Michigan Youth Treatment Infrastructure Enhancement (MYTIE)

Financial Map

Michigan State Youth Treatment Planning (SYT-P)

July 2017

INTRODUCTION

The purpose of the Michigan Youth Treatment Infrastructure Enhancement (MYTIE) project is to increase access to quality substance use disorder (SUD) treatment and recovery services for Michigan residents, age 16 to 21 years old. One step in this process is the improvement of the service delivery infrastructure. To achieve this goal, there is a need for collaboration among State of Michigan departments, Prepaid Inpatient Health Plans (PHIPs), and publicly funded treatment centers, as well as youth and families. A step in this collaboration is the completion of a map of federal and state fiscal resources supporting treatment and recovery supports for the target population. Thus, the first goal of the financial map is to identify and understand the funding streams that support substance use disorder (SUD) treatment and recovery services for adolescents and transitional youth age 16-21. This will allow the state to make the best decisions about treatment infrastructure enhancement strategies for individuals ages 16-21 in Michigan. In addition to understanding the funding sources, the financial map will identify overlaps and gaps in funding, if any exist. The information will be used to determine areas for potential changes to increase efficiency and improve service delivery for young adults

The treatment system in Michigan consists of assessment, case management, withdrawal management, medication assisted treatment, outpatient, intensive outpatient, residential and recovery support services. Michigan is grappling with several SUD service system challenges. The 2013-2014 National Survey on Drug Use and Health data showed 3.1% of adolescents (12-17) and 5.7% of young adults (18-25) in Michigan needed illicit drug use treatment, but did not receive specialty treatment; while 1.5% of adults aged 26 and older needed but did not receive treatment for illicit drug use. Currently, if an adolescent or transitional youth is placed in a residential level of care, there is often very little connection between the residential program and supportive services upon the youth's return to their home community. Also, although SUD services are available for all age groups, both treatment and recovery support services for adolescents and youth are not prevalent across the state. By building an infrastructure that will support all levels of care for adolescent and transitional age youth, Michigan can expand treatment and recovery support services to better meet the needs of youth and their families, and support their progress in recovery upon returning to their home communities.

While a higher percentage of transitional youth age 16-21 in foster care and juvenile justice were identified as having a substance abuse or mental health concern as compared to the general population, they are typically already connected to other service providers who will facilitate their access to needed SUD services. Transitional youth age 16-21, not already connected to a state agency, are harder to reach and a strategy for getting them involved in services will be a goal of this project. Another identified population of concern are the transitional youth age 16-21 with a co-occurring substance use and mental health disorder who are not involved in a service or being served by a state agency.

METHODOLOGY

To create a comprehensive financial map and to meet the requirements of the State Youth Treatment – Planning grant, stakeholders in adolescent and transitional age youth SUD treatment were brought together to form an Interagency Council (IAC). From the IAC members, a Financial Mapping Subcommittee was created. The Financial Mapping Subcommittee includes: representatives from the Michigan Department of Health and Human Services (MDHHS), Office of Recovery Oriented Systems of Care (OROSC), Children's Services Agency (CSA), Child Welfare and Juvenile Justice, and Population Health; Prepaid Inpatient Health Plans (PIHPs); Michigan Department of Corrections (MDOC); Michigan Department of Education (MDE); and the State Court Administrators Office (SCAO).

The Financial Mapping Subcommittee created a template for collection of financial data using the American Society of Addiction Medicine (ASAM) Levels of Care and potential funding sources. Each agency represented in the Financial Mapping Subcommittee was instructed to use the template to collect fiscal year 2015 data regarding SUD treatment funding for individuals ages 16 to 21 years old. Data were collected from multiple databases, which are listed in the data collection section below.

DATA COLLECTION

OFFICE OF RECOVERY ORIENTED SYSTEMS OF CARE

The data on spending for Michigan's Community Grant comes from the Treatment Episode Data Set (TEDS) and the annual Legislative Report that OROSC completes.

Michigan's Community Grant is comprised of federal Substance Abuse Block Grant (75%) and State General Funds (25%) that are blended and dispersed to the PIHPs. The publicly funded system supported by OROSC served 4,544 adolescent and transitional youth age 16-21 during fiscal year 2015. TEDS data was used to identify actual spending for individuals' ages 16 to 21 by level of care or service. To further identify spending by federal vs. state funds, it was necessary to identify the percentage of federal and state funding that comprise Michigan's Community Grant and Medicaid funding. Spending on SUD services was broken down based on the total expended amount identified for each level of care, and the percentage of federal and state funds was determined using the previously identified rate. Several of the service categories in TEDS were merged into a single category in the annual Legislative Report, and as a result the formula for these service categories used the average percentage from those service types with unique percentages.

Table 1 reflects federal funds expended for all levels of care, and accounts for the vast majority of spending for SUD treatment for this population in Michigan. Both Medicaid and the Substance Abuse Block Grant flow through regional entities to contracted SUD providers. OROSC manages the Substance Abuse Block Grant, and the Medical Services Administration manages Medicaid funding. In Michigan, foster children and wards of the State may stay on Medicaid through age 21, but a young adult age 18-21 who is newly applying for Medicaid may alternatively be placed in the Medicaid Expansion program. Child sitting and transportation costs are included in this table, as a small portion of the target population was eligible for Pregnant and Parenting Women program services, which include transportation and child sitting.

