July 27, 2018

FRIDAY FACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance Members
Executive Board Members

FROM: Robert Sheehan, Chief Executive Officer
Alan Bolter, Associate Director

RE:

- **Contact information of the CMH Association's Officers:**
- **Work, Accomplishments, and Announcements of CMH Association and its Member Organizations**
- **State and National Developments and Resources**
  - **Great Lakes Addiction Technology Transfer Center Network announces rural workforce webinar**
  - **Poverty: a community call to action conference announced**
  - **Revisiting the Rationale and Evidence for Peer Support**
  - **Alarming connection between zip code and life expectancy**
  - **Office of Disease Prevention and Health Promotion issues SUD infographic**
  - **Nominations Open for Recipient Rights Directors Award and Cooke Gant Spirt Award**
- **Legislative Update**
  - **If Dems See Big Wins, Will We See A Busy Lame Duck?**
- **National Update**
  - **Court Blocks Kentucky's Medicaid Work Requirements**
- **Additional Dates Added: Ethics Training for Social Work and Substance Abuse Professionals for 2018/2019**
- **Recipient Rights Conference – September 11-14, 2018 – Crystal Mountain Resort**
- **CMHAM Association committee schedules, membership, minutes, and information**
- **Behavioral Health Hepatitis A Outbreak Survey Report, June 25, 2018**

Contact information of the CMH Association's Officers: 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

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Great Lakes Addiction Technology Transfer Center Network announces rural workforce webinar

WEBINAR:
Workforce Recruitment and Retention Part 3: Rural Workforce, Recovery Workforce

DATE & TIME:
Wednesday, July 25, 2018
11:00 am - 12:00 pm (Central)
(12pm Eastern, 10 am MT, 9 am PT)

This is the **third webinar** in a three-part series on workforce recruitment and retention in behavioral health, with a specific focus on the field of addictions.

Presenters Dr. Christine Chasek and Dr. Michael Flaherty will provide insight and strategies to help you:

- Recruit and retain skilled professionals to work in **rural and remote areas**
- Build a peer support worker and recovery coach workforce with **people in recovery**

Register for this webinar at: https://events-na6.adobeconnect.com/content/connect/c1/813211227/en/events/event/shared/default_template/event_landing.html?sco-id=1621679572

Poverty: A Community Call to Action

Tuesday, October 9, 2018
6:00 pm - 9:00 pm

MSU College of Nursing - Bott Nursing Building
1355 Bogue St.,
Room C160-C170
East Lansing, MI 48824

Register Now:
https://povertycalltoaction.eventbrite.com

$15 registration fee per person (NO REFUNDS)
Group discounts available for 5+ individuals
All seminar materials and CE included!

Target Audience: Interested leaders, community members, law enforcement, teachers, nurses, social workers and other professionals.

Outcome: Event participants will actively engage in a role-playing, simulated experience, immersed in the realities of living conditions of poverty and be empowered to brainstorm strategies for a call to action in the greater Lansing community.

Continuing Nursing Education: 3.0 CNE
Social Work Contiuing Education Contact Hours (CECH): 3.0 CECHs
Contact hours will be provided to eligible nurses or social workers who participate in the entire event and submit a completed evlaluation. **No partial credit will be awarded.**

Jointly Provided by the Michigan State University College of Nursing and School of Social Work

Registration questions: con.nurse.ce@msu.edu or call (517) 355-3393

Revisiting the Rationale and Evidence for Peer Support

Below is a recently published article, in Psychiatric Times, that underscores the value of peer support in mental healthcare.

The authors argue that that stating that peer support "lacks evidence" is simply not accurate. *Patients in the treatment group—with peer support— had fewer psychiatric hospital admissions on average and more episodes of crisis stabilization than those in the comparison group*

