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 4135 Washtenaw Ave, Ann Arbor**
OR
Virtually at https://zoom.us/j/93746387220
June 21, 2024
9:30 – 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 Quality-Finance Committee Meeting Minutes and Actions 2/12/24 (Attachment #1A)
- B. WCCMH Millage Advisory Committee Meeting Minutes and Actions 4/8/24 (Attachment #1B)
- C. WCCMH Board Meeting Minutes and Actions-4/26/24 (Attachment #1C)
- D. WCCMH Consumer Advisory Council Meeting Minutes and Actions- 3/13/24 (Attachment #1D)
- E. WCCMH Consumer Advisory Council Meeting Minutes and Actions- 4/10/24 (Attachment #1E)
- F. WCCMH Consumer Advisory Council Meeting Minutes and Actions- 5/8/24 (Attachment #1F)
- G. Contracts and Leases (recommended approval by Qualify-Finance Committee on 6/10/24 (Attachment #1G))
- H. Program Dashboard FY24, Quarter 4, 2023 (Attachment #1H)
- I. 2024 Budget Amendment (Attachment #1I)
- J. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
  - Ethics and Conduct 2024 (Attachment #1J)
  - Clinical Record Content 2024 (Attachment #1K)
  - Critical Incident Sentinel Rise Event 2024 (Attachment #1L)
  - Continuity of Care Policy 2024 Pre-Final (Attachment #1M)
  - Transition Planning Policy 2024 Pre-Final (Attachment #1N)

V. Treasurer's Report **ACTION** (10 minutes)
- WCCMH FY2023 Financial Audit (Attachment #2) – **N. Phelps ACTION**
- WCCMH FY23 Compliance Examination (Attachment #3) **N. Phelps ACTION**
- Financial Status Report (Attachment #4) - **N. Phelps ACTION**
- WCCMH Millage Financial Status Report (Attachment #5) **N. Phelps ACTION**

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

VII. CMHPSM Regional Update (5 minutes)

VIII. New Business (65 minutes)
- Consumer Advisory Council – **M. Concannon/B. Higman**
- WCCMH Board Officers for 4/1/24-3/31/25 (Attachment #6) **ACTION**
  - Chair – K. Walker
  - Vice-Chair – H. Heaviland
  - Secretary – A. Dusbiber

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.

  - Treasurer – M. Udow-Phillips
- WCCMH Committee assignments 4/1/24-3/31/25 (Attachment #6) **ACTION**
  - WCCMH Quality-Finance Committee
  - WCCMH Millage Advisory Committee
  - WCCMH Executive Committee
  - CMHPSM Regional Board
- WCCMH Resolution Opposing Conflict Free Access and Planning in Michigan (Attachment #7 & #8) – **T. Cortes ACTION**
- Request BOC Resolution Opposing Conflict Free Access and Planning in Michigan (Attachment #9) – **T. Cortes ACTION**

IX. Old Business (5 minutes)
- None

X. Items for Future Discussions (5 minutes)
- Employee Engagement Survey
- Homelessness Updates
- U of M Contracting
- Millage Re-Authorization

XI. Adjournment of Public Meeting (Next WCCMH Board Meeting: August 23, 2024)

****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/93746387220

Or One tap mobile:
+12678310333, 93746387220# US (Philadelphia)
+13126266799, 93746387220# 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: 937 4638 7220

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

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 21, 2024

CONSENT AGENDA

A. WCCMH Quality-Finance Committee Meeting Minutes and Actions 2/12/24 (Attachment #1A)
B. WCCMH Millage Advisory Committee Meeting Minutes and Actions 4/8/24 (Attachment #1B)
C. WCCMH Board Meeting Minutes and Actions-4/26/24 (Attachment #1C)
D. WCCMH Consumer Advisory Council Meeting Minutes and Actions- 3/13/24 (Attachment #1D)
E. WCCMH Consumer Advisory Council Meeting Minutes and Actions- 4/10/24 (Attachment #1E)
F. WCCMH Consumer Advisory Council Meeting Minutes and Actions- 5/8/24 (Attachment #1F)
G. Contracts and Leases (recommended approval by Qualify-Finance Committee on 6/10/24 (Attachment #1G))
H. Program Dashboard FY24, Quarter 4, 2023 (Attachment #1H)
I. 2024 Budget Amendment (Attachment #1I)
J. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
    1. Ethics and Conduct 2024 (Attachment #1J)
    2. Clinical Record Content 2024 (Attachment #1K)
    3. Critical Incident Sentinel Rise Event 2024 (Attachment #1L)
    4. Continuity of Care Policy 2024 Pre-Final (Attachment #1M)
    5. Transition Planning Policy 2024 Pre-Final (Attachment #1N)

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

WCCMH QUALITY-FINANCE COMMITTEE MEETING MINUTES

DRAFT

February 12, 2024
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/99510108421 (virtual)
2:00-3:30 pm

ROLL CALL: N. Graebner-Sundling attending in person

MEMBERS ABSENT: S. Antonow, A. Dusbiber, H. Heaviland, B. Higman, M. Udow-Phillips

STAFF PRESENT: R. Avedisian, T. Cortes, M. Harding, L. Gentz, N. Phelps, K. Snay, S. Ray, M. Taylor, E. Montgomery, M. Tasker, S. Amos O'Neal, B. Hagaman

OTHERS PRESENT: K. Walker, L. Lutomski, T. Gavalier M. Creekmore, K. Homan

N. Graebner-Sundling called the meeting to order at 2:11 pm.

NO QUORUM

N. Graebner-Sundling asked if there was any audience participation then closed out the meeting.

I. Introductions
- None

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Quality-Finance Committee Meeting Minutes and Actions from 12/11/24 (Attachment #1)
- None

MOTION BY A. DUSBIBER SUPPORTED BY M. UDOW-PHILLIPS TO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM DECEMBER 11, 2024, QUALITY-FINANCE COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

ANTONOW		**DUSBIBER**	
GRAEBNER-SUNDLING		**HIGMAN**	
HEAVILAND		**UDOW-PHILLIPS**	

V. Financial Status Report
- None

MOTION BY XXX SUPPORTED BY XXX TO RECOMMEND APPROVAL OF THE FINANCIAL STATUS REPORT ENDING DECEMBER 31, 2023, AS PRESENTED.
ROLL CALL VOTE:

ANTONOW		**DUSBIBER**	
GRAEBNER-SUNDLING		**HIGMAN**	
HEAVILAND		**UDOW-PHILLIPS**	

VI. Contracts and Leases
- None

MOTION BY XXX, SUPPORTED BY XX TO RECOMMEND APPROVAL OF THE CONTRACTS AND LEASES AS PRESENTED.

ROLL CALL VOTE:

ANTONOW		**DUSBIBER**	
GRAEBNER-SUNDLING		**HIGMAN**	
HEAVILAND		**UDOW-PHILLIPS**	

VII. Executive Director Authorizations
- None

MOTION BY XXX, SUPPORTED BY XX TO RECOMMEND APPROVAL OF THE EXECUTIVE DIRECTOR AUTHORIZATIONS AS PRESENTED.

ROLL CALL VOTE:

ANTONOW		**DUSBIBER**	
GRAEBNER-SUNDLING		**HIGMAN**	
STRONG		**UDOW-PHILLIPS**	

VIII. Regional Finance Update
- None

IX. Old Business
- None

X. New Business
- Office of Recipient Rights Annual Report (Attachment #5)

XI. Items for Future Discussions
- Accounts Receivable
- Cost Per Case Comparisons

MOTION BY XXX, SUPPORTED BY XXX, TO ADJOURN THE WCCMH QUALITY-FINANCE COMMITTEE MEETING.

XII. Meeting adjourned at 2:12 pm.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH MILLAGE ADVISORY COMMITTEE MEETING MINUTES *DRAFT*
April 8, 2024
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/98461324058 (virtual)
3:30–5:00 pm

K. Walker called the meeting to order at 3:32 pm.

ROLL CALL:	A. Carlisle attending in person H. Heaviland attending in person B. Higman attending in person R. Rion attending virtually A. Somerville attending in person G. Waddles Jr attending in person K. Walker attending in person
MEMBERS ABSENT:	D. Jackson, M. Radzik, A. Rooks, M. Udow-Phillips,
STAFF PRESENT:	R. Avedisian, M. Harding, T. Cortes, M. Tasker, L. Gentz, M. Taylor, E. Montgomery
OTHERS PRESENT:	S. Petty, T. Gavalier, W. Cornelius, D. Anderson, G. Pratt, L. Lutomski, YCEA, D. Goldbaum, K. Holman

I. Introductions
- S. Petty, the new WCCMH Board Member introduced himself to the Committee.

II. Audience Participation
- K. Holman spoke on interest of the millage funding, asking the Millage Advisory Committee to consider changes to the millage to provide more funds to CMH and entities who receive CMH funding.

III. Committee Response to Audience Participation
- None

IV. Millage Advisory Committee Minutes and Actions from 2/12/24 (Attachment #1)
- Millage Advisory Committee Minutes and Actions of 2/12/24 were reviewed.

MOTION BY A. CARLISLE, SUPPORTED BY A. SOMERVILLE TO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM THE FEBRUARY 12, 2024, MILLAGE ADVISORY COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

CARLISLE	**Y**	**HIGMAN**	**Y**
HEAVILAND	**Y**	**SOMERVILLE**	**Y**
RADZIK	**N/A**	**ROOKS**	**N/A**
RION	**Y**	**M. UDOW-PHILLIPS**	**N/A**
WADDLES JR	**Y**	**K. WALKER**	**Y**

V. Discussion Items

- Millage Process, Investments and Progress Update (Attachment #2)
  - L. Gentz presented the Millage Process, Investment and Progress update to the Committee.
- CARES/CCBHC Data Report
  - M. Tasker presented the CARES/CCBHC Data Report to the Committee.
  - H. Heaviland asked about potential to breakout under 18 from this data.
  - R. Avedisian distributed a WCCMH Millage One Pager from M. Udow-Phillips to the WCCMH Board and Millage Advisory Committee.

M. Radzik arrived at 3:46

VI. Financial Budget Update
- Financial Budget Update (Attachment #3)
  - L. Gentz presented the Financial Budget update ending February 29, 2024, to the Committee.

VII. Old Business Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
  - None

VIII. New Business –
- Mental Health and Public Safety Preservation Millage Renewal Update
  - T. Cortes provided an update on the Mental Health and Public Safety Preservation Millage.
  - A. Somerville spoke on updates to the millage renewal to the Committee.

- Structure for Future Community Funding
  - T. Cortes presented on the structure of future community funding.
  - T. Cortes proposed the Millage Advisory Committee consider a new RFP based on the areas of need identified in the strategic plan.
  - A. Carlisle mentioned a visual would be helpful to see how funds are currently being allocated.

IX. Items for Future Discussions
- Millage Investment Plan
- Washtenaw Coordinated Funding Partnership Update
- CHRT gaps analysis

MOTION BY A. CARLISE, SUPPORTED BY G. WADDLES JR TO ADJOURN THE WCCMH MILLAGE ADVISORY COMMITTEE MEETING.

Meeting adjourned at 4:33 pm.

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/99199406149
April 26, 2024
9:30am

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

ROLL CALL: S. Antonow attending virtually
A. Dusbiber attending virtually
B. Higman attending in person
H. Heaviland attending in person
B. King attending in person
A. LaBarre attending in person
A. Somerville attending in person
K. Walker attending in person

MEMBERS ABSENT: S. Petty, A. Rooks, M. Udow-Phillips, K. Scott

STAFF PRESENT: R. Avedisian, N. Phelps, T. Cortes, M. Harding, L. Gentz, K. Snay, B. Hagaman, E. Montgomery, L. Higle, K. Dieboll, R. Dornbos, S. Amos O'Neal, S. Swisher, T. Bragiel

OTHERS PRESENT: M. Strasz, M. Creekmore, Pathlight Zoom Acct,

I. Introductions
- None

II. Audience Participation
- None

III. Board response to audience participation
- None

IV. Consent Agenda Actions (Attachment #1)
- WCCMH Millage Advisory Committee Meeting Minutes and Actions 2/12/24 (Attachment #1A)
- WCCMH Executive Committee Meeting Minutes and Actions from 11/17/23 (Attachment #1B)
- WCCMH Board Meeting Minutes and Actions-2/23/24 (Attachment #1C)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions- 1/10/24 (Attachment #1D)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions- 2/14/24 (Attachment #1E)
- Contracts and Leases (recommended approval by Quality-Finance Committee on 3/22/24 (Attachment #1F)
- Strategic Plan Goals (recommended approval by Executive Committee on 3/22/24 (Attachment #1G)
- Board Governance Policy (recommended approval by Executive Committee on 3/22/24 (Attachment #1H)
- CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
  - Clinical Practice Guidelines 2024 (Attachment #1I)
  - Person Centered Planning Policy 2024 (Attachment #1J)

MOTION BY A. LABARRE SUPPORTED BY B. HIGMAN TO ACCEPT AND APPROVE THE APRIL 26, 2024, WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**

HEAVILAND	**Y**	**HIGMAN**	**Y**
KING	**Y**	**LABARRE**	**Y**
PETTY	**N/A**	**ROOKS**	**N/A**
SCOTT	**N/A**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**N/A**	**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 April 18, 2024 (Attachment #2).

MOTION BY B. KING SUPPORTED BY A. SOMMERVILLE TO ACCEPT AND APPROVE THE FINANCIAL STATUS REPORT FOR THE PERIOD ENDING APRIL 18, 2024, AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
KING	**Y**	**LABARRE**	**Y**
PETTY	**N/A**	**ROOKS**	**N/A**
SCOTT	**N/A**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**N/A**	**WALKER**	**Y**

MOTION CARRIED

- WCCMH Millage Financial Status Report (Attachment #3)
  - N. Phelps presented the WCCMH Millage Financial Status Report to the Board for the period ending February 29, 2024.

MOTION BY B. KING, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE WCCMH MILLAGE FINANCIAL STATUS REPORT ENDING FEBRUARY 29, 2024, AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
KING	**Y**	**LABARRE**	**Y**
PETTY	**N/A**	**ROOKS**	**N/A**
SCOTT	**N/A**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**N/A**	**WALKER**	**Y**

MOTION CARRIED

VI. Executive Director report

- T. Cortes presented the Executive Director report to the WCCMH Board
  - T. Cortes provided updates from the State to the Board.
  - T. Cortes provided updates on the Millage to the Board.
  - A. Sommerville spoke on potential changes to the millage proposal to the Board.
  - A. LaBarre provided updates on potential changes to the millage proposal to the Board.
  - T. Cortes spoke to recruitment and retention efforts to the Board.
  - B. King spoke about his concerns surrounding the need to increase wages for County staff and proposed the Board put out a statement encouraging structural wages for all employees, including topped out staff.
    - A. LaBarre spoke to his support of B. Kings proposal.

- A. Sommerville spoke to her support of B. Kings proposal.
- K. Walker spoke to the importance of what CMH employees do and the importance of fair/competitive wage increases.

MOTION BY B. KING, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE PROPOSAL FOR THE WCCMH BOARD TO RECOMMEND TO COUNTY ADMINISTRATION STRUCTURAL WAGE INCREASES FOR CMH STAFF AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
KING	**Y**	**LABARRE**	**Y**
PETTY	**N/A**	**ROOKS**	**N/A**
SCOTT	**N/A**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**N/A**	**WALKER**	**Y**

MOTION CARRIED

VII. CMHPSM Regional Update

- T. Cortes provided the CMHPSM regional update to the Board.
- B. King provided CMHPSM Regional updates to the Board.

VIII. New Business

- Annual Conflict of Interest Policy
  - The Annual Conflict of Interest policy was distributed to the Board.
  - Board members will complete and return to R. Avedisian to fulfill their annual training requirements.
- Annual Ethics Statement
  - The Annual Conflict of Interest policy was distributed to the Board.
  - Board members will complete and return to R. Avedisian to fulfill their annual training requirements.
- Annual Recipient Rights Training for Board Members
  - K. Snay, Program Administrator for the Recipient Rights Department, conducted the annual training for the Board.
  - R. Avedisian will send out a signature sheet for the Board members not in attendance.
- Recipient Rights Advisory Committee new member review/approval
  - K. Snay, requested Board approval of S. Iekel to the Recipient Rights Advisory Committee.

MOTION BY B. KING SUPPORTED BY A. SOMMERVILLE TO ACCEPT AND APPROVE THE APPOINTMENT OF A NEW MEMBER OF THE RECIPIENT RIGHTS ADVISORY COMMITTEE, AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
KING	**Y**	**LABARRE**	**Y**
PETTY	**N/A**	**ROOKS**	**N/A**
SCOTT	**N/A**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**N/A**	**WALKER**	**Y**

MOTION CARRIED

- Board of Commissioners – WCCMH Board member appointment Resolution
  - A copy of the Board of Commissioners member appointment resolution was presented to the Board.

- WCCMH Board Officers for 4/1/24 – 3/31/25 discussion
  - K. Walker stated committee assignments will be finalized at the June WCCMH Board Meeting
- WCCMH Committee assignments for 4/1/24 – 3/31/25
  - WCCMH Quality-Finance Committee member assignments
  - WCCMH Millage Advisory Committee
    - A. Somerville will be the new Chair for the WCCMH Millage Advisory Committee
  - WCCMH Executive Committee
  - CMHPSM Regional Board
- WCCMH Board Training Manual
  - M. Harding discussed the WCCMH Board Training Manual with Board members.
  - T. Cortes offered the opportunity to Board members interested in the boots to the ground concept for committee tours.

IX. Old Business
- None

X. Items for future discussion
- Employee Engagement Survey
- Homelessness Updates
- U of M Contracting
- Millage Re-Authorization

MOTION BY B. KING SUPPORTED BY A. LABARRE TO ADJOURN THE WCCMH BOARD MEETING.

Meeting adjourned at 11:34 am.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY
WC-CMH ADVISORY COUNCIL MEETING – MINUTES

March 13, 2024

Members potentially Present on the Call: Anton Clark, Melissa Concannon (Co-Chair), Joy Duffy, Leo Hanifin, Barb Higman, Pam Rathbun (Chair), Jason Zurawski (Secretary).
Staff: Mert Hershberger (Staff Liaison).
Absent: Alayna Manzanares, Lisa Porzondek

Meeting called to order at: _ 12:34 _ pm_.
MOTION BY _ Melissa _ - SUPPORTED BY _ Joy _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED

I. Regional details:
   A. Fall Regional Training – will happen November 13: Suggested Trainings: Work Plans for 2025; Public speaking (Cristobal Acosta and Lisa from Washtenaw were suggested); Health Meal Planning & grocery Shopping (Joy Duffy offered to help with this talk/Training. Farmer's Market options were suggested.)
   B. Summer Picnic: Aug 8 or 13. Region will get Burgers (beef & turkey) and beef franks. Mert will bring cutlery, plates, cups, napkins, coolers, ice (or ask Lisa to help with the ice & veggies & water), Barb-fruit salad, Anton-Hawaiian salad, Melissa-condiments, Jason-Sprite Zero&CokeZero, Pam-charcoal & lighter & diet Coke & Coke; Joy-Diet Coke & Coke; Leo-sun tea. Mert will email Connie about arrangements for the pre-picnic pickup.
   C. Art show: Mert will send rules and guidelines to Pam Rathbun, Melissa Concannon, and Carole Hittinger, who all have a background in working with arts and crafts with individuals served.

II. **Council Recruitment Brochure:** With minor revisions, there was general consensus to approve the brochure. Mert invited people to look it over after the meeting for any additional revisions they might want to make before publication. Barb was thanked for her help in editing.

III. **Newsletter:** Spring 2024: to send out in May, have everything ready by April 10. Anton will share an essay on Failure is not an option. Jason said he would work on a graphic of an overflowing cup.

IV. **NAMI** – Peer-To-Peer Class: This class wrapped up last night, 3/12/24. The Family-To-Family class will start soon. Barb said that the report on the Chelsea Hospital Closure was completed and the findings are ready to be shared with various outlets. Mert suggested the newsletter post quorum.

V. **Walk-A Mile: 9/12/2024-** Leo said he was willing to help design the T-Shirts by July for tie-dying in late August. He said that he would ask his daughter if she wanted to help with this. Mert will reach out to Sally Amos O'Neal about getting tie-dye supplies. We need the Logo by early July.

VI. **Celebration of Success –** We talked about Mert sending out a monthly reminder with the nomination form and about reminding teams to nominate people throughout the year. This will likely happen in October for the big celebration.

VII. **Report to WC-CMH Board 2/23/2024 –** Melissa said it was a learning experience and that she will consult with Barb prior to any future reports. She also asked to learn more about the Mental Health and Public Safety Millage. Barb and Mert explained a little about how the millage works to fund these priorities and how millages in general work. Barb informed us that CMH receives 38% of the millage money, sheriff gets 38%, outlying municipalities each get 24%. Mert will contact Lisa Gentz about reporting on the millage after April. There is discussion of a youth assessment center.

VIII. **New Business:** Melissa reported how it went delivering her first board presentation last month.

_ Joy _ motioned to adjourn the meeting at _ 1:39 pm_, Supported by _ Melissa _.

The next meeting will be April 10, 2024 at 2140 E. Ellsworth, Ann Arbor; via Zoom or in person, with things starting by 12:30pm. Please arrive a few minutes early (as early as 12:15pm) if possible.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY
WC-CMH ADVISORY COUNCIL MINUTES

April 10, 2024

Members potentially Present on the Call: Anton Clark, Melissa Concannon (Co-Chair), Joy Duffy, Leo Hanifin, Barb Higman, Alayna Manzanares, Lisa Porzondek, Pam Rathbun (Chair), Jason Zurawski (Secretary).
Staff: Mert Hershberger (Staff Liaison).
Guests: Lisa DeRamos (NAMI groups & presentation, also a potential new member)
Potential New Members: Lisa DeRamos.
Absent: Katie Hoener and Mike Harding had other business today.

Meeting called to order at: _ 12:33 _ pm_.

MOTION BY _Melissa _ - SUPPORTED BY _ Barb _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED

I. **Lisa DeRamos - NAMI** – Peer-To-Peer Class: Lisa described this class and she talked about the Family-To-Family class, the "End the Silence" Program (that is on pause till there is a coordinator, and all the various support groups with NAMI and described the purposes and common purposes of those involved with NAMI. She touched on its unique role as a judgement free zone where people could get mutual support and encouragement in their endeavors to understand their mental health and strive for more recovery together. She gave several links to the volunteer page, to the groups list, to the Peer to peer class, all on the NAMI Washtenaw County - NAMI Washtenaw County (namiwc.org) website.

II. Regional CAC – From Today.

A. **Fall Regional Training**: November 13 and we talked about the plans to have Joy talk about grocery shopping & healthy meal planning and going to the farmer's markets. Then a talk on diversity, then a lunch, then legislative updates, then working on regional and county workplans, then reports, then a public speaking training:

B. **Summer Picnic**: Region will get Burgers (beef & turkey) and beef franks & buns. Mert will reserve a county car to take people down to Lenawee on August 8th.

C. **Art show**: We reviewed what this is about and who qualifies.

III. **Fresh start** is going to Walk-A-Mile, Joy thinks.

IV. **Council Recruitment Brochure: We requested at least 5 copies for each member, and 10 copies for members who are CMH peers.**

V. Newsletter: Spring 2024: Final Submissions. Joy and Anton said they would work on these.

VI. **Walk-A Mile: 9/12/2024-** Leo said he would work with his daughter to have a T-Shirt design ready by July and would work with Sally & Hayley to get the T-Shirts ordered and ensure the design is executed well. He said that he could also work with Sally and Hayley to ordering Tie-Dye materials for a late August Tie-die party. MOTTO: We're Not Alone – Lift Up Your Head. Mert will Price out the menu to get an estimate to Sally ahead of time.

VII. **Celebration of Success –** monthly reminder with the nomination form – Date set for: October 22, 2024, sometime between 1-5 pm.

VIII. **New Business:** Millage is set to expire or be renewed by 2025-Barb updated us. Melissa said she would work to coordinate visits with legislators at the Walk-A-Mile and perhaps invite them to monthly meetings. Mert directed Melissa where to find the information about legislators on the Public county website (especially Jeff Irwin and Felicia Brabec)

Anton would like to see progress on how to grow the workforce.

_ Alayna _ motioned to adjourn the meeting at _ 1:51 pm_, Supported by _ Leo _.

The next meeting will be May 8, 2024 at 2140 E. Ellsworth, Ann Arbor; via Zoom or in person, with things starting by 12:30pm. Please arrive a few minutes early (as early as 12:15pm) if possible.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY
WC-CMH ADVISORY COUNCIL MINUTES

May 8, 2024

Members potentially Present on the Call: Anton Clark, Melissa Concannon (Co-Chair), Lisa DeRamos, Joy Duffy, Leo Hanifin, Barb Higman, Alayna Manzanares, Lisa Porzondek, Pam Rathbun (Chair – may be absent), Jason Zurawski (Secretary).
Staff: Mert Hershberger (Staff Liaison).
Guests: Katie Hoener (PA – Adult MI)

Meeting called to order at: _ 12:32_ pm_.
MOTION BY _ Alayna _ - SUPPORTED BY _ Leo _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED.

I. **Katie Hoener – Program Administrator for Services to Adults with Mental Illnesses**: The regular clinical teams at Towner and the Annex, the ACT team, and the PATH team. She also helps with the Crisis Negotiation team at the Sheriff's department and was there for training today. She emphasized that we seek to serve people in their best environment by moving the place of service to the community either at home or in the clinic. There are barriers to care everywhere. She talked about helping people recognize their signs and symptoms of illness in their better times to avoid harm and prevent petitioning, though this is done at times. Much of this is done through case management (connecting to food, to services, to housing, creating safe spaces at the clinic and at homes, or in groups. She detailed how PATH team helps build connection to the homeless and then connects the homeless to housing through various means, though it does take time to plan and build affordable housing so that vouchers can be used appropriately. Katie mentioned that there are 8 properties planned for Ann Arbor for Affordable Housing in the next 8 years. But this will all take time. She talked about how the vouchers are a lottery system. Joy chimed in that some transportation help is available for those with Medicaid so that people can get to their appointments.

II. **Regional CAC**:
   A. Picnic on August 8. Save the date.
   B. After mentioning that Monroe CMH will host a table at the county fair there, Mert said it might be nice if CMH & Public Health did something similar here. Lisa deRamos said she would look into reserving a table for CMH & the County Health Department for the Celtic Festival and the County Fair later in the year since she lives in that area.

III. **Newsletter**: We have Anton's & Joy's writing. Leo may write a paragraph on Momo his adopted dog, and Melissa may draft a short paragraph on being a turtle steward. There will also be short announcements about Celebration of Success & Walk-A-Mile (by Mert) & the Day of Giving for Fresh Start (by Joy).

IV. **Walk-A Mile: 9/12/2024 -** Talk it up in various settings, Mert will send an announcement on this by the end of the month. Leo has started on a design for T-Shirts. He suggested that we just have "Keep Your Head Up" on the back of the shirts, along with "Walk-A-Mile." The plan is to have designs finished and shirts ordered by mid July, with Leo coordinating with Hayley T. or Sally A-O and the printer to ensure that the shirts are done excellently. He will also coordinate ordering sufficient tie-dye materials for the event with them and ensure that is done well. We settled on a time for Tie-dying the shirts from 1-3pm on Thursday, August 22, 2024 at the 2140 E. Ellsworth location with Leo and Melissa tag-teaming on setting up.

V. **Celebration of Success**: Mert to send out the nomination form & to announce the date of the Celebration of success to all CMH once the newsletter is set before the end of the month. Melissa suggested asking artists and crafters in the Arts and Crafts groups with Pam and Carole at the Ellsworth and Annex locations to come up with crafts so that there could be a little something to give to celebrants:

a card, a bookmark, a paper craft flower … something. Mert will suggest this to the different art group leaders.

VI. **Fresh start (Joy)**: Day of Giving: We are Not Alone. Listen to Members tell recovery stories and try some mock-tails and enjoy circus-themed entertainment. Saturday, June 1, 2024; 4-9pm; 211 E. Michigan Ave, Ypsilanti, MI 48198.

