PREPAID INPATIENT HEALTH PLAN

Promoting Opportunities for Recovery, Discovery, Health and Independence

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

Fiscal Years 2021-2023

Contents

Introduction

In accordance with *Section 274 of P.A 500 (Mental Health Code, P.A 258 as amended)*, Region 10 Pre-Paid In- Patient Health Plan (hereinafter the "PIHP") developed the following three-year strategic plan for substance use disorder (SUD) services within the region's boundaries. The PIHP's strategic plan is consistent with the guidelines established by the Michigan Department of Health and Human Services (MDHHS). The plan consists of nine narratives addressing the key components necessary for implementing a Recovery Orientated System of Care (ROSC). The PIHP is committed to implementing a ROSC, including prevention, treatment, and recovery services that is conducive to an individual's recovery, as well as the community's overall journey towards recovery.

1. The Region's Epidemiological Profile and Prioritized SUD Problems of Impact

The following narratives, *1.A- 1.E.*, identify and prioritize the SUD problems impacting the region, with respect to a ROSC, including both prevention and treatment, as well as all other services necessary to support recovery. To identify populations of focus relevant to the access, use, and outcomes of the PIHP's treatment and prevention efforts, the PIHP considered the region's *Michigan Profile for Healthy Youth (MiPHY)* data, as well as *MDHHS Substance Use in Michigan Data* and the MDHHS "*Guidelines for Developing Three-Year Strategic Plans for Substance Use Disorder Prevention, Treatment and Recovery Services"* document. To prioritize SUD problems, the PIHP considered the epidemiological profile of the region and the extent and prevalence of SUD, along with the consequences of SUD that impact the region. In addition, the PIHP identified gaps of service and barriers to treatment, as well as described how the PIHP's communicable disease efforts will continue to be implemented and maintained.

- **1.A. Regional Demographics and Trend Data**

The PIHP serves four counties located in the Eastern Lower Peninsula of Michigan. The region includes Genesee, St. Clair, Sanilac, and Lapeer counties, with a combined population of approximately 698,505 people. Geographic and demographic information for each county is outlined below, extracted from *2018 Federal Census* data.

With a population of 409,361 people, Genesee County makes up the largest portion of the region's population. The land area of Genesee County is 636.8 square miles yielding a population density of 643 people per square mile. As with the other counties in the region, English is the primary language spoken in Genesee County. The racial make-up of Genesee County varies significantly from that of the other 3 counties in the region. 74.9% of individuals residing in Genesee County self-identify as white/non-Hispanic, 19.8% self-identify as black/non-Hispanic, 3.4% self-identify as Hispanic or Latino, less than 2% of the Genesee County population self-identify as Asian. Of the individuals residing in Genesee County, 51.86% are female. 18.8% of the population are under 15 years of age, while 16.6% of the population are over the age of 65. Of the adult population, 90.4% of persons age 25 and older hold a high school diploma or higher, and 20.9% hold a bachelor's degree or higher. The median household income in Genesee County is $47,006 which is $7,932 less than the overall State of Michigan median

income. Approximately 69.5% of individuals who reside in Genesee County are homeowners. The county-wide poverty level is 19.8%, which is approximately 5.7% higher than the State of Michigan average.[1]

St. Clair County has a population of 159,566. The land area of St. Clair County is 721 square miles with a population density of 222 people per square mile. 93.5% of individuals residing in St. Clair County self-identify as white/non-Hispanic, 2.1% self-identify as black/non-Hispanic, 3.3% self-identify as Hispanic or Latino, less than 2% self-identify as Asian. Of the individuals residing in St. Clair County, 50.4% are female. 17.6% of the population are under 15 years of age, while 20.5% of the population are over the age of 65. Of the adult population, 90.5% of persons age 25 and older hold a high school diploma or higher, and 18.3% hold a bachelor's degree or higher. The median household income in St. Clair County is $55,240 which is about equal to the overall State of Michigan median income. Approximately 76.8% of St. Clair County residents are homeowners and the poverty level is at 13.3%, which is approximately 0.8% lower than the state average.[2]

Sanilac County has a population of 41,376 people. The land area of Sanilac County is 962.3 square miles. Geographically, Sanilac County is the largest county in Michigan's Lower Peninsula. Sanilac County is the most rural county in the region, with a population density of 43 people per square mile. 96.7% of individuals residing in Sanilac County self-identify as white/non-Hispanic, less than 1% self-identify as black/non-Hispanic, and less than 2% self-identify as two or more races. Of those residing in Sanilac County, 50.4% are female. 18.1% of the population are under 15 years of age, while 17.7% of the population are over the age of 65. Of the adult population, 87.9% of persons age 25 and older hold a high school diploma or higher, and 14.1% hold a bachelor's degree or higher. The median household income in Sanilac County is $45,277 which is $9,661 less than the overall State of Michigan median income. Approximately 79.8% of county residents are homeowners. The poverty level is 15.6%, which is approximately 1.5% higher than the state average.[3]

The population of Lapeer County is 88,202 people, with a land area of 644 square miles. Lapeer County is a rural area, with a population density of 137 people per square mile. 95.8% of individuals residing in Lapeer County self-identify as white/non-Hispanic, 1.2% self-identify as black/non-Hispanic, less than 2% self-identify as Asian, and 1.5% self-identify as two or more races. Of the individuals residing in Lapeer County, 49.2% are female. 17% of the population are under 15 years of age, while 17% of the population are over the age of 65. Of the adult population, 90.7% of persons age 25 and older hold a high school diploma or higher, and 17.8% hold a bachelor's degree or higher. The median household income in Lapeer County is $58,952 which is $4,014 higher the overall State of Michigan median income. Approximately 83.5% of

[1] U.S. Department of Commerce, *U.S. Census Bureau*, 2018 [website] https://data.census.gov/cedsci/profile?g=0500000US26049&hidePreview=true&tid=ACSDP1Y2018.DP05 (*accessed 06.2020)*
[2] U.S. Department of Commerce, *U.S. Census Bureau*, 2018 [website] https://data.census.gov/cedsci/profile?q=St.%20Clair%20County,%20Michigan&g=0500000US26147 (*accessed 2020*)
[3] U.S. Department of Commerce, *U.S. Census Bureau*, 2018 [website] https://data.census.gov/cedsci/profile?q=Sanilac%20County,%20Michigan&g=0500000US26151 (*accessed 06.2020*)

the population are homeowners. The Lapeer County poverty level is 10.1%, which is approximately 4% less than the state average.[4]

St. Clair, Sanilac, and Lapeer counties show little racial diversity, with approximately 93-97% of their populations self- identifying as white/ non- Hispanic. Within those three counties, there is also a very low percentage of the population that self-identify as Hispanic and even less of the population self-identifying as black/ non- Hispanic, including less than 1% in Sanilac County. However, the racial makeup of Genesee County varies significantly from that of the other three counties in the region, with approximately 20% of the Genesee County population self-identifying as black/ non- Hispanic. Of the region's four counties, Genesee County has the highest poverty level and unemployment rates while Sanilac County has the lowest median income. All four of the region's counties have a lower portion of the population who have attained a bachelor's degree or higher than the State of Michigan average. Sanilac County, being the most rural of all four counties, has a slightly larger population of those over the age of 65, as compared with the state average[5]

Refer to *Attachment I- pg. 2 Tables A- B* for a summary of the above demographic and trend data, extracted from *2018 Federal Census* data.

- **1. B. The PIHP's Populations of Focus**

The PIHP has identified the following populations of focus relating to the access, use, and outcomes of prevention, treatment, and recovery support in the region: individuals living in a rural community, women that have a SUD who have dependent children, older adults (50+), and adults supervised by the Michigan Department of Corrections (MDOC) who are returning to their communities.

