LAKESHORE REGIONAL ENTITY

Meeting Agenda

SUD OVERSIGHT POLICY BOARD

Wednesday, September 17, 2025 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 17, 2025, LRE Oversight Policy Board meeting agenda as presented.

6. Review/Approval of Minutes-Chair *(Attachment 2)*
   Suggested Motion: To approve the July 30, 2025, LRE Oversight Policy Board meeting minutes as presented.

7. Old Business
   a. PA2 Fund Balance Report *(Attachment 3)*

8. New Business
   a. CMHOC Request for Additional PA2 Funding *(Attachment 4)*
      Suggested Motion: To approve the request from Community Mental Health of Ottawa County for Reserve PA2 funds in FY26 in the total amount of $200,000 to continue funding for the Prevention and Stigma Reduction: SoBar Community Recovery Center.

   b. CMHOC Request for Additional PA2 Funding *(Attachment 5)*
      Suggested Motion: To approve the request from Community Mental Health of Ottawa County for Reserve PA2 funds in FY26 in the total amount of $60,000 to continue funding for Recovery Coach Supportive Services.

   c. West Michigan Request for Additional PA2 Funding
      Suggested Motion: To approve the request for the use of $40,311 reserve PA2 funds for SUD Services by West Michigan Community Mental Health System in FY2026 as follows: Lake County $6,953; Mason County $17,344; and Oceana County $16,014

d. Finance Report - Maxine Coleman
    i. Statement of Activities *(Attachment 6)*

    ii. FY26 Proposed Budget *(Attachment 7, 7A, 7B)*

    LRE FY26 Prevention and Treatment Providers PA2 Allocation

    Suggested Motion: To Approve the FY26 allocation of PA2 funds for the LRE SUD Budget as presented and to recommend that the LRE Board approve the FY25 non-PA2 fund budgets for SUD services as presented.

9. Prevention/Treatment Updates
    a. Prevention – Amy Embury
        i. Talk Sooner
        ii. Gambling Prevention Campaign
    b. Treatment – Amanda Tarantowski
        i. FY25 Q3 Treatment Evaluation Report *(Attachment 8)*
        ii. Healing and Recovery Community Engagement Grant

10. State/Regional Updates – Stephanie VanDerKooi
    a. FY26 MDHHS Grant Allocations delay
    b. MDHHS PIHP System Rebid *(Attachment 9)*

11. Round Table
    a. Opiate Settlement Updates

12. Next Meeting
    December 10, 2025 – 4:00 PM
    CMHOC Board Room

ATTACHMENT 2

Meeting Minutes (proposed)

SUD OVERSIGHT POLICY BOARD

Wednesday, July 30, 2025 4:00 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 July 30, 2025, LRE Oversight Policy Board meeting to order at 4:02 PM.

ROLL CALL/INTRODUCTIONS:

i. Jordan Jorritsma – Ottawa County
ii. Jessica Cook – Muskegon County

MEMBER	P	A		MEMBER	P	A
Zee Bankhead		X		Richard Kanten	x	
Shelly Cole-Mickens		x		David Parnin	x	
Jessica Cook	x			Sarah Sobel	x	
Mark DeYoung	x			Stan Stek		x
Dawn Fuller		x		James Storey		X
Kristine Huston	x			Joe Stone		X
Jordan Jorritsma	x			Patrick Sweeney	x	
Rebecca Lange	x			Robert Walker		x
Horace Lattimore	x					

PUBLIC COMMENT

No public comment

CONFLICT OF INTEREST

No conflicts of interest declared

REVIEW/APPROVAL OF AGENDA

LRE OPB 25-22 Motion: To approve the July 30, 2025, LRE Oversight Policy Board meeting agenda as presented.

Moved by: Kanten Support: Parnin

MOTION CARRIED

REVIEW/APPROVAL OF MINUTES

LRE OPB 25-23 Motion: To approve the April 16, 2025, LRE Oversight Policy Board meeting minutes as presented.

Moved by: Parnin Support: DeYoung

MOTION CARRIED

OLD BUSINESS

No Old Business

NEW BUSINESS

Finance Report (Maxine Coleman)

i. **Statement of Activities** – through April, 2025. Target for expenditures 58 percent – slightly below target. Prevent Program is at 100 percent due to internal billing process. PA2 percent under projected at 38 percent as grand dollars are used prior to using PA2 funds. Some line items expenses are reflecting as over budge. Those items are reflected in the budget adjustment #2. SUD Medicaid Revenue is below target, Healthy Michigan is higher than anticipated.

ii. **Budget Amendment #2 –** Amendment #2 to the FY25 budget includes: an adjustment to ARPA that reflects that final amounts spent; an adjustment to HealthWest to reflect prevention funds that were originally allocated to Muskegon Department of Public Health; PA2 is amended to reflect request from CMHSP for additional funds; updated budgets for Medicaid and Healthy Michigan; and a new budget line for Alcohol Use Disorder Treatment to cover services for individuals with an AUD diagnosis.

LRE OPB 25-24 Motion: To approve Amendment #2 to the allocation of FY25 PA2 funds for the LRE SUD Budget as presented and to advise and recommend that the LRE Board approve the amended FY25 non-PA2 fund budgets for SUD services as presented.

Moved by: DeYoung Support: Kanten
MOTION CARRIED

WMCMHS Request for Reserve PA2 Funding

Jane Shelton, WMCMHS, reported on the request for additional PA2 funds to continue to support SUD services in Lake, Mason, and Oceana County. The need for additional PA2 funds is due to reduction in grant funding along with a higher demand for grant-funded SUD services. SOR funds were reduced in FY25 and a Department of Justice fund grant expired.

LRE OPB 25-25 Motion: To approve the transfer of Reserve PA2 funds to West Michigan Community Mental Health System in the total amount of $26,329 to be allocated as follows: Lake County: $6,036; Mason County: $2,088; Oceana County: $18,205

Moved by: Cook Support: Sobel
MOTION CARRIED

Mr. Sweeney requested that an accounting of the exact amount of PA2 reserve funds per county be provided when additional PA2 funds are being requested

STATE/REGIONAL UPDATES – Stephanie VanDerKooi

MDHHS PIHP System Rebid - In May 2025, MDHHS published a press release outlining the parameters around what types of organizations can submit a proposal. CMHA (Board Association) has distributed information about advocacy around this topic. The timeline for implementing the changes is very aggressive, with the currently defined date as 10/1/2026. There are several options being discussed on how to proceed. Information will be shared with the OPB members as it becomes available.

LRE Board has approved an already-budgeted FY25 retention incentive for LRE staff toward retaining talent while the RFP is pending.

FY22 Cost Settlement Update – In FY17/18 LRE experienced a deficit that was resolved using excess funds from FY22. Michigan's Attorney General contends that the LRE was not permitted to use those funds and now owes $13 million. LRE Counsel is working on a settlement. Currently the case is expected to be resolved in September.

Legislative Activity Update – updated report is attached.

State SUD Conference – Please advise if interested in attending virtually.

PREVENTION/TREATMENT UPDATES

Prevention – Amy Embury

- Amy Embury has been a participant in the planning for the SUD Conference
- FY26 allocations for prevention services have been received. Budgets will be presented to the OPB in September. No significant difference in funding allocations from FY25.
- September is Family Meal month – Talk Sooner is working on the "Anyway you Slice It" campaign for the month of September. Additional information will be distributed as it becomes available.

Treatment – Stephanie VanDerKooi

SUD Treatment Evaluation Quarterly Update – Q2FY25 data is presented quarterly and aligns with the 3-year strategic plan. Data reviewed is available in the plan.

ROUND TABLE

Opiate Settlement Updates by County

- Muskegon County just released a link for an open bid to receive funds (bid due August 13). Advisory Committee is administering the City of Muskegon Grants along with the County grant.
- Oceana County has started their assessment phase in collaboration with MSU Extension
- Allegan County has engaged in a process guided by the Michigan Association of County. County Commission approved a plan for a two-year distribution of funds in the amount of $160,000. Funds are being directed to both treatment and prevention.

NEXT MEETING

September 17, 2025 – 4:00 PM
CMHOC Board Room

ADJOURN

LRE OPB 25-26 Motion: To adjourn the July 30, 2025, Lakeshore Regional Entity Oversight Policy Board Meeting

Moved by: Kanten
Support: Parnin
MOTION CARRIED

Mr. Sweeney adjourned the July 30, 2025, Lakeshore Regional Entity Oversight Policy Board meeting 4:54 p.m.

ATTACHMENT 3

Lakeshore Regional Entity PA2 Fund Balance Report

Bank Balances as of:	**07/31/2025**
LRE PA2 Checking	100,000.00
LRE PA2 Repurchase Agreement Account	13,185,768.46
	13,285,768.46

County PA2 Checking Balances as of:	**07/31/2025**
Allegan County	671,863.12
Kent County	5,688,139.77
Lake County	310,852.11
Mason County	812,665.09
Muskegon County	1,621,177.96
Oceana County	420,459.23
Ottawa County	3,760,611.18
Total County Checking Balances	**13,285,768.46**

County Fund Balances	**PA2 Beginning Balance**	**FY25 Revenue & Interest**	**FY25 Expenses**	*Unaudited*	**07/31/2025 Fund Balance**
Allegan County	802,660.95	140,022.47	183,074.77		759,608.65
Kent County	7,917,532.01	1,290,941.15	3,544,427.79		5,664,045.37
Lake County	304,138.06	15,793.17	16,491.00		303,440.23
Mason County	797,419.12	58,070.08	38,264.00		817,225.20
Muskegon County	1,623,214.13	237,203.98	264,322.18		1,596,095.93
Oceana County	405,617.24	26,463.80	14,172.00		417,909.04
Ottawa County	3,781,891.26	430,905.96	481,718.31		3,731,078.91
County Fund Balance Total	**15,632,472.77**	**2,199,400.61**	**4,542,470.05**		**13,289,403.33**

As of 9/10/25

SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 8/29/2025

PROVIDER NAME: CMHOC CURRENT PROVIDER: _____ ❍ YES ❍ NO

PROGRAM TITLE**: Prevention and Stigma Reduction: SoBar Community Recovery Center**

CONTACT PERSON: Joel Ebbers

CONTACT EMAIL: jebbers@miottawa.org

PROVIDER ADDRESS: 12265 James Street, Holland MI, 49424 AMOUNT REQUESTED: $200,000.00

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:	
Problem Statement: describe the problem that your activities are designed to improve.	Prior to SoBar Recovery Community Center there was no place that offered community, connection, and sober activies.
Describe the conditions that contribute to the identified problem (List the data sources if applicable)	During active use individuals lose positive connections to a supportive social network.
Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.	Target population is individuals in, and interested in, recovery, recovery resources, supporters of those in recovery, and a sober community

Describe why your agency is best fit to provide this service?	SoBar Community Recovery Center is now its own 501c3 Non-profit community recovery organization. They have moved to a new location at 347 Hoover Blvd in Holland as the first step in a sustainability plan. Volunteers have given over 400 hours in the renovation of the new location. They are beginning phase two of renovations which include a larger meeting room and a recovery art space.
II. Describe what you will do to address the situation:	
Describe the program's activities (what are you going to do?):	SoBar offers 13 mutual aid groups including AA, NA, Smart Recovery, women's recovery, All Recovery, and Methamphetamine Anonymous. They are open for individuals to come and talk with recovery coaches, pick up recovery resources like Narcan, treatment information, or other recovery litature. They host social events like karaoke, watch parties for sporting events. More information can be found here: https://sobarrco.com/
Describe the expected frequency of the activity(ies) and how you determined this.	SoBar is open throughout the week and hosts numerous support meeting.
Describe the number of persons in the target population you expect to serve during each activity event	SoBar is currently offering 13 support groups and has seen 3,920 check-ins this year for those meetings. They have had 6,670 individuals check-in this past year.

III. Explain the necessary costs for your program *(provide narrative to support the resources identified that require funds).*
Funds are utilized for the lease of the building, utilities, staff costs, and supplies.

IV. Describe the goals you have established for the program. (goals do not have to be measurable) *(TO BE COMPLETED BY NEW PRORGRAMS ONLY)*
1. Click or tap here to enter text.

2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
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:*** *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.*	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: *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.*	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: *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.*	1. Click or tap here to enter text.
		2. Click or tap here to enter text.
		3. Click or tap here to enter text.

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

August 29, 2025

Stephanie VanDerKooi
Lakeshore Regional Entity
5000 Hakes Dr, Suite 500
Norton Shores, MI 49441

Dear Ms. VanDerKooi,

I am writing to request Ottawa County PA2 funds to continue two successful programs within Ottawa County. I am requesting $200,000.00 to continue to fund SoBar Community Recovery Center. This recovery center has recently moved into a new location and is continuing to offer space for individuals to find community, connection, and recovery resources. Last year they had over 6,600 check-ins at there center and are continuing to offer more resources.

I am also requesting $60,000.00 to continue funding a homeless outreach recovery coach through Community Action House. This recovery coach works with Community Action House's homeless outreach team to connect individuals with substance use treatment resources.

Please feel free to contact me with any additional questions.

