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

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

Fiscal Years 2015-2017

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Overview:

Southwest Michigan Behavioral Health (SWMBH) took a very methodical and inclusive approach to the development of this strategic plan. As an already integrated region, we were fortunate to have a functioning Oversight Policy Advisory Board and many communities already working on their community Recovery Oriented System of Care (ROSC) plans. We took advantage of this momentum to ensure that there was involvement from all of the local communities at each step in the planning process. Our first step was to meet with the Policy Advisory Board and review the strategic plan document guidelines. What was discussed with the board, and consensus was reached, it was decided we first hire an epidemiologist to gather and compile data that was available. It was then proposed that we meet with board members and local providers from each community to review the data and the impact it may on them as we wrote and formulated the plan.

At these local county meetings we planned to develop the Stakeholder initiatives and determine if there were gaps that need to be addressed. It was also planned that we would discuss local epidemiological data and the impact this may have on the service delivery needed in the county. Finally, we continued to have counties where a full continuum of services was not available and this issue was to be addressed as well.

This plan came to fruition better than anticipated. While there were differences amongst the epidemiological data, there were many more similarities. These findings, coupled with some similarities across the region in current delivery in Evidence Based Practices (EBP), a more long-term, interactive based process was discussed regarding implementing more EBP's. Specifically, it was discussed with providers and the Substance Use Disorder (SUD) policy board members and they supported choosing EBP and research based practices as part of a series of clinical forums to be held in late summer and early fall with all providers in the region participating. This process allows for providers to learn from one another and for providers to each do research about different practices and to dialogue about implementation issues and clinical needs. We intend to draw upon the clinical expertise in the region to make critical decisions about practices.

This cooperation amongst providers is a great asset in our region and part of a regional ROSC strategy. We intend to draw upon the strength found in Prevention as an area that uses almost solely EBP's to assist us in strengthening the treatment framework. While the administrative pieces of prevention are new to the PIHP, the good works of prevention are not. Thus far in our integration we have found nothing but support from our administration, our board and our communities. The former Kalamazoo Coordinating Agency (CA) staff moving intact into the PIHP assures that the strength of the CA will continue to grow. We consider this a huge strength as a good prevention system is the key to any good SUD system. It touches the lives of families everywhere and we know the positive impact of prevention. We will use this strong prevention and treatment network to develop the ongoing recovery supports people may need as they complete the formalized treatment or at any time in their recovery journey. The goal will be that at any point from prevention, to long term recovery, it will be a seamless entry and customers will find what they need available either through formalized service or community support.

1. A narrative identifying and prioritizing substance use disorder problems impacting the community and epidemiology profile:

Most counties of the SWMBH region have a very limited urban flavor (with the exception of Kalamazoo, Berrien and Calhoun), and most of their populations live in small communities spread across rural areas. A critical effort for provision of SUD services in these communities, especially for Prevention services and Recovery supports, is to forge collaborative efforts with key stakeholders in each community. It is imperative to reach out to them personally in order to garner the support of the institutions they represent (e.g.: schools, municipal administration, law enforcement, etc.). Partnership efforts with these institutions is the most effective way to reach out credibly to target community groups within these areas and to the community at large, and their involvement is critical. Below is a description of each representative county within SWMBH:

Barry County's population is distributed mainly in rural areas and along small municipalities, villages and communities that offer a sparse to moderate demographic concentration and limited urban dynamics. Demographic data indicates limited ethnic diversity in the County: Hispanics are the largest minority and account for only 2.4% of the population (1/2 of the state avg.).

Berrien County is a lakeshore County and the second most populous county of the SWMBH region. It is a border county (Indiana state line) and it has to deal with the benefits and drawbacks of being traversed by two busy highways (I-94 and I-196). The county is home to two large minority communities (African Americans, 15.6% and Hispanic/Latino, 4.8%), which are larger than their state counterparts' averages. Because sustained collaborative efforts with stakeholders and organizations in these minority communities, SUD services and recovery supports (formal and informal) already have a history and an established presence in these communities (especially amongst African Americans).

Branch County's population is distributed mainly in rural areas and along small municipalities, villages and communities that offer a sparse to moderate demographic concentration and limited urban flavor/dynamics.

Calhoun County is a relatively diverse County populated by several minority ethnic groups of varied economic/social status, which seem to be concentrated in specific and identifiable geographic areas of the County. Example: Certain neighborhoods in Battle Creek (main urban area of the County) and the eastern edge of the County (the City of Albion and its surroundings) have a greater concentration of ethnically minority groups (Hispanics, 2+ races and especially African American) than other areas of the County. The presence of these communities/groups in specific municipalities and areas of the County requires a strategic effort by SUD service providers to ensure planned outreach efforts and effective delivery of culturally responsive interventions.

Cass County is a border County (Indiana Stateline). The County's population is distributed mainly in rural areas and along small municipalities, villages and communities that offer a sparse to moderate demographic concentration and limited urban dynamics. Demographic data indicates limited ethnic diversity in the County: African Americans are the largest minority and account for only 5.5% of the population (almost 1/3 of the state avg.). This is also home to a tribal population, the Pokagon Band of Potawatomi Indians accounts for 1.1% of the population.

Kalamazoo is the largest County of the SWMBH area and has a rather diverse population, which consists of several minority groups and groups of varied economic/ social status, etc. The County comprises several municipalities in which the dynamics of living may range from mainly urban/college town living (City of Kalamazoo) to those of suburban & rural life styles. Most resources from the public service sector can be accessed from its larger urban/suburban center: Greater Kalamazoo/Portage area where 77% of its 256,000 residents live in a cluster of contiguous municipalities along the I-94/US 131 corridor. The City of Kalamazoo is also a college town (WMU, K College and KVCC), which guarantees a permanent influx of diversity into the demographics of the County and its surroundings.

St. Joseph County: "Scenic St. Joe" is a border county (Indiana Stateline), and its population lives in rural communities, small municipalities and villages, which tend to have sparse demographics concentration and limited urban flavor/dynamics.

Van Buren is a lakeshore County, close to the border with Illinois and Indiana, and traversed by a two busy highways (I-94 and I-196). Its population is distributed mainly in rural areas and along small municipalities and villages, communities that offer a sparse concentration of people and limited urban flavor/dynamics. In the lakeshore communities, the County has also significant tourist presence, especially in the summer time. Significant also is the presence of the Hispanic Community in the County: 10.5% (twice as large as the next minority group).

Note on Cultural Responsiveness/Competence Skills needed for provision of SUD services in the eight counties of the SWMBH area:

To provide effective SUD services in the SWMBH region, SUD providers must develop cultural competence skills commensurate with the demographic characteristics, diversity and richness found across the region. Generally speaking, provision of culturally competent SUD services in the SWMBH region, requires that work force of SWMBH and its provider network develop minimally, the following set of cultural competence skills:

1) Ability to constantly conduct a self-examination leading to awareness of own cultural values, priorities, perspective and biases: Attitudes, unstated beliefs, inherited values from previous generations, upbringing, "white privilege" and other influences (personal or societal) that form our world view, influence judgment, create our social norms and shape our values;
2) Knowledge of the outreach techniques or dynamics of communication that will ensure most effective communication with target groups (ex. vocabulary choice, level, topics of conversation, gesturing);
3) Knowledge of living characteristics and dynamics of social functioning of the target social groups and communities (role/composition of family; social networks; rural-X-urban distinctions; age; silent majority dynamics; economic status; education level; institutions that shape norms of the community/group, etc.).
4) Also it is noteworthy that, as a consequence of the steady shift in demographics in the region, with an increasingly significant presence of migrant workers and the influx of families from other parts of the world, the demand for bilingual/multilingual resources and skills (especially as it pertains to the use of Spanish language) for provision of SUD services in the SWMBH area is increasing. That will require SWMBH to position to

increasingly emphasize the utilization of bilingual/multilingual resources and to develop a strategy for hiring and training of its workforce.

The demographics served by SUD treatment services in the SWMBH region generally correlates with that of the general demographic composition of the counties in the region with the exception of the gender subset. Based on TEDS information available, men are more heavily represented in the treatment population than in the general population.

