

Michigan Department of Community Health, Behavioral Health and Developmental Disabilities Administration
OFFICE OF RECOVERY ORIENTED SYSTEMS OF CARE

Recovery Oriented System of Care, Transformation Steering Committee Meeting

MINUTES

DATE/TIME: September 18, 2014, 9:00 am to 3:30 pm

LOCATION: Horatio S. Earle Learning Center, 7575 Crouner Drive, Dimondale, MI 48821

MEETING CALLED BY: The Office of Recovery Oriented System of Care (OROSC)

TYPE OF MEETING: Quarterly Meeting of the Recovery Oriented System of Care (ROSC)
Transformation Steering Committee (TSC)

FACILITATOR: Felix Sharpe

NOTE TAKER: Recorded

ATTENDEES: *In Person:* Sandra Bullard, David Blankenship, Yarrow Halstead, Lisa Miller, Nancy Miller, Brittany Pazdan, Su Min Oh, Kevin O'Hare, Sam Price, Dawn Radzioch, Marci Scalera, Larry Scott, Felix Sharpe, Mindie Smith, Ronnie Tyson, Grady Wilkinson, Mark Witte, Kristie Schmiede, Jackie Wood, Jeff VanTreese, Kathy Worthem

GUESTS: Jay Calewarts and Jim Hoyt, Michigan Department of Licensing and Regulatory Affairs

CONFERENCED IN: Deborah Hollis and Liz Knisely

TOPIC SUMMARIES

I. WELCOME AND INTRODUCTIONS – Felix Sharpe

Felix welcomed the Transformation Steering Committee (TSC) and communicated the importance of this meeting, laying out the agenda for the day.

II. WORKGROUP UPDATES

• **Medication Assisted Treatment Guidelines (MAT) – Lisa Miller**

- On August 13, Dr. Haveman applauded the development of the MAT guidelines and requested a rollout within 60 days. Therefore, the guidelines and a cover letter were distributed to the field indicating that the Michigan Department of Community Health (MDCH) has adopted the guidelines. For a copy of the guidelines, you may request them by e-mailing Lisa Miller at MillerL12@michigan.gov. Lisa went on to talk about important details of the guidelines and other states, such as Missouri who are also looking at adopting the guidelines.

These guidelines will begin to change the science of addiction by identifying outcomes, how we gather data on the success of treatment that is being used, and alternatives to try with individuals from a medical treatment focus.

Next steps now that the guidelines have been released are that some clinics may or may not be ready to go forth. We are looking at developing an electronic educational series for doctors to utilize pathways to opioid treatment, and staffing services, credentials needed to work one-on-one with individuals vs group, to name a few. At this time, we have a broad timeline of 18 months to two years. Therefore, each region needs to identify where they are with their programs that they contract with, supports needed, to full fruition of the process.

Felix mentions that now we have the PIHPs who will be the designated mental health entities beginning October 1 who will oversee the process, the practitioners, the court systems, as well as

internal partners. Our roll-out strategy will include technical assistance and statewide training moving forward. The cover memo that accompanied the guidelines states how the rollout will be codified, as “The Behavioral Health and Developmental Disabilities Administration (BHDDA) fully intend to incorporate the *Guidelines for the Provision of Medication Assisted Treatment Services for Opiate Use Disorders* in the Prepaid Inpatient Health Plans and Community Mental Health Service Programs contract.” Larry states that although this will happen, it will not be immediate. However, a technical advisory and policy will be forthcoming and technical assistance will be available.

Lisa addresses Felix’s question regarding the immediate issue of the licensed practical nurses (LPN) vs registered nurses (RN). The state administrative rules for substance abuse states the specifics regarding how to administer treatment. One area, staffing treatment is very specific; indicating one full-time physician and two, duly licensed registered nurses. Our interpretation is that the duly licensed registered nurse has extensive training around pharmacology vs LPNs. A few providers have been cited by LARA for not following the administrative rules and hiring LPNs. However, LARA offered and is working through this by offering any clinic the opportunity to submit a waiver and provide justification. Each waiver will be considered on an individual basis. Mark states concerns about the RN vs the LPN issue in his PIHP. He states that RNs have become difficult to recruit and the fact that there are limited funding sources that do not allow for the higher level of pay for RNs.

- **Licensing and Regulatory Affairs (LARA) – Jay Calewarts and Jim Hoyt**

- Explained were LARA’s responsibilities in reference to substance abuse, as well as the chain of command. They are currently working on administrative rule changes, focusing on substance abuse. They are also proposing to the legislature a licensing fee to charge to providers/agencies. Felix mentions that LARA is also working with MASACA and the transitioning of the PIHPs. Jay explains that the PIHPs will be the focus. Applications will be thoroughly reviewed. A provisional license will be issued before a final by seeking public comment.

