through	9,263,483	771,957	-	(771,957)	-100.00%
CCBHC Supplementary	4,059,000	338,250	752,290	414,040	122.41%
Behavioral Health Home	-	-	1,872	1,872	0.00%
TOTAL PIHP Revenue	$ 106,949,029	$ 8,912,419	$ 9,020,918	$ 108,499	1.22%
MDHHS Revenue					
State General Funds	$ 4,597,669	$ 383,139	$ 383,139	$ (0)	0.00%
Grants & Earned Contracts	1,790,168	149,181	117,639	(31,542)	-21.14%
All Other Revenue					
County Appropriation	$ 1,751,761	$ 145,980	$ 46,574	$ (99,406)	-68.10%
Project Revenue	847,984	70,665	55,328	(15,337)	-21.70%
All Other	1,917,652	159,804	252,391	92,587	57.94%
TOTAL Operating Revenue	**$ 117,854,263**	**$ 9,821,189**	**$ 9,875,989**	**$ 54,800**	0.56%
Operating Expenses					
Administrative Expenses					
General Administration	$ 7,733,373	$ 644,448	$ 541,743	$ (102,705)	-15.94%
Program Administration	4,150,194	345,850	267,424	(78,426)	-22.68%
Residential Services					
Community Living Supports	$ 34,600,000	$ 2,883,333	$ 2,029,730	$ (853,603)	-29.60%
Licensed Residential	16,600,000	1,383,333	1,348,498	(34,835)	-2.52%
Outpatient Services					
Autism Services	$ 7,700,000	$ 641,667	$ 648,805	$ 7,138	1.11%
Case Management	5,750,761	479,230	379,199	(100,031)	-20.87%
Supports Coordination	3,243,708	270,309	196,483	(73,826)	-27.31%
Skill Building	5,004,548	417,046	301,777	(115,269)	-27.64%
Supported Employment	1,556,862	129,739	133,596	3,858	2.97%
Psychiatry	4,134,073	344,506	307,208	(37,298)	-10.83%
Nursing Services	2,659,925	221,660	174,278	(47,382)	-21.38%
Therapy Services	2,758,751	229,896	183,545	(46,351)	-20.16%
All Other	11,339,062	944,922	825,214	(119,708)	-12.67%
Other Expenses					
Community Inpatient	$ 7,550,000	$ 629,167	$ 783,838	$ 154,671	24.58%
Local Matches & Shelter	1,282,838	106,903	127,459	20,556	19.23%
Grants & Earned Contracts	1,790,168	149,181	117,053	(32,128)	-21.54%
TOTAL Operating Expenses	**$ 117,854,263**	**$ 9,821,189**	**$ 8,365,850**	**$ (1,455,339)**	-14.82%
Revenue Over/(Under) Expenses	-	-	1,510,139	1,510,139	

Washtenaw County Community Mental Health
Budget to Actuals
For One Month Ending October 31, 2022

