MSHN
Mid-State Health Network

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

Fiscal Years 24-26

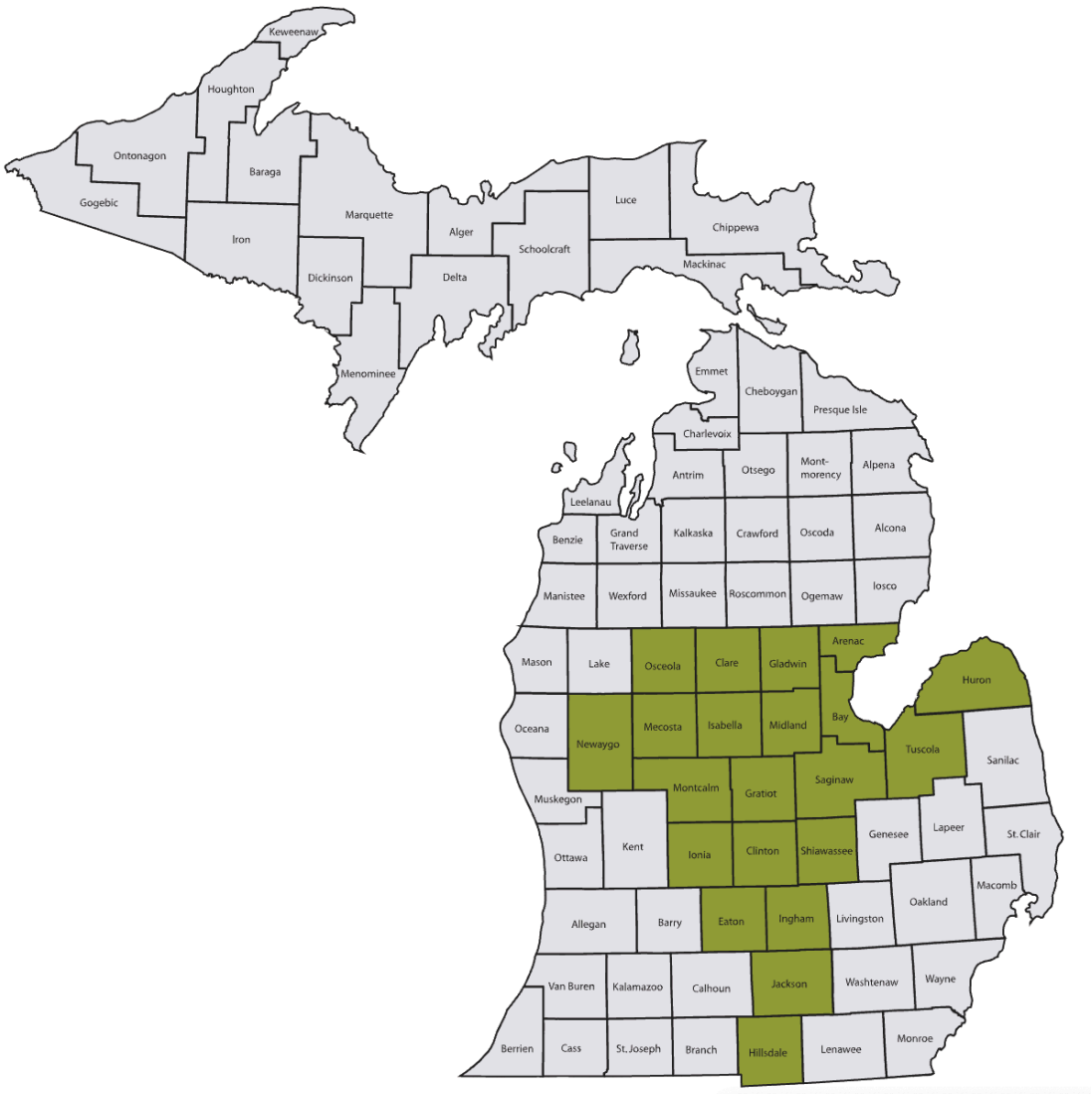
TABLE OF CONTENTS

Contents

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 a network of substance use disorder (SUD) prevention, treatment, community recovery, harm reduction and recovery housing providers and with the twelve Community Mental Health (CMH) agencies that provide behavioral health services to these twenty-one (21) counties. 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, FY24-26.



Region 5

Historical Context for this FY24-26 Strategic Plan

The global COVID-19 pandemic was unfolding in 2020 when Mid-State Health Network (MSHN) developed its 2021-2023 Substance Use Disorder (SUD) Strategic Plan. Over the course of subsequent years, the pandemic led to unprecedented changes in the health of our region, our state and our nation, as well as to the health care systems of which MSHN is a part.

As this new FY24-26 SUD Strategic Plan is being developed, Michigan is in a post-pandemic unwind. Certain pandemic-driven changes—like the broad use of telehealth[1] and the expansion of remote work—constitute "a new normal" that's not likely to go away. Other changes, like the expiration of the continuous enrollment condition authorized by the Families First Coronavirus Response Act (FFCRA) presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act. Medicaid continuous enrollment ended on March 31, 2023,[2] which will result in declining Medicaid enrollment as ineligible Michigan residents are removed from the rolls.

This FY24-26 SUD Strategic Plan is informed throughout by epidemiological and demographic data from the Michigan SUD Data Repository, Michigan Profile for Healthy Youth (MiPHY), Center for Disease Control & Prevention (CDC), Substance Addiction & Mental Health Services Administration (SAMHSA), Michigan Overdose Data to Action (MODA) dashboard, and other traditional data sources. That said, the pandemic's long-term impacts on Michigan's social determinants of health are often not captured in traditional data. Workforce shortages, for example, and the highest inflation rates in decades have had ripple effects that contributed to poor outcomes across multiple health indicators. Michigan experienced spikes in mental illness as well as increases in overall overdose death (ODD) rates and in particular, spikes in ODD rates in communities of color.[3]

This strengthens Mid-State Health Network's commitment to our mission to ensure access to high-quality behavioral health and substance use disorder services for all citizens in our 21 counties. The strategies and mechanisms to operationalize our mission are detailed in the strategic plan that follows.

Demographic Profile of Region 5

MSHN recognizes that within its large 21-county region, there is significant variation between counties and communities particularly in terms of income and educational levels, population density, ethnic and racial composition, and primary sources of economic activity.

Household income varies across the region, and it should be noted that the census data that follows reflects pandemic conditions in 2020 and 2021 as the state experienced significant economic disruptions. Data from the 2021 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. [4]

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%.[5]

According to U.S. Census Bureau 2020 population estimates, most residents of Region 5 are non-Hispanic White with sixteen of Region 5's twenty-one counties being 87% White or higher.

Region 5 as a whole 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.

At the county level, Saginaw has the highest Black or biracial population (20.3%) as well as the highest percentage of Hispanic/Latinos (6.9%).[6] The county with the highest Native American population is Isabella (6.3%). Ingham county had the largest population of Asians at 7.9% and "Two or more races" at 4.2%.[7]

Populations of Focus

During FY24-26, SUD treatment services and supports funded by Medicaid, Block Grant, State Opioid Response (SOR) grant, American Rescue Plan Act (ARPA) funds, COVID Block Grant (until 3-14-2024), and Public Act 2 funds 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.[8]

Prevention activities in the region are designed to serve all three Institute of Medicine (IOM) classifications: Universal Populations, Selective Populations, and Indicated Populations. Universal populations will mainly be served through educational groups to youth and parents along with community and environmental strategies with the general population.

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, recovery housing, case management, peer supports and Medication-Assisted Treatment (MAT) which is inclusive of both Opioid Treatment Providers (OTPs) and Outpatient-Based Opioid Treatment providers (OBOTs). MSHN contracts with providers geographically in and out of region to support the broadest availability of ASAM levels of care, which enhances consumer choice with multiple

pathways to access providers and services throughout the MSHN network. Other than Osceola County, every Region 5 county has at least one SUD outpatient 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 Life Skills, and ENDS 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 continued to include recovery housing in its treatment service array. Twenty-seven recovery homes, with a total bed count of 234 beds, are currently located across Newago, Montcalm, Ingham, Saginaw, 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) 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 30 minutes for all levels of care in urban, settings, within 60 miles in rural areas for outpatient and SUD Women's Specialty, and 90 minutes/90 miles in rural areas for SUD residential and Withdrawal Management, from the beneficiary's home;
- What change(s) can reasonably be anticipated over time?

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

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

The 2022 NAA contains the region's 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 Withdrawal Management services and medication-assisted treatment (MAT), 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;
- Assess and monitor new MDHHS Network Adequacy standards specific to opioid treatment programs (OTPs);
- Identify places where racial disparities in access, engagement and health outcomes are pronounced and actively engage in remedies;
- Support an RFI/RFP process to expand provider network to support needed ASAM Levels of Care for adolescent withdrawal management, residential, and outpatient services.

