LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD

VISION

"We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life."

AGENDA
May 26, 2016

705 N. Zeeb Road, Ann Arbor
Patrick Barrie Conference Room
9:30 a.m. – 11:30 a.m.

1. Introductions & Welcome – 5 minutes

2. Approval Of Agenda (Board Action) – 2 minutes

3. Approval of March OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business
   a. CMHPSM Regional SUD Financial Report (Discussion) {Att. #2} – 10 minutes
   b. Treatment RFI Update {Att. #3, 3a} -10 Minutes
   c. By-laws final vote {Att. #4} (Board Action) - 5 minutes

6. New Business
   a. Funding Request – Livingston CMH Project Lazarus Coordinator {Att.#5} 10 minutes
   b. Home of New Vision – Engagement Center Renovation Costs {Att. #6} 10 minutes
   c. Prevention Mid-Year Progress {Att. #7} 10 minutes
   d. Vivitrol Information – presentation (Marci) 10 minutes
   e. Halo Mid-Year Report {Att. #8} 5 Minutes

7. Report From Regional Board (Discussion) – 5 minutes

8. SUD Director Updates (Discussion) – 10 minutes
   a. State Information Update
   b. Naloxone update
   c. Strategic Planning Retreat

Next meeting: Thursday, June 23, 2016 9:30 a.m. – 11:30 a.m.

Parking Lot:

LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
Summary of March 24, 2016 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present:	David Oblak, Tom Waldecker, Charles Coleman, Kim Comerzan, Sheila Little, Mark Cochran, Dianne McCormick, Ralph Tillotson, Cheryl Davis, Dave DeLano, William Green, John Lapham, Amy Fullerton
Members Absent:	Laura Rodriguez, David Oblak, Cheryl Davis, William Green
Guests:	Elijah Wheeler, Therese Langdon (Parkside Family Counseling)
Staff Present:	Stephannie Weary, Marci Scalera, Katie Postmus, Suzanne Stolz, Jane Terwilliger, Roxie McUmber

OPB Vice-Chair A. Fullerton called the meeting to order at 9:30 a.m.

1. Introductions

2. Approval of the agenda

   Motion by R. Tillotson, supported by C. Coleman, to approve the agenda
   Motion carried

   Move agenda item 7 Report from Regional Board, and item 6c Governors Proposed Budget and Future Strategies to follow Audience Participation

3. Approval of January 28, 2016 OPB minutes

   Motion by M. Cochran, supported by J. Lapham, to approve the January 28, 2016 OPB minutes
   Motion carried

4. Audience Participation
   - None

5. Old Business
   a. Governor's proposed budget
      - J. Terwilliger provided an update on the proposed FY 17 state budget, which included language to eliminate PIHPs. This language has been removed from the proposed budget, after advocacy and discussion. Lieutenant Governor Calley now has a stakeholder workgroup to discuss plans going forward.

   b. Report from Regional Board
      I. Director's presentation on Health Plans
         - J. Terwilliger provided an overview of plans for coordination of care and performance expectations for the PIHPs and the health plans.

c. CMHPSM Regional SUD Financial Report
   - S. Stolz presented the SUD financial status.

d. Treatment RFI
   - M. Scalera reviewed the draft treatment RFI.
   - The RFI will be posted on the RFI web site and a state web site.
   - OPB members want the RFI to be clear that a response to the RFI is required in order to be eligible for any resulting the RFP.
   - T. Waldecker noted that the timeline might be too tight, and suggested a save-the-date be sent for the informational conference.

   Motion by T. Waldecker, supported by J. Lapham, to approve the RFI posting, giving providers 2 weeks' noticed of the informational conference.
   Motion carried

e. Bylaws Review
   - OPB members would like to enhance language in section E.2 to state that board will review attendance in cases of 3 consecutive absences, to consider action steps, if necessary.
   - M. Scalera will update the bylaws and bring back to OPB for approval to recommend to the Regional Board for final approval.

6. New Business
   a. New CFR 42
      - M. Scalera reported on proposed changes to CFR 42 (protection of confidentiality)
   b. Presentation: Parkside Family Counseling
      - T. Langdon provided an overview of her agency.
      - The agency's license is up for renewal, and it's OPB's responsibility to forward any comments re: the agency, to the state.
   c. Recovery Community Organization funding request
      - M. Scalera provided an overview on Real Michigan, which is requesting funding.
      - If OPB decides to fund the training initiative, M. Scalera would like to invite a participant from each of the 4 counties.
      - If approved, block grant funds would cover this funding.
      - The initiative is for training for advocacy.

      Motion by T. Waldecker, supported by M. Cochran, to approve funding for statewide training academy for Recovery Community Organizations (RCO)
      Motion carried

7. SUD Director Updates
   a. Women's Specialty program {Att. #8}
      - M. Scalera provided an update on expanded services.
      - Monroe has developed a women's-specific program.
   b. PA2 Updates {Att. #9}
      - M. Scalera provided a written report.
   c. Budget amendment – program changes to shift funding streams
      - SUD staff is working to shift some awards away from PA2 to block grants in order to ensure block grant spending.
   d. Naloxone update
      - Naloxone is present in all 4 counties, and local trainings are going on.
   e. Strategic Planning Retreat

- OPB will consider a June retreat, after the release of the RFI.

8. Meeting adjournment

Motion by J. Lapham, supported by C. Coleman, to adjourn the meeting
Motion carried

Meeting adjourned 11:32 a.m.

Attachment # 2 - May 2016

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
March 2016 FYTD

Summary Of Revenue & Expense	Funding Source						Total Funding Sources
	Medicaid	MIChild	Healthy Michigan	SUD - Block Grant	SUD-COBO/PA2	Other	
Revenues							
Funding From MDCH	$ 806,949	$ 3,046	$ 1,535,994	$ 1,855,752		$ -	$ 4,201,741
PA2/COBO Tax Funding	$ -	$ -	$ -	$ -	$ 565,372 *	$ -	$ 565,372
Other	$ -	$ -	$ -	$ -	$ -	$ 1,027	$ 1,027
Total Revenues	$ 806,949	$ 3,046	$ 1,535,994	$ 1,855,752	$ 565,372	$ 1,027	$ 4,768,140
Expenses							
Funding for County SUD Programs							
Lenawee	$ 115,048	$ -	$ 190,908	$ 143,379	$ 28,926	$ -	$ 478,261
Livingston	$ 107,605	$ -	$ 154,113	$ 315,800	$ 8,239	$ -	$ 585,757
Monroe	$ 77,712	$ 360	$ 202,479	$ 188,767	$ 124,590	$ -	$ 593,908
Washtenaw	$ 371,955	$ -	$ 794,787	$ 637,530	$ 231,504	$ -	$ 2,035,776
Total SUD Expenses	$ 672,320	$ 360	$ 1,342,288	$ 1,285,475	$ 393,259	$ -	$ 3,693,702
Other Operating Costs							
SUD Use Tax	$ 48,256	$ 182	$ 91,852	$ -	$ -	$ -	$ 140,290
SUD HICA Claims Tax	$ 6,052	$ 23	$ 11,520	$ -	$ -	$ -	$ 17,595
Total Operating Costs	$ 54,308	$ 205	$ 103,372	$ -	$ -	$ -	$ 157,885
Administrative Cost Allocation	$ 48,227	$ 24	$ 96,288	$ 131,289	$ -	$ -	$ 275,827
Total Expenses	$ 774,855	$ 589	$ 1,541,948	$ 1,416,764	$ 393,259	$ -	$ 4,127,414
Revenues Over/(Under) Expenses	$ 32,094	$ 2,458	$ (5,954)	$ 438,988	$ 172,113	$ 1,027	$ 640,726

	Revenues	Expenditures	Revenues Over/(Under) Expenses
PA2 by County			
Lenawee	$ 45,838	$ 28,926	$ 16,912
Livingston	$ 134,720	$ 8,239	$ 126,481
Monroe	$ 97,907	$ 124,590	$ (26,683)
Washtenaw	$ 286,908	$ 231,504	$ 55,403
Totals	$ 565,372	$ 393,259	$ 172,113

Unallocated PA2	
Lenawee	$ 1,017,138
Livingston	$ 2,393,356
Monroe	$ 243,366
Washtenaw	$ 2,542,374
Total	$ 6,196,234

*Note - Financials presented to board did not include 2nd quarter PA2 distributions.

