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

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH)
EXECUTIVE COMMITTEE MEETING
AGENDA

In-person: Learning Resource Center-Michigan Room
4135 Washtenaw Ave, Ann Arbor
OR
Virtual: https://zoom.us/j/96402132290

January 27, 2023
9:30 – 10:30 AM

I. Roll Call (5 minutes)

II. Introductions (5 minutes)

III. Audience Participation (see guidelines below) (5 minutes)

IV. Executive Committee Minutes (5 minutes) **ACTION**
- Executive Committee Minutes and Actions-9/23/22 (Attachment #1)

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

VI. Old Business (20 minutes)
- Legislative Update **T. Cortes/F. Brabec** (Attachment #2)

VII. New Business (5 minutes)
- WCCMH 2022 Annual Board Calendar (Attachment #3) **ACTION**
- WCCMH Board Member terms expiring on March 31, 2023
    1. S. Antonow
    2. B. Higman
    3. D. Jackson
    4. R. Jefferson
    5. R. Rion
    6. D. Strong

VIII. Items for Future Discussion (5 minutes)

IX. Adjournment of Public Meeting

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, and advance health equity in Washtenaw County by providing, high quality, integrated behavioral health services to adults and youth with intellectual/developmental disabilities, mental health and/or substance use needs.

VIRTUAL MEETING LINK:

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. https://zoom.us/j/96402132290

Or One tap mobile:
+16465189805, 96402132290# US (New York)
+19292056099, 96402132290# US (New York)

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

Webinar ID: 964 0213 2290
International numbers available: https://zoom.us/u/aiwfJFdxX

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

ATTACHMENT #1
JANUARY 2023

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH EXECUTIVE COMMITTEE MEETING MINUTES *DRAFT*
In person: Learning Resource Center-Michigan Room
4135 Washtenaw Ave, Ann Arbor
OR Virtually at https://zoom.us/j/99734756284

September 23, 2022
9:30 am

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

ROLL CALL: A. Dusbiber attending virtually
B. King attending in person
A. LaBarre attending in person
K. Walker attending in person

MEMBERS ABSENT: S. Antonow, N, Graebner-Sundling

STAFF PRESENT: R. Avedisian, M. Harding, T. Cortes, N. Phelps; H. Linky, B. Hagaman, M, Taylor, T. Gavalier

OTHERS PRESENT: L. Lutomski, T. Gavalier

I. Introductions
- None

II. Audience Participation
- None

III. Executive Committee Minutes and Actions
- Executive Committee Minutes and Actions from 5/9/22 were reviewed (Attachment #1).

MOTION BY A. LABARRE, SUPPORTED BY B. KING TO APPROVE THE MINUTES AND ACTIONS OF THE MAY 9, 2022, WCCMH EXECUTIVE COMMITTEE MEETINGS.

ROLL CALL VOTE:

ANTONOW	**N/A**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**N/A**	**KING**	**Y**
LABARRE	**Y**	**WALKER**	**Y**

MOTION CARRIED

IV. Executive Director Report
- T. Cortes presented the Executive Director Report to the committee.
- N. Marchand will be invited back to the next full board meeting to provide update – closed session.

V. Old Business
- Strategic Plan Update
  - T. Cortes and M. Harding presented an update on the Strategic Plan.
  - M. Harding requested Executive Committee input on front end for reporting purposes. K. Walker proposed Green/Yellow/Red versus a progress bar. A. LaBarre suggested no more than 10 measurables.

VI. New Business
- WCCMH 2023 Annual Board/Committee Meeting schedule was presented reflecting the change of meeting dates/days/time. (Attachment #2)

VII. Items for Future Discussions
- T. Cortes will continue to provide feedback on progress from public comments on I/DD population.

MOTION BY B. KING SUPPORTED BY A. LABARRE TO ADJURN THE PUBLIC MEETING OF THE WCCMH EXECUTIVE COMMITTEE.

The WCCMH Executive Committee Meeting was adjourned at 10:03 am.