	Prior Year Comparison			
	FY 2023 YTD Actuals	FY 2022 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 4,826,845	$ 3,721,479	$ 1,105,366	29.70%
HSW	2,238,219	2,313,068	(74,849)	-3.24%
Children & SED Waivers	85,962	231,483	(145,521)	-62.86%
Healthy Michigan Capitation	576,114	523,740	52,374	10.00%
Autism Capitation	539,616	490,560	49,056	10.00%
Direct Care Worker Pass-Through	-	668,361	(668,361)	0.00%
CCBHC Supplementary	752,290	345,815	406,475	0.00%
Behavioral Health Home	1,872	-	1,872	0.00%
TOTAL PIHP Revenue	$ 9,020,918	$ 8,294,506	$ 726,412	8.76%
MDHHS Revenue				
State General Funds	$ 383,139	$ 352,920	$ 30,219	8.56%
Grants & Earned Contracts	117,639	145,388	(27,749)	-19.09%
All Other Revenue				
County Appropriation	$ 46,574	$ 46,574	$ -	0.00%
Project Revenue	55,328	60,328	(5,000)	-8.29%
All Other	252,391	208,317	44,074	21.16%
TOTAL Operating Revenue	**$ 9,875,989**	**$ 9,108,033**	**$ 767,956**	8.43%
Operating Expenses				
Administrative Expenses				
General Administration	$ 541,743	$ 423,404	$ 118,339	27.95%
Program Administration	267,424	220,180	47,244	21.46%
Residential Services				
Community Living Supports	$ 2,029,730	$ 2,505,038	$ (475,308)	-18.97%
Licensed Residential	1,348,498	1,386,550	(38,052)	-2.74%
Outpatient Services				
Autism Services	$ 648,805	$ 502,553	$ 146,252	29.10%
Case Management	379,199	310,006	69,193	22.32%
Supports Coordination	196,483	153,968	42,515	27.61%
Skill Building	301,777	257,878	43,899	17.02%
Supported Employment	133,596	98,399	35,197	35.77%
Psychiatry	307,208	225,060	82,148	36.50%
Nursing Services	174,278	167,297	6,981	4.17%
Therapy Services	183,545	135,528	48,017	35.43%
All Other	825,214	549,869	275,345	50.07%
Other Expenses				
Community Inpatient	$ 783,838	$ 428,745	$ 355,093	82.82%
Local Matches & Shelter	127,459	148,833	(21,374)	-14.36%
Grants & Earned Contracts	117,053	145,388	(28,335)	-19.49%
TOTAL Operating Expenses	**$ 8,365,850**	**$ 7,658,696**	**$ 707,154**	9.23%
Revenue Over/(Under) Expenses	1,510,139	1,449,337	60,802	

Community Mental Health Association of Michigan

Advancing Michigan's mental health system by strengthening the partnership between MDHHS and Michigan's community based mental health system [1]

September 2022

This document, developed by the Community Mental Health Association of Michigan (CMHA) and its members, outlines a number of recommendations designed to advance the state's public mental health system by strengthening the partnership between the Michigan Department of Health and Human Services (MDHHS) and the state's community based mental health system – the state's Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP), and the private providers in the networks of the state's CMHSPs and PIHPs. These parties - MDHHS and the community-based mental health system - make up the state's public mental health system.

The nationally recognized development, design, and work of Michigan's public mental health system have been the result of a number of factors, **chief among them the longstanding partnership between the State of Michigan and the state's community based mental health system**. Given this, steps to strengthen that relationship are outlined below.

Partnership strengthening and system advancement recommendations

Below is a set of **concrete recommendations**, designed to address the observations cited above.

Given the urgency of the issues faced by the system and the growing needs of Michiganders for ready access to high quality mental health care, these recommendations are **not intended as long term goals, but, instead, as actions to be taken immediately and in the near future.**

1. Vision of public system – co-developed and widely circulated: The changing healthcare landscape in Michigan and across the country (with the emergence of a number of innovative clinical, financing, and partnering developments), the impact of the COVID pandemic, the reorganization of the behavioral health operations within MDHHS, and growing recognition, among Michiganders, of the central importance of mental health and mental health care call for a clear vision for the state's public mental health system.

Such a vision, containing concrete actions to fulfill that vision, and widely circulated:

- Is key to the advancement of the state's public mental health system
- Will close the currently existing vision vacuum that invites a range of system change and redesign proposals that are, at times, well-intended but not linked to sound practice, financing, nor structure nor to the desires articulated by the persons served by that system.
- Unifies the work of the system by preventing system fragmentation, and project conflict, and a sense of continual system threat or erosion

[1] For ease in reading, the terms "mental health system" and "behavioral health system", when used in this document, refer to the system that serves persons with mental illness, emotional disturbance, intellectual/developmental disabilities, and persons with substance use disorders.

This vision, to be sound and supported by the large and diverse set of system stakeholders, should be co-developed, under the leadership of MDHHS, by MDHHS, representatives of the community based system, and representatives of other stakeholder groups, develop a written vision for the state's public mental health system.

2. Designate behavioral health lead within MDHHS: Clearly identify the lead, within MDHHS, for the department's behavioral health (BH and IDD) work. This person would: hold the responsibility and authority for the Department's mental health work; serve as the point person, within the Department, for the system; have the responsibility for ensuring that the efforts led by MDHHS, on the behavioral health front are driven by the co-developed vision for the state's public mental health system; ensure that the Department's behavioral efforts are in sync with each other and not in conflict.