> A recent issue of *Psychiatric Times* featured an opinion piece (http://www.psychiatrictimes.com/blogs/jury-out-paid-peer-support-people-mental-illness)by D.J. Jaffe who argued that there is little empirical support for the effectiveness of paid peer-support staff—persons in recovery from mental illnesses who are trained to provide support to others—on the outcomes of "homelessness, arrest, incarceration, violence, and needless hospitalization."[1] In this article, we rebut Mr. Jaffe's argument by revisiting the rationale and evidence base for peer support.
>
> While we agree that the government needs to fund more research on this important topic, we argue that stating that peer support "lacks evidence" is simply not accurate. In fact, as we will explain below, over 30 studies have found positive effects in numerous outcome domains. But first it is important to understand the nature and intended impact of this form of service delivery.
>
> Rationale for Peer Support
> The rationale for peer support is neither new nor limited to psychiatry. Paid peer support has been around since the birth of the discipline in the late 18th century, with the hiring of recovered patients as staff identified as one of the most essential components of "moral treatment."[2] Harry Stack Sullivan continued this practice in his hospital in the 1920s, while the milieu therapy models that dominated psychiatry for the following decades relied in large part on the benefits of peer support and role modeling.
>
> Outside of psychiatry, the Institute of Medicine reports that various forms of peer support can be found in virtually every branch of medicine that deals with chronic conditions, from asthma and cancer to diabetes and hypertension.[3] The rationale here is simple; as explained by Fisher and colleagues[4] in a recent review, persons with chronic illnesses spend about 6 hours every year in a health professional's office, while spending the remaining 8760 hours of the year living with and trying to manage their health conditions. In psychiatry, this ratio is likely much less. Whether it is diabetes or mental illness, helping someone to live well with a serious illness is different from treating the illness, and it takes a different investment of time and effort. Simply put, people living with serious mental health conditions need more assistance and support than can be provided by a physician alone.
>
> In psychiatry, as in other areas of chronic illness management, that "more" is typically provided by paraprofessionals. In medicine, there is currently rapid growth in the hiring of community health workers to assist patients with all manner of conditions to engage in self-care and to navigate complex health systems. In public psychiatry, paraprofessionals spend the most time with persons with chronic conditions, but usually have little to no training.
>
> Training and hiring persons in recovery to provide peer support represents a win-win situation for resource-strapped systems. Patients receive support from trained peers who instill hope, model self-care, and help navigate the health care system. Peer support providers are gainfully employed in a role that supports their own recovery by allowing them to do personally motivated work. Systems gain a trained, effective workforce that pushes providers beyond the basic outcomes of decreased homelessness, incarceration, and hospitalization to include other outcomes that also matter to patients and their loved ones, ie, those associated with reclaiming a meaningful life.
>
> To aspire to help persons with mental illnesses to establish meaningful lives is not to overlook or minimize the need to address homelessness, incarceration, and hospitalization. Because many have walked in their shoes, peer-support staff are especially expert in forging caring relationships with people who are overcome by the direst of circumstances and who have not responded to traditional approaches. Peer-support staff can effectively engage patients because they understand how they live (all too often on the street or in shelters) and offer practical help with basic needs and everyday living. In contrast to coercive measures that further erode patients' sense of self and basic dignity by focusing solely on illness, peer-support staff can earn patients' trust by providing assistance with

day-to-day struggles, offering a more effective and sustained pathway to needed care tan 2-week involuntary inpatient stays.

The Evidence for Peer Support

It should be no surprise that the CMS study Jaffe references found that deploying peer staff increased the use of crisis services while decreasing hospitalizations.[5] This increase in service use was a positive outcome for persons who otherwise were disconnected from all outpatient treatment. Perhaps it is on this score, above all, that the effectiveness of peer services has been shown most consistently.

When reviewing this evidence, it is important to recognize that neither peer nor non-peer non-clinical staff "treat" mental illness, that is not their role. Peer-support staff complement clinical care; their role is to instill hope, engage patients in self-care and health services, help them navigate complex and fragmented systems, and promote their pursuit of a meaningful life. When assessed on their ability to do these jobs for which they have been trained, peer-support staff clearly demonstrate effectiveness.

The Table **(**found at: http://www.psychiatrictimes.com/special-reports/revisiting-rationale-and-evidence-peer-support **)**provides examples of the roles peer-support staff have played that have garnered consistent evidence in improving patient outcomes.[6] To date, over multiple studies have found that peer staff who are working in peer-specific roles are better able to engage people in caring relationships[7–8]; improve relationships between clients and outpatient providers, thus increasing engagement in non-acute and less costly care[9–17]; decrease substance use, unmet needs, and demoralization[8,11,17–18]; and increase hope, empowerment, self-efficacy, social functioning, quality of and satisfaction with life, and activation for self-care.[8,11–13,16,18–30]

Patient-Care Outcomes

Why would these kinds of gains not be worthy of funding? Presumably because they have yet to be connected directly to reductions in the negative outcomes of arrest, incarceration, and violence. But these poor outcomes are more reflective of societal and systemic failures than of mental illness per se. They are due primarily to long-standing discrimination that has resulted in a lack of parity in funding for community-based mental health care.

