LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
VISION
"We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life."

AGENDA
January 28, 2016

705 N. Zeeb Road, Ann Arbor
Patrick Barrie Conference Room
9:30 a.m. – 11:30 a.m.

1. Introductions & Welcome – 5 minutes

2. Approval Of Agenda (Board Action) – 2 minutes

3. Approval of October OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business
   a. CMHPSM Regional SUD Financial Report (Discussion) {Att. #2, 2a-e} – 15 minutes
   b. OPB Membership Attendance (Discussion) {Att. #3} - 10 minutes
   c. OPB Officer Elections (Board Action) – 10 minutes

6. New Business
   a. Washtenaw Communities that Care Contract (Discussion) {Att. #4} – 10 minutes present on Eastern Michigan University
   b. Prevention Program Briefs (Discussion) {Att. #5} 10 minutes
   c. ROSC Concept Paper Draft (Discussion) {Att. #6} – 20 minutes
   d. PA 2 requests – Livingston Catholic Charities (Action) {Att. #7} -5 minutes

7. Report From Regional Board (Discussion) – 5 minutes
   a. New org chart {Att. #8}

8. SUD Director Updates (Discussion) – 10 minutes

   a. Naloxone update – policy {Att. #9}
   b. Engagement Centers updates
   c. Vivitrol
   d. State Updates
   e. Strategic Planning Retreat April

Next meeting: Thursday,
February 25, 2016 9:30 a.m. – 11:30 a.m.

Parking Lot:
PA2 funded program reports (February)
OPB Bylaws

LENAWEE-LIVINGSTON-MONROE-WASHTENAW OVERSIGHT POLICY BOARD
Summary of October 22, 2015 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present: David Oblak, Tom Waldecker, Charles Coleman, Kim Comerzan, Sheila Little, Mark Cochran, Dianne McCormick

Members Absent: Ralph Tillotson, Cheryl Davis, Dave DeLano, Smith, Amy Fullerton, William Green, Laura Rodriguez, Cletus Smith

Guests: Elijah Wheeler

Staff Present: Stephannie Weary, Marci Scalera, Marie Irwin, Anne Marshall, Jane Goerge, Katie Postmus, Kristen Ora

OPB Chair D. Oblak called the meeting to order at 9:44 a.m.

1. Introductions

2. Approval of the agenda

   No quorum was present, so no vote was taken to approve the agenda.

3. Approval of September minutes

   No quorum was present, so no vote was taken to approve the minutes.

4. Audience Participation
   - None

5. Old Business
   a. CMHPSM Regional SUD Financial Report
   - M. Irwin presented the report.
   - The trends that we have been seeing are continuing.
   - We received notice that we'll be getting 27K more in Medicaid funding.
   - At the December meet M. Irwin will bring a draft FY 15 year-end report. It won't be finalized until February, after the financial audits.

6. New Business
   a. OPB Officer Elections
      - No quorum was present, so elections did not take place.

   b. RFI, RFP Treatment Services Timeline
      - M. Scalera presented the timeline.
      - M. Scalera proposed a workgroup to draft a concept paper within the next month. The time-limited workgroup that would include staff and board members in some capacity.

- The concept paper would be released for comment, and then be used to write the RFP.
- D. McCormick suggested asking for input and participation from the current provider models that are already out there.
- Per M. Scalera, there are currently gaps in the ROSC model and the challenge will be to determine where our core providers are currently.
- The timeline will include: concept paper, RFI, pilot in Monroe, RFP.
- K. Comerzan would only want to see Monroe do the pilot if all the elements are nailed down and concrete.
- A draft concept paper will be presented at the Dec. 10 OPB meeting.

c. Process for ensuring a quorum
- S. Weary will ask for RSVPs in the packet email. By Monday the week of the meeting, she will contact those who haven't responded, and then advise D. Oblak and M. Scalera of all responses.
- T. Waldecker suggested revising the bylaws to allow attendees by phone to count toward the quorum.
- Board members who are not in compliance with the attendance requirements of the bylaws will need to be contacted.

7. Report from Regional Board
- The new CEO contract was approved. She will start on Dec. 7th.
- The WCHO has dissolved.
- CMH services in Washtenaw reverted to the county: Washtenaw County Community Mental Health. Because their status is provisional as a CMH, the PIHP's contract with them is a 3-month provisional contract.
- In Washtenaw, the mental health board is advisory to the Board of Commissioners.

8. SUD Director Updates

a. Unite to face addition CARA information
- M. Scalera reported on the National Event that occurred in Washington DC. The CARA act proposes changes to funding and services for addictions nationally.

b. State Updates
- Naloxone is ready to go.
- Efforts are underway to redesign what MASACA is. The entity was turned over to the PIHP directors. But now I the consideration is what it can look like as a 503c, and what it can do for the 10 PIHPs.

9. Meeting adjournment

Adjourned at 11:00 a.m.

Attachment #2

Community Mental Health Partnership of Southeast Michigan

STATEMENT OF REVENUES, EXPENSES CHANGES IN NET POSITION

Substance Use Disorder

For the Two Months Ending 11/30/2015

	Original Budget	YTD Actual	YTD Budget	YTD Actual O/(U) Budget	
Operating Revenue					
Medicaid Capitation	$1,463,301	$261,747	$243,884	$17,863	
Healthy Michigan Plan	3,334,500	485,058	555,750	(70,692)	
MIChild	0	2,053	0	2,053	
SUD Community Grant	3,767,460	615,676	627,910	(12,234)	
SUD PA2 - Cobo Tax Revenue	2,105,798	350,966	350,966	0	
Total Operating Revenue	**$10,671,059**	**$1,715,500**	**$1,778,510**	**$(63,010)**	1a
Funding For SUD Services					
Lenawee County	$1,278,823	$137,721	$213,137	($75,416)	
Livingston County	1,614,420	189,537	269,070	(79,533)	
Monroe County	1,506,177	154,288	251,029	(96,741)	
Washtenaw County	4,026,893	570,340	671,149	(100,809)	
Total Funding For SUD Service	**$8,426,313**	**$1,051,886**	**$1,404,385**	**$(352,499)**	1b
Other Contractual Obligations					
USE and HICA Tax	322,891	50,398	53,815	(3,417)	
Total Other Costs	**$322,891**	**$50,398**	**$53,815**	**$(3,417)**	
CMHPSM Administrative Costs					
Salary& Fringe	$433,670	$68,135	$72,279	($4,144)	
Administrative Contracts	82,064	10,698	13,677	(2,979)	
All Other Costs	64,482	7,938	10,747	(2,809)	
Total Administrative Expense	**$580,216**	**$86,771**	**$96,703**	**$(9,932)**	1c
Total Operating Expense	**$9,329,420**	**$1,189,055**	**$1,554,903**	**$(365,848)**	
Operating Income (Loss)	$1,341,639	$526,445	$223,607	$302,838	
Non-Operating Revenues					
Interest Revenue	$0	$0	$0	$0	
Change In Net Position	$1,341,639	$526,445	$223,607	$302,838	

1a Medicaid revenue is on trend with budget. Healthy Michigan paid rates per eligible are less than what was projected in the FY16 budget. Carry Forward will be utilized to fund services.

1b Services are currently under budget. Many new programs were awarded in FY16 and they have not been fully implemented at this time.

1c Administrative expenses are running under budget.

Community Mental Health Partnership of Southeast Michigan

SUD Financial Highlights

November FYTD Report

Statement of Revenues and Expenses

1. Revenue

   - Medicaid revenue for the Region for SUD services is $17,863 more than what was budgeted through November.
   - Healthy Michigan revenue is ($70,692) less than the budget through November. The rates established by MDHSS for FY2016 are lower than the rates used for the initial budget. We anticipate having sufficient carry forward from FY2015 to bridge the gap.
   - There was a slight reduction in Community Grant funding for FY2016.
   - PA2 funding for FY2016 is a mixture of current year revenue and carryforward. The revenue being recorded is an accrual, there have not been any current year distributions yet.

2. Funding For SUD Services

   - All four counties are currently running under budget. Many of the new programs awarded in FY2016 have not been fully implemented at this time.

Summary of Revenue and Expense by Fund

- We are currently showing sufficient revenue for all funding sources. There have not been any adjustments made for utilization at this time.

