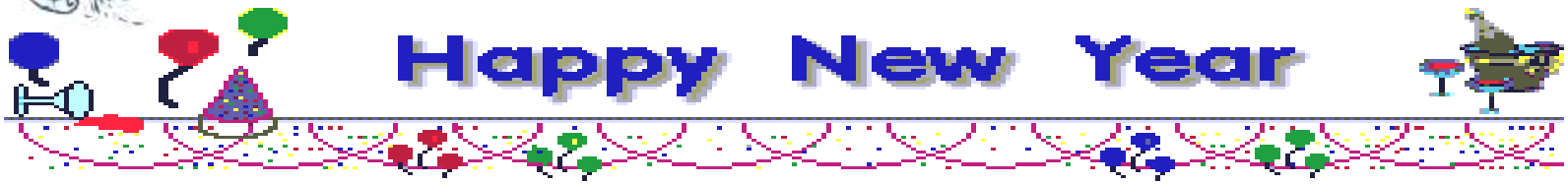
Northeast Michigan Community Mental Health Authority
Board Meetings - January 2018



All meetings are held at the Board's Main Office Board Room located at 400 Johnson St in Alpena unless otherwise noted.

* Meeting held in the Administrative Conference Room

- Board Meeting, Thursday, January 11 @ 3:00 p.m.
- Recipient Rights Advisory Committee*, Wednesday, January 17 @ 3:15 p.m.

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD

BOARD MEETING

January 11, 2018 at 3:00 p.m.

A G E N D A

I. Call to Order

II. Roll Call & Determination of a Quorum

III. Pledge of Allegiance

IV. Appointment of Evaluator

V. Information and/or Comments from the Public

VI. Approval of Minutes..... (See pages 1-5)

VII. Educational Session – ..... (To Be Determined)

VIII. Consent Agenda..... (See page 6)
1. **Contracts**
   a. **Blue Horizons Management Agreement**
2. **Grant Application**
   a. **Community Foundation for Northeast Michigan – Home Based Grant Award**
   b. **Federal Block Grant Application for Peer Health Coaches**

IX. January Monitoring Reports
1. **Budgeting – 01-004 ....(Available at the Meeting)**
2. **Emergency Executive Succession 01-006... ..... (See page 7)**

X. Board Policies Review and Self Evaluation
1. **Emergency Executive Succession 01-006... [Review] ..... (See page 8)**
2. **Chief Executive Role 03-001..... [Review & Self Evaluation]..... (See page 9)**

XI. Linkage Reports
1. **CMHAM**
   a. **Winter Conference (Feb 6 & 7 – Radisson Hotel Kalamazoo).....(Verbal)**
2. **Northern Michigan Regional Entity**
   a. **December 28th Board Meeting Report.....(Verbal Report)**

XII. Chair's Report
1. **By-Law Review .... (See pages 10-21)**

XIII. Director's Report.....(Verbal)
1. **QI Council Update..... .....(Available at the Meeting)**

XIV. Information and/or Comments from the Public

XV. Next Meeting – Thursday, February 8 at 3:00 p.m.
1. **Set February Agenda..... ..... (See page 22)**
2. **Meeting Evaluation ....All**

XVI. Adjournment

MISSION STATEMENT

To provide comprehensive services and supports that enable people to live and work independently.

Northeast Michigan Community Mental Health Authority Board

Board Meeting

December 14, 2017

I. Call to Order

Chair Gary Nowak called the meeting to order in the Board Room at 3:00 p.m.

II. Roll Call and Determination of a Quorum

Present: Lester Buza, Bonnie Cornelius, Steve Dean, Alan Fischer, Roger Frye, Judy Hutchins, Judy Jones, Albert LaFleche, Terry Larson, Eric Lawson, Gary Nowak,

Absent: Pat Przeslawski (excused)

Staff & Guests: Dennis Bannon, Carolyn Bruning, Lee Ann Bushey, Cheryl Jaworowski, Cathy Meske, Nena Sork, Peggy Yachasz

III. Pledge of Allegiance

Attendees recited the Pledge of Allegiance as a group.

IV. Appointment of Evaluator

Gary Nowak appointed Terry Larson as evaluator for this meeting.

V. Information and/or Comments from the Public

There was no information or comments presented.

VI. Educational Session – Bylaw Review

This month Board members reviewed the current bylaws. Gary Nowak noted the reference to the "Boards Officer Nominating Committee" indicates the Board or Executive Committee appoints members for this; however, the Chair has been appointing committee members. Language will be revised to indicate the Board Chair will make a recommendation to the Board for approval of members to this Committee. Concerns were raised as to whether current officers should be allowed to serve on this committee and consensus was this would not be an issue.

The agenda items for regular meetings was discussed. The Medical Director's Report (if any) will be changed to the Operation's Report (if any). This will include information which was previously reported under a Clinical Services and Supports Report. Board members will be provided with information as to number of individuals served breaking down by county if desired, numbers served by populations groups, etc. Nena Sork noted Majestic is able to provide much information. The Clinical Services and Supports Report had been discontinued due to unreliable reporting of the various statistics due to the report writing complexity.

Board members questioned if the second paragraph of Article VI, Section 8. Decorum during Debate was necessary. Gary Nowak suggested this paragraph remain as this does provide the Chair with direction should there be a disorderly individual in attendance.

Article VII – Committees – language will be removed in parentheses to eliminate the reference of the appointment of the Board Officers Nominating Committee as the Board Chair has been recommending Committee appointment.

Article IX, Section 2. Rules of Order – language will be revised to indicate Robert's Rules of Order will be a "guideline" versus the "authority" for all matters.

Article IX, Section 8. Assurances – the discrimination list was reviewed with questions about the "record of arrest without conviction" being identified as something the Board or Authority would not discriminate against. Cathy Meske noted the charges and history of an individual would need to be reviewed. Eric Lawson reported "deferred adjudication" is sometimes used to plea bargain down to a less severe charge. Christine Taylor will be consulted to determine the appropriateness of this non-discrimination mandate.

VII. Approval of Minutes

Moved by Albert LaFleche, supported by Roger Frye to approve the minutes of the November 9, 2017 minutes as presented. Motion carried.

VIII. Consent Agenda

1. **Contracts**
   a. **NASPO ValuePoint (formerly WSCA)**
   b. **North Country – Software Hosting and Support Agreement**
   c. **Tunstall Agreement**
   d. **Partners in Prevention**
      i. **Children's Friendship Services**
      ii. **Mental Health First Aid Training**
      iii. **Trauma Training Project and Suicide Prevention Education**
      iv. **Public Safety Mental Health Certification**
      v. **Caring for Children Who Experience Trauma**

2. **Grant Applications**
   a. **Block Grant Application for PSR (Psychosocial Rehabilitation)**

Moved by Eric Lawson, supported by Steve Dean, to approve the Consent Agenda. Roll Call Vote: Ayes: Lester Buza, Bonnie Cornelius, Steve Dean, Alan Fischer, Roger Frye, Judy Hutchins, Judy Jones, Albert LaFleche, Terry Larson, Eric Lawson, Gary Nowak; Nays: None; Absent: Pat Przeslawski. Motion carried.

IX. December Monitoring Reports

1. Budgeting 01-004

Cheryl Jaworowski reviewed the Statement of Expense and Revenues for month ending October 31, 2017 noting this is a very preliminary report. She highlighted the line items with the largest variances. The variance in the Private Contracts is related to the MC3 grant staffing vacancy. Contracted Inpatient is over budget. Board Travel/Education expenses are timing issues due to the Fall Conference. Most line items over budget are due to timing issues.

Cheryl Jaworowski reported with these preliminary numbers Medicaid and Healthy Michigan Funds are over budget and General Funds are under budget. The Medicaid and Healthy Michigan funds will be cost settled with the NMRE and are hoping to receive some excess dollars they have in reserve.

2. Grants or Contracts 01-011

Cathy Meske provided Board members with a review of the Grants or Contracts monitoring report. Last year the Board revised the policy slightly resulting in the addition items related to grants and emergency approval of contracts. This monitoring report addresses those new additions under #6 and #7.

Moved by Steve Dean, supported by Judy Hutchins, to accept the December monitoring reports as presented. Motion carried.

X. Board Policy Review and Self Evaluation

1. Grants or Contracts 01-011

Board members reviewed this policy and had no recommended changes. Each bulleted item of the policy was included in the monitoring report just provided.

2. Board Member Recognition 02-011

Board members had no comments regarding this policy. The 20-year "appropriate" gift is a monetary gift based on years of service similar to that of agency staff.

3. Board Member Orientation 02-015

Board members had no comments regarding this policy.

XI. Linkage Reports

1. CMHAM

Section 298

Cathy Meske reported the Department is actively encouraging Boards to step up and volunteer to be a pilot for 298. She reports Boards are reluctant to volunteer as they don't know what impact it would have on funding. She reports there will be a meeting in Cadillac with Senator Darwin Booher and other legislative members from northern Michigan to address concerns related to the pilot.

Judy Hutchins inquired as to what happened with the dual eligible project. Cathy Meske reported our Board is not in the pilot program.

2. Northern Michigan Regional Entity (NMRE)

a. Board Meeting November 22, 2017

The minutes for this meeting is a handout today. Roger Frye reported there is a new Veteran's Navigator, Brian Martinus. Cathy Meske reported Brian will be providing this Board with an educational presentation in the future. Gary Nowak reported this Board had written a letter to CMHAM suggesting the elimination of the Winter Conference and instead provide regional opportunities. Cathy Meske reported Members Services Committee will be looking at the recommendations. She noted Member Services is also looking at a new location in Novi to host the Winter Conference rather than in Dearborn.

Cathy Meske noted concern based on the minutes of the November 22nd meeting related to the "Dedicated and Reliable SUD Funding" where a portion of the liquor tax (4%) would be used to fund SUD services. This would mean 4% of each county's current liquor tax allocation would be redirected with no guarantee those dollars would actually flow back into those counties. Further clarification will be requested during the next NMRE Board Meeting.

b. Board Meeting October 25, 2017

This meeting was reported on last month; however, the hard copy of the minutes was not available. The minutes were included in the packet for this meeting.

3. Consumer Advisory Council

The minutes of the most recent meeting held on Monday were reviewed with no comments.

XII. Chair's Report

The December meeting's Chair's report traditionally is a review of the by-laws, which was handled as the Educational Session addressed earlier in this meeting.

XIII. Director's Report

1. Director's Report Items

A. Operation's Report

Cathy Meske noted Nena Sork and she had been discussing bringing back a form of the Clinical Services and Support report and discussed other items which may interest Board members. Nena Sork provided Board members with data which could be included in a monthly report to the Board. Currently there are 1,559 active consumers currently served. In October staff provided 1,245 services and in November 1,071 services. The agency serves 1,220 individuals with an SMI diagnosis and 339 with an I/DD diagnosis. There were 268 Access appointment or phone calls between October and November. Access staff received 152 phone calls in October and 142 in November (294 total) with 26 persons were referred elsewhere. Crisis services for October included 135 services (87 were walk- ins, 48 hospitalization needs) and in November 93 services (65 were walk- ins, 28 hospital prescreens).

The Agency currently has two individuals in the state hospital and is actively working to get one transitioned out back to the community.

The ACT program has 33 participants. Nena notes the Agency is trying to increase capacity in ACT now that it is fully staffed. Nena reports the Agency is also trying to blend more services so capacity is evened out. Case Managers may serve those individuals with a SMI and also an I/DD diagnosis.

Nena Sork provided some information on how a crisis appointment might occur.

Steve Dean inquired as to how the caseloads compare. Some individuals may require contact daily and others require less frequent contacts. ACT generally makes contacts daily.

Cathy Meske reported there could be reports broken down by county as well. She requested if Board members have any particular report request, please get that information to her. Cathy Meske noted when she attends the Commissioners meetings annually, she does stress the number of individuals served in that county, etc.

Bonnie Cornelius inquired as to whether this time of year is more intense than other. Cathy Meske noted October and April have traditionally been the peak service months.

B. MIPAD (Michigan Inpatient Psychiatric Admissions Discussion) Update

The recommendations for the Continuum of Care Sub-Workgroup and the recommendations from the project workgroup were included in the mailing. Cathy Meske reports this was focused on inpatient beds and the availability. During the project it was identified that hospitals are only at 60% capacity at any given time. The other 40% beds sit idle due to staffing issues, patient census and their treatment needs and their medical health needs, etc. Recommendations were submitted and it is hoped these issues will be resolved over a two year timeframe.

C. DABs (Disabled, Aged and Blind) and TANF (Temporary Assistance for Needy Families) Migration

Cathy Meske reported individuals on Medicaid annually complete a recertification process. The State of Michigan did an upgrade to their system and the new software assigns a class of Medicaid to the individual based on some responses made during the recertification process not based on what their current class was. She noted this is affecting the funding received by the agency as the new system automatically determines Healthy Michigan as their class of Medicaid when it should be DAB. Cathy Meske notes the minutes from the NMRE addressed this same

issue. Cathy reported next month she will get the rates for DABs and Healthy Michigan to let Board members know the impact this has on our funding.

D. Grant Approval

Cathy Meske informed Board members the Autism Grant for $895 submitted to the Community Foundation for Northeast Michigan was approved. This grant will provide supplies for the autism program.

E. CARO Hospital

Cathy Meske reported at the recent Director's Forum meeting, Directors were informed the new state facility hospital will be built on the grounds of the current CARO facility.

2. QI Council Update

The minutes from the last meeting were included in the mailing. Board members had no questions. Cathy Meske notes Lynne Fredlund is really keeping the agency informed on Risk and CARF to assure compliance is maintained.

XIV. Information and/or Comments from the Public

Diane Hayka informed Board members of the receipt from Montmorency County of the reappointment of Albert LaFleche beginning a three-year term April 1, 2018. Cathy Meske noted the Strategic Plan booklet was distributed in final format to Board members.

XV. Next Meeting

The next regularly scheduled meeting of Northeast Michigan Community Mental Health Authority Board will be held Thursday, January 11, 2018 at 3:00 p.m.

1. Set January Agenda

The January agenda items were reviewed.

XVI. Evaluation of Meeting

Terry Larson reported this was a good meeting and started on time. Bonnie made wonderful cookies. Going through the by-laws as a group was a good exercise.

XVII. Adjournment

Moved by Bonnie Cornelius, supported by Albert LaFleche, to adjourn the meeting. Motion carried. This meeting adjourned at 4:08 p.m.

_____

Alan Fischer, Secretary

_____

Gary Nowak, Chair

Diane Hayka
Recorder

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Cathy Meske

SUBJECT: Consent Agenda

DATE: December 27, 2017

1. **Contract Approvals**
   a. **Blue Horizons Management Agreement**
   This is the continuation of the Blue Horizons Management Agreement. The total contract is $18,318.00. This includes a $360.00 (2%) increase from the contract amount last year. Previously the monthly payment was $1,496.50 per month, this year the monthly payment will be $1,526.50 per month. This is the amount the Blue Horizons Board will pay our Agency to manage the services provided at that home. We recommend approval.

2. **Grant Applications**
   a. **Community Foundation for Northeast Michigan**
   In September the Board was informed of an application submitted to the Community Foundation for Northeast Michigan by our Home Based Services Program. We have been notified the grant was awarded. This grant will provide funding for some additional supplies for the Children's Program. The grant would also provide funding for activity fees and materials such as Cobby Goose Art Studio, Bowling Alley and art supplies. The total amount of the award is $500.

   b. **Federal Block Grant Application for Peer Health Coaches**
   This is notification of the Agency's application for a FY19 Adult Block Grant for development and use of peers as Health Coaches to support integrated behavioral and physical health care. The grant would cover the appropriate training of peers so they can be placed in an integrated care setting to provide services and support medical staff in providing services to those with a serious mental health and/or co-occurring disorder. This grant could also include peer-driven efforts to address tobacco cessation among the target population. We recommend support of this application for funding. This grant must be submitted to the Department by Monday, February 5.

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Two Months Ending November 30, 2017
16.7% of year elapsed

		Actual November Year to Date	Budget November Year to Date	Variance November Year to Date	Budget FY18	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 21,105	$ 20,816	$ 289	124,646	16.9%
2	Private Contracts	2,993	9,681	(6,688)	57,967	5.2%
3	Grants from Local Units	46,734	44,529	2,205	266,638	17.5%
4	Interest Income	1,208	1,219	(11)	7,300	16.5%
5	Medicaid Revenue	4,002,934	3,865,838	137,096	23,148,729	17.3%
6	General Fund Revenue	139,736	118,551	21,185	709,887	19.7%
7	Healthy Michigan Revenue	271,942	222,166	49,776	1,330,338	20.4%
8	3rd Party Revenue	42,000	38,517	3,483	230,643	18.2%
9	SSI/SSA Revenue	81,456	81,619	(163)	488,736	16.7%
10	Other Revenue	10,758	9,663	1,095	57,864	18.6%
11	**Total Revenue**	**4,620,866**	**4,412,599**	**208,267**	**26,422,748**	**17.5%**
	Expense					
12	Salaries	2,123,968	2,203,940	79,971	13,197,243	16.1%
13	Social Security Tax	94,183	107,159	12,975	641,669	14.7%
14	Self Insured Benefits	423,217	487,460	64,243	2,918,919	14.5%
15	Life and Disability Insurances	35,704	38,516	2,812	230,633	15.5%
16	Pension	166,082	175,038	8,957	1,048,135	15.8%
17	Unemployment & Workers Comp.	36,721	43,096	6,375	258,058	14.2%
18	Office Supplies & Postage	4,540	9,454	4,914	56,610	8.0%
19	Staff Recruiting & Development	19,507	18,903	(605)	113,190	17.2%
20	Community Relations/Education	327	536	209	3,210	10.2%
21	Employee Relations/Wellness	27,324	11,694	(15,630)	70,021	39.0%
22	Program Supplies	60,187	82,652	22,465	494,925	12.2%
23	Contract Inpatient	153,129	166,332	13,203	996,000	15.4%
24	Contract Transportation	20,008	17,427	(2,580)	104,356	19.2%
25	Contract Residential	748,954	798,821	49,867	4,783,361	15.7%
26	Contract Employees & Services	397,726	421,094	23,368	2,521,524	15.8%
27	Telephone & Connectivity	16,533	22,029	5,496	131,912	12.5%
28	Staff Meals & Lodging	2,843	7,658	4,815	45,857	6.2%
29	Mileage and Gasoline	75,647	73,944	(1,702)	442,780	17.1%
30	Board Travel/Education	4,922	2,441	(2,481)	14,616	33.7%
31	Professional Fees	4,699	9,050	4,352	54,194	8.7%
32	Property & Liability Insurance	17,355	8,945	(8,409)	53,563	32.4%
33	Utilities	27,407	34,251	6,844	205,096	13.4%
34	Maintenance	36,737	41,858	5,121	250,650	14.7%
35	Rent	44,042	44,029	(12)	263,649	16.7%
36	Food (net of food stamps)	10,398	15,670	5,272	93,834	11.1%
37	Capital Equipment	788	7,949	7,161	47,600	1.7%
38	Client Equipment	871	3,503	2,633	20,978	4.2%
39	Miscellaneous Expense	7,969	16,211	8,241	97,071	8.2%
40	Depreciation Expense	48,261	45,626	(2,635)	273,212	17.7%
41	Budget Adjustment	-	(502,689)	(502,689)	(3,010,115)	0.0%
42	**Total Expense**	**4,610,049**	**4,412,599**	**(197,450)**	**26,422,748**	**17.4%**
43	**Change in Net Position**	**$ 10,817**	**$ (0)**	**$ 10,817**	**$ (0)**	**0.0%**
	Contract settlement items included above:					
44	Medicaid Funds Over Spent	186,281				
45	General Funds Under Spent	(1,476)				
46	Healthy Michigan Funds Over Spent	(63,652)				

Rates Paid

Funding Group	Fund Source	Code Group	Age Group	Payment Month	M	F
HMP						
	HMP_MH					
		HMP	19 - 20	201712	$27.26	$17.77
		HMP	21 - 25	201712	$29.56	$17.77
		HMP	26 - 39	201712	$31.20	$20.61
		HMP	40 - 49	201712	$31.10	$26.84
		HMP	50 - 64	201712	$26.76	$21.94
	HMP_SA					
MACap						
	MHB3					
		DAB	0 - 5	201712	$11.03	$6.94
		DAB	06 - 18	201712	$18.16	$12.99
		DAB	19 - 20	201712	$16.79	$15.25
		DAB	21 - 25	201712	$314.19	$263.93
		DAB	26 - 39	201712	$363.94	$268.97
		DAB	40 - 49	201712	$227.64	$150.86
		DAB	50 - 64	201712	$173.46	$115.81
		DAB	65+	201712	$85.36	$45.95
		TANF	0 - 5	201712	$0.75	$0.57
		TANF	06 - 18	201712	$1.30	$0.70
		TANF	19 - 20	201712	$0.73	$0.76
		TANF	21 - 25	201712	$0.57	$1.62
		TANF	26 - 39	201712	$0.66	$1.52
		TANF	40 - 49	201712	$0.79	$1.86
		TANF	50 - 64	201712	$0.98	$1.42
		TANF	65+	201712	$0.04	$0.14
	MHSP					
		DAB	0 - 5	201712	$89.25	$51.92
		DAB	06 - 18	201712	$156.98	$127.89
		DAB	19 - 20	201712	$262.97	$215.28
		DAB	21 - 25	201712	$262.97	$215.28
		DAB	26 - 39	201712	$208.11	$170.90
		DAB	40 - 49	201712	$202.60	$160.47
		DAB	50 - 64	201712	$173.88	$134.77
		DAB	65+	201712	$72.32	$45.41
		TANF	0 - 5	201712	$9.96	$5.55

Funding Group	Fund Source	Code Group	Age Group	Payment Month	M	F
		TANF	06 - 18	201712	$31.32	$26.80
		TANF	19 - 20	201712	$19.36	$17.81
		TANF	21 - 25	201712	$12.01	$17.81
		TANF	26 - 39	201712	$12.53	$19.42
		TANF	40 - 49	201712	$13.45	$23.04
		TANF	50 - 64	201712	$10.68	$18.12
		TANF	65+	201712	$0.99	$8.49
	SAB3					
	SASP					

PREPAID INPATIENT HEALTH PLAN
REVENUE ANALYSIS
DISABLED, AGED, BLIND

November 29, 2017

FISCAL YEARS
2016-2017

Rehmann
Business wisdom delivered.

PREPAID INPATIENT HEALTH PLANS

REVENUE ANALYSIS - DISABLED, AGED, BLIND

Methodology

Purpose

The purpose of this analysis was to identify migration from the Disabled, Aged, and Blind (DAB) population to the Temporary Assistance for Needy Families (TANF) and Healthy Michigan Plan (HMP) populations, and to quantify the impact to the Prepaid Inpatient Health Plan (PIHP) system as a result of this migration. Results are quantified in terms of unique consumers, member months (MM), and dollars.

Limitations

This analysis was performed exclusively on data as reflected in the payment files received by the PIHPs from the Michigan Department of Health and Human Services (MDHHS) and provided to Rehmann from the PIHPs.

Completeness

A cursory review of payments was performed to gain confidence that files or months were not excluded. Incomplete TANF payment data would increase the member months and dollars identified in the analysis.

Assumptions

Receipt of payment - it is assumed that payment received by the PIHP under one of the DAB program codes represents an accurate reflection of eligibility of the individual for that month.

Payment retraction - it is assumed that payment retractions are for a bonafide reason and do not represent an underlying payment error.

Loss of eligibility - it is assumed that once identified as DAB the individual should not arbitrarily lose that status (i.e. it is difficult to no longer be disabled, aged, or blind once qualified for that status).

Payment amount accuracy - it is assumed that the payment amounts for each individual and month is an accurate calculation of the Per Eligible Per Month (PEPM) based on the individual's demographics and the actuarially determined rates.

Conservative Nature of Analysis

This analysis only captures situations where a payment was received for a medicaid eligible individual in either a TANF or HMP program code after the same individual was identified as DAB eligible (by receiving a DAB payment). It is possible that there are months with no payment received in any category but a DAB payment should have been received. In this instance the number of member months and dollars in the analysis would increase.

Program Q (Medicaid for persons under age 21) was excluded as movement from DAB to TANF can be considered normal as individuals age out of this category. Additional analysis might find some erroneous migration that would increase the number of member months and the dollars that should have been paid as DAB.

PREPAID INPATIENT HEALTH PLANS

REVENUE ANALYSIS - DISABLED, AGED, BLIND

Results

		State-Wide
Fiscal Year 2016		
Member Months paid as Disable, Aged, or Blind (DAB)		5,407,627
DAB eligibles paid as Temporary Assistance for Needy Families (TANF) or Health Michigan Plan (HMP)		27,008
Member Months for DAB eligibles paid as TANF or HMP		91,803
Percent Member Months erroneously classified		1.70%
Funds received for DABs as TANF/HMP	$	2,257,406
Funds that should have been received for DABs		28,802,409
Funding impact of erroneous classification	$	26,545,003
Fiscal Year 2017		
Member Months paid as Disable, Aged, or Blind (DAB)		5,282,393
DAB eligibles paid as Temporary Assistance for Needy Families (TANF) or Health Michigan Plan (HMP)		41,775
Member Months for DAB eligibles paid as TANF/HMP		240,935
Percent Member Months erroneously classified		4.56%
Funds received for DABs as TANF/HMP	$	9,120,112
Funds that should have been received for DABs		80,172,445
Funding impact of erroneous classification	$	71,052,333
Combined Impact of Migration	$	97,597,336

Note

These numbers include an estimate for Macomb County as a full analysis of Macomb's payment data has not yet been completed.

