WEEKLY UPDATE

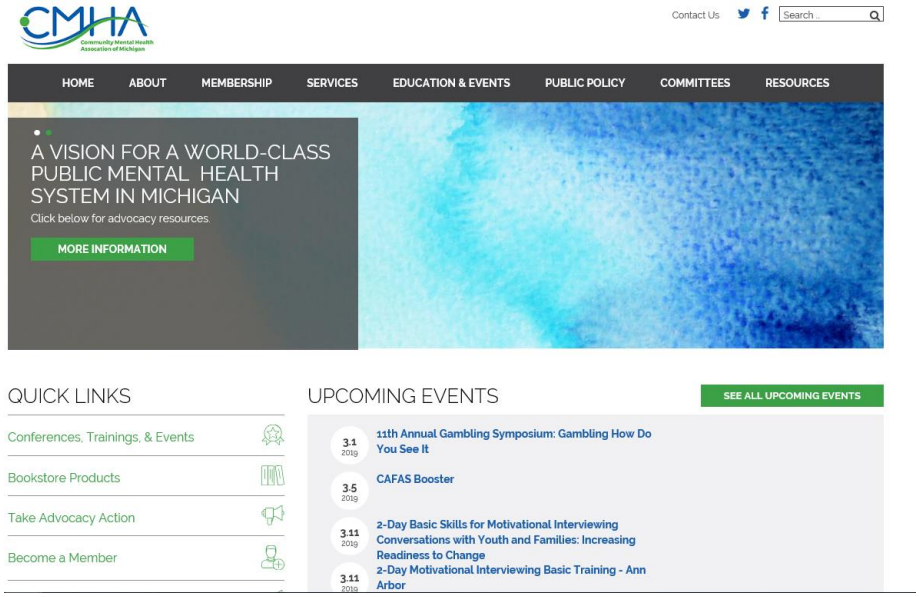
March 8, 2019

Contents:

CMH Association and Member Activities:

CMH Association of Michigan Launches New Website

The Community Mental Health Association of Michigan recently launched its new website. The website (the cover page of which is pictured below), is greatly modernized with a fuller range of features – from information and registration for hundreds of professional development and education offerings to access to white papers from the Association's Center for Healthcare Integration and Innovation (CHI2), from contact information on the Association's members and staff to access to the Association's Weekly Update.



The new website can be found at: https://cmham.org/

Southwest Solutions announces 2nd annual Celebration of Impact

From Southwest Solutions, a member of the CMH Association of Michigan:

Save the date: Our second annual Celebration of Impact event will take place:

Friday, September 13 at 6PM
MGM Grand Detroit Hotel

Last year's event sold out and was a great success. We're building on this momentum and raising the bar - with another compelling and fun gala to celebrate the mission-based work of Southwest Solutions to improve lives and neighborhoods in our community.

Because we expect this year's event to sell out also, we encourage you to purchase your tables and tickets early. You can do so through this online form.

Sponsorship opportunities are now available, too. Please call Linda at 313-297-1376 .

As we get further along in our planning, we'll provide more information about the event, including the social impact leaders we'll be honoring this year.

CMHAM Committee Schedules, Membership, Minutes, and Information

Visit our website at **https://www.cmham.org/committees**

News from Our Corporate Partners:

Relias announces maternal opioid use webinar

Are You Preparing to Participate in the Maternal Opioid Misuse (MOM) Model and Funding?

You should be. The MOM model is the next step in the Center for Medicare and Medicaid Innovation's multi-pronged strategy to combat the nation's opioid crisis. The model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce costs for mothers and infants.

Join our expert presenters, Dr. Joe Parks and Dr. Carol Clayton, for an informative webinar: Combating Maternal Opioid Misuse (MOM) Model: The Role of Innovation and Technology

This webinar will cover:
Information about the MOM model and funding
Statement of the problem relative to maternal and child health immediate and long-term risks
Challenges associated with linkages across the needed continuum of care
Evidence-based solutions for strengthening the linkages with actual case study outcomes
How Relias can help state agencies and provider systems get better at addressing this concern

Register today: http://go.reliaslearning.com/WBN2019-03-12CombatingMaternalOpioidMisuseMOMModel_Registration.html?utm_source=marketo&utm_medium=email&utm_campaign=wbn_2019-03-12_combating-maternal-opioid-misuse-

model_opioids&mkt_tok=eyJpIjoiTmpZM1ptVmpaakJpWVRsbSIsInQiOiJ4NWIzYzk1aFwvY3cyTWhsaUdxSkRSbzJUSFI6eDhPelZIRzFxa1ZxMllmSHZlZUtFc3dKKzJwM1pZcERHZE5jTjV3Nm5aSm8wc3BkNkRVaVd4dEpRZTBicWhuM3l0WnpmWVVEenRuOXczVlduQjVQejd0U3NnbjQ5Vk96VG9xdituVjZqVmU1V052NGM4T2JIdTNTbzF3NkxaUFwvUHdjVnR1Q05BdXFxUFdzYz0ifQ%3D%3D

If you can't attend the live event, we will send you the recording and slides!

State and National Developments and Resources:

Change Leader Academy Available to CMH Association Member

Great Lakes (HHS Region 5)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

The nationally known *NIATx* Change Leader Academy (CLA) is a **one-day face-to-face workshop followed by three months of peer networking and support from a NIATx coach**. The CLA trains change leaders in the *NIATx model of process improvement*: a structured, team-based approach to change management for organizations large and small.

With support from peer and a NIATx Coach, CLA participants will select a change project, set a project aim, engage senior leaders and staff in the change process, and achieve measurable, sustainable improvements. Past CLA participants have led successful projects to:

- Reduce waiting time between first request for service and first treatment session
- Reduce no-shows by reducing the number of patients who do not keep an appointment
- Increase admission to treatment
- Increase continuation from the first through the fourth treatment session

Who Should Attend?
Anyone interested in leading change, improving service delivery, or guiding staff to do the same: senior leaders, managers, supervisors, and front-line staff are all encouraged to attend. The CLA provides both beginners and those with some experience in process improvement with the tools to lead change projects within their organization. Organizations may send **up to five representatives**; change projects are most successful when organizations send a small, diverse team.
When and Where?

The CLA will kick off with a face-to-face workshop this **May**. A registration fee of **less than $150 per person** will cover:

- Registration for the face-to-face kick off
- Three months of individualized coaching and support from national NIATx/CLA consultants
- 4.5 CEUs

We want to hear from you about how many people from your organization are interested and where you would prefer the training be held. Please follow this link to provide your feedback by Friday, March 15: https://www.surveymonkey.com/r/XRX696K

Learning Objectives & Deliverables:

At the end of the workshop, participants will be able to:

- Explain the NIATx principles and change model to team members and begin a change project.

- Use four, key quality improvement tools - the walk-through; flowcharting; the nominal group technique; and Plan-Do-Study-Act (PDSA) rapid cycle testing.
- Commit to carrying out a 3-month change project in their organization with one NIATx coaching call and three peer learning follow-up calls.
- Offer a standard approach to process improvement in their agency and begin to develop staff to be change leaders and engaged, change team members.