WCCMH Three Legislative Priorities

WORKFORCE SHORTAGE CRISIS

WAGES FOR FRONT LINE STAFF

Increase funding to the state's public mental health system to allow for competitive wages and benefits for direct support professionals the persons who provide daily supports in the homes and community activities of persons with complex mental health needs (Three - Pronged Strategy – attachment 2)

RECRUITMENT/LOAN FORGIVENESS

- *Expand federal (National Health Services Corps) and state loan repayment programs to attract psychiatrists, social workers, psychologists, and other clinicians to underserved Michigan communities (Three - Pronged Strategy)*
- *Develop and fund a training and career pathway infrastructure for Michigan's direct support professionals (Three - Pronged Strategy – attachment 2)*

DIRECT CARE WORKFORCE SHORTAGE

See attached CHRT document (Attachment 1)

ADMINISTRATIVE BURDENS

Overhaul the paperwork and administrative-related demands that are currently borne by the state's mental/behavioral healthcare workforce to allow more time to be spent in providing care and increase the attractiveness of the work. (Three - Pronged Strategy – attachment 2)

RETAIN SUFFICIENT RISK RESERVE TO ACHIEVE SUSTAINABLE FUNDING

Failure of the state to fund federally required contributions to public mental health system's risk reserves*: For the past twenty years, the Medicaid funding provided to the state's public mental health system* ***did not include the federally required risk-reserve contribution component*** *that would have allowed Michigan's public mental health system to build and retain the necessary risk reserves –* ***reserves necessary for any risk-bearing managed care entity.***

If the Medicaid rates paid to the public mental health system had included even a modest component (2%) to provide for contributions to reserves and risk margins, the public mental health system would have ***received $50 million more in Medicaid payments in the current fiscal year****, FY 2018 and nearly $700 million over its twenty-year history, providing reserves sufficient to weather a range of fiscal storms.*

***Inability of the public system to retain savings of sufficient size to ensure fiscal stability**: **The PIHPs (**the public health plans that receive the Medicaid payments from the state) **are prohibited from holding sufficient risk reserves**. Similarly, the **CMHs are prohibited from retaining any Medicaid savings** that they generate through efficiencies and effective clinical practices. These savings, **permitted for any other healthcare provider**, would allow the CMHs to invest in meeting community needs and ensuring their clinical and fiscal stability.*
(Systemic-underfunding-of-Michigans-public-mental-health-system-rev2 CMHAM)

SYSTEMS TRANSFORMATION

*Support the implementation of Michigan's Certified Community Behavioral Health Centers **(CCBHC)** in the initial pilot sites and then scale up statewide. This CCBHC designation for the state's Community Mental Health (CMH) centers and their provider network partners, brings federal dollars to Michigan to expand, to all Michiganders, access to the broad array of mental health services and supports currently available to Michiganders enrolled in Medicaid. (Three - Pronged Strategy – Attachment 2)*

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

See CMHAM attachment 3 for recommendations

Attachment 1

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

Summary

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

Background

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

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

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

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

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

Recommendations

To address Michigan's behavioral health care staffing crisis:

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

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

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

Attachment 2

Draft: for discussion only

Community Mental Health Association of Michigan

A call to continue and bolster the three-pronged strategy: ensuring the strength & viability of Michigan's public mental health system

November 2022

Context for and aim of this document

With the end of the recent threats to the public mental health system – the result of the successful advocacy efforts by that system and its allies - CMHA members and partners may assume that the privatization threats to the public mental health system are permanently dead.

To counter this belief, this paper calls for the continuation and, wherever possible, the bolstering of the three-pronged strategy that has been implemented by CMHA members, allies, and CMHA itself over the past several years.

