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
February 23, 2017

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 1-26-2017 OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business
   a. Finance Report {Att #2} – 15 minutes

6. New Business – 30 minutes
   a. FY 2016 Dashboard report, Findings and Corrective Action Plans {Att #3}
   b. Prevention Providers Status {Att #4}
   c. Recovery Self-Assessment (RSA) Analysis {Att #5}

7. Report from Regional Board (Discussion) – 5 minutes
   a. Representation change needed

8. SUD Director Updates (Discussion) – 5 minutes
   a. Naloxone Report

Next meeting: Thursday, March 23, 2017

Parking Lot:

LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
Summary of January 26, 2017 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present: Kim Comerzan, Sheila Little, Dianne McCormick, Mark Cochran, William Green, Tom Waldecker, Amy Fullerton, Ralph Tillotson, John Lapham, Dave O'Dell

Members Absent: Dave DeLano, Charles Coleman, David Oblak

Guests:

Staff Present: Stephannie Weary, Marci Scalera, Suzanne Stolz, Dana Darrow

OPB Vice-Chair Amy Fullerton called the meeting to order at 9:00 a.m.

1. Introductions

2. Approval of the agenda

   Motion by R. Tillotson, supported by W. Green, to approve the agenda
   Motion carried

3. Approval of October 27, 2016 minutes

   Motion by D. McCormick, by W. Green, to approve the OPB meeting minutes from October 27, 2016
   Motion carried

4. Audience Participation
   - None

5. Old Business
   a. FY 16 Final Finance Report
      - S. Stolz presented. Discussion followed.
   b. Women's Specific Program
      - M. Scalera presented an overview of services provided by Catholic Charities of Southeast Michigan, and the proposed budget and plan.
      - The Women's Specific program would be funded by block grant dollars.
      - The program was brought to OPB before, and the program was approved. The budget was not brought to OPB at that time, and thus was not approved.
      - The proposed board action request for budget approval would be retroactive to March 2016.
      - OPB's preferred to address each fiscal year in a separate board action.

Motion by T. Waldecker, supported by R. Tillotson, to recommend CMHPSM Regional Board acceptance of proposed budget total of $78,387 for the Women's Specific program for FY 2016
Motion carried

Motion by T. Waldecker, supported by R. Tillotson, to recommend CMHPSM Regional Board acceptance of proposed budget total of $78,387 for the Women's Specific program for FY 2017
Motion carried

c. Media Campaign Policy

Motion by W. Green, supported by J. Lapham, to approve the Substance Use Disorder (SUD) Media Campaigns policy
Motion carried

d. OPB Action Request for Strategic Plan
   i. Strategic Planning Follow-Up SWOT Analysis
   M. Scalera provided an overview of efforts at the state, and how those efforts relate to potential programs that could be considered by OPB.

   Motion by D. McCormick, supported by J. Lapham, to endorse and approve the SUD Strategic Plan with consideration of planned programming enhancements
   Motion by T. Waldecker to add a friendly amendment requesting that RFP responses avoid citing national data and focus on the proposal requirements
   Motion carried as amended

6. New Business
   a. Funding Requests
      1. WRAP

      Motion by R. Tillotson, supported by J. Lapham, to approve the funding for Home Of New Vision, Washtenaw Recovery Advocacy Project (WRAP), a recovery community organization (RCO)
      Motion by D. McCormick to add a friendly amendment indicating that grant dollars will be the first source, with the flexibility use PA2 dollars as a backup funding source if necessary
      Motion carried as amended

      2. Hegira SBIRT
         - D. McCormick requested a breakdown of residency of those attending the clinic.

      Motion by M. Cochran, supported by J. Lapham, to recommend funding in the Amount Of $100,000 Washtenaw PA2 for HPI. In the event MDHHS Block Grant Funds are available, recommend CMHPSM Board approve funding shift to block grant funds for the HPI program in the amount of $100,000
      Motion carried

      3. Monroe's Women's Specialty

Motion by W. Green, supported by T. Waldecker, to recommend CMHPSM regional board approve funding of this program out of MDHHS SUD block grant funds in the maximum amount of $123,250
Motion carried

4. RFP Timeline
   - D. McCormick noted the mandatory bidders' conference doesn't give responders a lot of time, and suggested that staff share a draft of the proposal, to give more time.
   - M. Scalera will share a draft on the web site by the end of February.

7. Report from Regional Board
   - There will need to be a change of representation from the OPB on the Regional Board because Charles Coleman has a scheduling conflict, and can't participate on OPB or the Regional Board.
   - Per the Regional Board bylaws, the OPB representative to the Regional Board must be in recovery.
   - OPB questioned that requirement as 1) unethical, and 2) not necessarily possible.