The demographic profile for each county of SWMBH, the SWMBH region, and the State of Michigan are summarized below:

Demographic Profile for SWMBH Counties, Region & State

Variable	Barry		Berrien		Branch		Calhoun		Cass		Kalamazoo	
	#	%	#	%	#	%	#	%	#	%	#	%
Total Population*	59,173	100%	156,813	100%	45,248	100%	136,146	100%	52,293	100%	250,331	100%
Race*#												
White	58,105	98.2%	126,169	80.5%	42,713	94.4%	115,733	85.0%	47,966	91.7%	211,987	84.7%
Black	459	0.8%	25,882	16.5%	1,545	3.4%	17,375	12.8%	3,639	7.0%	32,118	12.8%
American Indian & Alaska Native	654	1.1%	2,077	1.3%	448	1.0%	2,114	1.6%	1,119	2.1%	3,479	1.4%
Asian	342	0.6%	3,196	2.0%	398	0.9%	2,705	2.0%	477	0.9%	6,809	2.7%
Native Hawaiian & Pacific Islander	18	0.0%	239	0.2%	29	0.1%	198	0.1%	26	0.0%	287	0.1%
Other	415	0.7%	3,356	2.1%	831	1.8%	2,528	1.9%	747	1.4%	4,772	1.9%
Ethnicity*												
Hispanic or Latino	1,336	2.3%	7,054	4.5%	1,804	4.0%	6,177	4.5%	1,570	3.0%	9,959	4.0%
Not Hispanic or Latino	57,837	97.7%	149,759	95.5%	43,444	96.0%	129,969	95.5%	50,723	97.0%	240,372	96.0%
Tribe												
Language spoken at home**##												
English (only)	54,301	97.4%	135,327	92.0%	38,502	91.6%	119,682	94.0%	47,309	95.7%	219,848	93.4%
Language other than English	1,463	2.6%	11,721	8.0%	3,529	8.4%	7,692	6.0%	2,140	4.3%	15,479	6.6%
Males*	29,705	50.2%	76,373	48.7%	23,840	52.7%	66,519	48.9%	26,094	49.9%	122,569	49.0%
Females*	29,468	49.8%	80,440	51.3%	21,408	47.3%	69,627	51.1%	26,199	50.1%	127,762	51.0%
18 years or older*	44,715	75.6%	120,141	76.6%	34,412	76.1%	103,137	75.8%	40,035	76.6%	193,405	77.3%
21 years or older*	42,458	71.8%	113,848	72.6%	32,805	72.5%	96,994	71.2%	38,078	72.8%	177,491	70.9%
Socioeconomic characteristics												
Total households**	22,455	100%	61,286	100%	16,036	100%	53,290	100%	19,801	100%	99,720	100%
Avg household size**	2.62	n/a	2.48	n/a	2.62	n/a	2.49	n/a	2.61	n/a	2.43	n/a
High school graduate or higher (%)**###	n/a	90.9%	n/a	87.3%	n/a	87.0%	n/a	88.6%	n/a	87.2%	n/a	92.4%
Unemployment (%)***####	n/a	9.9%	n/a	11.5%	n/a	12.1%	n/a	13.3%	n/a	10.5%	n/a	11.6%
Median household income***	$53,541	n/a	$43,471	n/a	$42,995	n/a	$42,164	n/a	$45,462	n/a	$46,011	n/a
With health insurance coverage***	52,626	89.6%	135,115	86.9%	36,793	87.0%	117,169	87.2%	45,439	87.1%	222,948	89.6%
Literacy												
Sexual identity												

(Demographic Profile: Continued)

Variable	St Joseph		Van Buren		SWMBH Region		Michigan	
	#	%	#	%	#	%	#	%
Total Population*	61,295	100%	76,258	100%	837,557	100%	9,883,640	100%
Race*#								
White	56,792	92.7%	68,011	89.2%	727,476	86.9%	8,006,969	81.0%
Black	2,196	3.6%	3,946	5.2%	87,160	10.4%	1,505,514	15.2%
American Indian & Alaska Native	706	1.2%	1,470	1.9%	12,067	1.4%	139,095	1.4%
Asian	595	1.0%	554	0.7%	15,076	1.8%	289,607	2.9%
Native Hawaiian & Pacific Islander	27	0.0%	59	0.1%	883	0.1%	9,348	0.1%
Other	2,384	3.9%	4,413	5.8%	19,446	2.3%	181,749	1.8%
Ethnicity*								
Hispanic or Latino	4,034	6.6%	7,758	10.2%	39,692	4.7%	436,358	4.4%
Not Hispanic or Latino	57,261	93.4%	68,500	89.8%	797,865	95.3%	9,447,282	95.6%
Tribe								
Language spoken at home**##								
English (only)	51,416	90.1%	64,209	90.1%	730,594	93.0%	8,463,248	91.0%
Language other than English	5,657	9.9%	7,043	9.9%	54,724	7.0%	840,240	9.0%
Males*	30,316	49.5%	37,803	49.6%	413,219	49.3%	4,848,114	49.1%
Females*	30,979	50.5%	38,455	50.4%	424,338	50.7%	5,035,526	50.9%
18 years or older*	45,420	74.1%	56,850	74.5%	638,115	76.2%	7,539,572	76.3%
21 years or older*	43,179	70.4%	53,973	70.8%	598,826	71.5%	7,085,405	71.7%
Socioeconomic characteristics								
Total households**	22,258	100%	28,378	100%	323,224	100%	3,818,931	100%
Avg household size**	2.72	n/a	2.60	n/a	n/a	n/a	2.53	n/a
High school graduate or higher (%)**###	n/a	84.5%	n/a	84.8%	n/a	n/a	n/a	88.7%
Unemployment (%)***####	n/a	15.2%	n/a	11.0%	n/a	n/a	n/a	12.6%
Median household income***	$44,214	n/a	$44,425	n/a	n/a	n/a	$48,471	n/a
With health insurance coverage***	52,399	86.4%	64,467	85.3%	726,956	87.8%	8,653,751	88.5%
Literacy								
Sexual identity								

Notes for Demographic Profile:

** Data from 2010 Census*

*** Data from Selected Social Characteristics in the United States: 2008-2012 American Community Survey 5-Year Estimates*

**** Data from Selected Economic Characteristics: 2008-2012 American Community Survey 5-Year Estimates*

 # Race: alone or in combination with one or more races

For population 5 years and over

For population 25 years and over

For population 16 years and over

For the SUD Prevention Component of services, the focus on specific high risk populations/categories for implementation and provision of education-based strategies, ensures that services are provided to groups that represent the demographic diversity of the region. Collectively all Center for Substance Abuse Prevention (CSAP) high risk categories are being targeted in the entire region, especially categories #10 "Persons who are economically disadvantaged", and # 11 "Youth who are beginning to experiment or are occasional drug users", which are targeted and served in each and every of the 8 counties of SWMBH.

Additionally, the systematic utilization of environmental and community-based Prevention strategies ensures that prevention services are provided to the population at large and to certain strategic universal groups in particular such as parents, families, medical professionals, retailers, leaders, which are the people who can affect the norms and practices in each community that may contribute to drug use.

Through the integrated service approach of the Recovery Oriented Systems of Care (ROSC), the SUD service system of SWMBH is having a unique opportunity to deepen its roots in communities across the region by forging unique partnerships and collaborative efforts with multiple disciplines of services, supports and institutions. This multidisciplinary and integrated approach to SUD services has the potential to redefine in our area the concept of SUD service delivery; this will ensure that services address needs of persons in recovery and their families in multiple and critical domains of life such as healthcare, employment/finance, housing, legal matters, family/relationship issues, others. On the treatment and recovery side of SUD services, this integrated approach with focus on multiple domains of life is expected also to help overcome some of the barriers for services, which have contributed to disparity of access and care that historically have affected certain population subsets/categories in each community of the region.

While the SWMBH current system for providing SUD includes a fairly broad array of providers both in and out of the region, the goal continues to be to enhance and expand the array of services that these providers offer. SWMBH is hoping to expand the array of services that these providers offer. Currently, there are 10 Prevention providers in the region. There are 14 outpatient providers located within the region, three residential providers located within the region as well as 8 additional residential providers under contract located outside of the SWMBH geographic regional boundaries. We also have two potential residential contracts pending within the region with providers who have approached us about becoming contracts in the near future.

There are two Medication Assisted Treatment providers within the boundaries of the region. Our shared boundary with the state of Indiana leads to a numbers of customers living in closer to proximity to the state line and as a result, we arrange courtesy dosing in Indiana for those customers that this is much more convenient and facilitates better treatment compliance. There are 6 additional contracts for services under PA2 which include additional services such as peer supports and jail services. The providers offer a variety of treatment models, some are based on research and Evidence Based Practices (see Attachment XIII for specifics) and some are more general therapy models. There has been an extensive support in our region over the last several years to use mainly evidence based and research based models and this has been met with varying degrees of success. There are contractual changes and expectations coming that will make the treatment

system more similar to the prevention system in terms of the expectations of percentages of services based on these proven practices.

There are strong recovery service supports within the SWMBH region that vary county to county. Recovery Institute based in Kalamazoo provides many services that persons with both Mental Illness and Substance Use Disorders can participate in. This belief in people with lived experience being available to assist others wherever they are at in their journey is something that SWMBH is committed to ensuring is woven into the fabric of what we do. The challenge can lie within our smaller counties in that these services may have to be available at the provider as the demographics don't necessary support standalone entities for peer services. However, we have had some 12-step referrals for Recovery Coach's so some of the 12-step community hope to integrate these principles on a volunteer basis. This working together mentality is just one of the things that makes the recovering community such a powerful force.

All of the outpatient providers have peer/ Recovery Coach services codes and care coordination codes within their contracts. There have been varying use of these billable codes. Some providers have chosen to use PA2 dollars to support net cost arrangements to have a Recovery Coach peer on staff at their agency. There are also some providers that have been slower to embrace to the concept of using peers or recovery coaches for service delivery. In counties where there is only one SUD treatment provider, this can prove to be a challenge. We are working with all outpatient providers in the region to set timelines about availability of a full continuum of care for customers receiving services at their agency. Additionally, we also have piloted four Early Intervention programs that we are funding using PA2 dollars, but have plans for expansion into whole region over the course of this fiscal year using a Motivational Enhancement model that can be billed fee for service. Finally, there are also several recovery housing options available within the region, though this continues to be an area that could benefit from growth. Kalamazoo, Calhoun and St. Joseph Counties currently have options for individuals in recovery for long term residence. Berrien County is currently in the planning stages for this service, though there remain significant details to be worked out. Lack of sober and stable housing during vulnerable periods becomes a huge barrier in early recovery and expanding this array of options should be an ongoing issue to address in this region.