VII. **NAMI (Barb & Alayna)**: The Family-To-Family class has concluded and there is not yet another Peer-To-Peer class planned.

VIII. **Public Health (Lisa deRamos)**:

Lisa said that she would look into what the requirements are to having a table at the Celtic Festival in July or at the County Fair later in the year.
Social Media & Print Media: The campaign to reduce stigma and increase awareness around mental health being integral to all health.
https://www.instagram.com/wishyouknewwashtenaw/
#wishyouknewwashtenaw – The social media tagline.
https://www.washtenaw.org/2868/wishyouknew-Mental-Health-Campaign
Local Mental Health Resources:
https://www.washtenaw.org/2995/Local-Mental-Health-Resources
Mental Health Awareness Month Toolkit: The Health Department is doing a campaign to share resources all month long.
https://www.samhsa.gov/mental-health-awareness-month/toolkit
Parents Talk – How to Talk to Your Kids about Mental Health: Helping parents with kids.
https://www.facebook.com/photo/?fbid=874517594715491&set=a.573760354791218
Suicide Data for Washtenaw County: The full report is due out later this month.
https://www.washtenaw.org/1936/Suicide-Data
Mental Health Index: This is an index for mental health here in Washtenaw County.
https://www.healthforallwashtenaw.org/indexsuite/index/mentalhealth?localeType=3&parentLocale=1363
Washtenaw Alive: A coalition of civic and other partners working together to reduce suicide in the county.
https://www.washtenaw.org/1912/Washtenaw-Alive---Suicide-Prevention-Coa

IX. **New Business**:

A. **The Michigan Peer Conference 2024** later this May 20-22 in Novi, MI at the Suburban Collection convention center. Highlights from the agenda for the conference:
https://mipeers.org/event/2024-mipeer-conference-2/

1. Linda Rama is presenting on Tuesday morning at 10:30am on staying ACTIVE.
2. We have a few folks from Home of New Vision Presenting on Tuesday at 1:30pm
3. Though not presenting, Mert participated in the development and early implementation of PREVAIL (Suicide Prevention Intervention) which will be presenting on Tuesday at 1:30pm, and Yarrow Halstead, formerly of Washtenaw County-CMH, will participate in that presentation.
4. Mert will be presenting on the Tobacco Endgame, also at 1:30pm on Tuesday. Breathe easy!
5. Though not listed for space reasons, Mert will also help present on Wednesday at 10:30am on Oral Health Recovery on what peers have to offer to those seeking to recover oral health. Dental health is mental health.
https://mipeers.org/agenda/

B. **Stipends:** If a person chooses to get a stipend, they cannot get mileage for their Advisory Council involvement. If a person gets mileage for attendance, they cannot get a stipend. This topic arose out of a conversation with colleagues in Monroe.

C. The vote was unanimous to welcome **Lisa deRamos** as an active member of the council.

_Anton _ motioned to adjourn the meeting at _ 1:39 pm_, Supported by _ Barb _.

The next meeting will be June 12, 2024 at 2140 E. Ellsworth, Ann Arbor; via Zoom or in person, with things starting by 12:30pm. Please arrive a few minutes early (as early as 12:15pm) if possible.

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

BACKGROUND:

1. A Heart That Cares: provides Community Living Supports (CLS) services.
2. A Touch of Grace 1596 Inc.: provides Specialized Licensed Residential services.
3. Acorn Health of Michigan, LLC: provides Applied Behavior Analysis (ABA) services.
4. Flourish Recreational Therapy Consultants, LLC: provides Recreational Therapy services.
5. Harbor House Ministries Inc.: provides Specialized Licensed Residential services.
6. Magnet ABA Therapy, LLC: provides Applied Behavior Analysis (ABA) services.
7. RISE Center for Autism, LLC: provides Applied Behavior Analysis (ABA) services.
8. Unique Care Connect Community Center: provides Skill Building and Supported Employment Services.

Service Contracts

Contractor	Funding	Estimated Budget	Contract Term	Service Description
1. A Heart That Cares	Medicaid	As Authorized	June 1, 2024-September 30, 2024	CLS Services
2. A Touch of Grace 1596 Inc.	Medicaid	As Authorized	May 1, 2024-September 30, 2024	Specialized Licensed Residential Services
3. Acorn Health of Michigan, LLC	Medicaid	As Authorized	May 15, 2024-September 30, 2024	ABA Services
4. Flourish Recreational Therapy Consultants, LLC	Medicaid	As Authorized	June 1, 2024-September 30, 2024	Recreational Therapy Services
5. Harbor House Ministries, Inc.	Medicaid	As Authorized	June 1, 2024-September 30, 2024	Specialized Licensed Residential Services
6. Magnet ABA Therapy, LLC	Medicaid	As Authorized	May 1, 2024-September 30, 2024	ABA Services

7. RISE Center for Autism, LLC	Medicaid	As Authorized	June 1, 2024- September 30, 2024	ABA Services
8. Unique Care Connect Community Center	Medicaid	As Authorized	July 1, 2024- September 30, 2024	Skill Building & Supported Employment Services

Program and Quality Board Committee
Dashboard Data FY 2023 4th Qtr (July - September 2023)

4th quarter Human Resources
Turnover Rate:

1st Qtr –

Turnover - 4.1%- 15 terminations (both involuntary and voluntary) divided by 362 active positions.

2nd Qtr –

Turnover - 2.5% - 9 terminations (both involuntary and voluntary) divided by 362 active positions.

3rd Qtr –

Turnover - 3.6% - 13 terminations (both voluntary and involuntary) divided by 363 active positions.

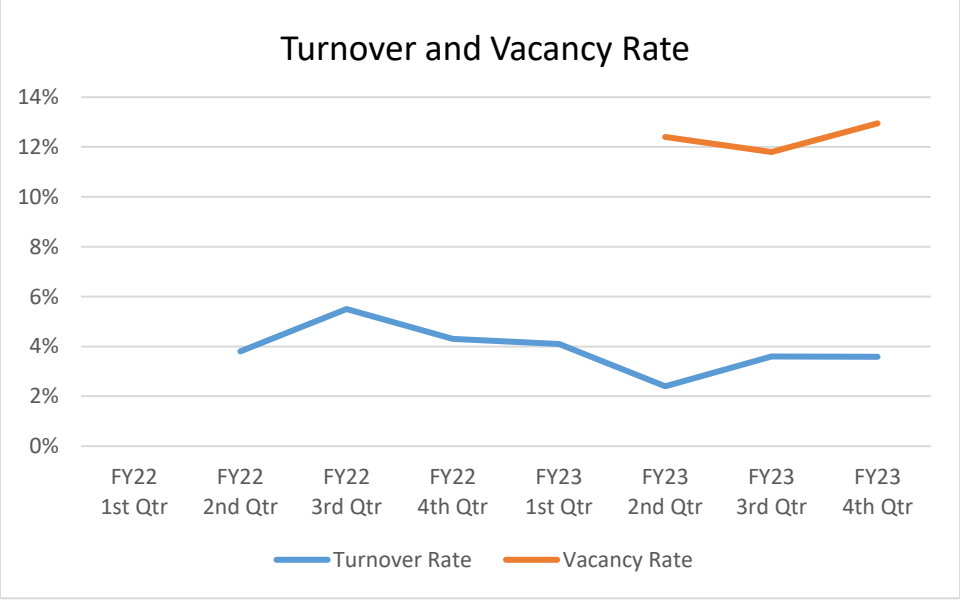
4th Qtr – Turnover – 3.6% - 13 terminations (both voluntary and involuntary) divided by 363 active positions.

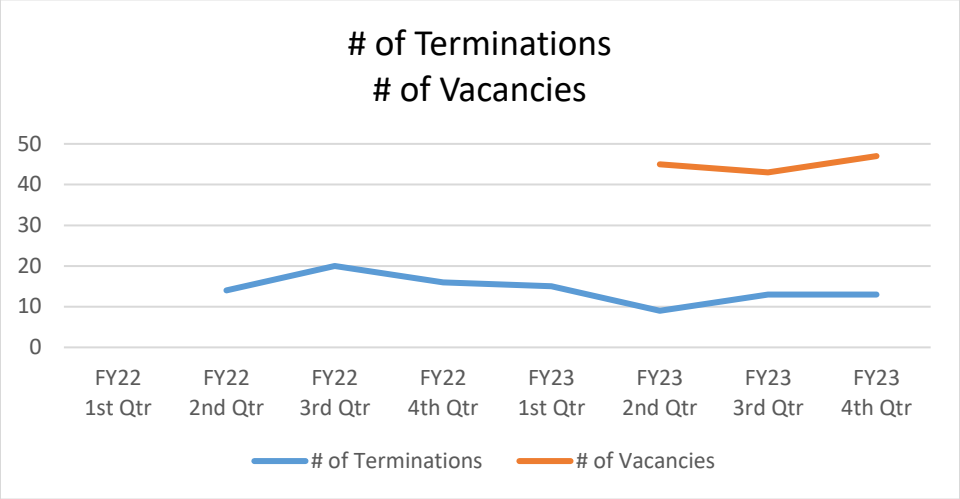
Vacancy Rate – measuring and reporting began FY 23 2nd Quarter

2023 2nd quarter: 12.43%. We had 362 active positions with 45 vacancies.

2023 3rd quarter: 13.22%. We had 363 active positions with 48 vacancies.

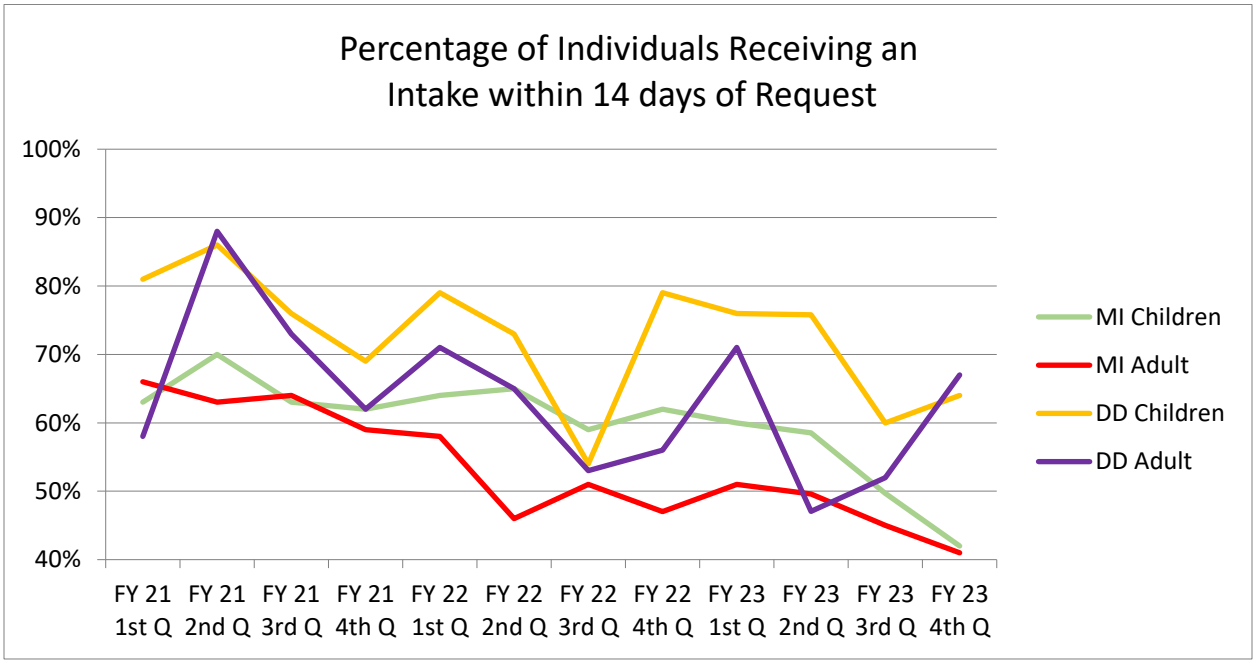
2023 4th quarter: 12.95% We had 363 active positions with 47 vacancies. (Note: we had 7 more "Day Ones" than terminations this quarter, but 6 internal transfers which created other vacancies.)



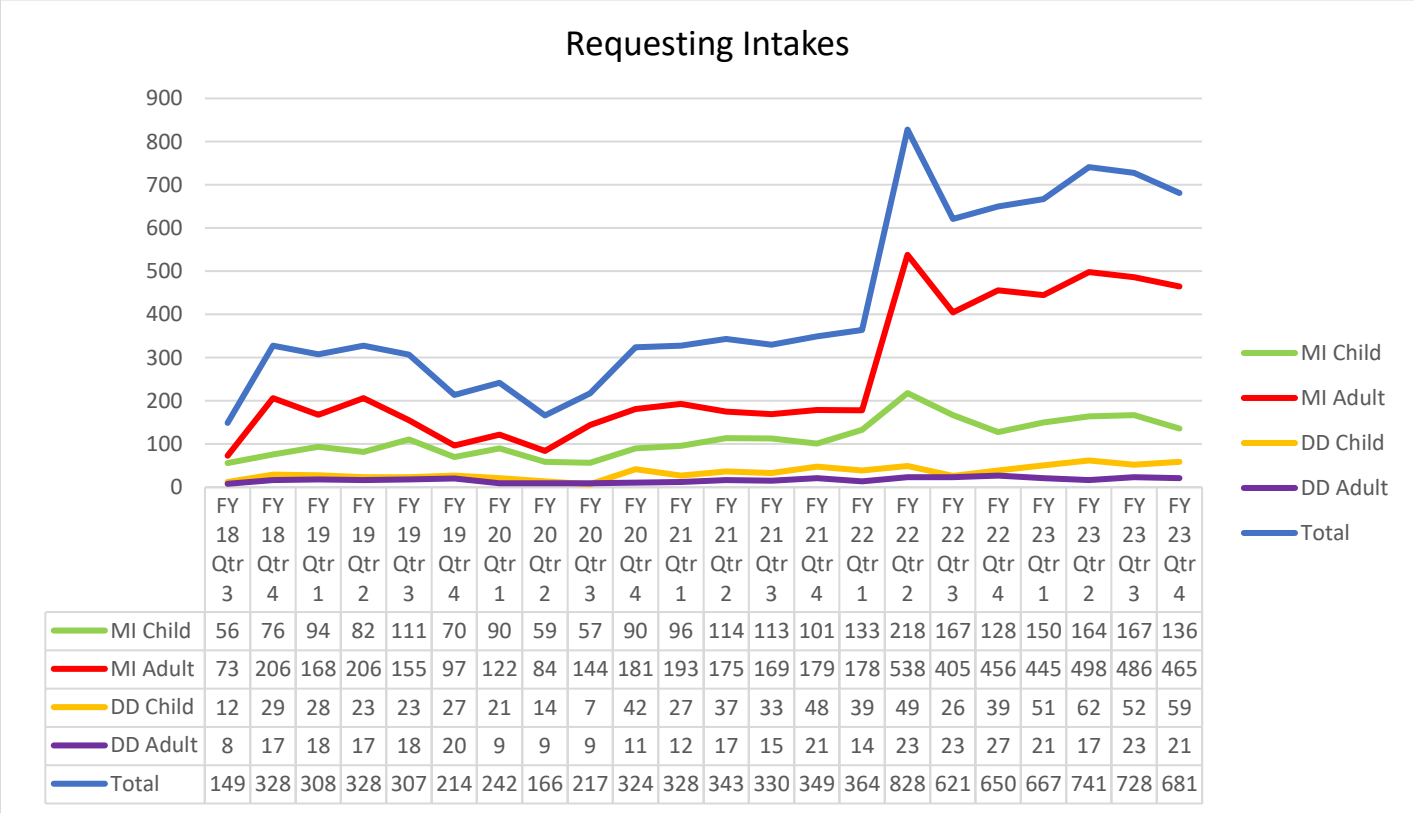


Michigan Department of Health and Human Services (MDHHS) Performance Indicators:
As of April 1, 2020, MDHHS changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to Ongoing Service) and removed the 95% historical expected goal.

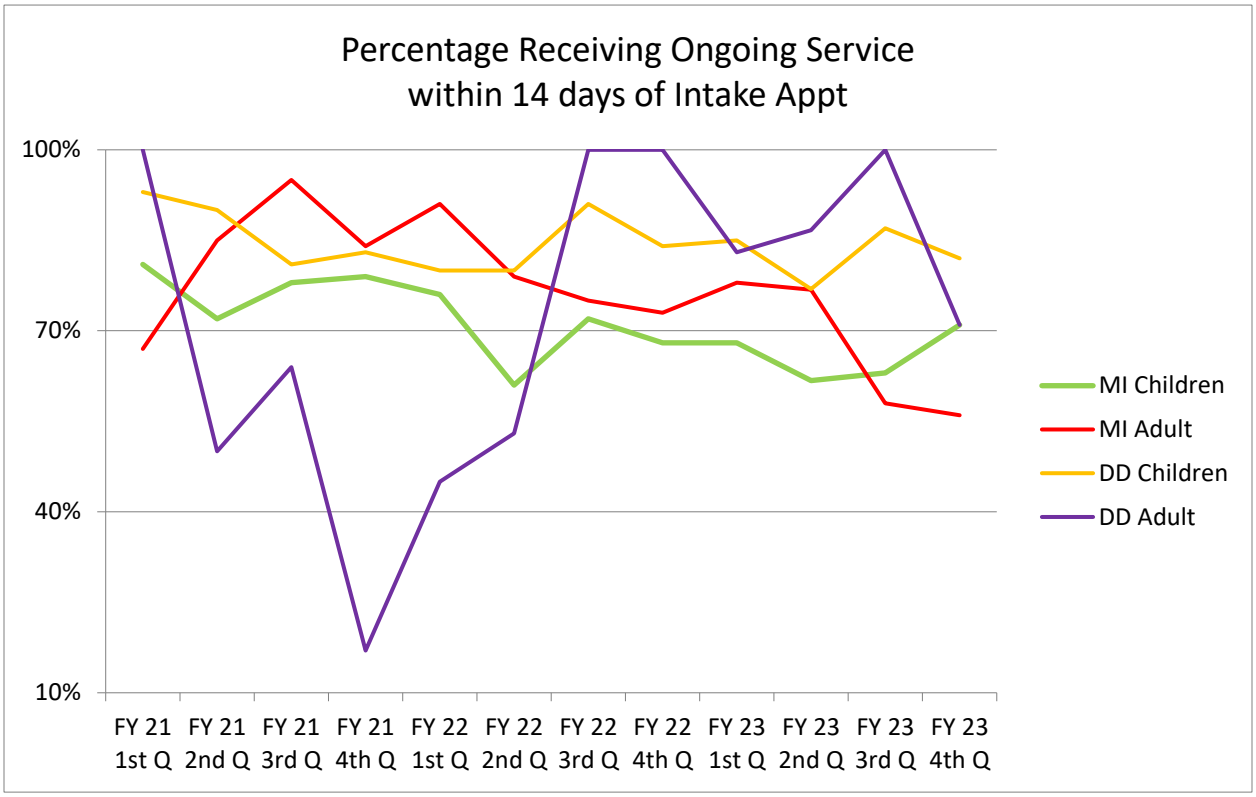
The major change in the operational definition does not allow accounting for consumer choice and for counting every request of service. Consumer choice is indicated by requesting an appointment outside of the 14-day window, rescheduling, canceling or not attending an appointment. If an individual requests a service, is found eligible but declines our services or even passes away, this is still considered "out of compliance".



FY 23 4th Qtr Intake Appt within 14 days Detail						
Population	Total # of new persons requesting service	Number receiving appt. within 14 days of request	State defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- was formerly removed from the denominator	Percent Compliant by new State definition	Percent Compliant in previous definition
MI Child	136	56	80	77	41%	95%
MI Adult	465	189	276	262	41%	93%
DD Child	59	38	21	21	64%	100%
DD Adult	21	14	7	6	67%	93%

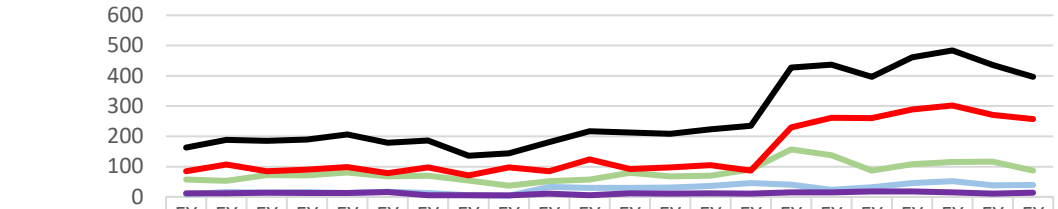


	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4	FY 22 Qtr 1	FY 22 Qtr 2	FY 22 Qtr 3	FY 22 Qtr 4	FY 23 Qtr 1	FY 23 Qtr 2	FY 23 Qtr 3	FY 23 Qtr 4
MI Child	56	76	94	82	111	70	90	59	57	90	96	114	113	101	133	218	167	128	150	164	167	136
MI Adult	73	206	168	206	155	97	122	84	144	181	193	175	169	179	178	538	405	456	445	498	486	465
DD Child	12	29	28	23	23	27	21	14	7	42	27	37	33	48	39	49	26	39	51	62	52	59
DD Adult	8	17	18	17	18	20	9	9	9	11	12	17	15	21	14	23	23	27	21	17	23	21
Total	149	328	308	328	307	214	242	166	217	324	328	343	330	349	364	828	621	650	667	741	728	681



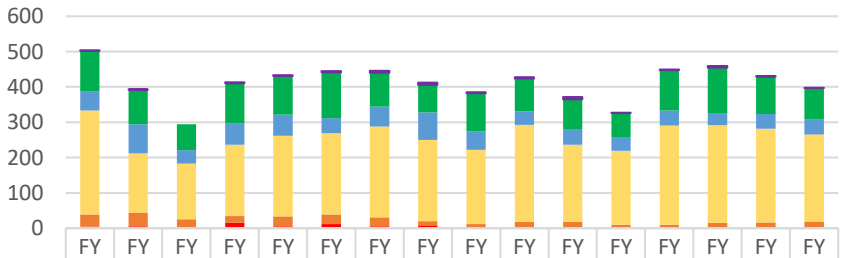
FY 23 4th Qtr Detail Ongoing Service						
Population	# of New Persons Eligible for Service	# of New Persons who started a new service within 14 days of eligibility	State Defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- used to be removed from the denominator	Percent Compliant under new definition	Percent Compliant under previous definition
MI Child	87	62	25	24	71%	98%
MI Adult	257	145	112	72	56%	78%
DD Child	39	32	7	7	82%	100%
DD Adult	14	10	4	0	71%	71%

Number Eligible for Service



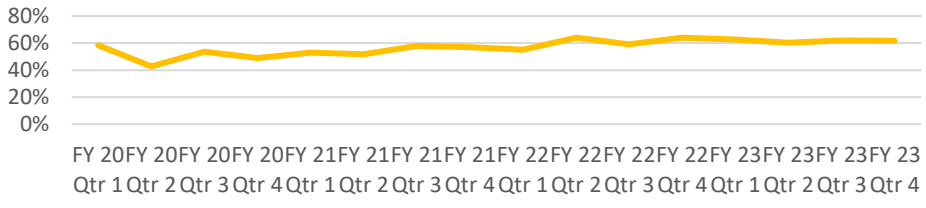
	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4	FY 22 Qtr 1	FY 22 Qtr 2	FY 22 Qtr 3	FY 22 Qtr 4	FY 23 Qtr 1	FY 23 Qtr 2	FY 23 Qtr 3	FY 23 Qtr 4
MI Child	57	53	72	71	81	68	70	54	37	52	57	79	68	70	91	157	138	87	108	115	116	87
MI Adult	85	107	85	90	99	78	97	71	98	85	124	92	98	105	87	230	261	260	289	302	271	257
DD Child	9	16	14	16	13	17	13	5	4	33	30	30	31	36	46	40	23	32	46	52	38	39
DD Adult	12	12	14	13	13	16	6	6	5	11	6	12	11	12	11	15	15	18	18	15	11	14
Total	163	188	185	190	206	179	186	136	144	181	217	213	208	223	235	427	437	397	461	484	436	397

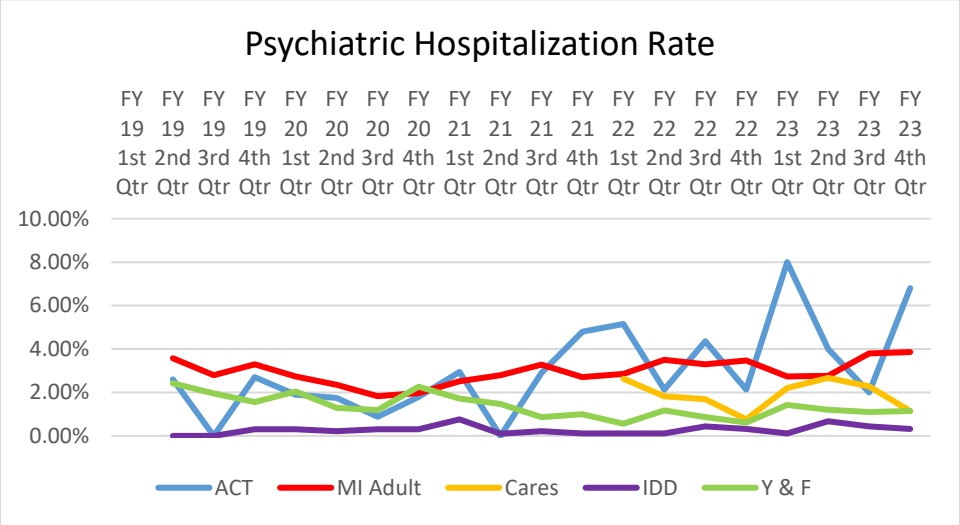
Prescreen Dispositions



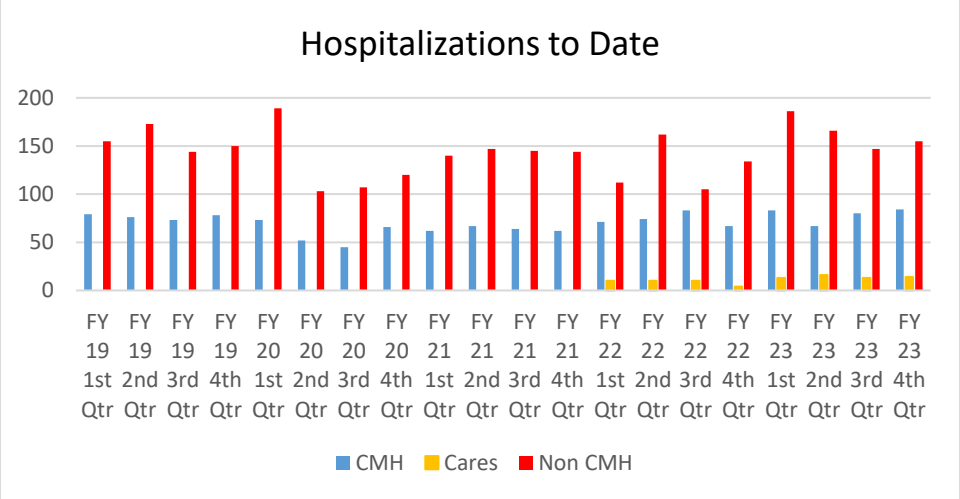
	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4	FY 22 Qtr 1	FY 22 Qtr 2	FY 22 Qtr 3	FY 22 Qtr 4	FY 23 Qtr 1	FY 23 Qtr 2	FY 23 Qtr 3	FY 23 Qtr 4
Blank	2	1		3	2	4	6	6	3	4	6	1	1	4	1	1
Partial Hospitalization	115	98	73	114	109	129	96	78	108	93	84	68	115	129	106	88
Outpatient/ Support Services	54	82	38	60	60	43	56	78	52	38	45	39	42	34	41	44
Inpatient Admission	294	168	158	202	229	230	257	230	210	275	218	209	281	277	266	246
Crisis Residential	35	39	22	19	28	27	26	12	11	17	17	9	10	15	16	19
Crisis Outreach	4	5	3	15	5	12	5	8	1	1	1	1	0	0	0	0