Motion by R. Tillotson, supported by T. Waldecker, that the Regional Board consider revising its bylaws to remove the requirement that the OPB representative to the Regional Board must be in recovery
Motion carried

8. SUD Director Report
   a. Provider Dashboard
      - M. Scalera provided an overview of the Provider Dashboard.
   b. State Grant Application
      - There is New Cares Act funding targeting the opiate epidemic.
   c. Livingston Engagement Center Update
      - The Engagement Center will be opening February 1.
      - The center is open through the evening on weekdays, and open 24 hours for the weekend. There won't be beds, but there will be couches for resting.
      - Some of its features include clinical staff, a peer on staff, and a washer and dryer.
      - 1 of the center's goals is to work with families. It has room to hold meetings.
      - Lenawee County is still working on developing an engagement center.
      - Monroe is also investigating an engagement center.

9. Adjourn

Motion by J. Lapham, supported by W. Green, to adjourn the meeting
Motion carried

- The meeting adjourned at 11:15.

Attachment #2 - February 2017

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
December 2016 FYTD

Summary Of Revenue & Expense	Funding Source					Total Funding Sources
	Medicaid	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	
Revenues						
Funding From MDCH	$ 434,598	$ 837,039	$ 923,513		$ -	$ 2,195,149
PA2/COBO Tax Funding	$ -	$ -	$ -	$ 451,651 *	$ -	$ 451,651
Other	$ -	$ -	$ -	$ -	$ -	$ -
Total Revenues	$ 434,598	$ 837,039	$ 923,513	$ 451,651	$ -	$ 2,646,800
Expenses						
Funding for County SUD Programs						
Lenawee	$ 63,653	$ 130,795	$ 48,301	$ 24,066	$ -	$ 266,815
Livingston	$ 51,387	$ 94,863	$ 93,080	$ 85,812	$ -	$ 325,143
Monroe	$ 36,247	$ 64,599	$ 173,122	$ 11,388	$ -	$ 285,356
Washtenaw	$ 175,861	$ 377,641	$ 493,128	$ 80,791	$ -	$ 1,127,420
Total SUD Expenses	$ 327,148	$ 667,898	$ 807,632	$ 202,057	$ -	$ 2,004,735
Other Operating Costs						
SUD Use Tax	$ 25,989	$ 50,055	$ -	$ -	$ -	$ 76,044
SUD HICA Claims Tax	$ 3,259	$ 6,278	$ -	$ -	$ -	$ 9,537
Total Operating Costs	$ 29,248	$ 56,333	$ -	$ -	$ -	$ 85,581
Administrative Cost Allocation	$ 28,208	$ 57,581	$ 86,257	$ -	$ -	$ 172,045
Total Expenses	$ 384,603	$ 781,812	$ 893,889	$ 202,057	$ -	$ 2,262,361
Revenues Over/(Under) Expenses	$ 49,994	$ 55,227	$ 29,624	$ 249,594	$ -	$ 384,439

Unallocated PA2	
Lenawee	$ 1,017,138
Livingston	$ 2,393,356
Monroe	$ 243,366
Washtenaw	$ 2,542,374
Total	$ 6,196,234

CMHPSM SUD PROVIDER DASHBOARD
REVIEW AND CORRECTIVE ACTION PLANS

The CMHPSM SUD Team works with providers to collect data on services, state indicators and national outcome measures. Data is extracted on a quarterly basis and given to providers to review and correct any submission errors. Once the data is 'cleaned' it can be submitted to the state for review and used in aggregate to describe how services are being delivered. This information is sent up to the federal government as part of Medicaid and Block Grant regulatory requirements. The data is also used by actuaries to determine rates and intensity factors by region. Prevention reviews providers on a quarterly basis as well. This ranges from program reports and other data reviews.

Additional aspects of care are reviewed and included in our expectations for providers. These help us determine the impact of treatment on individuals. The outcome measures are established by SAMHSA. We also look at clinical indicators using the Arizona Self-sufficiency matrix. We took the results of the four quarters in FY 2016 and rated compliance, and outcomes as positive (good), neutral or 'OK", or negative (needs improvement). Indicators that were rated neutral or negative required providers to identify action steps to foster improvement. The following information includes feedback and actions items from providers.

It is equally important to review this data and logic behind the information with the providers, especially in areas that need improvement. We want to make sure the way we pull the data into the report makes sense and fits with the provider practice. We have asked providers to identify areas where the logic may need to be reviewed. An example of this is a short term residential program where the client is only in services for 14 days, having a measure for improvement that would occur over a three-month time frame would not be appropriate. Measures should match the service provided.