Table 1: Federal Funds for All Youth Ages 16-21

Service Type	Total Federal Spending	Substance Abuse Block Grant	Federal Medicaid (ages 16-21)	Healthy Michigan Plan (Medicaid Expansion) (ages 18-21)
Treatment Services				
Screening (AMS)	$1,535	$483	$384	$668
Psychiatric Evaluation	$13,721	$4,320	$3,434	$5,967
Assessment	$161,882	$50,961	$40,518	$70,403

Case Management	$1,931	$608	$483	$840
Withdrawal Management	$212,176	$66,794	$53,106	$92,276
Outpatient	$1,123,572	$353,707	$281,220	$488,645
Intensive Outpatient	$142,531	$44,870	$35,674	$61,987
Domiciliary	$191,286	$60,218	$47,877	$83,191
Residential	$2,010,691	$632,977	$503,258	$874,456
Medication Assisted Treatment				
Buprenorphine	$1,138	$358	$285	$495
Methadone	$95,885	$30,185	$23,999	$41,701
Drug Screening	$38,650	$12,167	$9,674	$16,809
Service Type	**Total Federal Spending**	**Substance Abuse Block Grant**	**Federal Medicaid (ages 16-21)**	**Healthy Michigan Plan (Medicaid Expansion) (ages 18-21)**
Recovery Services				
Peer Recovery	$6,218	$1,958	$1,556	$2,704
Recovery Supports	$1,786	$562	$447	$777
Recovery Housing	$29,025	$9,137	$7,265	$12,623
Ancillary Services				
Child Sitting	$399	$399	$0	$0
Transportation	$164	$164	$0	$0
Total	**$4,032,590**	**$1,269,868**	**$1,009,180**	**$1,753,542**

Table 2 below identifies Medical Services Agency administered state funds used to support SUD treatment for adolescent and transitional youth age 16-21. As above, this table also includes the ancillary services of transportation and child sitting, reflective of the small number of individuals who were eligible for Pregnant and Parenting Women programming. Medicaid Expansion has been included in Table 2. However, during fiscal year 2015, this was completely supported by federal funds, as such no state spending is reflected in this table for this fiscal year.

Table 2: State Funds for All Youth Ages 16-21				
Service Type	**Total State Spending**	**State General Fund**	**State Medicaid Match**	**Healthy Michigan Plan (Medicaid Expansion)**
Treatment Services				
Screening (AMS)	$345	$146	$199	$0
Assessment	$36,378	$15,377	$21,001	$0
Psychiatric Evaluation	$3,083	$1,303	$1,780	$0
Case Management	$434	$183	$251	$0
Withdrawal Management	$47,684	$20,155	$27,529	$0
Outpatient	$252,506	$106,729	$145,777	$0
Intensive Outpatient	$32,032	$13,539	$18,493	$0
Domiciliary	$42,988	$18,170	$24,818	$0
Residential	$451,872	$190,997	$260,875	$0
Service Type	**Total State Spending**	**State General Fund**	**State Medicaid Match**	**Healthy Michigan Plan (Medicaid Expansion)**
Medication Assisted Treatment				
Buprenorphine	$256	$108	$148	$0
Methadone	$21,549	$9,108	$12,441	$0
Drug Screening	$8,686	$3,671	$5,015	$0
Recovery Services				
Peer Recovery	$1,398	$591	$807	$0
Recovery Supports	$402	$170	$232	$0
Recovery Housing	$6,523	$2,757	$3,766	$0
Ancillary Services				
Child Sitting	$121	$121	$0	$0
Transportation	$50	$50	$0	$0
Total	**$906,307**	**$383,175**	**$523,132**	**$0**

Table 3 identifies Medicaid and Michigan's Medicaid Expansion (Healthy Michigan Plan) spending amounts. During FY2015, the Medicaid Expansion project was 100% federally funded. Medicaid and the Healthy Michigan Plan are designed to work seamlessly for individuals needing health insurance. Medicaid covers children through

their 18th year, and can cover foster children and permanent wards through age 26. For those who apply for coverage at age 18 and over, their eligibility is assessed and they may be placed under the Healthy Michigan Plan based on their income. Those individuals will receive Early and Periodic Screening, Diagnostic and Treatment or EPSDT screenings and subsequent assessments, and be referred for specialty SUD services as appropriate. Michigan's SUD services are a Medicaid carve out, and as a result, all publicly funded SUD services are managed and reported through the regional PIHPs.

As identified on the following page, many individuals in Michigan have taken advantage of the Medicaid expansion opportunity, and if that funding stream is no longer available, the state will struggle to continue to offer the same level of services to the population.

Table 3: Medicaid and Medicaid Expansion Spending

Service Type	Total Medicaid Spending	State Medicaid Match	Federal Medicaid Match (16-21)	Healthy Michigan Plan (Medicaid Expansion) (18-21) 100% Federal
Treatment Services				
Screening (AMS)	$1,251	$199	$384	$668
Assessment	$131,922	$21,001	$40,518	$70,403
Psych Evaluation	$11,181	$1,780	$3,434	$5,967
Case Management	$1,574	$251	$483	$840
Withdrawal Management	$172,911	$27,529	$53,106	$92,276
Outpatient (OP)	$915,642	$145,777	$281,220	$488,645
Intensive Outpatient (IOP)	$116,154	$18,493	$35,674	$61,987
Domiciliary	$155,876	$24,818	$47,877	$83,181
Residential	$1,638,589	$260,875	$503,258	$874,456
Medication Assisted Treatment				
Buprenorphine	$ 928	$148	$285	$495
Methadone	$78,141	$12,441	$23,999	$41,701
Drug Screen	$31,498	$5,015	$9,674	$16,809
Recovery Services				

Peer Recovery	$5,067	$807	$1,556	$2,704
Recovery Services/ Recovery Support	$1,456	$232	$447	$777
Recovery Housing	$23,654	$3,766	$7,265	$12,623
Ancillary Services				
Child Sitting	$0	$0	$0	$0
Transportation	$0	$0	$0	$0
Total	**$3,285,844**	**$523,132**	**$1,009,180**	**$1,753,532**

Table 4 combines state and federal resources and shows the total amount of public funding for SUD services for adolescents and transitional youth age 16-21. Based on the TEDS information, Michigan's publicly funded SUD service system provided treatment and recovery services for 4,544 individuals between the ages of 16 and 21 in fiscal year 2015, equating to an average of $1,087 spent per adolescent and transitional youth.

