Northeast Michigan Community Mental Health Authority
Board Meetings - December 2018

All meetings are held at the Board's Main Office Board Room located at 400 Johnson St in Alpena unless otherwise noted.

Board Meeting – Thursday, December 13 @ 3:00 p.m.

Merry Christmas

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD
BOARD MEETING
December 13, 2018 at 3:00 p.m.
A G E N D A

I. Call to Order

II. Roll Call & Determination of a Quorum

III. Pledge of Allegiance

IV. Appointment of Evaluator

V. Acknowledgement of Conflict of Interest

VI. Information and/or Comments from the Public

VII. Educational Session – Special Presentation ..... All

VIII. Approval of Minutes .....(See pages 1-6)

IX. Consent Agenda .....(See page 7)
1. Contracts
   a. NEMROC

X. December Monitoring Reports
1. Budgeting 01-004 ....(Available at the meeting)
2. Financial Condition 01-005..... ..(addition to November report See pages 8-9)
3. Grants or Contracts 01-011 ....(See pages 10-11)

XI. Board Policies Review and Self Evaluation
1. Grants or Contracts 01-011 ..... [Review] .....(See pages 12-13)
2. Board Member Recognition 02-011..... [Review & Self-Evaluation] .....(See page 14)
3. Board Member Orientation 02-015..... [Review & Self-Evaluation] .(See pages 15-16)

XII. Linkage Reports
1. CMHAM
   a. World Class Public Mental Health System in Michigan .....(See colored insert)
   b. How we are Funded ..... (See insert)
2. Northern Michigan Regional Entity
   a. Board Meeting (12/12/18) .....(Verbal)
   b. Board Meeting (10/24/18) .....(See pages 17-21)
3. Consumer Advisory Council Update (12/10/18) .....(Verbal)

XIII. Operations Report .....(See page 22)

XIV. Chair's Report
1. By-Law Review.....(See pages 23-34)

XV. Director's Report
1. Director's Update .....(Verbal)
2. Northland Area Federal Credit Union – Authorized Signers .....(See page 35)

XVI. Information and/or Comments from the Public

XVII. Next Meeting – Thursday, January 10, 2019 at 3:00 p.m.
1. Set January Agenda.....(See page 36)
2. Evaluation of meeting..... All

XVIII. Adjournment

MISSION STATEMENT

To provide comprehensive services and supports that enable people to live and work independently.

Northeast Michigan Community Mental Health Authority Board

Board Meeting

November 8, 2018

I. Call to Order

Chair Gary Nowak called the meeting to order in the Board Room at 3:00 p.m.

II. Roll Call and Determination of a Quorum

Present: Lester Buza, Bonnie Cornelius, Steve Dean, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski

Absent: Alan Fischer (excused), Roger Frye (excused), Judy Hutchins (excused), Albert LaFleche (excused)

Staff & Guests: Lisa Anderson, Carolyn Bruning, Lynne Fredlund, Cheryl Jaworowski, Margie Hale-Manley, Cathy Meske, Nena Sork, Jen Whyte, Peggy Yachasz

Gary Nowak requested Board members keep Roger Frye in their prayers as he is recovering from recent surgery.

III. Pledge of Allegiance

Attendees recited the Pledge of Allegiance as a group.

IV. Appointment of Evaluator

Gary Nowak appointed Judy Jones as evaluator for this meeting.

V. Acknowledgement of Conflict of Interest

No conflicts were identified.

VI. Information and/or Comments from the Public

Pat Przeslawski apologized for her comments presented in the last meeting. She notes emotion fed into some of the comments and since then has learned more about the situation. She reported her grandson is now in rehab and on the way to recovery.

Judy Hutchins arrived at 3:03 p.m.

VII. Educational Session – Compliance Report

Jen Whyte provided the Board with the Agency's annual report related to Compliance. She reports this is part of the reporting requirement established in the perpetual calendar.

Jen reviewed the Medicaid Verification Audit noting the 1st and 2nd Quarter for last fiscal year the Agency achieved 100% compliance. Claims are reviewed to assure documentation aligns with the billing code associated with the service.

Jen reports the supervisors conduct monthly record reviews on the clinical records to assure staff are capturing needed elements to the record and billing properly.

Jen reported there was one investigation reported to the Office of Inspector General. She reported there was a large amount of dollars which will be returned to the Agency due to this investigation.

She reported there were 18 terminations or dis-enrollments over the past year. She noted there are many reasons for this such as retirements, transfers to a lessor restrictive environment, etc.

VIII. Approval of Minutes

Moved by Bonnie Cornelius, supported by Steve Dean, to approve the minutes of the October 11, 2018 minutes as presented. Motion carried.

IX. Consent Agenda

1. **NEMROC Contract Extension**
2. **Catholic Human Services – Wraparound Services**
3. **MDHHS FY19 Amendment #1**

Moved by Steve Dean, supported by Eric Lawson, to approve the Consent Agenda as presented. Roll call vote: Ayes: Lester Buza, Bonnie Cornelius, Steve Dean, Judy Hutchins, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski; Nays: None; Absent: Alan Fischer, Roger Frye, Albert LaFleche. Motion carried.

X. Bay View Center Contract

Cathy Meske reported this contract will be handled as an individual item due to a conflict of interest as one Board member must recuse herself. Cathy Meske reports the Bay View Center offers a good program and when you don't have complaints about the program from community and members you know it is running well.

Moved by Pat Przeslawski, supported by Lester Buza, to approve the Bay View Center contract as presented. Roll call vote: Ayes: Lester Buza, Bonnie Cornelius, Steve Dean, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski; Nays: None; Abstain: Judy Hutchins; Absent: Alan Fischer, Roger Frye, Albert LaFleche. Motion carried.

XI. November Monitoring Reports

1. Treatment of Consumers 01-002

The monitoring report was distributed which included the minutes from the most recent Right Committee meeting, the 4th Quarter Report and the preliminary Annual Report. The minutes from the Recipient Rights meeting noted at the time of the submission of the Annual Rights Report there were six remedial actions pending and with the report due by December 30, 2018, the report will be updated to reflect actions for the six pending items. Board members had no questions or concerns.

2. Budgeting 01-004

The monitoring report for month ending September 30, 2018 was distributed noting this is a very preliminary report. Cheryl Jaworowski noted a change in net position of $39,443. She reports this is much less than the last report as the last report reflected the incentive payment received from NMRE which was spent in September. Cheryl Jaworowski reviewed the line items with the largest variances.

Cheryl Jaworowski reviewed the contract settlement lines related to Medicaid Funds/General Funds/Healthy Michigan. She reports the lapse back to the State in the General Fund line of $10,000 is due to those dollars strictly dedicated for Assisted Outpatient Treatment (AOTs). If the dollars are not used for that purpose, the dollars must be sent back to the State. She again noted this is a preliminary statement. She reported both the Medicaid Funds and Healthy Michigan Funds are over spent and the deficit will be covered by the NMRE's risk reserve fund.

3. Financial Condition 01-005

Cheryl Jaworowski reported the unrestricted revenues and net position has increased. She notes there are 51 days of operating cash this year where last year was 52 days. Cheryl Jaworowski reported an actuary firm had reported there should be between 8 and 25 percent on hand and this Agency is at 14.1%. Steve Dean inquired as to whether there is ready information as to comparison of other mental health agencies similar to the size of this Agency. Cheryl Jaworowski reported information is shared within our affiliate members.

Cheryl Jaworowski reported all affiliates within the PIHP will be pulling the data on the same date, which is scheduled the day before Christmas. Due to this, the audit proceedings will begin later in the year than in the past and most likely the audit will not be available until March or April.

Steve Dean inquired as to when the dollars for the cost settlement on the Medicaid deficits are received. Cheryl Jaworowski noted this can be as late as May.

4. Ends 04-001

The Ends monitoring report was included in the packet mailed to Board members. Status of all goals was summarized in the report. This monitoring report concludes review of the Ends, which were established by the Board during last year's Strategic Planning and adopted on November 9, 2017. Board member had no questions or concerns related to the monitoring report.

Moved by Pat Przeslawski, supported by Lester Buza, to accept the November monitoring reports as presented. Motion carried.

XII. Board Policy Review and Self Evaluation

1. Treatment of Individuals Served 01-002

Board members reviewed the policy and had no concerns and requested no revisions.

2. Staff Treatment 01-003

Board members had no comments regarding this policy.

3. Ends 04-001

The Ends Policy 04-001 was updated to reflect the most recent Strategic Plan sub-ends.

Moved by Eric Lawson, supported by Pat Przeslawski, to approve revision to Policy 04-001 updating the sub-End as developed during Strategic Planning as presented. Motion carried.

XIII. Linkage Reports

1. Northern Michigan Regional Entity (NMRE)

a. Board Meeting October 24, 2018

The minutes from this meeting were not available at the time of the meeting. Gary Nowak reported the NMRE Board approved a few liquor tax expenditures at their last meeting.

b. Board Meeting September 26, 2018

The minutes of this meeting were included in the mailing.

2. CMHAM

a. Fall Board Conference – October 22 & 23 – Traverse City Update

Gary Nowak reported the conference was very good. The Red Wings announcer Ken Daniels provided a testimony related to his son's opiate overdose. Gary also noted he attended a BoardWorks session which was very informative.

Judy Jones reported she attended a BoardWorks session related to how meetings ran and this Board is right on target.

Cathy Meske noted the Fall Conference is her favorite. She reported she attended many of the opiate workshops. She reported one presentation was by a nurse practitioner responsible for a medication assisted treatment program.

Nena Sork reported she attended a staff retention workshop and she applauds our human resource department for our low turnover rate. Nena reports we talk about exit interviews during our monitoring reports related to "Treatment of Staff;" however, in this presentation they also recommend doing stay interviews to determine what it is that keeps staff.

Jen Whyte reported she attended the Home and Community Based segments and some of the substance use disorder segments.

Eric Lawson inquired as to whether there was any speculation individuals will utilize the new marijuana legislation versus using opiates.

3. Consumer Advisory Council

Diane Hayka reported there was no quorum for this meeting so the minutes included in the mailing were just of the discussion occurring during the meeting.

XIV. Operation's Report

Nena Sork reviewed the Operation's Report for month ending October 31, 2018. She reports there has been an increase in the hospital prescreens. In addition, the numbers for home-based services has increased and this is due to having a fully staffed department. There were 1,206 individual receiving some type of service during the month of October.

XV. Nomination's Committee Report

Terry Larson reported the Nomination's Committee met just prior to this meeting. Terms were reviewed and letters will be sent to the County Commission's with recommendations for those seeking to be reappointed. Judy Hutchins has elected not to seek re-appointment.

XVI. Chair's Report

There was no new business to discuss.

XVII. Director's Report

1. **Director's Update**

Cathy Meske reviewed the activities she participated since the last Board meeting. She reported one area she was disappointed in was the MCG Health (part of the Hearst Health Network) parity software demonstration. She reports this system is not able to be integrated into the PCE system. At this point, it would require double entry. Nena Sork reported PCE has 38 CMHs in the state and PCE will be looking to see if this can be resolved.

Cathy Meske noted only one bid had been received in the recent RFP for Clubhouse Management and that bid came from Touchstone. She and Mary Jamieson traveled to a

Clubhouse in Bay City to survey the participants in their clubhouse which is run by Touchstone. She notes she participated in two roundtables with individuals. She recommends this Board enter into a contract with Touchstone to begin management of the Light of Hope Clubhouse beginning January 1, 2019. Initially, the cost per unit will be higher than our current costs to cover some initial costs for start-up. Based on attendance this rate could be decreased. The contract will be cost-settled at the end of the year. Cathy Meske reported this will be a new type of contract having performance indicators and monitoring. She reported the current staff will be encouraged to apply for positions and the provider has been encouraged to consider hiring current staffing.

One of the performance indicators would be increased daily participants. She would like to see more than a 20% increase of daily attendance, a performance indicators suggested by Touchstone. 20% is only an increase of two individuals. Cathy and Lynne will be working with Touchstone staff in the development of agreed upon performance indicators.

Cathy Meske reported she will be notifying Eric Kurtz, NMRE Director, of the change of Management of the Clubhouse once all the details have been finalized.

Moved by Pat Przeslawski, supported by Judy Hutchins, to approve the contract with Touchstone when all details are finalized. Roll Call Vote: Ayes: Lester Buza, Bonnie Cornelius, Judy Hutchins, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski; Nays: None; Absent: Alan Fischer, Roger Frye, Albert LaFleche. Motion carried.

2. **QI Council Update**
The minutes of the most recent Council meeting of October 15, 2018 were distributed. Cathy Meske provided a story about Bette and the woodcock hunting experience.

XVIII. Information and/or Comments from the Public

Cathy Meske invited Board members to a "Lunch for a Cause" luncheon scheduled for November 14 beginning at 11:30 a.m. in the Board Room. She noted sandwiches are provided by Nena Sork and herself and other staff bring dishes as well. A free-will donation is made by those attending and these dollars are used to acquire some items for the individuals served by this Agency who might not otherwise get anything during the holidays. Some of the items include simple items such as toiletries, paper products, etc. In the past, this event raised between $800 and $1,200 for this purpose.

Diane Hayka also informed Board members of the generosity of staff for the United Way and Endowment Fund campaigns. This year staff pledged just over $10,000 to these campaigns.

XIX. Next Meeting

The next regularly scheduled meeting of Northeast Michigan Community Mental Health Authority Board will be held Thursday, December 13, 2018 at 3:00 p.m.

1. Set December Agenda

The December agenda items were reviewed. Diane Hayka reported Lynne Fredlund requested to provide a CARF training prior to April 1. Cathy Meske reported Eric Lawson had requested a presentation from the Freedom Clinic related to opiates.

Judy Jones inquired as to whether there have been any rules established for Proposal 1. The proposal was passed prior to any type of rules being developed. Cathy Meske reported Karl Kovacs had a lot of information related to the marijuana proposal.

Gary Nowak reported the December Board meeting will include a special presentation.

XX. Evaluation of Meeting

Judy Jones reported the meeting started on time and moved along. She reported the reports were all good – clubhouse, conference, compliance.

XXI. Adjournment

Moved by Steve Dean, supported by Judy Jones, to adjourn the meeting. Motion carried. This meeting adjourned at 4:05 p.m.

_____

Alan Fischer, Secretary

_____

Gary Nowak, Chair

Diane Hayka
Recorder

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

INTEROFFICE MEMORANDUM

TO: Board Members

FROM: Cathy Meske

SUBJECT: Consent Agenda

DATE: December 4, 2018

1. **Contract**
    a. **NEMROC Inc.**
    Last month, the existing contract with NEMROC was extended through November 30, 2018 while negotiations continued based on the requirements of rate restructuring. NEMROC Inc. provides supported employment and community living support services to persons served by the Board. Rate restructuring focuses on the supported employment services offered through NEMROC. This contract includes elements of the rate restructuring which provides incentives as well as unit rates. This contract is a ten-month contract. This contract will be in effect from December 1, 2018 through September 30, 2019. The total amount of the contract, including the approved two-month extension, is $650,658.71. This total is $15,769.69 less than last fiscal year's contract. We recommend approval.