The following contract standards are looked at when considering where treatment agencies fall on each data element:

CONTRACTOR will maintain a "sustained engagement" target at quarterly intervals based on engagement standards. At least 30% of consumers must stay engaged for six (6) months after admission, and at least 10% must stay engaged for twelve (12) months after admission:

- *A consumer is "engaged" if no more than 90 days pass without at least one encounter.*
- *An encounter is a billable service that is accepted by the State*
- *Error rates for TEDS Submissions and Encounter submissions must be less than 20%. (**Data to be calculated for FY 2017)***
  - *CONTRACTOR will offer an array of services each month based on the individual plan of service, and must include **at least one** recovery support or case management encounter.*
  - *CONTRACTOR will have a minimum completion rate of **70%** for the self-sufficiency matrix, for each client, as part of the concurrent review process that informs the National Outcome Measures.*
  - *NATIONAL OUTCOME DATA MEASURES: Contractor must meet timeliness AND outcome thresholds as indicated below. A score of 3 – 5 on the self-sufficiency matrix is considered "positive."*
  - ***75%** improvement rate on the reduction of frequency of 30 day use from admission to discharge or over time in ROSC services.*
  - ***50%** improved employment status from admission to discharge or over time in ROSC services.*
  - ***50%** improved housing status from admission to discharge or over time in ROSC services.*
  - ***80%** reduction in, or maintenance of, legal involvement status in the 30 days before admission and 30 days prior to discharge or over time in ROSC services.*

MDHHS Quality Indicators:

- ***95%** of initial assessments completed within 14 days of request.*

- ***95%*** *of SUD services started within 14 days of initial assessment.*
- ***95%*** *of SUD detox discharges are seen in services within 7 days*

	Catholic Charities of Lenawee	McCullough-Vargas (Lenawee)
REPORT ELEMENT	**Information or Plan**	**Information or Plan**
Unique consumers with an open admission	Average Open Admit per Quarter =119	Average open admit per quarter =98
Number that received at least one service during the quarter	Average per quarter = 85 Average % = 71 	Average per quarter = 90 Average % = 91% 
Percent that received at least one service during the quarter	Keep striving to ensure clients are receiving services, which  leads to more sustained recovery. Both our Case Manager & Recovery Coach will implement a process of contacting all clients who miss two or more sessions in a row. Contact will encourage participation and discussion surrounding barriers to attendance and engagement. Every effort will be made to resolve any barriers to treatment engagement.	
Median months in service (among those receiving services ***30% of clients engaged for 6 months; 10% for 12 months***	***Please discuss ways you will improve the length of stay***  ***clients are engaged in. Submit ways to meet the sustained engagement thresholds.*** CCLC will implement processes to engage clients immediately following the assessment. Case Manager will meet for individual sessions to build a relationship and assist in the acquisition of necessary resources. CCLC will additionally utilize Recovery Coach in connecting with clients at least twice weekly during the first two weeks of treatment.	***Please discuss ways you will improve the length of stay clients***  ***are engaged in. Submit ways to meet the sustained engagement thresholds.**** Improve the number of attempts to contact clients to assist to in wanting to re-engage in treatment. Every chart will go through case conference for potential discharge. The increased use of case management and recovery coaches to improve length of stay.
Percent with concurrent review up to date ***70%***	***CCLC has been somewhat out of compliance with this***  ***threshold. Please submit a plan on how your agency will improve this to consistently achieve the desired 70%.*** CCLC will begin reviewing the status of all cases during our weekly treatment team meeting. Clients who are flagged for concurrent review dates will be noted for therapist to take immediate action. Case Manager will assist in monitoring an Excel Spreadsheet for due dates.	

Percent with self-sufficiency matrix up to date **70%**	***CCLC has been somewhat out of compliance with this threshold. Please submit a plan on how your agency will improve this to consistently achieve the desired 70%.*** Case Manager will monitor the completion of Self Sufficiency Matrix. A Self Sufficiency Matrix training was given during the treatment team meeting and all therapists were asked to complete as required.	
Percent whose concurrent review indicates coordination with PCP	 **Please discuss ideas on how you will ensure coordination with the client's primary care provider.** CCLC will implement processes during the client intake that encourages clients to sign an authorization form to involve PCP. Case Manager will additionally follow-up with client to encourage PCP involvement. Therapists will provide information to all clients both individually and in the group setting that speaks to the medical model of treatment and the benefits of having a multi-treatment team approach.	 **Please discuss ideas on how you will ensure coordination with the client's primary care provider.** ** Every client is asked to sign a release to their doctor upon intake. If a client doesn't have a PCP, a list of possible physicians will be given to them. Encouragement to have them contact a PCP will occur during tx. We are also considering going back to an old system we use to use where after the release we faxed a form stating that the mutual client in SA services and ask that they take that into consideration when giving any meds. After faxing, it was ask on the form that the doctor or representative sign the form and fax back to us acknowledging they understand **
Service Array		
STATE QUALITY INDICATOR DATA:		
Percent of admissions with 14 or fewer days between first contact and admission (***Indicator 2e; >95%)***		
Percent of admissions with 14 or fewer days between admission		