Factors in environment behind call to continue and bolster three-pronged strategy

Factors supporting the strength and viability of Michigan's public mental health system

1. **Central safety net role, structure, and history of performance and innovation**: Michigan's public mental health system is uniquely equipped to foster the health and well-being of the individuals and communities that is serves given its
    - **Fundamental to the architecture of Michigan's health care system**
    - **A system with a longstanding state statutory, regulatory, and policy foundation**
    - **Direct connection to local county governments, as a creation of county government** to serve to fulfill each county's mental health responsibilities. - as part of the longstanding partnership between the county, state, and federal governments
    - **Decades of high performance in directly providing and purchasing the full range of behavioral health and intellectual/developmental disability services**
    - **Role as each community's mental health safety net –** serving as the clinical risk and responsibility-bearing mental health body in every community in Michigan
    - **Central role in community mental health needs assessment, stakeholder involvement, and community dialogue**
    - Role in serving as the state's **screening and admission points to state psychiatric hospitals** and discharge planning and implementation from those hospitals
    - **Central role in managing and ensuring the quality of care** of comprehensive community-based service networks
    - **Highly visible community convener and collaborator** around a wide range of community needs and social determinants
    - **Leadership** in the development, use, and replication of **evidence-based and promising practices**
    - **Source of guidance and expertise** to other healthcare and human services providers, elected officials, policy makers, the media

2. Trends in the environment <u>that align with</u> Michigan's public mental health system. Chief among these are the Certified Community Behavioral Health Clinic (CCBHC), Behavioral Health Home (BHH), and Opioid Health Home (OHH) initiatives across the country. The close alignment of the philosophy, structure, services, and operations of Michigan's mental health safety net system with those of the CCBHC, BHH, and OHH constructs position Michigan's public mental health system to be a central component of the emerging healthcare landscape

3. Political advocacy strength: Over the past several years, Michigan's public mental health system and its allies have designed and implemented a sophisticated and powerful political advocacy effort that has successfully thwarted a number of privatization efforts that would have dramatically harmed or, potentially, destroyed the state's public mental health safety net.

These advocacy efforts, starting in 1997 when the system took on managed care functions and risk, have grown stronger and more sophisticated over the past several years, as has the coalition of organizations and Michiganders supporting Michigan's public mental health system.

<u>Factors threatening the strength and viability of Michigan's public mental health system</u>

1. **Trends in the environment <u>that do not align with</u> Michigan's public mental health system:** Healthcare transformation initiatives that lead to private managed care companies taking on the roles historically played by the public mental health sector have been taking place across the country. Michigan is one of the nation's few remaining county-based public mental health systems carrying out the system's managed care functions.

2. **Continued privatization goals and political power of private health plans**: The private health plans will not retreat from their efforts to take over the management of the state's $3.5 billion Medicaid behavioral healthcare benefit. Their political power, fueled almost exclusively by campaign and corporate donations to elected officials, is substantial.

3. **Medicaid health plan rebid & dual eligible DSNP:** In 2023 MDHHS will be issuing new contracts to Medicaid health plans, which will include a behavioral health component, the question is to what extent will it be included (the rumor during the last contract period was MDHHS was close to moving all of the Medicaid behavioral health benefit into the health plans contract).

   Additionally, in the near future MDHHS is expected to announce a continuation of the MI Health Link, the state's dual eligible initiative, through 2025. It is anticipated in that announcement MDHHS will explore a Dual Eligible Special Needs Plan (DSNP), which would allow one managed care entity to control all Medicaid and Medicare services for roughly 200,000 citizens who are eligible for both programs. This would include 30,000-40,000 people served in the public mental health system. This change would privatize the management of the Medicaid benefit for these persons -a role currently played by the state's PIHP and CMHSPs, and reduce the funding for the public system by 40%.

Analysis of impact of strengthening and threatening factors and the need to continue and bolster three-pronged strategy

The system strengthening factors outlined above are considerable and have thwarted privatization threats for years. However, even with the system strengthening factors noted above and the support of the system's allies – of which the system has many – these factors will continue to be challenged by the system threatening factors.

Given the fiscal allure of the Medicaid mental health market (including Michigan's $2.5 billion Medicaid mental health market), a number of private sector parties in the healthcare arena will use their considerable political and financial power – political power that is exercised within individual states, such as Michigan, and nationally – to enter this market.