3. Focus on a small number of high leverage efforts: MDHHS to prioritize its major initiatives, relative to the community system, to focus on a smaller number of issues and initiatives – driven by the vision described above. This effort would prioritize those of central importance to the work of that system and those with the greatest potential positive impact on the system and those served by the system. This prioritization would be driven by a focus on the persons served – their access to quality care, health, safety, and their experience of care/services/supports.

Such prioritization is key in recognition of the system's scarce staff and time resources must be focused on core issues and not fragmented and depleted with the pursuit of more minor, less central issues.

With such prioritization, MDHHS and the community based system will be able to allocate staff and other resources to those prioritized issues, leaving other initiatives, with lower priority, in abeyance until significant progress has been made on the high priority issues and projects.

4. Use of a co-development approach to policy and practice development and decision making: Based on the view that MDHHS and the community-based mental health system are partners, pursue a co-development approach to policy and practice development and implementation.

The co-development approach is based on several assumptions:

- MDHHS holds the final responsibility, authority, and expertise for a range of issues
- The community system holds a parallel set of responsibilities, authorities, and expertise on many if not all of these issues. This expertise is grounded in years of experience in the field and the current real-time knowledge of the behavioral health needs of their communities and the dynamics within their organizations and their communities.
- Integrating these responsibilities, authority, and expertise into the decision making process will ensure a sound and actionable set of policies and practices

This approach consists of two components:

A. MDHHS drawing in subject matter experts, from the community system, through the appointment to MDHHS workgroups of staff identified by CMHA and its members, with those representatives of the system being seen as active participants (not merely advisors) in a process that is open to revision and refinement of the aim, content, and core premises and constructs of proposed policies or practices.

B. A parallel se of regular discussions with CMHA and the leaders of the state's CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks, of the progress of these co-development efforts. This discussion would be an active dialogue with the aim of integrating the views, revisions of the draft policy and/or practices, and alternate approaches, raised by these system leaders, on the content and core premises and constructs of the emerging policies and practices – views that only leaders can provide, given their organization-wide and system-wide perspective.

This co-development approach leads to the timely development of sound, inclusive, dialogue-rich, transparent and actionable/realistic policies, practices, and decisions.

5. Identify, for each MDHHS initiative, a clear lead and decision maker: A single lead for each MDHHS initiative – and, where appropriate, the lead for the community based system on these initiatives - would improve the clarity of the decision making process, the timeliness of that process. This lead, while holding the final responsibility and authority for a given initiative, could, of course, work with a team within MDHHS to guide that decision making.

The designation of a single lead for a given initiative would:

- Foster real-time dialogue and the prompt resolution of issues, as part of – and not outside of – the dialogue or workgroup process
- Provide a reliable source for the provision of answers to questions, from the field, on policy or initiative development and implementation.
- Clarify from whom the written confirmation of a decision, related to a given initiative, is to come and, when needed, changes to that decision.

6. Ensure that all involved recognize the unique government-to-government relationship between MDHHS and the community based system and the foundational constructs of this relationship: Ensure that all involved in the leadership of the state's public mental health system – MDHHS and the community based system have a clear understanding of the fact that the MDHHS relationship with the CMHSPs and PIHPs is a government-to-government partnership relationship – one intentionally designed to be a system with each party playing a key role - and not a payer-to-vendor relationship.

This relationship is the foundation of the system and has been for been for the past fifty years. In addition to the description of this relationship in statute, this government-to-government relationship has been reiterated, since 1997, in the Medicaid managed care waivers that undergird the state's Medicaid managed behavioral healthcare system.

This relationship drives contracting, contract negotiations, system financing and every part of the work of the MDHHS-community based system partnership.

Additionally, it is key that the leaders and staff of MDHHS and the community based system have a sound grasp of core constructs of Michigan's unique system – constructs contained in a range of archival sources – including :

- The history and context of the state's Medicaid waivers
- The formation of the state's PIHP system (as public/governmental regional entities created and governed by the state's CMHSPs)
- The breadth of roles played by the CMHSP and PIHP systems, as outlined in statute, rule, Medicaid waivers, and contracts

- The value of the modern/pioneering capitation payment system that is at the heart of the financing of the state's community based system.

The development of such a common understanding could be done as part of the policy and practice co-development efforts or through dialogues built specifically around the development of this common understanding.