Don't miss this opportunity! Visit https://www.surveymonkey.com/r/XRX696K to confirm your interest by Friday, March 15.

Questions? Contact Chris Ward at cward@cmham.org

Suicides, often linked to opioids, spike in rural Michigan and among young

Below are excerpts from a recent Bridge article on the findings of a recent study of opioid use in Michigan.

> About every five hours, a Michigan resident dies by suicide. Fatal drug overdoses happen even more frequently.
> New research by the University of Michigan suggests an upsurge in opioid overdoses and suicides may be linked. This finding suggests that public health specialists may need to reexamine their approach to policies intended to prevent such tragedies.
>
> Unlike other common causes of death, overdose and suicide deaths have increased over the last 15 years in the United States," Amy Bohnert, associate professor of psychiatry at the University of Michigan Medical School, told Bridge in an interview.
>
> Both outcomes share "factors that increase risk for each. (and) support the idea that they are related problems and the increases are due to shared fundamental causes."
>
> Bohnert co-authored the study by U-M and the Veterans Affairs Center for Clinical Management Research, published in January in the New England Journal of Medicine. Across the U.S., deaths from suicide and unintentional overdoses went from a combined 40,000 in 2000 to over 110,000 in 2017, a rise of 168 percent.
> The spike has been even more pronounced in Michigan – rising three-fold from 1,100 to 3,300 over this same period, a disturbing mosaic of suffering across Michigan that treatment policies have failed to slow.
> Large rural swaths of the Upper Peninsula and northern Lower Peninsula saw the highest suicide rates – in some counties, double the state average. Fueled by the opioid crisis, southeast Michigan urban areas like Wayne, Macomb and St. Clair counties led the state in overdose deaths from 2015 through 2017.

The full report can be found at:
https://www.bridgemi.com/children-families/suicides-often-linked-opioids-spike-rural-michigan-and-among-young

MDHHS releases latest report on potential for a Managed Long-term Services and Supports Program

Below are excerpts from a recent press release, from MDHHS, regarding the Department's recently completed study of what could become Michigan's Medicaid Long Term Services and Supports (LTSS) program. Representatives of this association and a number of our members were interviewed by the research team that developed this report.

The Michigan Department of Health and Human Services (MDHHS) has released the latest report on its investigation into the possibility of establishing a Managed Long-term Services and Supports (MLTSS) Program.

In 2017, the Michigan Legislature requested the department explore operational implications and possible implementation of a managed system for long-term care throughout the state. MDHHS enlisted the assistance of the Center for Health and Research Transformation, Public Sector Consultants and Health Policy Matters to conduct research and analysis. The report details the initial three phases of that work.

The report, Michigan Medicaid Long-term Services and Supports, reviews the existing landscape of Medicaid programs and presents ideas from a broad group of stakeholders gleaned through a survey and individual interviews. Quality metrics are analyzed relative to national standards and a gap analysis is presented to highlight potential areas of improvement in the existing Medicaid programs. Finally, the report provides potential options for the state to consider in terms of program structures, implementation strategies and timeline recommendations.

Going forward, Michigan will begin looking at designing and implementing opportunities for improvement in existing LTSS systems, such as options counseling, comprehensive assessments, person-centered planning and a quality strategy; convening stakeholder work groups for each of the improvement opportunities; and evaluating the MI Health Link demonstration program as a possible MLTSS model.

For more information about an MLTSS system in Michigan, visit Michigan.gov/mltss. Questions may be emailed to MDHHS-MSA-MLTSS@Michigan.gov

The full report can be found at: https://www.michigan.gov/documents/mdhhs/MLTSS_Phase3_FinalReport_12-14-18_Rev_3_19_647943_7.pdf

Landmark ruling against private health insurance plan for denying mental health and substance use disorder treatment

Below are excerpts from recent announcements from Pych-Appeal (one of the plaintiffs in the case) the Kennedy Forum (the nation's leader in advocacy around mental health insurance parity) regarding a recent ruling in Federal District Court against one of the nation's largest health insurance company/health plan for its denial of mental health and substance use disorder services. This ruling is being hailed as a landmark ruling, signaling a new day in the efforts, by many of us, to ensure needed access to mental health services, on par with physical health services. **The length of the description provided in this edition of Weekly Update is reflective of the importance of this ruling.**

Psych-Appeal notice of the court ruling: write to inform you of a landmark mental health ruling. Today, in a nationwide class action suit, the United States District Court for the Northern District of California held that United Behavioral Health ("UBH/Optum"), the country's largest managed behavioral healthcare organization, illegally denied mental health and substance use coverage based on flawed medical necessity criteria.

The federal court found that, although required by the class members' health plans to make coverage determinations consistent with generally accepted standards of care, UBH developed restrictive medical necessity criteria with which it systematically denied outpatient, intensive outpatient, and residential treatment. Specifically, the federal court found that UBH's internal guidelines limited coverage to "acute" care, in disregard of highly prevalent, chronic, and co-occurring disorders requiring greater treatment intensity and/or duration. The court was particularly troubled by UBH's lack of coverage criteria specific to children and adolescents. Additionally, the court held that UBH misled regulators

about its guidelines being consistent with the American Society of Addiction Medicine (ASAM) criteria, which insurers must otherwise use in certain states such as Connecticut, Illinois, and Rhode Island. (The court also found that UBH failed to apply Texas-mandated substance use criteria for at least a portion of the class period.)

Although the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires parity for mental health and substance use benefits, insurers are permitted to evaluate claims for medical necessity. By applying internal guidelines or medical necessity criteria developed by for-profit, non-clinical specialty associations, however, insurers can easily circumvent parity in favor of financial considerations and prevent patients from receiving the type and amount of care they actually need. The consequences to patients can be devastating.

In his detailed ruling, Chief Magistrate Judge Joseph Spero found the following to be the generally accepted standards for behavioral healthcare from which UBH's guidelines deviated:

- It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms;
- It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care;
- It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective – the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care in addressing a patient's overall condition, including underlying and co-occurring conditions;
- It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care;
- It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration;
- It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment;
- It is a generally accepted standard of care that the unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders;
- It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.

The court acknowledged that accreditation by organizations such as URAC and NCQA does not entail substantive review of medical necessity criteria developed by insurers. Therefore, such accreditation does not guarantee use of medical necessity criteria that are consistent with generally accepted standards for behavioral healthcare or with the terms of insurance policies or any laws.

In light of the court's findings, including that UBH's experts (comprised of several of its own medical directors) "had serious credibility problems" and "that with respect to a significant portion of their

testimony each of them was evasive – and even deceptive," robust safeguards against abuses by managed behavioral healthcare organizations are clearly warranted, such as:

Legislation mandating exclusive adherence to medical necessity criteria developed by nonprofit, clinical specialty organizations such as the American Society of Addiction Medicine (ASAM), American Academy of Child and Adolescent Psychiatry (AACAP), and the American Association of Community Psychiatrists (AACP);

Formal recognition by the American Psychiatric Association that managed care psychiatric reviewers owe a primary ethical obligation to insureds, consistent with:
AMA Principles of Medical Ethics: I,III,VII and AMA Code of Medical Ethics Opinion E-10.1.1 (https://www.ama-assn.org/delivering-care/ethical-obligations-medical-directors) and
their fiduciary duties under ERISA (https://www.dol.gov/general/topic/retirement/fiduciaryresp).