Community Mental Health Partnership of Southeast Michigan
Statement of Revenues and Expenditures
For the Quarter Ending March 31, 2016

	1st Amend Budget	YTD Actual	YTD Budget	YTD Actual O/(U) Budget	
Operating Revenue					
Medicaid Capitation	$134,282,264	$67,155,870	$67,141,132	$14,738	
Medicaid Carryforward	1,473,549	-	736,775	(736,775)	a
Healthy Michigan Plan	12,188,927	6,146,789	6,094,464	52,325	
Healthy Michigan Carryforward	5,224,847	-	2,612,424	(2,612,424)	a
Autism	1,661,715	124,355	830,858	(706,502)	b
Medicaid Health Home-Washtenaw On	419,801	389,208	209,901	179,308	c
10% Health Home Match Washtenaw	41,980	38,852	20,990	17,862	
SUD Community Grant	3,767,460	1,855,752	1,883,730	(27,978)	
SUD PA2 - Cobo Tax Revenue	2,105,798	388,606	1,052,899	(664,293)	d
Local Match	1,577,780	788,890	788,890	-	
Other Revenue	217,567	136,552	108,784	27,769	
Total Revenue	**$162,961,688**	**$77,024,874**	**$81,480,844**	**$(4,455,970)**	
Funding For CMHSP Partners					
Lenawee CMHSP	16,987,987	8,416,767	8,493,994	(77,227)	
Livingston CMHSP	23,466,599	11,457,019	11,733,300	(276,280)	
Monroe CMHSP	25,356,719	12,576,535	12,678,360	(101,825)	
Washtenaw CMHSP	64,704,549	32,388,988	32,352,275	36,713	
Total Funding For CMHSP Partners	**$ 130,515,854**	**$ 64,839,309**	**$65,257,927**	**$(418,618)**	
Funding For SUD Services					
Lenawee County	1,278,823	473,609	639,412	(165,803)	d
Livingston County	1,614,420	585,757	807,210	(221,453)	d
Monroe County	1,506,177	593,908	753,089	(159,181)	d
Washtenaw County	4,026,893	2,040,428	2,013,447	26,982	
Total Funding For SUD Services	**$ 8,426,313**	**$ 3,693,702**	**$4,213,157**	**$(519,455)**	
Other Contractual Obligations					
Hospital Rate Adjuster	2,122,900	1,079,625	1,061,450	18,175	
USE and HICA Tax	9,967,501	4,921,403	4,983,751	(62,348)	
Local Match	1,577,780	788,890	788,890	-	
10% Health Home Match Washtenaw	41,980	38,825	20,990	17,835	
Total Other Costs	**$13,710,161**	**$6,828,742**	**$6,855,081**	**$(26,338)**	
CMHPSM Administrative Costs					
Salary& Fringe	1,768,037	749,209	884,019	(134,809)	e
Administrative Contracts	1,031,952	575,783	515,976	59,807	
Board Expense	12,980	2,517	6,490	(3,973)	
All Other Costs	168,136	57,226	84,068	(26,842)	
Total Administrative Expense	**$2,981,105**	**$1,384,734**	**$1,490,553**	**$(105,818)**	
Risk Reserve Provision	**$2,581,623**		**1,290,812**	(1,290,812)	
Carry Forward	**$4,746,632**		**2,373,316**	(2,373,316)	
Total Expense	**$162,961,688**	**$76,746,487**	**$81,480,844**	**$(4,734,357)**	
Revenues over (under) Expenditures	**$0**	**$278,387**	**$0**		

a - Timing difference, recognization will occur at year end corresponding to expenditures.
b - Timing difference, Autism benefit receipts delayed.
c - Correlates with Home Health expenditures, budget to be amended.
d - New program implementation delay.
e - Administration continues under budget due to vacant positions throughout the year.

COMMUNITY MENTAL HEALTH PARTNERSHIP of Southeast Michigan

RFI #2016-A: ROSC SUD TREATMENT SERVICES

INFORMATIONAL MEETING: APRIL 29, 2016

PURPOSE:

- WHAT DOES OUR CURRENT SYSTEM OF CARE REALLY LOOK LIKE?
- ARE SERVICES BEING DELIVERED WITH CONSISTENCY?
- ARE WE HOLDING TRUE TO THE RECOVERY ORIENTED SYSTEM OF CARE?
- ARE THE DELEGATED FUNCTIONS BEING CARRIED OUT WITH IMPROVED EFFICIENCY?
- IS THERE ROOM FOR IMPROVEMENT?
- DO WE HAVE THE RIGHT INFRASTRUCTURE TO HANDLE CAPACITY AND CHANGING NEEDS?
- CREATE AN INCENTIVE FOR PARTICIPATION…☺

CURRENT STRUCTURE…

- FOUR COUNTIES – FOUR DIFFERENT WAYS TO DELIVER SERVICES
- CORE PROVIDER vs. SINGLE CONTRACTOR SYSTEM
- ALLOCATION MODEL vs. FEE FOR SERVICE
- USE OF PEERS AND RECOVERY COACHES
- USE OF CASE MANAGEMENT
- INCONSISTENT SERVICE ARRAY – LOCAL vs. OUTSIDE OF REGION
- POPULATION GAPS – KIDS; OLDER ADULTS; GENDER SPECIFIC; COD
- LIMITED FULL ARRAY OF MEDICATION ASSISTED TREATMENT

THINGS TO CONSIDER…

- THIS IS JUST AN *INFORMATION GATHERING* TOOL…
- THIS DOES NOT GUARANTEE ANYONE A CONTRACT IN THE FUTURE
- THIS WILL HELP US THINK ABOUT THE SYSTEM OF CARE IN THE REGION
- CORE PROVIDERS AND INTERESTED PROVIDERS SHOULD COMPLETE SECTION 10…
  - *THIS IS NOT JUST FOR NON CORE PROVIDERS*

CORE PROVIDER EXPECTATIONS:

- DELEGATED FUNCTIONS:
  - ACCESS
  - CONTRACTING
  - MONITORING
  - CREDENTIALING
  - UTILIZATION MANAGEMENT
  - QUALITY IMPROVEMENT & OUTCOMES
- ELECTRONIC HEALTH RECORDS
- COMMUNITY COLLABORATION
- MENTAL HEALTH AND PRIMARY CARE COORDINATION

NON CORE PROVIDERS….

- COMPLETE SECTION 9
- COMPLETE SECTION 10.4

QUESTIONS – Tell us what you can!