- **State Epidemiological Outcomes Workgroup (SEOW) – Su Min Oh**

- Su Min explains how she has been working with the SEOW and draws the audience’s attention to the one page document called, “*A Profile of Drug Overdose Deaths Using the Michigan Automated Prescription System (MAPS)*” by passing it around to the group. She states that she will be presenting more detailed information regarding the *Profile of Drug Overdose Deaths Using the Michigan Automated Prescription System* report at the Substance Use Disorder/Co-occurring Disorder Conference on Monday, September 22, 2014.

Two days ago, the Center for Health Statistics published data brief on drug poisoning deaths using the 2011 national data set. In 2011, there were over 40,000 individuals who died from drug poisoning, and pharmaceutical drugs. Of those 40,000, about 40 percent die of opioid analgesics. This translates that death involving opioids occurs every 30 minutes in the United States. For Michigan, one death occurs every other day.

Su Min continues by explaining the statistics listed on the document she passed out and explained what those statistics mean. Of significance is the fact that we learned that 36 percent of those deaths had five or more prescribers within a year which defines that they were doctor shopping. We know that 40 percent of prescribers are using MAPS. We are looking forward to MAT reducing death consequences. Tim Smith replaced Mike Wissel.

III. Behavioral Health and Developmental Disabilities Administration (BHDDA) Administrative Update – *Liz Knisely, Deborah Hollis, Felix Sharpe, Larry Scott*

- **Medicaid:** Legally on October 1, 2014, the coordinating agencies (CA) will be fully into their health plans. We have been talking with them about their roles with the Michigan Association of Substance Abuse Coordinating Agencies given the various groups, and their individual roles and the uniqueness of those roles. The system consists of three plans; Healthy Michigan, Medicaid, and traditional Medicaid. We will meet with the Community Mental Health (CMH) Board to figure out what their vision is for the future as well as the behavioral health system over the next three to five years.

BHDDA is working closely with Medicaid about how certain health plans are going to be bid out next October 1. Our vision is that it will be a contractual arrangement with the state vs what we have right now. We must have specialty services carved out. There will be a lot more sharing of information, coordination of care, relational contracting with the CMHs and PIHPs and the substance use system going forward after next October 1 and discussions about what the future will look like with the feds.

- **Healthy Michigan:** More than 385,000 individuals signed up for Healthy Michigan which is more than we anticipated. Many providers are aggressively making sure that if someone is enrolled in the Healthy Michigan Plan that they are not using block grant dollars for those services. Jeff Wieferrich is head of our Medicaid policy area and working with the Medical Services Administration on some of the changes that have to take place in the Medicaid Provider Manual and making sure all services for substance use disorders are incorporated into the manual.
- **Health Homes:** Three sites for health homes are up and running; Manistee, Grand Traverse, and Washtenaw. These CMHs are moving forward with full integration of primary care and behavioral health.
- **Drug Diversion:** Another request for proposal (RFP) is out for additional mental health boards and drug courts. We have a pilot through the lieutenant governor's diversion council. Steven Mays is heading up the oversight of those existing four (4) pilots. A little over three (3) Million will be expended for additional pilots around the state for diversion.
- **Primary Care:** Referrals are being sent back through the substance use system by connecting them to the PIHP. The clinical advisory system is working with this and it is going well.
- **Health Care Services:** To be truly integrated, individuals should not have to jump through a multiple of changes to get the service(s) they need. Unfortunately, this is happening in some areas in the state. Our responsibility is to monitor and find out how this is happening and fix it.
- **Dashboard:** A reporting dashboard is being developed to monitor administrative functions to avoid duplication of dollars, as well as to assure that administrative dollars are being used efficiently. Therefore, we are requiring that each PIHP region avoid duplication between CMHs, PIHPs, CAs, and providers. PIHPs must show us what their total administrative costs are for each of the 10 regions, at the CMH level. Comparison will occur by breaking out service costs and administrative costs.
- **Children:** Money has been appropriated to the Department of Human Services for pilot projects and initiatives throughout the state. Senator Levin's drug summit included a multitude of people, such as providers, drug enforcement agency officials, law enforcement, and individuals in recovery, etc. We need to focus on children and what we are doing in the areas of prevention and mental health promotion. We need to have protocols to identify high-risk children early on, such as parents in recovery or parents who have been in trouble with law enforcement, to name a few. MDCH continues to work closely with public health on this issue. We have the governor's policy academy

that upper administration attended at the national level. In attendance were OROSC’s Prevention, Medicaid, Public Policy, and the state police, among others. The plan as far as state policy is concerned, is to roll out media awareness and heighten attention around the state with local coalitions for unintentional overdose, opiates, and amphetamine of which the feds monitor closely. We will keep you informed regarding a rollout plan.

- **Integration:** Recovery housing must be approved by SAMHSA and they require it to be connected to services. We are researching ways to connect to services and we are also encouraging local CAs to use Public Act Two (2) (PA2) dollars. Vetting also needs to take place.

October 1, 2014 will end phase I of the integration process. Meetings with the CEOs and workgroups have taken place three to four times on how they will work together. This will be a two to three hour process. One regional entity will be restructuring how they will do MCPNs. The restructuring process will be efficient with a dashboard asking for ratios for direct service and administrative costs to measure funding.