Attachment #2b

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
November 2015 FYTD

Summary Of Revenue & Expense	Medicaid	MIChild	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	Total Funding Sources
Revenues							
Funding From MDCH	$ 261,747	$ 2,053	$ 485,058	$ 615,676		$ -	$ 1,364,534
PA2/COBO Tax Funding	$ -	$ -	$ -	$ -	$ 350,966	$ -	$ 350,966
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Revenues	$ 261,747	$ 2,053	$ 485,058	$ 615,676	$ 350,966	$ -	$ 1,715,500
Expenses							
Funding for County SUD Programs							
Lenawee	$ 32,831	$ -	$ 61,352	$ 30,389	$ 13,149	$ -	$ 137,721
Livingston	$ 33,825	$ -	$ 53,977	$ 100,205	$ 1,530	$ -	$ 189,537
Monroe	$ 19,773	$ 180	$ 32,935	$ 49,578	$ 51,822	$ -	$ 154,288
Washtenaw	$ 114,452	$ -	$ 230,363	$ 136,313	$ 89,212	$ -	$ 570,340
Total SUD Expenses	$ 200,881	$ 180	$ 378,627	$ 316,486	$ 155,713	$ -	$ 1,051,886
Other Operating Costs							
SUD Use Tax	$ 15,652	$ 122	$ 29,008	$ -	$ -	$ -	$ 44,782
SUD HICA Claims Tax	$ 1,963	$ 15	$ 3,638	$ -	$ -	$ -	$ 5,616
Total Operating Costs	$ 17,615	$ 137	$ 32,646	$ -	$ -	$ -	$ 50,398
Administrative Cost Allocation	$ 16,428	$ 15	$ 30,973	$ 39,355	$ -	$ -	$ 86,771
Total Expenses	$ 234,924	$ 332	$ 442,245	$ 355,841	$ 155,713	$ -	$ 1,189,056
Revenues Over/(Under) Expenses	$ 26,823	$ 1,721	$ 42,813	$ 259,835	$ 195,253	$ -	$ 526,444

Note: Medicaid, MIChild, Healthy Michigan, SUD - Block Grant, SUD-COBO/PA2 and Other are grouped under "Funding Source".

Community Mental Health Partnership Of Southeast Michigan
SUD PA2
FY 2015

WCHO PA2 Fund Balance		Received
Lenawee	799,869.47	13-Mar-15
Livingston	1,695,242.93	13-Mar-15
Washtenaw	1,654,185.74	13-Mar-15
SEMCA PA2 Fund Balance	265,254.39	24-Jul-15
Total Received	4,414,552.53	

Revenue By Fund/BU

FY2015 Fund/BU Name	BU Number	Great Plains G/L		Distribution Letters
Total Revenue				
Lenawee	500	277,457.50	January '15	1,429,612.00
Livingston	505	802,877.00	April'15	682,659.50
Monroe	510	588,887.00	June'15	660,552.50
Washtenaw	515	1,755,776.00	October'15	652,173.50
Total		3,424,997.50	Total	3,424,997.50
Total Expense				
Lenawee	500	60,189.29		
Livingston	505	104,763.91		
Monroe	510	610,774.71		
Washtenaw	515	867,588.19		
Total		1,643,316.10		
Deferral- Lenawee		217,268.21		
Deferral- Livingston		698,113.09		
Deferral - Washtenaw		888,187.81		
		1,803,569.11		
Draw Down - Monroe		(21,887.71)		

FY2015 YE Deferred	
Lenawee	1,017,137.68
Livingston	2,393,356.02
Monroe	243,366.68
Washtenaw	2,542,373.55
Total Deferred Revenue:	6,196,233.93

Community Mental Health Partnership of Southeast Michigan

September SUD Financial Highlights

Summary of Revenue and Expense by Fund

- Final reporting indicates Medicaid expenses exceeded revenue by ($8,479), there are sufficient Medicaid dollars in the system (includes Mental Health) to cover this overage.
- MICHILD and Healthy Michigan revenue exceeded expenses and those funds will be carry forward in FY2016.
- SUD Block Grant revenue that exceeded expenses will be lapsed back to MDHHS – there is no carry forward allowed for this funding.
- COBO/PA2 revenue has been adjusted to align with expenses. Excess revenue has been moved to deferred revenue on the balance sheet. A separate sheet has the amounts available by county.

Community Mental Health Partnership Of Southeast Michigan

SUD SUMMARY OF REVENUE AND EXPENSE BY FUND

Preliminary September 2015 FYTD

Summary Of Revenue & Expense	Funding Source						Total Funding Sources
	Medicaid	MIChild	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	
Revenues							
Funding From MDCH	$ 1,446,461	$ 14,031	$ 4,212,097	$ 3,724,460		$ -	$ 9,397,049
PA2/COBO Tax Funding	$ -	$ -	$ -	$ -	$ 1,643,316	$ -	$ 1,643,316
Other	$ -	$ -	$ -	$ -	$ -	$ 6,974	$ 6,974
Total Revenues	$ 1,446,461	$ 14,031	$ 4,212,097	$ 3,724,460	$ 1,643,316	$ 6,974	$ 11,047,339
Expenses							
Funding for County SUD Programs							
Lenawee	$ 228,979	$ -	$ 299,366	$ 363,680	$ 60,189	$ -	$ 952,214
Livingston	$ 207,268	$ 2,631	$ 295,816	$ 535,609	$ 104,764	$ -	$ 1,146,088
Monroe	$ 140,693	$ -	$ 288,805	$ 270,265	$ 610,775	$ -	$ 1,310,538
Washtenaw	$ 688,270	$ -	$ 1,264,617	$ 1,081,787	$ 867,588	$ -	$ 3,902,262
Total SUD Expenses	$ 1,265,210	$ 2,631	$ 2,148,604	$ 2,251,341	$ 1,643,316	$ -	$ 7,311,102
Other Operating Costs							
SUD Use Tax	$ 86,498	$ 839	$ 251,883	$ -	$ -	$ -	$ 339,220
SUD HICA Claims Tax	$ 10,848	$ 105	$ 31,591	$ -	$ -	$ -	$ 42,544
Total Operating Costs	$ 97,346	$ 945	$ 283,474	$ -	$ -	$ -	$ 381,764
Administrative Cost Allocation	$ 92,384	$ 207	$ 156,913	$ 253,962	$ -	$ -	$ 503,466
Total Expenses	$ 1,454,940	$ 3,783	$ 2,588,990	$ 2,505,303	$ 1,643,316	$ -	$ 8,196,331
Revenues Over/(Under) Expenses	$ (8,479)	$ 10,248	$ 1,623,107	$ 1,219,157	$ 0	$ 6,974	$ 2,851,008

OPB Attendance 10/2014-10/2015

	Amy Fullerton	Charles Coleman	Cheryl Davis	Cletus Smith	Dave Delano	David Oblak	Dianne McCormick	Kim Comerzan	Laura Rodriguez	Mark Cochran	Ralph Tillotson	Sheila Little	Tom Waldecker	William Green
	Lenawee	Washtenaw	Livingston	Lenawee	Livingston	Washtenaw	Livingston	Monroe	Monroe	Monroe	Lenawee	Washtenaw	Monroe	Livingston
10/23/2014	A	A		P	??	P	A	A			A	P	P	A
11/18/2014	P	P		P	??	P	P	P			A	A	P	P
1/22/2015	P	P	P	P	P	P	P	P			A	P	P	P
2/26/2015	P	P	A	A	P	P	P	P			P	A	P	P
3/26/2015	A	P	P	P	A	P	P	P			P	P	P	A
4/23/2015	P	P	P	P	P	P	P	P			A	P	P	P
5/28/2015	P	P	A	P	A	P	P	P			A	P	P	P
6/25/2015	A	P	P	A	A	P	A	P			A	P	P	P
7/23/2015	P	P	P	P	P	P	P	p			A	P	P	P
8/26/2015	A	P	A	P	P	A	P	P	A	P	A	P	P	P
9/24/2015	P	P	A	A	A	P	P	P	A	P	A	P	P	P
10/22/2015	A	P	A	A	A	P	P	P	A	P	A	P	P	A
# of Absences/ # of Meetings	5/12	1/12	5/10	4/12	5/10	1/12	2/12	1/12	3/3	0/3	10/12	2/12	0/12	3/12

Attachment #4 – January, 2016

Oversight Policy Board – Contract Change Notice

Board Meeting Date: January 28, 2016

Background: Due to staffing changes at Karen Bergbower and Associates, the agency is no longer able to fulfill the Communities That Care (CTC) program in Washtenaw County, for which it was awarded $50,000 in SUD prevention funds for FY16. Karen Bergbower and Associates will have their FY16 contract amended to remove all remaining CTC funding.

Eastern Michigan University has the capacity, willingness, and experience with the CTC program, and the CMHPSM SUD Prevention Team has recommended that EMU assume the contract and programing responsibilities of CTC for the remainder of FY16. Not only will this contract with EMU maintain the community momentum and progress garnered by the CTC program, but it also provides CMHPSM the opportunity to partner with EMU, which is a pillar in the Ypsilanti community, to cultivate future prevention programming opportunities.