Table 4: Combined Federal and State Funds for All Youth Ages 16-21

		Community Grant		Total Medicaid Spending		
Service Type	**Total Spent**	**Substance Abuse Block Grant Spent**	**State General Fund Spent**	**Federal Medicaid**	**State Medicaid**	**Health Michigan Plan (Medicaid Expansion) 100% Federal**
Treatment Services						
Screening (AMS)	$1,880	$483	$146	$384	$199	$668
Assessment/OP	$198,260	$50,961	$15,377	$40,518	$21,001	$70,403
Case Management	$2,365	$608	$183	$483	$251	$840
Withdrawal Management	$259,860	$66,794	$20,155	$53,106	$27,529	$92,276
IOP	$174,563	$44,870	$13,539	$35,674	$18,493	$61,987
OP	$1,376,078	$353,707	$106,729	$281,220	$145,777	$488,645
Psych Evaluation	$16,804	$4,320	$1,303	$3,434	$1,780	$5,967
Residential	$2,462,563	$632,977	$190,997	$503,258	$260,875	$874,456
Domiciliary	$234,274	$60,218	$18,170	$47,877	$24,818	$83,191
Medication Assisted Treatment						

Buprenorphine	$1,394	$358	$108	$285	$148	$495
Methadone	$117,434	$30,185	$9,108	$23,999	$12,441	$41,701
Drug Screen	$47,336	$12,167	$3,671	$9,674	$5,015	$16,809
Recovery Services						
Peer Recovery	$7,616	$1,958	$591	$1,556	$807	$2,704
Recovery Services/Recovery Support	$2,188	$562	$170	$447	$232	$777
Recovery Housing	$35,548	$9,137	$2,757	$7,265	$3,766	$12,623
Ancillary Services						
Child Sitting	$520	$399	$121	$0	$0	$0
Transportation	$214	$164	$50	$0	$0	$0
Total	**$4,938,897**	**$1,269,868**	**$383,175**	**$1,009,180**	**$523,132**	**$1,753,542**

In Michigan public funds are distributed regionally to the PIHPs that function as managed care organizations for individuals needing treatment for substance use and misuse. Allocations to each region are determined using a formula that includes the regions' population, Medicaid eligible individuals, income levels and a number of other factors. There are extreme differences in spending across regions, as noted in Table 5 below, and this is related to income level differences across regions, participation in private insurance and additional health and population disparities. Some differences may also be credited to the ability of the region to identify and facilitate referrals to treatment for the target population. Unfortunately, as Michigan moved from the previous coordinating agency managed care structure to the PIHP structure, data was lost in the transition. As a result, the information in Table 5 likely suffers from underreporting due to data loss. Appendix B includes a sample of spending across one PIHP region in Michigan.

Table 5: Total Spending (Federal and State) by Prepaid Inpatient Health Plan Region for All Youth Ages 16-21			
Prepaid Inpatient Health Plan Region	**Total Spending**	**Total Served**	**Regional Population 16-21**
CMH Partnership of SE MI	$124,530	152	81,517
Detroit-Wayne MH Authority	$1,025,904	564	139,601
Lakeshore Regional Entity	$413,002	468	108,118
Macomb	$325,156	428	61,934
Mid-State Health Network	$995,820	847	160,241
NorthCare Network	$304,991	240	27,622
Northern MI Regional Entity	$456,026	456	32,587
Oakland	$348,517	447	90,874
Region 10	$557,671	539	54,126
Southwest MI Behavioral Health	$387,280	403	74,352
Total	**$4,938,897**	**4,544**	**830,972**

CHILD WELFARE

The Michigan Department of Health and Human Services, Children's Services Agency (CSA) indicated that any foster child living in the community receiving SUD treatment would be using Medicaid to pay for treatment, thus these treatment dollars would be included in the Medicaid/Community Grant data. The CSA was able to determine the amount that was spent on all residential placements in fiscal year 2015, this includes placements for behavioral, mental health, and substance use disorder needs.

Table 6: Total Spending		
Fiscal Year	**Number of Youth Served in Residential**	**Amount Spent**
2015	439	$ 21,345,596

In addition, CSA was able to determine how many youth were placed in each of the contracted residential facilities with an identified SUD treatment program and the cost of care for these youth. (See Appendix B for additional detail).

JUVENILE JUSTICE

Youth involved with the justice system are treated by a variety of agencies, dependent upon their status as a ward of the court or the state and whether supervision is provided by the court or Michigan Department of Health and Human Services. The majority of delinquent youth in Michigan are court wards served by the local court probation system. Courts have the option of referring or committing delinquent youth to the Michigan Department of Health and Human Services for care and supervision. Court jurisdiction of delinquent youth typically is terminated when a youth turns 19 years of age, but some youth that have committed more serious offenses have jurisdiction extended until the youth turns 21 years of age. Youth sentenced as an adult may be sentenced to adult probation, jail or committed to the Michigan Department of Corrections.

MDHHS JUVENILE JUSTICE

The MDHHS Juvenile Justice program provides care and supervision for juveniles referred to MDHHS as court wards or committed to MDHHS as a public ward. MDHHS funds treatment for community-based services for youth and contracts for private juvenile justice residential treatment facilities using county, state and federal Title IV-E funds. The type of crime, age of the individual and discretion of the court determine whether a youth will be charged as a juvenile or adult. The MDHHS Juvenile Justice Program accounts for approximately 4% of the youth in Michigan involved with Juvenile Justice.

The Juvenile Justice Program has access to up to 33 contracted substance abuse rehabilitation services residential beds for females and 50 for males. These beds are in licensed child care facilities and are not always licensed SUD providers. As a result, data and spending for this group are basic averages. Based on a 6-year average, it is estimated that Juvenile Justice uses 22 beds per year. Based on this estimated use number, Juvenile Justice spends an estimated $2,528,727 per year on SUD treatment. The age of individuals receiving treatment through Juvenile Justice ranges from 16.8 to 17.9 years old. A review of the language in the residential provider contracts, indicates that Juvenile Justice Treatment should be categorized as Clinically Managed Medium-Intensity Residential Services for the purposes of this report. This information was

collected using historical data from the Juvenile Justice On-Line Technology (JJOLT) system which has been decommissioned and replaced with MiSACWIS, the statewide automated child welfare information system. MiSACWIS currently has no capacity to pull a similar report.

If a Juvenile Justice Program youth accesses services in the community via an outpatient provider, those services are funded through the youth's Medicaid Health Plan and supplemented through the PIHP system as needed.

