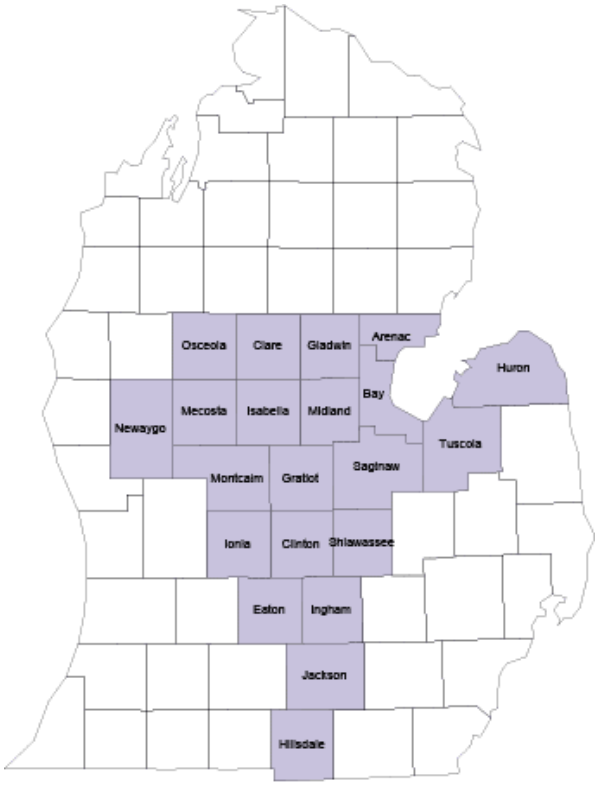
MSHN
Mid-State Health Network

THREE YEAR STRATEGIC PLAN FOR SUBSTANCE USE DISORDER PREVENTION, TREATMENT, AND RECOVERY SERVICES

FY2021-2023

Approved by MDHHS: September 8, 2020



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SECTION 1 - Introduction

Mid-State Health Network (MSHN) is the Prepaid Inpatient Health Plan (PIHP) for Region 5's twenty-one counties in the heart of Michigan's lower peninsula. These counties include Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola. MSHN works in partnership with the twelve Community Mental Health (CMH) agencies for these 21 counties and with a network of substance use disorder (SUD) prevention, community recovery, treatment and recovery housing providers. This document provides an overview of MSHN's current SUD delivery system, the epidemiological data for the region and the strategic plan for addressing identified needs over a three-year timeframe, FY21-23.

Historical Context for this FY21-23 Strategic Plan

The global COVID-19 pandemic of 2020 has resulted in an unprecedented historical context for our planet, our nation, and our state. During the development of this strategic plan, profound health and economic impacts are unfolding across Michigan's landscape in ways that we are evolving day to day. To the extent possible, this three-year Substance Use Disorder (SUD) Strategic Plan is informed by epidemiological and demographic data from the Michigan SUD Data Repository, MiPHY and other traditional data sources. We acknowledge at the outset, however, that the coronavirus pandemic has had and continues to have devastating and, at this point, unquantifiable effects on Michigan's social determinants of health, leading to poor outcomes across multiple health indicators. We face a behavioral health epidemic within the COVID-19 pandemic including inevitable spikes in mental illness, suicides, substance use driven by mass unemployment, economic instability, social isolation, increased domestic and sexual violence and other negative health indicators ranging from rising infant mortality to decreasing life expectancy.

Compounding the coronavirus crisis, the tragic videotaped death of George Floyd while in police custody on May 25, 2020, sparked national and international waves of grief, anguish and outrage. Protests took place around the world and across Region 5 in Saginaw, Jackson, Lansing and beyond. It brought renewed attention to historical and ongoing systemic racism, oppression and racialized trauma. This makes the mission to ensure access to high-quality behavioral health and substance use disorder services for *all* citizens in our 21 counties more critical than ever for MSHN and for our sister PIHPs.

Identification & Prioritization of Substance Use Disorder (SUD) Problems in Region 5

Demographic profile of Region 5

There is significant variation between counties and communities within this large geographic area, particularly in terms of population density, urban/rural/racial composition, and manufacturing vs. agricultural economic activity.

Poverty and unemployment rates vary across the region and it should be noted that the data that follows predates the massive job losses across Michigan starting in March 2020 as the state closed down due to the coronavirus pandemic. These figures are changing week to week. Data from the 2018 U.S. Census Bureau's *American Community Survey 5-year Estimates* show the median household income in Region 5 was $50,846. Household income varies widely among counties where the range was from $37,369 in Clare County to a high of $67,482 in Clinton County. Only three counties (Clinton, Eaton, and Midland) in the MSHN region exceeded the state median household income of $56,697.

Much like income levels, there was a stark difference in the percentage of those living in poverty from one county to the next. The percent of individuals living at or below the federal poverty level was highest in Isabella County at 26.5% and lowest in Clinton County at 9.3%. The region also has a significant range in high school education

attainment with a low in Clare County of 84.7% and a high in Midland County of 94.3%. As a region, MSHN's counties are in line with the state average for individuals with health insurance. However, two counties (Clare and Osceola) have an uninsured population of over 10%.

According to U.S. Census Bureau 2019 population estimates, Region 5 is 83.4% Non-Hispanic White, 6.8% Black/African American, 5.2% Hispanic/Latino, 2.5% self-identifies as "Two or more races," 0.7% American Indian/Alaska Native, and Pacific Islander/Native Hawaiians make up <0.1%.

There is considerable variation among counties, however. Twelve of MSHN's 21 counties have populations that are ≥ 90% Non-Hispanic White, while two of MSHN's 21 counties have non-white populations that exceed the Michigan average of 25.1%: Five of MSHN's 21 counties have populations that range from nearly 15% to over 30% people of color. Ingham and Saginaw counties have the highest non-white populations (30.8%) followed by Eaton (17.2%), Jackson (15.4%) and Isabella (14.8%). Saginaw county has the highest concentration of Black/African Americans (19.3%) and Hispanic/Latinos (8.5%), while Ingham county had the largest population of Asians at 7.9% and "Two or more races" at 4.2%. The highest concentration of American Indian/Native Alaskans was found in Isabella county (4.0%). Given disparities in health outcomes among people of color, MSHN recognizes the importance of attention to these populations' needs.

A demographic profile of each Region 5 county is identified in Appendix 1.

Populations of Focus

During FY21-23, Medicaid-covered SUD treatment services and supports will be provided, based on medical necessity, to eligible beneficiaries who reside in the MSHN region and request services. The MSHN *Utilization Management, Access System policy/procedure* provides regional Access Management System (AMS) eligibility standards for behavioral health service, including those individuals with a co-occurring mental illness, as well as determination of priority population status for SUD services and supports. SUD specific eligibility includes determination of medical necessity, provisional diagnostic impression of SUD dependence or abuse, determination of the level of care (LOC) based on American Society of Addiction Medicine (ASAM) criteria, and determination of priority population status.

Prevention activities in the region are designed to serve all three Institute of Medicine (IOM) classifications: Universal Populations, Selective Populations, and Indicated Populations. Universal population will mainly be served through educational groups to youth and parents along with community and environmental strategies with the general population. In the MSHN region, selective populations that will be served include children of people with substance use disorders, delinquent/violent youth, economically disadvantaged/homeless runaways, people with disabilities, people with mental health problems, physically/emotionally abused, pregnant women, school dropouts, and LGBTQ persons, youth in particular. Indicated services in the region will focus on people using substances and persons in recovery. The majority of community recovery activities focus on the Indicated (Persons in Recovery) Populations.

Recovery-focused activities are designed to assist people with increasing their overall wellness and support their recovery. Recovery Oriented Systems of Care (ROSC) groups were formed in geographic groupings across the region to enable neighboring counties to share information, best practices, and resources. A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. Across the MSHN region, recovery-focused activities include Community Recovery Organizations (RCOs), Recovery Housing, Project ASSERT, peers in community settings (i.e. urgent care facilities, domestic violence shelters, Federally Qualified Health Centers (FQHCs), primary care physicians' offices), peer supported Drop-In-Centers, Recovery Oriented Community Events, peers supporting syringe services programs, and university and college campus CREW (Collegiate Recovery Education Wellness) programs.

Overview of MSHN systems for SUD prevention, treatment, and recovery services

MSHN's twenty-one county region has a robust SUD prevention, treatment and recovery provider network that offers a full continuum of care for SUD services. MSHN's provider network extends to 141 provider sites, including new providers previously under contract with MDOC. MSHN has 77 unduplicated treatment, prevention and recovery provider agencies. These programs include but are not limited to outpatient group and individual counseling, intensive outpatient, withdrawal management, residential, Medication-Assisted Treatment (MAT), recovery housing, case management and peer supports. All levels of care can be found within the MSHN region, which enhances consumer choice with multiple pathways to access providers and services throughout the MSHN network. Other than Osceola county, the other 20 counties have at least one SUD treatment provider and all counties have their own prevention provider. MSHN has seen an expansion of evidence-based prevention activities including but not limited to Prime for Life, Botvin, and gambling disorder prevention programming. MSHN has also expanded on its treatment service array including MAT, Women's Specialty, and jail-based treatment services as well as expansion of recovery housing and evidence-based treatment initiatives like Project ASSERT, peer coaches working with treatment courts, and motivational interviewing. MSHN has also done extensive distribution of both Narcan and the much more cost-effective injectable naloxone kits. MSHN has extended its treatment service array with the inclusion of expanded recovery housing. Twenty-nine recovery homes are currently located across Mecosta, Hillsdale, Newago, Montcalm, Ingham, Saginaw, Bay, Eaton, and Midland Counties. All recovery homes must be certified by the Michigan Association of Recovery Residences (MARR) as a level III provider or higher.

Network Adequacy Assessment

Mid-State Health Network must assure the adequacy of its network to provide access to a full array of services for specified populations over its targeted geographical area. In order to meet this requirement, a Network Adequacy Assessment (NAA) (Appendix 2) is completed annually to ensure MSHN has the capacity to serve the population of people in need of services. Through the assessment process the PIHP must prospectively determine:

- How many individuals are expected to be in the target population in its geographic area for the upcoming year;
    - Of those individuals, how many are likely to meet criteria for the service benefit;
    - Of those individuals, what are their service needs;
- The type and number of service providers necessary to meet the need;
- For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home;
- How the above can reasonably be anticipated to change over time.

Once services have been delivered, the PIHP must retrospectively determine:

- Whether the service provider network was adequate to meet the assessed need;
- If the network was not adequate, what changes to the provider network are required?

The full 2018 NAA contains the region's full list of priorities for all populations served by MSHN as well as a full-list of evidence-based practices offered in Region 5. An abbreviated list of priorities that are specific to SUD treatment services based on the report are:

- Continue to support provider network capacity to offer key evidence-based programs, such as recovery and trauma informed programming, including ROSC;
- Continue to assess and address the integration of mental health, substance use disorder and physical

health care;
- Evaluate SUD residential and withdrawal management needs in the region;
- Continue to address network capacity for detox services and medication assisted treatment, including availability of Methadone, Vivitrol, and Suboxone at all MAT locations; Continue to support CMHSPs and SUD providers as Narcan kit distribution sites;
- Continue to support the BHDDA veterans and military member strategic plan;
- Evaluate the status of compliance with the enhanced requirements for trauma informed and sensitive treatment, including any changes that may be needed in provider network specializations;
- Continue to promote trauma informed care relative to SUD treatment and offer SUD providers opportunities for trauma competence training;
- Assess and monitor new MDHHS Network Adequacy standards specific to opioid treatment programs (OTPs).

MSHN will continue to work on these priorities through the strategic plan, continued staff effort, and the continued work of the provider network. The annual NAA may change the priorities based on the assessed need of the region. The priorities will be updated based on the NAA and will be used to support the strategic plan going forward.

Mobile Care Unit

An addition to MSHN's treatment and recovery services includes the addition of a mobile care unit (MCU) that was purchased through State Opioid Response (SOR) funds. The MCU has been named the *Action in Motion* (AIM) bus and MSHN contracted with Recovery Pathways, an Office-Based Opioid Treatment (OBOT) provider of MAT, counseling, case management, and peer support services. Images of the MCU are available in Appendix 3. The AIM bus is designed to expand access to treatment services (including MAT) in Region 5's more rural counties where there are few providers and transportation creates barriers to treatment. Due to the unexpected closure of MSHN's only provider in Eaton County, the MCU was deployed in November 2019 to Charlotte in Eaton County. It was on-site from November 2019 until early March 2020 when the COVID-19 lock-down precluded continuity of services under safe conditions (it continued services via telemedicine with existing Eaton County clients). On May 11, 2020, the opening of a new brick and mortar MSHN-contracted provider, Samaritas, located in Charlotte relieved pressure on the MCU's services in Eaton County.

The plan remains for the MCU to deploy as originally intended in rural counties like Arenac, Osceola, Clare, and Mecosta counties. However, a demand for expanded COVID-19 testing resulted in a MDHHS-MSHN-county health department collaboration to expand access to testing for a particularly vulnerable population, opioid-dependent individuals, especially those with intra-venous drug use. MSHN is deploying its MCU in Saginaw and Bay counties to provide COVID testing for Saginaw's 500 OTP clients and over 200 MAT clients in Bay county. In Ingham County, MSHN is partnering with a Community Recovery Organization (CRO), Wellness INX, and the Ingham County Health Department to offer COVID testing to the three Lansing OTPs 1,000 opioid-addicted clients.

Barriers to SUD prevention, treatment, and recovery services

Barriers MSHN will consider, at a minimum, are the long-term impact of the coronavirus pandemic on the populations we serve, lost capacity in our provider network, the new and expanded demands for telemedicine long term, the potential for repeal of the Affordable Care Act and with it Michigan's Medicaid expansion (Healthy Michigan), coronavirus-driven budget cuts to MDHHS and the public health infrastructure, the number of network providers not accepting new beneficiaries, the broad geographic distribution across 21 counties of providers and beneficiaries, limited broadband internet access (especially with demand for telemedicine services and virtual educational content delivery), travel time, and availability of transportation.

MSHN also recognizes the presence of systemic health disparities based on race, ethnicity, socio-economic status, linguistic differences, and other variables. Creating greater cultural competency in our provider system is a goal, and we recognize that institutional biases and disparities create barriers to equity in healthcare delivery across the region.

Communicable Disease

MSHN treatment providers will follow the MDHHS Prevention Policy #02 Addressing Communicable Disease Issues in the Substance Abuse Service Network (September 14, 2011).

This includes the following requirements:

1. All staff of a licensed SUD treatment provider who have client contact must have basic knowledge of HIV/AIDS, TB, Hepatitis and STDs and the relation to SUD through the requirement of completing Michigan Department of Health and Human Services (MDHHS) Level 1 web-training. This is reviewed through staff training records at site visits.
2. All providers who have persons who are infected by mycobacterium tuberculosis (TB) must refer clients for the appropriate medical evaluation and treatment.
3. All clients entering residential treatment and residential detoxification must be tested for TB upon admission.
4. All pregnant women presenting for treatment must have access to STD and HIV testing.
5. All SUD clients entering treatment must be appropriately screened for risk of HIV/AIDS, STDs, TB, and hepatitis and provided basic information.
6. For clients who enter SUD treatment with high-risk behaviors, additional information, and referral to testing and treatment must be made available.

SECTION 2 - Epidemiological Profile

MSHNs epidemiological profile describes substance use disorder patterns as well as other health variables for our 21-county region. This information establishes a baseline for evaluation, planning, and monitoring. The profile provides the most current information, primarily 2017-2019, with trend data, if available. In addition, MSHN utilizes data captured in our integrated electronic data collection systems (REMI) as well as data captured from state and federal sources.

As noted earlier, there are health impacts still unfolding as a result of the coronavirus pandemic: grief and anxiety associated with COVID's lethality, social isolation associated with the stay-home Executive Orders, and the social upheaval caused.

SUD Morbidity, Mortality and Prevalence

In 2019, Mid-State Health Network provided SUD treatment services for 12,646 individuals (unduplicated) receiving an admission for substance use disorder services, a 21% increase since 2015 (Appendix 4). This is not an indication of overall prevalence of people meeting a DSM-V diagnosis for a substance use disorder, but the number of admissions for people accessing SUD services with a DSM-V axis I substance use disorder.

MSHN utilizes a "no wrong door" approach to service which allows multiple pathways for people to access treatment services and the medically appropriate level of care. Within the MSHN region, the majority of admissions (65%) are for outpatient services and the lowest admissions, 2%, are for ambulatory withdrawal management. Since 2016, admissions to outpatient services have increased 13 percentage points. Admissions for ambulatory withdrawal management, withdrawal management, residential, and intensive outpatient services have remained relatively unchanged since 2016 (Appendix 5).

The National Survey on Drug Use and Health from SAMHSA from 2012-2014 identified 53.9% of the Mid-State Health Network region used alcohol, 27.3% binge drank alcohol, 26.4% used cigarettes, 10.10% used marijuana, and 3.8% used an illicit drug (not including marijuana) within the past 30 days (Appendix 6) (NSDUH, 2018)[1].

Using an illicit substance within the last 30-days may impact individuals with a multitude of diseases that can be separate from or comorbid with a substance use disorder. The impact that these issues have on the course of the substance use disorder and an individual's recovery journey must be accounted for and addressed during a treatment episode. Data was reviewed for diabetes, obesity, HIV, mental illness, and serious mental illness. These health issues must be addressed concurrently with treatment for SUD to support long term recovery.

According to the 2018 National Survey on Drug Use and Health approximately 8.9 million young adults in the U.S. aged 18 to 25 had any mental illness (AMI) in the past year, and 5.1 million had a past-year SUD. Among young adults, 2.4 million had both AMI and a SUD in the past year (SAMHSA, 2018)[2]. Regionally, 20.6% of the population experienced mental illness in 2018, 4.7% of which experienced serious mental illness in the past year, according to SAMHSA's National Survey on Drug Use and Health from 2012-2014 (NSDUH, 2018)[1]. Of people admitted to treatment in 2019, 24% indicated having co-occurring SUD and mental health (MH) problems and receiving treatment, while 18% indicated having co-occurring SUD and MH problems and were not receiving treatment. This is an increase by 13 percentage points since 2016 and 2 percentage points since 2018 in people having a co-occurring SUD and MH problem that are not receiving treatment (Appendix 7).

The County Health Rankings produced in collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute indicates that obesity impacts over 30% of people within the MSHN catchment region (Appendix 8) (County Health Rankings, 2020)[3]. The average

percentage of adults age 20 or older with a body mass index of (BMI) greater than or equal to 30kg/m2 is 36% within the region. Tuscola County has the lowest percentage at 31% for adults while Gladwin County has the highest at 43%. As no county has a range lower than 30% this is a health area for further treatment consideration. Additionally, the report indicated adults age 20 or older with diabetes ranges from 7% in Mecosta County to 19% in Gladwin County (Appendix 9) suggesting risks and referrals for medical care should be addressed in a more targeted way for higher risk counties in the MSHN region.

In 2016 there were 1,491 cases of HIV within the MSHN region (Appendix 10). Reported cases range from zero in Arenac County to 422 reported cases in Ingham County. SUD treatment providers complete communicable disease screenings on all people served, provide education, and provider referrals and testing resources based on risky behaviors, as requested or applicable. According to the CDC, one in ten HIV diagnoses occur among people who inject drugs. In 2016, injection drug use (IDU) contributed to nearly 20 percent of recorded HIV cases among men—more than 150,000 patients nationally. Among females, 21% (about 50,000) of HIV cases nationally were attributed to IDU (National Institute of Drug Abuse; Drug Use and Viral Infections (HIV, Hepatitis) Drug Facts, 2019)[4]. In Region 5, Ionia, Ingham, Jackson, and Saginaw counties all have needle exchange programs to reduce the risk of spreading HIV due to needle sharing.

There is a six-year age difference in life expectancy within the MSHN region. Clare County has the lowest life expectancy at 75.1 years and Clinton County has the highest life expectancy at 81.5 years (Appendix 11). Many factors contribute to the increase and decrease in life expectancy. It is noted that Clare County has the lowest average income in the MSHN region, the lowest education attainment in the region, and is one of two counties in the MSHN region with an uninsured population over 10%, while Clinton County has the highest average income in the MSHN region and the lowest percentage of people living in poverty within the MSHN region. Life expectancy is adversely impacted by overdose deaths, suicide, and automobile deaths which are explored in greater detail within the epidemiology section of the report. MSHN continues to distribute Naloxone kits throughout the region to reduce opioid related overdose deaths.

Youth Epidemiological Indicators

The youth indicators reported below were calculated from data provided by MDHHS Substance Use in Michigan data repository[5]. Data can also be accessed from the Michigan Profile for Healthy Youth (MiPHY) on the Michigan Department of Education website[6]. It is important to note that only counties who collected the same data in 2016 and 2018 were used to calculate averages. In addition, it is important to note that not all schools in all counties administer the MiPHY survey.

Tobacco/Nicotine (Appendix 12)
While there is a significant decrease in cigarette use, it is likely associated with the rapidly increased use of electronic nicotine devices (ENDs). The survey collects responses regarding ENDs related to use frequency and how the youth obtained the product. There is not data related to perceptions of risk or attitude associated with use.

- Cigarette Use Past 30 Days* (29% ***reduction*** from 2016 to 2018 for HS and 31% for MS)
- Electronic Vapor Product Use* (48% ***increase*** from 2016 to 2018 for HS and 84% for MS)

* If data is not reported for either cohort, then the data was not captured by MiPHY. Further if the dataset was not collected for the consecutive 2016 and 2018 cycles it was not included in the average.

Alcohol and Other Drugs (Appendix 13)
The SUD data collected by MiPHY indicates that substance use has mostly decreased or remained the same over the two-year span. However, there was a significant increase in marijuana use among middle school (MS) aged children. Further review indicates that these students reported a *reduced concern for risks associated with smoking*

marijuana once or twice a week. One plausible cause may be access combined with the changing laws (State Proposal 18-1 in 2018 approved the use of recreational marijuana) making the idea of using marijuana more socially acceptable.

- Alcohol Use Past 30 Days* (14% ***reduction*** from 2016 to 2018 for high school (HS) and 52% for MS)
- Cocaine Use Past 30 Days* (Average of 1% reporting use, ***no change*** from 2016 to 2018)
- Heroin Use Past 30 Days* (***Decreasing*** from an average of 1% to 0%)
- Inhalant Use Past 30 Days* (Average use of 2% among HS, and 3% among MS with ***no change*** from 2016 to 2018)
- Marijuana Use Past 30 Days* (The average for HS ***remained constant*** at 14% for 2016 and 2018 while MS increased from 3% to 4%)
- Marijuana concern for risk of use* (The average for MS ***decreased*** from 63% in 2016 to 56% in 2018)
- Methamphetamine Use Past 30 Days* (Average of 1% reporting HS use in 2016 to a ***reduction*** in 2018 to an average of 0%)

* If data is not reported for either cohort, then the data was not captured by MiPHY. Furthermore, if the dataset was not collected for the consecutive 2016 and 2018 cycles, it was not included in the average.

Suicide (Appendix 14)
Suicide remains the second leading cause of death for 10 to 24-year-olds. Data related to youth suicidal ideation and/or suicide attempts reflect national trends, with the Centers for Disease Control and Prevention (CDC) reporting a 30% increase in suicides in the United States from 2000 to 2016.

In August 2019, C.S. Mott (Mott Poll Report: Recognizing youth depression at home and school, 2019)[7] commissioned a survey of randomly selected households with at least one child in middle school, junior high, or high school. The results clearly indicate that youth depression is a critical issue for parents of adolescent children across the county. The responses indicate that 1 in 4 parents say their child knows a peer or classmate with depression, while 1 in 10 parents say their child knows a peer or classmate who died by suicide. This level of familiarity with depression and suicide is consistent with recent statistics showing a significant increase in suicide among American youth over the past decade. MSHN's data is similar with a clear trend of increased planned and attempted suicides. Next steps include surveying our regions schools to determine which have expanded their mental health services, with emphasis on depression and suicide prevention in addition to a broader approach that includes other mental health topics such as anxiety and substance use.

- Planned Suicide* ***Increase*** from 14% in 2016 to 19% in 2018 (MS)
- Attempted Suicide* ***Increase*** from 9% in 2016 to 12% in 2018 (MS)

*If data is not reported for either cohort, then the data was not captured by MiPHY. Further if the dataset was not collected for the consecutive 2016 and 2018 cycles it was not included in the average.

Adult Epidemiological Indicators

The adult indicators reported below were calculated from the most recent data available from the MDHHS Substance Use in Michigan data repository[6], BH TEDS, and REMI (MSHN's, Regional Electronic Medical Information) The opioid epidemic continues to dominate the SUD landscape for adults in Region 5 with increases in heroin and opioid use and alcohol abuse following closely behind. On the positive side, overdose deaths declined in 2018 from 2017 which may be correlated to declining opioid prescriptions where less than half of post op patients in Michigan get opioids. And of those who do, get 10 pills or less. Michigan Open 2019 reports that in post-operative opioid prescriptions physicians average prescribing decreased from 26 to 18 pills, and consumption decreased from 12 to 9 pills.

- Admissions
    - New AOD episodes 1-1-2019 thru 12-31-2019: 12,646

- Nearly half (~47% in 2018 & 2019) of admissions report first-use of their primary substance at ***17 years old or younger***
- Re-admissions within 30 days ***increased*** from 9.36% in 2018 to 9.91% in 2019
- Initiation and Engagement **63%** of Region 5 consumers initiated and persisted from first face to face and one service within 14 days and **47%** engaged in 2 additional services within 30 days
- Region Wide data available in Appendix 4.

- Primary Substance (trending similar to statewide averages)
  - Use of heroin & opioids was trending positively until 2019 where it ***increased*** to 43% from 40% in 2018.
  - Statewide, region-wide and County Specific data available in Appendix 15.
- Mortality and Overdose Rates (trending similar to statewide averages)
  - ALL Drug Overdose Deaths in 2018 were 316 a ***decrease*** from 2017's 332 deaths
  - Opioid Specific Overdose Deaths in 2018 were 228 a ***decrease*** from 2017's 246 deaths
  - Statewide and region-wide data available in Appendix 16.
- Traffic mortality related to SUD (trending similar to statewide averages)
  - While the number of alcohol-related crashes ***decreased*** slightly from 239.9 in 2017 to 217.3 in 2018, the number of fatalities ***increased*** from 194 in 2017 to 247 in 2018.
  - While the number of drug-involved crashes ***decreased*** slightly from 493 in 2017 to 442, in 2018 the number of fatalities ***increased*** from 92 in 2017 to 101 in 2018.
  - Statewide and region-wide data available in Appendix 17.
- Prescription Doses (trending similar to statewide averages)
  - Region 5 ***reduced*** prescription opioid doses by 29% from 2017-2018 and then by 17% from 2018 to 2019
  - Statewide, region-wide and county specific data available in Appendix 18.
- Suicide
  - In Region 5 there were 1,196 suicide deaths from 2013-2017.
  - Statewide, region-wide specific data available in Appendix 19.

County Health Rankings measure two factors, how long people live and how healthy they feel while alive. Data available in Appendix 20.

- Region 5 counties that ranked in the ***10 most healthy Michigan counties*** are:
  - Clinton #3
  - Midland #8
- Region 5 counties ranked in the ***10 least healthy counties*** are:
  - Claire #75
  - Saginaw #77

- Counties with Broadband Internet Connection (Appendix 21**)**
  - Region 5 households average 73.4% with broadband connection (Note: The importance of broadband access has been reaffirmed during the coronavirus pandemic, in particular the health domain with greatly expanded demand for telemedicine and in the educational domain for students during school, college and university closings).

Older Adult Epidemiological Indicators

Substance misuse by adults ages 55 and over has emerged as an impending public health crisis across the United States. While high-risk drinking and nonmedical use of prescription drugs have increased across all populations, the problem is particularly acute and problematic among older adults. Factors that make older adults uniquely vulnerable to the effects of alcohol and drugs include biological changes associated with aging that reduce the body's ability to absorb and metabolize substances, the higher level of medications prescribed to this age group, and the higher prevalence of stressful life events and transitions experienced by older adults.

The OROSC Michigan Older Adult Wellbeing Initiative of 2019 identified the following concerns:

1. Alcohol is the leading cause of AOD-related death among Michigan adults ages 55+, and alcohol use disorder is a significant cause of admission to publicly funded treatment;
2. Michigan's system is not designed to seamlessly address the specific substance use prevention, intervention, treatment and recovery support needs of adults ages 55+.

Veterans, Active Military and Military Families

Veterans and National Guard/Reserve Service Members are at an increased risk of behavioral health (BH) issues, substance use disorder (SUD) and suicide. The markedly different cultures of the military and civilian sectors create many reintegration issues and puts this population at risk for a host of negative social outcomes. Stigma associated with seeking help for mental and physical health problems is a significant deterrent in the veteran and military service member population. Military culture values strength, resiliency, self-sacrifice, and independence. Veterans and military service members may be unlikely, therefore, to report physical or mental health problems for fear of being perceived as weak.

Increasing outreach, reducing the stigma associated with seeking help, and increasing participation in behavioral health and SUD treatment is a public priority for our veterans and military personnel. The research surrounding peer support groups shows higher levels of engagement and satisfaction for those who utilize services. Studies have also shown an overall improvement of quality of life for those who utilize peer supports and a reduction in overall cost of services. Peer support groups may be a useful venue to help reduce the stigma associated with seeking help while participants learn skills and positive coping mechanisms that other veterans have used to reintegrate.

The 2019 *Report to Congressional Committees: Veterans Health Care Services for Substance Use Disorders* identified the following concerns:

1. Michigan only has one VA residential facility in Battle Creek, Michigan. The facility has 20 beds and the median wait is 25 days.
2. Alcohol use is the most common substance among veterans.
3. While opioid use disorder is lower in the veteran population, veterans are 1.5 times as likely to die from an opioid overdose than the overall population.

COVID-19 Pandemic - Epidemiological Impacts

MSHN is bracing for an increased need for services related to pandemic-related behavioral health issues, SUD, mental illness and beyond. Some nationwide data is available, but it's a challenge to collect COVID-specific data for Region 5. Below, we extrapolate need based on available reports:

The need for mental health specific support will increase according to RTI International (Eckhoff & Furberg; Using Mobile Apps to Reduce Stress and Promote Psychological Resilience During COVID-19, 2020)[8]. As of June 9, 2020:

- 51% are now worried or very worried someone in their household will get coronavirus, versus 35% the week prior
- 49% are now reporting experiencing anxiety in the prior week, versus 29% previously
- 52% of those without health insurance are worried about not being able to work and earn a living because of the coronavirus disruptions, compared to only 36% of those with insurance

The Recovery Village (LaNeve & Henson; Drug and Alcohol Use Increase During COVID-19; 2020)[9] conducted a survey which demonstrates a rise in drug and alcohol use during the COVID-19 Pandemic. The survey asked 1,000 American adults (ages 18 and older) about their use of drugs and alcohol in the past month. Some questions asked

respondents to select each option that applied, so in a few instances, the total percentage will be greater than one hundred.

The survey respondents most commonly used the following substances:

- Alcohol (88%)
- Marijuana (37%)
- Prescription opioids (15%)
- Benzodiazepines, such as Xanax (11%)
- Prescription stimulants, such as Adderall (10%)
- Cocaine (9%)

Additionally, many respondents displayed higher rates of drug and alcohol use. Of the respondents:

- 55% reported an ***increase*** in past-month alcohol consumption, with 18% reporting a significant increase
- 36% reported an ***increase*** in illicit drug use
- In the states hardest hit by the coronavirus (NY, NJ, MA, RI, CT), 67% reported an ***increase*** in past-month alcohol consumption, with 25% reporting a significant increase

The participants were asked why they were prompted to use substances within the last month. Of the respondents:

- 53% were trying to cope with stress
- 39% were trying to relieve boredom
- 32% were trying to cope with mental health symptoms, such as anxiety or depression

Others reported using substances for recreational reasons, to treat pain or because it was part of their daily routine.

The survey results indicate that many people could be turning to drugs and alcohol to cope with pressures created by coronavirus. Using drugs or alcohol to cope with life circumstances, such as stress or boredom, can become a habit that leads to a substance use disorder. When individuals use drugs or alcohol in an attempt to self-medicate and cope with symptoms of a mental health disorder, they can develop a co-occurring substance use disorder.

Impact of Police Brutality, National Protests & Violence

As noted earlier, the killing of George Floyd by a Minneapolis police officer gave rise to grief, anguish and outrage. Many communities suffered additional police violence, riots and looting as well. It brought renewed attention to historical and ongoing systemic racism, oppression and racialized trauma. The impacts of this trauma, historic and renewed, are difficult to quantify, but we anticipate increased health risks for those counties with high populations with people of color.

The epidemiological data isn't yet available but looking through a predictive lens at the coronavirus pandemic's social isolation, mass unemployment, trauma and loss, and the trauma and anxiety associated with racial upheaval, we anticipate increases in mental illness, substance abuse, suicide, domestic violence and other negative health outcomes.

SECTION 3 - Coordinating Services in Region 5

MSHN will continue to ensure and improve integration and coordination of services between its SUD prevention, community recovery and treatment providers, CMHSP partners, community service contractors, prevention coalitions and external stakeholders and community partners including probation and parole departments, primary care providers, vocational and employment services, treatment courts, hospitals, Federally Qualified Health Centers (FQHCs), law enforcement, domestic violence and homeless shelters, Michigan Association of Recovery Residences (MARR), MDHHS including adult and children's services and LARA, county health departments, faith based communities, educational institutions, housing authorities, agencies serving older adults, Syringe Service Programs, military, veteran and VA organizations, foundations, and volunteer services. Coordination and collaboration with these community resources helps increase sustainable recovery capital for individual clients, their families, and other significant allies within their local communities.

A list of current successful efforts at coordination with external community resources includes but is not limited to:

- MSHN's collaboration with county public health departments and SUD treatment providers in deployment of MSHN's Mobile Care Unit for COVD-19 testing.
- MSHN prevention and community recovery providers regularly collaborate with schools and institutions of higher learning to provide prevention and recovery programming.
- MSHN facilitated coordination and collaboration between the Michigan State Police (MSP) Angel program and SUD treatment providers.
- MSHN works with and facilitates coordination and collaboration between multiple hospitals, FQHCs and SUD providers who offer Project ASSERT coaches to be on site in the community.
- MSHN facilitates coordination between treatment providers and law enforcement—courts, MSP, city and county police departments, MDOC and MATCP.
- MSHN community recovery providers work with local university to participate in SBIRT trainings and simulations for nursing, pharmacy and other students.
- MSHN prevention providers work with a multitude of community stakeholders through their local community coalitions.

MSHN will work with all willing community partners to ensure ongoing communication, collaboration, and coordination between and among, but not limited to, the SUD service delivery system, recovery community, primary health care providers, mental health services, MDHHS, housing, education, military and veterans organizations, and courts through the establishment and use of Memoranda of Understandings, policies, and/or other contracts when appropriate.

SECTION 4 - Decision-making Processes

Decision-making around SUD strategic planning, implementation of best practices, policies, contracts and funding are guided by MSHN's Leadership and SUD Clinical teams with support and involvement of other MSHN departments including but not limited to Utilization Management (UM), Provider Network Management, Finance, and Quality & Process Improvement (QAPI) teams.

The MSHN Board of Directors is responsible for approving by majority vote all SUD policies and procedures, contracts and funding as well as providing input on strategic planning.

Per section 7.2 of the MDHHS-PIHP Contract, MSHN has an established regional Substance Use Disorder Oversight Policy Board (OPB). Per the language in the contract: "The PIHP shall establish a SUD Oversight Policy Board by October 1, 2014, through a contractual arrangement with the PIHP and each of the counties served under appropriate state law. The SUD Oversight Policy Board shall include the members called for in the establishing agreement but shall have at least one board member appointed by the County Board of Commissioners for each county served by the PIHP." MSHN's OPB was established in fall of 2014 and has been meeting in Lansing every two months over the subsequent 5 and ½ years. April's OPB meeting was canceled due to the COVID-19 pandemic and a lack of PA2-related contract items that required OPB approval. The most recent OPB packet with meeting minutes is in Appendix 22. The OPB Bylaws are here in Appendix 23.

All contracts or policies that involve use of PA2 funds must be approved by MSHN's Oversight Policy Board (OPB) which meets bimonthly in Lansing. Upon approval by the OPB, MSHN's Board of Directors will also review and offer final approval.

In addition to input and decision-making authority invested in the MSHN Board of Directors and Oversight Policy Board, MSHN established a SUD Provider Advisory Committee (SUD-PAC) whose role is to provide advisory input to our Prevention, Treatment, UM, QAPI and other teams on local and regional SUD issues. The SUD-PAC meets on the alternative months from months when the OPB meets. The SUD-PAC charter is in Appendix 24 and minutes of the most recent SUD-PAC meeting in May 2020 is in Appendix 25.

SECTION 5 - Allocation Plan

MSHN will develop an allocation plan to fund a full array of prevention, treatment and recovery services that represent a robust recovery-oriented system of care with input from the SUD Policy Oversight Board and with approval from MSHN's Board of Directors.

MSHN commits to the following in developing and finalizing the allocation plan:

1. Set aside and expend a minimum of 20 percent Community Grant funding for primary prevention services, including an emphasis on increasing efforts targeting environmental change, integration of SUD prevention and health promotion, collaboration with primary care, collaboration with Michigan Tribal entities, and workforce development activity related initiatives.
2. Allocate funding to implement a full continuum of research and evidence-based care available to individuals seeking treatment and recovery support services based on available resources.
3. Ensure that priority populations are served first and foremost with Substance Abuse Prevention and Treatment Block Grant funding, and methods for tracking the need for services to increase availability as needed.

