

Meeting Agenda

SUD OVERSIGHT POLICY BOARD

Wednesday, September 16, 2026 4:00 PM

Board Room - Community Mental Health of Ottawa County
12265 James Street, Holland, MI 49424

1. Call to Order: Chair
2. Roll Call/Introductions: Chair
3. Public Comment: Chair
4. Conflict of Interest: Chair
5. Review/Approval of Agenda-Chair (*Attachment 1*)
Suggested Motion: To approve the September 16, 2026, LRE Oversight Policy Board meeting agenda as presented.
6. Review/Approval of Minutes-Chair (*Attachment 2*)
Suggested Motion: To approve the June 10, 2026, LRE Oversight Policy Board meeting minutes as presented.
7. Old Business
8. New Business
 - a. LRE OROSC 3-Year (FY27 – FY29) Strategic Plan (*Attachment 3*)
Suggested Motion: To approve the LRE OROSC 3-year Strategic Plan as present and submit the final plan to MDHHS as required.
 - b. Policy/Procedure Review (*Attachment 4*)
 - i. 12.1, 12.1a – Recipient Rights (4, 4A)
 - ii. 12.4, 12.4a, 12.4b – PA2 Funds Distribution (4B, 4C, 4D)
 - c. Finance Report - Maxine Coleman
 - i. Statement of Activities (*Attachment 5*)
 - ii. PA2 Fund Balance Report (*Attachment 6*)
 - d. OnPoint Request for Additional PA2 Funding (*Attachment 7*)
Suggested Motion: To approve the request from OnPoint for Reserve PA2 funds in FY27 in the total amount of \$100,000 to support local drug courts that are now operating in the 48th Judicial Circuit Court.

- e. N180 Request for Additional PA2 Funding (*Attachment 8*)

Suggested Motion: To approve the request from n180 for Reserve PA2 funds in FY27 in the total amount of \$326,815 to support Overdose Education and Nalaxone Distribution.

- f. Ottawa County Community Mental Health Request for Additional PA2 Funding (*Attachment 9*)

Suggested Motion: To approve the request from Ottawa County Community Mental Health for Reserve PA2 funds in FY27 in the total amount of \$160,000 to support Building Men for Life Recovery Coaching services

- g. Ottawa County Community Mental Health Request for Additional PA2 Funding (*Attachment 10*)

Suggested Motion: To approve the request from Ottawa County Community Mental Health for Reserve PA2 funds in FY27 in the total amount of \$60,000 to support Recovery Coach Outreach services.

- h. Ottawa County Community Mental Health Request for Additional PA2 Funding (*Attachment 11*)

Suggested Motion: To approve the request from Ottawa County Community Mental Health for Reserve PA2 funds in FY27 in the total amount of \$200,000 to support SOBAR Community Recovery Center.

- i. FY27 Proposed Budget (*Attachment 12*)

LRE FY27 Prevention and Treatment Providers PA2 Allocation

Suggested Motion: To Approve the FY27 allocation of PA2 funds for the LRE SUD Budget as presented and to recommend that the LRE Board approve the FY27 non-PA2 fund budgets for SUD services as presented.

9. Prevention/Treatment Updates

- a. Prevention – Amy Embury
- b. Treatment – Amanda Tarantowski
 - i. FY26 Q3 Treatment Evaluation Report (*Attachment 13*)

10. State/Regional Updates – Stephanie VanDerKooi

- a. MDHHS RFP Status
- b. LRE 3-year Strategic Plan

11. Round Table

12. Next Meeting

December 9, 2026 – 4:00 PM

CMHOC Board Room

Meeting Minutes
SUD OVERSIGHT POLICY BOARD
 Wednesday, June 10, 2026 5:00 PM
 Board Room - Community Mental Health of Ottawa County
 12265 James Street, Holland, MI 49424

CALL TO ORDER:

Mr. Patrick Sweeney, LRE OPB Chair, called the March 11, 2026, LRE Oversight Policy Board meeting to order at 5:02 PM.

ROLL CALL/INTRODUCTIONS:

MEMBER	P	A		MEMBER	P	A
Zee Bankhead	x			Nancy Morales		x
Shelly Cole-Mickens	x			David Parnin	x	
Jessica Cook		x		Jamie Russell	x	
Mark DeYoung	x			Sarah Sobel	x	
Erin Gillmet	x			James Storey	x	
Jordan Jorritsma	x			Joe Stone	x	
Rebecca Lange	x			Patrick Sweeney	x	
Horace Lattimore	x			Robert Walker	x	
Richard Kanten	x					

PUBLIC COMMENT

No public comment

CONFLICT OF INTEREST

No conflict of interest declared.

REVIEW/APPROVAL OF AGENDA - Chair

LRE OPB 26-06 Motion: To approve the LRE June 10, 2026, Oversight Policy Board meeting agenda as presented.

Moved by: Walker

Support: Lattimer

MOTION CARRIED

REVIEW/APPROVAL OF MINUTES-Chair

LRE OPB 26-07 Motion: To approve the March 11, 2026, LRE Oversight Policy Board meeting minutes as presented.

Moved by: Kanten

Support: Cole-Mickens

MOTION CARRIED

OLD BUSINESS

No Old Business

NEW BUSINESS/ACTION

Finance Report – Stephanie VanDerKooi

- i. Statement of Activities – The Ideal target for expenses and revenue at this point in the year is 58%.
 - **Block Grant** / Revenues Received are at 41% / Expenditures are at 48%
 - **PA2** / Revenues Received are at 28% / Expenditures are at 39%
 - **Medicaid** / Expenditures are at 43.7%
 - **Healthy MI** / Expenditures are at 55.95%
- ii. PA2 Fund Balance Report - Revenue and Expenditures through April 30, 2026
 - Updated with county narratives for FY26 requests received after 9/30 (Allegan, Kent, & Ottawa)
 - Updated Fund Balance Totals show end of year fund balances (9/30) versus the fund balances at the beginning of the fiscal year. FY26 reflects a running YTD total versus the beginning total.

Request for Additional PA2 funds – HealthWest

LRE OPB 26-08 Motion: To approve the request from HealthWest for an additional allocation of \$27,000 in PA2 funds.

Moved by: Stone Support: Parnin

MOTION CARRIED

FY26 Budget Amendment #2

- The State approved LRE's request to shift WSS and Administration dollars to Treatment. In addition, LRE received an additional \$200,000 for Treatment.
- All SOR funds have been allocated.
- All HRCEI funds have been allocated. N180 returned \$9,950 which were shifted to HealthWest.
- Alcohol Use Disorder Treatment funds are being re-allocated. Ottawa returned \$27,432 which was shifted to HealthWest.
- PA2 updated including one shift for OnPoint (Treatment to Prevention).
- Medicaid and Healthy Michigan are updated based on the region's latest projections (April 2026).

LRE OPB 26-09 Motion: To approve Amendment #2 to the allocation of FY26 PA2 funds for the LRE SUD Budget as presented and to advise and recommend that the LRE Board approve the amended FY26 non-PA2 fund budgets for SUD services as presented.

Moved by: DeYoung Support: Parnin

MOTION CARRIED

PREVENTION/TREATMENT UPDATES

Prevention – Stephanie VanDerKooi

- i. [Providing Opportunities for Individuals In Need of Treatment & Support \(POINTS\) Act](#)
The Act is a federal response to gambling addiction which establishes a federal grant program. It is not yet clear how and when the funds will be made available.

- ii. Keep MI Kids Tobacco Free Alliance – goals include establishing tobacco licensing in Michigan, eliminate ineffective youth policies, and applying taxes to e-cigarettes.
- iii. [Problem Gambling Advocacy Day](#) - National Gambling Advocacy Day was held on June 10, 2026. One LRE staff member attended and was able to connect with legislators to share an overview of the need to support gambling prevention and treatment . This information supports national legislation (The POINTS Act).

Treatment – Amanda Tarantowski

- i. SUD State Audit Results – LRE was audited by the state of Michigan. Two areas for improvement were identified (educational requirements and communicable disease), which will require updates to policies and procedures.
- ii. ASAM Conference – Ms. Tarantowski attended session on adolescent SUD treatment where a pilot program in New York City was discussed and looks to be a promising practice. Recovery residences session provided information on a pilot program focusing on flexible sober living.
- iii. Dear Colleague Letter – correspondence from SAMHSA outlining specific limitations. Impactful for individuals related to discontinuing the use of Fentanyl test strips.
- iv. FY26 Q2 Treatment Evaluation Update – the data source had inaccurate calculation and reflected poorly on one member CMHSP. The issue is being addressed and corrected data will be presented when available.

STATE/REGIONAL UPDATES – Stephanie VanDerKooi

Legislative Update report provides information about legislative activity focusing on Substance Use Disorders, Tobacco, and Marijuana.

National Prescription Drug Abuse Summit was held in April. Information was presented on some new, more dangerous drugs that are being discovered on the street.

Change in the Availability of Buprenorphine Provider Lists – SAMSHA will no longer maintain a master list of treatment providers.

3-Year SUD Strategic Plan – LRE is updating the current plan (2024 – 2026). State will provide guidance about what details should be included in the plan. DRAFT will be presented to the OPB in September.

ROUND TABLE

Opiate Settlement Updates

Mr. Walker reported that Oceana County met about opiate settlements and has defined four areas of focus for treatment. The Board has decided to bring a proposal to the Board of Commissioners and ask that a sub-committee be convened. Recommendation is to release an RFP for treatment for those 4 areas.

ADJOURN

LRE OPB 26-10 Motion: To adjourn the June 10, 2026, LRE Oversight Policy Board meeting.

Moved by: Kanten

Support: Stpreu

MOTION CARRIED

Mr. Sweeney adjourned the June 10, 2026, LRE Oversight Policy Board meeting at 5:55 pm.

NEXT MEETING

September 16, 2026 – 4:00 PM



**THREE-YEAR SUBSTANCE USE DISORDER (SUD)
STRATEGIC PLAN**

Fiscal Years 2027-2029

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1. Identification and Prioritization of Problems

The mission of Lakeshore Regional Entity (LRE) is: “Through regional support and leadership for collaboration and innovation, we work to strengthen the public behavioral health system and ensure excellence in services.” [Mission and Values - Lakeshore Regional Entity \(lsre.org\)](https://lsre.org) LRE serves persons with developmental disabilities, adults with mental illness, children with emotional disturbance and persons with substance use disorders in Allegan, Kent, Lake, Mason, Muskegon, Oceana and Ottawa Counties. Lakeshore Regional Entity will promote performance that supports and advocates for and is informed by the needs of the individuals the Entity serves across the region. This 3-year Strategic Plan will provide a detailed summary of the region’s demographics, unique challenges the region faces, a focused logic model, an implementation plan and evaluation methods.

The logic model that is provided as Attachment 1, identifies and prioritizes the substance use disorder problems that impact the region’s community the most. Areas of focus include alcohol, tobacco, marijuana, vaping, methamphetamine, and opioid misuse.

1.1 Demographic Profile

The demographic profile for our population shows that the region’s total population was last estimated in 2024 at 1,348,206 with 85.5% of the population being White alone, 10.5%, Hispanic/or Latino, 8.2% African American alone, 2.8% Asian alone, 3.0% Multi-racial, and 0.7% as American Indian/Alaska Native (US Census). The majority of the population for the LRE region resides in Kent County with 49.9% of the total population. Kent and Oceana counties include the highest number of English as a second language-speakers in the county (see table 5). Federally recognized tribes in the region include The Nottawaseppi Huron Band of the Potawatomi (NHBP), Little River Band of Ottawa Indians, and the Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan.

LRE’s region is made up of 50.4% female residents. The high school graduation rate for the region is 81.2% and 27% of residents hold a bachelor’s degree or higher. It should be noted that at the time of this report, regional demographics including literacy and sexual identity were not able to be obtained as they were significantly out of date or nonexistent.

There is great variation in the demographic profile throughout the region. Kent County is the largest in the region and has half of the regional population. Ottawa County is one of the fastest growing counties in the state of Michigan with regards to population and is also one of the wealthiest with a median household income of \$81,071 in 2025, which is \$8,000 higher than state-wide. In contrast, the LRE region also includes Lake County with only 13,182 residents, and the poorest county in Michigan, with a median household income of \$50,805 and 24.2% of persons living below the poverty level. Lake county is also an ‘aging’ county with 27.8% of its population over the age of 65. Compared to the region’s average, this is 10% higher. 14.6% of Lake County residents are under the age of 18, compared the region’s average of 22.5%.

Regional estimates were calculated using population-weighted averages across counties.

Table 1: Population Distribution

	Allegan	Kent	Lake	Mason	Muskegon	Oceana	Ottawa	Region
Population	123,188	675,232	13,182	29,040	177,901	27,177	308,459	1,348,206
Percent of Total	9.1%	49.9%	1.0%	2.1%	13.1%	2.0%	22.8%	100%

Source: US Census Bureau, 2025 Population Estimates

Table 2: Socioeconomic Characteristics

	Allegan	Kent	Lake	Mason	Muskegon	Oceana	Ottawa	Region	MI
Median household income	\$83,283	\$82,631	\$50,805	\$64,748	\$65,024	\$62,417	\$90,502	\$81,071	\$72,875
Per capita income	\$39,282	\$42,992	\$28,058	\$37,554	\$32,532	\$33,025	\$42,799	\$40,774	\$40,735
Persons below poverty level	8.2%	9.2%	24.2%	11.7%	16.8%	14.5%	8.8%	10.4%	13.4%
Owner-occupied housing	87.4%	70.3%	82.0%	78.3%	78.1%	84.5%	79.3%	75.8%	73.2%
Persons w/out health insurance	6.0%	5.8%	8.5%	5.5%	5.4%	7.4%	4.3%	5.5%	6.2%

Source: US Census Bureau, 2025 Population Estimates

Table 3. Race/Ethnicity

	Allegan	Kent	Lake	Mason	Muskegon	Oceana	Ottawa	Region	MI
White alone	94.4%	80.8%	84.1%	94.5%	81.0%	95.0%	91.7%	85.5%	78.2%
Black alone	1.6%	11.2%	10.3%	1.0%	13.6%	1.3%	2.3%	8.2%	14.1%
Amer.Indian/ Alaska Native alone	0.8%	0.7%	1.3%	1.1%	0.9%	1.4%	0.6%	0.7%	0.8%
Asian alone	1.0%	3.8%	0.3%	1.0%	0.7%	0.4%	3.1%	2.8%	4.0%
2+ Races	2.1%	3.4%	4.0%	2.3%	3.7%	1.9%	2.3%	3.0%	2.9%
Hispanic or Latino	8.3%	11.9%	8.7%	5.2%	6.7%	15.8%	10.6%	10.5%	6.2%

Source: US Census Bureau, 2025 Population Estimates

Table 4. Language and Foreign Born

	Allegan	Kent	Lake	Mason	Muskegon	Oceana	Ottawa	Region	MI
Language other than English at home	7.1%	13.1%	4.6%	3.3%	4.0%	11.4%	8.1%	9.9%	10.4%
Foreign born persons	3.5%	8.9%	1.0%	1.7%	1.9%	4.1%	5.1%	6.3%	7.2%

Source: US Census Bureau, 2025 Population Estimates

Table 5. Gender

	Allegan	Kent	Lake	Mason	Muskegon	Oceana	Ottawa	Region	MI
Female	49.8%	50.4%	45.7%	49.7%	50.1%	48.9%	50.4%	49.3%	50.4%
Male	50.2%	49.7%	54.3%	50.3%	49.9%	51.1%	49.6%	50.7%	49.6%

Source: US Census Bureau, 2025 Population Estimates

Table 6. Age

	Allegan	Kent	Lake	Mason	Muskegon	Oceana	Ottawa	Region	MI
Persons < 18	22.4%	23.0%	14.6%	18.7%	21.8%	20.5%	22.2%	22.5%	20.8%
Persons 65+	19.6%	15.7%	27.8%	27.5%	19.4%	23.9%	17.6%	17.6%	19.6%

Source: US Census Bureau, 2025 Population Estimates

1.2 Population of Focus

The focus population for treatment services includes all persons who have a diagnosable substance use disorder and who are covered by one or more of the several public funding streams managed by the Region 3 PIHP. The relationship of the population of focus to the overall population in the PIHP catchment area is that they will be drawn from the same population in varying amounts based on the prevalence of use for various addictive substances in the region. Any individual who meets medical necessity criteria in our region will be served.

LRE provides ongoing workforce development to enhance provider capacity to improve outreach, engagement, and quality of care for minority and underserved populations. In addition to ensuring culturally competent services, LRE also requires providers to address social influencers of health, such as employment, housing, and access to physical healthcare within treatment plans because these are known to positively impact treatment outcomes among disparate populations.

As documented in Table 7, LRE has successfully engaged minority populations in treatment services. When comparing LRE SUD Treatment Admissions to population estimates, LRE successfully engaged African American/Black and multi-racial populations with the rate of admissions 2x that of the population. Admission rates for Hispanic and American Indian populations were in-line with population estimates while the Asian population was underrepresented in treatment, like state level admissions compared to population estimates.

Table 7: SUD Treatment Admissions, Minority Populations

	LRE Region		Michigan	
	% Admissions FY25	% of Population	% Admissions FY25	% of Population
American Indian/Alaskan Native	1.0%	0.8%	1.11%	.8%
Asian	0.4%	0.7%	0.23%	4%
African American/Black	18.8%	17.1%	27.95%	14%
Native Hawaiian or Pacific Islander	0.1%	0.2%	0.11%	0.1%
Other	5.0%	5.7%	3.06%	3.7%

Refused to Provide	0.1%	2.6%	0.32%	1.4%
2+ Races	4.4%	5.1%	3.63%	2.9%

Source: US Census Bureau, BHTEDS

1.3 Current System for SUD Prevention, Treatment, and Recovery services

The LRE region and its providers offer a full array of evidence-based prevention, treatment and recovery support services. It is our hope to continue expansion of the provider network and expand services in the coming years as needs arise in our region. LRE follows a conceptual framework for comprehensive system development which is intended to comport favorably with a medical model for responding to chronic disease. Scott Monteith, Chief Medical Officer and Dr. Richard Tooker, Medical Director, provide support and guidance in ensuring a robust system which addresses the following:

- Robust Prevention (from universal to targeted)
- Comprehensive Screening (early identification)
- Early Intervention
- Effective Treatment
- Continuous Care for Chronic Conditions
- Recovery Supports
- Community Advocacy

LRE will continue to offer a comprehensive system of care in the region which is fully capable of performing each of these functions for every person in every county in the region. The primary goal is to avoid onset in the first place through a robust prevention service system. The next step would be to find those with disease onset and to respond as quickly and effectively as possible to restore health and function. We strive to assist those with the most serious forms of the illness to achieve optimal health and wellness through intensive and extensive interventions. Overall, we intend to foster an optimal environment for all of the above and, in fact, achieve the ideal of a prevention-prepared community to prevent onset and provide a supportive environment for persons in recovery.

Prevention

The Lakeshore Regional Entity manages prevention centrally with LRE overseeing priorities for programming and contracting directly with prevention providers. LRE requires that all prevention programming is evidence-based and data-driven. To support this requirement, LRE provides ongoing training and technical assistance to support providers in finding and initiating evidence-based programming and models. A summary of programming and initiatives supported by LRE is provided in Exhibit 1.

LRE contracts with the following Prevention providers.

Arbor Circle	District Health Department #10 (3 locations)
OnPoint	Community Mental Health of Ottawa County
Network 180	Ottawa County Department of Public Health
HealthWest	Trinity Health- The Health Project
Kent County Health Department	Wedgwood Christian Services

Each of these providers is required to coordinate services with the local substance abuse prevention coalition, and to document how the planned prevention activities align and support the strategic plan for the coalition serving their county. To strengthen these coalitions, LRE provides funding to support the development and coordination of these county coalitions through this provider network when other funding is not available.

The Strategic Planning Framework is used by each of these coalitions to develop data-driven strategic plans to increase capacity and efforts to prevent and reduce substance abuse in the communities. This planning process increases capacity (skills and abilities) and organizes infrastructure (agencies, staff, and other resources) in local communities to create positive, lasting population level change involving substance use and abuse. Our focus is to engage local communities in Data Driven Decision Making to reach prevention outcomes. Communities utilize local, regional, state, and national data to identify needs, develop plans, and allocate resources.

Currently, each of the counties in the region has a robust prevention coalition or community collaborative to complete strategic, evaluation plans and key stakeholder engagement. The LRE provides technical assistance to strengthen these services and ensure alignment to the LRE Strategic plan and activities, often serving as a member of the coalition executive committees.

In addition to local initiatives LRE develops and supports regional initiatives through partnership with the prevention providers. Ongoing regional initiatives include:

No Cigs for Our Kids: A responsible tobacco retail campaign that focuses on educating the retailers on the importance of compliance with the youth tobacco act. The campaign has been an ongoing joint effort with local law enforcement to combat the problem of vendors selling tobacco to our kids. Local compliance checks along with vendor educations have been completed on a regular basis in all 7 counties, to bring awareness to retailers on the sales of tobacco to minors.

TalkSooner is another regional project and is the product of the region, with numerous coalitions from county's around the State joining in the effort. This campaign works together to send out a common message to parents of youth ages 10-18 about alcohol, tobacco, and other substances. The goal of TalkSooner is to delay the onset of substance use and gambling related behaviors through encouraging positive, honest conversations with youth that are centered on factual information.

Vaping and marijuana remain significant prevention concerns across our region and the state. As these trends continue, schools are increasingly seeking support for evidence-based programming to address them effectively. In response, LRE is strengthening evidence-informed interventions and evaluation efforts to monitor the impact of these critical services on substance use.

Treatment

On October 1, 2014, PA 500 of 2012 took effect in Michigan, changing the way the public SUD system was managed, moving from SUD Coordinating Agency regional management to PIHP regional management. Since that time, in the PIHP Region 3, the Lakeshore Regional Entity has maintained their current system for providing substance use disorder treatment and recovery services which delegates responsibility for managing treatment and recovery services to each of the five Member Community Mental Health Service Programs (CMHSP's) through subcontracts. This design allows for improved integration of Substance Use Disorder treatment within the CMH system. In addition, the CMHSPs ensure local priorities are quickly identified and addressed in partnership with community stakeholders. The five CMHSPs subcontracted to manage these services include OnPoint (Allegan County), Community Mental Health of Ottawa County, Healthwest

(Muskegon County), Network180 (Kent County), and West Michigan Community Mental Health System (Lake, Mason and Oceana Counties)

Each of these CMHSPs has established a provider network to fulfill the required continuum of treatment and recovery services and continues to support and incentivize new or enhanced services in their area on behalf of the LRE region. A complete list of treatment providers within this provider network is available at mirecovery.org.

In recent years, the rate of opioid use and the need for treatment has increased significantly. Additional providers have been added and work continues to address service gaps. The State Opioid Response (SOR) and the Healing and Recovery Community Engagement and Infrastructure grants have allowed the LRE region to expand services greatly in the past few years, including enhanced MAT for the incarcerated, expanded recovery homes, additional peer recovery coaches, and increased Narcan distribution through a Mobile Health Unit. We've also been able to support the opening of a Recovery Community Organization with SUD Treatment Access, supplement workforce development and provide transportation for rural clients to care.

Over the next year, LRE will work to better understand the rising admissions for methamphetamine use and support the provider network in responding accordingly. When methamphetamine was an issue in the early 2000's it presented very differently. Community stakeholders have requested support in better understanding what is contributing to the increase and guidance on how to respond accordingly to prevent further problems. In addition, treatment for methamphetamine requires unique methods and providers need support to ensure competence.

Another issue that continues to be a challenge to those in rural areas of the region is access to reliable transportation to and from treatment. Although we have made strides in this area we are continually looking for ways to ensure rural clients are connected to care as quickly as those in urban settings

Progress is being made regarding expanding services in jails in each county of the region. MAT is available for those in need, as well as peer recovery coaches. In April of 2020, LRE became responsible for recovery for individuals in the region who are transitioning back into the community after being incarcerated. Working together with the Michigan Department of Corrections, LRE is partnering with the SUD Regional Operations Advisory Team (ROAT) and our Priority Population Manager to identify ways to improve coordination and services for this population as they return to their communities.

The region also has a network of Women's Specialty Service (WSS) providers to ensure the unique needs and challenges of women who are pregnant, parenting, and/or at risk of losing custody of their children are met. A list of WSS providers and services is provided in section 8, Table 15. The LRE region plans to enhance this area of focus during the next 3 years, as the introduction of the CCBHC Model has threatened some WSS providers. We've made WSS issues a standing agenda item on our monthly SUD ROAT meetings and the LRE intends to provide support, training, technical assistance, and resources as issues arise. These meetings will also provide an opportunity for providers to identify and work on challenges as well as to highlight successful initiatives. We will also look for ways to expand WSS in Lake, Mason and Oceana counties.

1.4 Extent (morbidity and mortality) and prevalence of substance use disorder problems

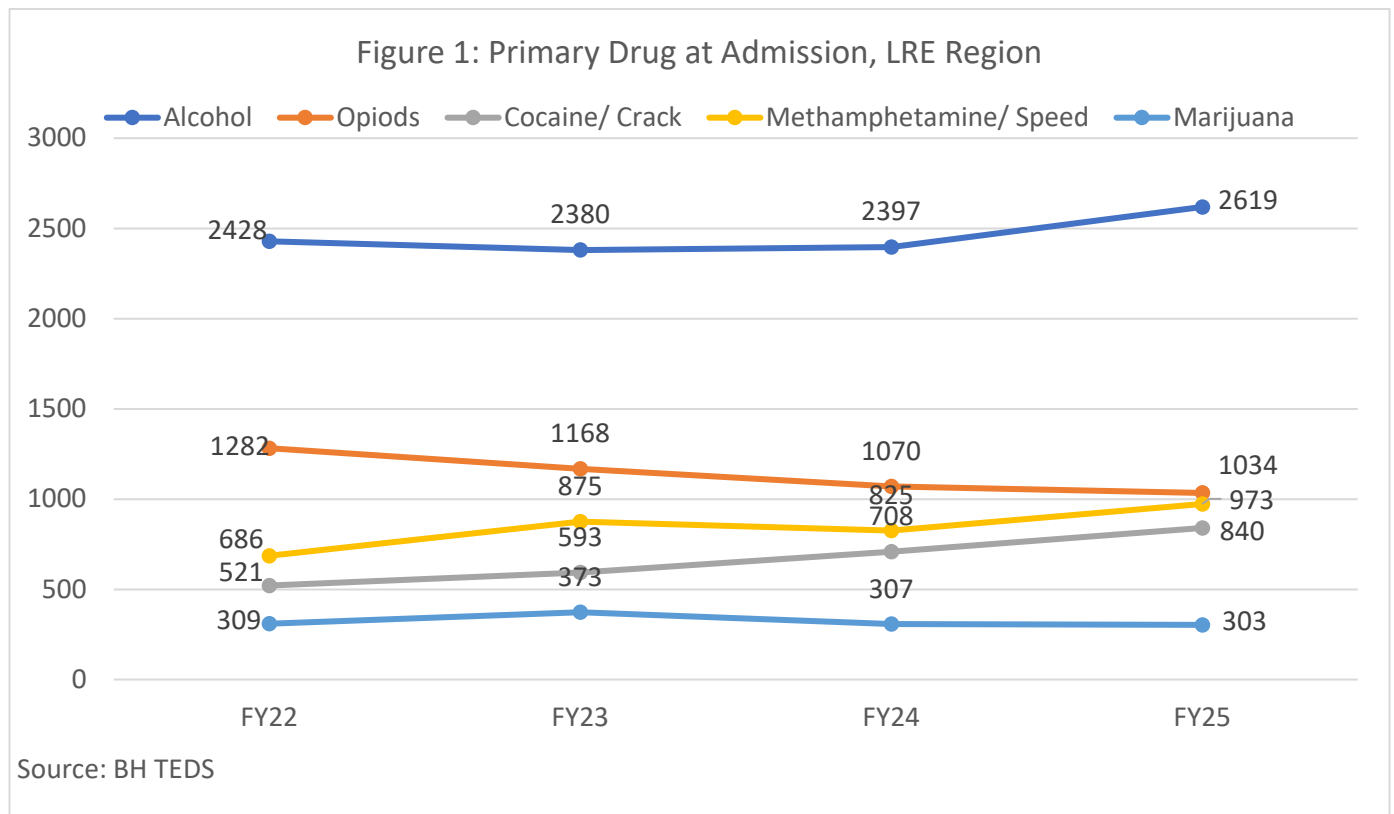
As shown in Table 8, the region's primary substances reported by persons admitted to publicly funded substance use disorder treatment are as follows: Alcohol (43.7%), Methamphetamine (16.2%), Cocaine (14.0%), Heroin (11.3%), Synthetic and Other Opioids (6.0%), and Marijuana (5.1%). All other substances represented less than 4% of admissions.

Table 8: Primary Substances of those admitted to publicly funded SUD treatment

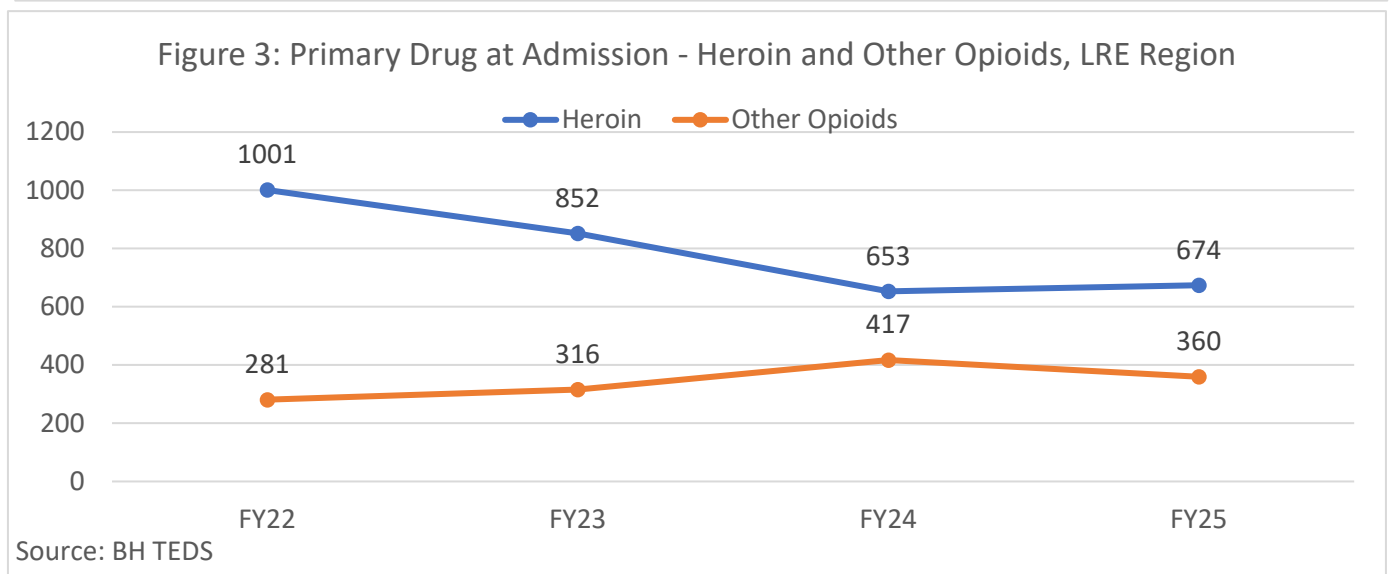
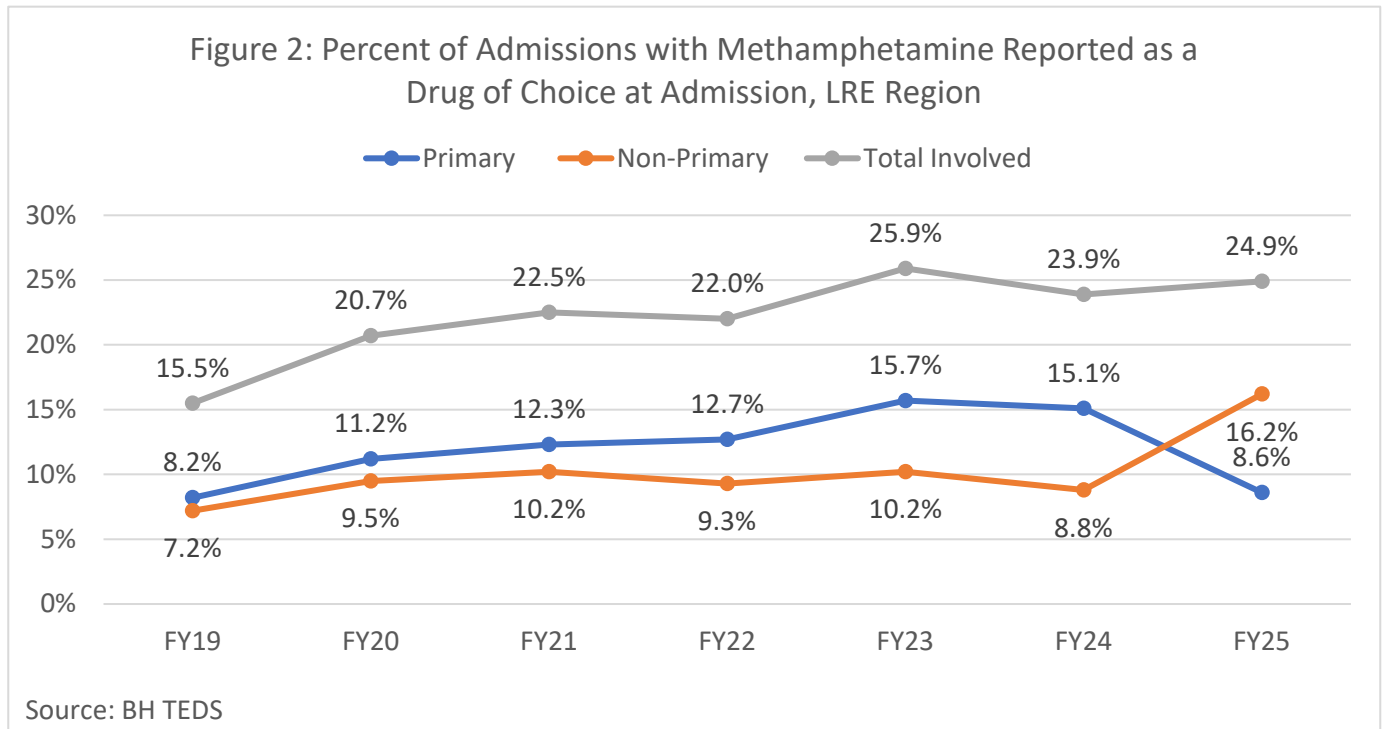
Primary Drug	LRE Region		Michigan	
Alcohol	2630	43.7%	29637	47.7%
Methamphetamine	979	16.2%	6935	11.2%
Cocaine	841	14.0%	8739	14.1%
Heroin	676	11.3%	8803	14.2%
Synthetic & Other Opiates	363	6.0%	4677	7.5%
Marijuana	304	5.1%	2156	3.5%
All Other Drugs	196	3.7%	1132	1.8%

Source: BH TEDS FY 2025

As shown in Figure 1, the number of admissions with alcohol and cocaine as the primary drug have been increasing while admissions for opioids and marijuana have remained relatively stable. Admissions for heroin and other opioids combined represent the second most reported substance of abuse at admission, with alcohol having the most admissions., followed closely by methamphetamine.



In prior years, the increase in methamphetamine primary admissions was concerning, but this has remained relatively stable since FY23 (Figure 2).



As seen in Figure 3, Opioid use is steadily decreasing throughout the region, a trend that will hopefully continue.

LRE has secured an independent evaluator to assess the system of care, to identify variations in the quality of substance use treatment and to determine competencies and concerns within the system. The treatment and recovery support logic model provided as Attachment 2 presents the data used to determine treatment priorities, as well as the areas of concern identified through this assessment. The logic model also informs the plan to address the system's service gaps and ensures a quality, comprehensive system that is able to provide adequate care, achieve positive outcomes, and reduce health disparities.

Substance Use Treatment priorities ensure that comprehensive services are readily available, effective, and support clients well into their recovery journey, including:

- The ability for clients to begin treatment quickly, including MAT;
- Engagement and continued success of clients in treatment, including successful transitions between level of care; and
- Ensuring client connections to community supports to maintain recovery.

The prevention logic model for the region provides the framework for determining the prioritized consequences and intervening variables for underage drinking, underage tobacco use, youth and young adult marijuana use, and prevention of opioid misuse. The logic model is developed in partnership with the provider network and updated every two years to reflect emerging issues and changing priorities determined throughout the region. Every two years, when updated Michigan Profile for Healthy Youth (MIPHY) becomes available, the LRE region conducts a regional analysis to identify trends in targeted issues and emerging areas of concern. This data is reviewed by the Regional Prevention Supervisor Workgroup and a discussion of issues being identified locally drives further data collection or analysis as necessary. The most recent version of the prevention logic model is being submitted for the SUGE strategic plan. Using this process, this version was enhanced to incorporate new efforts to address the emerging issues of vaping and the legalization of recreational marijuana in 2019. In addition, expansions to address prevention among older adults were added within the alcohol and opioid sections to address the SUGE continuation of this priority. The SUD prevention workgroup reviews each updated logic model and provides feedback and recommendations for improvement.

1.5 Communicable Disease

LRE will implement communicable disease screening and testing in accordance with requirements set forth in Prevention Policy #2: Addressing Communicable Disease Issues in the Substance Abuse Network. To do so, LRE will assure that screening for HIV/AIDS and other STI's will occur through its SUD Provider Network using a standardized Communicable Diseases screening tool, and that information about Communicable Disease is provided to them. Persons screening positively are referred for testing. In addition, persons engaging in higher risk activities will receive health education on risk reduction.

Contracts with providers issued through LRE specify that *all clients* are to be screened at assessment for risk of TB, STD, HIV, and Hepatitis in a manner that is consistent with MDHHS standards. If the screen identifies high risk behavior, the individual must be referred for testing. Referral for Hepatitis C testing is required for persons with a history of IV drug use. Referral for STD and HIV testing is required for all pregnant women. Persons entering residential treatment must receive TB testing upon admission. All pregnant women presenting for treatment must have access to STD/I and HIV testing.

Providers have referral agreements with communicable disease testing sites, including local health departments, which ensures that the agency to which the individual has been referred has the capacity to accept the referral. In addition, we require that providers have a protocol for linking infected individuals with appropriate treatment/support resources and/or recording the screening, referral, and linking activities in the client's clinical record. Finally, providers complete the communicable disease reporting requirement as specified by MDHHS.

Compliance with communicable disease requirements are monitored during annual site visits and providers not achieving compliance are required to submit a corrective action plan.

2. **Data-Driven Goals and Objectives**

2.1 Prevention

Based on the epidemiological profile, the following goals and objectives have been identified for the LRE region for prevention services. Unless otherwise specified, the data source is county-level youth surveys and these survey results will be used to monitor progress. Baseline data is provided from 2025-2026 survey results with regional rates calculated using county level results. Survey tools include the Michigan Profile for Healthy Youth for each county except Ottawa, where the Ottawa Youth Assessment Survey provides the necessary information.

The logic model provided in attachment 1 provides an overview of the data that was used to prioritize the selected problems and related intervening variables that resulted in the development of these goals and objectives. This logic model also provides an overview of the actions to be taken by LRE and providers to impact these goals and objectives.