As demonstrated in Attachment I (SUD Prevention Logic model), epidemiological data (prevalence and consequence data) from local and regional indicators indicate that the priority focus areas in the SWMBH region, much like the previous two years continue to be: Reducing Underage Drinking, Reducing Prescription Drug Abuse, Youth Access to Tobacco and addressing emerging trends, such as illegal Marijuana use amongst youth of school age.

Through a data driven effort to assess local needs, identify and allocate resources, select programs and activities with demonstrated ability to address these issues (EBPs) and through active involvement of local partners, SWMBH has developed a plan for each County in order to implement and evaluate activities designed to address and impact a number of critical contributing factors associated with each of the prevention priority focus areas identified in Attachment I.

Review of Treatment Episode Data Set (TEDS) data in the SWMBH area for the 2010 through the 2013 period reveals that treatment for alcohol addiction has by far mobilized most of the treatment resources for both Block Grant and Medicaid funding. The same data set also indicates a shift in the number two Primary Substance of Addiction: Starting in 2011 treatment services for all types

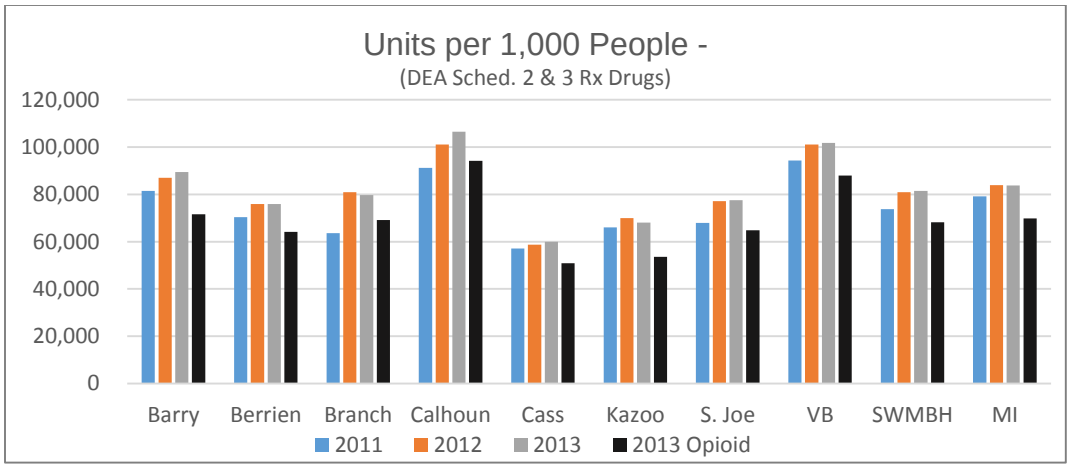
of opium-based addiction ("Heroin" and "Other Opiates" combined) have taken over as second most indicated primary substance of abuse*, surpassing treatment for marijuana addiction in the area. Treatment for methamphetamine addiction seems to continue to be a significant issue in the SWMBH area. However, there has been some positive change as evidenced by the data, which demonstrates that the problem seems to have decreased in some counties of our region. Specifically, there are fewer admissions in Barry, Berrien, Calhoun, Cass, and Kalamazoo; even though we have seen an increase in three other counties (Branch, St. Joseph and Van Buren). Noteworthy is also the data relative to treatment of other types of addiction such as cocaine, psychostimulants and others, along with the observation expressed by treatment professionals (which is not captured in TEDS data) that there appears to be an increase in treatment for polysubstance issues.

* Explanation: Attachment III of this Plan, which contains a SUD epidemiological profile of the SWMBH region, indicates that Marijuana Addiction is the second most treated SUD condition in the SWMBH area. That report, however, separates "Heroin" from the "Other Opiates" Treatment Category, whereas the analysis contained in the paragraph immediately above, combines them under one category "opium-based addiction," following the research of the National Institute on Drug Abuse (NIDA) publication "The Science of Drug Abuse & Addiction" (http://www.drugabuse.gov/publications/drugfacts/heroin), which demonstrates a link between the increase in abuse of pain killing medication (opium-based meds) and that of heroin addiction at a national level.

Analysis of the data from the Michigan Automated Prescription System (MAPS) for DEA schedule II and III Rx Drugs filled for residents of the SWMBH counties, indicates the following trends:

a) High availability level of prescription meds in the region, comparable to that of the state of Michigan
b) Increase in the number of RX meds in all counties of the region in each of the past three years
c) Pain killers (opium-based meds) account for 84% of all schedule II and III meds prescribed in the region; psycho stimulants account for 13%; other categories combined: 3%.
d) According to the National Institute on Drug Abuse (NIDA) publication "The Science of Drug Abuse & Addiction" (http://www.drugabuse.gov/publications/drugfacts/heroin) research has demonstrated at a definite link between the increase in abuse of pain killing medication (opium-based meds) and that of heroin addiction at a national level. This trend certainly seems to hold true in the SWMBH region where TEDS data demonstrates the number of treatment episodes for heroin has reached a four year-high in 5 of the 8 counties and the # of episodes for treatment of opioid med addiction has reached a four-year high in also 5 of the eight counties.
e) Opium-based addiction (heroin and opiates) was identified by SWMBH in 2013 as the second highest primary drug of addiction for treatment episodes in the region (25.4% of all Treatment episodes; second only to alcohol: 39.2%). Source: Block Grant TEDS data.

f) The average # of RX med units per year per household in the region has increased steadily in the past three years (since the SWMBH started monitoring this trend). In 2013 the availability per household was: 208 units per year/per household for schedule II/III meds and 174 units per year/per household for pain killer meds.



Programs and activities designed to address youth access to tobacco and underage smoking in the SWMBH area are developed as a result of the State mandate, as a consequence of the YTA law, and as result of the analysis of health consequences. Review of epidemiological data indicators for each of the eight counties of the region and for the state of Michigan demonstrates the following:

a) Elevated rate of past 30-day use of tobacco ("smoked cigarettes/ cigars or using other tobacco products such as chewing tobacco, snuff or dip") by youth of school age in the SWMBH area (Range: 11.3% to 16.9%, HS – MiPHY data);
b) Average age of first cigarette smoking in the SWMBH area Counties is too low (Range: As low as 9.9 in MS, and 12.7 in HS – MiPHY data);
c) Data related to perception of risk/harm and consequences of tobacco use amongst students: Perception of risk, harm & consequences of tobacco use is not high enough amongst youth of HS age (Smoking: "moderate to great risk?" Yes response range: 84.8% to 89.6%; MiPHY data);
d) Data indicating how easy HS students find it to access cigarettes: "Easy or very easy to get cigarettes?" Yes response, range in the region: from: 65.6% to 53.7%; MiPHY data).
e) Adult smoking rate in the region ranging from 15% (Branch County) to 26% in Calhoun County.
f) Data on critical health factors directly or indirectly associated with smoking and tobacco issues, such as the Center for Disease Control's (CDC) "Smoking Attributable Mortality" (SAM) statistics, which reports 14,522 smoke related deaths in state of Michigan between 2000 and 2004 (most recent SAM data), which ranks Michigan 23rd in the US for most deaths attributable to smoking.
g) According to the same CDC report, the economic impact attributable to smoking in the state of Michigan (during the same 2000 to 2004) period is rather staggering:
    - Smoking attributable productivity losses: $3,953,672,000
    - Smoking attributable Expenditures - healthcare related: $3,306,000,000

h) The same CDC report, concludes that smoking has a major health effects on those who use tobacco, especially, and those who are exposed to smoking and the that tobacco in its various forms is either a major know contributing factor or a direct causal factor for the following diseases:
    - Lung cancer: Smoking causes about 90% of lung cancer deaths in men and almost 80% in women.
    - Other types of cancer identified by the study, as caused by smoking: Cancers of the stomach, cervix, kidney, and pancreas and acute myeloid leukemia.
    - Smoking causes coronary heart disease, the leading cause of death in the United States. Coronary heart disease results from atherosclerosis of the coronary arteries, which are significantly increased by cigarette smoking
    - Stroke: Strokes are the third leading cause of death in the United States. Cigarette smoking is a major cause of strokes.
    - Other health effects smoking/tobacco use: a) Smokers are more likely to be absent from work than nonsmokers, and their illnesses last longer; b) Smokers tend to incur more medical costs, to see physicians more often in the outpatient setting, and to be admitted to the hospital more often and for longer periods than nonsmokers; c) Smokers have a lower survival rate after surgery compared to that of nonsmokers because of damage to the body's host defenses, delayed wound healing, and reduced immune response. Smokers are at greater risk for complications following surgery, including wound infections, postoperative pneumonia, and other respiratory complications;
    - Respiratory diseases: a) Smoking is related to chronic coughing and wheezing among adults; b) Smoking damages airways and alveoli of the lung, eventually leading to COPD; c) Smokers are more likely than nonsmokers to have upper and lower respiratory tract infections, perhaps because smoking suppresses immune function; d) In general, smokers' lung function declines faster than that of nonsmokers.

Southwest Michigan Behavioral Health is also acutely aware of the prevention of communicable disease. SWMBH, through its SUD Provider network, will assure:

a) Screening for HIV/AIDS-STD Communicable Diseases using the SWMBH-developed screening tool titled: Communicable Diseases Screening Tool (SWMBH Policy document 11.6, Attachment XV);
b) Referral for testing as needed;
c) Provision of health education to persons that meet certain high risk categorical definitions.