MSHN will continue to work on these priorities through the strategic plan, continued staff effort, and the continued work of the provider network.

Barriers to SUD Prevention, Treatment, & Recovery Services

Barriers MSHN will consider are, at a minimum, the long-term impact of the coronavirus pandemic on the populations we serve, workforce shortages and concomitant lost capacity in our provider network, limited broadband internet access which impacts the expanded demands for telemedicine, budget cuts to Substance Abuse Block Grant (SABG) and the public health infrastructure, and the broad geographic distribution across 21 counties of providers and beneficiaries, and lack of adequate 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 can help reduce provider-level implicit and explicit biases and discriminatory practices, but we recognize that some institutional and systemic disparities are not entirely within our control though they perpetuate barriers to equity in healthcare delivery across the region.

MSHN has overcome many previous barriers by drawing down federal grant funds via SAMHSA and MDHHS. In 2023, MSHN received over $7,000,000 in supplemental grant funding to support the expansion of prevention, treatment, and recovery programming throughout the region.

Communicable Disease

MSHN treatment providers will follow the MDHHS Prevention Policy #02 Addressing Communicable Disease Issues in the Substance Abuse Service Network (October 1, 2023).[9]

This includes the following requirements:

1. Each PIHP is required to assure that all individuals entering SUD treatment have been appropriately screened for risk of HIV/AIDS, STD/Is, TB, and hepatitis, and that they are provided basic information about risk.
2. All persons receiving residential SUD services who are infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The PIHP's responsibility extends to ensuring that the agency to which the client is referred, has the capacity to provide these medical services, or to make these services available, based on the individual's ability to pay. If no such agency can be identified locally, the PIHP must notify MDHHS/SUGE within two business days by sending an email notification to the Program Manager.
3. All individuals entering residential treatment and residential withdrawal management must be tested for TB upon admission. Arrangements can be made for an outside agency to test if they can be completed

within 24 hours. With respect to clients who exhibit symptoms of active TB, referrals must be made for follow-up medical intervention and policies and procedures must reflect this requirement to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and communicable disease best practice.

4. All pregnant women presenting for treatment must have access to STD/I and HIV testing.

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

This section looks at MSHN's epidemiological profile in relation to substance use disorder patterns. MSHN utilizes data captured in our integrated electronic data collection systems (REMI) as well as data captured from state and federal sources.

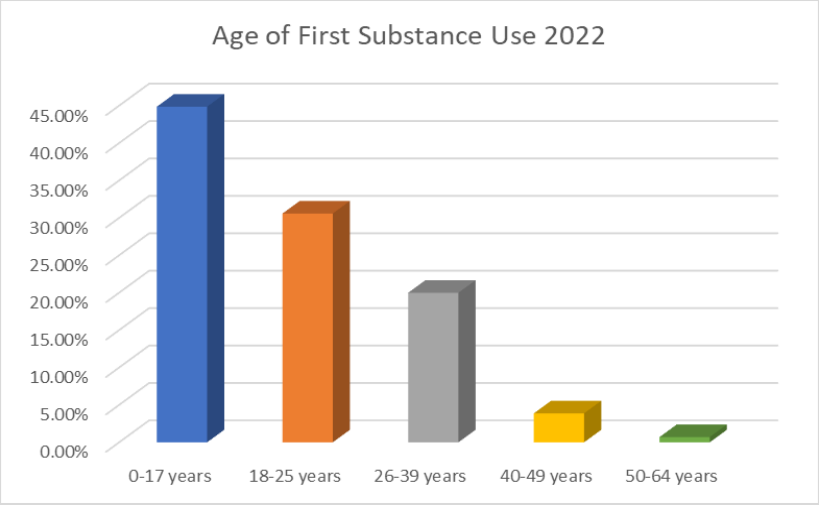
SUD Morbidity, Mortality and Prevalence:

In 2022, Mid-State Health Network provided SUD treatment services for 11,053 individuals (unduplicated) receiving an admission for substance use disorder services, a 3.7% decrease since 2021. 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 also utilizes a "no wrong door" approach to service which allows multiple pathways for people to access treatment services at 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 (Note: the information in this section is pulled from REMI - MSHN's Regional Electronic Medical Information system).

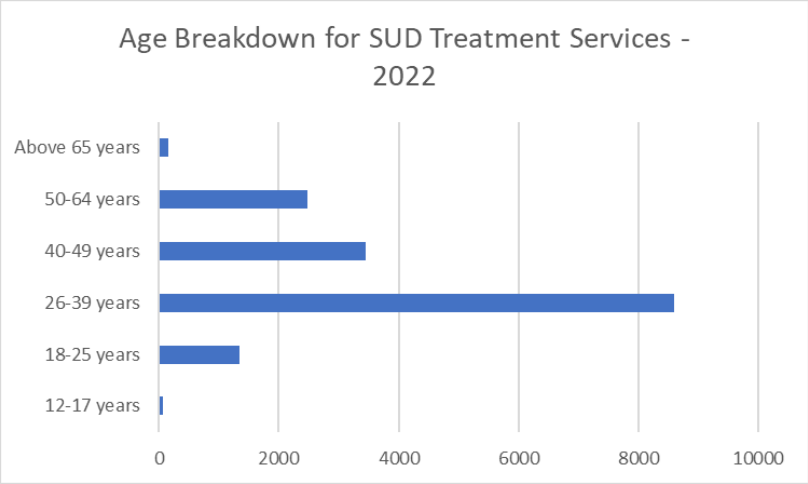
In MSHN's counties, for FY22 (10-1-2021 thru 9-30-2022), the primary substance at time of admission for individuals seeking SUD treatment services was the following: Alcohol 35.71%, Heroin/Synthetic Opioids/Other Opioids 31.23%, Methamphetamines/Speed 20.49% Cocaine/Crack 6.55%, and Marijuana 4.45%. All other substances were reported less than 1% of the time included the following: other amphetamines, benzodiazepines, inhalants, over the counter medications, barbiturates, non-prescription methadone, and other sedatives or hypnotics.

The MSHN region had the following demographics for individuals being supported by SUD treatment services in FY22.

- Age of First Substance Use: Was highest for the 0-17 years age group, with the next largest group being 18-25 years.



- Of individuals served, the age category of 26-39 years had the largest representation (53%), with 40-49 years as the next highest (21%), and 50-64 years (15%) in the top three.



- Education: 77% of individuals had completed a GED or higher education.
- Legally Involved: 45% of individuals were engaged in some level of legal involvement including parole, probation, in jail/prison, tether, etc.
- Marital Status: 61% of individuals were never married, 19% were divorced, and 12% reported being married or cohabitating.
- Employment Status: 63% of individuals were unemployed, 20% employed full or part time, and 16% identifying as not in the labor force.
- Gender: Males represented 60% of admissions and females 40%.

Per the county health rankings, there is a 6.8-year age difference in life expectancy within the MSHN region. Clare County has the lowest life expectancy at 74.3 years and Clinton County has the highest life expectancy in the MSHN region at 81.1 years[10]. 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, among the lowest education attainment in the region, and is one of three 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.

Youth Epidemiological Indicators:

The youth indicators reported below were calculated from data provided by MDHHS Substance Use in Michigan data repository[11]. Data can also be accessed from the Michigan Profile for Healthy Youth (MiPHY) on the Michigan Department of Education website[12]. It is important to note that only counties who collected the same data in 2020 and 2022 were used to calculate averages. In addition, it is important to note that not all schools in all counties administer the MiPHY survey.

Note: 1) If data is not reported for either cohort, then the data was not captured by MiPHY; 2) If the dataset was not collected for the consecutive 2020 and 2022 cycles, it was not included in the average; 3) High School is identified below as HS, Middle School is MS.

Tobacco/Nicotine: 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.

- Cigarette Use Past 30 Days: 56.4% ***reduction*** from 2020 to 2022 for HS and 46% ***reduction*** for MS
- Electronic Vapor Product Use: 23% ***reduction*** from 2020 to 2022 for HS and 4% ***increase*** for MS

Alcohol and Other Drugs: The SUD data collected by MiPHY indicates that substance use has mostly decreased or remained the same over the two-year span. In the past, there has been a significant increase in cannabis use among middle school (MS) aged children, but use remained the same over the last two-year span. Further review indicates that these students reported parental disapproval of cannabis use remaining steady.

- Alcohol Use Past 30 Days: 19% ***reduction*** from 2020 to 2022 for HS and 25% for MS.
- Cannabis Use Past 30 Days: Average for HS ***remained constant*** at 13.5% for 2020 and 2022; MS average ***decreased*** from 4% to 3%
- Cannabis parental disapproval: Average for HS ***increased*** from 86.4% in 2020 to 87.9% in 2022 while average for MS ***remained the same*** at 95% in 2020 and 2022
- Opioid Use Past 30 Days: 34% ***reduction*** from 2020 to 2022 for HS and 13% for MS

Suicide: Suicide is the third leading cause of death for 14 to 18-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 an increase in suicidal thoughts, making suicide plans, and suicide attempts for female students of all ethnicities.