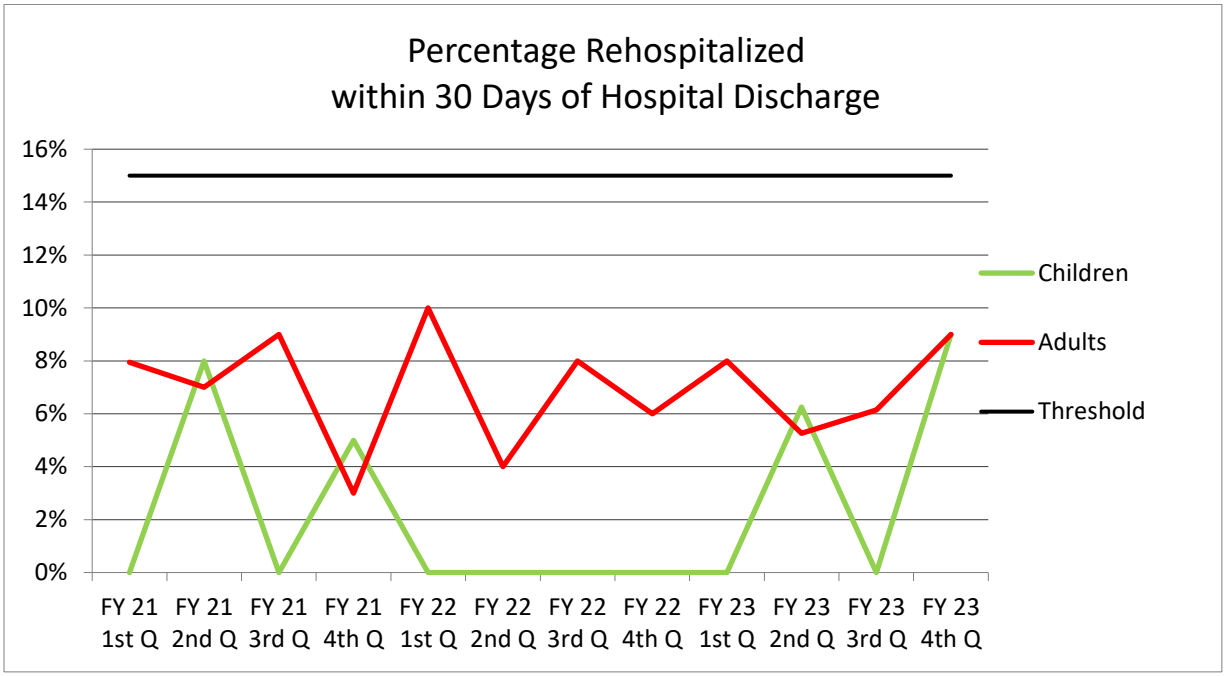
% Prescreens with Dispositions Psychiatric Hospitalization



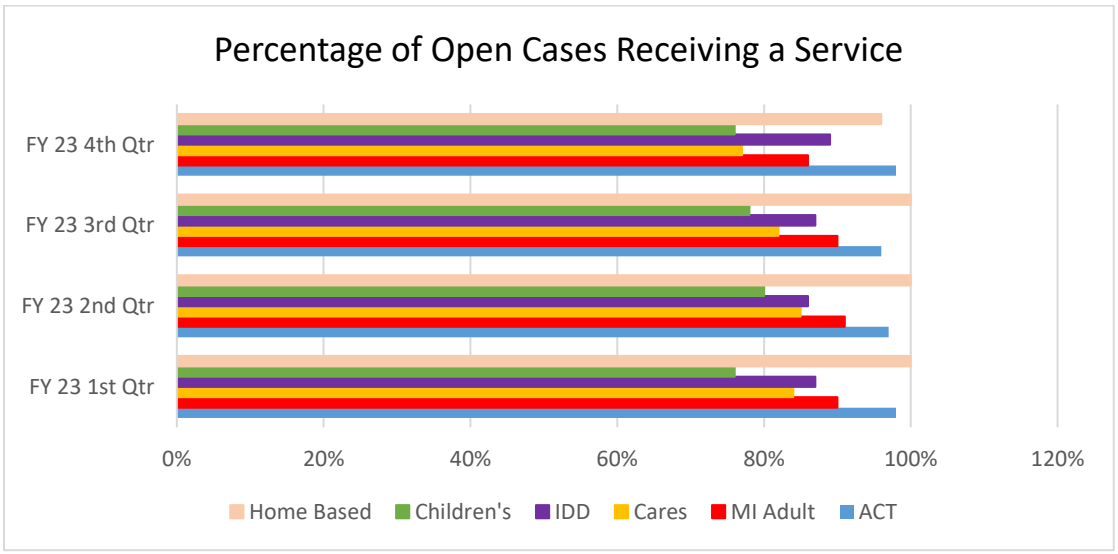


FY 23 4th Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	98	7 (4)	7%
MI Adult	1527	59 (8)	4%
Cares	489	14 (2)	3%
IDD	926	3 (0)	0%
Y & F	878	10 (0)	1%





FY 23 4th Qtr Detail Readmit within 30 days of Discharge			
Population	# Discharged and Core Team Assignment	# Readmitted within 30 days of Discharge	% Readmit
Child	11	1	9%
Adult	131	12	9%



Critical Event Data Reported Thru Qtr 4 FY 2023

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.

Time period	Team at Event	Type	Total
Qtr 1	ACT	Hospitalization	1
	Cares	Non Suicide Death	1
	Children's Services	Non Suicide Death	1
	IDD	Arrest	1
		Non Suicide Death	8
	MI Adult	Non Suicide Death	7
		Suicide	1
Qtr 1 Total			20
Qtr 2	ACT	Non Suicide Death	1
	IDD	Suicide	2
		Non Suicide Death	7
	MI Adult	Arrest	1
		Suicide	1
		Non Suicide Death	3
		Hospitalization due to Injury	1
Qtr 2 Total			16
Qtr 3	ACT	Non Suicide Death	2
	IDD	Non Suicide Death	2
		Arrest	2
	MI Adult	Suicide	1
		Non Suicide Death	8
		Arrest	3
		Hospitalization	1
Qtr 3 Total			19
Qtr 4	Cares	Non Suicide Death	2
	IDD	Non Suicide Death	6
		Hospitalization due to Injury	1
	MI Adult	Suicide	1
		Non Suicide Death	10
		Arrest	1
		Hospitalization	1
Qtr 4 Total			22

Mortality Data Thru Qtr 4 FY 2023

Cause of Death	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	Number of Deaths FY 23
Aspiration Pneumonia				2	3	4
Cancer	8	9	7	10	3	8
Cardiovascular	13	14	14	6	12	10
Dehydration	1					
Diabetes				1		
Drug Abuse	12	6	8	2	6	10
Endocrine System (Diabetes)						
Environmental Hypothermia		1				
Fluid Electrolyte Disturbance						1
Gastrointestinal			3	1		3
Hip Fracture Complications	1					
Homicide	3					3
Hyponatremia					2	
Inanition			2			
Infection	3	1	4 (2 - COVID 19)	5 (4 - COVID 19)	4 (3 - COVID 19)	
Kidney Disease	1		1			1
Liver Disease	2		2	3	1	1
Metabolic		1				
Natural/Other	1					
Neurological	2	1	3	7	3	3
Respiratory	5	10	10	4	5	5
Suicide	2	2	6	2	2	6
Trauma	1	2		2	3	2
Unknown	10	10	8	15	10	8
Grand Total (Previous years may not include detail of all causes of deaths but Grand Total is accurate.)	**65**	**57**	**68**	**60**	**54**	**65**

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

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget Amendment

	Current Fiscal Year			
	FY 2024 Original Budget	FY 2024 Amended Budget	Amended Budget Over/(Under) Original Budget	%
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 49,619,192	$ 49,969,192	$ 350,000	0.71%
HSW	30,015,227	31,275,389	1,260,162	4.20%
Children & SED Waivers	1,335,478	1,335,478	-	0.00%
Healthy Michigan Capitation	6,155,256	6,155,256	-	0.00%
Autism Capitation	7,423,397	7,423,397	-	0.00%
CCBHC Medicaid/HMP	8,500,000	8,500,000	-	0.00%
CCBHC Supplementary	8,500,000	11,800,970	3,300,970	38.83%
Behavioral Health Home	390,000	508,521	118,521	30.39%
TOTAL PIHP Revenue	$ 111,938,550	$ 116,968,203	$ 5,029,653	4.49%
MDHHS Revenue				
State General Funds	$ 4,597,669	$ 4,461,704	$ (135,965)	-2.96%
Grants & Earned Contracts	3,100,646	1,987,787	(1,112,859)	-35.89%
All Other Revenue				
County Appropriation	$ 1,751,761	$ 1,751,761	$ -	0.00%
Project Revenue	893,227	893,227	-	0.00%
All Other	1,917,652	1,917,652	-	0.00%
TOTAL Operating Revenue	**$ 124,199,505**	**$ 127,980,334**	**$ 3,780,829**	3.04%
Operating Expenses				
Administrative Expenses				
General Administration	$ 8,329,146	$ 8,329,146	$ -	0.00%
Program Administration	4,373,800	4,373,800	-	0.00%
Residential Services				
Community Living Supports	$ 29,800,000	$ 30,800,000	$ 1,000,000	3.36%
Licensed Residential	18,000,000	18,610,162	600,000	3.33%
Outpatient Services				
Autism Services	$ 11,400,000	$ 11,400,000	$ -	0.00%
Case Management	6,038,299	6,038,299	-	0.00%
Supports Coordination	3,405,893	3,405,893	-	0.00%
Skill Building	4,594,775	4,594,775	-	0.00%
Supported Employment	1,812,327	1,812,327	-	0.00%
Psychiatry	4,678,306	4,678,306	-	0.00%
Nursing Services	2,774,013	2,892,534	128,683	4.64%
Therapy Services	2,896,063	2,896,063	-	0.00%
All Other	12,204,965	15,369,970	3,165,005	25.93%
Other Expenses				
Community Inpatient	$ 9,700,000	$ 9,700,000	$ -	0.00%
Local Matches & Shelter	1,091,272	1,091,272	-	0.00%
Grants & Earned Contracts	3,100,646	1,987,787	(1,112,859)	-35.89%
TOTAL Operating Expenses	**$ 124,199,505**	**$ 127,980,334**	**$ 3,780,829**	3.04%
Revenue Over/(Under) Expenses	-	-	-	

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

Reviewed by:	**Recommendation Date:**
ROC	05/06/2024
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The policy establishes guidelines which ensure that all persons will perform ethically and professionally.

II. REVISION HISTORY

DATE	MODIFICATION
8-27-07	Original document
3-29-11	Re-formatted; Peer Support Specialists clarified; the authority and role of the Affiliation Ethics Committee; role of supervisor detailed; the Role of the Employee Exit Interviewer was added; Gift Giving/Receiving was expanded; Professional Boundaries section clarified
2014	Revised to reflect the new regional entity effective January 1, 2014.
5/16/17	Scheduled Review
7/27/20	Preferential treatment for board members, etc. prohibited
Will be Regional Approval Date	Scheduled 3-year review

III. APPLICATION

This policy applies to:

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☒ SUD Prevention Providers
☐ Other as listed:

IV. DEFINITIONS

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

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

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

V. POLICY

This policy establishes that all work shall be performed in an ethical and professional manner as determined by statute, code, accrediting organization standards, professional organizations' code of conduct standards, and the content of the policy itself. This includes engaging in courteous, respectful relationships with co-workers, other health care providers, educational institutions, payers, people served and their family members. Principles of consumer/individual served autonomy, compassion, safety, privacy, informed consent, competence and other related principles shall be demonstrated. Any and all ethical and relationship questions, issues or dilemmas arising from work relationships should be discussed proactively with a supervisor, and/or administrator

VI. STANDARDS

A. All consumers/individuals served, family members, community members, other treatment providers and internal colleagues shall be treated with the utmost respect, courtesy, compassion and dignity.

B. In making decisions, primary consideration shall be given to what is in the best interest of the consumer/individual served or what the consumer/individual served desires**.**

C. It is the responsibility of immediate supervisors to ensure the behavior of their employees is not in violation of the provisions of this policy.

D. All licensed and registered professional employees of any affiliation organization shall abide by their profession's Code of Ethics.

E. When in doubt about the ethical dimensions of a particular situation, a proactive approach shall be taken by discussing the situation with a supervisor or appropriate administrator.

F. Any staff member whose cultural, religious, or moral values conflict with aspects of a particular job responsibility or task may ask their supervisor to be excused from that responsibility or task. The supervisor shall seek other options for addressing that particular job responsibility by other staff and grant the request only if there is no negative impact on consumer/individual served care as a result of doing so.

G. Clinical decisions shall be based on the assessed needs and desires of the consumer/individual served, regardless of how leaders, managers and clinical staff are compensated.

H. Preferential treatment in the application and/or receipt of services for CMH Board members, CMH employees or consultants, or their family members or associates, is prohibited.

I. Service referrals given to current or past consumers/individuals served or service applicants shall not be influenced by any consideration of possible financial or personal gain for the referring person or his or her family members or the appearance thereof.

J. All new employees shall be informed during orientation of their obligation to follow this policy and shall provide written verification of having been thus informed. Any time there is a significant change made to this policy, all staff shall be informed, and new signatures shall be obtained and placed in the personnel file.

K. All staff, students and volunteers shall utilize their administrative chain of command and formal grievance procedure should they feel they are being asked to engage in an unethical activity.

L. Workers are encouraged to report observations of unethical conduct. There shall be no retaliation or repercussions for such good faith reporting

M. Violations of any of the provisions of this policy may be cause for disciplinary action up to and including immediate termination of employment.

VII. EXHIBITS

A. Ethical Guidelines for Consideration
B. Gift-Giving & Receiving Guidelines for Consideration
C. Ethical Practices Agreement
D. Request Not to Participate In Treatment

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
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		
The Joint Commission - Behavioral Health Standards	X	
Michigan Department of Health and Human Services (MDHHS) Medicaid Contract		
MDHHS Substance Abuse Contract		
Michigan Medicaid Provider Manual		
PIHP Policy Review Schedule	X	
Policy Tracking Form		

EXHIBIT A

ETHICAL GUIDELINES FOR CONSIDERATION

1. Respect and Dignity

The ethical worker treats everyone, whether colleagues or consumers/individuals served, with courtesy, respect and dignity, always being open to their unique characteristics, their unique histories and to the person as a whole. This is evident in their speech, appearance, manner, attitude and behavior.

2. Worker as Guide, Support and Provider of Assistance

The ethical worker guides, empowers and advocates for the people he or she serves, maintaining a focus on their desired outcomes and on helping them find their own way.

The focus of the relationship is on the needs of the person being assisted, not those of the worker. However, the ethical worker does not allow the needs or desires of the person to lead to a loosening of professional relationship boundaries which are always respected and maintained.

People are supported in deciding for themselves if, when, where, and how to use professional and non-professional supports and services.

3. Gift Giving and Receiving

The ethical worker is aware of the multiple perceived meanings and underlying intents that receiving or giving a gift may have for a consumer/individual served and a worker, meanings and intents that may interfere with the maintenance of an ultimately effective working relationship. Thus, consultation with a supervisor is pursued before money or gifts are accepted from or given to a consumer/individual served – See Exhibit B, Gift-Giving and Receiving Guidelines for Consideration

4. Worker as Role Model

The ethical worker recognizes that his or her values, beliefs, actions, and problem-solving methods impact others, both consumers/individuals served and staff members and acts accordingly.

5. Autonomy and Shared Power

In providing services, the ethical worker promotes consumer/individual served autonomy and shared power, never exerting strong influence on a person unless there is a clear and immediate threat to the person’s or others’ safety or health.

Consumers/individuals served are given the freedom to make their own decisions. The ethical worker offers suggestions rather than directives, identifies

and explores options and choices and discusses possible consequences of the consumer/individuals' decisions.

6. Compassion

The ethical worker demonstrates compassion in dealing with others, appreciating their struggles, their pain, our common humanity, and protecting them from imminent risk of harm.

The ethical worker advocates for and with the person.

7. Fairness and Justice

The ethical worker provides fair and just access to services, as well as fair and just ongoing care, never discriminating on the basis of race, color, gender, sexual orientation, religion, national origin, marital status, disability or other personal characteristics.

The rights of consumers/individuals served are acknowledged and protected.

8. Honesty

The ethical worker is honest with consumers/individuals served and co-workers as well as with himself or herself.

To maximize consumer/individuals' ability to make service decisions based on full and accurate information, the ethical worker communicates frankly about his or her role, relevant capacities, intent, limitations and role boundaries.

The ethical worker does not lie, cheat, steal, or condone or associate with others who are involved in such activities. He or she does not use his or her position or relationship with consumers/individuals served for personal advantage or give the appearance of the same.

9. Communication

The ethical worker communicates with consumers/individuals served openly, clearly, and frequently, doing what is promised, meeting expectations and fulfilling commitments, including those related to appointments and telephone calls.

Ambiguity, confusion and difficulty with consumer/individual served situations are to be expected and do not deter the worker from persisting in seeking guidance or consultation.

10. Confidentiality

The ethical worker upholds standards of consumer/individual served confidentiality and privacy while being candid about information that cannot be kept confidential and about with whom it can be shared.

The ethical worker also respects the privacy and dignity of co-workers.

11. Competence

The ethical worker performs job duties to the best of his or her ability, being open with supervisors when lacking the skills needed for a particular task and making efforts to enhance skills and competencies through timely professional development activities.

12. Personal Awareness and Self-Care

To fully appreciate each consumer/individual's perspective and, thus, be able to address their unique needs and desires, the ethical worker strives to identify his or her own personal issues, preconceptions, biases and areas of vulnerability and is open to making personal changes.

To reduce stress, time and space is carved out for a variety of self-care activities.

13. Professional Boundaries

The ethical worker always behaves professionally with all consumers/individuals served who receive services from the CMHPSM, avoiding interactions that are or might be perceived as flirtatious, provocative, threatening, harassing or hurtful.

The ethical worker never engages in a dating relationship with a person whom the worker directly or indirectly currently supervises or has done so in the past. ("indirectly supervises" is defined as having supervisory authority over the person's supervisor as evidenced by the organizational chart), including students and interns.

The ethical worker does not enter into a dating relationship with a consumer/individual served of the CMHSP who is served by another worker

The ethical worker does not provide services directly to individuals with whom they currently have or have had a prior friendship or dating relationship. Previous infrequent social contact or acquaintanceship would not preclude the provision of services by the worker.

The ethical worker notifies his or her supervisor regarding any past or current personal relationship with a CMHSP consumer/individual served. The worker whose helping relationship is becoming personal or intimate notifies a supervisor, discontinues the relationship and maintains professional boundaries. Direct treatment or support services are not provided to a person if there is intent to develop a personal or intimate relationship with him or her.

The ethical worker is aware of a consumer/individual's perceived power imbalance with the worker and the effect it may have on the consumer/individual's freedom to make her or his own decisions

The ethical worker respects consumer/individuals' religious and spiritual views and preferences and never pressures them to accept the religious or spiritual views of the worker. When initiated by the consumer/individual served and agreed upon as being related to an issue in the Individual Plan of Service, the worker may ethically explore spiritual issues with a consumer/individual served.

Depending on the worker's comfort and based on a determination that it is in the best interest of the consumer/individual served, the ethical worker may choose to disclose their own religious or spiritual views when an inquiry is made by the consumer/individual served.

Any worker-consumer/individual served service activity of a spiritual or religious nature, e.g., praying with a consumer/individual served, calls for prior approval by the worker's supervisor as well as the consumer/individual served himself or herself.

14. Alcohol and Drugs

The ethical worker never works under the influence of alcohol or drugs (legal or illegal).

The worker never purchases illegal substances from consumers/individuals served, never uses them with a consumer/individual served and never sells or gives them to a consumer/individual served.

Prescription medication is not to be shared with or borrowed from another person.

15. Alternative Interventions

Before engaging in support or treatment activities that might depart from traditional or conventional practices, the ethical worker discusses them with his or her supervisor to ensure their consistency with current professional standards.

16. Consumer/individuals' Right to Know

The ethical worker ensures that consumers/individuals served know and understand the rights, risks, opportunities and obligations associated with being a recipient of services.

Service activities and interventions are explained in understandable terms as are the limits of their impact and the implications and potential consequences of choices made by consumers/individuals served during the course of service provision.

Consumers/individuals served are informed of the cost of services and any available financial resources that may help them meet this obligation.

17. Organizational Relationships

The ethical worker, while taking into account funding/financial constraints, bases service provision decisions on standard clinical practice and organization criteria, regardless of how the agency compensates or shares financial risk with leaders, managers, clinicians, or licensed individual practitioners.

The ethical worker does not market or sell outside products or services to consumers/individuals served or engage in any non-job related activity with them that might result in or give the appearance of financial gain for the worker.

18. Equipment Use

The ethical worker only uses CMHPSM office equipment for CMHPSM business unless otherwise approved by his or her supervisor. Home use of equipment is authorized in advance by the appropriate supervisor or designee.

19. Service Provision and Documentation

The ethical worker ensures that all service~~s~~ types, amount, scope and duration are medically necessary and that their justification is clearly and thoroughly documented.

The ethical worker ensures that all services provided are in accordance with the Individual Plan of Service and with what has been authorized.

Documentation of a provided service is accurate, thorough and clear.

Assistance is obtained when there is uncertainty regarding the documentation requirements of service or financial information.

The ethical worker reports any suspected financial abuse or fraud to the Compliance Officer or designee and follows any other reporting requirements mandated by state or federal law.

20. Political Activity

The ethical worker ensures that any of his or her partisan political activities are conducted separately from his or her job responsibilities.

These activities never occur during those hours when the worker is being compensated for the performance of his or her work duties.

CMHPSM office supplies and equipment are not used for partisan political purposes.

The ethical worker never uses the authority or influence inherent in his or her CMHPSM position to interfere with or influence the results of an election or nomination for office.

The worker never requires contributions for political or partisan purposes as a duty or condition of employment, promotion or tenure and never coerces or

compels another CMHSPM employee to make contributions for political or partisan ends for any reason.

21. Self-Disclosure

The ethical worker only discloses personal information when it is consistent with the outcomes and interventions contained in the consumer/individual's Individual Plan of Service (IPOS).

These disclosures are intended to provide hope. They are intended to provide personal information as a means to facilitate consumer/individual served outcome achievement. Thus, the ethical worker does not self-disclose without considering the consumer/individual's service needs and current capacity to apply the information to his or her own life.

EXHIBIT B

GIFT GIVING & RECEIVING GUIDELINES FOR CONSIDERATION

Part One

1. The decision to accept or refuse a gift from a consumer/individual served should be given serious consideration as should the decision to give or not give a gift to a consumer/individual served. For the purposes of these Guidelines, "gift" is defined as a concrete object.

2. Like the majority of ethical decisions we face, we need to be fully aware of their possible positive and negative effects, both short and long term ones. This often takes a little time and involves the assistance of a supervisor and / or other staff with expertise in behavioral health ethics.

3. These effects might include a change in the consumer/individual's understanding of the nature of his or her relationship with the worker. For example, it might blur the difference between the worker as a professional and the worker as a friend, thereby interfering with the consumer/individual's progress toward outcome achievement.

4. Thus, accepting a gift from or giving a gift to a consumer/individual served may initially appear natural, innocent and without important consequences. Further analysis is often needed to confirm or bring into question this initial impression. A full understanding may involve consideration of the following:

   a. **What is the consumer/individual's intent in giving the gift?**

      - To express thanks for being helpful?
      - To express hope that the worker will be gentler in the future?
      - To express an apology for missing a contact or not achieving goals more quickly?
      - To express a wish to be personal friends?
      - To comply with the request of a parent or guardian?
      - To demonstrate good judgment in selecting the given item?
      - To express an interest in ending the work together via this thank-you gift?
      - To divert the worker's attention from the consumer/individual's anger or disappointment or misbehavior?
      - To express appreciation for sticking with the consumer/individual served through a crisis?
      - No intent, it's just what I do?
      - To express a wish for a gift in return?

   b. **Based on the intent, what might it mean to the consumer/individual served if the gift is graciously accepted without further discussion**?

      - I can expect better treatment?
      - The worker was so pleased; I will give more gifts in the future so as not to disappoint?
      - I am less uncertain about being seen as special by my worker?
      - I've found a nice way to make friends?
      - This is a good and easy way to show my private thoughts and feelings?

c. **What might it mean to the consumer/individual served if the gift is refused by the worker or there is some hesitation about accepting it?**

- My worker just makes things more complicated than they are?
- I can't do anything right? My worker doesn't understand my feelings?
- I have bad taste in gifts?
- My worker doesn't understand my cultural traditions and I am hurt and offended?
- This is interesting – I wonder why my worker won't accept it?
- My feelings are hurt – I'm sure other gifts are accepted?

d. **What behavior or personal quality does accepting a consumer/individual served gift reinforce?**

- Dependency?
- Subordination?
- Pleasing people in authority?
- Generosity?
- Sociability?
- Comfort with social norms?
- Need for social bonding?

e. **What impact might accepting a gift or giving a gift to a consumer/individual served have on the worker?**

- What personal needs does it satisfy?
- To what extent is the worker's self-esteem related to receiving the gift?
- Are those needs reducing the worker's focus on the consumer/individual's needs?
- How might the worker's objectivity be affected?
- Feelings of being appreciated, accepted?
- Increased sense of competence?

d. **What might it communicate to the consumer/individual served if the worker starts a discussion about gift giving in general or about the consumer/individual's thoughts and feelings behind the particular gift?**

- This is different; I wonder how it will help me to talk about my decisions and actions?
- I guess there are special rules at CMH?
- The worker thinks it's important to stick to how I'm doing with my outcomes?
- Pausing to talk before making a decision is something my worker values?
- Why is my worker making a mountain out of a molehill?

5. In summary, our natural inclination to graciously accept a gift might reduce consumer/individuals' hurt feelings in the short term but might not be the best response. More important may be the need to focus on providing a steady, predictable unambiguous professional relationship as well as on the consumer/individual's longer-term service goals. A lack of clarity about the relationship being more personal or professional can instill additional stress and distract the consumers/individuals served from the main purpose of the service provision.

It can be advisable to delay a decision until thoughtful consideration is given, often involving some timely and sensitive discussion with the consumer/individual served and / or a supervisor.

Guidelines for Consideration – Part Two

1. When feasible, discuss issues related to gift-giving in the early part of the consumer/individual served-worker relationship.

    - Opportunities can arise when expectations / logistics / parameters are being addressed, when the roles / tasks of those involved in implementing the IPOS are being discussed.
    - Talking about "working together" can provide an opportunity for elaborating on the meaning of the "working" part of the term, on what constitutes a working relationship.
    - Although some overlap exists, the uniqueness of the mental health working relationship, as distinct from those with friends, family members, religious officials, probation officers, judges, teachers and others can be spelled out.
    - For consumers/individuals served who have behavioral challenges or otherwise have difficulties with verbal emotional expression, the issue of gifts might be worked into an early conversation, as appropriate, when discussing more useful ways of expressing thoughts and feelings both in the community or with the mental health worker.
    - The consumer/individual's cultural background and resulting perspective on gift-giving can be discussed as a bridge to understanding later gift-related behavior and reactions.

2. Many consumers/individuals served can benefit from hearing the message from their workers that what is of greatest importance is "our work together," in outcome achievement and the satisfaction it can bring to the consumer/individual served. Other "gifts" might pale in comparison.

3. Although the meaning(s) given to gift giving and receiving is always an important thing to take into consideration or discuss before accepting or giving a gift, examples of less potentially impactful gifts can include:

    - Holiday cards
    - Very inexpensive gifts
    - Drawings or other artwork from children
    - Poems or songs composed or found by the consumer/individual served treated as an expression of something to be discussed and understood
    - Inexpensive food or decorative items that will be shared or displayed for a whole team or staff group.
    - Items created by the consumer/individual served as a result and demonstration of successful IPOS outcome achievement.
    - Anonymous staff donations to organized holiday gift-giving arrangements, e.g., "The Giving Tree."
    - Gifts given to young children on special occasions, like birthdays.