- **PA 200:** A notice was sent out by the Department of Treasury that there are unspent funds and 50 percent of those funds will be transferred. We will be providing technical assistance. MASACA is working with the CAs by issuing a Letter of Intent and Communique that they will be a dedicated voice on substance use disorder (SUD), as indicated by an e-mail shared with the TSC from Kristie.
- **PA 249:** We are conducting research on requirements. Gaps have been found on credentialing with differences and similarities. We are in a discovery/fact-finding mode at present.
- **SUD Strategic Plans:** The SUD Strategic Plans corrective notices were sent to all 10 PIHPs on September 17, 2014. We are requesting that the PIHPs respond with clarification and additional information.

Action Items:

Item	Person(s) Responsible	Deadline
N/A	N/A	N/A

IV. TSC Next Steps – Group Discussion

- **Roles and Membership**

- A suggestion was made proposing whether we need a new standard of recovery and how that would look and maybe it should be a “Continuum of Recovery.” The TSC *Purpose Document* was revisited and a second bullet was added to indicate SUD and Mental Health. Felix also went over the Coordinated Advancement of Recovery in Michigan diagram in the Purpose Document and explained how these are working in continuum with one another to justify “Continuum of Recovery.”

The charge of the TSC will be to include:

- Veterans
- Native American Tribes
- Faith Based
- Mental Health (MH) and Community Mental Health (CMH)
- Substance Use Disorder Oversight Policy Boards
- Michigan State Housing Development Authority (MSHDA)
- Michigan Department of Corrections (MDOC)
- Workforce Development
- Primary Care Providers

- Other Behavioral Health
- Department of Human Services (DHS)

V. TSC Next Steps continued – *Group Discussion*

- Results of the Representation spreadsheet indicated that of all the specialty areas that TSC members work in, we lack a Criminal Justice, Faith-Based, and Department of Human services representative, as indicated by a “0” on the spreadsheet.

Action Items:

Item	Person(s) Responsible	Deadline
N/A	N/A	N/A

VI. ADJOURNMENT

The meeting adjourned as scheduled.

ADDITIONAL INFORMATION

NEXT MEETING

Date/Time: November 20, 2014; 9:00 am to 3:00 pm

Location: Horatio S. Earle Learning Center, 7575 Crouner Dr., Dimondale, MI 48821

Recovery Oriented System of Care Transformation Steering Committee Discussion Document

June 19, 2014

Purpose

The Recovery Oriented System of Care Transformation Steering Committee (ROSC/TSC) will provide meaningful guidance to the Behavioral Health and Developmental Disabilities Administration (BHDDA) on priorities, guidelines, policies, and procedures related to recovery systems, services planning and operation, cross cutting issues, and integration with primary health.

TSC Membership

Current membership is 28 individuals. With behavioral health integration being on the forefront, TSC membership should be increased to include *a* substance use disorder (SUD) point person, or designee, from each of the ten regional PIHP entities. The full TSC membership should include representation from SUD treatment and prevention, mental health, *medical services administration or MSA*, lived experience, epidemiology, *a PIHP board member, administration, a representative of SUD Policy Oversight Boards*, and primary care. Also, engage criminal justice, child welfare, and gender specific at the local level through the ten entities.

Vision for the TSC

The TSC functions as the lead advisory committee for the behavioral health system's ROSC transformation efforts.

Priorities and Ensuing Action We:

- Support BHDDA in leading the behavioral health integration process and keeping the ROSC transformation moving forward, by assisting with the identification of next steps and keeping ROSC branding front and center within the process.
- Engage the SUD point person for each of the 10 regional entities as a liaison for implementing ROSC locally in their communities.
- Operate through workgroups to develop best practices, policies, and guidelines for strengthening and enhancing supports for successful recovery; including, but not limited to: housing, health and wellness, case management, workforce development, employment, education, parenting, prevention, medication assisted treatment, and mental health/SUD parity.
- Assure that ROSC principles are infused in BHDDA practices, policies, and procedures, as well as the entire statewide system of care.
- Generate agenda items and tasks for the TSC through feedback from the regions, and state direction on integration.
- Assist BHDDA in developing guidelines for the submission of multi-year strategic plans for ROSC-based SUD services as required by PA 500 and the AFP.

- *Review and provide technical assistance for regional implementation of ROSC-based services.*
- *Provide input and recommendations to the workgroups and advisory councils charged with coordinating the advancement of recovery from mental health and substance use disorders.*
- Inform the public of the outcome of ROSC system transformation.

Coordinated Advancement of Recovery in Michigan

- *As we move forward into an increasingly integrated system of care, the following is a coordinated means for advancing recovery for those receiving public sector mental health and/or substance abuse services within the State of Michigan. Tremendous effort has been expended by various groups, which at times has been duplicative or less than fully integrated.*
- *It is the intent and desire of this proposed structure, including the establishment of active communication channels (signified by the dotted lines), to advance the critically important focus of Recovery in a manner that is as effective and well-coordinated as possible, for the benefit of those we serve.*