RFI#2016A Questions from Potential Respondents

Question Deadline: May 12, 2016

Referenced Section: 9.6	Sub-Section: 2	Letter(s) : d, e, f
2. Tell us the types of COD services your organization in able to provide: d. How many staff have experience in working with both mental health and SUD populations? e. How many have MCBAP CREDENTIALS? f. How many are on development plans.		

Question/Statement:

Are the numbers being asked referring to the staffing chart worksheet you'd like us to fill out or asking for a number specific to staff that have experience working with both mental health & SUD populations?

CMHPSM Response:

The intent of the question is to determine the workforce capacity overall… I would just give a count under this section and then please complete the staff chart… this will provide more detail that can be analyzed regionally.

Question/Statement:

Also, do staff that have their experience working with both populations through their time at our organization count under the experience question?

CMHPSM Response:

Yes… one thing to look at when considering this question is the staffing credentials requirement under the Medicaid guidelines….. We will post the state's ***"CREDENTIALING AND STAFF QUALIFICATION REQUIREMENTS"*** *for your review.*

Referenced Section: 10.1 &10.2	Sub-Section: All	Letter(s) : All
10.2 Core Provider Interest: **10.2 Finance/Network Management Capacity:**		

Question/Statement:

These questions don't include enough detail and hold too much variable to answer appropriately.

CMHPSM Response:

The CMHPSM is just trying to get a feel for general interest and potential capability related to the delegation of treatment functions within the region. More specific questions, requirements, etc., would be developed for any significant change in what's delegated to either existing or new

core providers. If you are not a core provider or interested in becoming a core provider you are not required to answer 10.1 or 10.2

Referenced Section: General	Sub-Section: N/A	Letter(s) : N/A

Question/Statement:

The question I have is that the RFI appears to be making a distinction between Therapists with a CAADC and those with a CCDP-D. Is this going to be something that is being made to have a greater distinction in agency practice? Should I be preparing therapists to switch from CAADC to the CCDP-D?

CMHPSM Response: *The staff qualifications for service delivery are outlined in the credentialing document. Individuals with the CAADC will continue to meet criteria for credentialing. Currently the state allows for persons with development plans to work under supervision while they are obtaining the education and experience within their development plan.*

Referenced Section: 10.4	Sub-Section: 1	Letter(s) : N/A
1. **How are you addressing customer services, including obtaining input from persons served to inform your practice and service delivery?**		

Question/Statement:

I didn't see questions that addressed the capacity to implement Grievance and Appeal related functions (having a grievance process, giving denial notice(s), having a local appeal process, following the state level appeal process/having FHO/state level hearing representation), so I was asking for clarification on that and suggesting these be added as items for providers/core providers to respond in assessing capacity/needs in this area.

CMHPSM Response:

Thank you for pointing this out. All providers are required to be trained on the Medicaid fair hearings process and grievance and appeals process. Since this is a contractual requirement, future RFP's will have a more detailed emphasis on the providers internal capacity to meet this requirement

Referenced Section: General	Sub-Section: N/A	Letter(s) : N/A

Question/Statement: What is the average length of stay in "long term" residential programs that are funded by the PIHP?

CMHPSM Response:

The state defines "long term residential" as greater than 30 days in care.

Referenced Section: General	Sub-Section: N/A	Letter(s) : N/A

Question/Statement: Is there a specific or preferred treatment curriculum or treatment modality for residential programs?

CMHPSM Response: *Providers should have services available to meet the individual needs of each client. Residential services should be a mix of individual and group modalities that can be "prescribed" by the individual plan of service for the client. The state administrative rules describe minimum treatment offered as****: "Ten or more hours per week of scheduled activities shall be available to a client. Included in these activities shall be 2 or more hours of formalized individual, group, or family counseling for each client. The hours of counseling actually provided should vary according to the needs of the client. There shall be documentation of planned social, educational, and recreational activities consistent with the needs of the client. Activities shall include all clients and shall take place days, evenings, and weekends if clients are present during these times."***

Referenced Section: General	Sub-Section: N/A	Letter(s) : N/A

Question/Statement: What types of treatment does the PIHP currently fund specifically for individuals involved in the criminal justice system (e.g. early intervention, drug court programs, outpatient, residential, detox)?

CMHPSM Response:

The CMHPSM does not distinguish between folks involved in the criminal justice system or not. Services must meet medical necessity criteria. The definition of medical necessity for Medicaid services is included in the Michigan Medicaid Provider Manual: Mental Health –Substance Abuse section.

Referenced Section: 9.15	Sub-Section: 1,2,3	Letter(s) : N/A

Question/Statement: Should a program apply for the Medication Assisted Treatment Services if we currently provide Vivitrol only? We will also utilize Suboxone in the future when we obtain a Suboxone licensed doctor.

CMHPSM Response:

All providers should respond to 9.15, as we are interested in knowing the philosophy of your organization on the use of MAT. This is not just focused on those who are prescribing medication, but rather how would you support folks on medication at your agency, if at all. Do you prescribe or just coordinate care? Or do you not accept folks on medication assisted treatment and refer to another provider????

Referenced Section: 9.11 **Recovery Coaching & Peer Support Services**	**Sub-Section: 4**	**Letter(s) : N/A**

(The question is incomplete)-How do you ensure peers and professionals work collaboratively in partnership in serving individuals in...? *Is it just recovery?*

CMHPSM Response:

Woops! Sorry about the typo! Thanks for the catch… I think we were looking for, "How do you ensure peers and professionals work collaboratively in partnership in serving individuals ***in treatment?"*** *Are peers included in all aspects of the organization, especially when it comes to providing services… are they included in the planning and staff meetings, case consultation, treatment planning process, etc. or is their involvement limited???*

Attachment #4 - May 2016

DRAFT TO CONSIDER MODIFYING
~~August 2014~~Att #4 2-2016

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BY-LAWS

REGION 6
SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN (CMHPSM)

ARTICLE I – Name

Pursuant to Section 287 (5) of Public Act 500 of 2012 states, "A department-designated community mental health entity [PIHP/Regional Entity] shall establish a substance use disorder oversight policy board for Lenawee, Livingston, Monroe and Washtenaw Counties. This **BOARD** shall be named the **REGION 6 SUBSTANCE USE DISORDER OVERSIGHT POLICY BOARD** hereafter called the **OVERSIGHT POLICY BOARD (OPB).**

ARTICLE II – Objectives of the OPB

To assist the **CMHPSM** Regional Board by:

A. Providing an opportunity for individuals within the applicant's service delivery area to comment upon the issuance of a substance use disorders services license.

B. Assisting in the development of a comprehensive substance use disorders service delivery plan.

C. Providing review and recommendations to the CMHPSM Regional Board of the progress and effectiveness of services delivered in accordance with the plan.

D. Assuring that a mechanism exists for community input on substance use disorders needs and services throughout the region.

E. Providing such other assistance to the **CMHPSM** as necessary.

ARTICLE III – Membership of the OPB

A. The OPB shall be made up of a maximum of SIXTEEN (16) members, four (4) appointed from each member County.

1. Two representatives from Lenawee County, appointed by the Lenawee County Board of Commissioners, two (2) representatives from Livingston County, appointed by the Livingston County Board of Commissioners, two (2) representatives from Monroe County, appointed by the Monroe County Board of Commissioners and two (2) representatives from Washtenaw County, appointed by the Washtenaw County Board of Commissioners. The remaining two (2) members from each county will be appointed by the CMHPSM Regional Board with recommendations from each respective Community Mental Health Board.