Today's ruling stems from two consolidated class actions, Wit et al. v. United Behavioral Health. and Alexander et al. v. United Behavioral Health, brought by Psych-Appeal, Inc. and Zuckerman Spaeder LLP under the Employee Retirement Income Security Act of 1974 ("ERISA") in 2014, certified in 2016, and tried in October 2017. While the certified classes encompass tens of thousands of ERISA insureds, non-ERISA insureds (such as governmental employees) adversely impacted by UBH's defective guidelines must rely on state and federal regulators to intervene on their behalf.

Kennedy Forum notice of the court ruling: Chief Magistrate Judge Joseph Spero of the United States District Court for the Northern District of California has found that United Behavioral Health (UBH), the largest managed behavioral health care company in the country, developed review criteria for evaluating the medical necessity of claims for outpatient, intensive outpatient, and residential treatment of mental health and substance use disorders that was inconsistent with generally accepted standards of behavioral health care, and wrongly influenced by a financial incentive to suppress costs.

In Wit v. United Healthcare Insurance Company, 11 plaintiffs, on behalf of over 50,000 patients whose claims were denied based on flawed review criteria, sued UBH. Natasha Wit sought coverage for treatment of a number of chronic conditions, including depression, anxiety, obsessive-compulsive behaviors, a severe eating disorder and related medical complications. UBH repeatedly denied treatment using its flawed criteria. Like other families experiencing such denials, the Wit family paid nearly $30,000 out-of-pocket for Natasha's treatment, despite having health insurance coverage.

The class action lawsuit, litigated by Psych-Appeal, Inc. and Zuckerman Spaeder, LLP, and filed under the Employee Retirement Income Security Act (ERISA) of 1974 – a federal law that governs health insurance policies issued by private employers – alleged that UBH violated obligations under its administered health plans, and under ERISA, by developing and applying flawed and overly-restrictive guidelines to evaluate "medical necessity."
The Court held in favor of the plaintiffs, stating that under generally accepted standards of care, chronic and co-existing conditions should be effectively treated, including when those conditions persist, respond slowly to treatment, or require extended or intensive levels of care. UBH's review criteria, however, improperly limited coverage in such situations. Instead, UBH's internally-developed guidelines were intended to approve coverage solely for "acute" episodes or crises, such as when patients are actively suicidal or suffering from severe withdrawal.

Additionally, the Court held that UBH's guidelines improperly required reducing the level of care, e.g., removing the patient from residential treatment to some form of outpatient therapy, even if the treating providers – consistent with generally accepted clinical standards – believed maintaining a higher level of care was more effective.

The Court also found that UBH failed to follow specific guidelines mandated by certain states for evaluating the medical necessity of behavioral health services. For example, Connecticut, Illinois, and Rhode Island require that when reviewing substance use disorder claims for medical necessity, insurers must apply criteria consistent with American Society of Addiction Medicine (ASAM) standards.

"This is a turning point in our efforts to hold insurers accountable for discriminating against those with mental health and addiction challenges," notes Patrick J. Kennedy, founder of The Kennedy Forum and DontDenyMe.org, a website that educates consumers about parity rights and connects them to appeals guidance and resources. "This is a landmark case that reinforces the need for equity in how health plans cover physical and mental health conditions," Kennedy adds. "The Federal Parity Law, which is part of ERISA, requires insurers to cover illnesses of the mind no more restrictively than illnesses of the body. But the law is undermined when insurers base mental health denials on defective criteria that masquerade as generally accepted standards of care. Judge Spero's decision makes it clear that there will be consequences for disregarding established clinical practice in favor of a financial bottom line."

With this extraordinary win, the plaintiffs are now tasked with identifying what relief they believe is appropriate. Plaintiffs believe, at a minimum, UBH should revise and adopt new and appropriate guidelines to be upheld by the Court and reprocess class members' claims based on these guidelines. UBH will have a chance to respond. A final decision regarding the requested relief is expected later this year.

Federal legislation to ensure Medicaid coverage to inmates prior to release introduced in Congress

Below are excerpts from a recent media story on the introduction of the Medicaid Re-entry Act in Congress.

Tonko, Turner Reintroduce Bipartisan Addiction Treatment Bill. Grants states power to re-start Medicaid services for inmates 30 days before their release

Representatives Paul Tonko (NY-20) and Michael Turner (OH-10) have formally introduced bipartisan legislation empowering states to expand access to addiction treatment through Medicaid for individuals up to 30 days before their release from jail or prison. The bill, H.R. 1329: the Medicaid Reentry Act, responds to alarming evidence that individuals reentering society after incarceration are 129 times more likely than the general population to die of a drug overdose during the first two weeks post-release.

"Solving America's growing opioid crisis requires that we take bold steps to treat addiction where we find it," said Tonko. "Empowering states to deliver needed addiction treatment to individuals as they transition out of the criminal justice system not only helps combat the spread of this painful disease, it also makes our communities safer, saves money over the long term, and delivers vital services to a truly vulnerable group of people and families, many of whom have lost dearly at the hands of this disease. I am profoundly grateful to my colleague Michael Turner and our colleagues from both parties who have been steadfast in supporting this lifesaving legislation, and I look forward to working with them to advance it through the House."

"When people are incarcerated, they lose access to substance abuse treatment because they become Medicaid ineligible," said Turner. "Providing substance abuse treatment is imperative to overall rehabilitation of any individual and can help prevent both relapse and overdose after exiting prison or jail. I am proud to re-introduce this bill to assist inmates transition back into society successfully as drug-free individuals."
The Medicaid Reentry Act is supported by: American Society of Addiction Medicine, National Council for Behavioral Health, Treatment Advocacy Center, National Association of Counties, Treatment Communities of America, National Health Care for the Homeless Council, National Alliance to Advance Adolescent Health, A New PATH, Global Alliance for Behavioral Health and Social Justice, American

Psychiatric Association, The Kennedy Forum, Young People in Recovery, National Alliance on Mental Illness, Clinical Social Work Association, HIV Medicine Association, Mental Health America, New York Association of Psychiatric Rehabilitation Services, Shatterproof, American Psychological Association, Student Coalition on Addiction, National Association of Clinical Nurse Specialists, College of Psychiatric and Neurologic Pharmacists, Central City Concern

A previous version of this bill sponsored by Reps. Tonko and Turner was signed into law as part of H.R. 6 during the 115th Congress. That bill directed the Department of Health and Human Services to issue guidance to states interested in exploring a policy of this kind in their Medicaid programs, as well as to convene a stakeholder group charged with developing best practices for how state Medicaid programs can improve care transitions for incarcerated individuals.