Table 9: Prevention Service Goals and Objectives

Priority	Metrics	Baseline provided by MIPHY 2026 (unless otherwise specified)
Marijuana Use	Goal 1: Decrease in HS students reporting recent use of marijuana by 25% by 2029	6.9%
	Obj. 1.1: Reduction in % of HS students reporting it would be 'easy' to get marijuana by 25% by 2029	27.8%
	Obj 1.2: Reduce the % of HS students that report using marijuana 1 or 2x / week is low risk by 2% by 2029	51.6%
Underage Alcohol Use	Goal 2: Reduction in Past 30-day alcohol use by HS students by 2% by 2029	8.5%
	Obj 2.1: Reduction in % of HS students reporting it would be 'easy' to get alcohol by 2% by 2029	45.2%
	Obj 2.2 Reduce the % of HS Students reporting binge-drinking as low risk by 2% by 2029	23.9%
Prescription drug misuse, including Opioid Misuse	Goal 3: Reduction in opioid related deaths in the region by 2% by 2029 (Source: MI SUD Data Repository).	171 in 2024
	Obj 3.1 Reduce the % of HS Students reporting prescription drug use without a prescription is low risk by 2% by 2029	21%
Nicotine	Goal 4: Reduction in past 30-day use of electronic vaping products by HS students by 2% by 2029	7.4%

	Obj 4.1 Maintain a formal Synar compliance rate of 80% or greater each year through 2029	88%
Increase protective factors	Goal 5: Increase in % of HS students reporting that they could ask their mom/dad for help w/ personal problems by 2% by 2029	82.9%
	Obj 5.1 Increase in % of HS students reporting that parents or other adults in their family have talked with them about what they expected them to do or not to do when it comes to alcohol or other drug use by 2% by 2029	75.7%

2.2 Treatment and Recovery

Based on the epidemiological profile, the following goals and objectives have been identified for the LRE region for treatment and recovery services. Unless otherwise specified, the data source is Behavioral Health Treatment Episode Data Set (BH TEDS) and encounter data reported to LRE and will be used to monitor progress. Baseline data is provided from FY 2025 unless otherwise noted. The logic model provided in Attachment 2 gives an overview of the data that was used to establish the following priority areas and the metrics selected. This logic model also provides an overview of the actions that will be taken by LRE, the CMHSPs, and the provider network to impact these goals and objectives. Additional process measures are identified throughout the logic model as appropriate to monitor progress related to designated activities.

Table 10: Treatment and Recovery Service Goals and Objectives

Priority	Metrics	Baseline FY 25 (unless otherwise specified)
Increase access to for persons living with <u>Opioid Use Disorder</u>	Decrease average days between request for service and first service for outpatient with MAT	8.1 days
	Decrease average days between request for service and first service for persons with IVDU	7.5 days
Increase access to treatment for <u>criminal justice involved</u> population returning to communities.	Increase in admissions with legal status as on probation	22% of admissions
Increase engagement in treatment	Reduce % of discharge with reason as “dropped out” for all LOC.	34%
	Increase % of clients seen for a second appointment within 14 days of initial service.	91%
	Increase in % of clients w/ co-occurring diagnosis that received integrated services.	33%
	Increase in the # of pregnant women served	57
Clients establish connections to community supports to	Increase # clients that live in Recovery Housing following treatment.	TBD
	# of individuals in recovery engaging in prosocial opportunities	TBD

assist them in maintaining recovery		
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3. **Goals, objectives, and strategies for coordinating services**

As required in P.A. 500, LRE ensures collaboration and coordination with adult and children's services, faith-based communities, education, housing authorities; agencies serving older adults, agencies serving people who inject drugs/Syringe Service Programs, military and veteran organizations, foundations, and volunteer services.

3.1 Prevention

LRE works with community providers to support local coalitions, making coordination and collaboration central to prevention service delivery. These coalitions are the primary vehicle for local input, partnership, and stakeholder engagement in prevention efforts. LRE supports the work of these coalitions to implement the Strategic Planning Framework to guide substance abuse prevention in the local communities. Since its inception, LRE has sought to strengthen local coalitions and has succeeded in establishing a coalition for each county of the region. Each coalition seeks representation from the 12 key sectors recommended by the Community Anti-Drug Coalitions of America (CADCA).

To support these coalitions and ensure locally driven prevention services, LRE contracts with 10 prevention provider organizations throughout the region. Each of these providers is required to work in partnership with their local coalition to prevent substance abuse and each funded initiative must align with the data-driven strategic plan developed by their local coalition. Many of these providers are funded by LRE to support the work and coordination of their county coalition. More information about each coalition, their mission statements and activities may be found at [Talk Sooner](#) | [Contact](#)

County/Coalition:

Coalition	Established	Funded Providers
Allegan/Allegan Substance Abuse Prevention Coalition (ASAP)	2004	OnPoint
Kent/Kent County Prevention Coalition (KCPC)	2006	Network 180, Kent County Health Department, Arbor Circle, Wedgwood
Ottawa/Ottawa Substance Abuse Prevention Coalition (Osap)	2001	Arbor Circle, Ottawa Community Mental Health Services, Ottawa County Public Health Department
Muskegon/Define The Line Coalition	2005	Trinity Health – the Health Project, Healthwest, Arbor Circle
Lake/Lake County Community collaborative	2013	DHD#10
Oceana/ Oceana Leads	2016	DHD#10
Mason/ Leeward Initiative	2016	DHD#10

LRE's regional prevention logic model, provided as Attachment 1, was developed in partnership with the provider network while data is updated every two years to reflect youth survey cycles (MIPHY, Youth Assessment Survey (YAS), regional data). The prevention logic model is used to guide evaluation of initiatives as well as summarize efforts across the region by priority issue. Within this logic model, the county(s) addressing each area are identified. This most recent version was enhanced to incorporate new efforts to address the emerging issues of vaping and legalization of

recreational marijuana use. The logic model/evaluation efforts will also identify which prevention providers are working to address each goal and objective area.

For information on which county(s) are implementing activities related to each goal and objective, refer to the Prevention Logic Model provided as Attachment 1. In addition, a summary of programming offered at each prevention provider is provided in Exhibit 1.

To monitor coordination of services with public and private sectors, LRE has established the following goals, objectives, and strategies:

- Each county in the LRE region maintains a viable community coalition/collaborative with the mission of reducing and preventing substance use.
- Each of these coalitions will:
 - Collect and review local data to inform planning processes.
 - Engage local stakeholders as necessary to impact prioritized issues.
 - Maintain representation from each of the following 12 sectors: youth, parents, businesses, media, schools, youth-serving organizations, law enforcement, religious or fraternal organizations, civic or volunteer groups, healthcare professionals, state, local, or tribal governmental agencies with expertise in substance misuse, other organizations involved in reducing substance misuse.
- Each prevention provider receiving LRE funds will align services with the priorities and plans established by the coalition in their county.

3.2 Treatment and Recovery

Each of the 5 CMHSPs coordinates services with public and private service delivery systems in the managing and oversight of SUD Treatment and recovery services. The SUD Regional Operations Advisory Team (SUD ROAT) provides a mechanism to connect the work of these CMHSPs and provides the LRE with the ability to identify common priority areas and supports needed to enhance collaboration.

The SUD ROAT includes representatives from each of the five member CMHSPs and meets monthly to discuss provider network capacity, service gaps, and quality improvement initiatives. The discussions focus on whether providers have capacity to meet community need, if there are any problems associated with a provider (and address solutions), and ongoing review of BH TEDS data to identify issues in a timely manner. Possible solutions for any inaccuracies or outliers are discussed and addressed.

The work of this group has resulted in the treatment and recovery logic model provided in Attachment 2. This newly developed model will be used to provide a framework in the coming years to guide evaluation and monitoring for targeted improvement areas. The model was created in partnership with the SUD ROAT and is designed to address each of the applicable SUGE identified priority areas as well as those clarified through the evaluation of LRE SUD treatment conducted by KWB Strategies. Information was collected in partnership with the SUD ROAT to better understand current initiatives, service gaps, and opportunities for each SUGE identified priority. Results were used to develop a regional approach to address priorities while working to improve access to services, engagement in services, and connection to community recovery support. The SUD ROAT was then given an opportunity to provide additional feedback and recommend revisions for the logic model.

4. Key decision-making undertaken by the SUD Oversight Policy Board

In accordance with Public Act 500 of 2012, Section 287(5), the Lakeshore Regional Entity Board of Directors established a Substance Use Disorder Oversight Policy Board (SUD OPB). The SUD OPB includes at least 1 member appointed by the county Board of Commissioners for each county served in the LRE region. SUD OPB performs the following functions and responsibilities: (a) Approval of any LRE budget containing local funds for treatment or prevention of substance use disorders. (b) Advice and recommendations regarding department-designated community mental health entities' budgets for substance use disorder treatment or prevention using other non-local funding sources. (c) Advice and recommendations regarding contracts with substance use disorder treatment or prevention providers.

The LRE OPB meets quarterly with specific agenda items identified such as an annual review of the OPB bylaws and approval of the SUD budget.

The annual organizational meeting to elect officers of the OPB is held during the first meeting of each calendar year. New members are appointed by the member county Board of Commissioners in December of each year, and each new member is provided an orientation on the role and functions of the OPB. Bylaws are reviewed annually and updated as necessary.

5. Evidence-Based Programs, Policies and Practices

The LRE's partnerships with member CMHSPs and prevention provider network enables a system which is nimble enough to make rapid changes to respond to emerging issues. For example, when COVID-19 occurred, most prevention programming was able to move to a virtual system and treatment providers embraced the use of telehealth to continue serving clients.

5.1 Prevention

The Prevention Logic Model (Attachment 1) is developed in partnership with the provider network and updated every two years when new MIPHY/YAS data is released. A regional summary of county and regional level indicators for substance use and risk factors among youth is compiled and reviewed to inform identification of emerging issues that need to be addressed.

This most recently updated logic model, being submitted for the SUGE strategic plan, was enhanced to incorporate new efforts to address the emerging issues of vaping and legalization of recreational marijuana use. In addition, to address the continuation of the SUGE priority, expansions regarding prevention among older adults were added within the alcohol and opioid sections. The SUD prevention workgroup reviewed the draft and provided feedback and recommendations for improvement.

The prevention logic model identifies prioritized goals, related objects for intervening variables, activities designed to impact these issues, agencies responsible for implementation, and short-, intermediate- and long-term outcomes that will be monitored to track progress.

5.2 Treatment and Recovery

The Treatment and Recovery Logic Model (Attachment 2) is newly developed and was designed to address each of the applicable SUGE identified priority areas and findings identified in the LRE Evaluation of SUD Treatment conducted KWB Strategies in 2022.

Information was collected in partnership with the SUD ROAT to better understand current initiatives, service gaps, and opportunities for each SUGE identified priority. Results were used to

develop a regional approach to address priorities while working to improve access to and engagement in services, as well as connection to community resources to support recovery. The SUD ROAT was then given an opportunity to provide additional feedback and recommend revisions for the logic model. This logic model will provide a framework in the coming years to guide evaluation and monitoring for targeted improvement areas. The SUD Oversight Policy Board also reviewed and provided feedback on the draft logic model prior to submission.

6. Allocation Plan

Region 3 PIHP has centralized SUD administration/management/planning functions for the substance use disorder services. LRE employs a team of SUD Managers who are responsible, under the PIHP Chief Operations Officer, to implement the legal and contractual obligations of the entity related to SUD services. LRE delegates SUD Treatment and Recovery services to its five-member CMHSPs who are responsible for the following:

- SUD Treatment and Recovery Services
- Provider network evaluation, procurement, contracting and management
- Screening, authorization, and referral for services to all levels of care
- Data reporting
- Budget management
- Claims payment
- Overall treatment system development to meet the needs of our communities.

The CMHSPs ensure that there is a full continuum of evidence-based care available to individuals seeking treatment and recovery support services. SUD Prevention is managed directly by the PIHP and the Manager of SUD Prevention manages 10 contracted prevention agencies and several regional prevention projects.

SUD Medicaid and Healthy Michigan will be allocated to the member CMHSPs using the same methodology that MDHHS uses to allocate the dollars to the Entity. MDHHS Block Grant dollars will be allocated first by the allocation set by MDHHS to the splits between Prevention and Treatment Dollars.

Prevention funds are distributed to counties based on each county's share of the respective county's population. When multiple providers are funded within a county, allocations are determined by the documented need submitted during procurement and the extent to which funding will adequately address identified priorities.

Treatment funds will be divided between the Member CMHSPs based on General Fund (GF) need as calculated based on the population for each of the counties. The ACS 200% Federal Poverty Level (FPL) –(American Community Survey-United States Census Bureau) will be used to determine the base for initial need and subtracting the following: Medicaid Eligible, Healthy Michigan Eligible and Marketplace Enrollment (Less than or equal to 200% FPL). This method will determine the base for SUD GF Block Grant Distribution.

Public Act 2 (PA2) Liquor Tax funds will be approved for distribution by the Entity SUD Oversight Policy Board. PA2 funds will be allocated back to the county from which the funds originated. Any surpluses will be sent back to the Entity for distribution in the following years from which the funds originated.

The Oversight Policy Board Meets every year in September to review the allocation recommendations developed by LRE staff, based on the current year's spending and projections for the next fiscal year. After the OPB approves the PA2 funds and provides recommendations for other funding sources, the LRE Board of Directors reviews and approves the entire regional SUD budget. This process is designed to ensure each board has an opportunity to discuss and pose any questions or concerns. After allocations have been approved by the LRE Board of Directors, the LRE issues contracts to prevention providers directly and to each CMHSP for treatment and recovery for an October 1 start date.

Substance Abuse Block Grant Funds for treatment and recovery services are allocated based on population as well to the CMHSPs who work to identify and expand services to address local priorities. Local PA2 funds are allocated for use in the county for which the revenue was collected. Priority populations receive preference for SABG funded services as required. A wait list is maintained by each CMHSP's. The SUD ROAT uses this information to discuss service gaps and collaborate to enhance capacity to address unmet needs.

6.1 Prevention Services

Prevention services have been funded at or above 20% in the region for the entirety of the region's existence. This is well beyond what is required because this region values prevention and knows that if prevention is successful, we can reduce the demand for treatment and recovery. Procurement establishes a robust panel is operating in the region and will be planned for future years as needed. Priorities for prevention funds ensure inclusion of efforts targeting environmental change and integration of SUD prevention and health promotion. During the procurement process, any Michigan Tribal entities meeting requirements to contract as a prevention provider are notified of the opportunity and the procurement process will require all prevention providers to identify planned collaboration with tribal entities in their service area.

LRE allocates a portion of prevention funds to support region-wide prevention initiatives such as TalkSooner.org. Regional meetings of the provider network include efforts to work with community stakeholders to highlight emerging trends for parents/caregivers. Additionally, when other issues arise regionally, LRE convenes meetings to work on issues such as marijuana use, Family Meals Month, data tracking, vaping, opiates and stimulants. The LRE convenes a Regional Training workgroup to ensure current evidence-based trainings to support workforce development needs. This group also identifies activities to support SUD related issues in the region in order to leverage funded dollars. The LRE is an approved MCBAP training credits provider. Any related opportunities for workforce development initiatives are shared through the SUD Roat and LRE Prevention Providers communications.

Additional funds from several grants (SOR4, Gambling Prevention) and past supplement funding (COVID 19, ARPA) help to train the workforce in many programs such as: Life Skills, Prime for Life, Strengthening Families, emerging drug trends, evidence-based parenting programs and needs of older adults. These funds are procured through LRE contracted SUD treatment and prevention providers through a supplement funding request process.

6.2 Treatment and Recovery Services

The 5 CMHSP's have been budgeting and managing the SUD treatment services since 2014. LRE convenes the Finance ROAT (Regional Operations Advisory Team) monthly to review allocations and budgets for the region. In addition, the SUD Rate Group meets monthly to ensure regional rates are adequate and to address provider concerns regarding rates and capacity. This regional approach allows the region to establish and justify the rates for each service in a fair and

consistent manner. These processes include managing the funds for Healthy Michigan, Medicaid, Block Grant, PA2 as well as Specialty Grants such as the State Opioid Response (SOR 4) grant. These regional groups monitor spending throughout the year and develop a regional response to manage risk and reduce deficits while ensuring service delivery continues to meet requirements as established by SUGE.

The region will maintain current contracts moving forward. LRE will continue to allocate funds to implement a full continuum of evidence-based care for individuals in need of treatment and recovery support services through subcontracts with the five Community Mental Health Service Programs (CMHSPs). A comprehensive array of outpatient, intensive outpatient, detox, residential, medication assisted treatment exists within reasonable geographic reach of all persons needing SUD treatment. A range of outreach-based services exist to bridge the access gap for individuals. For those with transportation barriers, LRE will continue to support community-based Recovery Management and Women's Specialty teams. The region employs teams that specialize in homelessness, corrections, pregnant women and women who are pregnant or at risk of losing custody of dependent minors. An array of specialized case/recovery management services exists and is consistently being monitored for adequacy across the region. Included in this array are case management services for persons with chronic SUD, women with SUD – including those caring for dependent children, and persons involved in medication assisted treatment.

During the past several years, the region has achieved significant expansion of services to better meet the needs of the community and ensure a full continuum of services. Outcomes of expansion efforts that will be sustained include:

- Establishment of local Medication Assisted Treatment providers who offer the continuum of services and all MOUD. (Ottawa, Lake, Mason, Oceana, and Muskegon).
- Addition of Recovery Management Services (Allegan, Ottawa, Lake, Mason, Oceana, and Muskegon) and expansion (Kent) which includes case management and peer recovery coaching.
- Establishment of new Recovery Community Organization within Ottawa County that offers mutual aid peer support, sober social events, and also houses a CMH access clinician. As well as the continuation of community-based mutual aid recovery groups as alternatives to AA/NA, Celebrate Recovery (Lake, Mason and Oceana), and Smart Recovery (Muskegon).
- Initiation and several years of sustained Naloxone training and kit distribution to both the public and all law enforcement departments, which has resulted in many lives saved in all counties. As well as Naloxone Administration Follow-up Teams.
- Grant awards to address issues include MAT Service enhancement in corrections settings, a Mobile Health Unit, Expansion of Recovery Residences, expansion of recovery coach services at access centers, community-based models and within public housing complexes, expansion of naloxone distribution.

The LRE's long-standing relationship with Native American tribal organizations (e.g., Nottawaseppi Huron Band of the Potawatomi (NHBP), Grand River Band of Ottawa Indians (GRBOI), and other federally recognized or unrecognized tribes) in developing and providing culturally competent services will continue. As tribal organizations express the desire and capacity to provide services, LRE will encourage and support their efforts to do so through CMHSP provider panel opportunities.

Through multicultural grants obtained by LRE under Mental Health Block grant funding, robust training is available to support working with Native Americans under the guidance of Family Outreach Center who is the regional lead in working with this population. This effort has led to all providers being trained in how to improve our relationships and services with the local Native American population. This resource also provides enhanced opportunity to continue improving integration of Mental Health and SUD providers. The program itself delivers education, therapy and opportunities for community connection (i.e. talking circles) and utilizes culturally relevant practices as a space to improve mental health and provide education and harm reduction for SUD for Native individuals.

The LRE works to ensure a trauma-informed system of care by providing training to the provider network. Monitoring delivery of services and requiring the provider network to document how they ensure delivery of trauma-informed care during planning and procurement processes is also a fundamental requirement. Each of the CMHSPs ensures their Access Management System has staff and procedures that are trauma-informed and the regional clinical ROAT discusses issues related to trauma-informed care, as necessary.

LRE will ensure that there is knowledge of any problem, related research to be consulted, and services planned will consist of evidence-based interventions that will be effectively executed. Expertise is required at both planning and service implementation levels, which will be provided in part by the continuing participation of LRE's Medical Directors: Scott Monteith, Chief Medical Officer and Dr. Richard Tooker, Medical Director. In these roles, they assist the LRE in assessing and addressing the problem and developing service plans consisting of evidence-based interventions that will appropriately impact the identified issues.

7. Implementation Plan

LRE employs a manager of both Prevention and Treatment Services who are responsible, under the PIHP Chief Operating Officer, to implement the legal and contractual obligations of the entity related to SUD services. LRE delegates SUD Treatment and Recovery services to its 5 member CMHSPs who are responsible for the following: SUD Treatment and Recovery Services provider network evaluation, procurement, contracting and management, screening, authorization, and referral for services to all levels of care, data reporting, budget management, claims payment, and overall treatment system development to meet the needs of our communities. SUD Prevention is managed directly by the PIHP and the manager of SUD Prevention manages all 10 contracted prevention agencies and several regional prevention projects.

7.1 Prevention

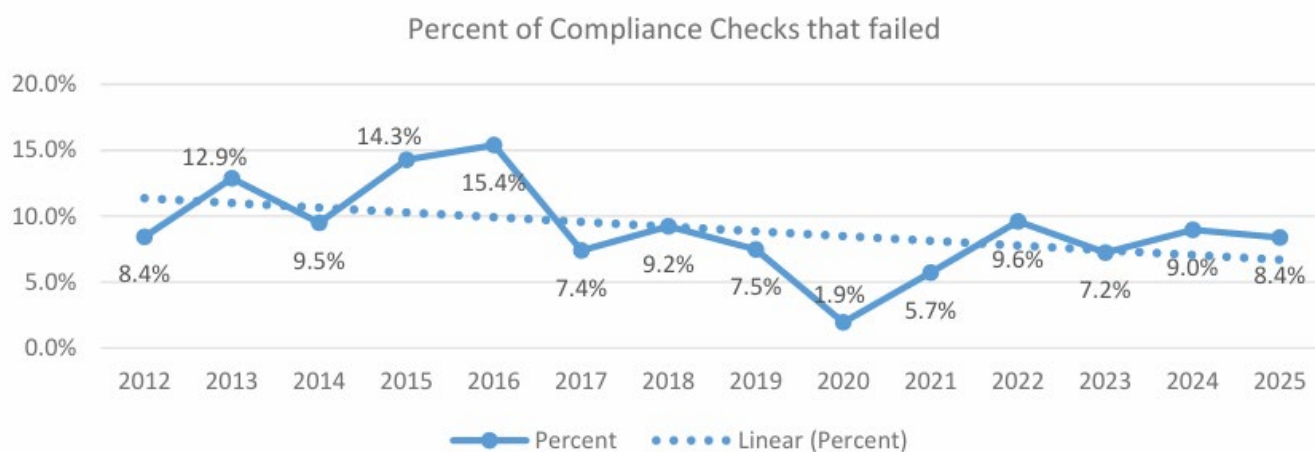
Prevention providers develop and submit yearly outcome workplans and budgets which adhere to the regional strategic plan, along with county plans. Regional meetings are held throughout the year to discuss new ideas providers may have, identify trends within the region and share best practices. Submitted plans are reviewed by the SUD Prevention Manager to be approved or modified to ensure that they meet the needs of the region and will help achieve the outcomes established in the strategic plan before yearly contracts are approved. Annually LRE conducts a site visit/audit of each prevention provider to ensure they are meeting all required expectations and a plan of correction is required for any non-compliant findings. Providers are required to submit bi-annual reports to document they are meeting established benchmarks and performing as expected. MPDS (Michigan Prevention Data System) activity is reviewed and verified by the LRE to ensure accuracy of data and achievement of adequate performance. Providers MPDS are monitored throughout the year and provided an annual report of MPDS activity that assesses units provided for each strategy. An

overview of planned key prevention services is detailed in the Prevention Logic Model (Attachment 1).

As noted earlier, LRE provides regional coordination of the TalkSooner Campaign to coordinate and spearhead regional collaboration. The TalkSooner Core team consists of regional prevention providers who provide expertise in the field and guide the efforts of TalkSooner messaging across the region via campaigns, a website and other resources.

LRE also coordinates the regional No Cigs for Our Kids campaign with the goal of ensuring LRE achieves 80% compliance during formal Synar investigations each year. The “No Cigs For Our Kids” campaign focuses on educating tobacco vendors in the region regarding the importance of compliance with the Youth Tobacco Act. Funding is provided to enable the substance abuse prevention coalitions in the region to work with local law enforcement agencies to ensure that tobacco retailers do not sell tobacco products to minors. These compliance checks have been occurring in several of the region’s counties since 2011 and, over the last three years, have occurred in each of the region’s seven counties.

This campaign has been in place since 2004 and has been shown to have successfully achieved the required compliance during formal Synar inspections. Figure 4 displays the percent of non-Synar compliance checks reported per year in the LRE region that failed. Tobacco sales to minors have remained below the twenty percent (20%) threshold established by the Synar Amendment since 2012, with the most recent percentage being 8.4%.



7.2 Treatment and Recovery

Implementation of Treatment and Recovery Programming is coordinated by the LRE SUD Manager in partnership with the SUD Leads at each of the 5 regional CMHSPs. These individuals, with support from other departments such as finance, utilization management, and provider network ensure that this strategic plan is implemented successfully.

The LRE convenes a clinical standards ROAT group to work on regional implementation of common clinical practices. This group consists of the designated Manager from the PIHP and the designated clinical lead from each of the five CMHSPs to establish and monitor implementation of a common system of care with common standards for admission and treatment, with common contract language and payment standards.

The SUD ROAT meets monthly to review the provider network. This includes any areas of concern from provider’s performance to their needs. The group also reviews the BH TEDS

submission to look for trends, outliers, proper data population, and overall usage patterns. This group also reviews the strategic plan and evaluation efforts to ensure that they are on track. Data reports will be developed and provided to the SUD ROAT quarterly in order to monitor trends within targeted goals and objectives as defined in the Treatment and Recovery Logic Model. Review of this data will allow for quick identification and response to ensure continuous improvement.

Each CMHSP has a utilization management department that oversees all authorizations and requests for higher levels of care. Although SUD treatment and recovery services are managed by each of the CMHSPs, LRE has established a ‘no wrong door’ access model to improve accessibility for individuals seeking services. LRE utilizes responsible screening and admission criteria to assure that MDHHS priority populations contractual standards are being met to comply with SUD Block Grant fund requirements. Each CMHSP will monitor their local concerns and collaborate across CMHSP boundaries through designated leads to assure that no need goes unmet while a capacity for service exists anywhere within (or outside of) the region. Routine reporting on the instances of demand for priority population services will be produced by CMHSPs and collated by the Region 3 PIHP to monitor demand and the need for increased capacity. Each CMH meets with their respective provider network quarterly, at a minimum, to ensure that the needs of the consumers are met, to provide technical assistance, and to ensure compliance with contractual obligations.

Audits of each SUD Provider and CMHSP are conducted annually to ensure they meet contractual requirements. Problematic findings are reviewed by the SUD ROAT and corrective action plans developed as necessary.

Priorities will include:

- Continued development of evidence-based management, auditing/oversight, financial risk management, and network management.
- Continued coordinated planning for utilization management, auditing/accountability, financial risk management, etc. through SUD ROAT, Finance and Rate groups.
- Focused development of evidence-based practices and best standards of service and care (e.g., co-occurring capability development, trauma-informed care, cultural competence, etc.)
- Capacity management for priority populations.
- Implementation of common outcomes tools and systems, including regional evaluation efforts.
- Provider education and technical assistance.
- Budget management for providers and services.

An overview of key treatment and recovery support initiatives have been detailed in the Treatment and Recovery Support Logic Model (Attachment 2). The timeline for achievement of goals and objectives has been provided under question 2.

7.3 Timeline

Table 11

Timeline:	Responsible	FY27	FY28	FY29
Prevention Annual Outcome Plan Submission	Prevention Providers	September 2027	September 2028	September 2029

Timeline:	Responsible	FY27	FY28	FY29
Provider Audit/Site Visits - Treatment and Recovery Providers	LRE Internal Team	Ongoing	Ongoing	Ongoing
Provider Audit/Site Visits- Prevention Providers	SUD Prevention Manager	Ongoing	Ongoing	Ongoing
SUD Treatment ROAT Workgroup	SUD TX Manager	Quarterly	Quarterly	Quarterly
Regional Prevention Workgroup	SUD Prevention Manager	Quarterly	Quarterly	Quarterly
Prevention Reporting MPDS	Prevention Providers	Monthly	Monthly	Monthly
Prevention Progress Reporting	Prevention Providers	Bi-Annually	Bi-Annually	Bi-Annually
Prevention Annual Reports - (Prevention Activities Summary and Tobacco Compliance Analysis)	LRE evaluator(s) SUD Prevention Manager	Yearly	Yearly	Yearly
SUD Treatment Evaluation Reports	LRE Evaluator SUD TX Manager	Quarterly	Quarterly	Quarterly

8. **Evaluation Plan**

LRE has consistently implemented evaluation processes that support identification of opportunities for improvement in implementation of a recovery-oriented system of care. An outside evaluator has and will continue to assist the SUD Managers in establishing data tracking mechanisms to monitor and review the effectiveness and impact on targeted outcomes for regionally planned services. In addition, discussions to facilitate provider and stakeholder review of evaluation findings will support engagement in developing regional plans to inform improvements across the region in response to findings.

8.1 Prevention

An evaluator has provided evaluation for prevention services in the past and will be retained to do so again. The previous evaluation report for prevention services is provided as Exhibit 2.

For this evaluation process, the regional logic model (Attachment 1) provides the framework for monitoring effectiveness and outcomes of the regional plan to improve targeted community indicators. Identified long-term goals and objectives for each targeted issue have been provided under question 2.

As data becomes available, data trends are reviewed and summary reports are created that include calculations for regional rates based on county MIPHY results. Any issues that have worsened or are not showing adequate improvement will be noted and discussed during Regional Prevention Provider meetings. Action steps will be developed to document what will be done to strengthen the likelihood of improvement in these areas.

In addition to regional evaluation, each provider establishes an evaluation plan with identified outcomes for local initiatives. Methods used to administer outcome surveys are based on evidence-based program. Several prevention providers in the LRE region use Qualtrics or Survey Monkey to

administer their pre/post tests and many coalitions use a contract evaluator to complete a formative assessment as needed. Progress toward achievement of these outcomes is reported to LRE in bi-annual reporting. For initiatives implemented at the regional level, evaluation tools and procedures will be developed prior to implementation and findings reviewed by the Regional Prevention Providers to inform improvement of efforts.

An annual evaluation of efforts to prevent youth access to tobacco will also continue to be provided by an evaluator (Exhibit 3). The purpose of this evaluation is to utilize the data that each county has collected through the compliance check process to analyze results, find possible trends, make recommendations for improvements to the compliance check process, and ensure compliance with the Synar Amendment of 1992. A standardized database has been developed for providers to enter each compliance check record which is used for analysis.

In addition, the LRE SUD Prevention Manager will monitor the following at least annual:

- Percent of evidence-based programming at each provider, and regionally, as measured by MPDS data records.
- Units of service provided
- MPDS Outcome Survey completion rate for each provider for programming that meets criteria.

8.2 Treatment and Recovery

The treatment and recovery support logic model provided as Attachment 2 displays a framework for monitoring and evaluating the effectiveness of the region in improving targeted issues. Goals and objectives identified for the intermediate and long-term outcomes for targeted improvement areas have been provided under question 2 and are referenced throughout this section as appropriate.

An evaluator will be retained to support ongoing monitoring and evaluation of treatment and recovery initiatives, including monitoring of data trends, progress, and identification of corrective action plans or enhancements as applicable.

Data for each indicator will be monitored, and the SUD ROAT will receive quarterly reports summarizing the trends related to each of the identified goals and objectives for each county and as a region. For issues that are not showing improvement, the evaluator will assist the group in further analysis of available data to understand the issue. Action items will be developed to address the issues of concern. Annually, an evaluation summary will be done to review trends in targeted data indicators, a summary of efforts undertaken to address each, and to provide recommendations for future improvement.

In addition, LRE will monitor and track performance in the following indicators:

Table 12

Domain	Measure	Evaluation Mechanism
Health and Safety	Sentinel Events	LRE data system reporting
Administration: use of public funds	On-time reporting	SUGE reporting
	Withdrawal Management	BH TEDS
	Subsequent Services	
	Outpatient Continuation	
	Treatment Outcome: – Housing – Employment – Education	

	– Recidivism	LRE Financial Reporting System
	Funds spent on services	
	Funds spent on integrated services	
	Funds spent on recovery supports	
Treatment Penetration Rates for Selected Populations	Youth ages 12-17	BH TEDS
	Young adults age 18-25	
	Women of childbearing age	
	African Americans	
	Hispanic	
	Native American	
	Persons with Opioid Use Disorder	

8.3 Evidence-Based Interventions and Integration of Trauma Responsive Services

LRE requires that all prevention, treatment and recovery support programming is evidence-based and data-driven. To support this requirement, LRE provides ongoing training and technical assistance to support providers in finding and initiating evidence-based programming and models. Just some of the evidence-based programs currently implemented in the LRE region include:

- Strengthening Families Program for Youth ages 10-14
- Prime for Life
- Botvin’s Life Skills
- Project Alert
- Community Trials to Reduce High Risk Drinking
- Compliance checks with alcohol and tobacco retailers
- Vendor education for alcohol and tobacco retailers
- Michigan Model
- No Cigs for Our Kids Responsible tobacco retailing campaign
- Motivational interviewing
- Matrix Model
- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy (DBT)
- Trauma Informed Cognitive Behavior Therapy
- Medication Assisted Treatment including Vivitrol, Suboxone, Methadone, Buprenorphine
- Contingency Management
- Eye Movement Desensitization Training (EMDR)
- Seeking Safety
- LEAD Program

LRE has worked to integrate trauma-responsive services throughout the entire continuum of services and each CMHSP is required to ensure that their Access Management System has staff and procedures that are trauma informed. LRE supports these requirements by providing ongoing training to the provider network. Providers are required to document how they ensure delivery of trauma-informed care during planning and procurement processes. LRE monitors delivery of services to ensure compliance during annual site review visits.

8.4 Women's Specialty Services (WSS)

There are currently 11 Women's Specialty Service programs throughout the LRE region. Strengths of the WSS network are the collective diversity of treatment offerings and the geographic coverage of the provider network. Of primary focus for the region is continuing efforts to strengthen trauma-informed services within WSS provider agencies, including expansion of the evidence-based programs Seeking Safety and Beyond Trauma. In addition, the LRE encourages providers to attend WSS state meetings where resources and training for trauma informed services are often provided. A list of providers and the services available is provided in Table 13.

Table 13:

WSS Providers	County/Location	Type of Care
Arbor Circle	Kent	OP, IOP, Enhanced Women's Services, Family Engagement Program, Women's case management, Women's Reentry
	Muskegon	OP, Recovery Management (Women's Services Embedded)
Family Outreach Center	Kent	OP, Family Engagement Program
Cherry Health	Kent	OP, Family Engagement Program
Samartias	Ottawa	Enhanced Women's Services
Reach for Recovery - Harbor House	Ottawa	Women's residential; Childcare: 0-1 years; Family Therapy: 0-17 years, infants may stay in residence with mom; transportation
Reach for Recovery. - Women's Services	Ottawa	IOP (w/domicile), OP; Childcare: 0-12 years; Family Therapy: 0-17 years; transportation
Our Hope Association	Kent	Residential, Childcare: 0-10 years of age
Wedgwood	Ottawa	OP, IOP Family Engagement Program
	Muskegon	Family Engagement Program, SPA

While much progress has been made to strengthen the WSS service provider network, the following deficits have been identified:

- The need to improve capacity for childcare arrangements for the number of children and ranges of ages as realistically presented for service.

- Ensuring that WSS programs fully identify and address the preventative and developmental needs of children, focusing especially on the offering of trauma-informed services/groups such as Seeking Safety.
- Expansion of WSS programs within Allegan County and the WMCMH area.

To address these deficits, and enhance effectiveness of WSS services, planned initiatives include:

- Establish consistent training for WSS providers to ensure clinicians and supervisors understand WSS requirements, expectations, and best-practices.
- Add WSS to standing agenda for SUD ROAT to ensure issues are addressed throughout treatment systems and increase awareness and visibility of program; establish agreements for how to implement consistently throughout region and monitoring procedures.
- Assess each county's relationship with Child Protective Services to identify opportunities for coordination and enhanced partnerships.

LRE has established the following metrics to monitor progress and improvement for WSS services:

- Increase number of women served,
- Increase number of counties in the LRE region with at least one WSS service provider.
- Regional consistency in services and supports available to WSS eligible clients as documented during LRE Site Visit reviews.

8.5 Persons with Opioid Use Disorder.

All treatment providers in the LRE region's network are able to provide treatment services for persons dependent on opioids. Programs specializing in the treatment of opioid dependence that provide medications for opiate use disorder include:

Table 14

MAT Providers	County	MAT offered
ACAC	Muskegon	Suboxone
Cherry Street Health Services	Kent	Methadone
Healthwest	Muskegon	Suboxone
Muskegon Recovery Center of Cherry Health Services	Muskegon	Methadone
Eastside Clinic	Muskegon	Methadone
Reach for Recovery	Ottawa	Suboxone
Wedgwood	Ottawa	Suboxone
West Michigan Treatment Center	Ottawa	Methadone
West Michigan CMH	Lake, Mason, Oceana	Suboxone

To evaluate the effectiveness of efforts to enhance and improve outcomes for persons with opioid use disorder, LRE will monitor the following:

Table 15

Metrics	Baseline FY25 (unless otherwise specified)
Decrease average days between request for service and first service for outpatient with MAT	8.1 days
Decrease average days between request for service and first service for persons with IVDU	7.5 days

9. **Cultural Competency of Policies, Programs and Practices**

LRE ensures that the policies, programs and practices at the PIHP, the CMH and the provider level are constructed and conducted in a culturally competent manner.. LRE requires planning documents to demonstrate how providers will ensure the implementation of programs with cross-cultural proficiency and monitors fidelity during each provider site visit.

As stated in the LRE’s Organizational Values and Principles, LRE, CMHSP members and our provider network maintain ‘Mutual commitment to ensuring the voice of persons served, their families and their supporters is solicited, heard, honored and reflected in the work of the Entity, Members, and regional service providers in a meaningful and substantive manner.’

Member CMHSPs and providers are encouraged to incorporate the recommended action steps outlined in the *Transforming Culture and Linguistic Theory into Action: A Toolkit for Communities* and CADCA’s *Cultural Competence Primer* into daily practices for achieving cultural competence. Specific actions to ensure cultural-competent services include:

- Develop support for change throughout the coalition and represented organizations.
- Identify the cultural groups to be involved.
- Identify barriers to cultural competence.
- Assess current level of cultural competence – (defining what knowledge, skills and resources to build on, as well as define gaps and barriers).
- Identify the resources needed – (define what is needed to bring about the change).
- Develop goals, implementation steps, and deadline for achieving cultural competence.
- Commit to an ongoing evaluation of progress and be willing to respond to change.

LRE monitors issues related to cultural competence during annual site visits. Technical assistance and trainings are provided by LRE to address identified local needs in this area. Currently all staff have taken the Implicit Bias Training., As noted earlier, the Native American and Hispanic Services grants obtained by LRE under Mental Health Block grant funding enables LRE to offer enhanced training for staff and culturally relevant service provision for these specific populations. In light of recent events, the LRE plans to work with each ROAT workgroup and provider network to identify how the region can improve services for minority populations, reduce health disparities, and address systemic racism and its impact on the health and well-being of those we serve.

The following logic model provides an overview of planned priorities, initiatives, and outcomes for substance use disorder services in the LRE region including prevention, substance use disorder treatment and recovery services, and gambling disorder prevention services. In addition to these activities the LRE will monitor emerging issues and opportunities and respond as appropriate.

Attachment 1: LRE Region #3 Prevention Logic Model, FY27-FY29

PREVENTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
Youth use of Alcohol Marijuana E-cigarettes In 2026, too many high school students reported recent use of alcohol (8.5%), marijuana (6.9%), Electronic vapor products(7.4%), painkillers (1.6%) and stimulants (1.5%) not prescribed to them.	Low perception of risk: Among HS students, too many report the following is low risk: Binge drinking (23.9%), Marijuana use (51.6%), (LRE Region, MIPHY 2026). In Lake County, 34.0% reported vaping w/ nicotine was low risk (LYS 2024), and in Ottawa, 16.6% reported vaping was low risk (OYAS 2026)	Raise youth awareness of the potential health and legal consequences of substance misuse.	Encourage parents to communicate the risks of substance misuse with their youth by promoting TalkSooner and parent educational presentations and programming.	Region	Increase in youth reporting a parent or other adult in their family has spoken to them about alcohol or other drug use.	Increase the % of HS students reporting moderate or great risk for the following, by 2029 as measured by the MIPHY: Binge drinking Regular marijuana use Rx misuse -E-cigs/vaping products use	Decrease in HS students reporting recent use of the following in the region by 2029as measured by the MIPHY: Alcohol use Marijuana use E-cigarette use Rx misuse
			Support schools and youth serving organizations to incorporate education and information into their programming.	Region	# of schools incorporating SUD education into programming across the region		
			Provide information to youth on the risks through educational programming and presentations. Raise youth awareness of the risks of substance misuse to correct inaccurate beliefs and enhance refusal skills.	Region	# Presentations # educational series		
		Improve the ability of adults to identify when youth are misusing substances and provide support.	Support parents and other adults who work with youth on how to identify and respond to youth substance misuse.	Region	.# of parent's education on substance use identification and resources available Creation of referral pathways for youth using substances.		