Sincerely,

Joel Ebbers, LMSW CAADC CCS
Director of Substance Use Services
Community Mental Health of Ottawa County

SPECIAL PROJECT APPLICATION FOR PA2 FUNDS

DATE: 8/9/2024

PROVIDER NAME: CMHOC CURRENT PROVIDER: ☒ YES ☐ NO

PROGRAM TITLE**: Recovery Coach Supportive Services**

CONTACT PERSON: Joel Ebbers

CONTACT EMAIL: Jebbers@miottawa.org

PROVIDER ADDRESS: 12265 James Street, Holland MI, 49424

Total Request: $60,000.00

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:	
Problem Statement: describe the problem that your activities are designed to improve.	Over the course of the last year Community Action House (CAH), working alongside CMHOC team members across teams including access, SUD, DDR and CIT worked to seek and engage individuals with specific concerns related to substance misuse concerns. Working to build pathways particularly with clients that present with co-occurring disorders. Homelessness proves to have significant effects on the overall wellbeing of individuals. CAH has seen a significant increase in the number of unsheltered individuals and accessing housing opportunities are limited particularly for those individuals with increased barriers including Mental Illness and/or substance use concerns. Last year the unsheltered number

	for the PIT (point in time count) jumped from 48 in 2023 to 95 in 2024, and is now 68 in 2025.
Describe the conditions that contribute to the identified problem (List the data sources if applicable)	Community Action House (CAH) has identified that knowledge of availability and access to services can be a barrier for many of our neighbors, especially among those experiencing housing instability and homelessness. Coordinating our effort with CMHOC improves the ability to connect those who are most vulnerable and in need of services. CAH recovery coach was able to respond to many of our agency partners including CIT, HDL, HPD, Gateway Mission, Good Samaritan, Reach for Recovery, Arbor Circle, etc to respond to need and set up integrated pathways and support clients to navigate those pathways quicker.
Describe the program's target population. Be sure to identify if you are targeting any specialty or priority population.	CAH has and will continue to focus on identifying those in the community with high needs and strong barriers to accessing services and building the connection to resources, particularly with those experiencing homelessness. The CAH Outreach team currently has approximately 173 clients experiencing some form of homelessness or housing instability in Ottawa county. CAH Data indicates that approximately 29.69% of their clients have a documented disability of mental illness and/or substance abuse disorder but we recognize that there is much greater need and will work to make the connections even deeper into the county if granted funding for this upcoming year.
Describe why your agency is best fit to provide this service?	CAH has well established trust in the community, especially among those experiencing homelessness in Ottawa County through the Street Outreach Program. The team has the unique ability to seek out and go to clients where they are and who may be facing multiple barriers to connect to resources including CMH SUD services. This connection point allowed them to bring many clients' needs forward to navigate with the SUD team such as treatment center access, insurance navigation and connections to recovery groups. CAH has seen an increase in unsheltered homeless serving 123 in 2020 and growing to 489 in 2024 and 331 from January to August in 2025.
II. Describe what you will do to address the situation:	
Describe the program's activities (what are you going to do?):	The recovery coach will be present in the community on a regular basis at programming including the Refresh Program at First United Methodist Church [program is offered 3 days a week] as a central location for people to get a meal and shower and meet with CAH

	case managers on-site for a variety of potential needs. The recovery coach has been able to connect with multiple people after overdose for those experiencing homelessness. The recovery coach began an weekly on-site recovery group at the Food Club that has been well attended.
Describe the expected frequency of the activity(ies) and how you determined this.	The recovery coach will be present at connection points within the community including the Refresh program 2-3x weekly. They will complete outreach activities at other locations regularly for connection and follow-up needs with clients on an ongoing basis. When navigating a treatment connection, knowing the time sensitivity with bed availability, they will work closely with the client until the barrier can be addressed.
Describe the number of persons in the target population you expect to serve during each activity event	From 10/1/24 to 8/25/25 the recovery coach connected and assessed 77 clients in potential need of SUD services. Of these, 61 clients made some mention of a SUD concern and potential treatment exploration. Some 54 clients made attempts at sobriety or maintained some sobriety with assistance from the recovery coach.

III. Explain the necessary costs for your program *(provide narrative to support the resources identified that require money).*
Costs are related to the staff cost of the recovery coach position. Salary, fringe, and direct costs for providing recovery coach services.

IV. Describe the goals you have established for the program. (do not have to be measurable) *(TO BE COMPLETED BY NEW PROGRAMS ONLY)*
1.
2.
3.

4. 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:*** *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.*	1. Recovery coach will maintain a caseload of 30 to 40 individuals - This past year the recovery coach connected and assessed 77 clients in potential need of SUD services. 61 made some mention of a SUD concern and potential treatment exploration, 54 made attempts at sobriety or maintained some sobriety with assistance from the recovery coach. CAH with connection to CMHOC, will continue this assessment of needs and reach to resources. We suspect the caseload will continue to fluctuate between 30-40 individuals on a regular basis.
		2. Recovery coach will maintain at least monthly contact with individuals on caseload - Currently the recovery coach meets with clients as needed but at least monthly, aiming for every 2 weeks or less. Once a client begins the desire to enter treatment, the frequency can increase. This may be daily as they work to navigate the locations of beds, opening, and if they need detox. The recovery coach helps navigate insurance barriers and transportation for access to treatment centers. This continues until they can be connected with appropriate supports for the presented need.
		3. Goals will be established for each participant. - Goals with each participant focus on housing stability as a long term goal. While on this journey the clients establish small goals focused on addressing their current recovery needs. These goals are revisited upon their case management meetings
	Participant: *Describe **(in specifically measurable terms)** what*	1. Each participant will establish goals for work with the recovery coach. Goals are focused on helping individuals increase motivation for recovery, finding/establishing safe housing, and entering into treatment services.

	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.	2. Participants will have increased opportunity for support group participation and recovery oriented social gatherings. Over this last year, the recovery coach set up recurring weekly recovery meetings on site at CAH. This offering allowed access for current clients but also others in the recovery community. The recovery coach also worked to establish their knowledge, attend other meetings and learn from others about the meetings that are available in the community to offer an array of options for the guest as they come up
		3. Participants will be given the opportunity to address co-occurring concerns with the recovery coach. This includes mental health and physical health concerns.
	Impact: *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.*	1. Increase the number of individuals who successfully move levels of care within the substance abuse treatment array. With the implementation of this connection the RC saw 61 clients express some level of SUD concern and 56 of those guests were maintained on her caseload and completed some level of sobriety. 8 of those had been maintaining their sobriety, 16-20 had a relapse but were still wanting to achieve sobriety and continuing work towards that.
		2. Increase the number of individuals who address their co-occurring concerns while in treatment. While guests are completing an intake, team members including RC are assessing for needs including connection with mental health services and or medical needs at the point of intake and ongoing with a case manager. Roughly 29.69% of the total clients served by CAH are considered having at least 1 documented disability. If SUD is assessed as a potential need then they are connected with the RC on CAH staff directly for further follow up and assessment.
		3. Increase the number of individuals who access recovery support services including housing and transportation supports. This partnership allowed capacity building into the community with a direct connection to CMH and SUD services. This includes direct work from CAH RC to follow up with transportation needs then presently available upon discharge from treatment facility, if returning to homelessness, to assess for continued housing needs.

Lakeshore Regional Entity
FY 2026 SUD Budget

Prevention	Initial FY25 Allocation	Proposed FY26 Allocation	Block Grants	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	PA2	Gambling	
Allegan County										
OnPoint (Allegan Co CMH)	317,252	304,843	111,163	50,000	-	-	-	143,680	-	-
Total	317,252	304,843	111,163	50,000	-	-	-	143,680	-	-
Kent County										
Arbor Circle	159,697	206,755	105,000	-	-	-	-	101,755	-	-
Kent County Health Department	514,073	497,393	246,000	-	-	-	-	251,393	-	-
Network 180	400,000	306,077	175,000	-	-	-	-	131,077	-	-
Wedgwood	162,270	167,585	75,000	-	-	-	-	92,585	-	-
Total	1,236,040	1,177,810	601,000	-	-	-	-	576,810	-	-
Lake County										
District Health Department #10	34,667	36,450	11,497	-	-	-	-	24,953	-	-
Total	34,667	36,450	11,497	-	-	-	-	24,953	-	-
Mason County										
District Health Department #10	152,897	90,974	28,631	-	-	-	-	62,343	-	-
Total	152,897	90,974	28,631	-	-	-	-	62,343	-	-
Oceana County										
District Health Department #10	175,076	157,952	26,438	47,500	-	-	-	46,014	38,000	-
Total	175,076	157,952	26,438	47,500	-	-	-	46,014	38,000	-
Muskegon County										
Healthwest	-	292,426	127,531	32,500	-	-	-	90,395	42,000	-
Mercy Health	79,200	57,507	44,000	-	-	-	-	13,507	-	-
Total	79,200	349,933	171,531	32,500	-	-	-	103,902	42,000	-
Ottawa County										
Arbor Circle (Ottawa Co)	467,411	524,354	175,000	35,500	-	-	-	269,854	44,000	-
CMH of Ottawa County	82,763	38,265	-	-	-	-	-	38,265	-	-
Ottawa Co. Department of Public Health	195,600	150,108	88,218		-	-	-	61,890	-	-
Total	745,774	712,727	263,218	35,500	-	-	-	370,009	44,000	-
LRE Regional Projects (TalkSooner, Trainings, Conference, Tech. Assistance, Family Meals Month)	124,000	101,000	63,000	-	-	-	-	-	38,000	-
LRE Staffing	221,975	299,369	194,317	17,052	-	-	-	-	88,000	-
Unallocated	135,632	-	-	-	-	-	-	-	-	-
Total	481,607	400,369	257,317	17,052	-	-	-	-	126,000	-
Overall Prevention Total	3,222,513	3,231,058	1,470,795	182,552	-	-	-	1,327,711	250,000	-

Treatment	Initial FY25 Allocation	Proposed FY26 Allocation	Block Grants (incl. SDA)	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	PA2	Medicaid	Healthy Michigan
OnPoint (Allegan Co CMH)	2,169,940	2,230,947	466,000	175,135	-	14,661	-	94,707	627,571	852,873
Healthwest	5,717,755	5,879,107	930,610	780,000	-	27,166	142,500	381,976	1,590,011	2,026,844
Network 180	15,436,669	14,945,780	2,455,982	535,139	-	104,350	-	1,701,619	4,023,364	6,125,326
CMH of Ottawa County	4,192,622	4,342,259	791,000	-	43,737	47,432	-	818,489	1,002,079	1,639,521
West Michigan CMH (Lake, Mason Oceana)	1,498,699	1,832,595	397,000	114,703	-	21,991	-	166,046	529,311	603,543
LRE Staffing & Regional Projects	1,608,008	1,368,132	349,099	255,636	10,935	-	7,500	-	286,280	458,681
Unallocated	256,076	386,228	329,393	56,835	-	-	-	-	-	-
Overall Treatment Total	30,879,770	30,985,047	5,719,084	1,917,448	54,672	215,600	150,000	3,162,837	8,058,617	11,706,789
SUD Total Prevention + Treatment:	**34,102,283**	**34,216,105**	**7,189,879**	**2,100,000**	**54,672**	**215,600**	**150,000**	**4,490,548**	**8,308,617**	**11,706,789**

Lakeshore Regional Entity
Oversight Policy Board

ACTION REQUEST

SUBJECT: FY2026 LRE SUD Budget

- Approval of PA2 Funds
- Advice and Recommendation to LRE Board for Budgets Containing non-PA2 Funds

MEETING DATE: September 24, 2025

PREPARED BY: Stacia Chick, LRE Chief Financial Officer

RECOMMENDED MOTION:

The Oversight Policy Board:

(a) Approves the allocation of PA2 funds for the LRE SUD Budget as summarized below.

(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 24, 2025

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 11, 2025

FY2026 LRE SUD Budget Summary:

PREVENTION (direct by LRE)	PA2	Block Grant	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	Gambling	Medicaid	Healthy Michigan	Total
Allegan County	$ 143,680	$ 111,163	$ 50,000	$ -	$ -	$ -	$ -	$ -		$ 304,843
Kent County	$ 576,810	$ 601,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,177,810
Lake County	$ 24,953	$ 11,497	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,450
Mason County	$ 62,343	$ 28,631	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 90,974
Oceana County	$ 46,014	$ 26,438	$ 47,500	$ -	$ -	$ -	$ 38,000	$ -	$ -	$ 157,952
Muskegon County	$ 103,902	$ 171,531	$ 32,500	$ -	$ -	$ -	$ 42,000	$ -	$ -	$ 349,933
Ottawa County	$ 370,009	$ 263,218	$ 35,500	$ -	$ -	$ -	$ 44,000	$ -	$ -	$ 712,727
LRE Regional Projects	$ -	$ 63,000	$ -	$ -	$ -	$ -	$ 38,000	$ -	$ -	$ 101,000
LRE Staffing	$ -	$ 194,317	$ 17,052	$ -	$ -	$ -	$ 88,000	$ -	$ -	$ 299,369
Unallocated	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PREVENTION TOTAL	$ 1,327,711	$ 1,470,795	$ 182,552	$ -	$ -	$ -	$ 250,000	$ -	$ -	$ 3,231,058

TREATMENT (delegated to CMH members)	PA2	Block Grant	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	Gambling	Medicaid	Healthy Michigan	Total
Allegan	$ 94,707	$ 466,000	$ 175,135	$ -	$ 14,661	$ -	$ -	$ 627,571	$ 852,873	$ 2,230,947
Healthwest	$ 381,976	$ 930,610	$ 780,000	$ -	$ 27,166	$ 142,500	$ -	$ 1,590,011	$ 2,026,844	$ 5,879,107
Network 180	$ 1,701,619	$ 2,455,982	$ 535,139	$ -	$ 104,350	$ -	$ -	$ 4,023,364	$ 6,125,326	$ 14,945,780
Ottawa	$ 818,489	$ 791,000	$ -	$ 43,737	$ 47,432	$ -	$ -	$ 1,002,079	$ 1,639,521	$ 4,342,259
West Michigan (Lake, Mason Oceana)	$ 166,046	$ 397,000	$ 114,703	$ -	$ 21,991	$ -	$ -	$ 529,311	$ 603,543	$ 1,832,595
LRE Staffing & Regional Projects	$ -	$ 349,099	$ 255,636	$ 10,935	$ -	$ 7,500	$ -	$ 286,280	$ 458,681	$ 1,368,132
Unallocated	$ -	$ 329,393	$ 56,835	$ -	$ -	$ -	$ -	$ -	$ -	$ 386,228
TREATMENT TOTAL	$ 3,162,837	$ 5,719,084	$ 1,917,448	$ 54,672	$ 215,600	$ 150,000	$ -	$ 8,058,617	$ 11,706,789	$ 30,985,047

TOTAL PREVENTION & TREATMENT	$ 4,490,548	$ 7,189,879	$ 2,100,000	$ 54,672	$ 215,600	$ 150,000	$ 250,000	$ 8,058,617	$ 11,706,789	$ 34,216,105

Snapshot - SUD Providers Additional PA2 Requests ("Reserve" PA2) September 2025 for FY 26

SUD Prevention Provider	FY 25 PA2 Contract	FY 26 PA2 Allocations	Add. PA2 Request
Kent Co Health Dept	$255,000	$145,621	$105,772
1.188 FTE Salary/Fringe (3 staff), mileage, printing & class materials, Evaluation, Other: office expenses			
Wedgwood (Kent Co)	$83,910	$54,615	$37,970
.55 FTE Salary/Fringe (2 staff), conference/training, Supplies, Other: office expenses			
DHD10 - Lake	$23,448	$6,953	$18,000
.105 FTE Salary/Fringe (2 staff), Travel, Supplies, Other: office expenses, printing materials			
DHD10- Mason	$58,304	$17,343	$45,000
.25 FTE Salary/Fringe (2 staff), Travel, Supplies, Other: office expenses, printing materials			
DHD10 - Oceana	$27,058	$16,014	$30,000
.2 FTE Salary/Fringe (2 staff), Travel, Supplies, Other: office expenses, printing materials			
Arbor Circle Site - Kent Co	$59,597	$32,790	$68,965
Salary/Fringe (1 staff), professional development, Other: office expenses and supplies			
Arbor Circle site- Ottawa Co	$200,000	$89,285	$180,569
1.65 FTE Salary/Fringe (3 staff), youth conference, coalition supplies, Safe Prom, Reducing Alcohol focus, Evaluation, Other: office expenses			
Ottawa Public Health	$71,800	$31,890	$30,000
Printing costs to promote initiatives, office supplies, operating supplies to support SUD initiatives, programming and community outreach.			