Northeast Michigan Community Mental Health Authority
Preliminary Statement of Revenue and Expense and Change in Net Position (by line item)
For the Month Ending October 31, 2018
8.3% of year elapsed

		Actual October Year to Date	Budget October Year to Date	Variance October Year to Date	Budget FY19	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 7,527	$ 8,051	$ (524)	$ 97,000	7.8%
2	Private Contracts	6,180	4,758	1,421	57,331	10.8%
3	Grants from Local Units	24,071	40,817	(16,746)	491,772	4.9%
4	Interest Income	666	830	(164)	10,000	6.7%
5	Medicaid Revenue	2,124,866	2,063,263	61,603	24,858,588	8.5%
6	General Fund Revenue	66,705	58,921	7,784	709,887	9.4%
7	Healthy Michigan Revenue	97,778	111,603	(13,824)	1,344,612	7.3%
8	3rd Party Revenue	11,676	53,211	(41,535)	641,100	1.8%
9	SSI/SSA Revenue	40,726	41,592	(866)	501,112	8.1%
10	Other Revenue	4,508	3,974	534	47,876	9.4%
11	**Total Revenue**	**2,384,703**	**2,387,020**	**(2,318)**	**28,759,278**	**8.3%**
	Expense					
12	Salaries	1,059,939	1,082,803	22,864	13,045,816	8.1%
13	Social Security Tax	47,254	53,230	5,976	641,324	7.4%
14	Self Insured Benefits	197,975	218,240	20,265	2,629,392	7.5%
15	Life and Disability Insurances	17,699	19,410	1,711	233,855	7.6%
16	Pension	77,177	84,923	7,746	1,023,166	7.5%
17	Unemployment & Workers Comp.	17,892	19,893	2,001	239,676	7.5%
18	Office Supplies & Postage	3,627	4,000	373	48,188	7.5%
19	Staff Recruiting & Development	11,697	10,090	(1,607)	121,567	9.6%
20	Community Relations/Education	-	197	197	2,373	0.0%
21	Employee Relations/Wellness	992	4,322	3,330	52,072	1.9%
22	Program Supplies	32,691	38,899	6,208	468,665	7.0%
23	Contract Inpatient	112,581	93,251	(19,330)	1,123,509	10.0%
24	Contract Transportation	10,857	10,894	37	131,253	8.3%
25	Contract Residential	421,889	449,136	27,247	5,411,280	7.8%
26	Contract Employees & Services	274,528	293,103	18,575	3,531,361	7.8%
27	Telephone & Connectivity	10,120	9,610	(510)	115,786	8.7%
28	Staff Meals & Lodging	2,658	3,170	512	38,194	7.0%
29	Mileage and Gasoline	42,810	37,567	(5,243)	452,618	9.5%
30	Board Travel/Education	3,657	1,134	(2,522)	13,664	26.8%
31	Professional Fees	2,349	4,624	2,275	55,712	4.2%
32	Property & Liability Insurance	9,137	5,039	(4,098)	60,711	15.1%
33	Utilities	10,573	14,326	3,753	172,605	6.1%
34	Maintenance	14,186	15,395	1,208	185,477	7.6%
35	Rent	21,055	19,369	(1,686)	233,367	9.0%
36	Food (net of food stamps)	4,562	4,774	212	57,512	7.9%
37	Capital Equipment	395	9,423	9,028	113,535	0.3%
38	Client Equipment	1,462	2,363	901	28,469	5.1%
39	Miscellaneous Expense	6,773	6,510	(262)	78,435	8.6%
40	Depreciation Expense	20,986	21,552	566	259,661	8.1%
41	Budget Adjustment	-	(150,227)	(150,227)	(1,809,967)	0.0%
42	**Total Expense**	**2,437,519**	**2,387,020**	**(50,499)**	**28,759,278**	**8.5%**
43	**Change in Net Position**	**$ (52,816)**	**$ (0)**	**$ (52,816)**	**$ (0)**	**-0.2%**
	Contract settlement items included above:					
44	Medicaid Funds Over Spent	(54,765)				
45	General Funds Over Spent	(45,127)				
46	Healthy Michigan Funds Under Spent	61,756				

NE Mich Community Mental Health Fund

10/1/17 - 9/30/18

LIABILITY\FUND BALANCE ACTIVITY	YTD
ENDOWMENT	
Beginning Balance	60,416.20
Revenue:	
Contributions	5,773.60
Increase(Decrease)	5,773.60
Ending Balance	66,189.80
RESERVE	
Beginning Balance	15,500.67
Revenue:	
Interest and Dividends	3,007.23
Realized Gain(Loss)	3,667.36
Unrealized Gain(Loss)	(380.70)
Total Revenue	6,293.89
Expense:	
Transfer To Spendable This FY	3,201.43
Administrative Fees	975.05
Total Expense	4,176.48
Increase(Decrease)	2,117.41
Ending Balance	17,618.08
SPENDABLE	
Beginning Balance	7,772.81
Revenue:	
Transfer From Reserve	3,201.43
Total Revenue	3,201.43
Expense:	
Grants Approved	5,000.00
Total Expense	5,000.00
Increase(Decrease)	(1,798.57)
Ending Balance	5,974.24

10/1/17 - 9/30/18

BALANCE SHEET	YTD
Assets:	
Investment Pool	89,782.12
Total Assets	89,782.12
Current Liabilities:	
Liability\Fund Balances:	
Endowment	66,189.80
Reserve	17,618.08
Spendable	5,974.24
Total Liability\Fund Balances	89,782.12
Total Liabilities and Equity	89,782.12

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

POLICY CATEGORY: EXECUTIVE LIMITATIONS
POLICY TITLE AND NUMBER: GRANTS OR CONTRACTS, 01-011
REPORT FREQUENCY AND DUE DATE: ANNUAL, DECEMBER

CEO Report:
Following each of the five sub-items within the policy, I will indicate my interpretation and status of each.

Policy Statement:
With respect to contracts and grants, the CEO may not enter into any grant or contract, unless it emphasizes the production of ends and the avoidance of unacceptable means. Accordingly, he or she may not:

1. Fail to prohibit particular methods and activities to preclude grant funds or contracts from being used in imprudent, unlawful or unethical ways.

- **Interpretation:** Contracts must include language that mandates all contractors, vendors, subcontractors and suppliers of goods to adhere to all applicable laws, ordinances and regulations when providing services. Contractors must agree to provide service in an ethical manner.
- **Status:** All service contracts contain language that requires the contractors to adhere to all applicable local, state and federal laws, ordinances and regulations when providing services as part of the agreement.

  Noted problems with contract compliance this past year include:

  1. As with years past, we continue to have a few homes which needed to complete their 16 hours of required training. These hours have been requested and providers are completing them. Plans of correction are in place for these sites.

  There continues to be two different contracts used, one for large group homes that contract with other CMH's and one for the AFC homes locally that just contract with NeMCMHA.

2. Fail to assess and consider an applicant's capability to produce appropriately targeted efficient results.

- **Interpretation:** Contracts must include language that indicates expected outcomes and evaluation of services provided by contractors, vendors and subcontractors.
- **Status:** Service Contracts contained language indicating what the measurable expected outcomes of the service contracts are and that contracts will be evaluated at least annually.

  The agency's major provider of service (other than residential) is NEMROC.

3. Enter into any contract for services without approval from the Board except for contracts for residential services and professional clinical services. In unusual circumstances, when a contract requires execution prior to the next regular meeting of the Board, the Director may approve such contracts when the total cost of the contract does not exceed $25,000.

- **Interpretation:** The Board will approve all service contracts excluding those pertaining to residential services or professional clinical services.
- **Status:** All contracts (excluding residential and professional clinical) are submitted to the Board on a regular basis for review and approval. As a matter of policy, routine contracts are included on the Board's consent agenda; contracts that require more detailed discussion and consideration (such as the provider agreement with the Affiliation) are handled as separate agenda items.

4. Fail to maintain financial obligations for contracts on a fiscal year basis.

- **Interpretation:** The contract term shall follow the fiscal year calendar.

- **Status:** For those contracts that Northeast provides payment, the contracts are written on a fiscal year basis. Occasionally, multi-year contracts are used (e.g., DHHS) but language limits financial obligations to fiscal year periods.

5. Fail to determine to the best of his/her ability that all contractors, vendors, subcontractors and suppliers of goods shall prohibit discrimination based on religion, race, color, national origin, age, sex, height, weight, marital status, political affiliation, sexual orientation, record of arrest without conviction, physical or mental handicap.

- **Interpretation:** All contracts must include language that prohibits discrimination based on religion, race, color, national origin, age, sex, height, weight, marital status, political affiliation, sexual orientation, record of arrest without conviction, physical or mental handicap.
- **Status:** All contracts contain language that prohibits discrimination based upon the above-mentioned areas.

6. For contracts over $25,000 needing execution prior to the next regularly scheduled meeting of the Board, the Director will request the Executive Committee to review the contract and take action. The Board will be notified at the next Board meeting of the recommendations and outcome of the Executive Committee.

- **Interpretation:** Any urgent contracts over $25,000 needing approval prior to the regularly scheduled Board meeting will get approval from Executive Committee members.
- **Status:** As this should be an infrequent occurrence, we have not yet had to utilized this method.

7. The Director will notify the Board, at the next regular Board meeting, when there is an application executed by the Agency for available grants which enhance the lives of the people we serve and/or assist in the day-to-day operations of the Agency. Grant funds will be included in the budget and presented to the Board for approval at the next regularly scheduled Board meeting.

- **Interpretation:** The Board will be notified for all applications for grant funds made through the Agency.
- **Status:** Grant application notices are included on the Consent Agenda as they are applied for and if the grant is awarded, the dollars for the grant are incorporated into the budget or budget amendment.

Summary:

I believe we are in substantial compliance with the Board's policy. Some contracts include an "Evergreen Clause" which allows the contract to continue on a month-to-month basis until a successor agreement can be completed. For this contract year, only residential contracts held with smaller adult foster are homes include this clause. The reason we include this language is often we frequently do not have a contract or budget with the State or the Northern Michigan Regional Entity at the beginning of the fiscal year. This year all out of catchment area residential homes and businesses have been reviewed by the NeMCMHA Contract staff. Going forward, contract staff will utilize "Monitoring Reciprocity" meaning that we can ask another CMH who has completed a site visit at a location we have someone living or receiving service, for their review of a site and determine compliance for the annual site visit from their form. We, in turn, will share with other boards our site visit information. This reduces the number of duplicate reviews the homes are involved with and allows less intrusion into the person's home situation. The Contract staff also completes provisional Home and Community Based Services (HCBS) surveys on all new providers who deliver adult foster care, community living supports, and supported employment services. This is to ensure the providers are prepared to meet the HCBS guidelines to be implemented at a future date.

Board Review/Comments

EXECUTIVE LIMITATIONS
(Manual Section)

GRANTS OR CONTRACTS
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision Approved by the Board:	December 8, 2016

●1 POLICY:

The CEO may not enter into any grant or contract, unless it emphasizes the production of Ends and the avoidance of unacceptable means.

Accordingly, he or she may not:

- Fail to prohibit particular methods and activities to preclude grant funds or contracts from being used in imprudent, unlawful or unethical ways.

- Fail to assess and consider an applicant's capability to produce appropriately targeted efficient results.

In addition, for **CONTRACTS:**

- Enter into any contract for services without approval from the Board except for contracts for residential services and professional clinical services. In unusual circumstances, when a contract requires execution prior to the next regular meeting of the board, the Director may approve such contracts when the total cost of the contract does not exceed $25,000.

- Fail to maintain financial obligations for contracts on a fiscal year basis.

- Fail to determine to the best of his/her ability that all contractors, vendors, subcontractors and suppliers of goods shall prohibit discrimination based on religion, race, color, national origin, age, sex, height, weight, marital status, political affiliation, sexual orientation, record of arrest without conviction, physical or mental handicap.

- For contracts over $25,000 needing execution prior to the next regularly scheduled meeting of the Board, the Director will request the Executive Committee to review the contract and take action. The Board will be notified at the next Board meeting of the recommendations and outcome of the Executive Committee.

In addition, for **GRANTS:**

- The Director will notify the Board, at the next regular Board meeting, when there is an application executed by the Agency for available grants which enhance the lives of the people we serve and/or assist in the day-to-day operations of the Agency. Grant funds will be included in the budget and presented to the Board for approval at the next regularly scheduled Board meeting.

●2 APPLICATION:
The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

BOARD MEMBER RECOGNITION
(Subject)

Board Approval of Policy	August 8, 2002
Board Revision of Policy	December 8, 2016

●1 POLICY:

The Board may recognize its members for extended tenure or upon termination or retirement, either upon completion of full terms or partial terms of office. Such recognition may take any form deemed appropriate by the Board. The Board may include such recognition for service within the Board meeting minutes.

The following schedule shall provide guidance concerning frequency and nature of awards to Board members:

Award Schedule

At 5 years	A framed Certificate of Appreciation signed by the current Board Chair and CEO
At 10 years	A Certificate of Appreciation signed by the current Board Chair and CEO
At 15 years	A Certificate of Appreciation signed by the current Board Chair and CEO
At 20 years and each 5 years thereafter	An appropriate gift
Upon retirement from Service at any other time	A Letter of Appreciation from the Board and if possible a Certificate of Appreciation from the Department of Health and Human Services

These acknowledgements shall be presented at the March Board meeting.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

BOARD MEMBER ORIENTATION
(Subject)

Board Approval of Policy	April 14, 2005
Last Revision to Policy Approved:	December 8, 2016

●1 POLICY:

The Board will provide an orientation for new board members as well as regular updates for all board members. This orientation program will include information addressing the areas noted below. Primary responsibility for delivery of each section is also noted:

- Community Mental Health History (General perspective: MACMHB Boardworks 2.0 module: "Foundations: Public Policy;" Northeast perspective: Executive Committee/Director)
- Community Mental Health Mission and Priorities (General perspective: MACMHB Boardworks 2.0 module: "Foundations: Intended Beneficiary Ownership," and "Foundations: Intended Beneficiary Orientation;" Northeast perspective: Executive Committee/Director)
- Michigan's Mental Health Code (General perspective: MACMHB Boardworks 2.0 module "Management: Legal;" Northeast perspective: Director)
- Policy Governance (primarily Executive Committee with elements from MACMHB Boardworks 2.0 modules: "Leadership: Fundamentals" and "Leadership: Character")
- Organizational structure of Northeast Michigan Community Mental Health Authority (General perspective: MACMHB Boardworks 2.0 modules: "Implementation;" Northeast perspective: Director)
- Services offered by Agency (Director, Services Directors, Boardworks 2.0 modules: "Management: System" and "Implementation: Best Practice")
- Basics of mental healthcare financing and managed care (General perspective: MACMHB Boardworks 2.0 modules: "Management: Budget" and "Management: System;" Northeast perspective: Director and Budget and Finance Director)
- The Board's relationships with the Counties, Department of Health and Human Services, the PIHP, the Board Association and other local agencies (Executive Committee/Director; MACMHB Boardworks 2.0 modules: "Management: Legal" and "Management: System")

For newly appointed board members, those portions of the orientation program that are to be delivered by members of the Executive Committee, other members of the Board or the Director shall be delivered within the first 90 days of the

members' terms. New Board members will be encouraged to complete the Michigan Association of Community Mental Health Boards' Boardworks 2.0 Training program within one year.

The Executive Committee shall assure that at least one board member is both knowledgeable in the area of policy governance and is willing and able to train other board members in its principles.

For each of the other curriculum areas, the Director, with the support of the Board, will assure that orientation material is developed, available in appropriate media and kept current.

●2 APPLICATION:
The Northeast Michigan Community Mental Health Authority Board members

●3 DEFINITIONS:

●4 REFERENCES:
On Board Leadership, Carver, John, Jossey – Bass, 2002
The Policy Governance Fieldbook, Oliver, Carolyn, Jossey – Bass, 1999
"John Carver on Board Governance" A Video Presentation
MACMHB Resource Manual
Mental Health Code, Michigan PA 258 of 1976
Plan of Service, NeMCMH

●5 FORMS AND EXHIBITS:

CMHA
Community Mental Health Association of Michigan

A Vision for a World-Class Public Mental Health System in Michigan

November 2018

Executive Summary

Michigan's public mental health system is nationally recognized as one of the most comprehensive, innovative, person-centered and community-driven systems in the country. **For this system to continue to stay at the forefront of the mental health field and to serve Michiganders and the communities in which they live, concrete action – all within the reach of state policymakers – needs to be taken.** [1]

The Community Mental Health Association of Michigan has outlined these actions below and in greater detail in this document.

Overarching vision for a world-class public mental health system in Michigan

Michiganders deserve and expect a world class public mental health system building on the nationally-recognized system that Michigan has built over the past fifty years. Such a world class system is accessible, innovative, person-centered, and community-driven; fosters whole person and whole population health; addresses the social determinants of health; is a vital member of the community; and is fiscally and clinically strong.

Actions to fulfill the vision for a world-class public mental health system in Michigan

Core values of the system: **self-determination, person-centered planning, full community inclusion, recovery orientation and cultural competence.**

Governance: **Ensure the governance of managed care, provider and collaborative convener roles of the state's public mental health system remain local, public, and with the involvement of persons served by the system on those governing bodies.** The governance should be embedded and linked to the counties served by the system, including the fiscal control of the system via a direct contract with the State of Michigan.

Central role of public system: **Foster the safety net role of the public mental health system** to address the health of the community, and social determinants of health and advocacy for the vulnerable, and serve as a convener of community collaboratives.

[1] *In this document the term mental health system refers to the system that serves persons with mental illness, children with emotional disturbance, persons with intellectual/developmental disabilities and persons with substance use disorders.*

Financing: **Increase Medicaid and General Fund support** to ensure the ability to meet the needs of all Michiganders in the face of growing demand and expectations for access to mental health services. Allow for the use of smart risk management practices such as the development of sufficient risk reserves.

Full range of persons to be served: **Retain and expand service to include persons with mild/moderate mental health needs,** the full range of persons served by the system, meeting the needs and expectations of the community, and to include prevention and early intervention.

Primary and mental health care integration: **Promote clinical integration** (where the client/patient receives services and supports) by supporting the current and emerging models in local communities.

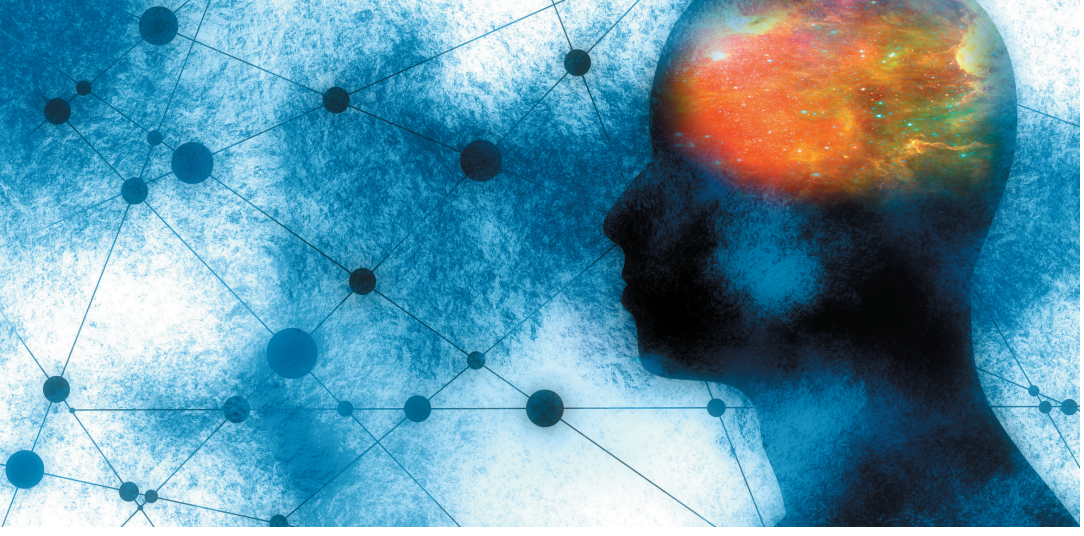
Evidence-based and promising practices: **Fund and support the use of evidence-based and promising mental health practices,** including access assurance methods, client/patient/clinician specific practices to organizational and community-wide practices.