Community Mental Health Association of Michigan

Internal Service Fund History, by PIHP, FY 2014 - 2017

December 2017

	Statewide Total		
Medicaid	**ISF at year end**	**Medicaid revenue**	**ISF as % of revenue +**
Medicaid FY 14 *	$148,692,692	*	*
Medicaid FY 15	$151,605,043	$2,480,135,348	6.11%
Medicaid FY 16	$152,616,759	$2,631,766,962	5.80%
Medicaid FY 17 **	$119,301,922	$2,631,766,962	4.53%
Healthy Michigan Plan (HMP)	**ISF at year end**	**HMP revenue**	**ISF as % of revenue +**
HMP FY 14 *	$6,308,397	*	*
HMP FY 15	$21,021,625	$345,080,276	6.09%
HMP FY 16	$18,849,967	$340,634,450	5.53%
HMP FY 17 **	$14,957,478	$340,634,450	4.39%

	Statewide total- Medicaid and HMP		
Total: Medicaid and Healthy Michigan Plan (HMP)	**ISF at year end**	**Medicaid and HMP revenue**	**Total ISF (Medicaid and HMP) at year end +**
FY 14 *	**$155,001,089**	*	*
FY15	**$172,626,668**	**$2,825,215,624**	**6.11%**
FY 16	**$171,466,726**	**$2,972,401,412**	**5.77%**
FY 17 **	**$134,259,400**	**$2,972,401,412**	**4.52%**

Notes:

*** Fiscal Year 2014 was a partial fiscal year for the new PIHPs and HMP, so annual revenues are not contained in this analysis.**

**** Fiscal Year 2017 ISF drawn from preliminary close out; FY 2017 revenues reflect FY 16 revenues, given that the FY 17 close out has not, as yet, been completed.**

+ The maximum total ISF (Medicaid and HMP) that a PIHP can hold is 7.5% of annual gross revenue for both Medicaid and HMP.

POLICY CATEGORY: Executive Limitations
POLICY TITLE AND NUMBER: Emergency Executive Succession
REPORT FREQUENCY & DUE DATE: Annual, January 2018

POLICY STATEMENT:
In order to protect the board from sudden loss of chief executive services, the CEO may not have less than one other executive familiar with board and chief executive issues and processes.

- **Interpretation**
  I interpret the policy to require plans to address two possible scenarios: 1) the temporary assumption of the CEO's responsibilities during, for example, a brief period of illness, and 2) the assumption of these responsibilities if the CEO's position were to be suddenly vacated.
- **Status**
  "Scenario 1"In the event of a temporary absence there should not be a significant problem with the current administrative staffing available at the agency. The leadership team, our program managers and clinical staff are competent and capable of managing services on a day-to-day basis.

  In "Scenario 2" situations, Nena Sork (Chief Operations Officer) is well-qualified to step in as interim director while the Board considered its options. Ms. Sork in fact would make fine CEO as a permanent replacement with an abundance of experience and history with this organization and the private sector. With many long standing members of the Administrative Team, I am confident the operations would not be adversely impacted, under Ms. Sork's guidance.

SUMMARY:
With the continuing pressure from the Department of Health and Human Services to reduce administrative costs, staffing restructuring is currently underway. We are fortunate to have a strong contingent of management staff members, many of whom have been employed for a lengthy period of time, on whom the Board will be able to rely if need be.

Board Review/Comments

Reasonableness Test: Is the interpretation by the CEO reasonable?

Data Test: Is the data provided by the CEO both relative and compelling?

Fine-tuning the Policy: Does this report suggest further study and refinement of the policy?

Other Implications: Does this report suggest the other policies may be necessary?

EXECUTIVE LIMITATIONS
(Manual Section)

EMERGENCY EXECUTIVE SUCCESSION
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved	July 13, 2006

●1 POLICY:

In order to protect the board from sudden loss of chief executive services, the CEO may not have less than one other executive familiar with board and chief executive issues and processes.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

BOARD STAFF RELATIONSHIP
(Manual Section)

CHIEF EXECUTIVE ROLE
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision to Policy Approved by Board:	January 11, 2007

●1 POLICY:

The CEO is accountable to the board acting as a body. The board will instruct the CEO through written policies, delegating to him or her interpretation and implementation of those policies.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM, DECEMBER 27, 2017
CROSS STREET CONFERENCE ROOM, GAYLORD

Board Members in Attendance:	**Roger Frye, Ed Ginop, Annie Hooghart, Randy Kamps, Terry Larson, Gary Nowak, Jay O'Farrell, Karla Sherman, Joe Stone, Don Tanner, Nina Zamora**
Board Members Absent:	**Carol Crawford, Gary Klacking, Dennis Priess, Richard Schmidt**
Staff in Attendance:	**Carol Balousek, Christine Gebhard, Sandy Kintz, Karl Kovacs, Eric Kurtz, Mary Marlatt-Dumas, Brian Martinus, Diane Pelts, Sara Sircely, Dee Whittaker, Deanna Yockey**
Public in Attendance:	**Heather Diggs, Scott Smith**

CALL TO ORDER

At 10:04AM, Mr. Kamps acknowledged that a quorum was not present. He provided additional time for Board Members to arrive considering the poor driving conditions. A quorum was present and Mr. Kamps called the meeting to order at 10:11AM.

ROLL CALL

Let the record show that Carol Crawford, Gary Klacking, Dennis Priess, and Richard Schmidt were absent with notice for the meeting on this date. All other NMRE Board Members were in attendance.

PLEDGE OF ALLEGIANCE

Let the record show that the Pledge of Allegiance was recited as a group.

ACKNOWLEDGMENT OF CONFLICT OF INTEREST

Let the record show that no conflicts of interest were expressed with any of the meeting agenda items.

APPROVAL OF PAST MINUTES

The minutes from the November Board meeting were included in the materials for the meeting on this date.

MOTION MADE BY GARY NOWAK TO APPROVE THE MINUTES OF THE NOVEMBER 22, 2017 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, SECOND BY JOE STONE. MOTION CARRIED.

APPROVAL OF AGENDA

No additions or changes were proposed to the agenda for the meeting on this date.

MOTION MADE BY ROGER FRYE TO APPROVE THE AGENDA FOR THE DECEMBER 27, 2017 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, SECOND BY GARY NOWAK. MOTION CARRIED.

CORRESPONDENCE

- The minutes of the December 7, 2017 PIHP CEOs meeting.
- A memorandum dated December 14, 2017 from Tom Renwick, Bureau of Community Based Services, Michigan Department of Health and Human Services (MDHHS), regarding the $0.50 Direct Care Wage increase.
- A letter dated December 20, 2017 to Eric Kurtz from Jeffery Wieferich (MDHHS) approving the application for Child Crisis Residential Services (SafeHaus) from AuSable Valley Community Mental Health.
- An email from Bob Sheehan Community Mental Health Association of Michigan (CMHAM) listing core elements that the Association is urging be included in the RFI for 298 pilots.

Mr. Kurtz said he will discuss the correspondence in more detail under his CEO Report.

ANNOUNCEMENTS

Mr. Kamps thanked Board Members for braving the severe weather conditions.

PUBLIC COMMENTS

Let the record show that no comments were made from the public during the meeting on this date.

REPORTS

Board Chair Report/Executive Committee

Let the record show that no Executive Committee meetings have occurred, and no report was given on this date.

CEO's Report

The NMRE CEO's report for December was included in the materials for the meeting on this date. Mr. Kurtz expressed he consulted with Region 1 (NorthCare Network) about bolstering psychiatric inpatient hospital capacity. A lot of time was put into the MiPAD Committees formed to address the bed shortage. During discussion at the recent Directors Forum, the responsibility was directed back to the PIHPs. Mr. Kurtz and NorthCare CEO, Bill Slavin, met December 18th to consider options. A meeting with War Memorial was scheduled for December 29th to discuss the willingness of providers to expand services.

Mr. Kurtz had a teleconference December 20th with MDHHS Autism staff regarding lack the of quality providers. Some ideas were bought forward. Information will follow as it becomes available. Ms. Sherman asked to quantify how much we're lacking. Mr. Kurtz expressed he was not sure off hand, but likely 100 or so. He noted there is a gap everywhere in the state but bigger in the rural counties. Mr. Kovacs noted the waiting list due to a lack of providers and the inability to establish a "Center" like they can downstate. Ms. Gebhard added that Centria has not delivered as promised. Mr. Kamps asked what the obstacle is. Ms. Gebhard answered talent and training, adding the CMHSPs ould be open to all providers. The state rolled out the benefit without the workforce in place. It was recognized that the model has a very rigid approach.

Mr. Kurtz discussed the memorandum from Tom Renwick on the $0.50/hour increase for direct care workers. The NMRE will be gathering the attestations due to the Department February 1, 2018. Mr.

Tanner noted not all providers are participating. Mr. Kurtz stated he has instructed staff to thoroughly document efforts to comply.

Mr. Kurtz stated that confirmation was received from Jeffery Wieferich approving the Child Crisis Residential Program (SafeHaus) submitted by AuSable Valley CMH.

Mr. Kovacs referenced the December 7th PIHP CEO meeting minutes regarding the DAB/TANF issue. Milliman has maintained that the rates remained actuarily sound. The aggregate impact to PIHPs was reported as $21M for FY16 and $71 for FY17. MDHHS will continue to involve Milliman evaluate the issue to determine whether it continues to grow.

Mr. Kamps asked for an update on the 1115 Waiver and the status of 298. Mr. Kurtz clarified that the delay in approving the 1115 waiver is also delaying the 298 process. The start date for the pilots has been pushed to July 1, 2018, and may be pushed again to October 1st. MDHHS is working to move the 76 policy recommendations from the 298 workgroups forward.

Financial Reports

Mr. Kurtz reported there is no report this month; October and November will be reviewed in January. Mr. Kurtz introduced Deanna Yockey to the Board. Ms. Yockey returned to the NMRE in December as Chief Financial Officer. The relationship with Rehmann will continue through the fiscal year.

NEW BUSINESS

NMRE/NCCMH Lease

Mr. Kurtz stated the agreement for FY18 is being brought forward for transparency. Action is needed on this date to move forward. Mr. Kurtz requested approval for one year, as the Operations Committee has requested NMRE do its due diligence regarding space and hiring.

MOTION MADE BY KARLA SHERMAN TO APPROVE THE EMPLOYEE, SPACE, AND SUPPORT SERVICES LEASE AGREEMENT BETWEEN THE NORTHERN MICHIGAN REGIONAL ENTITY AND NORTH COUNTRY COMMUNITY MENTAL HEALTH FOR FISCAL YEAR 2018, AS REVIEWED ON THIS DATE; SECOND BY ANNIE HOOGHART.

Discussion: Don Tanner asked about the open positions indicated on Attachment A; Mr. Kurtz responded that several have been filled. Gary Nowak asked about the total amount of the lease last year. Ms. Gebhard responded she recalled it being around $2.5M. The agreement for the current year is slightly more than last year but not more than is budgeted.

ROLL CALL VOTING TOOK PLACE ON MS. SHERMAN'S MOTION TOOK PLACE AND THE MOTION CARRIED BY UNANIMOUS VOTE.

Afia Data Warehouse Proposal

Mr. Kurtz explained the proposal to jumpstart the data warehouse. The need for consistent, reliable, data was loud and clear from June Planning Session. Mr. Kurtz has a standing relationship with Jeremy Nelson, Afia Founder and Managing Partner. Afia is also working with Northern Lakes CMH on another matter, and is performing this same function for other PIHPs that use PCE. Payment, encounter data, and eligibility data will all be in one place to enable data mining. The cost is a one-time expenditure with no carry over. Mr. Kurtz noted that this would delay the hiring of 1 FTE in the IT Department that was included in the FY18 budget.

MOTION MADE BY JOE STONE TO APPROVE THE PROPOSAL FROM AFIA FOR THE CREATION OF A DATA WAREHOUSE MODEL FOR THE NORTHERN MICHIGAN REGIONAL ENTITY AT A COST NOT TO EXCEED FORTY THOUSAND DOLLARS ($40,000.00); SECOND BY DON TANNER.

Mr. Kamps noted that North Country CMH indicated it intends to develop a warehouse as well and asked whether it makes sense to make this a collaborative effort. Mr. Kurtz noted SUD data is a different category. With this, the NMRE can combine, physical health, mental health, and SUD data to preform analytics. Ms. Gebhard noted the five CMHSPs will benefit from the PIHP effort.
ROLL CALL VOTING TOOK PLACE ON MR. STONE'S MOTION TOOK PLACE AND THE MOTION CARRIED BY UNANIMOUS VOTE.

Third Level
Mr. Kurtz discussed the potential of securing a different provider for after-hours phone answering services. The (Bachelors level) staff at Third Level Crisis Services/Child & Family Services of Northwestern Michigan is not performing crisis interventions. NMRE holds the Third Level contract for North Country CMH, Northeast Michigan CMH, AuSable Valley CMH, and a portion of Northern Lakes CMH. Rik Rambo has spoken with Third Level staff regarding their requested rate increase. NMRE will approve the increase and contract on a month-to-month while putting out an RFP. Mr. Kovacs asked how after hours calls for SUD services are handled. Ms. Sircely clarified that SUD calls are also directed to Third Level (typically referred to detox or the emergency department). Ms. Gebhard asked about the timeline for the RFP. Mr. Kurtz responded he is hopes to get it underway in January.

RFP for IMD
This topic arose out of a discussion with the Operations Committee. The Michigan Inpatient Psychiatric Admission Discussion (MiPAD) workgroups formed several months ago to improve access to inpatient psychiatric services. The findings turned the issue back on the PIHPs. NMRE Operations Committee proposed issuing an RFP or RFI to open an Institute for Mental Disease (essentially an inpatient mental health facility without an attached emergency department) in the northern region. The State would have to issue a certificate of need for the beds. Pine Rest has expressed interest. The beds would be exclusive to Region 2, with the option of opening to Region 1 (NorthCare Network). This would be a significant effort and would likely require the support of the community, law enforcement, etc. Mr. Tanner expressed there might be an opportunity to partner with tribes. Mr. Kurtz will keep the Board updated on the process.

RFI for Managed Care Plan/Partner
Given the current state of 298, and as NMRE moves forward with its Health Home initiatives and SUD Health Home, we should prepare ourselves for the future. There will be a day when the state is going to want to push risk; PIHPs will need a partner unless the insurance law is changed. In some rural states, Accountable Care Organizations are being formed. We could do an RFI as a provider sponsored health plan. Ideally, we would partner with another entity with risk reserves to get ourselves in a position to bid or take on the physical health care for the people we serve. There is a need for back-up plans A, B, and C. Another approach is that the money would stay with the governmental entity. Money needs to stay in the governmental entity's pocket. Mr. Kovacs noted that integration is taking different forms/different experiments. The focus needs to remain on what is best for the consumer. NMRE can

position itself to "control our own destiny," to be ready to be the premier provider for our specialty population. Mr. Kurtz emphasized this conversation is in the exploratory stage at this time.

OLD BUSINESS

SUD Health Home Update

"Michigan's Opioid Health Home Policy Draft – Consultation draft" document was included in the materials for the meeting on this date. The policy calls for the creation of Opioid Health Home services under the Opioid Health home benefit. Mr. Kurtz emphasized this is a unique opportunity for Region 2 PIHP (NMRE). The pilot will require the hiring of a Health Home Director and additional administrative support staff. The target date is July 1, 2018.

PRESENTATION

SUD RFI Results

Ms. Sircely presented on the recent RFI conducted for Substance Use Disorder treatment services. Ms. Sircely explained the goal was to set rates at the PIHP, rather than the current open panel policy. Twenty responses were received. Ms. Sircely distributed a list of recommended rates by service codes. Ms. Sircely expressed NMRE is looking at expanding services, normalizing rates; expectation is to come in close to budget utilizing the new rates. Mr. Kurtz noted one wild card is the SUD Health Home (up to $8M), and another is the expansion of codes and how much they'll be used. Some utilization management is needed with some of the codes. Projecting to be under budget with the caveat of the two areas noted. Mr. Kamps asked whether it is reasonable to assume the rate array will be accepted by providers and we won't lose any. Ms. Sircely responded that she doesn't anticipate too much of an issue. It was noted that NMRE would like to have providers in the future that can deliver the full-service array.

MOTION MADE BY JOE STONE TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER TREATMENT SERVICES RECOMMENDATIONS FROM THE REQUEST FOR INFORMATION AS PRESENTED AND REVIEWED ON THIS DATE; SECOND BY GARY NOWAK. MOTION CARRIED.

COMMENTS

Board

Mr. Stone wished everyone a Merry Christmas and Happy New Year.
Mr. Kamps asked Diane Pelts to pass along the Board's best wishes to Dr. Beck upon his retirement.
Mr. Frye noted he will be in Florida for the February 2018 Board meeting.

Public

Scott Smith from Pine Rest offered to present to the Board in the future.

MEETING DATES

Mr. Kamps suggested the Board not meet in January. Mr. Kurtz will review agenda items and decide if action is needed. Immediate issues could be addressed by the Executive Committee. Mr. Larson suggested the Board begin meeting every other month. Discussion will be placed on the next meeting Agenda. The suggestion was also made to meet via Skype.

ADJOURN

Let the record show that Mr. Kamps adjourned the meeting at 11:37AM.

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

BYLAWS

PREAMBLE[DH1]

Recognizing the responsibility of the Alcona, Alpena, Montmorency, and Presque Isle County Boards of Commissioners to provide suitable mental health services to the above named counties, the boards of commissioners have duly appointed a Community Mental Health Board as a Mental Health Authority according to Public Act 258, 1974, as amended.

Recognizing further the responsibility of this Authority in upholding the best interests of the citizens through concerted effort in providing and maintaining mental health services in accordance with Public Act 258, 1974, as amended, the Northeast Michigan Community Mental Health Authority hereby organizes in conformity with bylaws and regulations herein-stated.

For the purpose of these bylaws, whenever the term "Authority" shall appear, it shall be interpreted to mean the Northeast Michigan Community Mental Health Authority, who shall have authority in the government of the county mental health services for the above-mentioned counties. Whenever the term “Board” shall appear, it shall be interpreted to mean the Board of Directors of the Northeast Michigan Community Mental Health Authority. Whenever the term "Department" is used, it shall be interpreted to mean the Michigan Department of Health and Human Services.

ARTICLE I - NAME

The name of this Board shall be the NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY.

ARTICLE II - MISSION

To provide comprehensive services and supports that enable people to live and work independently.

ARTICLE III - DUTIES

This community mental health authority shall:

A. Examine and evaluate the mental health needs of the counties it represents and the public and nonpublic services necessary to meet those needs.

B. Review and approve an annual plan and budget for the program. (The format and documentation of the annual plan and budget shall be as specified by the Department.)

C. Provide and advertise a public hearing on the annual plan and budget.

D. Submit to each board of commissioners a copy of the Board's needs assessment, annual plan and requests for new State funds.

E. Take such actions as it deems necessary and appropriate to secure private, federal, and other public funds to help support the program.

F. Approve and authorize contracts for services.

G. Review and evaluate the quality, effectiveness, and efficiency of services being provided by the program.

H. Appoint a director of the community mental health program who shall meet standards of training and experience as established by the Department in Administrative Rules.

I. Establish general policy guidelines within which the director shall execute the program.

J. Subject to the provisions of Chapter II of Public Act 258, 1974, as amended, the Authority may enter into contracts for purchase of mental health services with private or public agencies.

   Contracts may be entered into with any facility or entity of the Michigan Department of Health and Human Services with the approval of the Michigan Department of Health and Human Services.

ARTICLE IV- MEMBERSHIP

Section 1. Appointment

The county boards of commissioners of the counties involved, being Alcona, Alpena, Montmorency, and Presque Isle, shall establish a 12-member community mental health

authority board of directors. Each board of commissioners shall appoint the board members from its county.

Section 2. Composition

The composition of the Board shall be as specified in the Mental Health Code, section 222.

Section 3. Terms; Vacancies; Removal of Member

The term of office of a board member shall be three (3) years from April 1 of the year of appointment. Vacancies shall be filled for unexpired terms in the same manner as original appointments. Board members are encouraged to attend all board meetings. If a Board member misses two consecutive meetings without advance notice to the Board Chairperson or his or her designee, a letter from the Board Chairperson will be sent to the board member inquiring about the member's intent to fulfill his or her term of office. If no response is received within 30 days, a second letter will be sent with a copy to the Chairperson of the appointing County Commission. If no response is received within 30 days, a letter will be sent to the Chairperson of the appointing County Commission requesting the removal of the board member according to the requirements of the Mental Health Code, § 224, which states in part: A board member may be removed from office by the appointing board of commissioners for neglect of official duty or misconduct in office.

ARTICLE V - OFFICERS

Section 1. Officers; Election; Term of Office

The officers of this Board shall consist of a Chair, Vice-Chair, and Secretary who shall perform the duties usually pertaining to such offices or as provided by the Board. All officers shall be elected for a term of one year and shall hold office until the next regular election; such election to be held at the April meeting of each year.

The annual election of Board Members to Board Offices shall be conducted in the following manner:

- By the October Meeting prior to the April election, the Chair will recommend to the Board, subject to the approval of the Board, ~~or the Executive Committee shall name~~ a "Board Officers Nominating Committee", a Special Committee of the Board which shall exist for the sole purpose of nominating candidates to fill the positions of the Board's Offices; that Committee shall consist of at least four and no more than six Board Members, preferably one from each county and excluding the Chair.

  The Nominating Committee shall also review the terms of all Board members to identify the need for consumer or consumer representative appointments. The

committee shall attempt to recruit or identify candidates for membership who meet the requirements of Section 222 (1) of the Mental Health Code. These recommendations shall be communicated to the county Boards of Commissioners as necessary by the Board's Chair.

- By the March Meeting, that Committee shall report its recommendations to the Board for its members' consideration prior to the April election meeting.

- During the April Meeting, a slate of candidates for the Board's three offices shall be placed in nomination first by the Nominating Committee, which shall give its report at the call of the Chair.

- Election of the Board's Chair for the next year shall be the first election, and shall be conducted by the current Chair, who shall state the Nominating Committee's nomination, then ask if there are any [further] nominations from the floor; if/when none is heard after *three* such invitations, then the Chair shall declare that nominations are closed and the election may proceed.

- Balloting may be by voice, by show-of-hands or by secret written ballot, as the Board may determine in advance or by its majority vote at any time during the election process; a majority of votes cast shall determine the outcome of the election.

- Following the election of a new Chair (and assuming the current Chair does not succeed to the office), the immediate-past-Chair shall relinquish the chair to the new Chair, who shall conduct the balance of the elections in the same manner.

- Elections then proceed in this order:
  Vice-Chair... then Secretary.

- Newly-elected officers assume their offices immediately upon elections.

- If questions of procedure arise before or during the meeting or elections, the Board shall resolve these questions via reference to its ByLaws, Policies and/or Robert's Rules.

Section 2. Duties

Chair - The Chair shall be the presiding officer at all meetings of the Board; shall be an ex officio member of all committees; shall appoint the Chair of the standing and special committees; shall sign and execute in the name of the Board; shall call meetings of the Board; and shall perform such other duties as are required by the Board.

Vice-Chair - The Vice-Chair, in the event of the incapacity or absence of the Chair, shall assume the duties prescribed to the Chair. In the absence of the Chair from a

meeting of the Board, the meeting shall be called to order by one of the officers of the appointed Board, designated as temporary Chair, in the following order of precedence:

Vice Chair ... then Secretary.

If the Chair does arrive, the temporary Chair shall surrender the chair to him/her.

Secretary - The Secretary or his/her designee shall send appropriate notices and prepare agendas for all meetings of the Board, shall act as custodian of all records and reports, and shall be responsible for the keeping and reporting of adequate records of all meetings of the Board.

Section 3. Additional Officers

The Board may elect or appoint such other officers or agents as it may deem necessary for the transaction of business of the Board, and for terms to expire the same as other officers provided for in these Bylaws.

Section 4. Removal of an Officer

The Board may remove an Officer for just cause by the majority of the Board (7). A member removed from office shall remain a member of the Board unless he or she is removed from the Board by the appointing board of commissioners according to Article IV, Section 3.

Section 5. Replacement of an Officer

Should an Officer be unable to finish their term of office, the Board Chair will appoint a replacement for the position vacated, preferably from the same County to assure equal representation on the Executive Committee. If the appointee rejects the appointment, the Chair will appoint another Board member.

ARTICLE VI - MEETINGS

Section 1. Regular Meetings

The board of directors of Northeast Michigan Community Mental Health Authority shall hold at least twelve regular meetings annually at a time and place to be designated by the Chair of the Board. All meetings of the Board shall be open to the public and shall be held in a place available to the general public. All meetings shall be held in accord with 1976 P.A. Act 267 (the “Open Meetings Act”) and 1976 P.A. 422 (the “Freedom of Information Act”). Within ten days after the April meeting of the Board in each year, the Secretary shall post a public notice stating the dates, times and places of its regular meetings.

If there is a change in the schedule of regular meetings of the Board, there shall be posted within three days after the meeting at which the change is made, a public notice stating the new dates, times, and places of its regular meetings.

Upon written request, at the same time a public notice of meeting is posted, the Secretary shall provide a copy of the public notice of that meeting to any newspaper published in the state and to any radio and television station located in the state, free of charge.

Other requirements pertaining to regular meetings of this Board contained in Public Act 267, 1976 shall be adhered to.

The agenda for regular meetings of the Board may include the following:

Call to Order
Roll Call and Determination of a Quorum
Pledge of Allegiance
Appointment of Evaluator
Information and/or Comments From the Public
Board Training
Approval of Minutes
Consent Agenda
Monitoring Reports
Policy Review, Approval & Self-Evaluation (if any)
Chair's Report
Director's Report
~~Medical Director's~~Operation's Report (if any)
Next Meeting – Setting Agenda
-- Meeting Evaluation
Adjournment

Section 2. Special Meetings

Special meetings of the Board may be called by the Chair or upon written request of any three members of the Board filed with the Secretary or his/her designee. Notices of a special meeting shall be given by one of the following means or as required by the Open Meetings Act:

a. Personal notice by telephone or otherwise to each Board member at least 24 hours before such meeting.

b. Public notice at least eighteen hours before such meeting, stating date, time, and place.

c. As otherwise determined by the Chair.

Each notice of a special meeting shall state the time, place, and purpose thereof.

The agenda for special meetings of the Board may include the following:

Call to Order
Roll Call and Determination of a Quorum
Statement of Purpose of Meeting
Transaction of Business According to Stated Purpose
Adjournment

Section 3. Closed Meetings

A 2/3 majority roll call vote of appointed Board members shall be required to call a closed session, for purposes stated in Section 8, Public Act 267, 1976. The roll call vote and the purpose or purposes for calling the closed meeting shall be entered into the minutes of the meeting at which the vote is taken.

Section 4. Meeting by Remote Communication

A Board member may participate in a meeting by conference telephone or any similar communication equipment through which all persons participating in the meeting can hear each other. Participation in a meeting pursuant to this Section constitutes presence in person at the meeting.

Section 5. Minutes

The Board shall keep minutes of each meeting showing the date, time, place, members present, members absent, any decisions made at a meeting open to the public, and the purpose or purposes for which a closed session is held. The minutes shall include all roll call votes taken at the meeting.