Attachment 1: LRE Region #3 Prevention Logic Model, FY27-FY29

PREVENTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
	Easy access to substances: Among HS students in the region too many report easy access to alcohol (45.2%), marijuana (27.8%), cigarettes (23.8), e-cigs, and Rx medications not prescribed for them.	Decrease youth access to legal substances in their homes (Rx, Alcohol, and Marijuana): Among HS students who drank recently, 6.7% report they usually got alcohol by taking from a family member, 43.2% report they usually drank at home, and 48.1% report they usually drank at another person's home. (LRE Region, MIPHY 2026)	Promote proper storage of substances in the home to prevent youth access.	Region	# of medication lock boxes distributed % HS students reporting they usually get their alcohol by taking it from home	Reduce the % of HS students reporting it would be sort of or very easy to get the following by 2029 as measured by the MIPHY: Alcohol Marijuana Cigarettes <i>Baselines for vaping and Rx drugs are monitored by where students report they get them from (store/gas stations, internet, giving someone money, borrowing ,etc)</i>	
			Promote proper disposal of Rx and OTC medications.	Region	# of pounds of medication collected.		
		Encourage responsible retailing of legal substances. (Alcohol, Marijuana, e-cigs, tobacco): Among HS students who drank recently, 2.6% usually got it bought from a retailer (LRE Region, MIPHY 2026). In Ottawa, 4.2% of 12 graders bought vape products in a store in	Retailer (tobacco, alcohol, and cannabis) compliance checks. Retailer education (tobacco, alcohol, and cannabis) Advocate for improved regulations and oversight of retailers.	Region	# of retailers participating in education # compliance checks completed.		

Attachment 1: LRE Region #3 Prevention Logic Model, FY27-FY29

PREVENTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
		the past year (OYAS 2026)					
	Youth lack protective factors necessary to prevent substance use and mental health problems.	Promote prosocial involvement and resistance skills: In 2026, HS students who report to having friends who feels it’s wrong to use alcohol (14.6%), Marijuana (22.5%), Rx drugs without a RX (9.1%) Cigarettes (14.5%)	Coordinate youth groups to develop leadership skills and messaging for their peers.	Allegan, Lake, Oceana, Ottawa	# of youth presentations delivered to their peers.	Increase the % of HS students reporting friends who feel it is wrong to use substances by 2029 as measured by the MIPHY.	
			Youth leadership training.	Region-wide	# of youth participate in leadership training		
			Provide education to their peers on the importance of avoiding substance misuse.	Allegan, Ottawa,	# of youth participate in education sessions		
			Provide youth community service opportunities (not part of a standing leadership group).	Ottawa	# of community service opportunities provided to youth.		
			Train students to provide support to their peers.	Allegan, Ottawa	# of youth who receive peer support training		
		Support Positive Family Dynamics In 2026, 17.1% of HS students in the region reported they could not ask their mom or dad for help with a personal	Parenting skills training programs to support effective parenting and positive family dynamics	Allegan, Lake, Mason, Oceana, Ottawa	# of parents to receive education on positive family dynamics	Increase the % of HS students reporting they could ask their mom or dad for help with	
			Promote positive family strengthening protective factors activities.	Region-wide	Estimated reach and/or # participants		

Attachment 1: LRE Region #3 Prevention Logic Model, FY27-FY29

PREVENTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
		problem. 24.3% of students have not had parents or other adults in their family talk with them about what they expected them to do or not to do when it comes to alcohol or other drug use. Youth with families that provide structure, supportive relationships, and clear expectations are less likely to develop addiction or mental illness. ¹				a personal problem by 2029 as measured by the MIPHY:	
		Enhance Skills: Youth with good coping, problem-solving, and social emotional regulation skills are less likely to develop addiction or mental illness. ¹	Provide youth and/or families with opportunities to improve their social/emotional, coping, and/or life skills.	Allegan, Lake, Muskegon, Oceana, Ottawa	# of youth to participate in positive coping, problem solving and social emotional regulation skills training.	Increase in % of youth with improved skills as demonstrated at post test.	
Mental, emotional, and behavioral (MEB) disorders—which include depression &	The ability to access services, support, and community resources can reduce the	Improve early identification of substance misuse or mental health challenges early so we can provide or	Improve problem identification and referral processes within community organizations.	Allegan, Kent, Lake, Mason, Muskegon, Oceana, Ottawa	% of individuals referred into treatment through referral pathway within community organizations, another	<u>Increase in referrals to services</u>	Decrease in youth and young adults with

¹ [Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle \(csifdl.org\)](https://www.csifdl.org/)

Attachment 1: LRE Region #3 Prevention Logic Model, FY27-FY29

PREVENTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
substance abuse, affect almost 20% of young people at any given time. Many disorders have life-long effects that include high psychosocial and economic costs, not only for the young people, but also for their families, schools, and communities ² Older adults may be more likely to experience mood disorders, lung and heart problems, or memory issues. Drugs can worsen these conditions, exacerbating the negative health consequences of substance use. (NIDA)	likelihood of addiction related harms . In 2026, 13.1 of HS students had seriously considered attempting suicide and 26.1% had felt so sad or hopeless almost every day for 2 weeks or more in a row they stopped doing some usual activities during the past 12 months (LRE Region, MIPHY 2026)	connect individuals to preventative interventions.			way to capture this if not direct		untreated mental illness or addiction.
			Integrate screening procedures in prevention programming to identify and refer youth as appropriate.	Kent,	# of screenings administered to youth in prevention programming		
			Increase availability of mental health training for individuals who work with youth and older adults (MHFA ,QPR, WISE Curriculum).	Allegan, Lake, Mason, Oceana, Ottawa	# of scheduled mental health trainings for individuals who work with youth/Older Adults		
			Educate youth on recognizing signs of suicide in their peers and how to find help.	Allegan, Kent,	# of youth provided with information on suicide prevention resources.		
			Educational programming for youth who have initiated substance misuse or their families.	Allegan, Kent, Ottawa	# of youth and/or families who participate in substance use education once use has initiated		
			Anti-stigma messaging and education to improve the willingness of persons with addictions to seek help.	Kent, Muskegon, Ottawa	% of Community exposure to anti-stigma messaging and treatment resources		

² [Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle \(csifdl.org\)](#)
[Substance Use in Older Adults DrugFacts | National Institute on Drug Abuse \(NIDA\)](#)

Attachment 1: LRE Region #3 Prevention Logic Model, FY27-FY29

PREVENTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
Gambling Disorders	The ability to access services, support, and community resources for problem gambling to reduce the likelihood of harms. 13.6% of Ottawa Co students have made a bet or gambling in the past 30 days (OYAS, 2026) In 2025, the LRE region incurred 164 calls to the MDHHS Gambling Helpline and 29 referrals to treatment.	Promote advocacy for gambling related issues.	Monitor advocacy opportunities related to GD prevention and encourage action as appropriate	Region	# of advocacy opportunities promoted	Increase in responsible gambling practices	Decrease in rates of problem gambling
		Increase access to gambling disorder treatment	Work to decrease stigma for problem gambling so individuals will seek help. Promote availability of self-help groups for individuals with gambling disorder	Region wide (specifically Ottawa, Lake, Mason, Oceana, Muskegon)	Estimated reach	Reportable calls and treatment referrals to the MDHHS helpline.	
		Increase awareness of risks and risk reduction strategies for problem gambling	Raise community awareness of the risks of gambling, strategies to reduce risk, and actual likelihood of winning; including messaging targeted to older adults Educate parents about the risks of online gambling, and how to support their youth in avoiding risky behavior. Incorporate education for youth into prevention programming on the risks and prevent 'magical thinking'	Region wide (specifically Ottawa, Lake, Mason, Oceana, Muskegon)	Increased perception of risk among youth for gambling	<i>MIPHY does not provide a baseline for gambling behaviors.</i>	

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

HARM REDUCTION SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
Individuals who misuse substances have an increased likelihood of high-risk behaviors that put themselves at risk of personal or community-level harm.	During 2024 there were 1,348 alcohol-involved & 314 drug-involved traffic crashes in the region.	Raise awareness of the risks of driving under the influence of substances.	Distribute information	Allegan, Ottawa	# of individuals receiving info on risks of driving under the influence of substances	Increased community awareness of the risks of driving under the influence.	Decreased in alcohol and drug-involved traffic crashes.
	Persons with untreated opioid addiction are at high risk of overdoses. In 2024 there were 171 overdose deaths in the region. ³	Overdose survivors are at high risk of a subsequent overdose in the days that follow. ⁴	Post overdose visits to OD survivors to provide resources and offer treatment resources	Ottawa, West MI, Kent	% of overdoses that receive a post-overdose visit.	Increase in individuals with overdose prevention resources.	Decrease accidental overdose poisonings by 2029
		Research suggests that high rates of naloxone distribution among laypersons and emergency personnel could avert 21 percent of opioid overdose deaths, and the majority of overdose death reduction would result from increased	Promote use of Narcan to reverse overdoses. Promote awareness & availability of Naloxone to prevent opioid overdose deaths. Dispense in vending machines at no cost.	Region-wide Vending: West MI, Muskegon	# of Narcan kits distributed # of Narcan administrations by a first responder.	Increase # of individuals connected to treatment through community-based supports.	

³ www.mi.suddr.com

⁴ [3] Weiner SG, Baker O, Bernson D, Schuur JD. One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. Ann Emerg Med. 2020 Jan;75(1):13-17. doi: 10.1016/j.annemergmed.2019.04.020. Epub 2019 Jun 20. PMID: 31229387; PMCID: PMC6920606.

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

		distribution to laypersons. ⁵	Promote use of Naloxone by first responders.				
		Provide outreach to provide resources and encourage linkages to treatment when ready.	Recovery management, community based recovery coaching services	Region-wide	# of SUD clients accessing recovery management.		
			Community-based support and outreach to provide resources and connection to treatment services Recovery coaches in homeless shelters and other community spaces Mobile Health unit Placement of a coach and therapist in public housing complex with high rates of substance misuse problems to provide ongoing services for residents	<i>Ottawa, Kent, Allegan</i>	# client contacts # of individuals connected to treatment through community-based supports.		

⁵ FDA. *FDA approves first generic naloxone nasal spray to treat opioid overdose [news release]*. 2019; Available from: <https://www.fda.gov/news-events/press-announcements/fda-approves-first-generic-naloxone-nasal-spray-treat-opioid-overdose>.

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

TREATMENT SERVICES							
Problem	Intervening Variables	Strategies	Activities	Counties	Outputs	Intermediate Outcomes	Long-Term Outcomes
Improve access to SUD Treatment Services.	Increase access to MAT services for persons living w/ <u>Opioid Use Disorder</u> and for <u>intravenous drug users (IVDU)</u> - In FY25 the avg time to service (TTS) for MAT was 8.1 days for clients w/ OUD, and 7.5 days for IVDUs.	Expand availability of Medication Assisted Treatment (MAT) services. In FY25, the average time to service for MAT was 8.1 days for persons with an OUD	Expand MAT providers to areas without current coverage. Provide transportation to MAT services through bussing services, gas cards, etc.* Continue providing MAT in jails with specialty grants as available*. Launch mobile MAT for difficult to engage populations.	Region	# of clients accessing medication assisted treatment.	Decrease avg TTS for MAT services	Decrease average days between request for service and first service for <u>persons w/ OUD</u>
		Expand capacity for higher levels of care. Among admissions w/ IVDU the average time to service in FY25 was 7.5 days for detox, 8.6 days for LT residential	Expand the number of detox and residential providers in the region	Region	# of detox and residential providers in the region.	-Decrease avg TTS for Detox. -Decrease avg TTS for LT Res.	Maintain an average wait time of less than 3 days for persons with IVDU.
		Among admissions w/ IVDU the average time to service in FY25 was 6.8 days for non-intensive outpatient.	Promote the use of Recovery Coaches as interim services providers	Region	# of clients accessing care through recovery coaches.	Decrease avg. TTS for clients w/ IVDU entering outpatient	
	Increase access to treatment for <u>criminal justice involved</u> population	Improve <u>coordination w/ probation</u> officers to connect to community-based services upon release.	Region ROAT team discuss management of MDOC clients on parole and establish guidance and best-	Kent Muskegon Region	# individuals served # individuals receiving resources LRE Policy established	LRE policy consistently implemented for MDOC clients.	Maintain admissions #s with legal status as on

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

	returning to communities on probation: In FY25 22% of admissions were for clients on probation, ranging from a low of 15% in Kent to a high of 37% in West MI.		practice procedures for these clients.				probation at admission.
			Priority Population Manager will monitor engagement in treatment for MDOC identified individuals following return to the community to increase accountability, oversight and coordination.	Region			
		Maintain <u>service provision for inmates in jail</u> to improve engagement and active referrals for community-based services upon release.	Designated SUD team provides therapist and a peer providing SUD services in county jails & ‘discharge’ planning to improve connection to resources upon release from jail	Lake, Mason, Oceana. Ottawa	# of individuals accessing SUD treatment within jail.	Sustain counties with services provided in the jails at 100%.	
			MAT provided in the jail	Region			
Improved continuity of care across treatment continuum	Increase engagement in services: In FY25, 34% of discharges were for clients who ‘dropped out’ and 10% of treatment	Increase in the use of <u>integrated services for persons with co-occurring</u> substance use and mental health disorders: In FY25 33% of clients at discharge who had a co-occurring SUD and MH problems were recorded	Establish expectations for provision of integrated services; annual review with corrective action plans required for those not meeting benchmark.	Region	# of corrective action(s) distributed across the region on integrated services.	↑ in % of clients w/ co-occurring diagnosis that received integrated services.	↓ % of discharges with reason as ‘dropped out’ for all LOC. ↓ % of treatment

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

	episodes had only one encounter. Of treatment episodes with more than one encounter, 91% had a second service within 14 days.	as having received integrated treatment.	Monitor provider data entry to improve our ability to record and monitor delivery of integrated care.	Region			episodes with only one encounter.
			Establish procedures and provide support for establishment of SUD Health Homes as opportunities present.	Region			
		Support providers in preventing and responding to <u>methamphetamine use among clients</u> , including those with an opioid use disorder.	Provide training for providers on evidence-based treatment for methamphetamine (e.g. Matrix Model). Monitor issue and provide forum(s) to identify emerging issues and develop coordinated response and supports.	Region		# of trainings for providers on evidence-based treatment for methamphetamine in region.	
		Improve process for discharge from ST residential levels of care to improve entry to subsequent level of care. In FY25, 50% of clients were admitted to a lower level of care within 7 days.	Work with providers to ensure they assist client in making appt in next LOC prior to discharge. Discuss issue with SUD ROAT and develop a plan to improve quality of discharge planning for detox and ST Residential.	Region	% of clients who successfully transferred into the next LOC prior to discharge.	↑ % discharges from ST Res with reason as 'transfer/ completed level of care'.	Among individuals discharged from ST residential, ↑ the % admitted to the next LOC w/in 30 days

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

			Review data quarterly to identify issues and respond as necessary.				
		Women's Specialty services providers work with pregnant and parenting women to reduce barriers to treatment, ensure appropriate medical care, and connect to community resources for other needs.	Enhanced women's services– work with women who are pregnant and using drugs to increase readiness for treatment with the aim of reducing drug exposed births.	Kent	# of pregnant women referred to specialty resources	# of supportive resources/ opportunities provided to treatment clinicians by the LRE. Regional WSS meeting 2x/year	↑ % of pregnant clients served at WSS provider with a drug-free birth. Regional consistency in services and supports available to WSS eligible clients as documented during LRE Site Visit reviews. Increase # of pregnant women served
			Provider training for provision of trauma responsive services. Support WSS staff in attending trauma-related trainings Pilot trauma-responsive outreach and groups with grant funding.	Region	# Attendees trained # trainings held.	↑ in WSS providers that demonstrate effective coordination with CPS as documented during Site Visit reviews	
RECOVERY SERVICES							
Problem	Intervening Variables	Strategy	Activities	Counties	Outputs	Intermediate Outcomes	Long-term outcomes
Increase clients that maintain recovery	Clients establish <u>connections to community supports</u> to assist them in maintaining recovery	Expand availability of Recovery Housing.	Continue current partnerships with recovery houses (all 7 counties). Incentivize establishment of new Recovery	Allegan, Kent, Lake, Mason, Muskegon, Oceana	# of recovery houses within the region. #of clients who stay in recovery residences	↑ capacity (as measured by # beds and # of residence locations) for Recovery	Increase in individuals sustaining recovery

Attachment 2: LRE Region #3 Treatment and Recovery Logic Model, FY27-FY29

			Residences and pursuing MARR certification Develop plan to continue support of Recovery Housing after SOR Funding.			Houses in the region.	
		Opportunities for persons in recovery to develop community connections.	Recovery organization funded in Ottawa to sustain and expand social center for sober activities in the community and linkage to community services	Ottawa	# of clients who engage in prosocial activities that are substance free and/or promote recovery	# of individuals in recovery engaging in prosocial opportunities within the community.	
			Partner and support local coalitions that support prosocial activities in their community that are substance free and/or promote recovery.	Muskegon, Ottawa	# of prosocial activities that are substance free and/or promote recovery		

Goal	Objectives	Expand availability of Recovery Housing .	Activities	Interm. Outcomes	Long-Term Outcomes
		Ensure clients have access to recovery housing			
		Promote healthy births	.		

*SOR Funded activities

Policy 12.1

ATTACHMENT 4

POLICY TITLE: ENSURING THE RIGHTS OF PERSONS SERVED		POLICY # 12.1	REVIEW DATES	
Topic Area:	SUBSTANCE USE DISORDERS	ISSUED BY: Chief Operating Officer APPROVED BY: Chief Executive Officer	12/16/21	9/1/26
Applies to:	LRE Staff, Member CMHSPs and Network Providers			
Developed and Maintained by:	COO			
Supersedes	N/A			
		Effective Date: 12/19/2026	Revised Date: 9/1/26	

I. PURPOSE

To ensure the legal authority and requirements for the rights and the protections for all recipients receiving substance use disorder services authorized and/or delivered by the Entity Provider Network.

II. POLICY

It is the Policy of the Lakeshore Regional Entity (Entity) to ensure that the rights of individuals receiving substance use disorder (SUD) services are protected.

- A. A program shall adopt official written policies and procedures to assure compliance with recipient rights rules and procedures as set for in R 325.1391 to R 325.1399 of the Administrative Rules for Substance Abuse Program in Michigan.
- B. The recipient rights policies and procedures shall be reviewed at least annually to consider any revisions that might be necessary. Such review and approval shall become a part of the administrative record of the program.
- C. The recipient rights policies and procedures shall meet all of the following requirements:
 1. Require the program director to designate a staff member to function as the program rights advisor who shall do all of the following:
 - a. Attend training concerning recipient rights procedures.
 - b. Receive and investigate all recipient rights complaints.
 - c. Communicate directly with the Entity rights consultant when a complaint cannot be resolved at the program level.
 - d. Where staffing permits, the program rights advisor shall not be a provider of counseling services.
 2. Outline the method of filling recipient requests to review, copy, or receive a summary of recipient treatment or prevention service case records.
 3. Provide simple mechanisms for notifying recipients of their rights, reporting apparent rights violations, determining whether in fact violations have occurred,

and for ensuring that firm, consistent, and fair remedial action is taken in the event of a violation of these rules.

- D. Copies of recipient rights policies and procedures shall be provided to each member of the program staff. Each staff member of the program shall review the policies and procedures and shall sign a form provided by the office which indicates that he or she understands, and shall abide by, the policies and procedures. The form shall be explained to the staff by the program director. A signed copy shall be maintained in the staff personnel file and a signed copy shall be retained by the staff member.
- E. A treatment program may choose to restrict specific rights of a recipient based on the program policies and procedures. These restrictions are permissible only when there is a documented therapeutic purpose and timeframe in the recipient's record. A restriction shall not be for more than 30 days without being renewed in writing in the recipient record and shall be signed by a licensed health professional.
- F. As part of the admission procedure to a program, a recipient shall receive all of the following:
 - 1. If incapacitated, receive the procedures described in this subrule as soon as feasible, but not more than 72 hours after admission to an approved service program.
 - 2. A written description of the recipient rights.
 - 3. A written description of any restrictions of the rights based on program policy.
 - 4. An oral explanation of the rights in language which is understood by the recipient.
 - 5. A form that indicates that the recipient understands the rights and consents to specific restrictions of rights based on program policy. The recipient shall sign this form. A copy of the form shall be provided to the recipient and also become a part of the recipient's record.
 - 6. A recipient rights complaint violation form shall be provided to the recipient after completing the consent form.
- G. Rights of recipients shall be displayed on a poster provided by the office in a public area of all licensed programs. The poster shall indicate the program rights advisor's name and phone number and the Entity rights consultant's name and phone number.
- H. The administrator of the office, with approval of the Entity, shall designate a staff member of the Entity to act as the recipient rights consultant for the region. The designation shall be renewed annually. The Entity recipient rights consultant shall conduct recipient rights activities according to procedures outlined by the office.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity, CMHSPs, and Network Providers.

IV. MONITORING AND REVIEW

This policy will be maintained by the CEO or designee and reviewed on an annual basis.

V. DEFINITIONS

Definitions for this policy are defined in the Michigan Administrative Code for substance Use Disorder Service Program R 325.1301.

VI. RELATED POLICIES AND PROCEDURES

Customer Service Policies and Procedures

VII. REFERENCES/LEGAL AUTHORITY

- A. Michigan Administrative Code, R 325.1391 to R 325.1399. Administrative Rules Substance Use Disorders Service Program
- B. Michigan Administrative Code, Definitions 325.1301. Administrative Rules Substance Use Disorders Service Program
- C. Michigan Public Health Code Act 368 of 1978, Article 6, Substance Abuse
- D. Michigan Public Health Code Act 258 of 1974, Chapter 2A, Substance Use Disorder Services
- E. MDHHS Medicaid Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
12/19/2016	New Policy	Chief Executive Officer
12/16/2021	Updated language	CEO and Designee
9/1/26	Updated Language	COO and Rights Consultant

PROCEDURE #	12.1a	EFFECTIVE DATE	REVISED DATE
TITLE:	RECIPIENT RIGHTS PROCEDURE	3/13/2023	
<u>ATTACHMENT TO</u>	REVIEW DATES		
POLICY #:	12.1	9/1/26	
POLICY TITLE:	ENSURING THE RIGHTS OF PERSONS SERVED		
CHAPTER:	SUBSTANCE USE DISORDERS		

I. PURPOSE

To ensure the rights of individuals receiving substance use disorder services by outlining the process by which the LRE and contracted SUD providers will respond to member second-level SUD Recipient Rights Complaints

Lakeshore Regional Entity (LRE) will establish a regional SUD Rights Office that shall:

- ensure the rights of individuals receiving substance use disorder (SUD) services in Region 3,
- provide support and technical assistance to SUD providers to ensure compliance with state and federal regulations, and
- address second-level SUD rights reviews in accordance with the Administrative Rules for Substance Use Disorder Service Programs in Michigan.

II. PROCEDURES

A. LRE will designate an individual to serve as the SUD Regional Recipient Rights Advisor.

The designated individual shall:

1. Attend state trainings on Recipient Rights;
2. Serve as the point-of-contact for the State for SUD Rights in Region 3;
3. Assist consumers with filing a SUD Rights complaint if requested;
4. Forward any SUD rights complaints received by the LRE to the appropriate SUD provider for investigation;
5. Provide support, training, and technical assistance to providers upon request;
6. Handle all second-level SUD Rights reviews;
7. Have no purview regarding Mental Health rights, which is the legal obligation of the Community Mental Health Service Provider (CMHSP) per the Mental Health Code.

B. If a member is dissatisfied with the results of the first-level SUD Rights complaint, they may appeal to the LRE SUD Rights Office. The Provider shall:

1. Assist the member in completing form BCHS-SUD-210
2. Ensure the member has signed the BCHS-SUD-210 form and/or a Release of Information for LRE

3. Utilize secure modes of information sharing to comply with HIPAA rules and confidentiality policies
4. Forward the BCHS-SUD-210 form and all related documentation to the LRE SUD Rights Advisor

C. The LRE SUD Rights Advisor Shall:

1. Acknowledge receipt of the second-level complaint appeal;
2. Review and investigate the second-level complaint appeal;
3. Provide the investigation report and findings to the member on the BCHS-SUD-215 form within 30 calendar days from the date the complaint was received by the LRE;
4. Provide a copy of the investigation report and findings to the SUD Provider;
5. If requested, assist the member with filing a third-level appeal with MDHHS within 15 working days of the date the second-level appeal was completed

III. APPLICABILITY AND RESPONSIBILITY

This procedure applies to LRE, Member CMHSPs, and their contracted providers.

IV. MONITORING AND REVIEW

The Chief Executive Officer or designee will review this policy on an annual basis.

V. DEFINITIONS

Definitions for this procedure are provided in the Michigan Administrative Code for Substance Use Disorder Service Programs; R325.1397.

VI. RELATED POLICIES AND PROCEDURES

LRE Policy 12.1: Ensuring the Rights of Persons Served

VII. REFERENCES/LEGAL AUTHORITY

- A. MDHHS Medicaid Specialty Supports and Services Contract
- B. Department of Community Health/Mental Health and Substance Abuse Administration/Substance Use Disorder Service Program; R325.14101
- C. Act 368 of 1978 Public Health Code, Article 6
- D. PA 358 of 1974 Mental Health Code, chapters 2A and 7

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
3/13/2023	NEW PROCEDURE	LRE CEO / Designee

PROCEDURE # 12.4a	EFFECTIVE DATE	REVISED DATE
TITLE: USE OF RESERVE PA2 FUNDS FOR SPECIAL PROJECTS	4/19/2018	1/7/2026 9/1/26
ATTACHMENT TO	REVIEW DATES	
POLICY #: 12.4	12/16/21, 7/21/23, 1/8/25, 1/7/26, <u>9/1/26</u>	
POLICY TITLE: PA2 RESERVE FUNDS DISTRIBUTION		
CHAPTER: SUBSTANCE USE DISORDERS		

I. PURPOSE

To provide LRE contract~~ed~~ SUD Treatment and Prevention Providers an opportunity to access reserve PA2 funds for the development of new and innovative programs for which other funding is unavailable. ~~All reserve PA2 funds requested must be used within the fiscal year in which they are granted. There will be no guarantee that funding will be available in subsequent years.~~

II. PROCEDURES

A. ~~Any~~Region 3 PIHP contracted SUD Treatment ~~and/or~~ Prevention providers ~~may requesting request~~ reserve PA2 funds for SUD Treatment or Prevention programs ~~will be required to submit by submitting~~ a letter of interest to the ~~Entity~~ Lakeshore Regional Entity (LRE) Chief Operating Officer detailing their project request.

1. For Prevention Services:

a. LRE Chief Operating Officer will review the request and determine if the specific county has an identified need for the project and if the project has merit.

i. In the event that reserve PA2 funds are needed for a region-wide prevention project, LRE Chief Operating Officer will complete the required documentation for consideration by the Oversight Policy Board. The request will include:

(i) Detailed information related to the specific special project

a. (ii) Allocation percentages will be determined as defined by the state allocation of PA2 funds by county of origin.

b. If there is an identified need and the project is found to have merit, the interested party must submit the "Special Project Application Form for PA2 Funds" to the Entity.

c. Priority will be given to projects that meet an identified community need and utilize evidence-based practices.

2. For SUD Treatment:

a. LRE Chief Operating Officer will consult with the appropriate CMHSP SUD Coordinator to determine if the project has merit and meets an identified need in the county.

i. In the event that reserve PA2 funds are needed for a region-wide SUD Treatment project, LRE Chief Operating Officer will complete the required documentation for consideration by the Oversight Policy Board. The request will include:

(i) Detailed information related to the specific special project

~~a.~~(ii) Allocation percentages will be determined as defined by the state allocation of PA2 funds by county of origin.

b. If both parties agree the project meets an identified need and has merit, the LRE Chief Operating Officer will instruct the interested party to submit the "Special Project Application Form for PA2 Funds".

c. Priority will be given to projects that meet an identified community need and utilize evidence-based practices.

~~3. Completed Special Project for PA2 Funds application(s) will be reviewed at the next regularly scheduled SUD Regional Operations Advisory Team (ROAT) meeting for recommendations.~~

4.3. LRE Chief Operating Officer will present the application(s) and any recommendations to the Oversight Policy Board (OPB) at their next regularly scheduled meeting.

a. ~~For Prevention applications:~~ Upon approval by the OPB members, the LRE Chief Operating Officer, in conjunction with the Finance team, will issue the necessary contract ~~amendmentss for prevention services.~~

~~b.i.~~ Unless otherwise specified in the contract amendment, reserve PA2 funds are granted in alignment with the current contract term (typically the fiscal year).~~applicab~~

~~c. For SUD Treatment and Recovery: A contract will be coordinated with the CMHSP's for fund distribution directly to the agencies.~~

5.4. PA2 funds that are distributed through the Special Project Application process will be available only for the fiscal year in which they are distributed. There will be no guarantee that funding will be available in subsequent years.

a. Providers will be required to submit the Special Project Application Form for PA2 funds annually should they wish to continue the project in subsequent fiscal years.

~~a.~~

All reserve PA2 funds requested must be used within the fiscal year in which they are granted. There will be no guarantee that funding will be available in subsequent years.

III. APPLICABILITY AND RESPONSIBILITY

This procedure applies to SUD Prevention Providers contracting directly with the LRE as well as member CMHSPs and SUD Treatment Providers who offer SUD Treatment and Recovery services.

IV. MONITORING AND REVIEW

This procedure will be reviewed annually by the LRE Chief Operating Officer with input from the SUD ROAT and OPB members.

V. DEFINITIONS

PA2: Public Act 2 Liquor Tax Funds

OPB: Oversight Policy Advisory Board

SUD: Substance Use Disorder

VI. RELATED POLICIES AND PROCEDURES

- A. LRE Policy 12.4 PA2 Reserve Funds Distribution
- B. Special Project Application for PA2 Funds Form

VII. REFERENCES/LEGAL AUTHORITY

- A. Public Act 206 of 1893, Section 24e, Paragraph 11, as amended; MCL 211.24e
- B. MDHHS Medicaid Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
4/19/2018	New Procedure	SUD Director
12/16/2021	Annual Review	SUD Director
7/21/2023	Annual Review – updated language	LRE Chief Operating Officer
12/1/2024	Annual Review	LRE Chief Operating Officer
<u>1/7/2026</u>	<u>Annual review and minor language updates</u>	<u>LRE Chief Operating Officer</u>
<u>9/1/2026</u>	<u>Revised and updated language</u>	<u>LRE Chief Operating Officer</u>

PROCEDURE # 12.4a	EFFECTIVE DATE	REVISED DATE
TITLE: USE OF RESERVE PA2 FUNDS FOR SPECIAL PROJECTS	4/19/2018	1/7/2026 1/26
ATTACHMENT TO	REVIEW DATES	
POLICY #: 12.4	12/16/21, 7/21/23, 1/8/25, 1/7/26	
POLICY TITLE: PA2 RESERVE FUNDS DISTRIBUTION		
CHAPTER: SUBSTANCE USE DISORDERS		

I. PURPOSE

To provide LRE contracted ~~ed~~ SUD Treatment and Prevention Providers an opportunity to access reserve PA2 funds for the development of new and innovative programs for which other funding is unavailable. ~~All reserve PA2 funds requested must be used within the fiscal year in which they are granted. There will be no guarantee that funding will be available in subsequent years.~~

II. PROCEDURES

A. ~~Any~~ Region 3 PIHP contracted SUD Treatment ~~and/or~~ Prevention providers ~~may requesting request~~ reserve PA2 funds for SUD Treatment or Prevention programs ~~will be required to submit by submitting~~ a letter of interest to the ~~Entity~~ Lakeshore Regional Entity (LRE) Chief Operating Officer detailing their project request.

1. For Prevention Services:

a. LRE Chief Operating Officer will review the request and determine if the specific county has an identified need for the project and if the project has merit.

i. In the event that reserve PA2 funds are needed for a region-wide prevention project, LRE Chief Operating Officer will complete the required documentation for consideration by the Oversight Policy Board. The request will include:

(i) Detailed information related to the specific special project

a. (ii) Allocation percentages will be determined as defined by the state allocation of PA2 funds by county of origin.

b. If there is an identified need and the project is found to have merit, the interested party must submit the "Special Project Application Form for PA2 Funds" to the Entity.

c. Priority will be given to projects that meet an identified community need and utilize evidence-based practices.

2. For SUD Treatment:

a. LRE Chief Operating Officer will consult with the appropriate CMHSP SUD Coordinator to determine if the project has merit and meets an identified need in the county.

i. In the event that reserve PA2 funds are needed for a region-wide SUD Treatment project, LRE Chief Operating Officer will complete the required documentation for consideration by the Oversight Policy Board. The request will include:

(i) Detailed information related to the specific special project

~~a.~~(ii) Allocation percentages will be determined as defined by the state allocation of PA2 funds by county of origin.

b. If both parties agree the project meets an identified need and has merit, the LRE Chief Operating Officer will instruct the interested party to submit the "Special Project Application Form for PA2 Funds".

c. Priority will be given to projects that meet an identified community need and utilize evidence-based practices.

~~3. Completed Special Project for PA2 Funds application(s) will be reviewed at the next regularly scheduled SUD Regional Operations Advisory Team (ROAT) meeting for recommendations.~~

4.3. LRE Chief Operating Officer will present the application(s) and any recommendations to the Oversight Policy Board (OPB) at their next regularly scheduled meeting.

a. ~~For Prevention applications:~~ Upon approval by the OPB members, the LRE Chief Operating Officer, in conjunction with the Finance team, will issue the necessary contract ~~amendmentss for prevention services.~~

~~b.i.~~ Unless otherwise specified in the contract amendment, reserve PA2 funds are granted in alignment with the current contract term (typically the fiscal year).~~applicab~~

~~c. For SUD Treatment and Recovery: A contract will be coordinated with the CMHSP's for fund distribution directly to the agencies.~~

5.4. PA2 funds that are distributed through the Special Project Application process will be available only for the fiscal year in which they are distributed. There will be no guarantee that funding will be available in subsequent years.

a. Providers will be required to submit the Special Project Application Form for PA2 funds annually should they wish to continue the project in subsequent fiscal years.

~~a.~~

All reserve PA2 funds requested must be used within the fiscal year in which they are granted. There will be no guarantee that funding will be available in subsequent years.

III. APPLICABILITY AND RESPONSIBILITY

This procedure applies to SUD Prevention Providers contracting directly with the LRE as well as member CMHSPs and SUD Treatment Providers who offer SUD Treatment and Recovery services.

IV. MONITORING AND REVIEW

This procedure will be reviewed annually by the LRE Chief Operating Officer with input from the SUD ROAT and OPB members.

V. DEFINITIONS

PA2: Public Act 2 Liquor Tax Funds

OPB: Oversight Policy Advisory Board

SUD: Substance Use Disorder

VI. RELATED POLICIES AND PROCEDURES

- A. LRE Policy 12.4 PA2 Reserve Funds Distribution
- B. Special Project Application for PA2 Funds Form

VII. REFERENCES/LEGAL AUTHORITY

- A. Public Act 206 of 1893, Section 24e, Paragraph 11, as amended; MCL 211.24e
- B. MDHHS Medicaid Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
4/19/2018	New Procedure	SUD Director
12/16/2021	Annual Review	SUD Director
7/21/2023	Annual Review – updated language	LRE Chief Operating Officer
12/1/2024	Annual Review	LRE Chief Operating Officer
<u>1/7/2026</u>	<u>Annual review and minor language updates</u>	<u>LRE Chief Operating Officer</u>
<u>9/1/2026</u>	<u>Revised and updated language</u>	<u>LRE Chief Operating Officer</u>

PROCEDURE # 12.4b	EFFECTIVE DATE	REVISED DATE
TITLE: REQUESTING RESERVE PA2 FUNDS	9/6/2023	1/7/2026
<u>ATTACHMENT TO</u>	REVIEW DATES	
POLICY #: 12.4	1/8/2025, 1/7/26, <u>9/1/26</u>	
POLICY TITLE: USE OF RESERVE PA2 FUNDS		
CHAPTER: SUBSTANCE USE DISORDER PREVENTION AND TREATMENT		

I. PURPOSE

Lakeshore Regional Entity (LRE) Oversight Policy Board (OPB) is responsible for approving all PA2 expenditures in Region 3 PIHP. This procedure outlines a process by which Substance Use Disorder (SUD) Treatment and/or Prevention Services Providers can access reserve PA2 funds within a Fiscal Year.

II. PROCEDURES

- A. Requests for reserve PA2 funds must be made no less than two weeks prior to the quarterly meeting of the LRE OPB to allow ample time to consider the request. All requests for reserve PA2 funds must be made within the current fiscal year and funds must be used within the current fiscal year.
- B. The total amount of requested reserve PA2 funds cannot exceed the contracted provider's total PA2 budget for the fiscal year in which the reserve PA2 funds are being requested.
- C. When a contracted SUD Treatment or Prevention provider wants to request reserve PA2 funds, a formal request must be made in writing to the LRE Oversight Policy Board through the LRE Chief Operating Officer. The request must include the following:
 1. The total amount of reserve PA2 funds being requested.
 2. A justification for why the reserve PA2 funds are needed.
 3. A description of the programs/services and applicable service codes for which the funds are intended.
 4. How funds will be applied.
 5. A complete budget and budget narrative.
 6. A sustainability plan.
 7. A list of other sources of funding (Block Grant, Specialty Grant, Medicaid, other) that have been considered and why these sources were not used.
- D. For Prevention Services, LRE Chief Operating Officer, in conjunction with the LRE Finance Team, will review the request and determine whether other funding sources are available and can meet the needs of the program requesting additional funds.
- E. For SUD Treatment, LRE Chief Operating Officer will consult with the appropriate CMHSP SUD Coordinator to review the request and determine whether other funding sources are available to meet the needs of the program requesting additional funds.

- F. LRE Chief Operating Officer will work with LRE Finance Team to develop a proposed budget adjustment to be presented to the LRE Oversight Policy Board during the next regularly scheduled meeting. The Oversight Policy Board, with support from LRE COO, Prevention Services Manager and SUD Treatment Manager will:
1. Invite the requesting agency to the next regularly scheduled OPB meeting to provide an informational presentation focusing on programs and services to be impacted by the additional funds requested.
 - a. Presentation to include plans for future sustainability without reserve PA2 funds
 2. Review the funding request and supporting documentation to ensure that all required components are present.
 3. Review current PA2 Financial status reports to ensure that requested funds are available for the specific county requesting additional funds.
 4. Upon approval by the OPB members, the LRE Chief Operating Officer, in conjunction with the Finance team, will issue the necessary contract amendments.
 - a. Unless otherwise specified in the contract amendment, reserve PA2 funds are granted in alignment with the current contract term (typically the fiscal year).
- G. If the request is denied by the Oversight Policy Board, the requesting organization will be notified within 5 business days of the determination.