Risk management: **Move to a full risk contract** between the state and the public system to allow for greater flexibility and innovation.

Workforce retention and recruitment: **Address the mental health workforce shortage** that exists for clinicians of all disciplines.

Administrative simplification: **Reduce administrative, regulatory, contractual and other requirements** by ensuring they tie to the core vision and values of the system and are uniform statewide and across payer types.

Health information technology, data analytics, outcome measurement: **Provide funding and support for the public mental health system** as it continues to build its health information technology and outcome measurement infrastructure.



Michigan's public mental health system is nationally recognized as one of the most comprehensive, innovative, person-centered, and community-driven systems in the country. In order for this system to continue to stay at the forefront of the mental health field and to serve Michiganders and the communities in which they live and work, concrete actions are needed – including actions by state policymakers.

The Community Mental Health Association of Michigan has outlined these action steps below.

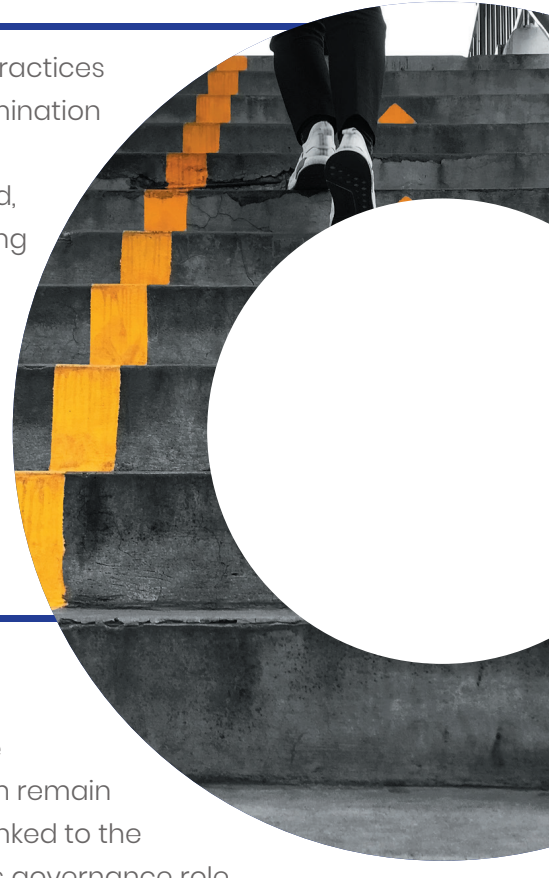
Overarching vision for a world-class public mental health system in Michigan

Michiganders deserve and expect a world class public mental health system building on the nationally-recognized system that Michigan has built over the past fifty years. Such a world class system is accessible, innovative, person-centered, and community-driven; fosters whole person and whole population health; addresses the social determinants of health; is a vital member of the community; and is fiscally and clinically strong.

Actions to fulfill the vision for a world-class public mental health system in Michigan

Self-determination, person-centered, full community inclusion, recovery orientation, cultural competence:

Ensure that funding, policies, and practices foster the following: the self-determination of the persons served, healthy development of the persons served, the use of person-centered planning with full integrity and fidelity, full community inclusion for those with mental health needs, recovery-oriented systems of care, and cultural and linguistic competence.



Governance:

Ensure that the governance of the managed care, provider, and collaborative convener roles of the state's public mental health system remain local and public; embedded and linked to the counties served by the system. This governance role includes the fiscal control of the system via a direct contract with the State of Michigan.

Ensure that the persons served are mandated members of the local governance bodies (not advisory).

Foster the safety net role of the public mental health system (a focus on population-health, social determinants, and community collaboration):

The community mental health system's role as the population-based and place-based resource and public safety net committed to the common good is in considerable contrast with the enrollee-based coverage used in insurance models.

To foster this role, it's important to do the following:

Support the work of the system in coordinating the network of services necessary to address the range of social determinants of health: housing, employment, food access, transportation, income supports, primary care, education, family support and child care.

Remove barriers to innovative service delivery, financing, and governance partnerships between the public mental health system and a number of community partners, such as the judiciary and criminal justice system, schools, homeless and housing providers, primary care providers, and long-term care providers.

Foster the full range of functions carried out by the public mental health system through the following roles:

- Providers, purchasers and managers of a comprehensive array of services and supports across a network of providers in fulfillment of statutory roles to serve the individuals, families and communities regardless of the ability to pay
- Community conveners and collaborators – initiating and participating, often in key roles, collaborative efforts designed to address the needs of individuals and communities
- Advocates for vulnerable populations and a whole-person, social determinant orientation
- Sources of guidance and expertise, drawn upon by the public, to address a range of health and human services needs

Financing:

Increase funding to the public system to ensure that it is sufficiently strong to meet the growing demand and expectations for access to mental health services by all Michiganders.

This growing demand centers around: ready access to crisis services for all Michiganders, fostering the ability of those with a range of mental health needs to live a full and productive life, treatment of substance use disorders, prevention of incarceration, prevention of homelessness, and the provision of services to children with mental health needs and their families.

Financial investment is needed in:

- **Michigan's Medicaid program:** The actuarial analysis used to determine Medicaid financing of the system must be improved to accurately reflect real and growing needs and real costs.
- **Michigan's non-Medicaid mental health line:** Restore the General Fund dollars to the system to ensure that Michiganders can continue to rely upon the state's mental health safety net for a range of crisis-response and non-crisis mental health services, regardless of their insurance coverage or income (by restoring the GF that was cut by 60% with the advent of the Healthy Michigan Plan).

Financing of risk reserves – the Medicaid rates must include sufficient contribution to the risk reserves of the PIHPs. Federal regulations required that the payments to risk-bearing entities, such as PIHPs, in a capitated/risk-based financing model, include a component for contribution to risk reserves.

Parallel to the changes needed to allow for the development of risk reserves by the PIHP's, the CMHs should be allowed to retain savings for investment in the system.

The fair and just distribution of funding, reflecting population needs, and population dispersion – achieved through the addition of funding not through redistribution; no community is over-funded for mental health services.

Foster local millages and other efforts to build the local funding base to support CMH and provider systems, while recognizing that local millages cannot/do not relieve the state's obligation to fund MH care via GF and Medicaid – to ensure uniformity of funding (blanket coverage for the state) regardless of the ability of counties to fund millages and the availability of other local funding.

Breadth of populations served and services provided:

Retain and expand the populations served by the system (to meet the expectations of the community). These expectations include all of the populations currently served by the public system: adults with serious mental illness; children and adolescents with serious emotional disturbance; children, adolescents, and adults with intellectual/developmental disabilities; children, adolescents, and adults with substance use disorders.

Unite the state's Medicaid mental health benefit under the system with the proven expertise to manage and provide such comprehensive services – the public CMH and PIHP system – by bringing the mild-moderate Medicaid mental health benefit, for adults and children, within the benefit package managed by the CMH and PIHP system.

Integrate substance use disorder treatment and prevention dollars into the financing, contracting, and network management system used for services to persons with mental illness and intellectual/developmental disability services.

Improve whole-person integrated care by fostering efforts to bring the management of the physical health care of the persons served by the public mental health system under the management of a service delivery system designed to serve that population, the CMH/PIHP system.

Promote and fund prevention and early intervention services for all populations – aimed at preventing the development of harmful, life-altering, and costly conditions.

Primary and mental healthcare integration:

Foster real health care integration, not the consolidation of funding and profits, via clinical integration (where the client/patient receives services and supports) by supporting the current and emerging models in local communities, often led by the CMH/PIHP/provider system.

Access to care:

In tandem with the financing and population health recommendations, fund and support same day access, early intervention (including services to persons experiencing their first episode of psychosis), simplified referral from other providers, aggressive outreach, and other proven access improving practices.

Evidence-based and promising practices:

Fund and support the use of evidence-based and promising mental health practices, from client/patient/clinician specific practices to organizational and community-wide practices.

Risk management:

Move to a full risk contract between MDHHS and PIHPs to allow for a range of standard risk management practices by the PIHPs and their CMH sponsors.

Eliminate barriers to CMHs taking on full-risk, shared incentive and shared savings structures across a range of public and private payers.

Foster value-based payments via regional approaches to payment and outcomes (to reflect the CMH-sponsored health plan structure of our system).

Allow CMHs to retain earnings and assets from their Medicaid line of business, as is allowed for all other Medicaid providers, all of which will be retained in the public system for use in meeting unmet community need and invest in system improvements.

Workforce retention and recruitment:

Address the mental health workforce shortage issue by: implementing the recommendations of the Section 1009 workgroup for direct care workers (e.g., improve compensation, foster a career ladder, support continuing education), broadening loan repayment programs for a range of clinical disciplines experiencing shortages (psychiatrists, nurses, social workers, psychologists, occupational therapists), and other recruitment and retention approaches.

Support the public system's longstanding role as the largest employer and trainer of mental health practitioners with experience in the latest clinical technologies.

Administrative simplification:

Reduce the administrative, regulatory, contractual, and other requirements by ensuring that these requirements tie to the core vision and values of the system and are uniform statewide and across payer types.

Health information technology, data analytics, outcome measurement:

Given the lack of access to the federal funds provided to the physical health system (via the Health Information Technology for Economic and Clinical Health (HITECH) Act), provide funding to the public mental health system to continue to build its health information technology infrastructure, fostering inter-organizational health care integration.

Foster the use of a small and focused number of nationally recognized outcome measures, applied statewide that are tied to client/patient outcomes.

Foster continued and expanded access to timely client-specific clinical and population health data and the data analytic tools to make use of these data.

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans [(PIHP) public health plans formed and governed by the CMH centers] and the private providers within the CMH and PIHP provider networks. Information on the CMH Association can be found at **www.cmham.org** or by calling **(517) 374-6848.**

Alan Bolter
Associate Director
abolter@cmham.org

Robert Sheehan
Chief Executive Officer
rsheehan@cmham.org

CMHA
Community Mental Health Association of Michigan

Community Mental Health Association of Michigan (CMHAM) is a trade association representing the 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and more than 90 provider organizations that deliver services to adults with mental illness, children and adolescents with emotional disturbances, persons with intellectual/ developmentally disabilities, and those with substance use disorders in every community across the state.

How we are Funded

$2.319 billion Medicaid Mental Health
$299 million Healthy Michigan
$175 million Substance Use Disorder
$192 million Autism

$125 million General Fund

10 Prepaid Inpatient Health Plans behavioral health managed care entities:
- Oversight & Compliance (Federal & State)
- Admin
- Utilization Management

Medicaid Mental Health
Healthy Michigan
Substance Use Disorder
Autism

46 Community Mental Health Centers and their provider network covering all 83 counties:
- Service Provision
- Coordinate Local Service Network
- Ensure Compliance (Federal & State)

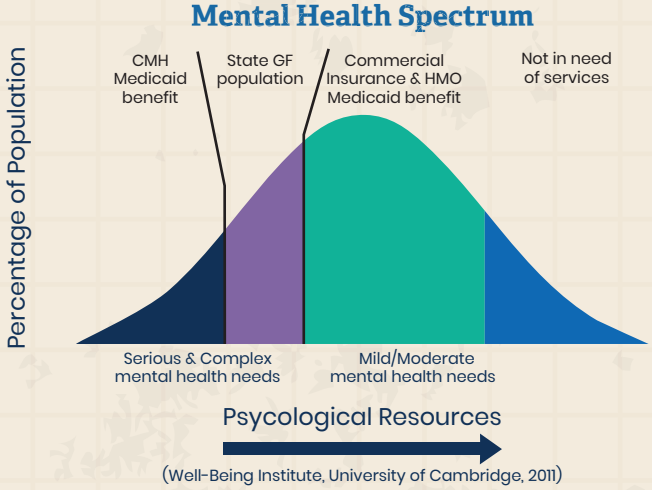
Who We Serve

Michigan's Public Mental Health System Serves 4 Main populations:

- Children with Serious Emotional Disturbances (examples: Obsessive-Compulsive Disorder (OCD) or Attention Deficit Hyperactivity Disorder (ADHD)
- People with Substance Use Disorders
- People with Developmental/Intellectual Disabilities
- Adults with Mental Illness.

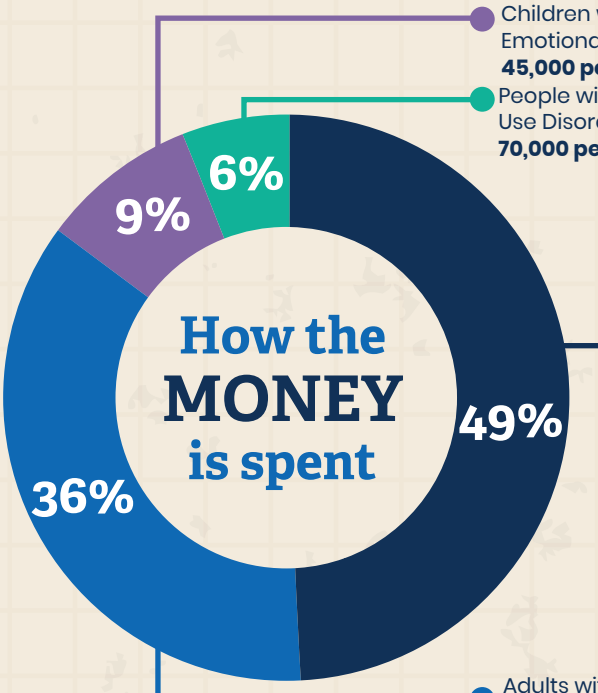
Michigan is the **ONLY** state that serves all 4 populations in a managed care setting.

Mental Health Spectrum



(Well-Being Institute, University of Cambridge, 2011)

How the MONEY is spent



Children with Serious Emotional Disturbance **45,000 people served**

People with Substance Use Disorder **70,000 people served**

People with Intellectual / Developmental Disabilities **45,000 people served**

Adults with Mental Illness **155,000 people served**

MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

DID YOU KNOW?

1 in 5

in the United States are impacted by a mental illness.

83 counties

in Michigan are covered by the 46 CMHs & 10 PIHPs.

94% medical loss ratio

(i.e. the percentage of dollars spent on actual care) of Michigan's public PIHP system has a statewide average spent on administrative costs of 6%.

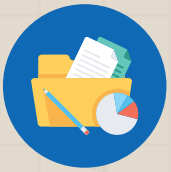
Since 1997, Michigan has remained the only state in the nation that provides publicly managed care for all four major populations; adults with mental illness, children and adolescents with emotional disturbances, persons with intellectual / developmental disabilities, and those with substance use disorders ***[saving the state more than $1 billion!]***

24 hours a day / 7 days a week, mental health professionals provide services for people with mental illness, intellectual / developmental disabilities, and substance use disorders regardless of ability to pay. As outlined in Michigan's Mental Health Code, Public Act 258 of 1974, Michigan's public mental health system serves as the local public safety net for the state's most vulnerable citizens.

91 percent of the CMH budget is from Medicaid and Healthy MI plan. State General dollars that serve people without insurance makes up only 4% of the total budget.

2 million people statewide are impacted by one of the 300,000 people served by Michigan's public community mental health system when you include family, friends, neighbors, and co-workers.

Michigan's public community mental health system is a ***$3 billion industry*** in our state employing more than ***50,000 people.***



750+ Michigan's CMH/PIHP system is leading the way with more than 750 on-the-ground healthcare integration initiatives across the state - co-location, electronic health records, and partnerships.

Substance Use Disorders

Opioid deaths in Michigan are increasing. From 1999 to 2016, the total number of ***overdose deaths involving any type of opioid increased more than 17 times in Michigan,*** from 99 to 1,689.3 ***Over six people in Michigan die every day from opioid-related causes.***

Every person can make a difference. Some things you can start doing today:

- Store medications safely.
- Don't share prescription medications.
- Learn to recognize the signs and symptoms of opioid abuse.
- Keep talking about the opioid epidemic and help break the stigma.

Healthy Michigan Plan provides dedicated and reliable funding for persons with substance use disorders and who have co-occurring mild to moderate mental disorders.

Prior to HMP (Medicaid Expansion), some regions had up to six month waiting lists for Medication Assisted Treatment (MAT) or withdrawal management /residential treatment. Oftentimes these are the most important services for people with opiate use disorders to begin the road to recovery.

Over 70,000 people receive Substance Use Disorder treatment and recovery services through Michigan's public system each year.

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM, OCTOBER 24, 2018
CROSS STREET CONFERENCE ROOM, GAYLORD

BOARD MEMBERS IN ATTENDANCE:	**Carol Crawford, Roger Frye, Ed Ginop, Annie Hooghart, Randy Kamps, Gary Klacking, Terry Larson, Gary Nowak, Jay O'Farrell, Dennis Priess (on phone), Richard Schmidt, Karla Sherman, Joe Stone, Don Tanner, Nina Zamora**
STAFF IN ATTENDANCE:	**Jodie Balhorn, Karan Bingham, Christine Gebhard, Judy Hursh, Karl Kovacs, Eric Kurtz, Valerie McBain, Stewart Mills, Diane Pelts, Brandon Rhue, Sara Sircely, Dee Whittaker, Tricia Wurn, Deanna Yockey, Carol Balousek**

CALL TO ORDER
Let the record show that Chairman Randy Kamps called the meeting to order at 10:00AM.