- Considered Suicide: ***Increased*** 23% in 2020 to 26% in 2022 MS, **steady** at 22% HS
- Attempted Suicide: ***Increased*** 11% in 2020 to 12% in 2022 MS, **steady** at 11% HS

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, BH TEDS, and REMI (MSHN's Regional Electronic Medical Information system).

Admissions: New AOD episodes 1-1-2022 thru 12-31-2022: Total 8,303

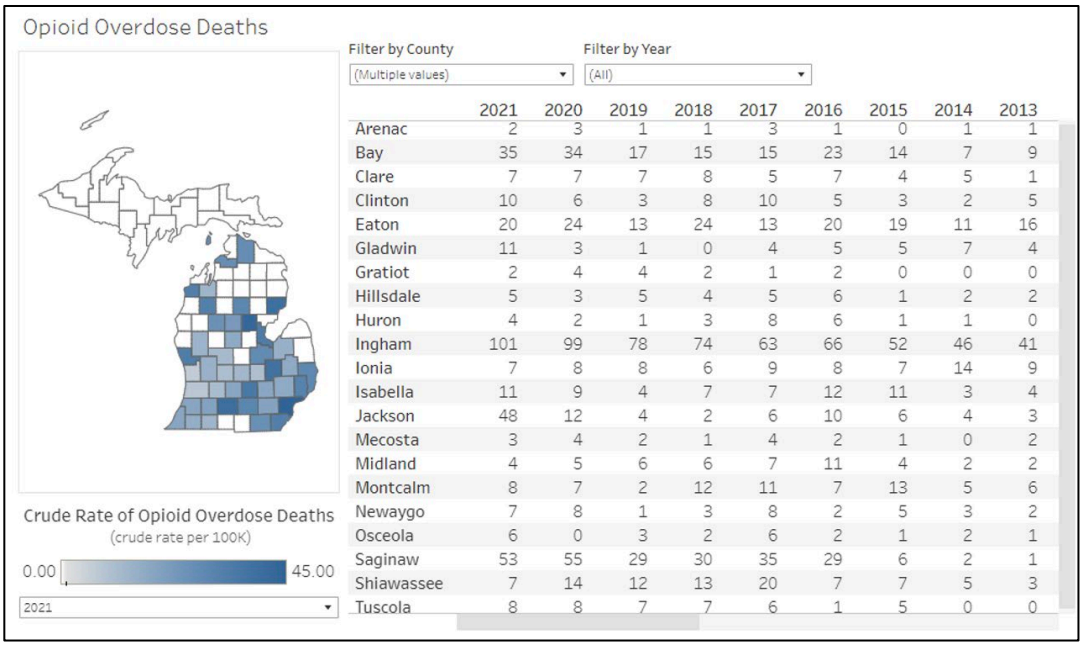
- Nearly half (~45% in 2022) of admissions report first-use of their primary substance at ***17 years old or younger***
- Re-admissions to withdrawal management levels of care within 30 days ***increased*** from 8.10% in 2021 to 8.84% in 2022; ***decreased*** within 60 days from 6.54% in 2021 to 4.74% in 2022; and ***increased*** within 90 days from 3.77% in 2021 to 4% in 2022.
- Re-admissions to residential levels of care within 30, 60, and 90 days ***increased*** across all time periods between 2021 and 2022 by 3-4 percentage points.
- Initiation and Engagement **49%** of Region 5 consumers ***initiated*** and persisted from first face to face and one service within 14 days and **32%** ***engaged*** in 2 additional services within 30 days.

Primary Substance:

- In 2022, alcohol became the largest primary substance reported (35.71%) at time of admission over heroin/synthetic opioids/other opioids.
- Use of heroin & opioids is ***decreasing*** as reported at time of admission from 34.34% in 2021 to 31.23% in 2022.
- The use of methamphetamines across the MSHN region has also ***increased*** from 16.34% in 2020 to 20.49% in 2022.

Mortality and Overdose Rates;

The opioid overdose epidemic predated the COVID pandemic, and it's continued to expand as COVID recedes. The chart below conveys the significant increase in overdose deaths from 2013 to 2021.[13]



	2021	2020	2019	2018	2017	2016	2015	2014	2013
Arenac	2	3	1	1	3	1	0	1	1
Bay	35	34	17	15	15	23	14	7	9
Clare	7	7	7	8	5	7	4	5	1
Clinton	10	6	3	8	10	5	3	2	5
Eaton	20	24	13	24	13	20	19	11	16
Gladwin	11	3	1	0	4	5	5	7	4
Gratiot	2	4	4	2	1	2	0	0	0
Hillsdale	5	3	5	4	5	6	1	2	2
Huron	4	2	1	3	8	6	1	1	0
Ingham	101	99	78	74	63	66	52	46	41
Ionia	7	8	8	6	9	8	7	14	9
Isabella	11	9	4	7	7	12	11	3	4
Jackson	48	12	4	2	6	10	6	4	3
Mecosta	3	4	2	1	4	2	1	0	2
Midland	4	5	6	6	7	11	4	2	2
Montcalm	8	7	2	12	11	7	13	5	6
Newaygo	7	8	1	3	8	2	5	3	2
Osceola	6	0	3	2	6	2	1	2	1
Saginaw	53	55	29	30	35	29	6	2	1
Shiawassee	7	14	12	13	20	7	7	5	3
Tuscola	8	8	7	7	6	1	5	0	0

- Since 2018, the rate of overdose deaths in Region 5 ***increased*** (+48%) from 19 to 29 (per 100,000).
- Between 2020 and 2021, the number of overdose deaths ***increased*** most (+30%) for Black individuals.
- The number of deaths involving psychostimulants ***increased*** sharply by 200%.
- The number of overdose deaths involving synthetic opioids has ***increased*** by 90% since 2018. The number of heroin deaths ***decreased*** (-63%), however, most (+69%) of overdose deaths currently involve more than one drug (poly-substance).
- The number of deaths involving heroin and synthetic opioids grew at a slower rate (+55%) than the number of deaths involving cocaine/psychostimulants (+78%).

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 due to their isolation and other health risks like increased vulnerability to the effects of alcohol and drugs, biological changes associated with aging that reduce the body's ability to absorb and metabolize substances, higher levels of medications prescribed to this age group, and the higher prevalence of stressful life events and transitions experienced by older adults.[14]

A challenge MSHN has faced in the past is accessing data on older adult data substance use and misuse. MSHN's 21 counties cover five Region Area on Aging service areas (each of which collects senior data for the counties MSHN serves as well). Dissecting and interpreting this data for MSHN counties has been a challenge as well as a growth opportunity. In addition, within the MSHN region itself, rural needs vs. urban needs of seniors differ greatly, creating barriers to access like transportation, for example, which is less available in rural counties. MSHN has also found that many older adults and their families are not aware of the full spectrum of services currently offered in their communities as MSHN looks to gather information on gaps in service and opportunities for growth/data collection. We look forward to coordinating increased access to prevention programs for this population.

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, Certified Community Behavioral Health Clinic (CCBHCs), Opioid Health Homes (OHHs), 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, harm reduction programs, active military and veteran support organizations including the Veterans Services Administration (VA), community foundations and community-based organizations, and local harm reduction and syringe services programs. 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.
- MSHN prevention and community recovery providers regularly collaborate with schools and institutions of higher learning to provide prevention and recovery programming.
- MSHN 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—jails, courts, MSP, city and county law enforcement, MDOC, and MATCP.
- MSHN community recovery providers work with a local university to participate in SBIRT trainings and simulations for nursing, pharmacy, and other students.
- MSHN works with harm reduction providers, syringe service programs, and Narcan distribution.
- 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), 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 (or via Zoom during the pandemic) every two months over the subsequent nine (9) years.