This becomes obvious when one looks beyond the borders of the US. Homelessness, arrests, and incarceration are not attributable to mental illness alone, because they are not significant problems for persons with mental illness in most other developed countries. Mental illness alone poses minimal risk for violence (around 4%).[31] Mass shootings are more a result of our failure to control access to assault weapons than a failure to treat mental illness. As Zakari[12] pointed out in the Washington Post, the incidence of mental illness in the US is the same as that of the UK, yet the rate of gun violence in the US is 40 times that of the UK. Surely, unaddressed factors other than mental illness contribute significantly to such poor outcomes.

Foremost among these is the long-standing stigma against persons with mental illnesses that has resulted not only in the lack of adequate funding for community-based care but also acts as a barrier to accessing what care is available sooner, which might prevent the need for more intensive care later on. Homelessness, incarceration, and violence among persons with mental illness are more of a consequence of our failure to accord such persons the rights of dignity, respect, and full citizenship that is their birthright than to mental illness per se.

Conclusion

No one would deny a person in recovery from cancer, or a person living with diabetes, the opportunity to contribute to the shaping and delivery of cancer or diabetes care. Persons in recovery from mental illnesses have insider knowledge of what it takes to have a life well lived with mental illness. In fact, two of the most influential visionaries in the history of mental health policy, Dorothea L. Dix and Clifford W. Beers[32] had their own experiences of mental illness. Based on the credibility and trustworthiness fostered by their lived experience, their passion to give back, and their dedication to making recovery a reality for others who suffer with mental illness, other people in recovery (ie, peers) can also make invaluable contributions to better outcomes by advocating for, transforming, expanding, and providing effective mental health services.

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Alarming connection between zip code and life expectancy

Below is an excerpt from a recent Slate article regarding recently issued video on the impact of poverty and other social determinants on health disparities.

> Where you live affects the quality of your life. Perhaps that's obvious, but this animated **video** about California shows just how true the statement really is. Narrator George Takei paints a picture of two imaginary California citizens who are the same age, are both employed, and have similar families. The only difference between them is that they live less than a mile away from each other—but that one difference turns out to be huge.
> One community is wealthy, the other impoverished. Other than the general disparity in wealth, that means that they have vastly different access healthy food, recreation, and schools. That small mileage difference can even result in lower air quality. And if you think not having access to these things sounds stressful, you're right. Which is also bad for your health.
>
> The ultimate outcome is a shorter lifespan. The video above bears out this heartbreaking connection between zip codes and life expectancy.

This video can be found at: https://vimeo.com/165205891

The full Slate article can be found at:
http://www.slate.com/articles/video/video/2016/06/this_video_from_the_california_endowment_explains_how_zip_code_affects_life.html

Office of Disease Prevention and Health Promotion issues SUD infographic

Check Out the New Substance Abuse Infographic from Healthy People 2020. Each month, the Office releases an infographic with the latest data related to a Healthy People 2020 Leading Health Indicator (LHI) topic. These infographics show progress toward Healthy People 2020 LHI targets — and show where there's still work to be done.

This month's featured LHI topic is Substance Abuse. Check out the infographic below, then head over to the Healthy People 2020 LHI Infographic Gallery (https://www.healthypeople.gov/2020/leading-health-indicators/LHI-Infographic-Gallery?source=govdelivery&utm_medium=email&utm_source=govdelivery)to see infographics for other LHI topic areas.…

The blog post can be found at:
https://health.gov/news/announcements/2018/07/check-out-the-new-substance-abuse-infographic-from-healthy-people-2020/?source=govdelivery&utm_medium=email&utm_source=govdelivery

Nominations for the Directors' Awards and the Cookie Gant Spirit Award

Michigan Department of Health and Human Services, Office of Recipient Rights is accepting nominations for its annual Directors' Awards and Cookie Gant Spirit Award. Office of Recipient Rights is pleased to announce its call for nominations

recognizing excellence in Recipient Rights Community by honoring individuals that deserve recognition in the areas of innovation, advocacy and empowerment. There are four awards presented each year at the Recipient Rights Conference. Each award has its own criteria and is summarized below:

Director's Award for Innovation and Rights Protection: Nominees will have created a new or different way of enabling the vision of recipient rights or of a rights office. This may include creating a valuable new process or product, constructing a difference way of approaching old problems, creating a new solution for a systemic problem.
Director's Award for Advocacy on Behalf of Mental Health Recipients: Nominees will have made an outstanding contribution toward, or have gone to extraordinary means, to advocate on behalf of people receiving mental health services.
Director's Award for Consumer Empowerment: Nominees will have made a profound or uniquely positive difference in the lives of consumers, so that consumers are empowered to transcend the "world of disability" and live a life of self-advocacy.
Cookie Gant Spirit Award: This award is issued by the State Recipient Rights Advisory Committee and is presented to an individual who exhibits the dedication, demonstrates tenacity, and advocates diligently for persons with mental illness or developmental disabilities.

Please take the time to nominate an individual within the rights system, a colleague, an organization, who deserves to be celebrated-consider nominating individuals or organizations whose accomplishment has yet to be publicly acknowledged. A nomination form to submit your referral for Directors' Awards and the Cookie Gant Spirit Award is attached. ***All nominations are due August 1, 2018.***

LEGISLATIVE UPDATE

If Dems See Big Wins, Will We See A Busy Lame Duck?

In times of political change, lame duck session in the Legislature would be seen as one last chance to complete an agenda, a last shot at getting things done. Below is a list of bills introduced and passed in lame duck shows that turning a chamber, or even the governor's chair, doesn't necessarily result in a high productivity lame duck session.

The last time there was significant turnover in Michigan was 2010, when Rick Snyder took over the governor's seat from Jennifer Granholm and Republicans wrestled control of the House away from the Dems, a pretty mild lame duck session followed. That year, 105 bills were introduced in lame duck, five of which were eventually passed. Overall, lawmakers moved 175 bills to the governor after the election, which she signed. But remember, the GOP controlled the Senate, and could have put an end to any last minute Democratic juggernaut in the Legislature.

Compare that to last election year, when the Republicans had and would retain the trifecta, holding the governor's office and both chambers. In 2016, 214 bills and resolutions were introduced in lame duck, six of which got passed. Overall, the governor signed 249 bills passed by lawmakers after the election.

In 2014, 337 bills and resolutions were introduced in lame duck, and 10 of those were passed. Overall, 217 bills were passed and signed after the election.

Oddly, the busiest lame duck in the last 18 years was in 2008, when lawmakers introduced 297 bills after the election and adopted 44 of them. Overall productivity in lame duck was 286 bills.

When Granholm took over from John Engler in 2002, there were 147 bills introduced after the election, and 15 of them were passed. Engler signed 152 bills from lame duck session.

Randy Richardville, who was Senate Majority Leader from 2011-2014, said it is not the number of bills that make lame duck count. "More important than the number of bills is the quality of the bills and the impact they may have on the state," he said. "Auto no-fault could be a significant thing to get done during this last shot, to get it done in a way that would be meaningful to people." Another important issue that might be addressed is returning the income tax to 3.9 percent, which Richardville said was a promise made during the Granholm years, that once the economy was back in good shape, the income tax would be returned to that level.

Richardville said this year's lame duck will be “unprecedented” because of the amount of turnover that will occur in both House and Senate. Seventy percent of Senate seats will be occupied by newcomers next year. The House will see 40 percent turnover, due both to term limits and legislators giving up time in the House to seek all those open Senate seats.

2016
214 bills and resolutions introduced in lame duck
6 of those passed and signed
249 total bills passed and signed after the election

2014
337 bills and resolutions introduced in lame duck
10 of those passed and signed
217 total bills passed and signed after the election

2012
174 bills and resolutions introduced in lame duck
9 of those passed and signed
282 total bills passed and signed after the election

2010
105 bills introduced in lame duck
5 of those passed and signed
175 total bills passed and signed after the election

2008
267 bills introduced in lame duck
44 of those passed and signed
286 total bills passed and signed after the election

2006
160 bills introduced in lame duck
15 of those passed and signed
240 total bills passed and signed after the election

2004
109 bills introduced in lame duck
12 of those passed and signed
195 total bills passed and signed after the election

2002
147 bills introduced in lame duck
15 of those passed and signed
152 total bills passed and signed after the election

NATIONAL UPDATE

Court Blocks Kentucky’s Medicaid Work Requirements

On June 29th, a district court judge blocked Kentucky’s waiver request to require Medicaid enrollees to work or participate in a job-related activity for at least 80 hours per month or lose their health coverage. The court ruled that the Centers for Medicare and Medicaid Services (CMS) had not properly considered whether the initiative would violate Medicaid’s central

objective of providing medical assistance to the state's citizens. The decision could have broad implications for other states hoping to limit Medicaid enrollment through work requirements.