EMU has requested $57,433.00 to assume the CTC contract; the additional funding will be managed within the SUD Prevention budget. The additional funding includes expanded outcomes for the contract. The contract term with Eastern Michigan University is from 12/1/2015 to 9/30/2016. The SUD Prevention Team has been working with EMU to provide technical assistance to ensure a smooth transition.

Action required by Oversight Policy Board

No action required of the OPB. The CMHPSM Regional Board approved this funding allocation change at their 12/9/15 meeting.

Lenawee
Livingston
Monroe
Washtenaw

SUBSTANCE ABUSE PREVENTION SERVICES

PROGRAM BRIEFS

As the Community Mental Health Partnership of Southeast Michigan (CMHPSM) continues to emphasize the use of an effective, data-driven, outcome-based approach to substance abuse prevention, various methods are utilized to promote the applicability of this system. For instance, as part of the overall reporting process, prevention providers develop year-end ***Program Briefs*** to:

- Highlight program results and spotlight specific interventions/initiatives.
- Share program information in a creative and informative way.
- Educate and inform decision-making bodies and others about prevention efforts in the CMHPSM region.
- Promote the effectiveness of substance abuse prevention.
- Utilize a reporting mechanism that is beneficial to both the agency and the CMHPSM.

While the CMHPSM provides a 'checklist' for potential inclusions, agencies are free to select the means for demonstrating program results (i.e., graphs, charts, anecdotal statements, trends, etc.). CMHPSM began using this informational sharing method at the end of 2013-2014 fiscal year and plans to gauge the usefulness of this approach.

For more information, visit the CMHPSM website at www.cmhpsm.org/sudprevention.

Concepts for Recovery Oriented Systems of Care for Lenawee, Livingston, Monroe, and Washtenaw Counties

DRAFT

Themes

1. Core Provider Model with consistency across the region
2. Recovery focused
3. Non-traditional treatment in non-traditional settings
4. Integration with mental health and primary care
5. Services to support pre and post engagement
6. Co-occurring services including psychiatry to support MH needs for mild to moderate population
7. Improved adolescent services
8. Community integration and participation
   a. Initiatives in the community such as human services collaborative coalitions
   b. Prevention integration
9. More delegated administrative functions:
   a. Access to care - screening and assessment that works within a no wrong door format
   b. Utilization management - ensuring right amount of care in the right setting
   c. Monitoring of finances and expenditures - IBNR, data, cost containment, risk assessment, rate setting
   d. Quality assurance through outcome indicators
   e. Contracting capabilities
   f. Claims Processing
   g. Data management and infrastructure

DRAFT

Concepts for Recovery Oriented Systems of Care for Lenawee, Livingston, Monroe, and Washtenaw Counties

Fiscal Year 2016

I. INTRODUCTION:

In 2009, the Washtenaw Community Health Organization embarked upon a transformational change that launched the existing Substance Use Disorders Treatment system of care into a new way of providing for and funding treatment services, with the goal to "embrace the philosophy that individuals (adolescents and adults) with substance use/addiction disorders can recover". The initiative focused on the primary principles and elements of recovery and wellness while ensuring that the individual is offered a level of service that is based on his or her readiness for change. This system moved services from an acute care model to one in which sustained engagement to address the chronic nature of substance use disorders. Community input was obtained, in order to best design the system of care in each local county that could accomplish the goals of ROSC in a way that worked best for their unique communities. The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is now interested in continuing to improve the service delivery system to incorporate significant changes that have occurred locally, statewide and nationally since this ROSC system transformation was implemented. The CMHPSM seeks to expand and refine the original vision of the Recovery Oriented System of Care in order to meet these new challenges and ensure the individuals seeking services receive the best possible outcomes.

II. VISION:

The Community Mental Health Partnership of Southeast Michigan envisions the service delivery system for the four county region will embrace a recovery focused infrastructure that addresses the complete

continuum of care for all individuals seeking services. The provision of care will incorporate cross system mechanisms that bridge mental health and physical health needs to ensure a holistic approach to care.

The CMHPSM considers readiness for change to be a key factor in designing the range of activities and or services (i.e. peer involvement, community groups, didactic/educational groups) that are available to individuals. Traditional treatment availability is the mainstay of the expected services that can be provided across the region. However, many individuals would benefit from something other than traditional treatment. The availability of community-based supports may be more effective in facilitating movement along their recovery path. Additionally, changes in benefits available offer new challenges and opportunities to the system of care. Providers must consider alternative settings, new and innovative treatments that include medication assisted treatment; screening, brief intervention, and brief treatment; prevention and early intervention modalities; integration with primary care and mental health services. As noted in the original concept for ROSC transformation, the following still holds true. *"Individuals with substance use/addictive disorders, who require more supports, may benefit from treatment services designed to maximize their current stage of readiness. For some, traditional treatment (i.e. Outpatient, Intensive Outpatient, Residential etc.) might be an appropriate step in recovery. However, an array of recovery support services should include pre and post engagement supports. This is necessary to address the chronic nature of substance use/addictive disorders and the importance of developing lasting relationships within the recovery community, as well as, maintaining consistent connections to caring individuals."*

Collaboration within the community is also a hallmark of ROSC. Available human services and resources within ones "healthy" community can serve to support an individual's path toward self-sustainable living situations. This would include supported recovery housing opportunities, employment, education, community and recreational activities. A ROSC provider should be involved in activities that shape the communities in which the individuals being served reside in. Assisting these individuals in engaging in their communities builds strength and supports hope, which lays a foundation for future reinvestment and "giving back".

An the future in healthcare moves toward an increased shift to value-based services (in which reimbursement is tied to effective outcomes) rather than volume-based services (in which payment is tied to the delivery of service units), the CMHPSM should look for providers to develop the capacity, technology, and ability to measure and report outcomes that demonstrate quality and effectiveness.

DRAFT

Additionally, in a system where providers take on increasing delegated functions, there must be greater attention to provider accountability.

III. CORE PROVIDER:

Ideally, the CMHPSM will continue to fund services through a *CORE PROVIDER* model. A CORE provider is defined as, "a provider that will provide, or arrange for the provision of the **entire** array of services -- the Pre-recovery/ Post-engagement continuum." The concept of the "core provider" role is to ensure a comprehensive delivery system either through the direct provision of, or a contracted arrangement for, services to individuals who are assessed as having a substance use or co-occurring disorder. The core provider will be responsible for the management of various delegated functions, such as access to quality care from assessment through placement and discharge; utilization management; fiscal management; monitoring of services; coordination of care; etc.

The extent to which the PIHP will delegate functions will be the subject of this concept paper, as the capacity to perform the functions may not be adequate at this time, warranting a development phase to prepare a core provider network in acquisition of technological skills, capabilities and infrastructure.

Currently, the core provider is responsible for the system of care within their defined population range, regardless of funding stream and age of individual seeking services. The core provider must abide by all regulatory and statutory requirements and uphold standards of care through licensing and accreditation. Staff providing services must have the appropriate training and credentials to carry out the service delivery. The core provider must have adequate infrastructure and capacity for both administrative and clinical functions.

The CMHPSM, under contract with the Michigan Department of Health and Human Services, is committed to serve residents better by providing services that are integrated and coordinated. To ensure that community collaboration and a high level of service delivery is given to clients, all contracted providers should have these elements:

- Person-Centered
- Services proportional to the level of readiness of change of the individual
- Continuity of care
- Strength-based

- Mechanisms for sustained engagement
- Commitment to peer recovery support services
- Integrated Services
- Workforce Training and Education to support retention
- Ongoing Monitoring of outcomes to ensure maximum impact and resource utilization

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IV. SERVICE ARRAY:

The CMHPSM believes that offering a full range of services is a vital part of ROSC. Some examples of the services that make the ROSC effective are:

- **Co-Occurring Services:** Services for Individuals who have an established diagnosis in one domain and exhibits signs or symptoms of an evolving disorder in the other; and/or Individuals who display one or both of their substance-related or mental disorders may have acute signs and/or symptoms of a co-occurring condition who present for services. Providers need to have the clinical and resource capacity to serve this population in the most efficient/expeditious manner, ideally through clinical staff who have the training and capacity to manage the client's needs simultaneously, as well as psychiatric support/oversight. Provider must ensure that any clients with dual-need receive appropriate ongoing psychiatric and mental health services. Providers will need to demonstrate how they determine whether they have the capacity to serve the co-occurring client and whether they have enough psychiatric time and clinician resources to address the mental health needs of the individuals served.
- **Collaboration:** a more formal process of sharing responsibility for treating a person with SUD or COD service needs in different settings, involving regular and planned communication, sharing of progress reports through case coordination. This would require entry into a qualified service agreement or memorandum of understanding that defines the operational efforts in coordinating care. Additional protections under confidentiality laws shall apply and appropriate releases must be obtained.
- **Recovery Coaching:** Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent

relapse and promote recovery. Peer services may be paid or volunteer. Employed peers must have adequate training and certification to meet reimbursement criteria.