Individuals living in a rural community, specifically those living in Sanilac and Lapeer counties, are a population of focus with an increased risk for the development of a SUD. 2015-18 MiPHY data shows rurally located students living in Sanilac County report a much higher percentage of perceived ease of access to alcohol, as compared with other the counties in the region (see *Attachment I, pg. 3- Table C*). The data also shows a much higher percentage of Sanilac County High School students who report past 30-day use of marijuana, as compared with other counties in the region (see *Attachment I- pgs. 3-4- Table D*). In addition, 2017-18 MiPHY data indicates Sanilac County students report a much higher percentage of past 30-day tobacco and electronic vapor products (EVPs) (see *Attachment I- pg. 4- Table E).* Further, the data shows a higher percentage of past 30-day use of a prescription medication that was taken non-medically for Sanilac County students (see *Attachment I- pg. 5- Table F*). Rurally located adults have higher rates of alcohol abuse, tobacco use, and methamphetamine use. Various factors contribute to the increased rate of SUD in rural communities, including lower educational attainment, poverty, unemployment, and isolation.[6]

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[4] U.S. Department of Commerce, *U.S. Census Bureau*, 2018 [website] https://data.census.gov/cedsci/profile?q=Lapeer%20County,%20Michigan&g=0500000US26087 (*accessed 06.2020*)
[5] U.S. Department of Commerce, *U.S. Census Bureau*, 2018 [website], https://data.census.gov/cedsci/ *(accessed 06.2020)*
[6] Rural Health Information Hub, *Substance Abuse in Rural Areas*, 2018 [website] https://www.ruralhealthinfo.org/topics/substance-abuse (*accessed 06.2020*)

Women that have a SUD who have dependent children are a population of focus in the region. From Fiscal Year (FY) 2017-19, the percentage of women that have dependent children at the time of admission to a PIHP SUD treatment services increased by 6%. 20% of those admitted to PIHP SUD treatment services in FY19 reported that they had dependent children (*see Attachment I- pg. 5- Table G*). 5% of those admitted were pregnant women (see *Attachment I, pg. 6, Table H*). In addition, the region had the second highest rate of Neonatal Abstinence Syndrome (NAS) in the State of Michigan during 2017.[7] Research has shown that children of parents with a SUD were found to be of lower socioeconomic status and had more difficulties in academic, social, and family functioning when compared with children of parents who do not have a SUD. Children of parents with a SUD show an increased risk for the development of their own addiction or dependency. These children are also more likely to have higher rates of mental and behavioral health disorders.[8] Based on data from the combined 2009 to 2014 National Surveys on Drug Use and Health (NSDUH), about 1 in 8 children (8.7 million) aged 17 or younger lived in households with at least one parent who had experienced a SUD in the past year.[9] Many of the PIHP's prevention efforts focus on children of those with a SUD. Early Intervention efforts targeting this population of focus are intended to help break the cycle of generational substance abuse.

Older adults (50+), are a population of focus with an increased risk for the development of a SUD. 19% of those admitted to PIHP SUD treatment services in FY19 were at least 50 years of age (see *Attachment I- pg. 6- Table I*). The University of Michigan Institute for Healthcare Policy and Innovation's poll of older adults, aged 50-80, found that nearly a third of older adults have received a prescription for an opioid pain medicine in the past two years. Additionally, many of those did not receive adequate counseling about the risks that come with the potent painkillers, how to reduce their use, when to switch to a non-opioid option, or what to do with leftover pills.[10]

Adults supervised by MDOC who are returning to their communities are a population of focus with an increased risk of SUD. While the exact rate of inmates with SUD is difficult to measure, some research shows that an estimated 65% percent of the United States prison population has an active SUD. Decades of research show that providing comprehensive substance use treatment to criminal offenders while and following incarceration works, reducing both drug use and crime after an inmate returns to the community.[11]

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[7] Michigan Resident Inpatient Files. Division for Vital Records and Health Statistics. Bureau of Epidemiology and Population Health, MDHHS. 2017 *Neonatal Abstinence Syndrome (NAS)*

[8] SAMSHA, The CBHSQ Report, (08.24.17) '*Children Living with Parents who have a Substance Use Disorder',* Rachel N. Lipari, Ph.D., and Struther L. Van Horn, M.A., [website] https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html (*accessed 06.2020*)

[9] SAMSHA, The CBHSQ Report, (08.24.17) '*Children Living with Parents who have a Substance Use Disorder',* Rachel N. Lipari, Ph.D., and Struther L. Van Horn, M.A. [website] https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html (*accessed 2020*)

[10] University of Michigan Medicine (07.30.18) '*Opioids and Older Adults: Poll finds support for Prescribing Limits, and need for better Counseling and Disposal Options'*

[11] Center on Addiction, Behind Bars II: Substance Abuse and America's Prison Population (02.10) [website] https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america's-prison-population *(accessed 06.2020)*

- **1. C. The PIHP's Provider Network, Service Gaps and Barriers to Treatment**

The PIHP has a comprehensive array of SUD prevention, treatment, and recovery programming through its Provider Network, offering evidence- based services at over 50 locations across the region (see *Attachment I- pg. 7- Table J*). These services include, but are not limited to; Screening and Assessment, Withdrawal Management, Out Patient Treatment, Recovery Coaching, Recovery Housing, Medication Assisted Treatment (MAT), Psychiatric Treatment, Women's Specialty Services, Residential Treatment, Naloxone Training and Distribution, along with various prevention strategies.

Although the PIHP has established a wide network of providers and services, the PIHP is still working to ensure that any gaps of service are filled. The PIHP has identified the following gaps of service within the region: access to MAT services, access to Recovery Coaching services, and access to Recovery Housing services. In addition, the PIHP has identified regional rural settings and the stigma associated with SUD as barriers to treatment within the region.

There is limited access to MAT services in the region. Currently, there are two Opioid Treatment Programs (OTPs)/Outpatient Based Opioid Treatment (OBOT) programs located within the region's boundaries – BioMed Behavioral Health and Sacred Heart Rehabilitation Center (SHRC). There are no OTPs/OBOTs located in Lapeer and Sanilac counties. There is a limited amount of treatment availability for Medicare clients, due to lack of clinicians that are approved Medicare providers at these locations. Federally Qualified Health Centers (FQHCs) provide limited MAT in Genesee and Lapeer counties. St. Clair County residents seeking MAT will often travel to the closest SHRC location by bus, funded by the PIHP. St. Clair County Community Mental Health (CMH) recently received funding to begin offering SUD and MAT services. However, there is still a limited number of unaffiliated physicians that will facilitate MAT throughout the region. The PIHP will issue a Request for Proposal (RFP) for the provision of MAT services with a strong preference towards provider(s) who would offer services within regional boundaries. In the wake of the COVID-19 Pandemic, the PIHP funded a virtual physician training session to support physicians in becoming X-Waivered, or certified to prescribe medications used to treat Opioid Use Disorder (OUD). The PIHP has also recently expanded services with a MAT capable Mobile Care Unit (MCU) in Genesee County. Currently, the PIHP funds MAT in the St. Clair County Intervention and Detention Center (SCCIDC) and is interested in expanding MAT to the Genesee County Jail.

The availability of Recovery Housing services is limited within the region. Recovery Housing services are not available in Lapeer and Sanilac counties. While St. Clair and Genesee County residents have access to Recovery Housing services located within their counties, there is still a limited number of beds. Providers often report being filled to capacity, with individuals waiting for placement into appropriate Recovery Housing facilities.

The rural communities within the region face additional barriers for access to SUD prevention and treatment services. These barriers include lower income and lack of transportation to services, which could be located further away. Sanilac County, being the most rural community in the region, has the lowest median income of the four counties. SUD can be especially hard to

combat in rural communities due to limited resources for prevention, treatment, and recovery, as discussed in narrative *1.B.*

In addition, the general stigma surrounding SUD continues to be a barrier to individuals receiving treatment in the region. People who experience stigma regarding their substance abuse may be less likely to seek treatment, and this results in increased economic, social, and medical costs. MDHHS recently launched the "End the Stigma" campaign at the State level, focusing on changing the language used surrounding SUD. The stigma and misconceptions that impact public understanding of mental health (MH) and SUD can potentially discourage individuals from seeking help.