It is key to recognize that if the system strengthening factors were the only ones influencing the future of our system, the state's public mental health system would be safe from attack and privatization. Such a world existed for our system over most of its life since 1963.

However, it is key that the system and its allies do not rely upon these factors, alone, to ensure the strength of the public system. Needed is a three-part parallel approach to ensuing the strength and viability of Michigan's public mental health system.

Three-pronged strategy

A three-pronged strategy has been pursued by CMHA for the past several years and has been successful in underscoring the innovative and collaborative nature of Michigan's public mental health system while weakening the political power of those working to privatize the system.

This three-pronged strategy consists of:

1. Strong and sophisticated advocacy: The continued development and use of a sophisticated, coalition-based political and media-based advocacy effort designed to thwart privatization efforts and other threats to the state's public mental health system

2. Public-private partnerships; The continued pursuit, by CMHA members and supported by CMHA, of partnerships with private health care entities including private health plans, hospitals, and primary care centers (including Community Health Centers/Federally Qualified Health Centers).

3. Push legislation and executive branch action on concrete approaches to advance the system: With the change in the state's legislative leadership, CMHA, its members, and allies have a unique opportunity to aggressively advocate for the passage of legislation and action, by the executive branch, to implement any of the recommendations made by CMHA and its allies over the past several years – recommendations that, if implemented, would address the real challenges facing Michiganders and the mental health system that serves them.

Actions in pursuit of the three-pronged strategy

1. Strong and sophisticated advocacy:

It is key that the public system and its allies build upon its sophisticated, coalition-based political and media-based advocacy effort designed thwart privatization efforts and other threats to the state's public mental health system

With the changes in the State Legislature and legislative leadership, there exists an opportunity to engage a new group of legislative leaders who will perhaps have a different political spin on this issue.

A summary of the broad array of advocacy tools used by CMHA, its members, and allies to thwart the most recent threats to the system – and which will be continually refined and prepared for future threats to the system - are outlined in " Summary of advocacy efforts to ensure the strength and survival of Michigan's public mental health system – in the face of legislative threat" (April 2022) https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:a9b2606a-2aa8-359b-9b8a-5293a6c70284

2. Public-private partnerships;

A. CMHA members and CMHA continue to pursue public-private partnerships: The state's CMHs, PIHPs, and providers continue to develop a range of public private partnerships with private health care entities including private health plans, hospitals, and primary care centers (including Community Health Centers/Federally Qualified Health Centers).

These partnerships should be guided by the principles adopted by the CMHA Board of Directors in June 2020. Those principles, excerpted from this June 2020 document, are found in Attachment A.

B. CMHA sponsored Learning sessions: In addition to the active pursuit of these partnerships by CMHA members, CMHA will host a series of learning sessions, with subject matter experts from across the country, who have led public-private partnerships in their states.

These learning sessions will address topics including: formation of Independent Practice Associations (IPA), Clinically Integrated Networks (CIN), joint public-private ventures, and other partnership models.

3. Push legislation and executive branch action on concrete approaches to advance the system

A. CMHA, its members, and allies continue to advocate for recommendations in "Within Our Reach" document: This document, found at: https://cmham.org/wp-content/uploads/2022/10/CMHA-Within-Our-Reach-Concrete-Approaches-Factsheet-final.pdf outlines a number of approaches that would significantly advance Michigan's public mental health system, address deep and prolonged gaps in care, and support innovative and promising practices. The text version of "Within Our Reach" is provided as Attachment B.

B. Build upon "Within Our Reach" and work to expand set of recommendations for concrete actions to advance the system and better serve the mental health needs of Michiganders: Continual work to identify, describe, and advocate for system advancement recommendations, in addition to those contained in the Within Our Reach document.