and first service ***(Indicator 3e; >95%)***	**CCLC has met the standards for admission timeliness in two of the four quarters. Please identify ways to consistently meet threshold.**  CCLC will utilize both the Recovery Coach & Case Manager to engage clients after assessment. This will be done through phone contact and through face/face sessions.	 **MVA has not met the standards for admission timeliness in the four quarters. Please identify ways to consistently meet threshold.** ** We believe the reason we did not meet the threshold is probably related to clients not making it to our engagement groups. We will talk in staff meeting about strategies to get clients to engage the same week of the admission. **
Percent of detox discharges with 7 or fewer days to first service ***(Indicator 4b;>95%)***	NA	NA
NATIONAL OUTCOME MEASURES:		
Percent of discharges with improvement in 30 days Frequency of Use 75**%**	**Please review this data and comment. Submit strategies on how to internally monitor and improve this outcome.**  CCLC will provide training on how to complete EII paperwork in order to provide more accurate data on frequency of use. Additionally, a greater emphasis will be placed on individualized treatment planning to better address identified goals.	 **Please review this data and comment. Submit strategies on how to internally monitor and improve this outcome.** ** An in-service training about this topic and the importance of with clinical staff. It will become part of our chart audit form that will have a date this is to be done and monitored by our clinical Supervisor.
Percent of discharges with improvement in employment **50%**	**Please review this data and comment. Submit strategies on how to internally monitor and improve this outcome.**  Both the Case Manager and Recovery Coach will identify employment issues immediately following the assessment and develop treatment plan goals surrounding the attainment of employment resources to assist clients in attaining gainful employment.	Please review this data and comment. Submit strategies on  how to internally monitor and improve this outcome. ** A training with staff will occur about the importance of documenting employment accurately in the EII system. We believe there are times they forget to look and update the information on employment accurately. **

Percent of discharges with improvement in housing **50%**	**Please review this data and comment. Submit strategies on how to internally monitor and improve this outcome.** CCLC will make every effort to connect clients with our Case Manger immediately following the assessment. Our Case Manager will identify housing needs and begin a plan of action to assist clients who are in need of stable housing. Our Recovery Coach will be made aware of clients who do not have stable housing and assist clients in accessing county resources for stable housing.	
Percent of consumers with **improvement** in Self Sufficiency Matrix **(Baseline data collected)**	**Please comment on how your agency will address the data review.** CCLC will make every effort toward utilizing our entire treatment team in assisting clients in achieving their designated goals. Increased efforts will be made in contacting those clients who dropped services in order to attain accurate data for the Self Sufficiency Matrix.	**Please comment on how your agency will address the data review.** ** The support staff will monitor whether the clinical staff have done the self Sufficiency Matrix in a timely way during changes in the client's situation. The clinical supervisor will monitor compliance. A staff meeting will occur about the importance of doing the SSM at all levels including admission, Concurrent review and discharge **

WASHTENAW COUNTY:

	DAWN FARM	HOME OF NEW VISION
REPORT ELEMENT	**Information or Plan**	**Information or Plan**
Unique consumers with an open admission	Average Open Admit per Quarter = 243	Average Open Admit per Quarter = 198
Number that received at least one service during the quarter	Average per quarter = 210 Average % = 86 	Average per quarter = 187 Average % = 95 
Percent that received at least one service during the quarter	*Keep striving to ensure clients are receiving services, which leads to more sustained recovery* 	*Keep striving to ensure clients are receiving services, which leads to more sustained recovery* 
Median months in service (among those receiving services	We maintain engagement with clients in many ways that are not reimbursed by CMHPSM and therefore not documented in E.ll. Some examples of maintained engagement include: volunteers at Spera, drop-in	