Wayne County's Juvenile Justice program was able to provide us with some additional data to help us build a picture of how services are provided. The data in Appendix D show that a small number are utilizing the inpatient system. The needs data however shows that several thousand screenings of various types are conducted across the justice system. Through the assessment system, we can see that nearly 89% of adjudicated youth meet the criteria for at least one behavioral health diagnosis. This data helps us to see the potentially high need for targeted services for this community.

STATE COURT ADMINISTRATIVE OFFICE (SCAO)

While the Juvenile Drug Courts only serve a small portion of Michigan's population of focus, their data does reflect the majority of 16 year olds who enter the juvenile justice system. As such, it was decided that this was a critical piece of the information needed to adequately assess and serve the population.

SCAO reported that juvenile drug courts that received grant funding in fiscal year 2015 allocated approximately $176,725 toward treatment services. Juvenile drug courts typically serve youth ages 12 to 16 but will work with younger children if needed. As shown below in Table 7, between 10/01/2014 and 9/30/2015 the Drug Court Case Management Information System indicates that 69% of clients received an average of 31 hours of substance abuse (SA) outpatient services, 27% of clients received an average of 166 hours of SA IOP, 25% of clients received an average of 787 hours of SA residential, <1% received an average of 36 hours of SA outpatient detox and < 1% received an average of 50 hours of SA detox. SCAOs funding included breakdowns of funding by area/department but is not included in the breakdown of funding by level of care because this information is not collected.

Table 7: Juvenile Drug Court Type of Services, Hours, and Funding		
Type of Service	**Average Hours of Outpatient Substance Abuse Services**	**%**
Outpatient Services	31 hours	69%
IOP	166 hours	27%
Residential	787 hours	25%
Withdrawal Management Level 1	36 hours	< 1%
Withdrawal Management Level 3 – 3.2	50 hours	< 1%
Total Spending	**$176,725**	

MICHIGAN DEPARTMENT OF CORRECTIONS (MDOC)

The Michigan Department of Corrections reported that an estimated $247,235 was spent on treating 175 individuals of the prison population age 16 to 21 years old for SUD during fiscal year 2015. Youth who are sentenced under Michigan's Holmes Youthful Training Act (HYTA) could not be included as they are not identified in DOC's data collection system. Also, the cost for treatment services are estimated, because MDOC services are billed per therapist hour as opposed to a service category. An estimated group size was used in estimating these costs. MDOC acknowledges the difficulties in estimating costs due to the complexities of their system and current data collection methods.

The MDOC collects data through the following methods:

1. ACCESS database that records residential referrals and placements.
2. Contractor prepared daily census reports.
3. Contractor prepared admissions and discharge reports entered by MDOC substance abuse services (SAS) staff in OMS.
4. OMNI and OMS for birth dates and SUD treatment completion reports.
5. Staff calculating average contract fee for type of service by OMS and OMNI list of offenders in age range

The MDOC provided treatment for 10 individuals 16 to 17 years of age and 165 individuals ages 18 to 21. MDOC treats individuals incarcerated and under the supervision of the Correctional Facilities Administration (CFA), including Residential

Substance Abuse Treatment and CFA Intensive Outpatient, and in the community. MDOC only treats individuals ages 16 and 17 within a correctional facility. The table below describes MDOC funding for SUD treatment by location of services and age.

Table 8: Michigan Department of Corrections SUD Treatment Funding

Type of Treatment	Age Group	Correctional Facilities Administration (CFA) – State Funding	CFA – Federal Funding (residential)	CFA Intensive Outpatient (IOP) – State Funding	Community – State Funding
Outpatient Services	16 & 17	$2,500		$0	$0
	18 to 21	$18,360		$3,825	$62,100
Group Counseling	16 & 17	$2,500		$0	$0
	18 to 21	$18,360		$6,510	$82,800
Clinically Managed Population Specific High Intensity Residential Services	18 to 21 ONLY	$8,280	$7,560		$42,000
Treatment Federal Funding	**$7,560**		$7,560	$0	$0
Treatment State Funding	**$247,235**	$50,000	$0	$10,335	$186,900
Total	**$254,795**	**$50,000**	**$7,560**	**$10,335**	**$186,900**

MICHIGAN DEPARTMENT OF EDUCATION (MDE) & MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, POPULATION HEALTH

The MDE and MDHHS Population Health and Community Services Administration use Child and Adolescent Health Centers (CAHC) within schools to offer assessment, referral and very basic early intervention for SUD. MDE was able to provide data from CAHCs from fiscal years, 2012, 2013 and 2014 but has stopped collecting this data for subsequent years. Table 9 below displays the number of SUD services (typically very basic counseling around substance use) provided in CAHC per year and the number of referrals to treatment per fiscal year. For fiscal year 2014, each site was awarded between $150, 000 and $225,000 for the funding of the entire health center. It is not possible to breakout the amount used for SUD treatment. Nor is the age breakdown of the clients treated at CAHC available, so this estimate may include youth outside of the

age range for this project. This data is collected by each CAHC for each quarterly and annual report.

Table 9: SUD Services & Referrals in CAHC		
Fiscal Year	**# of SUD Prev. Services Provided**	**# of Referrals to SUD Treatment**
2014	2820	43
2013	827	41
2012	805	54
Average	**1484**	**46**

DISTRIBUTION OF SPENDING & LEVEL OF CARE FIGURES

Also, school districts receive federal Title II.B. funding for regular school staff (teachers) training that can be used for SUD training, but this funding does not require SUD or any specific type of staff training to be provided.

Below, **Figure 1** displays combined federal and state funding for SUD treatment for individuals ages 16 to 21 years old by area/department. Child Welfare spending is indicated as zero on this graph, as we cannot concretely determine the portion of spending for SUD services.