- **1. D. The Extent and Prevalence of SUD in the Region, Including Consequences of SUD**

To quantify the regional need for prevention, treatment, and recovery services, the PIHP evaluated *National Survey on Drug Use and Health (NSDUH)* data in combination with *MDHHS Substance Use in Michigan* data. Below is a summary of the key findings, extracted from the most recent regional NSDUH and MDHHS data.

- From 2012-14, the average past month illicit drug use percentage for those over the age of 12 within the region was 12.74%. 3.6% of those reported using an illicit drug other than marijuana, coming in higher than both the state and national averages (illicit drugs include marijuana, heroin, prescription type psychotherapeutics used non-medically, cocaine (including crack), hallucinogens and inhalants).[12]
- From 2014-2016, alcohol, marijuana, heroin, and other opiates were the most abused primary substances in the region. [13]
- From 2014-16, 52% of persons over the age of 12 within the region reported alcohol use in the past month, with nearly 25% reporting an alcohol binge in the past month. 11.24% of persons aged 12 or older reported marijuana use in the past month. Nearly 2% reported cocaine use. 4.76% of persons over the age of 12 reported use of nonmedical pain relievers in the past year.[14]
- In 2018, 610 traffic crashes in the region were alcohol-involved, 202 traffic crashes involved drugs.[15]
- In 2018, there were over 300 drug overdose deaths in the region.[16]

To quantify the regional need for prevention, treatment, and recovery services in the region, the PIHP also considered 2015-18 MiPHY Survey data. Below is a summary of the region's key findings, extracted from the 2015-18 MiPHY Survey. Refer to *Attachment I, pgs. 3- 5- Tables C-F* for specific MiPHY data.

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[12] SAMHDA, *Interactive NSDUH Substate Estimates,* 2016 [website] https://pdas.samhsa.gov/saes/substate (*accessed 06.2020*)
[13] SAMHDA, *Interactive NSDUH Substate Estimates,* 2016 [website] https://pdas.samhsa.gov/saes/substate (*accessed 06.2020*)
[14] SAMHDA, *Interactive NSDUH Substate Estimates,* 2016 [website] https://pdas.samhsa.gov/saes/substate (*accessed 06.2020*)
[15] MDHHS, Substance Use in Michigan *'Michigan Traffic Crash'*, 2018 [website] https://mi-suddr.com/blog/2018/09/26/traffic-crashes/ (*accessed 06.2020*)
[16] MDHHS, Substance Use in Michigan, '*Drug Overdose Deaths',* 2018 [website] https://mi-suddr.com/blog/2018/09/26/opioid-heroin-poisonings/ (*accessed 06.2020*)

- 2015-18 MiPHY data shows an increase in Genesee County Middle School and High School students who reported an ease of access to alcohol.
- 2015-18 MiPHY data shows an increase in Genesee County Middle School students who reported an ease of access to marijuana. Perceived risk of marijuana use in Genesee County Middle School students decreased, while there was a slight increase in past 30-day marijuana use reported by St. Clair County High School students.
- 2015-18 MiPHY data for both Genesee and St. Clair counties students shows a decrease in reported past 30-day tobacco use.
- 2015-18 MiPHY data for both Genesee and St. Clair counties shows a large increase the percentage of students that reported past 30-day use of an EVP. Sanilac County students report a much higher percentage of past 30-day use than the other counties in the region.
- 2015-18 MiPHY data shows a slight increase in the percentage of Genesee County Middle School students who reported that they took a prescription medication, not prescribed to them in the past 30-days.

Further, to quantify the regional need for prevention, treatment, and recovery services, the PIHP extracted baseline information from the PIHP's Open Admission Report for SUD treatment services and the PIHP SUD Billing Summary Report. Below is a summary of the key findings.

- During FY2019, there were 9,796 admissions for SUD treatment services in the region. For 33.6% of those admissions, alcohol was the primary drug of choice. 30% reported heroin, 7.1% indicated marijuana, 10.8% listed other opiates, 13.4% stated cocaine (including crack), and 4.3% reported methamphetamine as the primary drug of choice (see *Attachment I, pg. 7- Table K).*
- From FY2017 to FY2019, the top 3 primary drugs of abuse identified at admission were alcohol, heroin and other opiates, and cocaine/crack. The number of alcohol and cocaine/crack open admissions increased, while heroin and other opiates open admissions slightly decreased. The number of overall open admissions in the region increased from FY2017 to FY2019 (see *Attachment I, pg. 7- Table K).*
- From FY2017 to FY2019, there was a large increase in the percentage of detoxification and short-term residential open admissions. Although the largest percentage of SUD open admissions is for outpatient service, there was a sizable decrease in the percentage of outpatient open admissions. The percentage of open admissions to long-term residential also decreased during this time (see *Attachment I, pg. 8- Table L).*
- From FY2017 to FY2019, there was a sizable decrease in the percentage of individuals identifying as unemployed at admission, while there was as increase in the percentage of open admissions identifying as not in the workforce (see *Attachment I, pg. 8- Table M)*
- The number of units billed for MAT services increased by 34,773 units from FY2016 to FY2019.
- The number of units billed for Recovery Housing services increased by 5,376 units from FY2016 to FY2019.

SUD is associated with numerous medical, psychiatric, psychological, spiritual, economic, social, family, and legal problems, creating a significant burden for affected individuals, their

families, and society.[17] Substance use in the region has many consequences, including traffic crashes, hospitalizations, criminal activity, unemployment, dependency, and deaths.[18] Looking retrospectively at these consequences is critical in the planning of future initiatives.

A comprehensive examination of relevant data, along with the MDHHS "*Guidelines for Developing Three-Year Strategic Plans for Substance Use Disorder Prevention, Treatment and Recovery Services"* document, led the PIHP to identify the following problems of focus in terms of prevention services: underage drinking in the region, underage marijuana use in the region, underage tobacco use in the region, and opioid prescription and over-the-counter drug abuse, including opiates in the region. In terms of treatment, the PIHP identified the following problems of focus: the need for additional MAT services in the region, the need for an increased number of recovery coaches, the need for increased capacity of Recovery Housing services, and the need for increased treatment services for women who have SUD that have dependent children.

The process of analyzing the data consisted of evaluation efforts by the PIHP's staff and input from the Region 10 PIHP and SUD Oversight Boards. In addition, the PIHP utilized contributions from prevention and treatment providers (i.e. examining their work plans, evaluation efforts and feedback from the community).

- **1. E. The PIHP's Communicable Disease Prevention Effort**

The purpose of the PIHP's communicable disease prevention effort is to promote service practices that focus on preventing and/or reducing the spread of communicable diseases among individuals who are high-risk for exposure. The PIHP prioritizes best practices in this area and recognizes epidemiological studies that demonstrate higher prevalence of communicable disease amongst persons who use substances, thus placing users at a higher health risk for contraction and dissemination of infectious diseases. The PIHP's efforts for communicable disease prevention focus on the entire SUD provider network and are centered on the following strategies:

- Educational sessions and available resources for persons receiving SUD services at our in-patient detox, residential and out-patient facilities.
- Information sessions are held throughout the entire year, and focus on education regarding HIV, TB, Hepatitis, and STIs (St. Clair and Lapeer counties).
- All providers of SUD treatment services are required to have a Communicable Disease Policy, which contains protocols for identification of individuals with SUD, who are at a higher risk for/have a communicable disease, to have access to community-based services for communicable disease prevention and treatment.
- Individuals entering residential detox/treatment are tested for Tuberculosis (TB) upon admission. Providers are also required to have policies and procedures in place that

[17] National Center for Biotechnology Information, U.S. National Library of Medicine (09.14) *Family and Social Aspects of Substance Use Disorders and Treatment*

[18] MDHHS, Substance Use in Michigan 'Michigan Traffic Crash', 2018 [website] https://mi-suddr.com/blog/2018/09/26/traffic-crashes/ (*accessed 06.2020*)

follow public health policy and are consistent with the MDHHS and Centers for Disease Control (CDC) guidelines and/or communicable disease best practice for cases in which a person tests positive to a TB test.