7. Ensure that all parties, within and outside of MDHHS, are aware of key initiatives and their development to avoid conflict or duplication: Develop cross-project communication and coordination systems to ensure that MDHHS-led initiatives are working complementarily and not at cross nor duplicative purposes.

8. Collaborative legislative advocacy between MDHHS and the community system: MDHHS, CMHA and its members and allies should plan and carry out joint legislative, public, and media advocacy on a range of issues.

9. MDHHS to ensure that it retains expertise and authority even when using outside consultants: It is key that MDHHS, in partnership with the community based system, works to retain the expertise and authority of MDHHS, even when outside consultants are used to provide technical expertise.

10. Use of external management and process consultants: Use ARPA and COVID-relief dollars to bring in consultants to strengthen the project management, cross-project communication, and co-development skills of MDHHS and the community based system.

11. Joint media relations touting strength of system: MDHHS to develop, jointly with CMHA, its members, and allies, a public education/media relations effort that highlights the performance, cutting edge practices, and positive impact of MDHHS and the community based system.

This effort could include the development of a description of the public mental health system that captures is full set of roles and responsibilities including its safety net and community convener roles, and its unique and central place in the life and health of the community.

12. Develop the relations and the political influence to impact the decisions, by other state departments, that directly impact Michigan's public mental health system: MDHHS and the community based system to develop intentional and coordinated approaches to improving cross-department collaboration – with LARA, MDE, MSP, and SCAO as the most frequent collaborators.

13. Process shepherding/oversight group: To support this effort, form an on-going group, made up of leaders within MDHHS and the community-based system, to shepherd this partnership strengthening effort. This group would work to ensure that key parties within MDHHS and the community based system are aware of this effort and to guide and rethink the design and processes of this effort as needed.

Draft: for discussion only

Community Mental Health Association of Michigan

Addressing Michigan's behavioral healthcare workforce shortage

April 2022

Summary of problem statement: The behavioral health workforce shortage, across all disciplines and job categories, is prolonged and deep. This shortage, being experienced in Michigan and across the country, has hindered the ability of the public and private mental health systems in Michigan to ensure access to care and the proper intensity and duration of that care while also hindering the system's ability to effectively manage the system. Additionally, the ability of these systems to pursue opportunities for system advancement has been significantly harmed by this workforce shortage.

Other resources: This document does not intend to outline all of the dimensions of nor solutions to Michigan's behavioral health workforce shortage, recently released resources on this topic provide additional context for addressing this issue. These resources include: a recent article from the Behavioral Health Workforce Research Center at the University of Michigan is relevant to this discussion. This article, "Certified Community Behavioral Health Clinic Workforce and Service Delivery Trends", can be found at:

- Forging a Path Forward to Strengthen Michigan's Direct Care Workforce (Center for Health Care Strategies; December 2021) https://www.chcs.org/media/Forging-a-Path-Forward-to-Strengthen-Michigans-Direct-Care-Workforce.pdf

- Strengthening the Direct Care Workforce: Scan of State Strategies (Center for Health Care Strategies; December 2021) https://www.chcs.org/media/Strengthening-the-Direct-Care-Workforce-Scan-of-State-Strategies.pdf

- Michigan's Direct Care Workforce: Living Wage and Turnover Cost Analysis (Public Sector Consultants; August 2021) (link coming)

- Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States (Health Management Associates; October 2021): https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf

- Certified Community Behavioral Health Clinic Workforce and Service Delivery Trends (Behavioral Health Workforce Research Center; National Council for Mental Wellbeing; August 2019) https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/NC-CCBHC_Brief-Report.pdf

Approaches to address the shortage across the entire behavioral health workforce

Recommendation 1: Cross-sector efforts: Because the behavioral workforce shortage faced by Michigan's CMH, PIHP, and providers is also being faced by Michigan schools (made clearer and more acute by increased, and sorely needed, funding for behavioral health staff within Michigan's schools), any behavioral health workforce plan should be jointly developed and implemented by MDHHS, MDE, and their stakeholders in communities across the state.