III. CHANGE LOG

Date of Change	Description of Change	Responsible Party
9/6/2023	NEW PROCEDURE	LRE COO
12/1/2024	Language Updates	LRE COO
1/7/26	Language Updates	LRE CO

**Lakeshore Regional Entity
Substance Use Disorders
FY26 Block Grant Expenditures**

	Year Ending 9/30/2026	Year To Date 7/31/2026	Budget to Actual	
	FY26 Budget Amendment 2	FY26 Budget to Date	Actual	Variance
Block Grant				
Operating Revenues				
SUD Block Grant (includes SDA)	7,389,879	6,158,233	4,526,544	1,631,689
SUD Block Grant SOR	2,100,000	1,750,000	1,208,031	541,969
SUD Block Grant Gambling	250,000	208,333	114,361	93,972
Healing & Recovery Comm Engagement Infrastr.	458,098	381,748	275,598	106,150
Alcohol Use Disorder Tx	215,600	179,667	184,937	(5,270)
Total Operating Revenues	10,413,577	8,677,981	6,309,470	2,368,510
Expenditures - Treatment				
LRE Direct & Regional Administration - Treatment (incl TBD)	311,592	259,660	204,322	55,338
LRE Direct & Administration - SOR	249,565	207,971	164,983	42,988
LRE Administration - Hlng & Rec Comm Enga Infrastr.	155,162	129,302	152,067	(22,765)
Treatment Payments to Members				
OnPoint (Allegan Co CMH) - Treatment	466,000	388,333	155,692	232,641
OnPoint (Allegan Co CMH) - SOR	170,370	141,975	38,321	103,654
OnPoint (Allegan Co CMH) - Hlng & Rec Comm Enga Infrastr.	82,987	69,156	72,134	(2,978)
OnPoint (Allegan Co CMH) - Alcohol Use Disorder Tx	14,661	12,218	0	12,218
Healthwest - Treatment	1,485,411	1,237,843	1,105,638	132,204
Healthwest - SOR	840,707	700,589	504,260	196,329
Healthwest - Hlng & Rec Comm Enga Infrastr.	98,878	82,398	45,906	36,492
Healthwest - Alcohol Use Disorder Tx	54,598	45,498	54,594	(9,096)
Network180 - Treatment	2,455,982	2,046,652	1,482,089	564,562
Network 180 - SOR	535,139	445,949	434,539	11,410
Network180 - Hlng & Rec Comm Enga Infrastr.	953	794	311	483
Network 180 - Alcohol Use Disorder Tx	104,350	86,958	104,324	(17,365)
CMH of Ottawa County - Treatment	791,514	659,595	524,933	134,662
CMH of Ottawa County - Hlng & Rec Comm Enga Infrastr.	114,594	95,495	25,757	69,738
CMH of Ottawa County - Alcohol Use Disorder Tx	20,000	16,667	4,028	12,638
West Michigan CMH - Treatment	408,585	340,488	283,779	56,708
West Michigan CMH - SOR	114,703	95,586	91,221	4,365
West Michigan CMH - Hlng & Rec Comm Enga Infrastr.	5,524	4,603	5,524	(921)
West Michigan CMH - Alcohol Use Disorder Tx	21,991	18,326	21,991	(3,665)

Expenditures - Prevention

LRE Direct & Regional Administration - Prevention	257,317	214,431	209,469	4,962
LRE Direct & Regional Administration - SOR	17,052	14,210	13,687	523
LRE Direct Administration - Gambling	126,000	105,000	96,036	8,964

Expenditures - Prevention - continued

OnPoint (Allegan Co CMH) - Prevention	111,163	92,636	111,163	(18,527)
OnPoint (Allegan Co CMH) - SOR	50,000	41,667	43,154	(1,488)
Arbor Circle / Pathways - Prevention	280,000	233,333	207,501	25,833
Arbor Circle / Pathways - SOR	35,500	29,583	17,755	11,828
Arbor Circle / Pathways - Gambling	44,000	36,667	25,673	10,994
District 10 Health Department - Prevention	66,566	55,472	59,056	(3,584)
District 10 Health Department - SOR	47,500	39,583	38,143	1,440
District 10 Health Department - Gambling	38,000	31,667	25,399	6,268
Healthwest - Prevention	127,531	106,276	75,079	31,196
Healthwest - Gambling	42,000	35,000	24,241	10,759
Healthwest - SOR	32,500	27,083	25,283	1,800
Kent County Health Department - Prevention	246,000	205,000	246,000	(41,000)
Mercy Health - Prevention	44,000	36,667	42,279	(5,613)
Network 180 - Prevention	175,000	145,833	127,272	18,561
Ottawa County Health Department - Prevention	88,218	73,515	74,250	(735)
Wedgwood Christian Services - Prevention	75,000	62,500	68,419	(5,919)

Total Expenditures	10,413,577	8,677,981	7,009,922	1,668,059
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Total Change in Net Assets

0	0	(700,451)	700,451
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As of 9/8/26

**Lakeshore Regional Entity
Substance Use Disorders
FY26 PA2 Expenditures**

	Year Ending 9/30/2026	Year To Date 7/31/2026		
	FY26 Budget Amendment 2	FY26 Budget to Date	Actual	Budget to Actual Variance
PA2				
Operating Revenues				
PA2 Liquor Tax - Current FY	4,350,731	3,625,609	2,859,882	765,727
PA2 Liquor Tax - Reserves	816,587	680,489	0	680,489
Total Operating Revenues	5,167,318	4,306,098	2,859,882	1,446,216
Expenditures - Prevention				
OnPoint (Allegan Co CMH) - Prevention	155,169	129,308	85,291	44,016
Arbor Circle / Pathways - Prevention	371,609	309,674	198,951	110,724
District 10 Health Department - Prevention	133,310	111,092	130,826	(19,734)
Healthwest	90,395	75,329	59,559	15,770
Kent County Health Department - Prevention	251,393	209,494	251,393	(41,899)
Mercy Health - Prevention	13,507	11,256	11,891	(635)
Network 180 - Prevention	131,077	109,231	60,632	48,599
Community Mental Health of Ottawa County	38,265	31,888	32,931	(1,044)
Ottawa County Health Department - Prevention	61,890	51,575	23,809	27,766
Wedgwood Christian Services - Prevention	92,585	77,154	43,570	33,584
Expenditures - Treatment				
Treatment Payments to Members				
OnPoint (Allegan Co CMH)	198,218	165,182	37,693	127,489
Healthwest	381,976	318,313	213,132	105,181
Network180	2,263,389	1,886,158	1,620,575	265,582
CMH of Ottawa County	818,489	682,074	431,996	250,078
West Michigan CMH	166,046	138,372	0	138,372
Total Expenditures	5,167,318	4,306,098	3,202,250	1,103,848
Total Change in Net Assets	0	0	(342,368)	342,368

As of 9/8/26

**Lakeshore Regional Entity
Substance Use Disorders
FY26 Medicaid Treatment Expenditures**

Year To Date Through 7/31/26

CATEGORY	CMHSP Medicaid YTD Totals	LRE Admin Med YTD Totals	LRE Medicaid Budget Totals	LRE % of Budget Spent
Total Expenditures for Treatment Services	\$ 4,410,500.78	\$ -	\$ 7,207,821	61.19%
Women's Specialty Services	\$ 611,569.48	\$ -	\$ 711,715	85.93%
Other Specialty Services - (incl SUD Health Homes)	\$ -	\$ -	\$ 27,700	0.00%
Access Management System	\$ 281,440.05	\$ -	\$ 356,327	78.98%
General Administration	\$ 136,418.48	\$ 257,853.33	\$ 598,048	65.93%
GRAND TOTAL OF SA EXPENDITURES	\$ 5,439,928.79	\$ 257,853.33	\$ 8,901,611	64.01%
SOURCE OF FUNDS				
Medicaid	\$ 5,439,928.79	\$ 257,853.33	\$ 8,901,611	64.01%
Other: Local	\$ -	\$ -	\$ -	0.00%
Other: Federal	\$ -	\$ -	\$ -	0.00%
Fees	\$ -	\$ -	\$ -	0.00%
TOTAL FUNDING	\$ 5,439,928.79	\$ 257,853.33	\$ 8,901,611	64.01%

As of 9/8/26

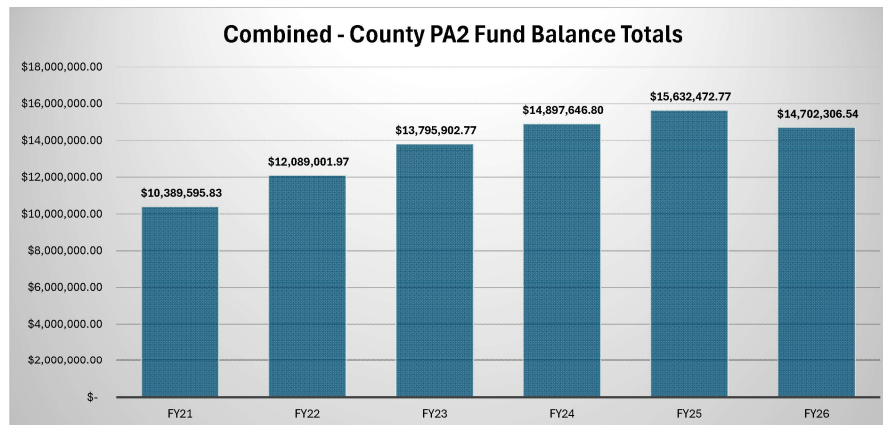
**Lakeshore Regional Entity
Substance Use Disorders
FY26 Healthy MI Plan Treatment Expenditures**

Year To Date Through 7/31/26

CATEGORY	CMHSP HMP YTD Totals	LRE Admin HMP YTD Totals	LRE HMP Budget Totals	LRE % of Budget Spent
Total Expenditures for Treatment Services	\$ 9,932,762.09	\$ -	\$ 12,418,849	79.98%
Women's Specialty Services	\$ 336,848.84	\$ -	\$ 290,835	115.82%
Other Specialty Services	\$ -	\$ -	\$ -	0.00%
Access Management System	\$ 558,912.52	\$ -	\$ 478,913	116.70%
General Administration	\$ 166,305.29	\$ 406,095.00	\$ 833,560	68.67%
GRAND TOTAL OF SA EXPENDITURES	\$ 10,994,828.73	\$ 406,095.00	\$ 14,022,157	81.31%
SOURCE OF FUNDS				
Healthy MI Plan	\$ 10,994,828.73	\$ 406,095.00	\$ 14,022,157	81.31%
Other: Local	\$ -	\$ -	\$ -	0.00%
Other: Federal	\$ -	\$ -	\$ -	0.00%
Fees	\$ -	\$ -	\$ -	0.00%
TOTAL FUNDING	\$ 10,994,828.73	\$ 406,095.00	\$ 14,022,157	81.31%

As of 9/8/26

**Lakeshore Regional Entity
PA2 Fund Summary Report
FY 2021 - FY 2026**



	FY21	FY22	FY23	FY24	FY25	FY26
County Fund Bal Total	\$10,389,595.83	\$12,089,001.97	\$13,795,902.77	\$14,897,646.80	\$15,632,472.77	\$14,702,306.54
Increase	\$1,699,406.14	\$1,706,900.80	\$1,071,889.92	\$734,825.97	\$ (1,311,069.13)	\$ (342,367.99)
% Change		14.1%	7.8%	4.9%	-8.4%	-2.3%

FY2018

On 2/6/2019 LRE requested \$ 5,315,565.70

Use of Reserve Funds - To address the FY2018 Medicaid and Healthy Michigan regional budget deficit. Each County's PA2 reserve funds shall only be applied against that county's Medicaid/Healthy Michigan operating deficit.

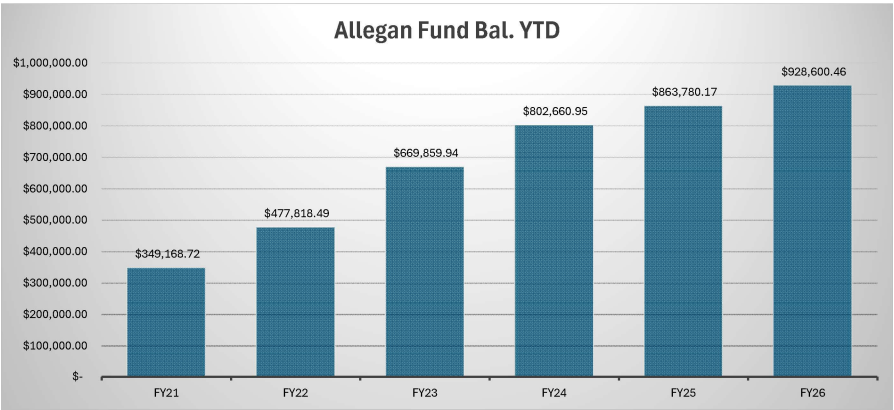
Per 10/3/2018 OPB Meeting Minutes

PA2 Reserve Funding Program Grants Update – A policy and application for providers to apply for reserve PA2 funds for special projects was developed early in 2019. The process was completed over the summer, with applications being submitted and reviewed. Unfortunately, due to the regional deficit, these project expenditures are not possible at this time. If, after final regional budget numbers allow for these grants, the applications will be presented to the OPB to discuss possible grants.

PA2 Fund Balance by FY

	FY21	FY22	FY23	FY24	FY25	FY26
County						
Allegan County	\$ 253,059.12	\$ 349,168.72	\$ 477,818.49	\$ 669,859.94	\$ 802,660.95	\$ 863,780.17
Kent County	\$ 5,812,785.29	\$ 7,002,883.63	\$ 7,982,606.15	\$ 8,103,054.08	\$ 7,917,532.01	\$ 6,691,501.92
Lake County	\$ 193,476.10	\$ 218,272.41	\$ 243,561.11	\$ 274,877.05	\$ 304,138.06	\$ 304,650.16
Mason County	\$ 519,997.72	\$ 584,441.99	\$ 614,093.94	\$ 700,862.34	\$ 797,419.12	\$ 819,391.03
Muskegon County	\$ 768,648.01	\$ 821,638.47	\$ 1,173,531.19	\$ 1,407,222.75	\$ 1,623,214.13	\$ 1,618,195.11
Oceana County	\$ 240,583.42	\$ 271,305.03	\$ 313,183.27	\$ 375,776.34	\$ 405,617.24	\$ 421,736.27
Ottawa County	\$ 2,601,046.17	\$ 2,841,291.72	\$ 2,991,108.62	\$ 3,365,994.30	\$ 3,781,891.26	\$ 3,983,051.88
	\$10,389,595.83	\$12,089,001.97	\$13,795,902.77	\$14,897,646.80	\$15,632,472.77	\$14,702,306.54

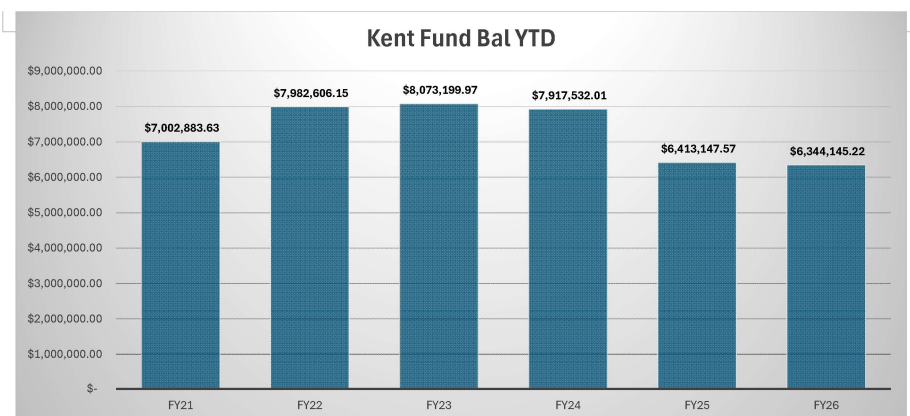
As of 9/9/26



Allegan County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	\$ 253,059.12	\$ 349,168.72	\$ 477,818.49	\$ 669,859.94	\$ 802,660.95	\$ 863,780.17
Revenues	\$ 186,148.60	\$ 188,688.77	\$ 282,080.45	\$ 301,240.13	\$ 293,802.19	\$ 187,804.41
Expenses	\$ 90,039.00	\$ 60,039.00	\$ 90,039.00	\$ 168,439.12	\$ 232,682.97	\$ 122,984.12
FY Total	\$ 349,168.72	\$ 477,818.49	\$ 669,859.94	\$ 802,660.95	\$ 863,780.17	\$ 928,600.46
% Change		38%	37%	40%	20%	8%

FY2025
On 9-4-2024 OnPoint requested up to \$100,000
Special Project- To fund local drug courts in FY25.

FY2026
On 12-10-2025 OnPoint requested \$115,000
Special Project- Provide funding support for local drug courts to obtain treatment services for individuals who have committed serious crimes and have substantial substance use disorders (and sometimes co-occurring mental health needs).



Kent County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	\$ 5,812,785.29	\$ 7,002,883.63	\$ 7,982,606.15	\$ 8,103,054.08	\$ 7,917,532.01	\$ 6,691,501.92
Revenues	\$ 1,837,707.72	\$ 1,826,393.32	\$ 2,781,259.25	\$ 2,829,011.02	\$ 2,692,847.13	\$ 1,672,977.62
Expenses	\$ 647,609.38	\$ 846,670.80	\$ 2,690,665.43	\$ 3,014,533.09	\$ 4,197,231.57	\$ 2,020,334.32
FY Total	\$ 7,002,883.63	\$ 7,982,606.15	\$ 8,073,199.97	\$ 7,917,532.01	\$ 6,413,147.57	\$ 6,344,145.22
% Change		20%	14%	1%	-2%	-19%

FY2023

On 9-6-2023 N180 requested up to \$1,400,000

Use of Reserve Funds - To fund two programs (Family Engagement Team and Recovery Management) at Network180 for FY2023 expenditures.

FY2024

On 1-8-2025 N180 requested \$1,256,139.47

Use of Reserve Funds - To offset budget shortfalls for FY 2024.

FY2025

On 1-8-2025 N180 requested \$294,060

Special Project - For 100 in 100 initiative targeting homelessness. Funding four (4) Housing Stabilization Case Managers (CM) employed through Mel Trotter Ministries and Degage Ministries to assist rehoused individuals in maintaining housing, meet health and wellness goals including access to SUD services and supports, and secure and maintain financial security.

On 3-12-2025 N180 requested \$1,879,569

Use of Reserve Funds - To fund two programs (Family Engagement Team and Recovery Management) at Network180 for FY2025 expenditures.

On 4-16-2025 Wedgwood Christian Services requested \$8,300

Use of Reserve Funds - Continue to provide SUD prevention services through the Project Success program at Burton Middle School due to ARPA funding cuts.

FY2026

On 9-17-2025 Kent County Health Department requested \$105,772

Use of Reserve Funds - To support 1.188 FTE Salary/Fringe (3 staff), mileage, printing & class materials, evaluation, and office expenses due to FY26 PA2 budget cut.

On 9-17-2025 Wedgwood requested \$37,970

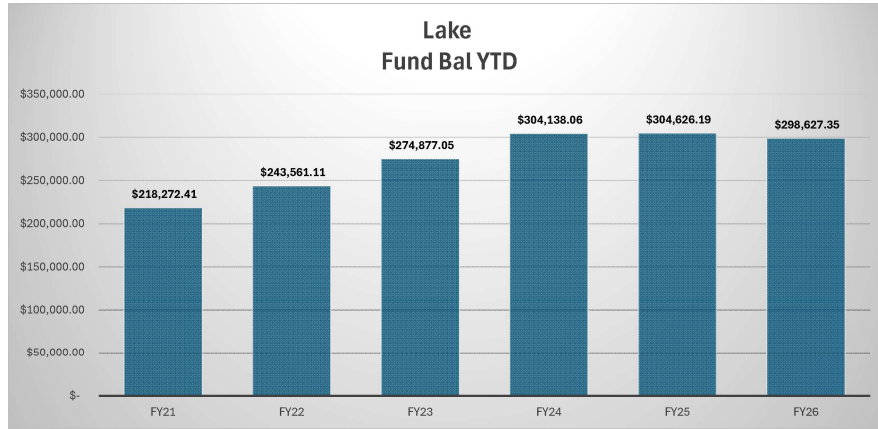
Use of Reserve Funds - To support .55 FTE Salary/Fringe (2 staff), conference/training, Supplies, and office expenses due to FY26 PA2 budget cut.

On 12-10-2025 N180 requested \$461,770

Special Project - For 100 in 100 initiative targeting homelessness. Funding Housing Stabilization Case Managers (CM) and .25 FTE director employed through Mel Trotter Ministries and Degage Ministries to assist rehoused individuals in maintaining housing, meet health and wellness goals including access to SUD services and supports, and secure and maintain financial security.

On 12-10-2025 N180 requested \$100,000

Special Project - For Real Clean individual and family treatment program work with youth who have a history of substance use.



Lake County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	\$ 193,476.10	\$ 218,272.41	\$ 243,561.11	\$ 274,877.05	\$ 304,138.06	\$ 304,650.16
Revenues	\$ 26,183.31	\$ 25,288.70	\$ 31,315.94	\$ 33,612.01	\$ 31,648.99	\$ 18,930.19
Expenses	\$ 1,387.00	\$ -	\$ -	\$ 4,351.00	\$ 31,160.86	\$ 24,953.00
FY Total	\$ 218,272.41	\$ 243,561.11	\$ 274,877.05	\$ 304,138.06	\$ 304,626.19	\$ 298,627.35
% Change		13%	12%	13%	11%	0%

FY2025

On 7-30-2025 West Michigan CMH requested \$6,036

Special Project - To cover projected shortfalls in Department of Justice for SUD jail bases services grant that will exceed available funding in SUD Block Grant and SOR grants.

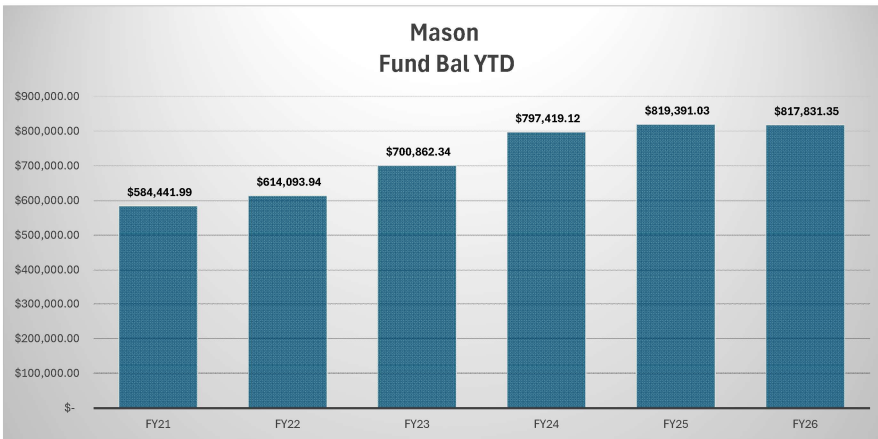
FY2026

On 9-17-2025 District Health Department #10 requested \$18,000

Use of Reserve Funds - To support .105 FTE Salary/Fringe (2 staff), Travel, Supplies, office expenses, printing materials due to FY26 PA2 budget cut.

On 9-17-2025 West Michigan CMH requested \$6,953

Use of Reserve Funds - To offset budget shortfalls in SUD Block Grant for FY 2026.



Mason County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	\$ 519,997.72	\$ 584,441.99	\$ 614,093.94	\$ 700,862.34	\$ 797,419.12	\$ 819,391.03
Revenues	\$ 78,252.27	\$ 78,065.95	\$ 116,724.08	\$ 125,849.78	\$ 97,161.27	\$ 58,466.32
Expenses	\$ 13,808.00	\$ 48,414.00	\$ 29,955.68	\$ 29,293.00	\$ 75,189.36	\$ 60,026.00
FY Total	\$ 584,441.99	\$ 614,093.94	\$ 700,862.34	\$ 797,419.12	\$ 819,391.03	\$ 817,831.35
% Change		12%	5%	14%	14%	3%

FY2025

On 7-30-2025 West Michigan CMH requested \$2,088

Special Project - To cover projected shortfalls in Department of Justice for SUD jail bases services grant that will exceed available funding in SUD Block Grant and SOR grants.

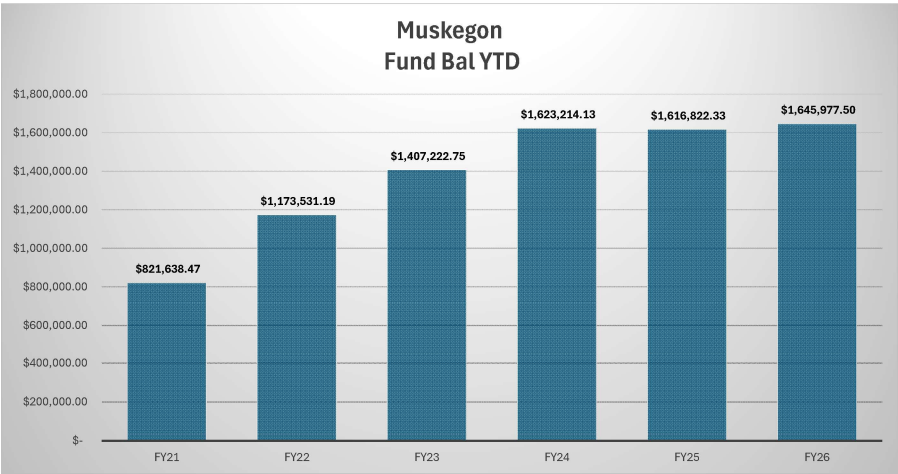
FY2026

On 9-17-2025 District Health Department #10 requested \$45,000

Use of Reserve Funds - To support .25 FTE Salary/Fringe (2 staff), Travel, Supplies, office expenses, and printing materials due to FY26 PA2 budget cut.

On 9-17-2025 West Michigan CMH requested \$17,344

Use of Reserve Funds - To offset budget shortfalls in SUD Block Grant for FY 2026.

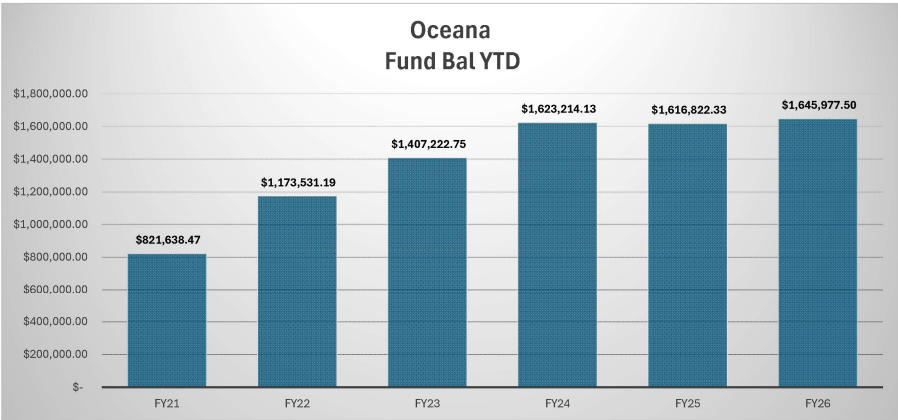


Muskegon County	FY21	FY22	FY23	FY24	FY25	FY26	
Beginning Fund Balance	\$ 768,648.01	\$ 821,638.47	\$ 1,173,531.19	\$ 1,407,222.75	\$ 1,623,214.13	\$ 1,618,195.11	
Revenues	\$ 436,285.19	\$ 436,332.91	\$ 499,788.81	\$ 512,428.93	\$ 495,143.63	\$ 312,364.17	
Expenses	\$ 383,294.73	\$ 84,440.19	\$ 266,097.25	\$ 296,437.55	\$ 501,535.43	\$ 284,581.78	
FY Total	\$ 821,638.47	\$ 1,173,531.19	\$ 1,407,222.75	\$ 1,623,214.13	\$ 1,616,822.33	\$ 1,645,977.50	
% Change		7%	43%	20%	15%	0%	2%

FY2025
On 3-12-2025 Healthwest requested \$80,470
Use of Reserve Funds - To fund FOC Recovery Management Team, support CCAR Trainings in Muskegon, support staffing for Fresh Coast Alliance in assisting individuals with accessing SUD and Recovery Supports within the community due to funding cuts in other areas.

On 4-16-2025 Healthwest requested \$76,000
Use of Reserve Funds - Staffing, administrative and organizational support for Life Align due to ARPA funding cuts.

FY2026
On 6-10-2026 Healthwest requested \$27,000
Use of Reserve Funds - To help fund a Law Enforcement Coordinator/CIT Coordinator position previously covered with funding by the Department of State Police for the Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program (COSSAP).



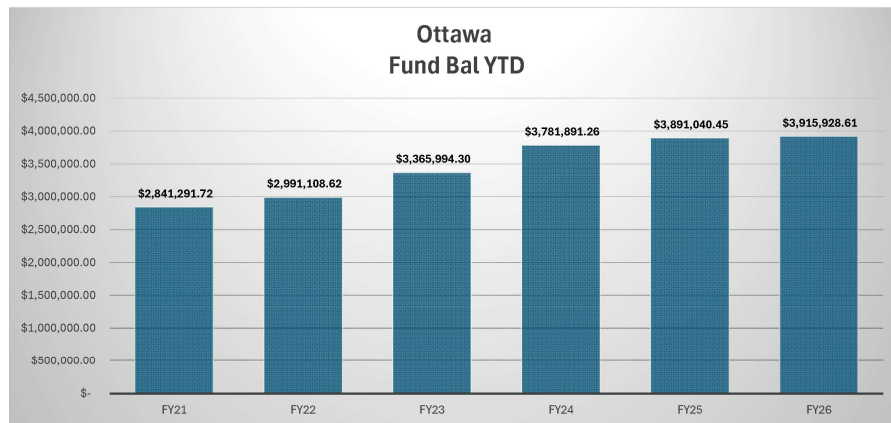
Oceana County	FY21	FY22	FY23	FY24	FY25	FY26	
Beginning Fund Balance	\$ 240,583.42	\$ 271,305.03	\$ 313,183.27	\$ 375,776.34	\$ 405,617.24	\$ 421,736.27	
Revenues	\$ 40,869.61	\$ 41,878.24	\$ 62,593.07	\$ 56,898.90	\$ 53,802.76	\$ 32,938.79	
Expenses	\$ 10,148.00	\$ -	\$ -	\$ 27,058.00	\$ 46,824.10	\$ 45,847.00	
FY Total	\$ 271,305.03	\$ 313,183.27	\$ 375,776.34	\$ 405,617.24	\$ 412,595.90	\$ 408,828.06	
% Change		13%	15%	20%	8%	2%	-3%

FY2025
On 7-30-2025 West Michigan CMH requested \$18,205
Special Project - To cover projected shortfalls in Department of Justice for SUD jail bases services grant that will exceed available funding in SUD Block Grant and SOR grants.

FY2026
On 9-17-2025 District Health Department #10 requested \$30,000
Use of Reserve Funds - To support .2 FTE Salary/Fringe (2 staff), Travel, Supplies, office expenses, printing materials due to FY26 PA2 budget cut.

On 9-17-2025 Arbor Circle requested \$68,965
Use of Reserve Funds - To support Salary/Fringe (1 staff), professional development, office expenses and supplies due to FY26 PA2 budget cut.

On 9-17-2025 West Michigan CMH requested \$16,014
Use of Reserve Funds - To offset budget shortfalls in SUD Block Grant for FY 2026.



Ottawa County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	\$ 2,601,046.17	\$ 2,841,291.72	\$ 2,991,108.62	\$ 3,365,994.30	\$ 3,781,891.26	\$ 3,983,051.88
Revenues	\$ 556,289.18	\$ 550,970.99	\$ 855,641.40	\$ 921,217.48	\$ 801,772.98	\$ 576,400.74
Expenses	\$ 316,043.63	\$ 401,154.09	\$ 480,755.72	\$ 505,320.52	\$ 692,623.79	\$ 643,524.01
FY Total	\$ 2,841,291.72	\$ 2,991,108.62	\$ 3,365,994.30	\$ 3,781,891.26	\$ 3,891,040.45	\$ 3,915,928.61
% Change		9%	5%	13%	12%	3%

FY2024

On 9-6-2023 CMHOC requested \$60,000

Special Project - To fund Recovery Coach Support Services to the Homeless Population in FY2024.

FY2025

On 9-4-2024 CMHOC requested \$61,147

Special Project - To fund the expansion of SoBar Recovery Community Center in FY25.

On 9-4-2024 CMHOC requested \$60,000

Special Project - To fund Recovery Coach Support Services to the Homeless Population in FY2025 (Continuation of 2024 project)

On 1-8-2025 CMHOC requested \$16,382

Special Project - Funding for a portion of a prevention specialist position to conduct prevention related activities to decrease stigma, prevent prescription drug misuse, and promote overdose prevention. Funding will also support Ottawa County's Recovery Fest celebration

On 4-16-2025 CMHOC requested \$60,000

Use of Reserve Funds - To continue SoBar Recovery Community Center's operations due to ARPA funding cuts.

FY2026

On 9-17-2025 CMHOC requested \$200,000

Special Project - To continue funding for the Prevention and Stigma Reduction program at SoBar Recovery Community Center in FY26.

On 9-17-2025 CMHOC requested \$60,000

Special Project - To continue funding Recovery Coach Supportive Services to work with Community Action House's homeless outreach team in FY26.

On 9-17-2025 Arbor Circle requested \$180,569

Use of Reserve Funds - To support 1.65 FTE Salary/Fringe (3 staff), youth conference, coalition supplies, Safe Prom, Reducing Alcohol focus, Evaluation, and office expenses due to FY26 PA2 budget cut.

On 9-17-2025 Ottawa Public Health requested \$30,000

Use of Reserve Funds - To support printing costs to promote initiatives, office supplies, operating supplies to support SUD initiatives, programming and community outreach due to FY26 PA2 budget cut.

On 3-11-2026 CMHOC requested \$172,000

Special Project - To provide community-based SUD treatment and support services to individuals engaged in the criminal justice system as they transition from the Ottawa County Jail into the community.

SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 8/21/2026

PROVIDER NAME: OnPoint

CURRENT PROVIDER: _____ ● YES ○ NO

PROGRAM TITLE: **Allegan County Adult Drug Court**

CONTACT PERSON: Mark Witte, CEO, OnPoint

CONTACT EMAIL: mwitte@onpointallegan.org

PROVIDER ADDRESS: 540 Jenner Drive, Allegan, MI 49010 AMOUNT REQUESTED: \$100,000

SERVICE TYPE

- Assessment
- Individual Therapy
- Group Therapy
- Family Therapy
- Didactic Groups
- Residential Detox
- Recovery Housing
- Level III.1 (low intensity)
- Level III.3 (moderate to high intensity)
- Level III.5 (significant/complex intensity)
- Medication Assisted Treatment
- Peer Recovery
- Prevention/Other: [Click here to enter text.](#)

PROGRAM DESCRIPTION

I. Describe the situation you intend to address:	
<i>Problem Statement: describe the problem that your activities are designed to improve.</i>	We are asking for funding to support local drug courts that are now operating in the 48th Judicial Circuit Court. Administrators of these courts have re-established specialty drug court operations that were temporarily suspended due to a lack of judges. Due to continuing state budget limitations, it is difficult to support the treatment services that are required by best practice standards.
<i>Describe the conditions that contribute to the identified problem (List the data sources if applicable)</i>	As noted above, court funding for treatment services may be insufficient to meet the need for treatment presented by participants. We anticipate that up to \$100,000 in funding for treatment may be needed to close the gap represented by full costs of the treatment court and the grant awarded by SCAO.

<i>Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.</i>	Drug courts serve individuals who have committed serious crimes and have substantial substance use disorders (and sometimes cooccurring mental health needs).
<i>Describe why your agency is best fit to provide this service?</i>	As the CMH for Allegan County, OnPoint is in the best position to support and manage a grant to the local courts for drug court treatment service provision using PA2 funds on behalf of the LRE.
II. Describe what you will do to address the situation:	
<i>Describe the program's activities (what are you going to do?):</i>	The drug court implements a program in compliance with the standards found in the "Adult Drug Court Standards, Best Practices, and Promising Practices" manual (November 2025). An electronic copy was sent with our 2025 application.
<i>Describe the expected frequency of the activity(ies) and how you determined this.</i>	The drug court implements a program in compliance with the standards found in the "Adult Drug Court Standards, Best Practices, and Promising Practices" manual (November 2025). An electronic copy was sent with this application.
<i>Describe the number of persons in the target population you expect to serve during each activity event</i>	We anticipate that the program will serve up to 80 participants.

III. Explain the necessary costs for your program <i>(provide narrative to support the resources identified that require funds).</i>
Up to \$100,000. SCAO responded to a grant request submitted by the court with slightly more than \$73,872. The court needs an additional \$100,000 to cover operations to meet total program needs for FY2027. The funding shortfall affected salaries for case managers and contractual treatment and drug testing costs obtained through from community providers (Arbor Circle for treatment, DnA for drug testing).

IV. Describe the goals you have established for the program. (goals do not have to be measurable) <i>(TO BE COMPLETED BY NEW PRORGRAMS ONLY)</i>

1. The drug court implements a program in compliance with the standards found in the “Adult Drug Court Standards, Best Practices, and Promising Practices” manual (November 2025). An electronic copy was sent with our prior application.
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5. Click or tap here to enter text.

PERFORMANCE MONITORING (TO BE COMPLETED BY NEW PROGRAMS ONLY)

V. Describe how you will measure your program’s success at meeting its goals. *(Please identify only those measures that make sense for your proposed program. Not all measurement categories identified below must be measured.)*

Outcomes	Process: <i>Describe (in specifically measurable terms) what you hope to achieve during this grant period. These process indicators should measure such things as “how many?” “how often?” etc. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. The drug court implements a program in compliance with the standards found in the “Adult Drug Court Standards, Best Practices, and Promising Practices” manual (November 2025). An electronic copy was sent with the prior application.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Participant: <i>Describe (in specifically measurable terms) what outcomes participants in your program can reasonably expect to achieve as a result. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. The drug court implements a program in compliance with the standards found in the “Adult Drug Court Standards, Best Practices, and Promising Practices” manual (November 2025). An electronic copy was sent with the prior application.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Impact: <i>Describe the impact you expect the program will have upon your community, target population, and/or intervention practices. Impact measurement is different from outcome measurement in that it is not consumer specific.</i>	1. The drug court implements a program in compliance with the standards found in the “Adult Drug Court Standards, Best Practices, and Promising Practices” manual (November 2025). An electronic copy was sent with the prior application.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.

SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 9/16/2026

PROVIDER NAME: Grand Rapids Red Project

CURRENT PROVIDER: ☒ YES ☐ NOPROGRAM TITLE: **Overdose Education and Nalaxone Distribution**

CONTACT PERSON: Don Avery

CONTACT EMAIL: don.avery@network180.org

PROVIDER ADDRESS: 401 Hall St. SE, Grand Rapids, MI 49507

AMOUNT REQUESTED: \$326,815

SERVICE TYPE

- | | |
|--|---|
| ☐ Assessment | ☐ Level III.1 (low intensity) |
| ☐ Individual Therapy | ☐ Level III.3 (moderate to high intensity) |
| ☐ Group Therapy | ☐ Level III.5 (significant/complex intensity) |
| ☐ Family Therapy | ☐ Medication Assisted Treatment |
| ☐ Didactic Groups | ☐ Peer Recovery |
| ☐ Residential Detox | ☒ Prevention/Other: Overdose education |
| ☐ Recovery Housing | |

PROGRAM DESCRIPTION**I. Describe the situation you intend to address:**

Problem Statement: describe the problem that your activities are designed to improve.