Figure 1: Fiscal Year 2015 Spending on SUD Treatment for Ages 16-21

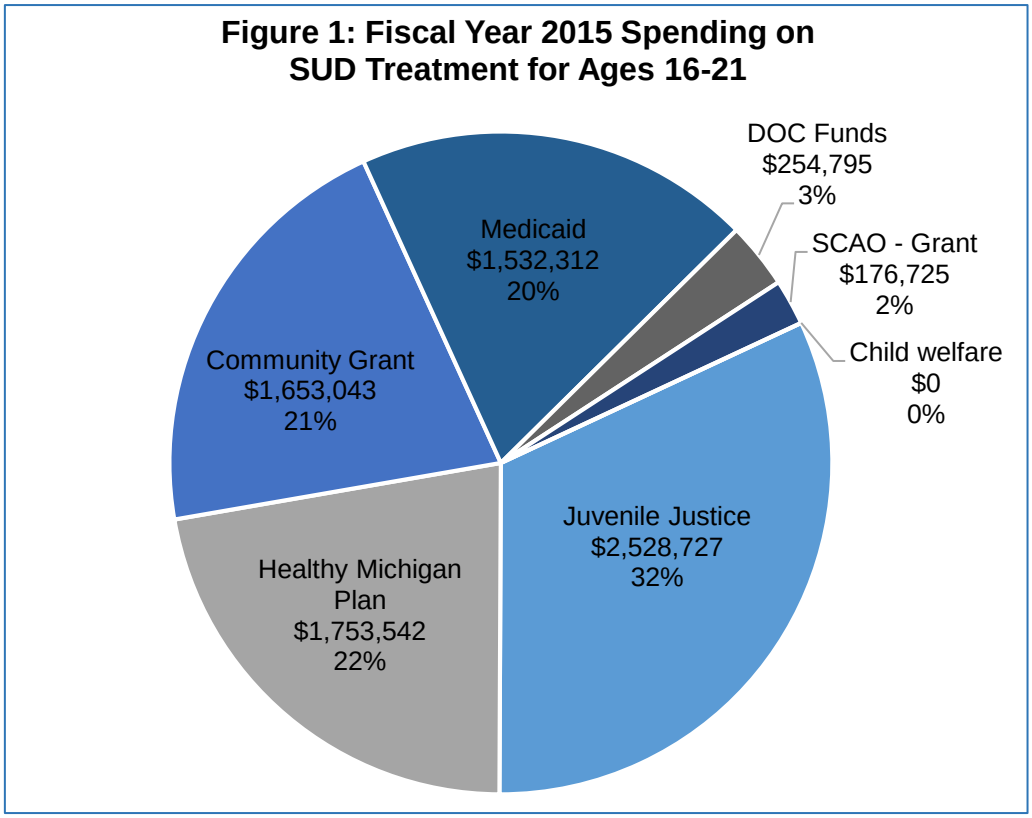
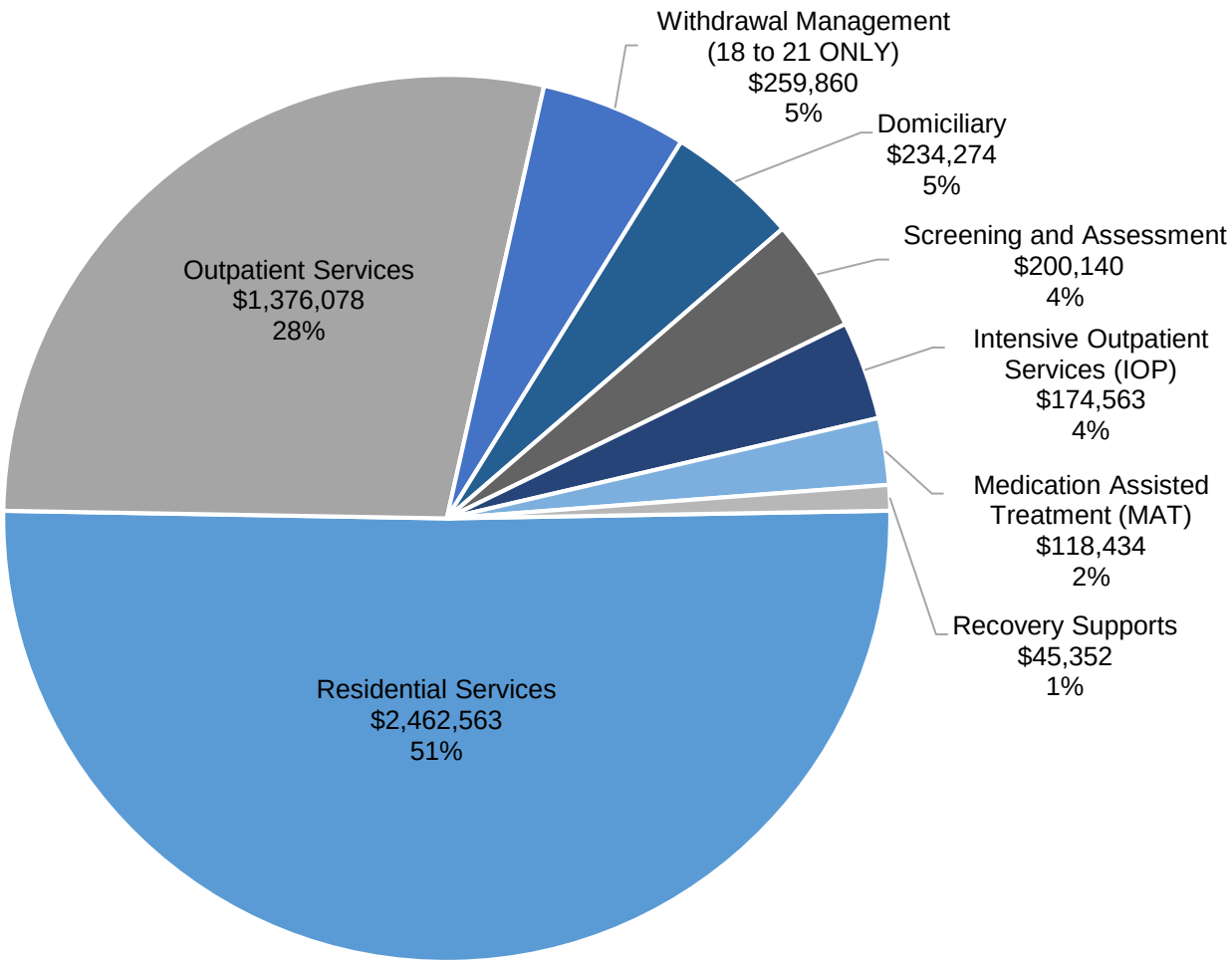


Figure 2, below displays the funding for SUD treatment for individuals age 16 to 21 years old by level of care. This graph only includes data from DOC, Juvenile Justice, Medicaid, Healthy Michigan Plan and Community Grant. Funding from other areas was unable to be broken down by level of care.