EXHIBIT C

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
ETHICAL PRACTICES AGREEMENT

I, (print name) _____ have read and understand the Ethics and Conduct policy of CMHPSM and I agree to follow its requirements including but not limited to the following:

I will not discuss or reveal consumer/individual served information to non-agency staff unless required by law and will only discuss or reveal it to agency staff on a need-to-know basis.

I will treat all consumers/individuals served with dignity and respect.

I will avoid any conflict of interest activities.

I do not have a mental or physical impairment that would interfere with my ability to carry out the requirements of the aforementioned policy.

In situations where my cultural values, ethics or religious beliefs conflict with those of a consumer/individual served to the extent that it influences my ability to provide appropriate services, I understand that I have the right and obligation to discuss this with my supervisor (EXHIBIT D).

I agree to be bound by applicable state laws including any / all reporting requirements

I agree to meet relevant accreditation standards.

Further, I agree to review the Recipient Rights policies, to be accountable for conducting myself in accordance with them, and to report any care concerns to my supervisor or to the Recipient Rights Officer.

_____ _____
Employee Signature Date

Employee to turn in signed form to Supervisor

_____ _____
Supervisor Signature Date

EXHIBIT D

Ethical Practices Agreement
Request Not to Participate in Treatment

Complete the following form and submit to your supervisor if there is an aspect of care that conflicts with your cultural values, ethics or religious beliefs:

Employee Name:

Date:

Consumer/Individual Served Name:

Aspect of Care requesting not to participate in:

Reason why (include the cultural values, ethic or religious beliefs that treatment conflicts with):

Resolution (to be completed by supervisor or Program Administrator) (include your conclusion as to whether the request, if granted, will or will not negatively affect treatment)

_____ _____
Supervisor's Signature Date

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

I. PURPOSE

To ensure consistency across the region in meeting clinical documentation standards.

II. REVISION HISTORY

DATE	MODIFICATION
10/02/2013	Revised to reflect the new regional entity effective January 1, 2014. Policy was formerly known as Clinical Services.
2/2017	3-year review
10/28/2020	3-year review
Will be Regional Approval Date	3-year review

III. APPLICATION

This policy applies to:

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. DEFINITIONS

Clinical Record: The medical and billing records, including protected health information that is maintained for the purpose of enrollment, treatment and decision making, payment and claims adjudication. This record shall include both electronic the health record and any historical paper records.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the Prepaid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, 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.

Network Providers: An individual or organization contracted to provide mental health or substance use disorder services.

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

V. POLICY

The clinical record will include both electronic and paper records.
All clinical records maintained by CMHPSM and Substance Abuse Treatment Provider will be complete and accurate.

VI. STANDARDS

A complete and accurate clinical record will include**:**

- Consumer/individual served name, gender, address, date of birth, race/ethnicity, authorized representative, preferred language, and special accommodation needs if any
- Legal status of consumers/individuals receiving behavioral health care, including legal issues, court/probationary/parole information, and guardianship status
- Emergency care provided to the consumer/individual served
- Documentation and findings of assessments
- Conclusions or impressions drawn from historical and ongoing information related to recipient's physical, behavioral health and trauma status and needs
- Reason(s) for admission or care, treatment or conditions
- Goals of the Individual Plan of Service (IPOS)/Treatment Plan
- Evidence of known advance directives, do not resuscitate orders
- Evidence of Informed Consent
- Evidence that notice of privacy practices was provided
- Diagnostic and therapeutic orders
- All diagnostic and therapeutic procedure, test and results
- All operative and other invasive procedures
- Progress notes made by authorized individuals toward meeting treatment goals
- All reassessments and plan of care revisions, when indicated
- Relevant observations
- Response to care, treatment and services provided
- Releases of information
- Primary Care Physician, name and address and a signed release or documentation or refusal for coordination of care.
- Consultation reports
- Allergies to foods and medications
- All medication ordered or prescribed, every dose of medication administered (including the strength, dose or rate of administration; adverse drug reactions), and every medication dispensed or prescribed on discharge
- Evidence indicating that medication side effects information was given
- All relevant diagnoses/conditions established during the course of care and treatment

- Records of communication with the consumer/individual served regarding care, treatment and services (i.e. phone calls, mail, etc.)
- Referrals or communications made to external or internal care providers and community agencies
- Documentation of clinical research interventions this distinct from entries related to regular care
- Member-generated information (i.e. information entered into the record over the Web or in Computer systems), if applicable
- Discharge planning
- Documentation of how services are integrated across the continuum of care based upon identified need in the IPOS/treatment plan:
    - Physical health
    - Community
    - Education
    - Vocational
    - Spiritual
    - Family/Significant other support systems
    - Socio-cultural
    - Special population needs
- Due process/appeal notices
- Record Release log: An accounting of disclosures for each consumer/individual served, indicating any information which is released.
- Evidence that Recipient Rights information was provided initially and at least annually thereafter.
- Evidence that the consumer/individual served was offered self-determination, independent facilitation, and choice of provider where applicable, and the consumer/individual's response
- Any other information required by policy

All clinical records maintained by network provider records must contain, at a minimum:

- Current IPOS/treatment plan
- Progress notes documenting service(s) delivered and the specific dates of delivery or other documentation of each service delivery.
- Medication administration records (including the strength, dose or rate of administration; adverse drug reactions) if medications are being dispensed by the provider
- Signed Releases of Information if any protected health information is being released or exchanged.
- An accounting of disclosures for each consumer/individual served, indicating any information which is released without a signed ROI form.

All information shall be protected in keeping with all state and federal laws regarding confidentiality and security. See Regional Confidentiality and Access to Clinical Records Policy.

The clinical record shall be retained in accordance to all Federal and State Laws and standards. See Record Retention and Destruction Policy.

VII. EXHIBITS

None

VIII. REFERENCES

A. Joint Commission Standards
B. BBA
C. HIPAA (45 CFR Parts 160 & 164)
D. Michigan Mental Health Code
E. Regional Confidentiality and Access to Clinical Records Policy
F. Regional Record Retention and Destruction Policy
G. Regional Communicable Disease Policy
H. The HITECH Act

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** *Critical Incident, Sentinel Event, and Risk Event Policy*
Committee/Department: **Corporate Compliance Committee**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	04/01/2024
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

This policy establishes the standards by which Community Mental Health Partnership of Southeast Michigan (CMHPSM) reviews, investigates, reports, and acts upon, critical incidents, sentinel events, and risk events related to practice of care for its consumers/individuals served.

II. REVISION HISTORY

DATE	MODIFICATION
5/5/2014	Revised to reflect the new entity. Replaces the Sentinel Event policy
8/29/2017	Due for regional review.
2/12/2020	Corrections from HSAG EQR Review on timeframes
Will be the Regional Approval Date	Removing SUD language/ referring to the SUD Sentinel Event Policy

III. APPLICATION

This policy applies to:

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☐ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

See the CMHPSM SUD Sentinel Event Policy for event reporting related to substance use providers.

IV. DEFINITIONS: All "events" or "incidents" as defined below, shall apply only to individuals actively receiving services.

A. **Actively Receiving Services**: For reporting purposes, a consumer/individual served is actively receiving services" when any of the following occur:

1. A face-to-face intake has occurred, and the individual was deemed eligible for ongoing service, or

2. A Regional Provider has authorized the individual for ongoing service, either through a face-to-face assessment or a telephone screening, or the individual has received a non-crisis, non-screening encounter; and

   The occurrence (defined above) takes place between the date when the decision is made to start providing ongoing non-emergent services and the date when the consumer/individual served is formally discharged from services.

B. **Actively Receiving a Specific Service**: For reporting purposes, a consumer/ individual served is considered a recipient of a specific service when service delivery for that specific service takes place between:
   1. The date when the consumer/individual served has been determined to be eligible, and
   2. The date then the consumer/individual served is formally terminated from that type of service.
   3. Examples of formal termination (end of service) include:
      a) Transfer to another Program,
      b) Discharge from the Program providing the service,
      c) Discharge from the CMHSP service system, or
      d) Removal of the service from the consumer's/individual's served individual plan of service.

   The consumer/individual served must have received the specific service at least once.

C. **Child-Caring Institution:** A facility providing residential care for children that is licensed under MCL 722.111, et seq.

D. **Clinical Risk Review**: All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:
   1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
   2. Involvement of medical personnel in the mortality reviews
   3. Documentation of the mortality review process, findings, and recommendations.
   4. Use of mortality information to address quality of care.
   5. Aggregation of mortality data over time to identify possible trends.

The review must be a formal process which includes a review of areas of clinical risk. The process must include individuals with the appropriate credentials to review the scope of care and include individuals who were not involved in the treatment/ care of the consumer/individual served as well as individuals / professionals who may contribute to a thorough review process.

The process shall result in an understanding of the causes of the event and if necessary, a root cause analysis with a subsequent action plan implemented in hopes of avoiding similar events from occurring.

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

F. **Critical Incidents:** Any of the following events which should be reported to MDHHS (within the timeframe indicated ~~in~~ below and reviewed by the contracted CMHSP within three (3) business days after occurrence to determine whether it meets the criteria for a sentinel event. If the critical incident is determined to be a sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event (as defined in section IV.B.):

1. **Suicide**: A death of a consumer/individual served when either of the following two conditions exists:
   a. The regional CMHSP or the CMHPSM determines through its death review process, that the consumer/individual's death was a suicide, or
   b. The official death report (i.e., coroner's report) indicates that the consumer/individual's was a suicide.

2. **Non-suicide death**: any death of a consumer/individual served that was not otherwise reported as a suicide. Within this category are expected and unexpected deaths.

3. **Emergency medical treatment due to injury or medication error**: Where an injury to a consumer/individual served or medication error results in face-to-face emergency treatment being provided by medical staff at any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms.

   a. **Injury**: Bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body, that results in treatment by medical staff at any treatment facility including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms or admission to a general medical facility. Examples of injuries include cuts, bruises (except those due to illness), contusions, muscle sprains, and broken bones.
   b. **Medication Error**: Where a mistake is made when a consumer/individual served takes prescribed medication (i.e., wrong medication, wrong dosage, staff failed to administer). It does <u>not</u> include instances in which consumers/individuals served have refused medication.

4. **Hospitalization due to injury or medication error**: See above definitions of injury and medication error. Where an injury or medication error results in admission of a consumer/individual served to a general medical facility. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

5. **Arrest**: situation where a consumer/individual served is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a consumer/individual served is transported for the purpose of receiving emergency mental health services, or situations where a consumer/individual served is held in protective custody, are not considered to be an arrest.

G. **Mortality Review**: A process for identifying the basic or causal factors that underlie variations in performance when the occurrence of a death of a consumer/individual served is determined not to be a sentinel event. (For a Sample of Review format, see Exhibit C, Mortality Review Report.)

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

I. **Risk Event**: An event that puts an individual at risk of harm. Such an event is reported internally and analyzed to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. Risk events minimally include:

1. **Harm to Self**: Actions taken by consumers/individuals served that cause physical harm requiring emergency medical treatment or hospitalization due to an injury that is self-inflicted (e.g., pica, head banging, self-mutilation, biting, suicide attempts).

2. **Harm to Others**: Actions taken by consumers/individuals served that cause physical harm to others (family, friends, staff, peers, public, etc.) that result in injuries requiring emergency medical treatment or hospitalization of the other person(s).

3. **Police Calls:** Police calls by staff of specialized residential settings, or general (AFC) residential homes or other provider agency staff for assistance with a consumer/individual served during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan (see the Behavior Treatment Committee Policy).

4. **Emergency Use of Physical Management**: Emergency use of physical management by trained staff in response to a behavioral crisis.

5. **Physical Management***:* A technique used as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her from physically harming him/herself or others. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand. *(See also definition in the "Behavior Treatment Committee Policy for additional information)*

J. **Root Cause Analysis**: A process for identifying the basic or causal factors that underlie variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis focuses on systems and processes, not individual performance, and gives the potential for redesign to reduce risk. *(See Exhibit A, Provider Root Cause Analysis Report)*

K. **Sentinel Event**: A critical incident that is an unexpected occurrence involving death or serious physical or psychological injury (emotional harm) or the risk thereof. Serious injury specifically includes the loss of limb or function.

The phrase, "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome (i.e., if the event had continued, death or serious physical or psychological injury would have occurred as determined by a physician or registered nurse.)

A sentinel event does not include a death due to natural causes. Additional sentinel events will be described in 1 – 8 below.

Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

Per Michigan Department of Health and Human Services (MDHHS), the sentinel event must be identified and defined as meeting criteria, having occurred for someone within the reportable population.

With the exception of arrests/convictions and serious challenging behaviors, all incidents involving the reportable population should be reviewed within three (3) business days to determine if the incidents meet the criteria and definitions for sentinel events and are related to the practice of care. The outcome of this review is a classification of incidents as either a) sentinel events or b) non-sentinel events.

1. **Unexpected Death***:* The death of a consumer/individual served that does not result from natural causes. Unexpected deaths include those that result from suicide, homicide, an undiagnosed condition, accident, or were suspicious due to possible abuse or neglect.

2. **Serious Physical Injury***:* Physical damage suffered by a consumer/individual served that a physician or registered nurse determines caused or could have caused the death of a consumer/individual served, the impairment of his or her bodily functions, loss of limb, or permanent disfigurement. Injuries that require emergency room visits or admission to hospitals include those resulting from abuse or accidents. Required visits to emergency rooms, medi-centers, and urgent care clinics/centers and/or admissions to hospitals should be included in the injury reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics or centers are used in place of hospital emergency rooms.

3. **Emotional Harm***:* Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional/psychiatrist.

4. **Death by Natural Causes***:* Deaths occurring as a result of a disease process in which death is an anticipated outcome. Examples of deaths by natural causes are as follows: death of a consumer/individual served due to an acute or long-standing disease process, increased susceptibility to death as a result of diabetes, cancer, advanced heart disease, AIDS, serious infection, etc.; or death of

consumer/individual served who has been receiving hospice care or treatment for end stage disease. Deaths by natural causes are not considered sentinel events.

5. **Physical Illness requiring admissions to hospitals:** Planned surgeries, whether outpatient or inpatient, are not considered unexpected occurrences and therefore are not included in the reporting of illnesses requiring admissions to hospitals. It also does not include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.

6. **Serious Challenging Behaviors:** Serious challenging behaviors include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leave of absence. They include behaviors not already addressed in a treatment plan.

7. **Medication Errors:** mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage that resulted in death or serious injury or the risk thereof. It does not include instances where consumers/individuals served have refused medication.

8. **Arrests/Convictions:** are any arrest or conviction that occurs with an individual who is in the reportable population at the time the arrest or conviction takes place. These events must be reported as Sentinel Events, but do not require a Root Cause Analysis. These must be reported as separate categories through the MDHHS Performance Indicator process.

L. **Unscheduled Hospitalizations**: Two or more unscheduled admissions to a medical hospital not due to planned surgery or the natural course of a chronic illness (such as a terminal illness) within a 12-month period. Admission to a medical hospital does not include use of an emergency room or emergency department.

V. POLICY

It is the policy of the CMHPSM that CMHSPs shall have and implemented processes to:

A. Review, investigate, analyze, act upon, internally report and track critical incidents, sentinel events, and risk events, in an accurate and timely manner.
B. Review, investigate, analyze, act upon and report critical incidents and sentinel events to MDHHS in an accurate timely manner.
C. Identify system factors associated with critical corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.
D. Develop and implement effective corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.

VI. STANDARDS

A. The CMHPSM and the CMHSPs shall collect and require internal reporting on all critical incidents (including sentinel events) and risk events related to practice of care according to MDHHS standards.

B. The CMHPSM electronic health record shall be the means by which critical incidents and risk events are reported by all entities in the CMHPSM system.

C. Incident reports shall be written for all critical incidents and risk events according to state incident reporting requirements and CMHPSM incident reporting practices.

D. The CMHPSM and the Regional CMHSPs shall report to the Michigan Department of Community Health (MDHHS) critical incidents occurring within the populations specified, and in the timeframes provided, for each critical incident, in accordance with the provisions of the MDHHS contract.

E. **CRITICAL INCIDENT REPORTING**

The following parameters shall be met in reporting **critical incidents**:

1. **Suicide**
   a. A consumer/individual's death that has been determined to be a suicide shall be reported on any consumer/individual served who was actively receiving services, and all consumers/individuals served who had received an emergency service within the last 30 calendar days prior to death.

   b. Deaths that have been determined to be a suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the responsible Service Providing Agency shall submit a "best judgment" determination of whether the death was a suicide. In this case, the submission is due within 30 days after the end of the month in which this "best judgment" determination was made.

2. **Non-Suicide Death**
   a. Deaths that have not otherwise been reported as a suicide shall be reported on all consumers/individuals served who, at the time of their deaths were actively receiving services and:

      1) Living in a 24-hour Specialized Residential setting (per Administrative Rule R330.1801-09), or a Child- Caring Institution, **or**

      2) Actively receiving Community Living Supports, Supports Coordination, Targeted Case Management, Assertive Community Treatment (ACT), 1915(i) Services, Home-Based, Wraparound, Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

   b. The non-suicide death shall be reported within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the responsible Service Providing Agency attempts to determine whether the death was due to suicide. In this case, the submission is due within 30 days after the end of the month in which the responsible Service Providing Agency determined the death was not due to suicide. Natural cause deaths shall be reported, indicating the specific natural cause (e.g., heart disease, pneumonia/influenza, lung disease, vascular disease, etc.)

3. **Emergency Medical Treatment Due to Injury or Medication Error**
   a. Situations where an injury to a consumer/individual served or a medication error results in face- to-face emergency treatment shall be reported on all consumers/individuals served who, at the time of the event were actively receiving services and:

      1) Living in a 24-hour Specialized Residential setting, or a Child-Caring Institution **or**

      2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services Child Waiver Services, or 1915(i) Services.

   b. The incident shall be reported within 60 days after the end of the month in which the emergency medical treatment began.

4. **Hospitalization Due to Injury or Medication Error**
   a. Situations where injury to a consumer/individual served or a medication error results in inpatient admission shall be reported on all consumers/individuals served who, at the time of the event were actively receiving services and:

      1) Living in a 24-hour Specialized Residential setting), or a Child-Caring Institution, **or**

      2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services, or 1915(i) Services.

   b. The incident shall be reported within 60 days after the end of the month in which the hospitalization began.

5. **Arrest of Consumer/Individual Served**
   a. Arrests shall be reported on all consumer/individual served who, at the time of the arrest, were:

      1) Living in a 24-hour Specialized Residential setting (), or a Child-Caring Institution, or living in a, or

      2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services, Child Waiver Services, or 1915(i) Services.

   b. The incident shall be reported within 60 days after the end of the month in which the arrest took place.

F. **REPORTING AND REVIEW OF DEATHS**

1. For all deaths of consumers/individuals served who are open to the CMHSP, and regardless of cause, the CMHSP shall conduct a review of that death in accordance with the CMHPSM Report and Review of Recipient Death Policy.

2. The CMHSP shall submit a written report of its review/analysis of the death to the PIHP, within 45 days of the after the month in which the death occurred.

3. The PIHP will submit the analysis to MDHHS within 60 days after the month in which the death occurred as a follow up to the critical incident report of that death.

G. RISK EVENT REPORTING

1. The responsible CMHSP shall internally track **risk events**, occurring within the populations specified below, as expeditiously as possible, and in accordance with the provisions of this policy, and MDHHS requirements.

2. Risk events are monitored by the providers and include actions taken by individuals receiving services as defined by MDHHS
   a. Actions taken by individuals who receive services that cause harm to themselves.
   b. Actions taken by individuals who receive services that cause harm to others.
   c. Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

3. The population group for risk event reporting includes all consumer/individual served who, at the time of the **risk event** (see definition) were actively receiving services and were receiving at least one actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services, or 1915(i) Services OR one of the following:
   a. Supports Coordination
   b. Targeted Case Management
   c. ACT
   d. Home-Based Services

H. MDHHS EVENT NOTIFICATIONS: DEATHS

1. The PIHP and/or the CMHSP shall immediately report to MDHHS:
   a. Any death that occurs as a result of suspected staff member action or inaction, OR
   b. Any death that is the subject of a recipient rights, licensing, or police investigation.
   c. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation.

2. This report shall be submitted electronically by designated individual of the PIHP within 48 hours of either the death, or the responsible service provider's receipt of notification of the death, or the responsible service provider's receipt of notification that a rights, licensing, and/or police investigation has commenced, and include the following information:
   a. Name of beneficiary
   b. Beneficiary ID number (Medicaid, MiChild)
   c. Consumer/individual served I (CONID) if there is no beneficiary ID number.
   d. Date, time, and place of death (if a licensed foster care facility, include the license #)
   e. Preliminary cause of death
   f. Contact person's name and e-mail address.

3. Following notification to MDHHS, the PIHP/ Service Provider shall submit information on relevant events through the MDHHS MiCAL Critical Incident Reporting System.

I. MDHHS EVENT NOTIFICATIONS: PROVIDER NETWORK CHANGES

Except for deaths, notification of the remaining events shall be made within five (5) business days to contract management staff members at MDHHS through the reporting structure required by MDHHS contract.

1. Relocation of a consumer/individual's placement due to licensing suspension or revocation.
2. An occurrence that requires the relocation of any PIHP or provider panel service site,
3. governance, or administrative operation for more than 24 hours.
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from
5. participation in federal reimbursement.

J. CLASSIFICATION AND DETERMINATION OF INCIDENTS/EVENTS

1. The CMHPSM shall ensure that each CMHSP has a mechanism for performance of the following tasks:
   a. Classifying and identifying incidents as either sentinel events "critical incidents, or "risk events;"
   b. Performing root cause analyses on sentinel events;
   c. Performing a review of risk events, and;
   d. Performing mortality reviews on deaths that are not sentinel events (e.g., death by natural causes).

   All critical incidents would be either a sentinel event or a risk event, and as such would be reviewed/analyzed.

2. Staff identified as responsible for classifying, reviewing, and analyzing the events must not have been directly involved in the incident that is the subject of the review and shall have the appropriate credentials to review the scope of care. For example, events that involved consumer/individual served death, or other serious medical conditions, must involve a physician or nurse.

3. The CMHPSM and each CMHSP shall ensure that, within three business days after occurrence an incident is classified as a sentinel event, risk event, critical incident, or non-sentinel deaths.

4. CMHSPs shall ensure guidelines are used in determining if an incident is a critical incident, a risk event, and/or a sentinel event. Once the determination is made, the CMHSP shall ensure that risk events and critical incidents are reviewed and analyzed, and a root cause analysis is completed for sentinel events within the required timeframes.

5. Guidelines for determining if a critical incident is a sentinel event include the following:

a. The qualifying event involves consumers/individuals served actively receiving services who meet the population specification for that event; **and**
b. The incident was unexpected; **and**
c. The incident resulted in death or serious physical or psychological injury, or (as determined by a physician or nurse) there is a significant change that had the events continued, death or serious physical or psychological injury would have occurred.
d. If the incident is a death, the following deaths shall be considered "unexpected" for purposes of defining the death as sentinel:
    a. Consumer/individual served deaths that result in a Recipient Rights investigation (e.g., possible abuse or neglect from a care provider.
    b. Consumer/individual served deaths that result in a police investigation (e.g., possible or actual suicide or homicide);
    c. Consumer/individual served deaths during elopement, or wandering, from a 24-hour care setting;
    d. Consumer/individual served deaths that were accidental;
    e. Consumer/individual served deaths that resulted from an undiagnosed condition.

A critical event will be reviewed within three (3) business days after occurrence to determine whether it meets the criteria for a sentinel event. If the critical incident is determined to be a sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event.

K. REVIEW OF INCIDENTS OR EVENTS

1. The CMHPSM shall ensure that CMHSP providers:

    a. Initiate root cause analyses of perceived sentinel events immediately upon the incident classification as sentinel, utilizing an approved review process, such as Exhibit A, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" based upon The Joint Commission (TJC) configuration. The root cause analysis must be initiated within five (5) days of the date of the occurrence.
    b. Initiate reviews of risk events not determined to be sentinel events within ten (10) business days of the date that the incidents are classified as a risk event, utilizing at a minimum, the classification of causal factors, below. Alternately, providers may utilize an approved review process, such as Exhibit A, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event."
    c. Minimally, reports of risk event reviews shall include:
        - Personal Identifying Information
        - Method/Procedure
        - Communication
        - Staff-Related
        - Environment
        - Equipment/Materials

2. When an incident under review is the subject of an active recipient rights investigation, the clinically-responsible provider shall be careful that it not impede, interfere or otherwise compromise the investigation of the ORR pursuant to the standards and procedures under the Policy Office of Recipient Rights (e.g. clinically-

responsible provider may not investigate the details of the event but shall instead focus on systemic issues, etc.).

3. For consumer/individual served deaths, if, upon receipt of additional documentation, it is determined that an event originally perceived as meeting the definition of a sentinel event is not sentinel (e.g., autopsy report indicates death is due to natural causes) the review team shall perform a mortality review of the death.

4. Initiate mortality reviews of non-sentinel deaths within ten (10) business days of the date that the deaths were classified as non-sentinel. The review must include standard death information, such coroner's report, death certificate (as available); involvement of medical personnel in the review; documentation of the review process and findings; a n d, a s applicable, recommendations for improvement and a corrective action plan. CMHSPs are encouraged to utilize Exhibit C, "Provider Mortality Review," as the review model.

5. For consumer/individual served deaths, if, upon receipt of additional documentation, it is determined that an event originally perceived as not meeting the definition of a sentinel event is determined to be a sentinel event (e.g., autopsy report indicates death is not due to natural causes) the CMHSP shall implement their procedures for a root cause analysis of the death.

6. Clinically responsible providers shall cooperate with and respond to requests by the PIHP to perform Root Cause Analyses, Mortality Reviews, or Risk Event Investigations, and to follow the PIHP's recommendations for additional action on corrective action plans.

L. DATA ANALYSIS

1. The PIHP requires that each CMHSP shall analyze at least quarterly the critical incidents, sentinel events, non- sentinel deaths and risk events to determine what actions need to be taken to remediate the problems or situations and to prevent the occurrence of additional events and incidents.

2. Quarterly reviews of sentinel and non-sentinel deaths shall serve as the basis for an internal report that examines mortality information to address quality of care, and aggregation of mortality data over time to identify possible causes and trends.

3. Quarterly reviews of risk events shall serve as the basis for a report that classifies the reasons for the events.

    a. For all risk events, except unscheduled hospitalizations, the report shall include an analysis of the total number of incidents per calendar month, and the rate of incidents per 100 people served in the identified population, with cumulative year to date from the beginning of the current fiscal year;

    b. For risk events that are unscheduled hospitalizations, the report shall include:

i. An aggregate of the total number of hospitalizations by reason/condition per calendar month, and the rate of number of total hospitalizations per 100 people served in the identified population, with cumulative year to date from the beginning of the current fiscal year; and

ii. An analysis of the data to identify trends and to identify individuals with multiple hospital admissions.

M. **RECORDS MANAGEMENT**

1. Each CMHSP shall ensure appropriate remediation at the individual and system level, when applicable, and shall maintain records as appropriate to document evidence of remediation efforts.

2. Upon the request of MDHHS or the PIHP, CMHSPs shall cooperate with any MDHHS/PIHP review in providing information/documentation related to the CMHSP's process for the review, investigation, and monitoring of critical incidents, sentinel events, and risk events.