- **Peer Supports:** Individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another in a treatment setting. Both peers and recovery coaches should work collaboratively and in conjunction with professional staff in the delivery of comprehensive services.
- **Community and Recovery Groups:** Services provided by other community agencies and or volunteer groups such as AA, NA, DRA that may be more applicable for addressing the individual's recovery. Providers must offer connections to these groups for persons in services.
- **Women's Specialty Programs:** SUD treatment services that are gender specific with connections to primary medical care for women including 1) referral for prenatal care, and while women are receiving such services, child care; 2) primary pediatric care, including immunization for children; 3) gender specific substance abuse treatment and other therapeutic interventions for women which address issues of relationships, sexual/physical abuse and parenting and child care while women are receiving these services; 4) therapeutic intervention for children in custody of women in treatment which may address their developmental needs, issues of sexual and physical abuse and neglect and; 5) sufficient case management and transportation to ensure that women and their children have access to services listed above.
- **Residential Services (Short/Long Term)**
  - **Short Term:** professionally supervised alcohol and/or drug treatment services, non-medical, non-acute program that includes planned individual and/or group therapeutic and rehabilitative counseling, didactics, peer therapy and rehabilitative care provided in a residential setting including an overnight stay. Short-term residential is less than 30 days.
  - **Long Term:** alcohol and/or drug treatment services that include planned individual and/or group therapeutic and rehabilitative counseling and didactics that are provided as an intense, organized daily treatment regime in a residential setting which includes an overnight stay. These programs have trained treatment staff that is supervised by a professional responsible for the overall quality of clinical care. Long-term residential is 30 days or more in a non-hospital residential treatment program.

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- **Outpatient – Individual, Family and Group:** Therapy using accepted individual and group treatment modalities focusing on recovery based issues that include but not limited to Didactics, Gender specific and Co-occurring issues. Providers utilize various evidence based practices to assist individuals with treatment needs.
- **Medication Assisted Treatment:** As we have seen locally, statewide and nationally, the opioid/heroin addiction, dependency and overdose death rates has risen to epidemic proportions. To increase client choice and availability of treatment options, the CMHPSM is committed to funding the cost of buprenorphine/naloxone (Suboxone®) or Vivitrol® medication as adjunct therapy for opioid addiction treatment services. Opioid Treatment Programs (OTP's) must conform to the Federal opioid treatment standards set forth under 42 C.F.R. Part 8, including off-site dosing.

  The CMHPSM believes that Medication Assisted Treatment is a necessary service that should be offered to clients seeking services within ROSC. Partnership with primary care in the delivery of comprehensive treatment services for persons prescribed MAT will be an expected role for the provider network.

- **Outreach:** Services that occur in the community where individuals who need assistance may be located. This can include home based, shelter based, street, jail, church or a number of other settings that the provider can engage with the individual of need. The goal of outreach is to meet the client where they are "at", literally. Often outreach services are paired/performed by case managers or peers.
- **Case Management:** Services provided to link individuals to, or to assist and support clients in gaining access to or developing their skills for accessing/obtaining needed medical, social, educational and other services essential to meeting basic human needs, as appropriate; to train the individual in the use of basic community services; and to monitor treatment progress and overall service delivery.

- **Integration with Faith-Based community:** According to 45 CFR part 96, which applies to both prevention and treatment providers/programs, faith-based organizations are eligible to participate as providers. This will create a level playing field with regard to participation in the PIHP provider panel. Regardless of service provider, enabling the individual to access spiritual services is encouraged. Partnering with the faith based organizations in the community are encouraged. In

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the event the faith based provider is also the service provider, the agency must uphold the charitable choice requirement to provide notice of choice.

- **Primary Care Coordination:**

  The CMHPSM believes that for a complete continuum of care under ROSC, that primary care coordination with substance use disorder treatment services are crucial to the overall health of the individual. The CMHPSM will work to ensure that our providers maintain a consistent level of coordination with primary care providers. It should be noted that “care coordination agreements or joint referral agreements by themselves are not sufficient enough to show that all appropriate steps have been taken to optimize client outcomes. Core providers will need to be able to show how coordination of care has been achieved through evidence of client case file documentation. Additional service coordination, such as co-location of clinical services, case consultation, and creative partnerships are encouraged.

  The CMHPSM recognizes that limitations in funding OR service capacity may impede the creation and array of services that an agency may be able to offer. However, it is our belief that systems can be and are in place that utilizes collaboration of agencies to provide a larger array of services for clients. This in turn will increase engagement of clients and families, increase retention rates, and reduce clients cycling in and out of treatment services.

V. ADMINISTRATIVE FUNCTIONS:

- **Requirements of Licensure:**

  According to the MDHHS PIHP 2016 Contract: “The PIHP shall enter into agreements for substance use disorder prevention, treatment, and recovery services only with providers appropriately licensed for the service provided as required by Section 6234 of P.A. 501 of 2012, as amended. The CMHPSM will work to ensure that all providers are appropriately licensed. A core provider must only contract with service providers who meet these standards.

- **Accreditation of Subcontractors:**

  According to the MDHHS PIHP 2016 Contract: “The PIHP shall enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the

American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The PIHP must determine compliance through review of original correspondence from accreditation bodies to providers.

Accreditation is not needed in order to provide access management (AMS) services which is a function of the core provider. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

The overall goal of the CMHPSM is to ensure that contracted providers have the required credentials to practice and provide services to clients within the ROSC environment.

- **Credentialing Responsibility:**

To maintain a high level of service to our clients, the CMHPSM must ensure that all providers maintain the correct licensure and credentialing for their own staff appropriately. The MDHHS PIHP Contract (2016) affirms that "primary responsibility for assurance that staff qualification requirements are met rests with the individual and the provider agency that directly employs or contracts with the individual to provide prevention or treatment services."

To ensure that these obligations have been met, the CMHPSM will be responsible for monitoring the provider agency performance to ensure that the above obligations have been met.

- **Prevention Integration/Coordination:**

The CMHPSM also believes that integration and participation between treatment and prevention service providers is an integral component to developing a successful ROSC network and continuum of care. Community involvement from core providers and prevention providers is needed; examples of such functions being community coalition meetings, collaborative events, and prevention events such as prescription take-back days.

Core Treatment Providers and Prevention providers should inform each other on changing trends in the client population, treatment modalities, etc. Data sharing is also a vital component of the unified philosophy in the ROSC which will also inform practice and assess community needs.

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Connection of resources and referrals between Core Treatment Providers and Prevention Providers is also imperative to ensure the continuity of care and a "warm hand-off" for the consumer.

- **Quality Improvement & Outcomes:**

  To maintain a successful ROSC in the four-county region, service providers must be able to continuously evaluate and improve services and identify strengths and weaknesses within their system. The CMHPSM will have a standard metric to use (qualitative and quantitative) to evaluate and measure both client outcomes and program outcomes. The PIHP will review and measure the outcomes of the provider agencies and their progress towards a complete ROSC.

- **Electronic Health Record and Information Technology:**

  Providers must meet all requirements related to health information technologies and protected health information standards.

- **Access to Care, Screening and Assessment:**

  Core providers will be performing access services in which screening, assessment and eligibility determinations for level of care is managed. Under full delegation of these services, utilization management and continued stay reviews and authorizations are performed. Use of standardized assessment tools and protocols will be necessary to provide regional consistency in level of care placement determinations. Staff making these determinations must have the clinical capacity through training and experience and appropriate qualifications or certifications.

VI. FUNDING MECHANISMS:

Funding for the regional SUD Service delivery system must be aligned with financing principles established by the state and federal regulations and laws. The CMHPSM receives Medicaid, Healthy Michigan and Community Grant funds for treatment services. Rates must be consistent across funding streams and services, and must be determined through utilization and demonstrated rate to cost ratios.

Funding core providers may be on an allocation basis with performance expectations established; fee for services with defined rates; case rate basis that bundles a series of services into a monthly

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rate, or finally, a staffing grant, assuring that staffing is provided to perform a service or set of services across a period of time, usually annually.

Funding initiatives covered by local resources, PA2 liquor tax dollars, are flexible and allocated through the Oversight Policy Board. These funds can supplement treatment and prevention initiatives, but typically are used for innovative programming not allowable by traditional means. The CMHPSM is committed to utilizing state and federal funds for all services covered under the allowable benefit and designations, thereby reserving the PA2 funds for supplemental programming and risk management where necessary.

VII. SYSTEM CHANGES AND OPPORTUNITIES:

The following table represents opportunities to review the current ROSC system and discuss potential changes for the future. Change is necessary to align the region, ensure the elements discussed above are implemented in a timely and value added fashion. Moving toward better integration of services across disciplines and systems of care requires a transformational approach. As in the original transformation from traditional treatment and prevention services to the ROSC concept in 2009, the process must include input from various stakeholders – internal and external, in order to obtain differing perspectives on impact and feasibility.