MSHN also commits to:

1. Maintain and enhance the provider panel for SUD treatment services.
2. MSHN, through the established regional Provider Network Committee (PNC), will review deficits and develop strategies to meet identified gaps. MSHN will assure network adequacy that includes data from our regional provider network assessment, capacity for SUD services and community need. The PNC will review and recommend appropriate action based on the network assessment.
3. MSHN will ensure adherence to the PIHP-MDHHS contract with all attached obligations.

SECTION 6 - Goals, Timeline & Evaluation

The narrative below captures the identified strategic goals encompassed in greater detail in the logic models in Appendices 26-27. Each strategy identified in MSHN's strategic plan has an implementation timeline following that goal and each will be evaluated quarterly to assess progress in meeting its objectives and milestones and to assess its impact on populations served. As outlined below, the evaluation is designed to ensure that: a) implementation will be monitored systematically and on an on-going basis; b) specific progress measures are utilized to assess the quality and completeness of activities; and c) specific progress measures are aligned with the goals, objectives and expected outcomes so that progress towards achieving them can be accurately assessed. The Clinical Team will ensure that regular reviews are conducted and will make recommendations as needed for modifications or implement adaptations as necessary to achieve continuous improvement. The findings will be utilized to inform service array and delivery.

Throughout this strategic plan baseline data has been established and used to inform the overall goals for each population served. Each goal includes the necessary processes and intended outcomes for implementing a recovery-oriented system of care (ROSC) that includes both prevention and treatment objectives.

Key elements to support plan success:

1. Full range of services
2. Inclusive of stakeholders (governance, provider network & consumer) and their input
3. Data informed decision-making
4. Development of performance measured outcomes
5. Sustainability

The key evaluation questions are:

1. Are the activities achieving the intended immediate outcomes and within the proposed timeline?
2. Are providers carrying out project activities with fidelity and according to contract requirements?
3. Are the resources adequate?
4. Is the plan achieving its long-term outcomes and overall goal?
5. What is the impact on populations served?

PREVENTION GOALS

MSHN prevention and community recovery services operate from the guiding principle to serve individuals and communities wherever they are across the entire spectrum of preventative care/services. In addition to this wholistic philosophy, MSHN has placed a priority emphasis on reducing health disparities among high-risk populations receiving prevention and community recovery services and increasing access to prevention services for older adults (age 55 and older). Detail on all prevention goals can be found in the SUD prevention logic models in Appendices 26.1-26.5.

1. Reduce underage drinking and reducing heavy and/or binge drinking among MSHN region adults age 55+;
2. Reduce marijuana use among youth and young adults;
3. Reduce opioid prescription abuse; including a reduction in the misuse and abuse of opioids for non-medical purposes for two specific populations – youth; and older adults (age 55+); and
4. Reduce youth tobacco access and tobacco use including electronic nicotine devices and vape products.

Goal #1: Reduce underage drinking.

Reduce underage drinking for youth and young adults under age 21 (For detail, please see this goal's logic model in Appendix 26.1)

MSHN has reviewed MIPHY regional use data stating use of alcohol by underage youth is trending down and that trend needs to be maintained. Education and information sessions will be provided in efforts to increase parental awareness of problems associated with underage drinking and provide resources to parents on how they can assist in keeping their children alcohol-free. Prevention and Community Recovery Providers will provide technical assistance to assist in developing local policies for schools/colleges and communities that are consistent and enforceable; as well as host town hall meetings and provide information across social platforms to impact community norms [by making communities more aware of underage drinking issues]. Prevention Providers will conduct alcohol vendor education and compliance checks in efforts to educate vendors and other adults on adverse effects of providing alcohol to minors. In addition, Prevention providers will provide education and information at driver's education sessions; Minor in Possession (MIP) classes; and student assistance programs to increase awareness of risk/consequences of use to self, family, and community.

Timeline and Evaluation (Reduce Underage Drinking):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) – Provide parenting education and information presentations, conduct town hall meetings, utilization of evidence-based practices youth school and community education, provide education about the risk of alcohol in driver education programming, conducting minor in possession education groups and provide education through local student assistance programs. All Phase #1 activities are anticipated to be on-going through the three years of this strategic plan. Phase #2 (Q3 and Q4 of 2021) - Develop materials for parent presentations, conduct alcohol vendor education, and provide TIPS training to local establishments. It is anticipated that all Phase #2 activities will be on-going through FY23. Phase #3 (Q1 and Q2 of FY22) – Provide technical assistance in developing school and local policies that are consistent and enforceable and develop and conduct social norming campaigns through FY23. Phase #4 (Q3 and Q4 of FY23) – Conduct Safe Prom and graduation initiatives throughout the region. Evaluation will consist of 1) Process date through MPDS, 2) Outcome evaluations are MiPHY data, and provider annual outcomes reports. Baseline data

and goals can be found in the prevention logic model for reducing underage drinking.

Goal #2: Reduce marijuana use.

Reduce marijuana use among youth and young adults ***(For detail, please see this goal's logic model in Appendix 26.2).***

Prevention and Community Recovery Providers will conduct research-based education both in schools and in community groups; conduct MIP programs; incorporate marijuana education into driver training programs; host Peer Assisted Leader programs and Student Assistance programs to increase awareness of risk/consequences of use to self, family and community. Prevention and Community Providers will conduct education classes and informational sessions and distribute resources as part of those classes and informational sessions to increase parental awareness of problems associated with use and parents have source documents to assist youth in remaining free of marijuana use. Prevention Providers will provide information or work with the community to conduct marijuana vendor education. They (as well as MSHN staff) will explore working with MI State Police [Marijuana Tax Team] to conduct marijuana compliance checks in efforts to address ease of availability issues. Prevention and Community Recovery Providers will support and guide technical assistance in developing local and school policies, consistent and enforceable; conduct Town hall meetings; and conduct or work with local community to provide social norming/ marketing and media campaigns to address favorable community norms.

Timeline and Evaluation (Reduce Marijuana Use):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) – Conducting research-based education both in schools and in the community and incorporate marijuana information into peer assisted leader and student assistance programs. These will be ongoing through FY23. Phase #2 (Q3 and Q4 of 2021) - Develop/adapt MIP Programs for youth experimenting with marijuana, incorporate marijuana education into driver training programs, provide education classes and information sessions to parents, conduct town hall meetings with focus on marijuana, and conduct or work with local community to provide social norming/marketing and media campaigns. All phase #2 activities are on-going through FY23. Phase #3 (Q1 and Q2 of FY22) – Develop and distribute resources as part of education classes and informational sessions, provide or work with the community to conduct marijuana vendor education, explore working with MI State Police (marijuana tax team) to conduct marijuana compliance checks, and provide TA in developing local and school policies, consistent and enforceable. Most activities are anticipated to be on-going through FY23. Evaluation will consist of 1) Process date through MPDS, 2) Outcome evaluations are MiPHY data, and provider annual outcomes reports, and compliance check results. Baseline data and goals can be found in the prevention logic model for reducing youth marijuana use.

Goal #3: Reduce opioid prescription use.

Reduce opioid prescription abuse including a reduction in the misuse and abuse of opioids for non-medical purposes ***(For detail, please see this goal's logic model in Appendix 26.3).***

Three intervening variables [1) ease of availability of prescription medications; 2) lack of perceived risk; and 3) favorable community norms] have been identified across the 21-county region in efforts to impact the goals of reducing opioid prescription abuse; including misuse for non-medical purposes. Prevention and Community Recovery Providers will conduct community based and environmental strategies – examples include; 1) providing or working with the community to partner with local DEA and law

enforcement on Prescription Take Back Programs; 2) working with local community law enforcement of establishing local drop boxes; and 3) work with local Medical Community to provide education on proper prescribing practices and in utilizing the MAPs system in efforts to reduce the availability of prescription drugs and over-the-counter medications that can be abused or misused. Prevention and Community Recovery Providers will implement education, information, dissemination and Problem ID and Referral Strategies to provide presentations to local groups regarding the importance of using medications as directed, and the dangers of sharing or using someone else's medication. Educational components about the dangers of prescription and over the counter medications will also be incorporated in youth educational programs to increase perceived risk, consequences related to the use of prescription drugs/misuse of opioids for non-medical purposes. Prevention and Community Recovery Providers will conduct community based and environmental strategies such as 1) providing technical assistance in developing local and school policies, that are consistent and enforceable; 2) hosting Town Hall Meetings; and 3) conducting social norming/marketing and media campaigns to affect favorable community norms opioid use by making community more aware of the issues of opioid misuse and abuse. In FY21-22, MSHN will continue its partnership with OROSC to utilize State Opioid Response (SOR) grant funds to support opioid use prevention projects, including implementation of youth education programs, such as Botvin's LifeSkills and Prime for Life. In addition, funds will be made available to SUD prevention coalitions to provide overdose education, naloxone distribution, and harm reduction, tailored to the needs in their communities.

Timeline and Evaluation (Reduce opioid prescription abuse):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) – Provide education classes and information sessions regarding ease of availability of opioids, develop and distribute resources for education and information sessions regarding ease of availability of opioids, and conduct town hall meetings. All activities are planned to be on-going through FY23. Phase #2 (Q3 and Q4 of 2021) – Provide education programs and informational sessions on risks of non-medical use of opioids, develop/distribute materials for education and informational sessions, and conduct work with local community to provide social norming/marketing and media campaigns for opioid prevention activities. Evaluation will consist of 1) Process date through MPDS, 2) Outcome evaluations are MiPHY data, and provider annual outcomes reports. Baseline data and goals can be found in the prevention logic model for reducing youth non-medical opioid use.

Goal #4: Reduce youth tobacco and nicotine use.

Reduce youth tobacco access and tobacco use including electronic nicotine devices [END] and vape products ***(For detail, please see this goal's logic model in Appendix 26.4).***

Prevention providers will conduct activities including: 1) advocating for consistency between state and federal regulations, for example, in regard to the age to legally use tobacco; and 2) provide parenting education and community informational presentations to increased law enforcement; local officials and other adult awareness regarding the dangers of smoking, vaping and secondhand smoke/vapor. Prevention providers will assist in developing technical assistance for schools and other local policy bodies to develop products that are consistent and enforceable in local communities. Providers will use evidence-based practices in school and community education; conduct Student Assistance Programs; and conduct social norming campaigns in efforts to increase awareness of the risks associated with tobacco and ENDS/vape use. Prevention providers will continue to conduct tobacco compliance checks and collect information on ENDS/vape retailers in efforts to increase knowledge and awareness surrounding issue of youth access to tobacco and ENDS/vape products. MSHN partners with MDHHS in ensuring that formal SYNAR is conducted each year with the intent of lowering youth use of tobacco rates.

Timeline and Evaluation (Reduce youth tobacco access):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) – Advocate for consistency between state and federal regulations, provide parenting education and community informational presentations, provide TA in developing school and local policies that are consistent and enforceable, and conduct tobacco vendor education and compliance checks to increase the number of clerks who verify ID during formal Synar. Compliance checks will continue through FY23. Phase #2 (Q3 and Q4 of 2021) – Work to reduce tobacco and ENDS sale rates to minors through vendor education and increase knowledge and awareness of youth access to communities. Phase #3 (Q1 and Q2 of FY22) – Activities included in increasing youth awareness of the risk associated with tobacco and ENDS use include EBP in youth school and community education, student assistance programs and social norming campaigns. Evaluation will consist of 1) Process date through MPDS, 2) Outcome evaluations are MiPHY data, provider youth tobacco act reports, Synar and non-Synar rates. Baseline data and goals can be found in the prevention logic model for reducing youth access to tobacco.

Goal #5: Reduce substance use in older adults.

Reduce alcohol abuse and non-medical use of opioids within older adults (55+) in the MSHN Region
(For detail, please see this goal's logic model in Appendix 26.5).

Given limited data on older adult use of alcohol/alcohol products in Michigan, MSHN will collect baseline regional data. Current research about the use/misuse of alcohol/alcohol products and heavy and/or binge drinking among older adults aged 55+ indicates three intervening variables: 1) lack of perceived risk; 2) easy access; and 3) favorable community norms. Education and information sessions on alcohol misuse among older adults will be offered by MSHN's network of Prevention and/or Community Recovery Providers. The information provided will increase awareness of the risks and consequences of alcohol misuse to older adults, their families, and communities. The type of event/milieu will be based on local need/conditions and could be a town hall meeting or a virtual focus group. These educational activities will jumpstart MSHN's efforts to change community norms. MSHN will also collect baseline regional data on older adult use of non-medical opioids. Review of current literature on non-medical opioid use among older adults age 55+ suggests three intervening variables similar to alcohol abuse: 1) ease of access to prescription medications; 2) lack of perceived risk; and 3) favorable community norms. These variables have been identified across MSHN's 21-county region as most likely to further its goal of reducing non-medical use of opioids within older adults. MSHN's network of Prevention and Community Recovery Providers will implement community-based and environmental strategies to achieve this goal, including 1) working with local DEA and law enforcement to promote Prescription Drug Take Back Programs; 2) collaborating with local law enforcement to install community-based medication drop boxes; and 3) partnering with local medical professionals to provide education on proper prescribing practices and Michigan's Automated Prescription System (MAPS); this is in an effort to curb the availability of prescription drugs and over-the-counter medications that can be abused or misused by older adults. Prevention and Community Recovery Providers will implement education, information, and problem identification and referral strategies to local groups on the importance of using medications as directed and the dangers of sharing or using someone else's medication. Information on the dangers of prescription and over-the-counter medications will also be incorporated in older adult venues, such as senior centers; senior living facilities; senior health fairs, etc. These efforts shall increase perceived risk/consequences associated with prescription drugs and the misuse of opioids for non-medical purposes. Prevention and Community Recovery Providers will also implement community-based and environmental strategies, including: 1) providing technical assistance in developing local and school policies that are consistent and enforceable; 2) hosting town hall meetings and focus groups; and 3)

conducting social norming marketing/media campaigns to shift community norms and increase community awareness of the risks/consequences of opioid misuse and abuse.

Timeline and Evaluation (Reduce Substance Use in Older Adults):
The timeline for implementation will be in three phases. Phase #1 (Q1 and Q2 of FY21) will include the provision of information on non-opioid options for pain management among older adults, such as Chronic Pain PATH (Personal Action Toward Health) and other educational programs. (Efforts related to alcohol use/misuse among older adults, shall begin in Phase #2.) Phase #1 will also include an increase in medication disposal options at local senior centers and senior living communities; these efforts will include a partnership with law enforcement and/or the distribution of drug disposal pouches.

To address alcohol abuse by older adults, Phase #2 (Q3 and Q4 of FY21) will include educational and informational presentations at senior centers and senior living communities, and the provision/promotion of alcohol-free activities for older adults. To address the non-medical use of opioids within older adults, Phase #2 will also include education and informational presentations delivered at senior centers and senior living communities, and include partnerships with local Meals on Wheels programs to distribute information to homebound seniors. Phase #3 (Q1 and Q2 of FY22) will focus on the development of social norming campaigns, including the development and distribution of alcohol- and opioid-specific print materials to local Meals on Wheels programs, churches, healthcare providers, senior centers and senior living communities. Evaluation will consist of 1) analyzing regional data through the Michigan Prevention Data System (MPDS), and 2) developing outcome indicators, which shall follow state recommendations. Baseline data and goals can be found in the prevention logic model for older adult substance misuse.

TREATMENT GOALS

There are four overarching goals related to the treatment of substance use disorders in Region 5. These goals include:

1. Increase access to services including:
    a. Expand access to Medication-Assisted Treatment (MAT)
    b. Expanded access to treatment of stimulant addictions
    c. Expand access to Women's Specialty Services (WSS)
    d. Expand access to jail-based services
    e. Expand trauma-informed care across the treatment system
2. Increase penetration rates for older adults, adolescents and veterans/military families
3. Increase cultural competence and reduce health disparities

Detail on each of these goals can be found in the SUD treatment logic models in Appendices 27.1-27.3.

Goal #1: Increase access to services.

Increase access to the full array of evidence-based treatment programs and services to support individuals in their journeys to recovery ***(For detail, please see this goal's logic model in Appendix 27.1).***

This treatment goal focuses on expansion of best treatment practices including Medication-Assisted Treatment (MAT), treatment for stimulant abuse, Women's Specialty Services (WSS), jail-based services, and trauma-informed care. The blueprint for how and where we expand is informed by epidemiological data and our Network Adequacy Assessment (NAA) that identifies service gaps in the region.

a. MAT Expansion:

Opioid Use Disorders (OUD) are prevalent across all Region 5 counties. OUD impacts physical health including risk of overdose & death, financial & family stability, and other social determinants of health. Prescription opioid painkillers, heroin, and Fentanyl/Carfentanil are widely available and inexpensive. People may not know when they are using a drug that has a potentially fatal dose of Fentanyl or Carfentanil. MSHN intends to address service gaps identified in the regional Network Adequacy Assessment (NAA), including the availability of all MAT medications, and maintaining access to MAT services within 30 minutes and 30 miles or less for people living in urban areas and 60 minutes and 60 miles or less for people living in rural areas. MSHN will work toward an increase in availability of MAT services throughout the MSHN region. MSHN will continue to provide access to naloxone through community partners in order to decrease opioid overdose deaths within the MSHN region and commits to adding information on accessing naloxone to the MSHN website.

Timeline and Evaluation (MAT Expansion):

The timeline for implementation will be: Through all phases (Q1-Q4 of FY21, FY22, and FY23) MSHN intends to evaluate service gaps identified in the region using the Network Adequacy Assessment (NAA), the availability or lack of availability for all MAT medications, and maintain access to MAT services within 30 minutes and 30 miles or less for people living in urban areas and 60 minutes and 60 miles or less for people living in rural areas. MSHN will continue to provide access to naloxone through community partners and monitor opioid overdose deaths within the MSHN region. Phase # 1 (Q1-Q2 of FY21) MSHN will add information on how to access naloxone to the MSHN website. Phase # 2 (Q1-Q4 of FY22 and FY23) as identified in the NAA, MSHN will work toward an increase in availability of MAT services. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

b. **Expand Stimulant Use Treatment**:

Stimulants are a growing drug of choice in Region 5. With continued growth, stimulants may become a more serious issue for MSHN. This could impact mental health hospital admissions as stimulant use may resemble mental health symptoms. Methamphetamines and other stimulants are becoming increasingly available and are often used in conjunction with opioids. Stimulant use in combination with opioids causes an increased risk of overdose and death. In order to address the growing concern around Stimulant Use Disorders, MSHN will educate the current contracted SUD providers through trainings and resource sharing. These resources will include information on Stimulant Use Disorders, overdose deaths related to stimulants in combination with opioid use and Stimulant Use Disorder Evidence Based Practices. MSHN will monitor the primary drug at admission to determine Stimulant Use Disorder growth or decline in the region, working toward a 5% decrease in Stimulants as primary drug at admission. MSHN will also monitor the use of Evidence Based Practices during Site Visits.

Timeline and Evaluation (Stimulant Treatment Expansion):

The timeline for implementation will be: Phase #1 (Q1-Q4 of FY21) MSHN will educate the current contracted SUD providers through trainings and resource sharing. Through all phases (Q1-Q4 of FY21, FY22, and FY23) MSHN will monitor the primary drug at admission to determine Stimulant Use Disorder growth or decline in the region, working toward a 5% decrease in stimulants as primary drug at admission. MSHN will monitor and evaluate progress quarterly on the goal's implementation during treatment team meetings.

c. **Expansion of Women's Specialty Services**:
Successful recovery for women requires that the service delivery system integrates women's specific substance use disorder treatment, to include mental health services, recovery supports, and frequently, treatment for past traumatic events. Without these Designated Women's Specialty services, many women are not able to make progress in attaining recovery from substances. All individuals working in women's specialty programs must have training in serving individuals with mental health disorders as well as *treating* individuals who have experienced trauma. Children of parents with substance use disorders often have special needs for services. MSHN will build capacity for Designated Women's Specialty Services where needs exist in the MSHN region and to expand Designated Women's Specialty Service programs throughout the region. MSHN will work to ensure that all providers offering Women's Specialty Services will be trained in trauma informed care and will assess for, treat, or refer out for mental health needs. MSHN will work with contracted SUD providers to ensure that there is an assessment for each child associated with a parent being served in women's specialty services, and that referrals for children are made when appropriate.

Timeline and Evaluation (WSS Expansion): The timeline for implementation will be: Phase #1 (Q1 of FY21) - MSHN will evaluate regional need for Designated Women's Specialty Services. Phase #2 (Q1-Q4, FY 21) - MSHN will review and evaluate all contracted providers that are designated or enhanced Women's Specialty programs to ensure all WSS staff are trained in identifying and assessing for mental health issues as well as training in trauma informed care. In cases where this training is lacking, MSHN will during Phase #2 support training in co-occurring and/or trauma treatment. In Phase #3 (Q1-Q4 FY22) - MSHN will work with Designated Women's Specialty programs to increase assessments for services for children and make referrals as appropriate. Through all Phases (Q1-Q4 of FY21, FY22 and FY23) MSHN will continue to work to expand Designated Women's Specialty Service programs where needs exist in the region. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

d. **Expand Jail-Based Services**:
Individuals who are incarcerated often do not receive treatment during their incarceration for their substance use disorders or mental health disorders. Medication Assisted Treatment (MAT) is not always offered to inmates while they are incarcerated. Overdose deaths occur frequently in individuals upon release from jail. Jail-based treatment services are not available throughout the jails in the MSHN region and there is not always a good collaboration of care between treatment providers and jail staff. MSHN will assess the need for SUD treatment services within the jails in the region and will work to increase access to re-entry services. MSHN contracted providers will work to build relationships with jails in the region. MSHN will monitor data on engagement from jail-based treatment services to re-entry services and will work with contracted providers to expand access to MAT within the jail setting. By expanding treatment and MAT within the jail, MSHN hopes to increase the individual's recovery capital and to decrease opioid overdose deaths for individuals being released from jail. State Opioid Response (SOR) grant funds will aid in the expansion of jail-based services.

Timeline and Evaluation (Jail-Based Services Expansion):
The timeline for implementation will be: Phase #1 (Q1-Q4 of FY21) - MSHN will assess the need for SUD treatment services within the jails in the region and work with contracted providers to build relationships with jails in the region. In phase #2 (Q1-Q4 of FY22 and Q1-Q4 of FY23) - MSHN will work to increase access to re-entry services and will work with contracted providers to expand access to MAT within the jail setting. In all phases MSHN will monitor data on engagement from jail-based treatment services to re-entry services and opioid overdose deaths for individuals being released from

jail. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

e. **Expansion of Trauma-Informed Care**:
There is a critical need to address trauma as part of substance abuse treatment. Misidentified or misdiagnosed trauma-related symptoms interfere with help-seeking, hamper engagement in treatment, lead to early dropout, and make relapse more likely. MSHN contracted providers will have training in Trauma Informed Care and will address or refer to appropriate provider(s) for trauma or mental health treatment needs. As a result, there will be an increase in documentation of mental health and trauma needs being addressed in treatment and clinicians will become more capable and competent in addressing trauma during treatment. Expanding ease of access to treatment will ensure individuals seeking treatment are not re-traumatized in the initial process. MSHN will work to ensure people accessing treatment are able to enter treatment no matter what avenue they try to enter services. MSHN will evaluate the Access Management System and implement changes that will improve efficiency and reduce duplication. These changes will produce a more streamlined/consumer-friendly experience for people seeking services.

Timeline and Evaluation (Trauma-Informed Care Expansion):
The timeline for implementation will be: In all phases (Q1-Q4 of FY21, FY22, and FY23) - MSHN will work to ensure people accessing treatment are able to enter treatment no matter what avenue they try to enter services. Phase #1 (Q1-Q4 of FY21) - MSHN contracted providers will have training in Trauma Informed Care. Also, in Phase #1, MSHN will evaluate the Access Management System (AMS) for efficiency and ease of access for the person entering services. Phase #2 (Q1-Q4 of FY22 and FY23) - MSHN will monitor for an increase in documentation of mental health and trauma needs being addressed in treatment and for clinicians becoming more capable and competent in addressing trauma during treatment. Also, in Phase #2, MSHN will implement changes to the AMS that will improve efficiency and reduce duplication. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

Goal #2: Expand penetration rates for adolescents, older adults and veterans/military families.

Expand penetration rates for historically underserved populations: adolescents, older adults, and veterans/military families. Each of these populations has reasons that their penetration rates have been low ***(For detail, please see this goal's logic model in Appendix 27.2).***

a. **Adolescents**:
Substance use is, for many teens and young adults, a rite of passage. Many abstain, but avoiding it entirely results in some teens feeling disconnected from their peer group at a time where peer connection is a peak priority. A lack of maturity and knowledge about addiction results in many teens developing substance use problems which they don't view as problematic or "a big deal" and they're therefore less likely to reach out for treatment. Many have few healthy and supportive adults in their lives, they may have instability in the home, or may have family members who may be using substances themselves. Traumatic histories, identity issues, bullying, isolation and grief are all contributing factors to substance abuse in teens. An adolescent mind is more vulnerable to the effects of substance use than those with a fully developed brain. Research suggests that the earlier someone uses drugs the more likely they are to develop serious SUD problems later in life. MSHN will work with contracted providers to increase the availability of adolescent treatment and work with

community partners to increase awareness of treatment options for adolescents. MSHN contracted providers will work to build a support network through collaboration with SUD treatment providers, CMHSPs, schools, courts, MDHHS, faith-based communities or other providers in the area. Based on these community connections, there will be an increase in coordination of care for adolescent supports and referrals.

Timeline and Evaluation (Improving penetration rates for adolescents):
The timeline for implementation will be: Phase #1 (Q1-Q4 of FY21) - MSHN will evaluate the availability of adolescent services in the region to determine where programs already exist and where there is need for new or expanded programming for adolescents. Phase #2 (Q1-Q4 of FY22 and FY23) - MSHN will work with contracted providers to increase the availability of adolescent treatment and work with community partners to increase awareness of treatment options for adolescents. MSHN contracted providers will work to build a support network through collaboration with SUD treatment providers, CMHSPs, schools, courts, MDHHS, faith-based communities or other providers in the area. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

b. **Older Adults**:
Alcohol is the most common substance of abuse among older adults entering publicly funded substance abuse treatment. In 2018, 49% of older adults entering treatment listed alcohol (only or with another drug) as their primary substance of abuse, with heroin accounting for 30% of admissions, cocaine accounting for 12% of admissions, and other opiates accounting for 6% of admissions. Over the past ten years, there has been a 179% increase in the number of older adults entering publicly funded treatment who list alcohol as their primary substance use problem at admission for treatment. According to the Michigan Older Adult Wellbeing Report (2020), from 2013 to 2017, the occurrence of older adult drivers using substances and leading to serious injuries increased by 181%. Data from this report also indicates trends for substance use of cocaine, heroin, and other opiates largely within the male (54% -73%) and African American (21% - 76%) population of older adults. Of considerable note, is the disproportionate rate of heroin overdose deaths amongst older adults from 2013 – 2017 increasing 238% among females, and 188% among males; with a death rate 8.5 times higher for Blacks than Whites. Michigan adults 65 and over are expected to increase significantly from 16 percent of the overall population in 2019 to 27 percent in 2050. As a result, Michigan expects to see a continued increase in the number of older adults coming into publicly funded substance abuse treatment. MSHN will work with community partners and contracted providers to increase awareness of prescription drug/alcohol reactions in the 55+ population and inform this population of available treatment options. MSHN will also work with contracted providers to build the knowledge, skills and abilities needed to create culturally tailored services that meet the unique needs of this population; as well as, addressing coordination of care for those eligible for Medicare.

Timeline and Evaluation (Improving penetration rates for older adults):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) – MSHN will conduct surveys to assess the availability of treatment services that are specialized to meet the needs of older adults in Region 5. Phase #2 (Q3 and Q4 of FY21) –- Conduct outreach campaign to increase awareness among older adults, and work with providers to develop programs and procedures that meet the needs of older adults. Phase #3 (Q1 and Q 2 of FY22) - Assess the level of increase in treatment and engagement for adults 55+ in the public system. Phase #4 (Q3 and Q4 0f FY22, & Q1 – Q4 of FY23) – Continue to expand services to older adults throughout the region and make necessary changes to existing programs based on provider feedback and utilization.

c. **Veterans and Military Families (V/MFs)**:
The State of Michigan had an estimated 574,350 veterans in 2019; 8.5% of these veterans (49,000) lived below the federal poverty level. Of all Michigan veterans, only 1 in 5 that are eligible for health benefits through Veterans Administration (VA) utilize these services. Family members are generally not eligible for healthcare services through the VA. It is difficult to accurately assess how and where veterans access behavioral health and substance use disorder treatment. The available data would suggest that most eligible veterans are not accessing benefits through either the VA or Medicaid/Healthy Michigan Plan.

Contributing to low utilization of VA benefits, Michigan is a military reserve state and does not have any active duty military bases. Therefore, 90% of all current military service members in Michigan are in either the National Guard or Reserve. Only 10% of Michigan's military service members are considered active duty. Membership in the National Guard or Reserve does not make service members eligible for VA benefits unless they were activated to Federal service or combat deployed. Military bases in the State of Michigan are designed for training and lack the resources that would normally be available on active duty military installations such as healthcare and behavioral health supports. States with active duty bases where service members live for extended periods also offer a sense of community that is lacking for Guard and Reservists in Michigan which can increase a sense of isolation.

Stigma associated with seeking help for mental and physical health problems is a significant deterrent in the veteran and military service member population. Military culture values strength, resiliency, self-sacrifice, and independence. Veterans and military service members may be unlikely to report physical or mental health problems for fear of being perceived as weak. Due to a history of stigma within the military culture, they may believe that seeking assistance will be detrimental to their employment-seeking success and reintegration into civilian society. The inability of many veterans to successfully reintegrate into the civilian culture is evidenced in the Veterans Administration's 2019 National Veteran Suicide Prevention Annual Report where the suicide rate for Michigan veterans of all ages was 1.6 times higher than the rest of the population. For veterans ages 18-34, the rate was over 3 times the rate of their non-veteran peers. The first 3 years when a veteran leaves active service or returns from a deployment is believed to be a critical period and highlights the need to improve outreach to this population to reduce the rate of suicide and other behavioral health issues.

MSHN will work with contracted providers to increase military cultural competency and improve coordination of care between the publicly funded BH/SUD system and the VA Health Systems within the Region. MSHN will also continue to identify best practices in treatment for V/MFs and offer trainings in these EBPs. MSHN also will create an awareness campaign to educate veterans on the prevalence of BH/SUD in the veteran population, reduce stigma associated with seeking help, and promote the availability of treatment services and of the Veteran Navigator to help meet specific needs of V/MFs.

Timeline and Evaluation (Improving penetration rates for V/MFs):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) - The Veteran Navigator (VN) will work with BHDDAs and Michigan Veterans Affairs Agency to identify opportunities to collaborate and improve outreach. This will allow MSHN to develop a coordinated outreach plan and to develop procedures that address the unique needs of V/MFs when accessing BH/SUD services. Phase #2 (Q3 and Q4 of FY21) - Develop and implement an outreach campaign for veterans to reduce stigma and promote awareness of BH/SUD services available through the public system. Coordinate

outreach to contracted providers regarding the availability of Military Cultural Competency (MCC) to coincide with the veteran outreach campaign. Phase #3 (Q1 and Q2 of FY22) - Conduct outreach campaign to increase awareness among the V/MF population. Deliver MCC to providers and community partners to improve the understanding of veteran specific issues and cultural aspects of military service. Phase #4 (Q1 and Q 2 of FY23) - Assess the level of increase in MCC training within the provider network and evaluate post training surveys to analyze level of increased competency following MCC training. Assess the level of increase in V/MFs contacting the VN. Phase #5 (Q1 and Q2 0f FY23) – Make necessary changes based on program evaluations and continue to expand MCC throughout the region while promoting the availability of BH/SUD services to V/MFs through the public system.

Goal #3: Increase cultural competence and reduce health disparities.

Increase cultural competence and reduce health disparities based on race, ethnicity, socioeconomic status, and LGBTQ identity ***(For detail, please see this goal's logic model in Appendix 27.3).***

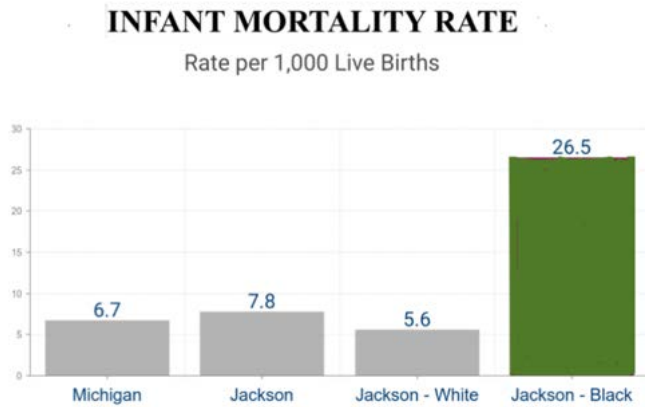
Identifying service gaps/deficits for marginalized populations: While data exists at the state and national level regarding health disparities experienced by at-risk populations, there is less data at the regional level. With the diversity across MSHN's 21 counties, moreover, one can't make generalizations that apply across the region. MSHN's plan therefore is to build on FY20's work in building coalitions and allies in health disparity work. Early FY21 will also be used to gather regional data on health disparities, to form focus groups and to learn from people of color and other at-risk groups who experience health disparities with negative health outcomes. MSHN will seek to listen and to understand the lived experience of people in our communities as it relates to their substance use, accessing treatment services, supports and barriers to recovery. MSHN will work with community partners, people in recovery, and our provider networks to form additional focus groups as needed and eventually establish an advisory group that fleshes out strengths and opportunities for improvement in our system.

Timeline and Evaluation (Reducing Health Disparities):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY21) – Create an internal workgroup to collect data from focus groups and research best practices related to reducing health disparities. This workgroup will also establish an ongoing advisory group to inform health disparity issues and approaches moving forward. Phase #2 (Q3 and Q4 of FY21) - Analyze the results of this collaborative dialogue and best-practices research to inform targeted objectives that may range from universal across the region to sub-regional pockets where particular issues are very localized. Phase #3 (Q1 and Q2 of FY22) – Engage provider partners and other stakeholders to implement identified objectives in targeted communities. Evaluation will be quarterly starting in Phase #3 with key targets identified for initiation. Each quarter, evaluation will focus on process outcomes with the understanding that reduction of health disparities may not be evident in short-term reviews. Evaluation will also include regular reengagement with and feedback from members of the targeted populations for whom we seek improvement including but not limited to surveys and new focus groups. Phase #4 (Timeline? Q3 and Q4 of FY22?) - Will be formalizing reforms and changes implemented and evaluated to be effective; Phase #5 will involve expansion of reforms from specified parts of Region 5 to be appropriate and meaningful for all counties in the region. Phase #5 will take place over the course of FY22.

SECTION 7 - Health Disparities & Cultural Competency

The Landscape of Health Disparities

The COVID-19 pandemic of 2020 has brought health disparities in the U.S. and in Michigan into stark relief. Though the African American population of Michigan is 14%, coronavirus deaths in the black community are at 40%. This largely reflects the high proportion of people of color employed in low-paying, essential service jobs where they are at high risk for exposure and infection, even as they often have limited access to insurance and health care. This is only one of several ways that African American communities face social determinants of health that disproportionately impact their health negatively. They are five times more likely to be imprisoned than white Americans, and twice as likely to be unemployed. Their communities are ravaged by economic and health disparities, not just from COVID-19. In Jackson County, for example, mortality for black infants is nearly five times higher than for white babies (see graph below).



(Jackson County Community Assessment Survey 2017)

As noted earlier, the police killing of George Floyd highlighted and underscored another long-established historical trend of oppression towards African Americans. The ongoing murder of black and brown citizens by police is another component of the systemic racism that disenfranchises and marginalizes people of color in education, employment, housing, and access to health care. The legacies of slavery, Jim Crow, the War on Drugs, mass incarceration, and police brutality have created racialized and inter-generational trauma that keeps on being repeated and that impacts the physical, emotional, mental and spiritual health of the affected communities.

Trauma and health disparities exist for other racial, ethnic, and cultural groups as well. Immigrants, Latinos, Native Americans and LGBTQ youth are all at higher risk for negative health outcomes. Given that backdrop, it is critical that when clients from at-risk groups enter our system, they encounter providers, staff and services who are culturally competent and responsive. MSHN is committed to acknowledging and addressing these legacies of racism, discrimination and trauma in the people we serve and to ensuring we remove barriers at all levels to support clients engaging in treatment and sustaining successful recovery.

Cultural Competency at MSHN and MSHN's Provider Networks

Ensuring cultural competency (CC) is one pathway to addressing health disparities by ensuring our provider systems are open and responsive to all people it serves, regardless of their cultural background. CC represents a set of values, behaviors, attitudes, and practices within a system, organization, or individuals which enables them to effectively work cross-culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services.

MSHN recognizes that cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time. Through planning, policy, and oversight implementation, MSHN will ensure that SUD services will be conducted in a culturally competent manner for all persons from diverse cultural backgrounds in our communities who need to access SUD treatment and prevention services. Cultural responsiveness includes removing barriers and embracing differences, in order to offer safe and caring environments for all who are in need of services.

MSHN adheres to its own cultural competency policy (Appendix 28) and requires that all SUD prevention, treatment, and recovery providers have their own policies and training for staff relative to cultural competency and available to MSHN for review. Cultural competency training must guide staff in supporting a diverse population of clients and help establish a workforce whose diversity is representative of the community and clients served. MSHN's SUD provider training grid (Appendix 29) includes cultural competency as a required training for providers' staff.

MSHN requires its SUD providers to use assessment tools and/or treatment methods that are culturally sensitive and validated, whenever possible, for use with people of color and other at-risk populations. Service/support/treatment plans and discharge plans must incorporate the natural supports and strengths specific to the racial, ethnic, and cultural background of the client, family, community, faith-based, and self-help resources. Prevention, education, and outreach efforts include linkages to racial, ethnic, and cultural organizations throughout the community.