3. Documentation generated during the peer review of sentinel events or deaths of consumer/individual served are considered confidential peer review/quality assurance documents. Therefore, all written reports, findings, and recommendations for remedial actions created during the root cause analysis or mortality review shall be kept in a confidential peer review administrative file. No copy of such documents shall be maintained in consumer/individual served clinical records. Peer review/quality assurance documents include, but are not limited to:

   a. The Provider Report of Death
   b. The Provider Root Cause Analysis Report
   c. The Mortality Review Report
   d. Risk Event Reviews
   e. Minutes of meetings where event incidents were reviewed and/ or discussed
   f. Reports by the CMHPSM ORR to MDHHS
   g. Incident Reports
   h. Peer Review reports
   i. Corrective Action Plans and other quality improvement plans

VII. EXHIBITS

A. Example of a Template for a Provider Root Cause Analysis Report, using *A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event* (based upon the Joint Commission configuration)
B. Example of a Provider Report of Death
C. Example of a Mortality Review Report
D. Critical Incident Reporting Chart
E. Sentinel Event Determination Chart
F. Risk Event Determination Chart (Internal Reporting and Maintaining)
G. Review of Action Plan Based on Root Cause Analysis / Mortality Review Report / Risk Event Investigation

VIII. REFERENCES

A. MDHHS-PIHP Medicaid Managed Specialty Supports and Services Contract, current FY
B. Michigan Mental Health Code, MCL 330.1748(9)2; MCL330.1100 c(5)
C. MDHHS, Administrative Rules R 330.1274; R330.7046
D. 42 CFR Part 438.330 Quality assessment and performance improvement program.
E. MDHHS Medicaid Provider Manual
F. A Framework for a Root Cause Analysis and Action Plan in Response to a
G. Sentinel Event (The Joint Commission)
H. CMHPSM Incident Reporting Policy
I. CMHPSM Office of Recipient Rights Policy
J. CMHPSM Report and Review of Death Policy

Exhibit A

Sample Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event (based on Joint Commission configuration)

SAMPLE

ROOT CAUSE ANALYSIS AND ACTION PLAN

Cover Sheet

Date:

Program:

Consumer

Name:

Case #:

Date of Event:

Date Event Determined as Sentinel Event:

Date Root Cause Analysis completed:

Meeting Attendees:

Name, Credentials	Position

Exhibit B

Sample Framework – Sentinel Event Root Cause Analysis and Action Plan

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel event	What are the details of the event? (Brief description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen? ---- What were the most proximate factors? *(Typically, "special cause" variations)*	The process or activity in which the event occurred	What are the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influenced this outcome?				
		What other areas or services are impacted?				

This template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for "root causes" and risk reduction. As an aid to avoiding "loose ends," the three columns on the right are provided to be checked off for later reference:

"Root cause?" should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.

"Ask "Why?" should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn't occur when it should have) - in other words, to drill down further. Each item checked in this column should be addressed later in the analysis with a "Why?" question. It is expected that any significant findings that are not identified as root causes will have check marks in this column. Also, items that are identified as root causes will often be checked in this column, since many root causes themselves have "roots."

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write the number of the associated Action item on page 3 in the "Take Action?" column for each of the Findings that requires an action.

Sample Framework – Sentinel Event Root Cause Analysis and Action Plan (continued)

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
Why did that happen? What systems and processes underlie those proximate factors?    *(Common cause variation here may lead to special cause variation in dependent processes).*	Human resources issues	To what degree are staff properly qualified and currently competent for their responsibilities?				
		How did actual staffing compare with ideal levels?				
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				
		To what degree is staff performance in the operant process(es) addressed?				
		How can orientation & in-service training be improved?				
	Information management issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				

		What emergency and failure-mode responses have been planned and tested?				
	Leadership issues: corporate culture	To what degree is the culture conducive to risk identification and reduction?				
	Encouragement of communication	What are the barriers to communication of potential risk factors?				
	Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?				
	Uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

Exhibit C

Framework for an Action Plan in Response to a Sentinel Event

	Risk Reduction Strategies	Measures of Effectiveness
For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, and associated measure of effectiveness, OR... If, after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time. Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	Action Item #1:	Measure:
	Action Item #2:	Measure:
	Action Item #3:	Measure:
	Action Item #4:	Measure:
	Action Item #5:	Measure:
	Action Item #6:	Measure:
	Action Item #7:	Measure:
	Action Item #8:	Measure:
Cite any books or journal articles that were considered in developing this analysis and action plan:		

ATTACHMENT #1L
~~JUNE 2024~~

Exhibit D

Vendor #_____
Provider #_____

PROVIDER REPORT OF DEATH

(to be completed by the clinically-responsible provider and submitted to ORR)

VENDOR ORGANIZATION
NAME: PROVIDER NAME

Consumer Information:	
Consumer:	Clinical Record #:

Incident Report sent to ORR or entered into EII: [ ] YES [ ] NO

Status of case at time of death: [ ] Open [ ] Closed Date closed:

Was the consumer discharged from a state-operated service within one year of the death?

[ ] No [ ] Yes, name of facility: Date of D/C:

Most Recent Address:

Is this a 24-Hour Supervised Residential Arrangement? [ ] Yes [ ] No

Name of Residence:
Type of supervised residence:

[ ] CLF [ ] SIP / Portable Support [ ] AFC [ ] Child Foster Care [ ] Respite Home

Gender: [ ] M [ ] F **Date of Birth:** **Date of Death:**

(Check all that apply)
[ ] Occurred on Provider Premises [ ] Transportation Accident [ ] Apparent Suicide [ ] Apparent Homicide

[ ] Current ORR, Police, or Licensing Investigation into circumstances surrounding death [ ] Undiagnosed condition

[ ] Elopement from WCHO funded 24-hr. Care [ ] Accident

Other:

Most recent diagnosis (DSM-IV):

DSM-IV DIAGNOSIS:		**CODE**							**AXIS IV:**		
AXIS I (A)					:				1 Primary Support		
									2 Social Environment		
AXIS I (B)					:				3 Educational		
									4 Occupational		
AXIS I (RO)					:				5 Housing		
									6 Economic		
					:				7 Health Care Access		
AXIS II (A)									8 Legal		
					:				9 Other:		
AXIS II (B)									**AXIS V:**		
					:						
AXIS II (RO)									Current		
					:						
AXIS III (A)									Highest in Last Yr		
					:						
AXIS III (B)									Expected at Dis		

Date of most recent med. review: **Physician assigned:**

Medications

All Current Meds (prescribed, OTC, physical, psychiatric)	**Dosage**	**Blood Levels**	**Date**	**Prescribing Physician**	**Prescribed**			**Consumer Used**		
		(If applicable, e.g., Lithium, Clozaril, Anticonvulsant)								
					W/N 30 days	W/N 24 hours	U/K	W/N 30 days	W/N 24 hours	U/K

(Use additional sheet(s) as needed)

Other substances used, e.g., alcohol, recreational drugs:

Current CMHSP-Arranged Services (provided/scheduled within 30 days prior to death) – Computer printout of services is acceptable:

Services	Scheduled (date)	Delivered Y/N

Most recent face-to-face contact with consumer, if any, within last 30 days prior to death (date and type of service):

All crisis interventions (e.g. emergency medication review, visit to hospital ER) within 30 days prior to death:

How was the consumer doing just prior to death or, if discharged, how was consumer doing at time of discharge?

If case was closed at time of death, condition at discharge:

[ ]	Greatly Improved	[ ]	Unchanged
[ ]	Moderately Improved	[ ]	Regressed
[ ]	Slightly Improved	[ ]	Unknown

Please circle consumer's condition at discharge.

- 0 1 2 3 4 5 6 7 8 9 10 +

(Worst) (Best)

Other relevant information:

Prepared by:

Signature:

Name / Credential / Date (print)

Exhibit E

PROVIDER MORTALITY REVIEW
(To be completed by clinically responsible provider Mortality Review Team)

Consumer Information:

Consumer:_____ Clinical Record # _____

Documents Reviewed: [List all documents reviewed, i.e.: clinical record, autopsy report]

_____

_____

_____

Summary of Findings: _____

_____

_____

Identified Areas for Improvement: _____

_____

_____

Plan of Action / Recommendations: _____

_____

_____

Review Team Members: _____

_____

_____

Exhibit F

Critical Incidents Reported to MDHHS

Service (Actively Receiving) or Living Situation	**Suicide**	**Non-Suicide Death**	**Emergency Medical Treatment (EMT) due to Injury or Medication Error**	**Hospitalization due to Injury or Medication Error**	**Arrest of Consumer**
Emergency Service within the last 30 calendar	X				
24-hour Specialized Residential Setting / Child-Caring Institution / Substance Abuse Residential Treatment Program	X	X	X	X	X
Community Living Supports	X	X			
Supports Coordination / Targeted Case Management	X	X			
ACT	X	X			
Home-Based	X	X			
Wraparound	X	X			
Habilitation Supports Waiver	X	X	X	X	X
SED Waiver	X	X	X	X	X
Child Waiver	X	X	X	X	X
Any Other Service	X				
***Reporting Time Frame**	□ Within 30 days after end of month death determined a suicide, or □ Within 30 days after end of month "best judgment" determination made that death was a suicide	□ Within 60 days after end of month death occurred, or □ Within 30 days after end of month death determined not due to suicide	□ Within 60 days after end of month in which the EMT began	□ Within 60 days after end of month in which the hospitalization began	□ Within 60 days after end of month in which the arrest took place

***Report the incident if the indicated services have been provided, or if the consumer resides in any of the living situations. Only one checked situation is necessary for the incident to require reporting.**

Exhibit G

Determining a Sentinel Event

Service (Actively Receiving) or Living Situation	Suicide	Non-Suicide Death	Emergency Medical Treatment due to Injury or Medication Error	Hospitalization due to Injury or Medication Error	Arrest of Consumer
Emergency Service within the last 30 calendar days	X				
24-hour Specialized Residential Setting / Child-Caring Institution	X	X	X	X	X
Community Living Supports	X	X	X	X	X
Supports Coordination Targeted Case Management	X	X	X	X	X
ACT	X	X	X	X	X
Home-Based	X	X	X	X	X
Wraparound	X	X	X	X	X
Habilitation Supports Waiver	X	X	X	X	X
SED Waiver	X	X	X	X	X
Child Waiver	X	X	X	X	X
1915(i)	X	X	X	X	X
Any Other Service	X	X			
The event is a "critical incident" if the indicated services have been provided, or if the consumer resides in any of the living situations. Only one checked situation is necessary for the incident to be a reportable "critical incident."					

Step 1: Is the Event a "Critical Incident?" (See above chart)
If no, Stop. If yes, go to Step 2.

Step 2: Was the incident an unexpected occurrence (not from natural causes)?
If no, Stop. If yes, go to Step 3.

Step 3: Did the incident result in death or serious physical or psychological injury? (Serious injury is major permanent loss of limb or function as determined by a physician or registered nurse; psychological injury is impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology, as determined by a mental health professional.)
If no, Stop. If yes, CLASSIFY AS SENTINEL EVENT.

Step 4: Was there risk of loss? (If the event had continued, loss, i.e., death or serious physical or psychological injury, would have occurred as determined by a physician or registered nurse.)
If no, Stop. If yes, CLASSIFY AS SENTINEL EVENT AND PERFORM ROOT CAUSE ANALYSIS.

Exhibit H

Determining a Risk Event

Service	Physical Harm to self (requiring EMT or hospitalization)	Physical Harm to others (requiring EMT or hospitalization)	Police Calls (by staff)	Emergency Use of Physical Management	Unscheduled Hospitalizations (2 in a 12-month period)
Targeted case management/ supports coordination	X	X	X	X	X
Home-Based	X	X	X	X	X
ACT services	X	X	X	X	X
HSW, CWP, SEDW, 1915(i)	X	X	X	X	X
The event is a "risk event" if the indicated services have been provided.					

Clinically Responsible Providers shall have available a written review each Risk Event, addressing, at a minimum, the following:

a. Personal Identifying Information – name, Medicaid ID, disability designation, residential living arrangement type, name of TCM/SC/HB/ACT provider agency, note if consumer self-directs services with name of provider. If the event occurred at home, collect the name of CLS or personal care, including Home Help. If occurred in a licensed AFC facility, include license number, licensee name and name of home.

b. Method/Procedure – adequacy of clinical assessment, completeness of plan(s), implementation of plans/procedures, consistency of plan(s) with technical requirements and/or best practices.

c. Communication – awareness of consumer's plan; awareness of organizational policies/protocols; contradictory, confusing, or missing information /instructions.

d. Staff-Related – staffing levels, staff skill set or competency in applying the methods or procedures, staff training.

e. Environment – noise levels, physical proximity, amount of space for consumer or staff, lighting, physical hazards, or condition of the environment.

f. Equipment/Materials – necessary equipment or materials not in proper condition, improperly used, in disrepair, missing.

Exhibit I

Clinical Risk Management Committee
Review of Action Plan Based on Root Cause Analysis / Mortality Review Report / Risk Event Investigation

Program Name: _____ Consumer: _____ Case: _____

Risk Reduction Strategies	Measures of Effectiveness	Reporting Period ☐ 1st Qtr ☐ 2nd Qtr ☐ 3rd Qtr ☐ 4th Qtr
Action Item #1:	Measure:	Actions Taken:
Action Item #2:	Measure:	Actions Taken:
Action Item #3:	Measure:	Actions Taken:
Action Item #4:	Measure:	Actions Taken:
Action Item #5:	Measure:	Actions Taken:
Action Item #6:	Measure:	Actions Taken:
Action Item #7:	Measure:	Actions Taken:
Signature		Date:

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

Reviewed by:	**Recommendation Date:**
ROC	06/12/2024
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. Purpose

Ensure consumers/individuals served receive care that is appropriate to their specific needs and is continuous and coordinated among agency departments and programs and between agency departments or programs and outside providers.

II. REVISION HISTORY

DATE	MODIFICATION
11/21/2006	
10/02/2013	Revised to reflect the new regional entity effective January 1, 2014.
04/01/2017	Revised per scheduled review
10/28/2020	3-year review
Will be Regional Approval Date	3-year review

III. Application

This policy applies to:

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. Policy

It is the policy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that consumers/individuals served will receive continuity of services and care throughout an episode of care, between levels of care, and across an integrated array of services. Additionally, with written consent from consumers/individuals served, care will be coordinated with other organizations and providers.

V. Definitions

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

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

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.

Providers: Those providing Mental Health and/or Substance Use Services as a CMHSP or under contract with the CMHSPM or any affiliated CMHSP, as an organization or an individual (LIP).

VI. Standards

A. Providers shall ensure that care management is a dynamic process incorporated in systemic, administrative, and clinical functions.

B. The system of care ensures access to the appropriate level of care, service providers, programs, and services to meet the assessed needs of consumers/individuals served.

C. Organizational barriers to care delivery are reduced and the individual receiving services is viewed as a consumer/individual served of the organization, not as belonging to separate program elements.

D. Fragmentation of service delivery will be reduced through the development of highly individualized person-centered plans and family-centered plans that holistically surround a consumer/individual served in such a way that the coordination of care enhances the effectiveness of the plan.

E. Staff shall be trained in the principles and practices of care coordination and management.

F. Provider services will be coordinated with services a consumer/individual served may receive from other managed care organizations or PIHPs.

G. Results of assessments will be shared with other managed care organizations or PIHPs providing services to jointly served consumers/individuals served so that services are not duplicated.

H. Plans of care will identify resources that consumers/individuals served have available, resources available in the community at large, and resources that are needed that will be provided by a CMHSP or network provider.

I. Integrated plans of care will be developed which outline needed services, how services will be provided, who is responsible for providing identified supports and services, and how ongoing coordination of services and supports will occur.

J. Referral, transfer, or discharge of consumers/individuals served to other levels of care, health professionals, or settings is based on the consumer/individual's assessed needs and the agency's capability to provide needed care.

K. Provider clinical staff are responsible for ensuring continuity and coordination of care.

L. Provider clinical staff will function as advocates for consumers/individuals served to ensure entitlements, services, and supports needed by consumers/individuals served are available.

M. At times of transitions for consumers/individuals served, such as between program service components, between service providers, to community service providers, and at termination of services, the current service provider is responsible to ensure that the new services have been initiated successfully before withdrawing from the consumer/individual's care.

N. Discharge planning will ensure that all necessary post-treatment referrals for services external to the agency have been considered and arrangements for these referrals have been completed. As desired by the consumer/individual served and as appropriate, aftercare plans will be developed.

O. When consumers/individuals served terminate services according to an agreed-upon discharge plan, aftercare services will be provided as described in the discharge plan.

P. At the time of discharge, coordination with the consumer/individual's primary healthcare provider will include a review of medications currently prescribed.

Q. Ethical and professional responsibilities will be met before a consumer/individual served is discharged from care if an external entity has denied care, service, or payment.

VII. Exhibits

None

VIII. References

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	438.208
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission Behavioral Health Standards	X	
MDHHS/PIHP Medicaid Contract	X	
Discharge Planning Policies	X	
CMHPSM Consumer Appeals Policy	X	
CMHPSM Customer Services Policy	X	
CMHPSM Coordination of Integrated Healthcare Policy	X	
CMHPSM Person Centered Planning Policy	X	

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **Transition Planning for Individuals Being Released from State Facilities**
Committee/Department: **Clinical Performance Team**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	06/12/2024
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure consistency across the region in meeting standards of good clinical practice in transitioning people with severe and persistent mental illness, intellectual and developmental disabilities, and serious emotional disturbance from state facilities back to the community.

II. REVISION HISTORY

DATE	MODIFICATION
10/07/2013	Written to meet the requirements of the Application for Participation. Regional entity effective January 1, 2014.
01/23/2017	Reviewed per CMHSPM policy.
11/23/2020	Reviewed for any needed updates
Will be Regional Approval	3-year review

III. APPLICATION

This policy applies to:

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. DEFINITIONS

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

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

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

State Facility: A center or hospital operated by the Michigan Department of Community Health which provides services for people with serious mental illness, serious emotional disturbance and/or persons with developmental disabilities.

V. POLICY

Transition planning for individuals being discharged from State Facilities shall be individualized, person-centered, strength–based, collaborative, comprehensive, timely, orderly, and focused on the safety of both the consumer/individual served and the public.

VI. STANDARDS

A. The CMHSP is responsible for planning and implementing community placement for each of its consumers/individuals served who are being discharged from a State Facility and who do not object to being so.

B. The CMHSP will begin the Transition Planning process within 30 days of admission.

C. CMHSP designated staff will make efforts to ensure that the Transition Planning process is a collaborative team endeavor involving CMHSP clinicians, State Facility staff, the consumer/individual served, family members, guardians and potential post-discharge care providers.

D. CMHSP is responsible for ensuring that the Transition Planning process includes practices that incorporate:
   1. engaging all involved and interested parties;
   2. conducting regularly scheduled meetings;
   3. including consumer/individual served/guardian preferences wherever possible;
   4. educating and training post-discharge caregivers/providers;
   5. supporting post-discharge medical necessity;
   6. incorporating relapse planning;
   7. post-discharge relationship building.

E. The CMHSP will take the lead in arranging and facilitating periodic Transition Planning meetings with involved individuals to assess consumer/individual served status and move the planning process forward.

F. Designated CMHSP staff will assess the need for and implement educational and training activities for family members and potential post-discharge care providers regarding the consumer/individual's needs, service options, and relationship building. When applicable, consumer/individual served-specific information regarding past relapse triggers and the associated signs and symptoms will be included in the training.

G. The Transition Plan will include a post-discharge plan to reduce the likelihood of re-admission to a community hospital or State Facility.

H. CMHSP staff will ensure that efforts are made to engage the consumer/individual served and/or their legal representative in voicing preferences for a post-discharge living arrangement, such as location and other related issues.

I. A consideration of community options will include standards and principles of medical necessity, least restrictive setting, and the safety of the person and those in the surrounding community.

J. The Transition Plan will assess and honor the factors that contribute to a person's feelings of safety, respect, respect from others, and engagement with service providers.

K. The Transition Plan will include relationship-building strategies wherever indicated.

L. The Transition Plan will include an assessment of the consumer/individual's post-discharge medical needs, and the CMHSP will be responsible for ensuring that necessary medical appointments are arranged and integrated into the consumer/individual's Individual Plan of Service (IPOS).

M. The Transition Planning group will ensure that written instructions for potential providers of care are completed either as part of the Transition Plan or as part of the IPOS.

N. As indicated, there will be a safety/support plan in place for the consumer/individual served prior to discharge that addresses individualized needs for assistance with medication adherence, personal safety, environmental safety, and services that match the consumer/individual's needs.

O. The CMHSP will ensure that all post-discharge supports and service providers are competent in meeting the needs unique to individuals exiting State Facilities while utilizing Culture of Gentleness principles.

P. The CMHSP will make efforts to arrange for pre-discharge visits to the person's home, including at least one overnight visit, when indicated.

Q. The CMHSP will arrange for and facilitate post-discharge team meetings with current service providers to evaluate and revise the IPOS as needed.

VI. EXHIBITS

None

VII. REFERENCES

A. Current MDCH/CMHSP Managed Mental Health Supports and Services Contract
B. Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness, Michigan Department of Community Health Behavioral Health and Developmental Disabilities Administration, June 2011
C. The Discharge Planning Process – State Operated Programs, Division of Development Disabilities, 2012
D. CMS Updates Guidance for Hospital Discharge Planning, Center for Medicare Advocacy, Inc., 2013
E. Protocols for Use, Center for Positive Living Supports, 2010

Washtenaw County Community Mental Health Fund

Year Ended September 30, 2023

Financial Statements

Rehmann

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WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Table of Contents

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Rehmann

INDEPENDENT AUDITORS' REPORT

May 8, 2024

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, 2023, 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, 2023, 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, Michigan, as of September 30, 2023, 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 May 8, 2024, 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 Lohan LLC

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FINANCIAL STATEMENTS

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH FUND

Balance Sheet

September 30, 2023

Assets	
Cash and pooled investments	$ 20,004,811
Receivables, net	1,504,934
Due from other governments:	
Community Mental Health Partnership of Southeast Michigan	16,826,828
Michigan Department of Health and Human Services	123,929
Prepaid items and other assets	484,927
Total assets	$ 38,945,429
Liabilities	
Accounts payable	$ 7,021,460
Accrued payroll	2,010,762
Due to other governments:	
Community Mental Health Partnership of Southeast Michigan	18,853,794
Michigan Department of Health and Human Services	4,243,864
Unearned revenue	2,688,722
Total liabilities	34,818,602
Fund balance	
Nonspendable	484,927
Restricted	3,641,900
Total fund balance	4,126,827
Total liabilities and fund balance	$ 38,945,429

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, 2023

	Original Budget	Final Budget	Actual	Actual Over (Under) Final Budget
Revenues				
Intergovernmental	$ 113,709,144	$ 113,709,144	$ 121,429,233	$ 7,720,089
Charges for services	824,821	824,821	411,529	(413,292)
Other revenue and reimbursements	1,568,537	1,568,537	2,168,448	599,911
Total revenues	116,102,502	116,102,502	124,009,210	7,906,708
Expenditures				
Health:				
Administration	6,915,643	6,915,643	6,593,243	(322,400)
Access and crisis services	3,466,098	3,466,098	2,920,276	(545,822)
Comprehensive supports and services	46,332,354	46,332,354	47,367,690	1,035,336
Residential and supported living	51,200,000	51,200,000	46,598,080	(4,601,920)
Inpatient services	8,150,000	8,150,000	9,745,269	1,595,269
Grants and contracts	1,790,168	1,790,168	1,648,895	(141,273)
Total expenditures	117,854,263	117,854,263	114,873,453	(2,980,810)
Revenues over (under) expenditures	(1,751,761)	(1,751,761)	9,135,757	10,887,518
Other financing sources (uses)				
Transfers from Washtenaw County	1,751,761	1,751,761	2,322,537	570,776
Transfers to Washtenaw County	-	-	(8,629,650)	(8,629,650)
Total other financing sources (uses)	1,751,761	1,751,761	(6,307,113)	(8,058,874)
Net change in fund balance	-	-	2,828,644	2,828,644
Fund balance, beginning of year	1,298,183	1,298,183	1,298,183	-
Fund balance, end of year	$ 1,298,183	$ 1,298,183	$ 4,126,827	$ 2,828,644

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 $2,355,193, 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, 2023. "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 function level. During the year, WCCMH incurred expenditures in excess of appropriations are as follows:

	Final Budget	Actual	Excess
Transfers out	$ -	$ 8,629,650	$ 8,629,650

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.

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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, 2023

	Administration	Access and Crisis Services	Comprehensive Supports and Services	Residential and Supported Living
Expenditures				
Personnel services	$ 5,182,392	$ 2,694,439	$ 27,236,473	$ -
Supplies	18,440	10,758	196,407	-
Other services and charges	722,269	30,972	16,450,999	46,598,080
Inpatient services - community	-	-	-	-
Inpatient services - local	-	-	-	-
Internal service charges	670,142	184,107	3,483,811	-
Total expenditures	$ 6,593,243	$ 2,920,276	$ 47,367,690	$ 46,598,080

Inpatient Services	Grants and Contracts	Total
$ -	$ 1,420,410	$ 36,533,714
-	4,660	230,265
-	198,251	64,000,571
9,033,684	-	9,033,684
711,585	-	711,585
-	25,574	4,363,634
$ 9,745,269	$ 1,648,895	$ 114,873,453

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Rehmann

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*

May 8, 2024

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, 2023, 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 May 8, 2024.

Report on 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 or significant deficiencies may exist that have not been identified.

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.*

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.

Report on Compliance

Washtenaw County Community Mental Health

September 30, 2023

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

Washtenaw County Community Mental Health
Table of Contents
September 30, 2023

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

To the Members of the Board
Washtenaw County Community Mental Health
Ypsilanti, Michigan

Report On Compliance
We have examined Washtenaw County Community Mental Health's (the CMHSP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and/or General Fund (GF) Contract for the year ended September 30, 2023.

Management's Responsibility
Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to the Medicaid Contract and/or GF Contract.

Independent Accountants' Responsibility
Our responsibility is to express an opinion on the CMHSP's compliance with the Medicaid Contract and/or GF Contract based on our examination of the compliance requirements referred to above.

Our examination of compliance was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the CMHSP complied, in all material respects, with the compliance requirements referred to above.

An examination involves performing procedures to obtain evidence about the CMHSP's compliance with the specified compliance requirements referred to above. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risk of material noncompliance, whether due to fraud or error. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the compliance requirements described in the *Compliance Examination Guidelines* issued by the Michigan Department of Health and Human Services.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. However, our examination does not provide a legal determination of the CMHSP's compliance.

Opinion on Each Program
In our opinion, the CMHSP complied, in all material respects, with the specified compliance requirements referred to above that are applicable to the Medicaid Contract and/or GF Contract for the year ended September 30, 2023.

Other Matters
The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with Compliance Examination Guidelines, and which are described in the accompanying Schedule of Findings and Comments and Recommendations as items 2023-01 and 2023-02. Our opinion is not modified with respect to these matters.

The CMHSP's responses to the noncompliance findings identified in our examination are described in the accompanying Schedule of Findings and Comments and Recommendations. The CMHSP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Purpose of this Report
This report is intended solely for the information and use of the Board and management of the CMHSP and the Michigan Department of Health and Human Services and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

June 12, 2024

Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract and/or General Fund Contract:

2023-01 Ability to Pay Forms (Repeat Comment)

Criteria or specific requirements:
The CMHSP is required to determine the responsible party's insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the CMHSP must annually determine the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828.

Condition:
The CMHSP is not in compliance with MCL 330.1817 and MCL 330.1828.

Examination adjustments:
None.

Context and perspective:
The CMHSP has adopted and implemented *ability to pay* policies and procedures as required. However, during our testing of their implementation of these procedures we found 38 out of 40 consumers selected did not have *ability to pay* documentation completed or the consumer had an ability to pay that was not billed.

Effect:
The CMHSP may not be billing and collecting available fees from individuals or third party payers for services provided to them.

Recommendations:
The CMHSP should review its current policies and procedures regarding ability to pay forms and make the necessary changes to ensure that forms are completed, or consumers are billed as required. Also, policies and procedures should require periodic monitoring for compliance and include adequate documentation of such monitoring.

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Management has implemented procedures to improve the gathering of consumer information and processing time for calculating an individual's ability to pay and continues to work towards full compliance of this requirement. Changes in consumer benefit eligibility causes confusion to individuals being served and often this process takes time to troubleshoot and resolve. Staffing challenges both administratively and clinically have resulted in increased challenges to financial determination compliance. Management continues to work towards full compliance of this requirement while ensuring consumer eligibility for entitlements is being processed accurately and timely by the local MDHHS office.