- All individuals receiving SUD treatment services with the PIHP who are identified as being infected with TB, are referred for appropriate medical evaluation and treatment.
- All pregnant women presenting for treatment must have access to STD/Is and HIV testing and follow-up services as necessary.
- Providers of SUD treatment services are required to screen persons entering treatment for risk of HIV/AIDS, STD/Is, TB, and hepatitis, and provide basic information about risk.

Adherence to these guidelines by the Provider Network will be monitored by the PIHP and reviewed during annual site visits. 0

In response to the COVID-19 Pandemic, the PIHP promptly began providing support to help decrease risk and increase safety measures. The PIHP increased communication with all providers by requesting updates on provider program closures, as well as addressing the need for and distributing Personal Protective Equipment (PPE) within the region. The PIHP began offering financial support to providers that may have been struggling due to the impacts of the pandemic. Resources were made available to cover expenses that the provider was unable to, given the public health crises. Provider due dates for standard reports were reviewed and extended if possible, considering staffing concerns because of the pandemic. The PIHP will continue to provide the highest level of care and support in dealing with the inevitable impacts of the COVID-19 Pandemic on the region.

2. The PIHP's Data-Driven Goals

The following narratives *2.A.- 2.B.* describe the data-driven prevention and treatment goals set by the PIHP, in an effort to improve the PIHP's ROSC over the next 3 fiscal years. Each goal is based on the region's epidemiological profile and MDHHS/OROSC directive, along with the appropriate data and statistics. Each goal can be quantified, monitored, and evaluated for progress by the PIHP over the next 3 fiscal years.

- **2. A. The PIHP's Data Driven Goals for Prevention Services**

After consideration of the region's epidemiological profile, discussed in narrative *1.A*, along with the region's MiPHY data, discussed in narratives *1.B- 1.C*, the PIHP identified the following six priority prevention goals: reduce rates of underage drinking, reduce rates of underage marijuana use, reduce rates of youth access to tobacco, reduce rates of opioid prescription drug abuse, reduce rates of older adult (50+) alcohol and opioid abuse, and combat the effects of the COVID-19 Pandemic.

1. Reduce Rates of Underage Drinking

2015-18 MiPHY data for the region indicates an increase of ease in access to alcohol by students in the region. In addition, the data shows lower perception of risk among rurally located students

(see *Attachment I, pg. 3- Table C).* The data supports a growing national concern regarding underage drinking in rural communities. The PIHP is interested in expanding community partnerships and relationships with key stakeholders in Sanilac County in an effort to increase access to prevention services in rural communities. The PIHP will continue to contract with prevention service providers within the region to implement appropriate Center for Substance Abuse Prevention (CSAP) Strategies to reduce underage drinking.

The PIHP has identified the following objectives for meeting the above goal: educate youth/young adults and families about risk/harm of use, educate families about communicating with youth/young adults about alcohol use and expectations not to use, and implement environmental prevention strategies to address underage access to alcohol. These objectives will be measured by EBP pre/post-test outcomes and regional MiPHY data.

2. Reduce Rates of Underage Marijuana Use

2015-18 MiPHY data for the region indicates an increase in students who reported an ease in access to marijuana. In addition, the data shows the perceived risk of marijuana use by students has decreased, and past 30-day use of marijuana slightly increased (see *Attachment I, pg. 3-4- Table D).* Research suggests that early exposure to cannabinoids is likely to precede the use of other licit and illicit substances and the development of addiction to other substances later in life. These findings are consistent with the idea of marijuana as a "gateway drug."[19]

The legalization of recreational marijuana use in Michigan during 2018 may have a future impact on perception of risk and increased use among Middle School and High School students. The PIHP will continue to partner with prevention service providers within the region to implement appropriate CSAP Strategies to reduce underage marijuana use.

The PIHP has identified the following objectives for meeting the above goal: educate youth/young adults and families about risk/harm of underage marijuana use, educate families about communicating with youth/young adults about marijuana use and expectations not to use, and implement environmental prevention strategies to address underage marijuana use. These objectives will be measured by EBP pre/post-test outcomes and regional MiPHY data.

3. Reduce Rates of Youth Access to Tobacco

2017-18 MiPHY data indicates a much higher percentage of past 30-day tobacco use by students living within rural Sanilac County. Synar retailer violation rates increased significantly from 2017 (2.8%) to 2018 (19.2%) and remained high during 2019 (20.7%), indicating a need for the PIHP to increase efforts to improve Youth Tobacco Act (YTA) compliance. Although 2015-18 MiPHY data indicates a large decrease in the reported past 30-day tobacco use by students in the region, a large increase was reported for past 30-day use of an EVPs. Again, rurally located Sanilac County students report a much higher percentage of past 30-day use of an EVP than the other counties in the region (see *Attachment I, pg. 4- Table E).* The data indicates the need for continued implementation of CSAP strategies within these communities to reduce youth access

[19] National Institute on Drug Abuse. (04.2020) *Is marijuana a gateway drug?* (*accessed 06.2020*)

to tobacco, particularly EVPs. The PIHP will continue to contract with prevention service providers within the region to conduct increased YTA activities to decrease youth access to tobacco.

The PIHP has identified the following objectives for meeting the above goal: contract with Designated Youth Tobacco Use Representative (DYTUR) to provide tobacco vendor education to retailers and conduct non-SYNAR and SYNAR tobacco compliance checks. These objectives will be measured by EBP pre/post-test outcomes, regional MiPHY data and review of Synar compliance data.

4. Reduce Rates of Youth Prescription Drug Abuse

2015-18 MiPHY data indicates an increase in the percentage of Genesee County Middle School students who reported that they took a prescription medication, not prescribed to them in the past 30-days (see *Attachment I, pg. 5- Table F).*The data indicates the need for increased intervention with Middle School students. Research shows that opioid prescription drug use in adolescence poses significant risks for opioid-related adverse outcomes and OUD in adulthood. Conversely, youth who are committed to academic achievement and finishing school, have a strong bond with their parent, and whose parents express disapproval of substance use, are at lower risk of substance abuse.[20] Targeting youth and young adults is imperative to reducing the long-term rates of opioid prescription drug abuse within the region. The PIHP will continue to partner with prevention service providers within the region to implement appropriate CSAP Strategies to reduce opioid prescription drug abuse.

The PIHP has identified the following objectives for meeting the above goal: educate youth/young adults and families about risk/harm of opioid prescription drug abuse, disseminate a statewide media campaign/toolkit, educate families about communicating with youth/young adults about opioid prescription drug abuse, and implement environmental prevention strategies to address opioid prescription drug abuse. These objectives will be measured by EBP pre/post-test outcomes and regional MiPHY data.