30% of clients engaged for 6 months; 10% for 12 months	group attendance at Spera, and peer volunteers/supports at our long term residential sites. This also does not capture clients, for example, who start a service and stay for a month or so, then get discharged, and come back a month later to re-engage in services. There are many examples of clients who follow this pattern of re-engaging in services, but don't count towards this number	Increasing a case manager from part-time to full time, to allow for additional hours to focus on outreach to individuals who do not attend their first scheduled session following the Action Group screening. All workers have been informed that at least three outreach efforts must occur and be documented prior to an individual receiving a SUD discharge.
Percent with concurrent review up to date ***70%***	 Outpatient is trying to make this a continued priority at their site and is encouraging staff to fill one out whenever phase changes are made. Often times the information entered into the concurrent review for discharge at Outpatient will be the same as admission, because staff does not have this most recent information at the time.	
Percent with self-sufficiency matrix up to date **70%**	 Dawn Farm does well capturing SSM information upon intake, but has struggled with capturing this at discharge for Outpatient (we aren't always able to capture this information at discharge). We discussed adding the most important questions on the SSM, such as: housing, frequency of use, & employment to the back of Outpatient's weekly feedback form, but once a month. This would enable us to have the most recent snapshot for SSM's at discharge, instead of putting in the same information entered for admission. *Also, where is the percentage being pulled from?* We would like to make sure we are on the same page for this expectation. The most recent decision that was communicated, was that Outpatient would be the one site required to fill this out upon admission and discharge.	

	Is it possible to have an option called "unknown" for some of the questions? This would be more accurate, we believe, than us putting the most conservative guess (same as upon intake) when we don't have the information. *Is it possible to have the areas for housing, frequency of use, and employment NOT auto-populate, to remind staff to find the most recent information?*	
Percent whose concurrent review indicates coordination with PCP	We coordinate with PCPs when appropriate, clinically necessary, or when client requested.	While there is no standard expectation for this area set by the CMHPSM, HNV agrees that the current percentages could increase. In order to address this need, we have implemented the following: • HNV will continue to obtain an ROI for PCPs during every Action Group. In the event that an individual reports having no PCP, he/she is linked to a case manager who assists the client in obtaining a PCP; the case manager first assists the individual in obtaining insurance (if applicable). • The primary worker for each client enrolled in Treatment, Case Management or Recovery Coach Services will reach out to the PCP via letter or phone call, with proper documentation in the file and indicated on the Concurrent Review. • Following initial contact, the primary worker will continue to include collaboration with the PCP as a component of the Concurrent Review.
Service Array	We will begin coding our OP Discovery groups as early intervention (H0022) instead of H005 (Group).	HNV provides a wide array of services to meet the needs of clients.

	We typically turn many ROSC candidates away from this group, because they often aren't "interested in treatment." This Discovery group generally encompasses those who do not identify yet as having a problem. If we lowered our threshold for this group, we would begin to have a capacity issue. RSS services at Dawn Farm are a blended service, but there is currently not an option to select both peer support and case management (half each for example). Our RSS's will select the Recovery option most of the time, even when there are Resource focused discussions included. In addition, most of our clients have Medicaid, which is the H0038 code (falling under peer services, not case management). *Please note-through this process and then touching base with HNV, we just realized there may be some clarification needed on what codes we are currently supposed to be using for RSS encounters. The codes we have been utilizing are: T1012 Recovery Focus, H0006 Resource Focus, and H0038 Medicaid focus. Again, the majority of our cases would be under H0038 Medicaid, but it seems like this is no longer the valid code. Can we please discuss this at our next Provider Meeting?*	
STATE QUALITY INDICATOR DATA:		
Percent of admissions with 14 or fewer days between first contact and admission (***Indicator 2e; >95%)***		

Percent of admissions with 14 or fewer days between admission and first service ***(Indicator 3e; >95%)***	 We continue to improve in this area and have hardly any clients on our Outpatient waitlists. During our quarterly error document packets, I do have to make notes for several admissions labeled as out of compliance to show they are exceptions or exclusions. We aren't capturing every single exception and hope to continue improving our documentation of the original Outpatient group date offered instead of only capturing the first one attended.	
Percent of detox discharges with 7 or fewer days to first service ***(Indicator 4b;>95%)***	 Almost every single detox client goes to their Outpatient Level of Care Assessment while at Spera. We believe this is good practice and would like to continue this. Is there any way to capture this in E.ll? We continue to do well in this area at 87% and plan to continue our practices.	
NATIONAL OUTCOME MEASURES:		
Percent of discharges with improvement in 30 days Frequency of Use 75**%**	 We have improved in this area and hope to continue to do so. As mentioned above, we plan on introducing a new way to capture this particular SSM information through Outpatient feedback forms, which should show a significant improvement.	 While the above issues impact the reliability of the data, HNV has taken actions that will assist in improving these numbers. These efforts include: J HNV has implemented a Relapse Prevention group that serves as a transition group for individuals who complete Chemical Education or Motivation to Change Groups; however, are not yet ready to commit to ongoing recovery. This was implemented in June 2016 (3rd Quarter), and we attained the highest percentage (70%) in the 4th Quarter.