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CMHPSM CURRENT SYSTEM	CMHPSM FUTURE SYSTEM (with alternatives)	OPERATIONAL DIFFERENCES AND ASSUMPTIONS
Contracts: Core Providers are used in Washtenaw, Livingston and Lenawee Counties. Fee for services contracted directly with providers in Monroe	**Choice A:** Contracts will be with ONE Core Provider for each county **Choice B:** Contracts will be central to the CMHPSM	**A:** Core provider will perform delegated functions of access and contract with SUD provider network for services **B:** CMHPSM will contract with providers and can integrate ACCESS SERVICES with CMHSP's
ACCESS: Services are handled differently in each county: **Lenawee** – CMH is the core provider, Access provides screening and authorization for fee for services. May be in or outside the county. **Livingston –** CMH is the core provider, Access provides screening and authorization for services…some services are case rate, some are fee for service. May be in or outside the county. **Monroe –** CMHPSM hires Access Staff and co-locates within Monroe CMH Access; Authorization for all Services go through CMHPSM staff. Contracts can be in and outside the county. **Washtenaw –** Two core providers, access screening is delegated for services provided by each core provider. CMHPSM Contracts with external providers which may be located within or outside the county. Core provider will screen on behalf of the CMHPSM for services at external providers. Coordination is essential but sometimes difficult to manage	**ACCESS: Goal is for consistency across the region** **Choice A**: Access Services can be delegated to the Core Provider with a standardized array of services that enables the ability to have case rates for some of the services, and still have services authorized though the core provider. Core provider would be responsible for the authorization of services provided by them as well as have a sub contractual relationship with external providers. This will ensure ongoing coordination of care amongst service providers. **Choice B:** Access services can be pulled out of the core provider function and integrated into the CMHSP Access in each county to provide for consistency in authorizing services and promoting integration with CMH services. **Choice C:** Maintain some external contracts at the CMHPSM for all core providers to use.	**A.** Financing can continue to be on a performance based allocation which is managed by the core provider. Performance standards and incentives should be considered **B.** Financing structure will have to be modified and managed by the CMHPSM AND the CMHSP Access. Strong collaborative care will be necessary between all service providers, especially where co-occurring services are needed **C.** Maintain clinical oversight and UM for external contracts. Work with core providers to improve utilization and coordination of care

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FINANCIAL /ADMINISTRATIVE CAPACITY: This involves the ability to act as a fiduciary, manage contracts, monitor performance standards, meet quality measures, process claims, and data reporting, etc. Many of these functions are delegated to the CMHSP's by the PIHP, but not necessarily to all SUD core providers. Currently Livingston and Lenawee CMH's perform these functions in their respective counties. The CMHPSM manages these functions for Monroe and Washtenaw Counties.	**Choice A:** To ensure the Core provider would have the capability to perform various Administrative Functions, the PIHP would need to delegate and the core provider would need to take on new functions as necessary. This may require financial investments that are not readily available. Additionally, this is time consuming and should be given the opportunity to build this capacity over a 1 year period. **Choice B:** maintain current system with limited delegated functions performed by core providers. Pilot partnerships within Monroe County to establish a core provider relationship between CMH and SUD providers similar to the other counties in the region. Goal to implement by FY 2017	**A.** Would need to invest in the core provider system to build the capacity for managing the administrative functions **B.** Could foster/create a partnerships within each county for performing these functions within the existing systems…may create new alliances between CMH and SUD core providers/non-core providers
INFORMATION INFRASTRUCTURE: SUD providers currently use the E2 information management system to access client information, report encounters, minimal qualitative data, and claims submission. The system is not an electronic health record for core or non-core SUD providers. SUD providers hold their own records, many have invested independently in their own EHR.	PHIP must ensure the data integrity in the system is accurate, timely and protected.	There is no need to change the system at this time, providing that core providers and non-core providers meet standards set for health records, billing capacity and privacy protections.
SERVICE PROVISION: Services are provided either directly by the core provider or by contract. Not all counties have the same service capacity. Livingston and Lenawee Counties do not have residential services within their county borders. Lenawee County does not have Opiate Replacement Therapy (methadone) services within the county. Adolescent services is limited across all counties as is co-occurring psychiatric services outside of the CMH system	Goal is to ensure all essential service levels are available within each county. Creative partnerships must be developed by the core provider with assistance from the CMHPSM staff. All levels of care should be sought after within the county if possible. Medicaid distance standards must be upheld and alternatives identified.	RFP's could be utilized to stimulate new programming within each county to cover gaps in services. Additionally, alternatives to traditional programming could be sought after that could be utilized to support the traditional service array. An example of this are ambulatory detox, engagement centers, recovery housing, recovery community organizations which are consumer run, etc.

Att. #7

Oversight Policy Board – Action Request

Board Meeting Date: January 28, 2016

Background: The Livingston Community Prevention Project (LCPP) and its fiduciary, Livingston County Catholic Charities (LCCC), is requesting a commitment of up to $20,000 in Livingston PA2 funds to be used as a cash match for a Federal Drug Free Communities (DFC) Grant. The DFC grant has a match requirement of $125,000 from the applicant community. The requested PA2 funds would assist in fulfilling this match requirement should Livingston County's proposal be awarded DFC funding for FY17 (DFC award announcements for FY17 are not made until August/September, 2016). The attached Request for Funds application provides an overview of the DFC grant and the proposed SUD Prevention programming that the grant would fund if awarded.

Action required by Oversight Policy Board: Staff recommend that the OPB approve a one-time PA2 award of up to $20,000 as a DFC match commitment to Livingston County.

Please note: Staff are exploring ways to modify existing allocations to free up agency funds to potentially reduce the amount of PA2 dollars needed for this commitment.

Att. #7

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Serving Lenawee, Livingston, Monroe, and Washtenaw Counties

Request for Funds	
Date:	January 19, 2016
Contact Person: (Name, email, phone)	Mark T. Robinson, mark@livingstoncatholiccharities.org, 517-545-5944
Requestor:	Livingston County Catholic Charities – Livingston Community Prevention Project
Amount of Request:	$20,000 PA2; to be used as Cash Match for a Federal Drug-Free (DFC) Communities Grant. Any amount will be appreciated.
Priority Area:	☐ TREATMENT for Substance Use Disorders (indicate specific populations to be served) ☐ Adolescents ☐ Opiate/Heroin ☐ Adults ☐ Alcohol Specific ☐ Gender specific ☐ Recovery Focused/Peers ☐ Other: ________________________ X PREVENTION (please check one of the following): X Reduce Childhood and Underage Drinking X Reduce Prescription and Over the Counter Drug Abuse/Misuse ☐ Reduce Youth Access to Tobacco ☐ Reduce Illicit Drug Use ☐ Other: ________________________
Targeted Community: (Geographic area)	Livingston County
PREVENTION ONLY Targeted Population: (Institute of Medicine Category)	X Universal (general public/whole population group) ☐ Selective (individuals – risk of developing a substance use disorder is significantly higher than average) ☐ Indicated (individuals in high-risk environments, minimal signs/symptoms, biological markers indicating a predisposition for disorder)
Primary Problem/ Consequence(s) Support Data: (Include Data Sources and reason for the request for funding)	This proposal is being submitted to assist with the Match Requirement of $125,000 for the Federal Drug-Free Communities Grant. We believe that the purpose of this grant complements the goals of the Livingston Community Prevention Project (LCPP) and the Livingston County Community Alliance (LCCA), the countywide prevention collaborative. Childhood and underage drinking has resulted in Delinquent/Problem Behavior among Livingston County youth at school and within the broader community. In the 2012-13 school year, 56 Livingston County public high school and middle school students were caught under the influence of or in possession of alcohol at school or at a school event