FY 25 Prevention PA2 Contract	$1,466,073
FY 26 Prevention Allocations	$811,435
FY 26 Prevention PA2 Reserve Requests	**$516,276**
Proposed FY 26 Prevention PA2 Contract	$1,327,711

SUD Treatment Provider		
Ottawa CMH – Peer Recovery Support Services	$60,000	
Ottawa CMH – SoBar Recovery Services - lease of the building, utilities, staff costs, and supplies	$200,000	
WMCMH - cover projected shortfalls in their SUD Block Grant for SUD Services	$40,311	
Allocation Treatment Amount	**$300,311**	
Total SUD Provider PA2 "Reserve" Requests		**$816,587**

ATTACHMENT 8

September 2025

LAKESHORE REGIONAL ENTITY

Substance Use Disorder Treatment Evaluation Quarterly Monitoring Report

3rd Quarter FY2025

This report outlines data indicators for monitoring and improving key data metrics for substance use disorder treatment and recovery services in the LRE region. Data covered in this report is through the **third quarter of FY25**. 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.

KWB Strategies

This page intentionally left blank

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 engagment 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 **08/12/25)** and encounters (refreshed on **08/13/25).** 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.

Throughout the report, you can click on any underlined text to navigate directly to that section of the document.

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)

OUD - 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)

★ ***Improved slightly*** *in Q3 from 9 days in Q2, to 7.4 in Q3. TTS for clients with IVDU improved for detox during Q3, remained steady in long term residential and IOP, and increased time in outpatient and short term residential.*

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

≈ *While Time to Service has been worsening for MAT since FY22, there was an improvement in TTS during Q3 to 7.9 days. TTS was longest for Ottawa and Mason Counties in Q3.* ***Relatively stable*** *since FY23.*

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

≈ *Just over one-third (37%) of admissions in Q3 had criminal justice involvement with 22% on probation, 9% on parole, and 6% in jail.* ***Relatively stable*** *since FY24.*

FY25 Q3

Treatment Access

Intra-Venous Drug Use (IVDU)

Metric

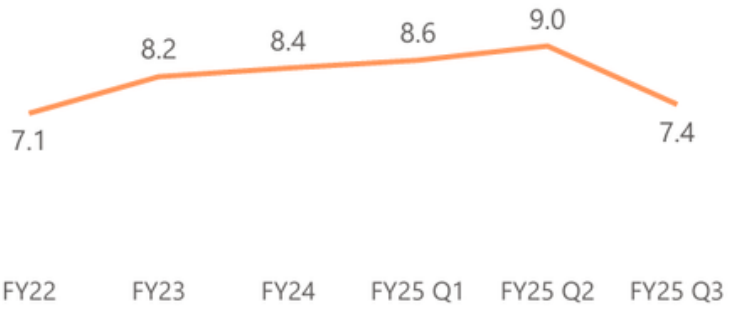
- Decrease the average days between request for service and first service for clients with IVDU.

Data Highlights:

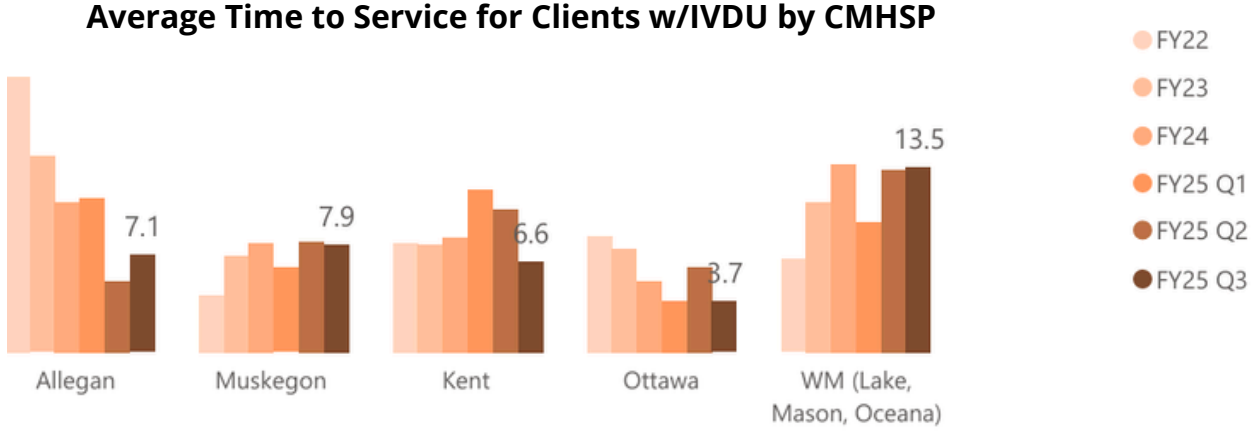
Among admissions for individuals with IVDU, the average time to service was 7.4 days in Q3; decreasing from 9 days that was noted during Q2.

Across the region, TTS for clients with IVDU ranged from a low of 3.7 in Ottawa to a high of 13.5 for West Michigan.

Average Time to Services for Clients with IVDU (Days)



Average Time to Service for Clients w/IVDU by CMHSP



FY22	20.0	4.1	7.9	8.4	6.8
FY23	14.2	7.0	7.8	7.5	10.9
FY24	10.9	7.9	8.3	5.2	13.7
FY25 Q1	11.2	6.1	11.9	3.7	9.5
FY25 Q2	5.2	8.1	10.4	6.2	13.3
FY25 Q3	7.1	7.9	6.6	3.7	13.5

FY25 Q3

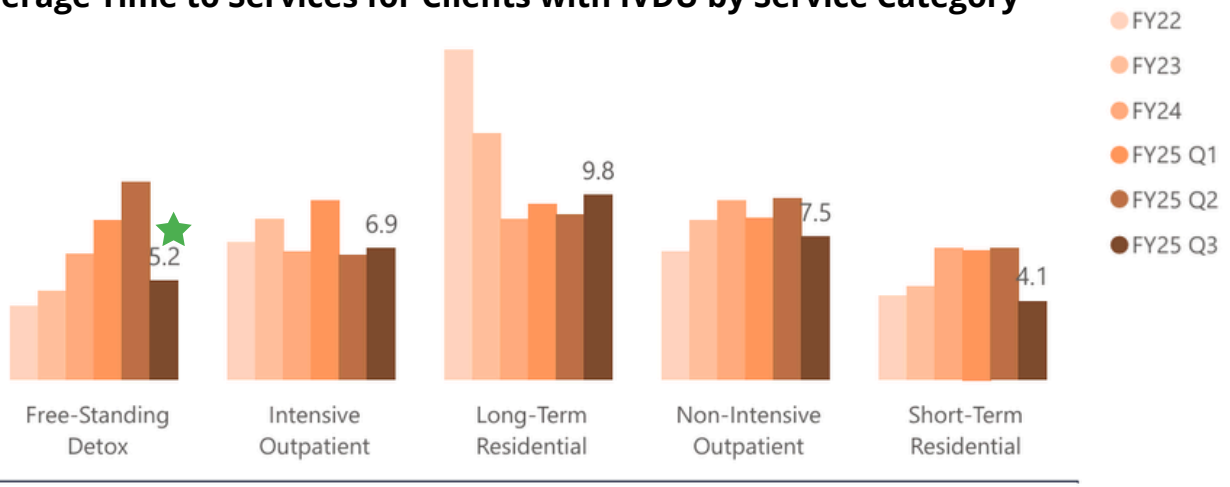
Treatment Access

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



	Free-Standing Detox	Intensive Outpatient	Long-Term Residential	Non-Intensive Outpatient	Short-Term Residential
FY22	3.9	7.3	17.4	6.7	4.4
FY23	4.7	8.5	13.0	8.4	4.9
FY24	6.6	6.7	8.5	9.4	6.9
FY25 Q1	8.4	9.5	9.3	8.5	6.8
FY25 Q2	10.4	6.5	8.7	9.6	6.9
FY25 Q3	5.2	6.9	9.8	7.5	4.1

Data Highlights:

In Q2, detox services had the longest Time to Service (TTS) for clients with intravenous drug use (IVDU) at 10.4 days. By Q3, this improved significantly, with TTS reduced to 5.2 days (highlighted with a star).
When broken down by service category in Q3, long-term residential services had the longest TTS at 9.8 days, followed by outpatient (7.5 days) and intensive outpatient (6.9 days).

FY25 Q3

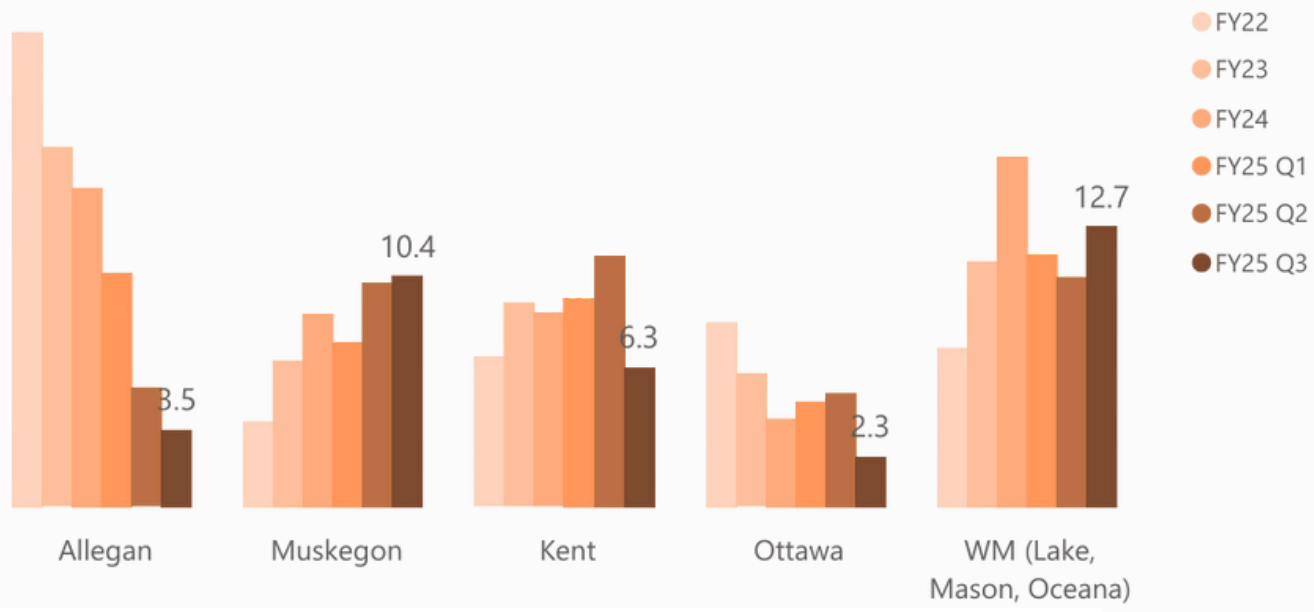
Treatment Access

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



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	21.5	3.9	6.8	8.3	7.2
FY23	16.2	6.6	9.2	6.0	11.1
FY24	14.4	8.7	8.8	4.0	15.8
FY25 Q1	10.6 (9)	7.5	9.4	4.8 (8)	11.4
FY25 Q2	5.4	10.1	11.3	5.1 (8)	10.4 (8)
FY25 Q3	3.5 (8)	10.4	6.3	2.3 (7)	12.7 (6)

Data Highlights:

In Q3, Time to Service (TTS) for clients with intravenous drug use (IVDU) seeking outpatient services ranged from 12.7 days in West Michigan to 3.5 days in Allegan. Allegan has shown steady improvement since FY22, Muskegon remained stable, and both Kent and Ottawa reduced their TTS during Q3.

FY25 Q3

Treatment Access

Medication Assisted Treatment (MAT)

Metric

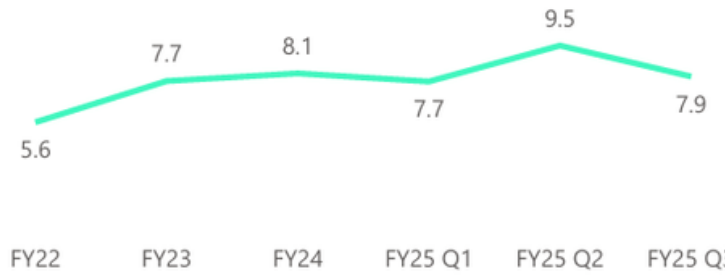
- Decrease average days between request for service and first service for persons living with an opioid use disorder (OUD).

Data Highlights:

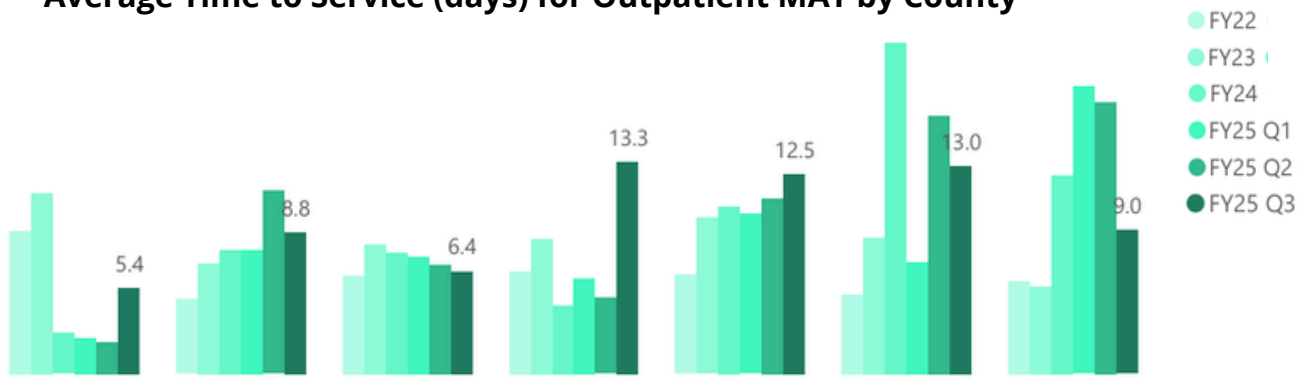
Time to Service (TTS) for individuals with an opioid use disorder (OUD) is most impacted by delays in admission to medication-assisted treatment (MAT). In Q3, the regional average TTS for MAT was 7.9 days, showing improvement from the peak of 9.5 days in Q2 of FY 2025.

By county, TTS in Q3 ranged from 5.4 days in Allegan to 13.3 days in Ottawa. Ottawa County saw a sharp increase from 4.8 days in Q2 to 13.3 days in Q3, while Oceana County experienced a notable decrease from 17 days in Q2 to 9 days in Q3. In both counties, small sample sizes should be considered when interpreting these averages.