Minutes shall be public records open to public inspection and shall be available at the address designated on posted public notices pursuant to Section 1. Copies of the minutes shall be available to the public at a reasonable estimated cost for printing and copying.

Proposed minutes shall be available for public inspection no later than eight (8) business days after the meeting to which the minutes refer. Approved minutes shall be available for public inspection not later than five (5) business days after the meeting at which the minutes are approved by the Board.

A separate set of minutes shall be taken by the Secretary or his/her designee at the closed meeting; these minutes shall not be available to the public, and shall only be disclosed if required by a civil action filed under Section 10, 11, or 13 of Public Act 267,

1976. These minutes may be destroyed one year and one day after approval of the minutes of the regular meeting at which the closed meeting was approved.

Section 6. Materials to be Furnished Board Members

Insofar as possible, all members of the Board shall be mailed a copy of the proposed agenda and copies of all material to be considered at regular Board meetings in advance of such meetings, unless this requirement shall be waived by unanimous consent of Board members present at any regular meeting; provided, however, that any Board member or the Director may place an item on the agenda by requesting the Chair to include such item or items.

Insofar as possible, all members of the Board shall be mailed copies of the agenda to be considered at special Board meetings, unless this requirement shall be waived by unanimous consent of all Board members.

Section 7. Quorum and Voting

One-half of the appointed Board members, which shall include one officer, shall constitute a quorum of the Board. Consistent with Robert's Rules of Order, motions made during Board and committee meetings shall require a second in order to be considered. The affirmative vote of the majority of the votes cast shall be required for the passage of any motion or resolution at any meeting of the Board or its committees. The Chair of the Board will be allowed to vote.

It shall be the prerogative of any Board member to require a roll call vote on any motion.

Section 8. Decorum during Debate

Board members shall confine their remarks to the question, be courteous in their language and behavior, avoid all personalities, not arraign the motives of another board member, and emphasize it is not the individual, but the measure which is subject of debate. The Chair will assure enforcement of these behavioral guidelines.

The Chair shall call to order any person who is being disorderly by speaking or otherwise disrupting the meeting proceedings by failing to be courteous, by speaking longer than a reasonable time or by speaking vulgarities. Such person shall thence be seated until the Chair shall have determined whether the person is in order. If the person shall have been ruled out of order, he/she shall not be permitted to speak further at the same meeting except upon special request of the board. If the person continues to be disorderly and disrupt the meeting, the Board Chair or a designee shall contact local law enforcement to have said individual removed from the meeting. No person shall be removed from a public meeting except for an actual breach of the peace committed at the meeting.

ARTICLE VII - COMMITTEES

The Board of Directors shall establish the following standing committees: Executive Committee and Recipient Rights Committee. The standing committees shall perform such functions and duties as designated by the Board.

At the annual organizational meeting of the Board, the Chair of the Board shall appoint the Chair and members of the standing committees; those persons shall be members of the Board, except that the Recipient Rights Committee membership may include Community Mental Health Board members, staff personnel, government officials, attorneys, mental health consumer interest group representatives, or other persons, at the discretion of the Board Chair.

The Chair shall appoint the chair and members of special committees ~~(except the "Board Officers Nominating Committee")~~, subject to the approval of the Board; those persons need not be members of the Board, shall be counted for quorum and shall be eligible to vote on committee matters. The Chair of the Board shall be the only ex officio member of any and all standing committees, shall be included in counting for quorum, if present, and shall be eligible to vote.

The Board may establish such other committees as it deems proper.

All standing and special committees shall meet upon the call of the committee Chair, with the concurrence of the Board Chair, to consider whatever business is before said committee in order to recommend appropriate action to the Board.

Committees of the Board may meet by teleconference providing all requirements of the Open Meetings Act are met including providing and announcing a location at which members of the public may attend and hear the entire deliberations of the committee and all committee members.

Matters reported by a committee may be reported with a recommendation for Board action, or solely for the information of the Board.

Tenure on standing committees shall be for a one-year term beginning in April or until the appointment of a new committee; however, nothing herein shall be construed to prevent reappointment of any committee member.

Nothing contained in this Article shall be construed to deny any Board member the right to attend any meeting of any standing or special committee.

For Board committees a quorum shall be defined as equal to at least fifty percent (50%) of the committee membership.

Notices to the public regarding committee meetings shall be posted pursuant to Section 5, Public Act 267 of 1976, and Article VI of these Bylaws.

Section 1. Executive Committee

The Executive Committee shall consist of four members: the Chair, Vice-Chair, Secretary of the Board and immediate past Chair. If the immediate past Chair is no longer a current member of the Board, the Board shall elect an additional board member to serve as an at-large member of the Committee. It is the preference of the Board to have all four counties represented on the Committee. This committee shall have authority to act on behalf of the Board during the period between meetings of the Board, subject to any prior limitation imposed by the Board and with the understanding that all matters of major importance be referred to the Board.

This Committee shall research and apprise Board members of proposed, pending and current legislation pertaining to mental health services, and shall recommend a Board position.

Section 2. Recipient Rights Committee

This Committee shall advise the Board and Director concerning implementation of policy as it relates to the Recipient Rights system and shall review the operation of the Office of Recipient Rights in accordance with Section 757 of the Mental Health Code. This Committee shall serve as the Appeals Committee under Section 784.

ARTICLE VIII - DIRECTOR OF COMMUNITY MENTAL HEALTH AUTHORITY

The Director of the Northeast Michigan Community Mental Health Authority shall be selected by the Board. The Director shall be given the necessary authority and responsibility to operate all mental health services and carry out all policies as may be adopted by the Board, or any of its committees to which it has delegated authority. The Director shall ensure that appropriate orientation programs for new Board members and continuing education programs for all Board members are carried out and shall represent the Board in all areas in which the Board has not formally designated some other person to so act.

ARTICLE IX - MISCELLANEOUS

Section 1. Amendment and Adoption of Bylaws

These Bylaws may be amended or repealed by the affirmative vote of a majority of the members of the Board present at any regular or special meeting of the Board if notices of the proposed amendment or repeal are contained in the written notice of the meeting, such notice to be given prior to such a meeting by ordinary mail. Bylaws may also be amended without notice by a three-fourths vote of the Board members present.

Section 2. Rules of Order

Robert's Rules of Order shall be the parliamentary ~~authority~~ guideline for all matters of procedure not specifically covered by the Bylaws or by specific rules or procedures adopted by this Board.

Section 3. Conflict of Interest

No Board member shall in any way be a contractor for purposes of remuneration of this Authority or its contracting agencies unless a competitive bid process is utilized, the Board member discloses the association and affiliation, and a two-thirds (2/3) majority vote of the Board supports such a contract.

Section 4. Employment

Employment of a Board member or any member of his or her immediate family is prohibited.

Section 5. Suspension of Rules

The rules governing all matters of procedure of the Board provided in the Bylaws and in subsequent governing resolutions may be temporarily suspended at any time by the unanimous consent of the members present to facilitate the accomplishment of any legal objectives of the Board.

Section 6. Depository

As a Mental Health Authority, the Board may act as its own depository of funds, or, at its discretion, designate a county willing to act as depository.

Section 7. Per Diem and Reimbursement

Board members shall be paid in accord with the payment schedule for Northeast Michigan Community Mental Health Authority.

Section 8. Assurances

With respect to both employment practices and services rendered, the Authority will not discriminate against persons because of religion, race, color, national origin, age, sex, height, weight, marital status, political affiliation~~, record of arrest without conviction,~~ or physical or mental handicap.

No service or program provided by the Authority will be withheld from any person on the basis of residence in a county other than Alcona, Alpena, Montmorency, and

Presque Isle counties. If a person cannot meet financial obligations incurred by such program or service, the county of residence will be billed.

DRAFT

QI Council Minutes

For Meeting on 12/18/17
10:15 AM to 11:23 AM
Board Training Room

Meeting called by: Margie Hale-Manley
Type of meeting: Monthly
Facilitator: Margie Hale-Manley
Note taker: Diane Hayka via dictation on digital recorder
Timekeeper: Lynne Fredlund

Attendees: Genny Domke, Lynne Fredlund, Joe Garant, Margie Hale-Manley, Teresa Kowalski, Cathy Meske, Judy Szott, Christine Taylor via OmniJoin

Absent: Bonnie Benac, Monika Arora MD, Donna Roussin

QI Coordinator: Lynne Fredlund

Guests: LeeAnn Bushey

Agenda Topics

New members were welcomed to the Council. Joe Garant from NEMROC is succeeding John Faber and Genny Domke is succeeding Julie Hasse.

Review of Minutes

Discussion:
By consensus, the minutes of the October 16, 2017 meeting were approved as presented.

Conclusions:

Action items:

Person responsible:
Diane Hayka via digital recorder

Deadline:
ASAP

Management Team

Discussion:
Cathy Meske reported Management Team met on December 11 and November 6. Cathy noted she will address the December meeting first with a brief overview of the November meeting to follow. She reported Cheryl Jaworowski had provided Management Team with a budget status for fiscal year 2018. For the month of October it appears to have a net income of $6,336. Medicaid and Healthy Michigan were overspent and General Funds were underspent. Healthy Michigan inpatient expenses were substantially higher than what our normal expenditure was during this time frame by about $30,000. Cathy noted she met with the supervisors of emergency services and

those staff providing continuing stay reviews. She noted the residential placements have also increased. Cathy noted there was some discussion about individuals with I/DD attending Clubhouse. Cathy Meske noted this is acceptable; however, their primary diagnosis must be SMI to attend. Cathy noted Dr. Arora also suggested those individuals with a SUD diagnosis also be included for Clubhouse. Again, this individual would need to have an SMI as their primary diagnosis.

Cathy Meske reported Nena Sork is currently taking up office at the Fletcher Street Office approximately three days a week to provide coverage for the position vacated by Deb Hemgesberg. Cathy reported Dennis informed Management Team that our email system will be moving to the cloud. As this transitions, small groups of individuals will be moved to assure any glitches are addressed prior to the complete migration. In addition, Presidio conducted an efficiency audit of the computer system. They will be provided a complete report shortly.

Cathy Meske reported Management Team also conducted some policy reviews. Noteworthy is the policy related to educational advancement. Employees obtaining a degree or in some cases a certification after hire were previously granted a salary increase incentive. Going forward this will be a one-time award and staff will need to apply six-months prior to completing their program. All current staff having attained the incentive under the previous criteria will have a statement included in their personnel file.

Cathy Meske reported the Environment of Care Manual revision was discussed. There were some concerns and related to the 'DON'T STOP' phrase and also substitution of the word 'driving' for 'transporting' in another bulleted item. She notes if the vehicle is stopped a staff person may need to use their cell phone. Lynne Fredlund noted there is no CARF standard to dictate staff cannot STOP for a stranded vehicle by the roadside. This will be referred back to the Safety Committee for further review.

Management Team also discussed the respite provider requirements. Christine Taylor is putting a packet together which will contain all the requirements with required information for respite providers.

Nena Sork and Lisa Anderson will be conducting a QI process to talk with the staff who previously reported to Deb Hemgesberg. Through this process it is hoped to be able to determine exactly what is needed to lead that Department, what the staff felt was lacking as well as good. Once this process is completed, recruitment can begin to fill that position. The job description will be revised to address the needs.

Cathy Meske reported the November meeting had an additional item address related to trainings held at the college and the need to have the presenter utilize the microphone system to assure all present can hear.

Cathy Meske noted the Agency is working with various groups to develop plans for emergency preparedness. In addition, she also noted the Agency is working with Thunder Bay Transportation Authority to complete their contract.

Conclusion:

Action Items:
Report Monthly

Person Responsible:
Director

Deadline:
ASAP

Consumer Advisory Council

Discussion:
Cathy Meske reported the Council met November 6, 2017. She reported the Council had an educational session provided by Amanda Sola. She noted the autism updates are always refreshing as there are many success stories. The NMRE hosted the Day of Recovery on October 27th. She notes the members of the Council that attended

enjoyed the event. Kevin's Law was briefly discussed at this event and Council members requested further information on this topic. At their December meeting, Amy Pilarski and Stephen Slaght provided an educational session on Assisted Outpatient Treatment (AOT), which is Kevin's Law.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Director

Deadline:
ASAP

CARF Committee

Discussion:
Lynne Fredlund reported the CARF Committee meets quarterly and there was no meeting since last report.

Conclusion:

Action Items:
Report Quarterly

Person Responsible:
Lynne Fredlund

Deadline:
ASAP

Customer Satisfaction Committee

Discussion:
Margie Hale-Manley reported the Customer Satisfaction Committee met twice since the last meeting. She informed Council members the October meeting focused on the Community Electronic Health Records in Majestic. She noted the Committee is working with Christine Taylor to provide input as to what should be included in the records individuals are able to view. Only those individuals currently seen by a doctor have access to their records. This will be expanded to individuals receiving outpatient services in early 2018. She notes the Committee placed index cards in the lobby to get input from individuals served as to what they would like to see available in the portal.

Margie reported Carolyn Bruning updated the Customer Satisfaction Committee with information related to the Home- and Community-Based Services Waiver surveys. Those homes placed on "high scrutiny" were identified and a session was held with the providers and Stuart (NMRE) to prepare for response.

Lynne Fredlund had requested this Committee review the recovery survey questions and make suggestions for improvement.

There were no suggestions in the suggestion boxes in the Agency's lobbies during this timeframe.

In December, the Committee met again to discuss the Community Electronic Health Records available to individuals through the portal. There were no suggestions from the cards placed in the lobby for individuals to fill out. Christine Taylor was provided with topics the Customer Satisfaction Committee identified as possible useful information to contain in the patient portal.

The Committee also reviewed the NMRE Recovery Self-Assessment and Family surveys. Lynne Fredlund noted the suggestions from the committee were forwarded to Mary Marlatt-Dumas at NMRE.

Margie reported there were two suggestions received since their last meeting. One in Hillman which read "Always smile it looks good on you!" and one in Alpena which read "I enjoy coming here. The staff's very nice and respectful."

The next meeting for this committee will be in March 2018.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Margie Hale-Manley

Deadline:
ASAP

Resource Standards & Development Committee

Discussion:
Genny Domke reported this committee met twice. The November Employee of the Month was Candy Cole an RTW and December's Employee of the Month was DJ Dehring Adult Case Manager. She notes Committee members are recognizing staff with RAKs (Random Acts of Kindness) items such as M & M's, LifeSavers, etc. are left for staff acknowledging their work. This is done not only in the offices but also items are sent to the group homes. She noted the Ugly Sweater Contest this year went over well. This year there were prizes associated with the contest. An anonymous person provided a Committee member with $20 to use for the prizes awarded.

Genny reports the Annual Staff Training is at 100%. Genny also reported there has been an increase in names submitted to the RS & D Bulletin as well as the nominations for Employee of the Month.

Genny reports there is a Board in the Administrative hallway for persons to put various pictures on it. In the summer, there were summer pictures posted. Over the holidays, staff posted Christmas pictures of past and present. She also reported sometime during the winter months, a chili cook off is in the works.

Lynne Fredlund inquired as to what the Committee felt attributed to the increase in nominations, etc. Genny notes staff are being made aware of the processes for submitting more in recent months.

Conclusion:

Action Items:
Report Monthly

Person Responsible:
Genny Domke

Deadline:
ASAP

Risk Management Committee

Discussion:
Lynne Fredlund reported the Risk Management Committee met on November 20, 2017. The Committee reviewed the Behavior Support Teams reports covering the period of September through November. Lynne Fredlund noted the Behavior Support Team continues with the process to review the programs annually. The Team reviewed two in September and two in October. This information will be added to their standard reports for future minutes.

Lynne Fredlund reported the Recipient Rights Committee met October 18, 2017. The annual rights report along with the quarterly report was reviewed by the Rights Committee. Lynne Fredlund reviewed the statistics from those reports with Council members. She noted there were 89 ¾ hours spent in conducting site visits. Cathy Meske inquired whether this included her time as well as the recipient rights staff. Lynne noted it does include her time. She reported this year site visits were conducted at all provider site including the out of area sites and next year the Agency will accept reciprocity, which means if another CMH Board has a resident in the same facility we will accept their site visit data. Lynne provided new Council members Joe Garant and Gennie Domke with information related to the site visit requirements for our contractual providers.

Lynne Fredlund reported the Risk Review process continues. She reviews the incidents reports and each event is investigated on with appropriate staff.

Lynne Fredlund noted Ruth Hewett provides a quarterly report to the Risk Review Committee related to Grievance and Appeals. This last quarter there was one grievance, no second opinions one local appeal (resulting in an overturn) and one administrative hearing which was still pending at the time of the report. Cathy Meske noted the opinion has since been received and the Agency's position was upheld.

Lynne Fredlund noted the Risk Committee was apprised of the collaboration efforts underway in developing Emergency Preparedness plans which would involve our Agency should a community-wide epidemic or disaster occur.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Lynne Fredlund

Deadline:
ASAP

Safety Committee

Discussion:
Teresa Kowalski reported the Safety Committee on November 28th. She noted Patti Briley provided the Safety Committee with a Consumer Injury/Falls report noting there were 17 accidents with injury and 9 falls with injury. One injury required emergency medical treatment diagnosed as a sprain.

Teresa reported NeMCMH will be responsible for any treatment with any staff having a negative test result for tuberculosis upon hire and then converting to a positive result. Any positive result upon hire will not result in the Agency's responsibility. She also reported Mary Hardies researched the Hepatitis A Outbreak and provided handouts and memos associated that have been disbursed to staff. She noted any staff with concerns may self-refer to the Health Department and NeMCMH will screen and apply criteria if staff incurs a position result.

Teresa also noted the Safety Committee reviewed the Emergency Drill Calendar and Rich Greer will follow up with any site deficient in conducting scheduled drills to assure compliance is attained.

She reported our Workers' Compensation Consultant, RTW, will be offering two Accident Investigation Trainings for supervisors in April 2018.

Teresa reported the Red Strap System for Van Lifts was a topic of discussion. Lance Abbert will be training staff in this usage. The Red Strap usage will be required unless specified in the Individual's Plan of Service not to use the strap. Teresa noted there are some chair designs which using the straps could result in injury if used.

Teresa informed Council members the eyewash stations for the four offices have arrived. The location of the eyewash station of the Alpena Office will be in the garage; other office locations have yet to be determined. In addition, the lockouts for the circuit breakers have been ordered.

Teresa noted a concern was discussed related to the use of shower-bed and shower chairs. It was determined individual's should not use another individuals equipment. If equipment is no longer used by the assigned individual, it needs to be removed from the home. Linda Stender noted home staff need training regarding the proper usage of shower chairs and proper body mechanics and assistive equipment for transfers. Margie Hale-Manley inquired about the statement in the minutes related to the safety of use of the PVC Shower Chairs. Teresa noted, Linda Stender believes the PVC Shower Chair is safe if used correctly as a Shower Chair and not a transport to and from the shower as well. She will be working with the homes to review individual cases and provide the training as needed. Margie noted, at one time, this was discouraged due to increased workers' compensation claims.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Teresa Kowalski

Deadline:
ASAP

Utilization Management

Discussion:
Christine Taylor reported the Utilization Management Committee met on November 2 and December 7. She notes there was discussion related to individuals coming for Intakes with their Medicaid registered in out of area counties. Christine noted CRS/Intake staff have a process identified to handle such instances and request individuals contact the local DHHS office to transfer their Medicaid to our county. I/DD case managers are to follow up with individuals to get them to the DHHS office to make this transfer as well. Cathy Meske inquired as to what timeframe the individual has to get this done. Christine Taylor reported this was not identified and she will follow up with the Clinical Team. She believes the intent is to get this transferred within the month. She reports this does not affect COFR arrangements.

Christine Taylor reported the UM Committee has also discussed clinical documentation standards. She reported many years ago there was a "Blue Book" with standards addressed indicating the documentation must be completed within 3 days. That book is obsolete and NeMCMH needs to have a standard for documentation. She noted this was brought to the forefront more upon implementation of Majestic as there are many documents waiting for signature in the medical record system. She reports it is acknowledged that different type of documents/assessments may take different lengths of time to complete. This will be a comprehensive set of guidelines to give clinical leaders some type of protocol to follow. Clinical leaders will be provided a draft of these guidelines, most likely in January, to review and provide input.

The UM Committee also reviewed some Majestic Standard Reports. She reported the Meaningful Use Dashboard, Discharge Summary report, and Total Access Screenings by Disposition report were reviewed by the Committee.

At the December meeting, issues related to Plans of Service, Addendums and Reviews in Majestic. Several items were identified as needing further investigation and these will be forwarded to Nena Sork who will work with PCE to get the software documents corrected.

Christine Taylor noted the December meeting also addressed the Respite Provider Credentialing process.

Christine Taylor reported the next meeting for the Utilization Management Committee is scheduled for January 4, 2018 and the Clinical Documentation Guideline Draft will be reviewed.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Christine Taylor

Deadline:
ASAP

Quality Oversight Committee - NMRE

Discussion:
Lynne Fredlund reported this Committee met on October 3, 2017. Lynne Fredlund reported the PIHP is reviewing the committees at the regional level to determine activity and relevance of each committee. Lynne Fredlund noted the work plan for the QOC was put on hold until the Entity has had the time to complete the review process and determine current needs.

Lynne Fredlund reported the QOC Committee also reviewed the Performance Indicators. In the past where a board was two or more quarters in a row where they were out of compliance, a corrective action plan was required. The new director, Eric Kurtz, is reviewing how corrective action plans are needed, for example, if the numbers are low and one would cause non-compliance it may be something where the corrective action plan would not be needed as the numbers are too low.

Lynne Fredlund reported the NMRE also identified a Performance Improvement Project focusing on diabetes screening for consumers prescribed an antipsychotic medication. She also noted smoking cessation was also encouraged; however, Northeast was the only Agency to follow through with sending letters to those individuals served self-reporting tobacco usage. The diabetes PIP will continue in 2018 and a second PIP will be developed, potentially looking at SUC/co-occurring services or Access to Care for Autism services.

The MDHHS Site Review was reviewed at the last QOC meeting and citations were minimal. It was a very good review. The next MDHHS Site Review will be April 2019.

Conclusion:

Action Items:
Report Bi-Monthly

Person Responsible:
Lynne Fredlund

Deadline:
ASAP

Q.I. Member Concerns

Discussion:
There were no QI Member concerns. Lynne Fredlund reviewed this agenda item with new Council member Joe Garant to address any concerns he may have during this part of the meeting.

Project Team/Workgroup Update

Discussion:

Disaster Management Program Update

Lynne Fredlund reported after attending the Disaster Management Training, our Agency has reviewed our internal plan and a book is being developed to include plans CMH may have a role in with other community partners. She noted Cathy Meske, Rich Greer, and she have a book and the contents will also be loaded electronically for staff access or backup needs. She reports the training was held late October and included many agencies within the Region 2 area. Alcona County is not part of Region 2 but we will actively participate in activities in that county as well. Rich Greer will be designated as our point person. He will be attending quarterly meetings. The primary focus will address the "impact of the disaster." Policies will be developed to cover the plan and memorandums of understanding will be developed to address roles of our Agency in various disasters or emergencies. She noted we will need to demonstrate we have tested the plans. We also will need to assure staff have training in the plans. Lynne reviewed the various component of the book, information contained in the book and training needs. She noted our Agency has flip charts already developed when the Agency was accredited under JCAHO which continues to be maintained.

Lynne Fredlund noted recently the Hepatitis A Plan was required by the State and this information will also be kept in the book. Cathy Meske noted having this disaster management program is a mandate of our contract with MDHHS and also the Mental Health Code.

Home- and Community-Based Services Update

Christine Taylor reported the individuals receiving b3 services was complete. The survey ended December 5th. We were successful in getting all providers to respond to the surveys. There were more than 102 individual surveys and 135 provider surveys completed. She noted it will take several weeks for the data to come back in report form. She reported also received was the data for those receiving Habs Support Waivers. NMRE has shared the data with us noting some of the providers needed to complete a corrective action plan. She reported many of the residential providers are on the "heightened scrutiny" list and we are working with those providers receiving notification. MDHHS has contracted with Michigan State University to conduct site visits. There will be some desk audits conducted through this process. A webinar is scheduled in January to share the process and give advice as to how to become compliant with the cited rules.

PIHP Recovery Surveys [sent to PIHP via US Mail]

This was addressed earlier in this meeting.

State Satisfaction Surveys

Margie Hale-Manley noted there will be no surveys conducted by the State this year due to staffing reductions. Surveys will only be conducted if the PIHP elects to develop a survey.

Meaningful Use Update

Christine Taylor provide background information on Meaningful Use origin and the various objectives associated with requirements by the federal government. Our IT Department worked with a consultant to assist our Agency in coming into compliance. PCE has allowed us to be able to collect the required data. At this point, the measurement is on those individuals seeing the doctors and does not extend to those individuals being see by other professional staff. She reported all three of our Agency doctors are meeting the measurements required. She reported in 2018 the same objectives are required in Meaningful Use. Lynne Fredlund requested Christine Taylor provide the nine objectives at the next QI Council meeting.

Old Business

Discussion:

There was no Old Business to address.

New Business

Discussion:

There was no New Business introduced.

Other

Discussion:
There was no other addressed or presented.

By consensus, this meeting was adjourned at 11:23 a.m.

Next Meeting will be held on February 19, 2018, 10:15 a.m. in the Board Training Room.

FEBRUARY AGENDA ITEMS

Policy Review
Asset Protection 01-007

Policy Review & Self-Evaluation
Board Committee Principles 02-005
Delegation to the Executive Director 03-002

Monitoring Reports
Treatment of Consumers 01-002 (Recipient Rights Report)
Staff Treatment 01-003 (Turnover Report)
Budgeting 01-004 (Finance Report)
Financial Condition 01-005 (CPA Audit Report)***
Asset Protection 01-007 (CPA Audit Report)***

Activity
Accept & File CPA Audit***

Ownership Linkage

Educational Session
Audit Presentation***

***Due to late onset of audit proceedings, this will be delayed.

Michigan Association of Community Mental Health Boards is now Community Mental Health Association of Michigan.