MSHN is committed to Region 5's substance abuse service delivery system being informed by the following principles:

- Inclusion – Utilizing an open process (from planning to implementation) that is personalized and sensitive to all stakeholders.
- Diversity – Seeking out, embracing, and valuing differences and similarities among stakeholders. This includes gender, age, race, ethnicity, sexual orientation, mental and physical abilities, and characteristics.
- Respect – Accepting, acknowledging value, not judging, and being responsive to differences.
- Excellence – Striving for quality services and measurable outcomes through clear expectations, best practices, and on-going training and education, and accountability.
- Relationships – Establishing partnerships among stakeholders that are productive, have shared goals, trust, and support.
- Accountability – Providing clear guidance regarding accountability, setting objectives, measuring progress, and further steps to improve quality, service delivery, and outcomes. Outcomes will be meaningful to both the provider and the recipient.

As noted in the goal section, applying these principles in localized and community-specific ways will be MSHN's work over the course of FY21-23.

SECTION 8 – In Closing...

MSHN recognizes that there are many unknowns facing our nation and our region. At this writing, COVID cases are again trending up, including in Michigan.

(Johns Hopkins University & Medicine Coronavirus Resource Center, 2020)

The short and long-term impacts on the physical and emotional health of already vulnerable populations in Region 5's twenty-one counties are likely to be dramatic and to require a ramping up of services and supports even as Michigan's economy moves deeper into a recession. There are unknowns as well regarding how the country will address the public health crises of police brutality and systemic racism. Lastly, the U.S. faces a presidential election less than four months from this writing at a time when our nation has rarely been more polarized.

Our nation's healthcare system will have to adapt to the changing landscape of American political, economic and social realities. MSHN recognizes the limitations on what our organization can do to impact the forces described above, but we remain firmly committed to adapting, innovating and applying best practices in SUD prevention, treatment and recovery, a commitment that is informed by the goals of reduced substance abuse in our communities, increased access to high quality care, strong recovery supports, reduced health disparities and continuous improvement in health equity.

Citations

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9. The Recovery Village; LaNeve & Henson; Drug and Alcohol Use Increase During COVID-19; 2020. https://www.therecoveryvillage.com/drug-addiction/news/drug-alcohol-use-rising-during-covid/
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Appendices

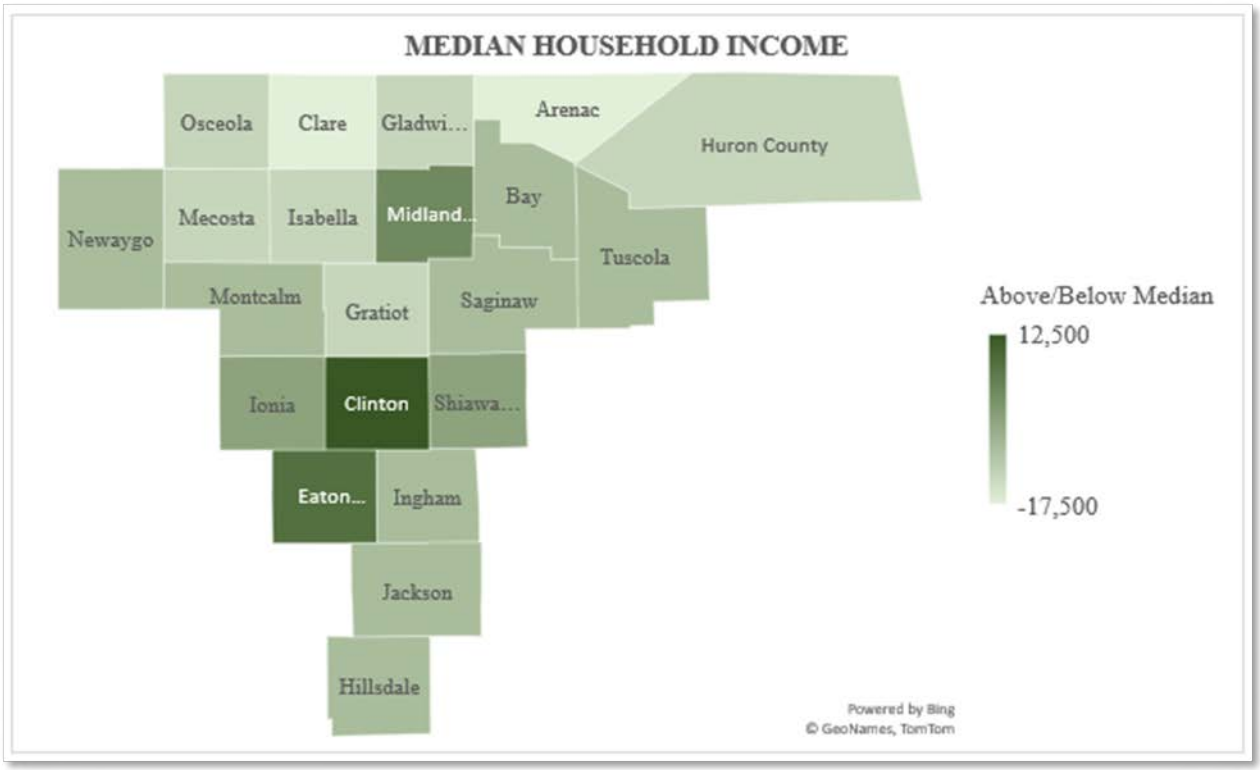
Appendix 1. Demographic Profile by County

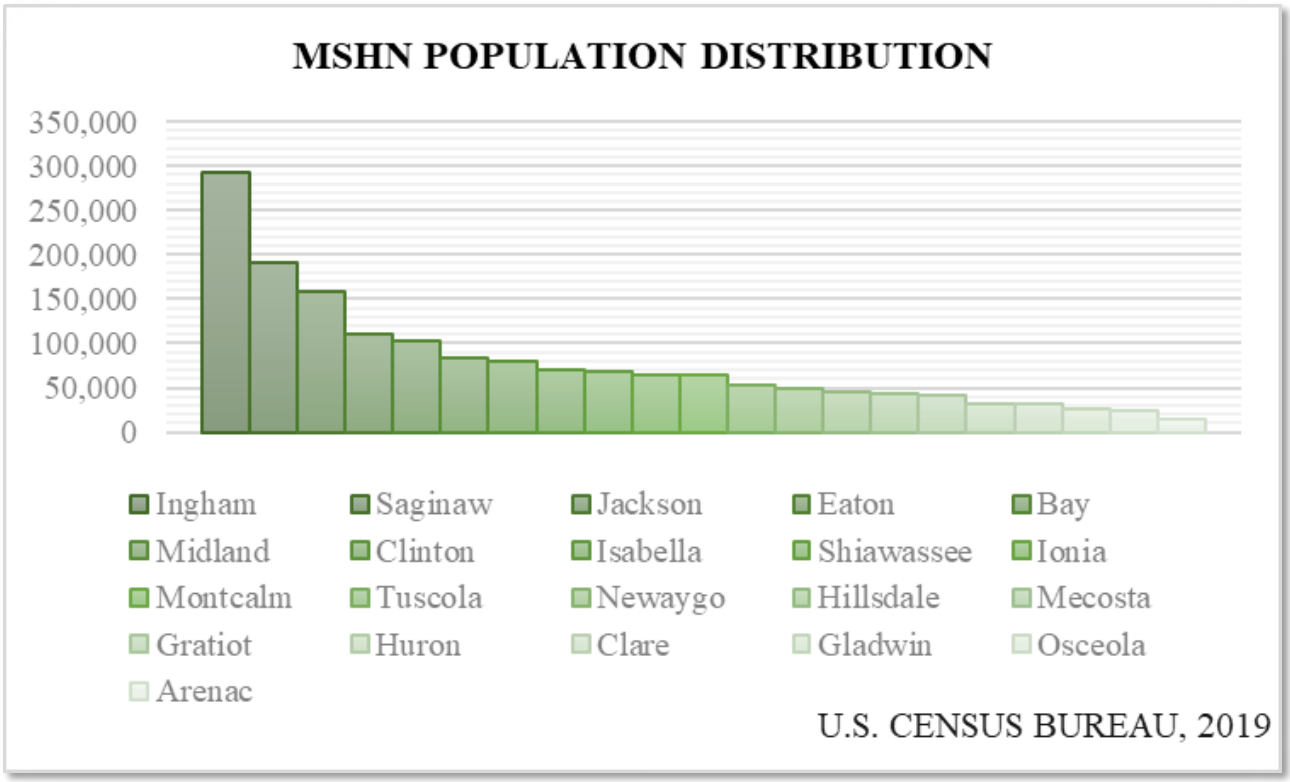
Demographic Variable	Arenac		Bay		Clare		Clinton		Eaton		Gladwin	
	#	%	#	%	#	%	#	%	#	%	#	%
2019 Population Estimate	14,833	100.0%	103,126	100.0%	30,950	100.0%	79,595	100.0%	110,268	100.0%	25,449	100.0%
Race												
White	14,332	96.3%	97,557	94.6%	29,867	96.5%	74,501	93.6%	96,485	87.5%	24,762	97.3%
Black/African American	74	0.5%	1,959	1.9%	217	0.7%	1,671	2.1%	7,719	7.0%	127	0.5%
American Indian/Alaska Native	179	1.2%	722	0.7%	279	0.9%	398	0.5%	551	0.5%	153	0.6%
Asian	45	0.3%	619	0.6%	93	0.3%	1,353	1.7%	2,757	2.5%	102	0.4%
Pacific Islander/Hawaii Native	15	0.1%		<0.1%		<0.1%	80	0.1%		<0.1%		<0.1%
Two or More Races	253	1.7%	2,372	2.3%	495	1.6%	1,592	2.0%	2,757	2.5%	280	1.1%
Ethnicity												
White alone, non-Hispanic/Latino	14,017	94.5%	92,710	89.9%	29,310	94.7%	71,317	89.6%	91,302	82.8%	24,355	95.7%
Hispanic/Latino	298	2.0%	5,569	5.4%	619	2.0%	3,582	4.5%	6,065	5.5%	458	1.8%
Language spoken at home												
English only	14,581	98.3%	100,754	97.7%	29,464	95.2%	76,093	95.6%	102,660	93.1%	24,813	97.5%
Language other than English	252	1.7%	2,372	2.3%	1,486	4.8%	3,502	4.4%	7,608	6.9%	636	2.5%
Male	7,501	50.4%	50,635	49.1%	15,475	50.0%	39,400	49.5%	54,142	49.1%	12,877	50.6%
Female	7,382	49.6%	52,491	50.9%	15,475	50.0%	40,195	50.5%	56,126	50.9%	12,572	49.4%
18 years or older	12,133	81.8%	84,357	81.8%	25,317	81.8%	65,109	81.8%	90,199	81.8%	20,817	81.8%
21 years or older	11,733	79.1%	81,573	79.1%	24,481	79.1%	62,960	79.1%	87,222	79.1%	20,130	79.1%
Veteran*	1,419	9.6%	8,545	8.3%	2,894	9.4%	4,486	5.6%	7,618	6.9%	2,462	9.7%
Socioeconomic Characteristics												
Total Households	6,684		43,891		12,406		29,421		44,390		10,999	
Average household size	2.27		2.39		2.47		2.65		2.46		2.30	
Median household income	$ 40,769		$ 48,005		$ 37,369		$ 67,482		$ 62,474		$ 43,290	
High school education or higher		87.4%		89.6%		84.7%		94.2%		93.9%		86.7%
Health Insurance		93.1%		94.5%		88.6%		96.2%		94.6%		91.5%
Unemployed		9.6%		6.9%		10.1%		4.0%		5.3%		7.0%
Below federal poverty level		18.2%		16.0%		23.5%		9.3%		10.7%		18.2%
2010 Population	15,899	-6.8%	107,771	-4.5%	30,926	0.1%	75,382	5.3%	107,759	2.3%	25,692	-1.0%

Demographic Variable	Gratiot		Hillsdale		Huron		Ingham		Ionia		Isabella	
	#	%	#	%	#	%	#	%	#	%	#	%
2019 Population Estimate	40,711	100.0%	45,605	100.0%	30,981	100.0%	292,406	100.0%	64,697	100.0%	69,872	100.0%
Race												
White	37,169	91.3%	44,100	96.7%	30,206	97.5%	221,059	75.6%	59,845	92.5%	61,487	88.0%
Black/African American	2,402	5.9%	319	0.7%	186	0.6%	35,674	12.2%	3,041	4.7%	1,887	2.7%
American Indian/Alaska Native	285	0.7%	274	0.6%	124	0.4%	1,754	0.6%	453	0.7%	2,795	4.0%
Asian	244	0.6%	228	0.5%	186	0.6%	21,346	7.3%	323	0.5%	1,397	2.0%
Pacific Islander/Hawaii Native		<0.1%		<0.1%		<0.1%	292	0.1%		<0.1%		<0.1%
Two or More Races	570	1.4%	684	1.5%	279	0.9%	12,281	4.2%	1,035	1.6%	2,236	3.2%
Ethnicity												
White alone, non-Hispanic/Latino	34,889	85.7%	43,142	94.6%	29,494	95.2%	202,345	69.2%	57,192	88.4%	59,531	85.2%
Hispanic/Latino	2,565	6.3%	1,049	2.3%	775	2.5%	3,582	4.5%	3,105	4.8%	2,795	4.0%
Language spoken at home												
English only	39,408	96.8%	43,735	95.9%	30,021	96.9%	256,440	87.7%	62,885	97.2%	65,819	94.2%
Language other than English	1,303	3.2%	1,870	4.1%	960	3.1%	35,966	12.3%	1,812	2.8%	4,053	5.8%
Male	21,862	53.7%	22,711	49.8%	15,336	49.5%	142,402	48.7%	34,678	53.6%	34,028	48.7%
Female	18,849	46.3%	22,894	50.2%	15,645	50.5%	150,004	51.3%	30,019	46.4%	35,844	51.3%
18 years or older	32,487	79.8%	36,393	79.8%	24,723	79.8%	233,340	79.8%	51,628	79.8%	55,758	79.8%
21 years or older	30,208	74.2%	33,839	74.2%	22,988	74.2%	216,965	74.2%	48,005	74.2%	51,845	74.2%
Veteran*	2,617	6.4%	3,018	6.6%	2,266	7.3%	13,212	4.5%	4,290	6.6%	3,321	4.8%
Socioeconomic Characteristics												
Total Households	15,177		17,904		13,918		112,200		22,858		24,889	
Average household size	2.71		2.56		2.27		2.58		2.81		2.84	
Median household income	$ 44,991		$ 48,005		$ 46,320		$ 50,940		$ 54,343		$ 44,408	
High school education or higher		90.6%		88.3%		88.9%		92.7%		90.1%		91.6%
Health Insurance		94.2%		92.3%		93.7%		94.1%		93.8%		91.2%
Unemployed (16 or older)		6.7%		5.0%		5.4%		6.5%		5.2%		7.6%
Below federal poverty level		18.3%		16.0%		12.9%		20.1%		12.8%		26.5%
2010 Population	42,476	-4.3%	46,688	-2.4%	33,118	-6.9%	280,895	3.9%	63,905	1.2%	70,311	-0.6%

Demographic Variable	Jackson		Mecosta		Midland		Montcalm		Newaygo		Osceola	
	#	%	#	%	#	%	#	%	#	%	#	%
2019 Population Estimate	158,510	100.0%	43,453	100.0%	83,156	100.0%	63,888	100.0%	48,980	100.0%	23,460	100.0%
Race												
White	138,855	87.6%	40,411	93.0%	78,083	93.9%	60,566	94.8%	46,874	95.7%	22,522	96.0%
Black/African American	12,839	8.1%	1,260	2.9%	1,164	1.4%	1,597	2.5%	588	1.2%	211	0.9%
American Indian/Alaska Native	634	0.4%	348	0.8%	416	0.5%	383	0.6%	392	0.8%	164	0.7%
Asian	1,427	0.9%	391	0.9%	1,996	2.4%	256	0.4%	245	0.5%	70	0.3%
Pacific Islander/Hawaii Native	159	0.1%	43	0.1%	83	0.1%		<0.1%		<0.1%	23	0.1%
Two or More Races	4,438	2.8%	1,043	2.4%	1,414	1.7%	1,086	1.7%	833	1.7%	469	2.0%
Ethnicity												
White alone, non-Hispanic/Latino	134,099	84.6%	39,586	91.1%	76,088	91.5%	58,521	91.6%	44,327	90.5%	22,123	94.3%
Hispanic/Latino	5,706	3.6%	1,043	2.4%	2,328	2.8%	2,300	3.6%	2,841	5.8%	469	2.0%
Language spoken at home												
English only	153,755	97.0%	41,976	96.6%	79,663	95.8%	61,716	96.6%	46,237	94.4%	22,569	96.2%
Language other than English	4,755	3.0%	1,477	3.4%	3,493	4.2%	2,172	3.4%	2,743	5.6%	891	3.8%
Male	80,999	51.1%	21,813	50.2%	40,996	49.3%	33,030	51.7%	24,588	50.2%	11,824	50.4%
Female	77,511	48.9%	21,640	49.8%	42,160	50.7%	30,858	48.3%	24,392	49.8%	11,636	49.6%
18 years or older	123,955	78.2%	33,980	78.2%	65,028	78.2%	49,960	78.2%	38,302	78.2%	18,346	78.2%
21 years or older	117,297	74.0%	32,155	74.0%	61,535	74.0%	47,277	74.0%	36,245	74.0%	17,360	74.0%
Veteran*	10,809	6.8%	2,936	6.8%	5,641	6.8%	4,475	7.0%	3,702	7.6%	1,972	8.4%
Socioeconomic Characteristics												
Total Households	61,696		15,858		34,017		23,761		19,007		9,100	
Average household size	2.58		2.73		2.45		2.66		2.53		2.55	
Median household income	$ 51,435		$ 44,460		$ 59,271		$ 47,000		$ 46,724		$ 42,689	
High school education or higher		90.6%		89.5%		94.3%		87.8%		86.8%		88.2%
Health Insurance		93.6%		93.5%		95.2%		91.8%		93.6%		89.9%
Unemployed (16 or older)		6.8%		7.0%		6.0%		5.1%		6.1%		6.9%
Below federal poverty level		14.1%		21.3%		10.8%		16.5%		17.8%		19.6%
2010 Population	160,248	-1.1%	42,798	1.5%	83,629	-0.6%	63,342	0.9%	48,460	1.1%	23,528	-0.3%

Demographic Variable	Saginaw		Shiawassee		Tuscola		MSHN - Region 5		State of Michigan	
	#	%	#	%	#	%	#	%	#	%
2019 Population Estimate	190,539	100.0%	68,122	100.0%	52,245	100.0%	1,640,896	100.0%	9,986,857	100.0%
Race										
White	145,191	76.2%	65,738	96.5%	50,312	96.3%	1,439,921	87.8%	46,874	79.3%
Black/African American	36,774	19.3%	477	0.7%	679	1.3%	110,866	6.8%	588	14.1%
American Indian/Alaska Native	1,143	0.6%	409	0.6%	313	0.6%	12,168	0.7%	392	0.7%
Asian	2,858	1.5%	409	0.6%	157	0.3%	36,500	2.2%	245	3.4%
Pacific Islander/Hawaii Native	191	0.1%	68	0.1%		<0.1%	954	<0.1%		<0.1%
Two or More Races	4,382	2.3%	1,090	2.4%	731	1.4%	40,320	2.5%	833	2.5%
Ethnicity										
White alone, non-Hispanic/Latino	131,853	69.2%	64,035	94.0%	48,745	93.3%	1,368,981	83.4%	7,480,156	74.9%
Hispanic/Latino	16,196	8.5%	2,044	3.0%	1,829	3.5%	84,734	5.2%	519,317	5.2%
Language spoken at home										
English only	181,393	95.2%	66,964	98.3%	50,730	97.1%	1,585,106	96.6%	9,008,145	90.2%
Language other than English	9,146	4.8%	1,158	1.7%	1,515	2.9%	55,790	3.4%	978,712	9.8%
Male	92,602	48.6%	33,652	49.4%	26,227	50.2%	816,776	49.8%	24,588	49.2%
Female	97,937	51.4%	34,470	50.6%	26,018	49.8%	824,120	50.2%	24,392	50.8%
18 years or older	149,383	78.4%	53,408	78.4%	40,960	78.4%	1,286,462	78.4%	7,829,696	78.4%
21 years or older	140,618	73.8%	50,274	73.8%	38,557	73.8%	1,210,981	73.8%	7,370,300	73.8%
Veteran*	12,278	6.4%	4,972	7.3%	4,125	7.9%	107,058	6.5%	574,350	5.8%
Socioeconomic Characteristics										
Total Households	78,648		27,741		21,759		646,324		3,957,466	
Average household size	2.45		2.47		2.45		2.54		2.53	
Median household income	$ 46,919		$ 54,742		$ 47,694		$ 50,846		$ 56,697	
High school education or higher		89.5%		92.4%		94.3%		91.0%		91.1%
Health Insurance		94.7%		94.3%		94.1%		93.8%		94.6%
Unemployed (16 or older)		7.5%		5.0%		6.4%		6.4%		6.3%
Below federal poverty level		17.7%		11.4%		15.4%		16.4%		14.1%
2010 Population	200,169	-5.1%	70,648	-3.7%	55,729	-6.7%	1,649,373	-0.5%	9,883,640	1.0%



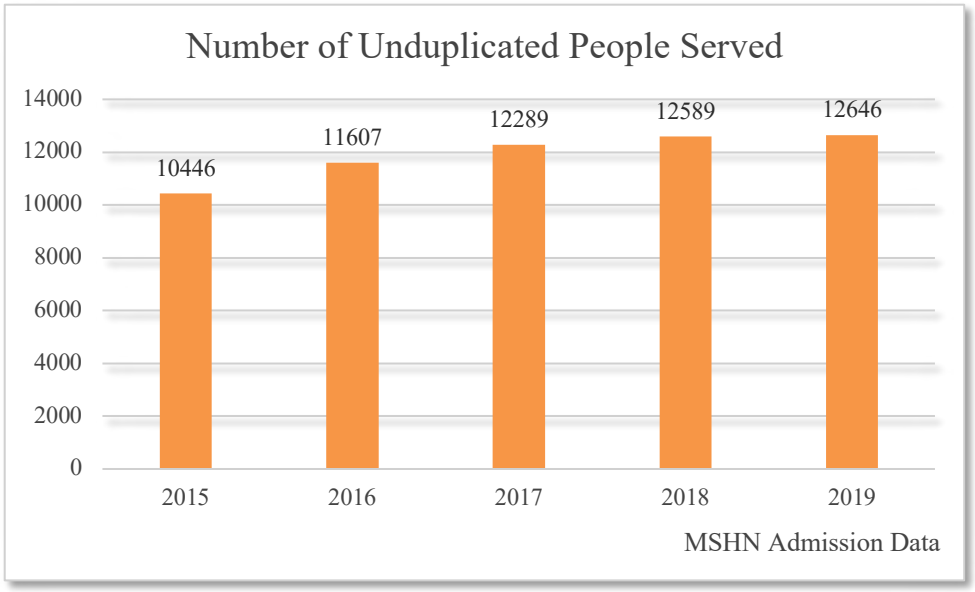


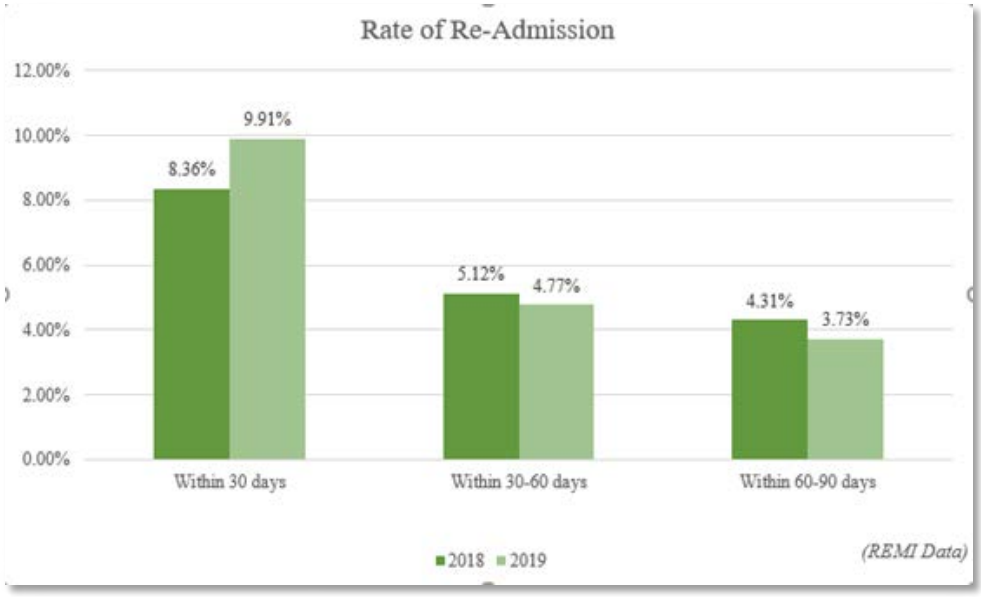
Appendix 2. Network Adequacy Assessment

Link to full document: Network Adequacy Assessment

Appendix 3. Mobil Care Unit Images

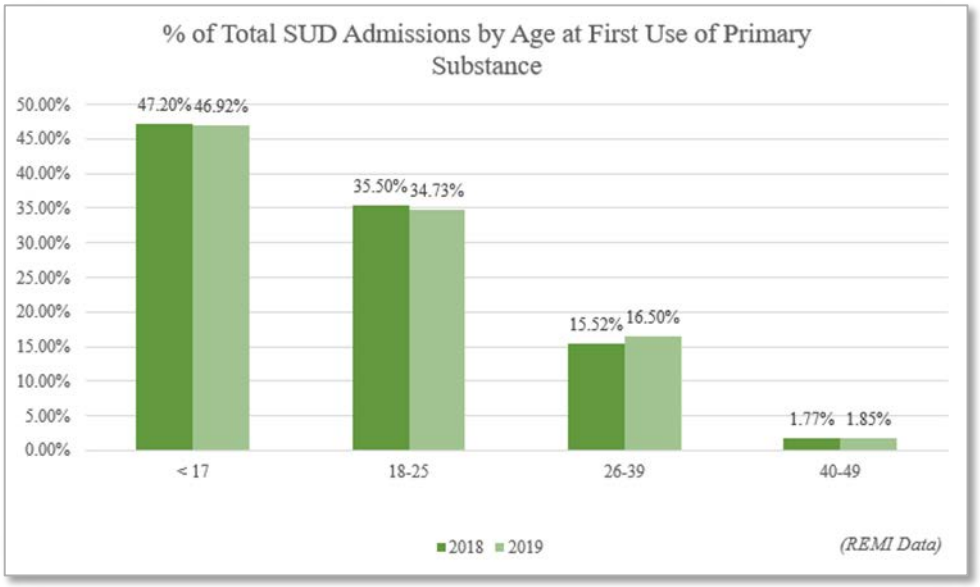
Appendix 4. Admission and Re-Admission



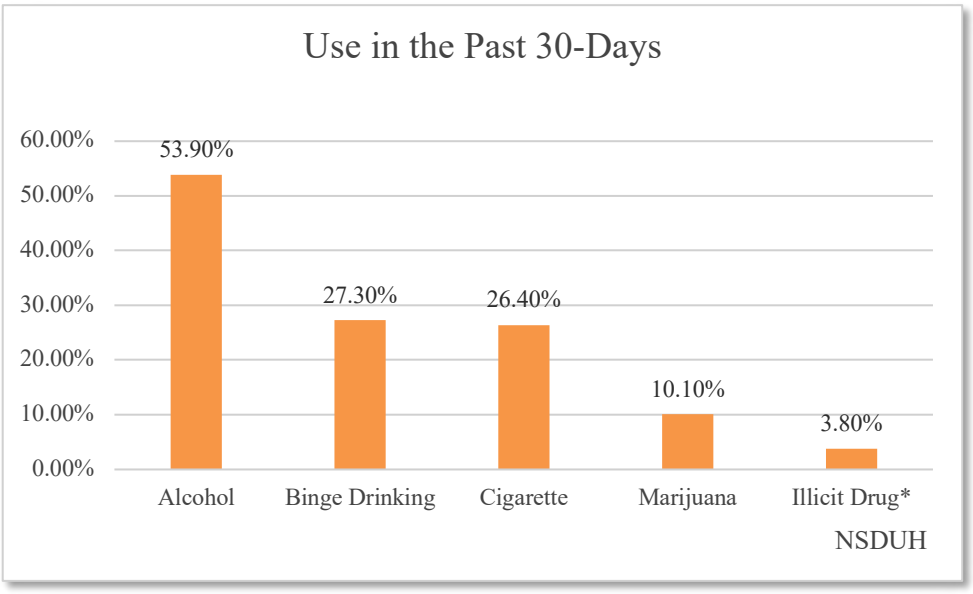


Appendix 5. Admissions by Service and Age of First Use

Admissions by Service	2016	2017	2018	2019
Not Identified	13%	5%	1%	1%
Ambulatory Withdrawal Management	2%	1%	1%	2%
Withdrawal Management	11%	11%	12%	9%
Intensive Outpatient	7%	9%	8%	9%
Outpatient	52%	60%	65%	65%
Residential	15%	15%	13%	14%

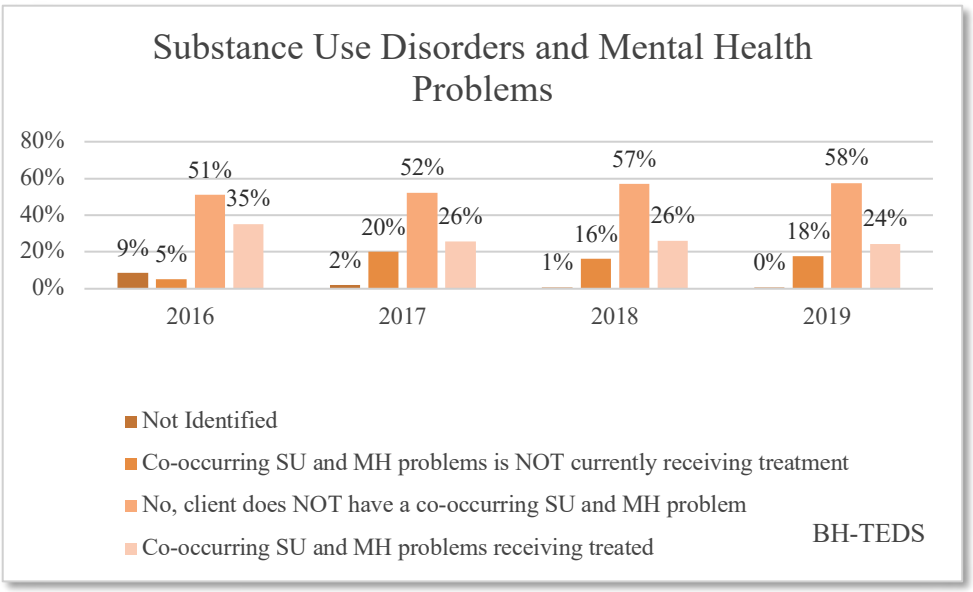


Appendix 6. Use in the Past 30 Days



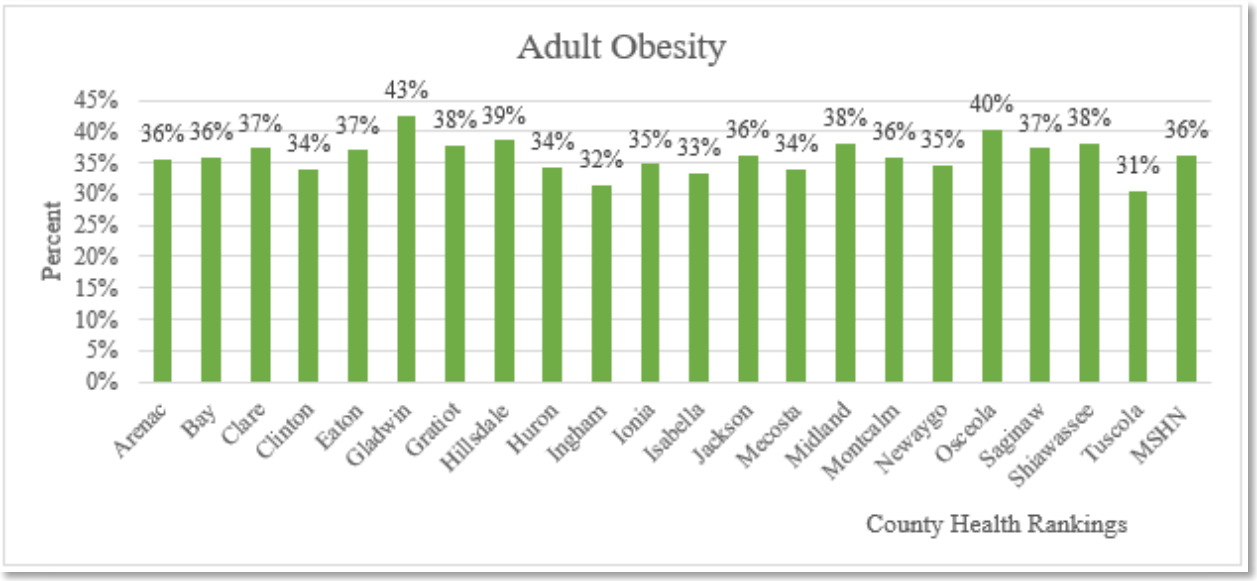
*Does not include marijuana

Appendix 7. Co-Occurring Disorder*



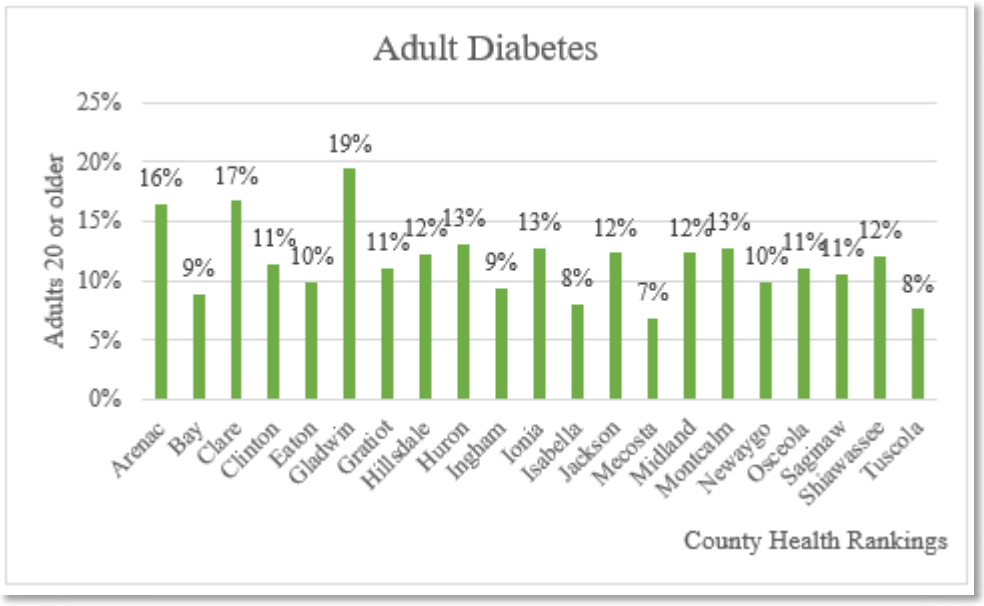
*Note this percentage is based on all admission for the year identified and may include duplicate people if they had more than one admission

Appendix 8. Adult Obesity*

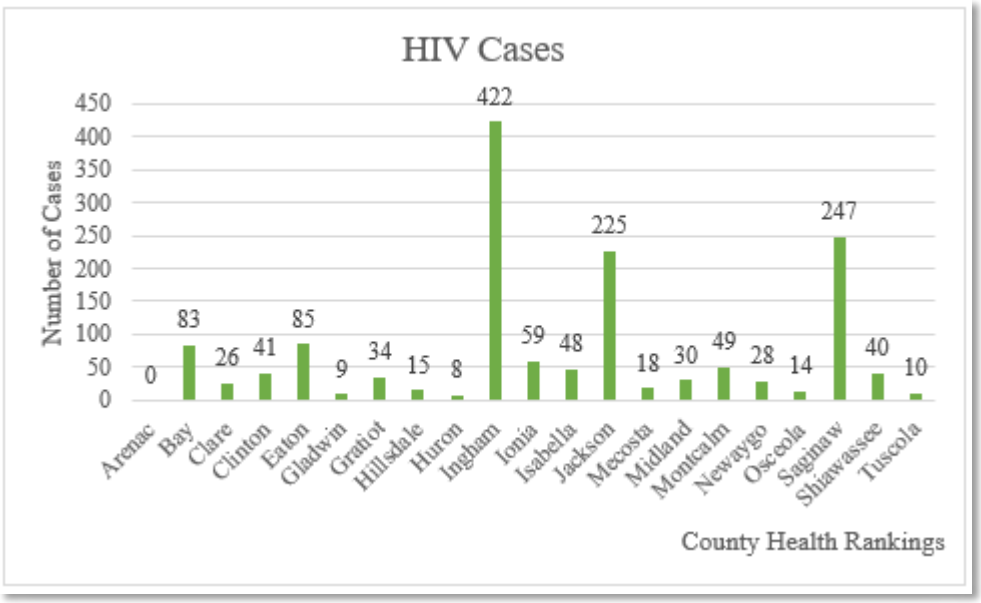


*Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.