Average Time to Service (days) for Medication Assisted Treatment (MAT), LRE Region



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



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	9.0	4.7	6.2	6.4	6.2	5.0	5.8
FY23	11.3	6.9	8.1	8.5	9.8	8.5	5.4
FY24	2.5	7.7	7.6	4.3	10.5 (4)	20.7	12.4
FY25 Q1	2.3 (4)	7.7	7.3	6.0 (1)	10.0 (1)	7.0 (1)	18.0 (2)
FY25 Q2	2.0 (4)	11.4	6.9	4.8 (4)	11.0 (1)	16.1 (7)	17.0 (6)
FY25 Q3	5.4	8.8	6.4	13.3 (8)	12.5 (2)	13.0 (1)	9.0 (9)

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

FY25 Q3

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'

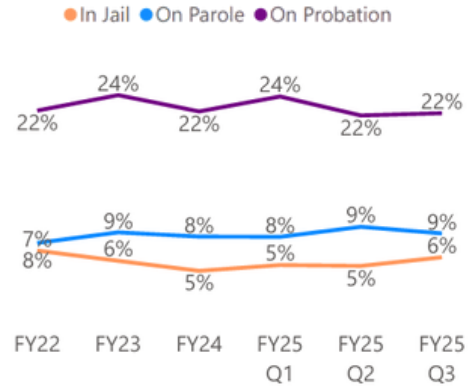
Data Highlights:

Region-wide, 37% 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%).

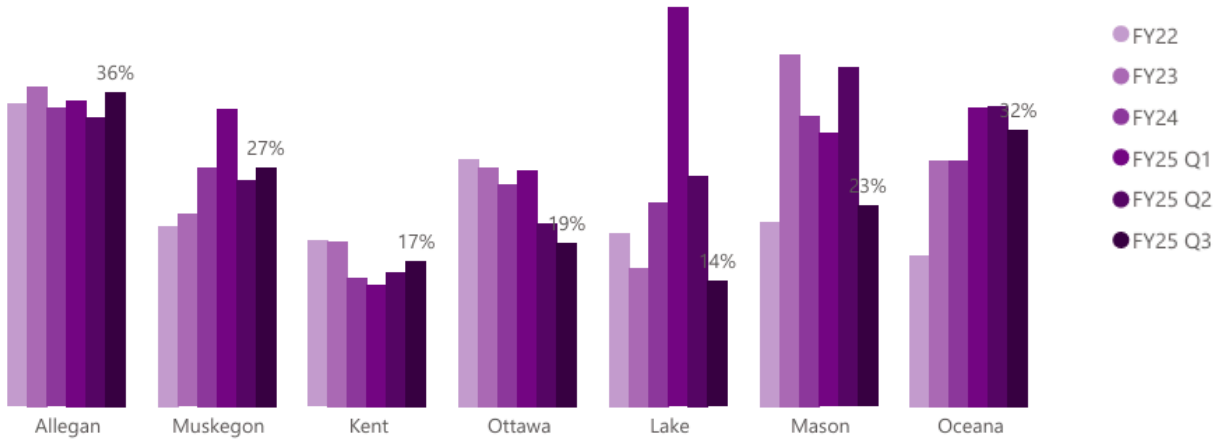
Rates of admissions for individuals on probation increased slightly in Allegan, Muskegon, and Kent Counties. Rates of admission decreased through Q3 in Lake, Mason and Ottawa Counties.

Percent of Admissions by Legal Status at Admission, LRE Region



Engaging criminal justice-involved populations in services when they return to the community is a priority.

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



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	34.5%	20.6%	18.9%	28.2%	19.7%	21.1%	17.2%
FY23	36.5%	21.9%	18.8%	27.2%	15.8%	40.1%	28.1%
FY24	34.0%	27.2%	14.6%	25.3%	23.3%	33.1%	28.0%
FY25 Q1	34.9%	33.9%	13.9%	26.9%	45.5%	31.1%	34.0%
FY25 Q2	33.0%	25.8%	15.4%	20.8%	26.3%	38.6%	34.2%
FY25 Q3	35.8%	27.2%	16.6%	18.6%	14.3%	22.9%	31.6%

FY25 Q3

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 **continued to increase**, with a high of 34% in Q1, and decreased slightly to 31% during Q3.*

In Q3, the percentage of clients with COD receiving integrated care, ranged from a low of 22% in West Michigan to a high of 40% in Ottawa.

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)

Episodes w/ only 1 encounter remained stable at 11% during Q3, remaining higher than in FY24 at 8%. However this may be due to delays in data entry for these most recent time periods. In Q3, rates were highest for Outpatient (35%) and IOP (14%).

FY25 Q3

Engagement and Retention

Integrated Treatment for Co-Occurring Disorders

Metric

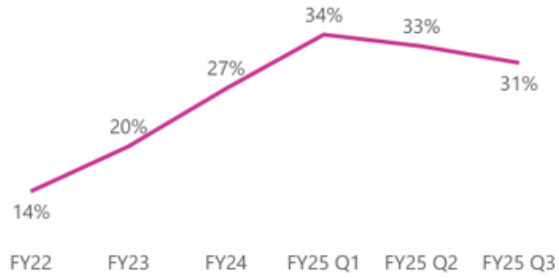
- Increase % of clients with co-occurring diagnosis that received integrated services.

Data Highlights:

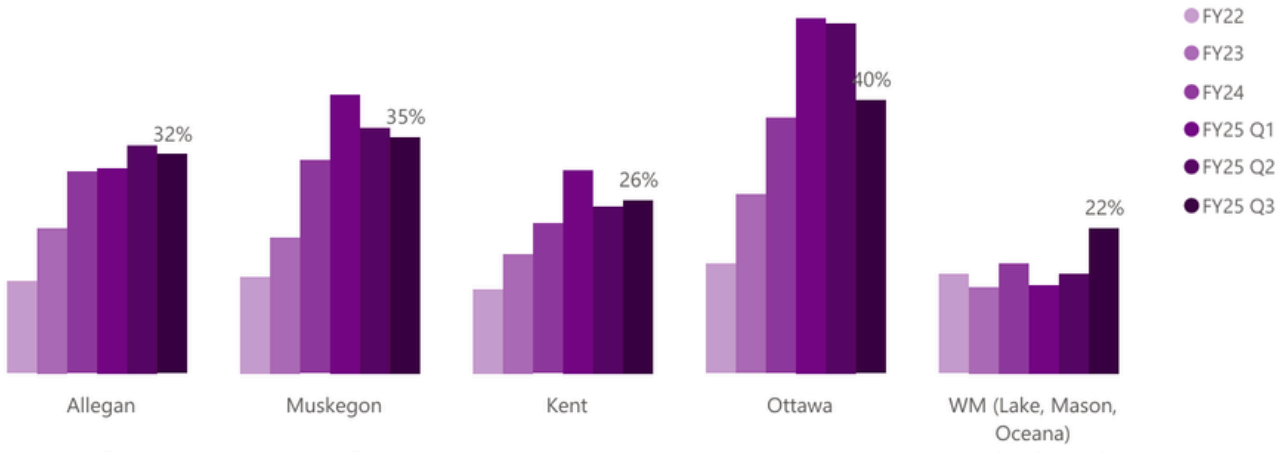
The percentage of clients with COD that were reported as having received integrated treatment has been continually increasing since 2017, with a substantial increase during the first half of FY25. In Q3, 31% of clients served had received integrated treatment for co-occurring disorders.

Rates of integrated treatment in Q3 ranged from a low of 22% for WM to a high of 40% in Ottawa County.

Percent of Clients with Co-Occurring Disorders that Received Integrated Treatment, LRE Region



Percent of Clients with COD that Received Integrated Treatment by CMHSP



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	13.6%	14.2%	12.5%	16.2%	14.7%
FY23	21.4%	20.1%	17.6%	26.4%	12.8%
FY24	29.8%	31.5%	22.2%	37.8%	16.3%
FY25 Q1	30.3%	41.2%	30.0%	52.5%	13.0%
FY25 Q2	33.8%	36.3%	24.7%	51.8%	14.7%
FY25 Q3	32.4% (5)	34.9%	25.6%	40.4%	21.5% (2)

FY25 Q3

Engagement and Retention

One Encounter

Metric

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

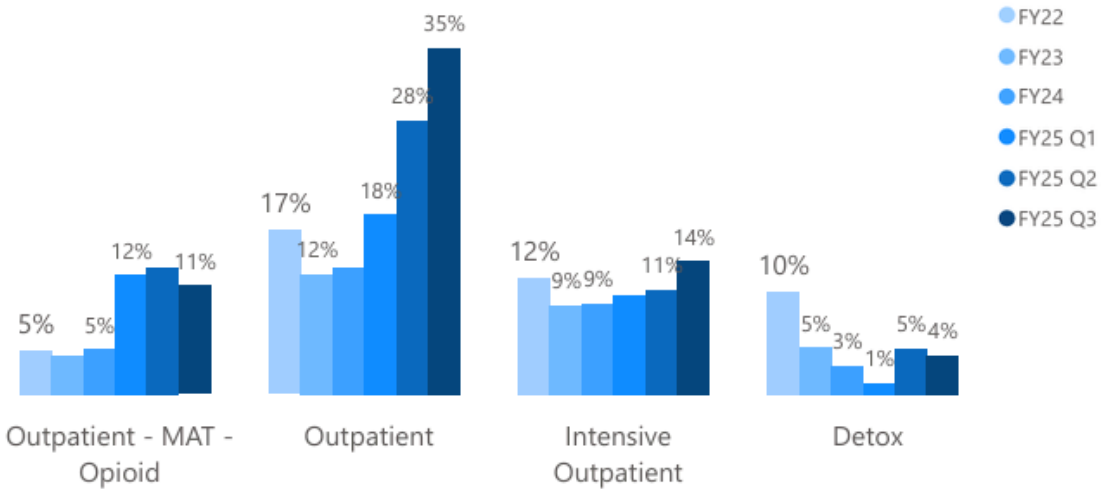
Data Highlights:

For treatment episodes that warranted more than an assessment, the percentage remained stable at 11% in 2Q and 3Q, an increase from 8% in prior periods. However, this increase may be due to encounter data that was not yet entered for these most recent time periods.

OP treatment episodes with only one encounter continued to increase in Q3 to a high of 35%. IOP increased slightly and outpatient MAT and detox remained relatively stable in Q3.

Percent of Treatment Episodes with One Encounter, LRE Region

Percent of Treatment Episodes with One Encounter* by Level of Care



Treatment episodes with only an assessment that had a discharge reason reported as something other than having 'dropped out' are excluded from the analysis.

FY25 Q3

Engagement and Retention

One Encounter Cont...

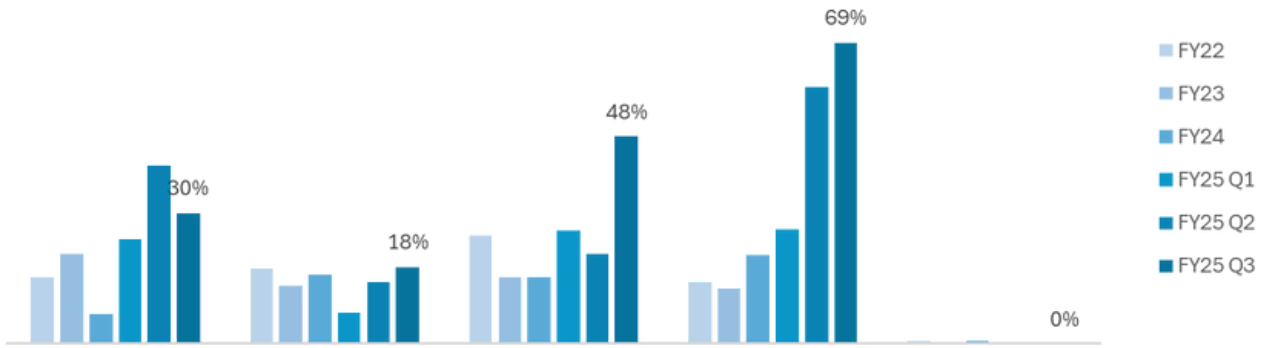
Metric

- 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.

Percent of Outpatient Treatment Episodes with Only One Encounter by CMHSP (excluding MAT)



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	15.2%	17.2%	24.7%	14.1%	0.4%
FY23	20.6%	13.3%	15.2%	12.6%	0.3%
FY24	6.8%	15.9%	15.2%	20.4%	0.4%
FY25 Q1	23.9%	7.1%	25.9%	26.1%	0.0%
FY25 Q2	40.9%(9)	14.0%	20.5%	59.0%	0.0%
FY25 Q3	30.0%(6)	17.6%	47.6% (10)	69.2%	0.0%

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.

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.

FY25 Q3

Metrics

↑ % 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 reached a **high** of 62% during Q3 of FY25, compared to 28% in FY24.*

↓ 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 1.3 days for those who were readmitted within 7 days. Among the 23% of clients discharged from ST Res who were readmitted between 8 & 30 days, the avg time to readmission was 15.2 days. **Relatively stable** since FY23.*

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

*In FY25, incorrect reporting of discharges from ST Res coded as "completed treatment" improved early in the year but rose to 36% in Q3, consistent with FY24. Detox discharge reported as "completed treatment" **remained stable** at 21%.*

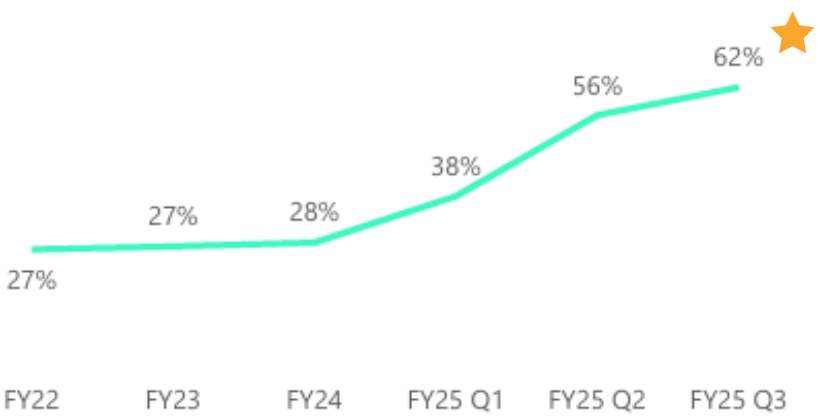
CONTINUITY OF CARE

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

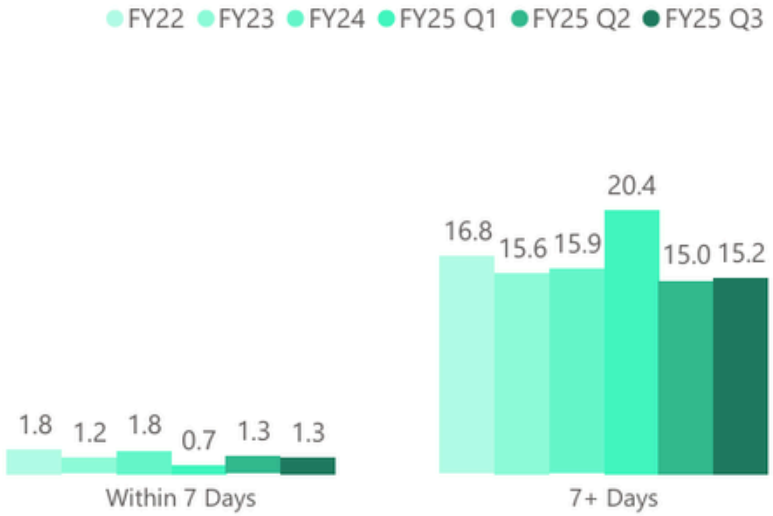


Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days by CMHSP

	FY22	FY23	FY24	FY25 Q1	FY25 Q2	FY25 Q3
Allegan	15%(2)	18%(3)	33%(4)	20%(1)	0%(0)	33%(2)
Muskegon	31%	18%(8)	9%(5)	14%(3)	60%(9)	76%
Kent	24%	27%	18%(6)	0%(0)	0%(0)	0%(0)
Ottawa	34%	31%	47%	85%	71%(10)	71%(5)
WM (Lake, Mason, Oceana)	30%	34%	33%	60%(6)	55%(6)	50%(4)

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



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 have continued to improve in Q3 of FY25 at a high of 62%.