Recommendation 2: Reduction in paperwork and administrative burden workforce: One of the chief barriers to the recruitment and retention of behavioral healthcare staff in the CMH, PIHP, and the providers in their networks is the very high paperwork and administrative-related demands. Persons who have sought careers in health and human services to provide service often express concern and fatigue related to these demands. While some paper and administrative-related demands are expected, the excessive levels of non-value-added demands causes these health and human services professionals to leave the system and, too often, the field.

Needed is an overhaul of the paperwork and administrative-related demands that are currently borne by the state's behavioral healthcare workforce, with the aim of reducing those demands to those with value to the provision of high-quality care.

Concrete recommendations on this front are contained in the paper, "Reducing administrative burden on Michigan's public mental health system (CMHA; April 2022).

Recommendation 3: Promotion campaign underscoring value of behavioral health work: Several years ago, the Section 1009 study group (called together in fulfillment of the requirements of Section 1009 of the MDHHS Budget Bill) issued the 1009 report that provided recommendations to address the recruitment and retention of direct support professionals. While those recommendation, in the main, address the needs of this classification of workers, one of the recommendations would apply to the issue that we discussed**.**

> *Develop and fund a promotional campaign to build public awareness and appreciation of people with disabilities and those who chose a career to support them.*
>
> *The campaign should build off the system's mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign.*
>
> *There are numerous successes and positive stories of individuals with disabilities that could be crafted to both educate and change attitudes of community members. There are likewise many individual employees who demonstrate the passion, commitment and resilience which*

Approaches to address the Direct Support Professional/Direct Care Worker shortage

The approaches to addressing the Direct Support Professional/Direct Care Worker (DSP/DCW) issue were outlined in the Section 1009 report and have been expanded since then, by the Direct Care Worker Coalition, the Impact Alliance, and other coalitions of which CMHA is an active member. attached. These recommendations are summarized below, with those drawn from or based on the recommendations of the Section 1099 report marked with an asterisk:

A. Immediate Actions Needed to Improve DSP/DCW Wages and Benefits: The Michigan Legislature and Governor need to make additional investments into all the named Medicaid covered supports and services to assure that:

Recommendation 4: * Increase the starting wages of DSP/DCW staff to $18 per hour, <u>not through wage pass throughs</u> that require dollar-specific hourly wage increases, but through increases in the

Medicaid and General Fund dollars provided to the state's PIHPs and CMHSPs. This is the recommendation of the statewide Direct Care Worker Coalition, of which CMHA is a core member.

These funds, retaining their earmark for use to pay DSP/DCW staff, could be used by the state's CMHSPs, PIHPs, and providers to raise starting pay to $18 per hour for all DSP/ DCW staff.

The level of this increased funding determined based on the costs of covering all employer costs associated with the increased DSP/DCW wages including FICA, worker's compensation, and other payroll-related costs, as well as overtime.

Recommendation 5: **Permanent increases in the Medicaid capitation and General Fund dollars** provided to the state's PIHPs and CMHSPs to **fund increases to the entire DSP/DCW wage scale** and the **wage scale of DSP/DCW supervisors** to align with the increased DSP/DCW starting wage.

Recommendation 6: * Paid leave: Direct support staff earn paid leave time at the minimum rate of 1 hour for every 37 hours worked (i.e., 10 days a year for full-time employment).

B. Longer range solutions to address DSP/DCW shortage

Recommendation 7: * **Change background check requirements:** Change Michigan's current laws and policies on criminal background checks to include a "rehabilitation review" similar to those authorized in 17 other states in order to increase the potential pool of applicants for direct support careers. Implementing a review process would allow people with a disqualifying criminal conviction to demonstrate that they no longer represent a threat to people needing supports and services or to their property.

Recommendation 8: * **Provide publicly financed tuition reimbursement** or incentives to direct support workers who are actively studying to become clinicians who serve people with intellectual and developmental disabilities, mental illness, and substance use disorders in order to increase the number of people interested in doing direct support work. This effort will also improve the frontline skills and broaden the experiences of other health care occupations serving these populations.

Recommendation 9: Support the development of a voluntary **DSP/DCW career pathway and credentialing program** – as outlined by the Impart Alliance, incompass Michigan, MALA, and CMHA. This proposal is outlined in the document, "Immediate Solution to the Direct Care Worker Shortage: Build a Sustainable Training Infrastructure" found at: https://www.cmham.org/wp-content/uploads/2022/04/MI-DCW-Training-Infrastructure-Proposal-10.14.21.pdf

A number of potential sources exist for this training including community colleges and DSP/DCW-specific training organizations. A pay differential could be provided (if funded) for those DSP/DCW staff attaining such credentials.