Attachment A

Foundational principles for system design

*These foundational constructs are **drawn from the principles of CMHA as adopted** by the CMHA Board of Directors in June 2020. The full document, "CMHA Recommendations: Advocacy and Promotion of a Vision for the Design of Michigan's Public Mental Health System" can be found at:* https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:fc13404c-a33f-334e-83a3-1dc28d2b88da

1. The design of Michigan's public mental health system must foster **an individual's right to self-determination, person-centered planning, full community inclusion, family driven/youth guided, cultural competence in the services and supports provided them.**

2. Any system design effort should **start with what is best for those served by the system with the financing, operations, and governance infrastructure of the system designed around to achieve what is best for those served.**

3. **Retain and strengthen the place-based structure of the system, with its strong local public governance**. Ensure that the governance (and ownership, if ownership structures are used) of the managed care, provider, and collaborative convener roles of the state's public mental health system remain local and public - **embedded and legally and financially linked to the county governments** served by the system. The need for the linking of foundational service delivery systems, such as behavioral health, physical health, and public safety has been underscored by the events of the past year.

4. **Foster consistency of services and access to those services statewide and contract requirements for providers**: Implement financing and practice guidance to ensure a core level of service access and intensity for all Michigander. Additionally, foster statewide uniformity of contract, reporting, and site visit requirements applied to provider organizations.

5. **Protect and strengthen the full set of safety net roles played by Michigan's the public mental health system:** The community mental health system's role as the population-based and place-based resource and public safety net committed to the common good, population-health, social determinants, and community collaboration.

The safety net role played by the state's CMHs and PIHPs/Regional Entities is made up of several components:

- **Organizers of care** - Providers, purchasers, and managers of a well-organized comprehensive array of services and supports across a **network of proven providers** in fulfillment of statutory role to serve the individuals, families, and communities regardless of the ability to pay. For this statutorily-defined safety net role to be retained and strengthened, the CMH in each community and, through the CMH, the provider network organized by the CMH, must serve as the **exclusive provider network** of any system redesign. Additional providers can be added to the network as needed and as requested by persons served through the joint work of the risk-bearing care manager and the CMH in each community.

- **Assurers of quality and accountability** – serving to ensure that Michigan's public mental health system provides quality services and supports to Michiganders in all of the state's counties while ensure that the system is accountable to the state's taxpayers and the local, state, and federal governments from which it derives its authority.
- **Community conveners and collaborators** – initiating and participating, often in key roles, collaborative efforts designed to address a broad range of social determinant-related needs of individuals and communities
- **Advocates** for vulnerable populations and a whole-person, social determinant orientation
- **Sources of guidance and expertise**, drawn upon by the public, to address a range of health and human services needs

6. **Recognize and build on the current system's strengths**, building on the nationally-recognized strengths and accomplishments of the state's leading edge public mental health system**:** and its proven performance over the last 60 years and during the COVID pandemic.

7. **Draw upon and learn from proven system design** changes implemented in Michigan and across the country.

8. **Avoid creating unnecessary chaos** to the system and those individuals, families, and communities served by Michigan's public mental health system in any system design effort.

9. While using an overarching design to guide the effort**, implement components in practical and achievable segments - sequentially and, at times, parallel efforts**, refining each component as they are designed, implemented, and evaluated.

10. The design should be **flexible enough to apply in urban, suburban, rural and frontier communities** and mental health organizations working in those communities.

11. **Foster real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports) and build structural and financial supports**

12**.** Ensure **adequate and sustainable funding** to the public system to ensure that it is sufficiently strong to meet the growing demand and expectations for access to mental health services by all Michiganders. This growing demand centers around the full range of mental health needs including: ready access to crisis services for all the Michiganders, fostering the ability of those with a range of mental health needs to live a full and productive life, treatment of substance use disorder (with opioid treatment being the highest profile SUD treatment currently), prevention of incarceration, prevention of homelessness, and the provision of services to children with mental health needs and their families.

Attachment B

Within Our Reach: Concrete approaches to building a world class public mental health system in Michigan

Rather than pursuing legislative proposals to move public mental health tax dollars to private health insurance companies, under the guise of healthcare integration - with all of the deficits inherent in such proposals – we, as Michiganders, should focus our energies on taking concrete steps in the areas where the continual advancement of Michigan's public mental health system is needed and doable. Those steps are outlined below.