5. Reduce Rates of Older Adult (55+) Alcohol and Opioid Abuse

According to the PIHP's FY19 Open Admissions Summary Report, 19% of those admitted to the PIHP's SUD services were at least 50 years of age (see *Attachment I- pg. 6- Table I*). Research suggests that substance abuse is an emerging public health issue among the nation's older adults. Older adults are more likely than people in other age groups to have chronic health conditions and to take prescription medication, which may further complicate adverse effects of substance use.[21]

To address alcohol and opioid abuse among older adults, the PIHP will apply for SAMHSA Partnership for Success (PFS) funding to address alcohol and opioid misuse among adults ages

[20]Office of Adolescent Health. (05.13.19). *Opioids and Adolescents*. HHS.Gov. (*accessed 06.2020*)

[21] Mattson, Ph.D., M., Lipari, Ph.D., R. N., Hays, M.A., C., & Van Horn, M.A., S. L. (n.d.). *A Day in the Life of Older Adults: Substance Use Facts*. (*accessed 06.2020*)

55 and older in Genesee County. Based on the examination of deaths due to liver disease or cirrhosis and opioid poisoning deaths among adults 55 and older, Genesee County was found to have one the highest death rates in the state. The PIHP will partner with prevention service providers in Genesee County to foster coalition development, provide technical assistance and training, and ensure the implementation of evidenced-based programs. The PIHP will partner with prevention service providers within the region to implement appropriate CSAP strategies to reduce alcohol and opioid use among older adults.

The PIHP has identified the following objectives for meeting the above goal: educate older adults and families about factors that make older adults more vulnerable to alcohol and opioid abuse and the risk/harm of alcohol and opioid abuse and implement environmental prevention strategies to address alcohol and opioid abuse amongst older adults. These objectives will be measured by EBP pre/post-test outcomes.

6. Combat the Effects of the Current COVID-19 Pandemic

While the long-term impact of COVID-19 on SUD Prevention Programming is unknown, the PIHP has the goal of continuing to maintain and enhance the array of prevention services available in the region. In the wake of the COVID-19 Pandemic, the PIHP provided technical assistance and support to providers as they adapted to virtual and alternative programming. Many providers have seen success in virtual prevention programming, including Evidence Based Practices (EBPs) such as Guiding Good Choices and Prime for Life.

In order to meet the above goal, the PIHP will continue to provide technical assistance and support to providers as they adapt to virtual and alternative programming.

- **2. B. The PIHP's Data Driven Goals for Treatment and Recovery Services**

After consideration of the region's demographic data and SUD prevalence, as discussed in narrative *1. The Region's Epidemiological Profile and Prioritized SUD Problems of Impact,* the PIHP identified the following six treatment goals: increase the region's capacity for MAT, increase the region's access to Recovery Coaching services, increase the region's access to Recovery Housing services, increase the treatment services and recovery supports for women with SUD who have dependent children, increase access to treatment services for adults supervised by the MDOC who are returning to their communities, and combat the effects of the COVID-19 pandemic. An increase in the number of admissions to SUD treatment and recovery services will necessitate an increase in the capacity of providers in the region. Within this trend, the demand for detoxification services, short-term residential services, MAT, and Recovery Housing services has been increasing in the past two years.

1. Increase the Region's Capacity for MAT

Individuals requesting and being considered appropriate for MAT services have increased because of the opioid crisis. While the admission data indicates a decreasing trend in heroin and other opiates as the primary of drug of choice, MAT is often a lengthy process, and involves many components of the SUD recovery network over an extended period of time. Health

providers with the ability to treat individuals with MAT, specifically those with the ability to prescribe naltrexone, buprenorphine, and methadone, will be needed in the region. Qualified health providers are required to complete the X-Waiver Training to be able to prescribe the federally approved MAT drugs for OUD treatment. With an increase in the number of MAT providers, there will be an increase in the accessibility to these treatment services for individuals in the region.

The PIHP has identified the following objectives to meet the above goal: continued support of EBPs to treat OUD in all SUD treatment and recovery services providers, increase opportunities for qualified health providers to complete the required training to become X-Waivered to support the use of MAT throughout the region, and improve access to MAT by utilizing mobile services and increasing service locations. These objectives will be monitored by the evaluation of PIHP Open Admission Report data and measurement of Performance Indicators (PIs).

2. Increase the Region's Access to Recovery Housing

Recovery Housing services are a necessary support to enhance the outcomes for long term recovery from SUD. While recovery homes are available in Genesee and St. Clair counties, no homes exist in Lapeer or Sanilac counties. The PIHP would like to support Recovery Housing services in these counties, in conjunction with access to SUD treatment services including Recovery Coaching. As the need for Recovery Housing has grown, so to have the concerns about the standards for this service. Michigan Association for Recovery Residences (MARR) is the appropriate organization to evaluate and certify homes as meeting the National Association of Recovery Residences (NARR) standards. The PIHP contractually requires Recovery Housing providers to obtain MARR certification. MARR review and certification increases cost, in terms of provider staff and monetary resources, which will impact the cost of those services/supports across the region. Additionally, more family friendly Recovery Housing services are necessary to support women with dependent children and their specialized recovery needs.

The PIHP has identified the following objectives to meet the above goal: increase the number of recovery homes located physically with the region, provide necessary resources and support for the MARR certification of recovery homes, and increase the resources needed for family recovery homes in the region. These objectives will be monitored by the evaluation of PIHP Open Admission Report data and measurement of PIs.

3. Increase the Region's Access to Recovery Coaches

Recovery Coaching services are an essential in the initial and ongoing engagement of individuals into the SUD treatment and recovery process, often meeting the person in the emergency department immediately following an overdose. The Recovery Coach is instrumental in facilitating admission to treatment and introducing the consumer to the recovery community for additional support. For interested and qualified individuals, training and certification is required for the delivery of Recovery Coaching services. Recovery Coaches provide information about the multiple pathways that exist for recovery. Recovery Coaches are often a key partner in the SUD treatment continuum regarding engagement. Research confirms that better long-term

outcomes are more likely the longer an individual remains engaged in treatment services and recovery supports.[22]

The PIHP has identified the following objectives to meet the above goal: continuous support of training and certification opportunities for Recovery Coaches, continuous training on evolving EBPs surrounding the various recovery pathways, and continuous training and monitoring of engagement in treatment and recovery services. These objectives will be monitored by the evaluation of PIHP Open Admission Report data and measurement of PIs.

4. Increase the Treatment Services and Recovery Supports for Women with SUD that have Dependent Children

As discussed in narrative *1.B*, the PIHP Open Admissions data depicts a large increase in the number of women with dependent children entering treatment and recovery services within the region over the past 3 fiscal years. During 2017, the region had the second highest rate of NAS in the State of Michigan, at 2095.4 per 100,000 live births. [23] The region has two sizeable Women's Specialty Services (WSS) providers and a regional Level IV NICU in Genesee County, where many of the women with high risk pregnancies receive services. Continued specialized care and a variety of support services are utilized by these women and their children. Children of parents with a SUD are at higher risk of developing a SUD and other behavioral health concerns. Beginning in 2016 and annually since 2018, the PIHP has facilitated a conference to address the recovery of women with SUD in the region. The goal of this event is to introduce women to the myriad of resources that are available to them and their families, while they are addressing their SUD recovery.

The PIHP has identified the following objectives to meet the above goal: provide education and support for SUD providers on the assessment of women of childbearing age upon admission for WSS, continue to facilitate the Women's Recovery Conference annually, and support training and education about the impact of SUD on women and their children. These objectives will be monitored by the evaluation of PIHP Open Admission Report data and measurement of PIs.

5. Increase Access to Treatment Services for Adults Supervised by the Department of Corrections who are Returning to their Communities

Individuals who are returning to their communities following incarceration are at an increased risk of SUD, as discussed in narrative *1.B*. Under an arrangement between the MDOC and MDHHS, the PIHP's designated providers are responsible for medically necessary community-based SUD treatment services for enrollees under the supervision of the MDOC once those enrollees are no longer incarcerated. It is the goal of the PIHP that those returning to their communities following incarceration are able to access the essential treatment services necessary to maintain recovery and reduce recidivism rates.