Kent County continues to experience significant harms associated with substance use disorders, including overdose risk, infectious disease transmission, untreated substance use, barriers to treatment engagement, and frequent utilization of emergency and crisis services. Many individuals who use substances remain disconnected from traditional healthcare and behavioral health systems, making it difficult to engage them in treatment and recovery services. Services provided by GRRP offer a critical point of contact for these individuals, reducing immediate health risks while creating pathways to treatment, recovery support, and other health services. Grand Rapids Red Project's program serves individuals who are often not connected to any other system of care

	and has demonstrated success in engaging people who use drugs in safer practices and recovery-oriented supports.
<i>Describe the conditions that contribute to the identified problem (List the data sources if applicable)</i>	The local substance use environment continues to be impacted by opioid and polysubstance use, overdose risk, unstable housing, limited access to healthcare, and social determinants that create barriers to treatment engagement. Individuals who inject drugs are at increased risk for overdose, soft tissue infections, and other negative health outcomes. These programs serve as a proven strategy to reduce these risks while building trust and engagement with individuals who may not otherwise access treatment. Existing program data demonstrates substantial community utilization of syringe access, naloxone distribution, test strip distribution, overdose education, and recovery support services. Grand Rapids Red Project reports serving more than 7,000 individuals annually through its programming. It's programming directly reduces overdose risk.
<i>Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.</i>	The target population includes adults with substance use disorders who are at high risk for overdose or other substance-related harms, particularly individuals actively using drugs, individuals who inject drugs, people experiencing homelessness or housing instability, justice-involved individuals, and persons who face significant barriers to accessing traditional treatment services. Special emphasis is placed on engaging individuals who are not currently connected to treatment, recovery, medical, or behavioral health services and who would benefit from harm reduction interventions and linkage to care.
<i>Describe why your agency is best fit to provide this service?</i>	The Grand Rapids Red Project is a key provider in Kent County. The organization has a longstanding history of engaging high-risk and underserved populations through evidence-based, low-barrier services. The organization has demonstrated expertise in overdose prevention, naloxone distribution, syringe access, safer use education, recovery support, and linkage to treatment. Through trusted community relationships and established outreach infrastructure, Grand Rapids Red Project is uniquely positioned to reach individuals who are often not engaged in traditional

	healthcare or behavioral health settings. Their existing service model has consistently demonstrated the ability to connect participants to treatment and recovery services while reducing overdose risk and other substance-related harms.
II. Describe what you will do to address the situation:	
<i>Describe the program's activities (what are you going to do?):</i>	PA2 Special Project funding will support expansion and enhancement of services in Kent County. Grand Rapids Red Project will provide community-based outreach; syringe access services; distribution of naloxone and overdose prevention supplies; distribution of fentanyl, xylazine, nitazene, and other drug-checking test strips as appropriate; overdose education and naloxone training; peer engagement and recovery support; referrals and linkage to substance use treatment programs; and connections to housing, healthcare, behavioral health, and other community resources. Funding will support direct service capacity, outreach efforts, supplies, and program infrastructure necessary to meet increasing community demand and reduce substance-related harms.
<i>Describe the expected frequency of the activity(ies) and how you determined this.</i>	Services will be available on an ongoing and continuous basis throughout the fiscal year through fixed-site and community-based outreach activities. Supplies, naloxone, and recovery support services will be available during all program operating hours. Outreach and engagement activities will occur multiple times each week based on participant need and community demand. Frequency estimates are based on historical service utilization, current program demand, overdose prevention needs within Kent County, and prior performance data demonstrating consistent community engagement and utilization of services.
<i>Describe the number of persons in the target population you expect to serve during each activity event</i>	The program expects to engage hundreds of participants monthly through outreach and service delivery activities. Annually, Grand Rapids Red Project's programming reaches more than 7,000 individuals, with thousands of naloxone kits, test strips, and safer use supplies distributed throughout the year. Special Project funding will help maintain and expand the organization's capacity to serve individuals at highest risk for overdose and other

	substance-related harms while increasing access to treatment and recovery pathways.
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III. Explain the necessary costs for your program *(provide narrative to support the resources identified that require funds).*

PA2 Special Project funding is requested to support the personnel, supplies, outreach, and operational resources necessary to expand services in Kent County. Funding will support outreach and direct support staff who engage high-risk individuals in the community, provide overdose prevention education, distribute naloxone and other overdose prevention supplies, conduct community outreach, and facilitate referrals to substance use treatment, recovery support, healthcare, housing, and other community-based services. Funding will also support the purchase and distribution of program supplies, including naloxone rescue kits, fentanyl and emerging-drug test strips, safer use supplies, and educational materials used to reduce overdose risk and other substance-related harms. Additional resources may support transportation, mobile outreach efforts, data collection and reporting requirements, and other program infrastructure necessary to reach individuals who are not connected to traditional treatment systems. These investments are essential to maintaining low-barrier access to services and ensuring that individuals at highest risk for overdose have access to lifesaving interventions and pathways to treatment and recovery. Existing program data demonstrates substantial community demand for these services, including the distribution of thousands of naloxone kits and engagement with thousands of Kent County residents annually through the organization's harm reduction programming.

Network180 has worked with Grand Rapids Red Project for several years. This funding represents the necessary amount needed to achieve program objectives and meet the needs of Kent County residents. Network180 is shifting this funding to special projects for closer scrutiny and oversight while Grand Rapids Red Project undergoes significant leadership and administrative transitions in the coming year.

IV. Describe the goals you have established for the program. (goals do not have to be measurable) *(TO BE COMPLETED BY NEW PRORGRAMS ONLY)*

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PERFORMANCE MONITORING (TO BE COMPLETED BY NEW PROGRAMS ONLY)

V. Describe how you will measure your program's success at meeting its goals. *(Please identify only those measures that make sense for your proposed program. Not all measurement categories identified below must be measured.)*

Outcomes	Process: <i>Describe (in specifically measurable terms) what you hope to achieve during this grant period. These process indicators should measure such things as "how many?" "how often?" etc. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Participant: <i>Describe (in specifically measurable terms) what outcomes participants in your program can reasonably expect to achieve as a result. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Impact: <i>Describe the impact you expect the program will have upon your community, target population, and/or intervention practices. Impact measurement is different from outcome measurement in that it is not consumer specific.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.

SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 9/16/2026

PROVIDER NAME: CMHOC CURRENT PROVIDER: _____ ● YES ○ NO

 PROGRAM TITLE: **Building Men For Life – Recovery Coaching**

CONTACT PERSON: Joel Ebbers

CONTACT EMAIL: jebbers@miottawa.org

 PROVIDER ADDRESS: 12265 James Stree, Holland, MI 49424 AMOUNT REQUESTED:
 \$160,000.00

SERVICE TYPE

- | | |
|---|---|
| ☐ Assessment | ☐ Level III.1 (low intensity) |
| ☐ Individual Therapy | ☐ Level III.3 (moderate to high intensity) |
| ☐ Group Therapy | ☐ Level III.5 (significant/complex intensity) |
| ☐ Family Therapy | ☐ Medication Assisted Treatment |
| ☐ Didactic Groups | ☒ Peer Recovery |
| ☐ Residential Detox | ☐ Prevention/Other: Click here to enter text. |
| ☒ Recovery Housing | |

PROGRAM DESCRIPTION

I. Describe the situation you intend to address:	
<i>Problem Statement: describe the problem that your activities are designed to improve.</i>	Individuals enter recovery housing with few resources and navigating the treatment, legal, medical, and occupational requirements is often difficult leading to missed appointments, lost opportunities, and relapse.
<i>Describe the conditions that contribute to the identified problem (List the data sources if applicable)</i>	Clients arrive to Recovery Housing with no money or transportation. Many have little motivation or cognitive issues to figure out how to get to treatment on their own.
<i>Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.</i>	The target population would be all Recovery Home clients for the first 60 days of housing to establish them in the local recovery community

<i>Describe why your agency is best fit to provide this service?</i>	Our agency is housing the clients in need and have 24 hour access to the clients.
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II. Describe what you will do to address the situation:

<i>Describe the program's activities (what are you going to do?):</i>	We will utilize 2 full time recovery coaches and a vehicle to provide transportation to and from SUD outpatient treatment 5 days a week with some medical appointments as well.
<i>Describe the expected frequency of the activity(ies) and how you determined this.</i>	We have 3 outpatient providers in the area our clients attend for IOP and counseling. 5 days a week transportation is needed for up to 20 individuals 3 times a week for IOP (Days vary by agency)
<i>Describe the number of persons in the target population you expect to serve during each activity event</i>	10-20 people in early recovery each week will get the transportation 3 times per week each.

III. Explain the necessary costs for your program (provide narrative to support the resources identified that require funds).

The funds needed would cover the salary of a full time recovery coaches and transportation costs.

IV. Describe the goals you have established for the program. (goals do not have to be measurable) (TO BE COMPLETED BY NEW PROGRAMS ONLY)

1. Increase the amount of participation in SUD treatment the first 60 days of recovery housing
2. Remove a barrier of Treatment accessibility to those with zero transportation and physical or mental limitations.
3. The recovery coach can increase recovery talk when driving and assist clients with finding recovery supports to add to the clients recovery toolbox
4. With proper treatment services the first 60 days we see a drastic reduction in relapse and increase of excitement for recovery.
5. Daily contact with new clients to provide encouragement and direction. The goal would be to make each new client feel supported

PERFORMANCE MONITORING (TO BE COMPLETED BY NEW PROGRAMS ONLY)

V. Describe how you will measure your program’s success at meeting its goals. *(Please identify only those measures that make sense for your proposed program. Not all measurement categories identified below must be measured.)*

Outcomes	Process: <i>Describe (in specifically measurable terms) what you hope to achieve during this grant period. These process indicators should measure such things as “how many?” “how often?” etc. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Participant: <i>Describe (in specifically measurable terms) what outcomes participants in your program can reasonably expect to achieve as a result. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Impact: <i>Describe the impact you expect the program will have upon your community, target population, and/or intervention practices. Impact measurement is different from outcome measurement in that it is not consumer specific.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3.

SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 9/16/2026

PROVIDER NAME: CMHOC

CURRENT PROVIDER:

☒ YES ☐ NO

 PROGRAM TITLE: **Recovery Coach Outreach**

CONTACT PERSON: Joel Ebbers

CONTACT EMAIL: jebbers@miottawa.org

PROVIDER ADDRESS: 12265 James Street, Holland, MI 49424

AMOUNT

REQUESTED: \$60,000.00

SERVICE TYPE

- | | |
|---|--|
| ☐ Assessment | ☐ Level III.1 (low intensity) |
| ☐ Individual Therapy | ☐ Level III.3 (moderate to high intensity) |
| ☐ Group Therapy | ☐ Level III.5 (significant/complex intensity) |
| ☐ Family Therapy | ☐ Medication Assisted Treatment |
| ☐ Didactic Groups | ☒ Peer Recovery |
| ☐ Residential Detox | ☐ Prevention/Other: Click here to enter text. |
| ☐ Recovery Housing | |

PROGRAM DESCRIPTION
I. Describe the situation you intend to address:

Problem Statement: describe the problem that your activities are designed to improve.

Community Action House (CAH), in partnership with Community Mental Health of Ottawa County (CMHOC) continues to identify individuals experiencing homelessness and housing instability who have substance use and/or co-occurring behavioral health concerns and significant barriers to accessing services.

In Ottawa County, we continue to see a need for our services among individuals experiencing homelessness. During this year's Point In Time (PIT) count, we counted **67** individuals experiencing unsheltered homelessness in **2026**. This number is a slight decrease of one from the previous year's data (68); however, the total number of individuals experiencing homelessness increased from **297 to 316**.

	Individuals experiencing homelessness often face additional barriers to accessing treatment and recovery services, including transportation, insurance, treatment availability, and difficulty navigating multiple systems. These challenges can be even greater for individuals who are unsheltered or disconnected from traditional services. The Recovery Coach provides an important bridge between CAH's established relationships with individuals experiencing homelessness and CMHOC's substance use and behavioral health services. Through this partnership, individuals can receive recovery support in familiar community settings while receiving assistance navigating treatment and other resources. This continued collaboration allows CAH and CMHOC to reach individuals who may otherwise remain disconnected from recovery and behavioral health services.
<i>Describe the conditions that contribute to the identified problem (List the data sources if applicable)</i>	CAH has identified that awareness, access, and navigation of available services remain significant barriers for individuals experiencing homelessness and housing instability, particularly those with substance use and co-occurring behavioral health concerns. Transportation, insurance, treatment availability, and the instability of homelessness can make it difficult for individuals to successfully connect with and remain engaged in services. CAH's Outreach team frequently encounters individuals who express a desire for recovery or treatment but need additional support to navigate these barriers. The Recovery Coach is able to meet individuals where they are, build relationships over time, and provide follow-up through the process of connecting to appropriate services. CAH also works closely with community partners including CMHOC, Gateway Mission, Holland Police Department, Reach for Recovery, Good Samaritan, and others to connect individuals with the broader spectrum of services they may need. Recovery is often only one part of the challenge; integrating recovery support with housing, behavioral health, medical, transportation, and other community resources is critical to helping individuals achieve greater stability.
<i>Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.</i>	CAH will continue to focus on individuals experiencing homelessness or who have significant barriers to accessing services, with particular attention to those experiencing substance use and/or co-occurring behavioral health concerns. CAH's Outreach team is currently working with 158 individuals experiencing homelessness or housing instability in Ottawa County. During the current program year (10/1/25–8/23/26), CAH has worked with 372 individuals, with 33.6% having a documented substance use disorder and/or mental illness, an increase from 29.69% in the previous year. The Recovery Coach will prioritize individuals with significant barriers to accessing recovery services, including those who are unsheltered or disconnected from traditional systems of care. Through CAH's outreach and community partnerships, the Recovery Coach will help connect individuals to CMHOC and the broader spectrum of services needed to support recovery, health, and housing stability.

<i>Describe why your agency is best fit to provide this service?</i>	CAH has established trust and relationships within the community, particularly among individuals experiencing homelessness, through its Street Outreach and Housing Access programs. The Outreach team has the ability to meet individuals where they are and engage people who may otherwise have difficulty accessing traditional services. Having a Recovery Coach embedded within our existing outreach structure creates a direct connection between individuals experiencing homelessness and CMHOC's recovery and behavioral health services. The Recovery Coach can provide ongoing engagement and help address barriers such as treatment access, transportation, insurance, and connections to recovery supports while coordinating with CAH staff and community partners. This allows CMHOC's expertise and services to reach individuals within settings where they are already engaging with trusted community providers.
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II. Describe what you will do to address the situation:

<i>Describe the program's activities (what are you going to do?):</i>	The Recovery Coach will maintain a consistent presence at CAH community connection points, including Refresh and Community Kitchen (CK), allowing for direct engagement with individuals experiencing homelessness as well as regular communication and case conferencing with CMHOC SUD clinicians and case managers. The Recovery Coach will serve as a liaison between CMHOC SUD services and the unhoused community, helping identify needs, facilitate connections, and coordinate services. The Recovery Coach will also provide outreach beyond traditional service locations by engaging individuals in encampments and other community settings. For individuals who have difficulty connecting to treatment independently, the Recovery Coach will provide hands-on support, including transportation and assistance navigating treatment access, recovery resources, and other identified barriers. The Recovery Coach will coordinate with CAH staff, CMHOC, and community partners to connect individuals to the broader services needed to support recovery, behavioral health, and housing stability.
<i>Describe the expected frequency of the activity(ies) and how you determined this.</i>	The Recovery Coach will maintain a consistent presence at CAH community connection points, including Refresh and Community Kitchen, 2–3 times per week, allowing individuals to access recovery support while receiving other services. The Recovery Coach will also participate in street outreach approximately 1–2 times per week and has the flexibility to engage individuals in the community on a daily basis as the needs arise. Because the Recovery Coach is embedded within CAH's Outreach team, services are not limited to an office or scheduled appointment. The Recovery Coach can work alongside Outreach staff to meet individuals where they are, including encampments and other community locations, and provide ongoing follow-up and support based on the individual's needs. This flexibility is particularly important for individuals who face barriers to accessing traditional service locations.

Describe the number of persons in the target population you expect to serve during each activity event	From 10/1/25–8/23/26, the Recovery Coach connected with 112 unique individuals. Of those, 102 individuals received recovery services and/or discussed substance use needs, and 74 individuals engaged in treatment-focused support or accessed some level of treatment, ranging from community-based recovery groups to inpatient treatment. Based on current engagement, CAH anticipates the Recovery Coach will serve approximately 100 unique individuals during the upcoming grant year. Recovery support is also integrated with other needs that impact long-term stability. During the current year, the Recovery Coach worked with 5 individuals on connections to SOAR (SSI/SSDI Outreach, Access, and Recovery), which can help eligible individuals experiencing homelessness access disability income and greater financial stability. This coordination will continue alongside CAH's Care Coordinator and broader Outreach team.
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III. Explain the necessary costs for your program (provide narrative to support the resources identified that require funds).

Costs are related to the salary, fringe, and direct costs associated with the Recovery Coach position. Funding supports the continued placement of a Recovery Coach within CAH's outreach and community-based service system to provide recovery support, treatment navigation, and coordination with CMHOC and other community partners.

IV. Describe the goals you have established for the program. (goals do not have to be measurable) (TO BE COMPLETED BY NEW PROGRAMS ONLY)

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V. Describe how you will measure your program's success at meeting its goals.

(Please identify only those measures that make sense for your proposed program.

Not all measurement categories identified below must be measured.

O u t c o m e s	Process: <i>Describe (in specifically measurable terms) what you hope to achieve during this grant period. These process indicators should measure such things as "how many?" "how often?" etc. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Recovery Coach will engage approximately 100 unique individuals during the grant period. During the current reporting period, the Recovery Coach connected with 112 unique individuals, with 102 receiving recovery services and/or discussing substance use needs. Based on current engagement, CAH anticipates serving approximately 100 unique individuals during the upcoming grant year.
		2. Recovery Coach will maintain consistent, community-based access to recovery support. The Recovery Coach will be present at CAH connection points 2–3 times weekly, participate in street outreach 1–2 times weekly, and meet with individuals in the community as needed. Contact may increase to daily when individuals are actively navigating treatment or other time-sensitive recovery needs.
		3. Recovery Coach will maintain direct coordination with CMHOC SUD services. The Recovery Coach will serve as a liaison between individuals experiencing homelessness and CMHOC SUD clinicians and case managers through referrals, direct communication, and case conferencing. This coordination will help individuals who struggle to access traditional office-based services connect with appropriate treatment and recovery resources.
	Participant: <i>Describe (in specifically measurable terms) what outcomes participants in your program can reasonably expect to achieve as a result. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Participants will increase engagement in treatment and recovery-focused services. Participants will be supported in exploring and accessing the level of recovery support appropriate to their needs, ranging from community-based recovery groups to outpatient, detox, residential, or inpatient treatment. During the current reporting period, 74 of 112 individuals engaged in treatment-focused support or accessed some level of treatment.
		2. Participants will establish individualized recovery and stability goals. Participants will work with the Recovery Coach to identify goals based on their needs and readiness, which may include reducing substance use, maintaining recovery, accessing treatment, behavioral health care, housing, income/benefits, transportation, and other supports that contribute to stability
		3. Participants will increase connection to ongoing recovery and community supports. Participants will be connected to recovery groups, CMHOC services, treatment providers, and other community resources based on individual need. The Recovery Coach will provide continued engagement and follow-up to help participants maintain these connections through periods of housing or recovery instability.
	Impact:	1. Increase access to substance use treatment and recovery services for individuals experiencing homelessness.

	<i>Describe the impact you expect the program will have upon your community, target population, and/or intervention practices. Impact measurement is different from outcome measurement in that it is not consumer specific.</i>	Embedding the Recovery Coach within CAH's Outreach team provides a direct pathway to recovery services for individuals who may otherwise struggle to access traditional service settings. The partnership will increase opportunities for earlier engagement, treatment exploration, and continued recovery support. 2. Strengthen coordination between CMHOC and the homelessness response system. The Recovery Coach will provide a direct bridge between CMHOC SUD services, CAH, and community partners serving individuals experiencing homelessness. Regular communication, case conferencing, and community-based engagement will improve coordination and reduce the likelihood that individuals become disconnected between systems. 3. Increase access to the broader supports that contribute to recovery and long-term stability. Recovery needs are often interconnected with housing, mental and physical health, transportation, income, and other basic needs. Through integration with CAH's Outreach team and community partners, participants will have increased opportunities to address these needs alongside recovery. This includes coordination with CAH's Care Coordinator around SOAR and other benefit connections when appropriate.
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SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 9/16/2026

PROVIDER NAME: CMHOC

CURRENT PROVIDER: _____ ● YES ○ NO

PROGRAM TITLE: **SOBAR Community Recovery Center**

CONTACT PERSON: Joel Ebbers

CONTACT EMAIL: jebbers@miottawa.org

PROVIDER ADDRESS: 12265 James Stree, Holland, MI 49424
\$200,000.00

AMOUNT REQUESTED:

SERVICE TYPE

- | | |
|--|--|
| ☐ Assessment | ☐ Level III.1 (low intensity) |
| ☐ Individual Therapy | ☐ Level III.3 (moderate to high intensity) |
| ☐ Group Therapy | ☐ Level III.5 (significant/complex intensity) |
| ☐ Family Therapy | ☐ Medication Assisted Treatment |
| ☐ Didactic Groups | ☐ Peer Recovery |
| ☐ Residential Detox | ☒ Prevention/Other: Click here to enter text. |
| ☐ Recovery Housing | |

PROGRAM DESCRIPTION

I. Describe the situation you intend to address:	
<i>Problem Statement: describe the problem that your activities are designed to improve.</i>	Before SoBar Recovery Community Center was established, there was no dedicated space in our community that provided opportunities for connection, fellowship, and sober activities. SoBar fills this important gap by creating a welcoming, supportive environment where individuals and families can build relationships, participate in substance-free activities, and strengthen their recovery through community.
<i>Describe the conditions that contribute to the identified problem (List the data sources if applicable)</i>	During active substance use, individuals often experience a loss of positive connections and may become isolated from supportive friends, family members, and community networks. Rebuilding those healthy relationships is an important part of the recovery journey.

<i>Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.</i>	The target population is individuals who are in recovery or seeking recovery, those seeking access to recovery resources and support, family members and supporters of individuals in recovery, and community members seeking a safe, welcoming, and sober environment.
<i>Describe why your agency is best fit to provide this service?</i>	SoBar Recovery Community Center is uniquely positioned to provide these services because it was created specifically to meet the needs of the population it serves. SoBar continually seeks new and innovative ways to strengthen recovery, build community, and expand access to supportive resources. Over the past year, SoBar has expanded its space and services by adding a large meeting room, a dedicated recovery art room, and a private office for one-on-one meetings. These additions have increased our capacity to provide meaningful opportunities for connection, creativity, support, and personal growth throughout the recovery journey.
II. Describe what you will do to address the situation:	
<i>Describe the program's activities (what are you going to do?):</i>	SoBar Recovery Community Center hosts 14 peer recovery meetings each week, including AA, NA, All Recovery, Crystal Methamphetamine Recovery, and other recovery-focused groups. In addition to meetings, SoBar offers a variety of sober social activities designed to promote connection, fellowship, and engagement, including Recovery Art, Recovery Workshops, and Friday night activities such as karaoke and bingo. Participants also have access to peer recovery coaches who provide support, encouragement, and connections to community resources. SoBar provides recovery resources such as Narcan and educational literature covering a variety of recovery supports and services. For more information about SoBar Recovery Community Center, programs, activities, and resources, visit www.sobarrco.com.
<i>Describe the expected frequency of the activity(ies) and how you determined this.</i>	SoBar Recovery Community Center is open throughout the week and provides recovery meetings at least once each day, ensuring participants have consistent access to peer support and community connection. Meeting schedules are available in print at the center and online through the SoBar website. Upcoming events and activities are promoted through our online calendar and Facebook page, as well as through monthly printed flyers available at the center.

Describe the number of persons in the target population you expect to serve during each activity event	Year to date, SoBar Recovery Community Center has recorded 9,461 visits, demonstrating the strong need for accessible recovery support and community connection. Of these visits, 3,318 were associated with peer recovery meetings, 1,193 with Recovery Art and other activities, and 480 with community partner meetings. SoBar also serves as a gathering place for community partners and recovery organizations. We regularly host commencement celebrations for Reach for Recovery's Harbor House and Chester Ray programs. Additionally, the Ottawa County Recovery Alliance, formerly known as the Opioid Task Force, holds its monthly meetings at SoBar. These partnerships strengthen collaboration within the recovery community and provide additional opportunities for individuals and families to connect with resources and support.
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III. Explain the necessary costs for your program *(provide narrative to support the resources identified that require funds).*

Funds are used to support the ongoing operations of SoBar Recovery Community Center, including building lease expenses, utilities, staffing costs, and other essential operational needs.

IV. Describe the goals you have established for the program. (goals do not have to be measurable) *(TO BE COMPLETED BY NEW PRORGRAMS ONLY)*

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PERFORMANCE MONITORING (TO BE COMPLETED BY NEW PROGRAMS ONLY)

V. Describe how you will measure your program's success at meeting its goals. *(Please identify only those measures that make sense for your proposed program. Not all measurement categories identified below must be measured.)*

Outcomes	Process: <i>Describe (in specifically measurable terms) what you hope to achieve during this grant period. These process indicators should measure such things as "how many?" "how often?" etc. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Participant: <i>Describe (in specifically measurable terms) what outcomes participants in your program can reasonably expect to achieve as a result. Include benchmark or threshold for measurement as well as expected achievement date.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.
	Impact: <i>Describe the impact you expect the program will have upon your community, target population, and/or intervention practices. Impact measurement is different from outcome measurement in that it is not consumer specific.</i>	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.



STATE OF MICHIGAN
ALMA L. VALENZUELA MPA, LMSW, CCJP, CCM
58th DISTRICT COURT PROB. & COMM. CORRECTIONS
85 WEST EIGHTH ST. | HOLLAND | MICHIGAN | 49423
PHONE: 616-355-4314
EMAIL: AVALENZUELA@MIOTTAWA.ORG

August 25, 2026

To the Community Mental Health Board:

I am pleased to provide this letter in support of SoBar and its request for funding to continue providing recovery-focused services within our community.

The 58th District Court collaborates with SoBar to provide participants in our Sobriety Treatment Program with valuable recovery services and opportunities. Through this partnership, our participants have access to a supportive, recovery-focused environment that complements the treatment, accountability, and other services provided through the court program.

SoBar provides an important resource for individuals working to build and maintain a life in recovery. Recovery requires more than abstaining from alcohol or other substances. It also requires connection, healthy relationships, positive activities, and opportunities to develop a sense of belonging outside of environments centered around substance use. SoBar helps create that space for individuals in recovery and their families.

We have seen the value of having community-based organizations like SoBar available to our participants. Their services provide additional support beyond the courtroom and treatment setting and help individuals establish connections that can contribute to long-term stability and recovery. These types of resources are especially important as participants work to develop healthier routines, strengthen their support systems, and successfully engage in the community.

We value our collaboration with SoBar and appreciate its commitment to serving individuals and families affected by substance use. Continued funding will help SoBar sustain and expand meaningful recovery-focused services and opportunities for those who need them.

We are pleased to support SoBar's funding request to the Community Mental Health Board and recognize the positive impact the organization is making within our local recovery community.

Sincerely,

A handwritten signature in blue ink that reads "Alma Valenzuela".

Alma Valenzuela
Director of Probation & Community Corrections

STATE OF MICHIGAN
TWENTIETH JUDICIAL CIRCUIT COURT

DEREK W. DALMAN
PRESIDING JUDGE



ANDREW BROWN
DIRECTOR

EMILY ACHTERHOF
SENIOR PROBATION OFFICER

OTTAWA COUNTY RECOVERY COURT

August 25, 2026

Dear Community Mental Health of Ottawa County

My name is Emily Achterhof, and I am the Probation Officer for the Ottawa County Recovery Court, (OCRC) a program of the 20th Judicial Circuit Court in Ottawa County, Michigan. I am writing in support of the SoBar Recovery Community Center. The OCRC has a variety of program requirements for the participants and attending recovery meetings and accessing local sober social services is one of them. My role within OCRC is case management and linkage of services to support a participant's recovery. In my orientation I always highlight the services of SoBar and discuss the importance of a safe sober environment.

Participants and graduates of OCRC have utilized the Friday night activities such as Bingo and Karaoke, it is a fun and stigma free family friendly weekend evening activity. We have had participants facilitate and regularly attend recovery meetings at SoBar. The Art Recovery meeting and activities like playing pool or foosball encourage clients to participate in activities sober, finding a new way of life. Having a local and free place like SoBar for the recovery community to gather facilitates and strengthens a person's recovery.

Walking through SoBar this morning at 10:00am, it was being utilized by individuals in recovery as a safe and inclusive place to be and a positive environment for them to continue to achieve recovery and attend local meetings. SoBar staff was available to clients and local resources were clearly displayed and available to them.

If Community Mental Health of Ottawa County uses funding resources to support SoBar there will be a direct positive benefit to our local recovery community. SoBar will be able to continue to support and inspire changes that directly benefit individuals, families and the Ottawa County Community as a whole.

Sincerely,

Emily Achterhof

Emily Achterhof
OCRC Senior Probation Officer
414 Washington Ave Ste. 300
Grand Haven, MI 49417
616 566 0283

August 24, 2026

Dear Members of the Community Mental Health Board:

On behalf of Reach for Recovery, I am pleased to offer our strong support for SoBar and its continued work as a Recovery Community Organization serving individuals and families in our local recovery community. Since opening more than three years ago, SoBar has become a trusted pillar of recovery support and a valued partner to organizations like ours.

Reach for Recovery operates two residential substance use disorder treatment homes in Holland, and our residents attend recovery meetings at SoBar on an almost daily basis. The welcoming, recovery-focused environment SoBar provides gives our residents consistent access to peer connection, mutual support, and a broader community of people who understand the recovery journey. These opportunities complement formal treatment by helping individuals build relationships and recovery supports that can continue long after they leave residential care.

SoBar has also been an exceptionally supportive community partner to Reach for Recovery. They have generously provided space for our residential commencement ceremonies, allowing our residents, families, staff, and supporters to celebrate important milestones in a setting that reflects hope, connection, and long-term recovery. Their willingness to collaborate and make their space available demonstrates the spirit of partnership that is essential to a strong recovery-oriented system of care.

From our experience, SoBar fills an important role in the continuum of recovery services in our community. Treatment providers can help individuals begin and stabilize their recovery, but sustainable recovery often depends on ongoing connection, belonging, peer support, and meaningful opportunities to remain engaged. SoBar helps provide that bridge and creates a place where people can continue strengthening their recovery while becoming connected to others with shared experiences.

Reach for Recovery strongly supports SoBar's request for funding from the Community Mental Health Board. Continued investment in SoBar will help preserve and expand a valuable recovery resource that benefits individuals in treatment, people in long-term recovery, families, and the broader community. We are grateful for our partnership with SoBar and look forward to continuing to work together in support of recovery throughout West Michigan.

Thank you for your consideration and for your investment in services that strengthen recovery in our community.

Sincerely,

Jeff Marschall
Executive Director
Reach for Recovery

Lakeshore Regional Entity
Oversight Policy Board

ATTACHMENT 12

ACTION REQUEST

SUBJECT: FY2027 LRE Initial SUD Budget

- * Approval of PA2 Funds
- * Advice and Recommendation to LRE

MEETING DATE: September 16, 2026

PREPARED BY: Stacia Chick, LRE Chief Financial Officer

RECOMMENDED MOTION:

The Oversight Policy Board:

- (a) Approves the allocation of PA2 funds for the
- (b) Advises and recommends that the LRE Board approve the non-PA2 fund budgets for SUD services as summarized below.

PROPOSED TO GO TO THE BOARD ON SEPTEMBER 23, 2026

SUMMARY OF REQUEST/INFORMATION:

- * Public Act 500 of 2012 requires each PIHP region to establish an Oversight Policy Board with certain roles and responsibilities related to substance abuse services.
- * The Lakeshore Regional Entity Oversight Policy Board is the Oversight Policy Board for Region 3 PIHP.
- * Among other functions, the Oversight Policy Board is responsible for approving budgets which contain local funds and to advise and recommend budgets containing non-local funds to the LRE board for services within the region.

STAFF: Stacia Chick, LRE Chief Financial Officer

DATE: September 10, 2026

FY2027 LRE Initial SUD Budget Summary:

<u>PREVENTION (direct by LRE)</u>	<u>PA2</u>	<u>Block Grant</u>	<u>SOR</u>	<u>SUD Health Homes</u>	<u>Alcohol Use Disorder Tx</u>	<u>PA2 Reserve</u>	<u>Gambling</u>	<u>Medicaid</u>	<u>Healthy Michigan</u>	<u>Total</u>
<i>Allegan County</i>	\$ 155,169	\$ 111,156	\$ 55,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 321,325
<i>Kent County</i>	\$ 369,240	\$ 601,055	\$ -	\$ -	\$ -	\$ 259,607	\$ -	\$ -	\$ -	\$ 1,229,902
<i>Lake County</i>	\$ 7,051	\$ 11,498	\$ -	\$ -	\$ -	\$ 20,000	\$ -	\$ -	\$ -	\$ 38,549
<i>Mason County</i>	\$ 17,581	\$ 28,630	\$ -	\$ -	\$ -	\$ 45,000	\$ -	\$ -	\$ -	\$ 91,211
<i>Oceana County</i>	\$ 16,240	\$ 26,436	\$ 50,000	\$ -	\$ -	\$ -	\$ 38,000	\$ -	\$ -	\$ 130,676
<i>Muskegon County</i>	\$ 105,368	\$ 171,519	\$ 45,000	\$ -	\$ -	\$ -	\$ 42,000	\$ -	\$ -	\$ 363,887
<i>Ottawa County</i>	\$ 161,689	\$ 263,200	\$ 55,000	\$ -	\$ -	\$ 210,569	\$ 44,000	\$ -	\$ -	\$ 734,458
<i>LRE Regional Projects</i>	\$ -	\$ 65,517	\$ -	\$ -	\$ -	\$ -	\$ 33,000	\$ -	\$ -	\$ 98,517
<i>LRE Staffing</i>	\$ -	\$ 191,784	\$ -	\$ -	\$ -	\$ -	\$ 93,000	\$ -	\$ -	\$ 284,784
<i>Unallocated</i>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PREVENTION TOTAL	\$ 832,338	\$ 1,470,795	\$ 205,000	\$ -	\$ -	\$ 535,176	\$ 250,000	\$ -	\$ -	\$ 3,293,309

<u>TREATMENT (delegated to CMH members)</u>	<u>PA2</u>	<u>Block Grant</u>	<u>SOR</u>	<u>SUD Health Homes</u>	<u>Alcohol Use Disorder Tx</u>	<u>PA2 Reserve</u>	<u>Gambling</u>	<u>Medicaid</u>	<u>Healthy Michigan</u>	<u>Total</u>
<i>Allegan</i>	\$ 81,346	\$ 466,000	\$ 170,370	\$ -	\$ 14,661	\$ 115,000	\$ -	\$ 709,015	\$ 1,041,878	\$ 2,598,270
<i>Healthwest</i>	\$ 385,202	\$ 978,893	\$ 840,707	\$ -	\$ 54,598	\$ -	\$ -	\$ 1,728,768	\$ 2,541,563	\$ 6,529,731
<i>Network 180</i>	\$ 1,744,411	\$ 2,455,982	\$ 535,139	\$ -	\$ 104,350	\$ -	\$ -	\$ 4,415,608	\$ 7,106,210	\$ 16,361,700
<i>Ottawa</i>	\$ 557,483	\$ 770,548	\$ -	\$ 24,493	\$ 20,000	\$ 200,000	\$ -	\$ 1,150,949	\$ 1,944,376	\$ 4,667,848
<i>West Michigan (Lake, Mason Oceana)</i>	\$ 126,528	\$ 393,000	\$ 115,032	\$ -	\$ 21,991	\$ -	\$ -	\$ 594,494	\$ 925,441	\$ 2,176,485
<i>LRE Staffing & Regional Projects</i>	\$ -	\$ 330,363	\$ 233,752	\$ 6,124	\$ -	\$ -	\$ -	\$ 308,792	\$ 486,734	\$ 1,365,765
<i>Unallocated</i>	\$ -	\$ 324,298	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 324,298
TREATMENT TOTAL	\$ 2,894,970	\$ 5,719,084	\$ 1,895,000	\$ 30,617	\$ 215,600	\$ 315,000	\$ -	\$ 8,907,625	\$ 14,046,201	\$ 34,024,097

TOTAL PREVENTION & TREATMENT	\$ 3,727,308	\$ 7,189,879	\$ 2,100,000	\$ 30,617	\$ 215,600	\$ 850,176	\$ 250,000	\$ 8,907,625	\$ 14,046,201	\$ 37,317,406
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Lakeshore Regional Entity FY 2027 SUD Budget

Prevention

	Initial FY26 Allocation	Initial FY27 Allocation	Block Grants	SOR	SUD Health Homes	Alcohol Use Disorder Tx	PA2 Reserve	PA2	Gambling	
Allegan County										
OnPoint (Allegan Co CMH)	304,843	321,325	111,156	55,000	-	-	-	155,169	-	-
Total	304,843	321,325	111,156	55,000	-	-	-	155,169	-	-
Kent County										
Arbor Circle	206,755	209,323	105,000	-	-	-	68,965	35,358	-	-
Kent County Health Department	497,393	522,318	246,055	-	-	-	130,642	145,621	-	-
Network 180	306,077	306,077	175,000	-	-	-	-	131,077	-	-
Wedgwood	167,585	192,184	75,000	-	-	-	60,000	57,184	-	-
Total	1,177,810	1,229,902	601,055	-	-	-	259,607	369,240	-	-
Lake County										
District Health Department #10	36,450	38,549	11,498	-	-	-	20,000	7,051	-	-
Total	36,450	38,549	11,498	-	-	-	20,000	7,051	-	-
Mason County										
District Health Department #10	90,974	91,211	28,630	-	-	-	45,000	17,581	-	-
Total	90,974	91,211	28,630	-	-	-	45,000	17,581	-	-
Oceana County										
District Health Department #10	157,952	130,676	26,436	50,000	-	-	-	16,240	38,000	-
Total	157,952	130,676	26,436	50,000	-	-	-	16,240	38,000	-
Muskegon County										
Healthwest	292,426	305,379	127,519	45,000	-	-	-	90,860	42,000	-
Mercy Health	57,507	58,508	44,000	-	-	-	-	14,508	-	-
Total	349,933	363,887	171,519	45,000	-	-	-	105,368	42,000	-
Ottawa County										
Arbor Circle (Ottawa Co)	524,354	543,836	174,982	55,000	-	-	180,569	89,285	44,000	-
CMH of Ottawa County	38,265	40,514	-	-	-	-	-	40,514	-	-
Ottawa Co. Department of Public Health	150,108	150,108	88,218	-	-	-	30,000	31,890	-	-
Total	712,727	734,458	263,200	55,000	-	-	210,569	161,689	44,000	-
LRE Regional Projects (TalkSooner, Trainings, Conference, Tech. Assistance, Family Meals Month)	101,000	98,517	65,517	-	-	-	-	-	33,000	-
LRE Staffing	299,369	284,784	191,784	-	-	-	-	-	93,000	-
Unallocated	-	-	-	-	-	-	-	-	-	-
Total	400,369	383,301	257,301	-	-	-	-	-	126,000	-
Overall Prevention Total	3,231,058	3,293,309	1,470,795	205,000	-	-	535,176	832,338	250,000	-

Treatment

	Initial FY26 Allocation	Initial FY27 Allocation	Block Grants (incl. SDA)	SOR	SUD Health Homes	Alcohol Use Disorder Tx	PA2 Reserve	PA2	Medicaid	Healthy Michigan
OnPoint (Allegan Co CMH)	2,230,947	2,598,270	466,000	170,370	-	14,661	115,000	81,346	709,015	1,041,878
Healthwest	5,879,107	6,529,731	978,893	840,707	-	54,598	-	385,202	1,728,768	2,541,563
Network 180	14,945,780	16,361,700	2,455,982	535,139	-	104,350	-	1,744,411	4,415,608	7,106,210
CMH of Ottawa County	4,342,259	4,667,848	770,548	-	24,493	20,000	200,000	557,483	1,150,949	1,944,376
West Michigan CMH (Lake, Mason Oceana)	1,832,595	2,176,485	393,000	115,032	-	21,991	-	126,528	594,494	925,441
LRE Staffing & Regional Projects	1,368,132	1,365,765	330,363	233,752	6,124	-	-	-	308,792	486,734
Unallocated	386,228	324,298	324,298	-	-	-	-	-	-	-
Overall Treatment Total	30,985,047	34,024,097	5,719,084	1,895,000	30,617	215,600	315,000	2,894,970	8,907,625	14,046,201
SUD Total Prevention + Treatment:	34,216,105	37,317,406	7,189,879	2,100,000	30,617	215,600	850,176	3,727,308	9,157,625	14,046,201

SUD Prevention Providers Additional PA2 Requests (“Reserve” PA2) FY 27

SUD Prevention Provider	FY 25 PA2 Contract	FY 27 PA2 Allocations	Add. FY 27 PA2 Request
Kent Co Health Dept (Kent Co)	\$255,000	\$145,621	\$130,642
Maintain Salary/Fringe (.989 FTE across 3 staff), mileage, printing & class materials, Evaluation, Other: office expenses			
Wedgwood (Kent Co)	\$83,910	\$57,184	\$60,000
Maintain Salary/Fringe (.725 FTE across 3 staff), conference/training, Supplies, Other: office expenses			
DHD10 (Lake Co)	\$23,448	\$7,051	\$20,000
Maintain Salary/Fringe (.13 FTE across 2 staff), Travel, Supplies, Other: office expenses, printing materials			
DHD10 (Mason Co)	\$58,304	\$17,581	\$45,000
Maintain Salary/Fringe (.3 FTE across 2 staff), Travel, Supplies, Other: office expenses, printing materials			
Arbor Circle Site (Kent Co)	\$59,597	\$35,358	\$68,965
Maintain Salary/Fringe (.748 FTE across 3 staff), professional development, Other: office expenses and supplies			
Arbor Circle site (Ottawa Co)	\$200,000	\$89,285	\$180,569
Maintain Salary/Fringe (1.580 FTE across 4 staff), youth conference, coalition supplies, Safe Prom, Reducing Alcohol focus, Evaluation, Other: office expenses			
Ottawa Public Health (Ottawa Co)	\$71,800	\$31,890	\$30,000
Printing costs to promote initiatives, office supplies, operating supplies to support SUD initiatives, programming and community outreach.			
FY 27 Prevention PA2 Reserve Requests			\$535,176



August 2026

Substance Use Disorder Treatment Evaluation Quarterly Monitoring Report

3rd Quarter FY2026

As one of Michigan's ten Prepaid Inpatient Health Plans (PIHP), the LRE manages services under contract with the Michigan Department of Health and Human Services, funded by various grants. Treatment and recovery services are provided by Community Mental Health Services Providers across Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa Counties.