SWMBH will monitor provider compliance with the requirements and guidelines set forth by the MDCH OROSC Prevention Policy #2 addressing Communicable Disease issues by:

a) Assuring that that all Treatment providers have a communicable disease policy on file with established procedures and protocols in place that minimally include counseling and referrals for testing;
b) Having Providers maintain records on persons serviced, which include a health

assessment that encompassing information on screens for high-risk behaviors;

c) NOTE: All records will include documentation of: referrals made for testing, counseling provided regarding communicable diseases, other healthcare referrals and referrals made to the regional HIV Case Manager;
d) Requiring that a Communicable Disease Screening Tool is to be completed for each new admission to Treatment Services;
e) Requiring that all direct service staff of provider agencies meet the OROSC and SWMBH defined training requirements for communicable diseases (as stated in SWMBH Policy 11.5 (Attachment XIV: "CD Testing and Education").

2. A narrative, based on the epidemiological profile, identifying and explaining data- driven goals and objectives that can be quantified, monitored, and evaluated for progress:

The epidemiological profile showed similarity throughout our region overall despite the variety of urban and rural demographics in our counties. It showed very specifically that alcohol is our highest primary substance for treatment admission rates. Additionally, epidemiological data from SAMHSA most recently available showed that while the SWMBH counties did not have a statistically significant difference in alcohol use by minors from the State, it was higher than the state average (p=0.0097). During this same time period, binge drinking by minors followed the same trends and showed a slight increase in the SWMBH counties from the 2007-2009 rating period to the 2009-2011 period of 7.7 to 8.2. Regional rates of alcohol related crashes death and injury are also higher than the statewide rate. Two of the counties in our region had a disproportionate rate of fatal crashes and number of persons who died related to alcohol as compared to regional and statewide averages. Overall, this lends overwhelming support to the continuation of efforts to address alcohol use in our region.

Marijuana and Opioids are also a predominant issue in our region with their positioning varying by county. There is also variance between Heroin and Other Opioid usage depending on the county. Additionally, in several of our counties, methamphetamines continue to be of significant concern and amongst the highest ranking of the treatment admissions.

The epidemiological data shows that the region is doing something right as it pertains to methamphetamine use. Close partnerships with law enforcement through task forces, coalitions and other initiatives to combat this destructive drug have wrought success in this area. A year over year look shows a reduction in methamphetamine admissions in five of the counties. This is due in part due to targeted treatment interventions, including use of the Matrix Model in high methamphetamine using counties, which is designed to address this stimulant use. Additionally, in three of these counties, treatment can begin while in jail. Again, this close partnership between treatment and law enforcement allows for better treatment outcomes. For the three counties where this is on the rise, we can look to strategies used in counties where improvement has been seen to see if any of these same strategies can be used.

There have been several initiatives to increase access to services that are also tied to quality improvement. One initiative to increase access has been targeted towards those seeking services at Community Mental Health Specialty Providers (CMHSP's) and those with co-occurring disorders. In several counties, the CMHSP's are the only providers for outpatient services. In our

region, the CMHSP's act as access points for services if they also provide them. So, while they must act as a neutral site and make referrals to any outpatient provider requested, they also have the ability to engage the client right on site who may already be receiving services there for a severe and persistent mental illness (SPMI), but needs more specialty SUD focused services. This model is functioning in 5 of the 8 counties in our region where the CMHSP's are service providers. This allows for more integrated services to occur. Additionally, in three of the counties, there are also primary care services available on-site as well. This move towards true integration of care in all facets of a customer's life is the direction of the future. While we have three sites with physical integration, we treat all of customers with a mind toward their total wellbeing and expect providers to do the same. Population health and long term wellness continues to be the focus of SWMBH.

Additionally, we had previously witnessed outpatient treatment stays that ended prematurely with client drop out. Customers may have stayed in treatment long enough to meet the State retention standard, but not long enough to truly experience an impact from treatment. This lack of follow through led to a hypothesis that one cause could be that not all interventions were stage matched. We had many court ordered referrals for treatment who attended only long enough satisfy a monitoring body, but not long enough to complete treatment. Consequently, we have piloted this past year and will more widely disseminate in the coming fiscal years, an early intervention, motivational enhancement model of care, for those court ordered or otherwise presenting as pre contemplative or contemplative in their stage of change.

These early intervention groups were based on the ATTC motivational enhancement curriculum. Early data shows that those who completed this intervention had a positive impact on their stage of change thus making them better candidates for standardized or more relapse prevention focused treatment. Those who did not complete the intervention were the same people who had dropped out previously and were perhaps better suited to addressing issues with the court. The fact that they had received more appropriate information for where they were at in their stage of change hopefully made the treatment experience one which would make them more likely to return when they were more ready to engage and did not give them a negative impression of the treatment experience.

Additionally, another issue addressed is that with high rates of alcohol, opiates and methamphetamine use, all drugs with devastating effects on multiple life domains, we believe it necessary for case management and recovery support services to routinely be incorporated into treatment planning. The impact these substances have on the functional areas of customer's lives is unquestionably substantial. Only with these elements available can we have a fully functioning ROSC. However, this is simply not something currently available across our provider network in a uniform way. Some providers have chosen to offer these service using PA2 funding. Additionally, our Women's Specialty providers also offer case management services. However, this unnecessarily limits the scope of the services to specific populations. While not every customer may desire or take advantage of these types of services, it should be made routinely available. These discussions have been ongoing with mixed results. We will be setting internal goals for increasing the percentage of providers to offer these both Recovery Coach and Care Coordination services. While we are functioning as an integrated region now, there were different policies and expectations from the different funders. We will spend the next several years focusing on figuring out the best of the previous practices and having providers focusing on discontinuing altogether conflicting practices. This plan from MDCH offers an opportunity to significantly

improve the quality of services available within our region if we are thoughtful in our implementation and not hasty about decisions.

The SUD service system is fortunate in that it does have access to well-established measurement systems. SWMBH intends to take advantage of these to review our success in all of the above areas. We have baseline rates of services from previous years for all levels of care. We will measure increases via encounter data by county and by provider. Additionally, as we now have the start of a new region at nearly the same time a new funding source (Healthy Michigan) is available as we implement new service strategies, we have a truly unique opportunity to measure the impact of access to health care in an unprecedented way. This includes access to Medication Assisted Treatments (Buprenorphine and Naltrexone) that are not funded by the SUD service system and access to more immediate care for non-priority population for those qualifying for the new health care plan.

We will be able to measure all service codes, as well as all types of substances, in addition to the traditional National Outcome Measurement System that we've had access to. It is our intention to measure all of this a minimum of twice yearly so that we can make any necessary adjustments if the data looks problematic. This more real time, during treatment episode information, can assist in learning if there are certain substances in which we experience higher dropout rates or certain types of services for which we have higher dropout rates. It will help us evaluate if some of our newer interventions designed to address this are successful. This combination of TEDS data and other standard evaluation measures we use such as real time encounter data, treatment continuation data, timeliness data, wait list data, sentinel events, etc., allow us to measure the impact of all of these goals. Additionally, our Utilization Management department's concurrent review of all treatment delivery assures that the services that customers receive are not only medically necessary, but the Care Coordination method our Utilization Management department employs with our highest risk customers (those needing Detox, Residential and Methadone) helps to assure that customer's needs are met and helps us towards our goals of overall population health.

In summary, based on our epidemiological data, several broad goals emerged which we have the tools and capacity to monitor. 1. Continuing our ongoing move towards a Recovery Oriented System of Care which provides a Continuum of Care rather than an Acute Care based model of Care for customers. 2. Continuing to increase the Evidence Based and Research based Treatments available with assurances these are stage matched in delivery to assure best practice. 3. Emphasize the need for improving overall population health as an understood goal for all providers which can begin to be achieved through contractual language and expectations. 4. Utilizing data to ensure that all decision points are based on current, relevant data and that unsatisfactory results can be addressed swiftly and outcomes measured routinely.

The SUD Prevention Goal/Objective/Outcome structure presented in the Prevention Logic Model (Attachment I) follows an evolutionary pattern and practice recommended by SAMHSA for planning of Prevention services, whereby prevention activities are developed and set up to address the identified factors that contribute or have a causal relationship (contributing factors, intervening variables, risk factors) with the substance abuse whose consequences have been demonstrated by data. Following this logical pattern, the activities listed by SWMBH in Column #4 (objective) are designed to support the immediate outcomes listed in Column #5 (immediate Outcome). These two sets of activities are developed and designed to address the Intervening Variables, identified in Column #3 for each of the Goal areas. Continuing with this pattern, the activities listed in

Columns #4 and #5 are, in turn, constructed to support achievement of the Long Term Outcomes listed in Column #6, which when achieved will directly impact the SA consequence identified by epidemiological data indicators in Column #1. All activities in every phase of this "sequential process" are designed to maximize results and outcomes in every phase of the process in order to enhance the chance of making a real impact on the prevalence and incidence of SA consequences identified in column #1.

Therefore, in order to effect change in our region regarding the consequences of Underage Drinking (Prevention Focus Area #1), Prescription Drug Abuse (Focus Area #2), Youth Access to Tobacco (Focus Area #3) and Drug Emerging Trends (mostly marijuana use amongst youth of school age), we have to ensure that prevention efforts/programs/activities in the SWMBH are directed to addressing critical factors that have been identified as either causing or contributing to these deleterious SA consequences in the community. For detailed and specific information regarding identification of strategies, programs, community partnerships and exact counties where these activities and efforts will be occurring, please refer to the appropriate columns of the attached Prevention Logic Model (Attach. I).