2. Each county must have at least one member representing the recovery community, or a person with lived experience.

3. Community representatives/ shall reside in the county represented.

B. Vacancies during Term of Office:

1. All vacancies shall be filled by the respective appointing bodies.

2. All vacancies shall be filled only until expiration of the term.

C. Length of Term:

1. All representatives shall serve three-year terms, starting October 1, of the year appointed.
2. Initial terms shall be staggered to ensure that no more than one-third of OPB members turn over each year.
3. Appointments shall be effective upon approval of the respective appointing body.
4. All reappointments shall be made by the respective appointing body.

D. Attendance:

1. Meeting attendance may be face to face or through electronic participation via phone or video conference when available.
2. Conference call participation must be arranged prior to the meeting.

E. ~~Termination~~ Removal and Resignation:

1. A member must resign in writing to the appointing body and to the CMHPSM Board.

2. An OPB member may be removed for lack of attendance. In the absence of a written resignation, three (3) consecutive absences from regularly scheduled meetings or three (3) absences within a twelve (12) month period would require a review by the OPB. The review may result in a recommendation for appointment of a new member by the respective appointing board. A vote of three-fourths (3/4) of the OPB is required for recommendation of removal and

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reappointment.~~without prior notification or four (4) consecutive absences regardless of notification would require a request for reappointment.~~

ARTICLE IV – Meetings

A. Regular meetings shall be scheduled at least six times per year, at least once each quarter, with each county being the site for at least one meeting during the calendar year.

B. Written notification and agenda shall be made at least one week in advance of all regularly scheduled meetings.

C. Special meetings may be called by the Chairperson or Acting Chairperson of the OPB or by four (4) members of the OPB.

D. OPB members must receive prior notification, in writing, of special meetings.

E. Eight (8) active members of the OPB shall constitute a quorum, *with* representation from each county. In the case of a less than full membership, 50% plus one (1) with representation from each county will constitute a quorum.

F. Electronic/Telephone votes will only be counted if there is a quorum present at the meeting.

G. Motions shall be passed by a majority vote of those present AND via Electronic/Telephone.

H. All regular and special meetings are open to the public, pursuant to the Open Meetings Act. Minutes will be made available.

Article V - **Conflict Of Interest Policy**.

The OBP shall adopt and adhere to a conflict of interest policy which shall require, among other things, the disclosure to the Board Chairperson and any committee chairperson any actual or possible conflicts of interest. This includes any OPB members who are current employees of licensed providers. All board members will annually disclose any conflicts of interest while serving on the board.

ARTICLE VI – Officers

A. The Chairperson, Vice-Chairperson, and Secretary shall be elected by the OPB. Elections shall be held annually in October.

B. Duties and Responsibilities:

1. The Chairperson shall:
    a. Call meetings.
    b. Preside over meetings.
    c. Appoint special committees as deemed necessary.
    d. Serve ex-officio on all committees with the right to vote.
    e. Make appointments as necessary.

2. The Vice-Chairperson shall, in the absence of the Chairperson, assume the duties of the Chairperson.

3. The Secretary shall:
    a) Assure that minutes are kept and distributed
    b) Keep attendance of members at meetings.
    c) Assume the responsibilities and duties of the Chairperson in the absences of the Chairperson and Vice-Chairperson

4. The Officers shall serve one year terms, and may be renewed.

ARTICLE VII – Amendments

A. The By-laws may be amended by a majority vote of the total membership of the OPB, provided that notice of proposed amendments is made available in writing to members at least two weeks in advance.

B. Amendments shall not become effective until they have been reviewed and approved by the Community Mental Health Partnership of Southeast Michigan.

C. Notification of Amendments shall be sent to the appointing Board of Commissioners in each partner county.

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ARTICLE VIII – COMMTTEES

A. Ad Hoc Committees may be formed by the OPB at any time and shall act only on the direction of the OPB.

B. Committee membership may include individuals other than OPB Members, but each Committee must have a least one OPB member appointed to it.

ARTICLE IX

A. For all items not otherwise covered in the By-Laws, Roberts Rules of Order shall apply.

ADOPTED BY THE CMHPSM ON: August 13, 2014

Attachment #5 - May 2016

ACTION REQESTED:

OPB to recommend funding of the part time staff Project Lazarus Coordinator for Livingston County "WAKE UP LIVINGSTON".

BACKGROUND:

Project Lazarus is an evidence based model for communities addressing the Opioid/Heroin epidemic. The model uses a hub and sector approach, with the steering committee driving the various sector workgroups of volunteers. Livingston County has adopted this model in early 2015. Subsequently, Washtenaw and Lenawee Counties have also followed suit with implementation. Because the complexity of the coordination is significant, Livingston County CMHA is requesting to have a dedicated coordinator for this project. The attached application describes the Project Lazarus program in Livingston County with goals for the position requested. Note: the program is very similar to the model developed in Monroe County through the prevention coalition. This coalition has a paid coordinator and has been very successful in coordinating sector workgroups and initiatives in Monroe.

RECOMMENDATION:

The OPB make a recommendation to the Regional CMHPSM Board to increase the current allocation of community grant funds for Livingston County CMHA by $25,000 to fund the Project Lazarus Coordinator position.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Serving Lenawee, Livingston, Monroe, and Washtenaw Counties

Request for Funds	
Date:	May 16, 2016
Contact Person: (Name, email, phone)	Connie Conklin cconklin@cmhliv.org 517-548-0081
Requestor:	Connie Conklin
Amount of Request:	$ 25,000 Annual cost for 16-20 hour a week staff position and other costs associated with Project Lazarus/Wake Up Livingston
Priority Area:	☒ TREATMENT for Substance Use Disorders (indicate specific populations to be served) ☐ Adolescents ☒ Opiate/Heroin ☐ Adults ☐ Alcohol Specific ☐ Gender specific ☐ Recovery Focused/Peers ☐ Other: _____ ☒ PREVENTION (please check one of the following): ☐ Reduce Childhood and Underage Drinking ☐ Reduce Prescription and Over the Counter Drug Abuse/Misuse ☐ Reduce Youth Access to Tobacco ☒ Reduce Illicit Drug Use ☒ Other: Project Lazarus Coordinator
Targeted Community: (Geographic area)	Livingston County
PREVENTION ONLY Targeted Population: (Institute of Medicine Category)	☐ Universal (general public/whole population group) ☒ Selective (individuals – risk of developing a substance use disorder is significantly higher than average) ☐ Indicated (individuals in high-risk environments, minimal signs/symptoms, biological markers indicating a predisposition for disorder)
Primary Problem/	In Livingston County, we have been implementing Project Lazarus