- Among discharges with a corresponding admission to the next level of care within 7 days, the average time between discharge and readmission was 1.3 days, representing 62% of all ST Res discharges.
- Among discharges admitted to the next level of care between 8 and 30 days post-discharge, the average time to readmission was 15.2 days, representing 23% of ST Res discharges.

FY25 Q3

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'

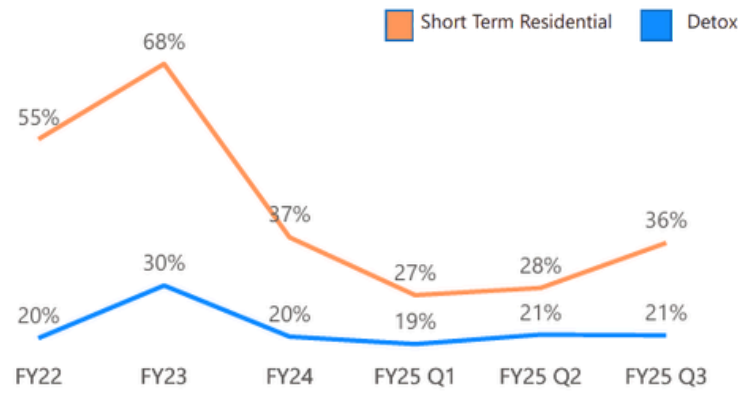
Data Highlights:

The percentage of discharges from ST Res incorrectly reported as 'completed treatment' showed improvement during 1Q & 2Q but worsened in Q3 to 36%, to a rate consistent with the prior FY.

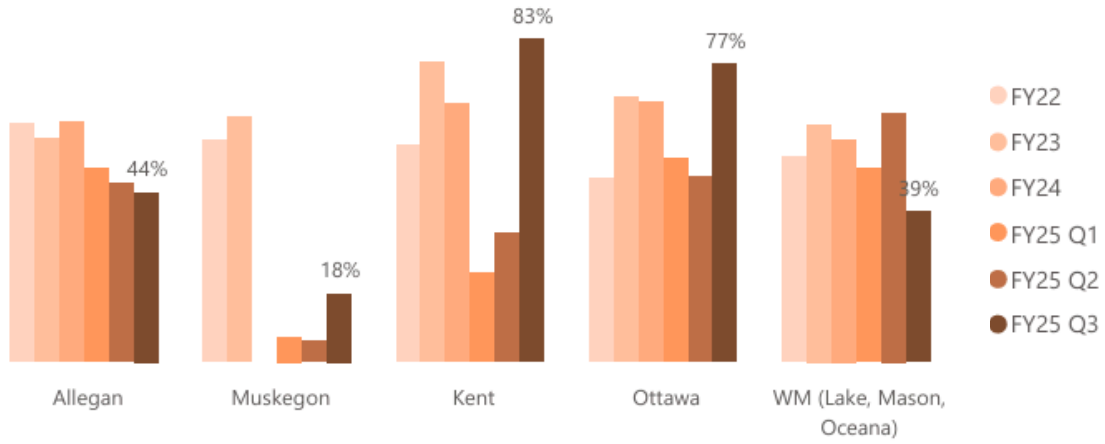
Rates for discharges from detox reported as having "completed treatment" have remained relatively stable.

Across CMHSPs, rates of discharges from ST Res incorrectly reported as 'completed treatment' increased sharply for Muskegon, Kent, and Ottawa in Q3.

Discharges from ST Res and Detox w/ Reason as "Completed Treatment"



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



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	61.5%	57.2%	56.0%	47.4%	52.9%
FY23	57.7%	63.3%	77.4%	68.4%	61.2%
FY24	62.0%	0.0% (0)	66.7%	67.0%	57.4%
FY25 Q1	50.0% (7)	6.6% (4)	23.1% (3)	52.6% (10)	50.0% (10)
FY25 Q2	46.2% (6)	5.5% (3)	33.3% (2)	47.8%	64.3% (9)
FY25 Q3	43.8% (7)	17.6% (9)	83.3% (5)	76.9% (10)	38.9% (7)

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

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

FY25 Q3

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 and Ottawa achieved an improvement between admission and discharge with a regional relative improvement of 25% (from 16% to 20%).

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, Allegan, Muskegon, & Kent achieved improvement. Regionally, rates increased from 62% for admission to 63% 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)

Overall, follow-up rates improved slightly between 2023 and 2024 from 34.0% to 37.8% in 2024 with 4-of-5 CMHSPs seeing an increase.

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 improved slightly between 2023 and 2024, from 36.7% in 2023 to 38.8% in 2024 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 2023 and 2024 to a high of 13.0% for the region.

FY25 Q3

Performance Bonus Incentive

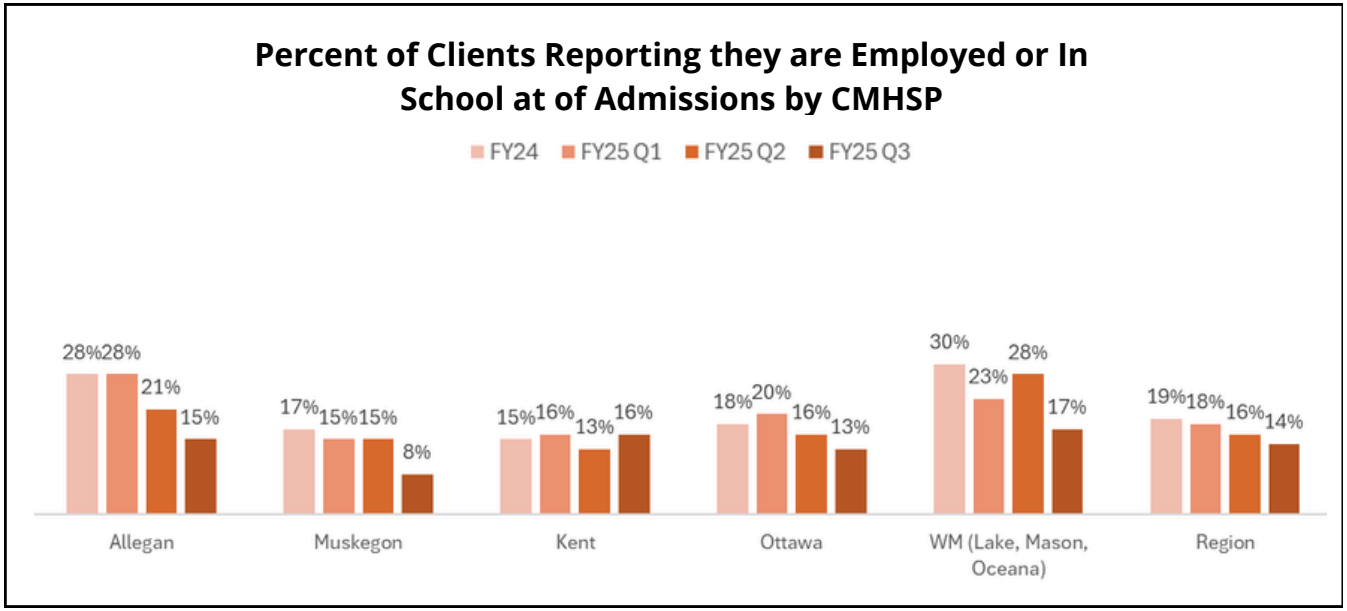
Employment/Education

Metric

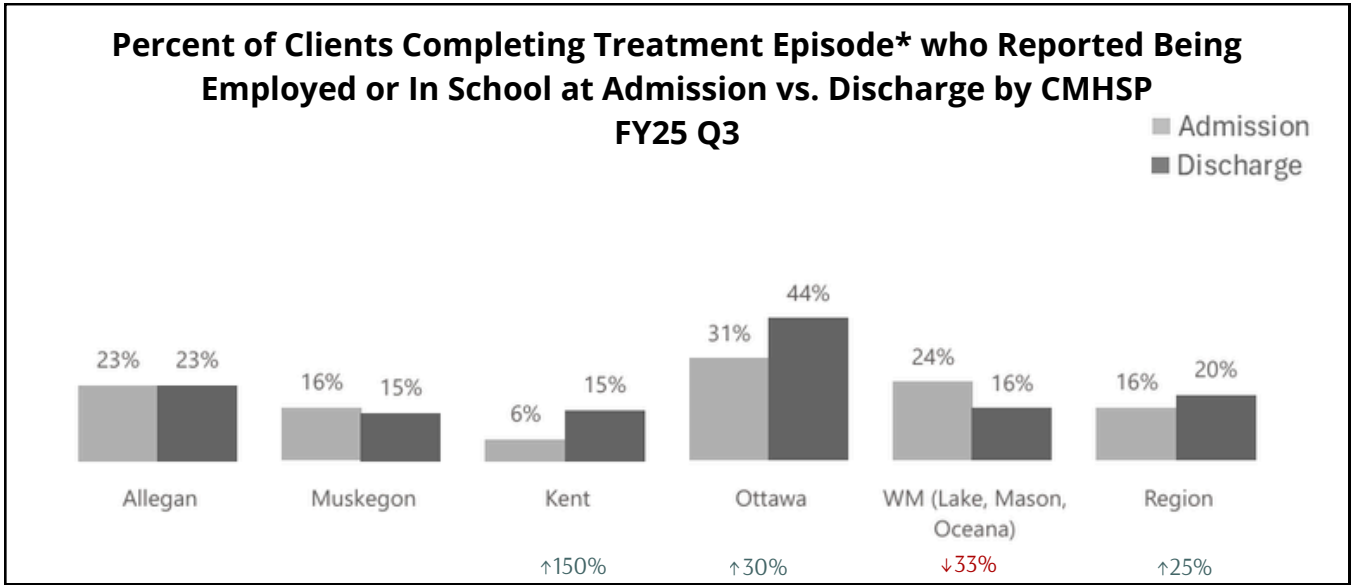
- ↑ % of clients employed or in school between admission & discharge.

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 8% in Muskegon and a high of 17% in WM counties. Every county except Kent had a decrease in clients reporting they were employed or in school at admission for Q3.



The graph to the right shows admission and discharge employment/education status for clients who were discharged during Q3 and their corresponding admissions. Only Kent and Ottawa reported increases between admission and discharge, resulting in a regional relative improvement of 25%. In contrast, WM reported a 33% relative decrease.



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

FY25 Q3

Performance Bonus Incentive

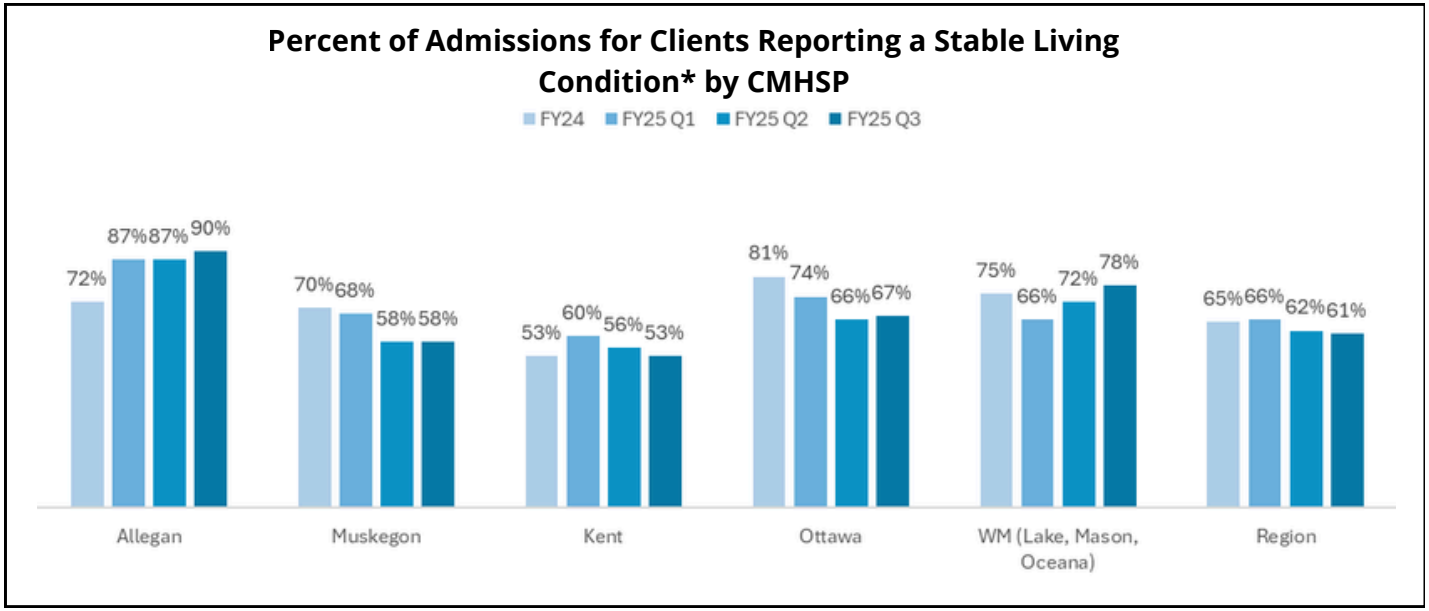
Living Arrangements

Metric

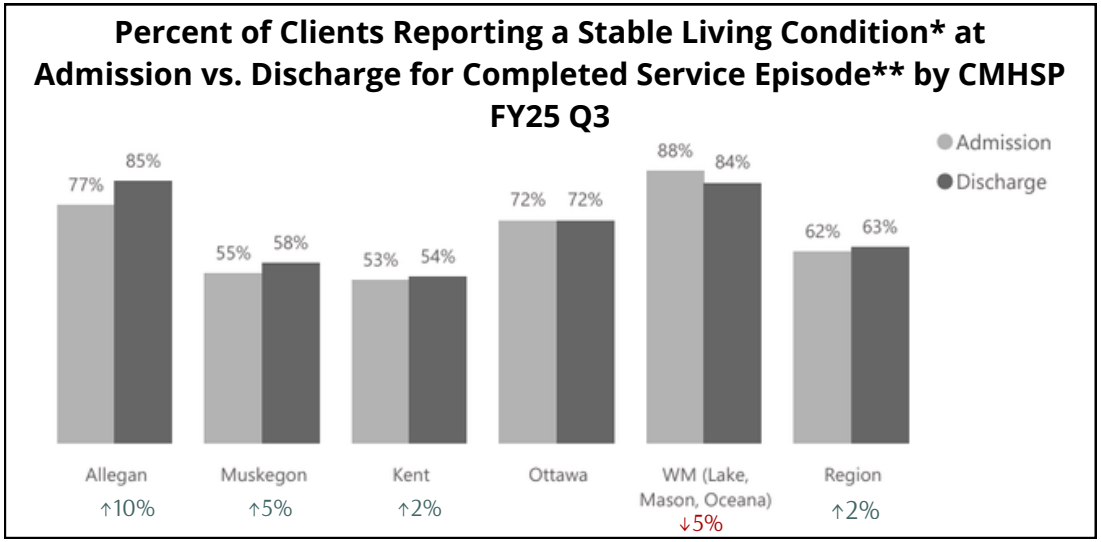
- ↑ % of clients with a stable living condition between admission & discharge.