3. A narrative illustrating goals, objectives, and strategies for coordinating services with public and private service delivery systems:

As can be seen from the stakeholders sheets completed in conjunction with each community, the SWMBH region is rich with collaboration. With the exception of Berrien County, each of the communities has a coalition where many stakeholders come together to address these issues. Most, if not all, of the stakeholders groups have some representative at the table through these coalitions. However, in addition to the coalitions, because of the importance of ROSC, additional workgroups have formed specifically to work on ROSC planning which has enticed additional membership from the communities. Specific goals were identified through the planning process in the few areas that the membership was deemed not as broad as needed. It should be noted that though Berrien County does not currently have a coalition, one of the goals of the prevention provider working in conjunction with the Regional Prevention Coordinator this year is to facilitate the development of this. Additionally, Berrien County stands as a model of involvement of the faith based community for the rest of the region. Focus groups conducted in Berrien County by SWMBH staff revealed involvement for recovery from transportation, to offering their own services to those in recovery. The efforts in that community are truly transformative and commendable.

Another strength in this region that can be grown upon is the presence of a Veteran's Affairs Medical Center in Calhoun County. As we move to partner more in service of Veterans, our proximity to this institution and the relationships formed with neighboring service systems -- both in Calhoun and adjacent counties -- can be fostered for even better service access and resources for those in need. A final strength for the region is the focus on integration with physical and behavioral health. This initiative has been ongoing for some time and can be seen with the many co-locations and projects in the region. With the health systems in the region and the new Western Michigan University School of Medicine as partners serving so many of the residents of the SWMBH region, we hope to continue to address all aspects of the lives of those we serve. It is advantageous that we have such large institutions in our region willing to be part of the mission of

our agency. From the largest hospital to the smallest church, there are partnerships across the region to advance the goals of a Recovery Oriented System of Care.

4. A summary of key decision making processes and findings undertaken by the SUD Policy Oversight Board or other regional advisory or oversight board if the SUD Policy Oversight Board is not established during the development of the Strategic Plan:

During the May 2014 SWMBH SUD Policy Oversight Board meeting, the MDCH Strategic Plans for SUD Prevention, Treatment and Recovery Services was introduced and discussed at length. Education for board members focused on the new requirements for SUD treatment services to utilize epidemiological data to guide treatment programming and the emphasis on providing evidence based treatment to customers of SWMBH contracted treatment providers. Board members were provided a copy of the plan and it was decided by Board members that the most appropriate course of action would be to hire an epidemiologist to assist with the procurement of relevant data. It was also then collectively decided by board members that these findings should be reviewed with respective board members, as well as local county providers. SWMBH SUD staff accommodated the Board member's decisions and explained that meetings with each County representative would be scheduled within the following weeks.

Throughout the month of June 2014, eight separate meetings were held by SWMBH SUD staff with each respective county's Board member(s). Also in attendance with SUD Policy Oversight Board members were Treatment and Prevention providers (Attachment IV). During these meetings, epidemiological data and Treatment Episode Data Set information was shared for each county, and the respective attachments regarding key stakeholders were completed. Highlights from the review of data included the emerging trend of heroin and other opiate use across the region and the omnipresent use of alcohol. For FY2013, alcohol was identified as the primary substance of abuse at admission for almost 40% treatment admissions for the SWMBH region.

Additionally, a review of current evidence based practices being utilized by treatment providers were reviewed. Gaps of evidence based treatment service delivery were identified within the respective counties and strategies to address this were discussed. As a result of the need to expand evidence based practices throughout the region, a clinical work group will be created with representatives from various treatment providers. This will allow providers to review current evidence based practices being utilized by other regional providers, identify new practices to be implemented, and an opportunity for resources sharing. This group will begin meeting in August 2014 and will serve as a forum to evaluate the individual treatment needs of each county while simultaneously identifying the collective needs of the SWMBH region.

5. A narrative complete with a detailed logic model for selecting and implementing evidence-based programs, policies, and practices for implementing a recovery oriented system of care that includes prevention and treatment, as well as all other services in your array necessary to support recovery.

SWMBH has identified a number of key areas to assist in the enhancement of the current recovery oriented system of care. The focus areas for SUD treatment include: continuing to address the rise in heroin and other opiate abuse, improving population health through care coordination, improving customer retention in services, improving Women's Specialty Services to assure all components of programming are delivered, using science-based and evidence based programs throughout the treatment network, enhancing current services such as early intervention, access to recovery coaches, and care coordination services. Additional focus areas include improving treatment technologies to address customers presenting with alcohol as their primary substance of abuse, and incorporating trauma focused/trauma informed into the provider network. For Prevention services, focus areas include a reduction in underage drinking, reduce prescription and over-the-counter drug abuse, including opiates, reduce youth access to tobacco, and reduce use of non-medical marijuana amongst youth of school age. Attachments I and II outline these respective areas in detail.

6. Provision of an allocation plan, derived from input of the SUD Policy Oversight Board or other regional advisory or oversight board for funding a recovery oriented system of care:

SWMBH is already working on its requirements to expend a minimum of 20% of block grant allocations on prevention services. SWMBH finds itself in a fortunate position as the financial analyst working primarily on the SUD budgeting comes from the Kalamazoo CA which has allowed for the block grant expertise to transfer to SWMBH and is already evident. While we do not yet have our budget numbers for the upcoming year, we are actively working with the providers to attempt to develop their working budget for the years.

Collaboration with Michigan Tribal entities is underway within the SWMBH region. SWMBH is currently working with the Pokagon Band of Potawatomi in attempt to further our involvement with them. They work on a limited basis with Prevention Coalition in Cass County and have attended a Recovery Coach training, but we would look to have this partnership occur in more robust ways.

SUD Prevention Component of services has, as a direct result of the now sunset SPF-SIG grant, developed a framework for services provided in the region, which is largely contingent upon community partnerships and collaborations in order to assess needs, develop, and implement activities that utilize environmental and community-based strategies. SWMBH does fund totally or partially eight (8) community coalitions in the region, which comprise representation of strategic and crucial sectors of each of each of the 8 communities in which they operate. SWMBH relies heavily on these collaborative efforts in order to determine and develop a course of preventive action that is most appropriate for each of these communities. The systematic utilization of data indicators and environmental strategies through these community collaborative efforts ensures that prevention services are provided to the population at large and to certain strategic universal groups in particular such as parents, families, medical professionals, retailers,

leaders, in order to impact in our communities the norms and practices that may contribute to drug use.

To ensure compliance with fidelity standards and a uniform effort in the implementation of these strategies across the region, the SUD Prevention Component of services has identified and developed a number of educational materials, which have been made available electronically to all Prevention providers per their request. SWMBH issues a certificate for completion to all provider staff that, after reviewing these materials, successfully completes a written test on their content. These materials cover best prevention practices and focus on the latest Prevention science and research.

SWMBH has also begun to use the SAMHSA developed Substance Abuse Prevention Skills Training (SAPST) curriculum as a center-piece of the education of its prevention workforce. The SWMBH SUD Prevention Specialist has recently received SAMHSA training as a trainer of this curriculum and has begun to hold sessions for the SWMBH Prevention workforce (to date two SAPST sessions were held, with 7 provider staff being able to complete all four sessions of the curriculum). SWMBH plans to make attendance of the SAPST training mandatory to all prevention staff of our provider network starting next fiscal year. We are also directly taking interns interested in the SUD services field for workforce development, and continuing to host trainings in order to strengthen workforce development of our provider network.

There is already a fairly substantial amount of research and EBP available in the provider SWMBH network. However, SWMBH supports buying only the best for the customers we serve and supports assisting our providers in offering this. Consequently, we are holding clinical workgroups to help our providers evaluate and chose which EBP's they would like SWMBH to host trainings in as it is our intent to host 3-5 training over the next year. As previously noted, it is our intent to put in contractual requirements phasing in EBP minimums over the next three years. Curriculums not listed on SAMHSA's National Registry of Evidence-base Programs and Practices (NREPP) must be reviewed and approved as meeting research based criteria by PIHP clinical staff. Examples of this would include SAMHSA approved, ATTC purchases, Hazelton curriculums, etc. For individual therapy, we would require clinical supervision with components such as fidelity checks to clinical models such as Motivational Interviewing models a minimum of yearly.

There is currently an adequate provider network in our region, though within the last two years, several small providers did close. We would like to provide more choice in outpatient providers for customers. We do have a tribal population, Pokagon Band of Potawatomi, who we are working to establish more close relationships with. They did participate in a recent Recovery Coach training and were invited to review the epidemiological data with the county. There has been a transition with their behavioral health staff within the past two years and there is a real potential for the relationship dynamic to really expand. We have already approached them to see if they have an interest in becoming a SUD treatment provider.

The PIHP's that merged and the Coordinating Agency had a broadly overlapping provider network. With its merger this past winter, the provider network only grew. As noted in the implementation plan, as a Coordinating Agency, the provider network had demonstrated the ability to remain flexible and responsive to the local needs of each community. That flexibility has resulted in improved service delivery for priority populations. In Kalamazoo, a public health

women's case management program that historically served a limited area has been expanded. This program has historically focused on decreasing infant mortality rates and eliminating racial disparities in maternal and infant health. However, with the recent program expansion, a new focus has been placed on pregnant women who also have substance use disorders. This service has now covered all of Kalamazoo County which allows greater service to this specific population.