[22] NIDA. Principles of Effective Treatment (05.29.20) [website] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment

[23] Michigan Resident Inpatient Files. Division for Vital Records and Health Statistics. Bureau of Epidemiology and Population Health, MDHHS. 2017 *Neonatal Abstinence Syndrome (NAS)*

Objectives to meet the above goal include providing guidance to the providers to ensure they are aware of this priority population and enhancing provider abilities to serve this population through training and support. These objectives will be monitored by the evaluation of PIHP Open Admission Report data.

6. Combat the Effects of the Current COVID-19 Pandemic

While the long-term impact of COVID-19 on SUD Treatment Programming is unknown, data indicates alcohol sales increased significantly during the pandemic.[24] The PIHP has begun experiencing an increase in the number of individuals reporting alcohol as their primary drug of choice at admission. It is anticipated that this trend will continue, as will the increasing demand for services to address Alcohol Use Disorder (AUD). Withdrawal from alcohol can be fatal and requires a skilled clinician to determine the best course of action. Detoxification facilities will need continued support for this type of treatment and additional training on EBPs to treat these individuals.

Objectives to meet the above goal include increasing support for detoxification facilities and their staff in the EBPs for alcohol withdrawal through training and providing support for an anti-stigma media campaign surrounding the treatment for AUD. These objectives will be monitored by the evaluation of PIHP Open Admission Report data.

3. The PIHP's Key Prevention, Treatment and Recovery Providers and Stakeholders

As stated in PIHP *Policy #06-02-01: Collaborative Work between Health Care*, the PIHP is committed to collaborating with local public and private community- based organizations and health care providers to address prevalent human conditions and issues that relate to a shared customer base to provide a more holistic health care experience for the individual. Collaboration takes place in formal partnered agreements among service providers/ practitioners that result in coordinated systems of care, as detailed within a person's comprehensive plan of service.

In addition, the PIHP coordinates with several of the regions public and private service delivery systems by participating in various coalitions across the region. The face-to-face relationships with many of these stakeholders occur through local community collaborative bodies where community need, including mental health (MH) and SUD, are discussed and relationships are built. The PIHP strives to have strong relationships with key public and private sector community stakeholders in the region. The PIHP's relationships with key stakeholders are an imperative component of treatment and prevention capacity, as stakeholders are a key to increased resources.

For prevention, the PIHP has partnered with many community organizations, such community coalitions, law enforcement and school districts, who are working to reduce the impact of substance abuse and other harmful behaviors in their communities and combined efforts and resources are critical to meeting the PIHP's priority prevention goals. Refer to *Attachment I, pg.*

[24] The Nielsen Company (05.07.2020) *Rebalancing the "COVID-19 Effect" on Alcohol Sales*.

9- Table N. for a comprehensive list of stakeholders with whom the PIHP has formed a relationship.

For treatment, the PIHP has partnered with key service providers and stakeholders in the region, such as rehabilitation centers, Federally Qualified Health Centers, and law enforcement, to create a robust provider network of treatment services. Contracts, letters of agreement (LOAs), and memorandums of understanding (MOUs) demonstrate the collaboration that is occurring between these providers/stakeholders and the PIHP. During each fiscal year, these LOAs and MOUs will be reviewed to ensure they are accurate and up to date. The PIHP will work to ensure that all stakeholders and providers outlined in this plan are included in the review. Refer to *Attachment I, pg. 7, Table J* for a comprehensive list of the PIHP's contracted SUD prevention and treatment providers.

4. The PIHP's Key Decision-Making Processes

As stated in the PIHP's *Policy #01-01-01: Region 10 PIHP Board*, the PIHP is governed by a 15-member Board of Directors that provides leadership, governance, and oversight of the region. The Region 10 PIHP Board is made up of Community Mental Health Board members and citizens at large from each of the four covered counties. The PIHP Board has significant representation by people recovering from (and/or family members of people recovering from) mental health and substance use conditions. The PIHP Board has the primary responsibility to manage the Medicaid Specialty Services and Supports and SUD Services for the region. The Board is a policy setting body, the fiduciary of the Medicaid funds for the region and holds the Medicaid Specialty Services and Supports contract with the MDHHS.

As stated in the PIHP's *Policy #01-01-03: Substance Use Disorder Oversight Policy Board*, the SUD Policy Oversight Board is charged with the approval of any SUD budget containing local funds for treatment or prevention of SUD. The composition of the SUD Policy Oversight Board requires representation from each county in the region. The SUD Policy Oversight Board provides advice and recommendations to the PIHP Board for SUD prevention and/or treatment services and contracts using other non-local funding sources. In addition, the SUD Policy and Oversight Board reviews data from the Consumer Satisfaction Questionnaire (CSQ) regularly.

5. The PIHP's Prevention and Treatment Logic Models

The Prevention Logic Model created by the PIHP includes: identification of the consequences of the primary SUD problem the region is attempting to prevent, intervening variables (risk and protective factors) impacting the problems, objectives for remedy, activities to employ for immediate and long term outcomes, and counties where the activity will occur. The Prevention Logic Model was created based on relevant epidemiological data. Refer to *Attachment I, pgs. 10-14 Tables O.- S.* for the completed Prevention Logic Model.

The Treatment Logic Model created by the PIHP includes: identification of the primary SUD problem(s) impacting the region based on epidemiological data; identification of strategies to employ to impact the SUD problem(s), listing of activities leading to immediate outcomes, listing of outputs from the activities, intermediate and long term outcomes, and counties

where specific activities will occur. Refer to *Attachment I, pgs. 15- 18 Tables T.- W.* for the completed Treatment Logic Model.

As the PIHP developed both the Prevention and Treatment Logic Models, careful consideration was given to identifying EBPs, along with policies and practices that would address the region's service array necessary to support recovery. The completed logic models are a result of considering common risk and protective factors contributing to SUD and MH disorders and its consequences, analyzing substance use and treatment data for each county within the region, assessing the current array of provider services, and determining gaps of services. Continued needs assessment will be conducted to identify additional service needs and then identify appropriate evidence-based programming for implementation within the region's ROSC.

The PIHP consulted the MDHHS "*Guidance Document: Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders*" in the creation of the logic models. In addition, programming being implemented by current providers was reviewed and assessed for best fit with the service population and identified priority area. It is a goal of the PIHP that EBPs be implemented in a ROSC. The MDHHS Guidance Document will be utilized for an increased ability for local prevention planners to critically assess prevention interventions based on the strength of evidence that an intervention is effective, to implement EBPs with a balance between fidelity and necessary local adaptations, and to demonstrate the relationship between evidence and achieving outcomes.

6. The PIHP's Allocation Plan

The following narratives, *6.A.- 6.F.*, describe the provision of the PIHP's allocation plan, derived from input of the SUD Policy Oversight Board for funding a ROSC. The allocation plan includes both prevention and treatment initiatives necessary to support recovery in the identified communities of greatest need consistent with the data-driven, needs-based approach and EBPs. The PIHP agrees to abide by the provision that at least 20% of Community Grant funding will be set aside for prevention services. In addition, the PIHP agrees to allocate funding to implement a full continuum of EBPs for individuals who are seeking treatment and recovery support services in the region. The PIHP will maintain and enhance the provider panel for SUD prevention and treatment services. Priority populations will be served according to the appropriate guidelines. Lastly, the PIHP agrees to implement a plan for a trauma informed system of care.

- **6. A. The PIHP's Commitment to a 20% Prevention Allocation and Environmental Change**

As stated in the contract between MDHHS and the PIHP, the PIHP agrees to abide by the provision that at least 20% of Community Grant funding will be set aside for prevention services. The PIHP plans to focus on primary prevention targeting environmental change, prevention and health promotion, and coordination of care with Primary Care Providers (PCPs) over the next 3 fiscal years.