A. Build on Michigan's existing high performing public mental health system – The performance of this system is highlighted earlier in this paper and is described in the report, by the Center for Healthcare Integration and Innovation (CHI2), "A Tradition of Excellence and Innovation"

B. Improve access to comprehensive set of mental health services to all community members - services now only available to Medicaid enrollees

- Support the implementation of Michigan's Certified Community Behavioral Health Centers **(CCBHC**) in the initial pilot sites and then scale up statewide. This CCBHC designation for the state's Community Mental Health (CMH) centers and their provider network partners, brings federal dollars to Michigan to expand, to all Michiganders, access to the broad array of mental health services and supports currently available to Michiganders enrolled in Medicaid

- **Restore the state General Fund dollars** that were cut, in 2015, from the CMH funding reserved to serve persons not enrolled in Medicaid. This cut was dramatic, eliminating 60% of the funding for the services that state's CMH system formerly provided to Michiganders without Medicaid.

- Support and expand access to the **first episode psychosis** (FEP) treatment approach – already piloted in Michigan communities.

C. Address mental/behavioral health workforce shortage

- Increase funding to the state's public mental health system to allow for **competitive wages and benefits for direct support professionals** – the persons who provide daily supports in the homes and community activities of persons with complex mental health needs

- Expand federal (National Health Services Corps) and state **loan repayment programs** to attract psychiatrists, social workers, psychologists, and other clinicians to underserved Michigan communities

- **Overhaul the paperwork and administrative-related demands** that are currently borne by the state's mental/behavioral healthcare workforce to allow more time to be spent in providing care and increase the attractiveness of the work

- Develop and fund a **training and career pathway infrastructure** for Michigan's direct support professionals

D. Improve access to inpatient psychiatric care and residential alternatives to hospitalization

- Financially support **inpatient psychiatric hospitals and wards** in covering the costs of physical plant and staffing changes and training to better meet the needs of children, adolescents, and adults with complex mental health needs

- Support the creation and expansion of short- to moderate-term **Psychiatric Residential Treatment Facilities (PRTF)**

E. Improve access to and coordination of crisis services

- Support creation and expansion of **Crisis Stabilization Units (CSU)** designed to provide a comprehensive set of services and supports to persons experiencing mental health crises

- Support and fully implement **Michigan Crisis and Access Line (MiCAL)** designed to link the proven system of local crisis lines operated by Michigan's CMH system

- Support implementation, in Michigan, of the **988 mental health crisis line system** - recently approved by the Federal Communications Commission as a line, akin to 911, but focused on responding to the needs of persons experiencing mental health crises

- Fully fund the emerging network of **mental health crisis response teams** – designed to partner with law enforcement and first responders at scene of a wide range of crises

F. Provide whole person care, especially to those with complex needs

- Support expansion of **Behavioral Health Homes (BHH) and Opioid Health Homes (OHH)** – mental health focused centers that provide intense care management and wide range of mental health, physical health, and human services and supports to persons with complex mental health needs or those with opioid use disorders

- Support the implementation of Michigan's Certified Community Behavioral Health Centers **(CCBHC)** – as described above.

- Fully fund and financially support the expansion of the hundreds of **existing health care integration efforts** led by public mental health system and primary care partners

These concrete actions, taken by state policy makers and legislators, would dramatically advance Michigan's nationally recognized public mental health system and its ability to meet the needs of all Michiganders

Attachment 3

Community Mental Health Association of Michigan

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

September 2022

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

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

Partnership strengthening and system advancement recommendations

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

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

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

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

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

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

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

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

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

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

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

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

The co-development approach is based on several assumptions:

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

This approach consists of two components:

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT #3
JANUARY 2023

Washtenaw County Community Mental Health (WCCMH) Board
2023 Annual Calendar

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

BOC=Board of Commissioners

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