Approaches to addressing the peer workforce shortage

Recommendation 10: Broaden definition of peer: For Peer Support Specialist positions, MDHHS currently requires that the individual have a history of participation in services through the public mental health system. This excludes a significant number of otherwise qualified candidates, which is significant now that providers are experiencing deep workforce shortages. Recommended is a change in this

requirement to allow persons with histories of serious mental illness, intellectual and developmental disabilities, or substance use disorders become peer support specialists/mentors/recovery coaches, regardless of where and from whom their services and supports were provided.

Approaches to addressing the clinical workforce shortage:

Recommendation 11: **Revise specific regulatory and licensing barriers to recruitment**

- Revise the current Michigan Qualified Mental Health Professional (QMHP) and Children's Mental Health Professional (CMHP) standards to shorten the number of years of experience requirement.

- Allow BA level staff, working as case managers/supports coordinators, to provide a number of the more common Medicaid crisis service encounters.

- Reduce the number of hours of clinical practice, post graduate school graduation, required for full licensure of behavioral health clinicians (primarily social workers, licensed professional counselors, and psychologist) to reflect experience obtained prior to graduation – via work experience and internships/practicums prior to or while enrolled in graduate school.

Recommendation 12: **Establish a Behavioral Health Workforce Student Recruitment Fund** to provide a temporary financial benefit/stipend to 1000 individuals (333 per year) who obtained a bachelor's degree in social work (BSW) and commit to ongoing education in accelerated masters' programs that would award a MSW in three continuous semesters.

These accelerated MSW programs are already in existence at many universities across Michigan (i.e., EMU, MSU, WSU, WMU, UM). However, program requirements are intense, including 16 – 24 hours per week in an unpaid internship. Given tuition costs, outstanding debt from the BSW program, the need to maintain employment, and the low level of scholarships available, students may opt to forgo ongoing social work education. Providing students with funds that might offset these barriers could quickly accelerate the number of professionals in the field in a short period of time. (Proposal by NASW, Wayne State University School of Social Work, and CMHA)

Recommendation 13: Create the Behavioral Health Crisis Continuum Workforce Sign-On Bonus, akin to what is being developed for first responders and teachers in Michigan. This program would provide a sign-on bonuses of $3000 for social workers entering into a public sector behavioral health (i.e. community mental health, substance abuse programs, crisis intervention, local crisis call centers, mobile crisis care, crisis stabilization, psychiatric emergency services, rapid post-crisis etc.) Social workers (MSW, LLBSW, LBSW, LLMSW, LMSW) must remain at the employer for a minimum of 3 years. Advancing workforce sign-ons provide an opportunity to ensure equitable distribution of the workforce across geographic areas and enables the workforce to deliver high-quality care, including through enhancing cultural and linguistic competency of social work professionals.

Recommendation 14: Expand federal (National Health Services Corps) and the Michigan State Loan Repayment Program (MSLRP) to attract psychiatrists, social workers, psychologists, and other clinicians to underserved Michigan communities. While his program is proposed for expansion in the Governor's proposed FY 2023 budget, the expansion is modest and of the magnitude needed to address the behavioral health workforce shortage.

Recommendation 15: Create a loan repayment program for behavioral health care workers, with a commitment to work in the public mental health system after graduation but **not tied to the federal Health Professional Shortage Areas (HPSAs).** This requirement, because it is based on only one discipline within the behavioral healthcare workforce, does not reflect the shortage in the broader behavioral health workforce.

Recommendation 16: Provide funding to the system to allow CMHs and providers to provide **tuition reimbursement for BA level employees pursuing their Masters degree in a behavioral health clinical discipline tied to a commitment to work in the public mental health system** - serving as both a recruitment and retention incentive for these employees.

Recommendation 17: Recognize that increased wages that have been required, over the past year, to attract and retain behavioral health clinicians and administrative staff, and their supervisors, are now the permanent expected wage levels. **These increased costs must be reflected, permanently, in the Medicaid capitation payments made to the state's PIHPs.**