Responsible party:
Nicole Phelps, CFO & Christy Diallo, Management Analyst

Anticipated completion date:
9/30/2024

Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid Contract and/or General Fund Contract:

None

Known fraud affecting the Medicaid Contract and/or General Fund Contract:

None

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

CMHSP:	Washtenaw County Community Mental Health		FISCAL YEAR:	FY 22 / 23		
			SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
			SUBMISSION DATE:	2/29/2024		
				Column A	Column B		
A		MEDICAID SERVICES - Summary From FSR - Medicaid					
AC		CCBHC SERVICES - Summary From FSR - Certified Community Behavioral Health Clinic					
AE		OPIOID HEALTH HOME SERVICES - Summary From FSR - Opioid Health Home Services					
AG		HEALTH HOME SERVICES - Summary From FSR - Health Home Services					
AI		HEALTHY MICHIGAN SERVICES - Summary From FSR - Healthy Michigan					
AK		MI HEALTH LINK SERVICES - Summary From FSR - MI Health Link					
RES		RESTRICTED FUND BALANCE ACTIVITY					
B		GENERAL FUND					
B	100	**REVENUE**					
B	101	CMH Operations			4,597,669		4,597,669
B	120	**Subtotal - Current Period General Fund Revenue**			4,597,669	-	4,597,669
B	121	1st & 3rd Party Collections (Not in Section 226a Funds) 100% Services			8,442		8,442
B	122	1st & 3rd Party Collections (Not in Section 226a Funds) 90% Services					-
B	123	Prior Year GF Carry Forward			211,753		211,753
B	140	**Subtotal - Other General Fund Revenue**			220,195	-	220,195
B	190	**TOTAL REVENUE**			4,817,864	-	4,817,864
B	200	**EXPENDITURE**					
B	201	100% MDHHS Matchable Services / Costs			1,230,596		1,230,596
B	202	100% MDHHS Matchable Services Based on CMHSP Local Match Cap			-	-	-
B	203	90% MDHHS Matchable Services / Costs - REPORTED		3,305,206			
B	204	90% MDHHS Matchable Services / Costs - EXAMINATION ADJUSTMENTS					
B	205	90% MDHHS Matchable Services / Costs - EXAMINED TOTAL		3,305,206	2,974,685	-	2,974,685
B	290	**TOTAL EXPENDITURE**			4,205,281	-	4,205,281
B	295	**NET GENERAL FUND SURPLUS (DEFICIT)**			612,583	-	612,583
B	300	**Redirected Funds (To) From**					
B	304	(TO) Targeted Case Management - **D301**			-	-	-
B	309	(TO) Allowable GF Cost of Injectable Medications - **G301**			-	-	-
B	310	(TO) PIHP to Affiliate Medicaid Services Contracts - **I304**			-	-	-
B	310.1	(TO) PIHP to Affiliate CCBHC Medicaid Contracts - **IA304**			-	-	-
B	310.2	(TO) PIHP to Affiliate Opioid Health Home Services Contracts - **IB304**			-	-	-
B	310.3	(TO) PIHP to Affiliate Health Home Services Contracts - **IC304**			-	-	-
B	310.4	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID304**			-	-	-
B	310.5	(TO) PIHP to CMHSP CCBHC Non-Medicaid Contracts - **L304**			(681,671)	-	(681,671)
B	312	(TO) CMHSP to CMHSP Earned Contracts - **J305** (explain - section Q)			-	-	-
B	313	FROM CMHSP to CMHSP Earned Contracts - **J302**			69,088		69,088
B	314	FROM Non-MDHHS Earned Contracts - **K302**					-
B	330	**Subtotal Redirected Funds rows 301 - 314**			(612,583)	-	(612,583)
B	331	FROM Local Funds - **M302**					-
B	332	FROM Risk Corridor - **N303**					-
B	390	**Total Redirected Funds**			(612,583)	-	(612,583)
B	400	**BALANCE GENERAL FUND (cannot be < 0)**			-	-	-
OTHER GF CONTRACTUAL OBLIGATIONS							
C		CCBHC NON-MEDICAID - (PIHP Use Only - Excluding Macomb)					
FEE FOR SERVICE MEDICAID							
D		TARGETED CASE MANAGEMENT - (GHS Only)					
D	190	Revenue					-
D	290	Expenditure					-
D	295	**NET TARGETED CASE MANAGEMENT (cannot be > 0)**			-	-	-
D	300	**Redirected Funds (To) From**					
D	301	FROM General Fund - **B304**					-
D	302	FROM Local Funds - **M304**					-
D	303	(TO) CMHSP to CMHSP Earned Contracts - **J304.4**			-	-	-
D	304	FROM CMHSP to CMHSP Earned Contracts - **J303.4**					-
D	390	**Total Redirected Funds**			-	-	-
D	400	**BALANCE TARGETED CASE MANAGEMENT (GHS Only) (must = 0)**			-	-	-
E		INTENTIONALLY LEFT BLANK					
F		INTENTIONALLY LEFT BLANK					
G		INJECTABLE MEDICATIONS					
G	190	Revenue			134,566		134,566
G	290	Expenditure			134,566		134,566
G	295	**NET INJECTABLE MEDICATIONS (cannot be > 0)**			-	-	-
G	300	**Redirected Funds (To) From**					
G	301	FROM General Fund - **B309**					-
G	302	FROM Local Funds - **M309**					-
G	390	**Total Redirected Funds**			-	-	-
G	400	**BALANCE INJECTABLE MEDICATIONS (must = 0)**			-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF) FINANCIAL STATUS REPORT - ALL NON MEDICAID					
CMHSP:	Washtenaw County Community Mental Health		FISCAL YEAR:	FY 22 / 23	
		SUBMISSION TYPE:	YE Final	YEAR TO DATE	EXAMINATION
		SUBMISSION DATE:	2/29/2024	REPORTING	ADJUSTMENTS
			Column A	Column B	

OTHER FUNDING					
H		MDHHS EARNED CONTRACTS			
H	100	**REVENUE**			
H	101	Comprehensive Services for Behavioral Health	1,275,107		
H	102	Housing and Homeless Services	-		
H	103	Juvenile Justice Programs	-		
H	104	Mobile Crisis Response	39,044		
H	105	Projects for Assistance in Transition from Homelessness	180,366		
H	106	Regional Perinatal Collaborative	-		
H	107	Substance Abuse & Mental Health COVID-19 Grant Program	-		
H	108	Substance Use and Gambling Services	-		
H	150	Other MDHHS Earned Contracts (describe):	-		
H	151	Other MDHHS Earned Contracts (describe):	-		
H	190	**TOTAL REVENUE**	1,494,517		
H	200	**EXPENDITURE**			
H	201	Comprehensive Services for Behavioral Health	1,275,107		
H	202	Housing and Homeless Services	-		
H	203	Juvenile Justice Programs	-		
H	204	Mobile Crisis Response	39,044		
H	205	Projects for Assistance in Transition from Homelessness	180,366		
H	206	Regional Perinatal Collaborative	-		
H	207	Substance Abuse & Mental Health COVID-19 Grant Program	-		
H	208	Substance Use and Gambling Services	-		
H	250	Other MDHHS Earned Contracts (describe):	-		
H	251	Other MDHHS Earned Contracts (describe):	-		
H	290	**TOTAL EXPENDITURE**	1,494,517		
H	400	**BALANCE MDHHS EARNED CONTRACTS (must = 0)**	-		

I		PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS - CMHSP USE ONLY			
I	100	**REVENUE**			
I	101	Revenue - from PIHP Medicaid	75,211,181		75,211,181
I	104	Revenue - from PIHP Healthy Michigan Plan	6,637,498		6,637,498
I	122	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Affiliate	266,309		266,309
I	123	1st & 3rd Party Collections - Healthy Michigan Plan Consumers - Affiliate			-
I	190	**TOTAL REVENUE**	82,114,988	-	82,114,988
I	201	Expenditure - Medicaid	75,477,490		75,477,490
I	202	Expenditure - Healthy Michigan Plan	6,637,498		6,637,498
I	203	Expenditure - MI Health Link (Medicaid) Services			-
I	290	**TOTAL EXPENDITURE**	82,114,988	-	82,114,988
I	295	**NET PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
I	300	**Redirected Funds (To) From**			
I	301	(TO) CMHSP to CMHSP Earned Contracts - **J306**	-	-	-
I	302	FROM CMHSP to CMHSP Earned Contracts - **J303**			-
I	303	FROM Non-MDHHS Earned Contracts - **K303**			-
I	304	FROM General Fund - **B310**			-
I	306	FROM Local Funds - **M309.1**			-
I	390	**Total Redirected Funds**	-	-	-
I	400	**BALANCE PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS (must = 0)**	-	-	-

IA		PIHP to AFFILIATE CCBHC SERVICES CONTRACTS - CMHSP USE ONLY			
IA	100	**REVENUE**			
IA	101	Revenue - Medicaid Base	11,432,306		11,432,306
IA	102	Revenue - Medicaid Supplemental	6,018,296		6,018,296
IA	103	Revenue - MI Health Link CCBHC Consumers			-
IA	104	1st & 3rd Party Collections - Medicaid			-
IA	121	Revenue - Healthy Michigan Base	2,962,888		2,962,888
IA	122	Revenue - Healthy Michigan Supplemental	1,987,696		1,987,696
IA	124	1st & 3rd Party Collections - Healthy Michigan			-
IA	190	**TOTAL REVENUE**	22,401,186	-	22,401,186
IA	200	**EXPENDITURE**			
IA	201	Expenditure - Medicaid (Including MI Health Link)	16,450,171		16,450,171
IA	202	Expenditure - Healthy Michigan	4,325,557		4,325,557
IA	290	**TOTAL EXPENDITURE**	20,775,728	-	20,775,728
IA	295	**NET PIHP to AFFILIATE CONTRACTS SURPLUS (DEFICIT)**	1,625,458	-	1,625,458
IA	300	**Redirected Funds (To) From**			
IA	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.2**	-	-	-
IA	302	FROM CMHSP to CMHSP Earned Contracts - **J303.2**			-
IA	303	FROM Non-MDHHS Earned Contracts - **K303.2**			-
IA	304	FROM General Fund - **B310.1**			-
IA	305	(TO) Local Funds - **M316**	(1,625,458)	-	(1,625,458)
IA	306	FROM Local Funds - **M309.2**			-
IA	390	**Total Redirected Funds**	(1,625,458)	-	(1,625,458)
IA	400	**BALANCE PIHP to AFFILIATE CCBHC SERVICES CONTRACTS (must = 0)**	-	-	-

IB		PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS - CMHSP USE ONLY			
IB	190	Revenue - Medicaid Opioid Health Home Services - from PIHP			-
IB	290	Expenditure - Medicaid Opioid Health Home Services			-
IB	295	**NET PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
IB	300	**Redirected Funds (To) From**			
IB	304	FROM General Fund - **B310.2**			-
IB	306	FROM Local Funds - **M309.3**			-
IB	390	**Total Redirected Funds**	-	-	-
IB	400	**BALANCE PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS (cannot be < 0)**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 22 / 23		
		SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
		SUBMISSION DATE:	2/29/2024		
			Column A	Column B		

IC		PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS - CMHSP USE ONLY			
IC	190	Revenue - Medicaid Health Home Services - from PIHP	393,390		393,390
IC	290	Expenditure - Medicaid Health Home Services	393,390		393,390
IC	295	**NET PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
IC	300	**Redirected Funds (To) From**			
IC	304	FROM General Fund - **B310.3**			-
IC	306	FROM Local Funds - **M309.4**			-
IC	390	**Total Redirected Funds**	-	-	-
IC	400	**BALANCE PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS (cannot be < 0)**	-	-	-

ID		PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS - CMHSP USE ONLY			
ID	100	**REVENUE**			
ID	101	Revenue - MI Health Link - from PIHP			-
ID	122	1st & 3rd Party Collections - MI Health Link Consumers - Affiliate			-
ID	190	**TOTAL REVENUE**	-	-	-
ID	200	**EXPENDITURE**			
ID	201	Expenditure			-
ID	290	**TOTAL EXPENDITURE**	-	-	-
ID	295	**NET PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
ID	300	**Redirected Funds (To) From**			
ID	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.3**	-	-	-
ID	302	FROM CMHSP to CMHSP Earned Contracts - **J303.3**			-
ID	303	FROM Non-MDHHS Earned Contracts - K303.3			-
ID	304	FROM General Fund - **B310.4**			-
ID	306	FROM Local Funds - **M309.5**			-
ID	390	**Total Redirected Funds**	-	-	-
ID	400	**BALANCE PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS (must = 0)**	-	-	-

J		CMHSP to CMHSP EARNED CONTRACTS			
J	190	Revenue	1,021,886		1,021,886
J	290	Expenditure	952,798		952,798
J	295	**NET CMHSP to CMHSP EARNED CONTRACTS SURPLUS (DEFICIT)**	69,088	-	69,088
J	300	**Redirected Funds (To) From**			
J	302	(TO) General Fund - **B313**	(69,088)	-	(69,088)
J	303	(TO) PIHP to Affiliate Medicaid Services Contracts - **I302**	-	-	-
J	303.2	(TO) PIHP to Affiliate CCBHC Medicaid Contracts - **IA302**	-	-	-
J	303.3	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID302**	-	-	-
J	303.4	(TO) Targeted Case Management - **D304**	-	-	-
J	303.5	(TO) PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L302**	-	-	-
J	304.4	FROM Targeted Case Management - **D303**			-
J	305	FROM General Fund - **B312**			-
J	306	FROM PIHP to Affiliate Medicaid Services Contracts - **I301**			-
J	306.2	FROM PIHP to Affiliate CCBHC Medicaid Contracts - **IA301**			-
J	306.3	FROM PIHP to MI Health Link Services Contracts - **ID301**			-
J	306.4	FROM PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L301**			-
J	307	FROM Local Funds - **M310**			-
J	390	**Total Redirected Funds**	(69,088)	-	(69,088)
J	400	**BALANCE CMHSP to CMHSP EARNED CONTRACTS (must = 0)**	-	-	-

K		NON-MDHHS EARNED CONTRACTS			
K	190	Revenue	165,566		165,566
K	290	Expenditure	165,566		165,566
K	295	**NET NON-MDHHS EARNED CONTRACTS SURPLUS (DEFICIT)**	-	-	-
K	300	**Redirected Funds (To) From**			
K	302	(TO) General Fund - **B314**	-	-	-
K	303	(TO) PIHP to Affiliate Medicaid Services Contracts - **I303**	-	-	-
K	303.2	(TO) PIHP to Affiliate CCBHC Medicaid Contracts - **IA303**	-	-	-
K	303.3	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID303**	-	-	-
K	303.4	(TO) PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L303**	-	-	-
K	304	(TO) Local Funds - **M315**	-	-	-
K	305	FROM Local Funds - **M311**			-
K	390	**Total Redirected Funds**	-	-	-
K	400	**BALANCE NON-MDHHS EARNED CONTRACTS (must = 0)**	-	-	-

L		PIHP to CMHSP CCBHC Non-Medicaid Contracts - CMHSP/Macomb USE ONLY			
L	100	**REVENUE**			
L	101	Revenue	559,089		559,089
L	102	1st & 3rd Party Collections (Not in Section 226a Funds)			-
L	190	**TOTAL REVENUE**	559,089	-	559,089
L	200	**EXPENDITURE**			
L	201	Expenditure	1,382,865		1,382,865
L	290	**TOTAL EXPENDITURE**	1,382,865	-	1,382,865
L	295	**NET SURPLUS (DEFICIT)**	(823,776)	-	(823,776)
L	300	**Redirected Funds (To) From**			
L	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.4**	-	-	-
L	302	FROM CMHSP to CMHSP Earned Contracts - **J303.5**			-
L	303	FROM Non-MDHHS Earned Contracts - **K303.4**			-
L	304	FROM General Fund - **B310.5**	681,671		681,671
L	305	(TO) Local Funds - **M316.1**	-	-	-
L	306	FROM Local Funds - **M309.6**	142,105		142,105
L	390	**Total Redirected Funds**	823,776	-	823,776
L	400	**BALANCE PIHP to CMHSP CCBHC Non-Medicaid Contracts (must = 0)**	-	-	-

ATTACHMENT #3
JUNE 2024

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 22 / 23		
		SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
		SUBMISSION DATE:	2/29/2024		
			Column A	Column B		

M		**LOCAL FUNDS**				
M	100	**REVENUE**				
M	101	County Appropriation for Mental Health		1,643,584		1,643,584
M	102	County Appropriation for Substance Abuse - Non Public Act 2 Funds				-
M	103	Section 226 (a) Funds		324,337	-	324,337
M	105	Medicaid Fee for Service Adjuster Payments				-
M	106	Local Grants				-
M	107	Interest				-
M	108	CCBHC Quality Based Payments (QBP)		823,844		823,844
M	109	SED Partner				-
M	110	All Other Local Funding		22,402		22,402
M	111	Performance Bonus Incentive Pool (PBIP) Restricted Local Funding				-
M	190	**TOTAL REVENUE**		2,814,167	-	2,814,167
M	200	**EXPENDITURE**				
M	201	GF 10% Local Match		330,521	-	330,521
M	202	Local match cap amount				
		Examination Adjustment Local match cap amount				
		Examined Total Local match cap amount	$ -			
M	203	GF Local Match Capped per MHC 330.1308		-	-	-
M	204	Local Cost for State Provided Services		711,585		711,585
M	205	Local Contribution to State Medicaid Match (CMHSP Contribution Only)		271,932		271,932
M	207	Local Match to Grants and MDHHS Earned Contracts				-
M	209	Local Only Expenditures		171,347		171,347
M	290	**TOTAL EXPENDITURE**		1,485,385	-	1,485,385
M	295	**NET LOCAL FUNDS SURPLUS (DEFICIT)**		1,328,782	-	1,328,782
M	300	**Redirected Funds (To) From**				
M	302	(TO) General Fund - **B331**		-	-	-
M	304	(TO) Targeted Case Management - **D302**		-	-	-
M	309	(TO) Injectable Medications - **G302**		-	-	-
M	309.1	(TO) PIHP to Affiliate Medicaid Services Contracts - **I306**		-	-	-
M	309.2	(TO) PIHP to Affiliate CCBHC Medicaid Service Contracts - **IA306**		-	-	-
M	309.3	(TO) PIHP to Affiliate Opioid Health Home Services Contracts - **IB306**		-	-	-
M	309.4	(TO) PIHP to Affiliate Health Home Services Contracts - **IC306**		-	-	-
M	309.5	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID306**		-	-	-
M	309.6	(TO) PIHP to CMHSP CCBHC Non-Medicaid Contracts - **L306**		(142,105)	-	(142,105)
M	310	(TO) CMHSP to CMHSP Earned Contracts - **J307**		-	-	-
M	311	(TO) Non-MDHHS Earned Contracts - **K305**		-	-	-
M	313	(TO) Activity Not Otherwise Reported - **O302**		-	-	-
M	315	FROM Non-MDHHS Earned Contracts - **K304**				-
M	316	FROM PIHP to Affiliate CCBHC Medicaid Services Contracts - **IA305**		1,625,458		1,625,458
M	316.1	FROM PIHP to CMHSP CCBHC Non-Medicaid Contracts - **L305**				-
M	390	**Total Redirected Funds**		1,483,353	-	1,483,353
M	400	**BALANCE LOCAL FUNDS**		2,812,135	-	2,812,135

N		**RISK CORRIDOR**			
N	100	**REVENUE**			
N	101	Stop/Loss Insurance			-
N	190	**TOTAL REVENUE**	-	-	-
N	300	**Redirected Funds (To) From**			
N	303	(TO) General Fund - **B332**	-	-	-
N	390	**Total Redirected Funds**	-	-	-
N	400	**BALANCE RISK CORRIDOR (must = 0)**	-	-	-

O		**ACTIVITY NOT OTHERWISE REPORTED**			
O	100	**REVENUE**			
O	101	Other Revenue (describe): Yost St. Rent	17,109		17,109
O	102	Other Revenue (describe): Private Grant	81,172		81,172
O	103	Other Revenue (describe):			-
O	190	**TOTAL REVENUE**	98,281	-	98,281
O	200	**EXPENDITURE**			
O	201	Other Expenditure (describe): Private Grant	81,172		81,172
O	202	Other Expenditure (describe):			-
O	203	Other Expenditure (describe):			-
O	290	**TOTAL EXPENDITURE**	81,172	-	81,172
O	295	**NET ACTIVITY NOT OTHERWISE REPORTED SURPLUS (DEFICIT)**	17,109	-	17,109
O	300	**Redirected Funds (To) From**			
O	302	FROM Local Funds - **M313**			-
O	390	**Total Redirected Funds**	-	-	-
O	400	**BALANCE ACTIVITY NOT OTHERWISE REPORTED**	17,109	-	17,109

P		**GRAND TOTALS**			
P	190	**GRAND TOTAL REVENUE**	116,015,500	-	116,015,500
P	290	**GRAND TOTAL EXPENDITURE**	113,186,256	-	113,186,256
P	390	**GRAND TOTAL REDIRECTED FUNDS (must = 0)**	-	-	-
P	400	**NET INCREASE (DECREASE)**	2,829,244	-	2,829,244

Q		**REMARKS**
Q		This section has been provided for the CMHSP to provide narrative descriptions as requested in the FSR instructions or where additional narrative would be meaningful to the CMHSP / MDHHS.
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MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)

FINANCIAL STATUS REPORT - ALL NON MEDICAID - SUPPLEMENTAL

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 22 / 23		
	SUBMISSION TYPE:	YE Final			YEAR TO DATE REPORTING
	SUBMISSION DATE:	2/29/2024			

H	MDHHS EARNED CONTRACTS				Column A	Column B	Column C	Column D	
H	**Grant Program Code**	**Grant Program Title**	**Project Code**	**Project Title**	**REVENUE**	**EXPENDITURES**	**CCBHC EXPENDITURES**	**BALANCE**	
H	CBH	Comprehensive Services for Behavioral Health	ABHS	Asian Behavioral Health Services				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	ATSUD	Alternative Treatment for Co-Occurring and Substance Usage Disorders				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BCDP	Branch County Diversion Project				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHD	Behavioral Health Disparities				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHSNA	Behavioral Health Services for Native Americans				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHSVV	Behavioral Health Services for Vietnam Veterans				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BWC	Benefits to Work Coaches				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CLUB	Clubhouse Engagement	895	895		-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CMCR	Community Crisis Response				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	COTR	Co-Occuring Treatment				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CRIM	Criminal Justice	145,048	145,048		-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CRMGT	Care Management				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CSC	Child System of Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CSUE	Crisis Stabilization Unit Establishment				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	DROP**					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	DROP**					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	DROP**					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	EPHS	Enhanced Peer Health Support				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	FFDI	Forever Friendship Drop-In				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	FIT	Fit Together				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	HBHS	Hispanic Behavioral Health Services				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	ICCD	Integrated Care Center Development				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	IECMHC	Infant and Early Childhood Mental Health Consultation				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	IECMHE	Infant and Early Childhood Mental Health Consultation Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	IHC	Integrated Healthcare				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	ITCP	Infant Toddler Court Project				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	**CSSE	Intensive Crisis Stabilization Service(s) Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	JIHC	Justice Involved Health Coach				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHAJJ	Mental Health Access and Juvenile Justice Diversion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHJJSE	Mental Health and Juvenile Justice Screening Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHJJSP	Mental Health Juvenile Justice Screening Project				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHTC	58th District Mental Health Court Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MICHT	Michigan Healthy Transitions				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	NCC	Enhanced Nutrition Care Coordination and Medical Culinary Ed Prgms				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	NTPH	Navigators for Transition from Psychiatric Hospitals				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	OBRA	Pre-Admission Screening Annual Resident Reviews	1,129,164	1,129,164		-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PACC	Promoting Access and Continuity of Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PCPCP	Psychiatric Consultantion to Primary Care Practices				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PDTOB	Peer Driven Tobacco Cessation				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PHC	Peer(s) as Health Coach(es)				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PIPBHC	Promoting Integration of Primary and Behavioral Health Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PMTO*					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RCVC	Recovery Conference				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RT	Rural Transportation				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RTTSE	Infant and Early Childhood Mental Health Consultation.				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SCLCA	988 Suicide and Crisis Lifeline SAMHSA Cooperative Agreement				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SCP	School Counselor Program				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SFEP	First Episode Psychosis				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SPTTA	Statewide PMTO Training and TA				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SWI	Senior Wellness Initiative				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TBRS	Technology-Based Recovery Support				-	Must = 0

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)

FINANCIAL STATUS REPORT - ALL NON MEDICAID - SUPPLEMENTAL

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 22 / 23			
		SUBMISSION TYPE:	YE Final			YEAR TO DATE REPORTING
		SUBMISSION DATE:	2/29/2024			

H	MDHHS EARNED CONTRACTS				Column A	Column B	Column C	Column D	
H	Grant Program Code	Grant Program Title	Project Code	Project Title	REVENUE	EXPENDITURES	CCBHC EXPENDITURES	BALANCE	
H	CBH	Comprehensive Services for Behavioral Health	TFCCT	Trauma Focused CBT Coordination & Training				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TFCO	Treatment Foster Care Oregon				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TIC / TISC	Trauma Informed Care / System of Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TPC	Tuscola Peer Center				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	VET*					-	Must = 0
H	**SUBTOTAL Comprehensive Services for Behavioral Health**				1,275,107	1,275,107	-	-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	ASIMC	Addressing Social Isolation In Montcalm County				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	BHWSS	Behavioral Health Workforce Stabilization Support				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	CCR	Children's Crisis Residential				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	CMHCSS	Children's Mental Health COVID Supplemental Services				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	EOPSA	Early Onset Psychosis Set-Aside				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	EUHIT	Enhanced Utilization of HIT				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	MHCM*	Mental Health COVID Mitigation and Testing				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	MHCSS	Mental Health COVID Supplemental Services				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	NMOS	CCBHC Non-Medicaid Operations Support				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	WFSS	ACT and Dual ACT/IDDT Financial Incentive				-	Must = 0
H	**SUBTOTAL COVID-19 Comprehensive Services for Behavioral Health**				-	-	-	-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	ADMIII	Administration 3 COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	CVEG	AVCMH COVID-19 Emergency Grant				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	PREVCV	Prevention 3 COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	PREVII	Prevention II COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	SUDADII	Substance Use Disorder Administration COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	TRMTCV	Treatment 3 COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	TRMTII	Treatment COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	WSSCV	Women's Specialty Services 3 COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	WSSII	Women's Specialty Services COVID				-	Must = 0
H	**SUBTOTAL COVID-19 Substance Use and Gambling Services**				-	-	-	-	Must = 0
H	DIBS	Diversion Intervention from Boundary Spanners	DIBS	Diversion Intervention from Boundary Spanners				-	Must = 0
H	**SUBTOTAL Diversion Intervention from Boundary Spanners**				-	-	-	-	Must = 0
H	EBRSJ	Evidence Based and Research Supported Services for Juvenile Justice Y	EBRSJ	Evidence Based and Research Supported Services for Juvenile Justice Youth				-	Must = 0
H	**SUBTOTAL Evidence Based and Research Supported Services for Juvenile Justice Youth**				-	-	-	-	Must = 0
H	HHS	Housing and Homeless Services	PSH	Permanent Supportive Housing Dedicated Plus				-	Must = 0
H	HHS	Housing and Homeless Services	RRP	Consolidated Rapid Re-Housing				-	Must = 0
H	HHS	Housing and Homeless Services	SH	Permanent Supportive Housing Statewide Leasing				-	Must = 0
H	**SUBTOTAL Housing and Homeless Services**				-	-	-	-	Must = 0
H	IAHS	Individual Aftercare and Housing Services	IAHS	Individual Aftercare and Housing Services				-	Must = 0
H	**SUBTOTAL Individual Aftercare and Housing Services**				-	-	-	-	Must = 0
H	MKNMR	MI Kids Now Mobile Response Grant Program	MKNMR	MI Kids Now Mobile Response Grant Program	39,044	-	39,044	-	Must = 0
H	**SUBTOTAL MI Kids Now Mobile Response Grant Program**				39,044	-	39,044	-	Must = 0
H	MCSHR2	Midland County Supportive Housing Resource 2	MCSHR2	Midland County Supportive Housing Resource 2				-	Must = 0
H	**SUBTOTAL Midland County Supportive Housing Resource 2**				-	-	-	-	Must = 0
H	PATH	Projects for Assistance in Transition from Homelessness	PATH	Projects for Assistance in Transition from Homelessness	180,366	180,366		-	Must = 0
H	**SUBTOTAL Projects for Assistance in Transition from Homelessness**				180,366	180,366	-	-	Must = 0
H	RPC	Regional Perinatal Collaborative	RPC	Regional Perinatal Collaborative				-	Must = 0
H	**SUBTOTAL Regional Perinatal Collaborative**				-	-	-	-	Must = 0
H	SAMHC	Substance Abuse & Mental Health COVID-19 Grant Program	SAMHC	Substance Abuse & Mental Health COVID-19 Grant Program				-	Must = 0
H	**SUBTOTAL Substance Abuse & Mental Health COVID-19 Grant Program**				-	-	-	-	Must = 0