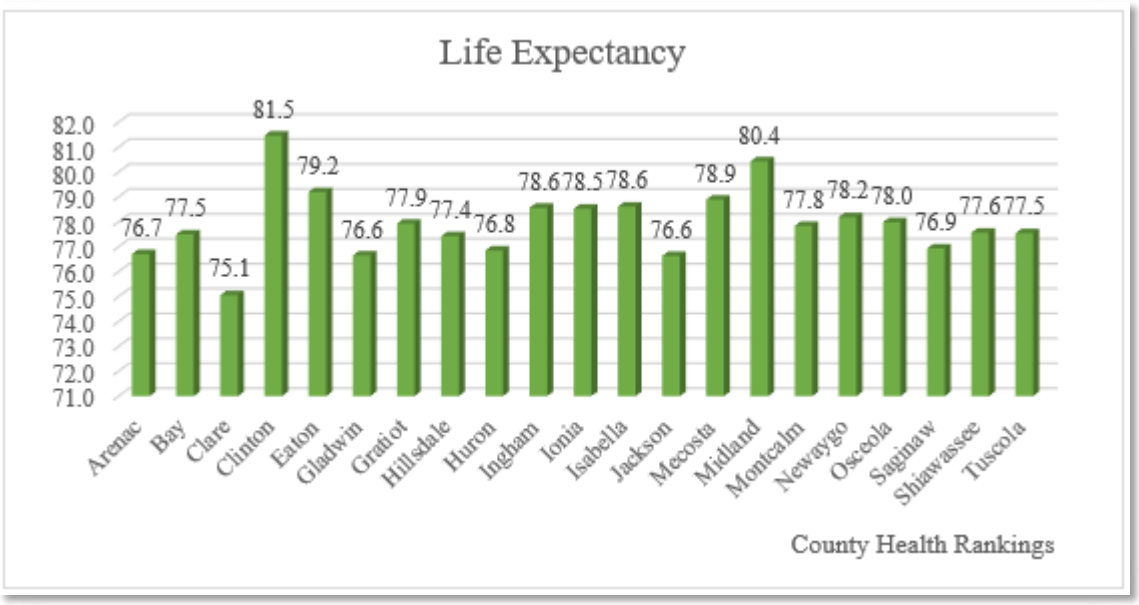
Appendix 9. Adult Diabetes



Appendix 10. Adult HIV



Appendix 11. Adult Mortality



Appendix 12. Youth Tobacco/Nicotine

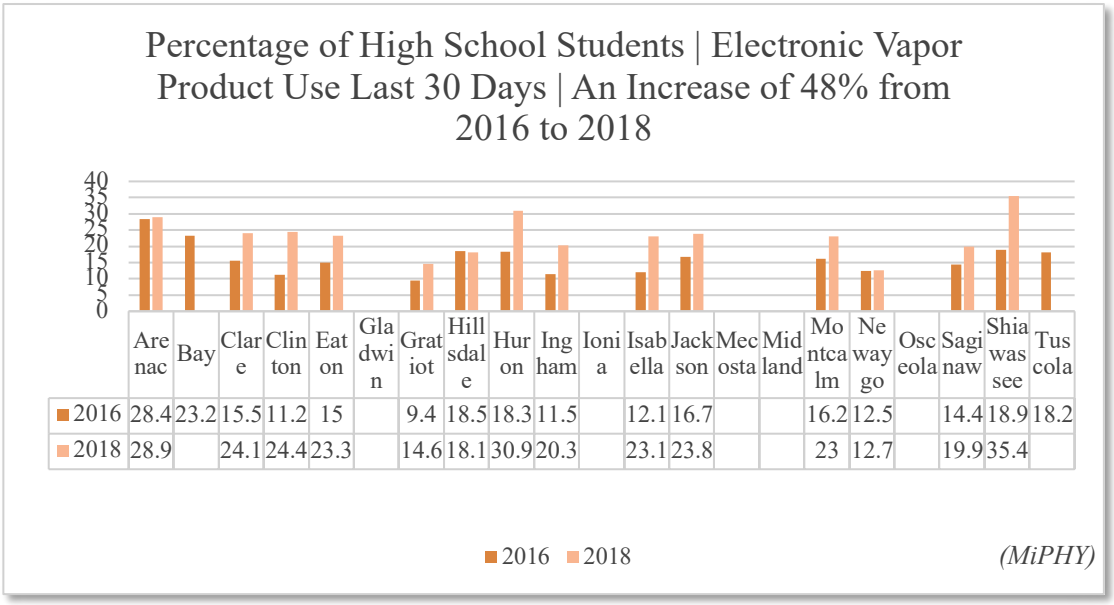
High School | Sum of Cigarette Use Past 30 Days | -29% from 2016 to 2018

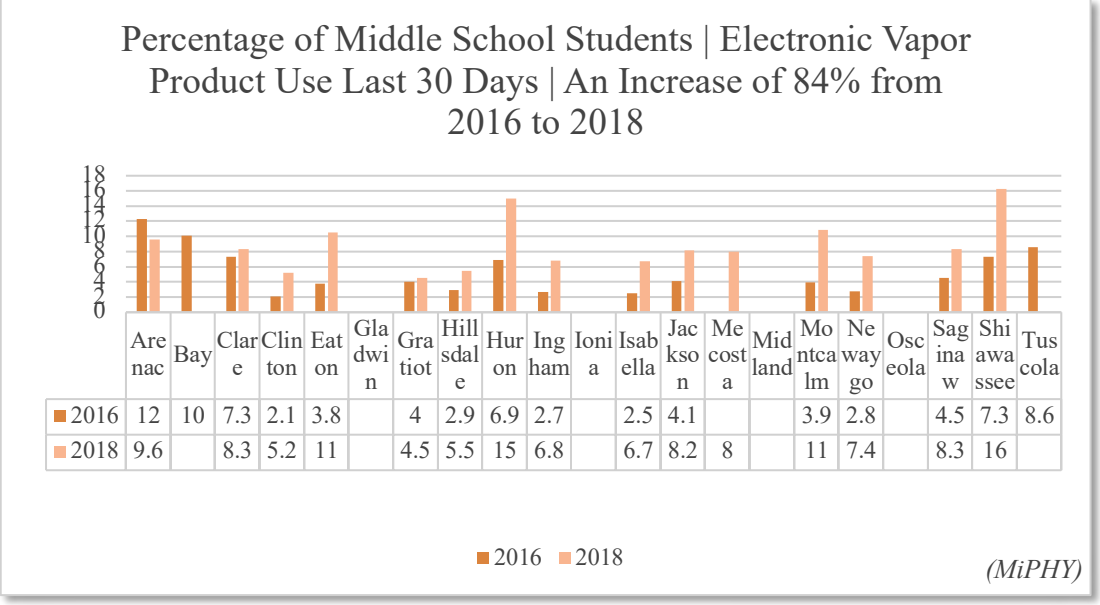
YEAR	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscecola	Saginaw	Shiawassee	Tuscola
2016	13%	10%	13%	4%	7%		6%	11%	12%	5%		9%	9%			11%	8%		6%	9%	10%
2018	16%		9%	4%	5%		3%	8%		3%		5%	5%			6%	5%		2%	6%	8%

Middle School | Sum of Cigarette Use Past 30 Days | -31% from 2016 to 2018

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscecola	Saginaw	Shiawassee	Tuscola
2016	8%	1%	7%	1%	2%		3%	2%	4%	1%		1%	2%			2%	1%		2%	3%	6%
2018	3%		4%		2%		0%	1%		1%		3%	1%	1%		1%	3%		2%	3%	4%

(MiPHY)





Appendix 13. Youth Alcohol and Other Drugs

High School | Percent Alcohol Last 30 Days | -14% from 2016 to 2018

Year	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	39%	25%	22%	15%	17%		18%	22%	36%	15%		16%	19%			24%	16%		20%	28%	24%
2018	31%		17%	17%	18%		18%	19%	30%	15%		14%	18%			19%	11%		17%	21%	24%

Middle School | Percent Alcohol Last 30 Days | -52% from 2016 to 2018

Year	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	19%	9%	8%	3%	5%		7%	8%	13%	4%		4%	5%			8%	5%		5%	7%	10%
2018	11%		3%	1%	3%		1%	2%	7%	2%		4%	2%	2%		3%	3%		3%	2%	7%

(MiPHY)

High School | Percent Alcohol Last 30 Days | -14% from 2016 to 2018

Year	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	39%	25%	22%	15%	17%		18%	22%	36%	15%		16%	19%			24%	16%		20%	28%	24%
2018	31%		17%	17%	18%		18%	19%	30%	15%		14%	18%			19%	11%		17%	21%	24%

Middle School | Percent Alcohol Last 30 Days | -52% from 2016 to 2018

Year	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	19%	9%	8%	3%	5%		7%	8%	13%	4%		4%	5%			8%	5%		5%	7%	10%
2018	11%		3%	1%	3%		1%	2%	7%	2%		4%	2%	2%		3%	3%		3%	2%	7%

(MiPHY)

High School | Cocaine Use Past 30 Days | Remained 1% for 2016 and 2018

YEAR	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	2%	2%	1%	1%	1%		1%	1%	1%	1%		2%	1%			1%	2%		2%	1%	2%
2018	1%		1%	1%	0%		0%	0%	0%	0%		1%	1%			1%	0%		0%	1%	1%

(MiPHY)

High School | Sum of Heroin Use Past 30 Days | Reduced from an average of 1% to an average of 0%

YEAR	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	0%	1%	1%	0%	1%		1%	1%	1%	1%		2%	1%			1%	1%		1%	1%	1%
2018			1%	1%				0%	0%	0%			0%			0%			0%	0%	

(MiPHY)

High School | Inhalant Use Past 30 Days | Remained at 2% for 2016 and 2018

YEAR	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	0.022	0.022	0.012	0.009	0.019		0.02	0.019	0.007	0.016		0.052	0.011			0.018	0.017		0.025	0.032	0.027
2018			0.019	0.01	0.015		0.005	0.02	0.027	0.012		0.012	0.011			0.013	0.015		0.015	0.018	0.018

Middle School | Inhalant Use Past 30 Days | Remained at 2% for 2016 and 2018

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	0.045	0.035	0.029	0.018	0.026		0.01	0.035	0.018	0.017		0.025	0.019			0.036	0.018		0.039	0.034	0.034
2018	0.025		0.042	0.013	0.032		0.045	0.033	0.045	0.027		0.021	0.033	0.038		0.025	0.048		0.041	0.034	0.043

(MiPHY)

High School | Methamphetamine Use Past 30 Days | Reduced from an average of 1% in 2016 to 0% in 2018

YEAR	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscoda	Saginaw	Shiawassee	Tuscola
2016	1%	1%	1%	1%	1%		0%	1%	1%	1%		2%	1%			1%	1%		1%	1%	1%
2018			1%	0%	0%			0%		0%			0%			1%	0%		0%	0%	0%

(MiPHY)

High School | Marijuana Use Past 30 Days | Remained at 14% for 2016 and 2018

YEAR	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscecola	Saginaw	Shiawassee	Tuscola
2016	21%	19%	18%	8%	14%		10%	14%	12%	13%		10%	17%			15%	13%		17%	18%	15%
2018	20%		13%	11%	16%		10%	15%	10%	17%		11%	18%			13%	10%		16%	17%	17%

Middle School | Marijuana Use Past 30 Days | Increased from 3% in 2016 to 4% in 2018

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscecola	Saginaw	Shiawassee	Tuscola
2016	6%	5%	7%	1%	3%		2%		2%	3%		2%	3%			3%	2%		4%	2%	4%
2018	9%		5%	1%	4%		2%	2%	3%	5%		3%	4%	2%		4%	3%		5%	4%	4%

(MiPHY)

Middle School | Risk of Using Marijuana | Reduction from 63% in 2016 to 56% in 2018

	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Oscecola	Saginaw	Shiawassee	Tuscola
2016	0.607	0.631	0.605	0.722	0.59		0.631	0.673	0.665	0.603		0.667	0.658			0.606	0.598		0.624	0.549	0.591
2018	0.548		0.553	0.726	0.584		0.596	0.506	0.566	0.571		0.556	0.585	0.467		0.493	0.55		0.576	0.515	0.528

(MiPHY)

Appendix 14. Youth Suicide

Middle School Ever Planned Suicide | Increased from 14% in 2016 to 19% in 2018

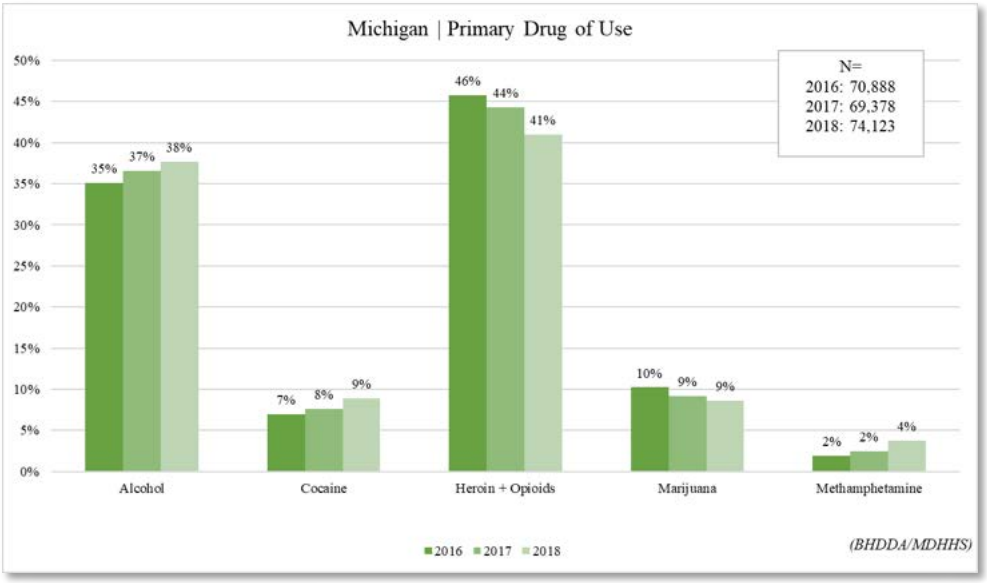
	Arenac	Bay	Clare	Clinton	Eaton	Gladwi	Gratiot	Hillsda	Huron	Ingham	Ionia	Isabella	Jackso	Mecos	Midlan	Montca	Neway	Oscecl	Saginaw	Shiawa	Tuscola
2016	15%	21%	20%	9%	14%		11%	18%	7%			13%	14%			15%	15%		15%	20%	20%
2018	25%		16%	10%	17%		16%	17%	18%	18%		29%	18%			16%	17%		21%		24%

Middle School Ever Attempted Suicide | Increased from 9% in 2016 to 12% in 2018

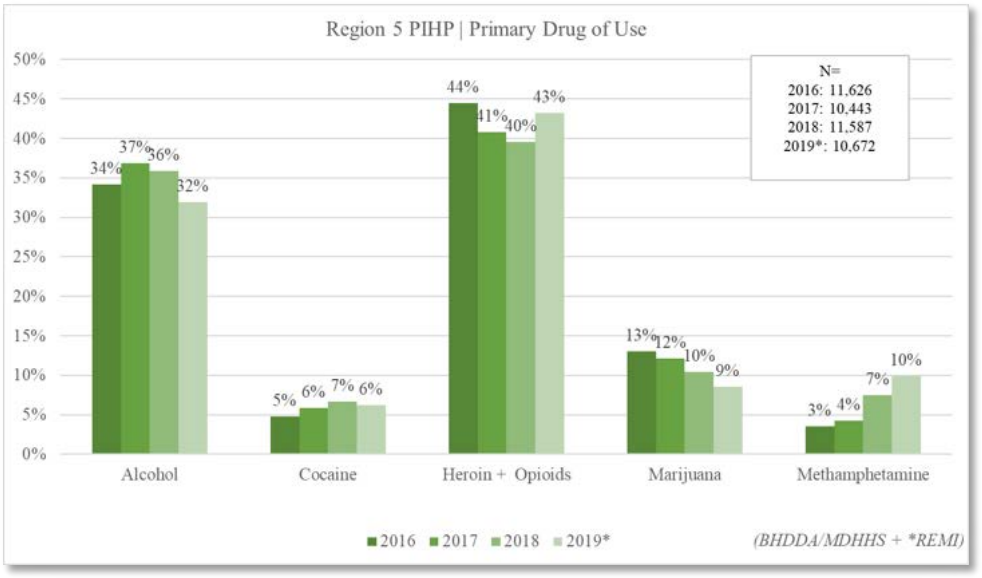
	Arenac	Bay	Clare	Clinton	Eaton	Gladwi	Gratiot	Hillsda	Huron	Ingham	Ionia	Isabella	Jackso	Mecos	Midlan	Montca	Neway	Oscecl	Saginaw	Shiawa	Tuscola
2016	9%	14%	14%	4%	8%		5%	11%	5%			10%	8%			11%	7%		8%	8%	13%
2018	7%		10%	5%	11%		14%	11%	13%	12%		25%	12%			13%	13%		14%		13%

(MiPHY)

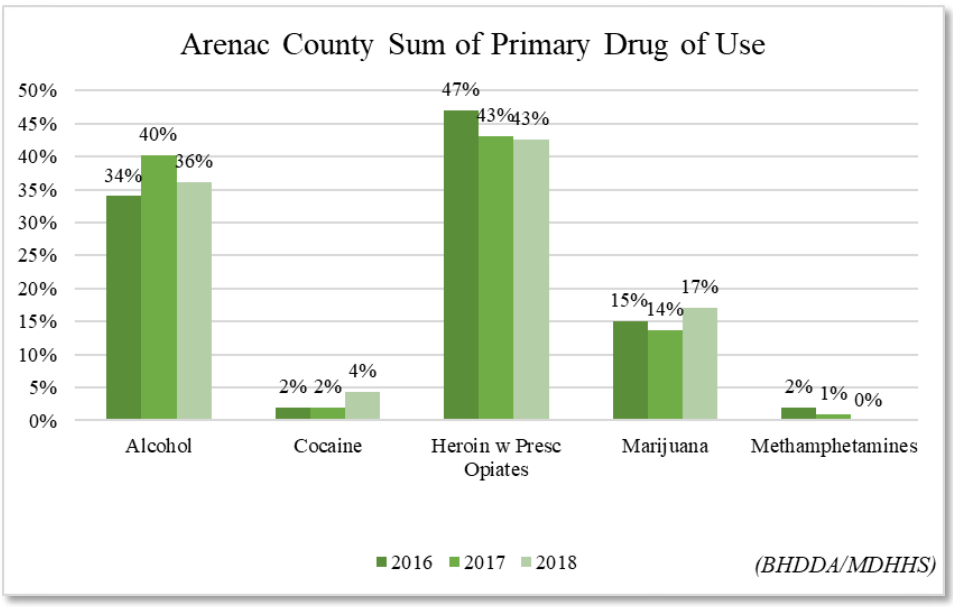
Appendix 15. Adult Primary Drug of Use: Statewide, Region, County and Statewide

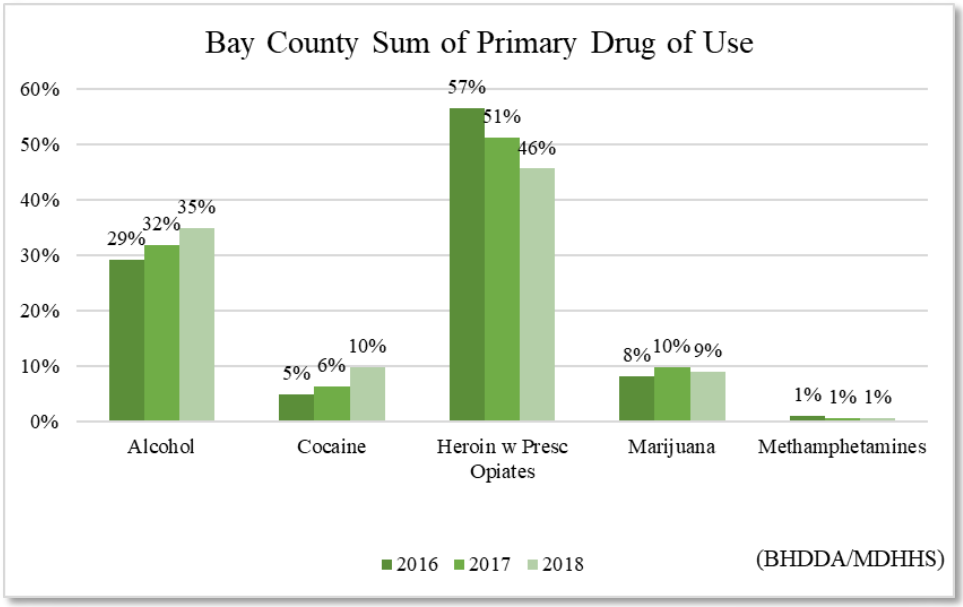


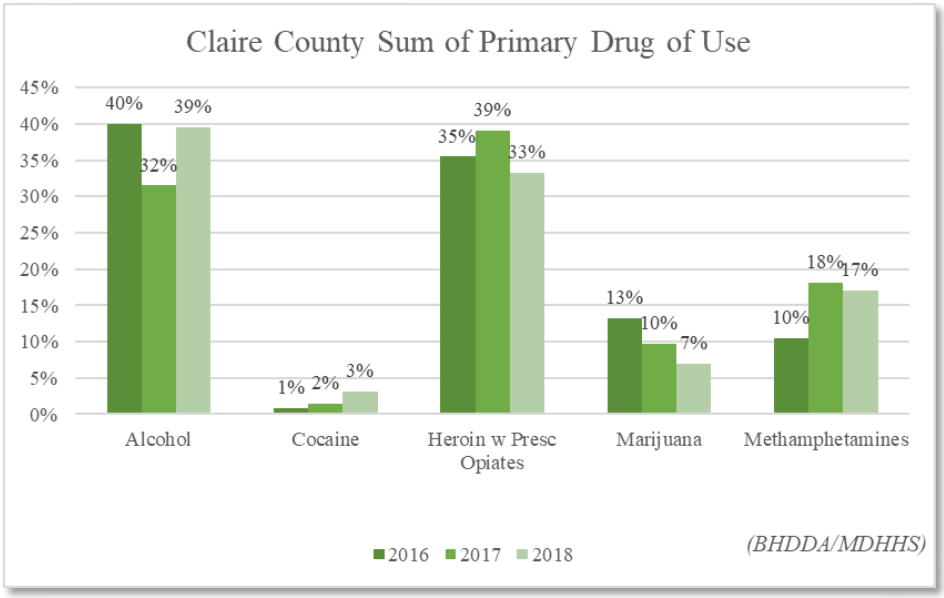
Region 5 PIHP

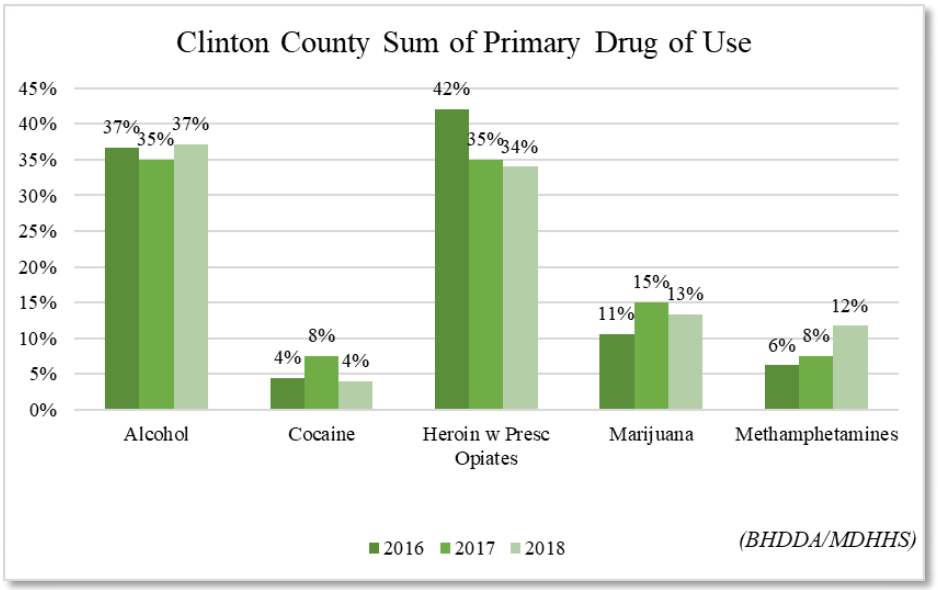


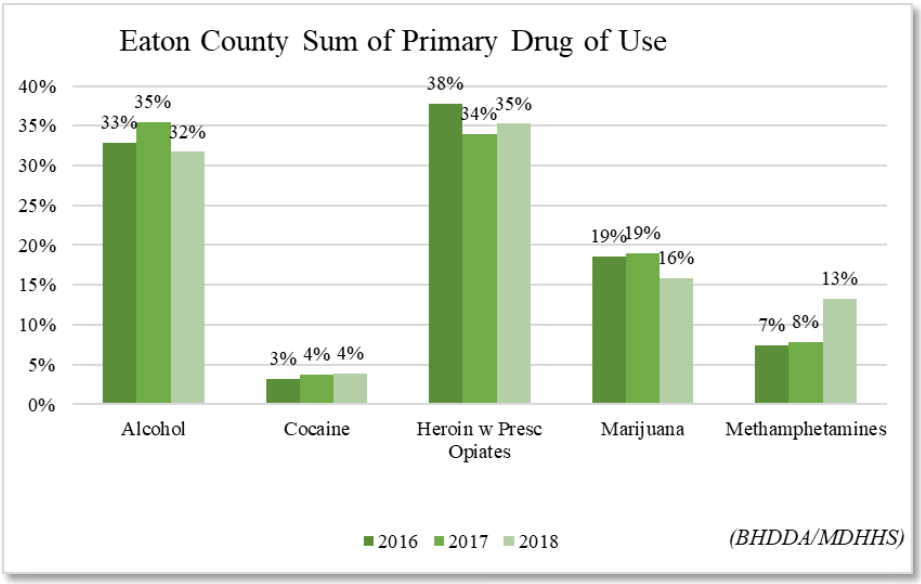
By Individual County

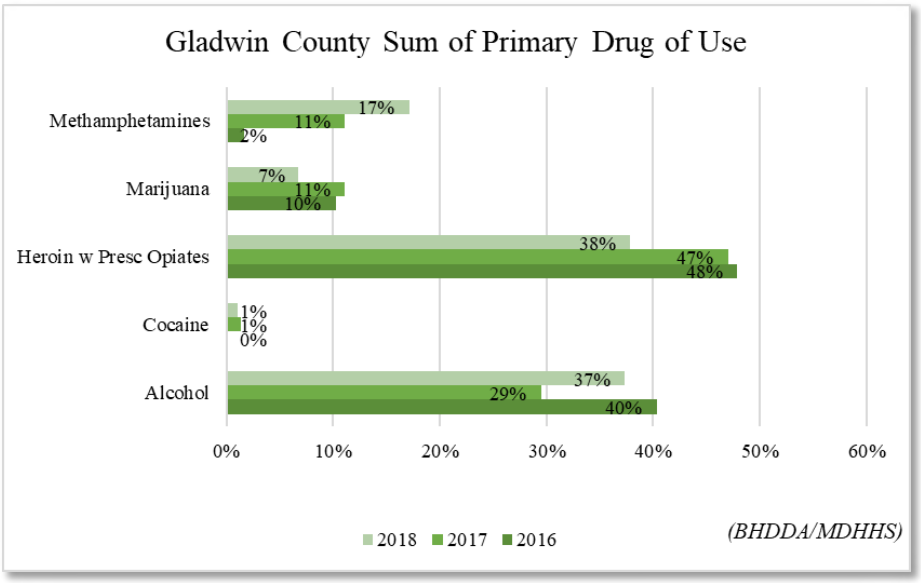


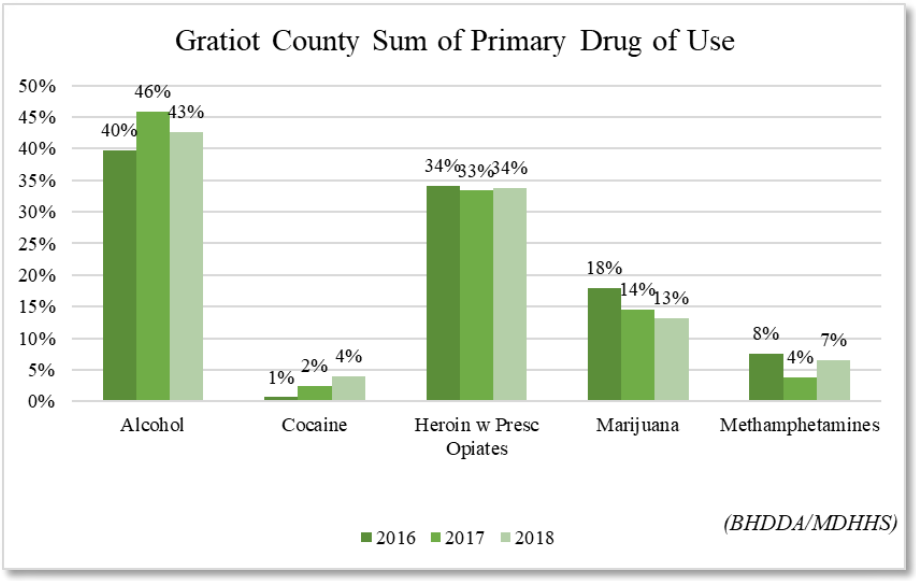


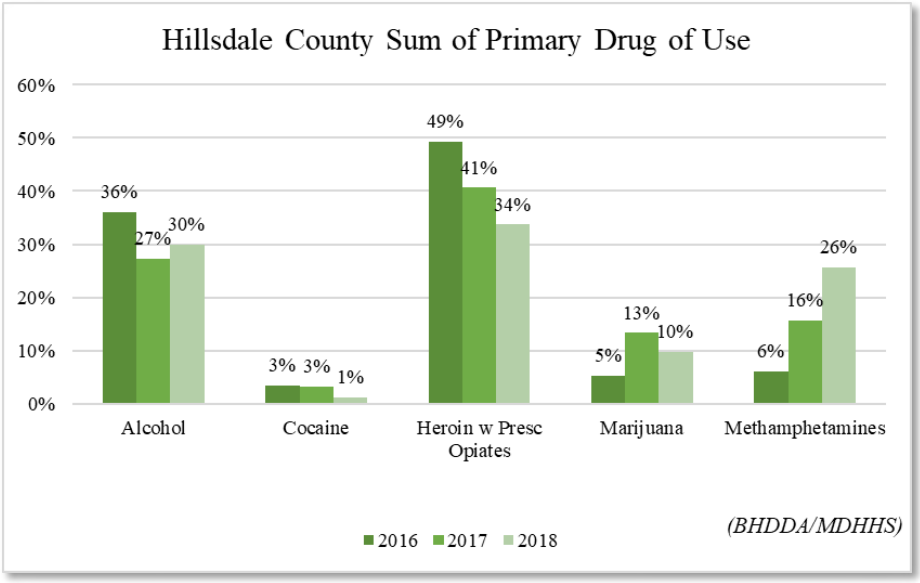

Claire County Sum of Primary Drug of Use
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
40%
32%
39%
1%
2%
3%
35%
39%
33%
13%
10%
7%
10%
18%
17%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

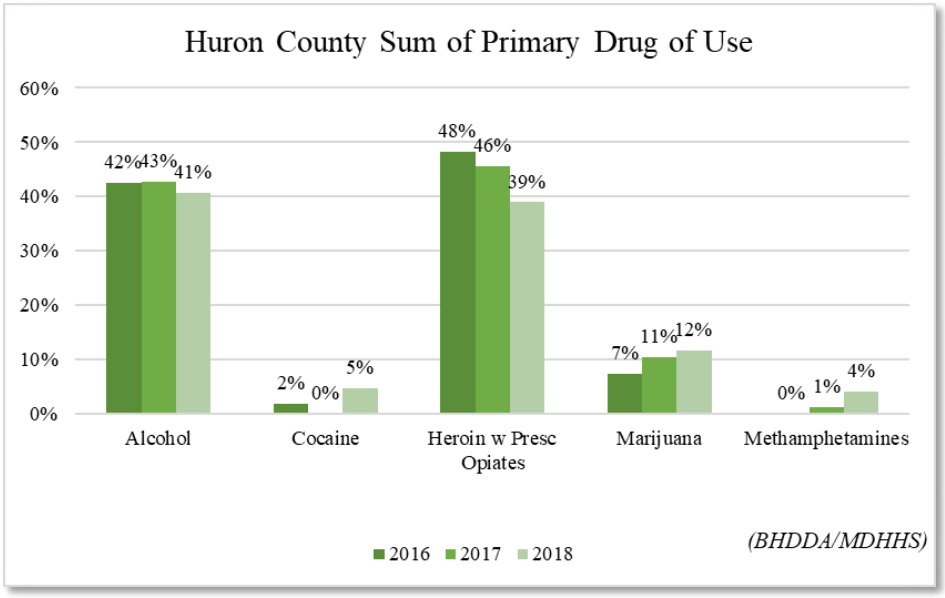

Clinton County Sum of Primary Drug of Use
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
37%
35%
37%
4%
8%
4%
42%
35%
34%
11%
15%
13%
6%
8%
12%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

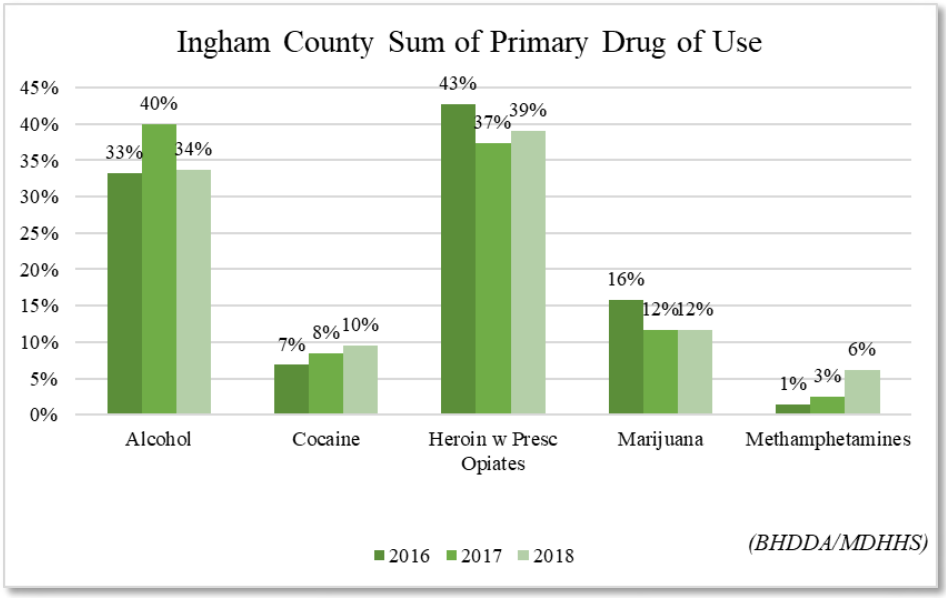

Eaton County Sum of Primary Drug of Use
40%
35%
30%
25%
20%
15%
10%
5%
0%
33%
35%
32%
3%
4%
4%
38%
34%
35%
19%
19%
16%
7%
8%
13%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

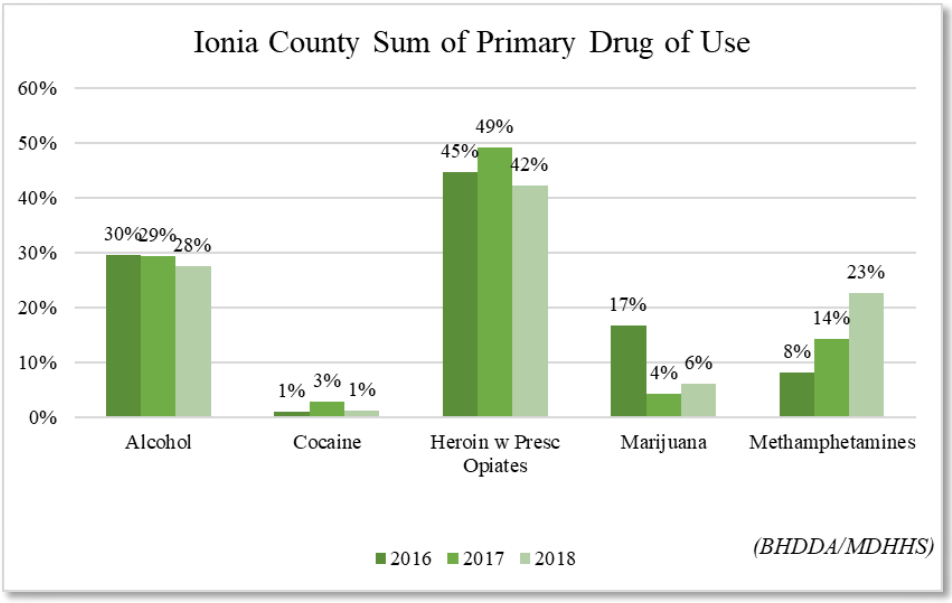

Gladwin County Sum of Primary Drug of Use
Methamphetamines
17%
11%
2%
Marijuana
7%
11%
10%
Heroin w Presc Opiates
38%
47%
48%
Cocaine
1%
1%
0%
Alcohol
37%
29%
40%
0%
10%
20%
30%
40%
50%
60%
2018
2017
2016
(BHDDA/MDHHS)