Complementing this program expansion is a renewed focus on women's specialty services in the SWMBH region. A review of the women's specialty services revealed many opportunities for improved services. The integration has brought several women's residential providers onto the panel and we are working with them to discover how they can best assist our customers. Additionally, as mentioned previously, with the expansion of the Medicaid benefit to Healthy Michigan, we are looking at bringing on two new detox/residential providers onto our panel by fiscal year 14/15. This should provide new opportunities for our customers to stay within the region and continue to work on other life domains as needed such as work, family and health issues. Specifically, should physical or mental health needs be discovered, we believe having the potential to have customers see their home provider, or to develop a relationship with a home provider, while in services can provide for more seamless transitions. We consider this expansion very positive and look forward to the opportunities for truly integrated care may this bring.

The Utilization Management (UM) staff monitors Substance Abuse Block Grant (SABG) requests, UM staff are aware of the SABG timeliness criteria as it has been part work protocols in the previous Coordinating Agency. Additionally, the PIHP that was not also a CA, functioned under these standards as well, making the priority populations standards something that has part of day to day practice for a number of years prior to the integration into SWMBH in February. While not ideal, a wait list is kept for SABG clients seeking detoxification/residential treatment. All BG priority population customers complete a screening with SWMBH. They are referred for an assessment and then, upon receipt of the assessment/ request for residential, they are referred for detox and residential services. So, they are linked with an agency and then are referred to detox/residential services, thus bypassing the wait list. With the Care Management approach that is the philosophy that SWMBH will be operating under for the Detox/Residential/Methadone (DRM) customers, we hope to provider additional monitoring services and coordination for these customers that assure that they receive the support they need. As a new region, we have yet to fully realize all aspects of this care management but it will include such coordination as assisting clients in locating MAT services who may need Suboxone as part of their residential discharge, or locating a primary care physician for clients whose chronic illness may play a role in their substance use disorder. This priority population makes up a large part of DRM population which is why we have retained central management of it, to ensure that they receive the excellent care that be a step toward their total wellness.

During the transition this past January, the new protocol referenced above was put in place that has been very successful. All customers, including SABG priority population customers, complete a screening for level of care with SWMBH. They are referred for an assessment at the agency they will receive their ongoing services at or if seeking residential services, the agency they would receive aftercare services at. As noted above, if they are seeking detox/residential services, upon receipt of the assessment/step-up request as noted above, this allows customers to bypass the wait list if there is a bed and funding available. For non-priority population customers this validates the needs for the service and in some cases, customers are so successful at this level of care they have

opted not to go to residential treatment. Most importantly, the idea is that with a secure connection established with a local community therapist, we enhance the likelihood of engagement in aftercare for all populations. Additionally, we have assisted in facilitating a local relationship with a therapist for them to return to.

The SABG wait list is monitored and reviewed by UM Staff multiple times per week to assure that clients are transitioned into the identified level of care as soon as possible. Interim care is offered to clients placed on the waiting list including, but not limited to, outpatient, intensive outpatient, case management, primary care, etc. Educational material is also sent to clients placed on the waiting list that includes resources about HIV and other communicable disease and a resource list which includes the local County health department contact information.

SWMBH has a network of providers who have long been working as a trauma informed system of care. Many of our providers offer specific trauma focused treatment and all are expected to be trauma informed (both in their practices and their environments). SWMBH policy states (Attachment XVI) that Trauma Informed Care is organizations, programs, services and supports that are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid re-traumatization. Trauma Informed Strategies are interventions that seek to do no further harm, create and sustain an environment of safety for those who may have experienced trauma, and promote understanding, coping, resilience, strength based programming and healing. We educate all of our providers that truly being trauma informed begins from the way one answers the phone, the way the waiting room is arranged, not just the clinical practice. Prevention, Treatment and Recovery service providers must all be aware of the vulnerability of those who have dealt been exposed to life circumstances that have caused them trauma. Environmental issues provide triggers more than is often understood. Writing a regional policy, is one step but expecting that our providers have their own trauma policy is another way to ensure that we can avoid re-traumatizing those we are charged with helping.

7. An implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery, will be implemented and a three (3) year timeline:

SWMBH honors that individual's recovery from substance use disorders is a unique journey that may ebb and flow, include setbacks, and involves extensive support from both formal services and community support. In order to assist individuals in their recovery, it is essential that a wide variety of clinically and medically appropriate services be available for customers. In conjunction with formal treatment and prevention services, SWMBH understands that recovery happens within individual's home communities. Community-based supports are paramount to an excellent ROSC and allows for greater success of recovery. Both of these elements – formal and community based services -- are essential to quality care with the ultimate goal to assist and support individuals wherever they present in the recovery process. To that end, SWMBH has reviewed many components of prevention, treatment, recovery supports, and have engaged key community-based stakeholders to help improve the overall breadth of services that are available to customers within the region.

The SWMBH SUD treatment provider network is well positioned to deliver a wide variety of services and supports to their customers. SWMBH currently has a strong outpatient provider network which offers a variety of outpatient services including individual treatment, group treatment, and peer services through the use of recovery coaches. Medication assisted therapy is also available with two providers located within the region, one located in the central regional county, Kalamazoo, and the other located in the south west regional county, Berrien. This not only offers customers choice in service providers, but also helps eliminate some access barriers as it relates to transportation and geography. Detox and residential services are not only readily available in Kalamazoo County, but also with various providers located outside of the 8 county region. Noting a limited availability of detox and residential services within the region, SWMBH is currently planning to expand the detox and residential provider network to include treatment providers located in Berrien County and Calhoun County. The SWMBH SUD treatment provider network allows for efficient access to appropriate level of services at well-established providers within the region. The strength of a well-established provider network that provides core SUD services also allows SWMBH to begin to identify and address service gaps within the region.

Although early intervention codes were in treatment provider's contracts, formal early intervention services were not offered within the previous Coordinating Agency. This was due to lack of clarification as to how to best utilize this level of service. Citing an obvious shortcoming of this level of service, in the summer of 2013, a pilot program was initiated with KCMHSAS CA providers to implement a new Early Intervention group. This pilot was then continued with the formation of SWMBH. For the purposes of this pilot project, four providers agreed to participate in the pilot project, delivering an early intervention group to customers who either presented in the pre-contemplative or contemplative stage of change. Many of the customers were not voluntarily seeking treatment and only were seeking treatment as a result of court-involvement, family pressure, etc. The Readiness to Change Questionnaire was administered to customers at the beginning of group and then re-administered at the conclusion of group. Results from the pilot have yielded positive results reinforcing the need to implement early intervention services across the entire provider network. Currently, rates are being established for early intervention services and will be reflected in provider contracts beginning next fiscal year. The goal will have early intervention services available in at least one provider in each respective county. Ultimately, it is likely that early intervention services will also be available through SUD prevention services.

Peer services through the use of Recovery Coaches is another clear area of growth within the SWMBH region. Although there are a variety of providers that currently utilize Recovery Coaches as part of their continuum of services, there continues to be a dearth of appropriate peer services within the SWMBH provider network. The SWMBH region has been fortunate to have held Connecticut Community for Addiction and Recovery (CCAR) trainings for peer certification over the past two years. As a result, there has been strong work force development within the region. However, many provider agencies have not begun to utilize the resources available to them. Recovery Coach Service codes were in some of the former Kalamazoo CA provider contracts and were expanded to all outpatient providers with the formation of SWMBH. We are setting internal goals for providers about making a full continuum of services available at their agency either through direct hiring of peers or through arrangements with other providers in order to remain a providers. Timelines are being established for this continuum. All customers must have necessary services available to them when they need them. This is a core value that must be upheld by all providers.

In reviewing Women's Specialty Services, it became apparent that although care coordination is being utilized within the WSS programs, this level of service was not being utilized across the SUD treatment network. With the introduction of Healthy Michigan, the limited utilization of care coordination service was another area which was identified as an area of needed growth. Care coordination services, when coupled with formal SUD treatment or other supports, provide opportunities and assistance to enhance the recovery process for individuals. Care coordination services are also critical to improve functional outcomes for customers such as attaining adequate housing and securing employment. Expanding care coordination will allow customers to utilize this service either as complimentary service to outpatient therapy services and/or as a service for customers as they prepare to discharge from services. This service allows customers another opportunity to focus on goals within their treatment plan outside of traditional therapy services. Although this may be a change in the way in which providers deliver services, this service will allow customers a greater chance of sustained recovery and SWMBH remains committed to not only providing quality services to customers, but also supporting providers in implementing a ROSC in practice. Consistent with the strategies identified above, case management rates and codes were included in provider contracts at the inception of SWMBH and targets are being established with providers for their usage of these codes.

A review of the evidence based practices available within the SWMBH region for SUD treatment services revealed that although many providers are utilizing some form of evidence based practice. These practices include, but are not limited to: Cognitive Behavior Therapy, Motivation Interviewing, Seeking Safety, IDDT, Matrix Model, Substance Abuse Management Model, MET/CBT5, Cannabis Youth Treatment Series, DBT for Co-Occurring disorders, Helping Women Recover, and Living in Balance. However, there was great discrepancy in the number of practices providers were using and in the way they were being implemented. A comprehensive list of available evidence practices is attached in Attachment XIII. Although there are some SWMBH SUD providers that have designed their treatment programs to have a variety of evidence based and research-supported practices, some providers are using very few ---- or none at all. In order to assure that customers of SWMBH that receive SUD treatment services have the highest level of quality treatment available, providers that provide group therapy services will have contractual requirements for target percentages of EBP and research based practices for the services purchased used public funding. For individual therapy, we would require fidelity checks to reportedly used therapy modalities such as motivational interviewing models a minimum of yearly. As part of our site review protocols we will begin to monitor clinical supervision and that clinical practices identified are monitored for fidelity and documented. This will ensure that our customers receive the best care and that public dollars are used to purchase the highest quality services.