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)

FINANCIAL STATUS REPORT - ALL NON MEDICAID - SUPPLEMENTAL

CMHSP:	Washtenaw County Community Mental Health		FISCAL YEAR:	FY 22 / 23		
		SUBMISSION TYPE:	YE Final			YEAR TO DATE REPORTING
		SUBMISSION DATE:	2/29/2024			

H	MDHHS EARNED CONTRACTS				Column A	Column B	Column C	Column D	
H	Grant Program Code	Grant Program Title	Project Code	Project Title	REVENUE	EXPENDITURES	CCBHC EXPENDITURES	BALANCE	
H	SUGS	Substance Use and Gambling Services	GRT	Gambling Residential Treatment				-	Must = 0
H	SUGS	Substance Use and Gambling Services	MGDPP	Michigan Gambling Disorder Prevention Project				-	Must = 0
H	SUGS	Substance Use and Gambling Services	MPAC	Michigan Partnership for Advancing Coalitions				-	Must = 0
H	SUGS	Substance Use and Gambling Services	PPWP	Pregnant and Postpartum Women-Pilot				-	Must = 0
H	SUGS	Substance Use and Gambling Services	PREV	Prevention				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SDA	State Disability Assistance				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SORII	State Opioid Response II				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SOR3	State Opioid Response 3				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SUDADM	Substance Use Disorder - Administration (ADM)				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SUDTII	Substance Use Disorder Services - Tobacco II				-	Must = 0
H	SUGS	Substance Use and Gambling Services	TRMT	Treatment and Access Management				-	Must = 0
H	SUGS	Substance Use and Gambling Services	WSS	Substance Use Disorder Services - Womens' Specialty Services				-	Must = 0
H	**SUBTOTAL Substance Use and Gambling Services**				-	-	-	-	Must = 0
H		Other MDHHS Earned Contracts (describe):						-	Must = 0
H		Other MDHHS Earned Contracts (describe):						-	Must = 0
H	**SUBTOTAL Other MDHHS Earned Contracts**				-	-	-	-	Must = 0
H	**BALANCE MDHHS EARNED CONTRACTS (must = 0)**				1,494,517	1,455,473	39,044	-	Must = 0

Q		REMARKS
Q		This section has been provided for the CMHSP to provide narrative descriptions as requested in the FSR instructions or where additional narrative would be meaningful to the CMHSP / MDHHS.
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MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
GENERAL FUND CONTRACT RECONCILIATION AND CASH SETTLEMENT

CMHSP:	Washtenaw County Community Mental Health
FISCAL YEAR:	FY 22 / 23
SUBMISSION TYPE:	YE Final
SUBMISSION DATE:	2/29/2024

1. General Fund Services - Available Resources		Funding Resources
a.	CMH Operations (FSR B 101)	4,597,669
b.	Intentionally left blank	
c.	Intentionally left blank	
d.	Sub-Total General Fund Contract Authorization	$ 4,597,669
e.	1st & 3rd Party Collections (FSR B 121 + B 122)	8,442
f.	Prior Year GF Carry-Forward (FSR B 123)	211,753
g.	Intentionally left blank	
h.	Redirected CMHSP to CMHSP Contracts (FSR B 313)	69,088
i.	Redirected Non-MDHHS Earned Contracts (FSR B 314)	-
j.	Sub-Total Other General Fund Resources	$ 289,283
k.	Local 10% Associated to 90/10 Services (FSR M 201)	330,521
l.	Local 10% Match Cap Adjustment (FSR M 203)	-
m.	Sub-Total Local 10% Associated to 90/10 Services	$ 330,521
n.	Total General Fund Services - Resources	$ 5,217,473

3. Summary of Resources / Expenditures		Amount
a.	Total General Fund Services - Resources	5,217,473
b.	Total General Fund Services - Expenditures	5,217,473
c.	Sub-Total General Fund Services Surplus (Deficit)	$ -
d.	Less: Forced Lapse to MDHHS (GF work sheet 5 d column F)	-
e.	Net General Fund Services Surplus (Deficit)	$ -

4. Disposition:		Amount
a.	**Surplus**	
b.	Transfer to Fund Balance - GF Carry-Forward Earned	-
c.	Lapse to MDHHS - Contract Settlement	-
d.	Total Disposition - Surplus	$ -
e.	**Deficit**	
f.	Redirected from Local (FSR B 331)	-
g.	Redirected from risk corridor (FSR B 332)	-
h.	Total Disposition - Deficit	$ -

5. Cash Settlement: (Due MDHHS) / Due CMHSP		Amount
a.	Forced Lapse to MDHHS	-
b.	Lapse to MDHHS - Contract Settlement	-
c.	Return of Prior Year General Fund Carry-Forward	
d.	Intentionally left blank	
e.	Contract Authorization - Late Amendment	-
f.	Intentionally left blank	
g.	Misc: (please explain)	
h.	Total Cash Settlement: (Due MDHHS) / Due CMHSP	$ -

2. General Fund Services - Expenditures		90/10 - Local Cap	Expenditures
a.	100% MDHHS Matchable Services (FSR B 201)		1,230,596
b.	100% MDHHS Matchable Services - CMHSP Local Match Cap (FSR B 202)		-
c.	90/10% MDHHS Matchable Services (FSR B 203 Column A)	3,305,206	
d.	Local 10% Match Cap Adjustment (FSR M 203)	-	3,305,206
e.	Intentionally left blank		
f.	Intentionally left blank		
g.	Sub-Total General Fund Services - Expenditures		$ 4,535,802
h.	Intentionally left blank		
i.	Intentionally left blank		
j.	Intentionally left blank		
k.	Intentionally left blank		
l.	Intentionally left blank		
m.	Intentionally left blank		
n.	GF Supplement for Unfunded Targeted Case Management (FSR B 304)		-
o.	Intentionally left blank		
p.	Intentionally left blank		
q.	GF Supplement for Injectable Medications (FSR B 309)		-
r.	GF Supplement for PIHP to Affiliate Medicaid Services Contracts (FSR B 310)		-
s.	GF Supplement for PIHP to Affiliate CCBHC Medicaid Contracts (FSR B 310.1)		-
t.	GF Supplement for PIHP to Affiliate Opioid Health Home Services Contracts (FSR B 310.2)		-
u.	GF Supplement for PIHP to Affiliate Health Home Services Contracts (FSR B 310.3)		-
v.	GF Supplement for PIHP to Affiliate MI Health Link Services Contracts (FSR B 310.4)		-
w.	GF Supplement for PIHP to Affiliate CCBHC Non-Medicaid Contracts (FSR B 310.5)		681,671
x.	GF Supplement for CMHSP to CMHSP Contracts (FSR B 312)		-
y.	Sub-Total General Fund Services Supplement - Expenditures		$ 681,671
z.	Total General Fund Services - Expenditures		$ 5,217,473

6. General Fund MDHHS Commitment		
a.	MDHHS / CMHSP Contract Funded Expenditures	4,597,669
b.	Earned General Fund Carry-Forward	-
c.	Total MDHHS General Fund Commitment	$ 4,597,669

7. Report Certification

	Cash Settlement	Carry Forward
Examined	$ -	$ -
Original	0	0
Increase (Decrease)	$ -	$ -

Comments:

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
GENERAL FUND CONTRACT SETTLEMENT WORKSHEET

CMHSP: Washtenaw County Community Mental Health
FISCAL YEAR: FY 22 / 23
SUBMISSION TYPE: YE Final
SUBMISSION DATE: 2/29/2024

1. General Fund (Formula and Categorical Funding)		Contract Authorization	Cash Received: Through 9/30	Cash Received: After 9/30 Prior to Settlement	Cash Received: Total	Amount Due CMHSP / (MDHHS) Cash Settlement
a.	CMH Operations	4,597,669	4,597,669		4,597,669	-
b.	Intentionally left blank				-	-
c.	Total Current FY GF Authorization / Cash Received / Cash Settlement	$ 4,597,669	$ 4,597,669	$ -	$ 4,597,669	$ -

2. Current Year - General Fund Carry-Forward - Maximum		Contract Authorization	Maximum C/F
a.	CMH Operations	4,597,669	
b.	Total Current Year Maximum Carry-Forward	$ 4,597,669	$ 229,883

3. Prior Year - General Fund Carry-Forward		FY	If balance of Prior Year GF Carry-Forward is not zero, balance must be explained
a.	Prior Year GF Carry-Forward Earned	211,753	
b.	Prior Year GF Carry-Forward (FSR B 123)	211,753	
c.	Balance of Prior Year General Fund Carry-Forward	$ -	

4. Categorical - Categories		Authorization	Expenditures	Lapse	Cost Above Authorizations
a.	Other Funding - Please explain			-	-
b.	Other Funding - Please explain			-	-
c.	Other Funding - Please explain			-	-
d.	Totals	$ -	$ -	$ -	$ -

5. Narrative: Both CRCS and Contract Settlement Worksheet

Prior Year GF Carry-Forward Earned was left blank on the FSR that was submitted to MDHHS. The following examination adjustment was made to address this:
- Row 3.a. Prior Year GF Carry-Forward Earned was increased from $0 to $211,753; a difference of $211,753

SPECIAL FUND ACCOUNT
For Recipient Fees and Third-Party Reimbursement
As Added to Mental Health Code per PA 423, 1980

CMHSP: Washtenaw County Community Mental Health
FISCAL YEAR: FY 22 / 23
SUBMISSION TYPE: YE Final
SUBMISSION DATE: 2/29/2024

Part A: Mental Health Code (MHC) 330.1311 - County Funding Level		EXAMINATION ADJUSTMENTS	EXAMINED TOTAL
1. County Funding - 1979/1980	$ 583,301		$ 583,301
2. County Funding - Current Fiscal Year	$ 1,528,080		$ 1,528,080

Part B: Mental Health Code (MHC) 330.1226a - Cash Collections
Year to Date by Service Category and Source

Service Category	(1) Individuals Relatives	(2) Insurers Including Medicare	(3) Medicaid Health Plan Organizations	(4) Total	EXAMINATION ADJUSTMENTS	EXAMINED TOTAL
1. Inpatient Services				$ -		$ -
2. Residential Services				$ -		$ -
3. Community Living Services				$ -		$ -
4. Outpatient Services	$ 9,609	$ 314,729		$ 324,338		$ 324,338
5. Total	$ 9,609	$ 314,729	$ -	$ 324,338	$ -	$ 324,338

Part C: Mental Health Code (MHC) 330.1226a - Cash Collections Quarterly Summary		EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
1. First Quarter	$ 32,802		$ 32,802
2. Second Quarter	$ 14,079		$ 14,079
3. Third Quarter	$ 68,903		$ 68,903
4. Fourth Quarter	$ 208,553		$ 208,553
5. Total	$ 324,337	$ -	$ 324,337

Explanation of Accrual and Examination Adjustments

Washtenaw County Community Mental Health
Explanation of Examination Adjustments
September 30, 2023

General Fund Contract Settlement Worksheet

Prior Year GF Carry-Forward Earned was left blank on the FSR that was submitted to MDHHS. The following examination adjustment was made to address this:

- Row 3.a. Prior Year GF Carry-Forward Earned was increased from $0 to $211,753; a difference of $211,753

During our compliance audit, we may have become aware of matters that are opportunities for strengthening internal controls, improving compliance, and increasing operating efficiency. These comments and recommendations are expected to have an impact greater than $25,000, but not individually or cumulatively be material weaknesses in internal control over the Medicaid Contract and/or General Fund Contract. Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2023-02 FSR Examination Adjustments

Criteria or specific requirements:
The CMHSP shall provide the financial reports to MDHHS as listed in the General Fund Contract. Forms and instructions are posted to the MDHHS website. (Contract Attachment C6.5.1.1)

Condition:
The CMHSP submitted financial reports that were not in compliance with FSR instructions referenced in Attachment C6.5.1.1 to the General Fund Contract.

Examination adjustments:
Examination adjustments were made to sections of the FSR. See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Context and perspective:
Context and perspective have been included in the description shown on the Explanation of Examination Adjustments page of this report.

Effect:
See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Recommendations:
The CMHSP should review its current policies and procedures regarding the preparation and review of the Financial Status Report to assure that all amounts are reported in compliance with the reporting instructions. Specifically, a review of the final draft should be performed by a knowledgeable person who is independent from the original preparation of the report(s).

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Management will continue to work towards full compliance with this requirement. Management has implemented a procedure for final report submission to include a person independent of the original preparer to review the final draft of the report(s).

Responsible party:
Nicole Phelps, CFO & Tracy Bragiel, Accounting Manager

Anticipated completion date:
9/30/2024

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

Communication with Those Charged with Governance at the Conclusion of the Audit

To the Members of the Board
Washtenaw County Community Mental Health
Ypsilanti, Michigan

We have examined Washtenaw County Community Mental Health's (the CMHSP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and/or General Fund (GF) Contract for the year ended September 30, 2023. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you during planning. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Compliance Practices
Management is responsible for the selection and use of appropriate accounting and compliance policies. We noted no compliance matters entered into by the CMHSP during the year for which there is a lack of authoritative guidance or consensus.

Accounting estimates are prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the compliance requirements, particularly those that may have an impact on the Financial Status Report (FSR). The most sensitive estimates relating to the compliance requirements were as follows:

> Management uses estimates when preparing the CMHSP's cost allocation workbook. The cost allocation workbook is used to spread shared costs across the programs and funding sources that benefit from these shared costs. Examples of allocation methodologies used to spread shared costs that use estimates may include full-time equivalent (FTE), square footage of space used, percentage of total salaries and wages, etc. These allocation methodologies should follow the guidance provided by the Michigan Department of Health and Human Services and 2 CFR 200 Subpart E.

Difficulties Encountered in Performing the Audit
We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements
Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. If any of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, they would be reported on Schedule of Findings as shown above. If any of the misstatements detected as a result of audit procedures were expected to have an impact greater than $25,000, but were not material, either individually or in the aggregate, they would be reported on Comments and Recommendations as shown above.

Disagreements with Management
For purposes of this letter, a disagreement with management is an accounting, reporting, compliance, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the CMHSP's compliance with the compliance requirements described in the *Compliance Examination Guidelines*. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations
We have requested certain representations from management that are included in the management representation letter.

Management Consultations with Other Independent Accountants
In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves the CMHSP's compliance with the compliance requirements or a determination of the type of auditor's opinion that may be expressed, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the CMHSP's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters
The CMHSP's responses to the noncompliance findings identified in our examination are described in the accompanying Schedule of Findings and Comments and Recommendations. The CMHSP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Restriction on Use
This information is intended solely for the information and use of the Board and management of the CMHSP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

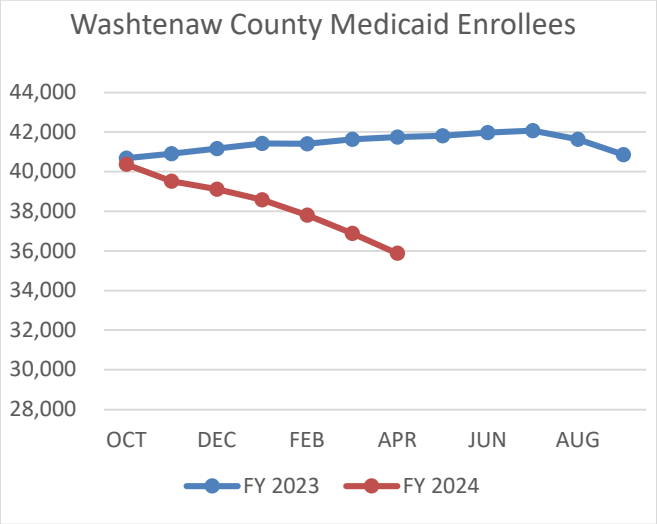
Roslund, Prestage & Company, P.C.

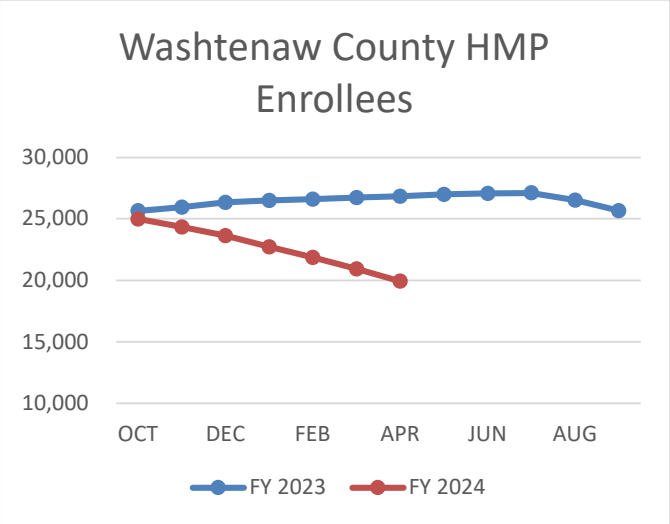
Roslund, Prestage & Company, P.C.
Certified Public Accountants

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2024: For the period ending April 30, 2024
Prepared: May 31, 2024

1. Washtenaw County Enrollees

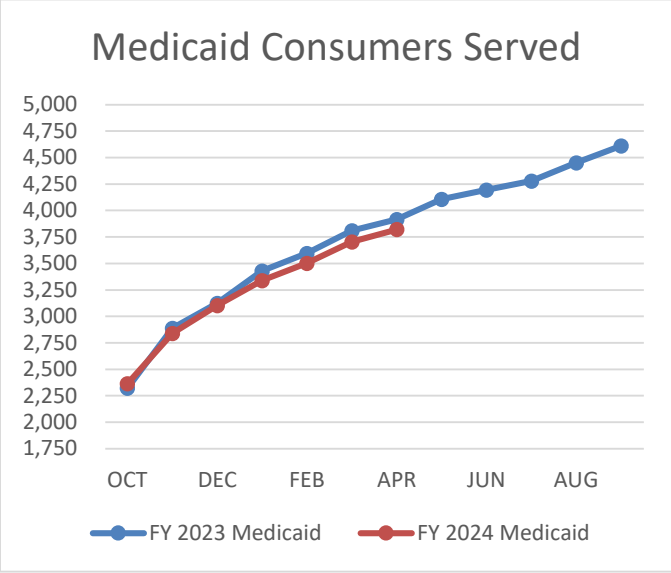
A summary of FY 2024 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

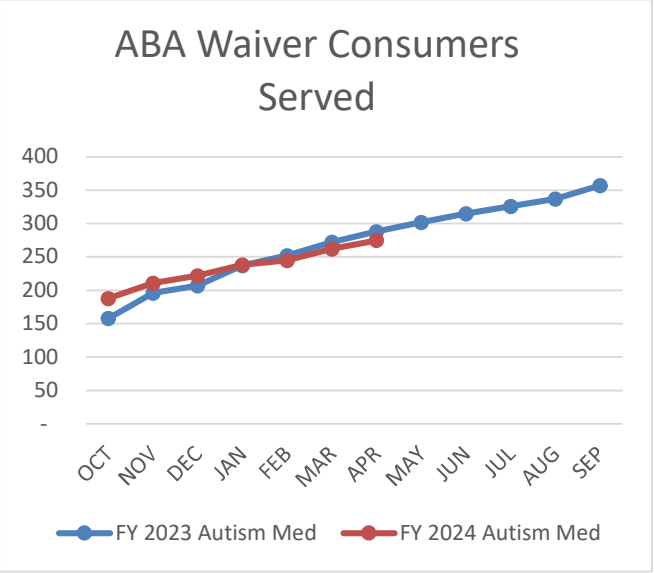




Washtenaw County Medicaid Enrollees were 35,877 in April 2024. This is a 14.07% decrease from the same time last year (5,873 less enrollees than in April 2023). Healthy Michigan enrollment in April 2024 was 19,929. This is a 25.75% decrease from the same time last year (6,910 less enrollees than in April 2023).

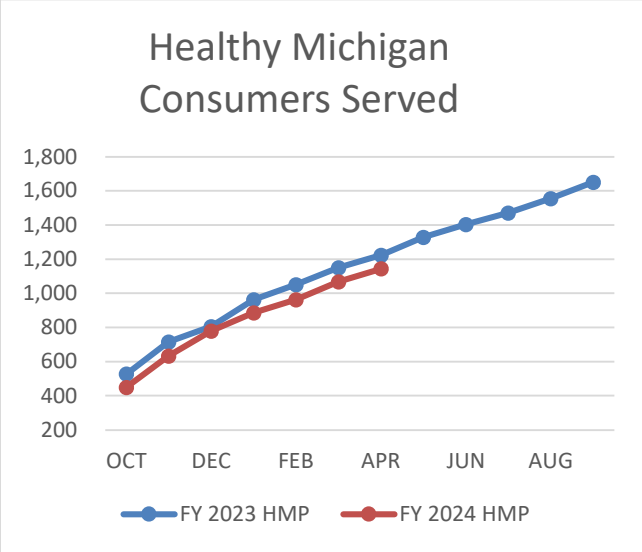
2. WCCMH Consumers Served to Date

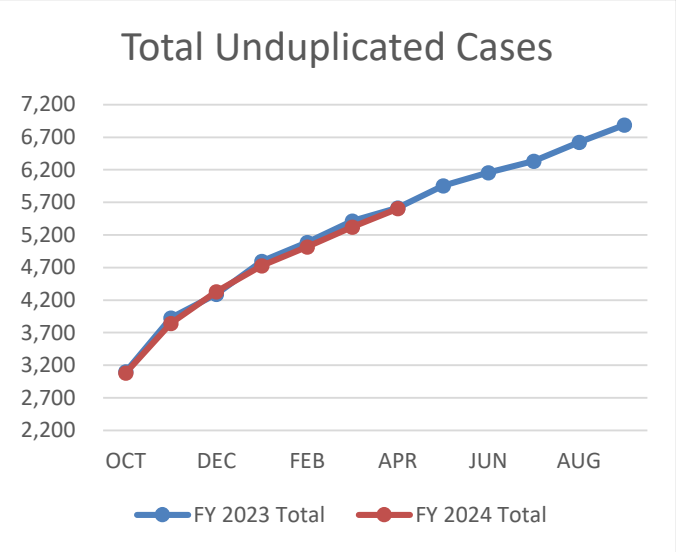




Medicaid consumers served through April 2024 are 3,822. This is 94 less consumers than the prior year (3,916 consumers were served through April 2023).

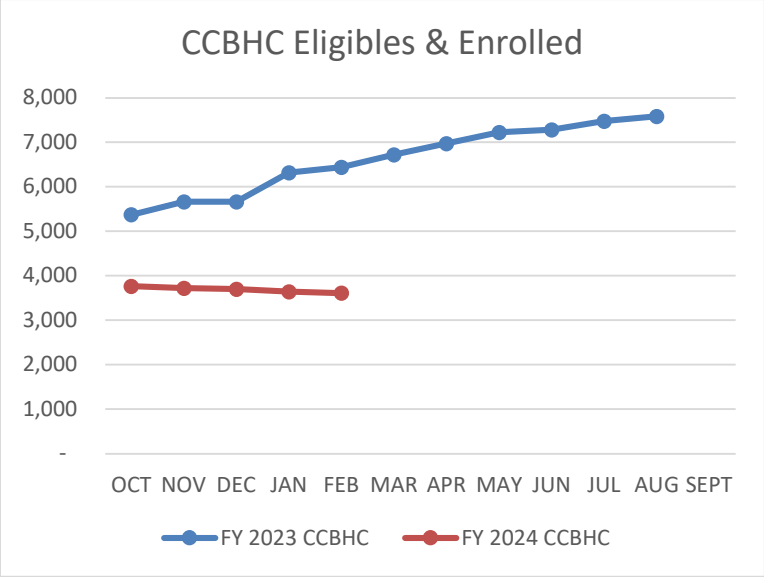
ABA Waiver consumers served through April 2024 are 275. This is 13 less consumers than prior year (288 consumers were served through April 2023).





Healthy Michigan consumers served through April 2024 were 1,145. This is 78 less consumers than the same period last year.

The total unduplicated consumers served by WCCMH through April 2024 were 5,607. This is 12 less consumers than served last year.

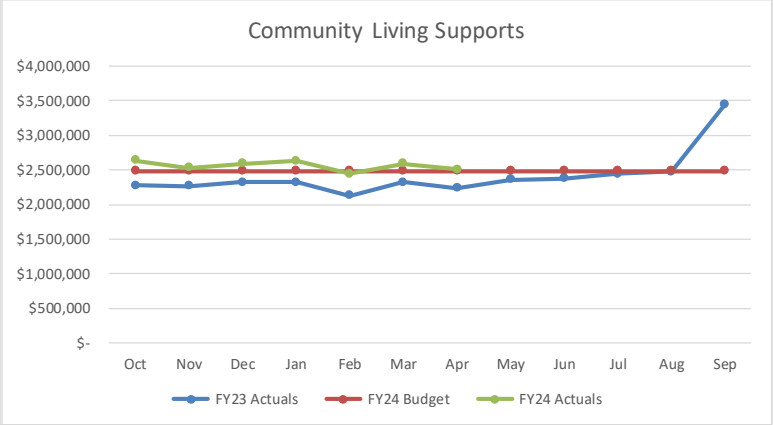


The YTD CCBHC eligibles and enrolled for FY 2024 as of April was 3,657.

3. Financial Statement Highlights

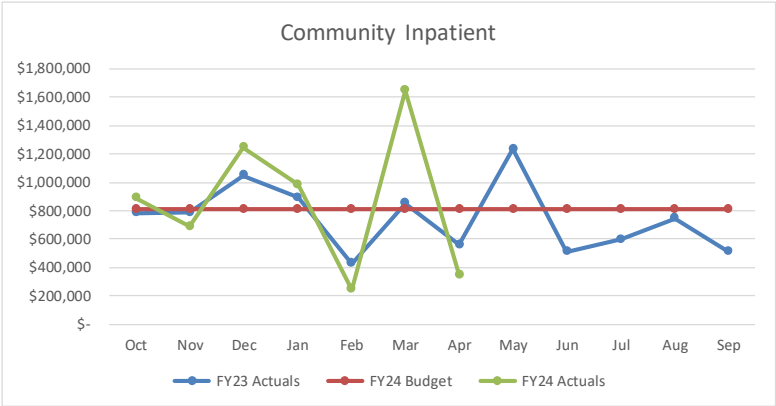
a. CLS service costs to date are estimated to be $17.9 and running just slightly under budget through the second quarter of FY 2024.

	FY23 Actuals	FY24 Budget	FY24 Actuals	YTD % Change
Oct	$ 2,277,066	2,483,333	$ 2,637,490	15.83%
Nov	2,268,391	2,483,333	2,528,065	13.64%
Dec	2,325,087	2,483,333	2,596,104	12.97%
Jan	2,322,970	2,483,333	2,631,239	13.05%
Feb	2,127,806	2,483,333	2,446,580	13.41%
Mar	2,324,287	2,483,333	2,594,033	13.10%
Apr	2,237,842	2,483,333	2,511,325	12.98%
May	2,362,630	2,483,333		
Jun	2,372,765	2,483,333		
Jul	2,444,471	2,483,333		
Aug	2,474,989	2,483,333		
Sep	3,451,817	2,483,333		



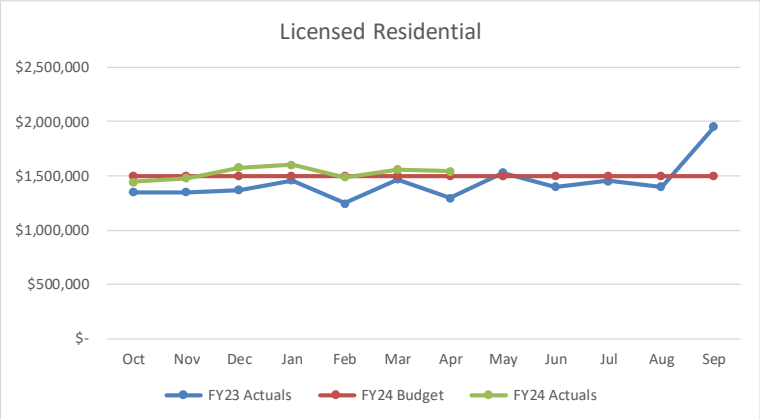
b. Community Inpatient costs to date are $6.0 Million. The costs year to date are 12.93% higher than this time last year and are about $379k over budget.