CMS Launches Podcast to Reach Stakeholders via Modern Platform

Below is a recent announcement by the federal Centers for Medicare and Medicaid Services (CMS) on its production of Medicare and Medicaid policy podcasts:

New podcast "CMS: Beyond the Policy" offers regular episodes that discuss agency updates and policies in a user-friendly medium

Today, the Centers for Medicare & Medicaid Services (CMS) launched "CMS: Beyond the Policy," a new podcast highlighting updates and changes to policies and programs in an easily accessible and conversational format. The podcast was created as a new method to explain the agency's policies and programs.

"The new Beyond the Policy podcast demonstrates our commitment to transparency and outreach by presenting CMS-related policies, updates, and innovations on as many platforms as possible," said CMS Administrator Seema Verma. "This program is a direct response to stakeholders' suggestions that a podcast
would be a modern, user-friendly way to stay informed about CMS."

CMS: Beyond the Policy's inaugural episode focuses on Evaluation and Management Coding (E/M Codes). Last November, CMS finalized changes in the Calendar Year 2019 Physician Fee Schedule (PFS) as part of efforts to help create a more accessible, affordable and innovative healthcare system that delivers quality for patients and empowers them to make the best decisions about their healthcare. The Calendar Year 2019 PFS included
significant changes to how doctors and other clinicians document office and outpatient visits billed to Medicare.

These changes are part of CMS's "Patients Over Paperwork" initiative and one of many steps CMS is taking to reduce the amount of burdensome regulations on physicians allowing them to focus on delivering the best quality care to their patients.

New episodes of the podcast will be released periodically and will welcome a range of subject-matter experts, stakeholders, and Administrator Verma herself.
The first episode of CMS: Beyond the Policy will be available for download on iTunes and Google Play in the coming days. This first episode is described at: https://www.cms.gov/podcast

New Research: 7.8 Million Direct Care Jobs Will Need to Be Filled by 2026

Below are excerpts from a recent discussion, by Stephen Campbell of the PHI (the nation's leading information source on the direct care/paraprofessional healthcare workforce) on the growing shortage of direct support professionals (direct care workers) across the country.

In a recent conversation, a state labor economist from Pennsylvania casually mentioned to me that every state has added new measures of "occupational separations" to their employment projections. I was intrigued: What are occupational separations? Did the Bureau of Labor Statistics (BLS) figure out how to measure turnover?

At PHI, we have historically presented job growth as the best metric of future demand for direct care workers. Growth figures deserve our attention, as I'll explain below. But growth alone tells an incomplete story because long-term care employers often struggle to fill their existing positions due to high turnover.

Could our methodological limitation be resolved with this new measure from the BLS? To answer this question, I spoke with BLS labor economists and pored over their methodological guidance. I learned that yes, the new separations data do offer a more complete picture of expected employment trends over the next decade. And when I analyzed these data for the direct care workforce for the first time, the results were startling. Let me explain why.

KEY FINDINGS

The BLS projects there will be 7.8 million direct care job openings from 2016 to 2026: 3.6 million workers will leave the labor force, 2.8 million workers will leave the field for other occupations, and 1.4 million new positions will be created due to rising demand. The direct care workforce will grow more than any single occupation in the country. From 2016 to 2026, the direct care workforce will add the greatest number of new jobs (as compared to other occupations) in 38 states.

FIRST: WHAT IS JOB GROWTH?

Employment growth figures from the BLS rely on past economic trends to capture how much the direct care workforce is expected to expand or contract in the coming decade. Based on the most current BLS projections, we expect the direct care workforce to grow by 1.4 million workers from 2016 to 2026. To put that figure in perspective, the direct care workforce will grow more than registered nurses and fast food workers combined, which are ranked second and third for net job growth according to the BLS. Of note, the total direct care workforce will be larger than any single occupation in 2026.

State-level employment projections show similar trends. From 2016 to 2026, the direct care workforce will add the greatest number of new jobs (as compared to other occupations) in 38 states—and by 2026, it will be the largest workforce in 21 states (see Figure 1). In California, Minnesota, New Mexico, and Vermont, personal care aides alone will be the largest single occupation in 2026. However, this projected growth only tells us how many new direct care worker positions will be created, not how many current workers we will need to replace.

WHAT DO 'OCCUPATIONAL SEPARATIONS' ADD?

To better understand future workforce needs, we can now turn to projected occupational separations, which have two components. The first—labor force exits—reflects the number of workers who will retire or leave the labor force for other reasons. The second component—occupational transfers—reflects the number of workers who are likely to leave their current occupations for new ones. On the latter, occupational transfers capture turnover for the aggregate direct care workforce—not churn within the workforce. For example, a personal care aide who leaves her job to become a cashier at a retail store would count as a transfer, while one who leaves her job to work at another agency in the same role would not count as a transfer.

That said, even though occupational separations don't account for all turnover in the workforce, the new estimates are striking. According to the BLS, the long-term care industry will need to replace 6.4 million direct care workers from 2016 to 2026, including 3.6 million workers who will leave the labor force and 2.8 million workers who will leave the field for other occupations. Taken together, long-term care employers will need to fill 7.8 million total direct care job openings from 2016 to 2026—double the population of Los Angeles.

WHAT DOES THIS MEAN FOR OUR SECTOR?
These statistics are startling, but they should serve to galvanize, not further stall, the long-term care sector. To reduce unnecessary turnover among direct care workers, the long-term care sector needs to improve the quality of direct care jobs through higher wages, better training, and opportunities for advancement, among other interventions. Also, employers should consider expanding the labor pool for this workforce through education campaigns that elevate the profile of direct care workers; through targeted recruitment of new populations (including men, younger workers, and older workers, among others); and through partnerships with community institutions such as schools, churches, and workforce development agencies.

In short, these BLS projections confirm that we need a large-scale investment to recruit new workers and reduce turnover within this workforce to ensure that older adults and people with disabilities can access proper supports in the coming years. To understand the future of this direct care workforce, PHI's Workforce Data Center reports projected growth, separations, and total job openings in every state from 2016 to 2026. For detailed occupational separations projections, refer to state-level labor market information agencies.

State Legislative Update:

FY20 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

	FY' 18 (final)	FY'19 (final)	FY'20 (executive budget)
-CMH Non-Medicaid services	$120,050,400	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$2,315,608,800	$2,319,029,300	$2,478,086,100
-Medicaid Substance Abuse services	$52,408,500	$67,640,500	$66,200,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$76,530,000	$76,956,200	$107,754,700
-Children's Waiver Home Care Program	$20,241,100	$20,241,100	$20,241,100
-Autism services	$105,097,300	$192,890,700	$221,718,600
-Healthy MI Plan (Behavioral health)	$288,655,200	$299,439,000	$346,548,100

Other Highlights of the FY20 Executive Budget:

- $10.0 million for Healthy Michigan Plan (HMP) work supports (general fund) to ensure that HMP beneficiaries impacted by new work requirements have access to needed employment supports and to provide resources to the department to help beneficiaries address the new requirements.