ROLL CALL
Let the record show that all Board Members were in attendance (Dennis Priess on phone) for the meeting on this date.

PLEDGE OF ALLEGIANCE
Let the record show that the Pledge of Allegiance was recited as a group.

ACKNOWLEDGEMENT OF CONFLICT OF INTEREST
Let the record show that no conflicts of interest were expressed with any of the meeting agenda items.

APPROVAL OF PAST MINUTES
The minutes of the September meeting of the NMRE Governing Board were included in the materials for the meeting on this date.
MOTION MADE BY JOE STONE TO APPROVE THE MINUTES OF THE SEPTEMBER 24, 2018 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS, SECOND BY DON TANNER. MOTION CARRIED.

APPROVAL OF AGENDA
Mr. Kamps called for approval of the meeting agenda. A typo was noted which will be corrected. Mr. Kurtz asked to add Electronic Board Packets under "New Business," and Inpatient Bed Capacity and ATS Liquor Tax request under "Old Business."
MOTION MADE BY GARY NOWAK TO APPROVE THE AGENDA FOR THE OCTOBER 24, 2018 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED, SECOND BY ROGER FRYE. MOTION CARRIED.

CORRESPONDENCE
- A letter dated October 1, 2018 from Jeffery Wieferich at Michigan Department of Health and Human Services (MDHHS) to PIHP and CMHSP Executive Directors in support of the parity plan submitted by the PIHP Parity Compliance Workgroup.
- Email correspondence dated October 12, 2018 from Robert Sheehan at CMHAM announcing a healthcare summit spo9nsored by Crain's Detroit Business on October 15th in Dearborn.
- The minutes from the October 4, 2018 PIHP CEO Meeting.

- A press release dated October 11, 2018 from Lieutenant Governor Brian Calley announcing the October 1st launch of the NMRE/Region 2 PIHP Opioid Health Home.
- The Fall 2018 edition of the NMRE Consumer Newsletter.

Mr. Kurtz highlighted the Press Release from the Lt. Governor, naming NMRE as the first Opioid Health Home under the pilot project.

It was noted the Community Mental Health Association of Michigan's (CMHAM) Fall Conference was very informative and provided good understanding regarding MDHHS priority activities.

Karan Bingham, NMRE Customer Services Specialist, gave a report on the Day of Recovery Education that was held on October 19th at Treetops Resort. A total of 171 beneficiaries and staff participated. Feedback received has been very positive.

ANNOUNCEMENTS

Joe Stone mentioned that Roger Frye will be having surgery October 26th and to please keep his recovery in mind.

PUBLIC COMMENTS

Let the record show that no comments were made from the public during the meeting on this date.

REPORTS

Board Chair Report/Executive Committee

Mr. Kamps stated the Executive Committee did not meet but has exchanged information via email regarding evaluation of the NMRE Chief Executive Officer. Mr. Kamps requested comments be directed to his attention. He asked the surveys to be completed prior to the December 12th Board meeting. A link to the SurveyMonkey evaluation will be sent to Board members by the end of the week with paper copies furnished to those members who do not have email.

CEO's Report

The NMRE CEO Report for October 2018 was included in the materials for the meeting on this date. Mr. Kurtz noted the need for NMRE representation on the Rural Health Initiative grant steering committee. The Rural Communities Opioid Response Program identified 11 counties with high HIV, Hepatitis C rates attributed to opioid use. The committee was formed under the Michigan Center for Rural Health. Cathy Meske represents the region on the Board. Areas of target are prevention, treatment, recovery, and workforce stability. Mr. Kamps acknowledged that stigma is a big hindrance to individuals seeking help.

Mr. Kamps requested an update on the Section 298 Initiative. Mr. Kurtz expressed that special legislation has been requested for Network 180 to do an undefined pilot with Cherry Health and Spectrum. Due to the turmoil with Lakeshore Regional Entity, it stalled. Bill Riley, Interim Executive Director at Network 180, indicated that discussions are back on but there is no skeleton of a plan to date. MR. Stone commented that 298 is basically "on life support." Mr. Kurtz noted the Department is split on the subject. Mr. Kovacs questioned the commitment of the Medicaid Health Plans (MHPs) to 298. Mr. Stone stated, from the way it was presented during the CMHAM Fall Conference, the MHPs are in charge. Mr. Kurtz encouraged Bob Sheehan to circulate the "Revised Program for Procurement" issued in 1998 as fundamental reading; the document will be forwarded to the Board Members.

SUD Board Report
Let the record show that the next meeting of the NMRE SUD Oversight Policy Board is scheduled for 10:00AM on November 5, 2018 in the Cross Street conference room in Gaylord. With a light agenda and several members unavailable to attend, it is possible the meeting will be rescheduled.

August Financial Report
The NMRE Monthly Financial Report for August 2018 was included in the materials for the meeting on this date. The "Eligibles" tables were corrected and reinstated. Mr. Kovacs requested revenue trending by CMH which will be added to the monthly report.

- Traditional Medicaid showed $138,345,924 revenue, plus $3,072,085 for SUD, and $141,449,251 in expenses, resulting in a net surplus of $1,490,547.
- Healthy Michigan Plan showed $9,969,242 revenue, plus $4,576,218 SUD, and $17,107,071 in expenses, resulting in a net deficit of $2,561,611, which may be offset by Medicaid savings
- Health Home showed $161,747 revenue and expenses of $124,72, resulting in a surplus of $37,026.
- SUD showed all funding source revenue of $12,197,977 and expenses of $12,576,131, resulting in a deficit of $378,154. NMRE will be requested additional Community Grant funds from the State; $535K was received in September.

Mr. Kovacs commented the NMRE's financial position is not the norm (based on what was expressed during the CMHAM Fall Conference). Mr. Stone requested detailed information on Autism benefit funding.

A discussion of overspending Community Grant funds followed. Historically, overages are covered by PA2 (liquor tax). Mr. Kurtz explained the Medicaid side is partly tied to the authorization processes and utilization management. NMRE is addressing these processes internally and with providers. The 1115 Waiver approval is pending for SUD. The adoption of the 1115 will be a big mind shift for providers; highly tied to ASAM standards. Mr. Kamps asked if there will be a time when Traditional Medicaid goes away leaving only HMP. Mr. Kurtz responded the reverse is more likely.

NEW BUSINESS
NMRE Employee Handbook
The NMRE Board Policy Committee met on this date at 9:00AM prior to on the NMRE Board Meeting to review the proposed NMRE Personnel Policies/Employee Handbook. Mr. Nowak reported the Policy Committee recommended approval. Paid Time Off (PTO) will be given to staff rather than sick, vacation, personal time. North Country will pay out 100% of accrued vacation time and 25% of accrued sick time. NMRE will carry over the remainder of sick time up to 40 hours to be used in 2019. The NMRE will recognize 12 paid holidays. Mr. Tanner mentioned forming a Board Human Resources Committee may be needed in the future. It was noted Operations Committee recommended approval of the Employee Handbook.
MOTION MADE BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY EMPLOYEE HANDBOOK, SECOND BY KARLA SHERMAN. MOTION CARRIED.

Home Help
Included in the materials for the meeting was a Memorandum dated August 7, 2006 from David Short, President, Combined Management & Marketing Services, Inc. to Michael Moran, Chief Executive office of Manistee Benzie CMH regarding findings by the Audit Office of the Michigan Department of Community Health against CMHSPs for the usage of MDCH-advanced Medicaid funds and/or State General Funds to improperly supplement the cost of Michigan Department of Human Services Home Help personal care services. Clarification was made that Home Help is not a PIHP-covered benefit; it is a DHS covered service.

Electronic Board Packet
Mr. Kurtz recognized that some boards are moving to electronic Board packets and providing Members with laptops, surfaces, or iPads. He asked whether the NMRE should move in the same direction. It was noted that a few Board Members do not have email to receive electronic packets. Diane Pelts explained that staff provided training to AuSable Valley Board Members. An added benefit is electronic storage of documents and resource materials on a web-based application. Mr. Kamps encouraged moving forward and touching base with the CMHSPs to coordinate. Mr. Tanner supported having a dedicated device in the event of a request under the Freedom of Information Act (FOIA).

OLD BUSINESS

Behavioral Health Home
A review of the 2017/2018 Behavioral Health Home for Centra Wellness Network was included in the materials for the meeting on this date. This was shared for informational purposes. Discussions continue with Jon Villasurda at the State. The NMRE's request to expand will address after new administration is in place. Mr. Kamps recommended he report, and one similar for Northern Lakes, with County Commissioners and legislators.

MOTION BY GARY NOWAK TO SEND APPROVED NMRE GOVERNING BOARD MEETING MINUTES TO THE TWENTY-ONE COUNTY CLERKS AND THE CHAIRPERSON OF THE TWENTY-ONE COUNTY BOARDS OF COMMISSIONERS.

Mr. Larson asked Mr. Nowak to amend to include the approved SUD Oversight Board meeting minutes. Mr. Nowak amended his prior motion.

(Amended) MOTION BY GARY NOWAK TO SEND APPROVED NMRE GOVERNING BOARD AND SUBSTANCE USE DISORDER OVERSIGHT BOARD MEETING MINUTES TO TWENTY-ONE COUNTY CLERKS AND THE CHAIRPERSON OF THE TWENTY-ONE COUNTY BOARDS OF COMMISSIONERS, SECOND BY DON TANNER.

Mr. Stone opposed sending the minutes to the Chairperson of the Boards of Commissioners.
Mr. Kamps asked whether the intent of Mr. Nowak's motion was to send electronic or paper minutes. Mr. Nowak responded that he intended paper minutes. Mr. Kovacs commented that the minutes are kept on the www.nmre.org website; he suggested that a link be emailed instead.

LET THE RECORD SHOW THAT MR. NOWAK WITHDREW HIS MOTION; MR. TANNER WITHDREW HIS SUPPORT.

The NMRE will send a link to approved meeting minutes on its website to County Clerks and the Chairperson of the Boards of Commissioners as applicable.

Opioid Health Home
The pilot program officially went live on October 1st. Business Associate Agreements are in place for the Health Home Providers. NMSAS is leading the way of getting individuals enrolled. More updates will follow in the coming months.

NMRE Transition
A letter dated October 5, 2018 from Christine Gebhard and Eric Kurtz to North Country CMH staff leased to the NMRE was included in the materials for the meeting on this date. December 14th will be the last day of North Country CMH employment; staff will move the NMRE employment on December 15th with the first day of work commencing on December 17th. Health Care through North Country will continue through December 31st. NMRE has selected a health insurance plan through Blue Care Network which will be in

effect beginning January 1st. Mr. Kurtz expects to sign a lease for the Gaylord location by the end of the month. Brandon Rhue and his team will begin working on the IT infrastructure as soon as access to the building is granted.

Inpatient Bed Capacity
Mr. Kurtz expressed he was approached by Cindy Kelley and Dr. Mellos during the Fall Association Conference. They indicated they are not impressed with the Caro site. Expanding community hospital availability is being discussed at the State which might involve some capacity in the NMRE region. Mr. Kurtz will report more as the topic develops.

ATS Liquor Tax Request
A liquor tax request from Addiction Treatment Services (ATS) to implement residential services to women while allowing their children onsite was presented during the September meeting. Mr. Kurtz requested revised language from ATS to focus on prevention and treatment; no revision has been received to date. Mr. Kurtz clarified no funds have been sent from NMRE to ATS. It is possible that ATS secured funding through a grant. Mr. Kamps suggested floating this topic back through to the SUD Oversight Board. The rest of the Board agreed.

PRESENTATION

Compliance Update
Jodie Balhorn, NMRE Compliance Officer, provided an update on the responsibilities of the Governing Board regarding Compliance. The MDHHS-PIHP contract states that regular reports must be delivered to the Board. Board responsibilities include:

1) Adhering to the NMRE Regional Compliance Plan
2) Reviewing Compliance-related Policies
3) Reviewing Annual Medicaid Encounter Verification reports
4) Reviewing the activities of the Compliance Program
5) Providing high level oversight to the NMRE Compliance Program

Ms. Pelts asked about the status of the NMRE assuming the grievance & appeal function for the region. Mr. Kurtz responded that is likely to happen around January 1, 2019.

COMMENTS

Board

- Mr. Stone asked Sara Sircely whether individual on methadone receive "take home" doses. Ms. Sircely responded that, typically, individuals do receive doses for Sundays. Mr. Stone commented that young adults in the jail system are testing positive for methadone.
- Mr. Kamps congratulated AuSable Valley on the recognition of its ROAR community outreach, anti-stigma, and political action project during the CMHAM Fall Conference.
- Ms. Sherman congratulated Mr. Stone for his statements as President of CMHAM delivered during the Fall Conference.

MEETING DATES

The next meeting of the NMRE Board of Directors is scheduled for 10:00AM on December 12, 2018 at the Otsego Club in Gaylord.

ADJOURN

Let the record show that Mr. Kamps adjourned the meeting at 12:09PM.

	Program	Consumers served November 2018 (11/1/18 - 11/30/18)	Consumers served in the Past Year (12/1/17 - 11/30/18)	Average Since January (1/1/18 - 11/30/18)
1	**Access / Crisis / Prescreens**	49 - Routine 0 - Emergent 0 - Urgent 87 - Crisis 57 - Prescreens	688 - Routine 2 - Emergent 6 - Urgent 1140- Crisis 546 - Prescreens	59 - Routine 0 - Emergent 0 - Urgent 96 - Crisis 47-Prescreens
2	**Doctors' Services**	1115	1569	1131
3	**Case Management**			
	Older Adult (OBRA)	126	181	129
	MI Adult	233	366	238
	MI ACT	29	39	32
	Home Based Children	16	26	9
	MI Children's Services	134	223	124
	DD	335	365	338
4	**Outpatient Counseling**	215(39/176)	530	212
5	**Hospital Prescreens**	57	546	47
6	**Private Hospital Admissions**	21	259	22
7	**State Hospital Admissions**	0	1	0
8	**Employment Services**			
	DD	76	117	89
	MI	52	83	52
	PSR Clubhouse	65	76	58
9	**Peer Support**	61	80	65
10	**Community Living Support Services**			
	DD	146	158	148
	MI	205	257	198
11	**CMH Operated Residential Services**			
	DD Only	59	62	60
12	**Other Contracted Resid. Services**			
	DD	33	38	35
	MI	27	33	29
13	**Total Unduplicated Served**	1133	2388	1154

County	Unduplicated Consumers Served Since December 2017
Alcona	261
Alpena	1515
Montmorency	235
Presque Isle	289
Other	67
No County Listed	21

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

BYLAWS

PREAMBLE[DH1]

Recognizing the responsibility of the Alcona, Alpena, Montmorency, and Presque Isle County Boards of Commissioners to provide suitable mental health services to the above named counties, the boards of commissioners have duly appointed a Community Mental Health Board as a Mental Health Authority according to Public Act 258, 1974, as amended.

Recognizing further the responsibility of this Authority in upholding the best interests of the citizens through concerted effort in providing and maintaining mental health services in accordance with Public Act 258, 1974, as amended, the Northeast Michigan Community Mental Health Authority hereby organizes in conformity with bylaws and regulations herein-stated.

For the purpose of these bylaws, whenever the term "Authority" shall appear, it shall be interpreted to mean the Northeast Michigan Community Mental Health Authority, who shall have authority in the government of the county mental health services for the above-mentioned counties. Whenever the term “Board” shall appear, it shall be interpreted to mean the Board of Directors of the Northeast Michigan Community Mental Health Authority. Whenever the term "Department" is used, it shall be interpreted to mean the Michigan Department of Health and Human Services.

ARTICLE I - NAME

The name of this Board shall be the NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY.

ARTICLE II - MISSION

To provide comprehensive services and supports that enable people to live and work independently.

Approved by the Northeast Board – March 10, 1994
Last revision approved by the Northeast Board – January 11, 2018

ARTICLE III - DUTIES

This community mental health authority shall:

A. Examine and evaluate the mental health needs of the counties it represents and the public and nonpublic services necessary to meet those needs.

B. Review and approve an annual plan and budget for the program. (The format and documentation of the annual plan and budget shall be as specified by the Department.)

C. Provide and advertise a public hearing on the annual plan and budget.

D. Submit to each board of commissioners a copy of the Board's needs assessment, annual plan and requests for new State funds.

E. Take such actions as it deems necessary and appropriate to secure private, federal, and other public funds to help support the program.

F. Approve and authorize contracts for services.

G. Review and evaluate the quality, effectiveness, and efficiency of services being provided by the program.

H. Appoint a director of the community mental health program who shall meet standards of training and experience as established by the Department in Administrative Rules.

I. Establish general policy guidelines within which the director shall execute the program.

J. Subject to the provisions of Chapter II of Public Act 258, 1974, as amended, the Authority may enter into contracts for purchase of mental health services with private or public agencies.

   Contracts may be entered into with any facility or entity of the Michigan Department of Health and Human Services with the approval of the Michigan Department of Health and Human Services.

ARTICLE IV- MEMBERSHIP

Section 1. Appointment

The county boards of commissioners of the counties involved, being Alcona, Alpena, Montmorency, and Presque Isle, shall establish a 12-member community mental health

authority board of directors. Each board of commissioners shall appoint the board members from its county.

Section 2. Composition

The composition of the Board shall be as specified in the Mental Health Code, section 222.