Consequence(s) Support Data: (Include Data Sources and reason for the request for funding)	(Wake UP Livingston) with some success but not to fully implementing the model. After some attempts to split up the primary facilitation across SUD providers and Project Lazarus participants, it is clear that we need one key facilitator/coordinator to provide leadership and facilitation to the steering committee and across the sectors. This position will pull all the sectors together and provide coordination across sectors and the steering committee. They will also work to engage other SUD prevention and treatment partners and ensure there is no duplication.
Underlying Root Causes to be Targeted: (Associated Intervening Variables, Risk/ Protective Factors)	Address Livingston County Heroin/Opiate problem by utilizing the Project Lazarus model. Like many other counties, Livingston County has had numerous deaths and overdoses.
Evidence-based Strategies/Initiatives:	Project Lazarus Model- The Project Lazarus public health model is based on the premises that drug overdose deaths are preventable and that all communities are ultimately responsible for their own health. The model components: (1) community activation and coalition building, (2) monitoring and epidemiologic surveillance, (3) prevention of overdoses through medical education and other means, (4) use of rescue medication to reverse overdoses by community members, and (5) evaluation of project components. The last four steps operate in a cyclical manner, with community advisory boards playing the central role in developing and designing each aspect of the intervention.
PREVENTION ONLY Primary Federal Strategies (CSAP)	<u>Check all that apply:</u> ☒ Information Dissemination ☒ Problem Identification & Referral ☒ Education ☒ Community-Based Process ☒ Alternatives ☒ Environmental

Short-term Outcomes (where applicable) :
 	
(CDC SMART objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-phased)
 	
For each outcome, please include the evaluation method (i.e., survey, questionnaires, etc.)
	Medical Sector
	• MAP Training
	• Social Media for messaging
	• Physician Checklist – how many you see. Track like communicable disease system.
	• Day of Caring INFO
	• Church Bulletins
	
	Law Enforcement
	• Expand and strengthen prevention
	• Need to increase our own awareness of resources/referrals
	• Education on prescriptions and fake scripts
	• Move back into schools on education. Danger of drugs.
	• They feel Narcan needs more discussion.
	Community
	• Provide a centralized position for the county
	  ◦ Embraced by the steering committee
	  ◦ Funded by county and local govt.
	  ◦ This is a piece of a successful model
	• Involve more people (elected officials)
	• Have Tom Cremonte present
	• Dianne McCormick and Commissioner Dolan support and networking
	
	Courts
	• Consistent policies on prescription meds
	• Increasing awareness about prescript. Drugs
	Bring big red barrel info to DNA testing sites.
	• Develop a unified policy across courts and probation regarding use/abuse of prescription drugs while on probation.
	• Gather statistics from specialty court grants on success with opiate users
	• Find a way to separate the stats of “operating under the influence” to show which are controlled substances and which are alcohol.
	
	SUD Providers
	• Increasing awareness of Project Lazarus and the community problem
	  ◦ Church bulletins
	  ◦ Social media
	  ◦ News outlets
	• County-wide Tag line
	• Increase access of SUD providers – distribute resource guide
	• Gather data, humanize it and tell it to the community.
	• Medicated assisted treatment.
	Received permission to use Project Lazarus Tag Line and Big

	Red Barrel Logo-completed
	- School prevention grant – increase awareness in schools
	- Engagement Center will support off hours
	- Increase awareness and value of MAPS
	
	Parents
	- Recovery
	  - Supportive services closer to home
	- Parents
	  - Early Childhood Education
	  - Get treatment, no stigma
	- Provide EMS/Police training on Narcan
	- Rescue breathing for Overdoses (No CPR)
	
	Data
	- Gather data that is accurate for all opiate addiction/overdose cases
	- Use data to begin to identify trends and gaps in services

Intended Long-term Outcome(s): (Describe how this funding will benefit service delivery and/or the community)	**Medical Sector:** In conjunction with hospitals lobby the Michigan Board of Pharmacy to update the current MAPS system, i.e., letter campaign, developing a position paper. Then implement a training to educate Livingston County physicians. **Law Enforcement:** Resource Guide for Law Enforcement Informational Rack Card for officers to distribute **Community:** Develop one Power Point and then change to reflect the issues of each municipality. **Courts:** Develop a unified policy across courts and probation regarding use/abuse of prescription drugs while on probation. **SUD Providers:** Focus on improvements to Medicated assisted treatment and access to

	services. **Parents:** To develop a message and communication approach in the community that reduces stigma and focuses on harm reduction. **Data:** Use results of data to address access, gaps and outcomes. Reduce the numbers of Opiate Overdose by statistically significant numbers.
Key People/Coalition:	⟩ Livingston Community Prevention Project ⟩ Livingston County Community Alliance ⟩ HSCB- SUD Workgroup ⟩ Pinckney Coalition ⟩ Karen Bergbower and Associates ⟩ Key Development Center ⟩ LACASA ⟩ Livingston County Catholic Charities ⟩ Livingston County Community Mental Health Authority ⟩ St. John Brighton Center for Recovery ⟩ 44th Circuit Court ⟩ St. Joseph Mercy Livingston ⟩ Livingston County Sheriff
Community Partners:	⟩ First National Bank ⟩ Brighton Area Schools ⟩ Hartland Community Schools ⟩ The Bridge Alternative High School ⟩ Hamburg Township ⟩ 44th District Court ⟩ St. Joseph Mercy Livingston ⟩ Livingston County Sheriff ⟩ Brighton Police Department ⟩ Howell Police Department ⟩ Brighton Rotary
Please note: All programming must be consistent with the implementation of Recovery-Oriented Systems of Care (ROSC). *Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems*	

(Center for Substance Abuse Treatment, 2005).
CMHPSM Office Use Only

Amount Recommended & Comments:	

ACTION REQESTED:

OPB to approve funds for the Engagement Center in Washtenaw County to cover Client Safety renovation expenses of $22,316

BACKGROUND:

In FY 15, Home of New Vision requested PA2 Funds for financial assistance with former Hope Clinic Building, as they were required move the program by the City of Ypsilanti. At the time, estimates of renovation costs were approximately $25,000, and the OPB approved a $22,000 allocation. Subsequently, the building was purchased and the City required more extensive renovations to ensure client safety, ADA compliant modifications and mold abatement. Attached is the explanation of additional costs by Home of New Vision and a request for financial assistance. The relocation of the Engagement Center allows for expansion of available beds from 8 to 12. Also, the location accommodates parking and it is in close proximity to Washtenaw Community Mental Health, Washtenaw Public Health, Department of Health and Human Services as well as Ypsilanti Family Practice (UM Health System) primary care center. The Engagement Center provided a total of 9,319 admissions since its inception on December 31, 2009!

RECOMMENDATION:

The OPB approve the request for funds in the amount of $22,316

Home of New Vision is a leader in the field of substance use disorder treatment and a voice in the State of Michigan. We help people find the hope, confidence, and courage to change, leading them to a new and better vision for their future.

May 18, 2016

Marci Scalera
Clinical and SUD Services Director
Community Mental Health Partnership
of Southeast Michigan
705 N. Zeeb Road
Suite 2120 (2nd Floor)
Ann Arbor, MI 48103

Re: Home of New Vision Engagement Center

Dear Ms. Scalera:

I am writing today to detail the unforeseen cost over-runs occurred during the renovation of the new Engagement Center. As you are aware, once demolition began at the new location, we encountered several issues that dramatically increased the cost of the renovation by $48,987.

Many of the cost over runs were client safety related issues and there was no question of being able to forego the items. $22,316 were client safety related issues such as: After work began, the City of Ypsilanti informed us that egress windows were required throughout due to the nature of the program, a cost of over $8,215. When wall coverings were removed, we found mold and wall damage that needed to be corrected, at a cost of $7,350. Originally, after being told that 1 ADA bathroom was needed, the inspectors required modifications to all 3 bathrooms to meet ADA specifications. Due to this ADA compliance issue, we had to replace a previously installed (and pre-approved by the City and then rescinded) shower stall and replacement or relocation of toilets and sinks, at an additional cost of $6,751.