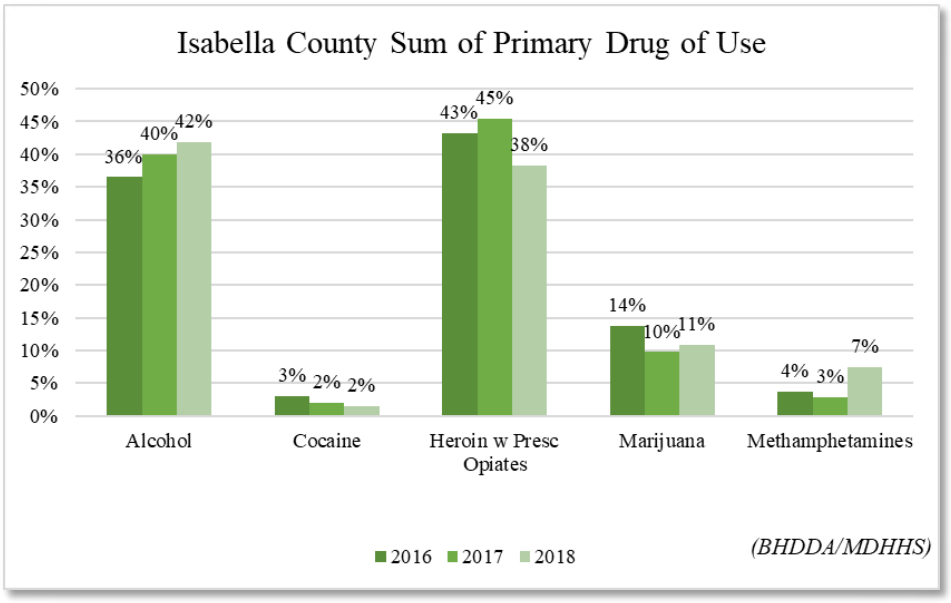

Gratiot County Sum of Primary Drug of Use
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
40%
46%
43%
1%
2%
4%
34%
33%
34%
18%
14%
13%
8%
4%
7%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

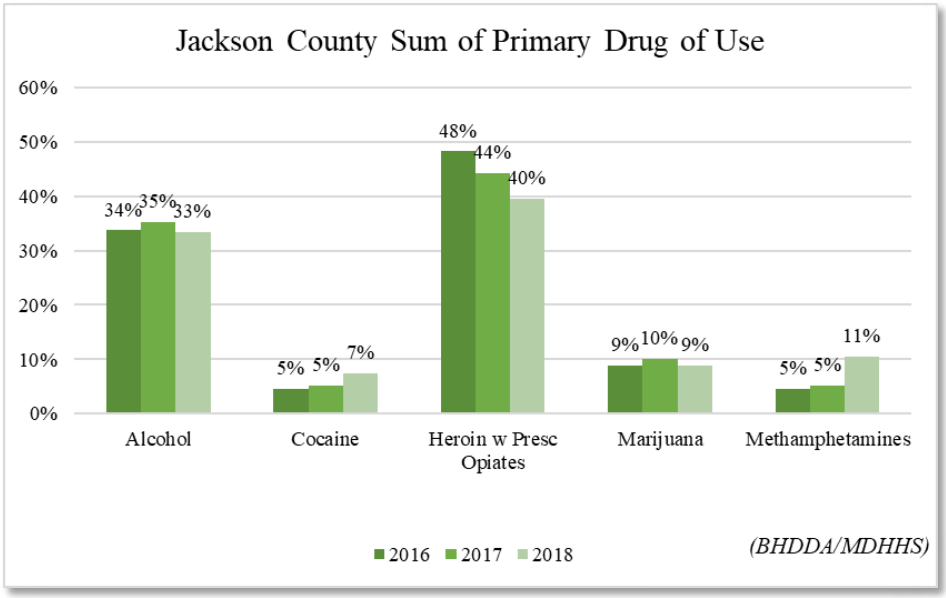

Hillsdale County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
36%
27%
30%
3%
3%
1%
49%
41%
34%
5%
13%
10%
6%
16%
26%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

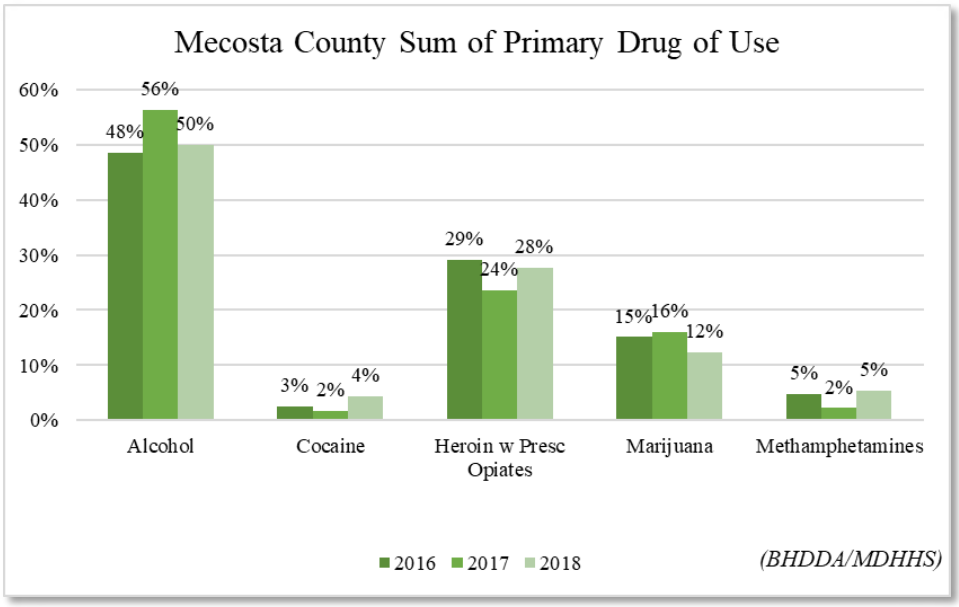

Huron County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
42%
43%
41%
2%
0%
5%
48%
46%
39%
7%
11%
12%
0%
1%
4%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

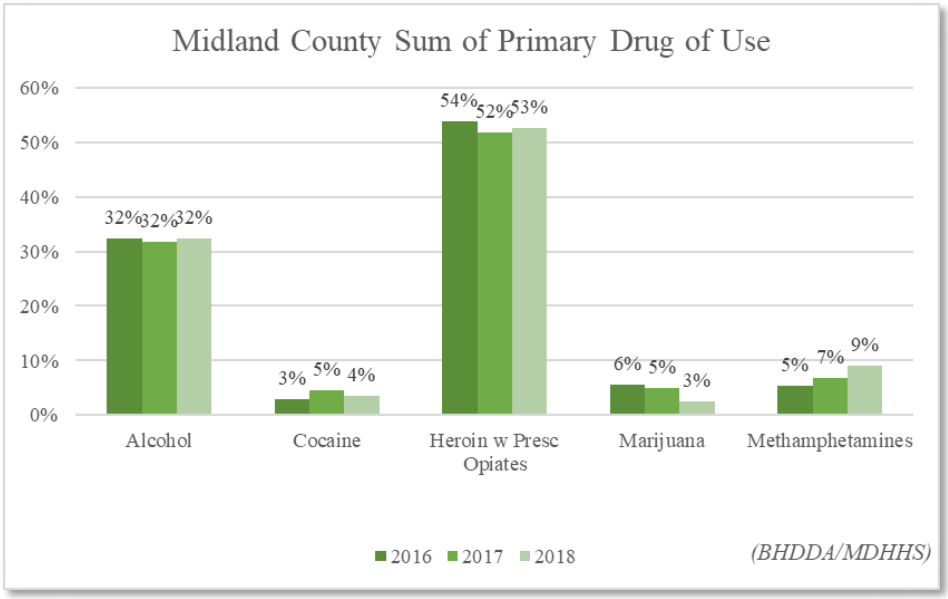

Ingham County Sum of Primary Drug of Use
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
33%
40%
34%
7%
8%
10%
43%
37%
39%
16%
12%
12%
1%
3%
6%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

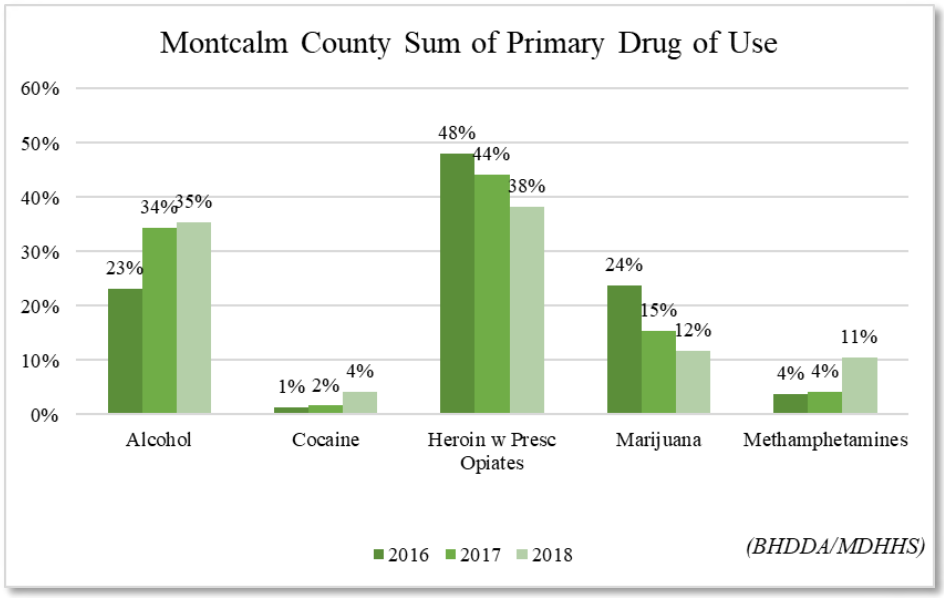

Ionia County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
30%
29%
28%
1%
3%
1%
45%
49%
42%
17%
4%
6%
8%
14%
23%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

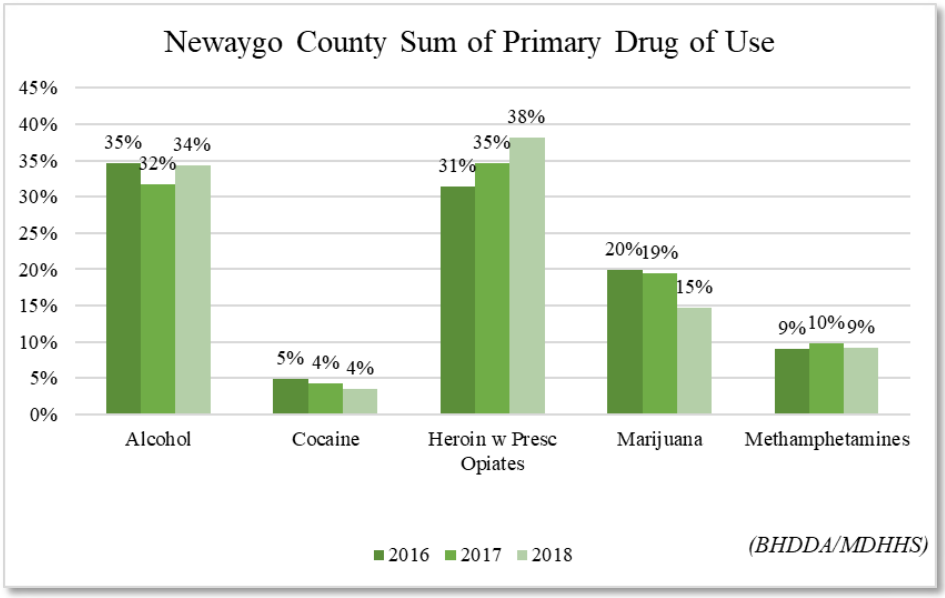

Isabella County Sum of Primary Drug of Use
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
36%
40%
42%
3%
2%
2%
43%
45%
38%
14%
10%
11%
4%
3%
7%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

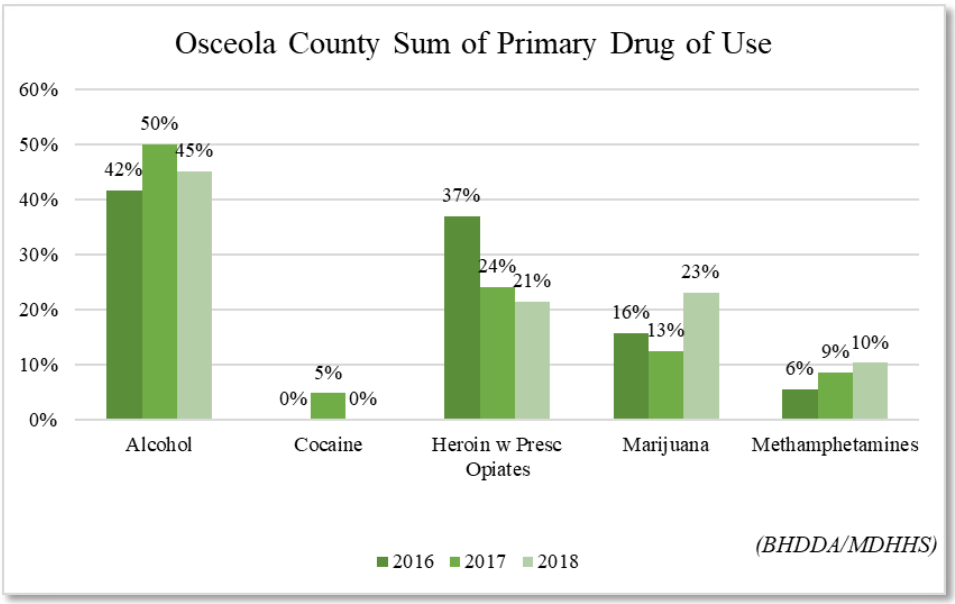

Jackson County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
34%
35%
33%
5%
5%
7%
48%
44%
40%
9%
10%
9%
5%
5%
11%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

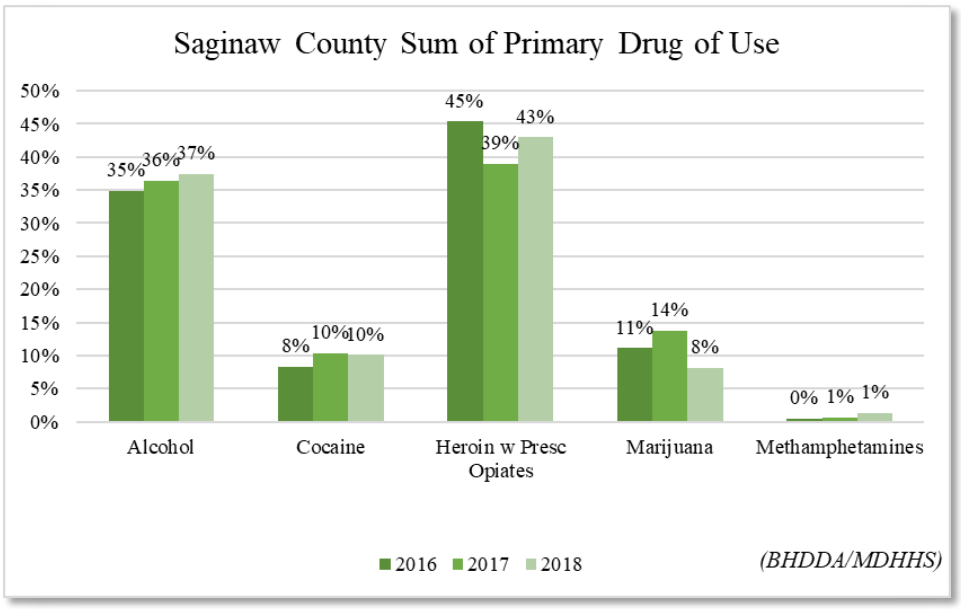

Mecosta County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
48%
56%
50%
3%
2%
4%
29%
24%
28%
15%
16%
12%
5%
2%
5%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

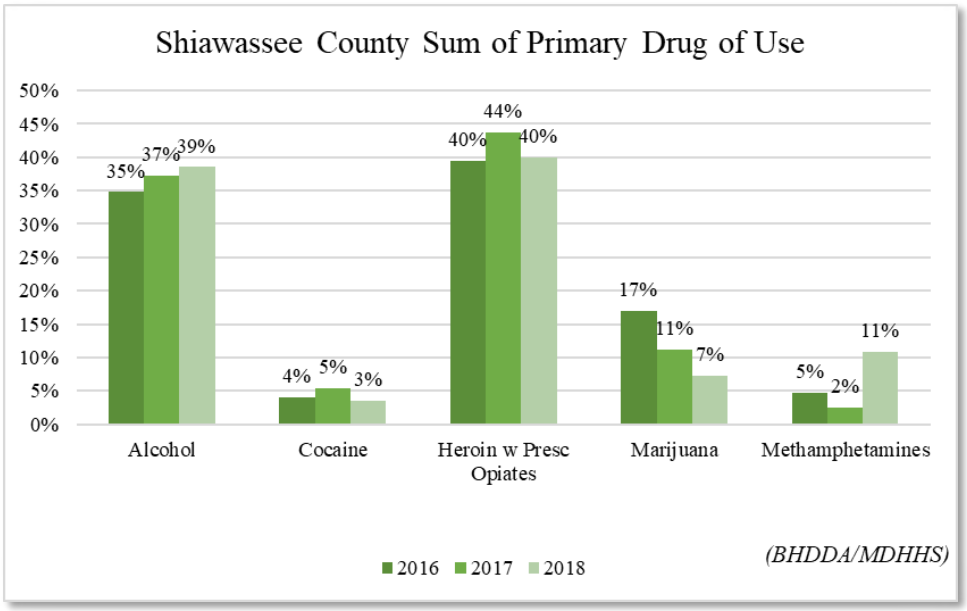

Midland County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
32% 32% 32%
3% 5% 4%
54% 52% 53%
6% 5% 3%
5% 7% 9%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016 2017 2018
(BHDDA/MDHHS)

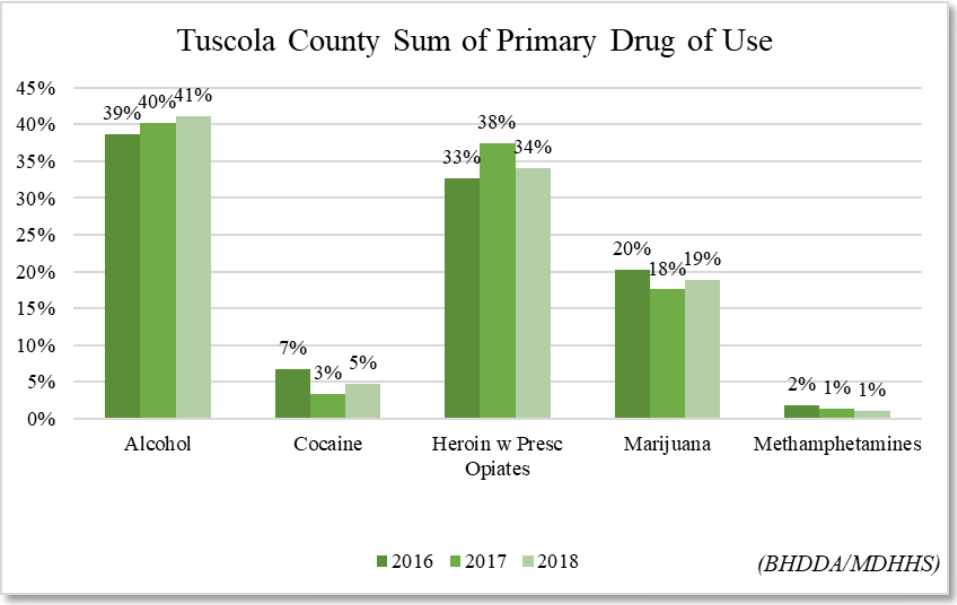

Montcalm County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
23% 34% 35%
1% 2% 4%
48% 44% 38%
24% 15% 12%
4% 4% 11%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016 2017 2018
(BHDDA/MDHHS)


Newaygo County Sum of Primary Drug of Use
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
35%
32%
34%
5%
4%
4%
31%
35%
38%
20%
19%
15%
9%
10%
9%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)


Osceola County Sum of Primary Drug of Use
60%
50%
40%
30%
20%
10%
0%
42%
50%
45%
0%
5%
0%
37%
24%
21%
16%
13%
23%
6%
9%
10%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

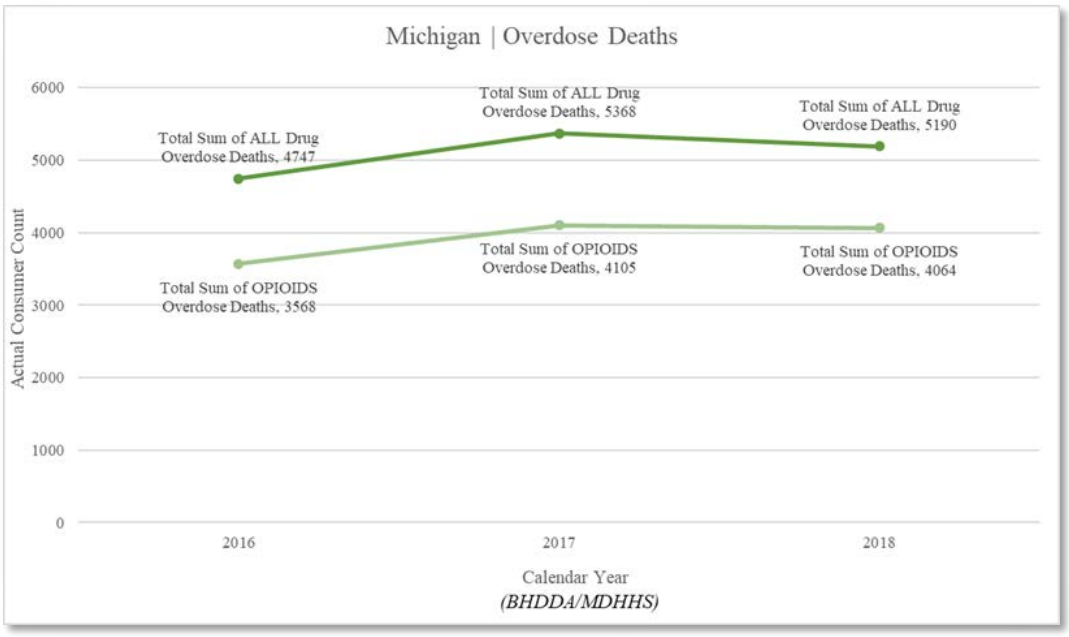

Saginaw County Sum of Primary Drug of Use
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
35%
36%
37%
8%
10%
10%
45%
39%
43%
11%
14%
8%
0%
1%
1%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)


Shiawassee County Sum of Primary Drug of Use
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
35%
37%
39%
4%
5%
3%
40%
44%
40%
17%
11%
7%
5%
2%
11%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

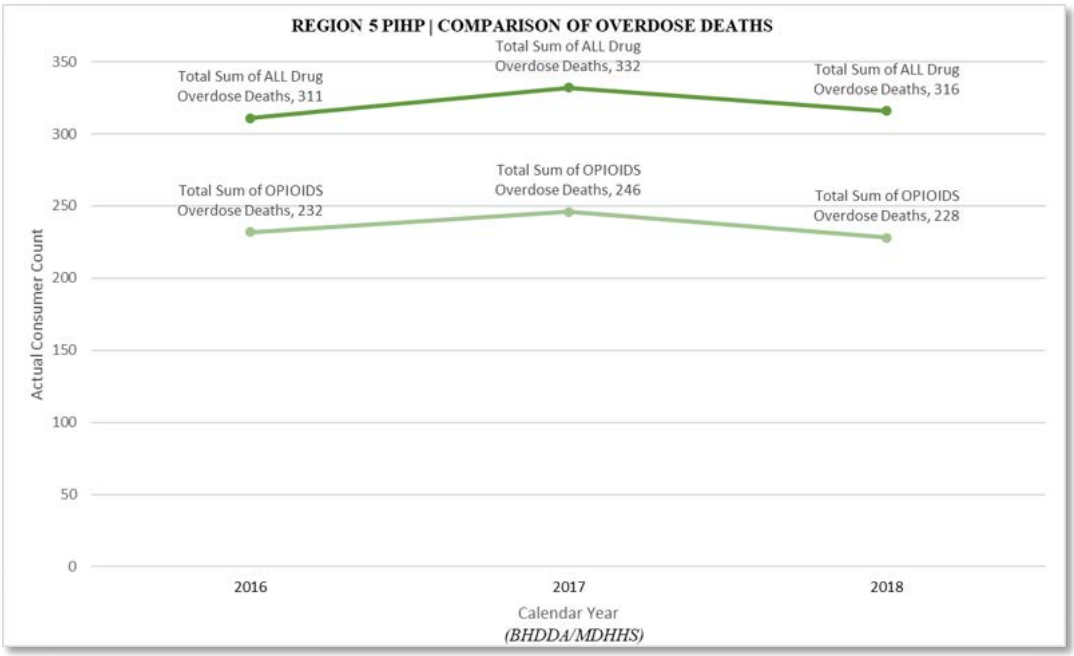

Tuscola County Sum of Primary Drug of Use
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
39%
40%
41%
7%
3%
5%
33%
38%
34%
20%
18%
19%
2%
1%
1%
Alcohol
Cocaine
Heroin w Presc Opiates
Marijuana
Methamphetamines
2016
2017
2018
(BHDDA/MDHHS)

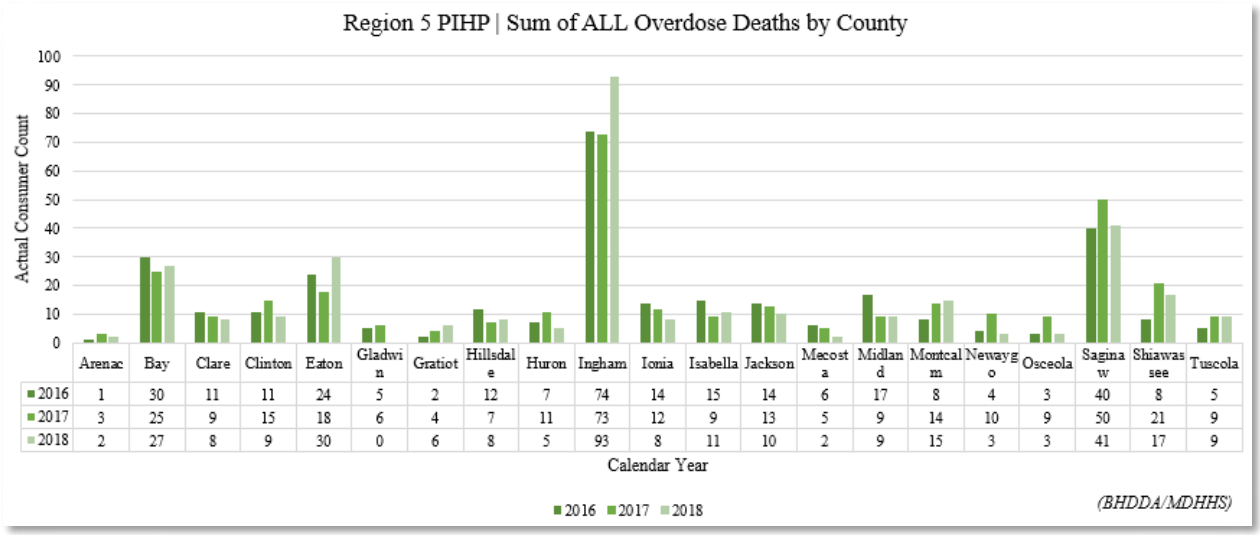
Appendix 16. Mortality and Overdose Rates, Statewide, Region, County

Statewide

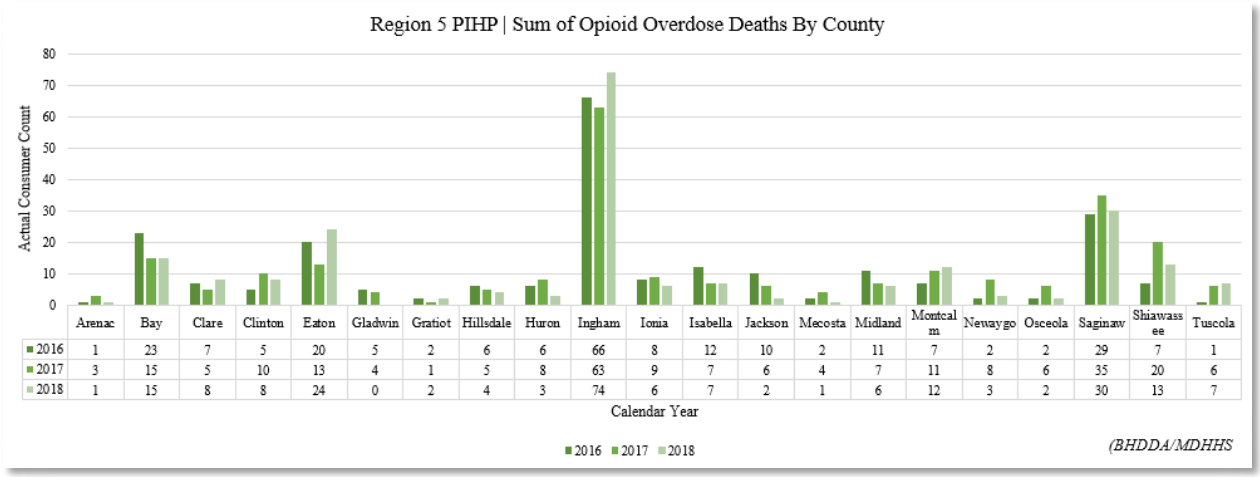


Region 5 PIHP

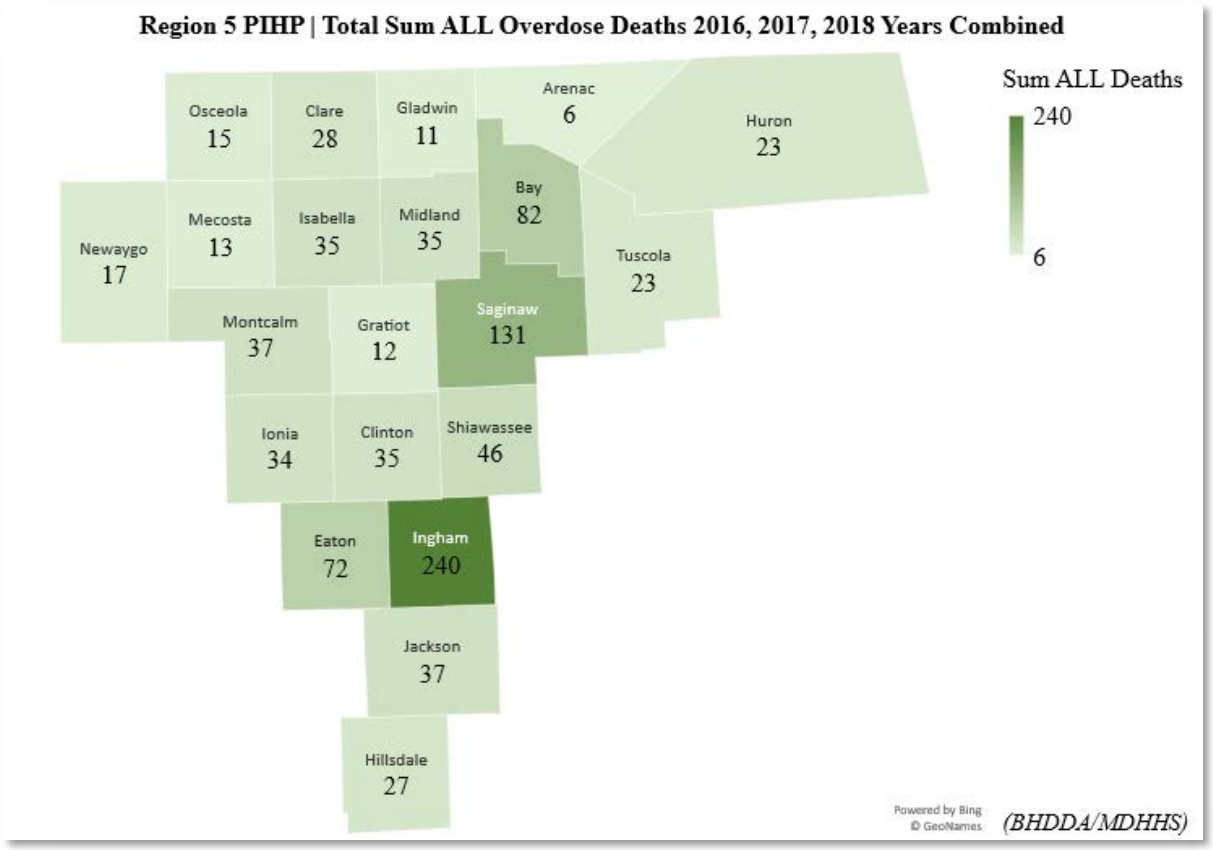




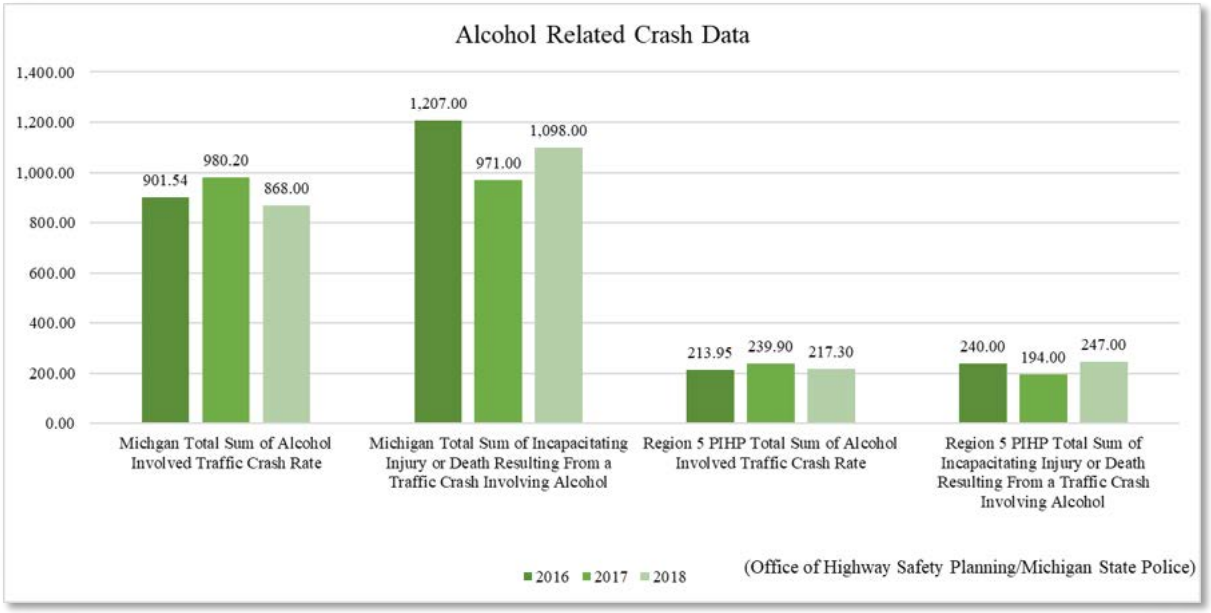
	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Osceola	Saginaw	Shiawassee	Tuscola
2016	1	30	11	11	24	5	2	12	7	74	14	15	14	6	17	8	4	3	40	8	5
2017	3	25	9	15	18	6	4	7	11	73	12	9	13	5	9	14	10	9	50	21	9
2018	2	27	8	9	30	0	6	8	5	93	8	11	10	2	9	15	3	3	41	17	9

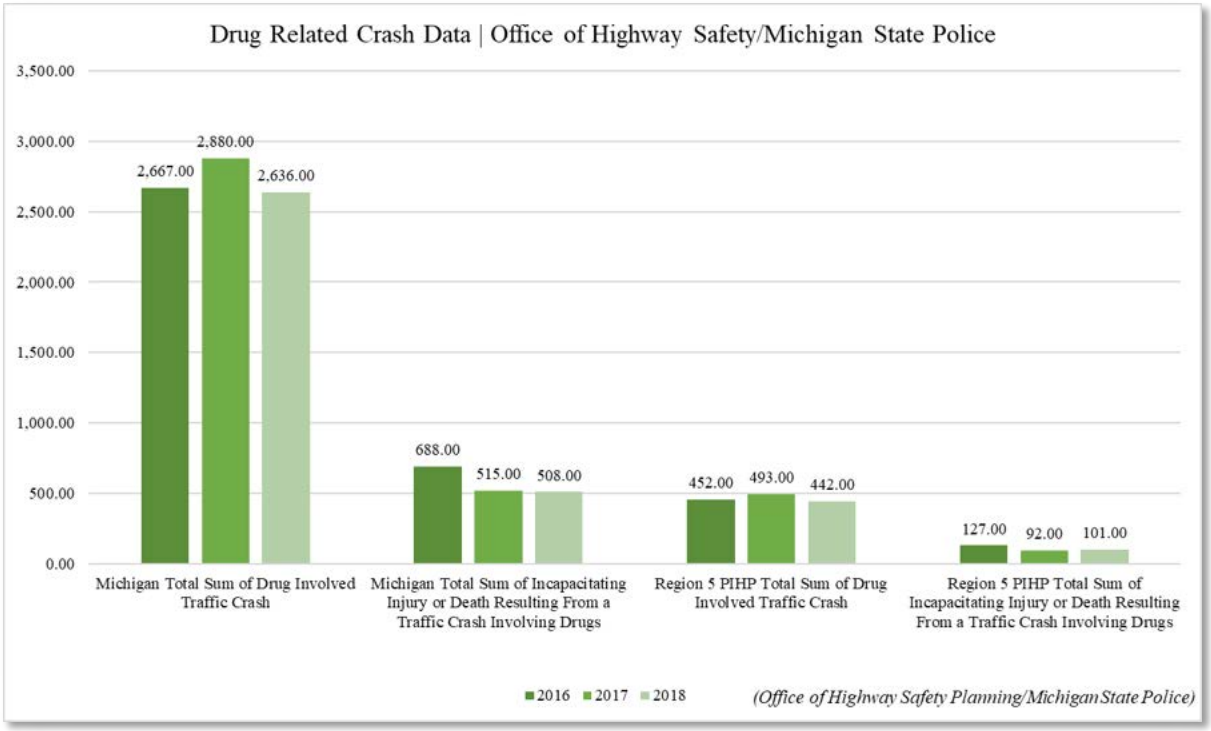


	Arenac	Bay	Clare	Clinton	Eaton	Gladwin	Gratiot	Hillsdale	Huron	Ingham	Ionia	Isabella	Jackson	Mecosta	Midland	Montcalm	Newaygo	Osceola	Saginaw	Shiawassee	Tuscola
2016	1	23	7	5	20	5	2	6	6	66	8	12	10	2	11	7	2	2	29	7	1
2017	3	15	5	10	13	4	1	5	8	63	9	7	6	4	7	11	8	6	35	20	6
2018	1	15	8	8	24	0	2	4	3	74	6	7	2	1	6	12	3	2	30	13	7