IMPLICATIONS

While Judge James Boasberg's ruling applies only to Kentucky, his reasoning for overturning CMS's decision to approve Kentucky's work requirements could extend to the other states that have implemented work requirement programs — namely, Arkansas, Indiana, and New Hampshire — and seven other states whose applications are currently being reviewed by the Department of Health and Human Services (HHS). Matt Salo, Executive Director of the National Association of Medicaid Directors, said the ruling is a "big roadblock for the four states looking to implement these already approved waivers."

Although the decision did not outlaw Medicaid work requirements outright, it requires that any Medicaid Section 1115 waiver demonstration be carefully assessed for its impact on people's health care coverage. The decision also sets an important precedent by finding Medicaid to be a health insurance program that provides equal treatment of all groups covered by its statute, including Medicaid expansion populations.

WHAT'S NEXT?

HHS will now reevaluate Kentucky's waiver approval and decide whether they will seek an appeal, which will need to be filed in the next 60 days. As a result, HHS may hold off on announcing any additional work requirement approvals — and states may wait to submit their requests — until this legal battle reaches its conclusion.

In the meantime, Kentucky Gov. Matt Bevin (R) has responded to the ruling by canceling Medicaid vision and dental benefits included in Kentucky HEALTH, and has threatened to reverse the state's Medicaid expansion.

TRAININGS:

ADDITIONAL DATES ADDED: 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 dates.

- August 22 – Lansing (training full)
- September 26 - Gaylord
- November 7 – Lansing
- January 23 – Lansing
- February 20 – Lansing
- March 13 – Lansing
- April 24 – Detroit Area

Training Fees: (fee includes training material, coffee, lunch and refreshments.
$115 CMHAM Members
$138 Non-Members

Registration for the new dates will open soon!
Three Trainings/Three Locations!

Register for the level of training and date/location of your choice.
2-day Motivational Interviewing Basic training - $89

2-day Motivational Interviewing Advanced training - $89
1-day Motivational Interviewing Supervisory training - $49

Agenda for all trainings:
Registration: 8:30am to 9:00am; training(s) start promptly at 9:00am and adjourn at 4:00pm each day.

Who Should Attend? 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 Specialist and any other practitioners at the beginning, advanced and supervisory levels of practice.

Dates	Location
July 30-31	Doubletree by Hilton, Grand Rapids 4747 28th Street SE, Grand Rapids, MI 49512 Phone: 616-957-0100 Hotel room block of $75 per night expires July 19
August 28-29	Courtyard Marriott, Mt. Pleasant 2400 East Campus Drive, Mt. Pleasant, MI 48858 Phone: 989-773-1444 Hotel room block of $75 expires August 10
September 11-12	Great Wolf Lodge, Traverse City 3575 N. US Highway 31 S, Traverse City, MI 49684 Hotel room block of $75 per night expires August 17 Call 866-962-9653 reference Reservation #18092DAY

Go to our website at www.macmhb.org for registration and further information

25th ANNUAL RECIPIENT RIGHTS CONFERENCE

The 25th Annual Recipient Rights Conference, "25 Years on the Right Path," will be held September 11-14, 2018 at Crystal Mountain Resort in Thompsonville. On September 11 from 9:00am to 3:30pm, will be the Pre-Conference Workshop: Preparing for the Interview: Critical Areas of Consideration. The main conference will be September 12-14 and features 2 keynote addresses and 24 workshops!
See full conference details here: https://macmhb.org/recipient-rights
To register, click here:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5185&AppCode=REG&CC=118071726516

CMH ASSOCIATION COMMITTEE SCHEDULES, MEMBERSHIP, MINUTES, AND INFORMATION: go to our website at https://www.macmhb.org/committees

Behavioral Health Hepatitis A Outbreak Survey Report, June 25, 2018

Reporting Period: April 1– May 31 2018

Reporting Rate

- 46 of 46 Community Mental Health Agency Services Providers.
- 42 Substance Use Disorder Clinics reported.