- $2.2 million for the Center for Forensic Psychiatry (general fund) to meet the growing demand for forensic evaluations and restoration treatment for adults deemed incompetent to stand trial and reduce current wait lists for these services. On a typical day, roughly 115 defendants wait in jail or while released on bond for an available bed to receive services to restore their competency. The wait lists strain local jails that are sometimes forced to provide behavioral health services to these defendants.

- $75.1 million for the Healthy Michigan Plan (general fund). The Executive Budget fully supports the health coverage needs of enrollees in the Healthy Michigan Plan and includes funding to cover increased state match requirements, which will move from 7 percent to a permanent rate of 10 percent starting in January 2020. The Administration is committed to working with the Legislature to make

improvements to current work requirement provisions scheduled to become effective in 2020 in order to support and encourage work for enrollees while simplifying procedures and reducing compliance burdens.

- $74.4 million to meet state match requirements within traditional Medicaid and Children's Health Insurance Program (CHIP) (general fund). Annual federal adjustments in Michigan's share for Medicaid expenditures will increase state Medicaid costs, while a more significant state cost in CHIP is recognized due to enhanced federal matching funds expiring in fiscal year 2020 and fiscal year 2021.

- $7.0 million for the State Innovation Model (SIM) (general fund). One-time funding will continue support for five Community Health Innovation Regions (CHIRs) initially developed under the federal SIM grant which expires in January 2020. Each CHIR provides a community-based structure for engaging critical community partners in identifying and addressing local health challenges with the goal of reducing intensive use of medical and social services. This bridge funding will maintain the CHIR infrastructure established with federal grant funds while an evaluation of the model is completed.

Boilerplate Sections Included:

Section 298 – retains language from FY19.

Section 928 – retains local match draw down requirement from past years.

Section 924 – Autism Reimbursement Limit – From the funds appropriated in part 1 for autism services, for the purposes of actuarially sound rate certification and approval for Medicaid behavioral health managed care programs, the department shall maintain a fee schedule for autism services reimbursement rates for direct services. Expenditures used for rate setting shall not exceed those identified in the fee schedule. The rates for behavioral technicians shall be maintained at the hourly rate in place in the previous fiscal year.

Section 961 – department shall allocate $150,000 to administer an electronic inpatient psychiatric bed registry consistent with the requirements in section 151 of the 19 mental health code, 1974 PA 258, MCL 330.1151.

Section 1009 – Direct Care Workers – From the funds appropriated in part 1 for Medicaid mental health services and Healthy Michigan plan - behavioral health, the department shall maintain the hourly wage for direct care workers from the previous fiscal year.

Section 1010 – Court Ordered Treatment – From the funds appropriated in part 1 for behavioral health program administration, up to $2,000,000.00 shall be allocated to address the implementation of court-ordered assisted outpatient treatment as provided under chapter 4 of the mental health code, 1974 PA 258, MCL 330.1400 to 330.1490.

Boilerplate Sections NOT included in Executive Recommendation:

Removed: Section 925 – Non-Medicaid Dollars – From the funds appropriated in part 1 for community mental health non-Medicaid services, each CMHSP is allocated not less than the amount allocated to that CMHSP during the previous fiscal year.

Removed: Section 959 – Medicaid Autism Benefit Cost Containment – The department shall establish a workgroup in collaboration with the chairs of the house and senate appropriations subcommittees on the DHHS budget or their designees, CMHSP members, autism service provider clinical and administrative staff,

community members, Medicaid autism services clients, and family members to make recommendations to ensure appropriate cost and service provision, including but not limited to, the following:

a. Ways to prevent fraud and overdiagnosis.
b. Comparison of Medicaid rates for autism services to commercial insurance rates.
c. Comparison of diagnosis process between Medicaid, Tricare, and commercial insurance.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house DHHS subcommittees, the house and senate fiscal agencies, and the state budget office.

Removed: Section1696 – Traditional Medicaid to HMP Migration Restriction – It is the intent of the legislature that, beginning in the fiscal year beginning October 1, 2019, if an applicant for Medicaid coverage through the Healthy Michigan Plan received medical coverage in the previous fiscal year through traditional Medicaid, and is still eligible for coverage through traditional Medicaid, the applicant is not eligible to receive coverage through the Healthy Michigan Plan.

Federal Update:

CMS' Medicaid Guidance Describes Non-Opioid Options for Pain Management

A new informational bulletin from the Centers for Medicare and Medicaid Services (CMS) suggests a range of strategies for states to promote non-opioid chronic pain management options within their Medicaid programs by leveraging waivers, bundled payments, and other mechanisms. The bulletin builds upon previous CMS guidance to highlight successful programs already in place in some states and to describe Medicaid authorities at states' disposal.

This bulletin fulfills a mandate from the package of opioid legislation that passed last year requiring CMS to issue guidance on safer alternatives to opioids for managing chronic pain, and it also aligns with the Department of Health and Human Services' (HHS) five-point strategy to combat the opioid crisis. Recommendations for states cover a wide range of strategies, including the following:

- Home and Community-Based Services: States can apply for 1915(c) Home and Community-Based Services (HCBS) waivers to target certain populations by location, age, or diagnosis. This can allow states to target chronic pain management strategies to populations most in need without covering expensive services for all beneficiaries. Additionally, states can use state plan amendments (SPAs) to establish new eligibility groups to allow certain beneficiaries to receive HCBS for a limited period of time with a limited scope of services.

- 1115 Demonstrations: States can use 1115 demonstration waivers to test treatment options for subsets of the Medicaid population, like a program in Rhode Island highlighted in the bulletin. Rhode Island created a multi-modal, multi-disciplinary program for chronic pain management under an 1115 waiver, and CMS suggests that states could implement similar waivers and design programs that fit their populations.

- Managed Care: Chronic pain management care can be delivered through a risk-based arrangement. Managed care plans have flexibility to provide alternative pain management services as well as supplemental benefits. Alternatives must be medically appropriate and cost-effective substitutes.

- Bundled Payments: States may design alternative payment methodologies for chronic pain management services associated with a given condition. In particular, CMS points to bundled payments, under which a state would pay a provider or group of providers one unified rate for pain management services, which could include cognitive behavioral therapy, physical therapy, and education.

CMS also suggests a variety of education and utilization management strategies for opioid prescriptions, including provider education, patient education, mandatory prescribing guidelines, prior authorization, and pharmacy lock-in programs. Read the bulletin in full here.

Education Opportunities:

Pain Management Training for Social Work Professionals – Required for Licensure Renewal

Community Mental Health Association of Michigan Presents: **2-HOUR TRAINING: PAIN MANAGEMENT AND MINDFULNESS.** ***This course qualifies for 2 CEs and fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for pain management.***

2 Date Options:
March 19, 2019 - 2:00pm – 4:00pm (registration at 1:30pm)
April 25, 2019 - 9:00am – 11:00am (registration at 8:30am)

Location:
Community Mental Health Association of Michigan at 426 S. Walnut, Lansing, Michigan 48933

Training Fee: (includes training materials)
$39 CMHAM Members
$47 Non-Members

To Register:
Click Here to Register for the March 19 from 2-4 Training!
Click Here to Register for the April 25 from 9-11 Training!