Section 3. Terms; Vacancies; Removal of Member

The term of office of a board member shall be three (3) years from April 1 of the year of appointment. Vacancies shall be filled for unexpired terms in the same manner as original appointments. Board members are encouraged to attend all board meetings. If a Board member misses two consecutive meetings without advance notice to the Board Chairperson or his or her designee, a letter from the Board Chairperson will be sent to the board member inquiring about the member's intent to fulfill his or her term of office. If no response is received within 30 days, a second letter will be sent with a copy to the Chairperson of the appointing County Commission. If no response is received within 30 days, a letter will be sent to the Chairperson of the appointing County Commission requesting the removal of the board member according to the requirements of the Mental Health Code, § 224, which states in part: A board member may be removed from office by the appointing board of commissioners for neglect of official duty or misconduct in office.

ARTICLE V - OFFICERS

Section 1. Officers; Election; Term of Office

The officers of this Board shall consist of a Chair, Vice-Chair, and Secretary who shall perform the duties usually pertaining to such offices or as provided by the Board. All officers shall be elected for a term of one year and shall hold office until the next regular election; such election to be held at the April meeting of each year.

The annual election of Board Members to Board Offices shall be conducted in the following manner:

- By the October Meeting prior to the April election, the Chair will recommend to the Board, subject to the approval of the Board, a "Board Officers Nominating Committee", a Special Committee of the Board which shall exist for the sole purpose of nominating candidates to fill the positions of the Board's Offices; that Committee shall consist of at least four and no more than six Board Members, preferably one from each county and excluding the Chair.

  The Nominating Committee shall also review the terms of all Board members to identify the need for consumer or consumer representative appointments. The

committee shall attempt to recruit or identify candidates for membership who meet the requirements of Section 222 (1) of the Mental Health Code. These recommendations shall be communicated to the county Boards of Commissioners as necessary by the Board's Chair.

- By the March Meeting, that Committee shall report its recommendations to the Board for its members' consideration prior to the April election meeting.

- During the April Meeting, a slate of candidates for the Board's three offices shall be placed in nomination first by the Nominating Committee, which shall give its report at the call of the Chair.

- Election of the Board's Chair for the next year shall be the first election, and shall be conducted by the current Chair, who shall state the Nominating Committee's nomination, then ask if there are any [further] nominations from the floor; if/when none is heard after *three* such invitations, then the Chair shall declare that nominations are closed and the election may proceed.

- Balloting may be by voice, by show-of-hands or by secret written ballot, as the Board may determine in advance or by its majority vote at any time during the election process; a majority of votes cast shall determine the outcome of the election.

- Following the election of a new Chair (and assuming the current Chair does not succeed to the office), the immediate-past-Chair shall relinquish the chair to the new Chair, who shall conduct the balance of the elections in the same manner.

- Elections then proceed in this order:
  Vice-Chair... then Secretary.

- Newly-elected officers assume their offices immediately upon elections.

- If questions of procedure arise before or during the meeting or elections, the Board shall resolve these questions via reference to its ByLaws, Policies and/or Robert's Rules.

Section 2. Duties

Chair - The Chair shall be the presiding officer at all meetings of the Board; shall be an ex officio member of all committees; shall appoint the Chair of the standing and special committees; shall sign and execute in the name of the Board; shall call meetings of the Board; and shall perform such other duties as are required by the Board.

Vice-Chair - The Vice-Chair, in the event of the incapacity or absence of the Chair, shall assume the duties prescribed to the Chair. In the absence of the Chair from a

meeting of the Board, the meeting shall be called to order by one of the officers of the appointed Board, designated as temporary Chair, in the following order of precedence:

Vice Chair ... then Secretary.

If the Chair does arrive, the temporary Chair shall surrender the chair to him/her.

Secretary - The Secretary or his/her designee shall send appropriate notices and prepare agendas for all meetings of the Board, shall act as custodian of all records and reports, and shall be responsible for the keeping and reporting of adequate records of all meetings of the Board.

Section 3. Additional Officers

The Board may elect or appoint such other officers or agents as it may deem necessary for the transaction of business of the Board, and for terms to expire the same as other officers provided for in these Bylaws.

Section 4. Removal of an Officer

The Board may remove an Officer for just cause by the majority of the Board (7). A member removed from office shall remain a member of the Board unless he or she is removed from the Board by the appointing board of commissioners according to Article IV, Section 3.

Section 5. Replacement of an Officer

Should an Officer be unable to finish their term of office, the Board Chair will appoint a replacement for the position vacated, preferably from the same County to assure equal representation on the Executive Committee. If the appointee rejects the appointment, the Chair will appoint another Board member.

ARTICLE VI - MEETINGS

Section 1. Regular Meetings

The board of directors of Northeast Michigan Community Mental Health Authority shall hold at least twelve regular meetings annually at a time and place to be designated by the Chair of the Board. All meetings of the Board shall be open to the public and shall be held in a place available to the general public. All meetings shall be held in accord with 1976 P.A. Act 267 (the "Open Meetings Act") and 1976 P.A. 422 (the "Freedom of Information Act"). Within ten days after the April meeting of the Board in each year, the Secretary shall post a public notice stating the dates, times and places of its regular meetings.

If there is a change in the schedule of regular meetings of the Board, there shall be posted within three days after the meeting at which the change is made, a public notice stating the new dates, times, and places of its regular meetings.

Upon written request, at the same time a public notice of meeting is posted, the Secretary shall provide a copy of the public notice of that meeting to any newspaper published in the state and to any radio and television station located in the state, free of charge.

Other requirements pertaining to regular meetings of this Board contained in Public Act 267, 1976 shall be adhered to.

The agenda for regular meetings of the Board may include the following:

Call to Order
Roll Call and Determination of a Quorum
Pledge of Allegiance
Appointment of Evaluator
Acknowledgement of Conflict of Interest
Information and/or Comments ~~From~~ from the Public
Board Training
Approval of Minutes
Consent Agenda
Monitoring Reports
Policy Review, Approval & Self-Evaluation (if any)
Chair's Report
Director's Report
Operation's Report (if any)
Next Meeting – Setting Agenda
-- Meeting Evaluation
Adjournment

Section 2. Special Meetings

Special meetings of the Board may be called by the Chair or upon written request of any three members of the Board filed with the Secretary or his/her designee. Notices of a special meeting shall be given by one of the following means or as required by the Open Meetings Act:

a. Personal notice by telephone or otherwise to each Board member at least 24 hours before such meeting.

b. Public notice at least eighteen hours before such meeting, stating date, time, and place.

c. As otherwise determined by the Chair.

Each notice of a special meeting shall state the time, place, and purpose thereof.

The agenda for special meetings of the Board may include the following:

Call to Order
Roll Call and Determination of a Quorum
Statement of Purpose of Meeting
Transaction of Business According to Stated Purpose
Adjournment

Section 3. Closed Meetings

A 2/3 majority roll call vote of appointed Board members shall be required to call a closed session, for purposes stated in Section 8, Public Act 267, 1976. The roll call vote and the purpose or purposes for calling the closed meeting shall be entered into the minutes of the meeting at which the vote is taken.

Section 4. Meeting by Remote Communication

A Board member may participate in a meeting by conference telephone or any similar communication equipment through which all persons participating in the meeting can hear each other. Participation in a meeting pursuant to this Section constitutes presence in person at the meeting.

Section 5. Minutes

The Board shall keep minutes of each meeting showing the date, time, place, members present, members absent, any decisions made at a meeting open to the public, and the purpose or purposes for which a closed session is held. The minutes shall include all roll call votes taken at the meeting.

Minutes shall be public records open to public inspection and shall be available at the address designated on posted public notices pursuant to Section 1. Copies of the minutes shall be available to the public at a reasonable estimated cost for printing and copying.

Proposed minutes shall be available for public inspection no later than eight (8) business days after the meeting to which the minutes refer. Approved minutes shall be available for public inspection not later than five (5) business days after the meeting at which the minutes are approved by the Board.

A separate set of minutes shall be taken by the Secretary or his/her designee at the closed meeting; these minutes shall not be available to the public, and shall only be disclosed if required by a civil action filed under Section 10, 11, or 13 of Public Act 267,

1976. These minutes may be destroyed one year and one day after approval of the minutes of the regular meeting at which the closed meeting was approved.

Section 6. Materials to be Furnished Board Members

Insofar as possible, all members of the Board shall be mailed a copy of the proposed agenda and copies of all material to be considered at regular Board meetings in advance of such meetings, unless this requirement shall be waived by unanimous consent of Board members present at any regular meeting; provided, however, that any Board member or the Director may place an item on the agenda by requesting the Chair to include such item or items.

Insofar as possible, all members of the Board shall be mailed copies of the agenda to be considered at special Board meetings, unless this requirement shall be waived by unanimous consent of all Board members.

Section 7. Quorum and Voting

One-half of the appointed Board members, which shall include one officer, shall constitute a quorum of the Board. Consistent with Robert's Rules of Order, motions made during Board and committee meetings shall require a second in order to be considered. The affirmative vote of the majority of the votes cast shall be required for the passage of any motion or resolution at any meeting of the Board or its committees. The Chair of the Board will be allowed to vote.

It shall be the prerogative of any Board member to require a roll call vote on any motion.

Section 8. Decorum during Debate

Board members shall confine their remarks to the question, be courteous in their language and behavior, avoid all personalities, is this still necessary? not arraign the motives of another board member, and emphasize it is not the individual, but the measure which is subject of debate. The Chair will assure enforcement of these behavioral guidelines.

The Chair shall call to order any person who is being disorderly by speaking or otherwise disrupting the meeting proceedings by failing to be courteous, by speaking longer than a reasonable time or by speaking vulgarities. Such person shall thence be seated until the Chair shall have determined whether the person is in order. If the person shall have been ruled out of order, he/she shall not be permitted to speak further at the same meeting except upon special request of the board. If the person continues to be disorderly and disrupt the meeting, the Board Chair or a designee shall contact local law enforcement to have said individual removed from the meeting. No

person shall be removed from a public meeting except for an actual breach of the peace committed at the meeting.

ARTICLE VII - COMMITTEES

The Board of Directors shall establish the following standing committees: Executive Committee and Recipient Rights Committee. The standing committees shall perform such functions and duties as designated by the Board.

At the annual organizational meeting of the Board, the Chair of the Board shall appoint the Chair and members of the standing committees; those persons shall be members of the Board, except that the Recipient Rights Committee membership may include Community Mental Health Board members, staff personnel, government officials, attorneys, mental health consumer interest group representatives, or other persons, at the discretion of the Board Chair.

The Chair shall appoint the chair and members of special committees, subject to the approval of the Board; those persons need not be members of the Board, shall be counted for quorum and shall be eligible to vote on committee matters. The Chair of the Board shall be the only ex officio member of any and all standing committees, shall be included in counting for quorum, if present, and shall be eligible to vote.

The Board may establish such other committees as it deems proper.

All standing and special committees shall meet upon the call of the committee Chair, with the concurrence of the Board Chair, to consider whatever business is before said committee in order to recommend appropriate action to the Board.

Committees of the Board may meet by teleconference providing all requirements of the Open Meetings Act are met including providing and announcing a location at which members of the public may attend and hear the entire deliberations of the committee and all committee members.

Matters reported by a committee may be reported with a recommendation for Board action, or solely for the information of the Board.

Tenure on standing committees shall be for a one-year term beginning in April or until the appointment of a new committee; however, nothing herein shall be construed to prevent reappointment of any committee member.

Nothing contained in this Article shall be construed to deny any Board member the right to attend any meeting of any standing or special committee.

For Board committees a quorum shall be defined as equal to at least fifty percent (50%) of the committee membership.

Notices to the public regarding committee meetings shall be posted pursuant to Section 5, Public Act 267 of 1976, and Article VI of these Bylaws.

Section 1. Executive Committee

The Executive Committee shall consist of four members: the Chair, Vice-Chair, Secretary of the Board and immediate past Chair. If the immediate past Chair is no longer a current member of the Board, the Board shall elect an additional board member to serve as an at-large member of the Committee. It is the preference of the Board to have all four counties represented on the Committee. This committee shall have authority to act on behalf of the Board during the period between meetings of the Board, subject to any prior limitation imposed by the Board and with the understanding that all matters of major importance be referred to the Board.

This Committee shall research and apprise Board members of proposed, pending and current legislation pertaining to mental health services, and shall recommend a Board position.

Section 2. Recipient Rights Committee

This Committee shall advise the Board and Director concerning implementation of policy as it relates to the Recipient Rights system and shall review the operation of the Office of Recipient Rights in accordance with Section 757 of the Mental Health Code. This Committee shall serve as the Appeals Committee under Section 784.

ARTICLE VIII - DIRECTOR OF COMMUNITY MENTAL HEALTH AUTHORITY

The Director of the Northeast Michigan Community Mental Health Authority shall be selected by the Board. The Director shall be given the necessary authority and responsibility to operate all mental health services and carry out all policies as may be adopted by the Board, or any of its committees to which it has delegated authority. The Director shall ensure that appropriate orientation programs for new Board members and continuing education programs for all Board members are carried out and shall represent the Board in all areas in which the Board has not formally designated some other person to so act.

ARTICLE IX - MISCELLANEOUS

Section 1. Amendment and Adoption of Bylaws

These Bylaws may be amended or repealed by the affirmative vote of a majority of the members of the Board present at any regular or special meeting of the Board if notices of the proposed amendment or repeal are contained in the written notice of the

meeting, such notice to be given prior to such a meeting by ordinary mail. Bylaws may also be amended without notice by a three-fourths vote of the Board members present.

Section 2. Rules of Order

Robert's Rules of Order shall be the parliamentary guideline for all matters of procedure not specifically covered by the Bylaws or by specific rules or procedures adopted by this Board.

Section 3. Conflict of Interest

No Board member shall in any way be a contractor for purposes of remuneration of this Authority or its contracting agencies unless a competitive bid process is utilized, the Board member discloses the association and affiliation, and a two-thirds (2/3) majority vote of the Board supports such a contract.

Section 4. Employment

Employment of a Board member or any member of his or her immediate family is prohibited.

Section 5. Suspension of Rules

The rules governing all matters of procedure of the Board provided in the Bylaws and in subsequent governing resolutions may be temporarily suspended at any time by the unanimous consent of the members present to facilitate the accomplishment of any legal objectives of the Board.

Section 6. Depository

As a Mental Health Authority, the Board may act as its own depository of funds, or, at its discretion, designate a county willing to act as depository.

Section 7. Per Diem and Reimbursement

Board members shall be paid in accord with the payment schedule for Northeast Michigan Community Mental Health Authority.

Section 8. Assurances

With respect to both employment practices and services rendered, the Authority will not discriminate against persons because of religion, race, color, national origin, age, sex, height, weight, marital status, political affiliation, sexual orientation or physical or mental handicap.

No service or program provided by the Authority will be withheld from any person on the basis of residence in a county other than Alcona, Alpena, Montmorency, and Presque Isle counties. If a person cannot meet financial obligations incurred by such program or service, the county of residence will be billed.

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

MEMORANDUM

TO: Board Members

FROM: Cheryl Jaworowski
Finance Director

SUBJECT: Northland Area Federal Credit Union – Change in Authorized Signers

DATE: December 13, 2018

We are requesting Board approval to change an authorized signer on our account at the Northland Area Federal Credit Union. We use this Credit Union for the sole purpose of purchasing CD's of no more than $250,000 in principal amount.

Signers on the account will be Cathy S. Meske (Director), Cheryl Jaworowski (Finance Director), and Larry Patterson (Accounting Supervisor). We will be removing Joell Anthony (Staff Accountant) as a signer on this account.

JANUARY AGENDA ITEMS

Policy Review
Emergency Executive Succession 01-006

Policy Review & Self-Evaluation
Executive Director Role 03-001

Monitoring Reports

Emergency Executive Succession 01-006
Budgeting 01-004

Activity

Ownership Linkage

Educational Session

CMHA Community Mental Health Association of Michigan
Connections
for communities that care
FALL 2018

LEADERSHIP LIES IN THE POWER OF CONVENING

Clint Galloway


John VanCamp

Leaning over the table for emphasis and to assure I heard, John said, "Leadership lies in the power of convening." This begged the question; what is the secret to that power of convening? Paraphrasing Jim Collins, author of *Good to Great*, John said, "Creating a compelling vision that others see as their own." Later, John made clear that the ensuing vision for Southwest Solutions (SWSOL) was a shared vision articulated by numerous individuals to give expression to their passion, not one he created by himself. The vision is *"to enhance the quality of life, success and self-sufficiency of individuals and families."*

That was the key; it all began to come together. The late lunch in one of John's favorite Mexican restaurants in Southwest Detroit was not only a treat, it was part of the "show and tell" whirlwind tour of a renaissance occurring in Southwest Detroit that was exhibit "A" of this shared passion. Commensurate with this style of leadership, John possesses some profound personal characteristics, three of which have become obvious to me: a sense of mission rooted in compassion, a vision constantly honed by a deepening appreciation for the complexity of life and what constitutes emotional well-being, and finally, humility. To again quote Jim Collins, commenting on the five levels of leadership: "The X factor of truly great leadership is humility – humility combined with a ferocious will for something bigger than yourself, humility in a very special way. I want to be very clear. These people are ambitious. They have tremendous energy. They are often exhausting. They never want to stop. They're utterly relentless. Okay, they have all that, but here's the difference. See, for a 5 versus a 4 – so, for a 4, all that energy and ambition and drive is about them. It's about what they get. It's about how they look. It's about what they make. It's about what accrues to them. It's about whether they are the center. That's a 4. [In] 5s, all that same level of energy and drive and ambition is channeled outward into a cause, into a company, into a culture, into a quest, into something that is bigger and more enduring than they are. Level 5s lead in a spirit of service, and they subsume themselves and sacrifice for that."[1] That's John, and that helps explain the renaissance occurring in Southwest Detroit.