Figure 2: Fiscal Year 2015 Level of Care for Ages 16-21



IMPLICATIONS

The financial mapping process brought attention to many deficits in the data collection processes in practice across the state and allowed members of the financial mapping subcommittee and the IAC to view the SUD system holistically. This also led to many questions regarding policy and procedure, and the implications and influences of such on services within Michigan.

The financial map content is useful in several ways; separating spending into federal vs. state contributions enabled the developers to identify several areas where improvements might be made and efforts increased. The Level of Care tables are very helpful in identifying where the majority of funding for SUD treatment and recovery services for individuals from ages 16-21 is being used. Residential services consumed the most funding in fiscal year 2015. Conversely, the community-based system needs to be expanded to keep youth in the community when possible and to provide step-down services for youth returning from residential care. Increasing the utilization of intensive outpatient for the population may alleviate some of the residential costs, while keeping youth in the community, and focused on building recovery capital with local resources. Our understanding of treatment services and supports will lead us to explore additional strategies to reduce reliance on residential care. Medication assisted treatment is underutilized for youth, and this is due in part to policy restrictions at the state level. Also clearly identified, is the need to expand recovery support services. The array of recovery support services is limited across the state, and funding directed to that area is a very small fraction of expenditures annually. Changes to this structure will help to reduce the reliance on residential treatment services, maintain the treatment gains and promote long-term recovery success in youth.

The financial mapping process exposed issues within the service array provided. The PIHPs all manage their provider panel independently, and as a result the continuum of care in each region can vary greatly and lead to disparities. Many PIHP regions contract with the few adolescent residential providers across the state, but few have targeted efforts to expand recovery supports within their region or ensure that community-based treatment is meeting the needs of the population. As underage youth (16-17) transition to adult services, some of the supports and robust coverage of services is lost, and this is also an area of concern for the IAC.

When averaged, the SUD system spent $1,078 on each of the adolescents and transitional age youth 16-21 who entered treatment during fiscal year 2015. However, of this amount, state spending averaged only approximately $200 for each youth. As we move forward in our efforts to expand treatment and recovery supports to adolescents and transitional age youth 16-21, and report on our efforts to curb the rise of opioid use in this population to our Director, Governor and Legislature, we will use this financial

mapping report to show areas where the state could improve its ability to offer youth SUD treatment and support.

CONCLUSION

Financial mapping represents a new activity for all the partners involved, and discussions held to date indicate that each unit saw this exercise as eye-opening. By raising the issue and reviewing the data, each unit is now more aware of its own budget, how to access their data related to the population, and the challenges presented in the data. Each unit is working internally to improve their ability to collect outcomes related to the project and continue this financial mapping process.

As a first step in the financial mapping process, we are generally pleased with the data received so far, but we have identified multiple opportunities for improvement and methods to track our improvement. The process of developing the financial map for the first time has highlighted the shortcomings in the data collection methods from department to department. Availability of data and outcomes vary based on past departmental requirements and the capacity of each department's database and staff.

Differences in type of data collected exists across departments. Some identify use of a therapist's hours as opposed to a service category for billing, which can lead to difficulty in quantifying cost for SUD services across agencies. For example, in group therapy the number of participants in the group may vary. Also it was determined that in some areas financial data were not readily divided so that substance abuse specific services were clearly delineated as a separate service category. Some agencies have expenditures for mental health services blended with expenditures for substance use disorder services included in those numbers reported.

Due to the complexity of collecting the data needed for this financial map data collection improvement objectives will be added into the MYTIE strategic plan, as well as other identified challenges including differences in definitions of level of care, and inconsistencies between departments that are not adhering to ASAM Level of Care definitions.

The IAC and Financial Mapping Subcommittee will review spending annually to track residential, community-based treatment, recovery support services, and medication assisted treatment expenditures. Ideally, the amounts invested in residential services will decrease as the recovery supports and medication assisted treatment expenditures

increase. The financial mapping subcommittee discussed the financial aspect of residential treatment needing to keep their beds full to stay in business and how this fits into the overall financial picture for SUD treatment. This issue will be forwarded to the IAC for discussion at the policy level.

As a committee and a whole, the IAC members will continue to discuss all of the financial mapping findings. A possible solution to the unreliable data is to begin asking for the data more regularly going forward. By asking for the data at regular and planned intervals, we hope to encourage data system changes that might allow easier identification of how much is spent on SUD treatment.

A second data related objective is to expand the financial map to address the potential differences between what each department allocates for SUD treatment and the amount expended on SUD treatment. Additionally, it would be helpful to have access to treatment spending for those youth receiving services through private insurance. Collecting this information will ensure that all Michigan residents, ages 16 to 21 years old who receive SUD treatment, are represented in our financial map.

Appendix A

The Detroit Wayne Mental Health Authority (DWMHA, Region 7) was able to pull the data specific to their region to provide a snap shot of what funding for an individual region looks like. DWMHA funded services for a total of 1,038 individuals ages 16 to 21 during fiscal year 2015, 739 individuals ages 16 and 17 years old and 299 individuals ages 18 to 21 years old. DWMHA used $1,259,822.00 in fiscal year 2015 to fund SUD services for individuals 16 to 21 years old in their region. The table on the next page provides a breakdown of spending by DWMHA in fiscal year 2015.