	FY23 Actuals	FY24 Budget	FY24 Actuals	YTD % Change
Oct	$ 783,838	$ 808,333	$ 888,374	13.34%
Nov	786,506	808,333	686,783	0.31%
Dec	1,046,711	808,333	1,243,366	7.70%
Jan	890,910	808,333	981,798	8.33%
Feb	428,822	808,333	244,417	2.74%
Mar	851,148	808,333	1,643,710	18.81%
Apr	558,658	808,333	349,426	12.93%
May	1,233,470	808,333		
Jun	511,519	808,333		
Jul	598,407	808,333		
Aug	743,351	808,333		
Sep	508,767	808,333		



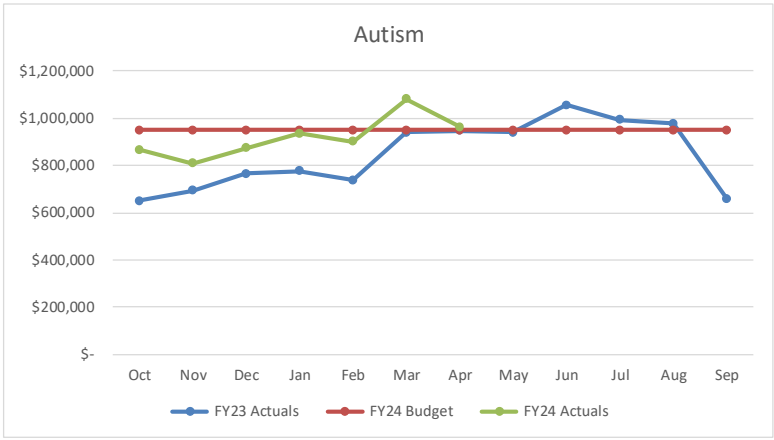
c. Licensed Residential costs to date are $10.6 Million and coming just slightly under budget. The costs year to date are about 11% more than this time last year.

	FY23 Actuals	FY24 Budget	FY24 Actuals	YTD % Change
Oct	$ 1,348,498	$ 1,500,000	$ 1,441,874	6.92%
Nov	1,351,230	1,500,000	1,476,079	8.08%
Dec	1,371,021	1,500,000	1,577,380	10.43%
Jan	1,456,672	1,500,000	1,601,609	10.30%
Feb	1,244,640	1,500,000	1,484,367	11.95%
Mar	1,466,361	1,500,000	1,553,224	10.88%
Apr	1,292,818	1,500,000	1,539,948	11.99%
May	1,529,546	1,500,000		
Jun	1,396,384	1,500,000		
Jul	1,451,490	1,500,000		
Aug	1,396,094	1,500,000		
Sep	1,952,399	1,500,000		



d. Applied Behavior Analysis/Autism service costs to date are $6.3 Million. The costs year to date are 15.5% more than this time last year and $285,000 under budget.

	FY23 Actuals	FY24 Budget	FY24 Actuals	YTD % Change
Oct	$ 648,805	$ 950,000	$ 867,186	33.66%
Nov	694,140	950,000	808,841	24.80%
Dec	765,065	950,000	874,088	20.97%
Jan	776,181	950,000	936,517	20.89%
Feb	737,877	950,000	900,686	21.13%
Mar	939,566	950,000	1,081,448	19.89%
Apr	948,251	950,000	963,660	16.74%
May	939,851	950,000		
Jun	1,056,440	950,000		
Jul	992,730	950,000		
Aug	977,197	950,000		
Sep	658,111	950,000		



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

4. PIHP Revenue Key Points

a. Medicaid, CCBHC and Healthy Michigan Plan revenues are collected from the PIHP.
b. By funding source, Medicaid and CCBHC is showing a surplus of $6,545,726 through April.
c. By funding source, HMP is showing a deficit of $590,136 through April.
d. Overall, the PIHP surplus is $5,937,733 through April.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a deficit of $508,762. The deficit is primarily resulting from CCBHC Non-Medicaid costs as well as covering Medicaid deductibles (spenddowns) for individuals served.

6. Local Key Points

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

b. Local Funds are showing a surplus of $270,902 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

a. At the end of FY 2023, WCCMH has a fund balance of $4,126,826.

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
APRIL 2024 FYTD

		Total
Medicaid **		
Revenue		
B & 1115i	$	29,023,513
HSW		17,952,350
Behavioral Health Home		280,439
Child Waiver/SED Waiver		688,914
Autism		4,330,315
Prior Year Adjustments		-
Care for Caid		36,032
Total Medicaid Revenue	$	52,311,562
Total Medicaid Expense	$	45,073,513
Medicaid Surplus/(Deficit)	$	7,238,049
CCBHC PIHP Section **		
Supplemental Revenue	$	7,654,583
CCBHC Capitation	$	4,958,334
Total CCBHC Revenue	$	12,612,917
CCBHC HMP Expense		2,447,205
CCBHC Medicaid Expense		10,858,035
Total CCBHC Expense	$	13,305,240
CCBHC Surplus/(Deficit)	$	(692,323)
CCBHC Local Section		
GF/Local Redirect	$	(766,219)
CCBHC Non-Medicaid Expense		766,219
CCBHC Surplus/(Deficit)	$	-
Healthy Michigan **		
Revenue	$	3,590,566
Expense		4,180,702
Healthy MI Surplus/(Deficit)	$	(590,136)
General Fund		
Revenue		
CMH Operations	$	2,580,000
CMH Operations Contra		-
GF Carryforward		-
Categorical		-
Redirect To Injectable Meds.		-
Redirect To CCBHC Non-Medicaid		(766,219)
Funding Fr. Other Local Sources		331,624

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
APRIL 2024 FYTD

		Total
Total General Fund Revenue	$	2,145,406
Total General Fund Expense	$	2,654,168
General Fund Surplus/(Deficit)	$	(508,762)
Injectable Meds		
Revenue	$	51,714
Expense		69,571
Inj. Meds. Surplus/(Deficit)	$	(17,857)
Grants And Contracts		
Revenue	$	583,650
Expense		583,188
Grants & Cont. Surplus/(Deficit)	$	462
CMHSP To CMHSP		
Revenue	$	612,920
Redirect to GF		(45,331)
Expense		567,589
CMHSP to CMHSP Surplus/(Deficit)	$	-
Local		
Revenue	$	978,040
Expense		707,138
Local Surplus/(Deficit)	$	270,902
Private Grant & All NOR		
Revenue	$	64,663
Expense		56,706
Priv. Grant & NOR Surplus/(Deficit)	$	7,957
Grand Total		
Revenue	$	72,906,106
Expense		67,197,815
Grand Total Surplus/(Deficit)	$	5,708,292

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	5,937,733
WCCMH Surplus/(Deficit)		(229,441)
	$	5,708,292

Washtenaw County Community Mental Health
Budget to Actuals
For Seven Months Ending April 30, 2024

	Current Fiscal Year				
	FY 2024 Amended Budget	FY 2024 Amended Budget YTD	FY 2024 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 49,969,192	$ 29,148,695	$ 29,023,513	$ (125,182)	-0.43%
HSW	31,275,389	18,243,977	17,952,350	(291,627)	-1.60%
Children & SED Waivers	1,335,478	779,029	688,914	(90,115)	-11.57%
Healthy Michigan Capitation	6,155,256	3,590,566	3,590,566	-	0.00%
Autism Capitation	7,423,397	4,330,315	4,330,315	0	0.00%
CCBHC Medicaid/HMP	8,500,000	4,958,333	4,958,333	(0)	0.00%
CCBHC Supplementary	11,800,970	6,883,899	7,654,584	770,685	11.20%
Behavioral Health Home	508,521	296,637	280,439	(16,198)	0.00%
TOTAL PIHP Revenue	$ 116,968,203	$ 68,231,452	$ 68,479,014	$ 247,562	0.36%
MDHHS Revenue					
State General Funds	$ 4,461,704	$ 2,602,661	$ 2,580,000	$ (22,661)	-0.87%
Grants & Earned Contracts	1,987,787	1,159,542	1,088,416	(71,126)	-6.13%
All Other Revenue					
County Appropriation	$ 1,751,761	$ 1,021,861	$ 454,459	$ (567,402)	-55.53%
Project Revenue	893,227	521,049	293,046	(228,003)	-43.76%
All Other	1,917,652	1,118,630	4,650,427	3,531,797	315.73%
TOTAL Operating Revenue	**$ 127,980,334**	**$ 74,655,195**	**$ 77,545,362**	**$ 2,890,167**	3.87%
Operating Expenses					
Administrative Expenses					
General Administration	$ 8,329,146	$ 4,858,669	$ 4,425,626	$ (433,043)	-8.91%
Program Administration	4,373,800	2,551,383	5,023,857	2,472,474	96.91%
Residential Services					
Community Living Supports	$ 30,800,000	$ 17,966,667	$ 17,862,010	$ (104,657)	-0.58%
Licensed Residential	18,610,162	10,855,928	10,674,481	(181,447)	-1.67%
Outpatient Services					
Autism Services	$ 11,400,000	$ 6,650,000	$ 6,432,565	$ (217,435)	-3.27%
Case Management	6,038,299	3,522,341	3,188,544	(333,797)	-9.48%
Supports Coordination	3,405,893	1,986,771	1,728,572	(258,199)	-13.00%
Skill Building	4,594,775	2,680,285	2,344,502	(335,783)	-12.53%
Supported Employment	1,812,327	1,057,191	1,039,905	(17,286)	-1.64%
Psychiatry	4,678,306	2,729,012	2,174,569	(554,443)	-20.32%
Nursing Services	2,892,534	1,687,312	1,503,512	(183,800)	-10.89%
Therapy Services	2,896,063	1,689,370	1,565,537	(123,833)	-7.33%
All Other	15,369,970	8,965,816	6,164,082	(2,801,734)	-31.25%
Other Expenses					
Community Inpatient	$ 9,700,000	$ 5,658,333	$ 6,037,873	$ 379,540	6.71%
Local Matches & Shelter	1,091,272	636,575	629,605	(6,970)	-1.09%
Grants & Earned Contracts	1,987,787	1,159,542	1,041,980	(117,562)	-10.14%
TOTAL Operating Expenses	**$ 127,980,334**	**$ 74,655,195**	**$ 71,837,220**	**$ (2,817,975)**	-3.77%
Revenue Over/(Under) Expenses	-	-	5,708,142	5,708,142	

Washtenaw County Community Mental Health
Budget to Actuals
For Seven Months Ending April 30, 2024

		Prior Year Comparison		
	FY 2024 YTD Actuals	FY 2023 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 29,023,513	$ 33,756,143	$ (4,732,630)	-14.02%
HSW	17,952,350	15,754,552	2,197,798	13.95%
Children & SED Waivers	688,914	684,322	4,592	0.67%
Healthy Michigan Capitation	3,590,566	4,032,229	(441,663)	-10.95%
Autism Capitation	4,330,315	3,777,314	553,001	14.64%
CCBHC Medicaid/HMP	4,958,333	-	4,958,333	0.00%
CCBHC Supplementary	7,654,584	2,824,118	4,830,466	0.00%
Behavioral Health Home	280,439	210,863	69,576	0.00%
TOTAL PIHP Revenue	$ 68,479,014	$ 61,039,541	$ 7,439,473	12.19%
MDHHS Revenue				
State General Funds	$ 2,580,000	$ 2,893,726	$ (313,726)	-10.84%
Grants & Earned Contracts	1,088,416	926,364	162,052	17.49%
All Other Revenue				
County Appropriation	$ 454,459	$ 212,444	$ 242,015	113.92%
Project Revenue	293,046	323,233	(30,187)	-9.34%
All Other	4,650,427	1,832,186	2,818,241	153.82%
TOTAL Operating Revenue	**$ 77,545,362**	**$ 67,227,494**	**$ 10,317,868**	15.35%
Operating Expenses				
Administrative Expenses				
General Administration	$ 4,425,626	$ 4,005,684	$ 419,942	10.48%
Program Administration	5,023,857	1,757,537	3,266,320	185.85%
Residential Services				
Community Living Supports	$ 17,862,010	$ 16,732,542	$ 1,129,468	6.75%
Licensed Residential	10,674,481	9,531,240	1,143,241	11.99%
Outpatient Services				
Autism Services	$ 6,432,565	$ 5,509,886	$ 922,679	16.75%
Case Management	3,188,544	2,716,334	472,210	17.38%
Supports Coordination	1,728,572	1,508,289	220,283	14.60%
Skill Building	2,344,502	2,116,879	227,623	10.75%
Supported Employment	1,039,905	956,075	83,830	8.77%
Psychiatry	2,174,569	2,360,977	(186,408)	-7.90%
Nursing Services	1,503,512	1,293,028	210,484	16.28%
Therapy Services	1,565,537	1,363,502	202,035	14.82%
All Other	6,164,082	5,869,455	294,627	5.02%
Other Expenses				
Community Inpatient	$ 6,037,873	$ 5,346,594	$ 691,279	12.93%
Local Matches & Shelter	629,605	727,839	(98,234)	-13.50%
Grants & Earned Contracts	1,041,980	900,244	141,736	15.74%
TOTAL Operating Expenses	**$ 71,837,220**	**$ 62,696,105**	**$ 9,141,115**	14.58%
Revenue Over/(Under) Expenses	5,708,142	4,531,389	1,176,753	

Washtenaw County Community Mental Health - Millage Advisory Committee
Millage Financial Update - For Four Months Ending April 30, 2024

	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 202
Community Wide Service Expansion							
CARES Team							
Access & Triage	$ 577,500	$ 192,500	$ 169,114	$ (23,386)	$ 577,500	$ -	$ 606,375
Treatment & Stabilization Services	577,500	192,500	181,779	(10,721)	577,500	-	606,375
Crisis Response	787,500	262,500	247,002	(15,498)	787,500	-	826,875
Crisis Stabilization Center	367,500	122,500	62,000	(60,500)	367,500	-	385,875
Other CARES Team	417,480	139,160	126,447	(12,713)	417,480	-	438,354
Criminal Justice Diversion & Deflection							
WCCMH Staffing - LEADD/Jail Services	$ 450,000	$ 150,000	$ 89,700	$ (60,300)	$ 400,000	$ 50,000	$ 450,000
Prosecutting Attorney Office	122,779	40,926	40,926	-	122,779	-	127,690
Supportive Housing							
Supportive Housing	$ 200,000	$ 66,667	$ 150,000	$ 83,333	$ 150,000	$ 50,000	$ 150,000
Michigan Ability Partners	120,000	40,000	-	(40,000)	120,000	-	120,000
Avalon - Permanent Supportive Housing	380,000	126,667	161,804	35,137	380,000	-	380,000
Emergency Housing	175,000	58,333	34,935	(23,398)	175,000	-	175,000
Youth Initiatives and Support							
Washtenaw Intermediate School District	$ 800,000	$ 266,667	$ 133,936	$ (132,731)	$ 800,000	$ -	$ 815,000
Student Advocacy Center	380,672	126,891	126,891	0	380,672	-	380,672
Community Family Life Centers	211,000	70,333	47,364	(22,969)	211,000		211,000
Health Dept - Anti Stigma Campaign	170,000	56,667	103,535	46,868	170,000	-	-
Ozone House	120,000	40,000	45,800	5,800	120,000	-	120,000
Packard Health - YBMen	125,000	41,667	31,250	(10,417)	125,000	-	-
Other Youth Initiatives and Support	250,000	83,333	-	(83,333)	130,000	120,000	-
Other Service Expansion							
Washtenaw Health Plan	$ 165,000	$ 55,000	$ 55,000	$ -	$ 165,000	$ -	$ 165,000
Other	125,000	41,667	-	(41,667)	125,000	-	-
TOTAL Community Wide Service Expansion	$ 6,521,931	$ 2,173,977	$ 1,807,483	$ (366,494)	$ 6,301,931	$ 220,000	$ 5,958,216

	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 2024
Education & Prevention							
Education & Outreach							
NAMI Contract	$ 225,900	$ 75,300	$ 75,300	$ -	$ 225,900	$ -	$ -
MHFA Trainings	25,000	8,333	-	(8,333)	25,000	-	25,000
TOTAL Education & Prevention	$ 250,900	$ 83,633	$ 75,300	$ (8,333)	$ 250,900	$ -	$ 25,000
Evaluate & Communicate							
Evaluate							
CHRT Contract	$ 63,435	$ 21,145	$ 18,193	$ (2,952)	$ 63,435	$ -	$ -
Communicate							
CHRT Contract	$ 178,875	$ 59,625	$ 39,724	(19,901)	$ 178,875	$ -	$ -
TOTAL Evaluation & Communication	$ 242,310	$ 80,770	$ 57,917	$ (22,853)	$ 242,310	$ -	$ -
Administration of the Millage							
WCCMH	$ 555,000	$ 185,000	$ 202,162	$ 17,162	$ 555,000	$ -	$ 555,000
5 Healthy Towns (Planning)	30,000	$ 10,000	-	$ (10,000)	30,000	-	-
Grand Totals	**$ 7,600,141**	**$ 2,533,380**	**$ 2,142,862**	**$ (390,518)**	**$ 7,380,141**	**$ 220,000**	**$ 6,538,216**

WCCMH BOARD AND BOARD COMMITTEE MEMBERS CONTACT INFORMATION FOR 4/1/24-3/31/25

WCCMH Board

Name	Representation	Term expiring
Kari Walker (Board Chair)	Community Member	3/31/27
VACANT	Community Member	
Anna Dusbiber (Secretary)	Primary Consumer	3/31/27
VACANT	Community Member	
Holly Heaviland (Vice-Chair)	Community Member	3/31/26
Barbara Higman	Primary Consumer	3/31/26
Bob King	Community Member	3/31/25
Andy LaBarre	Board of Commissioners	3/31/25
Steve Petty	Community Member	3/31/27
Alfreda Rooks	Community Member	3/31/25
Katie Scott	Secondary Consumer	3/31/25
Annie Somerville	Board of Commissioners	3/31/26
Marianne Udow-Phillips (Treasurer)	Community Member	3/31/27

WCCMH Executive Committee Members

Kari Walker (Chair)
Anna Dusbiber
Holly Heaviland
Bob King
Andy LaBarre
Marianne Udow-Phillips (Co-Chair)
VACANT

WCCMH Quality-Finance Committee Members

Anna Dusbiber
Holly Heaviland
Barb Higman
Marianne Udow-Phillips (Co-Chair)
VACANT
VACANT

Community Mental Health Partnership of Southeast Michigan (CMHPSM) Board Representatives

Bob King
Alfreda Rooks
Annie Somerville

WCCMH Millage Advisory Committee Members

Name	Representation	Term Expiring
Anna Dusbiber	Primary Consumer	3/31/27
Barbara Higman	WCCMH Board Representative	3/31/26
Amanda Carlisle	Washtenaw Housing Alliance Representative	3/31/25
Holly Heaviland	Washtenaw Intermediate School District Representative	3/31/26
Derrick Jackson (non-voting)	Washtenaw County Sheriff Office Representative	3/31/25
Alfreda Rooks	WCCMH Board Representative	3/31/25
Steve Petty	Community Member	3/31/27
Marlene Radzik	Washtenaw County Sheriff Office Representative	3/31/25
Ray Rion	Packard Health Representative	3/31/25
Annie Somerville (Chair)	WCCMH Board Representative Board of Commissioners Representative	3/31/26
Marianne Udow-Phillips	WCCMH Board Representative	3/31/27
George Waddles, Jr.	Community Member	3/31/25
Kari Walker	WCCMH Board Representative	3/31/27

Please email wccmhboard@washtenaw.org for questions and/or concerns. Revised 6/18/24 rla

RESOLUTION OF THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD OPPOSING MDHHS APPROACH TO MEETING THE FEDERAL CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN AND URGING COLLABORATIVE DEVELOPMENT OF AN ALTERNATIVE APPROACH

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has a requirement ensuring conflict free casemanagement/conflict free access and planning in relationship to Medicaid-funded Home and Community Based Services.

WHEREAS, a number of approaches to meeting this requirement have been proposed by stakeholders to the state's public mental health system, including the state's Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) that ensure ease of access to care in the state's public mental health system.

WHEREAS, the Michigan Department of Health and Human Services (MDHHS) has, instead of working with these stakeholders around the pursuit and implementation of these approaches, announced its plans to implement an approach to meeting the CMS requirement that will fragment the state's public mental health system, hinder access to care for Michiganders, and make an already complex system more complex.

WHEREAS after careful review, the Washtenaw County Community Mental Health Board concludes that the conflict-free approach being pursued by MDHHS:

- Ignores the voice of persons with lived experience who have consistently stated that the MDHHS proposal hinders access and quality service delivery and makes a complex system more complex;
- Is diametrically opposed to state, national, and local efforts to integrate and coordinate mental health care, including Michigan's innovative Behavioral Health Home and Certified Community Behavioral Health Clinic (CCBHC) initiatives in place in communities across the state;
- Conflicts with the statutory responsibilities of Michigan's county-based Community Mental Health system;
- Moves service authorization farther from the point of service delivery and further from the oversight and partnership of Michigan counties, thus emulating a private for-profit system – in rather than in concert with the county-based public system;
- Erroneously implies profit-driven or undue enrichment motives on the part of governmental entities (CMHSPs) instead of recognizing what is statutorily a formal transfer of governmental responsibility from the State of Michigan to the counties for the delivery of public mental health services.

THEREFORE, BE IT RESOLVED THAT, for the reasons noted herein, the Washtenaw County Community Mental Health Board opposes the approach being proposed by MDHHS to meet the federal Conflict Free standards; and strongly urges MDDHS to halt its efforts in pursuit of this approach.

BE IT FURTHER RESOLVED THAT the Washtenaw County Community Mental Health Board requests MDHHS: work with the state's counties, CMHSPs, and PIHPs, and their associations, and other stakeholder groups in the design and implementation of an approach to meeting the CMS Conflict-Free standards; involve these parties in any communication with the federal Centers for Medicare and Medicaid Services (CMS) regarding CMS's understanding and approval of the Michigan plan; and seek approval, by CMS, for this jointly developed conflict-free plan.

ATTACHMENT #8
JUNE 2024

Minimizing Complexities

Meeting Federal Conflict Free Requirements in Ways That Promote Simplicity and Access to Care

CMHA Community Mental Health Association of Michigan

The Michigan Department of Health and Human Services (MDHHS) recently proposed new requirements for individuals seeking mental health services through the public mental health system. While the new requirements would comply more directly with federal Conflict-Free Access and Planning (CFA&P) guidelines, they would create access challenges for those seeking care, service delays and additional costs to providers.

What is Conflict-Free Access and Planning?

CFAP is based on a 2014 federal requirement for Home and Community-Based Services (HCBS), a type of Medicaid service, which attempted to limit perceived conflicts of interest for beneficiaries obtaining HCBS. In Michigan, agencies can have more than one role: access, plan development, and service delivery. If one agency is helping an individual access and plan their services it is key to ensure that a conflict of interest does not exist and that persons served/clients/consumers have a choice of providers. A conflict of interest happens when a professional uses their role to benefit themselves or their employer.

CMHA and our members fully support the intent to limit conflicts, however we believe the proposed "solutions" outlined by MDHHS cause unnecessary disruption and complexity and provide a greater threat than the conflicts they are attempting to prevent.

APPROACH PROPOSED BY MDHHS

Requires you to go to one "provider" for assestment, planning, and case management, and another "provider" to receive services. If you change your service plan, you must go back to the planning "provider."

MICHIGAN'S CURRENT COMMUNITY MENTAL HEALTH-BASED MODEL

Allows a 1-stop shop for people to do an assestment, planning, case management and receive services.

Concerns with MDHHS Conflict-Free Proposal

1. The MDHHS proposal makes an already complex system more complex: Same day service would be impossible under the separation of functions that MDHHS is proposing. Outreach to persons, school children, homeless, would be seriously hindered by prohibiting the services provider from assessing and building a treatment/services plan with the person in need.
2. Persons served/clients/consumers are concerned with the MDHHS proposal: The comments of persons served (clients/consumers), obtained during the MDHHS listening sessions underscore their concerns with the MDHHS proposal:
    - "I think [separating access/planning from direct service] could be problematic due to a person having to repeat providing their info…"
    - "Having to go from here, to here, to here…to do it when being in a place where I need help would be a lot. It's a lot to ask one person to go through."

    - "Between the point of access and referral, things get dropped and lost."
3. The MDHHS proposal is in conflict with state law and other federal requirements:
    - The statutorily required core functions of Michigan's CMHs.
    - The federally required core functions of Michigan's Certified Community Behavioral Health Clinics (CCBHC) and Behavioral Health Homes (BHH)

DISADVANTAGES OF MDHHS' PROPOSED APPROACH

- Delays service delivery
- Increases costs
- Increases administrative burden
- Adds confusion and barriers for people served

CMHA-Recommended Process

Rather than add complexity to the system, Michigan can build upon the conflict mitigation approaches that already have the approval of the Federal Government.

There are a number of alternate approaches that Michigan could use to meet the federal Conflict-Free standards. One of those alternate approaches is:

1. Because it is not known until the assessment and Individual Plan of Service (IPOS) are completed, whether the person is in need of Home and Community-Based Services (HCBS), the initial assessment and Plan of Service should be carried out as it is now, by the CMHSP or their designated assessment and planning organization.
2. If HCBS are part of a person's Plan of Service, the person is presented with a list of organizations which provide those HCBS services, from which to choose. The organization carrying out the assessment and Plan of Service cannot be on that list unless that organization is the only organization who can provide that service.

Continue to strengthen the structural conflict mitigation components approved by the Federal Government

a. Persons facilitating the Person-Centered Planning (PCP) process cannot be providers of any HCBS to those with whom they facilitate PCP processes.

b. The person facilitating the PCP process or serving as the case manager/supports coordinator for the person served cannot authorize the services contained in the plan for that person.

c. Neither the persons facilitating the PCP process nor the providers of any HCBS can be the person responsible for the independent HCBS eligibility determination. This latter role is held by MDHHS.

This process is nested in a robust monitoring and contract compliance process.

Accessible, frequent, and readily-available information to persons served regarding the rights outlined above – through the use of:

(1) A uniform set of hard-copy handouts and electronic messages; (2) Notices on the websites of the state's CMHSPs, PIHPs, providers, and MDHHS; (3) Social media posts

Continual education, training, supervision, and coaching of CMHSP, PIHP, and provider staff around these rights – efforts led by MDHHS, the state's major advocacy organizations, and CMHA.

The use of contractual powers, corrective action plans, and sanctions, when needed, to ensure that these rights are afforded persons served – via the MDHHS/PIHP contract, the MDHHS/CMHSP contract, and the PIHP/CMHSP contract.

CMHA Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

RESOLUTION OF THE WASHTENAW COUNTY BOARD OF COMMISSIONERS OPPOSING MDHHS APPROACH TO MEETING THE FEDERAL CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN AND URGING COLLABORATIVE DEVELOPMENT OF AN ALTERNATIVE APPROACH

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stakeholder groups in the design and implementation of an approach to meeting the CMS Conflict-Free standards; involve these parties in any communication with the federal Centers for Medicare and Medicaid Services (CMS) regarding CMS's understanding and approval of the Michigan plan; and seek approval, by CMS, for this jointly developed conflict-free plan.