There continues to a number of primary care initiatives being implemented throughout the SWMBH region. Currently, there are a number of well-established partnerships as well as new partnerships emerging. In Kalamazoo, Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) has a long standing relationship with the Federally Qualified Health Center (FQHC) to better coordinate behavioral and primary care needs. KCMHSAS has also sponsored an Integrated Health Care class at Kalamazoo Valley Community College for behavioral health practitioners to assist them in coordinating their consumer's medical care. It is also noteworthy that SWMBH SUD staff have been participated in this class over the past two years as presenters on the SUD sections.

Also in Kalamazoo, the partnership between the new Western Michigan University School of Medicine (WMed) and SWMBH is growing. Western Michigan University Behavioral Health Services began an SBIRT program in partnership with WMed. This program has Behavioral Health staff embedded in the internal medicine and medicine/pediatric clinics at WMed. This project allows for true integrated care while simultaneously assisting with the training of medical students and residents. WMU Behavioral Health staff have also provided training to WMed faculty, residents, and medical students on topics such as motivational interviewing, assessing/screening for SUD, and addiction. Partnerships with other physicians at WMed are also emerging with the Office Based Opioid Therapy in Primary Care Work Group. WMed psychiatry staff and internal medicine staff are active participants in this work group.

In Calhoun County, a SWMBH SUD provider works closely with the Family Health Center of Battle Creek by providing on site SUD screening and assessment to patients. Additionally, a new SUD provider, Summit Pointe, also has primary care services available at their office in downtown Battle Creek. In St. Joseph County, Community Mental Health and Substance Services (CMHSAS) of St. Joseph County is also an FQHC. CMHSAS of St. Joseph County also is the primary SUD treatment provider in the county so this will position them well for integrating primary and behavioral health in the future. In Cass County, Woodlands Behavioral Health has a therapist who is co-located at the local FQHC (Cass Family Clinic) and provides behavioral health services to their clinic customers.

Berrien County has multiple primary care initiatives going that include a primary care facility through the FQHC, Intercare, located within Riverwood Center. Additionally, Intercare has been an active partner with ROSC efforts in Berrien County. Also of note is the current development of a clinic in Berrien County that will address the high utilization of the emergency room for patients presenting with pain and SUD. This collaborative project is modeled after Dr. R. Corey Waller's Center for Integrated Medicine and Dr. Waller will be serving as a consultant to assure that patients are receiving the highest level of care. This project is also a unique endeavor as it partners potential grant funding from a commercial insurance company with resources from Berrien County to improve the overall health of the community.

The SWMBH region has been developing both local and a regional ROSC plan to build on the ROSC initiatives already started in each county. The ROSC structure within each respective county is being developed in conjunction with the already existing Community Substance Abuse Coalitions. SWMBH has developed a regional ROSC plan and the following counties have completed a local plan: Kalamazoo, Cass, Berrien, and Barry. The other four counties are in the process of developing/completing their respective plans. A review of the completed plans reveals the most common and repeated theme across counties, goals and objectives were increased collaboration, communication and coordination with various providers and other services in the communities. This includes primary care, pediatric providers, criminal justice systems and currently operating SUD and Prevention providers and schools. Every county identifies a need for increasing education to providers and the community regarding SUD as a disease process. Completed plans have been attached and are indicated as Attachments XVIII-XXI.

Other key developments within the SWMBH implementation of ROSC include meeting with local providers and community members in Berrien County to outline and map relevant resources and services that support recovery across multiple domains. In Kalamazoo, recent focus has been on developing appropriate training material that can be presented and disseminated to broad spectrum

of audiences. As a result of this, a power point presentation has been established and is currently being used to educate different sectors within the community about ROSC and integrated systems of care. Additionally, SWMBH SUD staff have worked closely with the Kalamazoo ROSC work group and to develop and publish a protocol for hiring recovery coaches/peers for SUD services, a brochure for community distribution that explains ROSC (Attachment XXIX), and a guide for local providers and organizations to link customers with resources and various recovery supports within the community (Attachment XXX).

Although each county is at various stages of implementing ROSC, beginning next fiscal year, SWMBH will monitor each SUD provider agency's level of collaboration with other disciplines of service with a ROSC framework. During site visits, provider will be evaluated on their ability to: "demonstrate that it participates in a planned and sustained collaborative/partnership effort (outside of the scope of the work of the local Coalition) with a community organization, which represents/delivers services in another domain of service (ex. SA TX, MH, Peer Recovery, Primary Healthcare, Employment, Housing, etc.). Such partnership effort must be designed/intended to deliver Prevention Services within an integrated care model/approach that meets the definition of Recovery Oriented Systems of Care (ROSC)."

A review of current status of ROSC initiatives within the SWMBH region reveals that progress has been made in the following domains:

- Develop a shared ROSC vision
- Increase awareness and understanding of ROSC among partners and stakeholders
- Develop a ROSC operational structure for each county
- Enhance the ability of service systems funded by SWMBH to support and promote health, wellness and resilience of individuals in recovery, their families, and their communities by developing prevention prepared communities
- Enhance the ability of people with behavioral health conditions in the region to both initiate and sustain their recovery
- Ensure that residents in need of SUD treatment in the region receive effective services and supports, regardless of the systems they enter.
- Mobilize the recovery community and increase the community's understanding of the effectiveness of recovery in each community.
- Ensure that service integration initiatives and efforts are sustained and become embedded in systems of behavioral health in all counties.

Much work towards ROSC has occurred in recent months. However, Berrien County has the most recent relationship with more MDCH sponsored ROSC and the least time to work on the ROSC planning from a funding perspective. While they have a ROSC team that had pre-dated their involvement with our region, and have exhibited a commitment to this concept, as of yet SWMBH has not been part of their ROSC team. For the purpose of MDCH and SWMBH, ROSC is a concept that is ultimately tied to public funding and the use of Medicaid and Block Grant dollars. Assurance is needed that the dollars will be maximized by being used in a well-developed ROSC system inclusive of all identified partners with all necessary services in place. SWMBH will continue to work with the county stakeholders to assure this occurs. There are powerful advocates for those with substance use disorders in the community, motivated treatment providers, and a court system that is supportive of those with substance use disorders. Despite the challenges

inherent in implementing a ROSC, they are a community with really tremendous potential and promise for the future for those on a recovery journey.

8. An evaluation plan that identifies baseline and outcome data for implementing a ROSC that includes prevention and treatment, as well as all other services necessary to support recovery:

SWMBH has multiple data monitoring mechanisms in place. We are currently in the process of merging two versions of our electronic medical record in order to have one, comprehensive IT system. All of the required domains required in section 8, with the exception of Sentinel Events, are data elements that are found within our IT system. As part of the development and planning for the launch of our new IT system, these items have been provided to the IT Project Management staff. It is planned that the new electronic medical record, with the data monitoring/evaluation capacity, will be implemented by October 1, 2014.

Although SWMBH is a new regional entity, we have access to baseline data from multiple years to look at as starting points. This allows us to review service data across years. We can also compare this to our census data by county to make a more accurate determination of penetration. It is also important to note that data has been, and will continue to be, used when making strategic changes. The use of data has afforded us to look at the local trends of individual counties or providers. For example, in our planning we identified high dropout rates for customers in the outpatient level of care. Consequently, we implemented a motivational group to help improve treatment retention. Even within this group, data was compared between pre and post administration of the Readiness to Change Questionnaire to determine success of the intervention for those completing it. Another example of data driven decision making is the plan to incorporate elements of the Women's Specialty Services reporting elements into the new electronic medical record. As we look to improve ancillary services for women's services, this feature will allow us to monitor data elements and outcomes in a more real-time capacity. Finally, we continue to use the state provider report card but plan to do local provider report cards twice a year based on our review of SATWEB data as well as local site reviews. In doing so, we provide more timely feedback to providers. If corrective action is needed, the feedback is provided closer to the time. Providers is our region are receptive to change and it is believed once this is disseminated, it will be seen not as a tool of punishment, but as tool of positive change (See Attachment XXIV for a detailed overview of the IT plan for data monitoring).

As noted in the implementation plan response, Women's Specialty Services was an area of growth for the region and continues to be so. There have been strides made but given the importance of this area, this will continue to be an area of focus. There are 8 counties in the region and currently there are Designated Women's Providers in six of the counties. Berrien, the newest county in the region has two providers that are currently planning on becoming Designated Women's providers and are working on solidifying their programming. Barry County does not have designated women's programming, but did previously. They do have gender competent programming and continue to be in discussions with SWMBH about becoming a Designated Women's Program again. With the exception of the program in Kalamazoo, all of the DWP's are located in outpatient treatment programs. Therefore, in addition to the therapeutic services, they also provide the required ancillary services. However, the level and quality of these ancillary services vary from

site to site. This has been, and will continue to be, a focus in the region. Kalamazoo has a specialty Case Management program that serves all of the treatment programs in the county as well as offering specialty support groups. They will coordinate transportation residential treatment to out of county treatment for non- county residents as well.