		) Case Managers have been informed that all clients receiving case management services must attend recovery focused services (range from Early Intervention-Residential), with a focus on progressing their stage of change and lowering their frequency of use.
Percent of discharges with improvement in employment **50%**	 As mentioned above, we plan on introducing a new way to capture this particular SSM information through Outpatient feedback forms, which should show a significant improvement. We have also recently stressed the importance to staff of capturing this information. Again, it would be helpful if these three particular areas (employment, frequency of use, and housing) could NOT auto-populate that way staff have a reminder to double check these specific areas.	 The target for the CMHPSM is 50%, and HNV has ranged from 28%-31%. The same factors that influence the frequency of use impact the employment ratings. While there are issues that impact the reliability of the data, HNV has taken actions that will assist in improving these numbers. These efforts include:) All individuals who are in the competitive labor force, and identify as unemployed, are assigned a case manager. This case manager will work with the individual to connect with employment services, assist in finding employment or assist with the process of filing for disability if there is a reason the individual is unable to work.
Percent of discharges with improvement in housing **50%**	see above 	
Percent of consumers with **improvement** in Self Sufficiency Matrix **(Baseline data collected)**	see above 	 The CMHPSM has not identified the expected percentage; however, HNV has ranged from 51%-61% during the fiscal year. There are factors that influence these numbers, including:) These measurements occur at intake, discharge and every three months during the Concurrent Review, which may not be enough time to adequately address the specific issues that are identified on the Matrix.

		) Not all services desired/requested by the client address the areas on the Self Sufficiency Matrix (i.e. early intervention services). While there are issues that impact the reliability of the data, HNV has taken actions that will assist in improving these numbers. These efforts include:) All individuals identified as in crisis or vulnerable on the Self Sufficiency Matrix, will be assigned a case manager to assist in addressing needs.

MONROE COUNTY PROVIDERS

	Catholic Charities of Southeast Michigan	Salvation Army Harbor Light
REPORT ELEMENT	Information or Plan	Information or Plan
Unique consumers with an open admission	Average Open Admit per Quarter =183	Average Open Admit per Quarter = 123
Number that received at least one service during the quarter	Average per quarter = 160 Average % = 88% 	Average per quarter = 106 Average % = 86% 
Percent that received at least one service during the quarter		

Median months in service (among those receiving services ***30% of clients engaged for 6 months; 10% for 12 months***	01/06/17 – Monroe Provider Meeting  01/10/17 – CCSEM Staff meeting. Clinicians will provide immediate phone contact with clients who miss their appointments in addition clinicians will send a letter if phone contact is not made. CCSEM provides reminder calls prior to the next day appointments. CCSEM works with clients to transiton their sessions from weekly to bi-weekly to monthly while increasing peer contact and group sessions.	 Due to the larger number of residential clients, I believe the data is skewed lower. Many of the residential clients follow thru with outpatient services at other agencies and thus are only engaged in services for 14 days.
Percent with concurrent review up to date ***70%***		 Staff training has been completed with clinical staff to understand concurrent review process and time frames. The concern with the measure is that concurrent reviews are not being done in outpatient at the 90-day mark if there are still authorized services available.
Percent with self-sufficiency matrix up to date **70%**		 The clinical supervisor and site administrator will look at data monthly to ensure the matrix is being completed and identify staffs that need retraining
Percent whose concurrent review indicates coordination with PCP	 01/10/17: SUD Client checklist was created in November 2016 and is provided to each therapist with intake forms for all new clients. PCP forms are being completed in CCSEM Electronic record. Staff were	 An MOU was signed with Family Medical Center of Carleton (the FQHC) to be a primary referral source and better co-ordinate health care services. As most clients do not have a PCP or are being refused services by PCP due to lack of attendance at scheduled appointments