Somewhat acquainted with John's legacy, I approached him about two years ago to write this story. After numerous unwarranted apologies by John, it dawned on me that to capture the essence of this story, I needed to go to Detroit and witness John's work. A few days later I was swallowed up in the morning rush hour traffic on interstate 96 all the way into Detroit, exiting just before the Ambassador Bridge. My presence was another example of John's engaging gift of bringing people to the table. John had meticulously planned a tightly packed eight hour schedule of "show and tell" during which I saw, heard, and even tasted what's happening in Detroit. It has forever changed my impressions of not only what is occurring in Detroit, but how the same transformative strategies can and are fostering a new generation of healthcare that includes not just people based strategies but also incorporates place based strategies. Enhancing the quality of life requires more than addressing what afflicts our bodies; it also demands attention to the place where we live. Touring the streets of Detroit I saw both the signs of decay that we often associate with what has afflicted many metropolitan areas as well as the impressive transformations occurring under the style of healthcare leadership practiced

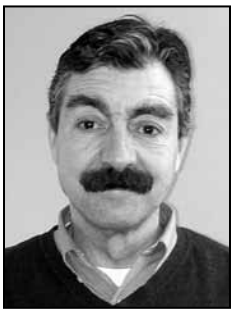
(Continued on Page 17)

[1] https://www.jimcollins.com/media_topics/level-5-Leadership.html

Healthcare Transformation

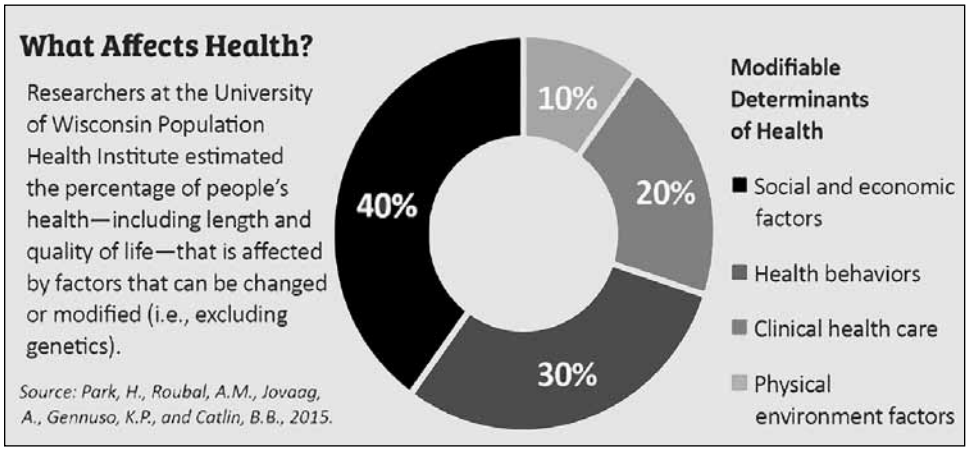
Social Determinants and Adverse Childhood Events

Robert Sheehan, CEO, Community Mental Health Association of Michigan



Robert Sheehan

This edition of Connections revolves around a number of themes, central among them the power and importance of social determinants to the health of all of us. While our system and Michigan's healthcare system is involved, in the main, in the provision of clinical and related services and supports, it is key that we recognize and take on the challenge related to the recognition that these social determinants – housing, employment, income/poverty, race, social connections, family functioning, environmental factors, among others – are more important to the health of individuals and the entire community than any of our clinical interventions.



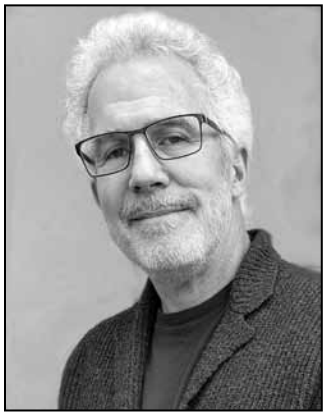
As the chart here illustrates, only 20% of a person's health is impacted by clinical healthcare and related supports and services. So, while we must continue to provide high quality, accessible, person-centered, community based services and supports, (recognizing that Michigan's public mental health system is one of the most advanced and comprehensive and community-oriented in the country), we cannot stop there. To provide these services and supports while not addressing these social determinants, physical environmental factors and healthy behaviors (most of which are the result of the social determinants and environmental/family factors) is to ignore the causes of the mental and physical health needs that we are working to address.

One of the starkest examples, and one that thankfully is highlighted by the popular press, is the impact of adverse childhood events (ACE) on the health of children, continuing as they mature into adulthood. ACEs include: physical abuse, sexual abuse, emotional abuse, physical neglect, intimate partner violence, substance misuse in the family, household mental illness, parental separation or divorce, and incarcerated household member. While the resilience of children is often sufficient to overcome the impact of one or two of these, since the initial study in the 1990s, research repeatedly finds that the impact of a number of incidents without intervention, seriously impacts both childhood and adulthood. The cumulative impact is dramatically negative in a number of the dimensions of that person's life. Without services and supports, the effects include: early and harmful drug use, higher rates of suicide attempts, higher rates of lifetime depression, higher rates of high-risk sexual behaviors, poorer fetal outcomes of babies born to high ACE mothers, poorer physical health, and poorer dental health.

There are two lessons to learn in the recognition of the impact of ACEs on the lives of children and adults. The first, and the one often taken up by health care providers, educators, and human services providers, is the need to identify children and adults with a high number of ACEs and to provide the trauma-informed interventions needed to overcome or mitigate the impact of these events. The second lesson – and one that is often ignored – is the need to work to prevent these events from happening to the children in our nation, our state, and our community. We cannot treat these conditions as simply being the normal course of life in the world as it is. We must recognize that these events are the result of actions that we, as a society, choose. We must work to prevent these events from happening through supports, services, and preventative measures in our families and in our communities. Only when we recognize the need for such pre-emptive action that address these social determinants will we be able to prevent the devastating harm that adverse childhood events have on our fellow community members.

On Community and Healing

James Madden, System Coordinator
Children and Youth Mental Health System, Ontario, Canada



James Madden

In the Spring 2018 issue of *Connections*, Ron Manderscheid called on us to incorporate the neglected dimension of *community* into our efforts to more effectively support, care for, and promote the healing of those of us who suffer with mental and emotional distress. In his article, Manderscheid reminded us that our understanding of mental health and wellness has undergone a corrective, has become enlarged and enriched in recent decades – *health* being defined by the World Health Organization (WHO) as more than the mere absence of disease, to include "a complete state of physical, mental, and social well-being."[1] Further to this, the WHO (2014) has defined *mental health* as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." In this article I want to dialogue with and expand upon some of the ideas Manderscheid introduced, particularly the notion that intervening at the level of community may be an impactful and fruitful way of promoting and supporting mental health. We will explore current understanding of how social and community context influence mental health and mental illness, and consider some particular examples of community-level mental health interventions. I will conclude by suggesting some principles and qualities that characterize effective community-level mental health practice.

Beyond Biomedical and Individualistic Models of Mental Health

Many readers will recognize in this call for inclusion of a community-level perspective, a shift away from exclusive reliance on a bio-medical model as the dominant paradigm for our understanding of health and illness. The bio-medical model has held sway in our approach to treating illness more generally for good reason; it has been and continues to be very effective and powerful – lifesaving – for individuals suffering from many bio-physical, "medical" conditions.

I would argue that the bio-medical model is not wrong, but rather incomplete and limited, especially as regards mental health. An indicator of the ongoing, outsized influence of the medical model on community mental health systems, is the extent to which we treat those suffering with mental and emotional distress as though the source of their suffering lie exclusively or predominantly in some genetically or biologically-based disorder or malfunction of their individual organism, or in some individual character weakness or moral failing leading to poor behavioral and lifestyle choices. Even when our therapeutic modalities are not specifically medical (e.g. prescribing psychotropic medicine), we predominantly rely on individual treatment behind closed doors (individual psychotherapy). We tend to pathologize those suffering mental and emotional distress, treating them as defective individuals that need to be fixed. To the extent that we employ approaches such as family systems therapy we have moved a degree away from an overly individualistic model toward understanding individual mental health and well-being as being embedded in a social context.

The Social Determinants of Mental Health

If bio-medical and individual psychotherapy models are insufficient, then what? As Mandersheid briefly alluded to, the idea that through the dimension of "community" may lie critical and effective mental health interventions, this fits with the social determinants of health (SDOH) model. The SDOH model took root within the disciplines of public health and population health and has arguably become the most important model guiding public health interventions over the last 10 to 15 years. The fundamental insight of the SDOH perspective is that social, economic, political, and cultural factors within which individuals are born, grow and develop have the greatest impact on health and well-being over the life course, far greater than "lifestyle" and individual health behaviors.[2]

Consistent with both bio-physical and SDOH perspectives, we know that a complex interacting *(Continued on Page 4)*

[1] To this definition I would add the spiritual dimension, in solidarity with the world's great religious traditions. The medicine wheel shared in common by many of North America's Indigenous communities, depicts the physical, emotional, intellectual, and spiritual dimensions of healthy life in balanced harmony.

[2] Having made that point, I think it is important to avoid casting the discussion in simplistic either/or terms. Of course individual agency matters, but individuals are always embedded in social contexts which profoundly shape, enable or constrain, the structure of opportunities, choices, and life chances.

On Community and Healing *(From Page 3)*

web of causal factors – genetic, familial, community, and broader social forces – influence whether any individual will come to struggle with mental illness.[3] We know that at any given point in time, about 20% of the population in "westernized" societies suffers with a clinically significant mental health problem – i.e. a problem that interferes with reasonably normal functioning in terms of carrying on satisfying relationships with family and friends, the ability to find and maintain reasonably satisfying work, and participate meaningfully in community life. No doubt this statistic will have included at one time or another many people reading this article. All of us, regardless of socio-demographic, religious, or cultural background have a friend or family member who has struggled with mental health concerns. All of us struggle from time to time with what might be called ordinary emotional distress – anxiety and depression – just as a function of being human. Just by virtue of being human and living in a complex society undergoing rapid social, economic, and technological change wherein many are displaced, and the once secure basis of identity has become tenuous, most all of us are at risk for developing mental illness. In addition, a particularly provocative and robust finding from the SDOH literature indicates that the greater the degree of economic and social inequality in a society, the poorer the health outcomes for the entire society (all social strata), including those in higher income groups.[4]

All of us struggle from time to time with what might be called ordinary emotional distress–anxiety and depression–just as a function of being human.

The literature on SDOH typically enumerates lists of specific social determinants that vary somewhat depending on context. The U.S. Center for Disease Control, in a report entitled "Healthy People 2020," describes five SDOH domains:

- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Built Environment
- Social and Community Context.[5]

Applying the SDOH model to mental health per se, the Canadian Mental Health Association (CMHA) specifies the following three social determinants as particularly important with respect to mental health: *freedom from discrimination and violence, social inclusion, and access to economic resources.*[6]

Trauma and Attachment

Embedded in these social determinants of mental health, are two factors that demand particular emphasis – *trauma and disordered attachment* relationships in early childhood. Over the last 20 years or so, tremendous advances in neurobiology – in our understanding of the way brain, body, and social relationships interact to produce mental health and well-being or mental distress and illness – have demonstrated how profoundly childhood physical and sexual abuse, and emotional neglect and abuse affect mental health. The emotional responses to adverse childhood and subsequent traumatic events become encoded in implicit memory, in the body and the brain. Individuals become susceptible to being re-traumatized (flooded with implicit memories and fight/flight/freeze responses) when triggered by events or situations in the present that in some way resemble the past traumatic event. The individual literally experiences this neurologically as though the past event or situation is happening again in the present. This is how a person suffering with PTSD experiences a traumatic flashback.

Those with insecure or disordered attachment unconsciously reproduce relationships in their adult lives that restage early childhood experience, leaving them feeling fearful, insecure, and unloved. In addition to these stressors, many face systemic factors including structural unemployment, with its attendant chronic economic insecurity, and racialized discrimination. The result is chronic activation of the fight/flight/freeze response which literally transmutes psychosocial stress into physical and mental illness. And as Gabor Maté demonstrates in his brilliant book, *In the Realm of Hungry Ghosts* (2010), virtually all addiction originates in early childhood trauma and abuse which over time neurologically predisposes the *(Continued on Page 8)*

[3] Research indicates that this is true even for mental illnesses that are usually understood to have a genetic basis such as schizophrenia and bi-polar disorder. For example, Barlow, et. al., in Abnormal Psychology: An Integrative Approach. Toronto: Nelson (2015), conclude that the only safe generalization that can be made with respect to genetic influences, is that "genes are responsible for making some individuals vulnerable to schizophrenia" and that moreover, that there is a "complex interaction between genetics and environment" (pp. 476-477).

[4] See for example, "The Inner Level: How More Equal Societies Reduce Stress, Restore Sanity and Improve Everyone's Wellbeing" by Richard Wilkinson and Kate Pickett (2018).

[5] https://www.cdc.gov/nchs/data/hpdata2020/HP2020MCR-C39-SDOH.pdf

[6] http://ontario.cmha.ca/documents/mental-health-promotion-in-ontario-a-call-to-action/

ACQUIRING CULTURAL COMPETENCY

Dr. Hakeem Lumumba, PhD, LMSW, LPC

Dr. Hakeem Lumumba

The purpose of this paper is to explore the concepts of what is cultural competence, how to become culturally competent, and why becoming culturally competent is imperative to the delivery of behavioral healthcare to clients. More importantly, this paper is designed to stimulate your intellect and your ability to apply sound reasoning.

I have had the privilege and pleasure of serving as a clinician and as an administrator in Behavioral Health since 1982. In doing so, I have encountered and interacted with various cultures. It has been my experience that we all share some similarities and some differences. However, each individual has his/her own uniqueness from a genetic perspective. One of the challenges that we face is establishing an appreciation for our differences without feeling too uncomfortable. How does one accomplish this task?

Recently, I read a West African Proverb that states, "To not know is bad; not to wish to know is worse." How many of us wish to know? How many of us are willing to admit that we are too afraid to know? How many of us are aware of what we do not know and that our perceptions have been formed by our environment? What is your definition of the following terms – a) indoctrination and b) education? Based on your definition of these terms, which one best describes your state of mind towards cultures other than your own?

What is Cultural Competence?

First, we must approach it from the following standpoints: historically, geographically, anthropologically, climatically, and scientifically. Historically, there have been many scholarly debates as to the origin of human beings. According to Louis Leaky and Mary Leaky, British Anthropologists, the original human beings came from the region known as Kenya, Africa. They came to their conclusion after extensive examinations of human fossils using sophisticated radiocarbon dating. According to the Leakys, there is only one race, the human race. From a geographical point of view, at one point of time the earth was one land mass known as the Pangaea (large land mass). Scholars have estimated that humans began to migrate to various parts of the world and their physical features changed due to the various climates.

Scientists have proven that individuals who reside in the warmer climates, tend to develop certain physical features such as dark skin complexion. On the other hand, an individual who resides in a colder climate tends to develop light skin complexion. The reason for the changes in our skin complexion is due to the body production and/or under production of melanin which is a natural defense mechanism to protect us from our indigenous climates. There are other physical features that are influenced by the indigenous climates, such as our hair texture, the shape of our lips and nostrils, height and weight, etc.

Of all our various physical features, it seems that mainstream society tends to focus on skin complexion as the marker to determine what is acceptable. For example, historically, in the United States, there has been significant focus on two groups of people, those who are of dark complexion (i.e., African Americans) and those who are of light complexion (i.e., European American). We have missed opportunities to expand our knowledge of humanity more specifically of our diverse cultures. I have often wondered what goes through the minds of individuals from other cultures when most of the mainstream's focus is on the relationship between African Americans and European Americans. Do they feel left out, ignored, or have they simply accepted this reality?

To become culturally competent, we need to challenge ourselves to go beyond skin complexion and give ourselves permission to explore other cultures. This is especially true in the field of behavioral health where our client population has become more diverse and unique. In addition, I would invite the readers to enhance their scholarship by reading about the Leakys and their work with identifying the original humans. Furthermore, study the effects that climates have on human beings' physical features and the role of melanin.

How to Become Culturally Competent

To become culturally competent, we must examine the formulation of our perceptions of people in general. For example, it is common for human beings to have certain biases whether it be towards race, religious beliefs, sexual orientations, or languages. How do we arrive at our perceptions that lead us to develop biases? Today, we are inundated with a plethora of information via the media. This information is

(Continued on Page 6)

available 24 hours per day, 365 days per year. Oftentimes, the information is delivered very quickly and with biases. We do not take time to analyze the information before formulating our opinions and perceptions, therefore, whether consciously or unconsciously, we develop our perceptions about certain people before getting to know them.

For example, how often have the media painted a grim picture about a certain culture to the point that it has influenced your perception about this culture? Most likely, you have already formed an opinion before interacting with this culture. As behavioral health providers, we are supposed to deliver quality, fair, and unbiased care to our consumers. However, because we are exposed to the media's perceptions of a certain culture, we do not deliver unbiased care. Often, we are assigning diagnoses to clients based on our perceptions of their culture rather than from a sound clinical evaluation. Quite frankly, I believe that we have become apathetic when it comes to filtering out the accuracy of information that has been disseminated. Part of the reason is due to the speed that information is conveyed. To become culturally competent is being able to form our own perceptions with minimal influence from the media and from other people.

To become culturally competent is to explore the impact of our significant influencer (e.g., parents, guardians, educators, entertainers, etc.) early in life. For example, depending upon who reared you, their influence shaped your perceptions and attitudes toward your culture and other cultures. It is conceivable that you grew up being afraid or having negative thoughts about certain cultures. The sad part about this is that your attitudes and negative thoughts were formulated before you had contact with these cultures.