This report outlines data indicators for monitoring key metrics for substance use disorder treatment and recovery services in the LRE region. Data covered in this report is through the third quarter of FY26 (June 30, 2026).



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Introduction

This quarterly report provides an update on key performance metrics aligned with four priority areas, along with trends in primary substances reported at admission. These indicators assess how well the regional system is meeting the needs of diverse populations—including those involved in the criminal justice system, individuals with co-occurring disorders, and those with opioid or intravenous drug use—while supporting timely access and smooth transitions across the continuum of care. Data is tracked at both the regional and CMHSP levels to inform planning, guide system improvements, and support ongoing evaluation.

pg 5

Treatment Access



Treatment access refers to how easily and quickly individuals can begin receiving appropriate substance use disorder (SUD) services once they seek help. Metrics in this area assess whether people can get into care in a timely manner and whether access is equitable across different populations and service types.

pg 11

Engagement & Retention



Engagement and retention metrics evaluate how effectively the treatment system keeps individuals connected to services post-initial contact. Early and ongoing engagement correlates with better outcomes, such as lower relapse risk and enhanced long-term recovery. Monitoring these metrics identifies areas needing additional support or system changes to minimize drop-off and improve care continuity.

pg 15

Continuity of Care



Continuity of care metrics evaluate whether people move smoothly to the next level of care after going through detox or short-term residential programs. These transitions are important because during these period clients have a high risk of relapse, overdosing, or losing touch with services.

pg 18

Performance Bonus Incentive Program



Michigan Department of Health and Human Services allocates funding annually to reward PIHPs for strong performance in certain measures such as timely follow-up after an emergency department visit for addiction, decreasing disparities in initiation and engagement in treatment, and supporting social needs like housing and employment. Higher performance on these measures results in a larger bonus.

pg 24

Drug Trends



This section reviews trends in substances reported at admissions. Monitoring these metrics helps identify shifts in substance use patterns that can inform system planning and response. Unlike other indicators in this report, these data are not targeted for performance improvement but are tracked for monitoring purposes only.

Using this Report

At the start of each section in this report, you'll find a summary for each metric. This includes a concise explanation of why the metric is important to track, recent findings, and an assessment of whether the trend is improving or declining. Detailed results for each metric related to the region and Community Mental Health Service Providers (CMHSPs) are provided on the pages that follow.

Throughout the report, the following icons have been used to describe data trends.

-  Data has worsened and should be monitored
-  Data has remained relatively stable without a clear pattern
-  Data has been improving

When a data indicator reflects only a portion of admissions and the sample size or count is 10 or less, both the number and the percentage will be presented.

Unless otherwise specified, data analyzed comes from BH TEDS (refreshed on **07/30/26**) and encounters (refreshed on **07/29/26**). Any data entered after these dates will be reflected in subsequent reports. For details on data parameters, refer to the [appendix](#), starting on page 30.



Important Data Limitation: Incomplete CCBHC Data

FY26 data does not include CCBHC funded clients while prior fiscal year data does. Because of this variance in trends should be interpreted with caution, as they likely reflect data limitations rather than true operational change. Specifically:

- Encounter data are likely underrepresented and not comparable to prior years.
- Admission data will be substantially impacted, with potential underreporting of up to ~60%.
- Discharge data may be under reported by 10% to 20%

Commonly Used Acronyms and Abbreviations:

Q1 - 1st quarter

Q2 - 2nd quarter

Q3 - 3rd quarter

Q4 - 4th quarter

avg - Average

BH - Behavioral Health

CJ - Criminal Justice

CY - Calendar Year

IOP - Intensive Outpatient

LRE - Lakeshore Regional Entity

LOC - Level of care

LT Res - Long term residential level of care

MA - Methamphetamine

MAT - Medication Assisted Treatment

OP - Outpatient

PBIP - Performance Based Incentive Program

Pt./Pts. - Point(s)

OD - Opioid Use Disorder

ST Res - Short term residential level of care

TTS - Time to Service

WM or West MI - Lake, Mason, & Oceana Counties

Treatment Access

Treatment access refers to how quickly individuals can begin substance use disorder (SUD) services once they seek help and whether access is equitable across different populations and service types. These indicators help determine whether the system is responsive to those who need care—and whether wait times or barriers differ based on location, demographics, or clinical need.

This page provides an overview of the treatment access metrics monitored quarterly by the LRE, the rationale for each indicator and a brief snapshot of current data trends through the most recent quarter. Additional detail for each metric can be found on the pages noted.



Intra-Venous Drug Use (IVDU)

Admissions for individuals with IVDU are prioritized due to elevated risk for overdose, infectious disease, and other serious health complications.

Medication Assisted Treatment (MAT)

Timely access to MAT for individuals with opioid use disorder is prioritized because it reduces the risk of overdose, enhances treatment engagement, and supports long-term recovery. MAT is widely recognized as the gold standard in evidence-based care for opioid use.

Criminal Justice Involved Admissions

Individuals involved in the criminal justice system are prioritized due to their increased risk of overdose and untreated substance use. With the MDOC delegating probation services to PIHPs, timely and coordinated access to treatment is crucial.

Metrics

↓ avg days between request and 1st service for persons with intra-venous drug use (IVDU) (pgs 6-8)

★ TTS for individuals with IVDU increased substantially in Q2 to a high of 12.1 days and then improved in Q3 to a low of 6.8 days.

↓ avg days between request and 1st service for persons with opioid use disorder (OUD) to MAT (pg 9)

★ TTS to MAT for persons with OUD increased substantially in Q2 to a high of 13.3 and then improved in Q3 to a low of 6.7 days.

↑ admissions for individuals on parole/probation, in jail, or diverted (pre or post booking) (pg 10)

⚡ Just over one-third (35%) of admissions in Q3 had criminal justice and has remained **relatively stable** since FY24.

Treatment Access

Intra-Venous Drug Use (IVDU)

Metric

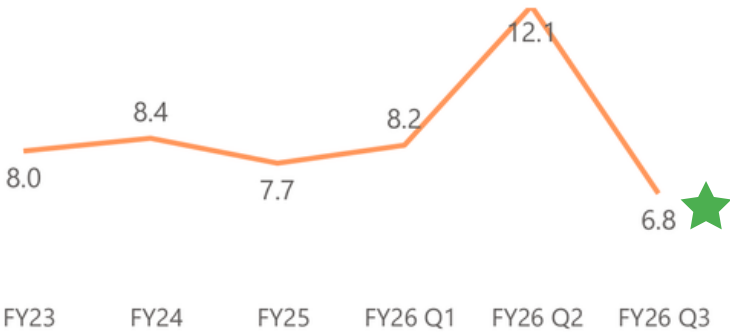
- Decrease the average days between request for service and first service for clients with IVDU.

Data Highlights:

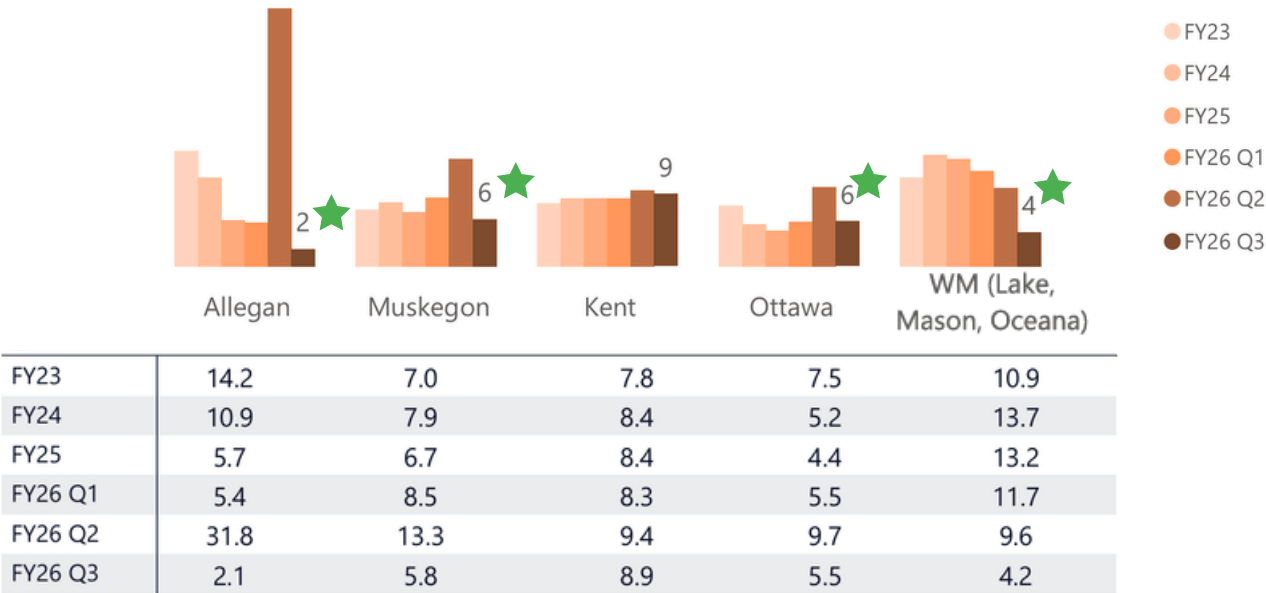
Among admissions for individuals with IVDU in Q3, the average time to service was 6.8 days which is a dramatic decrease from the outlier of 12.1 days in Q2 and the lowest average TTS since FY23.

Across the region, TTS for clients with IVDU ranged from a low of 4.2 in West Michigan to a high of 8.9 days for Kent in Q3.

Average Time to Services for Clients with IVDU (Days)



Average Time to Service for Clients w/IVDU by CMHSP



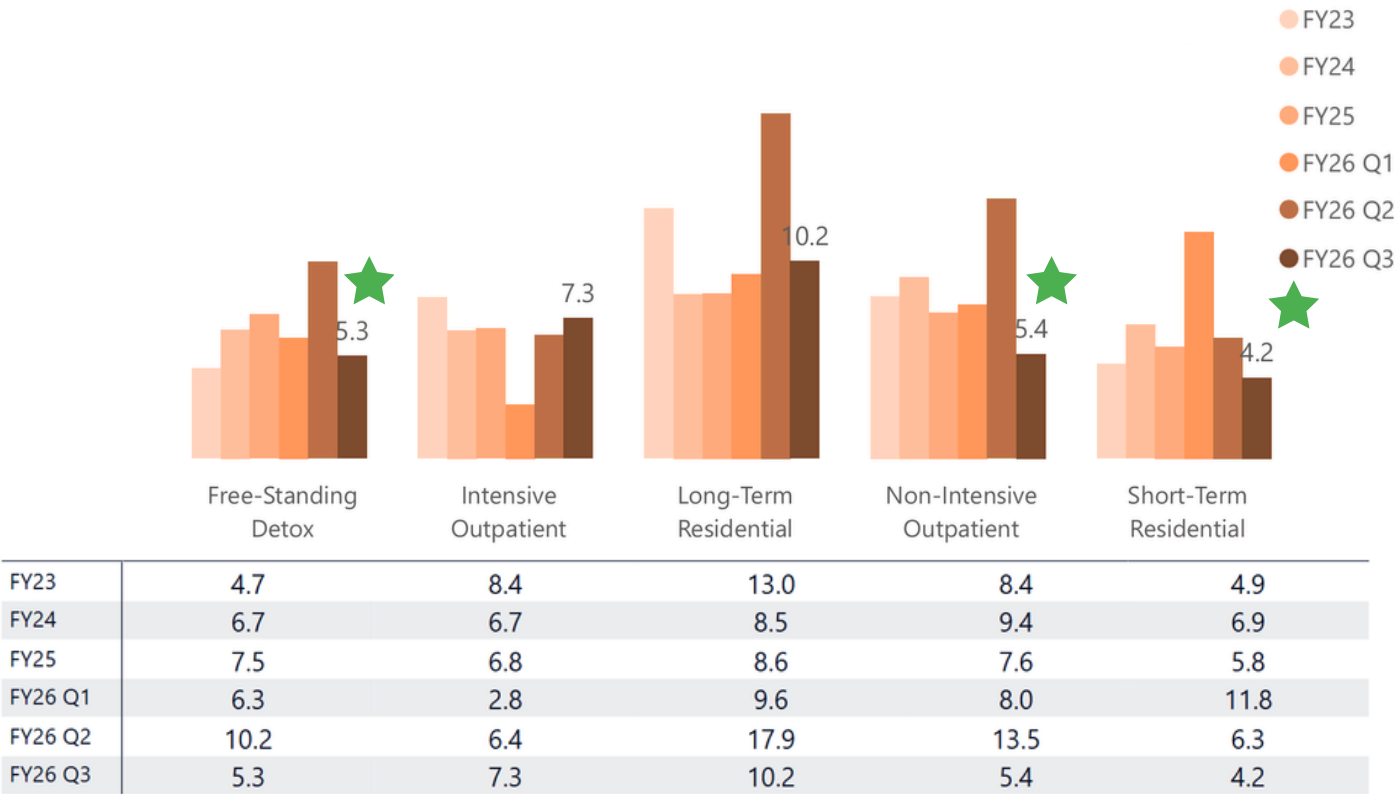
Treatment Access

Intra-Venous Drug Use (IVDU) cont...

Metric

- Decrease the average days between request for service and first service for clients with IVDU.

Average Time to Services for Clients with IVDU by Service Category



Data Highlights:

Average time to service for IVDU decreased substantially for Detox, Long Term Residential, and Outpatient Services in Q3. Short Term Residential experienced a slight decrease from Q2 to Q3, and IOP experienced a slight increase in average TTS. In Q3, long term residential services continued to have the longest Time to Service (TTS) for clients with intravenous drug use (IVDU) at 10.2 days. Excluding the high of 17.9 days in Q2, this has been slowly increasing since FY24.

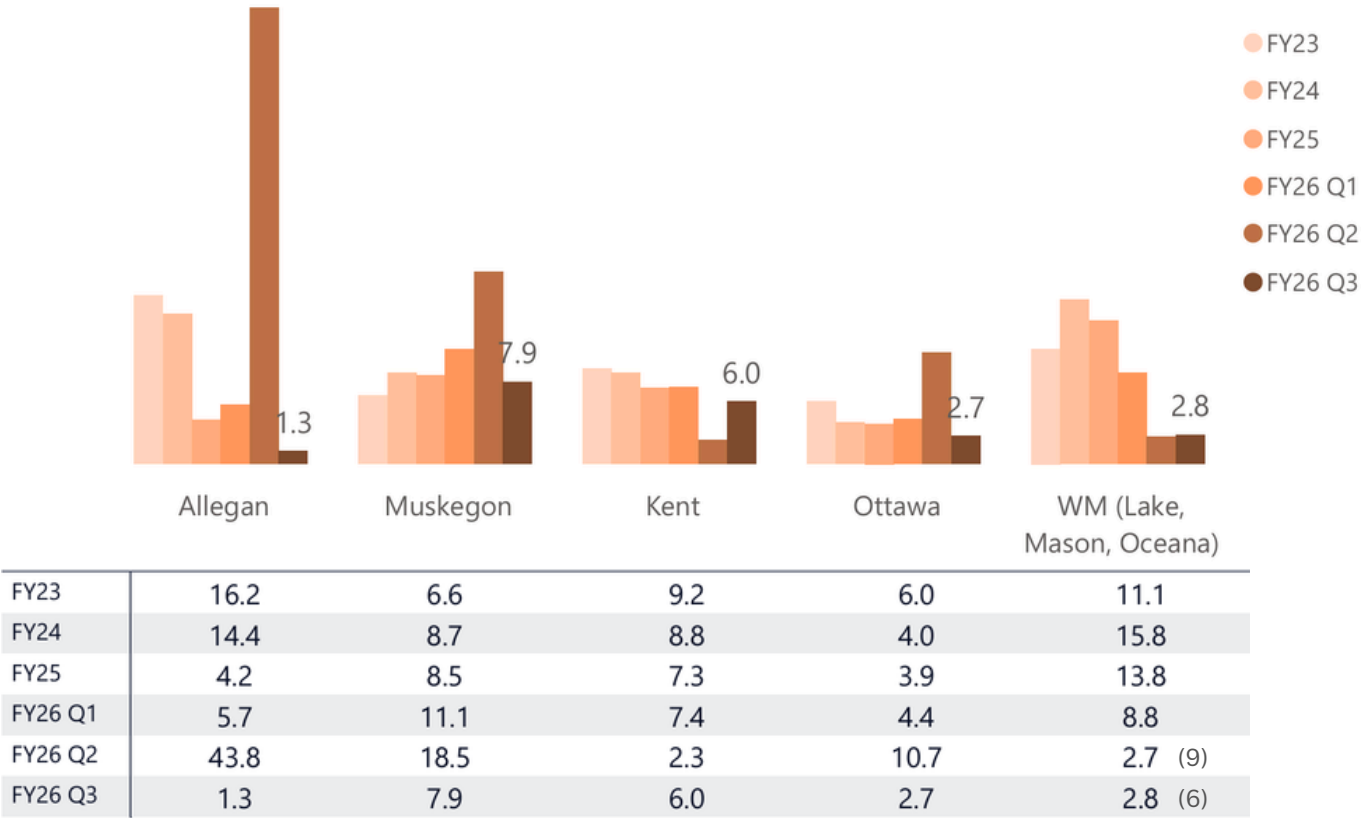
Treatment Access

Intra-Venous Drug Use (IVDU)
continued...

Metric

- Decrease the average days between request for service and first service for clients with IVDU.

Average Time to Outpatient (non-intensive) Services for Clients with IVDU by CMHSP



Data Highlights:

In Q3, Time to Service (TTS) for clients with intravenous drug use (IVDU) seeking outpatient services ranged from 1.3 days in Allegan County to 7.9 days in Muskegon. Although most counties throughout the region had a spike in TTS for outpatient services during Q2, the TTS not only recovered but also improved in all communities during Q3.

Treatment Access

Medication Assisted Treatment (MAT)

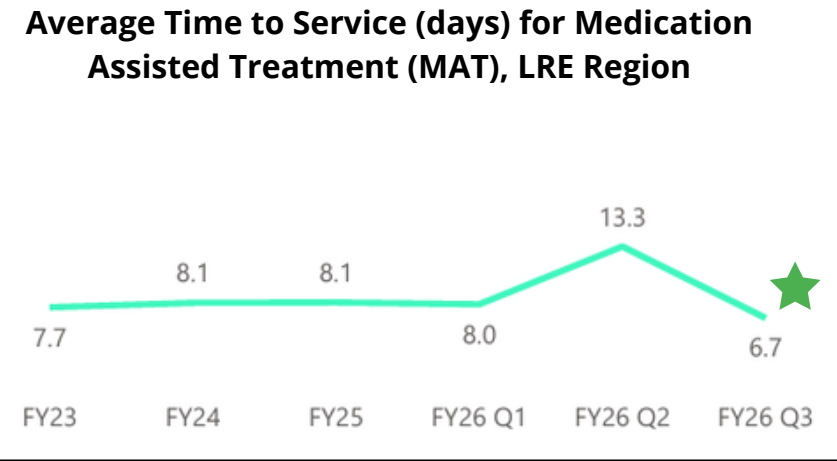
Metric

- Decrease average days between request for service and first service for persons living with an opioid use disorder (OUD).

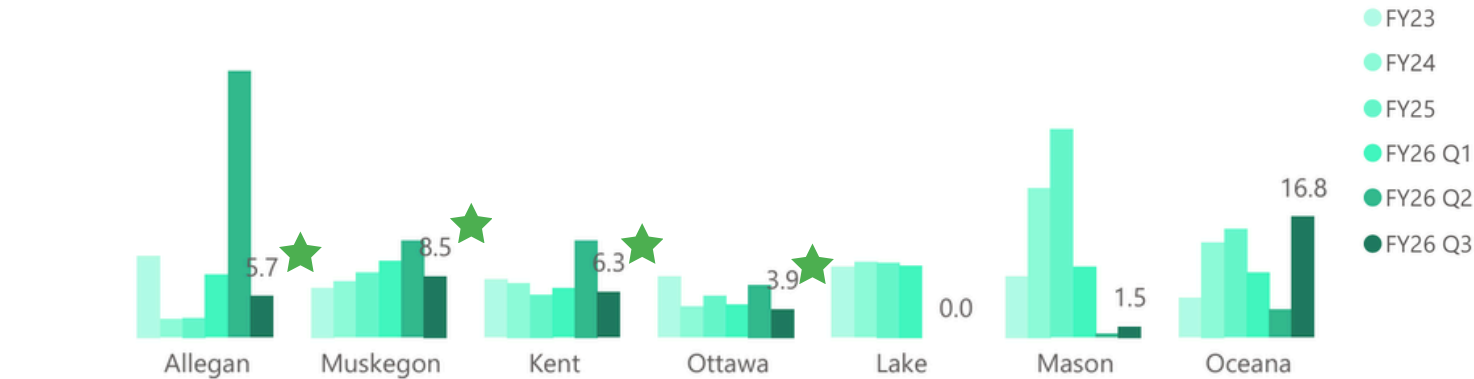
Data Highlights:

Time to Service (TTS) for individuals with an opioid use disorder (OUD) is most impacted by delays in admission to medication-assisted treatment (MAT). During Q2 TTS for MAT increased dramatically to a high of 13.3 which corrected in Q3 to a low of 6.7 days which is the lowest TTS during review period.

By county, TTS in Q3 ranged from 0 days in Lake County to 16.8 days in Oceana County. However, both the of these communities had a small number of admissions to MAT in Q3, which should be considered when interpreting trends. Allegan, Muskegon, Kent, and Ottawa all experienced substantial decreases in TTS for MAT in Q3.



Average Time to Service (days) for Outpatient MAT by County



TTS:
Time to Service is the number of days between the request for service and date of first service received.

Treatment Access

Criminal Justice Involved Admissions

Metric

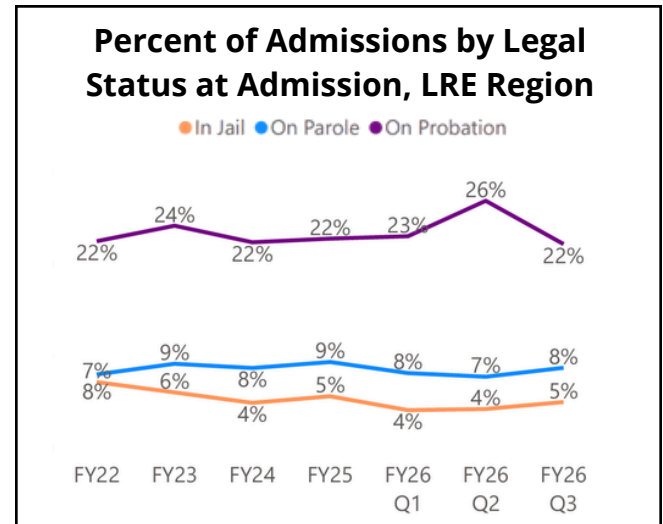
- Increase admissions with legal status, on parole/probation
- Increase admissions with legal status as diversion pre or post booking
- Increase admissions with legal status as 'in jail'

Data Highlights:

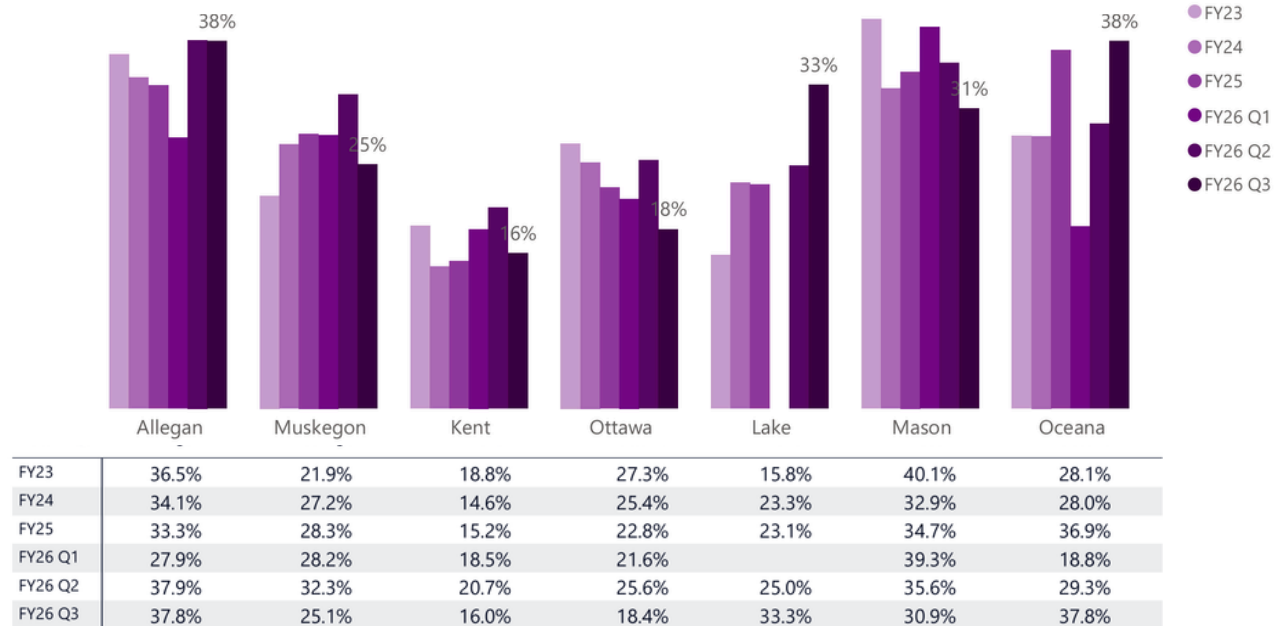
Region-wide, 35% of admissions had criminal justice involvement in Q3. The majority of these were individuals 'on probation'.

The rate for admissions with legal status as pre- or post-booking diversion remains consistently low (<1%).

Rates of admissions for individuals on probation increased in Lake and Oceana Counties. Rates remained stable in Allegan and decreased in Muskegon, Kent, Ottawa, and Mason Counties.



Percent of Admissions with Legal Status as 'On Probation' at Admission by County



Engagement and Retention

Engagement and retention metrics help assess how well the treatment system is supporting individuals to stay connected to services after their initial contact. Early and sustained engagement is linked to better outcomes, including reduced relapse risk and improved long-term recovery. Tracking these indicators helps identify where additional support or system changes may be needed to reduce drop-off and strengthen care continuity.

This page provides an overview of the engagement and retention metrics monitored quarterly by the LRE, the rationale for each indicator and a brief snapshot of current data trends through the most recent quarter. Additional detail for each metric can be found on the pages noted.



Metrics

Integrated Treatment for Co-Occurring Disorders (COD)

Individuals with co-occurring mental health and substance use disorders have more complex needs, and receiving integrated care helps improve outcomes and retention by ensuring both conditions are addressed in a coordinated, person-centered approach.

↑ % of clients w/ co-occurring diagnosis (COD) receiving integrated services (pg 12)

⌘ The % of clients with COD reported as having received integrated treatment has remained relatively stable since Q1.

In Q3, the percentage of clients with COD receiving integrated care, ranged from a low of 17.6% in West Michigan to a high of 51.1% in Ottawa County.

One Encounter

The percent of treatment episodes with no second visit is a key indicator of early engagement. A high rate may suggest barriers to continued care—such as accessibility issues, unmet needs, or poor treatment fit—and can signal where additional support or system improvements are needed to keep individuals engaged in services.

↓ % of treatment episodes with no 2nd visit (pgs 13-14)

⌘ For treatment episodes that warranted more than an assessment, the percentage of treatment episodes with only one encounter experienced a slight decrease from Q2, but overall remains stable at 8%.

Engagement and Retention

Integrated Treatment for Co-Occurring Disorders (COD)

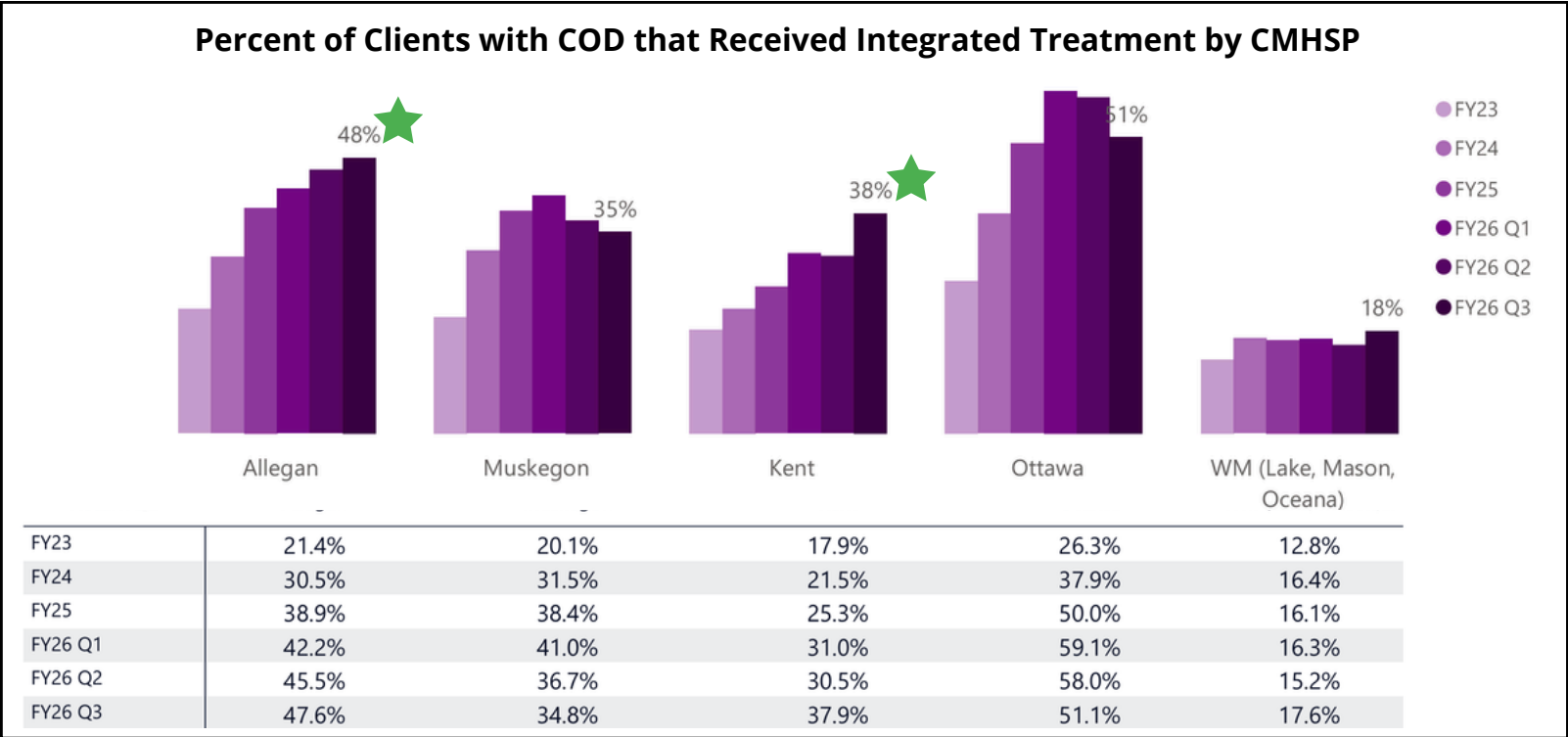
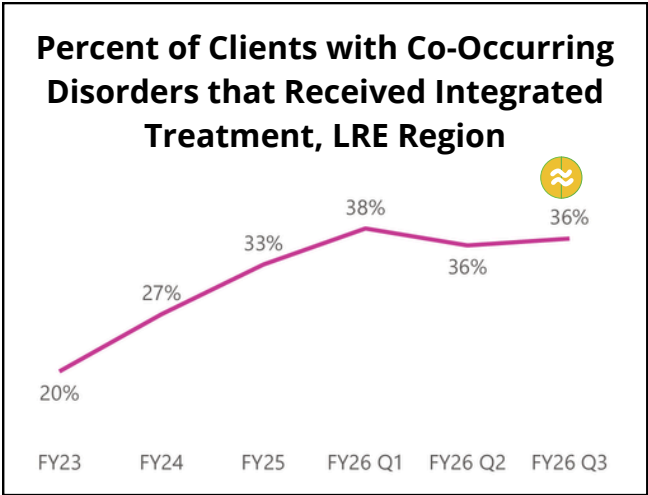
Metric

- Increase % of clients with co-occurring diagnosis that received integrated services.

Data Highlights:

The percentage of clients with COD that were reported as having received integrated treatment has been continually increasing since 2017, reached a high of 38% in Q1 of FY26 and has remained relatively steady since then.

Rates of integrated treatment in Q3 ranged from a low of 17.6% for WM to a high of 51.1% in Ottawa County. When looking at CMHSPs, Allegan, Kent, and WM county rates of integrated treatment continue to increase. Muskegon and Ottawa experienced a slight decrease during Q3 but overall rates remained stable across the region.



Engagement and Retention

One Encounter

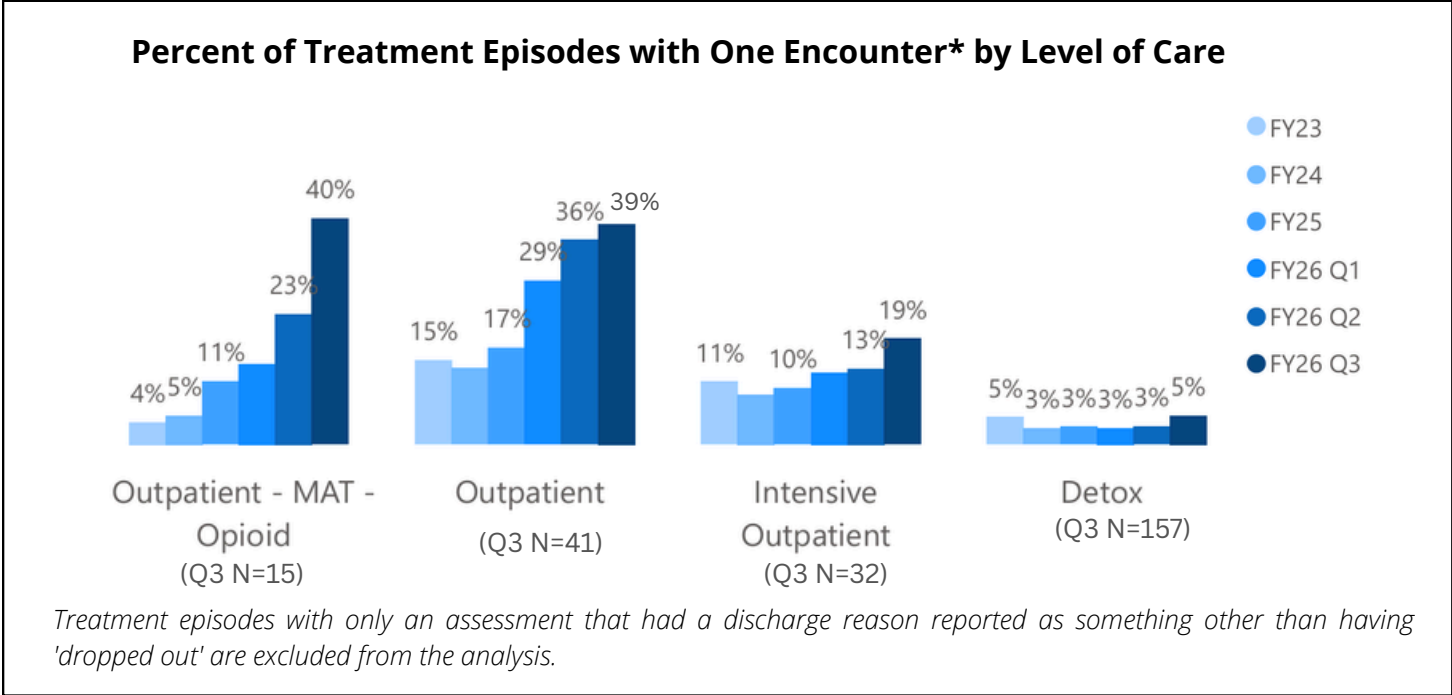
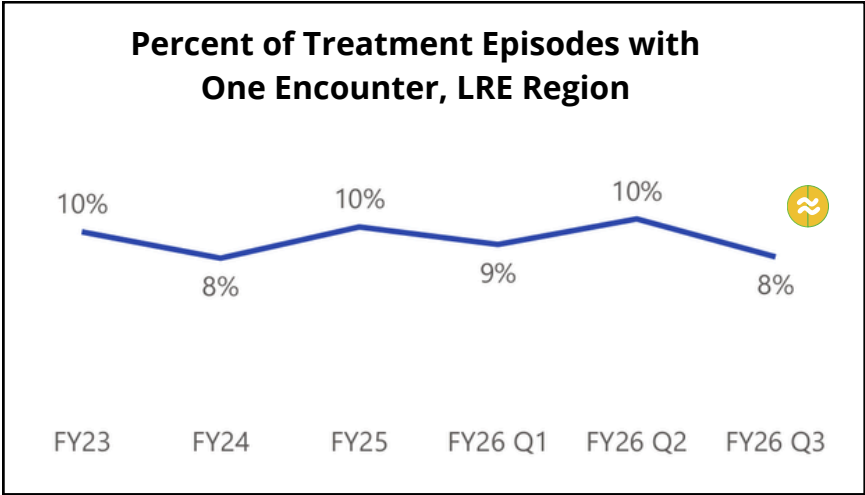
Metric

- Decrease % of treatment episodes with no 2nd visit.