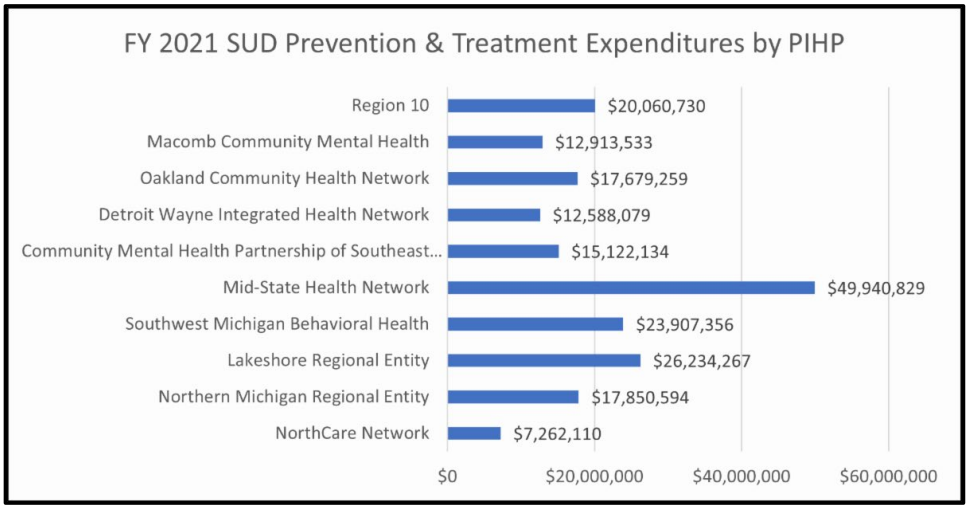
All contracts or policies that involve use of PA2 funds must be approved by MSHN's Oversight Policy Board (OPB) which meets bimonthly in Lansing. Upon approval by the OPB, MSHN's Board of Directors will also review and offer final approval.

In addition to input and decision-making authority invested in the MSHN Leadership, its Board of Directors and its Oversight Policy Board, MSHN established two new advisory workgroups in 2022: the Regional Equity Advisory Committee for Health (REACH) comprised of persons with lived experience who are external to MSHN staff and the Inclusion, Diversity, Equity & Access (IDEA) workgroup comprised of MSHN staff. Both these advisory bodies are intended to provide an equity lens to MSHN's external and internal policies, processes and operations across the region.

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.

Historically, MSHN has outspent the rest of the state in its allocations dedicated to SUD services. In FY 2021, for example, MSHN spent a total of $49,940,829 on Substance Use Prevention & Treatment Services, nearly twice the amount spent by any other PIHP in the state, spending that accounted for 24% of all substance use disorder (SUD) expenditures statewide in FY 2021.[15]



MSHN also served the most individuals in each service category statewide.

Type of Service	Unduplicated Persons Served by MSHN	% of All Persons Served Statewide
Outpatient	10,862	37%
Detoxification	1,598	20%
Residential	3,215	24%

In FY24-26, 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. Maintaining and enhancing the provider panel for SUD treatment, prevention, harm reduction, and recovery services.
2. Review of deficits and developing 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.
3. Ensuring adherence to the PIHP-MDHHS contract with all attached obligations.

Additional Grant Funding

In 2023 and 2024, Mid-State Health Network was allocated over $7 million in State Opioid Response (SOR) supplemental grant funds to help reduce the number of overdose deaths in our region. Driven by the recommendations in the 2023 Opioid Advisory Committee's Annual Report, we will utilize these funds to increase access to youth prevention services, especially in priority populations. We will promote anti-stigma messaging and add at least ten (10) additional vending machines to the eleven (11) we've funded around the region, helping people access Narcan, wound care, and fentanyl test strips. We will also continue to expand diversion programs, access to treatment in jails incarcerated settings, and local harm reduction supplies and services.

The COVID-19 pandemic presented us with unique challenges to the way we treat and reach people. Mid-State Health Network has received over $3.5 million to meet these unprecedented needs through the supplemental COVID-19 and American Rescue Plan Act (ARPA) funding. We have increased and improved access to telehealth, mail-order naloxone and harm reduction supports, and began holding community town halls and meetings virtually. A portion of these funds supported the *Equity Upstream Spring Lecture Series,* and they will continue to support future lectures and the *Equity Upstream Learning Collaborative* pilot in FY24 and FY25 per the grant parameters. These and other grant funds have supported media campaigns to curb problem gambling and youth vaping, fund local contingency management programs to encourage people to stay in treatment and add collegiate recovery programs to local campuses.

Opioid Settlement Funds

Michigan anticipates it will receive over $1.45 billion from opioid settlements which will be divided between local subdivisions and the State of Michigan. MSHN and the other PIHPs will not, for the most part, be direct recipients of opioid settlement funds. We will nonetheless continue to be guided by values like advancing health equity, reducing stigma and cross-system collaboration, and we fully endorse the Opioid Advisory Commission's recommendations in its first 2023 Annual Report that opioid settlement funds be applied to best practice strategies for SUD prevention, treatment, harm reduction and recovery, and in particular to strategies with otherwise limited fund streams, e.g., jail-based services which currently can't be funded by Medicaid. MSHN will continue to collaborate with the OAC and other statewide and local stakeholders, including the local subdivisions in our regions involved directly in the receipt and deployment of opioid settlement funds.

SECTION 6 - GOALS, TIMELINE, & EVALUATION

Each strategy identified in MSHN's strategic plan has an implementation timeline following that goal and each will be evaluated monthly 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 SUD 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 prevention, treatment, and recovery 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 below.

1. Reduce underage drinking and reducing heavy and/or binge drinking among MSHN region adults age 55+;
2. Reduce cannabis use among youth and young adults;
3. Reduce opioid prescription misuse; including a reduction in the misuse 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.
5. Increase access to prevention services for Older Adults (55+)

Goal #1: Reduce underage drinking for youth and adults under 21 years

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 to adults who interact with youth (parents/guardians, teachers, etc.) in efforts to increase awareness of problems associated with underage drinking and provide resources to adults on how they can assist in keeping children alcohol-free. 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. TIPS trainings to both on and off premises alcohol vendors will continue to be an activity provided by Prevention Providers in their communities. In addition, Prevention Providers will provide education and information through classroom education; and student assistance programs to increase awareness of risk/consequences of use to self, family, and community.

PREVENTION FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Regional use of alcohol is slightly trending down and that trend needs to be maintained.	Continued decrease in regional underage drinking. - Age of first alcohol use in MSHN Region: 11.66 years - Youth alcohol use in past 30 days in MSHN Region: 10.66% (MiPHY, 2022)	Parental Approval of Underage Drinking, Community Norms Favorable to Alcohol Use	Provide adult education and informational presentations	Number of adult education and information presentations conducted as indicated by specific county/ communities	Increase adult awareness of problems associated with underage drinking.
		Parental Approval of Underage Drinking, Community Norms Favorable to Alcohol Use, Ease of Access	Evidence-Based Practices used in youth school and community education	Number of evidence-based practices in place	Increase youth awareness of the risk/consequences of alcohol use to self, family and community.
			Student Assistance Programs	Number of active student assistance programs	
		Community Norms Favorable to Alcohol Use	Town Hall Meetings	Number of Events Held	Reduce community norms favorable to alcohol use by making community more aware of underage alcohol issues.
			Social Norming Campaigns	Materials available as indicated by local county/community	
			Alcohol vendor education and compliance checks	Number of vendor education and compliance checks completed as indicated by county/community	Provide local vendors and adults with knowledge and information on the laws and responsibilities of providing alcohol to minors.
			TIPS Trainings	Number of classes completed as indicated by county/community	

Timeline and Evaluation (Reduce Underage Drinking):

The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY24) – Provide parenting education and information presentations, conduct community forums addressing underage drinking, 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 2024) - 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 FY26. Phase #3 (Q1 and Q2 of FY25) – Provide technical assistance in developing school and local policies that are consistent and enforceable and develop and conduct social norming campaigns through FY26. Phase #4 will be a continuation of all activities and expectations from previous phases. Evaluation will consist of 1) process data through MPDS, 2) outcome evaluations using MiPHY data and provider annual outcomes reports.

Goal #2: Reduce cannabis use among youth and young adults

Prevention and Community Recovery Providers will conduct research-based education both in schools and in community groups; conduct MIP 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. Education and information sessions will be provided to adults who interact with youth (parents/guardians, teachers, etc.) in efforts to increase awareness of problems associated with youth cannabis use and provide resources to adults on how they can assist in keeping youth cannabis-free. Prevention and Community Recovery Providers will; work with local communities to provide social norming/ marketing and media campaigns to address favorable community norms.