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 53% in Kent and a high of 90% in Allegan. Additionally, the percentage of clients reporting a stable living condition at the time of admission has improved in Allegan compared to FY24, while it has worsened in Muskegon and Ottawa Counties during 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, Allegan, Muskegon, and Kent improved, contributing to a regional relative improvement of 2%. In contrast WM saw a slight decrease from admission to discharge.



**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.*

FY25 Q3

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)

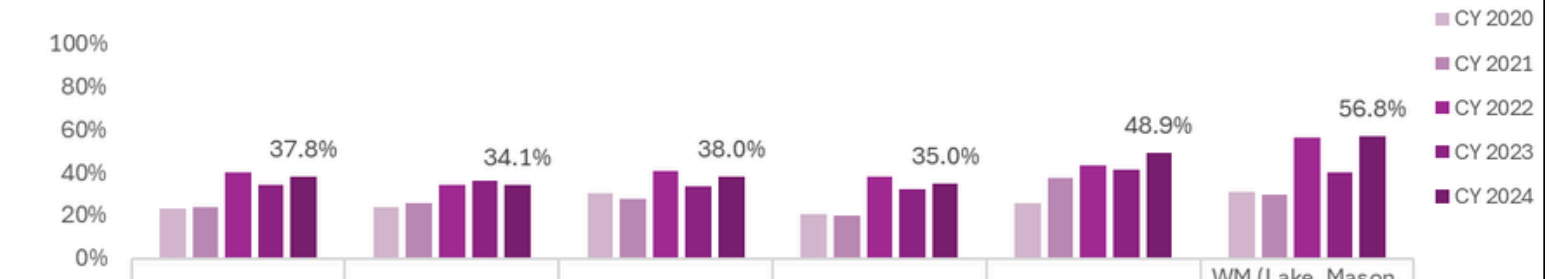
Source: CC360 KPI Summary Dashboard

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.

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



	Region	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
CY 2020	23.2%	23.9%	30.3%	20.2%	26.0%	31.0%
CY 2021	23.8%	26.0%	27.8%	19.6%	37.3%	29.8%
CY 2022	39.9%	34.1%	40.7%	38.2%	43.4%	56.0%
CY 2023	34.0%	36.1%	33.3%	32.4%	41.4%	40.2%
CY 2024	37.8%	34.1%	38.0%	35.0%	48.9%	56.8%

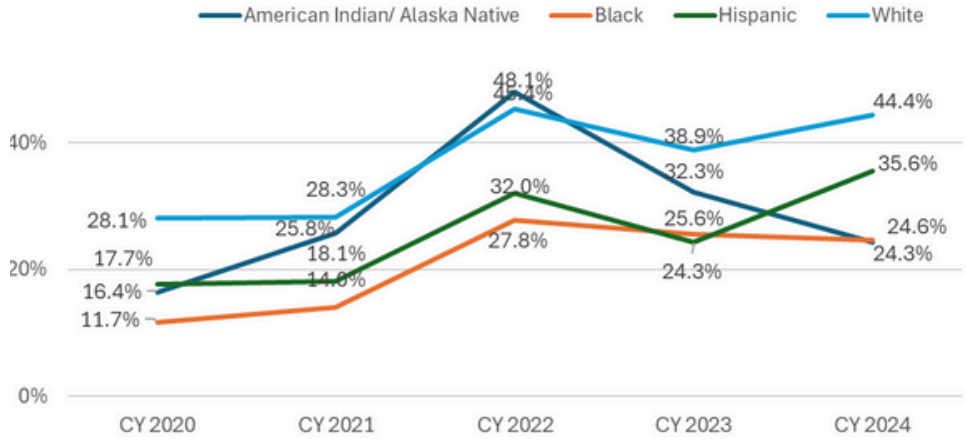
Data Highlights:

Overall, follow-up rates improved slightly between 2023 and 2024 with 4-of-5 CMHSPs seeing an overall increase.

Between 2023 and 2024:

- Rates were highest for white beneficiaries and increased (from 38.9% to 44.4%).
- Rates for Amer. Indian/Alaskan Native beneficiaries worsened (from 32.3% to 24.3%); a 7% pt. disparity in 2023 increased to 20% pts.
- Rates for Black beneficiaries worsened slightly (from 25.6% to 24.6%); a 13% pt. disparity in 2023 worsening to 20% pts. in 2024
- Rates improved for Hispanic beneficiaries (from 24.3% to 35.6%); w/ a 15% pt. disparity in 2023 narrowing to 9% pts. in 2024.

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.

FY25 Q3

Performance Bonus Incentive

Initiation

Metrics

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

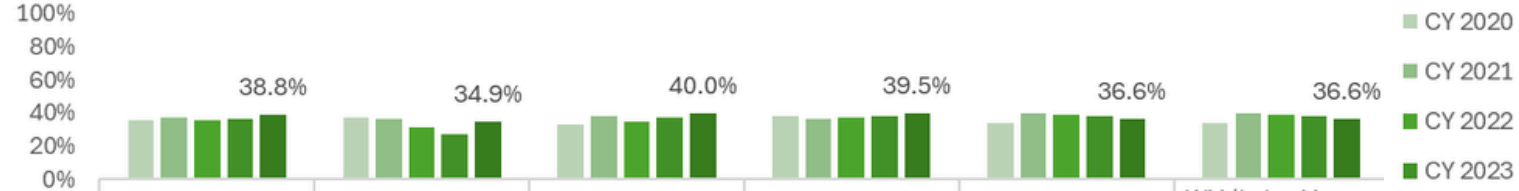
Source: CC360 KPI Summary Dashboard

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 is 40%.

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



Region	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
CY 2020	35.2%	37.0%	32.6%	37.8%	33.7%	33.7%
CY 2021	36.9%	36.5%	37.8%	36.7%	40.0%	40.0%
CY 2022	35.8%	31.3%	34.4%	37.2%	39.0%	39.0%
CY 2023	36.7%	27.1%	37.6%	37.8%	37.7%	37.7%
CY 2024	38.8%	34.9%	40.0%	39.5%	36.6%	36.6%

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

	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Amer. Ind./ Alaska Native	29.0%	39.4%	28.8%	37.4%	41.7%
Black	32.8%	32.4%	31.9%	34.9%	35.6%
Hispanic	28.6%	32.5%	31.0%	33.7%	33.5%
White	37.1%	38.5%	38.2%	37.8%	40.8%

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

Data Highlights:

Overall, initiation rates improved slightly between 2023 and 2024 with 3-of-5 CMHSPs seeing an increase.

In CY24, rates of initiation were highest for American Indian/Alaska Native (AA/AN) (41.7%) followed by white (40.8%)beneficiaries, both improving from CY23.

Between 2023 and 2024:

- Rates for Black beneficiaries increased slightly (from 34.9% to 35.6%); a 3% pt. disparity in 2023 increasing to 5.2% pts. in 2024.
- Rates for Hispanic beneficiaries remained stable (from 33.7% to 33.5%); a 4% pt. disparity in 2023 increasing to 7% pts. in 2024.

FY25 Q3

Performance Bonus Incentive Program

Engagement (IET)

Metrics

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

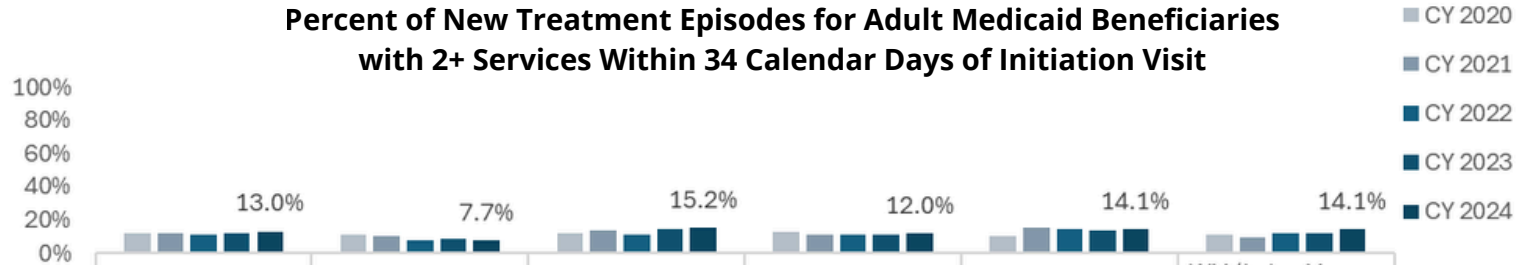
Source: CC360 KPI Summary Dashboard Title

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 calculated benchmark for LRE's overall rate for CY24 is 14%

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



	Region	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
CY 2020	11.8%	10.6%	11.7%	12.4%	10.5%	11.1%
CY 2021	12.0%	10.2%	13.5%	11.1%	15.2%	9.6%
CY 2022	11.2%	7.2%	11.2%	10.9%	14.2%	12.1%
CY 2023	12.2%	8.7%	14.8%	11.2%	13.6%	11.5%
CY 2024	13.0%	7.7%	15.2%	12.0%	14.1%	14.1%

Data Highlights:

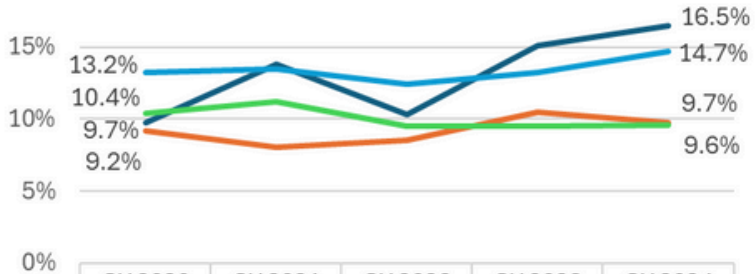
Overall, engagement rates have remained relatively stable with a small increase between 2023 and 2024 to a high of 13.0% for the region.

In CY24 rates of initiation were highest for American Indian/Alaska Native (AA/AN) (16.5%) followed by white (14.7%) beneficiaries, both improving slightly from CY23.

Between 2023 and 2024:

- Rates for Black beneficiaries decreased slightly (from 10.5% to 9.6%), with a 3% pt. disparity in CY23 increasing to 5% pts. in CY24.
- Rates for Hispanic beneficiaries: remained stable (from 9.5% to 9.6%); with a 4% pt. disparity in CY23 increasing to 5% pts. in CY24.

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



	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Amer. Ind./ Alaska Native	9.7%	13.8%	10.3%	15.1%	16.5%
Black	9.2%	8.0%	8.5%	10.5%	9.7%
Hispanic	10.4%	11.2%	9.5%	9.5%	9.6%
White	13.2%	13.5%	12.4%	13.2%	14.7%

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

FY25 Q3

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: Alcohol remains the leading primary drug, followed by methamphetamine (MA). MA-involved admissions remained high (41%) and MA-opioid co-use increased substantially from earlier in FY25 to 11% in Q3.

Muskegon County: Alcohol remains the leading primary drug, followed by heroin (declining). MA-involved admissions remained high (31%) in Q2. MA-opioid co-use also was high at 14% in Q3.

Kent County: Alcohol remains the leading primary drug, followed by cocaine (16%). MA-involved admissions remained low at 18% in Q3, with MA-opioid co-use also low at 5%.

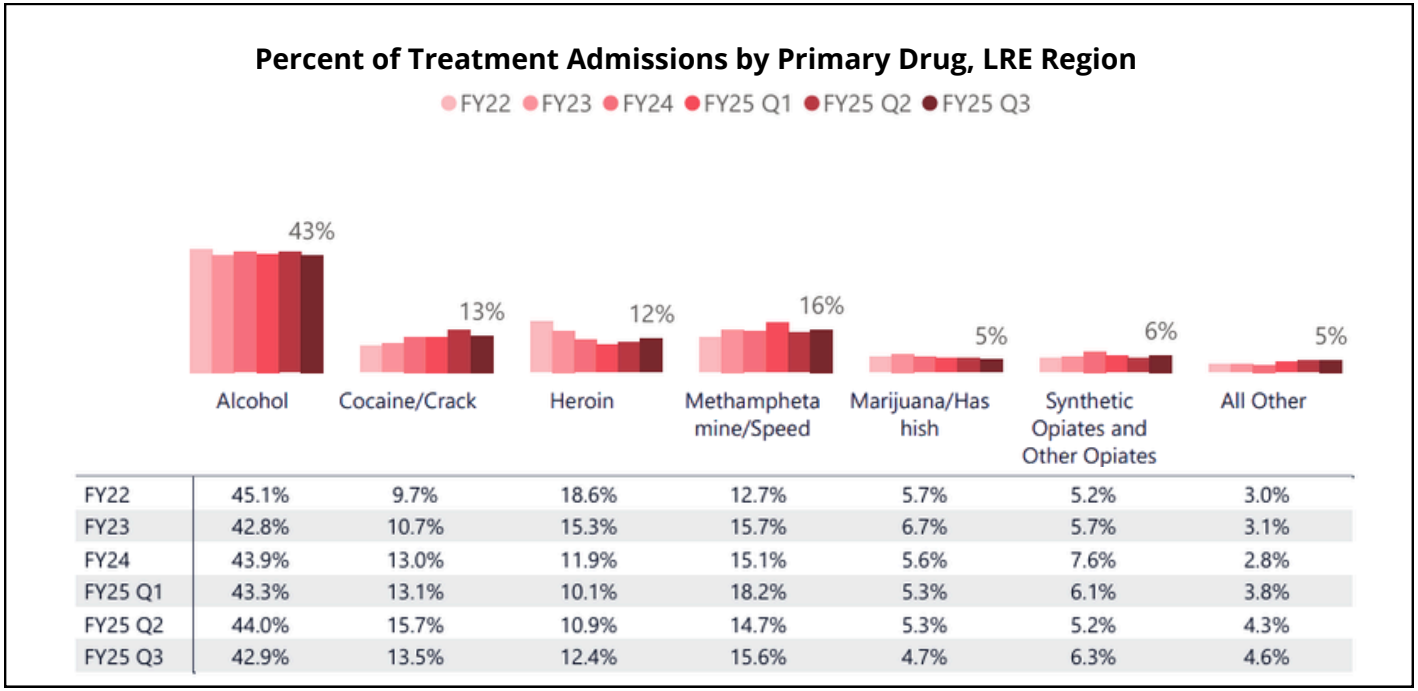
Ottawa County: Alcohol remains the leading primary drug. MA & heroin admissions declined, with MA-involved admissions dropping to 14% & MA-opioid co-use decreasing to 3% in Q3.