Data Highlights:

For treatment episodes that warranted more than an assessment, the percentage of treatment episodes with only one encounter experienced a slight decrease from Q2, but overall remains stable.

OP treatment episodes with only one encounter continued to increased to 39% in Q3. Between Q2 and Q3, IOP experienced an increase in treatment episodes with one encounter (13% → 19%). OP MAT also saw an increase in treatment episodes with one encounter, however the count was small which should be considered when interpreting the data.



Engagement and Retention

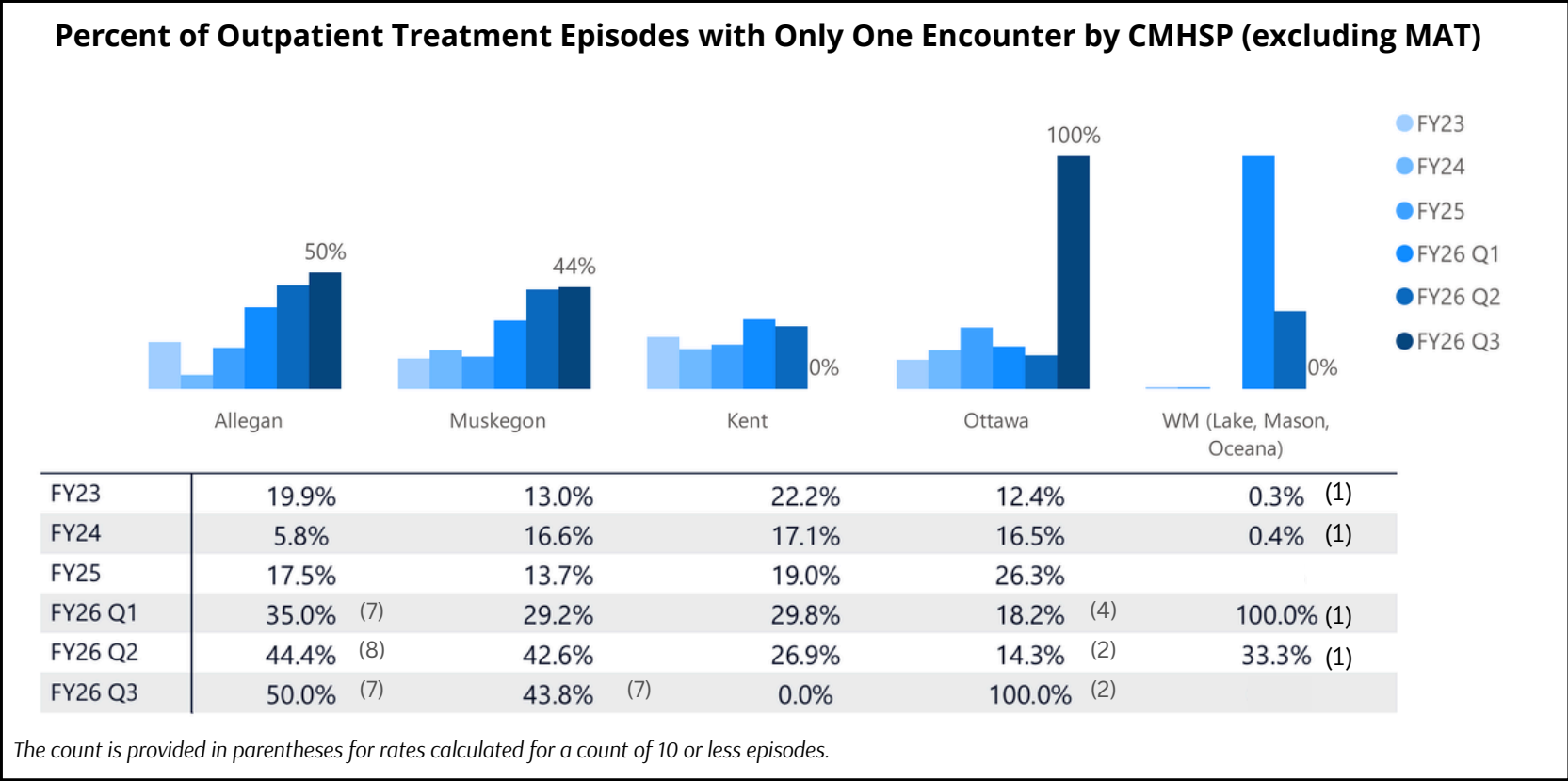
One Encounter Continued...

Metric

- Decrease % of treatment episodes with no 2nd visit.

The chart below shows the percentage of outpatient treatment episodes with only one encounter for each CMHSP. Rates vary across CMHSPs and time periods. Those showing substantially higher rates in the most recent quarters may be attributable to incomplete data entry for encounters at the time records were pulled for this review.

Use caution when reviewing the most recent time periods, as delays in the entry of service encounters can limit the validity of results. Allegan, Muskegon, and Ottawa had a very small number of episodes with only one encounter making up the percentage, which should be considered when looking at this data.



Note: This analysis only includes treatment episodes meeting the following criteria: 1) warranted more than an assessment, 2) discharge date entered, and 3) at least one service encounter entered. Due to this, more recent data periods have a small sample size and may not reflect all service encounters.

Continuity of Care

Continuity of care metrics assess whether individuals successfully transition to the next level of care following high-intensity services of detoxification and short-term residential (ST Res). These transitions are critical periods when individuals are especially vulnerable to relapse, overdose, or disengagement from services. Monitoring these metrics helps ensure individuals don't fall through the cracks during this high-risk period and that the treatment system is working as a coordinated continuum rather than a series of disconnected services.

This page provides an overview of continuity of care metrics monitored quarterly by the LRE, the rationale for each indicator and a brief snapshot of current data trends through the most recent quarter. Additional detail for each metric can be found on the pages noted.



Metrics

Timely Transition after Detox/ST Res

Timely transition to the next level of care following discharge from detox or short-term residential is critical for sustaining treatment momentum and reducing the risk of relapse, overdose, or dropout during a vulnerable period in early recovery.

Metrics such as the percent of clients admitted within 7 days and the average number of days between discharge and admission offer complementary ways to assess how effectively the system supports seamless, coordinated care.

ST Res Discharge Reason

Discharges incorrectly coded as "completed treatment" instead of "completed program/transferred to another provider" can skew state-level analysis of outcomes for the region. Accurate coding is essential for understanding completion rates, monitoring service transitions, and ensuring individuals receive the full continuum of recommended care.

↑ % of discharged detox and ST Res clients successfully transitioned to the next LOC w/in 7 days (pg 16)

★ *The % of clients discharged from ST Res and successfully admitted to the next LOC within 7 days decreased slightly between Q2 and Q3 to 63%. However, this is a higher rate of admission within 7 days compared to previous fiscal years.*

↓ average # days between discharge and admission to next level of care for ST Residential (pg 16)

⌚ *In Q3, the time between discharge and readmission averaged a little more than half a day for those who were readmitted within 7 days. Among the clients discharged from ST Res who were readmitted between 8 & 30 days, the avg time to readmission was 19.4 days.*

↓ discharges from detox and ST Res levels of care with discharge reason as 'completed treatment' (pg 17)

★ *In Q3 of FY26, incorrect reporting of discharges from ST Res coded as "completed treatment" **continued to improve** to a low of 11%. Detox discharge reported as "completed treatment" also **improved** to a low of 11% in Q3.*

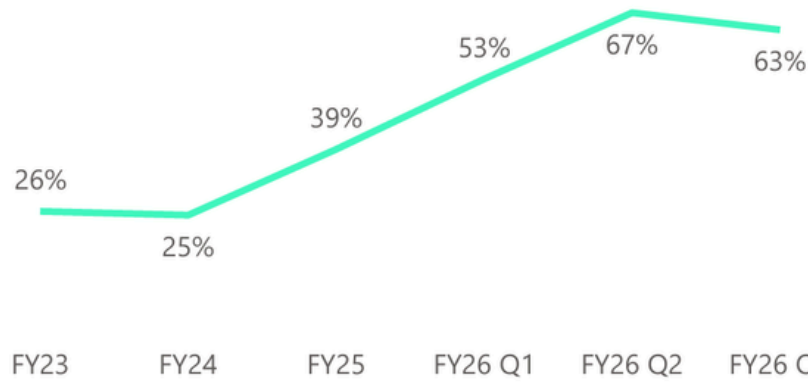
CONTINUITY OF CARE

Timely Transition after Detox/ST Res

Metrics

- ↑ % of discharged ST Res clients successfully transitioned to the next LOC w/in 7 days.
- ↓ average # days between discharge and admission to next level of care for ST Residential

Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days, Region



Data Highlights:

Following detox (24-hour), clients typically transition to ST Res at the same service provider. Following discharge from ST Res, it is ideal for clients to engage in services at a lower level of care as soon as possible, with a goal of no more than 7 days between discharge and the subsequent admission.

Rates of readmission within 7 days across the region decreased slightly between Q2 and Q3 to 63%.

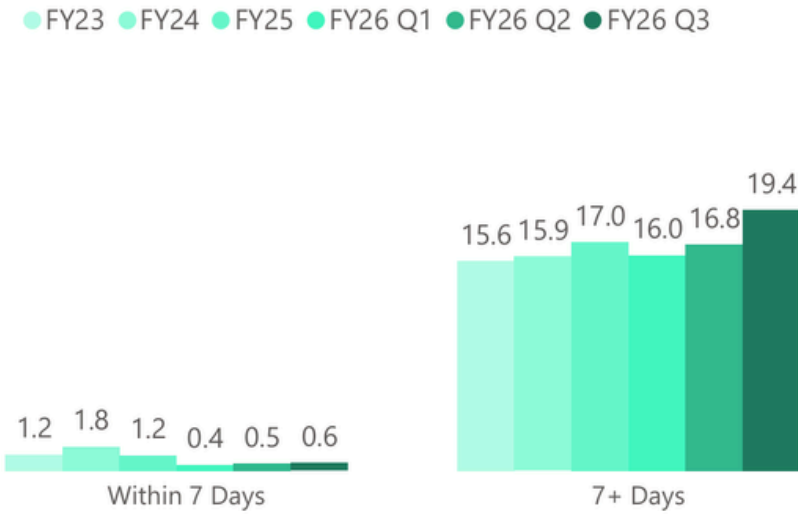
- Among discharges with a corresponding admission to the next level of care within 7 days, the average time between discharge and readmission was a little more than half a day.
- Among discharges admitted to the next level of care between 8 and 30 days post-discharge, the average time to readmission was 19.4 days, which was the highest length of days since FY 23.

Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days by CMHSP

	FY23	FY24	FY25	FY26 Q1	FY26 Q2	FY26 Q3
Allegan	18%	24%	14%	0%	33% (1)	100% (2)
Muskegon	17%	8%	40%	62%	67%	63%
Kent	25%	17%	0%	100%(1)		
Ottawa	30%	39%	59%	63%	80%	40% (2)
WM (Lake, Mason, Oceana)	32%	32%	42%	80% (4)	64%	70% (7)

The count is provided in parentheses for rates calculated for a count of 10 or less episodes.

Average # Days between Discharge from ST Res and Admission to Next Level of Care



CONTINUITY OF CARE

ST Res Discharge Reason

Metric

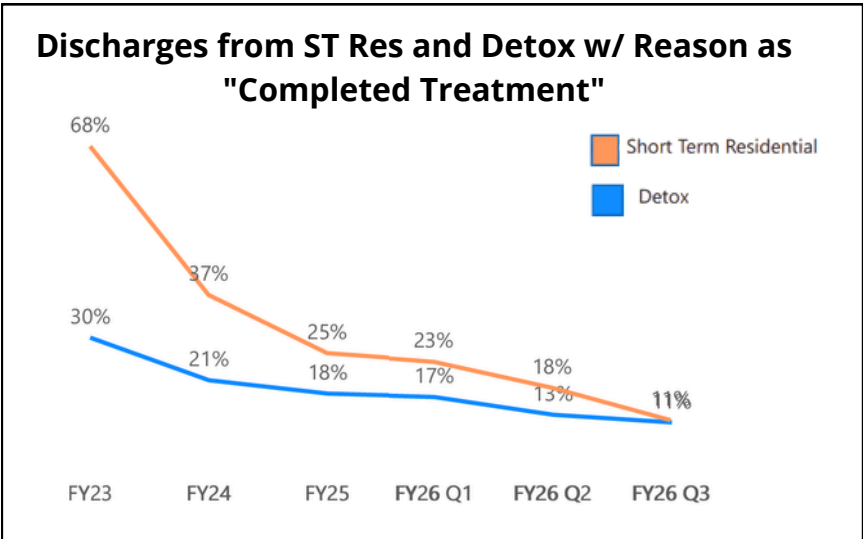
- Decrease discharges from detox and/or residential levels of care with discharge reason identified as 'completed treatment'

Data Highlights:

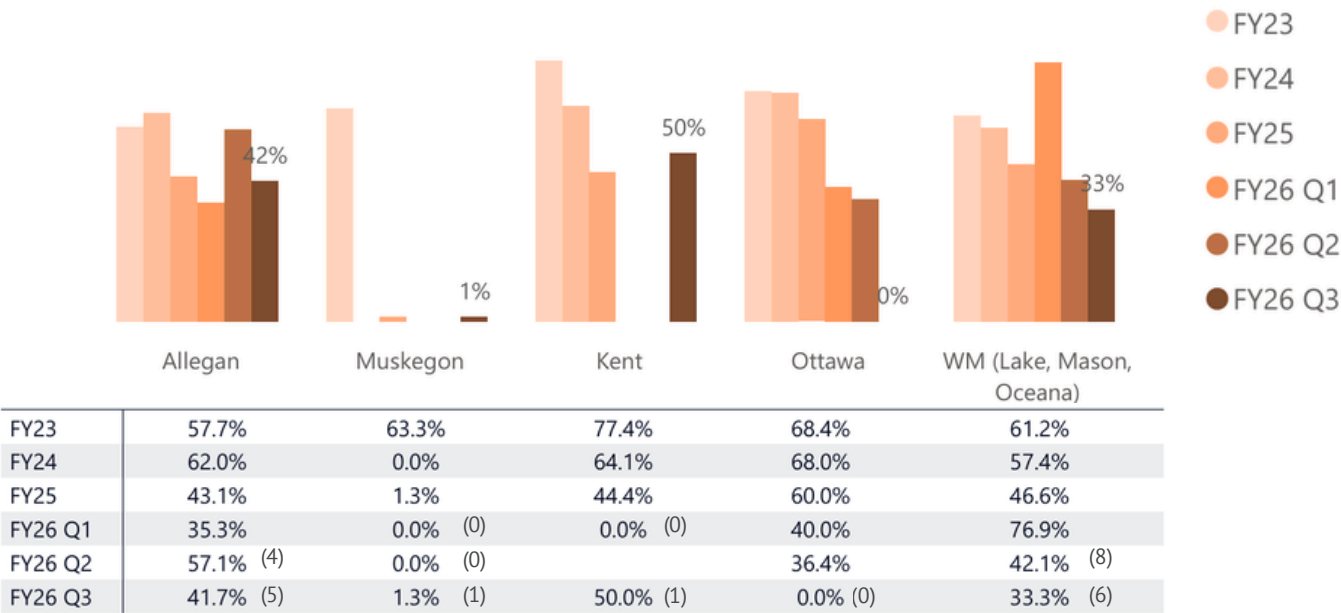
The percentage of discharges from ST Res incorrectly reported as 'completed treatment' continues to improve and reached a low of 11% in Q3 of FY26.

Rates for discharges from detox reported as having "completed treatment" have also improved to 11% during Q3 of FY26.

In the table below, the count has been provided for recent quarters. Because of the small number of cases, use caution when interpreting trends.



Percent of Discharges from ST Res w/ Reason as "Completed Treatment" by CMHSP



Discharge reason for detox and ST Res should never be "Completed Treatment"

Performance Bonus Incentive Program

The Michigan Department of Health and Human Services (MDHHS) sets aside a small portion of funding each year to reward PIHPs for strong performance. To earn this bonus, PIHPs must meet key goals like making sure people get timely follow-ups after emergency visits, improving access to care, addressing racial disparities, and helping people with social needs like housing and employment.

The better the region does on these measures, the more of the bonus they earn.
PBIP metrics relevant to SUD treatment are summarized below.



Metrics

Employment/Education

The state monitors whether a higher % of clients are employed or enrolled in school at discharge compared to admission as an indicator of recovery progress.

↑ % of clients who report they are employed or in school at discharge, compared to admission. (pg 19)



During Q3 Kent, Muskegon and West Michigan achieved an improvement between admission and discharge with a regional relative improvement of 25% between admission and discharge (from 16% at admission to 20% at discharge).

Living Arrangements

The state monitors whether a higher % of clients report a stable living condition at discharge compared to admission as an indicator of recovery progress.

↑ % of clients who report a stable living condition at discharge, compared to admission. (pg 20)



During Q3, Muskegon, Kent, and Ottawa achieved small improvement between admission and discharge. Regionally, rates increased slightly from 48% at admission to 50% at discharge.

Follow Up After Emergency Dept. Visit

The state monitors follow-up after ED Visits for SUD disorder or overdose for Medicaid beneficiaries as a measure of coordination across care settings.

Decrease disparities for the % of emergency department (ED) visits for SUD that receive follow up within 30 days. (FUA 30) (pg 21)

Regionally, rates of follow up increased to a high of 44.2% in CY2025 and every race/ethnicity showed improvement. The disparity was not eliminated and rates for white beneficiaries continued to exceed all other groups.

Initiation & Engagement in Treatment

The state monitors these metrics to assess initiation and engagement in SUD services for Medicaid beneficiaries following SUD diagnosis at a BH provider or hospital.

Initiation: The % of new treatment episodes who initiate treatment within 14 calendar days of the diagnosis. (pg 22)



Overall, initiation rates remained relatively stable with a slight increase between 2024 and 2025 to 39.5% with 3-of-5 CMHSPs seeing an increase.

Engagement: % of new treatment episodes with 2+ services within 34 calendar days of initiation visit. (pg 23)



Overall, engagement rates have remained relatively stable with a small increase between 2024 and 2025 to a high of 13.8% for the region.

Performance Bonus Incentive

Employment/Education

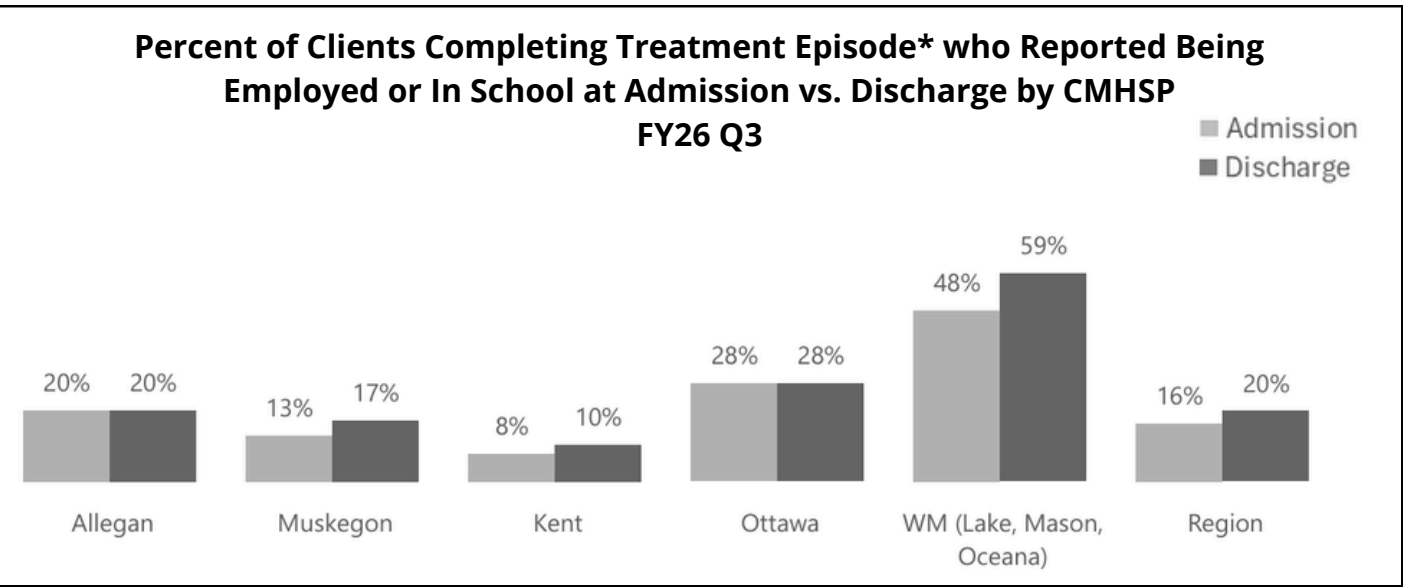
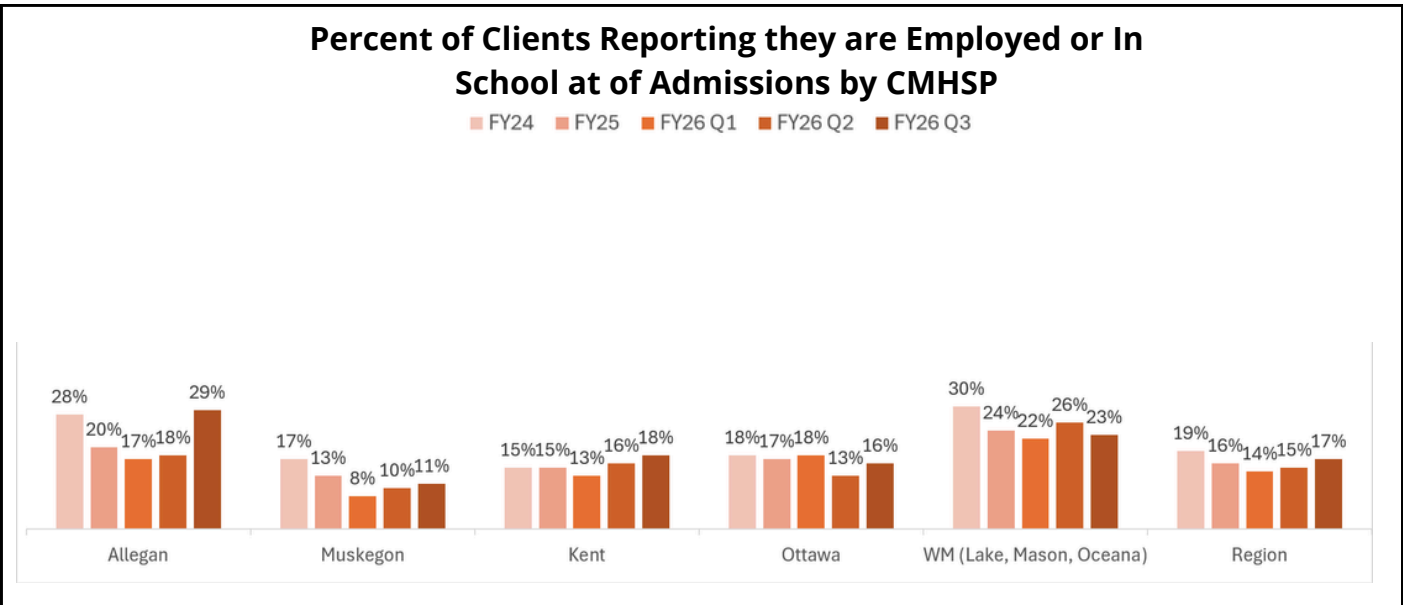
Metric

- ↑ % of clients employed or in school between admission & discharge.

Data Highlights:

Among clients who were admitted to services during Q3, the proportion of admissions where clients indicated they were either employed or attending school ranged from a low of 11% in Muskegon and a high of 29% in Allegan County. Overall, the % of clients reporting they are employed or in school at time of admission are relatively stable compared to FY25 rates.

The graph to the right shows admission and discharge employment/education status for clients who were discharged during Q3 and their corresponding admissions. Muskegon, Kent, and WM reported increases between admission and discharge, resulting in a regional relative improvement of 25% (from 16% to 20%). Allegan and Ottawa had the same percentage of clients who reported being employed or in school at admission and discharge.



*Analysis includes clients who were in services for at least 6 weeks and were discharged as having completed treatment or transferring to another program.

Performance Bonus Incentive

Living Arrangements

Metric

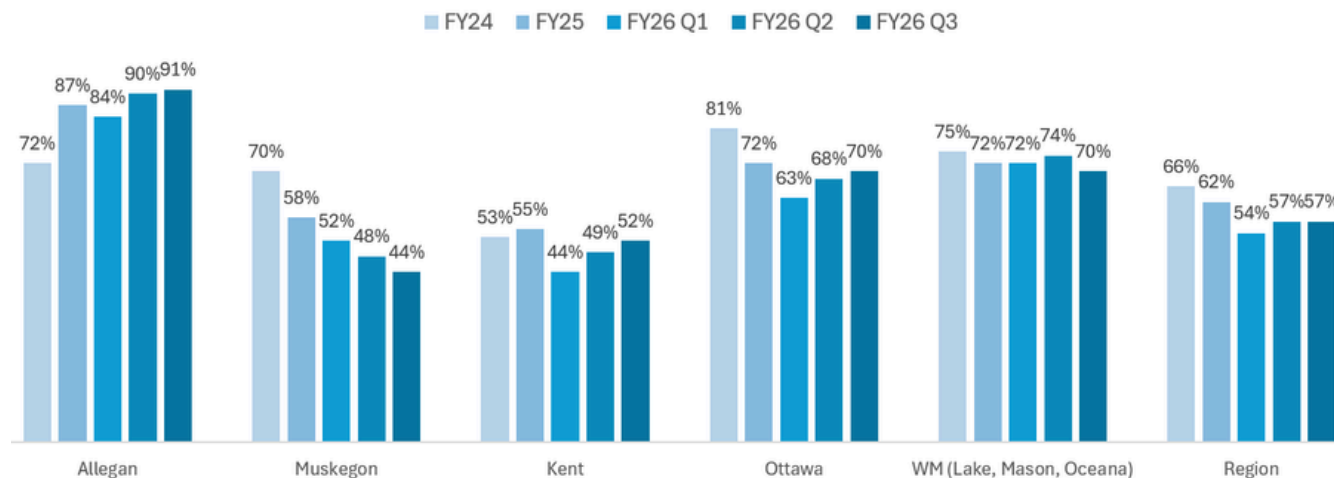
- ↑ % of clients with a stable living condition between admission & discharge.

Data Highlights:

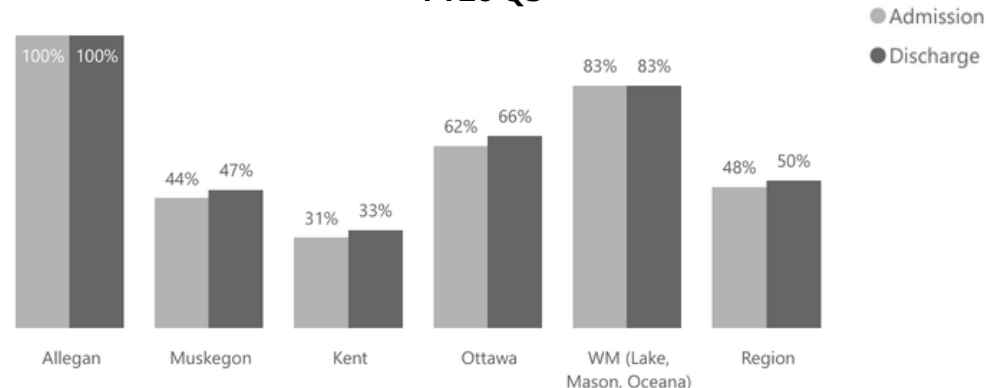
Among clients who were admitted to services during Q3, the proportion of admissions where clients indicated they had a stable living condition varied, with a low of 44% in Muskegon and a high of 91% in Allegan. Additionally, the percentage of clients reporting a stable living condition at the time of admission has improved in Allegan compared to FY25, while it has worsened in Kent, Muskegon, Ottawa, and WM Counties. **As a region, housing stability at admission has decreased since FY25.**

The graph to the right shows the percentage of clients discharged from treatment during Q3 who reported a stable living condition at admission compared to at discharge. In Q3, Muskegon, Kent, Ottawa, and the region overall experienced a slight increase in clients who reported a stable living condition at admission vs discharge.

Percent of Admissions for Clients Reporting a Stable Living Condition* by CMHSP



Percent of Clients Reporting a Stable Living Condition* at Admission vs. Discharge for Completed Service Episode by CMHSP FY26 Q3**



*Stable Living is defined as Living Arrangement = Independent

**Analysis includes clients who were in services for at least 6 weeks and were discharged as having completed treatment or transferring to another program.

Performance Bonus Incentive

Follow Up After ED Visit (FUA)

Metric

Decrease disparities for the % of emergency department (ED) visits for SUD that receive follow up within 30 days. (FUA 30)

Source: CC360 KPI Summary Dashboard

This PBIP measure tracks the percentage of ED Visits for Medicaid Beneficiaries with an SUD diagnosis recorded that received an SUD service (i.e. medication treatment or visit) within 30 days of the ED Visit w/ SUD diagnosis.

The state is incentivizing a reduction in the disparity between the index population (white beneficiaries) compared to minority groups. To do this, the state monitors the disparity between white beneficiaries and each minority group with a sufficient sample size.

Note: Data feeds are not available to support local identification of individuals with an ED Visit for SUD to prompt follow-up.

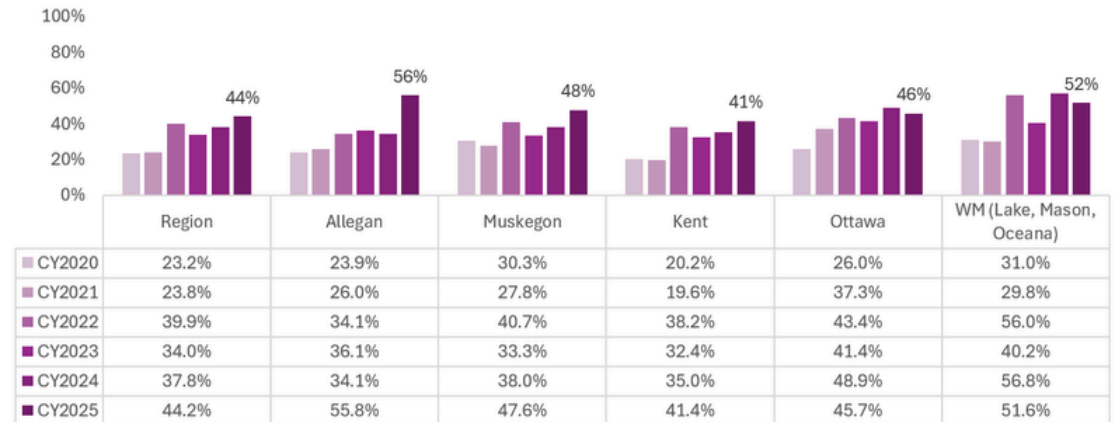
Data Highlights:

Overall, follow-up rates improved between CY24 and CY25, with 3 of 5 CMHSPs seeing an overall increase in follow-up within 30 days of an ED visit. However, disparities by race and ethnicity persisted.

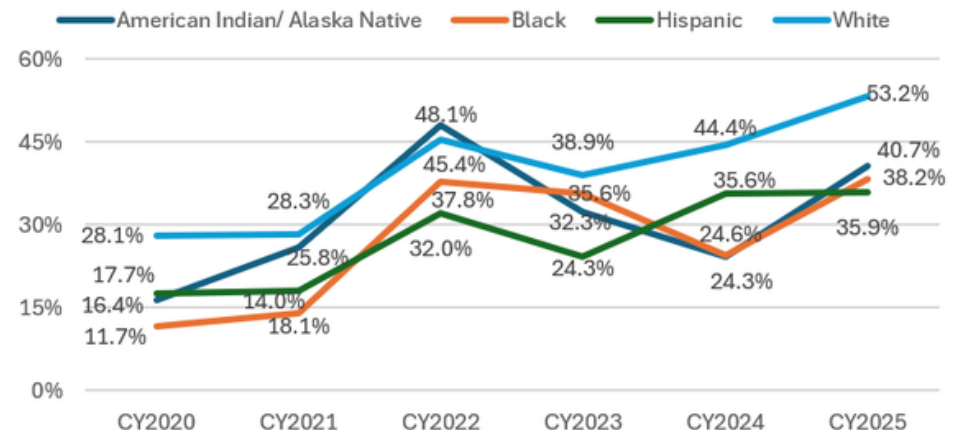
Between CY24 and CY25:

- White beneficiaries had the highest rates, increasing from 44.4% in CY24 to 53.2% in CY25.
- American Indian/Alaska Native beneficiaries had the largest improvement, increasing from 24.3% to 40.7% (+16.4 percentage points), narrowing the gap with White beneficiaries to 12.5 points in CY25.
- Black beneficiaries improved from 24.6% to 35.9% (+11.3 points), but remained 17.3 points below White beneficiaries in CY25.
- Hispanic beneficiaries increased slightly from 35.6% to 35.9% (+0.3 points) and were also 17.3 points below White beneficiaries in CY25.

Percent of ED Visits for AOD by Medicaid Beneficiaries that have a follow up service within 30 days of the ED visit (FUA 30)



Percent of ED Visits for AOD by Medicaid Beneficiaries that have a follow up service within 30 days of the ED visit (FUA 30)



Data excluded for Asian and Native Hawaiian/Pacific Islander due to sample sizes of <30 in CY2024.

Performance Bonus Incentive

Initiation (IET 14)

Metrics

- Initiation: The % of new treatment episodes who initiate treatment within 14 calendar days of the diagnosis. (IET 14)

Source: CC360 KPI Summary Dashboard

This PBIP initiation measure tracks the percentage of Medicaid beneficiaries ages 18-64 who received SUD diagnosis (at a behavioral health provider, or at a hospital) and whether they received an SUD service (medication treatment or visit) within 2 weeks of the diagnosis event.

The state is incentivizing overall improvement as well as reduction of disparity between the index population (white beneficiaries) compared to minority groups with a sufficient sample size.

Note: The state benchmark for LRE's overall rate for CY24 was 40%; the CY25 benchmark is currently being re-evaluated.

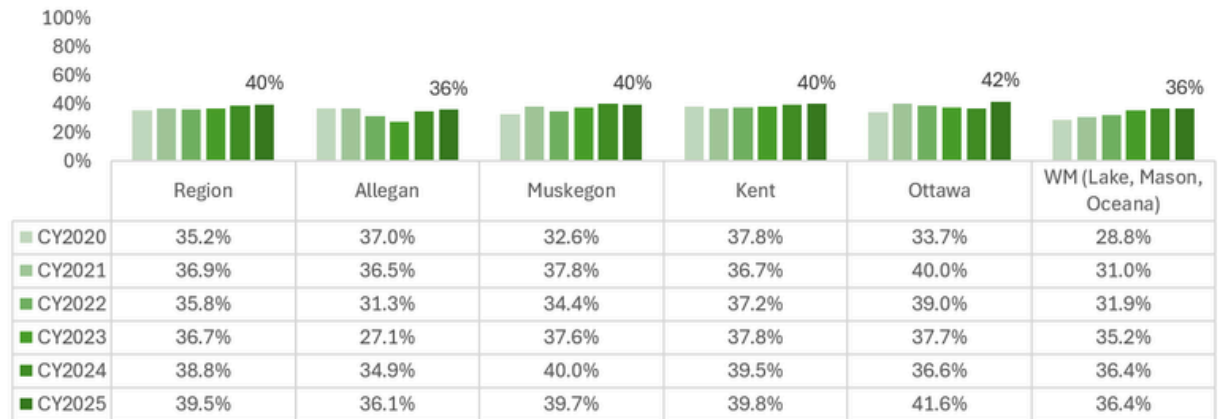
Data Highlights:

Overall, initiation rates improved slightly between CY24 and CY25, with 3 of 5 CMHSPs seeing an increase. Differences by race and ethnicity persisted.

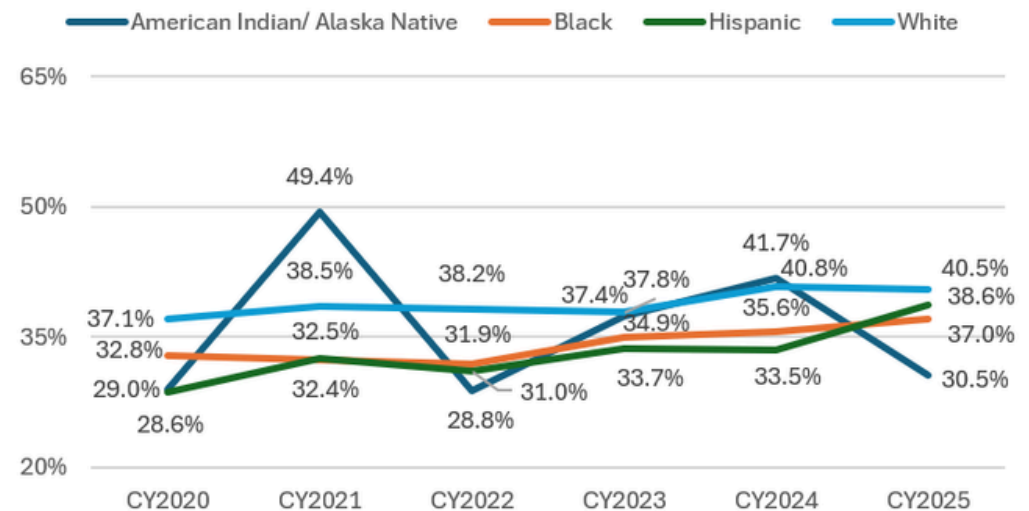
Between CY24 and CY25:

- White beneficiaries had the highest CY25 rate at 40.5%, a slight decrease from 40.8%.
- Hispanic beneficiaries increased from 33.5% to 38.6% (+5.1 percentage points), narrowing the gap with White beneficiaries to 1.9 points.
- Black beneficiaries increased from 35.6% to 37.0% (+1.4 points), narrowing the gap with White beneficiaries to 3.5 points.
- American Indian/Alaska Native beneficiaries decreased from 41.7% to 30.5% (-11.2 points), resulting in the largest CY25 disparity at 10.0 points below White beneficiaries.

Percent of New Treatment Episodes for Adult Medicaid Beneficiaries who Initiate Treatment Within 14 Calendar Days of Diagnosis - By CMHSP



% New Treatment Episodes for Adult Medicaid Beneficiaries who Initiate Treatment W/in 14 Days of Diagnosis



Data excluded for Asian and Native Hawaiian/Pacific Islander due to sample sizes of <30 in CY24

Performance Bonus Incentive

Engagement (IET)

This PBIP engagement measure tracks the percentage of Medicaid beneficiaries ages 18-64 who received SUD diagnosis (at a behavioral health provider or hospital) who received 2+ SUD services (medication treatment or visit) within 34 days of the initiation event.

The state is incentivizing overall improvement as well as a reduction in disparity between the index population (white beneficiaries) compared to minority groups with a sufficient sample size.

Note: The state benchmark for LRE's in CY24 was 14%; the CY25 benchmark is currently being re-evaluated.

Data Highlights:

Overall, engagement rates have remained relatively stable with a small increase between CY24 and CY25 to a regional high of 13.8%.