	(aggregate informal report from school administrators, May 2014). In 2013, there were 24 petitions filed in Livingston County Juvenile Court for Minor in Possession of Alcohol (informal report prepared by Tanya Morrow, Juvenile Services Supervisor, Livingston County Juvenile Court, 5/21/14). Ms. Morrow also reports that many of the youth within the juvenile court system present with alcohol use disorders. Unfortunately, she did not have formal support data available. Project SUCCESS Counselors have also reported that students with whom they work continue to present with alcohol related problem behaviors. Early Addiction is another consequence of childhood and underage drinking. In our community, the average age of first use of alcohol among high school students is 13.4 (Livingston County MiPHY 2012) and the average age of first use of alcohol among 7th graders is 9.7 (Livingston County MiPHY 2012). According to CASA Columbia (2011), people who began using addictive substances before age 15 are six and a half times likelier to become addicted than those who delay first use until age 21 or older. The rise in the use of opiate prescription medication in Livingston County has led to an epidemic use of Heroin when the prescription medication is not available. It has also resulted in opiate related overdoses and deaths. According to Livingston County 911 Central Dispatch (6/3/11), there were 254 opiate-related overdoses reported to police in 2010, up from 164 overdoses in 2009. In 2012, the Livingston County Coroner's Office (2/17/14) reports there were 22 controlled substance related fatalities in Livingston County. Unfortunately, the coroner does not have records that specify "overdose" nor the related "controlled substance". Data summarized in a 5/23/14 press release from the Washtenaw Health Initiative Opioid Project further supports our concerns. They reported "drug-related deaths for Washtenaw County residents increased over 80% between 2000 and 2011. In 2012, drug-related deaths were responsible for more years of life lost than lung and breast cancer, pneumonia, influenza, and HIV combined for Washtenaw County residents. The majority of these deaths involved opioids, both illicit and prescription."
Underlying Root Causes to be Targeted: (Associated Intervening Variables, Risk/ Protective Factors)	<u>Targeted Intervening Variables</u> *Low perceived risk of alcohol use.* 24.8% of high school students and 29.6% of middle school students do not perceive regular alcohol use to be a moderate or great risk (Liv. Co. MiPHY 2012). *Easy access to alcohol.* 65.2% of high school students reported it is easy or very easy to get alcohol (Liv. Co. MiPHY 2012). Among high school students who drank recently, 25.4% usually got their own alcohol by giving someone else money to buy it, 39.7% obtained their own alcohol by someone giving it to them, and 17.3% obtained their own alcohol by taking it from a family member (Liv. Co. MiPHY 2012). *Early onset of alcohol use.* The average age of first use of alcohol among high school students is 13.4 and among 7th graders is 9.7 (Liv. Co. MiPHY 2012). *Perceived peer pressure.* Perception of peer disapproval of alcohol use decreases 19.8% between 9th and 11th grades (Liv. Co. MiPHY 2012). 53.9% of 11th graders report alcohol use by peers to be wrong or very wrong (Liv. Co. MiPHY 2012). *Prosocial attitudes toward school.* 38.3% of high school students report they often or almost always hated being at school during the past year (Liv. Co. MiPHY 2012). *Norms that support alcohol use.* 25.6% of high school students think that half or more of the students in their grade drank alcohol sometime in the past month (Liv. Co. MiPHY 2012).

	Parent norms, attitudes, and knowledge of alcohol use. According to the Livingston County Behavioral Risk Factor Survey (2009), 45.8% of respondents perceive alcohol as widely available to youth in the community and 28.1% perceived underage drinking to be a big problem. *Lack of perceived risk of prescription drug use.* The perception of harm for prescription drugs is decreasing over time. In 2012, 40.3% of 10th graders report there is great risk for harming themselves (physically or in other ways), if they take Vicodin occasionally. In 2013, that number decreased to 36.0% (MTF 2013). *Easy access to prescription medications.* In 2012, there were more than 54,271 scripts filled in Livingston County for Schedule 2 Controlled Substances, which includes OxyContin, Adderall, and Codeine (MAPS Drugs Utilization Report 2012). In 2012, there were more than 71,667 scripts filled in Livingston County for Schedule 3 Controlled Substances, which includes Vicodin, Tylenol with Codeine, Suboxone, Ketamine, and anabolic steroids (MAPS Drugs Utilization Report 2012). 993.5 lbs of unused medications have been collected in Livingston County from April 2011 – July 2013 (Livingston County Sheriff Dept, July 2013). Nearly 1 in 10 14-20 year olds who used UofM emergency department for care report nonmedical prescription opiate or sedative use and only 14.6% and 12.3% report having current prescriptions for opiates and sedatives (Pediatrics 2013; 132:825-832). *Early Onset of Prescription Drug Use.* Nearly 1 in 10 14-20 year olds who used UM emergency department for care report nonmedical prescription opiate or sedative use and only 14.6% and 12.3% report having current prescriptions for opiates and sedatives (Pediatrics 2013; 132:825-832). 5.9% of high school students took painkillers such as OxyContin, Codeine, Percocet, or Tylenol III without a doctor's prescription during the past 30 days (Liv. Co. MiPHY 2012). *Prosocial attitudes toward school.* 38.3% of high school students report they often or almost always hated being at school during the past year (Livingston County MiPHY 2012).
Evidence-based Strategies/Initiatives:	The Livingston County Recovery Oriented System of Care (ROSC) includes prevention, early intervention, treatment, and continuing care, all within the ecological context of the community. The focus of ROSC is promoting community health and wellness for all and equipping people with the resources, opportunities, and support needed to live meaningful lives in the community. (Michigan's ROSC: An Implementation Plan for SUD Service System Transformation, Bureau of Substance Abuse and Addiction Services, Behavioral Health and Development Disabilities Administration, Michigan Department of Community Health, May 2011). The LCPP, the LCCA and the planned expanded efforts will be provided within the local ROSC framework. *Communities Mobilizing for Change on Alcohol* (CMCA) is a community-organizing program designed to reduce teens' (13 to 20 years of age) access to alcohol by changing community policies and practices. CMCA seeks both to limit youth access to alcohol and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable. It employs a range of social-organizing techniques to address legal, institutional, social, and health issues related to underage drinking. The goals of these organizing efforts are to eliminate illegal alcohol sales to minors, obstruct the provision of alcohol to youth, and ultimately reduce alcohol use by teens. The program involves community members in seeking and achieving changes in local

	public policies and the practices of community institutions that can affect youth access to alcohol. Over the 8 year duration of the LCPP, CMCA activities have included alcohol compliance checks, vendor education, Registered Beverage Server Training, Project Sticker Shock and One-on-Ones. In the last 5 years, LCPP has expanded the scope to also address prescription and over-the-counter drug abuse. In the upcoming years, CMCA interventions will seek to impact the issue of access (both medical and social) to prescription drugs by assessing policies and practices related to prescribing and dispensing these medications as well as educating and promoting the broad community regarding proper storage of addictive medications and proper disposal of unused medications via the use of Big Red Barrels across the community. Over the past eight years, many of the CMCA efforts have been more heavily targeted to the Pinckney community, with significant youth involvement through "It Stops with Students". The DFC Grant, over the course of five years, will support efforts for similar increased targeting in the Livingston County communities of Fowlerville, Hartland, Howell and Brighton. A primary, though not exclusive emphasis will be on the organizing of youth.
PREVENTION ONLY Primary Federal Strategies (CSAP)	Check all that apply: X Information Dissemination X Education ☐ Alternatives ☐ Problem Identification & Referral X Community-Based Process X Environmental
Short-term Outcomes (where applicable) : (CDC SMART objectives – Specific, Measurable, Achievable, Realistic, and Time-phased) For each outcome, please include the evaluation method (i.e., survey, questionnaires, etc.)	The DFC proposal will focus on creating a youth led prevention team that will become part of the Livingston County Community Alliance. It is anticipated by the end of Year 5 of DFC funding, all Livingston County Public Middle and High Schools will have at least three youth representatives that will contribute to the youth led prevention team. We will utilize SAMHSA's Strategic Prevention Framework (SPF) each year for DFC funding to ultimately increase collaboration, coordination, and community-based networking to prevent youth substance abuse. • (Assessment) With support from an evaluator, Livingston County teens currently involved with substance abuse prevention will assist substance abuse professionals to identify local youth substance use problems. This will be done through qualitative data such as yearly focus groups and informal discussions with teens, and quantitative data such as survey results from the Livingston COMMUNITY Prevention Project (LCPP) initiatives, and the Michigan Profile for Healthy Youth (MiPHY). An assessment will be completed each year of DFC funding. • (Capacity) The youth lead prevention team will continue to build capacity throughout the DFC funding cycle. In Year 1, the team will focus on building membership in Fowlerville and strengthening in Pinckney. Annually, the youth led prevention team will continue to grow and build capacity by focusing on a different school/community to increase membership within the team. • (Planning) The prevention team will develop a comprehensive 12-month Action Plan and multi-year strategic plan. The action plan will be based on the information gathered in the assessment. The action plan will include yearly initiatives and activities which will be identified, selected, created and implemented by the youth. This will assist in identifying opportunities for expansion, increase mobilization, and continue to build capacity among the team. • (Implementation) According to the action plan and multi-year strategic plan, the youth led prevention team will implement all identified prevention