By default, as we mature, we tend to interact with various cultures. Sometimes, we discover that we were misinformed by our significant influencers. In some cases we begin to change our perceptions and attitudes. However, there are other times when we maintain our negative attitudes toward other cultures because of our family traditions even after we have discovered that we were misinformed. Having the courage to rethink and challenge old ideas are crucial in becoming culturally competent.

One final thought; what are the main differences between cultural competence and political correctness? At face value, one could say that cultural competence is having accurate knowledge and perception about a culture, while political correctness is a conscientious effort to not offend anyone. With the latter comes a certain degree of anxiety due to being afraid of not offending anyone. However, if we allow ourselves to interact with other cultures, it will increase our comfort level to the point we are aware of what is offensive versus what is not. Our interactions would become less anxiety provoking and less uncomfortable. Perhaps you have noticed that we have evolved into a highly sensitized society where we can make a benign statement and be viciously attacked by our supervisor, peer, or perhaps by the media. I have often wondered why we have evolved into this level of intense scrutiny. There is a part of me that believes that it is designed to keep us from communicating with each other, especially interculturally. In other words, if we are too afraid of saying something that may be perceived as offensive and of being viciously penalized by default we will gradually refrain from interacting with other people or, if we do, make a conscious effort to "say the correct thing" even if we do not believe what we are saying. If my perceptions are correct, then we will remain in our cultural silos.

The Importance of Cultural Competence in Behavioral Health

In early 2000, I began to observe a cultural shift in the type of individuals seeking substance abuse disorder treatment and mental health treatment. At the time, I was employed as an administrator for a major healthcare system in an affluent area of Metropolitan Detroit. Up to this point, my experience had been that most individuals seeking the aforementioned treatments were of either European American descent and/or African American descent. However, there started to be a gradual influx of individuals seeking treatment of East India descent, Chaldean descent, Jewish descent, Spanish descent, and Asian descent. In addition, there was an influx of individuals with various sex orientation preferences and Islamic individuals. Finally, we began to see an increase in young adult, Suburban European American individuals who were opiate dependent.

As this was occurring, I began to ponder, "Are we prepared to serve this growing diverse population?" Starting with myself, I concluded that we were not prepared, primarily because of our "cultural encapsulation." This is a term that means cultural blindness. For me, it was somewhat surprising that the East Indian descent and Asian descent populations struggled with certain social issues such as substance abuse and mental illness. The reason being is because in all my academics, counseling courses, seminars, and trainings, there was never any mentioning of these populations suffering from substance abuse and mental illness. In addition, mainstream media had not focused on these population as having substance abuse and mental illness along with some of the activities that are related such as crime, domestic violence, and incest. As we began to admit and treat these various cultures, I began to decrease my cultural encapsulation by not only providing therapy but *(Continued on Page 16)*

Memories and Life Lessons – *Seeing the person behind the face*

Michael Geoghan, L.M.S.W., R.N., Executive Director (retired), Newaygo County Mental Health

Michael Geoghan

Following the announcement of his retirement as CEO of Newaygo Community Mental Health, Connections *asked Michael Geoghan if he would consider sharing some of his most memorable stories. He graciously complied. What it reveals is none other than a remarkable legacy of compassion. — Editor*

Learning to see the person behind the face was a process that started with my parents teaching me, among many things, the "Golden Rule," that is, treating others as you would like to be treated I learned through both words and example, not only in how they honored one another in their marriage, but in how they responded to those they served through their church, work, and friendships.

My first job in the healthcare field was working as an orderly in an extended care facility. My primary duties were to attend to the care of the male residents. My primary interests in pursuing that job were, in part, due to the reported hourly wage of $1.71 (which at the time was far better than what I was making as an assistant manager at a fast food restaurant); and in large part, a growing desire to help others. I must admit I really had no idea what I was getting into at the time.

Some of my first memories of this job were when I first walked into the care facility and smelled the lingering odors of urine and feces, heard the crying and moaning of bed ridden patients, and saw the harried looks on some of the care staff as they answered a patient's light. My initial orientation and training was to shadow the orderly on the first shift. My training was primarily "OTJ," being taught the duties by whomever I was assigned to. My first mentor, if you will, was a young male orderly who was also enrolled in the nursing program at a local hospital. It was during that time that I first became aware of and interested in becoming a nurse – a professional career that was predominantly staffed by women. After my enrollment into the Nursing Program, I met a young lady who was in the class ahead of me who would later become my wife. The work was hard, but as I got to know the folks I took care of, I began to see it less and less as a burden and more like an honor to care for them – if but for a few hours a day – to show kindness and respect in an environment that sometimes left them forgotten.

In getting to know the folks I cared for, and as I earned their trust, they shared snapshots of their lives. One gentleman for example, use to drive for Al Capone. Another was a former pool shark. Still another told me how it was growing up in the South as a black man and having to use a "colored" washroom, and to eat in the back room of restaurants as the white patrons dined in the main dining rooms. Many of my patient's faces would brighten in recalling past memories, and yet others would tear up when remembering loved ones that had passed but were not forgotten. During my time working in the nursing home, I became the "adopted grandson" by several as they got to know me, my family, and my girlfriends (and as they had to "approve" of the latter). Lasting friendships developed with some of the patients I cared for that carried over into my personal life. When a small number were able to return to their homes, they would invite me to visit them; but I also witnessed the first of many of their deaths – people I had cared for and cared about.

After acquiring my RN degree, on my first job as an RN charge nurse on an acute care unit in an extended care facility, I found out quickly that I was in over my head without enough medical/surgical or management experience to oversee other care staff such as LPNs and CNAs. Working as an RN on an acute care inpatient psychiatric unit, I had my first experiences working with persons struggling with acute behavioral health care illnesses such as schizophrenia, manic depression (i.e., bipolar disorder), major depression, multiple personality disorder (DID), borderline personality, etc. I decided to pursue an LMSW.

I also learned a lot working as a RN in correctional settings, in both a medium security prison, and a county jail. I was trained as a correctional officer at the Michigan Reformatory (MR) in Ionia, during which time I experienced a "lock down" in the middle of the night due to an attempted escape. While there, I learned about all the various weapons prisoners make while "doing time." I was trained how to defend myself were I to be confronted with a physically aggressive inmate, including use of take down and physical restraint techniques. I was exposed to a "culture of incarceration."

The majority of my correctional health care experience was in the county jail where I cared for men and women from all walks of life. I managed an ambulatory clinic in a 250 bed jail, working independently under the clinical oversight of physicians and using established clinical protocols. I recorded an average of 17 inmates *(Continued on Page 14)*

developing brain to impaired executive functioning and poor emotional self-regulation. Implicit, non-conscious memories of trauma, abuse, or profound neglect trigger the embodied brains of vulnerable individuals to send signals and release chemicals which result in compulsive, addictive behavior. Particularly under adverse circumstances, such vulnerable individuals can seem to find some measure of relief only through ingesting substances or engaging in neurochemical inducing behaviors (cutting, gambling, shopping, sex, video games) just to be able to live in their own skin.

Community Level Intervention

What is the relevance of all this for the work of public community mental health associations? The SDOH perspective reframes our understanding of the forces that generate increasing demand for mental health services in our communities, beyond individual psychopathology. It also begins to suggest *more impactful levels of intervention* beyond individual treatment of persons listed on a mental health agency's roster of clients. This is not to disparage the importance of individual treatment for any particular individual. Indeed, readily available, high quality, affordable mental health treatment is usually a necessary element in an individual's recovery of mental health, and may be considered one of the social determinants of mental health. Treatment may be necessary, but is not sufficient. The root and ongoing maintenance of good individual mental health is a health-supporting community context which invites the knowledge and use of community level interventions

Treatment may be necessary, but is not sufficient.

What is Community?

Before we begin exploring more concretely what effective community interventions look like, it is important to acknowledge there are different meanings of the notion of community, and by implication, different types of community-level mental health interventions. From a sociological point of view *community* may have distinct, multiple and/or overlapping meanings. Community may refer to, for example, a specific geographical place (a neighborhood or town), an interest group (the chamber of commerce or neighborhood association), an affinity group (a community theater association), a recreation association (local running club), an identity group (LGBTQ), a cultural/ethno group, or a religious community. We can talk about a *sense of community* – a feeling among people of belonging and being included based on shared identity, and common experiences. From a mental health promotion point of view, any activity that brings people together based on some sense of community, as a context in which to provide formal support and services, or promote informal peer support, may be considered a community-level intervention. In this sense, a community intervention may be based on both shared pain and struggle, as well as shared strengths. From an ecological point of view, we can envisage intervening anywhere along a continuum from small group, through informal association, formal organization, neighborhood, to the municipal level.

A community intervention may be based on both shared pain and struggle, as well as shared strengths.

Intervening at the community level is not a new idea (although its application to mental health specifically may be to some degree). There is a very rich, multidisciplinary, *community development* tradition, international in scope. One particular variant that is worth exploring in the context of community mental health is John McKnight's "asset-based" approach, which is very congruent with various strengths-based approaches to mental health. In a nutshell, McKnight advocates building community (and hence individual) resilience by weaving together and leveraging informal associations and formal organizations that already exist in a community in novel combinations (i.e.,creating partnerships), based on perceived needs and community-defined priorities, and harnessing and applying the collective expertise and energy of its members toward these community-defined goals.

An Example of a Municipal–level Community Intervention

Let me give an example of a municipal-level intervention along these lines, from London, Ontario, the community I have been living in for the past 32 years. London is a city with a population of almost 390,000, located about 60 miles due east of Port Huron. About 10 years ago, municipal community and social services staff were empowered by senior administrators to work with various community and social service providers, both public and private, to promote greater coordination of family and children's services. All community-level stakeholders serving social service needs

of families and children were invited to be part of a comprehensive process. The existing system was to be analyzed for gaps, unnecessary duplication, barriers, etc. Over time more than 170 organizations became involved from various sectors including child care, child welfare, public health, the school system, mental health, recreation, religious, public library, and informal associations. The result was the formation of the *London Child and Youth Network* (CYN).[7] A multi-pronged effort evolved over several years involving hundreds of people. Work conducted with and by community members, and supported by municipal staff, included an analysis of community strengths and risk factors, neighborhood by neighborhood, using various available data sources. By consensus, the community identified four priority areas:

- Ending Poverty
- Making Literacy a Way of Life
- Leading the Nation in Healthy Eating & Healthy Physical Activity
- Creating a Family-Centered Service System

Each area has multi-year work plans and evaluation frameworks with community-level indicators identified to monitor progress. (Go to the CYN website to learn more about this initiative, including performance measures and outcomes.) It is worth noting that there has been much research and many innovative practices developed for the purposes of guiding communities in effectively conducting these kinds of community-level interventions. Perhaps the most prominent example of this currently comes under the heading of *collective impact.* (An internet search of this term will turn up a great deal of applied research and practical tools.)

The CYN's *Family-Centered Service System* priority deserves special attention. A number of at-risk neighborhoods were identified though analysis of census, municipal planning, and school-system data. Substantial resources were made available to begin creating a network of multi-service, Family Centers, physically integrated within existing or newly built publicly-funded elementary schools. The particular configuration of services offered and partners engaged at any given Family Center depended on the particular needs of the community, but typically included child care, mental health, and public health services. Initially four *Family Centers* were created. Three more came on line within the last year, and one more is slated to open very soon.

These Family Centers create a new, *non-stigmatizing* institutional setting or context in which mental health promoting synergies may be generated through creative partnerships and authentic engagement of community members. As an excellent example of this, the children's mental health agency I work for –*Vanier Children's Services* – has recently begun offering infant/parent mental health clinics at each of the seven Family Centers on a rotating basis. These early identification, early intervention clinics are staffed by just one highly skilled Child and Family Therapist, a member of Vanier's Early Years team who is trained in "Circle of Security," an evidence-based infant/parent attachment intervention model. The neurobiology research over the past few years has demonstrated irrefutably how an infant born into an environment of "toxic stress" is at very high risk of developing mental illness.[8] In partnership with day care and other child and family support staff, community members who exhibit symptoms of toxic stress and poor infant/parent attachment are referred to the Child and Family Therapist for counselling and support. The clinician also offers consultation, support and guidance to other Family Center staff members, so that they may recognize and respond appropriately when signs of toxic stress and poor attachment are evident.

There are many different levels and intersecting opportunities for community mental health interventions.

In Bronfenbrenner's framework (page 16), the creation of Child and Youth Network would be an example of intervening at the exosystem level.[9] The creation of a network of Family Centers as part of the CYN initiative would be an example of an intervention at the intersection of the meso- and exosystem level. The locating of the infant/parent mental health clinics on site would be an example of an intervention *within an intervention*, at the intersection of the meso-and microsystem level. These examples illustrate that there are many different levels and intersecting opportunities for community mental health interventions.

(Continued on Page 10)

[7]http://londoncyn.ca/

[8]Clinton, J., Feller, A., & Williams, R. (2016). "The Importance of Infant Mental Health." Paediatrics & Child Health, 21(5), 239–241.

[9]One would expect that the macrosystem in Canada is more amenable to the marshalling and application of public funds for interventions such as this, as compared to most places in the U.S. at this moment in time.

On Community and Healing *(From Page 9)*

My Sister's Place: Healing a Marginalized Community

A second example of a community-level intervention I would like to describe is also based in London, Ontario. *My Sister's Place* (MSP) is a transitional support program for women who experience mental illness, substance misuse, and chronic poverty. This is arguably the most marginalized and stigmatized population in London. Many of the women who visit MSP engage in street-level survival sex work. Many are Indigenous women. MSP started out as an initiative by a few feminist community activists who saw a need and acted, including members of the Sisters of St. Joseph, and women with lived experience. While MSP is now incorporated as a program within Middlesex branch of the Canadian Mental Health Association (CMHA), which is the publicly-funded, adult community mental health agency in the London area, it got started when one paid community mental health worker reached out to the Sisters and a handful of women's advocates, and began reflecting on the problem and imagining what might done.[10] This led to a series of participatory, action-research projects which gave central voice to the women of lived experience these activists wanted to serve. Over time, a program of formal and informal supports and services was built up, with many community partners. The program was initially housed within one of the properties owned by the Sisters, and eventually moved to a rented old house in the core of the city. Initially, there was only one position, and then eventually a few workers' positions funded. Much of the work is done through partnerships.

On the strength of the leadership and charisma of the program director, the strength of community partnerships, the quality of engagement with the women, and the impact of the program on participants, MSP began to gain greater and greater notice in the community. Full disclosure: Susan Macphail, the founding Director of MSP (until she retired this past July) happens to be my spouse. I had the privilege of watching this program evolve in fits and starts over the course of about 15 years. Susan is particularly gifted at engaging authentically with people and speaking and acting from deeply held principles and values. I have observed her speak extemporaneously about MSP, sometimes alone but most often with the women who form community there, to groups large and small, religious and secular, charitable and business organizations. A turning point came when the matriarch of a local entrepreneurial family heard Susan speak, was deeply moved, and decided to fund the purchase and renovation of a beautiful Victorian-era mansion near the city's core to become the home of MSP. As it stands now, about one-third of MSP staff salaries are supported by the publicly-funded CMHA, one-third are supported by other community funders including the United Way and the City of London, and one-third through fund-raising. Virtually all program and infrastructure costs are supported by community fund-raising. CMHA also runs a program for men who experience mental illness and chronic poverty, based on the same principles and values which I will discuss further below. The community of London has stepped up (with the aid of very intentional and skilled community relations work) to support this initiative through millions of dollars in donations and hundreds of thousands of hours of volunteer power.

Many of the women who have come to MSP have been supported in transforming their lives from conditions of chronic poverty, addiction, and incarceration to find stable housing and employment. Some have gone from chronic homelessness to earn university degrees and find meaningful work helping others based on their own lived experience. Many others continue to struggle, but have a safe place and sense of community. The emphasis is on peer support and "sisterhood." In addition to clinical supports, programs include a theater group, a music group, and a social enterprise in which women make exquisite jewelry, a portion of the proceeds go to the women and a portion to program support. The principle is to support people by creating a safe, radically inclusive space, accepting people where they are, in their pain or brokenness, while also recognizing, emphasizing, and building on their strengths, skills, and abilities. Another way of putting this is that, at MSP women are healed through community.

The principle is to support people by creating a safe, radically inclusive space…

[10]For an excellent and inspiring guide (based on a complexity theory perspective) to what is possible when a few committed people pour sustained and creative energy into a project like MSP, see Getting to Maybe (2007) by Westley, Zimmerman, & Patton.

What is a Healing Community?

I want to pause for a moment and reflect on that last idea – to be "healed through community." As many others writing on health and healing have observed, the etymological root of the word health is akin to whole. So at an individual level, to be healthy is to have various facets of our human being, – physical, mental, emotional, and spiritual, become conscious, integrated and congruent. From psychodynamic (depth psychology) and mindfulness points of view, we know that we must have self-compassion and self-acceptance of our imperfections, lest we repress and project our fears and insecurities about what we might become on others, and consequently rejecting and lashing out at the "other" – the mentally ill, the homeless, the addict, the refugee, etc. If an individual's mental health is shaped, enabled, or constrained by the community, then for healing to happen, the community must strive to be whole, that is, inclusive of various facets of its social being. A community that is unduly exclusive or too homogenous is not a potential context for healing. An unduly inward looking community that demands rigid conformity and the squelching of individual uniqueness and aspiration is not a healing context. I know of no more insightful accounting of this essential dialectal tension between individual and community than a little book by Jean Vanier, the founder of *l'Arche* – the network of international communities for people with intellectual disabilities – entitled *Becoming Human* (1998). Vanier writes,

> "It is not easy to strike a balance between closedness, having a clear identity that fosters growth in certain values and spirituality, and openness to those who do not live with the same values… being too open can dilute quality of life and stunt growth to maturity and wisdom; being too closed can stifle. It requires the wisdom, maturity, and inner freedom of community members to help the community find the harmony that not only preserves and deepens life and a real sense of belonging but also gives and receives life. Then the community truly becomes an environment for becoming human, helping all to openness, freedom and commitment to the common good (p. 65)."