I and The Board of Directors at Home of New Vision are requesting the assistance of the Community Mental Health Partnership of Southeastern Michigan in meeting the additional costs related to client safety. While there were other costs associated with the renovations, we are only requesting assistance with costs related to client safety. As you are aware, this program provides a vital community service and a safe and welcoming facility is necessary in serving our mutual clients.

Home of New Vision is contributing in-kind funding to this project and additionally, we obtained volunteered services to complete this project. Now, we find ourselves in a situation where the costs associated with the facility rehab are straining our financial resources. I am hopeful that you and your Board might be able to assist us in meeting the additional costs for the renovation.

On the attached sheet, I have detailed the cost overruns for which we are seeking assistance. I am very appreciative of your previous willingness to assist Home of New Vision in this project, thereby assuring that the Engagement Center remains a place for clients in crisis to find safe haven and a chance to enter recovery.

Kind Regards,

Glynis Anderson, ACSW, LMSW
Founder and CEO
Home of New Vision

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Home of New Vision Engagement Center – Costs for Arnet Building Renovations:

Original Bid:	$25,250
Additional Cost:	$ 48,987
Total Project Costs:	$74,237

CMHPSM's Original Contribution:	$22,000
Additional Costs relates to Client Safety:	
Egress Windows	8,215
Mold & Wall Damage	7,350
ADA Bathrooms	6,751
Additional Costs Related to Client Safety:	**$22,316 (Amount we are seeking)**
Home of New Vision's In-Kind:	$29,921
Total Project Costs:	$74,237

Attachment #7 - May 2016

Lenawee
Livingston
Monroe
Washtenaw

SUBSTANCE ABUSE PREVENTION SERVICES

MID-YEAR PROGRAM STATUS

May 2016

All CMHPSM funded prevention programs are monitored on a regular basis. The mid-year point allows for a more in-depth analysis based on a variety of factors including: the amount of time for program implementation, the submission of Outcome Progress Reports, EBI Program Assessment/Fidelity Forms, and Coalition Community Sector Checklists (where applicable). Mid-Year Report submissions are reviewed from multiple perspectives, including: financial, contractual, MPDS entries, programming, and progress on planned activities in relationship to outcomes.

Current Status:

Based on the reviews, overall the substance abuse prevention programs are progressing as planned with very few exceptions. For those areas that have not produced the results anticipated, either a 'course correction' is required, or a reduction in funds may be warranted. The CMHPSM promotes the rectification of program implementation to enhance the opportunity for successful efforts within the respective targeted community. Thus, feedback and consultation are provided where necessary.

Prevention Program Observations:

Program observations are conducted every other year, occurring the opposite year of the Fiduciary Site Visit. In April, the Prevention Coordinators conducted nine observations and were overall very impressed with the performance of the prevention providers. This included programming in all four counties and a variance in prevention efforts observed.

Site Visits:

The CMHPSM conducted site visits on two new prevention providers. The respective total scores were 88% and 78%. Given our threshold of 85%, one Corrective Action Plan was required. The lower score was mainly due to an unanticipated staff change and the associated effect on programming. The CMHPSM met with this provider and anticipates receiving an Action Plan by the end of May.

Notes:

EBI Evidence-based Intervention
MPDS Michigan Prevention Data System

For additional information and examples of monitoring tools, please see the ***CMHPSM Substance Abuse Prevention Monitoring Procedures*** (booklet).

May 12, 2016

This letter serves as a report as to what HALO Lenawee has accomplished from October 1, 2015 to present day. We have changed our name from Adrian Andy's Angels to HALO Lenawee. Helping Addicted Loved Ones. In order to avoid future confusion with Andy's Angels based in Jackson, Mi.

We were approached by the Morenci Chapter of the American Legion to come and help educate their community and participate in a "benefit poker run". We were able to give away and sell tee shirts we had printed to promote awareness. During the dinner that was provided later in the evening, we spoke about addiction, heroin, opiates and how addiction occurs. Our members who have lost family members were key speakers in helping to educate this group. We provided them with factual information and resources for help.

Earlier in the spring we hosted a "party in the park" for families of the addicted people in our community. Free hot dogs, pop corn, cotton candy, water were provided as well as games for kids of all ages, nail painting, face painting, jump house and a live band playing for four hours. A day for families to come and relax, forget about the stigma and have a good time.

We also held a presentation for the community with Rise Transitional Living group of Lansing. We have become affiliated with this organization in order to provide a competent, structural rehabilitative program for the addicts who have the desire to detox and go through the 9 month to yearlong program. We have developed a very close, personal relationship with the administrators of this group, therefore allowing us priority when we have someone who needs treatment right away. We have several successful outcomes for a few of the Lenawee addicts we have sent there so far. This in turn has helped us to gain very important access to the Lenawee County and Jackson County court systems in which HALO president or co-president, most usually my husband Marv will appear in the court room with addicts, work with the Prosecuting Attorneys and lawyers as well as meeting with the Judges and probation departments in order to get the addict the help they need to get on the right path to a new life. This occurs almost on a daily basis.

In March, I was asked by Parkside Counseling to come to Maurice Spear Campus to speak to a group of parents and minors who had to participate in the MIP program for the court systems.
March, we also were instrumental in lining up the key speakers for the addiction summit as well as helping with the planning and position on the panel.
In late April 2016 we had our first billboard posted along US223 in Adrian to warn about the consequences of using heroin. This billboard has generated several phone calls from community members looking for support as well as help for addicts.
We as a group, hold monthly support meetings in the Adrian High school library to educate the new members who come to us, and to plan the future events to help promote awareness and to offer ongoing support to those who have addicted loved ones.
We participate in the Adrian community "First Friday" events downtown every month. Providing education and awareness, and referring individuals to counseling.
In October 2015, three of our members including myself traveled to Lansing every weekend for recovery coach classes, acquiring 30+ hours of recovery coach training from CCAR.
The month of October we also participated in the Appleumpkin festival in Tecumseh. Our booth was loaded with educational information, shirts and arm bands for the three days.
We are very busy making ourselves heard on social media, our FB page has our mission statement, educational material as well as opinions and conversations of addicts and family members educating each other, offering support.
The schedule for the rest of this year is full, doing much of the same activities with more and more people helping break the stigma.
Also, as we hold the monthly meetings at the high school, we have now included several addicts who are interested in telling their stories and helping to educate. We are usually successful in helping them decide to detox and go into rehab at the same time.

I will submit a plan for the upcoming year as soon as possible.
Thank you for taking time to read our accomplishments this year so far.

Beginning balance $8987.00
12/10/2015 Request for funds itemized list

- 10/5/2015 Participation in Adrian downtown fall scarecrow display-angel scarecrow to promote awareness… supplies $53.80…….won first prize
- CCAR training for three members @913 W. Holmes Rd Lansing Mi mileage= 166 miles per
- day x 5 = 830 miles x .575 Per mile =$477.25
- food for three members for 2 days =$51.57
- Printed t-shirts and Sweatshirts $4136.00
- 10/24/15 100 Heroin education brochures =$56.80
- 11/18/2015 20 Heroin informational copies for new group members $40.28

$53.80
$477.25 mileage
$51.57 food
$4136.00 shirts
$56.80
$40.28

_____
TOTAL $4815.70

04/13/16 request for funds $ 312.50 monthly invoice for billboard cost (one of 4)

Final balance $3858.80

Sincerely,
Janee' Cox
HALO Lenawee
517-270-0403

Vivitrol for
Opioid Dependence: Epidemiology and Treatment

Medication Assisted Treatment

Vivitrol®
(naltrexone for extended-release injectable suspension)
Once-monthly dosing. Day by day control.