The PIHP is currently pursuing workforce development related initiatives in SUD prevention and treatment services. The PIHP actively monitors the need for trainings and requests feedback from

current prevention and treatment staff about training concerns. In an effort to promote and support continued workforce development, the PIHP forwards information about upcoming free/low-cost trainings specific to skills and Michigan Certified Board of Addiction Professionals (MCBAP) requirements to all prevention providers. The PIHP will continue to do this over the next 3 fiscal years.

Prevention and health promotion are areas that the PIHP's prevention providers have been focusing on since 2015. The EBPs for which funding is planned not only address substance abuse prevention, but also many areas of physical health and/or mental health promotion. Continuing to utilize EBPs with a focus on primary prevention that addresses the shared risk and protective factors for both mental health and substance abuse is something that the PIHP will continue to pursue and implement. Some of the shared risk and protective factors that our EBPs address include one's ability to control emotions/behaviors, effective communication, positive self-esteem, ability to use coping and problem-solving skills, parental involvement including monitoring and clear expectations expressed on behavior/substance use, and policies limiting youth access to substances. Key stakeholders in the community, such as local health departments and medical facilities, also support our quest for health promotion. While the PIHP does not contract with Primary Care Physicians (PCPs), coordination of care is provided on all levels of SUD treatment service.

The PIHP is not aware of any active tribal entities in the region. If this changes over the course of the next 3 fiscal years, the PIHP will create a plan to collaborate with the tribal entity.

- **6. B. The PIHP's Intent to Allocate Funding to EBPs**

The PIHP continues to assess EBPs and policies to identify the service array necessary in support of best-practices for prevention, treatment, and recovery. The PIHP is contracted with prevention service providers throughout the region to implement EBPs. Strategies, including alternative, community based, educational, environmental, information dissemination, and problem identification and referral will continue to be implemented by contracted prevention service providers and coalitions to meet the priority prevention goals identified. Refer to *Attachment I, pg. 19- Table X.* for a comprehensive list of the EBPs implemented throughout the region.

- **6. C. The PIHP's Commitment to Provider Maintenance and Enhancement**

The PIHP strives to maintain and enhance our SUD Treatment and Prevention Provider Network through regular communication, training, and collaboration. The majority of the PIHP's current SUD Providers began engaging with the PIHP at its inception. Contract monitoring is facilitated by PIHP staff throughout each contract period. This extensive monitoring process includes desk audits for the review of written materials and in-person visits at the facility with the provider. The PIHP hosts regularly scheduled provider network meetings, which include all providers and allow for direct communication between all parties. These meetings incorporate presentations on trending topics of concern or interest in the region. Multiple PIHP staff members are in attendance to ensure that questions and concerns are addressed efficiently and effectively.

The PIHP has identified a deficit of SUD Providers in Sanilac and Lapeer counties, as compared with the other two counties. As previously stated, the PIHP is interested in expanding community partnerships and relationships with key stakeholders in rural communities in an effort to increase access to prevention and treatment services in rural communities.

- **6. D. The PIHP's Commitment to Serve Priority Populations—Waitlist**

As stated in the PIHP's Policy *#05-01-04: SUD Waitlist,* the PIHP is committed to providing access to treatment services for priority populations, first and foremost. These populations include, but are not limited to, pregnant women, injecting drug users, parents at risk of losing their children due the effects of SUD, and adults supervised by the Department of Corrections who are returning to their communities. The PIHP has established a waitlist policy as required by federal block grant rules. In accordance with federal requirements, the PIHP will report on programs providing treatment for priority populations.

The PIHP operates an Access Management System (AMS) via two Access Centers. The Flint Access Center and the Port Huron Access Center operate within PIHP policies pertaining to Utilization Management, Clinical Practice Guidelines, Access Standards, and Customer Services Standards, as directed within the MDHHS contract with the PIHP. Waitlist responsibilities are maintained directly within AMS operations, as the PIHP policy specifically outlines the requirements and monitoring of waitlist practices. In conjunction, monitoring of the SUD provider waitlist process/procedures also takes place through the AMS.

- **6. E: The PIHP's Evidence of Problem Knowledge**

Evidence of the PIHP's knowledge of regional SUD problems is based on the data analysis provided in narrative *1.D*. After review of relevant local, regional, state, and national data, the PIHP developed the Prevention and Treatment Logic Models (see *Attachment I, pgs. 11-19- Table O.- W.)* which specifically address the known SUD problems in the region. Funding of local prevention and treatment efforts through the PIHP's allocation plan requires the utilization of EBPs. This includes programs such as Guiding Good Choices, Botvin Life Skills, Motivation Interviewing, etc. (see *Attachment I- pg. 19- Table X.).*

- **6. F: The PIHP's Plan for Trauma Informed Care**

As stated in the PIHP's Policy *#05-01-01: Access to Services,* the PIHP's Access Centers are staffed by professionals who are trained in trauma informed care practices. The PIHP promotes pathways to recovery that reduce stigma and recognize resiliency and the strengths of persons served and their natural supports. The PIHP's AMS fully complies, in policy and practice, with MDHHS philosophies of person-centered, self-determined, recovery oriented and trauma-informed care in the least restrictive environments possible. SUD prevention and treatment programs across the region provide services that are trauma informed. The PIHP supports training initiatives for trauma informed care services for individual clinicians serving the region.

The PIHP's annual Women's Recovery Conference focuses on trauma informed care practices. In addition, *Seeking Safety* is an example of an EBP that is utilized by several PIHP SUD

providers in the region. SUD providers continue to express interest in expanding trauma informed programing and include trauma informed trainings as part of their training plans.

7. Implementation Plan and Timeline

While the PIHP currently has a comprehensive provider network in the region, expansion and development of capacity is an on-going task. See *Attachment I, pg. 20, Table Y.* for the PIHP's implementation task-list, including completion dates, for key prevention, treatment, and recovery service goals.

8. The PIHP's Evaluation Plan

The following narratives *8.A.- 8.E.* describe the PIHP's evaluation plan for identifying baseline, process and outcome data for implementing a ROSC that includes prevention and treatment, as well as all other services necessary to support recovery. For prevention, the PIHP identified the proposed outcomes of prevention goals, as well as the percentage of EBPs implemented in the region. For treatment and other recovery services, the PIHP identified evaluation mechanisms to track performance in health and safety, administration, and treatment penetration rates for selected populations. The PIHP also included an evaluation plan for measuring the outcomes of WSS and for treatment of persons with OUD.

- **8. A. Prevention Services**

To ensure completion of the proposed outcomes identified in the Prevention Logic Model (see *Attachment I- pg. 10-14- Table O.- S.)*, the Strategic Prevention Framework (SPF) will be utilized. The SPF includes needs assessment, capacity review, planning, implementation, and evaluation. The PIHP will use regional data, including the PIHP Open Admissions Report and regional MiPHY data to assess need throughout the region and build capacity for prevention services. The PIHP strategic plan will serve as guidance to identify appropriate CSAP strategies to meet priority prevention goals. Per the Michigan Prevention Data System (MPDS) Manual, 90% of all prevention services implemented will be EBP. Process outcomes will be evaluated for all prevention services through satisfaction surveys. Immediate and long-term outcomes will be evaluated through EBP pre/post tests and regional MiPHY data. Synar retailer violation rates will be used to evaluate YTA activities. The PIHP will continue to contract with prevention service providers to administer the MPDS outcome survey. The PIHP will use the process and outcome data collected to direct prevention service delivery throughout the region.