	trained on 01/10/17 on where to document PCP coordination in E-II. PCP Coordination form is printed and faxed to the primary care physician with a request for up to date physical information.	
Service Array	 CCSEM will speak with CMHPSM regarding peer support and case management codes for E-II. Peer support services and case management is documented in CCSEM electronic records, however units are not entered in to the E-II system. Staff to mark box on Concurrent Review.	
STATE QUALITY INDICATOR DATA:		
Percent of admissions with 14 or fewer days between first contact and admission (***Indicator 2e; >95%)***		
Percent of admissions with 14 or fewer days between admission and first service ***(Indicator 3e; >95%)***	 CCSEM provides appointment reminder calls to all clients prior to their appointment date. CCSEM clinicians will follow-up with clients the day of the missed appointment and attempt to get them in before the 14 days. CCSEM will work with referring agencies to assist with client engagement in services to include: DHHS, PO's, Touchstone Recovery, and Paula's House.	 On average this indicator has been at or above average. For 1 month there was an issue with capacity which was corrected when additional staff was hired
Percent of detox discharges with 7 or fewer days to first	NA	 The issue tends to be with clients who leave detox AMA and fail to follow thru or refuse to accept referrals/appointments for continuing services

service ***(Indicator 4b;>95%)***		
NATIONAL OUTCOME MEASURES:		
Percent of discharges with improvement in 30 days Frequency of Use 75**%**	 CCSEM Staff Meeting – 1/10/17: Provided clarification of frequency of use, identified where to update on discharge with staff, and requested most current information be documented. Clinicians to do frequency check-ins with clients in the instance client drops out of treatment.	 This is a training issue for the staff. This was again reviewed with the medical and clinical staff to be mindful of changing this measure as it is pre-filled with intake data on the discharge form.
Percent of discharges with improvement in employment **50%**	 CCSEM Staff Meeting – 1/10/17: Provided clarification of employment, identified where to update on discharge with staff, and requested most current information be documented. Clinicians to do employment check-ins with clients in the instance client drops out of treatment. CCSEM peer to host Ready-To-Work workshops 2-3x per month with different temporary employment agencies.	 While a job skills class is offered weekly and clients attend workshops at MI Works (escorted by staff) clients are not allowed to leave residential treatment to seek employment. Also people, who may be employed coming into IOP or residential with entry level jobs do not have employers who will hold those jobs while in treatment.
Percent of discharges with improvement in housing **50%**	 CCSEM Staff Meeting – 1/10/17: Provided clarification of housing, identified where to update on discharge with staff, and requested most current information be documented. Clinicians to do	 There was only the first quarter that this measure was not met. The other 3 quarters have improvement at 80%.

	housing check-ins with clients in the instance client drops out of treatment.	
Percent of consumers with **improvement** in Self Sufficiency Matrix **(Baseline data collected)**	CCSEM Staff Meeting – 1/10/17:  Reviewed Self-Sufficiency Matrix and provided clarification of areas measured and how areas should be measured. Emphasized the importance of updating at Admission, 90 days with concurrent review and at discharge.	 This is a training issue for the staff. This was again reviewed with the medical and clinical staff to identify as a staff what is considered: vulnerable, in crisis, empowered and building capacity. So that all staff has a similar frame of reference for these subjective measures.

Lenawee
Livingston
Monroe
Washtenaw

SUBSTANCE ABUSE PREVENTION SERVICES

PREVENTION PROGRAM MONITORING

FY 2016-2017

All CMHPSM funded prevention programs are monitored on a regular basis. The mid-year point allows for a more in-depth analysis based on a variety of factors including: the amount of time for program implementation, the submission of Outcome Progress Reports, EBI Program Assessment/Fidelity Forms, and Coalition Community Sector Checklists (where applicable). Prevention programs are reviewed from multiple perspectives, including: financial, contractual, MPDS entries, programming, and progress on planned activities in relationship to outcomes.

For those areas that have not produced the results anticipated, either a 'course correction' is required, or a reduction in funds may be warranted. The CMHPSM promotes the rectification of program implementation to enhance the opportunity for successful efforts within the respective targeted community. Thus, feedback and consultation are provided where necessary.

FY 2016 Prevention Program Observations:

Program observations are conducted every other year, occurring the opposite year of the Fiduciary Site Visit or Desk Audit. In April, 2016, the Prevention Coordinators conducted nine observations and were overall very impressed with the performance of the prevention providers. This included programming in all four counties and a variance in prevention efforts observed.

FY 2016 Site Visits:

In 2016, the CMHPSM conducted site visits on two new prevention providers. The respective total scores were 88% and 78%. Given our threshold of 85%, one Corrective Action Plan was required. The lower score was mainly due to an unanticipated staff change and the associated effect on programming. The CMHPSM met with this provider and received an Action Plan.