West MI: In Q3, MA was the leading primary drug, followed closely by alcohol. MA-involved admissions remain high in each county, with MA-opioid co-use notably high in Lake (19%) and Oceana (17%) in Q3.

Drug Trends: Primary Drug at Admission

LRE Region

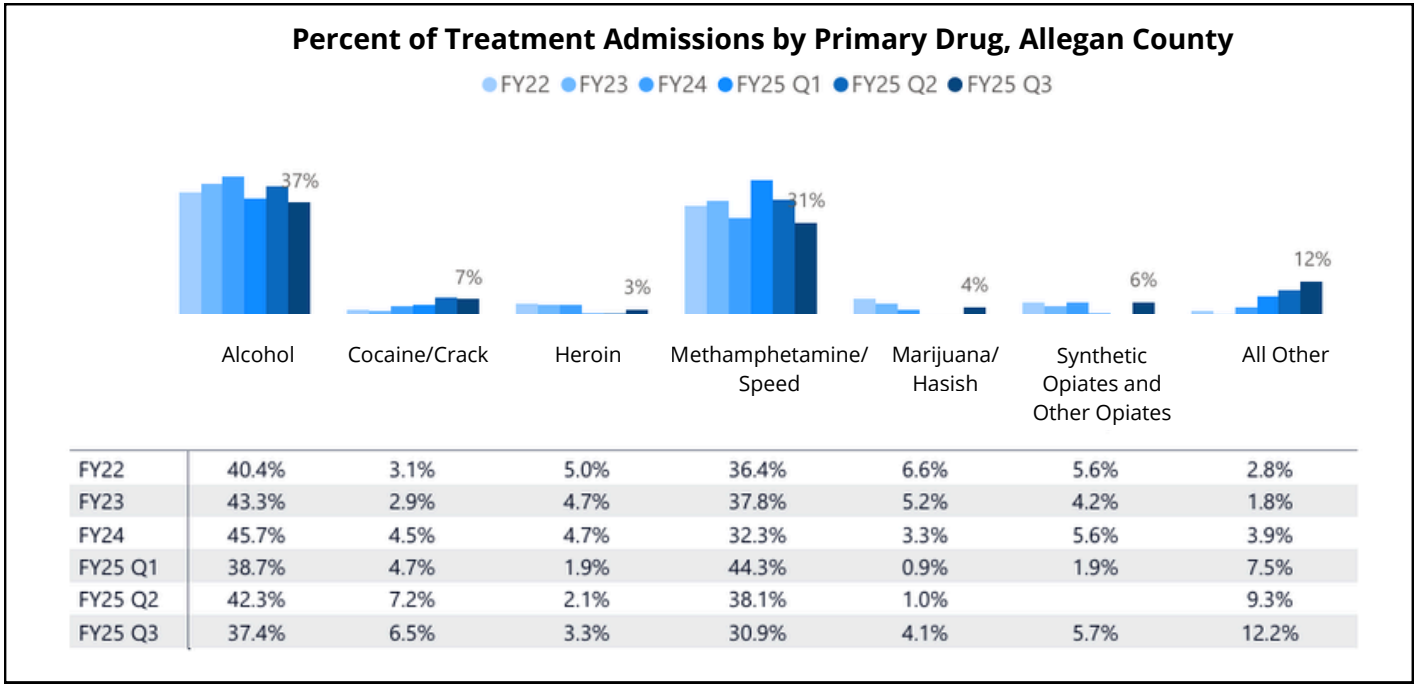
Data Highlights: Alcohol remains the most frequently reported primary drug at admission in the LRE region. Admissions for each substance have remained relatively stable since FY24.



FY22	45.1%	9.7%	18.6%	12.7%	5.7%	5.2%	3.0%
FY23	42.8%	10.7%	15.3%	15.7%	6.7%	5.7%	3.1%
FY24	43.9%	13.0%	11.9%	15.1%	5.6%	7.6%	2.8%
FY25 Q1	43.3%	13.1%	10.1%	18.2%	5.3%	6.1%	3.8%
FY25 Q2	44.0%	15.7%	10.9%	14.7%	5.3%	5.2%	4.3%
FY25 Q3	42.9%	13.5%	12.4%	15.6%	4.7%	6.3%	4.6%

Allegan County

Data Highlights: In Allegan County, alcohol is the most frequently reported primary drug of choice followed by methamphetamine which is substantially higher than region-wide (31% vs. 16% in Q3). Admissions for cocaine and 'all other' drugs have increased slightly since FY24.



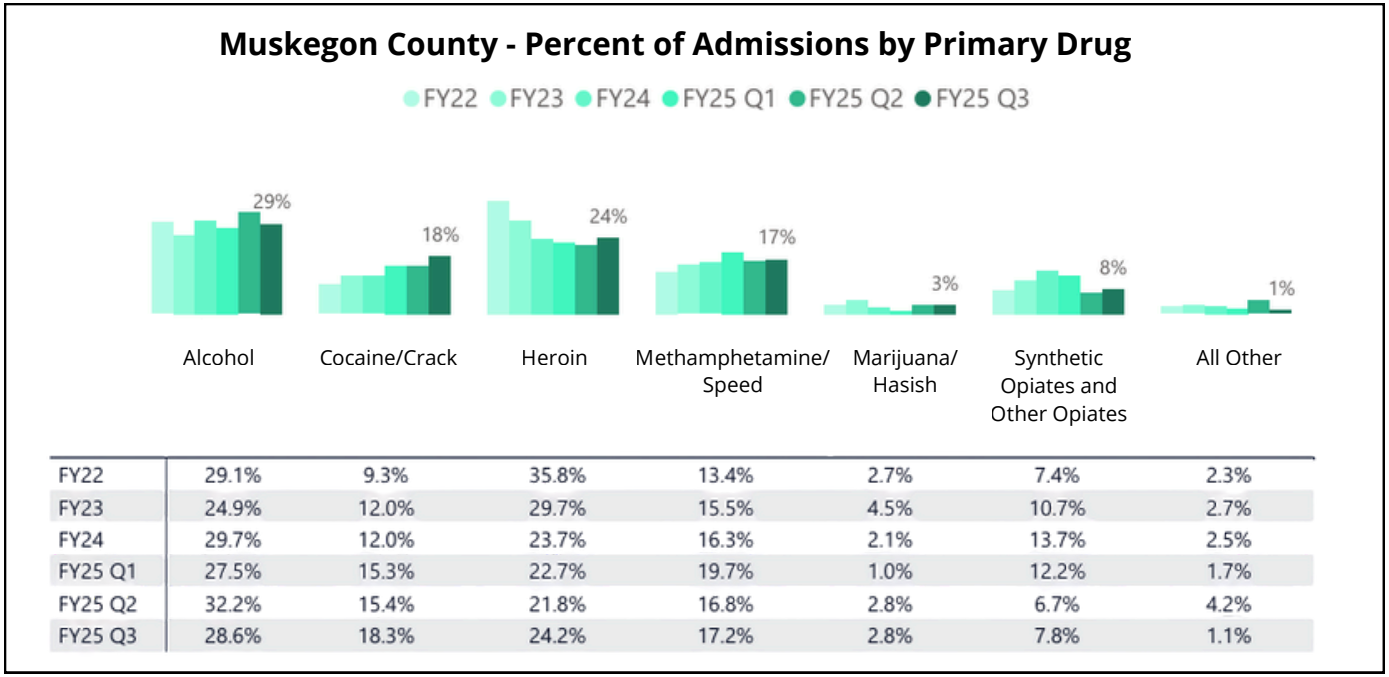
FY22	40.4%	3.1%	5.0%	36.4%	6.6%	5.6%	2.8%
FY23	43.3%	2.9%	4.7%	37.8%	5.2%	4.2%	1.8%
FY24	45.7%	4.5%	4.7%	32.3%	3.3%	5.6%	3.9%
FY25 Q1	38.7%	4.7%	1.9%	44.3%	0.9%	1.9%	7.5%
FY25 Q2	42.3%	7.2%	2.1%	38.1%	1.0%		9.3%
FY25 Q3	37.4%	6.5%	3.3%	30.9%	4.1%	5.7%	12.2%

FY25 Q3

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

Muskegon County

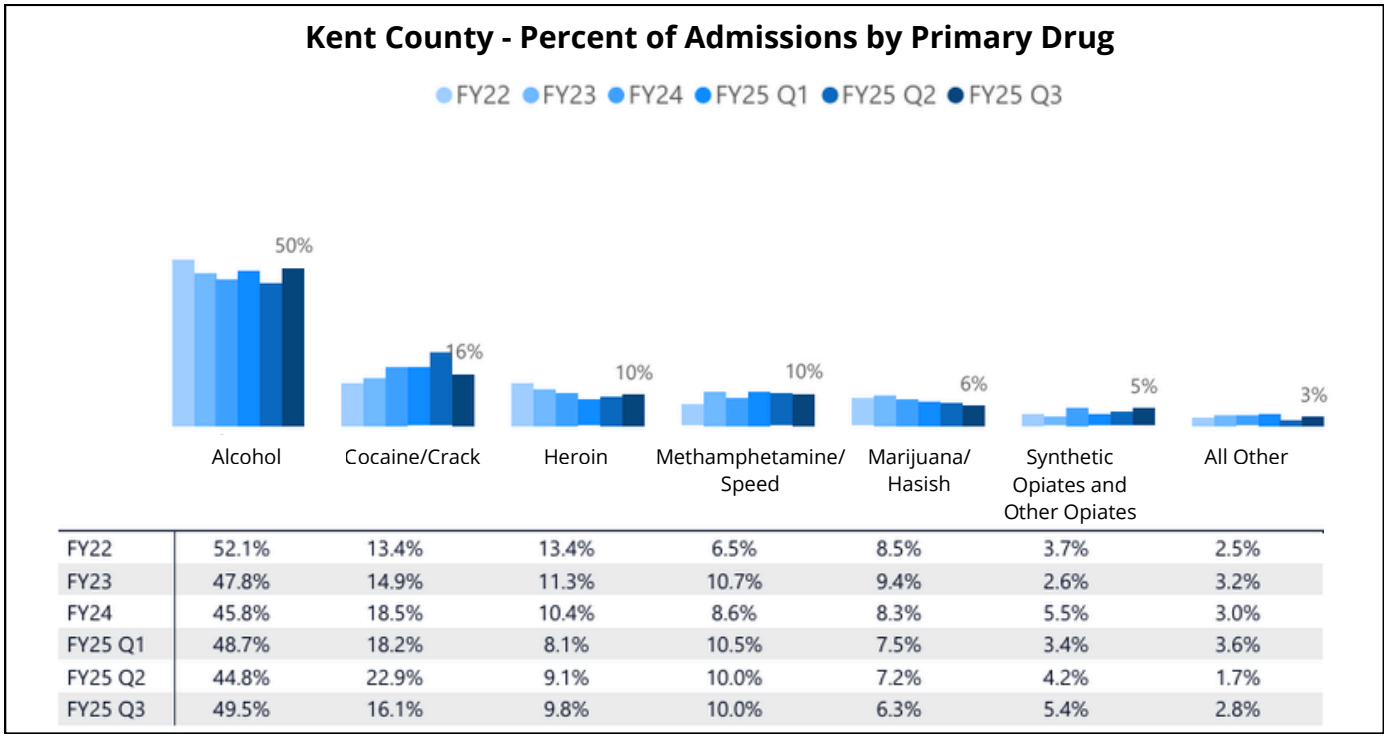
Data Highlights: Alcohol continues to be the most frequently reported primary drugs in Muskegon County, followed by heroin (24%), cocaine (18%) and methamphetamine (17%). Admissions for heroin remain higher than region-wide (24% vs 12% in Q3).



FY22	29.1%	9.3%	35.8%	13.4%	2.7%	7.4%	2.3%
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 Q1	27.5%	15.3%	22.7%	19.7%	1.0%	12.2%	1.7%
FY25 Q2	32.2%	15.4%	21.8%	16.8%	2.8%	6.7%	4.2%
FY25 Q3	28.6%	18.3%	24.2%	17.2%	2.8%	7.8%	1.1%

Kent County

Data Highlights: In Kent County, admissions for alcohol continue to surpass other substances with 50% of admissions, followed by cocaine which decreased to 16% in Q3.



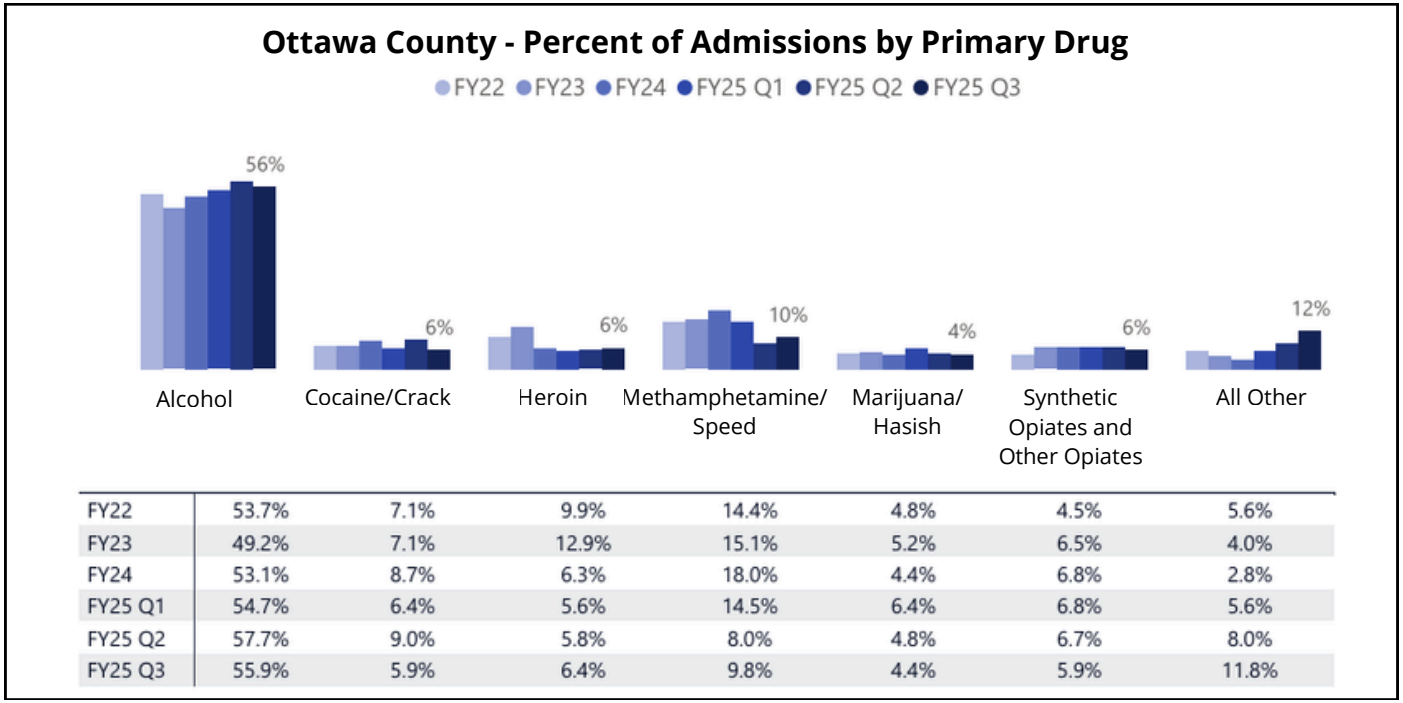
FY22	52.1%	13.4%	13.4%	6.5%	8.5%	3.7%	2.5%
FY23	47.8%	14.9%	11.3%	10.7%	9.4%	2.6%	3.2%
FY24	45.8%	18.5%	10.4%	8.6%	8.3%	5.5%	3.0%
FY25 Q1	48.7%	18.2%	8.1%	10.5%	7.5%	3.4%	3.6%
FY25 Q2	44.8%	22.9%	9.1%	10.0%	7.2%	4.2%	1.7%
FY25 Q3	49.5%	16.1%	9.8%	10.0%	6.3%	5.4%	2.8%