January 5, 2018

FRIDAYFACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance
Executive Board

FROM: Robert Sheehan, Executive Director
Alan Bolter, Associate Director

RE:

- **New e-mail addresses for Association staff**
- **Association soon to announce new membership opportunities**
- **Friday Facts to become a members-only electronic newsletter**
- **Work and Accomplishments of CMH Association Organizations**
  - **AuSable Valley CMH announces leadership change**
- **State and National Developments and Resources**
  - **MDHHS updates Veterans Services strategic plan**
  - **Design firm approved to build new psychiatric hospital in Caro**
  - **State training guidelines find new website home**
  - **MI Bridges partner registration process opened**
  - **Detroit, Macomb among 9 municipalities suing drug companies over opioid epidemic**
  - **SAMHSA strategies for pain management and the prevention of opiate misuse among service members, veterans, and their families**
  - **CDC announces death toll due to drug overdoses**
  - **HHS highlights Office for Civil Rights' ongoing response to the opioid crisis, while implementing the 21st Century Cures Act**
  - **2018 NACo Health Legislative Priorities**
  - **NACo Health Legislative Update**
  - **Medicaid Chief Says Feds Are Willing To Approve Work Requirements**
  - **RRTC year end report: Reflecting on a Good Year: Meaningful Research Promoting Community Inclusion and Participation**
- **CMHAM Winter - Registration Open Next Week**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Webinar: Business or Exploitation?" Exposure of the Tobacco Industry's Exploitation of Individuals with Mental Health Conditions**

New e-mail addresses for Association staff: The Michigan Association of CMH Boards is now COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN.

Please update your email address for CMHAM staff:

Robert Sheehan, CEO: rsheehan@cmham.org
Alan Bolter, Associate Director: abolter@cmham.org
Chris Ward, Administrative Executive: cward@cmham.org
Dana Owens, Accounting Clerk: dowens@cmham.org
Michelle Dee, Accounting Assistance: acctassistant@cmham.org
Monique Francis, Executive Board/Committee Clerk: mfrancis@cmham.org
Annette Pepper, Training and Meeting Planner: apepper@cmham.org
Anne Wilson, Training and Meeting Planner: awilson@cmham.org
Carly Palmer, Training and Meeting Planner: cpalmer@cmham.org
Chris Lincoln, Training and Meeting Planner: clincoln@cmham.org
Nakia Payton, Receptionist: npayton@cmham.org

Association soon to announce new membership opportunities: In response to requests for a broader range of membership options and a fuller list of benefits of each membership type, the CMH Association of Michigan will soon be announcing several new membership opportunities for organizations and individuals. Look for the revised Association membership brochure to be available in November.

Friday Facts to become a members-only electronic newsletter: Note that the receipt of this electronic newsletter will become a members-only benefit sometime in the next few months. While there will be another electronic newsletter for a wider range of non-members, it will not contain the depth nor breadth of information contained in this newsletter. **So, if you find the information in this newsletter useful and are not an Association member, consider becoming a member when the new membership opportunities are announced.**

WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

AuSable Valley CMH announces leadership change

Below is an excerpt from a recent letter from Dave Beck, the out-going CEO of AuSable Valley Community Mental Health Authority, announcing the appointment of Diane Pelts as the incoming CEO. We congratulate and welcome Diane and wish Dave the best in his future endeavors.

> I am pleased to inform you that effective January 1, 2018 Ms. Diane Pelts will begin her duties as Chief Executive Officer for AuSable Valley Community Mental Health Authority. I share with the Board of Directors great confidence in her management and leadership skills. She will continue to work closely with me during the month of December to finalize the transition process.
>
> I would like to take this opportunity to thank you for your support of the Agency during my tenure as Chief Executive Officer. Your collegiality and contributions are appreciated.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

MDHHS updates Veterans Services strategic plan

Attached to this Friday Facts is the r updated Veteran and Military Member Strategic Plan, updated to reflect 2017 activity, as recently issued by the Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration.

Design firm approved to build new psychiatric hospital in Caro

Below is a recent press release, from MDHHS, related to the development of the state facility to replace the current Caro facility:

> A state Ad Board today is approved of a contract with a Troy firm to design the new Caro Center that will be on the same site as the existing state-operated psychiatric hospital.
> The contractor is Integrated Design Solutions, which will provide design, architectural and engineering services for the project.
>
> "We are pleased to begin moving forward with the design of a new Caro Center that will better meet the needs of people who need mental health services," said Michigan Department of Health and Human Services Director Nick Lyon. "The State of Michigan made a commitment to the Caro community that the new psychiatric hospital would remain in the community, and we are keeping that promise."
>
> Design of a more modern facility will allow the state to replace the aging hospital in Caro. The design phases kicks off in early 2018. State officials expect the new hospital to be completed in 2021.
> An evaluation committee with representatives from the Michigan Departments of Health and Human Services and Technology, Management and Budget, as well as the State Budget Office, recommended Integrated Design Solutions from 14 firms that submitted proposals. The committee determined that Integrated Design Solutions, a premier design consultant with expertise in psychiatric facility design, provides the best value to the state. The contract is for $5,483,490.
>
> The Caro Center is a regional state hospital for adults with mental illness. The new facility is proposed to be built as a separate standalone complex on the existing Caro Center grounds. The vision and goals are for a new hospital to provide 200 beds –compared to the capacity of 150 beds in the current hospital – in an environment that is safe, efficient and flexible for patients and staff.
> Dear Friends and Colleagues:

State training guidelines find new website home

Below is an update from the State Training Guidelines Workgroup related to the placement of the Training Guidelines on the Improving Practices website:

> I hope this message finds you well. I am writing to inform you that the State Training Guidelines Workgroup's Training Guides can now be found on the Improving MI Practices site.
>
> The State Training guidelines Workgroup (STGW) is an active workgroup under the Community Mental Health Association of Michigan (CMHA).
>
> We are a group of training leaders, curriculum designers, adult learning experts, training delivery experts, and content experts. Our primary focus is to maintain and update The Guidelines, which give structure to the direct support professional curriculum; it is directly linked to the quality of care provided to individuals receiving supports!
>
> We are guided by best practices and standards within the training industry. These standards include recommended competencies, content, delivery methods and format, trainer qualifications, assessment

methods, and requirements for legal and contractual staff training. The Guidelines are an invaluable resource and can be found on the Improving MI Practice; here is the link: https://www.improvingmipractices.org/

Additional projects include work with the Department of Health and Human Services, Improving MI Practices, and the Community Mental Health Association of Michigan on statewide training reciprocity, compiling a test bank of assessment questions, curriculum content review and consultation, plus evaluation of current trends.

There are a total of 30 training guides, a review of the purpose and functions of the State Training Guidelines Workgroup as well as a flowchart of key training requirements. To gain access to the guides you will need to set up an account within IMP. Once logged in, look for Advisory Groups located at the bottom of the home page, then click on State Training Guidelines Workgroup. You will see a link to each guide after clicking the "enroll" button.

MI Bridges partner registration process opened

All agencies that would like to become a MI Bridges partner must register in the new MI Bridges portal. This registration process will be entirely electronic—there will not be any paper applications to email or fax. If you have already registered your organization as a community partner, we thank you for your commitment to assisting Michigan's residents on a path to self-sufficiency.

As a reminder, registration is open. Here is the link to register:
https://newmibridges.michigan.gov/s/isd-communitypartner-landing

After registering, you will receive a confirmation email with details on next steps. We encourage you to register by January 19th to ensure you receive all pertinent information regarding the MI Bridges portal launch.
We want to support you in choosing your partner role and completing the registration process as best we can. Visit our website http://www.michigan.gov/mdhhs/0,5885,7-339-71551_82637_82639-454651--,00.html to access the materials below:

- A guide to choosing the partner role that best fits your agency
- A tip sheet on how to prepare for the registration process
- A spreadsheet template to help you assemble the information you will need
- A job aid on how to complete the registration process
- A list of the items your Authorized Representative will need to certify when they approve your agency's MI Bridges community partnership. Please share this document with your Authorized Representative so they are prepared for this approval process. When you register your agency, they will receive an automatic email asking them to certify these items.

If you would like more information about the new MI Bridges, please visit our new MI Bridges Partners web site:
www.Michigan.gov/mibridgespartners

Agency Lead Point of Contact: Each organization that registers as a MI Bridges community partner will need one or two staff members that will serve as a Lead Point of Contact (LPOC). The LPOC should have a leadership role within the organization as they will receive all communication from MDHHS and ensure all requirements of their partner role are met.

If you will serve as your agency's Lead Point of Contract for your MI Bridges community partnership, we encourage you to register for our Lead Point of Contact webinar. Here is the registration link:
LPOC Webinar – Jan. 9, 2018 – 12:30 – 2:00 pm

MI Bridges Navigation Partner Training: If you will be registering as a Navigation Partner, all users you assign to the Navigator role will need to attend an in-person, 4-hour MI Bridges Navigator training. This in-person, 4-hour training is necessary due to the enhanced features Navigation Partners will be expected to assist clients with, as needed.

The MI Bridges Navigation Partner training dates, cities, and times are listed at MI Bridges Community Partner Training webpage. http://www.michigan.gov/mdhhs/0,5885,7-339-71551_82637_82640--,00.html. We encourage you to check this website for the most up-to-date training information. Once you register your agency in MI Bridges, you will receive more information on registration for the training.

Detroit, Macomb among 9 municipalities suing drug companies over opioid epidemic

The city of Detroit, Macomb County and seven other Michigan municipalities on Tuesday filed lawsuits against big pharmaceutical companies over the nation's opioid epidemic, following the lead of Oakland and Wayne counties and several other state and local governments across the country.
Also joining the lawsuit filed Tuesday with the U.S. District Court are Genesee, Saginaw, Grand Traverse, Delta and Chippewa counties, as well as the cities of Lansing and Escanaba. There are more than 20 defendants listed in Detroit's civil action document, including drug manufacturers, distributors and pharmacies:
http://www.crainsdetroit.com/article/20171219/news/648116/detroit-macomb-among-9-municipalities-suing-drug-companies-over-opiod

SAMHSA strategies for pain management and the prevention of opiate misuse among service members, veterans, and their families

SAMHSA's Service Members, Veterans, and their Families
Technical Assistance Center Presents:
Strategies for Pain Management and the Prevention of Opiate Misuse Among
Service Members, Veterans, and their Families
Date: January 10, 2018
Time: 2:00 – 3:30 p.m. ET
Register: https://goto.webcasts.com/starthere.isp?ei=1174536&tp_key=ef92a9137c

Throughout the country, communities are striving to address the effect of serious pain in service members, veterans, and their families (SMVF) by offering prevention, treatment, and recovery alternatives, while simultaneously confronting the public health demands of the opioid crisis. As communities work to achieve these goals, the role that pain management and opioid use play in the lives of SMVF must be factored into their efforts.

Pain management is an important consideration for many SMVF. The National Institutes of Health cited a recent study that found that "veterans were about 40 percent more likely to experience severe pain than nonveterans[1]." Because opiate misuse is linked to factors including chronic pain and non-medical use of prescription opioids, community-planning efforts must take into account the unique needs of SMVF. Special consideration must be given to the inter-relationships of opioid misuse and condition SMVF may experience, such as depression, chronic pain, post-traumatic stress disorder, traumatic brain injury, and suicidal ideation. Coordinated planning and implementation of military-culturally competent, alternative strategies that will address chronic pain and prevent SMVF opioid misuse and addiction are needed.

The Substance Abuse and Mental Health Services Administration (SAMHSA) SMVF Technical Assistance (TA) Center will conduct a webinar in partnership with the U.S. Department of Veterans Affairs (VA) and RAND, focusing on essential information surrounding the relationship between pain management and opiate misuse and addiction among SMVF. Presenters will also review other compounding factors that SMVF may experience. Strategies will be presented detailing how to support communities in their work to reduce the effects of severe pain, which can contribute to SMVF abuse of opioids. Research on SMVF alternatives for pain management will be included:

[1]National Institutes of Health. (2016) Veterans endure higher pain severity than nonveterans [Press release]. Retrieved from https://www.nih.gov/news-events/news-releases/veterans-endure-higher-pain-severity-nonveterans

Learning Objectives:

- Provide an overview of the research that explores the connection between SMVF opioid misuse, pain management, and use of alternative therapies for those with chronic pain

- Review risk factors—including chronic pain, post-traumatic stress disorder, traumatic brain injury, and suicidal ideation—that may be experience by SMVF and con correlate to an increased incidence of opioid misuse and addiction
- Identify alternative approaches to pain management
- Describe the steps that SAMHSA and the VA are taking to address these interrelated issues
- Provide suggestions, resources, and best practice approaches that communities can use to develop concrete action plans to reduce and prevent SMVF opiate misuse and addiction

Presenters
Elinore F. McCance-Katz, M.D., Ph.D. [Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration
Adam J. Gordon, M.D., M.P.H., F.A.C.P., D.F.A.S.A.M. [Chief, Addiction Medicine Primary Care, Salt Lake City VA Health Care System
Patricia M. Herman, N.D., Ph.D. | Senior Behavioral and Social Scientist; Faculty Member, Pardee RAND Graduate School
Moderator
Donna Aligata, R.N.C. | Project Director, SAMHSA's Service Members, Veterans, and their Families Technical Assistance Center, Policy Research Associates, Inc.

Target Audience: Representatives serving SMVF from state, territory, and tribal behavioral health systems; health care providers; suicide prevention coordinators; mental health and addiction peers; military family coalitions and advocates.

Register for the webinar today. https://goto.webcasts.com/starthere.isp?el=1174536&tp_key=ef92a9137c

If you have any questions about your registration, please contact Lisa Guerin at (518) 439-7415, ext. 5242, or by email at lguerin@prainc.com

CDC announces death toll due to drug overdoses

Today the Centers for disease Control and Prevention (CDC) announced that **63,600 Americans died from drug overdose in 2016**—an average of 174 a day:

"The grim numbers released today by the CDC reinforce that we are losing a generation of Americans to addiction, a preventable and treatable disease. To put the numbers in perspective, we lose the equivalent of nearly three sold-out 747s every week to drug overdose deaths; seven if we include alcohol related deaths. Enough is enough.

"We simply don't have a moment to waste when it comes to helping families who are struggling. We must get people access to the quality care, resources and information they need. We need everyone at the table to address this crisis and help save lives.

"The Addiction Policy Forum has proposed an eight-point plan that was developed by impacted families and experts in the field. While there is no silver bullet for ending addiction, we know that a comprehensive approach will get us on the right path to ending this public health crisis.

"As we prepare for the holidays with family and friends, let's make a point to remember those we have lost to addiction-174 a day – as well as those who are still struggling and looking for answers. Today's report is a reminder that America must double – or triple – down on its approach to this epidemic. We will only be successful if we do so together."
Understanding the Numbers: To better understand the latest CDC report, the Addiction Policy Forum has broken down key points in "174 a Day: Understanding the Numbers." Click here to review: http://www.addictionpolicy.org/

HHS highlights Office for Civil Rights' ongoing response to the opioid crisis, while implementing the 21st Century Cures Act

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) today launched an array of new tools and initiatives in response to the opioid crisis, while implementing the 21st Century Cures Act (Public Law 114-255). OCR continues its work to ensure that patient and their family members can get the information they need to prevent and address emergency situations, such as an opioid overdose or mental health crisis. At the same time, these tools and initiatives also fulfill requirements of the 21st Century Cures Act to ensure that the healthcare sector, researchers, patients, and their families understand how the Health Insurance Portability and Accountability Act (HIPAA) protects privacy and helps improve health and healthcare nationwide.
Highlights of these actions include:

- Two new HIPAA webpages focused on information related to mental and behavioral health, one for professionals and another for consumers. These webpages reorganize existing guidance to make it more user-friendly and provide a one-stop resource for our new guidance and materials. This guidance is an important step forward in clarifying the circumstances under which HIPAA permits a covered entity to disclose information to family members and caregivers.
    - For consumers: https://www.hhs.gov/hipaa/for-individual/mental-health/index.html
    - For professionals: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- These webpages contain new HIPAA guidance on sharing information related to mental health and substance use disorder treatment with a patient's family, friends and other involved in the patient's care or payment for care. The new information includes: a package of face sheets; and infographic; decision charts, including materials specifically tailored to the parents of children who have a mental health condition; and scenarios that address sharing information when an individual experiences and opioid overdose.
- New collaboration with partner agencies within HHS to identify and develop model programs and materials for training healthcare providers, patients, and their families regarding permitted uses and disclosures of the protected health information of patients seeking or undergoing mental health or substance use disorder treatment, and to develop a plan to share the programs and material with professionals and consumers.
- Updated guidance on HIPAA and research, as called for in the Cures Act: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- Launch of a working group to study and report on the uses and disclosures under HIPAA of protected health information for research purposes. The working group will include representatives from relevant federal agencies as well as researchers, patients, healthcare providers, and experts in healthcare privacy, security, and technology. The working group will release a report addressing whether uses and disclosures of PHI for research purposes should be modified to facilitate research while protecting individuals' privacy rights.

For additional information on HIPAA, visit: https://www.hhs.gov/hipaa/

2018 NACo Health Legislative Priorities

Below are the recently announced federal legislative priorities of the National Association of Counties (NACo), of which NACBHDD (on which this Association is an officer and the Associations' members are on the NACBHDD Board) is a key partner organization:

- ***Protect the federal-state-local partnership structure for financing and delivering Medicaid services while maximizing flexibility to support local systems of care.*** Medicaid is the primary payer for long-term services and supports, including approximately 900 county-supported nursing homes. Measures that would further shift Medicaid costs to counties should be opposed, including proposals to institute block grants or per capita caps, as they would result in counties taking on the cost of uncompensated care and reduce counties' ability to provide for the health of their residents. Meanwhile, efforts to enhance flexibility in the program to support local systems of care should be championed, including easing Medicaid's Institute of Mental Diseases (IMD) and inmate exclusions.

- ***Ensure federal funding for and protect the integrity of key health safety net programs while also preserving funding for core local public health and prevention efforts.*** From the Children's Health Insurance

Program (CHIP) and community health centers to federal payments to county Disproportionate Share Hospitals (DSH) and the 340B drug pricing program, counties are looking to protect reductions in funding for and regulatory changes that would threaten the multitude of health safety net programs supported by the federal government. Counties also support the majority of American's nearly 3,000 local public health departments that protect their resident's health and safety and prevent the leading causes of death. Counties support preserving federal investments such as the Prevention and Public Health Fund (PPHF) that are responsible for approximately one-fourth of local health departments' funding.

- ***Advance legislation and administrative changes that will enhance counties' abilities to provide adequate services for people with mental illnesses, including justice-involved individuals.*** One in five adults in the U.S. experience a mental illness and one in 25 a serious mental illness, with the current mental health workforce and support systems inadequate to meet demand. Counties support maintaining funding for the Community Mental Health Services block grant and support other measures including developing and expanding the workforce, fully implementing and expanding mental health parity, expanding access to health information technology and clarifying privacy provisions. Additionally, counties support measures to improve health services for and reduce the number of individual in county jails with mental illnesses and co-occurring conditions.

- ***Provide targeted funding and administrative changes to help counties combat addiction and its effects, particularly as it relates to the opioid epidemic.*** Since 1999, the number of overdose death involving opioids (prescription drugs and heroin) has quadrupled. The opioid epidemic has further strained counties' 750 behavioral health authorities who help to treat people with a variety of substance abuse conditions. While some funding has been made available to state agencies, counties support ensuring targeted funding is directed down to county behavioral and public health agencies and other local health stakeholders to help prevent and treat substance misuse and abuse.

The Board of Directors considered each of NACo's policy committee's priorities, and decided on NACo's top 8-10 legislative priorities (across all issue areas). These will be publicly released in the new year, and we will share them then.

NACo Health Legislative Updates

Below are the recently announced health-related legislative updates from the National Association of Counties (NACo), of which NACBHDD (on which this Association is an officer and the Associations' members are on the NACBHDD Board) is a key partner organization:

- In late December, NACo participated in a Congressional briefing with our coalition—the Partnership for Medicaid—to highlight the role that Medicaid plays in treating addiction. Commissioner Debbie Lieberman of Montgomery County, Ohio represented NACo at the briefing and underscored the importance of Medicaid in helping her county combat the opioid epidemic and the need for a sustained strong federal-state-local partnership for Medicaid. See the slides from the briefing attached.

- As Rodney discussed on the call, there will be many opportunities—outside of Congressional action—to make changes to Medicaid through waivers for purposes including covering even more of the continuum of care for people with substance use disorders. We recently wrote an article about new guidance from CMS that sims to give states greater flexibility to treat addiction, including easing Medicaid's IMD exclusion.

- Congress continues to close in on tax reform. It is expected that the final compromised bill will include the repeal of ACA's individual mandate but maintain the medical expense deduction (and even slightly expand for two years). Senator Susan Collins (R-Maine) is still trying negotiate the inclusion of legislative proposals that are intended to stabilize the ACA marketplaces. Legislative text is expected to be released this evening. We will keep you posted on how the final compromised bill would impact counties, especially as it relates to our committee.

- Tax reform is holding up everything else, including a final spending bill for the federal government. As you may recall, on December 8 President Trump signed into law a two-week continuing resolution (CR) that funds the federal government through December 22, 2017 and avoid a government shutdown. There has been discussion of another short-term CR that goes into January if Congress is not able to negotiate a final spending bill next week. We will keep you posted!

- We still await the reauthorization of federal funding for the Children's Health Insurance Program (CHIP) and other health safety net programs important to counties. If you need a refresher on these programs, click here. The CR only contained a temporary patch for CHIP, directing the secretary of Health and Human Services to allocate previously unused CHIP funding to "emergency shortfall states"—or ones that are in danger of running out of money by the end of the year. The House has proposed reauthorizing CHIP in the next spending package, but utilizing an offset that includes the Prevention and Public Health Fund, which we have concerns with

- Forecasting next year is very difficult, but Speaker Ryan has already indicated he plans for Congress to address entitlement reform, inclusive of Medicare, Medicaid and welfare. Yesterday, it was reported that Speaker Ryan would like to use the reconciliation process to do this, and he also wants to return to repealing and replacing the ACA. With the outcomes of the election on Tuesday, the Senate will have one less Republican, making this more difficult—but not impossible. Nonetheless, our work will continue into the new year!

Medicaid Chief Says Feds Are Willing To Approve Work Requirements

The Kaiser Health News reported that the Trump administration signaled Tuesday that it would allow states to impose work requirements on some adult Medicaid enrollees, a long-sought goal for conservatives that is strongly opposed by Democrats and advocates for the poor.

"Let me be clear to everyone in this room: We will approve proposals that promote" employment or volunteer work, Seema Verma, the head of the Centers of Medicare & Medicaid Services (CMS) said in a speech to the nation's state Medicaid directors.

Such a decision would be a major departure from federal policy, and critics said it would lead to a court fight. President Barack Obama's administration ruled repeatedly that work requirements were inconsistent with Medicaid's mission of providing medical assistance to low-income people.

https://khn.org/news/medicaid-chief-suggests-feds-are-willing-now-to-approve-work-requirements/

Mental Health Weekly Year in Review

Below is a recent (and rather lengthy) review, by the Mental Health Weekly, of the major national health care issues of the past year:

> The mental health community witnessed some defeats and some wins in 2017. Preserving key protections in the health care law for people with mental illness and substance use disorders dominated the field in 2017. Following the advent of a new administration protections afforded by the Affordable Care Act (ACA) had been threatened by a number of bills to repeal and replace the health care program.
>
> Over the past year, the field fought tirelessly to preserve the Medicaid expansion, along with protections for people with pre-existing conditions—which would have been lost if Congress had succeeded in overhauling health care reform.
>
> The field sounded the alarm over the reform bills urging Congress to reject the legislation that would overhaul Medicaid and leave millions without insurance coverage. A number of organizations asked their respective

members to urge lawmakers to improve the current law in a bipartisan fashion (see MHW, Feb. 27, May 29, Sept. 25, 2017).

House lawmakers introduced the American Health Care Act March 6, which would have changed Medicaid to a per capita payment system, a big concern for the field (see MHW, March 13, 2017). The per capita cap would have placed a cap on what the federal government would pay each state for its Medicaid enrollees, essentially ending the 50-plus-year federal guarantee of matching each state's actual Medicaid spending and replacing it with a capped, preset amount and preset growth rate. Other bills followed, such as the "skinny repeal" of the ACA and the Better Care Reconciliation Act.

One the evening of Dec. 21, 2017, the Senate passed a short-term Continuing Resolution, by a vote of 66 to 32, that includes a three-month funding extension for the Children's Health Insurance Program (CHIP).

The year concluded with an overhaul of the country's tax code. The Tax Cuts and Jobs Act, signed into law on Dec. 22, 2017, repealed the ACA's individual mandate, and will have other ramifications for health care. The National Council for Behavioral Health released a statement, saying, "It is disturbing that with virtually no input from the people who depend on entitlement programs like Medicaid. Medicare and Social Security, the bills cut the federal revenue necessary to care for millions of Americans living with mental illnesses and addictions."

'Difficult Year'

"It was a difficult year for people with mental illnesses," Jennifer Mathis, deputy legal director and di-rector of policy and legal advocacy for the Bazelon Center for Mental Health Law, told MHW. In looking at legislative actions that took place over the past year, the field has witnessed some significant victories, including the defeat of some potentially "disastrous" legislation, she said. "The legislation would have gutted the Medicaid program, and most of the advances brought by the ACA for people with disabilities, including psychiatric disabilities," she said.

Mathis added that preserving the ACA was a significant victory. "Obviously, some of the damage will be done by the [provision] in the tax bill because it repeals the individual mandate – a core part of the ACA and one of the pieces that made protections of the ACA possible," she said.

According to the Congressional Budget Office, repealing the individual mandate will increase the number of uninsured people by 4 million in 2019 and 13 million in 2027.

Premiums are expected to go up as young and healthy people exit the insurance pool, Mathis noted. In addition to repealing the individual mandate, the new tax law has impacted other programs as well, she said. "Creating that deficit will trigger automatic cuts to other programs, including Medicare, Temporary Assistance for Needy Families, and rehabilitation services and social services," she noted. "These are significant cuts triggered by the whole sequestration."

The Bazelon Center is very concerned about CHIP, which was allowed to expire at the end of September 2017, said Mathis. Some states are expected to run out of funding in January, she said. CHIP provides low-cost health insurance to 9 million children. "That's significant for kids with disabilities and kids not covered by Medicaid," she said. "That's very concerning and the reason I say it's been a very difficult year."

Other issues include workplace privacy protections for people with disabilities, which are being eliminated under the Americans with Disabilities Act (ADA), said Mathis. H.R. 1313, which preserves employee wellness programs, has stalled, she said. "If Congress starts weakening the [bill], that doesn't bode well for people with mental illness," she said. "We've been monitoring and advocating for that as well. These are some of the main actions we're watching in Congress."