Table 10: DWMHA Region 7 Spending Fiscal Year 2015

Level of Care	Ages	Medicaid	Block Grant	Healthy MI	PA 2	Expenditures for Ages 16 & 17	Expenditures for Ages 18 to 21	Expenditures by Level of Care
Screening	**16 & 17**	$7,515	$1,920			**$9,435**		**$41,865**
	18 to 21	$15,975	$10,860	$5,595			**$32,430**	
Early Intervention	**16 & 17**	$3,810	$3,650		$194,783	**$202,243**		**$203,361**
	18 to 21	$841	$277				**$1,118**	
Outpatient Services								
Individual Counseling Therapy	**16 & 17**	$65,894	$8,022	$504		**$74,420**		**$132,585**
	18 to 21	$16,723	$22,624	$18,818			**$58,165**	
Group Counseling	**16 & 17**	$6,399	$1,207	$504		**$8,110**		**$18,443**
	18 to 21	$3,139	$3,063	$4,131			**$10,333**	
Urine Drug Screens	**16 & 17**		$2,048			**$2,048**		**$7,045**
	18 to 21		$4,967	$29			**$4,996**	
Didactic Therapy	**16 & 17**							**$209**
	18 to 21		$182	$27			**$209**	
Medication Assisted Treatment	**16 & 17**	$190				**$190**		**$3,800**
	18 to 21	$275	$1,590	$1,745			**$3,610**	
Assessment	**16 & 17**	$9,118	$1,883	$204		**$11,205**		**$21,171**
	18 to 21	$2,240	$2,618	$5,108			**$9,966**	
Recovery Supports	**16 & 17**				$96,400	**$96,400**		**$103,221**
	18 to 21		$6,821				**$6,821**	
Recovery Housing	**16 & 17**							**$30,720**
	18 to 21		$4,720	$1,000	$25,000		**$30,720**	

Table 10: Continued								
Level of Care	**Ages**	**Medicaid**	**Block Grant**	**Healthy MI**	**PA 2**	**Expenditures for Ages 16 & 17**	**Expenditures for Ages 18 to 21**	**Expenditures by Level of Care**
Intensive Outpatient	**16 & 17**	$640				**$640**		**$54,479**
	18 to 21	$12,551	$14,548	$26,739			**$53,839**	
Clinically Managed Medium-Intensity Residential Services	**16 & 17**	$241,574	$97,558			**$339,132**		**$630,738**
	18 to 21		$147,729	$143,877			**$291,606**	
Psychiatric Evaluations	**16 & 17**							**$110**
	18 to 21		$110				**$110**	
Withdrawal Management (18 to 21 ONLY)	**18 to 21**	$1,802	$4,978	$5,297			**$12,077**	**$12,077**
Grand Total		**$388,686**	**$341,374**	**$213,578**	**$316,183**	**$743,823**	**$515,999**	**$1,259,822**

Appendix B

Children Services Agency Detail

Table 11: Foster Care Residential Placements in Fiscal Year 2015				
Provider Name	**Description**	**Number of Children Placed Here**	**Days Paid**	**Amount Paid**
East Campus (Wedgwood)	0746-Substance Abuse Treatment	3	1134	$165,787
Vassar House (Wolverine)	0746-Substance Abuse Treatment	1	234	$36,844
Vista Maria	0746-Substance Abuse Treatment	6	1062	$167,217
Vista Maria Specialty Residential	0746-Substance Abuse Treatment	1	262	$41,253
Wolverine Growth & Recovery Center	0746-Substance Abuse Treatment	1	180	$28,342
			TOTAL	**$439,443**

Child Welfare was also able to determine which foster youth have an identified substance use need. Foster care workers use the Child Assessment of Needs and Strengths (CANS). The scoring system in the CANS is:

- +1 (No Substance Use.),
- 0 (Past experimentation. Child may have past experience with alcohol and/or other drugs but there is no indication of sustained use.),
- -2 (Situational concern. Child may have an isolated incident or experience with alcohol, tobacco, or other drugs that is not recurring.),
- -3 (Periodic substance use. Child's alcohol and/or other drug use has resulted in problematic behavior at home, school, and/or in the community. Use may include multiple drugs. Child may be involved in peer relationships/social activities involving alcohol, drugs, and other substances.), and
- -4 (Frequent substance use. Child's frequent alcohol, drug, or other substance usage results in severe behavior disturbances at home, school, and/or in the community. Child may require medical intervention to detoxify).

CSA staff pulled data for all youth over age 16 with an identified substance abuse need (scores of -2 through -4), but were unable to cross-reference for those with a residential need. A total of 978 youth were identified at some point during FY16 to have a substance abuse need. Please note these are subjective assessments based on a child welfare caseworker's observations or information received, not substance abuse professionals.

From this data 968 youth were assessed using the CANS as having an identified substance abuse need. We found 188 were identified with -4 meaning frequent use and 502 with -3. These scores are the most likely to be provided services either in the community or residential placement. There were 278 youth who scored with -2 situational concern these youth are most likely placed in foster homes thus not included in the residential data. CSA is unable to determine services or funding for these foster youth who are not in residential.

Appendix D:

Wayne County Juvenile Justice Data FY 15

Provider Name	Description	Number of children placed here	Days paid
Wedgewood EAST CAMPUS	0746-Substance Abuse Treatment	0	0
VISTA MARIA	0746-Substance Abuse Treatment	28	5682
HOLY CROSS KARIOS		3	151
WOLVERINE ALL RESIDENTIAL	0746-Substance Abuse Treatment	28	3946
STARR COMMONWEATH SA		14	2,310
WOLVERINE VICTORS SA		3	415
		76	

Diagnoses of Adjudicated Youth

*In 2016, DSM V defined diagnosis differently that may change proportionality in counting diagnosis of each youth. 88.5% of adjudicated youth met criteria for one or more diagnosis. The chart below provides insight regarding the prevalence and frequency of youth that meet diagnostic criteria and experience the need to critical treatment necessity to support development, learning, socialization and stability.