Reporting Rate	Yes	No	Total	%
CMH Reporting Rate	46	0	46	100%
SUD Reporting Rate	42	N/A	TBD	N/A

Screening Rate

- 21 of 46 (46%) Community Mental Health Agency Services Providers are screening.
- 26 of 42 (62%) Substance Use Disorder Clinics are screening.

Screening Rates	Yes	No	Total	%
CMH Screening for High Risk Conditions	21	25	46	46%
Public SUD Screening for High Risk	26	16	42	62%

Community Mental Health Service Provider Screening Information

- Persons who use injection or non-injection drugs and homeless/transient are the two highest risk behaviors.

Reported number of clients screened	10347*
Reported number of clients with high risk behaviors	20951
Persons who use injection or non-injection drugs	19592
Men who have sex with men	304
Homeless or in transient living condition	3884
Incarcerated	822
Chronic Liver Disease	132

* Not all CMHSPs reported their total number of consumers screened but did report on number of high risk behaviors and risk factors, therefore percentages could not be calculated and risk factors could be duplicated.

SUD Screening Information from April 1 – May 31, 2018

- Persons who use injection or non-injection drugs and incarcerated are top two high risk behaviors.

Reported number of clients screened	n = 2081	%
Reported number of clients identified with high risk behaviors	1356	65%
Persons who use injection or non-injection drugs	1299	62%
Men who have sex with men	187	9%
Homeless or in transient living condition	562	27%
Incarcerated	714	34%
Chronic Liver Disease	419	20%

Vaccine Responses (CMHSP/SUD combined results)

Referring clients that need vaccination to:		
Answer Choices	Responses n = 125	
Local Health Department	121	97%
Primary Care Provider	90	72%
Pharmacy	18	14.4%
Mobile Clinic	9	7%
Other (please specify)	9	7%

Does your organization have staff that have been trained to administer vaccines?	Yes	No	Blank	Total	%
CMH Response	21	20	5	46	46%
SUD Response	7	24	11	42	17%

Would your organization be willing to host a vaccination clinic?	Yes	No	Blank	Total	%
CMH Response	29	10	7	46	63%
SUD Response	12	19	11	42	45%

If a hepatitis A case is confirmed in your agency, would you like to offer hepatitis A vaccination routinely to all your residents/patients during intake?	Yes	No	Blank	Total	%
CMH Response	22	17	7	46	48%
SUD Response	10	20	12	42	24%

Highlights from CMHSP/SUD Open Ended Responses (From All Reporting Periods)

Several important open-ended questions in the baseline survey allowed the CMHSPs and SUD organizations to report communication and prevention strategies and needs on which they feel MDHHS and other partners could coordinate and support their hep A efforts.

Survey data suggested that follow up with specific providers to clarify answers and the perceptions of the outbreak was needed. Some CMHSPs and SUD providers have been contacted, and others may hear from MDHHS regarding immunization follow-up, updating on barriers (i.e. transportation), and encouragement to respond to the hepatitis A outbreak. The following are examples of narrative answers received from the two types of organizations (content edited to remove organizational identifications).

- Based on needs expressed in survey responses, MDHHS Division of Immunizations has been able to connect with several CMH and SUD providers to support the local provision of hepatitis A immunization.

- Any barriers to behavioral health providers are being reported to the MDHHS Bureaus supporting the hep A response, to identify assistance that is available. The following are examples of challenges that have been identified:

    - Transportation for the providers' service population
    - Rural location of offices
    - Determining financing and insurance issues for immunizations
    - Time and staff necessary to screen and follow up with people who are at risk for hepatitis A

- Responses inform MDHHS on circumstances under which providers are not screening/vaccinating, and different perceptions of risk.

- Efforts that have been highly effective in informing provider staff and the service population are being reported in the survey. Some examples of those include:

    - The use of mobile units to educate, screen, and provide vaccination
    - A MDHHS webinar to inform providers about the hepatitis outbreak
    - Collaboration with local health departments to provide on-site immunization clinics at CMH and SUD locations
    - Efforts to educate and vaccinate CMH and SUD clinic staff

For more information on the hepatitis A outbreak please visit: http://www.mi.gov/hepAoutbreak