FY25 Q3

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

Ottawa County

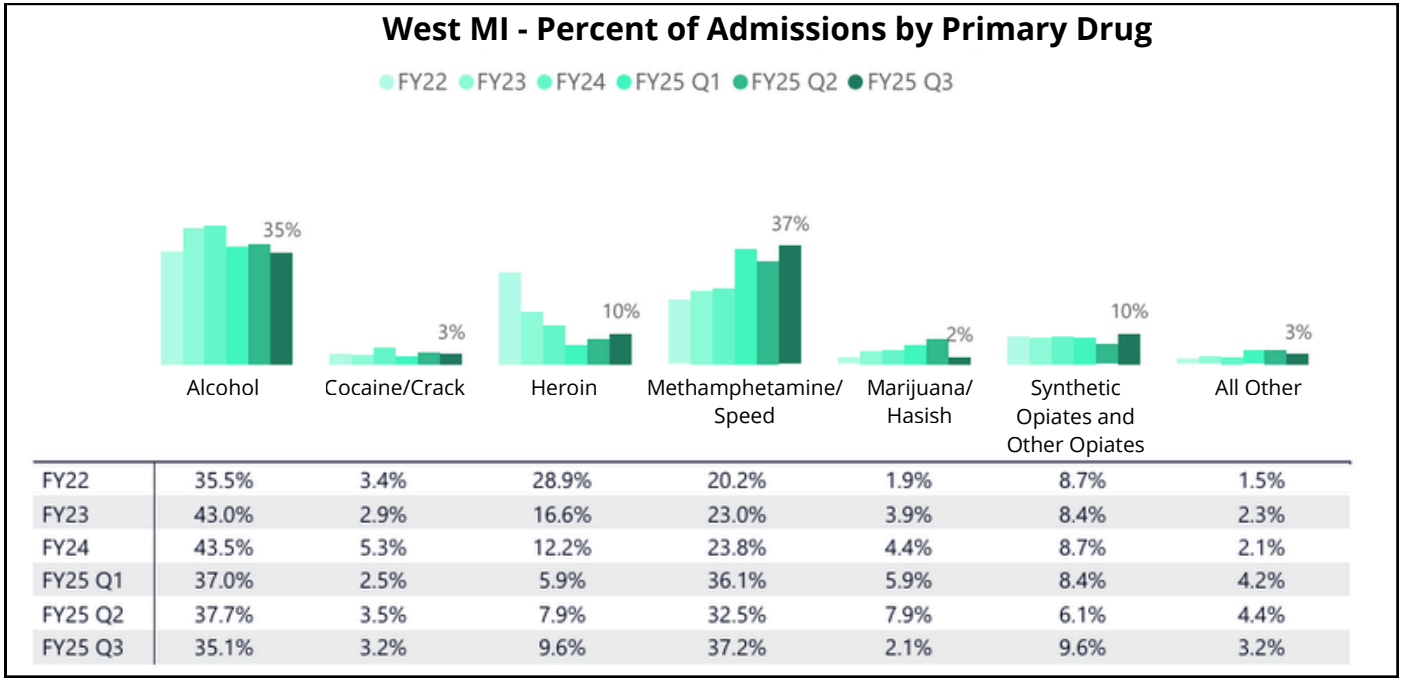
Data Highlights: In Ottawa County, alcohol remains the most frequently reported primary drug, representing 56% of admissions in Q3. Admissions for 'all other' drugs has been increasing since FY24, with a high of 12% in Q3.



FY22	53.7%	7.1%	9.9%	14.4%	4.8%	4.5%	5.6%
FY23	49.2%	7.1%	12.9%	15.1%	5.2%	6.5%	4.0%
FY24	53.1%	8.7%	6.3%	18.0%	4.4%	6.8%	2.8%
FY25 Q1	54.7%	6.4%	5.6%	14.5%	6.4%	6.8%	5.6%
FY25 Q2	57.7%	9.0%	5.8%	8.0%	4.8%	6.7%	8.0%
FY25 Q3	55.9%	5.9%	6.4%	9.8%	4.4%	5.9%	11.8%

West Michigan Counties

Data Highlights: In West MI counties, methamphetamine was the most frequently reported primary drug of choice, representing 37% of admissions in Q3, followed by alcohol at 35%.



FY22	35.5%	3.4%	28.9%	20.2%	1.9%	8.7%	1.5%
FY23	43.0%	2.9%	16.6%	23.0%	3.9%	8.4%	2.3%
FY24	43.5%	5.3%	12.2%	23.8%	4.4%	8.7%	2.1%
FY25 Q1	37.0%	2.5%	5.9%	36.1%	5.9%	8.4%	4.2%
FY25 Q2	37.7%	3.5%	7.9%	32.5%	7.9%	6.1%	4.4%
FY25 Q3	35.1%	3.2%	9.6%	37.2%	2.1%	9.6%	3.2%

FY25 Q3

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.

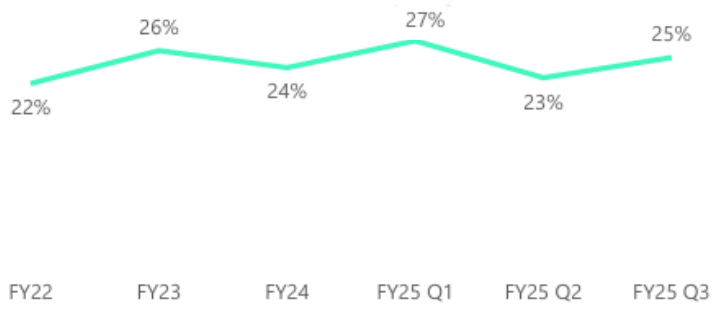
"Involved"
An admission with the substance reported as the primary, secondary, or tertiary drug of choice.

Data Highlights:

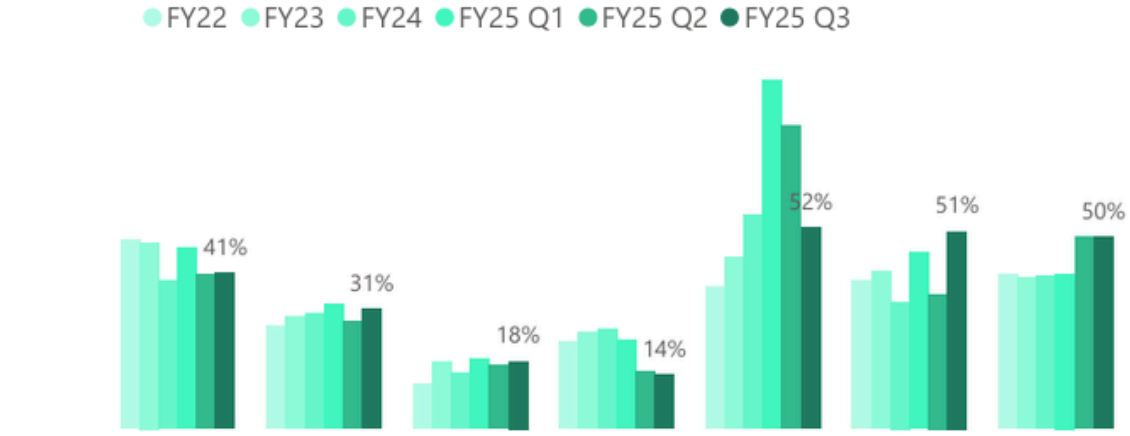
In FY24, 24% of admissions were MA-involved. During the first 3 quarters of FY25 the rate has ranged from a high of 27% to a low of 23%.

During Q3, MA-involved admissions remain highest in Lake (52%), Mason (51%) and Oceana (50%) counties.

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



Percent of Admissions That Were MA-Involved by County



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	49.2%	26.6%	11.7%	22.7%	36.8%	38.6%	40.2%
FY23	48.6%	29.2%	17.4%	25.0%	44.7%	41.1%	39.4%
FY24	38.7%	30.2%	14.4%	25.8%	55.8%	33.1%	39.7%
FY25 Q1	47.2%	32.5%	18.2%	23.1%	90.9%	45.9%	40.4%
FY25 Q2	40.2%	28.0%	16.5%	15.1%	78.9%	35.1%	50.0%
FY25 Q3	40.7%	31.1%	17.6%	14.2%	52.4%	51.4%	50.0%

FY25 Q3

Drug Trends: Opioid & Methamphetamine-Involved

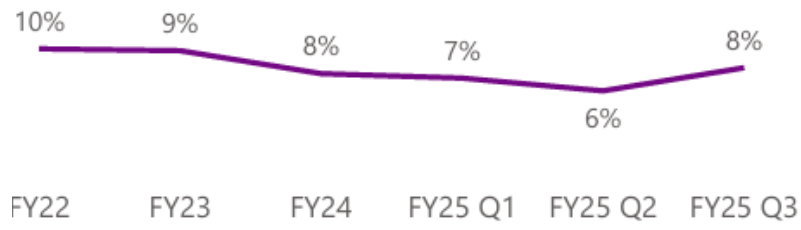
Admissions involving both opioids and methamphetamine are monitored due to the unique clinical challenges they pose. Research indicates that individuals using both substances have lower treatment retention and completion rates compared to those using opioids alone. In addition, the alternating or combined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

Data Highlights:

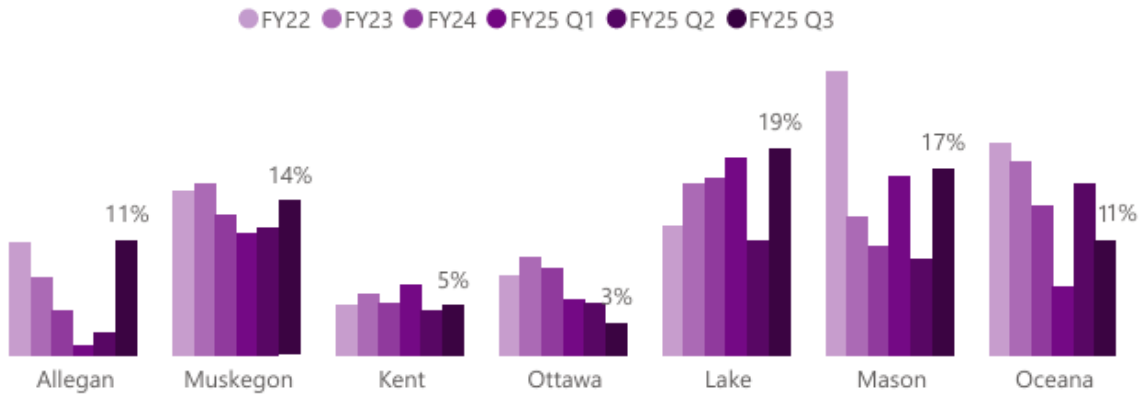
Admissions involving both an opioid and methamphetamine have remained relatively stable since FY24, with a rate of 8% in Q3.

Admissions involving both an opioid and methamphetamine increased substantially in Q3 for Allegan, Lake, and Mason counties. Rates have been increasing throughout Fy25 for Muskegon County, but less dramatically. Rates have been decreasing throughout FY25 in Ottawa County.

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



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



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	10.3%	15.0%	4.6%	7.3%	11.8%	26.1%	19.5%
FY23	7.1%	15.7%	5.7%	9.0%	15.8%	12.8%	17.7%
FY24	4.2%	12.9%	4.8%	8.0%	16.3%	10.0%	13.8%
FY25 Q1	0.9%	11.2%	6.4%	5.1%	18.2%	16.4%	6.4%
FY25 Q2	2.1%	11.8%	4.1%	4.8%	10.5%	8.8%	15.8%
FY25 Q3	10.6%	14.2%	4.6%	2.9%	19.0%	17.1%	10.5%

FY25 Q3

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

Appendix Data Parameters Cont...

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

NEW

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.

NEW

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.

NEW

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.

Bidding out the Management of Michigan's Public Mental Health System

On August 4, 2025, the Michigan Department of Health and Human Services (MDHHS) announced the release of a Request for Proposals (RFP) to competitively bid the state's public mental health managed care system. Proposals are due by September 29, 2025. This approach brings with it several risks without addressing real gaps in the system.

Myth	Fact
The proposal eliminates an administrative layer and related costs and does not cut funding for services.	Switching to private insurance companies does not eliminate an administrative layer – in fact it replaces the single payer, per region, with multiple payers per region all with much higher overhead. Private insurers spend 15% on overhead, while the public system only spends 2%. That higher overhead will cut funding for services by $500 million.
The proposal keeps the CMH system intact.	The proposal strips funding from local public CMHs by diverting CMH dollars to private organizations. It violates the Michigan Mental Health Code by prohibiting CMHs from managing their established provider networks and performing the contract oversight and management functions. It forces CMHSPs to relinquish decision-making authority to outside entities and join regional entities against their will. The proposal dismantles the very foundation of the public mental health system rather than keeping it intact.
MDHHS survey results, of stakeholders to the system, indicate a demand for competitive bidding of system management.	The survey results actually highlight the need to address workforce shortages, lack of transparency, long-term care gaps, funding issues, and client rights concerns. None of these are fixed by competitive bidding.
The current system just wants no change.	The current system supports bold and dramatic change but wants it to be open, transparent, include all stakeholders in the new system design and ensure a sound mental health safety net in Michigan.
Federal government (CMS) requires competitive bidding.	The Centers for Medicare and Medicaid (CMS) does not require this. MDHHS admits that there is no written communication from the federal government requiring competitive bidding of the system. Since 1997, CMS has approved Michigan's sole source contract with the state's public health plans. In 2014, Michigan reduced PIHPs from 18 to 10 via sound sole source contract development, and CMS fully supported it.

CMHA
Community Mental Health Association of Michigan