ISMICC report

The field hailed the release of the first report to Congress by the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) on Dec. 14, 2017. "The Way Forward: Federal Action for a System That

Works for All People Living with SMI and SED and Their Families and Caregivers" provides a roadmap for improving mental health services for adults living with serious mental illness (SMI) and children and youth who experience serious emotional disturbances (SEDs).

The report's area of focus included increasing access to care and developing financial strategies that increase the availability and affordability of care. It also calls attention to screening and early intervention across all primary care settings and in schools (see MHW, Dec. 18, 2017).

The ISMICC, chaired by Elinore F. McCance-Katz, M.D., Ph.D., U.S. Health and Human Services (HHS) assistant secretary, is charged with making specific recommendations for actions that federal departments can take to better coordinate the administration of mental health services for adults with SMI or children with SEDs. Its inaugural meeting was held Aug. 31 (see MHW, Sept. 11, 2017).

Maintaining Protections

"Congress was not successful in repealing the ACA," Laurel Stine, J.D. director of congressional affairs for the American Psychological Association Practice Organization, told MHW. "We wrote several letters this year predominantly on the ACA," Stine said of the Mental Health Liaison Group, which she co-chairs. Defending the Medicaid expansion was critical, she said, particularly in light of the number of bills that "at-tacked" the ACA in one way or another, she said.

Marketplace protections are also strong, she noted. However, the major attack on the ACA was the repeal of the individual mandate, a "devastating blow to the ACA," she said.

"The big issue in 2017 is advocates keeping the ACA as strong as it is," said Stine. The Medicaid expansion and other consumer protections still exist, she noted. "The ACA is still the law of the land," said Stine. "It's still a victory in and of itself." ACA enrollment is also at its highest, she noted. A recent poll revealed the ACA received a 56 percent approval rating, Stine said. "it's another thing advocates can hail," she said. "Those are victories. The ACA still remains strong and that's our message."

Last year represented the first time Congress had bipartisan bills in both chambers involving the Health Information Technology for Economic and Clinical Health (HITECH) Act, said Stine. Sens. Sheldon White-house (D-Rhode Island) and Rob Portman (R-Ohio) and former Rep. Tim Murphy (R-Pennsylvania) all had bills to include behavioral health providers in the HITECH Act. Additionally, Reps. Doris Matsui (D-California) and Lynn Jenkins (R-Kansas) have also introduce legislation.

"We're very excited about these bills, particularly because the legislation would help psychologists, community mental health centers, psychiatric hospitals, social workers, [all of whom had been] initially left out of the HITECH Act," Stine said.

The HITECH Act provides HHS with the authority to establish pro-grams to improve health care quality, safety and efficiency through the promotion of health IT, including electronic health records and a private and secure electronic health information exchange.

Stine also pointed to a letter prepared by Sens. Whitehouse and Portman and Reps. Matsui and Jenkins to Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma on Nov. 17, 2017. The letter urged the CMS to build financial incentives for adoption and use of health information technology by mental health and substance use treatment providers into new models the agency plans to pursue for behavioral health.

"The overarching issue is that the ACA remains strong despite GOD-led acts on the ACA, which would have undermined Medicaid expansion and other hallmark provisions within the ACA," said Stine.

Vulnerable Populations

2017 has been a year of significant change, Mark Covall, president and CEO of the National Association of Psychiatric Health Systems (NAPHS), told MHW. The organization's first mandate was to ensure that health insurance coverage continued to be available for all Americans with mental health and addiction disorders. "Our priority was to maintain coverage for the most vulnerable population," he said.

Another main focus in 2017 was keeping parity protections, said Covall. A very important message had been sent to Congress, he noted: Patient protections are essential and critical and need to be maintained.

"That's our main message around recovery and parity," he said. The ACA was a bipartisan deal, he added.

NAPHS is also very involved in addressing the opioid crisis and in trying to obtain additional resources, Covall said. The Medicaid expansion was key for addiction treatment, and wasn't available previously, he said. Medicaid is the largest funder of mental health services and a significant funder of addiction treatment, said Covall. "That program continues to be there," he added.

Covall said it's been a huge disappointment to the field that CHIP was not extended for an additional five years. "Nine million children are on the program, many with mental health and addiction problems," he said. "That is a safety net for them." States will experience difficulty continuing the program, he said. It's still unknown what the long-term impact will be, said Covall.

"One thing everyone agrees on is the growing consensus about the real need to deal with barriers to accessing care called the IMD [the Medicaid Institutions for Mental Dis-eases] exclusion," he said. It's one issue that continues to receive sup-port from Democrats and Republicans, he noted.

The CMS is looking at different waiver opportunities for the IMD exclusion, including a specific waiver for substance use disorders, Covall said. "We have a legislative fix," he said. "We're getting close to an ultimate remedy for this long-standing, discriminatory practice."

CMS approves first 10-year section 1115 demonstration extension

(Note: while this 1115 waiver address Medicaid eligibility extension and family planning services, its approval, by CMS, sets the stage for other longer-life 1115 waivers, including those covering Medicaid mental health care))

Recently, CMS approved for Mississippi the first ever 10-year extension under the Medicaid program demonstration extension to provide further coverage of family planning services in the state. This will extend eligibility for women and men ages 13 through 44, with income up to 194 percent of the federal poverty level (FPL) that are not enrolled in Medicaid, Medicare, the Children's Health Insurance Program (CHIP) or other creditable health insurance coverage that includes family planning services. Mississippi's waiver will be the 25th demonstration action approved by CMS since January 21, 2017.

"This is the first ten-year demonstration extension in the history of CMS, and allows Mississippi to administer its Medicaid program without the inconvenience of obtaining routine approvals from CMS," said CMS Administrator Seema Verma. "This action shows our continuing commitment to giving states the flexibility they deserve to meet the unique needs of their people."

CMS has instituted a series of improvements to reduce regulatory burdens, increase efficiency and promote transparency in the review and approval of Section 1115 demonstrations. In accordance with the new section 1115 policy released on November 6, 2017, Mississippi's program meets all elements required for a 10-year approval.

Other changes made to the demonstration's Special Terms and Conditions (STCs) for this approval also align with this Administration's priority to assure adequate federal oversight and evaluation:

- On an annual basis, the state will submit monitoring reports and participate in calls with CMS.
- The state will have a new streamlined template for annual monitoring and reporting while ensuring that CMS receives the appropriate information for assessing demonstration outcomes.

"CMS has responded to state requests to reduce administrative burden," said CMCS Director and Deputy Administrator Brian Neale. "Mississippi's waiver shows the concrete steps we are taking to improve efficiency across the board and throughout the country."

In a March 14, 2017 letter to Governors (https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html), the Department of Health and Human Services and CMS announced a new commitment "to empower all states to advance the next wave of innovative solutions to Medicaid's challenges – solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner."

For more information regarding the 10-year extension of the Mississippi Family Planning Demonstration, please click here: https://www.medicaid.gov/Medicaid-DHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-family-planning-medicaid-expansion-project-ca.pdf

RTTC year end report: Reflecting on a Good Year: Meaningful Research Promoting Community Inclusion and Participation

Below is a recent, year-end report from the Temple University Rehabilitation Research and Training Center (RRTC) on a range of community inclusion efforts:

> The Temple University Center, funded by the National Institute on Disability, Independent Living and Rehabilitation Research (NIDILRR), has had a substantial number of research accomplishments this past year (see below), and we are encouraged by the continuing interest in this research from peers, policy makers, and practitioners coast-to-coast in the U.S. (and from Hawaii). We've had strong interest as well from around the world: in 2017 we shared our research findings in visits to New Zealand, Australia, Bosnia and Hercegovina, and the United Kingdom)!
>
> Here's some of what our research publications have been focusing upon:
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> Community participation in re-entry planning and policies for those with mental illnesses who have been involved in the criminal justice system
>
> - Liz Thomas, Jeff Draine, and others have a new article in press – **Conceptualizing Restorative Justice for People with Mental Illnesses Leaving Prison or Jail**" – with the American Journal of Orthopsychiatry
> - Amy Wilson (a colleague from the University of North Carolina) and Temple Center investigators published "**Community Participation among individuals with Psychiatric Disabilities Leaving Jail,**" in the Journal of Psychosocial Rehabilitation and Mental Health (https://link.springer.com/article/10.1007/s40737-016-0074-5).
>
> Understanding community participation from a developmental perspective
>
> - Thomas E., Snethen, G., & Salzer, M.S. (2017). **A Developmental Study of Community Participation of Individuals with Serious Mental Illnesses: Implications for Policy and Practice**. American Journal of Orthopsychiatry (https://www.ncbi.nim.nih.gov/pubmed/28394152)
>
> Examining inclusion of faculty members with mental health issues
>
> - Price, M., Salzer, M.S., O'Shea, A., & Kerschbaum, S. (2017). **Disclosing Mental Illness in Higher Education: A National Survey of Faculty Members.** Disabilities Studies Quarterly, 37(2). http://dsq-sda.org/article/view/5487/4653

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In the New Year we'll continue work on other exciting research initiatives: 1) continuing recruitment in our national supported education study; 2) analyzing our massive GIS, GPS, and accelerometer datasets; and 3) keeping up with the robust response to our "Welcoming Spaces" study, identifying characteristics of the places where people with mental illnesses feel most comfortable

Finally, we were excited by the decision of more than 200 researchers, consumers, family members, providers and policymakers from around the country to join us in July 2017 for our state-of-the-science institute on community inclusion: you can read a summary of the event at: (http://tucollaborative.org/wp-content/uploards/A-Report-from-the-National-State-of-the-Science-Institute-on-Community-Inclusion-2017-1.pdf)

CMHAM WINTER CONFERENCE – REGISTRTION OPEN NEXT WEEK

The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & &, 2018 at the Radisson Plaza Hotel & Suites, Kalamazoo. The conference will feature 4 powerful keynote addresses, a wide variety of workshops, as well as a pre-conference institute on Enhancing Employment. The Workforce Innovation and Opportunity and Opportunity Act and Other Developments. Watch for registration information next week!

Keynote Addresses:

Current Efforts toward Behavioral Health and Justice Collaborations for Better Outcomes
- *Debra A. Pinals, MD, Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services*

I Have Been Running my Entire Life – I am Finally Free
- *Dominic Carter, Veteran Newsman, Mental Health Advocate, Author, and Speaker*

What's Hot in Behavioral Health – A National Update
- *Charles Ingoglia – Senior Vice President, Public Policy and Practice Improvement, National Council for Behavioral Healthcare*

The Life, the Game, the Pain and the Transition
- *Adrian Muldrow, Founder, We Can Achieve Youth Advocacy Project*

Pre-Conference Institute
February 5, 2018 from 1:00pm – 4:00pm
Enhancing Employment: The Workforce Innovation and Opportunity and Opportunity Act and Other Developments
- *David Michael Mank, Ph.D., Professor Emeritus, Indiana University*

Hotel Information:
Radisson Plaza Hotel & Suites, 100 W. Michigan Ave., Kalamazoo, MI 49007
2018 Room Rates: $131 plus taxes (Single/Double)
Deadline for special room rate: Monday, January 15, 2018 or until the room block fills.
Parking: Discounted rate for self-parking of $5 per care per night for overnight guests.

To make online reservations:
- Go to: radissonkz.com

- Enter check in and check out dates: If a guest wants to extend their stay past the conference dates they must call the Hotel directly.
- Select more search options and enter promotion code: MACM18
- Complete reservations

To make reservations via phone: call 269-343-3333 and reference "CMHAM/MACMHB 2018 Winter Conference" to receive the discounted rate.

CMH Association committee schedules, membership, minutes and information go to our website at https://www.macmhb.org/committees

WEBINAR: BUSINESS OR EXPLOITATION?" EXPOSURE OF THE TOBACCO INDUSTRY'S EXPLOITATION OF INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

The Smoking Cessation Leadership Center (SCLC) is excited to be hosting our **75th webinar** with our partners, the National Behavioral Health Network for Tobacco and Cancer Control (NBHN), and the Truth Initiative®. We invite you to register for this **One-Hour Power Break** webinar: "***Business or Exploitation?" Exposure of the tobacco industry's exploitation of individuals with mental health conditions*** on **Thursday, January 18, 2018, at 1:00pm EST** (60 minutes).

We are honored to have the following speakers presenting on this topic for us:

- **Margaret Jaco Manecke, MSSW**, Project Manager, Practice Improvement, National Council for Behavioral Health
- **Ashley Persie,** Senior Brand Marketing Associate, Truth Initiative®
- **Judith (Jodi) Prochaska, PhD, MPH,** Associate Professor of Medicine, Stanford University

Webinar Objectives:

1. Explain why people with mental health conditions (depression and ADHD, for example) and substance use disorders have been historically targeted by the tobacco industry.
2. State whether adults with mental health conditions and substance use disorder smoke more than adults without those conditions.
3. Describe the morbidity rates of people with mental health conditions and name specific causes of death that can be attributed to tobacco use.
4. Explain the impact of the **truth®** campaign among its target audience.
5. Describe evidence-based approaches for treating tobacco use and tobacco addiction in persons with co-occurring mental illness.
6. Describe how you can leverage the National Behavioral Health Network for Tobacco & Cancer Control's tool, resources, and network to combat tobacco use & cancer disparities among individuals with mental illnesses and addictions and network members.

REGISTER HERE: https://cc.readytalk.com/r/eyjfkcfgqogs&eom

CME/CEUs will be available for participants who join the **LIVE** session, on **January 18, 2018.** You will receive instructions on how to claim credit via the post webinar email.

Have a Great Weekend!

Behavioral Health and Developmental Disabilities Administration

Veteran and Military Service Members Three-Year Strategic Plan Supplement

November, 2016

Updated December, 2017 to Reflect First Year Activity

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

STATC OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

November 16, 2016

The Service that our Veteran and Military families have rendered in Michigan, across our Nation and around our world demands that we take significant strides to assist them in recovering to health in the challenging areas of life. Veterans and Military families face mental health and substance abuse issues that, more often than not, remain unmet. As a result of those unmet needs these individuals and families struggle to reintegrate, thrive and effectively engage in their local community.

Based on National data that demonstrated the need for a more direct approach to Veteran and Military family behavioral health intervention, in May,2016 the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) created a Veteran liaison position. The BHDDA Veteran liaison is the recognized resource between the MDHHS, BHDDA and the Military and Veterans Affairs Administration (MVAA} for Veteran-related activities within the publicly funded behavioral health system. This includes responsibility to develop and oversee BHDDA-related activities and actions plans to support Veterans and Military families in Michigan.

The BHDDA Veteran liaison has been working diligently with others within MDHHS and the behavioral health service delivery system to implement a process of assessing the needs and identifying the gaps in services to our Veteran and Military families across the State. This information has been used to develop a plan for building capacity to better address these needs in the publicly funded behavioral health care system over the course of the next three years.

This has been and will continue to be a team effort. Other MDHHS and BHDDA staff, Prepaid Inpatient Health Plan directors, Community Mental Health Services Providers chief executive officers and staff, Substance Use Disorder directors, and other community organizations across the State have been open minded, supportive and encouraged by the goals and emphasis that is being proposed in this strategic plan. We thank them for their time, energy and input.

Our initial push is ongoing, the positive feedback we are receiving is evidence that we are heading in the right direction. There is much work to be done, relationships to build, and capacity to be developed. With the support of each of you reading this plan, we will, together, accomplish the mission of taking care of Veterans and Military families in the publicly funded behavioral health system who bear this Nation's burdens, as is our moral obligation. We are excited about the future of this collaborative venture as it evolves in the weeks, months and years to come. I thank you in advance for your support.

Lynda Zeller, Deputy Director
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Health and Human Services

MDHHS Behavioral Health and Developmental Disabilities Administration gratefully acknowledges the following organizations and individuals for their time, insights and support in the development of this strategic plan.

Prepaid Inpatient Health Plans (PIHP) Directors
PIHP Substance Use Disorder (SUD) Directors
Elena Bridges – Altarum Institute
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Psychological Health Team – Michigan Army National Guard
Dr. Adrian Blow – Michigan State University – Star Behavioral Health Providers
Center for Defense Psychology Team from Fort Hood
Dr. Lisa Gorman
Leslie Shonlian, CEO Michigan Veterans Health System
Star Behavioral Health Training Team
Veterans Community Action Team (VCAT) – Region 8 Leadership Team and organizations as well as leadership forum
VCAT – Region 10 Leadership Team and organizations
VCAT – Region 6 Leadership Team and organizations
VCAT – Region 5 Leadership Team and organizations
VCAT – Region 2 Leadership Team and organizations
VCAT – Region 1 Leadership Team and organizations
VCAT – Region 3 Veterans Leadership Forum
Robert Stewart – Give an Hour Executive Director/Michigan
Amy Smolski – Macomb County Community Mental Health Service Provider (CMHSP)
Shaun Taft – Outreach Director/Wayne County Volunteers of America, Easter Seals
Army Reserve Staff Meeting/Walker MI office
Lapeer County CMHSP Team
Sanilac County CMHSP Team
Tuscola County CMHSP Team
Jackson County/Integro Staff
Northern Lakes CMHSP Staff
Macomb County CMHSP Staff
Saginaw Veteran Affairs (VA)
Battle Creek VA
Ann Arbor VA
VA Summits in Traverse City, Ann Arbor, and Grand Rapids
211 Michigan – Tom Page
211 Northeast Michigan – Sarah Kile
Family Assistance Coordinators – Michigan Army National Guard
Jane Spinner – Military Support Programs and Networks (MSPAN) – University of Michigan
Stephanie Zarb – Director Buddy-To-Buddy
Nick Anderson – Family Program Director – Michigan Army National Guard
Mark Sutton – Public Affairs – American Legion
Nancy Grijalva – Michigan Department of Health and Human Services
Jo Moncher – Director – State of New Hampshire, Department of Health and Human Services
Vet Center in Milford
Vet Center in Shelby Township

EXECUTIVE SUMMARY

A WARNING ORDER AND HOPE

The culture of our Armed Forces is built around an ethos of Loyalty, Honor, Sacrifice and Brotherhood. A culture with its own language full of acronyms and names for each letter of the alphabet. A culture that can be Veteran-to-Veteran, Buddy-to-Buddy, which means they don't just tell anyone their "issues" or "challenges." Where discipline, motivation, leadership, love of Country and family are at the pinnacle of accomplishing the "Mission." In the Veteran/Military world, completing the "Mission" provides the right to go home. Long before a soldier goes on a deployment he gets a "WARNO", a warning order that he is going to fight or provide support for his unit, his Country, his family, his battle buddies. This Behavioral Health and Developmental Disabilities Administration (BHDDA) strategic plan is a warning order for our publicly funded behavioral health service delivery system. It is a worthy warning order that will describe the support that we all need to prepare ourselves to deliver effective services for our Veteran and Military families to fully complete their mission, and truly BE Home.

In 2013, Governor Rick Snyder initiated the Michigan Veterans Affairs Agency (MVAA) with the Mission to serve as the central coordinating point, connecting those who have served in the United States Armed Forces and their families, to services and benefits throughout the state of Michigan. Through the Veterans Community Action Teams (VCATs) that were created out of this mission, Veteran and Military family care throughout our State has increased significantly since 2013. There is momentum and a positive mindset which must now be translated across the landscape of multiple state, regional and local organizations within the publicly funded behavioral health care system.

The BHDDA plan that follows aligns with the MVAA vision for Michigan "to be the most Veteran-friendly state by providing the advice and assistance Veterans need as they transition through the chapters of their lives; creating a "no wrong door" customer service culture; and advocating for and on behalf of Veterans and their families." The BHDDA plan can also clearly be matched to the MVAA Goal #4 to Enhance Interagency Collaboration and Leverage Partnerships.

Over the course of the previous four months, various discussions and meetings were held with key stakeholders as this BHDDA plan was being developed. **The overarching goal of the BHDDA strategic plan is to create a system that will ensure Veterans, Military members and their families receive efficient, comprehensive and sustained behavioral health services in the publicly funded system, which includes access to other community resources to address their identified needs.**

The following objectives will lead toward achieving this goal:

1. Conduct cross-training initiatives to assure the publicly funded behavioral health care system is appropriately trained on Veteran and Military culture; and provide training on effective behavioral health care screening and referral for Veteran and Military groups as requested
2. Engage in inter-and-intra agency collaboration in order to leverage resources and partnerships
3. Identify, train and embed PIHP Regional Veteran Navigators into the publicly funded behavioral health care system throughout the State of Michigan

4. Provide the publicly funded behavioral health care system with resources to evidence-based programs in order to strengthen Military families
5. Develop processes and systems to gather and utilize data to gain a clearer perspective on Veteran and Military families in Michigan, their needs and gaps in services
6. Leverage additional resources for long-term sustainability of this plan

The core of this BHDDA plan is designed around a 5-pronged coordinated approach among key stakeholders and their partners to meet the comprehensive needs of Veterans and Military family members across the state: (1) MDHHS, including BHDDA and provider network of PIHPs, CMHSPs, and SUD treatment and prevention providers, as well as Adult/Family Services local offices and the Director's office Veteran Liaison; (2) Veteran's Affairs and MVAA, in conjunction with VCATs, MVTF, and VCAT Regional Coordinators; (3) MIARNG; (4) Other significant community assets including 211, Give an Hour, Partners in Care, MSPAN-Buddy-to-Buddy and service groups such as the VFW and American Legion; and (5) Cross-Training on military culture for the behavioral health care field and training on behavioral health issues for Military units.

This plan will be phased in over the course of three years utilizing three Cohorts identified by PIHP Regions. Cohort 1 (C1), prioritized for Year 1 includes the counties in PIHP Regions 2, 3, 9 and 10. Cohort 2 (C2) includes the counties in PIHP Regions 1, 4, 5 and 6. Cohort 3 (C3) will be implemented in the final year of the plan, and includes PIHP Region 7 and 8. Regions were determined based on identified need, capacity, and readiness. Outcomes will be monitored beginning in Year 1, and any adjustments needed will be made prior to the next Cohort initiating activity. **Update- During the first year of the plan's implementation, BHDDA was able to utilize a combination of mental health block grant and substance abuse block grant to provide funding to all 10 PIHP regions to embed a regional Veteran Navigator at the local level.**

BHDDA believes that with this all-encompassing approach of collaboration and coordination, an effective environment can be created to greatly increase capacity to provide adequate services to Veteran and Military families accessing the publicly funded behavioral health care system in Michigan.

VETERAN AND MILITARY FAMILY CHALLENGES

There are an estimated 23.4 million Veterans in the United States, approximately 2.2 million military service members, and 3.1 million immediate family members. Staggering numbers with significant challenges.

Here in the State of Michigan we have unique challenges as well. We are for the most part a National Guard and Reserve state. This means that with no large active duty bases to provide significant support and resources, we must be creative, innovative, collaborative and intentional in our approaches regarding Veteran and Military family care. These families have struggled and survived through multiple deployments, significant changes and are left with little support upon their return. (samhsa.gov/veterans-military-families)

Although active duty troops and their families are eligible for care from the U.S Department of Defense (DoD), a significant number choose not to access those services due to fear of discrimination or the harm receiving treatment for behavioral health issues may have on their own or a spouses military career. National Guard and Reserve troops who have served in Iraq or Afghanistan (approximately 40% of the total) are eligible for behavioral health services from the VA, but many are unable or unwilling to access those services for the same reasons. National Guard and Reserve in the State of Michigan may reluctantly seek out care in their local community and then become aware that they are not eligible for publicly funded behavioral health care services due to lack of insurance, ineligibility for Medicaid, or the agency where they are seeking services is not a TRICARE provider. (samhsa.gov/veterans-military-families)

The demanding environments of military life and experiences of combat, during which many Veterans experience psychological distress, can be further complicated by substance use and related disorders. Many service members face critical issues such as trauma, suicide, homelessness, and/or involvement with the criminal justice system. Approximately 18.5% of service members returning from Iraq or Afghanistan have post-traumatic stress disorder (PTSD) or depression, and 19.5% report experiencing a traumatic brain injury (TBI) during deployment. Approximately 50% of returning service members who need treatment for mental health conditions seek it, but only slightly less than half who receive treatment receive adequate care. Across the country, 11% of U.S. Veterans meet the criteria for a substance use disorder. (samhsa.gov/veterans-military-families/critical-issues)

Substance use, or the term used frequently in the military of “self-medicating,” is on the rise and giving birth to substantial challenges. Veteran Affairs (VA) data also shows that 22% of those from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the war in Afghanistan, have a substance use disorder. Studies show that alcohol misuse and abuse, hazardous drinking, and binge drinking are common among OEF and OIF Veterans. Multiple deployments and increased combat exposure involving violence or human trauma among OIF Veterans was linked to more frequent and greater quantities of alcohol use than was less exposure to such combat. (SAMHSA Newsletter Fall 2011 Volume 19 Number 3 Pg 7)

Behavioral health issues, such as depression, post-traumatic stress disorder (PTSD), substance use disorder (SUD), and traumatic brain injury (TBI), also increase the likelihood of suicide attempts. One study showed that Veterans with PTSD were more than four times likely to report thoughts of

suicide than were those without PTSD. Thoughts of suicide is a strong predictor of a future suicide attempt. A recent study also showed that Veterans who are unmarried or who report lower satisfaction with their social networks are at higher risk for suicide.

FEMALE VETERANS

The number of women involved in OEF and OIF, those who continue to serve today, and the scope of their duties are unmatched historically. The rates at which female Veterans experience certain behavioral health issues vary from those of male Veterans. For example, female Veterans are more than twice as likely as male Veterans to have experienced a major depressive event within the past year. VA data also shows that female Veterans are much more likely than male Veterans to screen positive for military sexual trauma, 1 in 5 versus 1 in 100. Such trauma is associated with both substance abuse and mental disorders including PTSD, depression and other anxiety disorders. (http://archive.samhsa.gov/samhsaNewsletter/Volume_16_Number_6/WomenInMilitary.aspx)

CHILDREN OF VETERAN AND MILITARY MEMBERS

Cumulative lengths of deployments are associated with more emotional difficulties among military children and more mental health diagnoses occur among U.S. Army wives. Children of deployed military personnel have more school, family and peer related emotional difficulties compared with national samples as well as being significantly at-risk regarding traumatic stress and grief based on the amount of negative social, political and media input they receive in abundant measures.