Between CY24 and CY25:

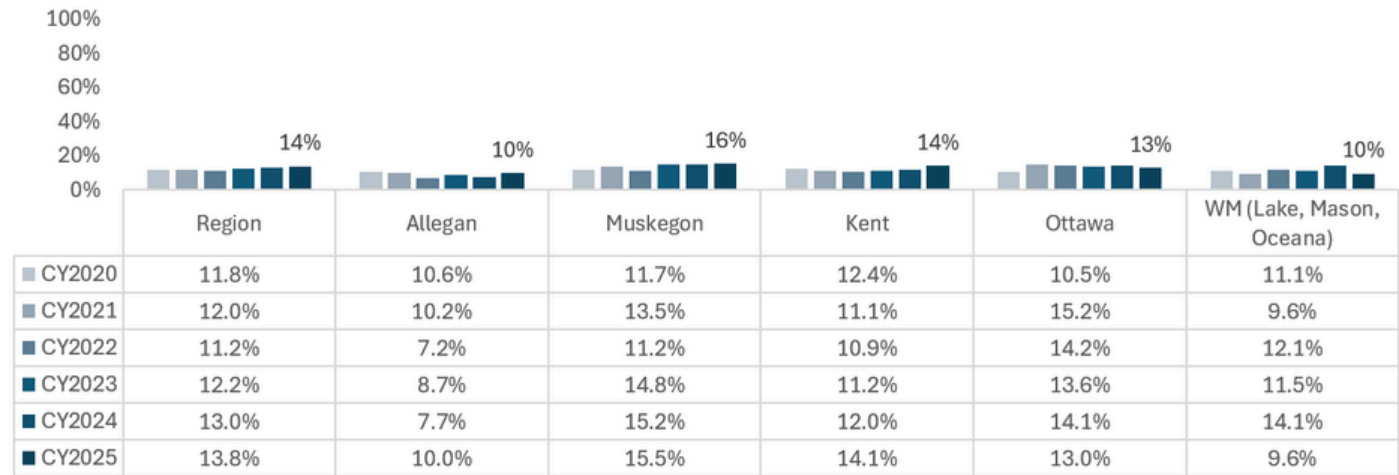
- White beneficiaries had the highest CY25 engagement rate at 14.7%, unchanged from CY24.
- Black beneficiaries increased from 9.7% to 12.5% (+2.8 percentage points), narrowing the gap with White beneficiaries from 5.0 to 2.2 points.
- Hispanic beneficiaries increased from 9.6% to 12.1% (+2.5 points), narrowing the gap with White beneficiaries from 5.1 to 2.6 points.
- American Indian/Alaska Native beneficiaries decreased substantially from 16.5% to 6.3% (-10.2 points), resulting in the largest CY25 disparity at 8.4 points below White beneficiaries.

Metrics

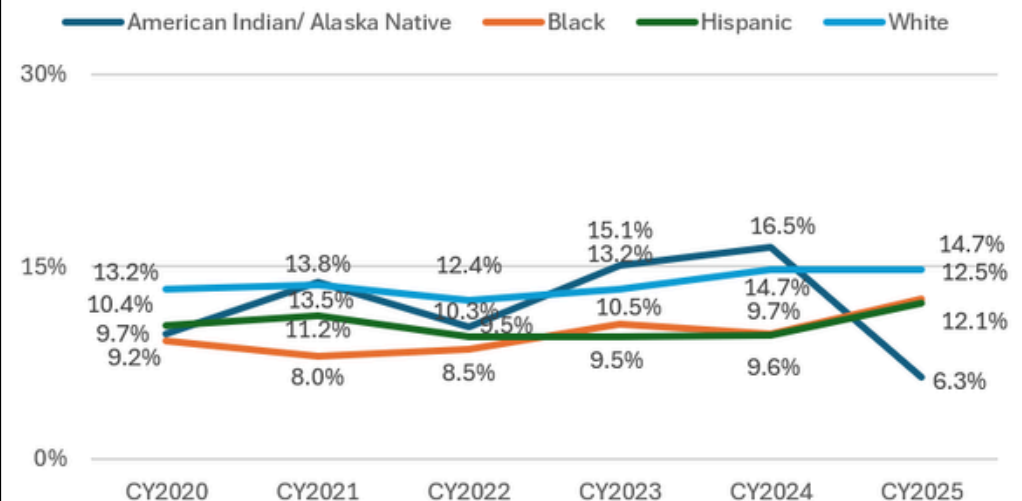
- Engagement: The % of new treatment episodes with 2+ services within 34 calendar days of the initiation visit. (IET 34)

Source: CC360 KPI Summary Dashboard Title

Percent of New Treatment Episodes for Adult Medicaid Beneficiaries with 2+ Services Within 34 Calendar Days of Initiation Visit



Percent of New Treatment Episodes for Adult Medicaid Beneficiaries with 2+ Services Within 34 Calendar Days of Initiation Visit



Data excluded for Asian and Native Hawaiian/Pacific Islander due to sample sizes of <30 in CY24

Drug Trends

This section provides an overview of trends in primary drug of choice at admission and methamphetamine-involved admissions across the region. These metrics are monitored to help identify shifts in substance use patterns over time, which can inform planning, resource allocation, and community awareness efforts. Unlike other indicators in this report, these data points are not currently targeted for performance improvement but are reviewed regularly to support system-level understanding and readiness.



Primary Drug at Admission *pgs 25-27*

At admission, clients can report up to three primary substances. We track the percentage of admissions for each substance to monitor trends and identify which substances most frequently drive treatment entry in the region.

Methamphetamine-Involved Admissions *pg 28*

Methamphetamine-involved admissions are monitored separately due to underreporting as a primary substance. Clients may list other drugs to secure detox services, leading to meth being underrepresented in data. Tracking overall involvement offers a clearer understanding of meth use in the region.

Opioid & Methamphetamine-Involved Admissions *pg 29*

We monitor admissions involving both opioids and methamphetamine due to unique treatment challenges and risks of co-use. These substances are often used in alternating or combined patterns, which can complicate treatment and increase the risk of relapse or overdose.

CMHSP Drug Trends

Allegan County: Methamphetamine surpassed alcohol as the primary drug for treatment admission in Q3 at 41% of admissions. Alcohol admissions remained high (33.3%).

Muskegon County: Alcohol remains the most frequently reported primary drug in Muskegon County, while cocaine, heroin, and methamphetamine admissions continue to exceed region-wide rates.

Kent County: Alcohol remains the leading primary drug (48%), followed by cocaine (19.4%) which is higher than the regional rate.

Ottawa County: Alcohol remains the leading primary drug (60%), followed by methamphetamine (15%). MA-opioid co-use increased slightly in Q3 to 8.3%.

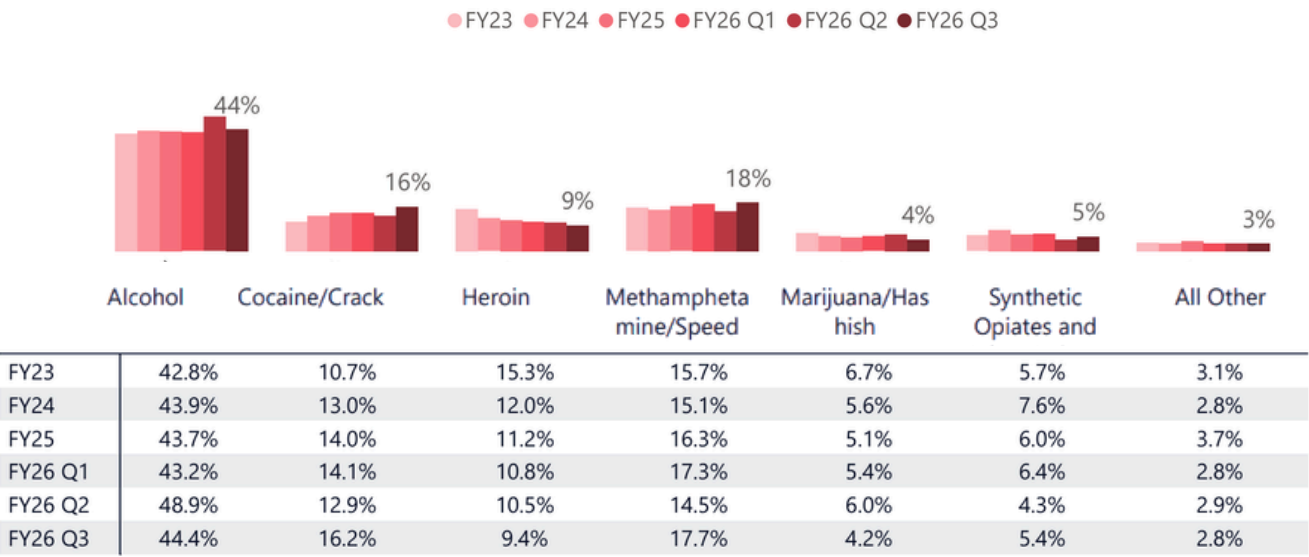
West MI: Alcohol remains the most frequently reported primary drug for West Michigan counties, while methamphetamine admissions exceed the regional rate. The percentage of admissions involving both opioid and meth decreased during Q3 to 25%, while increasing to 41% of admissions for both Lake and Oceana Counties.

Drug Trends: Primary Drug at Admission

LRE Region

Data Highlights: Alcohol remains the most frequently reported primary drug at admission in the LRE region. Rates of admission for alcohol, cocaine, and methamphetamine are slightly higher than FY25 rates. Admissions for heroin, marijuana, and opiates decreased slightly since FY25 rates.

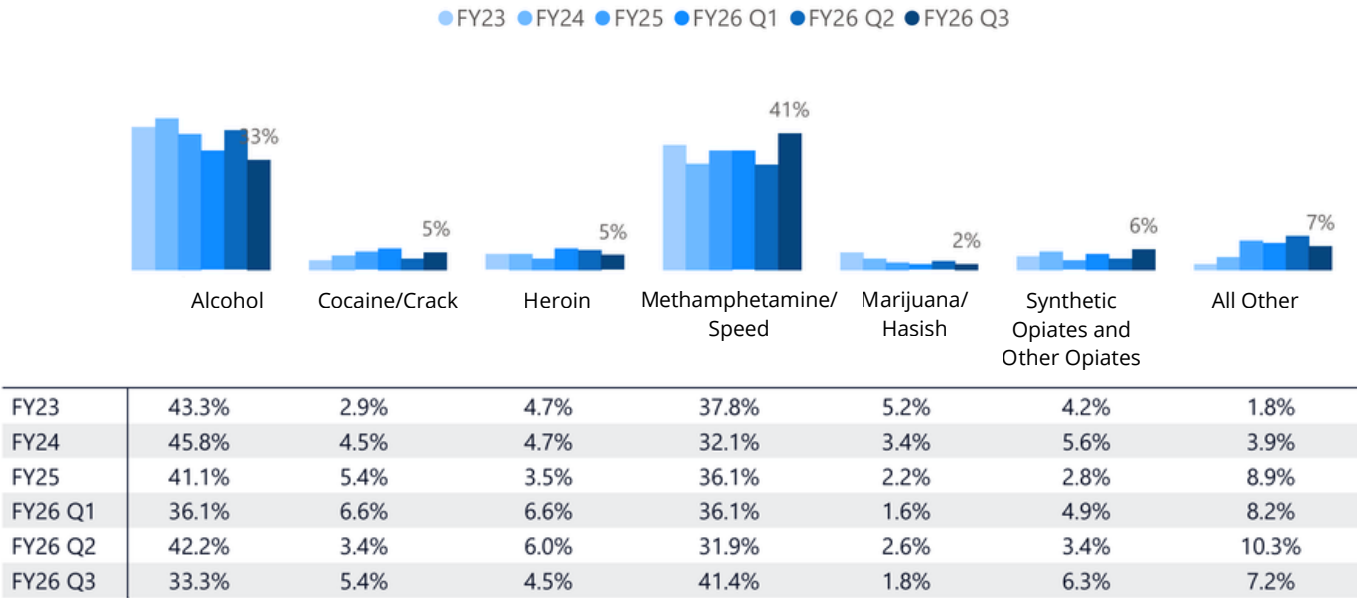
Percent of Treatment Admissions by Primary Drug, LRE Region



Allegan County

Data Highlights: In Allegan County, methamphetamine treatment admissions increased and became the most frequently reported primary drug of choice followed by alcohol. Methamphetamine treatment admissions continue to be substantially higher than region-wide (41.4% vs. 17.7% in Q3). Admissions for opiates also increased in Q3.

Percent of Treatment Admissions by Primary Drug, Allegan County

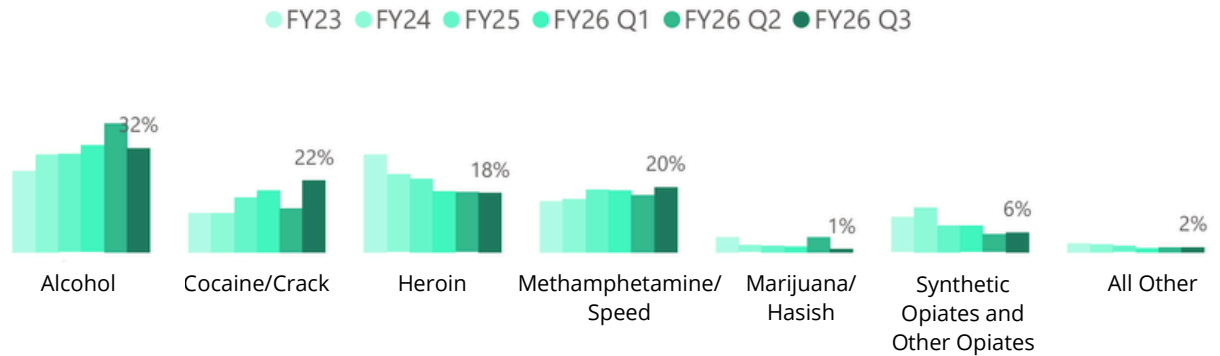


Drug Trends: Primary Drug at Admission, continued...

Muskegon County

Data Highlights: Alcohol continues to be the most frequently reported primary drug in Muskegon County, followed by cocaine, methamphetamine and heroin. Admissions for cocaine (21.9% vs 16.2% in Q3), heroin (18.1% vs 9.4% in Q3) and methamphetamine (19.8% vs 17.7% in Q2) remain higher than region wide.

Muskegon County - Percent of Admissions by Primary Drug

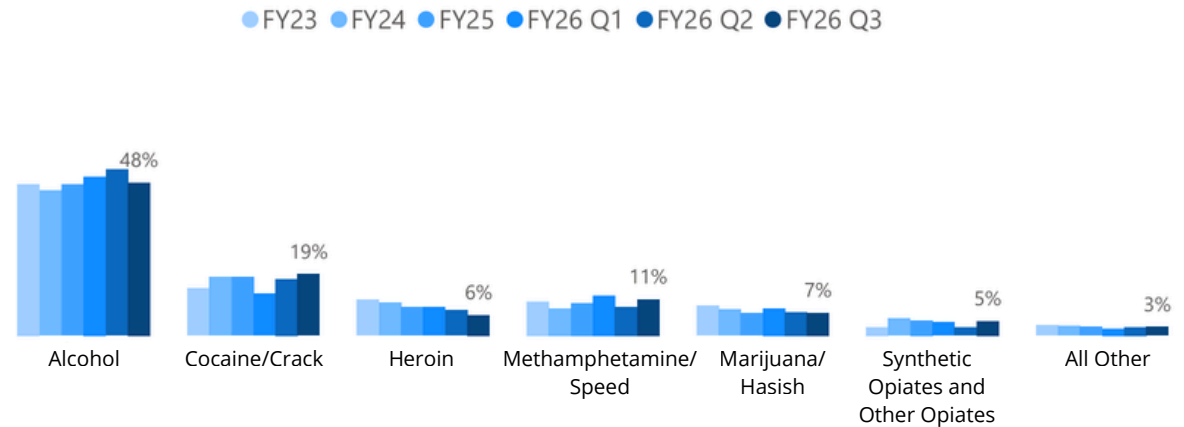


FY23	24.9%	12.0%	29.7%	15.5%	4.5%	10.7%	2.7%
FY24	29.7%	12.0%	23.7%	16.3%	2.1%	13.7%	2.5%
FY25	29.9%	16.6%	22.4%	19.0%	2.0%	8.1%	1.9%
FY26 Q1	32.5%	18.9%	18.6%	18.9%	1.9%	8.0%	1.2%
FY26 Q2	39.3%	13.3%	18.3%	17.5%	4.7%	5.4%	1.5%
FY26 Q3	31.7%	21.9%	18.1%	19.8%	1.0%	6.0%	1.5%

Kent County

Data Highlights: In Kent County, admissions for alcohol continue to surpass other substances with 48% of admissions, followed by cocaine, which is higher than the region wide (19.4% vs 16.2% in Q3). All other treatment admissions remained stable.

Kent County - Percent of Admissions by Primary Drug



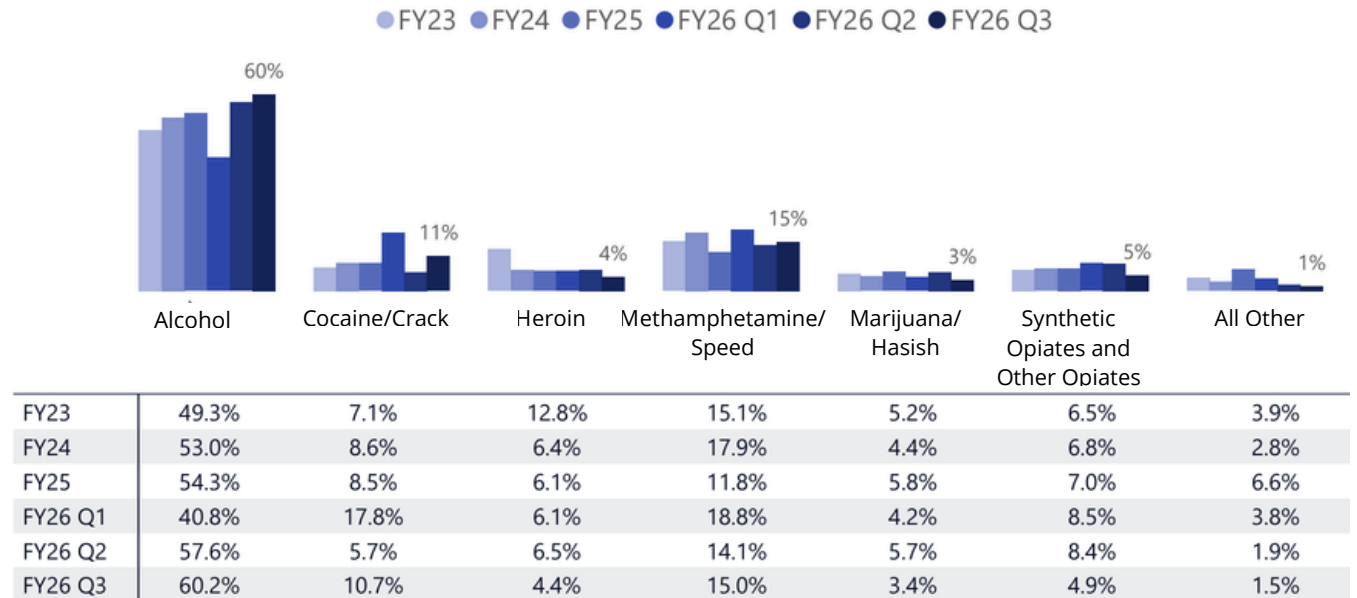
FY23	47.8%	14.9%	11.3%	10.7%	9.4%	2.6%	3.2%
FY24	45.8%	18.4%	10.4%	8.6%	8.3%	5.5%	3.0%
FY25	47.7%	18.5%	9.0%	10.2%	7.0%	4.8%	2.7%
FY26 Q1	50.1%	13.2%	8.9%	12.6%	8.7%	4.3%	2.2%
FY26 Q2	52.4%	17.9%	8.0%	9.1%	7.4%	2.5%	2.7%
FY26 Q3	48.2%	19.4%	6.5%	11.4%	7.2%	4.5%	2.8%

Drug Trends: Primary Drug at Admission, conti...

Ottawa County

Data Highlights: In Ottawa County, alcohol remained the most frequently reported primary substance, accounting for 60.2% of treatment admissions in Q3. Methamphetamine accounted for 15.0% of admissions, while cocaine accounted for 10.7%. Cocaine admissions have fluctuated throughout FY26 but increased compared with FY25 rates.

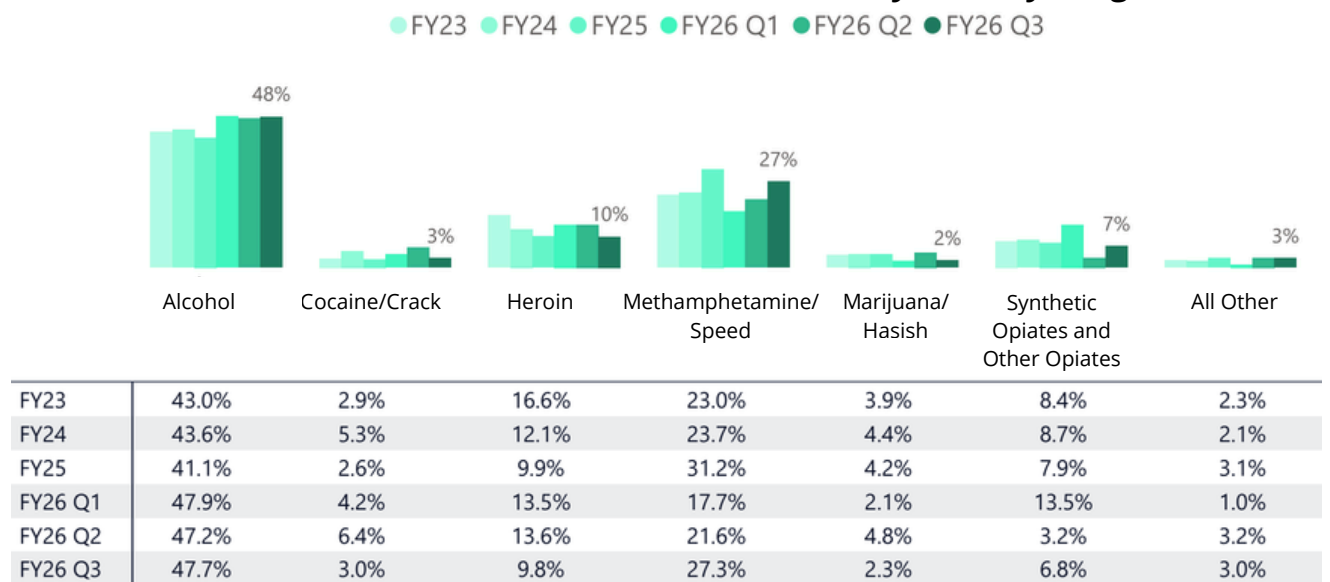
Ottawa County - Percent of Admissions by Primary Drug



West Michigan Counties

Data Highlights: In West MI counties, alcohol remains the most frequently reported primary drug representing 47.7% of admissions in Q3, followed by methamphetamine at 27.3% which is higher than the regional rate of 17.7%. WM saw an increase of treatment admissions for synthetic opiates and other opiates between Q2 and Q3 (3.2% → 6.8%).

West MI - Percent of Admissions by Primary Drug



Drug Trends: Methamphetamine-Involved Admissions

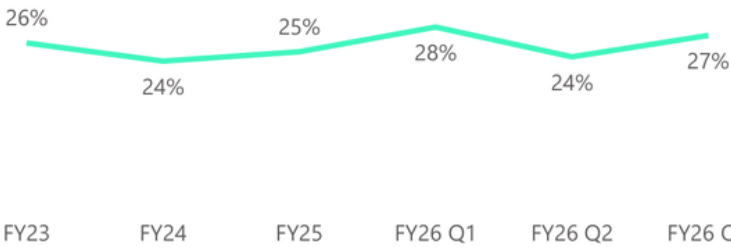
Methamphetamine-involved admissions are monitored separately due to underreporting as a primary substance. Clients may list other drugs to secure detox services, leading to meth being underrepresented in data. Tracking overall involvement offers a clearer understanding of MA use in the region.

Data Highlights:

In FY25, 25% of admissions were MA-involved which remained steady at 26.7% during Q3 of FY26.

During Q3, MA-involved admissions remain highest in Allegan (48.6%), Lake (40.7%) and Oceana (40.5%) counties. Mason County saw a large decrease in admissions that were MA involved between Q2 and Q3 (44.1% → 25%). Inversely, Oceana and Lake counties saw an increase in MA involved admissions between Q2 and Q3.

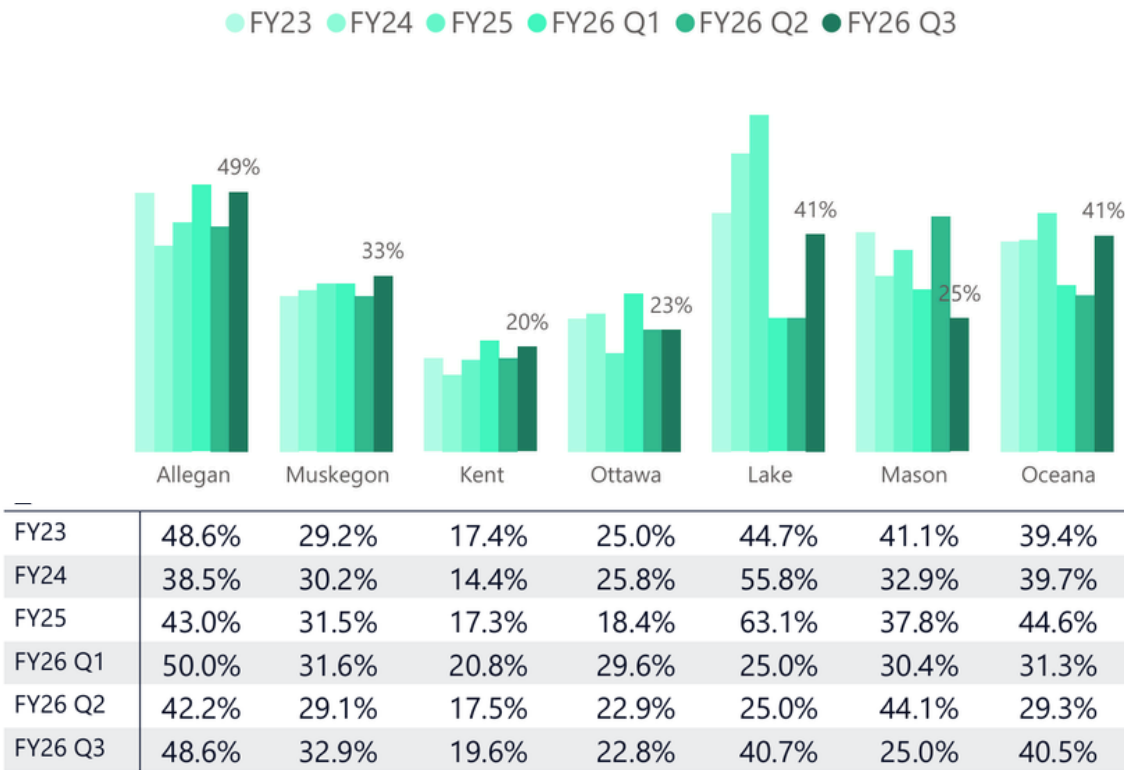
Percent of Admissions that were Methamphetamine (MA)-Involved, LRE Region



"Involved"

An admission with the substance reported as the primary, secondary, or tertiary drug of choice.

Percent of Admissions That Were MA-Involved by County



Drug Trends: Opioid & Methamphetamine-Involved

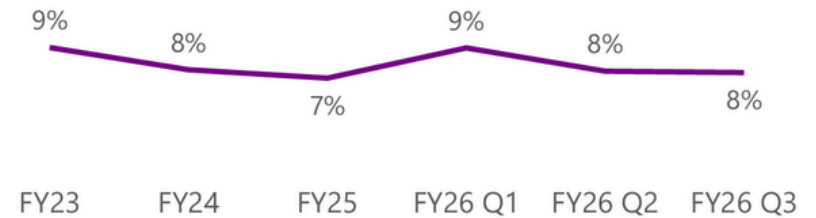
Admissions involving both opioids and methamphetamine are monitored due to the unique clinical challenges they pose. Research indicates that individuals using both substances have lower treatment retention and completion rates compared to those using opioids alone. In addition, the alternating or combined use of these drugs complicates withdrawal management and raises overdose risks.

Data Highlights:

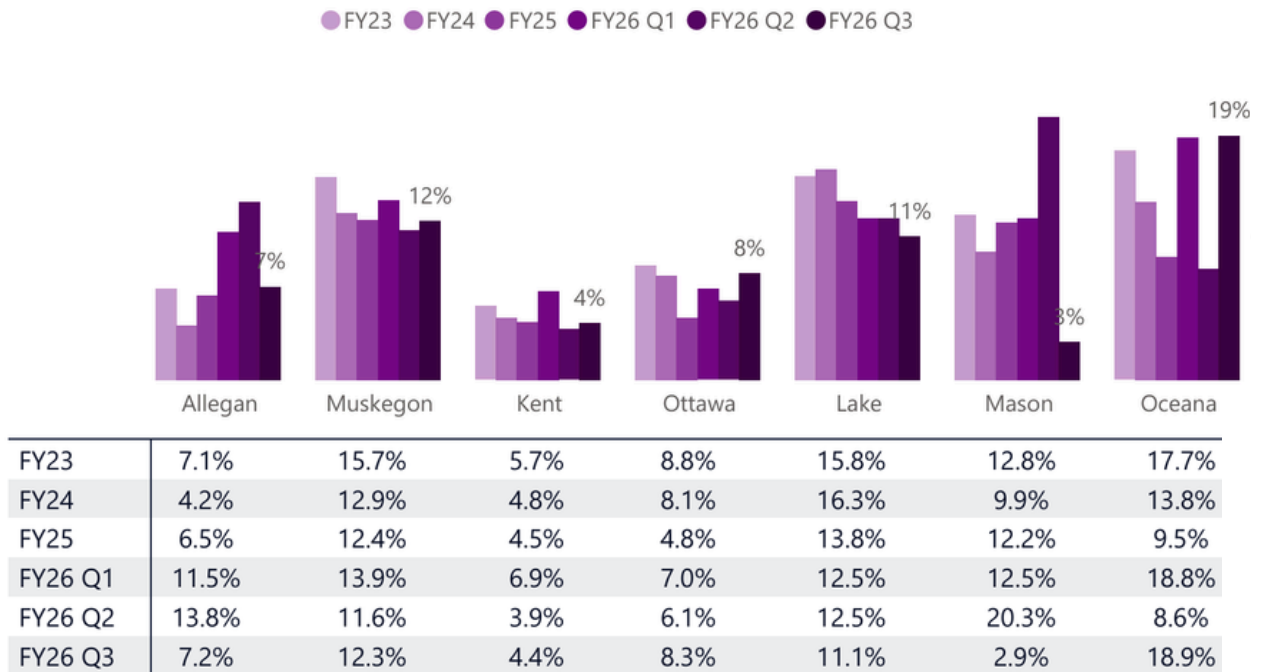
Admissions involving both an opioid and methamphetamine have remained relatively stable since FY23, with a rate of 8% in Q3.

Admissions involving both an opioid and methamphetamine increased substantially in Q3 for Oceana County (18.9%). Rates of admissions for both opioid and MA in Mason County spiked during Q2, and then decreased to 2.9% which is the low since FY23. Rates remain relatively stable in Muskegon, Kent, Ottawa, and Lake counties.

Percent of Admissions that Involved Both Methamphetamine (MA) and an Opioid, LRE Region



Percent of Admissions that Involved Both an Opioid & MA by County



Appendix Data Parameters

The following provides data parameters used for analysis for data referenced throughout this report. For all data that includes County, County = If no data provided in BHTEDS - falls under 'Out of Region'

- Pg. 6 Average Time to Service (days) for Medication Assisted Treatment (MAT)**
- BHTEDS Fields Used: Service Start Date, County of Residence, Time to Treatment, State Provider Identifier, Type of Treatment Service Setting and Medication-assisted Opioid Therapy
 - Time to Service = Days between request for service and date of first service received.
 - MAT is based on Admission Opioid Therapy = Yes and LOC = Outpatient
 - Excludes those Admissions where Time to Treatment was not provided
- Pg. 7 Average Time to Services for Clients with IVDU by Service Category**
- BHTEDS Fields Used: Service Start Date, County of Residence, Time to Treatment, Type of Treatment Service Setting, Primary and Secondary and Tertiary Route of Admission, Substance Use Diagnosis
 - Time to Service = Days between request for service and date of first service received.
 - IVDU = Primary, Secondary or Tertiary Route of Admission = Injection
 - Excludes those Admissions where Time to Treatment was not provided.
- Pg. 10 Percent of Admissions by Legal Status at Admission**
- BHTEDS Fields Used: Service Start Date, County of Residence, Corrections Related Status
- Pg. 12 Percent of Clients with Co-Occurring Disorders that Received Integrated Treatment**
- BHTEDS Fields Used: Service Update/End Date, County of Residence, Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment
 - Integrated services identified in discharge record for clients reports as "Client with co-occurring substance use and mental health problems is being treated with an integrated treatment plan by an integrated team."
 - Only includes those episodes with a Discharge Date
- Pg. 13 Percent of Treatment Episodes with One Encounter**
- Data Source: BHTEDS and LRE Encounters
 - Data only includes those episodes with a Discharge Date
 - Data only includes those with a Service in the Encounter Database
 - Excluded Services Codes: H0020 (Methadone Dosing) and S9976 (Room and Board)
 - Excludes episodes where the only service code is H0001 and has a Discharge Reason of Completed Treatment, Death or Transferring to Another Program
 - Program or facility/Completed Level of Care
 - MAT is based on BHTEDS Admission Opioid Therapy= Yes and LOC = Outpatient

Pgs. 10-11	Percent of Treatment Episodes with One Encounter by Level of Care • Data Source: BHTEDS and LRE Encounters • Data only includes those episodes with a Discharge Date • Data only includes those with a Service in the Encounter Database • Excluded Services Codes: H0020 (Methadone Dosing) and S9976 (Room and Board) • Excludes episodes where the only service code is H0001 and has a Discharge Reason of Completed Treatment, Death or Transferring to Another Program or facility/Completed Level of Care • MAT is based on BHTEDS Admission Opioid Therapy = Yes and LOC = Outpatient
Pg. 16	Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days • BHTEDS Fields Used: Service Start Date, Service Update/End Date, County of Residence, and Type of Treatment Service Setting • If Admit Setting did not equal Discharge Setting, assumption made that readmit days is 0. • Only includes those episodes with a Discharge Date • Excludes discharges from ST Res that were admitted to 24-hour detox.
Pg. 16	Average # Days between Discharge from ST Res and Admission to Next Level of Care • BHTEDS Fields Used: Service Start Date, Service Update/End Date, County of Residence, and Type of Treatment Service Setting • Only includes those episodes with a Discharge Date in the Reported FY • Only includes those episodes with a Readmit within 30 days of Discharge • Excludes those Readmits with a new Admission Date that is prior to the Discharge Date • If Admit Setting did not equal Discharge Setting, assumption made that readmit days is 0
Pg. 17	Discharges from Detox & ST Res w/ Reason as "Completed Treatment" • BHTEDS Fields Used: Service Update/End Date, County of Residence, Reason for Service Update/End and Type of Treatment Service Setting at Discharge • Detox Includes both Ambulatory - Detox and Detox 24-hr free-standing residential • Excludes those Discharges where Time to Treatment was not provided.
Pg. 19	Percent of Treatment Admissions reporting Employed or In-School • BHTEDS Fields Used: County of Residence, Employment Status, Detailed Not in the Competitive, Integrated Labor Force, and Service Start Date • Includes: Employment status identified as "Part-Time Competitive, Integrated Employment" or "Full-Time Competitive, Integrated Employment" and individuals identified as a "Student" in Detail for Not in Competitive, Integrated Labor Force

Pg. 20 Percent of Treatment Admissions reporting Stable Living Condition

- BHTEDS Fields Used: County of Residence, Living Arrangement, and Service Start Date
- Stable Living is defined as Living Arrangement = Independent

Pg. 20 Percent of Clients Reporting a Stable Living Condition at Admission vs. Discharge

- BHTEDS Fields Used: Service Update/End Date, Reason for Service Update/End, Living Arrangement, and Service Start Date
- Only includes Discharges with the Discharge Reason = Treatment Completed and Transferred to Another Program or Facility/Completed Level of Care.
- Only includes Episodes discharged that had a minimum of 6 weeks of Service (42 days or more).
- Stable Living is defined as Living Arrangement = Independent

Pg. 21 Percent of ED Visits for AOD by Medicaid Beneficiaries that have a follow up service within 30 days of the ED visit (FUA 30)

- Source: CC360 Multiple Measures Client Level Detail Extracts
- Denominator: Number of ED visits ((ED Value Set), with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. If a beneficiary has more than one ED visit, all eligible ED visits are counted in the denominator.
- Exclusions: ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 30 days after. Members in hospice or receiving hospice services anytime during the measurement period excluded.
- Numerator: A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

Pg. 22 Percent of New Treatment Episodes for Medicaid Beneficiaries who Initiate Treatment Within 14 Calendar Days of Diagnosis

- Source: CC360 Multiple Measures Client Level Detail Extracts
- Denominator: Eligible population with a new episode of SUD during the intake period. Number of beneficiaries, ages 18-64 as of the last day of the measurement period, with a diagnosis for alcohol or opioid use or dependence or other substance use disorder, who had continuous enrollment during reporting period.
 - Continuous enrollment defined as 194 days prior to index episode thru 47 days after episode date for total of 242 days.
 - SUD diagnosis may have occurred during a hospital stay or short-term hospital monitoring, or in SUD services including (OP, IOP, and Residential).
 - Exclusions:
 - Dual-enrolled Medicare/Medicaid and spenddown beneficiaries are not included in the denominator.
 - Beneficiaries who do not meet continuous enrollment requirement or who died during the measurement period.
- Numerator: Number of new and recurring (no SUD treatment in past 6 months) episodes of SUD who received the first medication or treatment or visit within 2 weeks (14 days) of a new/recurring SUD diagnosis. Note: If the 1st SUD encounter with initial diagnosis is an inpatient stay or is a monthly-billed opioid treatment service, the standard is considered met.

- Pg. 23 Percent of New Treatment Episodes for Adult Medicaid Beneficiaries with 2+ Services Within 34 Calendar Days of Initiation Visit**
- Source: CC360 Multiple Measures Client Level Detail Extracts
 - Denominator: Eligible population with a new episode of SUD during the intake period. Number of beneficiaries, ages 18-64 as of the last day of the measurement period, with a diagnosis for alcohol or opioid use or dependence or other substance use disorder, who had continuous enrollment during reporting period.
 - Continuous enrollment defined as 194 days prior to index episode thru 47 days after episode date for total of 242 days.
 - SUD diagnosis may have occurred during a hospital stay or short-term hospital monitoring, or in SUD services including (OP, IOP, and Residential).
 - Exclusions:
 - Dual-enrolled Medicare/Medicaid and spenddown beneficiaries are not included in the denominator.
 - Beneficiaries who do not meet continuous enrollment requirement or who died during the measurement period.
 - Numerator: Number of new and recurring (no SUD treatment in past 6 months) episodes where the beneficiary received 2 additional treatment/visits within 34 days following the initiation visit. Note: If the 1st SUD encounter with initiation visit is an inpatient stay or is a monthly-billed opioid treatment service, the standard is considered met.
- Pgs. 25-27 Percent of Treatment Admissions by Primary Drug**
- BHTEDS Fields Used: County of Residence, Service Start Date, Primary, Secondary and Tertiary Substance Use Problem
- Pg. 28 Percent of Admissions that were Methamphetamine (MA)-involved**
- BHTEDS Fields Used: County of Residence, Service Start Date
 - Primary, Secondary and Tertiary Substance Use Problem
 - Involved includes admission with MA/Speed identified as primary, secondary or tertiary drug of choice.
 - Primary includes admission with MA/Speed identified as the primary drug of choice.
 - Non-Primary includes admission with MA/Speed identified as secondary or tertiary drug of choice.
- Pg. 29 Percent of Admissions that Involved Both an Opioid & MA by County**
- BHTEDS Fields Used: Service Start Date, County of Residence, Primary, Secondary and Tertiary Substance Use Problem
 - Includes all Admissions with Both Methamphetamine/Speed and an Opioid (Heroin, Methadone, Synthetic Opioid) identified within Primary, Secondary or Tertiary Drug of Choice response.