Behavioral Health Diagnosis Data	2016	2015
Behavioral Disorders (ADHD, Oppositional, Disruptive, Impulsive, Conduct Disorder)	**30.5%**	28.6%
Substance Abuse (Polysubstance, Marijuana, Alcohol, Cocaine, Opiates, Other Illegal Substance as primary diagnosis with or w/o Behavioral Disorder) **85% of Level 2 youth self-report substance use,70% of all adjudicated youth report substance use**	**52%**	22.3%
Depression (All Categories)	**12%**	10.6%
Learning and Communication (Self & Family Report)	**2%**	2.0%

Bipolar, Intermittent Explosive, Mood Disorder (Diagnosis may be reported as designated prior to Juvenile Adjudication)	**14.1**	22.2%
Anxiety Disorders (PTSD and/or Anxiety)	**3.6%**	3.5%
Active Psychosis (Schizophrenia, Delusional, Psychotic, Prior Treatment)	.1%	0.1%
Adjustment Disorders	**1.2%**	0.9%
Asperger's, PDD, Reactive Attachment and/or Stuttering as Primary Diagnosis	**.3%**	0.3%
Other Diagnosis or Diagnosis Deferred for Further Evaluation (may be a history of abuse, sexual abuse, neglect, bereavement due to loss, or unable to finalize in single assessment	**3.6%**	9.4%
2016 PTSD and Trauma - recent CMH training and research provides more insight into youth development, brain development and the effect of trauma on behavior that may result in arrest, disruption, substance use, conflictual relationships or service attention for behavioral concerns.	**7.8%**	na

Addictive Behaviors and Treatment Needs Assessed in FY 2016

An attempt to complete an Alcohol and Other Drug urine (AOD) screen is made with every juvenile entering the WCJDF, unless deemed to be underage (youth under age 14 without parental consent).

- 2,793 unduplicated youth were AOD (THC, Opiates, Cocaine, Urine Alcohol and Amphetamines) screened in 2016
- 1,266 unduplicated youth were screened at the WCJDF for 1,608 AOD screens
- 32 detained youth were under age 14 and unable to be screened without guardian consent for 35 not provided screens
- 937 unduplicated youth were screened at Lincoln Hall for 2,383 AOD screens @ Court
- 380 unduplicated caregivers were AOD screened at Lincoln Hall per Jurist order for 608 screens
- 81 unduplicated Juvenile Drug Court youth were screened at Lincoln Ct per Jurist Court order for 1,124 screens
- Over all 962 unduplicated adjudicated youth were screened randomly at the CMO locations for 5,104 AOD random screens to guide CMO treatment and monitor youth use and relapse
- Overall 2,560 unduplicated youth were screened for 10,884 youth AOD screens
- Overall 773 unduplicated female youth clients were screened for 2,615 AOD screens
- Overall 1,827 unduplicated male youth clients were screened for 8,269 AOD screens

(*Note: Drug screens must be authorized by a Court Order and an individual must give permission, youth under age 14 must have parental permission.)*

2,560 youth were provided an *Alcohol and Drug Diagnosis Global Assessment of Individual Need Quick* (GAIN-Q) to determine the treatment level of care recommended

for documented substance abuse. 214 youth required subsequent re-evaluations were also provided to address lack of treatment effect and increased use to increase intensity of treatment.

Data for GAIN Assessments

Location	Level 1 (outpatient)	Level 2 (intensive outpatient)	Level 3 (residential stabilization)
Wayne County Juvenile Detention (WCJDF)	421	467	304
Lincoln Hall of Justice*	72	176	147
Total	**493**	**643**	**451**

*Includes youth in the community (CMO, Court Ordered, STAND)

*Some youth required assessment more than once due to continued substance use and are not counted in the unduplicated count of final assessed treatment need.

*Western Wayne treatment provides assessment of care for WWCMO. If admitted into JDF or screened at LHJ, a GAIN is completed if needed by AFS.

Appendix D

Definitions

Assessment: The process of interviewing an individual to obtain the sociological background, psychological makeup, education and work history, family and marriage difficulties, and medical issues to better identify an individual's needs.

Case Management: A process to coordinate behavioral health care resources used in the provision of care and services.

Continuum of Care: An available range of service types utilized to address the level of needs individuals have over time.

Early Intervention: (two definitions)

Prevention "Early Intervention" is a term generally used to describe those early efforts to intervene when an individual is seen as being at risk or in the early stages of use (not yet indicating a need for treatment).

Treatment "Early Intervention" refers to specifically focused programs, including stage-based intervention for persons with substance use disorders, as identified through a screening or assessment process, including individuals who may not meet the threshold of abuse or dependence.

Medication-Assisted Recovery: The use of specific medications, in combination with counseling and/or other components of recovery.

Outpatient Therapy: Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week, but when medically necessary can total over 20 hours in a week. Most of the programs involve individual or group counseling. It is a program where individuals are treated, while residing at home or in another supportive environment.

Peer: A person in a journey of recovery who identifies with an individual based on shared background and life experience.

Recovery Centers: Places where recovery support services are designed, tailored, and delivered to individuals within local communities.

Recovery Coach: An individual who links the recovering persons to the community, serves as a personal guide or mentor in the process of personal and family recovery, and helps remove personal and environmental obstacles.

Recovery Support Services: Non-clinical services designed and delivered by individuals and families in recovery. These community-based services are included to strengthen and enhance those offered through the service delivery system to help prevent relapse and promote long-term recovery.

Residential Treatment Program: Services that are provided in a full or partial residential setting where individuals reside while receiving services. Such services may be supplemented with diagnostic services, counseling, vocational rehabilitation, work therapy, or other services that are judged to be valuable to clients in a therapeutic setting. Levels of residential services are defined by the American Society of Addiction Medicine.

Substance Use Disorders: Those disorders in which repeated use of alcohol and/or other drugs results in significant adverse consequences. Substance dependence and substance abuse are both considered substance use disorders.

Treatment: An array of services whose intent is to enable the individual to cease substance abuse in order to address the psychological, legal, financial, social, and physical consequences that can be caused by abuse or dependence.

Treatment Episode Data Sets (TEDS): SAMHSA's Treatment Episode Data Set (TEDS) is a major national data collection system from SAMHSA's Office of Applied Studies that produces an annual report of the demographic characteristics and substance abuse problems of the individuals admitted to substance abuse treatment facilities. In addition, trend data are provided for monitoring changing patterns in substance abuse treatment admissions and discharges. This system also provides treatment outcomes data.

Withdrawal Management: A set of interventions performed within a treatment program aimed at managing acute intoxication and withdrawal. It denotes to a clearing of toxins from the body of the patient who is acutely intoxicated and or dependent on substances of abuse.