Technical Assistance in the Area of Best Practices to Promote Recruitment and retention of Direct Support Professionals

The State of Michigan has secured Technical Assistance from the Department of Labor's Office of Disability Employment Policy (ODEP), in the area of best practices to promote recruitment and retention of direct support professionals. One element of this TA will be two separate one-day training sessions - one in the Metro Detroit area on March 21 and one in Lansing on March 22. The Subject Matter Expert and presenter for these sessions will be Kelly Nye-Lengerman, Research Associate at the University of Minnesota. Additional information about the training is available through the link below. Here is an excerpt from the outline of this element of the Technical Assistance: *A cross-systems statewide awareness-raising and knowledge acquisition initiative which targets providers in Michigan which serve both individuals with mental illness and intellectual and developmental disabilities, and people with dual diagnosis. This initiative proposes two regional trainings, which will each be one day in length and will present a comprehensive overview of research-informed best and evidence-based organizational practices to maximize retention and recruitment of direct service professionals (DSPs).*

For additional information, and to register:
http://campaign.r20.constantcontact.com/render?m=1102591619935&ca=58703865-e507-496e-81d9-9c05ec232a78

Dialectical Behavior Therapy (DBT) Trainings for 2018/2019

5-Day Comprehensive DBT Trainings

- This training is designed for CMH, CMH service providers, PIHP, and PIHP service provider staff who are directly responsible for delivering DBT.
- Due to the fact DBT is a comprehensive treatment that treats high-risk individuals, one's core training ought to be comprehensive as well.
- IT IS EXPECTED THAT ALL PARTICIPANTS WILL MAKE A FULL COMMITMENT TO ATTEND ALL 5 DAYS mindfully and will participate fully in discussion, role-plays and complete daily homework assignments.
- Participants are asked to bring a copy of "Cognitive Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan, PhD, with them to the training.
- COMPLETION OF A 2-DAY INTRODUCTION TO DBT TRAINING OR EQUIVALENT IS A PRE-REQUISITE FOR ATTENDING THIS TRAINING.
- This is NOT a training that teaches DBT skills. There will be very little focus on DBT skills. The majority of the focus of this training will be to help clinicians on how to conduct individual DBT sessions. If your goal is to come to this training in order to learn DBT skills, do not attend. By attending, you understand and consent to knowing this ahead of time.

Training Fee:
$250 per person. Fee includes training materials, continental breakfast and lunch for 5 days.

Dates/Locations:
May 20-24, 2019 | Detroit Marriott Livonia | REGISTER HERE
June 3-7, 2019 | Best Western, Okemos | REGISTER HERE
August 12-16, 2019 | Great Wolf Lodge, Traverse City | REGISTER HERE

Implementation of Integrated Dual Disorder Treatment (IDDT) and Co-Occurring Evidence-Based Practices Annual Trainings for 2018/2019

Course Description:
Adults with co-occurring mental illness and substance use disorders have far worse outcomes in employment, hospitalization, housing, and criminal justice involvement than their single disordered peers. This co-prevalence has been studied since the 1980s, yet despite this substantive increased risk, most service systems were organized to treat individuals with a single disorder, excluding those with co-occurring disorders, or providing sequential or parallel treatments that were incompatible or in conflict with each other. Integrated services offer superior outcomes to parallel or sequential treatments and call on providers to develop interventions to assist individuals in moving toward recovery for both illnesses simultaneously. Recovery-oriented care requires changes at a systems and individual practitioner level in areas including assessment, treatment planning, and delivery. Integrated co-occurring providers will learn about the research on integrated care including evidence-based practices (EBP), and ways to develop stage-matched assessment, treatment planning, and treatment interventions for adults with co-occurring mental health and substance use disorders.

This training fulfills the annual requirement for persons who are part of an IDDT team, as well as for persons providing COD services in Adult Mental Health outpatient services.

Training Fee:
$65 per person. The fee includes training materials, continental breakfast and lunch.

Dates/Locations:
April 26, 2019 | Hotel Indigo, Traverse City | REGISTER HERE
June 19, 2019 | Okemos Conference Center | REGISTER HERE

Motivational Interviewing College Trainings for 2018/2019

4 Levels of M.I. Training offered together at 4 convenient locations!

This event is sponsored by the adult mental health block grant and is intended for persons who serve adults only through the mental health and substance abuse provider network in the state of Michigan. It contains content appropriate for CEOs, COOs, clinical directors, supervisors, case managers, support coordinators, therapists, crisis workers, peer support specialists and any other practitioners at the beginning, advanced and supervisory levels of practice.

New This Year! We are excited to add a new 2-Day TNT: Teaching Motivational Interviewing training to the lineup.

Dates/Locations:
April – Shoreline Inn Muskegon
Basic: Monday & Tuesday, April 8-9, 2019
Advanced: Monday & Tuesday, April 8-9, 2019
Supervisory: Tuesday, April 9, 2019
Teaching MI: Wednesday & Thursday, April 10-11, 2019
June – Holiday Inn Marquette
Basic: Monday & Tuesday, June 10-11, 2019
Advanced: Monday & Tuesday, June 10-11, 2019
Supervisory: Monday, June 10, 2019
Teaching MI: Wednesday & Thursday, June 12-13, 2019

Training Fees: (The fees include training materials, continental breakfast and lunch each day.)
$125 per person for all 2-day trainings (Basic, Advanced
$69 per person for the 1-day Supervisory training.

CLICK HERE for full training details, CE information, overnight accommodations and registration links.

Individualized Service Plans Using the ASAM Criteria and Motivational Interviewing Trainings

- April 30-May 1, 2019 – Drury Inn & Suites, Grand Rapids
- June 18-19, 2019 – Holiday Inn, Marquette
- July 16-17, 2019 – Best Western/Okemos Conference Center, Okemos
- August 13-14, 2019 – Hilton Garden Inn, Detroit
- August 27-28, 2019 – Radisson Plaza Hotel, Kalamazoo
- September 24-25, 2019 – Great Wolf Lodge, Traverse City

Visit www.cmham.org for more information.

SAVE THE DATE: 20th Annual Substance Use and Co-Occurring Disorders Conference

- September 15, 2019 - Pre-Conference Workshops – Cobo Hall, Detroit
- September 16-17, 2019 – Cobo Hall, Detroit

Ethics for Social Work & Substance Use Disorder Professionals Trainings for 2018/2019

Community Mental Health Association of Michigan is pleased to offer 6 Ethics for Social Work & Substance Use Disorder Professionals Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This training fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for ethics. This training fulfills the MCBAP approved treatment ethics code education – specific.

Trainings offered on the following date.

- April 24 – Troy Click Here to Register for April 24

Training Fees: (fee includes training material, coffee, lunch and refreshments.