	activities and initiatives. Modifications to the multi-year strategic plan may be needed according to changing conditions related to youth substance use, and teen input. • (Evaluation) Throughout each year of DFC funding, the prevention team, with assistance from an evaluator, will evaluate their prevention activities, efforts, and strategies; they will modify them according to effectiveness. These modifications will be reflected in each subsequent 12 month action plan.
Intended Long-term Outcome(s): (Describe how this funding will benefit service delivery and/or the community)	The overarching goal of pursuing the DFC Grant is to expand on the current efforts of the LCPP as was described in the FY 2014-15 funding application. Therefore, the two long-term outcomes for the DFC Grant and the required matching funds are: To ultimately result in reduced opiate related overdoses and deaths. And, to ultimately result in reduced delinquent/problem behavior and reduced childhood and underage drinking.
Key People/Coalition:	Livingston County Catholic Charities (LCCC) currently serves as the fiduciary of the LCPP and the LCCA. This fiduciary role will continue with the DFC grant for continued coordination. Mark Robinson, ACSW, LMSW is the Executive Director and will serve as the Program Director as defined by the DFC requirements. *Kaitlin Fink*, LLMSW, CPS is a MCBAP certified substance abuse prevention specialist. She earned her MSW at Wayne State University, specializing in Community Organization. She is a CMCA implementer and coordinates all alcohol compliance checks, and responsible beverage server trainings. She is the primary coordinator of Parents Who Host Lose the Most. Kaitlin also is the Livingston County Community Alliance (LCCA) coordinator and facilitates its parental subcommittee (P3) and the Big Red Barrel project. Some of these responsibilities will change if the DFC Grant proposal is successful. Kaitlin has over 5 years of substance abuse prevention experience. *Amy Johnston*, LLMSW, CPS earned her MSW from The University of Michigan specializing in Community Organizing. Amy currently serves as The Pinckney Coalition Coordinator and as the Designated Youth Tobacco Use Representative (DYTUR) for Livingston and Washtenaw Counties, though some of these responsibilities will change if the DFC Grant proposal is successful. The plan is to hire one additional prevention specialist, with education and experience similar to Kaitlin and Amy, to complement their activities. Kathleen Zimmerman-Oster, PhD, is a Psychology Professor at the University of Detroit-Mercy and will provide program evaluation for this grant. Kathleen has served in this same capacity for numerous DFC grants, currently in Barry County and in the Chippewa Valley area of Macomb County. This will be a contract relationship.
Community Partners:	In addition to LCCC, the LCPP includes the licensed substance abuse prevention agencies: Karen Bergbower & Associates, Key Development Center and LACASA. The LCPP partnership will continue. The LCCA has a broad community representation, which currently includes law enforcement, Juvenile Court Probation, Livingston Family Center – The Connection, St.

	Joseph Mercy Livingston Hospital, parents, businesses and other community members.

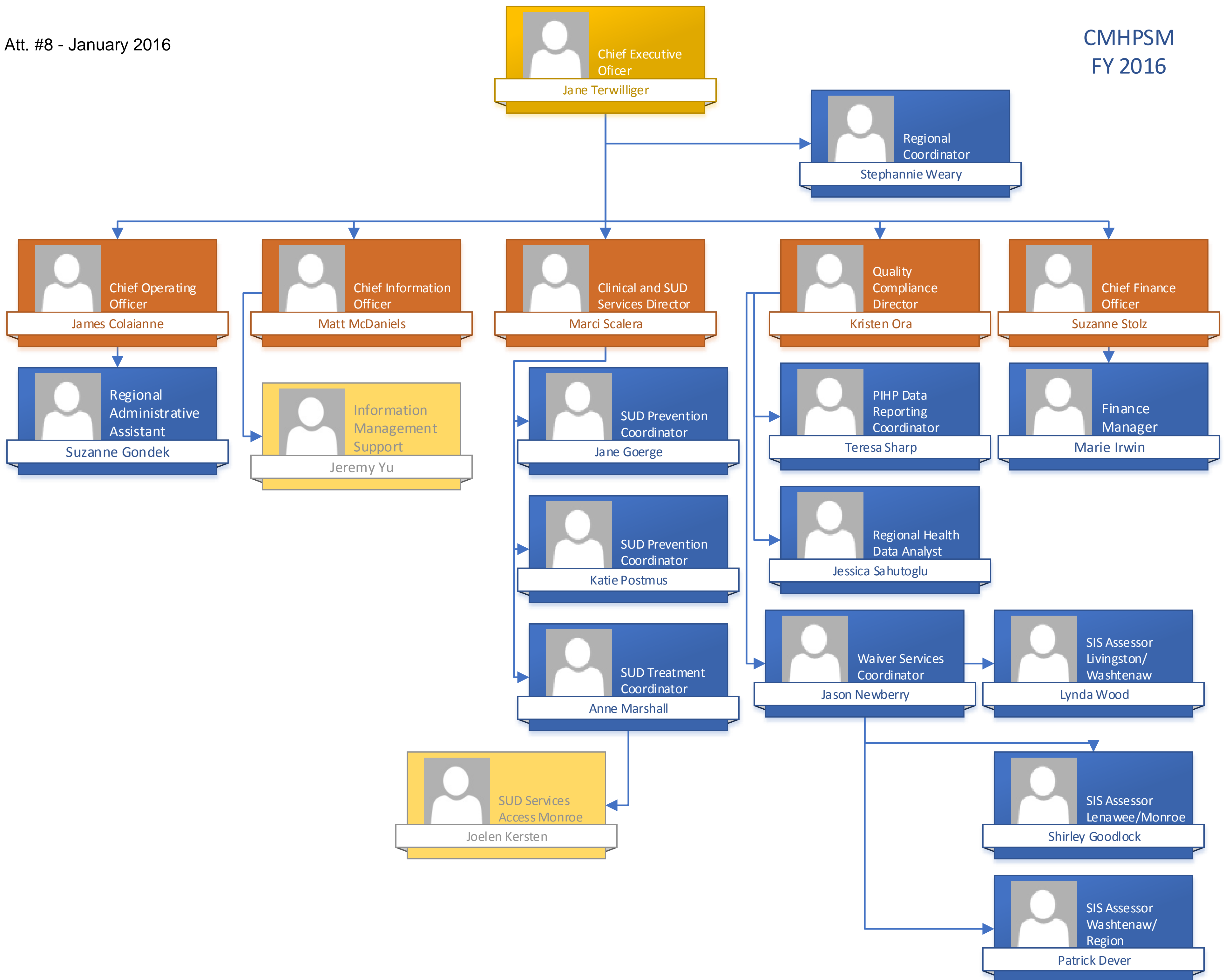
Please note:
All programming must be consistent with the implementation of Recovery-Oriented Systems of Care (ROSC).

Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems (Center for Substance Abuse Treatment, 2005).

CMHPSM Office Use Only	
Amount Recommended & Comments:	

Att. #8 - January 2016

CMHPSM
FY 2016



<table>
<tr><td>Community Mental Health Partnership of Southeast Michigan/PIHP</td><td>Policy and Procedure

REGIONAL NALOXONE OVERDOSE RESCUE KIT DISTRIBUTION AND UTILIZATION</td></tr>
<tr><td>Department:
Author: Marci Scalera</td><td>Local Policy Number (if used)</td></tr>
<tr><td>Regional Operations Committee Approval Date
January 13, 2016</td><td>Implementation Date
January 14, 2016</td></tr>
</table>

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I. PURPOSE

To reduce fatal opioid overdoses by allowing the distribution of CMHPSM funded Naloxone **Overdose Reversal Kits** by regional law enforcement agencies, first responders, crisis staff and other authorized individuals.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
	1	

III. APPLICATION

This policy applies to all staff and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) **or** *The first responders and law enforcement officers who will be delivering the Naloxone who are not under contract or in the provider network*, and any responder who will be authorized to utilize the CMHPSM issued Naloxone Overdose Rescue kits.

IV. DEFINITIONS

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

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

Crisis Staff: Any staff assigned to a crisis response team/program within a CMHSP or SUD provider network who is involved in urgent/emergent responding to individuals engaged in using opiates/heroin and who are at risk of an overdose. This pertains to mobile outreach and crisis teams within the CMHSP, Regional Engagement Centers, emergency shelters,

etc.

<u>Medical Director/Consulting Physician</u>**:** A physician licensed in Michigan as an MD or DO, for or in conjunction with the CMHPSM, a CMHSP or Core Provider.

<u>Naloxone</u>**:** Naloxone is an opioid antagonist that can be used to counter the effects of opiate overdose. Specifically, it can displace opioids from the receptors in the brain that control the central nervous system and respiratory system. It is marketed under various trademarks including, “Narcan.” *Naloxone is only effective if administered to an individual who has an opiate in their system.*

<u>Naloxone Overdose Reversal Kit:</u> Kit containing up to two doses of Naloxone 2mg/2ml as pre-filled Needleless Luer Jet Prefilled Syringe (NDC# 0548-3369-01) and 2 X intranasal mucosal Atomizing Device (MAD 300); instructional cards and other local resource information.