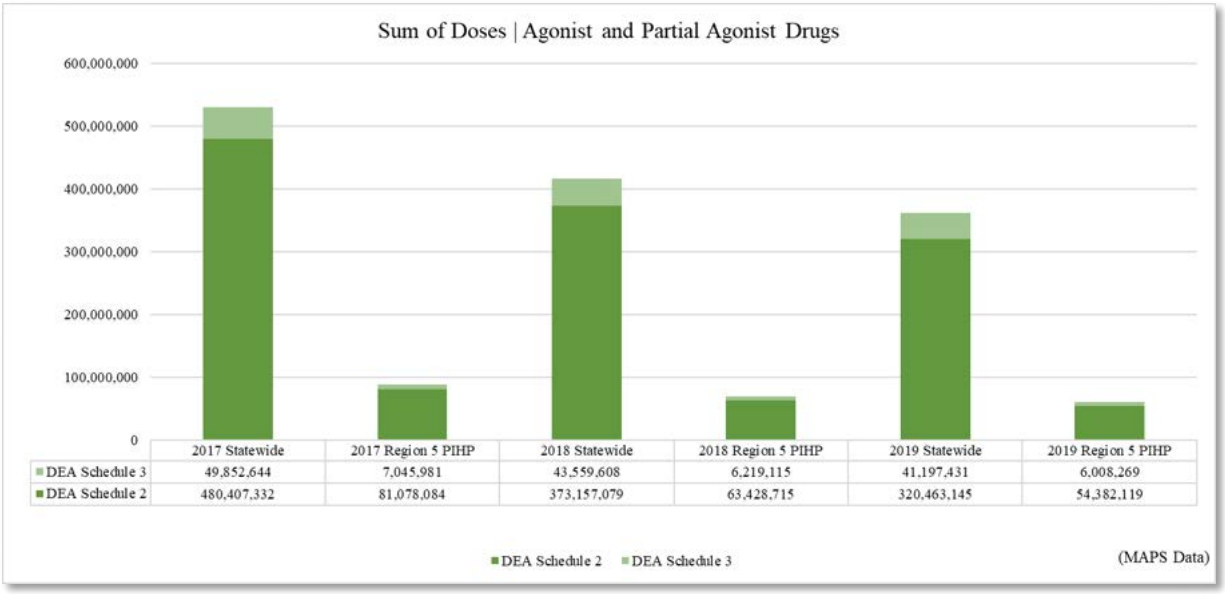

Region 5 PIHP | Total Sum ALL Overdose Deaths 2016, 2017, 2018 Years Combined
Sum ALL Deaths
240
6
Osceola 15
Clare 28
Gladwin 11
Arenac 6
Huron 23
Bay 82
Newaygo 17
Mecosta 13
Isabella 35
Midland 35
Tuscola 23
Saginaw 131
Montcalm 37
Gratiot 12
Ionia 34
Clinton 35
Shiawassee 46
Eaton 72
Ingham 240
Jackson 37
Hillsdale 27
Powered by Bing
© GeoNames
(BHDDA/MDHHS)

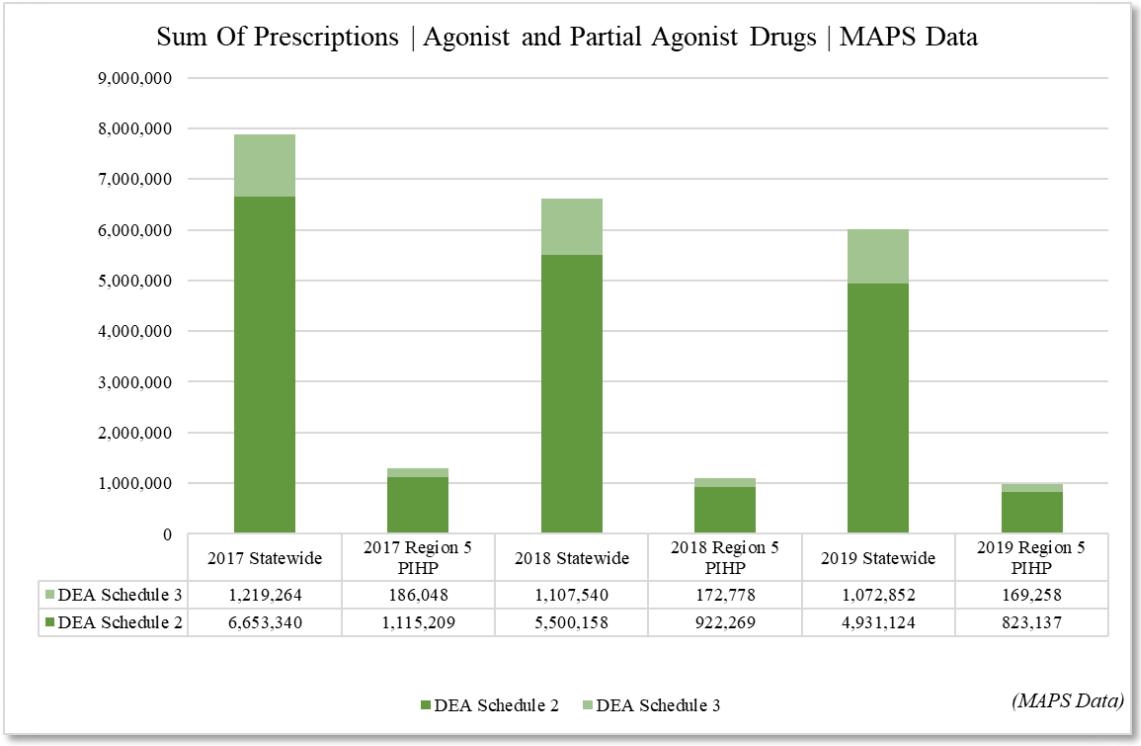
Appendix 17. Alcohol and Drug Related Traffic Mortality



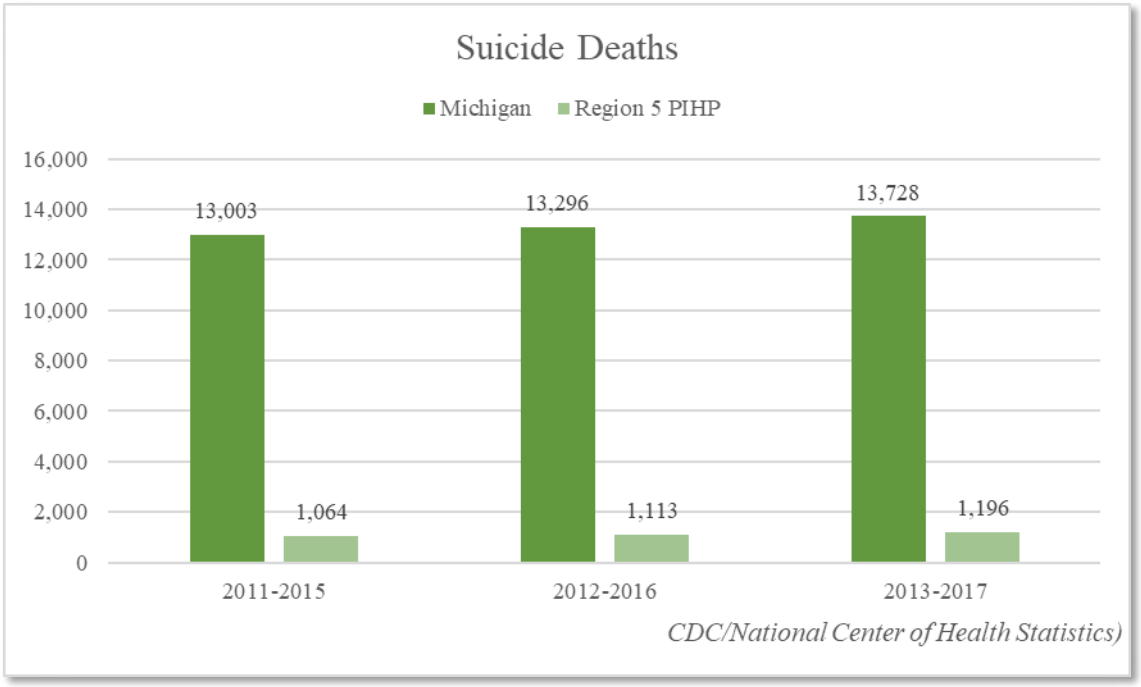


Appendix 18. Prescription Doses

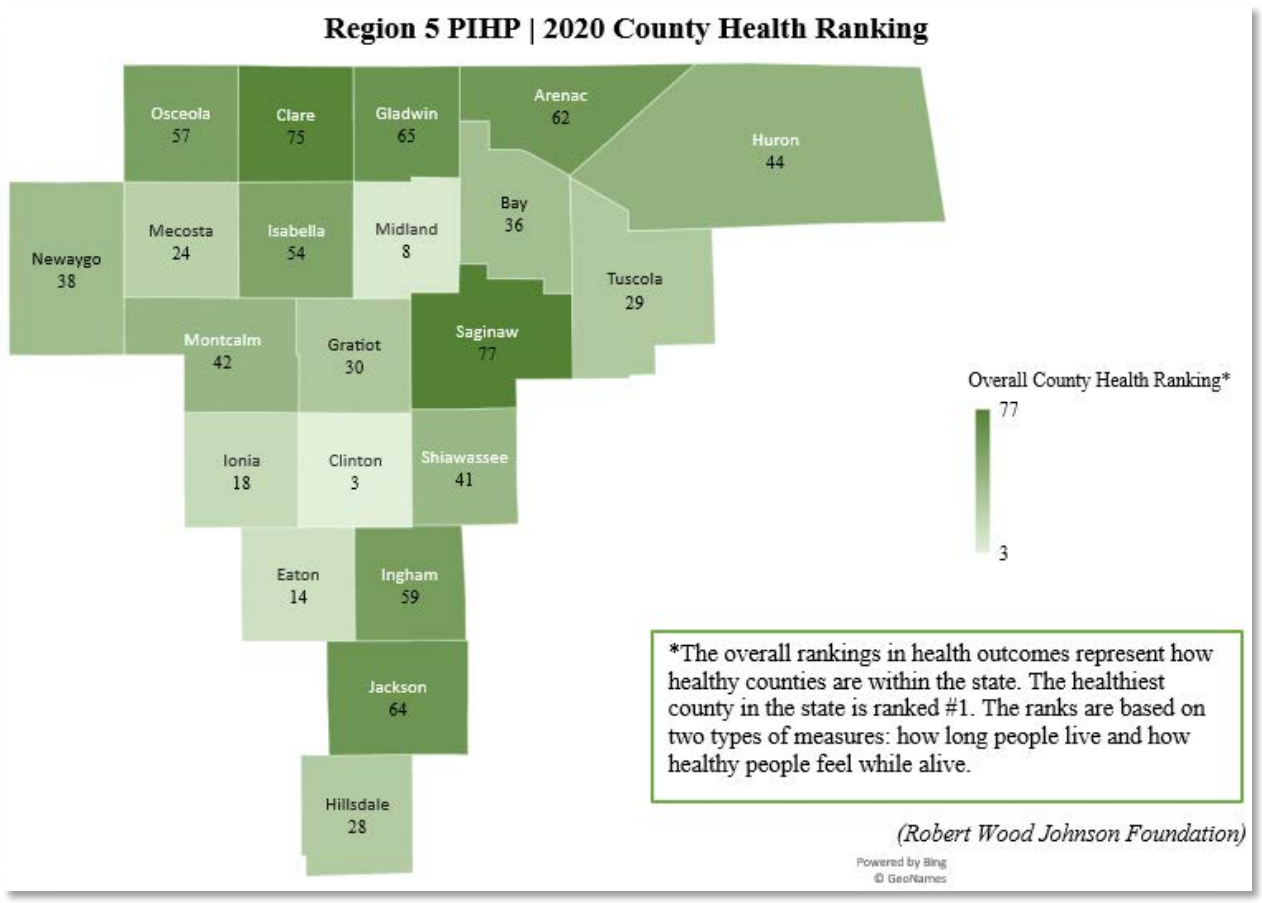




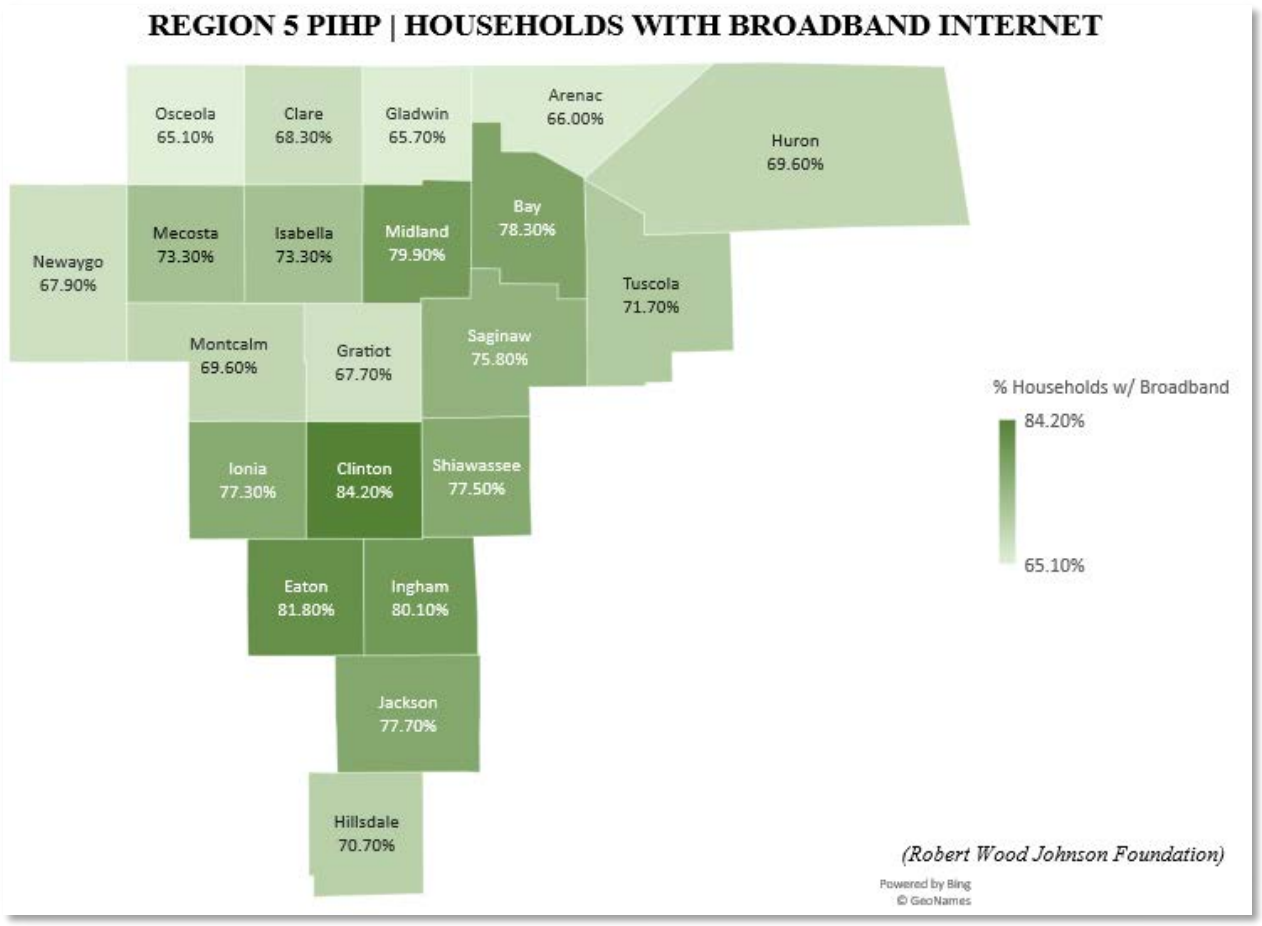
Appendix 19. Adult Suicide



Appendix 20. County Health Ranking



Appendix 21. Availability of Broadband Internet



Appendix 22 Oversight Policy Board June 2020 Packet

(Click HERE for link to Full Document)

MSHN
Mid-State Health Network

Substance Use Disorder (SUD)
Oversight Policy Advisory Board Meeting
June 17, 2020 ~ 4:00 p.m. via Zoom Video Conferencing

For Meeting Participation:
To Join the Meeting Using Your Computer:
Link: https://us02web.zoom.us/j/5624476175; **Meeting ID:** 562 447 6175
Join Using Your Phone: Dial: 1.312.626.6799; **Meeting ID**: 562 447 6175

Meeting Agenda

1) Call to Order
2) Roll Call
3) ACTION ITEM: Approval of the Agenda for June 17, 2020
4) ACTION ITEM: Approval of Minutes of February 19, 2020 (Item 4)
5) Public Comment
6) Board Chair Report
7) ACTION ITEM: Approval of FY 2021 Board Meeting Calendar (Item 7)
8) Deputy Director Report
   A. FY2020PA2 Funding & Expenditures by County (Items 8A1/8A2)
   B. FY2020 PA2 Use of Funds by County and Provider (Item 8B)
   C. FY2020 SUD Financial Summary Report of April 2020 (Item 8C)
   D. MSHN COVID-19 Update
9) ACTION ITEM: FY20 Substance Use Disorder PA2 Contract Listing (Item 9)
10) Operating Update
   A. Chief Clinical Officer Update
      i) Quarterly Treatment and Prevention Activities (Fiscal Year 2020 1st and 2nd Quarter Narratives) (Items 10-1 and 10-2)
         (1) County-Specific Reports Provided Separately
      ii) Operational Update
         (1) Three-Year Strategic Plan Feedback
         (2) Other Updates
11) Other Business
12) Public Comment
13) Board Member Comment
14) Adjournment

MSHN

SUBSTANCE USE DISORDER
OVERSIGHT POLICY ADVISORY
BOARD OF DIRECTORS
Chair: Deb Thalison
Vice-Chair: John Hunter
Secretary: Bruce Caswell

JUNE 17, 2020
VIDEO CONFERENCE PARTICIPATION:
https://us02web.zoom.us/j/5624476175
MEETING ID: 562 447 6175

TELEPHONE PARTICIPATION:
DIAL: 1.312.626.6799;
MEETING ID: 562 447 6175

UPCOMING FY20
BOARD MEETINGS
August 19, 2020:
(Location To be Determined)

FY21 Board Meeting Dates Will Be Announced By September 1, 2020

MSHN Board Approved Policies May be Found at:
http://www.midstatehealthnetwork.org/policies/

Please direct questions and/or concerns pertaining to MSHN's SUD Oversight Policy Advisory Board to Merre Ashley, Executive Assistant, at 517.253.8203

Mid-State Health Network | 530 W. Ionia Street, Ste. F | Lansing, MI 48933 | P: 517.253.7525 | F: 517.253.7552

Mid-State Health Network SUD Oversight Policy Advisory Board
Wednesday, February 19, 2020, 4:00 p.m.
CMH Association of Michigan (CMHAM)

Meeting Minutes

1. Call to Order

Chairperson Debbie Thalison called the MSHN SUD Regional Oversight Policy Board of Directors Organizational Meeting to order at 4:01 p.m.

Board Member(s) Present: Lisa Ashley (Gladwin), Nichole Badour (Gratiot) (via phone), Bruce Caswell (Hillsdale), Steve Glaser (Midland), Dick Gromaski (Bay) (via phone), Susan Guernsey (Mecosta) (via phone), Christina Harrington (Saginaw) (via phone), John Hunter (Tuscola), Jerry Jaloszynski (Isabella), Carol Koenig (Ingham), Bryan Kolk (Newaygo), Tom Lindeman (Montcalm), Robert Luce (Arenac) (via phone), Vicky Schultz (Shiawassee), Leonard Strouse (Clare), Deb Thalison (Ionia), Dwight Washington (Clinton), and Ed Woods (Jackson)(via phone)

Board Member(s) Absent: John Bodis (Huron), Larry Emig (Osceola), and Kim Thalison (Eaton)

Alternate Members Present: John Kroneck (Montcalm)

Staff Members Present: Amanda Horgan (Deputy Director), Dr. Dani Meier (Chief Clinical Officer), Carolyn Watters (Director of Provider Network Management Systems), Dr. Trisha Thrush (Lead Treatment Specialist), Jill Worden (Lead Prevention Specialist) (via phone), and Merre Ashley (Executive Assistant)

2. Roll Call

   Secretary Bruce Caswell provided the Roll Call for Board Attendance.

3. Approval of Agenda for February 19, 2020

   Board approval was requested for the Agenda of the February 19, 2020 Regular Business Meeting, as presented.

ROPB 19-20-007 MOTION BY BRYAN KOLK, SUPPORTED BY JOHN HUNTER, FOR APPROVAL OF THE AGENDA OF THE FEBRUARY 19, 2020, REGULAR BUSINESS MEETING, AS PRESENTED. MOTION CARRIED: 16-0.

4. Approval of Minutes from the December 18, 2019 Regular Business Meeting
   Board approval was requested for the draft meeting minutes of the December 18, 2019 Regular Business Meeting.

ROPB 19-20-008 MOTION BY JOHN HUNTER, SUPPORTED BY JERRY JALOSZYNSKI, FOR APPROVAL OF THE MINUTES OF THE DECEMBER 16, 2019 MEETING, AS PRESENTED. MOTION CARRIED: 16-0.

5. Public Comment

   There was no public comment.

6. Board Chair Report

   Chairperson Thalison welcomed board members to the annual organizational meeting, advising no officer elections were slated to occur due to bylaws specification of 2-year terms. She voiced her appreciation to members for their commitment and service to the board and also thanked MSHN staff for their time, efforts and support.

Ms. Carol Keonig (Ingham County) arrived at 4:10 p.m.

Ms. Susan Guernsey (Mecosta County) joined via teleconference at 4:12 p.m.

7. Deputy Director Report

Ms. Horgan thanked Ms. Thalison for her willingness to serve as Chair through 2020 and to all members for their continued support and service to the region.

Ms. Horgan provided an overview of the following information:

- FY2020 PA2 Funding and Expenditures by County
- FY2020 PA2 Use of Funds by County and Provider, as of December 31, 2019
- FY2019 SUD Financial Summary Report, as of December 2019

8. FY20 Substance Use Disorder (SUD) Public Act 2 (PA2) Requests/Contract listing

Ms. Carolyn Watters drew attention to county-specific reports of PA2 Funding Requests, provided in hardcopy in each member's meeting folder, and gave background and historical information which led to implementation and inclusion of the new reporting. Following her overview of the information/data elements, members were encouraged to provide feedback to guide generation and continued reporting.

Ms. Watters referenced and provided an overview of the contract listing, recommended for board approval, as presented.

ROBP 19-20-009 MOTION BY STEVE GLASER, SUPPORTED BY JOHN HUNTER, TO APPROVE THE FY20 SUD CONTRACT LISTING, AS PRESENTED. MOTION CARRIED: 18-0.

9. Operating Update

Dr. Dani Meier provided information and reporting on the following:

- Treatment and Prevention Activities: FY19 4th Quarter Report
  - Referencing data provided in the table on page 19, which displayed numbers specific to engagement, retention and completion of treatment, members were advised the figures focus on two (2) out of eleven (11) Discharge Reason Codes; *Completion of Treatment* and *Continuing in Treatment/Transfer*
- County-Specific Quarterly Treatment and Prevention Activity Reports
  - Hardcopy provided in board folders onsite
  - Members participation via teleconference will receive their count-specific reports via email following the meeting

- Operational Update
  - Services and Programs Evolving:
    - Certified Peer Support Specialists: Peers in the Community
    - Local/Community Prevention Related Trainings
      - Prevention Activity: Consists of 2 Tiers; County Coalitions and Providers. County Coalitions focus mainly on community and environmental-based strategies (i.e. population health strategies). Providers within communities focus and provide direct services to families and children, dependent on the specific needs of the community
      - For a list of activities within your county, contact the chairperson of your local county coalition. Contact MSHN's prevention team if direction/information is needed
  - Mobile Care Unit:
    - Continues to serve 3-days per week in Eaton County
    - MSHN continues to develop additional supports within Eaton county. The Mobile Care Unit will remain in Eaton County until the provider is operational.
    - Recent visits by the Mobile Care Unit have occurred in Arenac and Gladwin Counties. The intent is to extend those visits as well as add visits/stays in other counties within Region 5 which are underserved.
    - Mobile Care Unit link to be available from the MSHN website within the next few months, which will provide dates and locations of the unit. Updates and information will be relayed via MSHN's SUD Provider Update, released weekly on Monday afternoons.
  - Grant Funded Trainings:
    - Grant funds are being utilized to assist providers to attend both state and national conferences

- Grant funds being used to provide training on evidence-based practices and programs
- All trainings are listed in MSHN's weekly SUD Provider Update. Listings include dates/locations and other specifics

  - MDOC-MDHHS-PIHP Contract Update:
    - MSHN/MDHHS contract has been executed that includes services under MDOC, effective April 1, 2020.
    - Current focus is developing consistent regional and state-wide practices

10. Other Business

- Chairperson Thalison announced this week (Thursday) is opening day for Ionia County Health Department's syringe services program
  - Program will be open weekly; every Thursday, from 10am-4pm
  - Appreciation voiced to The Red Project for being such wonderful partners, and to MSHN for their work/support to get the program up and running
- Mr. John Kroneck informed of the Recovery Symposium on Saturday, February 22; open to all and booths available

11. Public Comment
    There was no public comment

12. Board Member Comment

- Intergovernmental Agreement: Mr. Bryan Kolk inquired whether fully executed copies of the Intergovernmental Agreement had been distributed to counties. MSHN's Executive Assistant confirmed the document had not yet been distributed throughout the region, but county clerks/commissions could expect to see that come through prior to the April meeting of the SUD Oversight Policy Board.
- Alternative School(s) for Addicted Youth: Mr. Bruce Caswell reported on information gleaned while attending the CMHAM Winter Conference pertaining to an Alternative/Drug Rehabilitation High School which exists in southeast Michigan. Discussion around the use of PA2 dollars to fund a school within Hillsdale County/the

MSHN region ensued. Ms. Carol Koenig offered meaningful insight and information specific to the workings and funding of Ingham Academy in Lansing, a day treatment program for court-adjudicated youth, operated by Ingham County Circuit Court, Ingham Intermediate School District and Highfields. Ms. Koenig offered to assist Mr. Caswell/others who may be interested with arranging a tour of Ingham County Academy's campus and encouraged Mr. Caswell/others to visit the website, at https://www.inghamisd.org/ouracademics/highschoolprograms/inghamacademy/

13. Adjournment

Chairperson Thalison adjourned the February 19, 2020, MSHN SUD Oversight Policy Advisory Board Meeting at 5:11 p.m.

Meeting minutes submitted respectfully by:
MSHN Executive Assistant

Substance Use Disorder (SUD) Oversight Policy Advisory Board of Directors

Fiscal Year 2021 *Tentative* Board Meeting Calendar

***ALL* SUD Oversight Policy Advisory Board Meetings:**
Meeting Time: 4:00-5:30 P.M. Unless Otherwise Noted
Meeting Location: To Be Determined

Date	Meeting
Wednesday, October 14, 2020	Regular Business Meeting
Wednesday, December 16, 2020	Regular Business Meeting
Wednesday, February 10, 2021	Annual Organizational Meeting
Wednesday, April 14, 2021	Regular Business Meeting
Wednesday, June 9, 2021	Regular Business Meeting
Wednesday, August 11, 2021	Regular Business Meeting
Meeting Location to be Determined Following Board Approval of the Meeting Calendar	

Prepared June 1, 2020: All Dates are Tentative

Please direct questions and/or concerns pertaining to the MSHN's SUD Oversight Policy Advisory Board to Merre Ashley, Executive Assistant, at 517.253.8203

Mid-State Health Network | 530 W. Ionia Street, Suite F | Lansing, MI | 48933 | Phone: 517.253.7525 | Fax: 517.253.7552

Mid-State Health Network
FY2020 PA2 Funding Summary by County

County	Beginning PA2 Fund Balance	Payment Amount	Date Received	Payment Amount	Date Received	Payment Amount	Date Received	Total Amount Anticipated	Total Amount Received	Beginning PA2 Fund Balance and Receipts
Arenac	130,020	17,822	05.13.20					35,878	17,822	147,842
Bay	1,214,640	102,715	05.14.20					203,737	102,715	1,317,355
Clare	261,055	25,591						50,768	25,591	286,646
Clinton	544,518	61,007						119,636	61,007	605,524
Eaton	644,943	118,513						234,942	118,513	763,456
Gladwin	72,734	19,673						39,217	19,673	92,407
Gratiot	130,253	23,568						46,749	23,568	153,821
Hillsdale	108,133	26,788						55,935	26,788	134,920
Huron	252,048	32,449						67,899	32,449	284,497
Ingham	860,238	349,362						680,857	349,362	1,209,600
Ionia	462,471	37,199						73,232	37,199	499,670
Isabella	778,557	71,923						148,149	71,923	850,480
Jackson	899,037	164,737						323,869	164,737	1,063,773
Mecosta	448,568	45,233						90,004	45,233	493,801
Midland	539,613	74,340						149,096	74,340	613,952
Montcalm	343,565	51,293						102,924	51,293	394,857
Newaygo	140,352	39,518						74,206	39,518	179,870
Osceola	154,092	15,585						31,051	15,585	169,676
Saginaw	2,707,777	235,836						471,346	235,836	2,943,613
Shiawassee	638,986	50,438						100,734	50,438	689,424
Tuscola	340,464	27,342						53,308	27,342	367,806
	$ 11,672,063	$ 1,590,927		$ -		$ -		$ 3,153,534	$ 1,590,927	$ 13,262,990

Mid-State Health Network
FY2020 PA2 Expenditure Summary by County

County	Beginning PA2 Fund balance and Receipts	County Code	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD Payments	Ending PA2 Fund Balance
Arenac	147,842	06	3,407	21,290	1,078	5,329	4,267	3,441	4,866						42,877	$ 104,965
Bay	1,317,355	09	20,971	29,416	22,614	25,895	35,767	38,065	27,883						200,612	$ 1,116,743
Clare	286,646	18	9,855	8,175	9,672	10,349	9,462	9,017	6,325						62,855	$ 223,791
Clinton	605,524	19	24,056	19,816	20,039	24,864	17,706	14,954	13,692						135,127	$ 470,398
Eaton	763,456	23	22,693	22,431	23,913	25,663	21,830	26,071	19,313						162,014	$ 601,442
Gladwin	92,407	26	2,607	2,697	2,513	3,164	2,409	2,286	1,871						17,647	$ 74,760
Gratiot	153,821	29	3,917	4,394	5,793	9,014	5,193	5,229	4,375						37,914	$ 115,907
Hillsdale	134,920	30	6,969	3,164	3,182	2,920	2,845	4,027	1,228						23,533	$ 111,387
Huron	284,497	32	5,902	9,313	6,848	6,809	7,701	12,103	4,357						53,034	$ 231,463
Ingham	1,209,600	33	52,826	52,672	49,882	51,157	53,056	50,622	45,018						355,233	$ 854,367
Ionia	499,670	34	4,700	7,140	5,715	12,161	5,883	3,698	4,784						44,081	$ 455,589
Isabella	850,480	37	28,840	17,156	22,096	20,431	16,477	22,638	15,708						143,345	$ 707,135
Jackson	1,063,773	38	40,221	47,088	48,837	46,077	55,636	56,030	27,471						321,361	$ 742,413
Mecosta	493,801	54	24,220	8,770	19,606	14,320	10,326	9,949	6,847						93,238	$ 400,563
Midland	613,952	56	11,700	11,723	9,442	14,507	18,394	11,264	13,823						90,853	$ 523,099
Montcalm	394,857	59	2,520	3,856	2,316	1,811	3,330	1,216	6,518						20,768	$ 374,090
Newaygo	179,870	62	6,039	6,206	4,044	10,295	5,822	7,990	5,878						46,474	$ 133,396
Osceola	169,676	67	2,466	2,158	2,970	3,595	3,117	2,624	1,364						18,295	$ 151,381
Saginaw	2,943,613	73	63,819	57,152	54,839	88,726	81,848	114,404	110,637						571,524	$ 2,372,088
Shiawassee	689,424	78	7,416	38,946	10,956	26,762	9,434	14,769	7,336						115,618	$ 573,805
Tuscola	367,806	79	14,000	16,722	11,354	12,920	13,899	11,827	7,285						88,107	$ 279,699
	$ 13,262,990		$ 359,144	$ 389,483	$ 337,708	$ 416,771	$ 394,003	$ 422,223	$ 325,178	$ -	$ -	$ -	$ -	$ -	2,644,509	$ 10,618,481

Item 8B

Mid-State Health Network
Summary of PA2 Use of Funds by County and Provider
October 1, 2019 through April 30, 2020

County and Provider	Case Management	Early Intervention	Outpatient	Prevention	PFS 2015-2020	Recovery Support	STR Grant	Grand Total
Arenac								
Peer 360 Recovery						26,559		26,559
Sterling Area Health Center				16,318				16,318
Arenac Total				**16,318**		**26,559**		**42,877**
Bay								
Bay Arenac Behavioral Health					1,435			1,435
Boys and Girls Club Bay Region				15,084				15,084
Families Against Narcotics Great Lakes Bay Region				774				774
Lint Psychological Services			291	665				956
McLaren Bay Region Neighborhood Resource Center				92,808				92,808
Peer 360 Recovery						70,084		70,084
Sacred Heart Rehabilitation		3,678		11,052				14,730
Sterling Area Health Center				4,742				4,742
Bay Total		**3,678**	**291**	**125,124**	**1,435**	**70,084**		**200,612**
Clare								
Ten Sixteen Recovery		10,016		36,860		15,979		62,855
Clare Total		**10,016**		**36,860**		**15,979**		**62,855**
Clinton								
Child and Family Charities			5,120					5,120
Community Mental Health Authority of Clinton, Eaton, Ingham			51,872	1,591				53,463
Eaton Regional Education Service Agency				66,320				66,320
Prevention Network				5,223				5,223
State of Michigan MRS	5,000							5,000
Clinton Total	**5,000**		**56,992**	**73,135**				**135,127**
Eaton								
Barry Eaton District Health				10,521				10,521
Child and Family Charities			5,120					5,120
Community Mental Health Authority of Clinton, Eaton, Ingham			51,890	2,237				54,127
Eaton Regional Education Service Agency				55,592				55,592
Prevention Network				13,584				13,584
State of Michigan MRS	5,000							5,000
Wellness, Inc						18,070		18,070
Eaton Total	**5,000**		**57,010**	**81,934**		**18,070**		**162,014**
Gladwin								
Ten Sixteen Recovery		8,692		2,927		6,028		17,647
Gladwin Total		**8,692**		**2,927**		**6,028**		**17,647**
Gratiot								
Gratiot County Child Advocacy Association				29,420				29,420
Ten Sixteen Recovery		8,494						8,494
Gratiot Total		**8,494**		**29,420**				**37,914**
Hillsdale								
McCullough, Vargas, and Associates				23,533				23,533
Hillsdale Total				**23,533**				**23,533**
Huron								
Lint Psychological Services			725	6,302				7,028
Peer 360 Recovery						46,006		46,006
Huron Total			**725**	**6,302**		**46,006**		**53,034**
Ingham								
Child and Family Charities	21,770		10,194	31,197			2,888	66,049
Community Mental Health Authority of Clinton, Eaton, Ingham			50,169	5,882				56,052
Cristo Rey Community Center		15,092	20,947	17,041				53,081
Eaton Regional Education Service Agency				26,755				26,755
Ingham County Health Department				21,934				21,934
Prevention Network				18,749				18,749
State of Michigan MRS	15,000							15,000
WAI-IAM, Inc. & RISE Recovery Community						3,022		3,022
Wellness, Inc						93,691		93,691
Ingham Total	**36,770**	**15,092**	**81,310**	**122,459**		**96,713**	**2,888**	**355,233**
Ionia								
County of Ionia				44,081				44,081
Ionia Total				**44,081**				**44,081**
Isabella								
Addiction Solutions Counseling Center			5,373	8,251				13,624
Sacred Heart Rehabilitation		1,839						1,839
Sisters of Sobriety						15,471		15,471
Ten Sixteen Recovery		7,404		37,393		67,614		112,411

Mid-State Health Network
Summary of PA2 Use of Funds by County and Provider
October 1, 2019 through April 30, 2020