$115 CMHAM Members
$138 Non-Members

CALL FOR PRESENTATION: CMHAM Annual Spring Conference

We're looking for the Best of the Best! Submit your workshop ideas by April 4, 2019.

The CMHAM Annual Spring Conference will be held on:
June 10, 2019: Pre-Conference Institutes
June 11 & 12, 2019: Full Conference
Suburban Collection Showplace, Novi, Michigan

Click Here to Download Presentation Submission Form!

Note: Hotel reservation and Conference registration are not available at this time.

Second Annual Michigan CIT Conference Save-the-Date

Crisis Intervention Teams (CIT) were established in 1988 in response to an officer killing a young man experiencing a mental health crisis. Since that event, crisis interventions teams across the country have formed to develop better ways to actively intervene real time with individuals in a mental health crisis and establish improved community partnerships that support community members to obtain mental health treatment first rather than involvement with the judicial system.

The first annual Michigan CIT conference was hosted by Riverwood Community Mental Health in Berrien County. After this conference, a state collaborative was formed to support Michigan CIT programs and to establish standards for CIT initiatives across the state. The next conference will be hosted by Summit Pointe Community Mental Health in Battle Creek. Law enforcement personnel, corrections personnel, behavioral health professionals, persons living with behavioral health disorders, family members, advocates, judges / court personnel, public defenders / prosecutors and policy makers are encouraged to attend!

Mark your calendars and join us in Battle Creek for the second annual CIT: Crisis Intervention Team Conference October 2-4, 2019. Hear from various presenters on strategies to start your CIT in your community, or ways to improve your existing program. Also, learn more about how CIT is benefiting communities in our state and how to collaborate with other counties. CIT is more than just a training! We look forward to seeing you at our conference as we 'Bring it All Together'. For more information, please email MICITConference2019@gmail.com.

Workshop: Finding Possibility in a Sea of Challenges: Building a Quality Direct Support Workforce

Finding possibility in a sea of challenges: building a quality direct support workforce
Presenter: Kelly Nye-Lengerman, PhD University of Minnesota

The goal of the session will be to equip provider organizations with knowledge and awareness of the organizational models, strategies and tools correlated with higher rates of DSP retention and more successful DSP recruitment.

Who Should Attend: Targeted participants include all providers serving persons with mental illness and intellectual/developmental disabilities.

Some priority will be given to employment service providers that have received prior federal (ODEP) or state technical assistance in provider transformation through the Employment First Initiative.

A quality Direct Support workforce is a key ingredient to supporting people with disabilities to live their best, most inclusive lives in the community. Now more than ever, almost every industry in health and human services is affected by the Direct Support workforce crisis. The crisis represents more than just a shortage of workers, but it also reflects the many challenges Direct Support Professionals (DSPs) and organizations face: wages, benefits, education, certification, professional standards, and budgets. While there is no quick fix to these longstanding issues, there are proven solutions that can assist organizations and state agencies in addressing the crisis. Investment in, and commitment to, building and sustaining a strong Direct Support workforce will pay dividends for the individuals supported.

This session will:

- Explore the context for the Direct Support workforce crisis;
- Discuss strategies for developing knowledge, skills, and abilities in Direct Support workers and frontline supervisors;
- Examine various strategies and interventions for workforce stabilization and growth;
- Identify key tools and resources for workforce development
- Identify key tools and resources for workforce development
- Present a comprehensive overview of research-informed best practices and evidence-based organizational practices to maximize retention and recruitment of direct service professionals (DSPs).
- The DSP workforce is critical to realizing the goals of Employment First and community living, including job developers and job coaches who are an essential link between people with disabilities seeking employment and the employers/business community that can hire them. To achieve the desired outcomes of increased employment for people with disabilities, and ensure high quality employment services, organizations engaged in provider transformation must adopt transformation plans that address DSP workforce stabilization and empowerment.

As noted above, all service providers employing Direct Support Professionals are welcome to register for one of the seminar options below - but seating is limited!

Registration Fee is $30 per person.

Session Offerings:

Thursday March 21, 2019 at OCHN 5505 Corporate Dr, Troy, MI 48098
Click here to register: https://maro.org/events/dsp-training-ochn/

Friday March 22, 2019 at Lansing Community College West 5708 Cornerstone Dr, Lansing, MI 48917 Click here to register: https://maro.org/events/dsp-training-lansing/

35th Annual Developmental Disabilities Conference

The Annual Developmental Disabilities Conference will focus on issues related to healthcare, social, community, and educational services which are of critical importance to the future of persons with DD. The program will provide an overview of issues related to the spectrum of services currently available as well as strategies for enhancing these services. This educational program is designed for physicians, nurses, psychologists, social workers, therapists, dietitians, educators, home care providers, and other professionals interested in the delivery of care and services to persons with developmental disabilities.

For more information, please contact Courtney Puffer. Courtney.Puffer@med.wmich.edu // (269) 337-4305

Date & Location
Tuesday, April 16, 2019, 7:30 AM - Wednesday, April 17, 2019, 4:30 PM, Kellogg Hotel & Conference Center, East Lansing, MI

Objectives

- Identify effective methods for the practical application of concepts related to improving the delivery of services for persons with developmental disabilities.
- Identify advances in clinical assessment and management of selected health care issues related to persons with developmental disabilities.
- Discuss the ethical issues related to persons with developmental disabilities.
- Identify and emphasize attitudes that enhance the opportunities for persons with developmental disabilities to achieve their optimal potential.
- Develop strategies to promote community inclusion in meeting the needs of persons with developmental disabilities.

Registration: Register at: wmed.cloud-cme.com/2019DDConference

REGISTRATION FEES
When registering please use your personal log-in to access your CloudCME account. If you do not have an account, you must create one using your email. If you have trouble navigating this process, please do not hesitate to contact the Conference Coordinator.

Early Bird Discounts, postmarked before March 1
$185, Tuesday Only
$185, Wednesday Only
$245, Two Days, entire conference
Regular Registration, postmarked March 1-31
$205, Tuesday Only
$205, Wednesday Only
$260, Two Days, entire conference
Late Registration, postmarked after April 1 or onsite
$230, Tuesday Only
$230, Wednesday Only
$280, Two Days, entire conference
By registering, you agree to the terms of our photo release policy listed under Conference Info.
By registering, you also agree to the current cancellation policy listed below. Your confirmation email will be sent via email. Attendees must log-in to register - if you have issues logging-in, please contact ce@med.wmich.edu for assistance

All cancellations must be received in writing email, and are subject to a 10% cancellation fee. If you cancel with 1-6 business days notice, between April 8th and April 15th, you will receive a 50% refund. No refunds will be issued after the conference begins. Send cancellation notices to ce@med.wmich.edu.

2019 Annual Michigan Rural Health Conference Announced

The Michigan Center for Rural Health (MCRH) is pleased to invite you to the 2019 Michigan Rural Health Conference on April 25th-26th, 2019 in Mt Pleasant, MI! The theme of this year's conference is, "Roadmap to Improving Rural Health." Participants will gain knowledge of timely and effective methods to enhance their organization. Whether it's concentrating on improving clinical quality, leadership, or focusing on patient satisfaction, participants will have the opportunity to learn from subject matter experts and rural health peers. The conference sessions will feature a variety of informative topics such as Innovations in Rural, Federal Update on Rural Health Issues, National RHC Update, Strategies for Better Recognizing & Engaging Employees, Health Law Update, Multiple Pathways and Recovery Coaches, as well as several other valuable presentations.