PREVENTION FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Reduce youth use and access to cannabis/cannabis products	Regional youth use of cannabis - cannabis products is increasing as evidenced by: - Age of first cannabis use in MSHN Region: 12.75 years - Youth cannabis use in past 30 days in MSHN Region: 10.07% -Youth reporting parents felt cannabis use to be wrong or very wrong in MSHN Region: 90.49% (MiPHY 2022)	Ease of Access, Lack of Perceived Risk, Community Norms	Provide adult education classes and informational sessions	Number of adult education sessions held	Increased adult awareness of problems associated with underage cannabis use and providing cannabis/cannabis products to minors
		Ease of Access, Lack of Perceived Risk	Evidence-Based Practices used in youth school and community education	Number of evidence-based practices in place	Increased youth awareness of risk/consequences to self, family and community
			Student Assistance Programs	Number of active student assistance programs	
		Parental Approval of Problem Behavior, Lack of Perceived Risk, Community Norms	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	Reduction in community norms favorable to cannabis use by making community more aware of underage cannabis issues

Timeline and Evaluation (Reduce Cannabis Use):

The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY24) – Conducting research-based education both in schools and in the community and incorporate cannabis information into peer assisted leader and student assistance programs. These will be ongoing through FY26. Phase #2 (Q3 and Q4 of 2024) - Develop/adapt MIP Programs for youth experimenting with cannabis, provide education classes and information sessions to parents, and conduct or work with local community to provide social norming/marketing and media campaigns. All phase #2 activities are on-going through FY26. Phase #3 (Q1 and Q2 of FY25) – Develop and distribute resources as part of education classes and informational sessions, provide or work with the community to conduct cannabis vendor education, and provide technical assistance in developing local and school policies that are consistent and enforceable. Most activities are anticipated to be on-going through FY26. Evaluation will consist of 1) process data through MPDS, 2) outcome evaluations using MiPHY data and provider annual outcomes reports.

Goal #3: Reduce opioid and opioid prescription misuse including reduction in the misuse of opioids for non-medical purposes

Prevention and Community Recovery Providers will conduct community based and environmental strategies such as partnering with local DEA and law enforcement on Prescription Take Back Programs. 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 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 and conducting community forums as necessary. In FY24-26, 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 Life Skills 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. MSHN will continue to promote the state's naloxone portal and encourage distribution through trainings and naloxone vending in communities as needed.

PREVENTION FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
To reduce prescription and over-the-counter drug abuse, including the misuse of opioids for non-medical purposes	Increase in prescription drug and over- the-counter use and abuse of prescription drugs leads to increase in overdoses and treatment admissions. Youth past 30-day use of painkillers such as Oxycontin, Codeine, Vicodin, or Percocet without a Dr. prescription in MSHN region: 3.27% (MiPHY, 2022)	Lack of Perceived Risk	Provide education programs and informational sessions	Education programs and information sessions provided as directed by individual local community need	Increased youth awareness of risk/consequences to self, family, and community
		Community Norms, Lack of Perceived Risk	Conduct or work with local community to provide social norming/marketing and media campaigns Conduct community forums	Social norming - marketing materials and media campaign materials available Number of community forums held	Reduction in community norms favorable to opioid misuse by making community more aware of opioid issues
		Community Norms, Lack of Knowledge of Harm Reduction Benefits	Distribute resources throughout the community (SOR Grant)	Narcan orders through the state Narcan portal for MSHN region agencies	Narcan provided to communities to address issues of opioid abuse and misuse

Timeline and Evaluation (Reduce opioid prescription abuse):
The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY24) – 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 community forums. All activities are planned to be on-going through FY26. Phase #2 (Q3 and Q4 of 2024) – 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 data through MPDS, 2) outcome evaluations using MiPHY data, and provider annual outcomes reports.

Goal #4: Reduce youth tobacco and nicotine use including electronic nicotine devices [ENDs]

Prevention providers will conduct activities including providing parenting education and community informational presentations to law enforcement, local officials and other adult awareness regarding the dangers of smoking, vaping and secondhand smoke/vapor. 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 vendor education and formal SYNAR is conducted each year with the intent of lowering rates of youth access to and use of tobacco.

PREVENTION FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Reduction of youth use of tobacco/ENDS products	Increased regional youth use of tobacco/ENDS products as evidenced by: - Age of first tobacco use in MSHN Region: 11.7 years - Youth tobacco use in past 30 days in MSHN Region: 1.39% - Youth ENDS use in past 30 days in MSHN Region: 14.14% (MiPHY 2022)	Community Norms	Provide adult education and community informational presentations	Number of adult education sessions held	Increased adult awareness and knowledge on the dangers of smoking, vaping & secondhand smoke/vapor
		Community Norms	Evidence-Based Practices used in youth school and community education	Number of evidence-based practices in place	Increased youth awareness of the risk associated with tobacco and ENDS use.
			Student Assistance Programs	Number of active student assistance programs	
		Retail Access, Laws and Policies, Community Norms	Tobacco vendor education and compliance checks	Number of vendor education checks as assigned per county/community. Success of compliance checks as assigned per county.	Reduced ENDS sale rate to minors
			Tobacco vendor education and compliance checks	Number of vendor education checks as assigned per county/community. Success of compliance checks as assigned per county.	Increased vendor knowledge and awareness surrounding issue of youth access to tobacco products

Timeline and Evaluation (Reduce youth tobacco access):

The timeline for implementation will be: Phase #1 (Q1 and Q2 of FY24) – Provide parenting education and community informational presentations, provide technical assistance 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 FY26. Phase #2 (Q3 and Q4 of 2024) – 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 FY25) – 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 data through MPDS, 2) outcome evaluations using MiPHY data, provider youth tobacco act reports, Synar and non-Synar rate.

Goal #5: Increase access to prevention services for older adults.

Ageism leads to poorer health, social isolation, earlier deaths and cost economies billions according to the *World Health Organization Global Report on Ageism*.[16] This report concludes that healthcare rationing based solely on age is widespread. A systematic review in 2020 showed that in 85 percent of 149 studies, age determined who received certain medical procedures or treatments. Ageism has serious and wide-ranging consequences for people's health and well-being. Among people aged 55 and above, ageism is associated with poorer physical and mental health, increased social isolation and loneliness, greater financial insecurity, decreased quality of life, and premature death.

Given limited data on older adult access to prevention services, MSHN will collect baseline regional data. The State of Michigan is in the process of collecting needs assessment data currently for this population and MSHN will follow a similar example upon publication of state-wide data. Current research about the lack of access to prevention services for 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 will be offered regarding current resources and current deficits in efforts to build current data base and build upon deficits across the region. The type of event/milieu will be based on local need/conditions and could be a town hall meeting in one county; face-to-face partnership with a Commission on Aging facility; or a virtual focus group. These education efforts will jumpstart MSHN's efforts to change community norms as well as build baseline data for complete, accurate older adult needs assessment.

In addition, MSHN will develop an internal workgroup to address older adult issues across the twenty-one-county region with membership from current older adult aging partners from community coalitions (where many County on Aging (COA) and regional Area on Aging (AAA) organizations already participate). Across the MSHN region, five different AAAs exist currently (Regions 2, 5, 6, 7 and 8). It is the intent to bring appropriate membership to the MSHN Older Adult Workgroup and to have appropriate MSHN Prevention and Community Recovery Providers participate in their local groups to build a resource network; identify gaps in service; and to efficiently use limited resources across multiple counties. MSHN Prevention and Community Recovery Providers will also increase their presence at senior centers, senior living facilities, senior health fairs, etc. These efforts shall increase access to prevention services throughout the MSHN region. In addition, MSHN Prevention and Community Provider network will look toward developing appropriate social media campaigns addressing lack of access to prevention services for adults aged 55 and older in efforts to increase resources within the MSHN region and to reduce stigma surrounding the older adult community.

PREVENTION FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Increase in access to prevention services for older adults	Lack of access to prevention services for older adults (55+yr.) results in misuse of ATOD substances; misuse of poly-substances; and higher number of serious illness and/or death in MSHN region. Lack of knowledge and awareness surrounding community resources and how to access them is prevention older Michiganders from receiving needed services.	Norms Favorable to Alcohol Use, Lack of Perceived Risk, Ease of Access to ATOD	Provide education and informational presentations at senior centers and senior living communities/community events	Number of education and informational presentations conducted as indicated by local county/community	Increased awareness of problems, risks and consequences associated with lack of access to prevention services focused on ATOD misuse/poly-substance misuse.
		Community Norms, Lack of Perceived Risk	Implement Social Norming Campaigns	Campaign materials available as indicated by local county/community	Increased protective factors and reduction of risk factors that result in lowering community norms favorable to older adult ATOD and poly-substance misuse
			Offer substance-free activities for older adults.	Number of events conducted as indicated by local county/community	
		Lack of Older Adult ATOD Evidence-Based Programs	Reasearch to find appropriate Older Adult EBP and provide evidenced based programming at senior centers and senior living communities/community events	Number of EBP and informational presentations conducted as indicated by local county/community	Expedited implementation of evidence-based programs
			Develop/implement/ create provider workgroup to address older adult access to services	Workgroup created with mission statement and goals for future integration of services	
		Community Norms, Lack of Perceived Risk, Ease of Access to Rx Drugs	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.	Increased knowledge of and use of poly-substance misuse and safe medication disposal

Timeline and Evaluation (Increase Access to Prevention Services for Older Adults):
The timeline for implementation will be in three phases. Phase #1 (Q1 and Q2 of FY24) 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. 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. Phase #2 (Q3 and Q4 of FY24) will include educational and informational presentations at community locations, and the provision/promotion of alcohol-free activities for older adults. These activities will aim to promote and increase access to prevention services. In addition, we will begin a provider workgroup to address increased programming for Older Adults. Phase #3 (Q1 and Q2 of FY25) will focus on the development of social norming campaigns, including the development and distribution of information on local prevention resources to community locations such as churches, healthcare providers, senior centers and senior living communities. Activities and expectations from all phases will continue through FY26. 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.