THE CURRENT SITUATION IN MICHIGAN REGARDING VETERAN AND MILITARY FAMILY MENTAL HEALTH CARE

The Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) in Michigan has exceptional leaders and staff in place to effectively work with and treat our Veteran and Military families. This includes the publicly funded network of regional Prepaid Inpatient Health Plans (PIHPs), local Community Mental Health Service Providers (CMHSPs) and Substance Use Disorder (SUD) prevention and treatment providers. There are, however, significant barriers to treatment and gaps in services across the continuum of providing adequate treatment and wrap-around community based services to these members.

Substance abuse issues remain significantly unmet within the Veteran and Military families, and have been consistently overlooked. There exists within certain segments of behavioral health across the State a sense of territorialism in regards to implementation and personnel. In regards to publicly funded behavioral health care system across Michigan there has not been an intentional approach to treatment of Veteran and Military families. It has been, at best, hit and miss due in part to no specific program to support this mission holistically from beginning to end.

There are several individuals and organizations across the state who are informally providing various supports and services to some degree. Currently, limited data is being captured through the screening, assessment and referral to treatment process that would allow insight into best practices and/or barriers to treatment. There is no formal process in place within the publicly funded behavioral health care system to ensure that Veteran and Military families receive appropriate mental health or substance abuse treatment. Among publicly funded behavioral health care providers, there is also sporadic or limited awareness of other community resources available

where Veterans can be referred. The process of referral must include follow-up on referrals in order to ensure that these individuals and families are engaged in supports and services that are meeting their needs.

The best way to provide effective treatment to any demographic group is to KNOW that group. As previously mentioned, military families have a specific culture and unique behavioral health care needs that may not be understood within the larger community and general population. At the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) supports the behavioral health care needs of America's service men and women, active duty, National Guard, Reserve and Veterans, as well as their families. SAMHSA is leading efforts to ensure that community based services are accessible, culturally competent, and trauma informed. One Veteran stated "Finding a community-based provider who understands the military culture and language is hit and miss; and that understanding can be the difference between receiving ongoing effective treatment and not returning for a second appointment." Another active duty soldier concurs, and said that after months of heavy drinking and misuse of prescription drugs, he turned to a community-based provider for help because he didn't want to risk being kicked out of the Army after 20 years of service. (SAMHSA News Fall 2011, Volume 19 Number 3, Pg 5)

Currently there exists no formal advertising/marketing campaign to expose our Veterans and Military family members to possible publicly funded behavioral health care services. A significant push regarding advertising and marketing of proposed programs will be necessary to the success of BHDDAs goals and long term vision.

Due to Michigan being a majority National Guard and Reserve state, there are a significant number of service members that have TRICARE insurance and/or access to CHOICE insurance through the VA. TRICARE and CHOICE insurances are legally designated as Non-VA Healthcare Insurance. Ninety-five percent (95%) of publicly funded behavioral health care service providers in Michigan are not paneled or certified as TRICARE/CHOICE providers. SAMHSA encourages private-sector and publicly funded service providers to become TRICARE-authorized (certified) practitioners to ensure they are eligible for reimbursement for their services to military members and their families. SAMHSA also encourages behavioral health care professionals to serve our men and women in uniform, noting their help can ensure our military consumers continue treatment and therapy and have a greater opportunity to recover. Supporting and strengthening our military families is not only critical to our national security, it is a national moral obligation. (SAMHSA News Fall 2011, Volume 19 Number 3)

Update: During the first year of this strategic plan's implementation (2017) federal mental health block grant (MHBG) and substance abuse prevention and treatment block grant (SABG) funding began to be used to fund Regional Veteran Navigators in each of the ten PIHP regions. Although it is anticipated this will help build a solid infrastructure moving forward, there currently remains a significant barrier to treatment for Veteran and Military families. As Veterans and their family members are introduced to resources available within and through the publicly funded behavioral health care system, there must be consistent processes in place that will make it possible for them to receive ongoing treatment and care.

PAVING THE WAY: Updated to Reflect First Year Activity

The needs and challenges that our Veteran and Military families have are significant; however we must find a path over, around, or through any obstacle. Many times Military families figure this out

on their own, at great cost. BHDDA believes we have an opportunity before us to help move some of these mountains for them.

As the strategic plan was being developed and in the first year of implementation, the BHDDA Veteran Liaison met and spoke with PIHP Directors, CMHSP CEO's and their staff, SUD Directors, community leaders, and Veteran Community Action Teams (VCATs) in conjunction with the MVAA. In addition to face-to-face meetings, there have also been several phone conferences. These meetings and conferences were used initially to gather input on needs and challenges facing Veteran's and Military families, as well as ideas on how to address, alleviate and remove barriers for access to behavioral health care services in Michigan.

In addition to the above contacts, other major stakeholders at the state and national level were consulted and have provided input into the BHDDA plan. Attempts were made to contact all the key stakeholders when it comes to providing essential, effective and immediate delivery of services to our Veteran and Military families. These stakeholders include the Veterans Affairs Administration (VA) and the Michigan Veterans Affairs Agency (MVAA). The VA currently provides the highest delivery of services to Michigan's military community through facilities in Detroit, Ann Arbor, Battle Creek, Saginaw and Iron Mountain. The MVAA, with their Resource Center and Regional Coordinators located throughout the State, is also a key stakeholder. The MVAA VCATs, a system of community organizations currently functioning across the 10 Prosperity Regions in Michigan, were also instrumental in the development and implementation of this plan.

Other statewide collaborators include the Michigan Army National Guard (MIARNG), which has significant resources in the areas of psychological health, substance abuse, suicide prevention, Military child programs, and Family Assistant Coordinators stationed at armories across 9 Regions. Relationships have also been developed with 211, Give-An-Hour, faith-based organizations and two major service organizations for Veterans: the Veterans of Foreign Wars (VFW) and the American Legion.

One of the overarching needs identified through these conversations is a lack of understanding of military culture in the publicly funded behavioral health care service delivery network. To address this need, military cultural competency training for all publicly funded behavioral health providers is an integral part of the BHDDA plan. Star Behavioral Health Providers has been providing training to many CMHSP leaders and staff, as well as many Veteran organizations throughout Michigan. After participating in two of these trainings, the BHDDA Veteran Liaison believed this is the appropriate model to address military cultural competency to serve the needs in the publicly funded behavioral health system. Feedback from clinicians receiving the training have stated "before learning about the military culture, I couldn't fully appreciate my military clients' problems. I didn't understand much of the terminology. I have a new appreciation for their experiences and I am changing my goals to being more family centric." Clinicians also report feeling more confident asking individuals who are Veterans or Military member's questions about their experiences. These questions help build rapport, and demonstrate that the clinician understands some of their culture. (SAMHSA News Fall 2011, Volume 19 Number 3, Pg 5-6)

At the core of this BHDDA plan, the base is designed around a 5-pronged coordinated approach among the stakeholders identified above and their partners to meet the comprehensive needs of Veterans and Military family members across the state. These prongs are:

1. **Michigan Department of Health and Human Services**
    a. BHDDA, in conjunction with
        i. Regional Prepaid Inpatient Health Plans (PIHPs)
        ii. Community Mental Health Service Providers (CMHSPs)
        iii. Substance Use Disorders Prevention and Treatment Providers (SUDs)
    b. Adult/Family Services
        i. Local County offices
    c. Director's Office Veteran Liaison

2. **Veteran's Affairs and the Michigan MVAA**
    a. Veteran Community Action Teams (VCATs)
    b. Michigan Veteran Trust Fund (MVTF)
    c. VCAT Regional Coordinators and Call-In line

3. **Michigan Army National Guard (MIARNG)**
    a. Family Assistance Centers (FACs)
    b. Independent contractors for substance abuse, suicide prevention and psychological health
    c. Military Child Program

4. **Other Significant Community Assets**
    a. 211
    b. Give An Hour
    c. Partners in Care
    d. Buddy-to-Buddy
    e. Service Groups (VFW, American Legion, etc.)

5. **Cross-Training**
    a. Military Culture training for the behavioral health care field through Star Behavioral Health Providers
    b. Behavioral health training for Military units
    c. Regional Veteran Navigators T4T to foster and instill culture of Veteran care within their respective PIHP Region

WINNING THE BATTLE: IMPLEMENTATION

The initial 3-year plan outlined a step-by-step process that provides specific, measurable benchmarks that will spur efforts forward as BHDDA continues to build capacity throughout the State to encourage a proactive approach to the delivery of behavioral health services to our Veterans and Military families.

As part of the needs assessment and capacity building process, information gathered was prioritized and turned into goals, objectives and action steps. Once the plan began to be developed, significant discussions with stakeholders continued to determine if we were accurate in identifying their challenges and barriers, and that the plan was heading in the right direction. These discussions generated much support and encouragement. In addition, over the last four years the State of New Hampshire has been embarking on a similar journey as the BHDDA strategic plan outlines. Michigan is farther ahead in the areas of collaboration within our communities than New

Hampshire was when they began their mission, yet they have been overwhelmingly successful. Despite the need to first build collaborative partnerships, the accomplishments New Hampshire and Texas have achieved is further confirmation what we have set goals and a direction that is doable and effective.

Update: As previously identified, utilizing federal MHBG and SABG funding, beginning in April, 2017 support began to be provided to the 10 PIHP regions to support the implementation and ongoing increase in service delivery. The first cohort receiving priority from October 1, 2016 through September 30, 2017 included Region 2, 3, 9, and 10. The second cohort receiving priority from October 1, 2017 through September 30, 2018 includes Region 1, 4, 5, and 6. Outcomes will be monitored on the first two cohorts, and any adjustments needing to be made will be complete for the third and final year of this plan's implementation. Cohort 3 will be implemented during the final year of this plan, October 1, 2018 through September 30, 2019. Regions 7 and 8 will be included. A map of the Regional PIHP's is attached to this document.

Update Note: As the first year of this strategic plan implementation ended, it has been updated to reflect accomplishments achieved and any readjustments needed moving forward in the remaining two years. Those are identified in the following tables of objectives and action steps.

The overarching goal is to create a system that will ensure Veterans, Military members and their families receive efficient, comprehensive and sustained behavioral health services in the publicly funded system, which includes access to other community resources to address their identified needs. As noted previously, the base of this plan is designed around a 5 prong coordinated approach to meet the comprehensive needs of these individuals and families.

Objectives, Action Steps, and Timeframes of the BHDDA strategic plan.

Objective 1: Conduct cross-training initiatives to assure the publicly funded behavioral health care system is appropriately trained on Veteran and Military culture; and provide training on effective behavioral health care screening and referral for Veteran and Military groups as requested.

Action Steps	Start Date	End Date	Update
1.1: Develop contract with Michigan State University for Star Behavioral Health Providers to conduct up to 6 regional trainings per year for behavioral health care system in target communities on Military competency, Mental Health First Aid for Veterans, and other evidence-based programs	C1: 4/1/17	9/30/17	Complete
	C2: 10/1/17	9/30/18	Initiated & Planned
	C3: See new item 1.5 below		Determined FY18 will be last for Star training
1.2: Identify and confirm locations and logistics at least three months prior to scheduled trainings	Varies by date/region	4/1/19	Ongoing
1.3: Conduct Motivational Interviewing (MI) and Screening, Brief Intervention & Referral to Treatment (SBIRT) training for MIARNG Chaplain Corp; provide follow-up technical assistance as requested	July, 2017	9/30/17	Deferred to FY18 due to other priorities of MIARNG
1.4: Conduct MI and SBIRT training for other Veteran and Military groups as requested	10/1/17	Ongoing	Initiated and Ongoing
1.5 **NEW**: Develop, train, and certify 2-3 individuals to conduct training of trainers for Regional PIHP Veteran Navigators in order to	10/1/18	Ongoing	New Action Step FY18

equip them to train PIHP/CMHSPs/SUD provider networks to build a culture of Veteran care within the CMH/SUD system in a sustainable way			

Objective 2: Engage in inter-and-intra agency collaboration in order to leverage resources and partnerships

Action Steps	Start Date	End Date	Update
2.1: Meet face-to-face with PIHP, CMHSP and SUD directors in regions of each Cohort to collaborate, engage and receive feedback on needs, gaps and capacity in terms of serving Veterans and Military families	C1: 6/1/16	12/31/16	Complete
	C2: 3/1/17	9/30/17	Complete
	C3: 3/1/18	9/30/18	Initiated
2.2: Collaborate with University of Michigan MSPAN Buddy-to-Buddy (BTB) program to develop a plan for how Veteran peers can best be utilized to supplement and enhance regional behavioral health Veteran Navigators	September, 2016	3/30/17	Complete
2.3: Begin to initiate plan for BTB involvement, which may include funding a BTB Behavioral Health Coordinator, providing additional training for BTB volunteers, securing funding, etc.	4/1/17	Ongoing	Initiated
2.4: BHDDA Veteran Liaison will attend Veteran events, VCAT meetings and trainings, behavioral health conferences, and other relevant events across Michigan; as needed, prioritization will be given to statewide events, summits and regional events during each Cohorts initial roll-out year	6/1/16	9/30/19	Initiated and Ongoing
2.5: Conduct annual BHDDA Veteran Summit to publicly acknowledge inter-and-intra collaboration, recognize individuals and organizations, celebrate successes, report on activities and data, and promote the next year activities	September, 2018	Ongoing	Planned
2.6: Develop agreement with MIARNG to reflect leadership commitment to help promote BHDDA behavioral health care system across their command and state	1/1/17	7/1/17	Initiated
2.7: Engage and collaborate with other Veteran and Military Reserve units and programs to gain support in promoting BHDDA behavioral health care system across their commands	10/1/17	9/30/18	Initiated and Ongoing
2.8: In partnership with MIARNG and MDHHS Communications, develop and produce promotional materials to encourage Veterans and Military Family members to access behavioral health care services	~~4/1/17~~ 7/1/18	~~9/1/17~~ 9/30/19	Revised date
2.9: After promotional materials are developed, target distribution to regions of the state based on Cohorts of roll-out	10/1/18	9/30/19	Planned

Objective 3: Identify, train and embed Regional Veteran Navigators into the publicly funded behavioral health care system throughout the State of Michigan

Action Steps	Start Date	End Date	Update
3.1: BHDDA Veteran Liaison will coordinate initial contacts and networking within each region to ensure efficient capacity building opportunities	C1: 10/1/16	3/30/17	Complete
	C2: 4/1/17	3/30/18	Initiated and Ongoing
	C3: 4/1/18	3/30/19	Initiated

3.2: Provide support for local CMHSP Veteran Navigators embedded within the publicly funded behavioral health care system to be the point of contact for all Veterans and Military family members to assure access to and receipt of adequate, effective and timely mental health care as needed. Note: (There are currently 6 CMHSP Veteran Navigators in 8 counties)	C1: 4/1/17	Ongoing	Initiated and Ongoing
	C2: 1/1/18	Ongoing	Initiated and Ongoing
	C3: 1/1/19	Ongoing	Planned
3.3: **NEW:** Assure that the Regional Veteran Navigators are embedded within the 10 PIHP Regions and are responsible for the same as above on a Regional level and encompassing SUD	4/1/17	Ongoing	Initiated and Ongoing
3.4: PIHP Regional and local CMHSP Veteran Navigators will develop a strong referral network and resources within their local community to address the multitude of potential needs Veterans and Military family members may have, including but not limited to housing, employment, health care and other supports. In order to accomplish this, Regional Veteran Navigator will collaborate and coordinate with Buddy To Buddy volunteers that have been identified in their Region as reciprocal partners. They will be responsible to share basic information and provide guidance and referrals to any and all Veteran and Military families that they encounter in their day to day functions	C1: 4/1/17	Ongoing	Initiated and Ongoing
	C2: 1/1/18	Ongoing	Initiated and Ongoing
	C3: 1/1/18	Ongoing	Planned
3.5: Based on Performance Indicators identified in the State of Michigan, Regional Veteran Navigators in coordination with Buddy To Buddy will seek to: Identify Veteran and Military families that would not otherwise be identified for MH/SUD Treatment.	4/1/17	Ongoing	Initiated and Ongoing
3.6: BHDDA Veteran Liaison and or State Regional Veteran Coordinator will host quarterly meetings via conference call or face-to-face for all Regional and local CMHSP Veteran Navigators/Liaisons for networking, addressing challenges and barriers, and providing on-going training	4/1/17	Ongoing	Initiated 9/7/17 and Ongoing

Objective 4: Provide the publicly funded behavioral health care system with resources to evidence-based programs in order to strengthen Military families

Action Steps	Start Date	End Date	Update
4.1: BHDDA Veteran Liaison will forward resources from the SAMHSA Veterans & Military Families website with the entire publicly funded behavioral health care system	1/1/17	Ongoing	Initiated and Ongoing
4.2 BHDDA Veteran Liaison will research various evidence-based programs to strengthen Military families, including children	~~1/1/17~~ 4/1/18	~~12/30/17~~ 7/1/18	Revised date
4.3: BHDDA Veteran Liaison will provide justification and rationale to recommend up to three evidence-based programs for Michigan to focus on to address needs of and strengthen Military families across the state	~~1/1/18~~ 7/1/18	~~3/1/18~~ 9/30/18	Revised date
4.4: BHDDA Veteran Liaison will meet with publicly funded behavioral health prevention coordinators and providers across the state to encourage use of identified evidence-based programs and gather input from their perspective	4/1/18	9/30/18	Planned

Objective 5: Develop processes and systems to gather and utilize data to gain a clearer perspective on Veteran and Military families in Michigan, their needs, and gaps in services

Action Steps	Start Date	End Date	Update
5.1: Identify specific questions to be asked and tools to be used to gather data on individuals accessing the publicly funded behavioral health care system in Michigan to measure and track identified outcomes	1/1/17	3/31/17	Complete and began to gather in BH TEDS 10/1/17
5.2: As each Cohort rolls out, Regional Veteran Navigators will compile aggregate data on identified metrics and submit to BHDDA on monthly basis to track progress/gaps in services/ barriers to receiving services/ and best practices	4/1/17	Ongoing	Initiated and Ongoing
5.3: Standard questions will be added BH Treatment Episode Data System (BH TEDS) to track all individuals who are Veterans and Military members entering the publicly funded behavioral health care system	10/1/17	Ongoing	Complete
5.4: An annual report will be compiled to track admissions into system and measure outcomes	1/1/18	Ongoing	Planned

Objective 6: Leverage additional resources for long-term sustainability of this plan.

Action Steps	Start Date	End Date	Update
6.1: Collaborate with other Veteran organizations across the state to design an unduplicated, cost-effective system to reach Veterans and Military family members in Michigan in order to reduce stigma and increase willingness to access to behavioral health care	10/1/16	Ongoing	Initiated and Ongoing
6.2: In conjunction with Buddy-to-Buddy program, establish a plan to identify Veteran peers in each PIHP region, and develop guidance/protocol on how to utilize these peer navigators/liaisons in the publicly funded behavioral health care system	10/1/16	9/30/17	Initiated and Ongoing
6.3: Provide a successful model to be utilized to assure 90% of publicly funded mental health and SUD treatment providers are TRICARE Paneled and Choice Certified within three years	10/1/16	9/30/19	Initiated
6.4: Coordinate at least two workshops/educational seminars each year for the publicly funded behavioral health care system on the process of becoming TRICARE Paneled and Choice Certified	10/1/16	9/30/19	Initiated and Ongoing
6.5: At minimum, one time per month monitor the Federal Register, as well as federal, state, and appropriate private foundation websites to ascertain potential Requests for Proposals that fit the direction of this plan	10/1/16	Ongoing	Initiated and Ongoing

OUTCOMES

As the system described above is developed, anticipated outcomes to be monitored include the following:

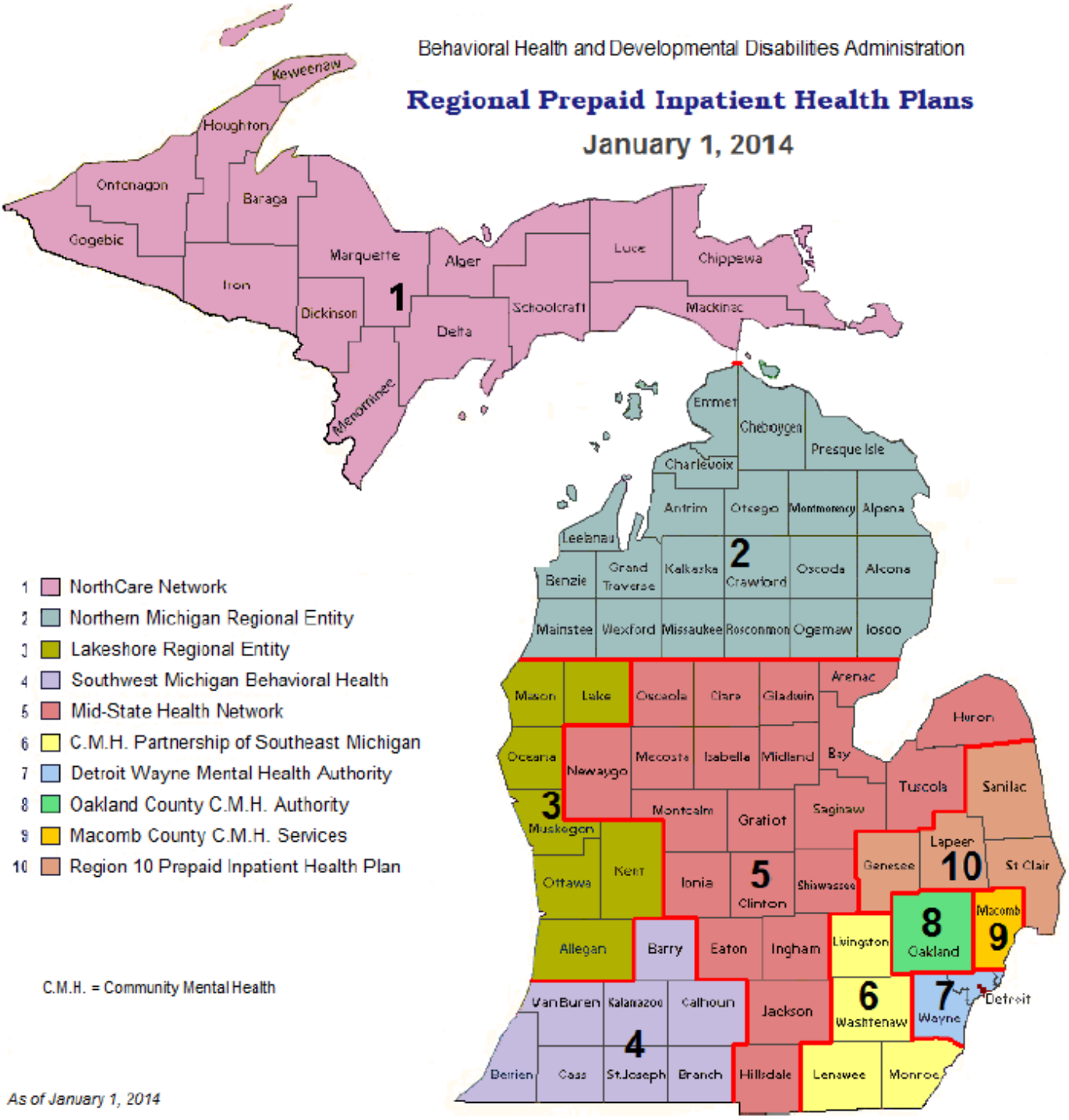
- Increased awareness of and access to publicly funded behavioral health care service providers in the local community
- Reduction of stigma for Veterans and Military family members to reach out for help
- Reduction in the number of suicides within the Veteran and Military family community

- Implementation of a holistic approach to the delivery of publicly funded behavioral health services leading to a reduction in stress and activating events, and an increase in resilience, employment, and overall physical and mental health for Veterans and Military families
- Veterans and Military families will identify feeling better equipped to function effectively within their community and social environments
- Sustainability of a robust publicly funded behavioral health care service provider network addressing the needs of Veterans and Military families in a culturally appropriate manner

LOOKING TO THE FUTURE WITH GREAT HOPE

When Veterans and Military families look to their future, often there is significant stress, much that is unknown, and a feeling of walking alone. This BHDDA plan will create a system that will ensure Veterans, Military members and their families receive efficient, comprehensive and sustained behavioral health services in the publicly funded system. This includes access to other community resources that will address their identified needs; access to and the delivery of quality services in the areas of mental health and substance abuse treatment; providing culturally appropriate, evidence based programs for Veteran and Military family members that effectively address their needs; and establishing linkages to community resources. It is envisioned this will create a sense of hope, and that Veterans and Military family members in Michigan will realize there is someplace to go and someone to talk to who will be able to provide needed resources for them and their family. By meeting these needs, Michigan Veterans and Military family members will be healthier, more productive, and able to participate in and succeed in our communities.

Michigan Department of Health & Human Services



Michigan Association of Community Mental Health Boards is now Community Mental Health Association of Michigan.

12-15-17

FRIDAYFACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance
Executive Board

FROM: Robert Sheehan, Executive Director
Alan Bolter, Associate Director

RE:

- **New e-mail addresses for Association staff**
- **Association soon to announce new membership opportunities**
- **Friday Facts to become a members-only electronic newsletter**
- **Work and Accomplishments of CMH Association Member Organizations**
  - **Shiawassee CMH Authority changes name to Shiawassee Health & Wellness**
- **State and National Developments and Resources**
  - **Michigan's SIM effort publishes third newsletter**
  - **MDHHS announces Winter 2018 Youth Peer Support Specialist Training**
  - **MDHHS announces Winter 2018 Parent Support Partner Training**
  - **2018 BAAM Conference**
  - **5th Annual Midwestern Behavior Analysis Job Fair**
  - **Searching for New Insurance Options, States Consider Medicaid Buy-in and Other Strategies**
  - **CCBHCs are reviving the safety-net**
  - **Citizens' Research Council announces study of Healthy Michigan Plan impact**
  - **Study: Half of Michigan Medicaid expansion enrollees work**
  - **Behavioral Health Workforce Research Center announces two new reports**
  - **Blue Cross to limit opioid scripts to 30-day supply**
  - **Flint lead pipe replacement could be jeopardized by CHIP stalemate**
  - **A health care paradox: measuring and reporting quality has become a barrier to improving it**
  - **Ascension and Providence St. Joseph in talks to merge to form nation's largest hospital chain**
- **2017 PAC Campaign Update**
- **Legislative Update**
  - **Opioid Bills Head to the Governor**
  - **298 Pilot Creation Bills Heads to the Governor**
- **National Update**
  - **Republican Leaders Nearing Final Tax Deal, Release New Funding Bill**
- **CMHAM Winter Conference Call for Presentations**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Assertive Community Treatment Training Opportunity for Physicians & Nurse Practitioners**

New e-mail addresses for Association staff: The Michigan Association of CMH Boards is now COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN.