- **8. B. Preventing Youth Access to Tobacco**

The process used to determine the consequences and intervening variables associated with youth access to tobacco involved review of past Synar compliance data, non-Synar compliance data, and overall retailer response to vendor education activities. In addition, the PIHP considered youth and adult smoking rates within the counties of the region. The data indicates that retailers are selling tobacco products to youth under the age of 18, and research has identified that the

availability of tobacco products to youth leads to increased nicotine addiction among teens and adults.[25]

In December 2019, the Federal Food, Drug, and Cosmetic Act was amended raising the federal minimum age of sale of tobacco products from 18 to 21 years. The PIHP will stay apprised of any changes to the YTA and will adjust Synar protocol according to MDHHS guidance. Synar protocol will remain the same, with the exception of Electronic Cigarettes/EVPs also being requested during routine Synar inspections beginning in FY20. Continued vendor education and compliance checks will be employed with the retailing segments shown most likely to sell, with special emphasis on convenience stores and gas stations. Other tobacco retailers will be identified through random sampling of each county's master retailer list. The PIHP plans to fund non-Synar and vendor education for 25% of the region's retailers.

- **8. C. Treatment and Recovery Evaluation Mechanisms**

The PIHP employs the following evaluation mechanisms to track performance of treatment and other recovery services:

- Health and Safety: SUD provider programs are required by the PIHP's *Policy #07-01-03: Sentinel Events, Critical Incidents and Risk Events* to have processes in place to conduct risk management, including the reporting and monitoring/evaluation of critical incidents, reporting and monitoring/evaluation of unexpected deaths, and reporting of sentinel events to the PIHP Sentinel Events Review Committee (SERC). The SERC and the PIHP Contract Management Department ensure accurate and timely reporting by provider programs within the SUD network, and conduct follow-up reviews when necessary.

- Administration: As stated in the PIHP's *Policy #04-01-01: Budgeting*, the PIHP is committed to using a Budget Process Tool that creates stability and consistency regarding the planned distribution of funds to support agency operations. A budget, in conjunction with short-term and long-term program planning, allows for the maximum utilization of public funds to support clinical and clinical support programs. In addition, the PIHP's *Policy #04.02.01: Auditing* states that the PIHP will maintain a system of financial monitoring, control and reporting for all operations and funds in order to provide effective means of ensuring that the overall PIHP goals and objectives are met.

[25] Youth and Tobacco Use. (2019, December 10). Centers for Disease Control and Prevention.[website] https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm (accessed 06.2020)

- Treatment Penetration Rates: The PIHP will continue to monitor treatment penetration rates for youth and young adults, women of childbearing age, minorities, and persons with OUD to ensure the threshold for penetration is met.

In conjunction, the PIHP's *Policy #01-05-01: Utilization Management Programs* states that the PIHP operates within a Quality Assessment and Performance Improvement Program (QAPIP) that includes an Improving Practices Leadership Team (IPLT). A key operational area within the IPLT is to identify and support the implementation of both MH and SUD EBPs throughout the region. This structure ensures an informative and supportive share-and-learn process. A second key operational area within IPLT is its monitoring the utilization of Clinical Practice Guidelines (CPGs) established for the PIHP. In this regard, the FY19 Biannual CPG evaluation report assessed and updated all SUD CPGs, which included ASAM level of care guidelines and SUD best practices promulgated by the American Psychiatric Association. Also included in the report was an annual-effectiveness evaluation of MAT guidelines. Further, the PIHP Utilization Management (UM) Program conducts a variety of Utilization Review (UR) activities. The UM Program conducts prospective and concurrent UR through the AMS, including monitoring of SUD second opinion reviews. All Access clinicians receive training in ASAM and, in addition to LARA regulations for SUD practice credentials, all SUD programs are required by the PIHP to provide co-occurring capable treatment. The PIHP's UM Committee oversees annual retrospective UR on sampled SUD case records to help ensure effective recovery-based clinic practices, ASAM-informed level of care, and adherence to medical necessity criteria.

- **8. D. Women's Specialty Services**

As stated in the PIHP's *Policy #05-03-06: SUD Women's Specialty Services,* the PIHP is committed to having care delivery guidelines for SUD WSS, in accordance with the MDHHS policies and contract. Federally mandated SUD services are made available to the priority populations of pregnant women, women with dependent children, and women attempting to regain custody of their children

The PIHP has 4 designated WSS Programs which include: Sacred Heart Rehabilitation Center, Flint Odyssey House, Holy Cross Counseling Services, and Alcohol Information and Counseling Center. The PIHP's WSS Programs provide a variety of treatment and recovery services including residential, intensive outpatient, outpatient, and recovery housing. The PIHP has increased its capacity to ensure women can access the appropriate treatment and recovery services, as needed.

The PIHP contracts with high quality WSS providers that have a strong desire and commitment to facilitate the best services available to the women and children in the region. The PIHP's WSS providers encourage women to participate in the annual Women's Recovery Conference.

While the PIHP has a full continuum of care available to women seeking services, the PIHP recognizes that there is no WSS program in Sanilac County. As previously discussed, rurally located individuals face additional barriers to treatment in the region. The PIHP will encourage the availability of gender competent practitioners in Sanilac County.

The PIHP will continue to conduct annual site visits and contract monitoring of WSS programs. In accordance with PIHP *Policy #01.06.05: Credentialing and Privileging*, the PIHP will facilitate organizational and induvial credential reviews of all of those providing SUD services, including those with a gender competent designation and approved to provide WSS. WSS providers are required to submit information on an annual basis regarding unduplicated treatment services provided, designated specialty program information, outcome information, program information including any changes made to their program or services over the past year, and specific improvement areas.

- **8. E: Opiate Dependence Service Availability**

The PIHP has multiple locations throughout Genesee, St. Clair and Lapeer counties that are contracted to provide pharmacological support services to persons with OUD. Genesee Community Health Center (GCHC) combines primary health care and Suboxone services. Psychosocial supports and case management will continue to be offered at the GCHC Integrated Physical and Behavioral Healthcare Clinic. In partnership with GCHC, New Paths Sobering Facility and Recovery Coaches, a service is being offered as an alternative to the utilization of Methadone treatment. Individuals with opiate dependence are screened at GHS, offered the option of receiving the assistance of a Recovery Coach and medication to support withdrawal. This has shown to be a clinically effective as well as low in cost. In addition, the PIHP funds the newly developed and innovative Opioid Overdose Recovery Program (OORP) serving Genesee County, and Project ASSERT serving St. Clair County. Program outcomes shall be reviewed to assess long-term effectiveness.

The PIHP will continue to evaluate new approaches to pharmacological support services during the next 3 fiscal years. The PIHP currently facilitates a MAT Workgroup which includes MAT providers and the PIHP's SUD administrative staff. This group discusses SAMHSA MAT Guidelines, how they are being implemented within their respective agencies, and gaps in MAT services in the region. The PIHP has developed a contract monitoring tool that identifies key factors found within the MAT Guidelines. This tool will continue to be used for the review of current policies and practices of MAT providers to ensure the completion of outcomes identified in the Treatment Logic Model (see *Attachment I- pg. 15- Table T.).*

9: Cultural Competency

The PIHP's Policy #05-01-03: Cultural Competency establishes the expectation of providing culturally appropriate services to all individuals. The PIHP's SUD network providers are expected to promote mutual respect and awareness of people of varied cultures. Each provider is required to assess its overall program structure and identify if there are cultural issues in any specific program or for an individual within a program. Identification of and training on cultural issues will be on-going and will often occur at the individual program / person level. Providers will ensure pictures, posters, artwork, reading materials, brochures and videos reflect the diversity of cultures represented in the service area. Lastly, providers will communicate with people in the most functional way to accommodate their cultures.

Prevention and Treatment contracts between the PIHP and providers require Cultural Diversity training for all employees at initial hire. Training includes, but is not limited to, diversity issues in the workplace, embracing differences, an understanding what each unique person brings to an organization. Providers are required to maintain a copy of training attestation and completed exam or training certificate, if applicable. Compliance with the PIHP's Cultural Competency Policy is evaluated during annual contract monitoring and site visits for all SUD network providers. The PIHP intends to examine racial disparities more thoroughly in access to and experience with SUD treatment. Additionally, providers will be encouraged to look at methods to identify and address implicit bias across the PIHP's network.

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