WHO'S INVITED? The conference is designed to be of interest to a wide range of rural health advocates including community leaders, clinicians, administrators, board members, public health officials, rural health clinics, federally qualified health centers, local health departments and others interested in the development of healthcare in their community.

WHEN
Thursday, April 25, 2019 at 7:00 AM EDT
-to-
Friday, April 26, 2019 at 11:45 AM EDT)

WHERE
Soaring Eagle Casino & Resort
6800 Soaring Eagle Boulevard
Mt Pleasant, MI 48858

REGISTER NOW
https://events.r20.constantcontact.com/register/eventReg?oeidk=a07eg2d27i600bec3f4&oseq=&c=&ch=

Agenda:
https://files.constantcontact.com/ad8db403301/aa9d962c-7390-4b36-9098-196e3f478b89.pdf
https://files.constantcontact.com/ad8db403301/aa9d962chttps://files.constantcontact.com/ad8db403301/aa9d962c-

HOTEL RESERVATIONS
Soaring Eagle Casino & Resort
877-232-4532
Use the Group Code MC042419

CONTINUING EDUCATION AVAILABLE:
Nursing
Social Work
More info on MCRH Website: http://mcrh.msu.edu/events/Participants_Rural_Health_Conference.html

CONTACT US!
Michigan Center for Rural Health
mcrhaa@hc.msu.edu
517.355.7979

Michigan fetal alcohol conference announced

Miscellaneous News and Information:

Job Opportunity: CEO of Rose Hill Center

Kittleman & Associates is pleased and honored to announce the search for the next President & CEO of Rose Hill Center in Holly, Michigan, and I wanted to make sure that you saw the attached Position Guide.

As one of the nation's leading long-term mental health facilities, Rose Hill Center in Holly, Michigan offers comprehensive psychiatric treatment and residential rehabilitation programs for adults, 18 and over, on 400 serene acres close to major amenities offered by Ann Arbor and the greater Detroit region. With an emphasis on Recovery, the programs offered by Rose Hill provide individuals with the insights, life skills, attitudes, opportunities and medication management needed to manage their illness and live fulfilling lives. Rose Hill provides five levels of mental health treatment that are supported largely through private pay with financial assistance provided through the Rose Hill Foundation as well as through Community Mental Health (Medicaid) and commercial insurance. https://www.rosehillcenter.org/

Job Opportunity: Project Coordinator for Arc Michigan

The Arc Michigan is seeking applicants for a new, full-time position!
Job Title: Project Coordinator
Location: The Arc Michigan, Lansing MI

Job Description: The Project Coordinator and the Arc Michigan will partner with the Michigan Department of Health and Human Services (MDHHS) to enhance and support the department's quality assurance and improvement activities. The project coordinator will 1) supplement the MDHHS site review process by interviewing people who receive CMH services about their experience with the person-centered planning process and 2) support MDHHS efforts to meet the training needs of Pre-paid Inpatient Health Plans (PIHPs), Community Mental Health entities (CMH), other providers, families and people with disabilities, by developing, coordinating and delivering training on the key topics of Person-Centered Planning, Self Determination and Independent Facilitation.

Primary Duties and Responsibilities:

- Conduct interviews with individuals who receive Person Centered Planning services.
- Secure and coordinate subcontractors who will conduct interviews with people who receive mental health services and provide support during the MDHHS site review process.
- Collaborate with evaluation contractor for analysis of interviews.
- Participate in MDHHS department groups related to training areas and support MDHHS in finalizing training policy
- Develop a statewide training plan in partnership with MDHHS
- Help plan yearly Self-Determination conference
- Develop initial training curriculum
- Host train the trainer events
- Evaluate training: refine curriculum and incorporate system updates
- Develop a statewide multi-year training plan in partnership with MDHHS
- Host quarterly technical assistance sessions for trainers

Desired Qualifications:

- Knowledge of, and experience interacting with, MDHHS's behavioral health care system
- Experience working with, for and on behalf of people with disabilities
- Knowledge of person-centered planning, independent facilitation, self-determination and other issues pertinent to people with mental illness and/or intellectual and developmental disabilities who receive state-funded services
- Event planning skills
- Excellent written and oral communication skills
- Computer skills with knowledge of Microsoft programs like Word, Excel and Publisher

Salary Range and Benefits: Salary commensurate based on experience and education
Benefits include: 403B plan with employer match, available medical, dental and vision coverage, paid personal, sick and vacation leave and amazing co-workers!

To Apply:
Submit cover letter, resume and salary requirements to Sherri Boyd, Arc Michigan Executive Director and CEO, at sherri@arcmi.org or 1325 S. Washington Avenue, Lansing MI 48910 by February 15, 2019.

Job Opportunity: Executive Director of Network 180

Network180 is seeking its next Executive Director to direct the management and delivery of a complete array of mental health, intellectual /developmental disability, and substance abuse services to the citizens of Kent

County, Michigan. With an annual budget of over $140 million, Network180 annually serves over 18,000 individuals in Kent County through a network of over 30 non-profit providers. Interested candidates can apply through our website at: http://www.network180.org/en/employment/employment-opportunities.

CMH Association's Officers and Staff Contact Information:

CMHAM Officers Contact Information:

The Officers of the CMH Association of Michigan recently proposed, in their commitment to fostering dialogue among the members of the Association with the Association's leaders, that their contact information be shared with the Association membership. While this dialogue will not take the place of the regular dialogue and decision making that occurs during the meetings of the Association's Executive Board, Steering Committee, Provider Alliance, Association Committees, Directors Forum, PIHP CEOs meeting, nor any of the great number of Association-sponsored and supported dialogue venues, the Officers want to ensure that the members of the Association can reach them to discuss issues of interest to the Association's members. The contact information for the officers is provided below:

President: Joe Stone Stonejoe09@gmail.com; (989) 390-2284
First Vice President: Lois Shulman; Loisshulman@comcast.net; (248) 361-0219
Second Vice President: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

CMHAM Staff Contact Information:

CMH Association staff can be contacted at (517) 374-6848 and via the e-mail addresses below:

Alan Bolter, Associate Director, abolter@cmham.org
Christina Ward, Director of Education and Training, cward@cmham.org
Monique Francis, Executive Secretary/Committee Clerk, mfrancis@cmham.org
Nakia Payton, Data-Entry Clerk/Receptionist, npayton@cmham.org
Dana Ferguson, Accounting Clerk, dferguson@cmham.org
Michelle Dee, Accounting Assistant, acctassistant@cmham.org
Anne Wilson, Training and Meeting Planner, awilson@cmham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
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Alexandra Risher, Training and Meeting Planner, arisher@cmham.org
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