Treatment with VIVITROL® plus counseling

- VIVITROL is the only FDA-approved once-monthly extended-release injectable formulation of naltrexone. It provides patients who have completed opioid detoxification the opportunity to receive effective medication monthly to help prevent relapse[1]

VIVITROL is indicated for:

- Treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting. Patients should not be actively drinking at the time of initial VIVITROL administration
- Prevention of relapse to opioid dependence, following opioid detoxification
- VIVITROL should be part of a comprehensive management program that includes psychosocial support

Reference: 1. Volkow ND. Important Treatment Advances for Addiction to Heroin and other Opiates. October 2010. National Institute on Drug Abuse website. http://www.drugabuse.gov/about-nida/directors-page/messages-director/2010/10/important-treatment-advances-addiction-to-heroin-other-opiates. Accessed July 8, 2015.

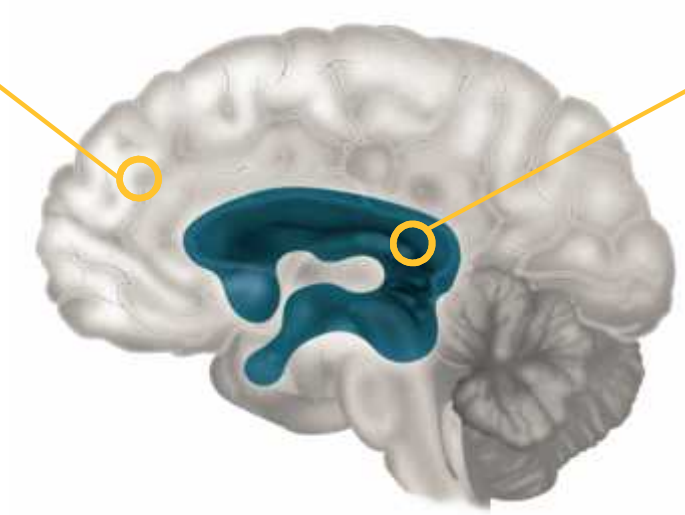
PLEASE SEE IMPORTANT SAFETY INFORMATION THROUGHOUT THIS PRESENTATION.
PRESCRIBING INFORMATION AND MEDICATION GUIDE WILL BE FURNISHED DURING THIS PROGRAM.

VIV-001865

Opioid dependence affects 2 regions of the brain

Counseling targets the cortex

The role of the cortex includes[1,2]
- Decision making
- Thinking
- Reasoning
- Planning



Medication targets the limbic region

The role of the limbic region includes[1]
- Basic drives or urges
- Rewards
- Pleasure

References: 1. National Institute on Drug Abuse. *Drugs, Brains, and Behavior: The Science of Addiction*. Bethesda, MD: National Institute on Drug Abuse, US Department of Health and Human Services; 2007. NIH publication 10-5605. **2.** Fowler JS, Volkow ND, Kassed CA, Chang L. Imaging the addicted human brain. *Sci Pract Perspect*. 2007;3(2):4-16.

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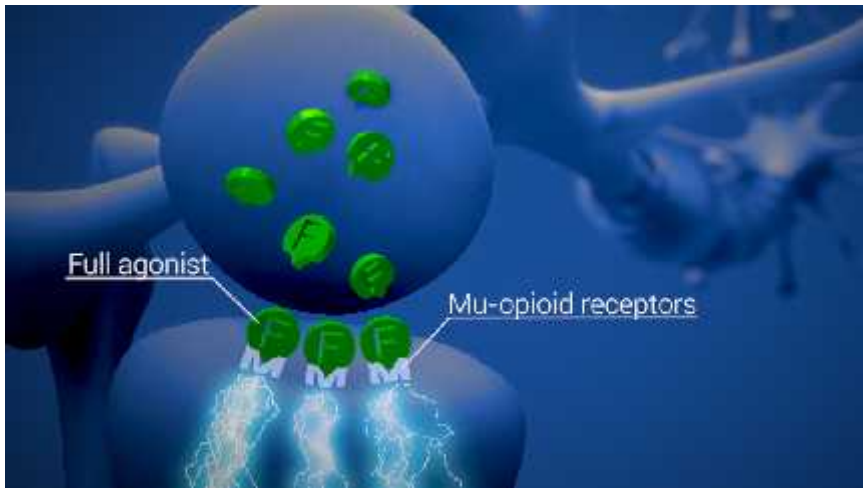
VIV-001865

There are 3 classes of medicines that can be used with counseling for the treatment of opioid dependence

- Medications to treat opioid dependence are classified by the effect they have on mu-opioid receptors on brain cells. They are classified as either opioid agonists or opioid antagonists. Agonists stimulate the mu-opioid receptor like opioids do, while antagonists block the effect of opioids on the mu-opioid receptor
- Opioid detoxification is required prior to treating opioid dependence with an opioid antagonist (naltrexone). Opioid detoxification is not required before treating opioid dependence with a full (methadone) or partial (buprenorphine) agonist[1,2]

References: 1. Kosten TR, George TP. The neurobiology of opioid dependence: implications for treatment. *Sci Pract Perspect*. 2002;1(1):13-20. **2.** Substance Abuse and Mental Health Services Administration booklet. The facts about naltrexone for the treatment of opioid addiction. Printed 2009. Revised 2012. HHS Publication No. (SMA) 12-4444. store.samhsa.gov/shin/content/SMA12-4444/SMA12-444.pdf.

Treating opioid dependence with a full agonist or opioid-maintenance medication



- Full opioid agonists attach to and activate opioid receptors in the same way as opioid drugs, such as heroin and oxycodone, triggering the brain's pleasure response[1-3]

References: 1. Dolophine hydrochloride [prescribing information]. Roxane Laboratories, Inc. Columbus, OH; 2013. **2.** Oxycontin [prescribing information]. Purdue Pharma, LP: Stamford, CT; 2013. **3.** Center for Substance Abuse Treatment. *Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction.* Treatment improvement protocol (TIP) series 40. DHHS Publication No. (SAM) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

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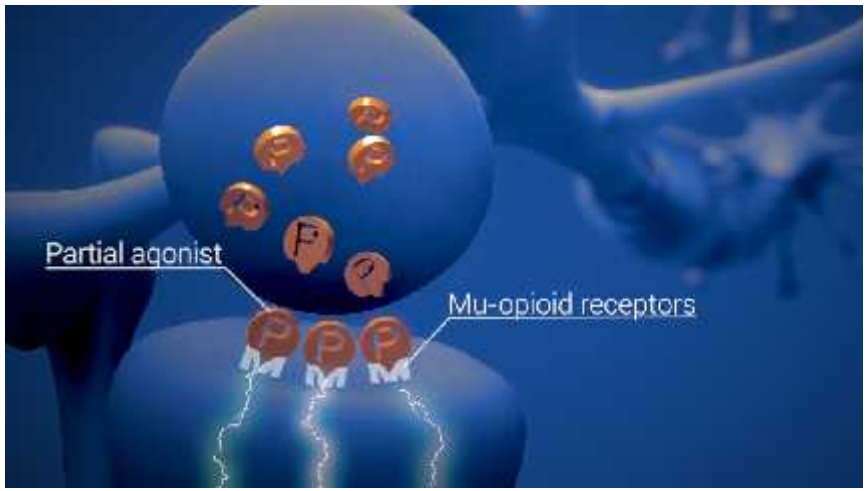
VIV-001865