Treatment Goals

MSHN will be supporting Region 5 with a focused set of goals to support expansion and enhancement of an array of services within the recovery-oriented system of care. These goals will also have an alternative purpose to reduce the health disparities among high-risk populations receiving, prevention, treatment, harm reduction, and recovery services.

Therefore, MSHN will be focusing on the following three overarching goals for treatment, harm reduction, and recovery of substance use disorders in Region 5:

1. Treatment & Harm Reduction:
    a. Increase access to behavioral health and primary care services for persons at-risk for and with mental health and substance use disorders.
    b. Increase access to OUD treatment and harm reduction for persons living with Opioid Use Disorder.
    c. Increase access to treatment and re-entry treatment for criminal justice involved population returning to communities.
    d. Increase access to trauma responsive services.
    e. Reduction in percentage of substance exposed births/infants with WSS/NAS/FAS.
    f. Increase access to treatment services for older adults 55 and older.
2. Recovery:
    a. Increase coordination of prevention, follow-up, and continuing care in recovery.
    b. Increase in supporting coordinated strategies to support recovery.
    c. Increase access to recovery services that promote life enhancing recovery and wellness for individuals and families.
3. Cultural Competency & Health Disparities:
    a. Increase cultural competence and reduce health disparities.

Goal #1: Treatment & Harm Reduction

Behavioral Health & Primary Care Expansion:

Due to the highly rural nature of the MSHN region, the accessibility and capacity of behavioral health and primary care providers can be a challenge. MSHN region SUD Treatment Providers are charged with supporting the evaluation of needs related to these items, and then subsequent connection to available resources, as needed.

TREATMENT FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Behavioral health and primary care services for persons at-risk for and with mental health and substance use disorders	Not all individuals have access to primary care or behavioral health services when needed within our region.	Individuals are unsure of how to access or receive necessary medical and behavioral health services.	Providers will educate on access to services and assist with referrals for PCP and/or behavioral health services as needed.	Individuals will be connected to primary care and behavioral health services throughout our region.	Increased access to primary care and behavioral health services.
	Limited access to services for underserved populations	Social Determinants of Health	Implementation of a DEI Learning Collaborative	Increased knowledge of how to identify underserved populations to increase their access to care.	Increase in services being provided to underserved populations within our region.

Timeline and Evaluation (Behavioral Health & Primary Care Expansion):
The timeline for implementation will be: Through all phases (Q1-Q4 of FY24, FY25, and FY26) MSHN intends to evaluate service gaps identified in the region using the Quality and Process Improvement Process (QAPI). Providing coordination of care with behavioral health and primary care are standards in the MSHN site review tools and monitored bi-annually with each SUD Treatment Provider. On the year that the provider does not receive a full review, MSHN reviews to ensure the providers corrective action plan (CAP) has been implemented. The MSHN SUD Clinical Team supports provider network trainings as indicated by the annual QAPIP to help support provider network improvement in areas determined as needing strengthening and improvement.

Expansion of OUD Treatment: 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) during FY24-26. 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.

TREATMENT FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Access to OUD treatment and harm reduction for persons living with Opioid Use Disorder (OUD)	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.	Identify regional service gaps	Service gaps across the region will be addressed.	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 medications for opioid use disorders (MOUD)	Expand array of MOUD services availability	Availability of MOUD throughout the MSHN region.
		People do not know when they are using a drug that has a fatal dose of fentanyl in it.	Continue to provide access to naloxone and fentanyl test strips through community partners.	Add information about how to access naloxone and fentanyl test strips as well as locations of naloxone vending machines on the MSHN Website	Decrease in opioid overdose deaths in the MSHN region

Timeline and Evaluation (MAT Expansion):

The timeline for implementation will be: Through all phases (Q1-Q4 of FY24, FY25, and FY26) 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. During phase #1 (Q1-Q2 of FY24) MSHN will add information on how to access naloxone to the MSHN website. Phase #2 (Q1-Q4 of FY25 and FY26) 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.

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

TREATMENT FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES & INPUTS	ACTIVITIES & RESOURCES	OUTPUTS & OBJECTIVES	OUTCOMES
Access to treatment and re-entry treatment for criminal justice involved population returning to communities	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 individuals while they are incarcerated. Overdose deaths occur frequently in individuals upon release from legally involved settings.	Incarceration-based treatment services are not available throughout incarcerated settings in the MSHN region	MSHN will explore SUD treatment opportunities within legally involved settings as they arise in our region	Increase access to Re-Entry Services throughout the MSHN region	Increase in SUD programs within legally involved settings in the MSHN region
		There is not always a good collaboration of care between treatment providers and incarceration staff, parole, and probation staff.		Work with MSHN contracted providers to build relationships with in-region jails, juvenile detention centers, and county parole and probation offices	Increase in referrals to ongoing treatment in the MSHN region following release from legally involved settings.
				Monitor data on engagement from legally involved treatment services to re-entry services.	Evaluate SUD services within legally involved settings for trends to inform treatment.
		Availability of MAT services is not accessible in all legally involved settings in our region	Work with the legally involved settings within the MSHN region to expand access to Medication Assisted Treatment within those settings to increase the individual's recovery capital and to decrease opioid overdose deaths for individuals being released back to their communities in our region.	Increase access to Medication Assisted Treatment services in legally involved settings throughout the MSHN region.	Increase in initiation of Medication Assisted Treatment within legally involved settings in the MSHN region.

Timeline and Evaluation (Jail-Based Services Expansion):

The timeline for implementation will be Phase #1 (Q1-Q4 of FY24) - MSHN will assess the need for SUD treatment services within the incarcerated settings in the region and work with contracted providers to build

relationships with jails/juvenile detentions in the region. In phase #2 (Q1-Q4 of FY25 and Q1-Q4 of FY26) - MSHN will work to increase access to re-entry services and will work with contracted providers to expand access to MAT within the incarcerated settings. In all phases MSHN will monitor data on engagement from incarceration-based treatment services to re-entry services and opioid overdose deaths for individuals being released from incarceration. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

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 SUD Treatment and Recovery 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.

TREATMENT FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Access to Trauma Responsive Services	As a region, not all contracted treatment providers have staff that have been trained in providing trauma responsive services.	Without training in providing trauma informed treatment, trauma competent services are not available to individuals in need of trauma responsive care.	Trauma informed and trauma responsive care trainings will be made available to providers serving individuals in the MSHN region.	Contracted providers will attend trainings for trauma informed care. Providers will be required to show that staff have completed training in trauma informed care.	Service providers will be trained and have the ability to provide trauma informed care to the individuals they serve in treatment.
		Unless providers assess their staff capabilities in providing trauma responsive services, they are unaware of service gaps.	All treatment providers will take part in completing the Agency Trauma Self-Assessment every 3 years.	All treatment providers will develop trauma-responsive goals for their agency where there are low scores on the self-assessment.	Individuals seeking treatment will have access to trauma informed care and trauma-responsive services.

Timeline and Evaluation (Trauma-Informed Care Expansion):
The timeline for implementation will be: In all phases (Q1-Q4 of FY24, FY25, and FY26) - MSHN will work to ensure people accessing treatment are able to enter treatment no matter what avenue they try to enter services. Phase #2 (Q1-Q4 of FY22 and FY23) - MSHN will implement the three-year Trauma Informed Organizational self-assessment for the majority of contracted SUD Treatment and Recovery providers. Providers are then responsible for identifying one goal for each of the 5 content areas of the assessment and reporting on their progress with the SUD Clinical Team annually at the subsequent years annual plan meeting. The use of trauma informed evidence-based practices by the treatment provider network is also reviewed through QAPI standards and will be reviewed annually in the QAPIP. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

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 (WSS), 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 Treatment Providers to ensure that there is an assessment for each child associated with a parent being served in WSS, and that referrals for children are made when appropriate.