County and Provider	Case Management	Early Intervention	Outpatient	Prevention	PFS 2015-2020	Recovery Support	STR Grant	Grand Total
Isabella Total		**9,243**	**5,373**	**45,644**		**83,085**		**143,345**
Jackson								
Big Brothers Big Sisters of Jackson County, Inc				3,568				3,568
Catholic Charities of Jackson, Lenawee, Hillsdale						38,277		38,277
Family Service and Childrens Aid (Born Free)			11,820	136,861				148,681
Henry Ford Allegiance				26,228				26,228
Home of New Vision						101,065		101,065
LifeWays Community Mental Health Authority				3,542				3,542
Jackson Total			**11,820**	**170,199**		**139,342**		**321,361**
Mecosta								
Sisters of Sobriety						31,675		31,675
Ten Sixteen Recovery		15,634		11,868		34,061		61,563
Mecosta Total		**15,634**		**11,868**		**65,736**		**93,238**
Midland								
Families Against Narcotics Great Lakes Bay Region				1,485				1,485
Peer 360 Recovery						45,943		45,943
Ten Sixteen Recovery		17,309				15,709		33,018
The Legacy Center for Community Success				10,407				10,407
Midland Total		**17,309**		**11,892**		**61,652**		**90,853**
Montcalm								
Cherry Street Services				1,680		12,847		14,527
Sacred Heart Rehabilitation		920						920
Wedgwood Christian Services						5,321		5,321
Montcalm Total		**920**		**1,680**		**18,168**		**20,768**
Newaygo								
Arbor Circle				46,474				46,474
Newaygo Total				**46,474**				**46,474**
Osceola								
Ten Sixteen Recovery		13,203		5,092				18,295
Osceola Total		**13,203**		**5,092**				**18,295**
Saginaw								
First Ward Community Service				176,209				176,209
List Psychological Services			1,950	7,148				9,098
Parishioners on Patrol				5,000				5,000
Peer 360 Recovery						65,580		65,580
Sacred Heart Rehabilitation		1,839		21,866				23,705
Saginaw County Youth Protection Council				59,910				59,910
Saginaw Police Department				30,533				30,533
Saginaw Psychological Services						90,394		90,394
Ten Sixteen Recovery						69,135		69,135
Women of Colors				41,951				41,951
Saginaw Total		**1,839**	**1,950**	**342,618**		**225,118**		**571,524**
Shiawassee								
Catholic Charities of Shiawassee and Genesee			32,441	64,062				96,502
Peer 360 Recovery						2,696		2,696
Prevention Network				4,795				4,795
Shiawassee County				6,625				6,625
State of Michigan MRS	5,000							5,000
Shiawassee Total	**5,000**		**32,441**	**75,482**		**2,696**		**115,618**
Tuscola								
List Psychological Services			721	40,044		3,197		43,964
Peer 360 Recovery						43,224		43,224
Sacred Heart Rehabilitation		920						920
Tuscola Total		**920**	**721**	**40,044**		**46,421**		**88,107**
Grand Total	**51,770**	**105,040**	**248,634**	**1,313,085**	**1,435**	**921,657**	**2,888**	**2,644,509**

Item 8C

Mid-State Health Network
Summary of SUD Revenue and Expenses as of April 2020 (58.3% of Budget)

	Year to Date Actual	Full Year Budget	Remaining Budget	% to Budget
Revenue				
Block Grant	8,231,681.56	14,114,615.00	5,882,933.44	58.32%
Medicaid	8,655,777.67	12,133,905.00	3,478,127.33	71.34%
Healthy Michigan	13,882,721.02	16,568,836.00	2,686,114.98	83.79%
PA2	2,644,509.03	4,763,273.00	2,118,763.97	55.52%
Totals	33,414,689.28	47,580,629.00	14,165,939.72	70.23%
Direct Expenses				
Block Grant	8,231,681.56	13,277,500.00	5,045,818.44	62.00%
Medicaid	6,670,667.86	11,900,000.00	5,229,332.14	56.06%
Healthy Michigan	11,894,022.20	19,350,000.00	7,455,977.80	61.47%
PA2	2,644,509.03	4,763,273.00	2,118,763.97	55.52%
Totals	29,440,880.65	49,290,773.00	19,849,892.35	59.73%
Surplus / (Deficit)	3,973,808.63			

Surplus / (Deficit) by Funding Source	
Block Grant	-
Medicaid	1,985,109.81
Healthy Michigan	1,988,698.82
PA2	-
Totals	3,973,808.63

Actual revenue greater than budgeted revenue
Actual expenses greater than budgeted expenses

Item 9

Mid-State Health Network
FY2020 PA2 Funding Recommendations by Provider
June 2020 Oversight Policy Board

Provider	PA2 County	PA2 Amount Recommended	*New Provider / Renewal Contract
Cherry Street Health Services	Montcalm	(112,647)	Renewal
Mid-Michigan District Health Department	Montcalm	112,647	New
GRAND TOTAL		-	

*New Provider / Renewal Contract:
New Provider could also indicate that provider did not receive PA2 funds from the identified county in FY2019

Mid-State Health Network
FY2020 PA2 Funding Recommendations by County

County	Projected Beginning FY2020 Reserve Balance	Projected FY2020 Funding*	Approved FY2020 PA2 Funding	FY2020 PA2 Funding Request June	Projected Ending Reserve Balance
Arenac	111,792	33,117	69,687	-	75,222
Bay	1,083,514	196,047	623,574	-	655,987
Clare	249,723	49,981	124,750	-	174,954
Clinton	340,355	119,285	200,904	-	258,736
Eaton	202,957	227,514	258,050	-	172,420
Gladwin	59,502	38,115	40,760	-	56,856
Gratiot	96,321	44,715	64,157	-	76,879
Hillsdale	66,145	49,092	75,912	-	39,325
Huron	220,202	63,495	143,596	-	140,101
Ingham	407,323	704,857	721,988	-	390,191
Ionia	305,026	72,520	80,875	-	296,671
Isabella	528,940	148,017	282,084	-	394,873
Jackson	769,904	322,843	644,512	-	448,235
Mecosta	195,499	89,568	160,750	-	124,317
Midland	519,645	147,336	278,364	-	388,617
Montcalm	239,333	100,762	156,151	-	183,944
Newaygo	96,014	72,341	97,198	-	71,157
Osceola	64,640	30,514	42,500	-	52,654
Saginaw	1,760,062	452,285	1,215,971	-	996,375
Shiawassee	540,420	95,841	170,068	-	466,193
Tuscola	291,969	50,928	157,032	-	185,865
Total	$ 8,149,286	$ 3,109,169	$ 5,608,883	$ -	$ 5,649,572

*FY2020 projected distributions to counties not available at the time of this report; used FY2019 projected distributions

Mid-State Health Network
Comparison of FY2018 and FY2020 PA2 by County and Provider

County	Provider		FY2018 Approved PA2 Funds	FY2020 Approved PA2 Funds	June Recommended PA2 Funds	Detail of Services Provided for FY2020 Requests
Montcalm						
	Cherry Street Health Services					Prevention and Recovery Supports: Project Success; HSLT leadership groups; recovery supports programming; host coalition activities; $6,800 in coalition discretionary funding; DFC/LP/SYNAR activities; Integrated Wellness Initiative; Rx Drug Presentations; Community Coalition/Committee involvement (Drug Tx Court, FAN, RDSC, RSC, Montcalm Prevention Coalition, SAP, HSC, Healthy Montcalm, Trauma Champions, MPA, MCBAP, Community of Care).
		PA2	81,560	127,174	(112,637)	Terminating FY20 Prevention Contract eff. 9.30.20
		Block Grant	200,000	150,000	-	
		Total	**281,560**	**277,174**	**(112,637)**	
	Mid-Michigan District Health Department					
		PA2	-	-	112,637	Prevention and Recovery Supports: Project Success; HSLT leadership groups; recovery supports programming; host coalition activities; $6,800 in coalition discretionary funding; DFC/LP/SYNAR activities; Integrated Wellness Initiative; Rx Drug Presentations; Community Coalition/Committee involvement (Drug Tx Court, FAN, RDSC, RSC, Montcalm Prevention Coalition, SAP, HSC, Healthy Montcalm, Trauma Champions, MPA, MCBAP, Community of Care).
		Block Grant	-	-	-	
		Total	-	-	**112,637**	
	Sacred Heart Rehabilitation Center					Early Intervention: HIV/STD prevention education
		PA2	1,071	1,877	-	
		Block Grant	-	-	-	
		Total	**1,071**	**1,877**	-	
	Wedgwood Christian Services					Recovery Supports; Project ASSIST
		PA2	15,000	27,100	-	
		Block Grant	-	-	-	
		Total	**15,000**	**27,100**	-	
	County Total		**297,631**	**306,151**	-	

PA2 Subtotal	9,042,153	9,408,883	-	
Block Grant Subtotal	3,048,199	3,001,800	-	
Medicaid/Healthy Michigan Plan	1,338,101	-	-	
Grand Total	**9,418,896**	**9,429,883**	-	

Region 5 Quarterly Reports
FY 20 Quarter #1

PREVENTION GOALS	RESULTS & PROGRESS
Reduce Underage Drinking	Evidence based education classes (such as Too Good for Drugs; Teen Intervene; Above the Influence; Jump; Break-Out; etc.) were conducted in multiple elementary schools; middle schools and high schools throughout the region during this quarter. Education on alcohol issues also occurred on CMU; FSU; and MSU campuses. MSHN staff also participated with Michigan Coalition to Reduce Underage Drinking (MCRUD) staff to update the State's Underage Drinking Strategic Plan. The draft strategic plan is available for public comment now. Some Prevention Specialists conducted education with vendors selling alcohol products.
Reduce prescription and over-the-counter drug abuse, including opiates	Education/awareness presentations continue to be conducted with variety of community groups regarding opioid misuse/ over-the-counter abuse; etc. A minimum of four presentations is required in prevention planning but most Prevention Specialists complete many more based upon local community need. Prescription drug boxes and drug collection drop-off dates continue to be well received in all communities hosting them. In addition, funding from STR and SOR grants has allowed purchase of supplies such as lock-boxes; syringe take-back containers; medication disposal bags to be distributed in communities expressing need. Naloxone kits have also been purchased and are distributed as needed for the 21-county region. Multiple efforts to educate on the issue of legalized recreational marijuana are occurring throughout the region as the State continues to develop regulations around this issue.
Reduce youth access to tobacco	The Master Retailer List of Tobacco Vendors is a first quarter activity that is updated by DYTUR/Prevention Specialists in each county and will be submitted to the State in March. This information is used for vendor education and in the formal SYNAR process conducted later this year. DYTURs from each county participated in MSHN regional SYNAR information meeting in November. This pro-active meeting shared information for the coming year on

	expectations of completing the process --- until new changes at the federal level 'Tobacco 21' took effect in late December. At present, MSHN staff is looking for clarity with the State in developing implementation of both informal and formal tobacco vendor checks later this year and in the presentation of new tobacco information provided through vendor education this year. Some counties did conduct tobacco vendor education before the 'Tobacco 21' law was implemented – they will be updating any information the State deems critical if needed in the coming months. "Vaping" by teens continues to be key focus of concern for multiple counties. Many Prevention Specialists have begun to hold education events for parents; schools; and community members on OEND products and vaping concerns. Some Prevention Specialists have been asked to develop/implement vaping education into classroom curriculums.

TREATMENT GOALS	RESULTS & PROGRESS
Increase women's specialty service programs	Mid State Health Network (MSHN) has lost three of it's Enhanced Women's Specialty programs due to program closures or discontinuation of contract. Due to the loss of one of these programs in Bay County, Recovery Pathways stepped up and added a Modified Enhanced Women's Specialty program in order to continue to serve the women in Bay County. They have re-hired the two staff persons that were previously managing home-based services for this Enhanced program, and the program is now up and running smoothly with no loss of clientele or staff. MSHN is proud to have them onboard.
Increase array of medication assisted treatment programs	MSHN has had no new Medication Assisted Treatment (MAT) programs contract in FY20 Q1. MSHN is continuing to work with doctors and providers in the counties that lack MAT services in order to increase availability of MAT programming in those counties.
Increase engagement, retention & completion of treatment	See below.
Increase inter-agency collaboration of service delivery	MSHN continues to collaborate with providers to build jail-based programming in the region. At this time, MSHN is funding services within the jails in 12 counties in the MSHN region.

FY20 Q1					
	Completion Of Tx.	% COT	Continuing Treatment/ Transfer	%Continuing Treatment/ Transfer	Total Discharges
Outpatient	495	20.2%	374	15.3%	2452
Withdrawal Management (Detox)	79	18.6%	205	48.2%	425
Residential	252	35.0%	194	26.9%	720

The figures above focus on two out of eleven discharge reason codes; Completion of Treatment (COT) and Continuing in Treatment/Transfer.

MSHN
Mid-State Health Network

Region 5 Quarterly Reports
FY Quarter #_2___

PREVENTION GOALS	RESULTS & PROGRESS
Reduce Underage Drinking	Evidence based education classes (such as Too Good for Drugs; Teen Intervene; Above the Influence; Jump; Break-Out; etc.) continued to be conducted in multiple elementary schools; middle schools and high schools throughout the region during this quarter. Education on alcohol issues also occurred on CMU; FSU; and MSU campuses. Some Prevention Specialists conducted education with vendors selling tobacco/vaping products and/or alcohol products.
Reduce prescription and over-the-counter drug abuse, including opiates	Education/awareness presentations continue to be conducted with variety of community groups regarding opioid misuse/ over-the-counter abuse; etc. A minimum of four presentations is required in prevention planning but most Prevention Specialists complete many more based upon local community need. Prescription drug boxes and drug collection drop-off dates continue to be well received in all communities hosting them. In addition, funding from STR (grant finished now) and SOR grants (plus SOR Supplemental funds) has allowed purchase of supplies such as lock-boxes; syringe take-back containers; medication disposal bags to be distributed in communities expressing need. Naloxone kits have also been purchased and are distributed as needed for the 21-county region.
Reduce youth access to tobacco	The Master Retailer List of Tobacco Vendors /was updated by DYTYR/Prevention Specialists in each county and was submitted to the State in February. This information is used for vendor education and in the formal SYNAR process conducted later this year. New changes at the federal level for 'Tobacco 21' took effect in late December. These new federal laws and Michigan State law conflict and are presenting some challenges this year as information on each is shared with retailers during vendor education. Some counties did conduct tobacco vendor education before the 'Tobacco 21' law was implemented – they will be updating any information the State deems

FY 2020, Q2	COP	% COP	Continuing Treatment Transfer	%Continuing Treatment Transfer	Total Discharges
Outpatient	400	19.8%	320	15.8%	2024
Detox/Withdrawal Management	106	27.3%	146	37.6%	388
Residential	196	28.7%	204	29.8%	684

The figures above focus on two out of eleven discharge reason codes; Completion of Treatment (COP) and Continuing in Treatment/Transfer.

	critical if needed in the coming months. "Vaping" by teens continues to be key focus of concern for multiple counties. Many Prevention Specialists have begun to hold education events for parents; schools; and community members on OEND products and vaping concerns. Some Prevention Specialists have been asked to develop/implement vaping education into classroom curriculums. And next report will include the variety of new innovative strategies and programs/ methods to deliver programs as a result of COVID19 restrictions which went into effect March 16th, 2020.

TREATMENT GOALS	RESULTS & PROGRESS
Increase women's specialty service programs	A modified Enhanced Women's Specialty Services (WSS) program has been added in Bay County with Recovery Pathways. These services are targeted at pregnant women and women who are post-partum up to 6 months with SUD diagnoses. This Enhance WSS program was approved to be modified to include all women with children under the age of 18. Many of the services are provided in the community and in the home. If a woman in this program drops out of treatment, extended measures are taken to try to reengage her in services.
Increase array of medication assisted treatment programs	Samaritan Health (Montcalm County) officially closed its doors in February, 2020. This is a loss for the MSHN region. Efforts will be made to find a new provider to restore these services if possible. MSHN is working with a new provider, Samaritas, to add Medication Assisted Treatment (MAT) services in Eaton County. They will be contracting with us soon.
Increase engagement, retention & completion of treatment	See figures in chart below.
Increase inter-agency collaboration of service delivery	MSHN continues to work contracted providers in many of the Treatment Courts in the region, assisting by funding treatment services to the participants of the court. This collaboration allows for SUD treatment services to be delivered to some of the most vulnerable and severe cases. Treatment Courts assist the participants in rebuilding their lives and gaining recovery from drugs and alcohol dependence.

FY 20 Quarter 2					

Appendix 23. Oversight Policy Board Bylaws

BYLAWS OF
MID-STATE HEALTH NETWORK
SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD

ARTICLE I
NAME AND FORMATION

1.1 NAME

The name of the entity is the Mid-State Health Network Substance Use Disorder Oversight Policy Board, referred to as the "Board" in these bylaws.

1.2 LEGAL BASIS FOR FORMATION

1.2.1 Mid-State Health Network ("MSHN") is a community mental health regional entity formed under Section 204 the Michigan Mental Health Code (Public Act 258 of 1974, as amended the "Code") which serves the following twenty-one (21) counties commonly referred to collectively as Region 5 by the Michigan Department of Community Health (MDCH): Arenac County, Bay County, Clare County, Clinton County, Eaton County, Gladwin County, Gratiot County, Hillsdale County, Huron County, Ingham County, Ionia County, Isabella County, Jackson County, Mecosta County, Midland County, Montcalm County, Newaygo County, Osceola County, Saginaw County, Shiawassee County and Tuscola County (referred to individually as a "County," and collectively as the "Counties).

1.2.2 MSHN has qualified for status as a MDCH-designated community mental health entity authorized to coordinate the provision of substance use disorder services in Region 5.

1.2.3. The Board is formed pursuant to Section 287(5) of the Code which requires "A department-designated community mental health entity (designated as a Pre-Paid Inpatient Health Plan or PIHP) shall establish a Substance Use Disorder Oversight Policy Board through a contractual agreement between the department-designated community mental health entity and each of the counties served by the community mental health services program under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536, or other appropriate state law." 1.2.4. As a designated community mental health entity, the Code requires MSHN to establish a substance use disorder oversight policy board through a written contractual agreement with the Counties

1.2.5. MSHN and the Counties entered into a written Intergovernmental Contract to establish the Board effective _____, 2014 (the "Intergovernmental Contract").

1.2.6. These Bylaws were adopted by the SUD Oversight Policy Board and approved by the MSHN Board in accordance with the provisions of the Code and the Intergovernmental Contract.

ARTICLE II
PURPOSES

2.1 PURPOSES

In accordance with the Code and the Intergovernmental Contract, the purposes of the Board are as follows:

2.1.1 Approval of any portion of MSHN's budget that contains 1986 PA 2 (MCL 211.24e(11) funds ("PA 2 Funds") or other local funds for the treatment or prevention of substance use disorders which shall be used only for substance use disorder treatment, intervention and prevention in the Counties from which the PA 2 Funds or other local funds originated;

2.1.2. Advise and make recommendations regarding MSHN's budgets for substance use disorder treatment or prevention using non-PA 2 Funds or other non-local funding sources; and

2.1.3 Advise and make recommendations regarding contracts with substance use disorder treatment or prevention providers.

2.1.4 Advise and make recommendations regarding any other matters as agreed to by the Counties and MSHN, and assigned to the Board by MSHN.

ARTICLE III
BOARD MEMBERSHIP

3.1 NUMBER AND SELECTION OF MEMBERS

3.1.1 The Board shall consist of twenty-one (21) members The Board of Commissioners of each County shall appoint one (1) person to serve as a member of the Board. Each County Board of Commissioners may appoint a county commissioners or others, as allowed by Michigan law, that it deems best represents the interests of the County. While the appointment decision is vested within the sole authority of the each County Board of Commissioners, the Board encourages appointments which represent the diversity and cultural diversity of the MSHN service area, appointments of persons in recovery from a substance use disorder, underserved population and other related constituencies such as education, health, and social services agencies; advocacy organizations; public or private substance abuse prevention, treatment or recovery providers; or, members of the general public, including civic organizations and the business community.

3.1.2 Each Board member shall have the right to assign a designated alternate to appear on his or her behalf at Board meetings, and such alternate shall carry the right to vote on behalf of the Board member. To exercise this option, the appointing County Board of Commissioner's must advise the Boards Chairperson in writing of the alternate's appointment. Unless such a written notification of appointment is on file with the Board, the Chairperson will not recognize the standing of the alternate at a Board meeting.

3.2 TERM, REMOVAL, AND RESIGNATION

3.2.1 The members of the Board shall serve at the pleasure of the appointing Board for a term of membership of three (3) years, from September 1 of the year of appointment. Members may be reappointed to additional or successive terms in the discretion of the respective appointing Board of Commissioners.

3.2.1.1 For purposes of initial Board appointment, members shall establish a process to stagger terms to assure no more than one-third (1/3) of the members terms expire in any given year.

3.2.2 Each Board member may be removed from the Board, with or without cause, by a majority vote of the appointing County Board of Commissioners, The removal shall become effective upon receipt by the Board of a duly adopted written resolution of the appointing County. The Board Chairperson is responsible for informing the appointing County of any lack of participation or attendance by the County's appointed Board member(s).

3.2.3 A Board member may resign at any time by providing notification to the appointing County of Commissioners and the Board. The resignation will become effective upon receipt of notice by the appointing County Board of Commissioners or at a later time designated in the notice.

3.3 VACANCIES

A vacancy on the Board may occur through death, removal or resignation of a Board member. A vacancy shall be filled for the unexpired term by the appointing County in the same manner as the original appointment. The County may notify the Board of its intent not to fill the vacant position.

ARTICLE IV
BOARD ACTION

4.1 PLACE OF MEETINGS

All meetings of the Board shall be held at the principal office of MSHN or at such other place as shall be determined by the Board members and stated in the notice of meeting.

4.2 ORGANIZATIONAL MEETING

The first meeting in each calendar year shall be the organizational meeting. At each such meeting, the previous Board Chairperson if he or she is still a member of the Board or another member if there is no former Chair shall initially preside ("Presiding Chair"). The organizational meeting shall be held within sixty (60) days of New Year's Day, at the call of the Presiding Chair. The first item of business shall be election of the Board Chairperson. The Presiding Chair shall call for nominations for the office of Chairperson and when nominations are closed by majority vote or no other nominations are forthcoming, the Presiding Chair shall call for a roll call vote. When one nominee receives a majority of the votes of the members elected and serving, the nominee shall be declared Board Chairperson. The newly elected Chairperson shall assume the role of Chairperson and proceed with the election to the Vice-chairperson and Secretary, which shall be conducted by roll call vote.

4.3 ANNUAL MEETING

The annual meeting of the Board for purposes of reviewing and approving the portions of the MSHN budget that contain PA 2 Funds, and such other business as may be come before the meeting, shall be held during the month of August each year after MSHN has prepared its budget.

4.4 SPECIAL MEETINGS

The Board may hold special meetings as needed in order to fulfill the purposes listed in Section 2.1. Special meetings of the Board may be called by the Chairperson, and shall be called by the Chairperson at the written request of two or more Board members. Notice shall be given as provided in Section 4.5 of these Bylaws.

4.5 NOTICE OF BOARD MEETINGS

Written notice of the time, place and purposes of each meeting of the members of the Board shall be given to each Board member and the public in accordance with the Michigan Open Meetings Act, 1976 PA 267, as amended. The attendance of a Board member at a Board meeting shall constitute a waiver of notice of the meeting, except for where a Board member attends the meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully convened. In addition, a Board member may submit a signed waiver of notice that shall constitute waiver of notice of the meeting.

4.6 QUORUM AND MEETING BY REMOTE COMMUNICATION

4.6.1 A majority of members of the Board, appointed and serving shall constitute a quorum for the transaction of ordinary business of the Board. In the event the Board shall meet and a quorum is not present, the Board, with the approval of those present, may adjourn the meeting to a later day and time provided that proper notice to members and the public is given

4.6.2 A Board member may participate in a meeting by conference telephone or any other similar communication equipment through which all persons participating in the meeting can hear each other and can be heard by and hear the public; provided that a quorum exists as defined in Section 4.6.1 of Board members who are physically present at the meeting. Unless permitted by law, Board members who participate by remote communication will not be considered in determining the existence of a quorum. If a quorum is physically present, Board members who participate by telephone or other similar communication equipment satisfying this Article are eligible to vote in and otherwise participate in the business of the meeting.

4.7 COMPENSATION AND EXPENSES

Board members will be eligible for a per diem and mileage expenses as fixed by the MSHN Board. However, Board members will not be eligible for reimbursement of mileage expenses if employed by a public entity and to the extent the Board member receives reimbursement of mileage expenses from the Board member's employer. A Board member may not receive more than one per diem per day regardless of the number of meetings scheduled for the Board on that day.

4.8 VOTING

The Board members shall be entitled to one vote each. No member present shall abstain from voting yes or no unless he or she has received the unanimous permission of the Board members in attendance.

Approval of any portion of MSHN's budget that contains PA 2 Funds or matters of a non-advisory nature shall be decided by a majority of the members appointed and serving, not just those attending at any meeting. Procedural matters or advisory matters are decided by an affirmative vote of the majority of Board members present at a meeting where a quorum is present.

4.9 AGENDA FOR MEETINGS

The Board Chairperson, after first reviewing pending matters and requests, shall prepare a draft of the agenda of business for all Board meetings. Matters on the agenda and not yet acted upon at the time of adjournment will be placed on the agenda of the next regular meeting or special meeting if one is called. The Chairperson of the Board shall review and add or delete items, as he or she considers proper. Unanticipated agenda items that require discussion or decisions may be covered under the Other Business agenda reference. It is each Board members responsibility to attend the meeting to understand other business items that may be covered. Upon completion of the agenda for a regular Board meeting, the Board Chairperson shall have distributed to Board members copies of the agenda, together with copies of reports, explanations, etc. which shall relate to matters of business contained within the agenda. Unless extenuating circumstances arise, the agenda and related materials shall be sent to each Board member at the address each has provided, at least five (5) calendar days prior to any regular meeting.

4.10 Order of Business

Generally, Board meetings should adhere to the following order of business, although the Board may deviate from this order if approved by a majority of the members attending a meeting:

a. Call to Order
b. Roll Call
c. Adoption of Agenda
d. Action on Previous Meeting Minutes
e. Correspondence/Communications
f. Committee and Liaison Reports
g. Old Business
h. New Business
i. Other Business (if Necessary)
j. Closed Sessions (if Necessary)
k. Public Comment
l. Adjournment

4.11. CONDUCT OF MEETINGS

4.11.1. Chairperson. The person elected Chairperson in the first meeting each year of the Board shall preside at all meetings of the Board. In the absence of the Chairperson, the person elected Vice-chairperson shall preside. If neither the Chairperson nor the Vice-chairperson is present, the Board members present shall elect a member to preside during the absence of the Chairperson or Vice-chairperson.

4.11.2 Minutes Requirements. All meetings shall be open to the public, with the exception of closed meetings as provided by the Open Meetings Act, 1976 PA 267. Minutes shall be kept on file in the office of MSHN.

4.11.3 Order of Precedence of Motions. When a motion is seconded and before the Board, or a Committee of the Board, no other motion shall be received except the following:

a. To fix the time to which to adjourn
b. To adjourn
c. For the previous question
d. To lay on the table
e. To postpone indefinitely
f. To postpone to a date certain
g. To refer
h. To amend

These motions shall have precedence in the order as above named.

4.11.4 Motions to Adjourn. A motion to adjourn shall always be in order except while a vote is being taken on any other motion already before the Committee or Board, or when a member has the floor; provided, that there shall be other intervening business or a change in the circumstances between the two motions to adjourn.

4.11.5 Motions to Reconsider. A motion for the reconsideration of any question shall be in order if made on the same day or at the Committee or Board meeting next succeeding that on which the decision proposed to be reconsidered was made; providing, however, that a second reconsideration of any question or a reconsideration at a later date may be had with the consent of two-thirds (2/3) of the members elected and serving, but in such event the moving member shall file written notice of his/her intention to move for a reconsideration in the office of the Executive Director of MSHN at least one day before making such a motion.

4.11.5 Reports and Motions Requiring Signatures. Reports of Committees shall be in writing and the names of the members of such Committees concurring in such reports shall be noted thereon. Every written resolution or motion shall have noted the name of the member or members introducing the same.

4.11.6 Division of Question. Upon request by any member, any question before the Committee or Board may be divided and separated into more than one question; provided, however, that such may be done only when the original is of such a nature that upon division, each of the resulting questions is a complete question permitting independent consideration and action.

4.11.7 Motion To Clear The Floor. If, in the judgment of the Chairperson, there is a confusion of parliamentary procedure existing, the Chairperson shall have the right to request a "motion to clear the floor" which motion, if made and seconded, shall be undebatable, shall take precedence over all other motions, shall be forthwith put by the Chairperson, and, if carried, shall clear the floor completely and with the same effect as if all matters on the floor were withdrawn. The motion to clear the floor shall not be reconsidered; but its passage shall not limit the right of any member to move the reconsideration of any other matter in the same manner as, but for the passage of the motion to clear the floor, would be in accordance with these Rules.

4.11.8 Appeal From A Decision Of Chairperson. When an appeal is taken from the decision of the Chairperson, the member taking the appeal shall be allowed to state his/her reason for doing so. The question shall be then immediately put in the following form: "Shall the ruling of the Chairperson be sustained?" The question shall be determined by a majority vote of the members present, except the Chairperson, upon the request of any member, shall not preside over such a vote.

4.11.9 Public Comment. A public comment period will be provided at every Board meeting. The length of comment during this period will be limited to three (3) minutes per person, unless the Board authorizes additional time

4.11.11 Procedures to Address the Board. Any person who addresses the Board shall state their name for the record. When there are many people who desire to address the Board, the Chairperson may implement other reasonable rules for public participation.

4.11.12 Parliamentary Authority. Robert's Rules of Order (Newly Revised) shall govern all questions of procedure not otherwise provided by these Bylaws, the Intergovernmental Contract, or by state law.

4.11.13 Temporary Suspension of the Rules. The Board's parliamentary rules may be suspended temporarily at any time by vote of two-thirds (2/3's) of the members elected.

4.12. RECORD OF MEETINGS

MSHN shall provide clerical support to take minutes as required by the Open Meetings Act, MCL 15.261, et seq. The Chairperson shall verify that such clerical support will be available prior to each meeting, and may appoint

a member to prepare such minutes in the absence of such support being available. The minutes shall include all the actions and decisions of the Board. The minutes shall include the names of the movant and second on all motions and resolutions and the vote of the members thereon. The record shall also state whether the vote was by voice or by roll call; when by roll call, and the names of persons addressing the Board. Copies of each resolution or other matter acted upon by the Board, as well as the official minutes, shall be maintained in a location designated by the Board. Copies of the approved, affirmed minutes shall be provided to each County. The minutes shall not be required to include a written record or summary of the discussion or comments of the Board members, nor of the comments made by members of the public.

4.13 COMPLIANCE WITH LAWS

The Board and its members shall fully comply with all applicable laws, regulations and rules applicable to its operation, including without limitation 1976 PA 267 (the "Open Meetings Act"), 1976 PA 422 (the "Freedom of Information Act"), 2012 PA 500, 2012 PA 501 and 1986 PA 2.

4.14 CONFLICT OF INTEREST

The Board shall adopt and adhere to a conflict of interest policy. Each member of the Board shall disclose any conflicts of interest while serving on the Board.

ARTICLE V
OFFICERS

5.1 OFFICERS

The officers shall be a Chairperson and a Vice Chairperson. Only Board members may serve as an officer.

5.2 ELECTION AND TERM OF OFFICE

Officers shall be elected from among the Board members for a term of one (2) year (or until their successors have been elected) by the Board at its annual meeting.

5.3 REMOVAL OF BOARD OFFICERS

Any officer of the Board may be removed from office with or without cause by the vote of a majority of the Board members elected and serving during a regular or special meeting of the Board.

5.4 VACANCIES

In the event of the death, resignation, removal or other inability to serve of any officer, the Board shall elect a successor who shall serve until the expiration of the normal term of such officer or until his or her successor has been elected.

ARTICLE VI
COMMITTEES

6.1 COMMITTEES

The Board may establish and define the responsibilities of such standing or special committees from time to time as it shall deem appropriate to fulfill the purposes of the Board set out in Section 2.1. The Chairperson shall, in consultation with the Board, select membership of any committee formed. Only Board members may serve as committee members.

ARTICLE VII
CONSTRUCTION AND AMENDMENTS

7.1. Interpretation

Wherever possible, these Bylaws shall be construed in a manner consistent with Michigan law, the Code and the Intergovernmental Contract. Where there is a conflict with Michigan law, the Code or the Intergovernmental Contract, the conflicting terms of these Bylaws shall be null and void and considered severed from the remaining

portions, which shall continue in full force and effect.

7.2 Amendment

These bylaws may be amended by the members of the Board acting in accordance with the voting requirements set forth in Section 4.8. The agenda of the meeting shall set forth a summary of the proposed amendment(s) at least fourteen (14) days prior to the date of the meeting. An affirmative vote to amend the Bylaws must be approved by the Board of Directors of MSHN. Any amendment of these bylaws must be consistent with the Michigan law, the Code and the Intergovernmental Contract

ATTESTATION

These Bylaws were adopted by the Mid-State Health Network Substance Use Disorder Oversight Policy Board at a regularly scheduled meeting held on _____.

_____ _____, 2014 Chairperson of Mid-State Health Network Substance Use Disorder Oversight Policy Board

These Bylaws were approved by the Mid-State Health Network Board of Directors at a regularly scheduled meeting held on _____.

_____ _____, 2014 Chairperson of Mid-State Health Network Board of Directors

Appendix 24. The Substance Use Disorder (SUD) Provider Advisory Committee Charter

MSHN
Mid-State Health Network

SUD Provider Advisory Committee (SUD-PAC)
Charter

Purpose:

MSHN's SUD Provider Advisory Committee is charged with serving in an advisory capacity to offer input to MSHN regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

Group Functions:

1. Support for implementation of evidence-based best practice service delivery to persons served.
2. Provide input on prevention (PX), treatment (TX), and recovery network policies & procedures.
3. Provide input on MSHN's Quality Assurance Reviews (review process, standards, QI enhancement).
4. Support and provide input on MSHN and MDHHS performance improvement initiatives.
5. Provide input on MSHN's PX/TX/Recovery annual plan processes.
6. Support and provide input on MSHN's Strategic Plan.
7. Provide input on regional concerns that impact providers and/or clients (e.g. barriers to access).
8. Support of MSHN's fulfilment of state and federal legislative, policy and regulatory goals.

Membership:

1. Selected from volunteers to MSHN application process.
2. Two (2) representatives will be chosen from each sub-group of providers: Prevention, Detox, Residential, Outpatient, Recovery Housing, and Recovery Coaches = 12 provider members + MSHN staff.
3. Each sub-group should include 1 administrator, 1 clinician/line worker/etc., not from the same provider.
4. Membership will be rotated between 2, 3, and 4 years during the first term to provide for ongoing experience within the group.
5. If a PAC member needs to step down from the group before the end of his/her respective term, a person from that same organization may be recommended by that member, preferably from that same service category. If no one is available from that category, the vacant seat will be opened to the full provider network for new members from that category.
6. Upon the end of a PAC member's full term, that seat will be open to the full provider network. Organizations with outgoing representatives may offer new staff members to fill that seat.

Meeting Frequency:

1. Every other month on off-months between OPB meetings. PAC meetings will be on the 2nd Monday of the months of January, March, May, July, September, and December.
2. Special meetings can be called if a pressing issue arises.
3. Consistent attendance is expected in person or by phone.
4. 1-2 hours at 1-3 pm.
5. Location: MSHN office in Lansing with call-in capacity.

Structure:

1. All twelve (12) provider PAC members are liaisons to MSHN's provider network. Any one of them can be conduits for information, feedback and/or agenda items from the full provider network to the PAC for consideration.
2. MSHN staff participating with and supporting the PAC will include representatives from the Prevention, Treatment, and Quality & Performance Improvement (QAPI) teams. Depending on agenda items for which required expertise extends to other departments (e.g. Utilization Management, Finance, etc.), MSHN personnel will be invited to attend on an as-needed basis. MSHN staff will be non-voting members.
3. MSHN's Prevention representative to the PAC will serve as the PAC Chair. Serving as PAC Vice-Chair will be MSHN's Treatment representative.
4. The Chair and Vice-Chair will develop the agenda with direction and input from PAC members, and the Chair will facilitate the meetings.
5. MSHN staff will ensure meeting notes are taken and distributed, and will perform other functions as needed to support the PAC.
6. Topics for discussion can be submitted for the agenda by any provider by contacting any PAC member or any MSHN PAC support staff two weeks in advance of the next scheduled meeting date.

Member Conduct/Ground Rules: MSHN's SUD Advisory Group seeks a culture that is professional, productive, and respectful. To that end, the ground rules include:

1. Only one person speaks at a time; no one will interrupt while someone is speaking.
2. Members express their (his/her) own views, rather than speaking for others at the table or attributing motives to them.
3. No sidebars or end-runs.
4. Members will avoid grandstanding (i.e., extended comments/speaking), so that everyone has a fair chance to speak.
5. No personal attacks. "Challenge ideas, not people."
6. Members will seek to focus on the merits of what is being said, making a good faith effort to understand the concerns of others. Questions of clarification are encouraged. Disparaging comments are discouraged.
7. Members will seek to identify options or proposals that represent shared interests, without minimizing legitimate disagreements.
8. Members agree to do their best to take account of the interests of the group as a whole.

Meeting Efficiency

1. Agendas will be distributed to members of the PAC by MSHN staff, when possible, seven (7) days ahead of time, but no less than four (4) days prior to the scheduled meeting.
2. Members will be prepared for the agenda content and have completed assignments on time.
3. Members agree to make a strong effort to stay on track with the agenda and to move the deliberations forward.
4. Members share equally in the work of the Committee.

Decision-Making

1. Members understand that decisions made by this advisory body will be framed as recommendations to MSHN.
2. Members are respectful of the defined decision-making protocol and supports majority recommendations, even when presenting a minority view.
3. Members reserve the right to disagree with any recommendation and accepts responsibility for offering alternatives that accommodates their interests and the interests of others.
4. Members will follow the "no surprises" rule. Concerns should be voiced when they arise, not later in the deliberations.
5. Consensus shall be the primary mode of decision making and efforts shall be made to extend dialogue and gather information toward consensus to the extent possible.