Please update your email address for CMHAM staff:

Robert Sheehan, CEO: rsheehan@cmham.org
Alan Bolter, Associate Director: abolter@cmham.org
Chris Ward, Administrative Executive: cward@cmham.org
Dana Owens, Accounting Clerk: dowens@cmham.org
Michelle Dee, Accounting Assistance: acctassistant@cmham.org
Monique Francis, Executive Board/Committee Clerk: mfrancis@cmham.org
Annette Pepper, Training and Meeting Planner: apepper@cmham.org
Anne Wilson, Training and Meeting Planner: awilson@cmham.org
Carly Palmer, Training and Meeting Planner: cpalmer@cmham.org
Chris Lincoln, Training and Meeting Planner: clincoln@cmham.org
Nakia Payton, Receptionist: npayton@cmham.org

Association soon to announce new membership opportunities: In response to requests for a broader range of membership options and a fuller list of benefits of each membership type, the CMH Association of Michigan will soon be announcing several new membership opportunities for organizations and individuals. Look for the revised Association membership brochure to be available in November.

Friday Facts to become a members-only electronic newsletter: Note that the receipt of this electronic newsletter will become a members-only benefit sometime in the next few months. While there will be another electronic newsletter for a wider range of non-members, it will not contain the depth nor breadth of information contained in this newsletter. **So, if you find the information in this newsletter useful and are not an Association member, consider becoming a member when the new membership opportunities are announced.**

WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

Shiawassee CMH Authority changes name to Shiawassee Health & Wellness

Below is a recent announcement from the Shiawassee County Community Mental Health Authority regarding its name change.

> Exciting news! We have changed our name from Shiawassee County Community Mental Health Authority to Shiawassee Health & Wellness (SHW). We believe this name represents what we have known for a while. When a person is receiving behavioral health services, you cannot treat the mind in isolation. It is important to treat the whole person; the behavioral health needs as well as physical health needs. Our new name describes what we strive to promote with our programs and services and provides an opportunity to expand our services and supports to the community in the future.
>
> Shiawassee Health & Wellness remains the designated Community Mental Health Service Program (CMHSP) with the responsibility for servicing the specialty behavioral health needs for individuals in Shiawassee County. We continue to provide quality services and support to Shiawassee County residents who are adult and children with developmental disabilities, adults with serious mental illness, and children with serious emotional disturbances.

We hope you will join us in celebrating our new name, Shiawassee Health & Wellness. Our address and contact information will remain the same: 1555 Industrial Drive, Owosso, Michigan 48867; telephone: 989-723-6791 or 800-622- 4514.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Michigan's SIM effort publishes third newsletter

Michigan's State Innovation Model (SIM) recently announced the publications of its December 2017 newsletter. The newsletter can be found at:
http://www.michigan.gov/documents/mdhhs/SIM_Newsletter_December_2017_608668_7.pdf

The newsletter is intended to inform stakeholders, participants and interested parties of the progress, status and achievements across all of the SIM components. Previous editions of the newsletter can be found on the SIM website.
http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491---,00.html

For more information on Michigan's SIM initiative, visit www.michigan.gov/SIM
Questions or comments may be sent to: MDHHS-SIM@michigan.gov

MDHHS announces Winter 2018 Youth Peer Support Specialist Training

The Michigan Department of Health and Human Services, in partnership with the Association for Children's Mental Health, is issuing this invitation to apply for the upcoming Youth Peer Support Specialist Training Cohort 8. The Youth Peer Support (YPS) model in Michigan is designed to support children and youth with serious emotional disturbance who are receiving services within the public mental health system through an intervention-based, skill development approach. YPS is a required EPSDT State Plan Medicaid services under the Managed Care Mental Health Specialty Services and Supports 1915 b/c waiver.

Certification includes an initial three days of training. The next scheduled YPS training for Cohort 8 will be February 5-7, 2018 with the two-day follow up on March 19-20, 2018. New YPS Supervisors must attend on February 7, 2018. Additional certification components include monthly coaching calls, quarterly technical assistance meetings and supervision consultation and support. Individuals who are seeking certification must be:

- Young adult, ages 18 through 26, with lived experience who received mental health services as a youth
- Willing and able to self-identify as a person who has or is receiving behavioral health services and is prepared to use that experience in helping others
- Experience receiving services as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.)
- Employed by PIHP/CMHSP or its contract providers
- Trained in the MDHHS approved curriculum and ongoing training model

To reserve a place in the upcoming certification cohort, please send a completed Organizational Readiness Assessment and Agency Readiness Checklist found at http://www.acmh-mi.org/get-information/acmh-projects/youth-peer-support **before January 22, 2018** to:

Krissy Dristy; Statewide Youth Peer Support Coordinator; Association for Children's Mental Health office 517-372-4016; cell 517-643-3314; kdristy@acmh-mi.org

Contact information regarding contracting with a family-run organization to provide YPS services, is also listed below:

ASK Family Services (Kalamazoo) Jill Angell 269-343-5896
Association for Children's Mental Health (Statewide), Jane Shank at 231-383-1595
Any additional questions please contact Kim Batsche-McKenzie at batsche-mckenziek@michigan.gov

MDHHS announces Winter 2018 Parent Support Partner Training

The Michigan Department of Health and Human Services, in partnership with the Association for Children's Mental Health is issuing this invitation to apply for the upcoming Parent Support Partner (PSP) Certification Cohort. The PSP model in Michigan is designed to support parents and caregivers whose children and youth are receiving services within the public mental health system through an intervention-based, skill development approach. PSP is a covered EPSDT State Plan Medicaid service under the Managed Care Mental Health Specialty Services and Supports 1915 b/c waiver. You are required to have this service available in sufficient capacity in your service array for children and families.

Certification includes five-days of training. Trainings are structured with an initial three-day segment with two additional days occurring approximately a month and a half later.

The next scheduled PSP training for Cohort 27 will be February 13, 14 and 15, 2018 and March 14-15, 2018. Additional certification components include monthly coaching calls, quarterly technical assistance meetings and supervision consultation and support. Individuals who are seeking certification must be:

- 18 years or older
- A parent or day-to-day caregiver who has lived experience and is currently raising, or has raised a child with emotional, behavioral health challenges and/or intellectual/developmental disabilities
- Directly hired and employed by a CMHSP or a contracted agency (family run organization or other CMHSP contract agency)

To reserve a place in the upcoming certification cohort, please send a completed Organization Readiness Assessment and Agency Readiness Checklist found at http://www.acmh-mi.org/get-information/acmh-projects/parent-support-partner-project **before January 29, 2018** to:

Kelly Bailey, PSP Statewide Coordinator; Parent Support Partner Program; kbailey@acmh-mi.org; (989)-324-9218

Contact information regarding contracting with a family-run organization to provide PSP services, is listed below:
ASK Family Services (Kalamazoo) Tina Robbins 269-353-5896
Association for Children's Mental Health (Statewide), Jane Shank at 231-383-1595

2018 BAAM Conference

Annual 2018 Behavioral Analysis Association of Michigan (BAAM) Conference (February 15-16, 2018) at the Eastern Michigan University-Student Center (Ypsilanti, MI) BAAM Conference includes keynotes, poster sessions, and breakout sessions. More details, including sessions will be released soon. More information at: http://www.baam.emich.edu/conference.html

5th Annual Midwestern Behavior Analysis Job Fair

The 5th Annual Midwestern Behavior Analysis Job Fair, slated for February 24, 2018, at Western Michigan University (Kalamazoo, MI) has recently been announced. This event is open to students and practitioners of all levels and from

all universities and employer Contact Nicholette Christodoulou at psy-mbajf@wmich.edu to be added to the contact list for further details.

Searching for New Insurance Options, States Consider Medicaid Buy-in and Other Strategies

Anita Cardwell, at the National Academy for State Health Policy, recently wrote a very useful review of the approach to health insurance coverage that a number of states are taking, through the use of federal 1115 and 1332 waivers. The article is provided below:

> Uncertainty about the future of health insurance options and concern about the ability of Affordable Care Act (ACA) marketplaces to offer adequate competition and choice have spurred states to look for new coverage approaches. Among the innovative strategies states are proposing are allowing consumers to buy into state Medicaid programs and developing state-specific coverage options within the ACA's framework.
>
> **State Medicaid Buy-in Proposals:** A new strategy some states are examining is to allow individuals who are not currently eligible for Medicaid to buy into the program. Cindy Mann of Manatt Health recently explored this proposal at a session at NASHP's annual health care policy conference. She outlined (https://nashp.org/wp-content/uploads/2017/10/mann.medicaidbuyin.pdf) some of the key issues that states need to consider to implement this approach. One approach allows states to offer Medicaid as a new "public option" product in their ACA marketplaces, which could help increase affordability and consumer choice, particularly in areas where there are limited number of participating plans. To be offered on the marketplace, a Medicaid plan would need to match marketplace coverage standards and be certified as a qualified health plan. Some session attendees wondered if a state could "deem" a Medicaid plan as qualified, particularly in bare counties where no insurance product was available.
>
> Another way states could leverage Medicaid to expand coverage would be to permit individuals with incomes above current Medicaid eligibility levels to buy into the program. States could choose to offer this Medicaid buy-in to consumers either with or without subsidies. However, if they offered subsidies, states would need to seek federal approval through a 1332 Waiver to obtain a Basic Health Program (BHP) state plan amendment. Also, in order for the Medicaid plan to be affordable, the benefit package may need to be less robust than traditional Medicaid benefits.
> Both strategies would require state Medicaid and insurance agencies to coordinate closely. Key advantages of Medicaid buy-in proposals include:
>
> - The statewide nature of Medicaid's provider networks:
> - The reach of the program overall; and
> - States would have the flexibility to set plan rates.
>
> Potential disadvantages include:
> - Medicaid's lower provider reimbursement rates could diminish provider participation; and
> - In some states, it may not be politically feasible to broaden the scope of Medicaid, even if individuals are required to pay premiums for coverage.
>
> **State and Federal Action on Medicaid Buy-in**
> Some states have already moved forward on these concepts. In early 2017, **Nevada** state Rep. Mike Sprinkle introduced and the state Legislature passed AB 374, which offered a public option on the marketplace. The bill directed the state to contract with insurers to provide a commercial health plan based on Medicaid (though without non-emergency medical transportation coverage), and allow eligible individuals to use ACA's tax credits to purchase this coverage. While the proposal may have required both a 1332 and a Section 1115 Medicaid waivers, the bill was ultimately vetoed by the governor. If re-elected, Sprinkle indicated he will reintroduce the proposal.
> In **Minnesota**, a bill was introduced in January 2017 that would have allowed individuals with incomes above 200 percent of the federal poverty level (FPL) to purchase coverage through MinnesotaCare, the state's BHP,

and they would have received a tax credit subsidy if eligible. The bill did not move forward in the state Legislature.
In **Massachusetts**, a provision in a recent bill that passed the state Senate in November proposes to allow any individual to purchase coverage through the state's Medicaid program.

On the **federal level,** Sen. Brian Schatz (D-HI) and Rep. Ben Ray Lujan (D-MN) in October introduced the State Public Option Act in the Senate and the House, which would allow states to create a Medicaid buy-in program for all residents earning any income level who are not currently eligible for the program.

Idaho's Health Care Plan: Idaho did not implement the ACA's Medicaid expansion, but the state has held many meetings since passage of the ACA to explore alternative options to provide coverage to low-income individuals. Most recently, and as discussed at a NASHP conference session, the Governor's Health Care Advisory Panel has proposed the Idaho Health Care Plan, designed to both stabilize the individual insurance market and offer coverage to some uninsured individuals.

Specifically, one aspect of the plan permits working individuals with taxable income below 100 percent of FPL to purchase subsidized marketplace coverage. The state estimates that 22,000 of the 78,000 uninsured residents with incomes under 100 percent of FPL would be able to purchase coverage.
The other component of Idaho's proposal creates a new Medicaid Complex Medical Needs program that allows adults and children with certain complex health conditions with incomes up to 400 percent of FPL to be covered by Medicaid. Individuals would qualify if they were not eligible for Medicaid and did not have access to affordable employer coverage.

The state anticipates that moving individuals with high-cost care needs to Medicaid could reduce premiums in the marketplace and would offer these individuals more comprehensive coverage to meet their needs. The draft waiver indicates that the program would cover individuals in need of ongoing medical support for genetic conditions such a hemophilia or cystic fibrosis as well as individual with end-of-life care needs. Most enrollees with incomes above 150 percent of FPL would be required to pay premiums for this coverage based on a sliding scale.

The two-pronged plan would require federal approval through both a 1332 waiver and a Section 1115 Medicaid waiver. The state held public hearings in December 2017 and is seeking public comments through Dec. 15, 2017. Idaho's goal is to implement the plan in mid-2018.

Also in 2018, while there may be new efforts in Congress to modify or repeal the ACA, some states are likely to continue to pursue their own options to provide health coverage to residents. NASHP will continue to monitor and share information about these emerging state health policy proposals.

CCBHCs are reviving the safety-net

Below are the opening paragraphs of a recent article from the National Council for Behavioral Health (of this this Association is a member) on the impact that Certified Community Behavioral Health Clinics (CCBHC) have had on the health care systems in their communities.

Three years ago, we celebrated the passage of the Excellence in Mental Health Act demonstration, designed to expand Americans' access to community-based addiction and mental health services. We hoped the initiative would provide sustainable footing to combat generations of funding cuts that have left the safety-net struggling to meet the mental health and substance use needs in our communities, while accelerating adoption of evidence-based practices and data-driven care.

Today, early results of the demonstration's Certified Community Behavioral health Clinics (CCBHCs) show our hope is being realized. They are: increasing access to mental health and addiction treatment; expanding capacity to address the opioid crisis; collaborating with partners in hospitals, jails, prisons and schools; and

attracting and retaining qualified staff who offer science-based, trauma-informed services – often on the same day patients present for care.

The full article can be found at:
https://www.thenationalcouncil.org/BH365/2017/11/28/ccbhcs-reviving-safety-net/

Citizen's Research Council announces study of Healthy Michigan Plan Impact

The Citizen's Research Council (CRC) recently announced a report, from CRC, examining the impact of Michigan's Medicaid Expansion: CRC's new report finds that Michigan's Medicaid expansion, known as the Healthy Michigan program, has paid dividends to the business sector, the overall economy and to residents who receive health insurance via other sources. Besides the overall advantages arising from Michigan's expansion, some key findings from the report:

- The Healthy Michigan Plan has led to health insurance coverage for more than 650,000 of Michigan's citizens and has kept insurance premiums lower for others, improving the physical, mental and financial well-being of Michigan's citizens. The program also improved the state's economy by reducing uncompensated care among Michigan's hospitals, and by supporting health sector job creation/retention, a healthier workforce, and increased federal spending in the state.
- The Medicaid program allows for substantial innovation, experimentation and variation at the state level, allowing states to be true "laboratories of democracy." While new mechanisms like cost-sharing and Health Risk Assessments still need refinement, Michigan has begun to use the program to incentivize healthier lifestyles and responsible health care consumption. Michigan has also become a leader in using Medicaid to address the social determinants of health.

The full report can be found at: https://crcmich.org/rpt399_medicaid-expansion

Study: Half of Michigan Medicaid expansion enrollees work

Below are the opening paragraphs of a recent Detroit News article that finds that have of the persons enrolled in Healthy Michigan are working.

> A new study finds roughly half of those enrolled in Michigan's Medicaid program since its expansion have jobs and another quarter unemployed are likely to be in poor health.
>
> Authors of the study released Monday by the University of Michigan Institute for Healthcare Policy and Innovation say the findings raise concerns about work requirements for Medicaid enrollees. The Trump administration urges states to consider changes to Medicaid programs to encourage work and independence and some have asked for work requirements of other waivers.
>
> Lead author Renuka Tipirneni asks if screening and tracking enrollees are worthwhile when a minority aren't employed and are potentially able to work.

The full article can be found at: http://www.detroitnews.com/story/news/local/michigan/2017/12/11/study-half-michigan-medicaid-expansion-enrollees-work/108516944/

Behavioral Health Workforce research Center announces two new reports

The Behavioral Health Workforce Research Center, based at the University of Michigan, recently announceds two new reports. These reports are described below:

> **National Assessment of Scopes of Practice for the Behavioral Health Workforce:** In April 2017, the BHWRC released its first report on behavioral health scopes of practice (SOPs). SOPs define which services a state or territory allows a licensed or certified professional to perform. These essential constructs can vary by state, potentially leading to service coverage gaps on a national scale. The results of this study showed that

SOPs lack standardization across states and professions nationally, with regard to SOPs. Peer and paraprofessionals, in particular, could use more formal SOPs, as many states have not codified the parameters of service authority or regulatory requirements for these professionals. Overall, more uniform definitions and requirements in SOPs would promote standardization and could aid reciprocity and endorsement procedures across states.

The full report can be found at:
http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/11/FA3_SOP_Full-Report_1.pdf

An Analysis of Behavioral Telehealth Authorization in Scopes of Practice: Similarly, in August 2017, an expansion to the original SOP project was published, looking at behavioral telehealth service authorization – the practice of providing behavioral health remotely, using telecommunications technology. This analysis utilized the SOP statutes and rules gathered for the first project, as well as Medicaid Provider Manuals and fee schedules from all 50 states and DC. The results of the study showed:

- Psychiatrists, psychologists, and APRNs were compensated at a higher rate than other behavioral health providers (BHPs) for the same service codes
- Psychiatrists were the BHP most likely to be authorized to perform behavioral telehealth, followed by psychologists and social workers
- Twenty-nine states require private payers to cover telehealth in the same way they'd cover in-person services

The full report can be found at:
http://www.behavioralhealthworkforce.org/wp-content/uploards/2017/11/Y2FA3P1.Telehealth_-Full-Report.pdf

Blue Cross to limit opioid scripts to 30-day supply

Below is an excerpt from a recent edition of Crain's Detroit Business regarding the policy change being implemented by Blue Cross and Blue Shield of Michigan, related to opioid prescriptions:

> Blue Cross Blue Shield of Michigan will begin a new policy on Feb. 1 that limits opioid prescriptions to members to 30 days and in some cases five days, according to Blue Cross letters to patients and agents that *Crain's* has obtained. Blue Care Network already has the 30-day policy in place.

The full article can be found at:
http://www.crainsdetroit.com/article/20171208/news/647161/blue-cross-to-limit-opioid-scripts-to-30-day-supply#utm_medium=email&utm_source=cdb-healthcare&utm_campaign=cdb-healthcare-20171211

Flint lead pipe replacement could be jeopardized by CHIP stalemate

Below is an excerpt from a recent edition of the Bridge magazine on the threat that the delay in Congressional approval of federal Children's Health Insurance Program (CHIP) poses for the efforts to replace Flint's lead pipes:

> If Congress fails to renew the Children's Health Insurance Program (CHIP) before state funding runs dry, plans to replace lead pipelines in Flint may stall and jeopardize Michigan's efforts to protect children from lead poisoning.
> The federal government last year gave Michigan permission to spend about $119 million of CHIP funds over five years to detect and remove lead hazards from homes in Flint and elsewhere, dramatically expanding aid to Michiganders who worry about lead paint or pipes in their homes.

The full article can be found at:
http://www.bridgemi.com/children-families/flint-lead-pipe-replacement-could-be-jeopardized-chip=stalemate

A health care paradox: measuring and reporting quality has become a barrier to improving it

Below are the opening paragraphs of a recent article in STAT News on the impact of excessive quality measurement on quality, written by Jerry Penso. Dr. Penso is the president and chief executive officer of AMGA, which has 175,000 physicians practicing in its member organizations, delivering care to one in three Americans.

> We are at an inflection point in our efforts to measure the quality of U.S. health care. Most medical professionals accept that rigorous quality measurement is essential to improving care and fundamental to transitioning the way we pay for health care. The question we face now is this: How should we measure quality in meaningful and efficient ways?
> The answer could either smooth the transformation to a value-based delivery and payment system or continue to allow performance measurement to impose a significant roadblock to this transition to value.
>
> I say "we" because physicians and other health care providers share ownership of this issue with patients, payers, and purchasers. In a recent speech[1] to representative of all four groups, Seema Verma, the administrator for the Centers for Medicare and Medicaid Services, called out the growing tension between patient-centered care and the administrative burdens that measurement imposes on physicians, hospitals, and health systems. Her diagnosis was spot on.

The full article can be found at: https://www.statnews.com/2017/12/13/health-care-quality/

Ascension and Providence St. Joseph in talks to merge to form nation's largest hospital chain

Below is an excerpt from a recent edition of Crain's Detroit Business and Modern Healthcare regarding the pending merger of two health care systems that play key roles in Michigan's healthcare industry.

> Ascension Health and Providence St. Joseph Health are in talks to merge and create the nation's largest hospital chain, the *Wall Street Journal* reported Sunday.
>
> A merger between St. Louis-based Ascension and Providence out of Renton, Wash., would give the combined not-for-profit entity 191 hospitals in 27 states and annual revenue of $44.8 billion. The deal would put the merged company ahead of HCA, which has 177 hospitals and report $41.5 billion in 2016, according to *Modern Healthcare* data.
>
> Ascension, the nation's largest Catholic system and which owns 15 hospitals in Michigan with $3.8 billion in revenue, declined to comment on the report. Providence, the nation's No. 2 Catholic hospital chain, did not respond to a request for comment.

The full article can be found at:
http://www.crainsdetroit.com/article/20171211/news/647351/report-ascension-and-providence-st-joseph-in-talks-to-merge#utm_medium=email&utm_source=cdb-healthcare&utm_campaign=cdb-healthcare-20171211

2017 PAC Campaign Update

Earlier this year we announced our 2017 CMH PAC campaign with the goal of increasing member participation. This year's campaign exceeded last year's contribution levels, but participation remained about the same. Last month we held the drawing for the Detroit Tiger box suite tickets donated by Muchmore Harrington Smalley Associates and the winner was… Lapeer CMH.

Congratulations to Lapeer CMH and thank you to all who generously contributed to the CMH PAC.

Just because the Tiger drawing has been completed does not stop the need for CMH PAC support. If you would still like to support our PAC efforts please mail your contribution to our office, below are the details:

Make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please)

Thank you. Please feel free to contact Bob or Alan with any questions.

LEGISLATIVE UPDATE

Opioid Bills Head to the Governor

Wednesday marked the last voting session day of the calendar year, the legislature will not return to Lansing until mid-January. However, before House and Senate members left town they had some unfinished business to attend too, one of those items included a package of bills addressing the opioid epidemic.

The package of bills included Senate Bills: 47, 166, 167, 270, 273, & 274 and House Bills: 4403, 4406, 4407, & 4408. The cornerstone bills of the package SBs 166 and 167 would require doctors to check on the Michigan automated prescription system (MAPS) for the history of new patients before prescribing schedule II-V drugs, and provides sanctions if doctors fail to check MAPS. Many believe
by using MAPS, doctors will be able to tell if new patients have been getting too many prescriptions for opioids. Critics argued it is another step in the process for doctors treating a patient.

Other bills in the package required a doctor have a bona fide prescriber-patient relationship before a doctor can prescribe drugs, requires the doctor provide treatment service information to patients who have suffered an overdose, requires the consent of parents before minors are prescribed opioids, and a bill that requires education on opioids in schools.

The bill now head to the Governor's desk where he is expected to sign them into law.

298 Pilot Creation Bill Heads to the Governor

This week, the full House passed SB 649, which allows for the existence of the private health plan pilots under section 298 of the FY 18 state DHHS budget. Sen. Mike Shirkey is the sponsor of the bill. The bill passed the House Appropriations Committee Wednesday morning, then the full House later in that day. The bill now goes to the Governor's desk where he is expected to sign it into law.

Two weeks ago, MDHHS submitted the required report to the legislature that identified several more legislative, policy and federal waiver changes that must be made before 298 pilots can start. According to the passed 298 budget language, the department was required to provide the legislature in report listing the various barriers to implementation. The department also published a white paper in conjunction with the barriers report, which expands on several of the concepts that were outlined in the November report. The white paper is also an intermediary step between the publication of the November report and the posting of the Request for Information. The goal of the white paper is to provide clarification and guidance to stakeholders about the department's current vision for the structure of the pilots. The November barriers report and white paper can be accessed through the project webpage, which is copied below"

www.michigan.gov/stakeholder298

NATIONAL UPDATE

Republican Leaders Nearing Final Tax Deal, Release New Funding Bill

On Wednesday, Republican leaders in Congress announced that they had brokered a deal amongst themselves on their sweeping tax reform plan, the Tax Cuts and Job Acts. Republican leaders plan to bring the bill to the floor of the

House and Senate next week and hope to have it signed into law by the New Year. House appropriators also introduced a spending bill to keep the government open until January 19th. The bill includes several health care measures, but is expected to undergo substantial revision to pass in the Senate.

IMPACT ON HEALTH CARE

While the final version of the tax reform bill is not expected to cut entitlement programs like Medicaid, Medicare, and Social Security directly, it is likely to lead to dramatic cuts to the federal revenue necessary to fund those programs. Speaker of the House Paul Ryan (R-WI) made clear his view that cuts to health care entitlement programs would be necessary should the Tax Cuts and Jobs Act become law, saying, "We're going to have to get back next year at entitlement reform, which is how you tackle the debt and the deficit."

In addition to these high-level concerns about the overall impact of the bill, the National Council has concerns with specific provisions that would harm community behavioral health organizations and the populations they serve. These concerns include:

- Preventing the doubling of the standard deduction as it would cause an estimated reduction of $13.1 billion in charitable giving, a critical revenue source for community behavioral health organizations;

- Preserving the medical expense deduction which keeps health care costs low for those with costly chronic conditions; and

- Preventing the repeal of the health law's individual mandate, a key component of the Affordable Care Act that helps lower premiums and fund comprehensive insurance plans.

FY-18 SHORT-TERM SPENDING PACKAGE

House Republicans have released the text of a continuing resolution (CR) that would fund federal domestic spending, including health care programs, for five weeks and defense spending for one year at current funding levels. The GOP-backed spending bill includes several health care measures, including five years of funding for the Children's Health Insurance Program (CHIP) and two years of funding for federally qualified health centers (FQHCs). The bill pays for these provisions with controversial cuts to the Affordable Care Act's Prevention and Public Health Fund and higher premiums for high-income Medicare beneficiaries. Democrats have rejected attempts to pay for CHIP with these offset in an earlier vote.