FY 2017 Desk Audit:

In lieu of a formal site visit, CMHPSM is conducting a desk audit of all contracted Prevention Providers for FY 2017. Audit submissions are due to the CMHPSM on March 3, 2017. At that time, the Prevention Coordinators will review and score submitted information and will require Corrective Action Plans from those out of compliance.

Notes:

EBI Evidence-based Intervention
MPDS Michigan Prevention Data System

For additional information and examples of monitoring tools, please see the ***CMHPSM Substance Abuse Prevention Monitoring Procedures*** (booklet).

CMHPSM REGIONAL ANALYSIS

RECOVERY SELF ASSESSMENT SURVEY

2016-17 RECOVERY SELF ASSESSMENT SURVEY

The Recovery Self-Assessment (RSA) is a 36-item measure designed to gauge the degree to which programs implement recovery-oriented practices. The survey was conducted in 2015 as part of the requirements of the Application for Participation (AFP) when the CMHPSM was designated as the PIHP. It is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care The RSA contains concrete, operational items to help program staff, persons in recovery, and significant others to identify practices in their mental health and addiction agency that facilitate or impede recovery.

The Survey can be aligned by RSA Subscales:

- Life Goals (how the system encourages clients to pursue individual goals and interests)
- Involvement (how the system allows clients to become involved in recovery-oriented programs)
- Diversity of Treatment Options (how the system offers a range of treatment options and styles)
  - Choice (how the system takes into account client preferences and choices during the recovery process)
- Individually-Tailored Services (how the system helps clients tailor their treatment program to their individual needs)

Ratings are on a 5 point Likert scale, with 1 being "strongly disagree" and 5 being "strongly agree".

Regionally, all community mental health service providers and substance use disorder treatment providers completed the survey, each having staff, administrator and client submissions. Analysis will be conducted from cross perspectives. The following is a snapshot of the client responses.

CLIENT RESPONSE		PROVIDER STAFF		ADMINISTRATOR	
2016	580	2016	154	2016	39
2015	683	2015	156	2015	26

	CLIENT	STAFF	ADMINISTRATOR
Lenawee	**23.99%** 137	**9.74%** **15**	**20.51%** **8**
Livingston	**22.42%** 128	**33.12%** **51**	**17.95%** **7**
Monroe	**23.99%** 137	**25.32%** **39**	**17.95%** **7**
Washtenaw	**29.60%** 16	**31.82%** **49**	**43.59%** **17**

CMH Clients vs SUD RESPONSES 2016	
unknown	11
CMH	172
SUD	397

CLIENT RATING OF DOMAINS BY PROVIDERS

	LIFE GOALS	INVOLVE-MENT	TREATMENT DIVERSITY	CLIENT CHOICE	INDIVIDUALLY TAILORED SERVICES
Ann Arbor Treatment Service (Ypsilanti)	4.1	3.9	4	4.4	4.2
Catholic Charities Lenawee	4.2	3.8	4.1	4.3	4.2
Catholic Charities Monroe	4.7	4.3	1.6	4.7	4.9
CSTS	4.3	3.7	4	4.3	4.3
Dawn Farm (Washtenaw)	4.3	4	4.3	4.4	4.4
Home of New Vision (Washtenaw)	4.6	3.7	4.6	4.8	4.8
Key Development Services (Livingston)	4.4	4	4.3	4.6	4.5
awee County Community Mental Health Authority	4.3	4.1	4.2	4.3	4.3
Livingston County Catholic Charities	4.6	4	4.4	4.8	4.7
Livingston County Community Mental Health Authority	4.4	3.7	4.1	4.7	4.6
McCullough-Vargus (Lenawee)	4.3	4.2	4.2	4.4	4.3
Monroe County Community Mental Health Authority	4.2	3.2	3.6	4.4	4.4
Rainbow Center	4	3.8	4	4	4

Salvation Army Harbor Light (Monroe)	3.7	3	3.6	3.8	3.7
The Brighton Center-Livingston County	4	3.4	3.8	4	4
UNKNOWN PROVIDER	4	3.8	4.1	3.9	4.1
TOTAL REGION:	4.3	3.8	3.9	4.4	4.3

Domain Analysis across surveys:

	LIFE GOALS		INVOLVEMENT		TREATMENT DIVERSITY		CHOICE		INDIVIDUALLY TAILORED SERVICES	
	2015	2016	2015	2016	2015	2016	2015	2016	2015	2016
Persons	3.64	4.3	2.76	3.8	3.27	3.9	3.7	4.4	3.77	4.3
Admin	3.87		3.28		3.75		4.1		3.79	
Provider	4.1		*		3.5		3.99		3.8	

*2015 Involvement questions were missing from analysis