6. Should consensus not be achieved, any member of the PAC may call for a vote of the members. A vote of the PAC is not binding, but will be used to further inform reporting to MSHN Leadership on the strength of PAC members' position on the subject. Minutes and reporting shall reflect both the majority and minority opinions on that matter.

Appendix 25. The Substance Use Disorder-Provider Advisory Committee May 2020 Meeting Minutes

MSHN Mid-State Health Network

MSHN Provider Advisory Committee (PAC)
5-11.2020 Meeting Minutes
Key Decisions and Required Action
DATE: March 09, 2020
Next Meeting: July 13, 2020

DRAFT

PURPOSE: MSHN's SUD Provider Advisory Committee is charged with serving in an advisory capacity to offer input to MSHN regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

Attendance (* via phone):

☒ Dani Meier ~ MSHN	☒ Jill Worden ~ MSHN	☒ Melissa Davis ~ MSHN	☒ Kate Flavin ~ MSHN
☒Mary Ellen Johnson	☐ Carolyn T. Watters ~ MSHN	☒Shannon Myers*	☐MSHN Guest(s)
☒Richard Simpson	☐Matt Mitchell	☒Patti Tygre	☒Rebecca Steenbergh
☒Daphne Hamburg	☒Sam Price	☒Shannon Douglas*	☒Tonya Evans*
	☒Kim Thalison	☒Kim Kwasnick	☒Other Sandy Gettel - MSHN

AGENDA ITEM	KEY DECISIONS	ACTION REQUIRED			
Introductions	• Introduction were made	By Who	NA	By When	NA
Review & Approve Previous Minutes (5.11.20) and Agenda	• Approved Minutes – 5.11.20 • Approved Today's Agenda – Rearranged Topics	By Who	PAC	By When	NA
PAC Member Lead Discussion	• Effective Prevention School Presentations – Kim T. shared that due to COVID, she has not had time to convene a sub-committee. The group agreed to table now and return to these once things settle down.	By Who	PAC	By When	• Kim T. will convene sub-committee on Effective Prevention School Presentations in the upcoming months.

AGENDA ITEM	KEY DECISIONS	ACTION REQUIRED			
	• COVID-19 – members discussed successes and barriers to providing SUD services during the Stay Safe COVID orders. • Drug Testing Discussion – Mellissa will meet with Rich S. to follow-up on the specifics of this.				• Melissa will call Richard S. with some specific data on cost of testing.
Annual Contracts	• Discussion was held on Annual Contracts. PAC members were asked to review FY21 changes and get any feedback to Carolyn in the next couple of weeks.	By Who	PAC – All	By When	May 31, 2020
Performance Measures	• Kim Zimmerman shared new Performance Measures FY21 Contract.	By Who		By When	
QAPI Quarterly Report	• Melissa shared link to QAPI Quarterly Report and discussed how the PAC could look at the report to identify performance measures from audits to offer suggestions on processes to improve.	By Who	Melissa	By When	Members to get any feedback to Melissa.
Synar Update	• Jill stated that for now – Synar will still be conducted with 16 and 17-year-old youth inspectors as Michigan's Tobacco law is still age 18. Formal Synar will be pushed back until July or August this year, due to COVID.	By Who	N/A	By When	N/A
NOFA – (Jill)	• Jill shared that do to funding uncertainties for FY21, MSHN has decided not to issue NOFAs this fall. It is important until we know how State funding will be impacted, we preserve PA2 to make sure we can keep existing programs solvent. Once FY21 funding is known, we may offer some NOFA funding in the	By Who	NA	By When	NA

AGENDA ITEM	KEY DECISIONS		ACTION REQUIRED		
	spring. PAC members agreed that for now we need to make sure that existing programs continue.				
Quality Improvement (Sandy)	• Sandy shared the Critical Incident/Sentinel Events report and discussed the Recovery self-Assessment (RSA) Discontinuation and Recovery Assessment Scale (RAS) and Satisfaction Survey implementation. She asked members for input to the process.	By Who	PAC members were encouraged to provide Sandy with input.	By When	5.31.20
Training Request	• Discussion was held on training needs of the provider network. Members were asked to get ideas to Melissa.	By Who	PAC members to get training needs to Melissa.	By When	N/A
GAIN Update	• Dani shared the State and SUD Directors are looking at possible alternatives to GAIN. Dani stated he would keep members updated	By Who	N/A	By When	N/A
SUD Provider Meeting (6.18.20)	• PAC members were asked to send Dani any possible ideas for the SUD Provider Meeting agenda. Member also agreed to survey breakout groups of things they need from MSHN.	By Who	All	By When	5.31.20
PAC Chair	• Discussion was held about having a PAC Member Chair the PAC. Sam Price agreed and was voted chair by the members. MSHN staff will work with Sam to develop agenda. Sam stated he some ideas on moving the PAC to focus more on improving outcomes.	By Who	Sam and MSHN staff	By When	7.7.20

Parking Lot

Appendix 26. Prevention Logic Models

Appendix 26.1 Underage Drinking

Alcohol & Underage Drinking
Assessment Summary
Consequence: · Continued decrease in regional underage drinking
Behavior: · **Age of first alcohol use in MSHN Region:** 13.21 years (MiPHY 2018) · **Youth alcohol use in past 30 days in MSHN Region:** 19.13% (MiPHY 2018)
Target Populations: · **Universal**: All youth in the MSHN Region · **Selected**: Youth with history of AOD use or other delinquent behaviors; Youth with depression/ MH issues · **Indicated**: Youth with alcohol addiction; Youth with school suspensions or law enforcement involvement for use/possession
Intervening Variables: · Parental Approval of Underage Drinking · Ease of Access · Community Norms Favorable to Alcohol Use

Alcohol & Underage Drinking

Problem Statement 1: Regional use of alcohol is slightly trending down and that trend needs to be maintained.

Overall Impact: Reduction of Youth Use of Alcohol

Goal 1: To Reduce Youth Access to Alcohol

Long-Term Outcomes 1:

Ø Increase age of first alcohol use from 13.21 years in 2018 to14 years by 2023 as measured by the MiPHY Survey

Ø Reduce past 30-day alcohol use from 19.13% in 2018 to 17.75% by 2023 as measured by the MiPHY Survey

Long-Term Outcome Indicator(s):

Ø Review age of first use of alcohol as measured by MiPHY survey and/or annual outcomes report from provider

Ø Review past 30-day alcohol use as measured by MiPHY survey and/or annual outcomes report from provider

Immediate Outcomes	Activities	Process/Evaluation Indicators	Timeline
Increase parents awareness of problems associated with underage drinking.	Provide parenting education and informational presentations	Number of parent education and information presentations conducted as indicated by specific county/ communities	Phase 1: FY21 Q1, Q2-Ongoing
Provide resources to parents on how they can assist their children in remaining alcohol-free.	Provide parenting education and informational presentations	Materials available as indicated from presentations conducted	Phase 2: FY21 Q3, Q4-Ongoing
Reduce community norms favorable to alcohol use by making community more aware of underage alcohol issues.	Technical assistance in developing school and local policies that are consistent and enforceable	Meeting minutes; new law or policy enacted	Phase 3: FY22 Q1, Q2
	Town Hall meetings	Sign-in sheets; summary of meeting; materials presented	Phase 1: FY21 Q1, Q2-Ongoing
	Social norming campaigns	Materials available as indicated by local county/ community	Phase 3: FY22 Q1, Q2-Ongoing
Provide local vendors and adults with knowledge and information on the laws and responsibilities of providing alcohol to minors.	Alcohol vendor education and compliance checks	Number of vendor education and compliance checks completed as indicated by county/community	Phase 2: FY21 Q3, Q4-Ongoing
	TIPS Training	Number of classes completed as indicated by county/community	Phase 2: FY21 Q3, Q4-Ongoing
	Safe graduation and prom initiatives	Number of initiatives conducted as indicated by county/community	Phase 4: FY22 Q3 and FY23 Q3

Alcohol & Underage Drinking			
Increase awareness of the risk/consequences of alcohol use to self, family and community.	Evidence-Based Practices used in youth school and community education.	Number of evidence based practices as indicated in MPDS system	Phase 1: FY21 Q1, Q2-Ongoing
	Driver Education Programming	Number of classes completed as indicated by county/community	Phase 1: FY21 Q1, Q2-Ongoing
	MIP Programs	Number of programs completed with materials included	Phase 1: FY21 Q1, Q2-Ongoing
	Student Assistance Programs	Number of programs completed with materials included	Phase 1: FY21 Q1, Q2-Ongoing

Appendix 26.2 Marijuana

Marijuana

Assessment Summary

Consequence:

- Increased regional youth use of marijuana/marijuana products

Behavior:

- **Age of first marijuana use in MSHN Region:** 13.83 years (MiPHY 2018)
- **Youth marijuana use in past 30 days in MSHN Region:** 14.23% (MiPHY 2018)
- **Youth reporting parents felts marijuana use to be wrong or very wrong in MSHN Region:** 88.7% (MiPHY 2018)

Target Populations:

- **Universal**: All youth in the MSHN Region
- **Selected**: Youth with history of AOD use or other delinquent behaviors; Youth with depression/ MH issues
- **Indicated**: Youth with marijuna addiction; Youth with school suspensions or law enforcement involvement for use/possession

Intervening Variables:

Lack of Perceived Risk
Parental Approval of Problem Behavior
Ease of Availability

Marijuana

Problem Statement 1: Regional youth use of marijuana/marijuana products is increasing.

Overall Impact: Reduction of youth use of marijuana/marijuana products

Goal 1: To reduce youth access to marijuana/marijuana products

Long-Term Outcomes 1:

Ø Increase age of first marijuana use from 13.83 years in 2018 to 14.25 years by 2023 as measured by the MiPHY Survey

Ø Reduce past 30-day marijuana use from 14.23% in 2018 to 13.75% by 2023 as measured by the MiPHY Survey

Ø Increase perception of youth that parents feel marijuana use to be wrong or very wrong from 88.7% in 2018 to 90% by 2023 as measured by the MiPHY Survey

Long-Term Outcome Indicator(s):

Ø Review age of first use of marijuana as measured by MiPHY survey and/or annual outcomes reports from provider

Ø Review past 30-day marijuana use as measured by MiPHY survey and/or annual outcomes reports from provider

Ø Review youth data of parental perception as measured by MiPHY survey and/or annual outcomes reports from provider

Immediate Outcomes - lack of perceived risk	Activities	Process/Evaluation Indicators	Timeline
Increased awareness of risk/consequences to self, family and community	Conduct research based education both in schools and in community groups	Number of research based education programs conducted	Phase 1: FY21 Q1-Ongoing
	Conduct MIP programs	Number of MIP programs conducted as assigned by county/community	Phase 2: FY21 Q3, Q4-Ongoing
	Incorporate marijuana education into driver training programs	Materials provided in driver education programs	Phase 2: FY21 Q3, Q4-Ongoing
	Conduct Peer Assisted Leader programs	Number of active Peer Assisted Leader programs	Phase 1: FY21 Q1-Ongoing
	Student Assistance programs	Number of active Student Assistance programs	Phase 1: FY21 Q1-Ongoing
Increased parent awareness of problems associated with underage marijuana use	Provide education classes and informational sessions	Number of education classes/ information sessions provided.	Phase 2: FY21 Q3, Q4-Ongoing
Resources provided to parents on how they can assist their child/ren in remaining free of marijuana use	Distribute resources as part of education classes and informational sessions	Materials available as indicative of each local county need	Phase 3, FY22Q1-Ongoing

Marijuana			
Information provided (knowledge increased) on current marijuana laws and responsibilities of providing marijuana/marijuana products to minors	Provide or work with the community to conduct marijuana vendor education	Materials available as indicative of each local county need	Phase 3: FY22 Q1-Ongoing
	Explore working with MI State Police [Marijuana Tax Team] to conduct marijuana compliance checks	Meeting minutes; documentation of compliance check documents	Phase 3: FY22 Q1-Ongoing
Reduction in community norms favorable to marijuana use by making community more aware of underage marijuana issues	Provide technical assistance in developing local and school policies, consistent and enforceable	Materials available as indicative of each local county need	Phase 3: FY22 Q1-Ongoing
	Conduct Town hall meetings	Sign-in sheets; materials distributed; summary of events	Phase 2: FY21 Q3, Q4-Ongoing
	Conduct or work with local community to provide Social norming/ marketing and media campaigns	Social norming/marketing materials available for review as developed by local community need	Phase 2: FY21 Q3, Q4-Ongoing

Appendix 26.3 Opioid Prescription Use

Opioid Abuse and Misuse

Assessment Summary

Consequence:

- Increase in prescription drug and over- the-counter use and abuse of prescription drugs leads to increase in overdoses and treatment admissions.

Behavior:

- Youth past 30 day use of prescription drugs such as Ritalin, Adderall, or Xanax without a Dr. prescription in MSHN region: 3.6% (2018 MIPHY data)
- Youth past 30 day use of painkillers such as Oxycontin, Codeine, Vicodin, or Percocet without a Dr. prescription in MSHN region: 4.37% (2018 MIPHY data)

Target Populations:

- **Universal**: All youth in MSHN region
- **Selected**: Youth with history of AOD use or other delinquent behaviors; Youth with depression/ MH issues.
- **Indicated**: Youth with opioid addiction; Youth with school suspensions or law enforcement involvement for use/possession.

Intervening Variables:

Lack of Perceived Risk
Ease of Availability
Community Norms

Opioid Abuse and Misuse

Overall Impact: Reduction of youth use.

Goal 1: To reduce prescription and over- the-counter drug abuse, including the misuse and abuse of opioids for non-medical

Long-Term Outcomes 1:

Ø Reduce past 30 use of students taking painkillers such as Oxycontin, Codeine, Vicodin, or Percocet without Dr. Prescription from 4.37% in 2018 to 3% by 2023 as measured by the MiPHY survey

Long-Term Outcome Indicator(s):

Review past 30 day use of students taking painkillers as measured by MiPHY survey and/or annual outcomes report from providers

Immediate Outcomes - lack of perceived risk	Activities	Process/Evaluation Indicators	Timeline
Increased awareness of risk/consequences to self, family and community	Provide education programs and informational sessions	Education programs and information sessions provided as directed by individual local community need	Phase 2: FY21 Q3, Q4- Ongoing
Resources provided to youth and parents on issues of opioid abuse and misuse, including the use of opioids for non-medical purposes	Distribute resources as part of education classes and informational sessions	Resources distributed as directed by individual local community need	Phase 2: FY21 Q3, Q4- Ongoing
Increased awareness of risk/consequences to self, family and community	Provide education classes and informational sessions	Education programs and information sessions provided as directed by individual local community need	Phase 1: FY21Q1, Q2- Ongoing
Resources provided to youth and parents on issues of opioid abuse and misuse, including the use of opioids for non-medical purposes	Distribute resources as part of education classes and informational sessions	Resources distributed as directed by individual local community need	Phase 1: FY21Q1, Q2- Ongoing
Reduction in community norms favorable to opioid abuse and misuse by making community more aware of opioid issues	Conduct or work with local community to provide Social norming/ marketing and media campaigns	Social norming/marketing materials and media campaign materials available	Phase 2: FY21 Q3, Q4- Ongoing
	Conduct Town hall meetings and/or focus groups	Number of town hall meetings or focus groups held	Phase 1: FY21 Q1, Q2- Ongoing

Appendix 26.4 Youth Tobacco

Tobacco

Assessment Summary:

Consequence:

- Increased regional youth use of tobacco/ENDS products

Behavior:

- **Age of first tobacco use in MSHN Region:** 12.7 years (MiPHY 2018)
- **Youth tobacco use in past 30 days in MSHN Region:** 23.25% (MiPHY 2018)
- **Youth ENDS use in past 30 days in MSHN Region:** 23.64% (MiPHY 2018)

Target Populations:

- **Universal**: All youth in the MSHN Region
- **Selected**: Youth with history of AOD use or other delinquent behaviors; Youth with depression/ MH issues
- **Indicated**: Youth with nicotine addiction; Youth with school suspensions or law enforcement involvement for use/possession

Intervening Variables:

- Laws and Policies
- Retail Access
- Community Norms

Tobacco

Overall Impact: Reduction of youth use of tobacco/ENDS products

Goal 1: To reduce youth access to tobacco products, including ENDS

Long-Term Outcomes 1:

- ØIncrease age of first tobacco use from 12.7 years in 2018 to 13.25 years by 2023 as measured by the MiPHY Survey
- Ø Reduce past 30-day tobacco use from 23.25% in 2018 to20.5% by 2023 as measured by the MiPHY Survey
- Ø Reduce past 30-day ENDS use from 23.64% in 2018 to 22% by 2023 as measured by the MiPHY Survey
- Ø Increase compliance of formal Synar from 88.2% in 2019 to 90.5% by 2023

Long-Term Outcome Indicator(s):

- Ø Review age of first use of tobacco as measured by MiPHY survey and/or annual outcomes reports from providers
- Ø Review past 30-day tobacco use as measured by MiPHY survey and/or annual outcomes reports from providers
- Ø Review past 30-day ENDS use as measured by MiPHY survey and/or annual outcomes reports from providers
- Ø Review formal Synar results

Immediate Outcomes	Activities	Process/Evaluation Indicators	Timeline
Education of local law enforcement and elected officials	Advocate for consistency between state and federal regulations	Materials/resources used in education sessions	Phase 1: FY21 Q1-Ongoing
Increased adult awareness and knowledge on the dangers of smoking, vaping and secondhand smoke/vapor	Provide parenting education and community informational presentations	Materials/resources used in education sessions	Phase 1: FY21 Q1, Q2- Ongoing
Increased number of local schools requesting TA	Technical assistance in developing school and local policies that are consistent and enforceable	Written documentation of steps taken to enact new policies	Phase 1: FY21 Q1-Ongoing
Increased youth awareness of the risk associated with tobacco and ENDS use.	Evidence-Based Practices used in youth school and community education	Number of evidence-based practices in place	Phase 3: FY22 Q1-Ongoing
	Student Assistance Programs	Number of active student assistance programs	Phase 3: FY22 Q1-Ongoing
	Social Norming Campaigns	Evidence of social norming materials available	Phase 3: FY22 Q1-Ongoing

Tobacco			
Reduced tobacco and ENDS sale rate to minors	Tobacco vendor education and compliance checks	Number of vendor education checks as assigned per county/community. Number of compliance checks as assigned per county.	Phase 2: FY21 Q3, Q4- Ongoing
Increased number of clerks who verify ID during formal Synar	Tobacco vendor education and compliance checks	Number of vendor education checks as assigned per county/community. Number of compliance checks as assigned per county.	Phase 1: FY21 Q1- Ongoing
Increased knowledge and awareness surrounding issue of youth access to tobacco products	Tobacco vendor education and compliance checks	Number of vendor education checks as assigned per county/community. Number of compliance checks as assigned per county.	Phase 2: FY21 Q3, Q4- Ongoing

Appendix 26.5 Substance Use in Older Adults

Older Adults

Assessment Summary

Consequences:

Death: 2,651 Michigan adults ages 55+ died from alcohol-related causes from 2013-2017, which comprised 51% of all alcohol and other drug (AOD)-induced deaths.

Addiction: In 2018 Michigan Adults ages 56+ admitted to publicly funded treatment comprised:

- 10.2% of all admissions
- 14.5% of those admitted for alcohol dependence alone
- 11.8% of those admitted for dependence on alcohol and another drug

Behavior:

Heavy Drinking:

- 6.9% of Michigan adults ages 55-64 reported past 30-day heavy drinking in 2017
- 3.9% of Michigan adults ages 65+ reported heavy drinking in the past 30-days in 2017

Binge Drinking:

- 12.9% of Michigan adults ages 55-64 reported past 30-day heavy drinking in 2017
- 6.1% of Michigan adults ages 65+ reported binge drinking in the past 30-days in 2017

Drinking in combination with Rx and/or other drug use: Although this is a significant issue, there is no known current data on this behavior

Target Populations:

- **Universal**: All older adults in the MSHN Region
- **Selected**: Adults 55+ with history of AOD use & trauma; Adults 55+ experiencing grief/loss, chronic health issues, depression/ MH issues, isolation, physical disabilities, & transitions
- **Indicated**: Adults ages 55+ who: have alcohol use disorders (AUD), have other/poly drug use (including Rx), and/or are in recovery from AUD

Intervening Variables:

- Ease of Access
- Community Norms Favorable to Alcohol Use
- Lack of Perceived Risk

Older Adults			
Problem Statement 1: Alcohol is the leading cause of AOD-related death among Michigan adults ages 55+, and alcohol use disorder is a significant cause of admission to publicly funded treatment.			
Overall Impact: Reduce the rate of alcohol-related deaths among adults ages 55+			
Goal 1: Increase Older Adult knowledge of consequences of alcohol use/misuse			
Immediate Outcomes	**Activities**	**Process/Evaluation Indicators**	**Timeline**
Increase awareness of problems, risks and consequences associated with binge and heavy drinking.	Provide education and informational presentations at senior centers and senior living communities	Number of education and informational presentations conducted as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
Reduce community norms favorable to alcohol use by making community more aware of older adult alcohol issues.	Social norming campaigns	Materials available as indicated by local county/community	Phase 3: FY22 Q1, Q2-Ongoing
	Offer alcohol-free activities for older adults.	Number of events conducted as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
Increase awareness of the risk/consequences of alcohol use with Rx drug and opioid use combined.	Provide education and informational presentations at senior centers and senior living communities	Number of education and informational presentations conducted as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
	Create/Distribute print materials to Meals on Wheels, churches, health care providers, senior centers and senior living communities.	Materials available as indicated by local county/community	Phase 3: FY22 Q1, Q2-Ongoing

Older Adults

Assessment Summary

Consequences:

Death:
- In 2017, heroin was involved in the following % of drug overdose deaths in Michigan: ages 65+ - 17%, ages 55-64 - 27%
- From 2013 to 2017, heroin overdose deaths among adults 55+ increased 238% among females and 188% among males.
- In 2017, Rx opioids were involved in the following % of drug overdose deaths in Michigan: ages 65+ - 26%, ages 55-64 - 28%.
- In 2017, synthetic opioids were involved in the following % of drug overdose deaths in Michigan: ages 65+ - 33%, ages 55-64 - 44%
- Synthetic opioid involvement in drug overdose deaths among Michigan adults ages 55+ increased from 6.3% in 2013 to 41.2% in 2017. (ages 65+: 130% increase, ages 55-64: 61% increase).

Addiction:
- In 2018, adults ages 56+ with heroin dependence comprised 10.8 % of all admissions to publicly funded treatment.
- In 2018, Adults ages 56+ with other opioid dependence comprised 5.9% of all admissions to publicly funded treatment.

Behavior:

Past 30-day Heroin Use: There is no known current data measure

Past 30-day Rx and Other Opioid Use: There is no known current data measure

Target Populations:

- **Universal**: All older 55+ adults in the MSHN Region
- **Selected**: Adults 55+ with history of AOD use, opioid Rx drug use or Rx opioid use disorder (OUD), criminal justice involvement, & trauma; experiencing chronic pain, age-related health issues, depression/ MH issues, social isolation, physical disabilities, African Americans
- **Indicated**: Adults ages 55+ who: have active OUD, have other/poly drug use (including Rx), and/or are in recovery from OUD

Intervening Variables:

- Ease of Access

Older Adults			
Problem Statement 2: Heroin and other opioids overdose deaths increased significantly among adults ages 55+ from 2013-2017.			
Goal 2: Reduce prevalence and incidence of heroin and other opioid overdose deaths in adults ages 55+			
Immediate Outcomes	**Activities**	**Process/Evaluation Indicators**	**Timeline**
Increase awareness of problems, risks and consequences associated with Rx and other opioid use.	Provide education and informational presentations at senior centers and senior living communities	Number of education and informational presentations conducted as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
	Provide education of non-opioid options for pain management, such as Chronic Pain PATH and other programs	Number of education and informational presentations conducted as indicated by local county/community	Phase 1: FY21 Q1, Q2-Ongoing
	Partner with Meals on Wheels to distribute information	Materials distributed as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
Increase knowledge of and use of safe medication disposal	Provide education and informational presentations at senior centers and senior living communities	Number of education and informational presentations conducted as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
	Partner with Meals on Wheels to distribute information	Materials distributed as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
	Increase drug disposal options for senior centers and senior living communities with law enforcement or by distribution of disposal pouches	Number of disposal events held for senior population in local county/community and/or number of pouches distributed.	Phase 1: FY21 Q1, Q2-Ongoing
Increase awareness of the risk/consequences of alcohol use with Rx drug and opioid use combined.	Provide education and informational presentations at senior centers and senior living communities	Number of education and informational presentations conducted as indicated by local county/community	Phase 2: FY21 Q3,Q4-Ongoing
	Create/Distribute print materials to Meals on Wheels, churches, health care providers, senior centers and senior living communities.	Materials available/distributed as indicated by local county/community	Phase 3: FY22 Q1, Q2-Ongoing

Appendix 27. Treatment Goals

Appendix 27.1 Access to Evidence Based Services

Goal #1: Improve evidence based service array within the MSHN region.					
Overall Impact 1. Increased access to evidence based practices services 2. Retention in treatment for successful recovery. 3. Reduction in overdose deaths.					
TREATMENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
MEDICATION ASSISTED TREATMENT	Opioid Use Disorders are prevalent across Region 5 counties. This impacts physical health including risk of overdose & death, financial & family stability, and other social determinants of health.	Prescription opioid painkillers are widely available on the black market. Heroin & Fentanyl are widely available & inexpensive.	Address service gaps identified in regional NAA	The Network Adequacy Assessment will be used to assess service gaps across the region.	5% Increase in availability of MAT services throughout MSHN region
					Maintain access to MAT services within 30 minutes and 30 miles or less for urban areas and 60 minutes and 60 miles or less in rural areas.
			Expand access to MAT	Expanded array of MAT services	Availability of all MAT medications throughout the MSHN region.
		People do not know when they are using a drug that has a fatal dose of Fentanyl or Carfentanil.	Continue to provide access to naloxone through community partners	Add information about how to access naloxone on MSHN Website	5% Decrease in opioid overdose deaths in the MSHN region

Goal #1: Improve evidence based service array within the MSHN region.					
Overall Impact **1. Increased access to evidence based practices services** **2. Retention in treatment for successful recovery.** **3. Reduction in overdose deaths.**					
TREATMENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
STIMULANT USE DISORDERS	There is a critical need to address trauma as part of substance abuse treatment. Misidentified or misdiagnosed trauma-related symptoms interfere with help seeking, hamper engagement in treatment, lead to early dropout, and make relapse more likely.	Trauma informed care is not available throughout the MSHN region. When trauma is not addressed during treatment it may lead to early drop out and relapse.	Providers will receive training in Trauma Informed Care Evidence Based Practices.	Providers will address or refer to appropriate provider for trauma or mental health treatment needs	Increase in documentation of mental health and trauma needs being addressed in treatment, monitored during MSHN Site Visits.
					Clinicians will become more capable and competent in addressing trauma during treatment.
		Expanding ease of access to treatment will ensure individuals seeking treatment are not re-traumatized in the initial process.	MSHN will work to ensure people accessing treatment are able to enter treatment no matter what avenue they try to enter services.	MSHN will evaluate the Access Management System and implement changes that will improve efficiency and reduce duplication.	Changes will produce a more streamlined/consumer-friendly experience for people seeking services.

Goal #1: Improve evidence based service array within the MSHN region.					
Overall Impact **1. Increased access to evidence based practices services** **2. Retention in treatment for successful recovery.** **3. Reduction in overdose deaths.**					
TREATMENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
STIMULANT USE DISORDERS	Stimulants are a growing drug of choice in Region 5. With continued growth, stimulants may become a more serious issue for our region. It could impact mental health hospital admissions as stimulant use may resemble mental health symptoms. Stimulant use in combination with opioids causes an increased risk of overdose.	Methamphetamines and other stimulants are becoming increasingly available and are often used in conjunction with opioids. There are no current medications to assist with treating stimulant use disorders.	Educate the current MSHN contracted SUD providers on stimulant use disorders. Make Stimulant Use Disorder Evidence Based Practice available throughout the MSHN region.	Monitor Primary Drug at Admission to determine Stimulant Use Disorder growth or decline.	5% decrease in Stimulant as Primary Drug at Admission
				Provide education to the MSHN SUD Provider Network on Stimulant Use Disorders, overdose deaths related to stimulant in combination with opioid use, and Evidence-Based Practices.	MSHN SUD Provider Network will become educated about Stimulant Use Disorders as evidenced by training attendance and resource sharing by MSHN.
				Provide education to the MSHN SUD Provider Network on Stimulant Use Disorders, overdose deaths related to stimulant in combination with opioid use, and Evidence-Based Practices.	MSHN will monitor the use of Evidence Based Practices during Site Visits.

Goal #1: Improve evidence based service array within the MSHN region.					
Overall Impact **1. Increased access to evidence based practices services** **2. Retention in treatment for successful recovery.** **3. Reduction in overdose deaths.**					
TREATMENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
WOMEN'S SPECIALTY SERVICES	Successful recovery for women requires that the service delivery system integrates women's specific substance use disorder treatment, to include mental health services, recovery supports and, frequently, treatment for past traumatic events. Without these Designated Women's Specialty services, women are not able to make progress in attaining recovery from substances.	Designated Women's Specialty services are not available throughout the region. This causes women not to access needed treatment.	Build capacity for designated Women's Specialty services where needs exist in the MSHN region.	Expand Designated Women's Specialty Service programs throughout region	5% increase in Designated Women's Specialty services programs in MSHN region

Goal #1: Improve evidence based service array within the MSHN region.					
Overall Impact **1. Increased access to evidence based practices services** **2. Retention in treatment for successful recovery.** **3. Reduction in overdose deaths.**					
TREATMENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
WOMEN'S SPECIALTY SERVICES	Children of parents with Substance Use Disorders may have special needs for services. These needs often go unidentified and the children experience life issues as a result of not receiving the services that they need.	Not all Women's Specialty programs are consistently identifying children's needs and making referrals for the children.	MSHN will work with all Designated Women's Specialty providers to do a thorough assessment of all needs of the children of the parents they serve.	Increase number of referrals made for children of parents experiencing a substance use disorder.	100% of all Designated Women's Specialty programs will assess for children's needs and will make referrals when appropriate. 10% increase in referrals for children's services.
	Women with substance use disorders often have experienced traumatic events in their lifetimes or may have mental health disorders. Gone untreated these disorders may cause the substance use to continue.	All individuals working in Women's Specialty programs must have training in serving individuals with mental health disorders as well as serving individuals who have experienced trauma.	Expectation for assessing for mental health disorders as well as having staff trained in Trauma Informed Care	Increase training in trauma informed care for women, and ensure that all Women's Specialty programs are assessing for and addressing or referring out for mental health disorders.	100% of designated Women's Specialty programs will assess for mental health disorders and will treat or refer out for identified mental health disorders. 100% of Designated Women's Specialty programs will have staff trained in Trauma Informed Care evidence based practices.

Goal #1: Improve evidence based service array within the MSHN region.					
Overall Impact 1. Increased access to evidence based practices services 2. Retention in treatment for successful recovery. 3. Reduction in overdose deaths.					
TREATMENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
JAIL BASED SERVICES	Individuals who are incarcerated often do not receive treatment during their incarceration for their substance use disorders or mental health disorders. Medication Assisted Treatment is not always offered to inmates while they are incarcerated. Overdose deaths occur frequently in individuals upon release from jail.	Jail-based treatment services are not available throughout the jails in the MSHN region There is not always a good collaboration of care between treatment providers and jail staff.	Assess need for SUD treatment services within the jails in the MSHN region	Increase access to Re-Entry Services throughout the MSHN region	10% increase in jail-based programs within the MSHN region
				Work with MSHN contracted providers to build relationships with in-region jails	10% increase in referrals to ongoing treatment in the MSHN region following release from jail.
				Monitor data on engagement from jail-based treatment services to re-entry services.	5% increase in individuals able to continue to receive medications for opioid use disorders while incarcerated.
			Work with the jails within the MSHN region to expand access to Medication Assisted Treatment within the jail setting Provide Medication Assisted Treatment within the jail to increase the individual's recovery capital and to decrease opioid overdose deaths for individuals being released from jail	Increase Jail-Based Treatment & Jail-Based Medication Assisted Treatment services throughout the MSHN region.	10% increase in initiation of Medication Assisted Treatment within the jails in the MSHN region.

Appendix 27.2 Expand Penetration Rates for Adolescents, Older Adults, Veterans and Military Families

Goal #2: Improve services to specialty populations in Region 5. **Overall Impact** **1. Increased access to SUD services.** **2. Reduction in overdose deaths.** **3. Reduction in comorbid health conditions.** **4. Retention in treatment for successful recovery.**					
TREAT-MENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/ INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
VETERAN	Veterans are at an increased risk for BH/SUD issues and face additional barriers due to stigma	A lack of provider understanding about veteran culture and internal stigma regarding seeking help	Increase access to BH/SUD services through anti stigma campaign and outreach to veterans.	Increased awareness of BH/SUD prevalence and services available	5% increase in calls to VN for veterans seeking BH/SUD services
			Expand Military Cultural Competency and military-specific trainings to the provider network	Improved access to cultural training for providers	5% increase in number of providers that have received MCC
	Availability and coordination of services for veterans with VA benefits can complicate access to BH/SUD services	Poorly designed structure to identify veterans who may be connected to VA benefits	Improve the ability of providers to identify veteran with VA benefits through improved screening protocols	Improved coordination of care	Improved access to BH/SUD treatment through public health system when VA services are not available
ADULT 55+	Alcohol is the leading cause of treatment admission. Alcohol is the leading cause of SUD-related deaths in individuals 55+. Substance Use Disorder is increasing in the 55+ population.	Limited awareness of the dangers of alcohol interactions with prescription medications	Develop and implement outreach stategies for individuals 55+	Increased awareness (utilization, engagement?) of BH/SUD services available for 55+	Improved access to BH/SUD treatment through public health system
		Current SUD treatment services are often not culturally competent for the 55+ population.	Educate providers on the unique needs of individuals 55+ to reduce stigma, improve access to telehealth, and inform consumers of health risks/ potential drug interactions associated with alcohol.	Improved access to cultural training for providers	Increase retention rates by 5% for consumers 55+

Goal #2: Improve services to specialty populations in Region 5. **Overall Impact** **1. Increased access to SUD services.** **2. Reduction in overdose deaths.** **3. Reduction in comorbid health conditions.** **4. Retention in treatment for successful recovery.**					
TREAT-MENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY - RESOURCES**	**OUTPUTS - OBJECTIVES**	**OUTCOME**
ADO-LESCENT	Upbringing, trauma and grief are all contributing factors to substance abuse in teens. An adolescent mind is more vulnerable to the effects of substance use than those with a fully developed brain. Research suggests that the earlier someone uses drugs the more likely they are to develop serious problems.	Adolescents are not likely to reach out for treatment.	Increase availability of adolescent treatment within the MSHN region.	Increase in awareness of treatment options for adolescents in the MSHN region.	5% increase in adolescents accessing treatment.
		Adolescents may not have support from family members, they may have instability in the home, or may have family members who may be using substances themselves.	Build a support network through collaboration with SUD treatment providers, CMHSP, schools, court, MDHHS, faith based communities or other providers in the area.	MSHN SUD treatment providers will increase engagement with community supports for adolescents within the community.	There will be an increase in coordination of care for adolescent supports and referrals as evident during Delegated Managed care Site Reviews.

Appendix 27.3 Cultural Competence and Health Disparities

Goal #3: Increase cultural competence in delivery of SUD treatment services to reduce health disparities **Overall Impact** **Successful engagement and retention in SUD treatment will improve recovery rates among targeted marginalized populations in Region 5 by 10% over 3 years.**					
TREAT-MENT FOCUS	**PRIMARY PROBLEM & CONSEQUENCE**	**INTERVENING VARIABLES/INPUTS**	**ACTIVITY-RESOURCES**	**OUTPUTS-OBJECTIVES**	**OUTCOME**
All Con-sumers	1. Historic and current systemic discrimination has created mistrust in marginalized populations including people of color, LGBTQ, and immigrants. 2. The SUD treatment workforce is underrepresented with staff from marginalized populations creating potential for unconscious bias in treatment programming by predominantly white heterosexual staff. 3. Marginalized populations are at high risk and are disproportionately suffering effects of substance abuse, suicide, mental illness, and other negative health outcomes. .	1. Community partners, people in recovery, and other MSHN allies who are people of color, LGBTQ, etc. 2. Data for MSHN region, per county, that identify health disparities gaps, barriers, and challenges to engagement with treatment services 3. A treatment provider network that is committed to best practices, inclusion, diversity and successful SUD treatment service delivery for all. 4. Evidence-based curricula to improve delivery of cultural competent treatment services.	1. Develop diverse focus groups, clinical workgroups and advisory committees to help identify key gaps in access delivery of treatment services. 2. Analyze social determinants of health (SDoH) data to support culturally competent strategies to address barriers/challenges to engaging marginalized populations in treatment. 3. Provide focus group feedback and SDoH analysis to MSHN treatment provider network to support increased cultural competency training and literacy among provider staff. 4. Provide all treatment providers with evidence-based training in cultural competency and impacts of racial trauma and other forms of discrimination-based trauma.	All MSHN treatment providers will offer culturally competent treatment programming at all levels of care that address historical trauma and other culturally specific aspects of treatment.	Recipients of treatment programming will experience culturally relevant and responsive messaging to which they can relate regardless of cultural background. MSHN treatment providers will bring heightened cultural awareness into their workplace and communities.

Appendix 28. Mid-State Health Network Cultural Competency Policy

Link to full document: Mid-State Health Network Cultural Competency Policy

Appendix 29. Mid-State Health Network's Substance Use Disorder Provider Training Grid

Link to full document: Mid-State Health Network's Substance Use Disorder Provider Training Grid