TREATMENT FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES & INPUTS	ACTIVITIES & RESOURCES	OUTPUTS & OBJECTIVES	OUTCOME
Reduction in the percentage of substance exposed infants/births WSS/NAS/FAS	Successful recovery for women requires the service delivery system integrates women's specific SUD treatment, to include mental health services, recovery supports and, frequently, treatment for past traumatic events. Without these Designated Women's Specialty services, women of child-bearing age and/or pregnant women are less able to make progress in their recovery.	Designated Women's Specialty services are not available throughout the region. This causes expecting women or women of child-bearing age 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	Increase in Designated and/or Enhanced Women's Specialty Services programs in MSHN region
		Providers are not always aware of the dangers of drinking alcohol during pregnancy	Provider education on the risks associated with drinking during pregnancy	Increase knowledge of FASD for all providers that serve women within the MSHN region	Reduction in the number of babies born with FASD
		Providers are not always aware of the dangers of using substances during pregnancy	Provider education on the risks associated with using substances during pregnancy	Increase knowledge of NAS for all providers that serve women within the MSHN region	Reduction in the number of babies born with NAS

Timeline and Evaluation (WSS Expansion):
The timeline for implementation will be Phase #1 (Q1 of FY24) - MSHN will evaluate regional need for Designated Women's Specialty Services. Phase #2 (Q1-Q4, FY 25) - 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 FY26) - 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 FY24, FY25 and FY26) 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.

Expand Treatment Services for 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. (Note: The Michigan Older Adult Wellbeing Report from 2020 is still the most recent/current data available for this group).

TREATMENT FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Access to treatment services for older adults 55 and older	Alcohol continues to be a leading cause of treatment admission for individuals 55+. Alcohol is the leading cause of SUD-related deaths in individuals 55+. Substance Use Disorder is increasing in the 55+ population. Limited access to treatment for individuals that have Medicare.	Limited awareness of the dangers of alcohol interactions with prescription medications	Develop and implement outreach strategies for individuals 55+	Increased awareness of BH/SUD services available for 55+	Improved access to BH/SUD treatment through public health system, including Medicare.
		Current SUD treatment service providers 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 persons served of health risks/ potential drug interactions associated with alcohol.	Improved access to cultural competency training specific to adults 55+ for providers	Increased retention rates for consumers 55+

Timeline and Evaluation (Improving penetration rates for older adults):
The timeline for implementation will be Phase #1 (Q1 and Q2 of FY24) – 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 FY24) – 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 FY25) - Assess the level of increase in treatment and engagement for adults 55+ in the public system. Phase #4 (Q3 and Q4 0f FY25, & Q1 – Q4 of FY26) – Continue to expand services to older adults throughout the region and make necessary changes to existing programs based on provider feedback and utilization. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

Goal #2: Recovery

Increase coordination of prevention, follow-up, and continuing care in recovery: Similar to other chronic diseases, SUD requires continuing care and follow-up. When coordination of care between different entities is lacking, this can inhibit a person's ability to attain their desired outcomes. In order for coordination of care to be effective, community partners must work collaboratively together to provide needed resources for people in their recovery journey. MSHN intends to cultivate community partnerships to expand the use of community services.

RECOVERY FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Increase coordination of prevention, follow-up, and continuing care in the recovery process	Separation of SUD prevention, follow up and continuing care services hinders recovery process.	Ensure adequate resources are available across the region.	Use annual Network Adequacy Assessment (NAA) to identify service gaps and support needs.	The Network Adequacy Assessment will be used to assess service gaps across the region.	Individuals seeking services will have access to and options for a full array of recovery supports in their local areas/counties.
		Coordination of care amongst community resources is lacking.	Use of Project Assert data to identify service resource gaps and opportunities for growth.	Cultivate relationships with jails, courts, hospitals, housing resources, food resources, FQHCs and other community partners to expand use of community services. a. Host training to increase knowledge of resources that will enhance coordination of recovery process. b. Providers participate in local community meetings to increase knowledge of resources that will enhance coordination of recovery process.	Increased number of culturally competent recovery services (community recovery groups (Prevention); collegiate recovery (prevention – MPDS); Project Assert referrals (REMI – T1012 and HO038) where there are identified service gaps.
		Identify current resources and opportunities for growth.	Utilize Michigan Prevention Data System to identify current resources and opportunities for growth.	Utilize the regional outcomes data from above, to determine culturally competent supports for individuals to initiate, engage and remain in SUD recovery services.	Individuals seeking services will be supported by culturally competent providers who work to address the unique needs for each person.

Timeline and Evaluation (Increase of coordination of care):
The timeline for implementation will be phase #1 (Q1 and Q2 of FY24) – MSHN will utilize the NAA and Project ASSERT data to identify service gaps. Phase #2 (Q3 and Q4 of FY24) MSHN will host training opportunities to increase their knowledge of community resources. Through all phases (Q1-Q4 of FY24, FY25 and FY26) MSHN will work to increase the coordination of prevention, follow-up, and continuing care in the recovery process and increase the number of culturally competent supports. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

Increase in supporting coordinated strategies to support recovery: MSHN currently supports a bi-monthly ROSC meeting for the south, northwest and east areas of the region. Quarterly meetings for the outpatient, women's specialty, and residential providers are also being supported. The purpose of these meetings is to increase the knowledge about local resources and increase the number of providers who are able to provide multiple coordinated strategies to help support a person in recovery.

RECOVERY FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Support coordinated strategies to support recovery.	Limited number of providers who can provide multiple coordinated strategies supporting recovery.	Identify service gaps in recovery services and support needs for people seeking recovery support.	• Host training for providers to increase knowledge of resources that will enhance coordination of recovery process. • Providers will participate in local community meetings to increase knowledge of resources that will enhance coordination of recovery process.	Cultivate relationships with jails, courts, hospitals, housing resources, food resources, FQHCs and other community partners to expand use of community services.	Expanded access to housing, food, health and medical resources as defined by the person in recovery is incorporated into recovery services/planning.
		Determine culturally competent supports for individuals to initiate and engage in recovery services.			Individuals seeking services will have access to and options for a full array of recovery services to support wellness for individuals and families in their local areas/counties.

Timeline and Evaluation (Increasing coordinated strategies to support recovery):
The timeline for implementation will be phase #1 (Q1 and Q2 of FY24) – MSHN will continue to encourage providers to participate in local community meetings around the region to gain a better understanding of the resources available. Phase #2 (Q3 and Q4 of FY24)- MSHN will host training opportunities to increase their knowledge of community resources. Through all phases (Q1-Q4 of FY24, FY25 and FY26) MSHN will continue to work to expand the number of providers who are able to provide multiple coordinated strategies in supporting recovery. MSHN will monitor and evaluate progress on the goal implementation quarterly during treatment team meetings.

Increase access to recovery services that promote life enhancing recovery and wellness for individuals and families: Recovery housing is a valuable resource for many individuals in recovery. While currently being able to support 27 recovery houses across the region, MSHN would like to expand recovery housing into counties where resources are limited. Block grant limitations has made expansion of this resource difficult. MSHN will continue to look for available funding to continue to support and expand this resource.

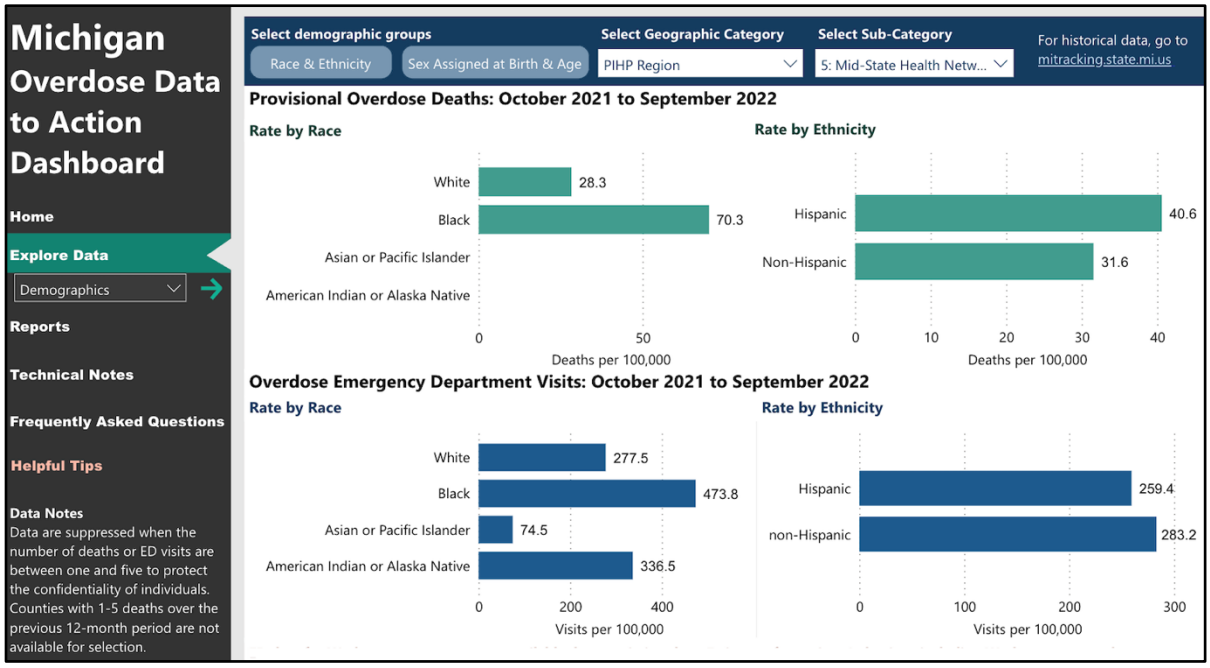
RECOVERY FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLES/INPUTS	ACTIVITY - RESOURCES	OUTPUTS - OBJECTIVES	OUTCOME
Increase in access to recovery services promotes life enhancing recovery and wellness for individuals and families.	Separation of SUD prevention, follow up and continuing care services hinders recovery process.	Utilize outcomes data to determine culturally competent supports for individuals to initiate, engage and remain in SUD recovery services.	Provide training opportunities to increase knowledge of resources that will enhance the access to recovery services.	Increase knowledge of resources that will enhance coordination of recovery process.	Individuals seeking services will be supported by culturally competent providers who work to address the unique needs for each person.
			Participate in local community meetings to increase knowledge of resources that will enhance coordination of recovery process.	Encourage participation in coalition and ROSC meetings	Individuals seeking services will be supported by culturally competent providers who work to address the unique needs for each person.
	Limited funds to expand recovery housing around the region.	Funding availability for recovery housing.	Continue to pursue and explore funding opportunities for sustainable recovery housing.	Increase funding availability for recovery housing.	Increase the number of recovery houses around the region.
	Limited number of recovery housing beds to support the region.	Limited number of recovery housing bed options due to Block Grant allocation.			Maintain or expand number of recovery housing beds available around the region.