Unlike the tax reform package, the spending bill will need to garner at least 60 votes to pass the Senate, meaning it will need the support of at least eight Senate Democrats. If the House passes their version of the bill, there are likely to be substantial revisions in the upper chamber, including changes to the CHIP funding offsets and the addition of Medicare extender provisions. As lawmakers remain focused on the GOP tax overhaul. Congress has limited time to negotiate a spending deal and avoid a government shutdown before the December 22nd funding deadline.

CMHAM WINTER CONFERENCE – CALL FOR PRESENTATIONS

Accepting Presentations! The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & 7, 2018 (February 5, 2018 Pre-Conference Institutes) at the Radisson Plaza Hotel & Suites, Kalamazoo. Deadline to submit your presentation is Tuesday, December 19, 2017. Find the workshop submission form here: https://www.macmhb.org/save-the-date/call-presentation-2018-winter-conference

Have a Great Weekend!

Michigan Association of Community Mental Health Boards is now Community Mental Health Association of Michigan.

December 11, 2017

FRIDAYFACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance
Executive Board

FROM: Robert Sheehan, Executive Director
Alan Bolter, Associate Director

RE:

- **New e-mail addresses for Association staff**
- **Association soon to announce new membership opportunities**
- **Friday Facts to become a members-only electronic newsletter**
- **State and National Developments and Resources**
  - **Section 298 Pilot RFI released**
  - **Webinar offered to guide CMHs, PIHPs, and Providers in assisting HMP enrollees during transition**
  - **MDHHS provides clarification on registration of atypical Medicaid providers**
  - **Employment First State Leadership Mentoring Program announced**
  - **Concerns grow over impact of federal tax cut bill on healthcare coverage**
  - **Federal Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) issues first report**
  - **MiBridges registration for community partners announced**
  - **Rural Health and Safety Education offers webinar on Combating Opioids**
  - **Survey: Michigan ranks 35th in nation for overall health**
  - **500 cities project issues interactive health status map**
- **2017 PAC Campaign Update**
- **Legislative Update**
  - **Online Gaming Issue To Be Taken Up in 2018**
- **National Update**
  - **Tax Bill Heads to President's Desk**
- **CMHAM Winter – Save the Dates**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Assertive Community Treatment Training Opportunity for Physicians & Nurse Practitioners**

New e-mail addresses for Association staff: The Michigan Association of CMH Boards is now COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN.

Please update your email address for CMHAM staff:

Robert Sheehan, CEO: rsheehan@cmham.org
Alan Bolter, Associate Director: abolter@cmham.org
Chris Ward, Administrative Executive: cward@cmham.org
Dana Owens, Accounting Clerk: dowens@cmham.org
Michelle Dee, Accounting Assistance: acctassistant@cmham.org
Monique Francis, Executive Board/Committee Clerk: mfrancis@cmham.org
Annette Pepper, Training and Meeting Planner: apepper@cmham.org
Anne Wilson, Training and Meeting Planner: awilson@cmham.org
Carly Palmer, Training and Meeting Planner: cpalmer@cmham.org
Chris Lincoln, Training and Meeting Planner: clincoln@cmham.org
Nakia Payton, Receptionist: npayton@cmham.org

Association soon to announce new membership opportunities: In response to requests for a broader range of membership options and a fuller list of benefits of each membership type, the CMH Association of Michigan will soon be announcing several new membership opportunities for organizations and individuals. Look for the revised Association membership brochure to be available in November.

Friday Facts to become a members-only electronic newsletter: Note that the receipt of this electronic newsletter will become a members-only benefit sometime in the next few months. While there will be another electronic newsletter for a wider range of non-members, it will not contain the depth nor breadth of information contained in this newsletter. **So, if you find the information in this newsletter useful and are not an Association member, consider becoming a member when the new membership opportunities are announced.**

STATE AN NATIONAL DEVELOPMENTS AND RESOURCES

Section 298 Pilot RFI released

MDHHS issued the Request for Information (RFI) for the pilot projects as outlined in Section 298 of the FY 2018 MDHHS Appropriations Bill. The RFI can be found at: http://www.michigan.gov/documents/mdhhs/RFI_298_Pilots_-_Medicaid_PH-BH_Financial_Integration_609174_7.pdf

The full announcement is provided below. **Note that the timeframe, below, contains a February 13, 2018 deadline for the submission of informational responses. Informational response is the language for the due date for the submission of proposals by CMHs applying to be Section 298 pilot sites.**

ISSUE DATE: DECEMBER 20, 2017
ANTICIPATED TIMELINE
DEADLINE FOR PROVIDERS TO SUBMIT QUESTIONS REGARDING THIS RFI: JANUARY 10, 2018
STATE ANSWERS TO PROVIDERS' QUESTIONS PROVIDED BY: JANUARY 23, 2018 DEADLINE TO SUBMIT INFORMATIONAL RESPONSES: FEBRUARY 13, 2018 ORAL PRESENTATIONS (IF NEEDED): FEBRUARY 20, 2018 ANTICIPATED NOTICE OF ANTICIPATED PILOT DECISION: FEBRUARY 28, 2018

Request for Information Released to Aid in Coordinating Physical and Behavioral Health Services in Michigan

LANSING, Mich. – Today the Michigan Department of Health and Human Services (MDHHS) released a Request for Information (RFI) (http://www.michigan.gov/documents/mdhhs/RFI_298_Pilots_-_Medicaid_PH-BH_Financial_Integration_609174_7.pdf) to select the pilot sites for the Section 298 Initiative.

The Section 298 Initiative is a statewide effort to improve the coordination of physical health services and behavioral health services in Michigan. This initiative is based upon Section 298 in the Public Act 268 of 2016. The Michigan legislature approved a revised version of Section 298 as part of Public Act 107 of 2017.

Under the revised Section 298, the Michigan Legislature directed MDHHS to implement up to three pilot projects and a separate demonstration model in Kent County to test the integration of publicly-funded physical and behavioral health services. MDHHS has been working since August to develop the structure of the pilots, which focuses on payer-level integration of Medicaid-funded physical health and behavioral health services. The department collected feedback and solicited input from representatives of the current system on specific issues pertaining to the development of the pilots. The department used this input to develop a white paper which describes the parameters for the pilots.
The department has posted the RFI to the State of Michigan procurement website. Interested applicants must submit their applications through the website by February 13, 2018. The deadline for applicants to submit questions on the RFI is January 10, 2018. The RFI also includes the following mandatory minimum requirements:

- The applicant is a Community Mental Health Service Provider.
- The applicant has submitted a signed memorandum of support from at least half of the Medicaid Health Plans (MHP) within the proposed pilot region, which demonstrates their engagement in pre-planning activities.
- The applicant has submitted a plan demonstrating full financial integration as required under Section 298 of Public Act 107 of 2017.

The State will evaluate each informational response that meets all of the minimum mandatory requirements utilizing an evaluation process. The State will use the results of the evaluation process to select up to three pilot projects in compliance with Section 298 of Public Act 107 of 2017. The anticipated notice of the pilot decision is February 28, 2018. The department is aiming to implement the pilots and demonstration model by July 1, 2018.

For more background on the Section 298 Initiative and the RFI for the pilots, visit www.michigan.gov/stakeholder298

Webinar offered to guide CMHs, PIHPs, and Providers in assisting HMP enrollees during transition

Friday Facts readers may remember an earlier e-mail from this Association regarding the distribution by MDHHS, in early November, of an L letter (an L letter is a formal communication to the field on operational issues) on the changes in enrollment status and the related actions that Healthy Michigan Plan (HMP) enrollees must take, as required by the Michigan law and federal 1115 waiver that initiated the Healthy Michigan Plan.

CMH/PIHP/PROVIDER-SPECIFIC WEBINAR: Below is an announcement of and instructions for participating in an upcoming CMH/PIHP/PROVIDER-SPECIFIC webinar, on January, designed to provide CMHs, PIHPs, and providers in our system, with sufficient background to guide the HMP enrollees, whom they serve, through this process. We urge the members of your staff, who guide HMP enrollees in retaining their HMP eligibility, to participate in this webinar.

The Michigan Department of Health and Human Services, in partnership with The Community Mental Health Association of Michigan, present.

HMP Transition CMH/PIHP/Provider-Specific Training
1:00pm to 2:00pm
Tuesday, January 9, 2018

Participation requires both computer and phone capabilities, however, if you are unable to use phone capabilities there is a "Chat" function described below in the instructions.

To access the Web Conference:

Go to www.anywhereconference.com
-Click on "I'm a participant"
-Enter your name
-From your phone, dial 1-800-250-2600 (can be landline or cell phone)
-Enter your PIN code: 16927953#
-Enter the 4 digit Synchronization code provided in Step 4, followed by the # symbol.
-Click "OK"

You will see a Welcome screen until documents are shared by the Moderator.
"Chat" capabilities for those unable to call in:
There is a "Chat" function as part of the Web Conference, so ***if you are unable to participate by audio call,*** you will be able to chat with other participants by hovering over the attendees name and clicking on the "chat" icon. This will enable you to chat with that attendee only.

If you would like to address the entire room, you can utilize the "To: All attendees" chat box in the bottom left corner of your screen. This will be seen by everyone logged in to the Web Conference.

L LETTER:

RE: MI Marketplace Option Provider Information and Webinar

This letter provides information about implementation of the Healthy Michigan Plan 1115 demonstration waiver amendment approved by the Centers for Medicare & Medicaid Services (CMS) on December 17, 2015. Approval of this waiver amendment was required by Public Act 107 of 2013, and provides the framework for a new health care coverage program known as the MI Marketplace Option. Information about this waiver amendment, including the operational protocols, can be found at www.michigan.gov/healthymichiganplan.

Consistent with the waiver amendment, the Michigan Department of health and Human Services (MDHHS) will begin transitioning eligible beneficiaries from the Healthy Michigan Plan to a MI Marketplace Option health plan starting in April 2018.

MI Marketplace Option health plans are not Medicaid health plans. They will provide a more limited benefit package, consistent with the Affordable Care Act's essential health benefits, and will have their own provider networks and prescription drug formularies. MDHHS will cover non-emergency medical transportation, family planning services provided by out-of-network providers, and any MI Marketplace Option Medicaid-covered services provided by out-of-network federally qualified health center, rural health clinics and tribal health centers as wrap-around services.

Not all Healthy Michigan Plan beneficiaries will be required to transition to the MI Marketplace Option. For example, only individuals age 21 and older who have incomes about 100% of the Federal Poverty Level and have been enrolled in a Healthy Michigan Plan health plan for at least one year without choosing a healthy behavior through a Health Risk Assessment (HRA) may move to the MI Marketplace Option. MDHHS will also identify other individuals who are exempt from the MI Marketplace Option. Specifically, MDHHS will exempt beneficiaries with serious health conditions or complex needs from the MI Marketplace Option, and will review beneficiary exemption requests. Providers may work with beneficiaries to request this exemption. MDHHS will provide more information on the medical exemption process at a later time.

MDHHS will begin notifying beneficiaries who may be eligible to transition to the MI Marketplace Option in November 2017 via a beneficiary letter. The notices will encourage beneficiaries to complete an HRA and choose a healthy behavior. Primary care providers are encouraged to assist their Healthy Michigan Plan beneficiaries with completing the HRA and choosing a healthy behavior.

MDHHS provides clarification on registration of atypical Medicaid providers

In response to questions from the filed regarding the recently issued requirement that individual Medicaid providers be enrolled in CMHAPS, the state's Medicaid provider and payment system, MDHHS issued the clarification, below, that exempts many individual providers, within the CMH, PIHP, and provider systems, from this requirement. That clarification is provided below:

DATE: December 20, 2017

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Thomas Renwick, Director
Bureau of Community Based Services
Behavioral Health and Developmental Disabilities Administration

SUBJECT: Question Regarding Provider Enrollment in CHAMPS

It has come to our attention that some CMHSPs have been given direction to enroll Adult Foster Care (AFC) workers into CHAMPS. Please know that at this time atypical providers who do not provide "traditional health care" cannot enroll in CHAMPS. A few examples of atypical providers are AFC workers, aides who provide community living support or personal care in specialized residential facilities, case managers, supports coordinators, and skill-building aides. MDHHS will be sending you further communication on the CHAMPS provider enrollment process as additional details become available.

Employment First State Leadership Mentoring Program announced

Community of Practice Monthly Webinar
January 10, 2018, 3:00-4:00 ET
Register for this webinar at: http://www.econsys.com/eflsmp/copwebinar/

The Employment First State Leadership Mentoring Program (EFSLMP) Community of Practice (CoP) Webinar Series is structured to augment the technical assistance areas of primary focus in Employment First systems change (Capacity Building, Provider Transformation, School-to-Work Transition, Employer Engagement, and Policy/Funding Alignment). CoP participants will benefit from national subject matter experts (SMEs) presenting information and resources to support Employment First efforts.

Theme: Provider Transformation Staffing

Topic: Staffing to Provide Competitive Integrated Employment
During this month's CoP webinar, participants will learn about strategies to recruit, train and retain staff that support the Employment First mission of the agency. Rick McAllister will discuss approaches to enhancing recruitment efforts. He will share a training paradigm that builds skills and supports retention with a focus on the value of competency based staff development.

Webinar Objectives

- Share strategies that will augment the recruitment process, and help us clarify our vision of which candidates can best support the Employment First mission.
- Provide a structure for staff training and development that facilitates the acquisition of skills needed to deliver competitive integrated employment services, and will also support effective retention efforts.
- Discus staffing considerations as we shift from sheltered employment to competitive integrated employment. Discuss how these skill sets compare in very different positions—
- Provide a focus on using competency-based assessment from the initiation of recruitment through long-term retention.

Special Guest: Rick McAllister: Rick McAllister, M.Ed., has over 30 years of experience in consulting, training and the day-to-day managing of service-based organizations. He is a nationally recognized speaker on employment strategies, leadership, management, and designing creative and effective organizational structures. He has extensive experience providing technical assistance to private, federal, and state sponsored employment initiatives. Rick has a bachelor's degree in business administration and a master's degree in applied behavioral analysis. He is the Managing Partner/EVP of Management Analytics Resource Collaborative, LLC, a consulting group based in New Hampshire.

Action Required: Seeking input in Advance: The webinar sponsors want to ensure that our speakers address your concerns. This is your opportunity to submit input in advance. Submit your questions or comments at (https://www.research.net/r/VKMZBFL) no later than December 29, 2017.

Webinar Procedures:

1. On the day of the webinar, enter room here: http://www.econsys.com/eflsmp/copwebinar/.
2. In the GUEST field, enter your first and last name followed by state abbreviation (i.e., Jeff, Smith, DC).
3. To connect your audio, follow the prompts to enter your phone number (direct line), and the system will immediately call you back (see step-by-step instructions).
4. If you are unfamiliar with Adobe Connect, please review these tips before participating.

Meeting Materials

- Meeting materials are forthcoming and will be distributed closer to the event.

Unable to Attend

EFSLMP Webinars are recorded and the link will be distributed to the list serve within two business days following the webinar. Share this announcement with your colleagues! If they are not a current subscriber to ODEP's EFSLMP mailing list, they can register at: http://econsys.us6.list-manage.com/subscribe?u=29aa515bd6e4d1a3e196930b4&id=63a8e8be13&subscribe

Concerns grow over impact of federal tax cut bill on healthcare coverage

The following is a press release from a national healthcare advocacy group that underscores the threat, caused by the tax cut bill recently passed by Congress (on its way to the President's desk for signing) to healthcare coverage for many Americans.

> Congressional Republicans Vote To Jeopardize The Health And Economic Security Of Americans To Finance Tax Cuts For The Wealthy
>
> *Statement of Robert Restuccia, executive director of Community Catalyst, in response to House and Senate passage of legislation that would take health care away from millions of Americans to finance tax cuts for the wealthiest households and corporations.*
>
> "House and Senate Republicans just rushed through passage of a tax bill that's a gift to the wealthiest households and corporations at the expense of the health and economic security of working and middle-class Americans. The Republican tax bill would leave 13 million people without insurance, hike premiums for millions more, and cause massive disruption in the health care marketplace. People in their fifties and sixties as well as those dealing with serious health conditions would be particularly at risk of losing or not being able to find affordable coverage.
>
> "The damage doesn't stop there. The bill would also trigger an automatic $25 billion cut to Medicare, increasing to $400 billion in cumulative cuts over 10 years. This would put the more than 55 million people with disabilities and working families across the country at risk of losing care they need, and further erode our nation's historic commitment to the basic health and economic well-being of all Americans.
>
> "People all across the country have made it abundantly clear in calls, emails and rallies – and by their votes – that they oppose cuts to their health care to finance tax cuts for the wealthy and big corporations. We call on Members of Congress in both branches and on both sides of the aisle to pledge they won't slash Medicaid or make additional cuts to Medicare to offset the more than $1 trillion increase in the nation's deficit this tax cut will create. Community Catalyst and our allies across the country will be watching – and we will continue to fight to protect people from future efforts to undermine their care or access to treatment."

Federal Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) issues first report

The federal Interdepartmental Serious Mental Illness Coordinating committee (ISMICC) reports to Congress and federal agencies on issues related to serious mental illness (SMI) and serious emotional disturbance (SED). ISMICC delivers the following to Congress and to other relevant federal departments and agencies:

- A summary of advances in serious mental illness (SMI) and serious emotional disturbance (SED) research pertaining to prevention, diagnosis, intervention, treatment, and recovery. This includes advances in access to services and supports for adults with SMI and children with SED.
- An evaluation of the effect federal programs related to SMI have on public health, including public health outcomes such as:

- Rates of suicide, suicide attempts, incidence and prevalence of SMIs, SEDs, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, interaction with the criminal justice system, homelessness, and unemployment
- Increased rates of employment and enrollment in educational and vocational programs
- Quality of treatment services for mental and substance use disorders
- Any other criteria as may be determined by the Secretary
- Specific recommendations for actions that agencies can take

Information about the ISMICC can be found at:
https://www.samhsa.gov/about-us/advisory-councils/ismicc

The ISMICC recently issued an in-depth report outlining the need for federal action to improve services to persons with serious mental illness and to strengthen the system, nationwide, designed to serve them. The full report and executive summary can be found at: https://store.samhsa.gov/product/PEP17-ISMICC-RTC

MiBridges registration for community partners announced

The Michigan Department of Health & Human Services (MDHHS) is excited to announce that registration is officially open to register as a MI Bridges Community partner. Organizations that have expressed interest in partnering with MDHHS as a MI Bridges Community Partner received an email from MDHHS with registration instructions and tips. Organizations can also go to this link to register: https://newmibridges.michigan.gov/s/isd-communitypartner-landing .

After registering, you will receive a confirmation email with details on next steps. For more information on the new MI Bridges, please visit the MI Bridges Community Partner website at www.michigan.gov/mibridgespartners.

Rural Health and Safety Education offers webinar on Combating Opioids

The Rural Health and Safety Education webinar series "Combating Opioids" is hosted by the Michigan State University North Central Regional Center for Rural Development, Purdue University Extension and the NCRCRD as part of a USDA/NIFA grant.

Combating Opioids
January 17, 2018 @ 12:30 PM-ET
Presented by: Robert Shupp and Scott Loveridge (Michigan State University)

Objective of this webinar series is to:

- Share information and best practices to prevent opioid misuse and abuse in rural counties
- Increase professional capacity to engage in health leadership in rural counties
- Increase access to new ideas and technologies related to opioid misuse and abuse in rural counties
- Increase public health knowledge and engage in health system
- Increase health literacy of opioid misuse or abuse in rural counties

To register for the webinar go to:
http://ncrcrd.msu.edu/webinars/rural_health_and_safety_education

For more information on the content of this webinar go to:
http://ncrcrd.msu.edu/uploads/files/Prescription_and_Alcohol_Abuse.pdf

Archived Webinars: (Recordings and Presentations): How the Opioid Crisis Impacts Individuals and Rural Communities (12/5/17)
Presented by: Michelle Sybesma, Parkdale Center for Professionals
Recorded presentation can be found at: https://www.youtube.com/watch?v=nO_9QLVkEKI&feature=youtu.be

Survey: Michigan ranks 35th in nation for overall health

Michigan slipped one spot from last year to 35th in the nation for overall health in 2017, according to an annual ranking from United Health Foundation.

It also fell from a ranking of 31 in drug deaths last year to 35 this year. In addition, poor rankings in smoking, violent crime, public health funding, air pollution and excessive drinking landed the state in the bottom half for health in the nation.

Michigan's score has fluctuated only slightly in the past few years, ranking 35th overall in 2015 and 37th in 2012.

MICHIGAN RANKINGS

The annual America's Health Rankings survey assesses each state based on 35 measures. Here's how Michigan rated this year:

The good

- 6th in primary care physicians
- 8th in adolescent immunizations
- 11th in people uninsured
- 12th in infectious diseases
- 16th in occupational fatalities

The bad

- 42nd in cardiovascular disease
- 41st in public health funding
- 40th in obesity
- 40th in smoking
- 40th in frequent mental distress
- 39th in excessive drinking
- 38th in cancer deaths
- 38th in violent crime

500 cities project issues interactive health status map

The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. These small area estimates will allow cities and local health departments to better understand the burden and geographic distribution of health-related variables in their jurisdictions, and assist them in planning public health interventions. See bottom of page for the note for data users. Learn more about the 500 Cities Project at: https://www.cdc.gov/500cities/

2017 PAC Campaign Update

Earlier this year we announced our 2017 CMH PAC campaign with the goal of increasing member participation. This year's campaign exceeded last year's contribution levels, but participation remained about the same. Last month we held the drawing for the Detroit Tiger box suite tickets donated by Muchmore Harrington Smalley Associates and the winner was… Lapeer CMH.

Congratulations to Lapeer CMT and thank you to all who generously contributed to the CMH PAC.

Just because the Tiger drawing has been completed does not stop the need for CMH PAC support. If you would still like to support our PAC efforts please mail you contribution to our office, below are the details:

Make checks payable to: CMH PAC ~ 426 S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please)

Thank you. Please feel free to contact Bob or Alan with any questions.

LEGISLATIVE UPDATE

ONLINE GAMING ISSUE TO BE TAKEN UP IN 2018

Members of the House Regulatory Reform Committee reported legislation to the full House for a vote on Wednesday that would legalize online gaming via regulation through the state's casinos and tribal casinos. The bills, House Bills 4926-4928, call for the allowance of casinos and tribal casinos to receive licenses from the Michigan Gaming Control Board for online gaming; though tribal casinos would have to alter their compacts with the state before receiving said license.

If passed in 2018, Michigan would become the fifth state to legalize online gaming, something opponents claim will threaten funding for the state's schools as revenue would not be tied to the School Aid Fund like casinos. However, those supporting the legislation claim the bills will increase revenue as they will bring in more players and entice those who feel comfortable only playing online. Sponsor of HBs 4926 and 4927, Representative Brandt Iden (R-Oshtemo Twp) noted the bills comply codify the online gaming process that many Michigan residents already partake in (unknowingly) an illegal fashion.

Mr. Iden also noted the bills outline protections that will be provided to consumers, including dealing with certified and regulated casinos (Detroit's three only: MotorCity, MGM Grand, and Greektown) or tribal casinos, prevention of identity or credit card theft, and use of Michigan's Compulsive Gambling Hotline. The bills saw passage out of Committee via a 12-3-1 vote. Representative Klint Kesto (R-Commerce Twp) sponsored HB 4928, which also saw a vote of 12-3-1 for movement to the House floor. Committee members also approved an amendment offered by Representative Jeremy Moss (D-Southfield) on a 13-0-3 vote, allocating an additional $1 million in funding to the Michigan Compulsive Gambling Fund which is currently capped at $2 million.

As reported, the bills also: place a 10 percent tax on internet gaming; call for the use of facial recognition and location software for determining age and in-state location; implement a $200,000 fee (application $100,00 and annual $100,000); require an online gaming license to be renewed every five years (with the option to renew for another five years); place age restrictions equal to those for casinos (21 and older); and require 45 percent of the gross gaming revenue to be deposited into the Internet Gaming Fund. The other four states that have legalized online gaming are Delaware, Nevada, Pennsylvania, and New Jersey.

NATIONAL UPDATE

Tax Bill Heads to President's Desk

The House, forced to vote a second time on the $1.5 trillion tax bill, moved swiftly to pass the final version on Wednesday, clearing the way for President Trump to sign into law the most sweeping tax overhaul in decades. House lawmakers approved the tax bill 224 and 201 on Wednesday, after being forced to vote on the bill again after last-minute revisions were made to it in the Senate, which passed the measure 51 to 48 early Wednesday morning.

The final House vote was essentially a formality, as the changes, which were made to comply with Senate budget rules, did not significantly after the overall bill. But the need for a second vote game ammunition to Democrats, who had already accused Republicans of trying to rush the tax overhaul through the House and Senate. The tax rewrite is the biggest legislative achievement for Republicans since they gained full control of Congress and the White House.

IMPACT ON HEALTH CARE

While the final version of the tax reform bill is not expected to cut entitlement programs like Medicaid, Medicare, and Social Security directly. It is likely to lead to dramatic cuts to the federal revenue necessary to fund those programs. Speaker of the House Paul Ryan (R-WI) made clear his view that cuts to health care entitlement programs would be necessary should the Tax Cuts and Jobs Act become law, saying, "We're going to have to get back next year at entitlement reform, which is how you tackle the debt and the deficit."

In addition to these high-level concerns about the overall impact of the bill, the National Council has concerns with specific provisions that would harm community behavioral health organizations and the populations they serve. These concerns include:

- Preventing the doubling of the standard deduction as it would cause an estimated reduction of $13.1 billion in charitable giving, a critical revenue source for community behavioral health organizations;
- Preserving the medical expense deduction which keeps health care costs low for those with costly chronic conditions; and
- Preventing the repeal of the health law's individual mandate, a key component of the Affordable Care Act that helps lower premiums and fund comprehensive insurance plans.

CMHAM WINTER CONFERENCE – SAVE THE DATE

The Community Mental Health Association of Michigan's 2018 Annual Winter Conference is February 6 & 7, 2018 (February 5, 2018 Pre-Conference Institutes) at the Radisson Plaza Hotel & Suites, Kalamazoo.

Have a Great Weened and Holiday Season!

This special Thursday edition of the Friday Facts will be the last Friday Facts of 2017.