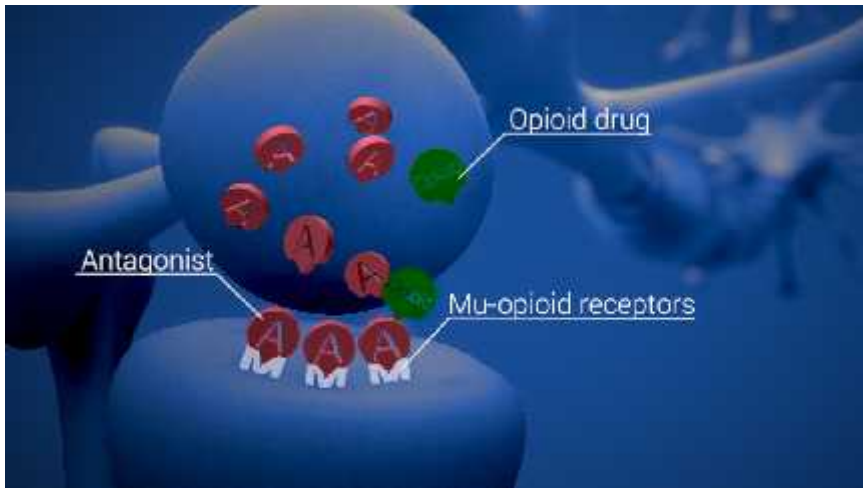
Treating opioid dependence with a partial agonist or opioid-maintenance medication



- Partial opioid agonists activate the mu-opioid receptors and stimulate the response of dopamine; however, partial agonists produce a more limited response than full agonists[1]

Reference: 1. Suboxone sublingual film [full prescribing information]. Richmond, VA: Reckitt Benckiser Pharmaceuticals Inc; 2011.

Treating opioid dependence with an antagonist or opioid-maintenance medication



- Opioid antagonists competitively bind to block opioid drugs from binding to these receptors. The blockade prevents the opioid drug from stimulating the dopamine reward pathway[1-3]

References: 1. Substance Abuse and Mental Health Services Administration. An introduction to extended-release injectable naltrexone for the treatment of people with opioid dependence. *Advisory*. 2012;11(1). HHS Publication No. (SMA) 12-4682. **2.** Substance Abuse and Mental Health Services Administration booklet. The facts about naltrexone for treatment of opioid addiction. Printed 2009. Revised 2012. HHS Publication No. (SMA) 12-4444. store.samhsa.gov/shin/content//SMA12-4444/SMA12-4444.pdf. **3.** Center for Substance Abuse Treatment. *Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction*. Treatment improvement protocol (TIP) series 40. DHHS Publication No. (SAM) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

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VIV-001865

Antagonist therapy may be an appropriate option

Key considerations for starting treatment

- Is the patient ready to commit to detoxification and becoming opioid-free?
- Is the patient willing to attend counseling?
- Is the patient ready to take the medication as prescribed?
- Does the patient have a support system in place?
- Is the patient willing to commit to recovery?

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VIV-001865

VIVITROL® is the only once-monthly extended-release injectable formulation of naltrexone

VIVITROL is[1]:

- Nonaddictive and nonnarcotic
- A competitive opioid blocker (ie, antagonist)
- One month of naltrexone therapy in a single shot
- Used in conjunction with psychosocial treatments

VIVITROL is NOT[1]:

- Pleasure-producing
- Associated with abuse
- A replacement or a substitute for opioids
- Associated with withdrawal upon discontinuation
- A controlled substance

- Patients should stop drinking before starting VIVITROL
- If patients take opioids or opioid-containing medications, such as prescription pain medications, opioid-replacement medications, or street drugs, they must stop these for a minimum of 7 to 10 days before starting treatment with VIVITROL to avoid precipitation of opioid withdrawal[1]
- VIVITROL may not work for everyone and has not been studied in children[1]
- **Additional Important Safety Information about VIVITROL, including precipitation of opioid withdrawal, is discussed later in this presentation**

Reference: 1. VIVITROL [prescribing information]. Waltham, MA: Alkermes, Inc; 2013.

PLEASE SEE IMPORTANT SAFETY INFORMATION THROUGHOUT THIS PRESENTATION. PRESCRIBING INFORMATION AND MEDICATION GUIDE WILL BE FURNISHED DURING THIS PROGRAM.

VIV-001865

Vivitrol®
(naltrexone for extended-release injectable suspension)

Important Safety Information

Warning/Precaution

Vulnerability to Opioid Overdose

- Because VIVITROL blocks the effects of exogenous opioids for approximately 28 days after administration, patients are likely to have a reduced tolerance to opioids after opioid detoxification. As the blockade dissipates, use of previously tolerated doses of opioids could result in potentially life-threatening opioid intoxication (respiratory compromise or arrest, circulatory collapse, etc).
- Cases of opioid overdose with fatal outcomes have been reported in patients who used opioids at the end of a dosing interval, after missing a scheduled dose, or after discontinuing treatment.
- Patients and caregivers should be told of this increased sensitivity to opioids and the risk of overdose.
- Any attempt by a patient to overcome the VIVITROL blockade by taking opioids may lead to fatal overdose. Patients should be told of the serious consequences of trying to overcome the opioid blockade.

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VIV-001865

Vivitrol®
(naltrexone for extended-release injectable suspension)

VIVITROL® plus counseling may help in recovery

Four important steps to guide you as you work with patients and their loved ones toward recovery

1. **IDENTIFY** appropriate VIVITROL patients
2. **WORK** together toward recovery
3. **COORDINATE** the treatment plan
4. **ENCOURAGE** adherence

PLEASE SEE IMPORTANT SAFETY INFORMATION THROUGHOUT THIS PRESENTATION.
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VIV-001865

Vivitrol®
(naltrexone for extended-release injectable suspension)

Vivitrol Pilots Monroe County

- Salvation Army Harbor Light - June 1st
  - Any eligible client will be offered Vivitrol
  - Medicaid/HMP covers cost of meds, CMHPSM covers bridge meds while client applies for Medicaid/HMP
  - CMHPSM covers treatment as usual

Vivitrol Pilots Monroe County

- Community Drug Diversion Program
  - Arrested clients screened for Opiate addiction/dependency
  - Assigned program case manager & referred to CMHPSM Access staff
  - Vivitrol started in Jail after confirming treatment referral. Continued medical through Family Medical (FQHC)
  - Medicaid/HMP covers cost of meds, CMHPSM covers bridge meds while client applies for Medicaid/HMP
  - CMHPSM covers treatment as usual

Vivitrol Pilots Monroe County

1. Medication Cost: $1100/month
2. Able to fund Indigent clients with block grant funds
3. Will have to create a contract with Family Medical or Pharma distributor.

Vivitrol Pilots Washtenaw County

1. Currently available through Dawn Farm for Medicaid Clients, St. Joe's Greenbrook
2. Exploring other options for indigent clients
3. Jail is willing to do similar program as Monroe
4. WCMH is also willing to explore for co-occurring clients