Timeline and Evaluation (Increasing access to recovery services):
The timeline for implementation will be Phase #1 (Q1 and Q2 of FY24) – MSHN will continue to encourage participation is bi-monthly regional ROSC meetings. Phase #2 (Q3 and Q4 of FY24)- MSHN will continue to explore funding opportunities for sustainable recovery housing. Through all Phases (Q1-Q4 of FY24, FY25 and FY26) MSHN will continue to explore funding opportunities to support recovery housing across the region and encourage ROSC participation to increase their knowledge of local resources.

SECTION 7 – HEALTH DISPARITIES, CULTURAL COMPETENCY & CULTURAL HUMILITY

The Landscape of Health Disparities

The COVID-19 pandemic of 2020 brought health disparities in the U.S. and in Michigan into stark relief and it prompted a deeper exploration of barriers to health equity in Region 5 and in the state. This was particularly urgent as the opioid overdose epidemic has shifted in recent years with the fastest growth rate in overdose deaths taking place in Communities of Color. See data below for our region.[17]



In response, MSHN began doing regular trainings across MSHN's 21 counties on structural barriers to access and quality care, impacts and relevance of social determinants of health, systemic racism and historical trauma. Also, as noted earlier, in 2022 MSHN established two advisory bodies, one internal (IDEA) and one external (REACH) to inform and advise MSHN leadership on mechanisms to identify and address barriers to access and quality care in our provider networks. In 2023, MSHN launched its *Equity Upstream Spring Lecture Series* which brought national experts to Michigan to offer perspectives on the opioid epidemic and its impacts on Black, Hispanic/Latiné, and Native American populations. The lecture series concluded with national-level data and initiatives by Dr. Larke Huang, Director of the Office of Behavioral Health Equity at the Substance Abuse and Mental Health Services Administration (SAMHSA). This lecture series reached hundreds of providers and community partners between April and June of 2023 and is available for viewing in perpetuity at no cost on MSHN's website *here*.

MSHN is committed to acknowledging and addressing the legacies of discrimination, racism, violence and trauma in the people we serve and their impact on health outcomes, and to ensuring we remove barriers at all levels so that Region 5 residents who need services are able to engage in treatment and to sustain successful recovery.

Cultural Competency & Cultural Humility in Region 5

Cultural competency is a developmental process in which one achieves increasing levels of awareness, knowledge, and skills along a continuum, improving one's capacity to work and communicate effectively in cross-cultural situations. *Cultural humility* is a reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them.[18] MSHN recognizes that cultural competency and cultural humility is a dynamic, ongoing, processes that requires a long-term commitment and are 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 prevention, treatment and recovery 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.

Specifically, MSHN has followed its *Equity Upstream* lecture series with a pilot learning collaborative (LC) that consists of Region 5 providers operating in the most diverse counties in our region (Saginaw, Ingham and Jackson). In early FY24, these LC providers will be developing action plans to reduce disparities in their client population which they'll implement and adjust over FY25 and FY26.

MSHN 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, wherever possible, help establish a workforce whose diversity is representative of the community and clients served.

MSHN requires its SUD providers to use assessment tools and/or treatment methods that are culturally sensitive and validated, whenever possible, for use with the diverse demographic groups that populate our region including individuals who are Black/African American, Indigenous/Native American, Hispanic/Latiné, and members of the LGBTQ+ community. 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 should include linkages to racial, ethnic, and cultural organizations throughout the community.

Goal: Increase cultural competence, increase cultural humility, and reduce health disparities based on race, ethnicity, socioeconomic status, & LGBTQ+ identity

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 apply the same solutions to all counties across the region. FY24 will also be used to expand and deepen regional data on health disparities, to form focus groups and to learn from all historically marginalized and 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 community partnerships to flesh out strengths and opportunities for improvement in our system.

EQUITY FOCUS	PRIMARY PROBLEM & CONSEQUENCE	INTERVENING VARIABLE & INPUTS	ACTIVITIES & RESOURCES	OUTPUTS & OBJECTIVES	OUTCOME
Successful engagement and retention in SUD treatment will improve among targeted populations in Region 5.	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 culturally competent treatment services.	Phase 1. Develop diverse focus groups, clinical workgroups and advisory committees to help identify key gaps in access delivery of services to inform Equity Upstream learning collaborative pilot's activities. Phase 2. Analyze social determinants of health (SDoH) data to support culturally competent strategies to address barriers/challenges to engaging marginalized populations in treatment. Phase 3. Provide focus group feedback and SDoH analysis to MSHN treatment provider network to support increased cultural competency training, literacy and humility among provider staff. Phase 4. Provide all treatment providers with evidence-based training in cultural competency and impacts of racial trauma and other forms of discrimination-based trauma.	Results of Equity Upstream learning collaborative initiative will be shared across Region 5's provider networks to encourage broad adoption of successful interventions. 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.	MSHN SUD services providers will bring heightened cultural awareness & humility into their workplace and communities. Recipients of SUD programming will experience culturally relevant and responsive messaging to which they can relate regardless of cultural background.

Timeline and Evaluation (Reducing Health Disparities):
The timeline for implementation is phase #1 (Q1, of FY24) – Create internal workgroup to collect data from focus groups and research best practices for reducing health disparities. Phase #2 (Q3 and Q4 of FY24) - Analyze results of collaborative dialogue and best-practices research to inform targeted objectives ranging from universal across the region to sub-regional pockets where particular issues are localized. Phase #3 (Q1 and Q2 of FY25) – 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 members of the targeted populations for whom we seek improvement including but not limited to surveys and new focus groups. Phase #4 (Q3 and Q4 of FY26) will be formalizing reforms and changes implemented and evaluated to be effective; Phase #5 will involve expansion of successes over the course of FY26.

SECTION 8 – CONCLUSION

MSHN recognizes that strategic plans are living documents and they must evolve to meet changing conditions on the ground in terms of population health, epidemiological data, and social determinants of health that impact outcomes in our region.

MSHN also recognizes the limitations on what our organization can do to impact all 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 misuse in our communities, increased access to high quality care, strong recovery supports, reduced health disparities and continuous improvement in health outcomes for all across the region.

CITATIONS

1. Michigan Governor signs new telehealth coverage guidelines into law
2. Medicaid Resources for States/coronavirus disease 2019 covid-19/unwinding and returning regular operations after covid-19
3. Michigan Opioid Data
4. Census Data
5. Census Data
6. Census Data Saginaw County
7. Census Data
8. Mid-State Health Network Utilization Management Policies and Procedures
9. Keeping Michigan Healthy/BH-DD/Recovery and Substance Use/Communicable Disease Prevention Policy
10. County Health Rankings
11. MDHHS Substance Use in Michigan Opioid Data
12. Michigan Department of Education School Health Surveys County Reports
13. MDHHS Substance Use in Michigan Opioid Epidemic
14. Michigan Older Adult Wellbeing Initiative Strategic Plan: Focusing on Our Future
15. MDHHS Report on CMHSPs, PIHPs, and Regional Entities
16. World Health Organization Global Report on Ageism
17. Michigan Opioid Data
18. U.S. Dept. of Health & Human Services: Think Cultural Health