<u>Opiate</u>**:** An opiate is a medication or drug that is derived from the opium poppy or that mimics the effect of an opiate (a synthetic opiate). Opiate drugs are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep. Law enforcement officers often encounter opiates in the form of morphine, methadone, codeine, heroin, fentanyl, oxycodone and hydrocodone.

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

<u>Responder</u>: Any individual authorized to utilize a CMHPSM Naloxone Overdose Reversal Kit *who has completed an approved training*.

<u>Substance Use Disorder (SUD) Core Provider:</u> A local provider of substance use services utilizing the ROSC Model that provides for and/or coordinates all levels of care for clients with substance use disorders.

<u>Approved Training:</u> Training on administration of Naloxone that is provided by a CHMPSM authorized agency; Designated Law Enforcement Training Department in conjunction with Medical Personnel; Hospital; Health Department personnel or Michigan Department of Health and Human Services Designated Trainers. Training should include experiential hands on practice with the administration devise and practice mannequin.

<u>Universal Precautions</u>**:** An approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other blood borne pathogens

V. POLICY

Only appropriately trained individuals are authorized to utilize CMHPSM funded Naloxone Overdose Reversal kits in an attempt to respond to an individual presenting with an apparent opiate/heroin overdose.

VI. STANDARDS

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1. ASSESSMENT AND ADMINISTRATION

In the event that a responder has arrived at the scene of a medical emergency prior to the arrival of EMS, and has made a determination that the patient *is displaying symptoms consistent with an apparent* opiate overdose, the responding individual shall administer two milligrams of naloxone to the subject by way of the nasal passages. One milligram should be administered to each nostril.

The following steps should be taken:

A. Responder shall use universal precautions.
B. Responder shall conduct a medical assessment of the subject as prescribed by First Aid Training.
    a. Taking into account statements from witnesses and/or family members regarding drug use.
    b. Drug paraphernalia observed at the scene.
C. If the responder makes a determination *the individual has symptoms consistent with* an *apparent* opiate overdose, the naloxone kit shall be utilized.
D. The responder shall attach the nasal mist adapter to the naloxone and administer a one milligram intra-nasal dose of naloxone to each nostril for a complete dosage of two milligrams. *Note: in the event the responder is using another FDA approved Naloxone device, they should follow the accompanying package insert instructions.*
E. Responder shall take appropriate protective measures as a rapid reversal of an opiate overdose may cause projectile vomiting by the patient and/or violent behavior.
F. EMS shall be contacted and the subject should be encouraged to be transported to the hospital for medical attention via EMS.
G. Responder should stay with the patient until EMS arrives. Check vital signs every 2 minutes, because the Naloxone could wear off before EMS arrives.
H. Responder shall perform CPR if needed.

2. REPORTING

A. A complete case report of the incident shall be completed by the responder. Report form (Exhibit C) will be provided in the kit. In the case of law enforcement, officer shall follow agency protocol as designated by the respective department. In the case of crisis or program staff, reporting the incident to supervisor and completion of incident report shall be made prior to the end of his/her shift. The report shall include the following if indicated in the procedure;

    a. Nature of Incident.
    b. Subject's name, date of birth, address and phone number.
    c. Time of arrival at scene.
    d. Time the subject was transported.
    e. Name of hospital where the subject was transported.
    f. Names of EMT/Paramedics that transported.
    g. Where was your Nasal Naloxone disposed of?
    h. Who replaced the used Nasal Naloxone (if indicated)?
    i. *Lot/serial number of the Naloxone Administered*

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j. Expiration date on the Nasal Naloxone.
k. Any referrals made on behalf of the individual.

B. Notify the CMHPSM within 24 business hours of the rescue.

3. EQUIPMENT AND MAINTENANCE

It shall be the responsibility of the responders to inspect naloxone overdose rescue kits issued to them prior to the start of each shift (in the case of Law Enforcement) or at a minimum monthly, to ensure that the kits are intact. The responder will be responsible for their assigned Naloxone Kit and must be able to account for it at all times.

Given the Naloxone shelf-life is approximately one year, it is important for the responder to know when the expiration date is and to make arrangements for replacement.

Naloxone kits shall be maintained by the responder they are assigned to and will be stored at controlled room temperature (59° - 77° F). For very brief intervals, a kit may be keep outside of this range, but no less than 39° or above 104° F."
.

Damaged equipment shall be reported to the supervisor immediately.
A written inventory documenting the quantities, lot numbers and expirations of naloxone replacement supplies, and a log documenting the issuance of replacement units shall be maintained by the entity receiving the naloxone overdose rescue kits.

4. REPLACEMENT

Naloxone kits that have been used should be replaced. In the event the inventory is nearing depletion, the agency should notify the CMHPSM to determine if additional resources are available to replenish the supply.

VII. EXHIBITS

A. Physician's Standing Order For Opiate Overdose Reversal With Naloxone
B. Naloxone Distribution Log
C. Opiate/Heroin Overdose Rescue Report Card Template

VIII. REFERENCES

State of Michigan Enrolled Senate Bill No. 857
https://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2014-PA-0314.pdf

Occupational Safety & Health Administration: Bloodborne Pathogen Definitions 1910.1030(b)
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030(b)

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EXHIBIT A.

PHYSICIAN'S STANDING ORDER
For OPIATE OVERDOSE REVERSAL WITH NALOXONE

ADMINISTRATION

705 N. Zeeb Rd.
Ann Arbor, MI 48103
Phone (734) 344-6079
FAX (734) 222-3844
www.cmhpsm.org

Jane Terwilliger
Chief Executive Officer

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Jan Plas
Patricia Spriggle
Ralph Tillotson
Bob Wilson

I ____________________________________, ***PRESCRIBER,*** authorize the COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN to act as the delegated entity for dispensing NALOXONE to named persons or entities within the four county region of LIVINGSTON, WASHTENAW, LENAWEE AND MONROE COUNTIES, as described in the attached policy. This authorizes the CMHPSM approved responders (Law Enforcement and other identified human service/treatment agency personnel), who have received approved training, to possess and administer medication, and authorizes the CMHPSM entity to maintain supplies.

NALOXONE will be used as an overdose reversal intervention in situations where the responder has observed the individual exhibiting signs and symptoms of an opiate/heroin overdose state. The intervention for this situation is to administer naloxone in a nasal preparation, as described in the CMHPSM policy, entitled "**REGIONAL NALOXONE OVERDOSE RESCUE KIT DISTRIBUTION AND UTILIZATION**".

This prescription is written for __________ doses of **2 mg/2 mL as pre-filled Needleless Luer Jet Prefilled Syringe (NDC# 0548-3369-01)**

Sig: as directed in the Regional Naloxone Overdose Rescue Kit Distribution and Utilization Policy instructions

And ______________ units of **2 X intranasal mucosal Atomizing Device (MAD 300).**

Prescriber Name:____

Prescriber Signature: ____

Prescriber DEA# ____

Date: ____

EXHIBIT B

NALOXONE RESCUE KIT DISTRIBUTION LOG

To be used by the CMHPSM staff to track distribution of kits, lot numbers and recipient departments

DISTRIBUTED TO	DATE DISTRIBUTED	NUMBER OF KITS DEPLOYED	NUMBER OF DOSES PER KIT	LOT NUMBER RANGE	EXPIRATION DATES	RECIPIENT INITIALS AND EMAIL
Sample department	*January 1, 2016*	*20*	*2*	*1234 -1254*	*January 1, 2017*	

OPIATE/HEROIN OVERDOSE RESCUE REPORT

Please complete this brief report and submit to CMHPSM for tracking:

Nature of Incident: Overdose Other ______________________

Subject's name: ____
(If OK with subject)

Date of birth: ____

Address: ____

Phone number: ____

Time of arrival at scene: __________Time transported: ____________

Name of hospital where transported: ___________________________

Names of EMT/Paramedics that transported: ____________________

Where was your Nasal Naloxone disposed of? __________________

Who replaced the used Naloxone (if indicated)? _________________

*Lot/serial number of the Naloxone Administered*__________________

Expiration date on the Naloxone: ______________________________

Any referrals made on behalf of the individual: ___________________

____

OPIATE/HEROIN OVERDOSE RESCUE REPORT

Please complete this brief report and submit to CMHPSM for tracking:

Nature of Incident: Overdose Other ______________________

Subject's name: ____
(If OK with subject)

Date of birth: ____

Address: ____

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Time of arrival at scene: __________Time transported: ____________

Name of hospital where transported: ___________________________

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Where was your Nasal Naloxone disposed of? __________________

Who replaced the used Naloxone (if indicated)? _________________

*Lot/serial number of the Naloxone Administered*__________________

Expiration date on the Naloxone: ______________________________

Any referrals made on behalf of the individual: ___________________

____