All Women's Specialty Services (WSS) programs meet the minimum standards but achieving true excellence, particularly in the area of coordinating with primary care is an area of growth. One of the goals for all of the providers is to have more standardized referral pathways. While this can be challenging in large counties with multiple providers, the treatment of the whole person in an integrated care model is our goal for all our customers. For this, our priority population, it should be a standard of care that is always achieved. In addition to a Prevention Coordinator, SWMBH employs a Treatment and Integrated Service Coordinator Position. This position is designed towards working on the population health initiatives, the WSS services being one of them. This is a master's level position designed to bring these services to the level of clinical excellence they need to be at, not just therapeutically using EBP's, but from a coordination standpoint. This includes work with health plans and other broad stakeholders. That will be a focus for the upcoming fiscal years. At this point we do not have providers interested in taking that next step towards becoming an Enhanced provider, however, we will work with towards incorporation of a ROSC model to include community services. As part of assurance of looking at all aspects of the customer's life, reports and documentation for monitoring play an important role. As part of this, in our new clinical record to debut October of 14', as was noted previously, all Designated Women's Programs are required to complete the required women's specialty questions at the time of the TEDS admissions and discharge. This will ensure data integrity as well as to serve as a prompter for responsibilities for the population.

Consistent with both national and state wide trends, the number of customers presenting for SUD treatment for heroin and other opiate abuse is concerning within the SWMBH region. Treatment for opiate dependence and addition is available for customers of SWMBH. All of the currently approved FDA Medication Assisted Treatments are available in our region. There are two clinics that provide Methadone. One of these also offers Suboxone at this time and the other is in the process of being able to do this. One of these clinics also offers Naltrexone injections as well. Additionally, The WMed School of Medicine in Kalamazoo has set up an induction clinic for Suboxone and this is available to customers throughout the region. Jim Gilmore Jr. Treatment Center also offers Suboxone as part of its treatment to those admitted. Based on individualized treatment planning, some customers receive Suboxone as a detox medication and some are placed on Suboxone as a maintenance medication and receive a referral for ongoing care in the community. Additionally, Naltrexone is being increasingly recommended, in great part due to publicity by the PIHP/CA due to its efficacy with our clients in helping them participate in aftercare/treatment. One of the larger CMHSP's in our region has agreed to utilize this as appropriate with their clients who are being treated for co-occurring conditions.

There has been, as is the case in many places, a shortage of physicians to provide the Suboxone. In partnership with several local addictionologists and primary care physicians, our PIHP is facilitating the formation of a coalition. The goal of this coalition is to remedy this situation and make Suboxone available throughout our region. Additionally, one of the goals of the coalition is to provide education regarding the relationship between pain treatment and addiction. This group of skilled physicians has agreed to act as a resource and panel of experts in order to recruit

additional physicians to become licensed to provide Suboxone. Early successes from these partnerships include a resident clinic at WMed to include inductions of Suboxone. Additionally, a tentative agreement from Family Medicine at WMed has been made to have their physicians begin taking this on. One of the rural hospital systems has met with physicians from the group to discuss how they can begin helping to address this problem in their community. The state representative for Vivitrol has recently started attending these meetings and is available to assist us with any barrier in getting this medication to customers who may need it. Ultimately, we would like to set this up as a Center for Excellence for Office Based Opioid Services. The fact that it is a private/public partnership makes it unique and exciting.

Also of note are the plans of the PIHP to sponsor trainings to help professionals address the heroin and other opiate challenges. The PIHP plans to partner with an our contracted addictionologist, Dr. Belal Hegazy, and offer a training for the CMHSP's on managing the treatment of addiction in the psychiatric setting. Because there is still some resistance to Medication Assisted Treatment (MAT) in the therapeutic community, SWMBH is sponsoring a training by Dr. Hegazy designed specifically for therapists to explain the benefits for Suboxone and how the partnership between the therapist and the MAT provides for the best outcomes for the customer. This training will be based on an ATTC curriculum as well.

One area of weakness we did discover in our treatment of opiate addiction was during our survey of all providers and their use evidence based practices throughout our region. Both of the clinics that provide MAT had limited utilization of research or evidence based practices for the therapeutic components of their treatment. However, as noted elsewhere, SWMBH will be implementing contractual requirements for all providers regarding use of Evidence Based Practices and/or Research based practices which should remedy this concern by the end of the fiscal year. In order to achieve the functional improvements in all areas of life that are necessary, therapy is a critical component of this. We will continue to partner with the MAT providers, and all providers in our region to ensure customers receive the best services designed to meet their needs. As noted in our Implementation plan of last year, staff in our region work in partnership with Network 180 (soon to be Lakeshore Regional Partnership) and Dr. Waller both due to geography and philosophical alignments. We support the philosophy of using the correct intervention and type of medication based on the customer's presenting need. Because of the expense of medications such as Suboxone and Vivitrol, and the fact it was not a benefit we managed, options were limited. However their more widespread availability (particularly in light of Medicaid expansion with Healthy Michigan) provides us far greater opportunity to offer the correct treatment intervention to people. We will take all factors into consideration including route of use, length of use, poly substance abuse, other health conditions, etc. We will work in conjunction with prescribing partners to offer the most efficacious treatment both as a first referral, and as a continuum of care should someone want to cease their current treatment.

9. Evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent manner:

SWMBH ensures cultural competency throughout the regional entity as the monitoring agency by the use of policies, programs, and practices that require participating providers to demonstrate compliance with federal and state requirements as accountable to the respective SWMBH departments: General Management, Provider Network, Customer Services, and Corporate Compliance.

In order to assure the highest quality and culturally competent care for customers, SWMBH outlines "Network Monitoring" and the reciprocal responsibility of SWMBH to the CMHSPs and CMHSPs to SWMBH. The requirements and expectations for communication to providers are as follows: 1) New provider orientation of contractual requirements and business practices 2) Designate provider network staff to address provider questions and concerns 3) Notification to providers of changes in federal and state regulations impacting contractual requirements and/or business practices 4) On-going training (Attachment XVII). The methods of provider monitoring are on-going and annual including: Desk audits, on-site reviews, monitoring results from another PIHP, and the use of a common review tool by SWMBH and the CMHSPs. The review tools are required to share the same elements including 1) Federal regulations 2) PIHP managed care administrative delegations to CMHSPs 3) State regulations including the Mental Health Code and Mental Health Administrative Rules 4) Provider contract compliance (Attachment XXIV) 5) Policies, standards, and procedures 6) Medicaid Provider Manual.

Embedded within the aforementioned elements are, among many other requirements, standards of cultural competency. This policy further enumerates upon provider non-compliance for failure to comply with these requirements for participation including sanctions for unsatisfactory performance, lack of response, failure to submit plans of correction within required timeframe, and/or discovery of significant risk (health hazard, injury, loss, exposure). By complying with federal and state regulations, a provider would demonstrate cultural competency as required and monitored by SWMBH.

SWMBH requires that participating CMHSPs develop procedures and practices consistent with federal and state regulations while maintaining delegated and subcontracted functions. SWMBH's Application for Participation (AFP) for CMHSPs states, "Applicant's provider network's position descriptions for all paid employees and volunteers contain language of…culturally competent practices." The "Essential Functions" of required job descriptions states, "This position will be knowledgeable about and support culturally competent, recovery-based practices (Attachment XVIII). "Special Needs" are considered by the SWMBH "Access System" to meet the needs of people contacting the access system including "Diverse cultural and demographic backgrounds (Attachment XX)." "Customer Advisory Committees" are utilized to provide an opportunity for customers to provide feedback and input regarding decisions/services impacting them or the region. SWMBH is accountable for the culture and demographic of the customers by a policy that states, "Best efforts will be made to appoint to the committee a spectrum of individuals representative of the various populations served by SWMBH including geographic, ethnic, and cultural (Attachment XXII)." "Customer Education and Marketing Orientation" materials disseminated by SWMBH are accountable for cultural considerations of its customers in a policy that states, "Materials will be available in alternate formats to meet the LEP, cultural, and linguistic needs of the service region (Attachment XXIII)." Adequate provision for accessibility is

demonstrated through compliance with Limited English Proficiency (LEP) requirements for equal access and quality care within the service area for customers who do not use English as their primary language for oral or written communication, visual, hearing, or cognitive communication impairment.

SWMBH ensures that "No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or be subject to discrimination in any mental health programs or services or related activities on the basis of the language spoken. Current and prospective customers seeking services shall be provided accurate and timely language assistance and effective communication at no cost to them (Attachment XXI)." Further accommodations are cited including assessing needs if a customer is unable to self-identify communication support needs, customers will be provided SWMBH materials written in plain language that are easily understood, materials can be read to those that are unable to read, using census data for language thresholds, translating vital documents into other languages based upon the percentage of affected population, vital documents can be read onto audio or provided in Braille for individuals with visual impairments, TTY/TDD services, LEP training to SWMBH and CMHSP staff as indicated per SWMBH guidelines, and annual adherence monitoring.

In order to embrace cultural competency, SWMBH has incorporates key components of cultural literacy including: "Inclusion, diversity, respect, excellence, relationships, and accountability." By incorporating cultural competency into daily business practices and accessible services, employees of SWMBH and CMHSPs will continue to examine their own values, strengths, and weaknesses. Demonstrating an ability to incorporate feedback from customers, SWMBH will remain flexible to the changes of needs of the customers. Both in our corporate policies and in our day to day functions internally and at providers, it is just a matter of doing business to meet people where they are at. In order to do this successfully, you must consider their culture and values system. Keeping awareness of this sharp requires more than policies, it requires ongoing efforts but this is something we are committed to.