Principles of Community-Level Mental Health Intervention

Working from the premise that healing in community can happen in many ways at many levels, let me try to pull together the various threads of this discussion by reflecting more broadly and attempting to formulate some general principles for community-level mental health work.

Effective community mental health interventions may not follow any particular formula or model, but they are always *highly intentional*, by which I mean developed collaboratively with a broad array of community partners, based on critical reflection, informed by research, including participatory research and evidence which includes the lived experience of those who would be served, and ongoing developmental evaluation.[11]

The healing community is radically inclusive and welcoming. The community is welcomed and present in its diversity. Individuals are welcomed in their strength and in their woundedness. For example at My Sister's Place, no one is banned or exiled from the community. This is unusual, as many agencies that provide services to people experiencing chronic mental illness and poverty routinely ban persistently aggressive or difficult to serve community members. In order for this principle to be operationalized, staff members must be temperamentally suited, well supervised and supported, and well trained in principles of trauma and violence informed care.

The healing community is radically inclusive and welcoming.

The community is welcomed and present in its diversity.

Individuals are welcomed in their strength and in their woundedness.

Relatedly, in a healing community members are actively engaged to envision together and articulate the values they want to see embodied. At My Sister's Place safety is a shared value. So many marginalized community members have suffered trauma and abuse so that they feel profoundly unsafe and are easily triggered, which sometimes activates violent behavior in self-defense. Community members help each other to remember and abide by this value of safety, with the support of skilled staff members. In the event of an aggressive or threatening incident, the triggered community member may be required to "step away" for a period of time, but he or she is supported in reconciling with and reintegrating into the community as soon as possible.

The healing community reflects the diversity of the community, including people of different ages and stages of life, different professions, ethnicities, religious beliefs, sexual orientations, etc. In the healing *(Continued on Page 12)*

[11]Patton, M. Q. (2011). Developmental evaluation: Applying complexity concepts to enhance innovation and use. New York, NY, US: Guilford Press.

On Community and Healing *(From Page 11)*

community people interact in a variety of life domains. There may be clinical supports and services, but also employment and educational support, recreation and artistic opportunities, community celebrations, etc. The emphasis is on building on strengths, and generating opportunities for growth and development.

Finally, it is also important to note in this age of social media, that although social media may be a powerful tool for facilitating community connections and supporting mental health, a genuine healing community of necessity involves actual face-to-face, human interaction and contact. In my view, there are essential qualities of human community and relationship that cannot be fully mediated through smart phones.

Conclusion

Toward the beginning of this piece I suggested that our traditional medical-model influenced, individualistic mental health treatment approaches were not so much wrong as incomplete and insufficient. I argued for an understanding informed by the social determinants of health and social ecological models, and interventions informed by community development approaches. It seems to me that as erstwhile healers, when we see individuals exclusively or primarily through the lens of psychopathology, we may see in them what we're afraid of or reject in ourselves. We risk rejecting part of what makes them up as whole human beings, and treating them as other or alien. To avoid this as community mental health workers, self-awareness and self-acceptance is required. Healing in community then, is a matter of emphasis and balance. In a healing community, the emphasis is on care more than cure, mutual support more than expert service. Instead of emphasizing the identity of patient or client, community mental health workers, administrators and policy makers working through the dimensions of community-level interventions emphasize and privilege the identity of neighbor and community member, and in doing so dignify and amplify their efforts.

(For those who want to dig deeper, continue reading)

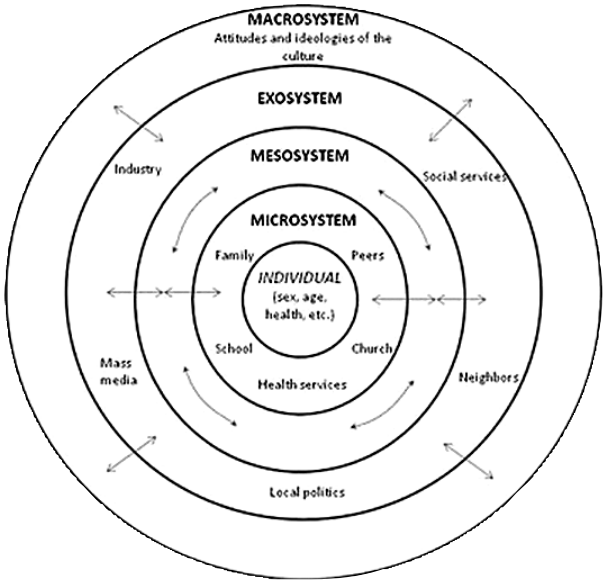
A Social Ecological Framework for Conceptualizing Community Level Intervention

Addendum to "On Community and Healing"

By James Madden

A very useful framework for exploring possible levels of intervention beyond the individual is Bronfenbrenner's ecological theory, which he originally articulated in 1977. Many readers will be familiar with this model.

Bronfenbrenner continued to develop and apply his model until his death in 2005, to understand how the multilayered and interacting web of social and biological processes affects mental health.[12] The image presented here is a basic depiction of a very complex model. It is presented here primarily as a conceptual tool that may be helpful in understanding how individuals are embedded in sets of interacting "microsystems" which bear on their mental health. (In any particular community, there may be a multitude or paucity of mental health promoting microsystems.) Formal and informal interactions and linkages between microsystems constitute a "mesosystem." From a complexity theory perspective, a mesosystem would be seen as an emergent phenomenon of interacting microsystems. Mesosystems and microsystems are in turn shaped, enabled, and/or constrained by the encompassing exosystem and macrosystem. Individuals are shaped by and shape microsystems, and through organized effort, can shape exo-and macrosystems. One can use this framework to analyze the social ecology of particular places, particular communities. To what extent does the social ecology of a particular community promote or inhibit resilience and mental health? When we see more clearly the dynamic social embeddedness of individuals, perhaps we can imagine more vividly and creatively community-level modes of mental health promoting and protecting interventions.



[12] For a current review of this model see "Different Uses of Bronfenbrenner's Ecological Theory in Mental Health Research: What is Their Value for Guiding Mental Health Policy and Practice." Eriksson, M., Ghazinour, M. & Hammarström, A. "Soc Theory Health" (2018). https://doi.org/10.1057/s41285-018-0065-6. See also "Introduction to Special Issue on Social Ecological Approaches to Community Health Research and Action." Lounsbury, D.W. & Mitchell, S.G. Am J Community Psychol (2009) 44: 213. https://doi.org/10.1007/s10464-009-9266-4.

Hindsight Is 20/20: Our Current Health Crisis

Dan Buettner

Fellow, National Geographic
Founder, Blue Zones

In the Blue Zones project cities, we've seen double-digit drops in smoking rates and obesity rates, millions of dollars in health-care savings, and a drastic rise in levels of community engagement and well-being.

For 30 years, my life's work has been identifying and then studying extraordinary populations around the world and unlocking their secrets to longevity and happiness.

Several longevity hot spots surfaced through my expeditions—the Barbagia region of Sardinia, Italy; Ikaria, Greece; Okinawa, Japan; the Nicoya Peninsula in Costa Rica; and Loma Linda, California. People in these "Blue Zones" regions not just live longer, but they live better. Besides having a large number of centenarians, people in these areas remain active into their 80s and 90s and do not suffer from the chronic diseases common in most parts of the industrialized world. Armed with a team of demographers and scientists and a grant from the National Institute on Aging, we set out to reverse-engineer longevity, or establish why these populations live the healthiest and longest lives in the world.

Several common denominators, or longevity lessons, were distilled into the "Power 9:"

Move naturally throughout the day

Have and cultivate a strong sense of **purpose**

Downshift every day to relieve stress

80% Rule: stop eating when you are 80 percent full

Plant Slant: Make beans, whole grains, veggies, and fruit the center of your diet

Wine @ 5: Enjoy wine and alcohol moderately with friends and/or food

Belong: Be part of a faith-based community or organization

Love Ones First: Have close friends and strong family connections

Right Tribe: Cultivate close friends and strong social networks

At the beginning of this exploration, we were interested in figuring out if DNA had anything to do with the exceptional health and longevity in these regions. What we learned was that it's not DNA and it's not geography. As the Western-influenced lifestyle and diet come in, these "Blue Zones" regions are dying out. The reason most of these places had such incredible health outcomes was partially because they were isolated, geographically, from the rest of the world. It took a while for fast food, processed food, and large quantities of meat to infiltrate their diets. But as we see in Okinawa, Japan, the newer generation has a more modern lifestyle and eat a more Western-pattern diet. And now they are starting to have the health problems of the Western world. Their geographic location hasn't changed—their lifestyle has.

It's a mistake and misunderstanding of research to think that you can go to a Blue Zones region and find a special anti-aging ingredient there to mix into your smoothie or rub onto your face. That's not at all how it works. You only have to look at the Blue Zones region of Loma Linda, CA to understand that the Blue Zones are not geographic locations. Loma Linda, CA, a town about 60 miles away from Los Angeles, is surrounded on all sides by unremarkable California suburban towns. But Loma Linda residents live about a decade longer than other Americans, with much lower rates of chronic diseases and afflictions like dementia. Seventh Day Adventists in Loma Linda have largely protected their lifestyle. The cafeteria at Loma Linda University is vegetarian, residents fought the introduction of fast food chains to the town, they remain actively involved in their faith and church community, and they are physically active into their 80s and 90s.

In the Blue Zones project cities, we've seen double-digit drops in smoking rates and obesity rates, millions of dollars in health-care savings, and drastic rise in levels of community engagement and well-being.

(Continued on Page 15)

Memories and Life Lessons *(From Page 7)*

per day. I assessed and treated (within established physician protocol) both physical and behavioral healthcare needs, including acute appendicitis, delirium tremors (DTs), prenatal care, hypertensive crisis, heart disease, diabetes, tonsillitis, body lice, scabies, liver disease, STDs, psychotic and depressive disorders, anxiety disorders, and other conditions. I counseled and provided health education to both inmates and deputies. An enduring lesson was becoming able to see each inmate as a person, many of whom were in jail from living in a generational culture of criminal activity, living in poverty, little to no education, unemployed and /or underemployed, or making poor choices.

Some of these indelible memories have a lighter side. As a civilian deputy, I was invited to observe, and in some cases, participate in law enforcement activities. One such activity was when I volunteered to participate in an undercover sting operation which took place around Halloween. I dressed up as a werewolf and was planted at a party where the land owner had been alleged to be selling alcohol to minors. My assignment was simply to infiltrate and observe until such time that the deputies would converge on the scene and bust the party.

At the time, there were only a limited number of command officers who knew that I was participating. When the deputies converged on the scene and started to gather all of the partiers, I of course was one of them, and in playing the part, I was less than cooperative and ended up being ordered to "assume the position" against a squad car, where I was patted down, handcuffed, and placed in the back of the squad car. Later, the arresting officer was informed by his command officer who it was he had just arrested, at which time he drove me to the outside perimeter of the area while profusely apologizing to me for having treated me as such. I assured him that he was just doing his job and reminded him that I was not cooperating and therefore, "got what I asked for."

However, this particular story did not end at that point. Simultaneous to the sting operation, the local law enforcement was conducting driver "stop and checks" for intoxicated drivers. Shortly after my "release from custody," and while driving with the undersheriff back to the station, we received a call for assistance in transporting to jail an intoxicated driver that had been detained by another deputy. So, with me still made up in my werewolf makeup and attire, I sat in the front seat of the command car and the drunk driver was placed in the back seat. While en-route back to the station, the Undersheriff and I were engaged in a conversation. The drunk driver, seeing my side profile, asked, "What kind of police force are you?" I simply turned to face him and said, "Canine Squad," and turned back around for the remainder of the ride. Upon our return to the station, while I was changing clothes and cleaning up, a booking officer came into the command officer's office and said to both the command officer and myself, "You have to hear this!" So, we went to the intercom outside of the booking office and listened in on the conversation the man we brought in was having with another booking officer. "I tell you, officer, that dog was talking!" We all had a laugh and I couldn't help but wonder what that man would say when he was arraigned before the judge.

Another time, while seeing inmates during a scheduled med clinic, a young man new to the jail asked me a question while waiting to be seen in the clinic waiting room. "Doc," (I received the nick name "Doctor Death" as a joke from the deputies) said the young inmate, "I heard you did time, is that true?" I paused before answering him and then said "Yes." The young man then asked, "For what?" I looked at him and said, "For impersonating a nurse," and walked into the exam room. The young man responded "Really? How big of a "bit" (i.e., sentence) did you do?" To which the older inmates started laughing and teasing the young man as they knew I was telling a tale.

I have many more stories that I could share, as I am sure each of you have as well. Each of my experiences came with a lesson in human behavior. Yes, unfortunately I often saw people at their worst, both the inmates and deputies, but I also saw moments of compassion and caring amidst this brokenness; and in those times, I found meaning and purpose in not only what others do, but in my role as a health care professional. I was able to see the person behind the behavior and to remember, "There but for the grace of God go I." As it was and is indeed by His grace that I can do what He has called me to do. Not by my strength or goodness, rather by His and His alone.

Carl Rogers once said, "True empathy is always free of any evaluative or diagnostic quality. This comes across to the recipient with some surprise. If I am not being judged, perhaps I am not so evil or abnormal as I have thought."

A longtime friend and spiritual mentor once told me "We are but turtles on a fence post," to which he added, "How does a turtle get on a fence post? It has to be placed on that fence post." Thus I believe we are called, and through faith and trust in the one who calls us, we can see the real face of our fellow man in times of triumph, but especially in times of failure.

Hindsight *(From Page 13)*

It isn't enough to simply try and adopt the Power 9 lessons individually. Our environment dictates so much of our habits and our health, and we've set up most of our communities in the United States to accommodate our sedentary lifestyles—sitting in our cars and on our couches—and to fill up on processed, high-calorie foods.

Stemming from extensive research, the Blue Zones Project came to life—an initiative that works with communities to introduce high-impact changes to make the healthier choice the easier choice. Based on the Power 9 longevity principles, permanent and semi-permanent changes are created aimed at affecting entire communities and future generations.

The results have been stunning. Albert Lea, MN was the first Blue Zones Project city, and in just a year, residents added 2.9 years to their lives and city healthcare claims dropped by 29 percent. In other Blue Zones Project cities, which we administer with a partnership with Sharecare, we've seen double-digit drops in smoking rates and obesity rates, millions of dollars in health-care savings, and drastic rise in levels of community engagement and well-being.

Even as Silicon Valley and researchers spend billions trying to find the magic bullet to living longer and better, the best way to improve health and longevity are low-tech. We won't find the answer to our current health crisis in a test tube or a line of code. Instead, we need to go backward to move forward. We need to eat and live as our great-grandparents did.

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http://powerofideas.milkeninstitute.org/global-conference/2018/hindsight-is-2020-our-current-health-crisis

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To learn more about Blue Zones which was founded by Dan Buettner, see:

https://www.bluezones.com/

https://www.bluezones.com/2018/08/secret-to-longer-life-is-low-tech/

Respond to the Surgeon General's Call to Action on community, health and prosperity

BEHAVIORAL HEALTHCARE EXECUTIVE, 10.19.18

By Ron Manderscheid, PhD, Executive Director
NACBHDD and NARMH

I am absolutely delighted to report that U.S. Surgeon General Jerome Adams, MD, MPH, is in the early phases of preparing a new *Surgeon General's Call to Action*. This effort will focus on how we can improve community health, wellbeing, safety and prosperity. Now, we have an opportunity to provide input on this endeavor.

Why is this report so important? We have known for quite some time that most issues with health, wellbeing, safety and prosperity have their origins in how our communities function. In healthcare, we call these community factors the "social and physical determinants of health", and we appreciate the exceptionally important role they play in physical and mental health and well-being.

Read more:

https://www.behavioral.net/blogs/ron-manderscheid/policy/surgeon-general-s-call-action-community-health-and-prosperity

by learning more about their cultural backgrounds as well as their culture's perceptions of substance abuse and mental illness. In addition, I began to learn how to greet clients in their indigenousness languages. I noticed an immediate impact in my ability to engage them and the high level of respect that developed between me and my clients. I began to examine the cultural makeup of my staff. It became apparent that the cultural makeup of the staff did not match our diverse client population. Consequently, there was a conscientious effort to increase our staff's diversity and as a result, we gradually became the provider of choice for various cultures. In addition, we noticed that our clients' retention and satisfaction rates increased.

This brings me to a crucial point; what are the main criteria used by Behavioral Health Key Decision Makers to hire their staff? Typically, most employers post a job description that provides a general overview of the position. As a result, there are several applicants. Afterwards, the recruitment process commences. So the question is raised again, what are the hiring criteria? Do some Key Decision Makers have a hidden agenda, and if so, for what purpose?

Recently, I developed a model to enhance cultural competence in the behavioral health workforce by examining the following:

a) Talent/Skills Natural Set.

b) Cultural Uniqueness (Race, Religious Belief, Dress Attire, Name, etc.).

c) Appreciation of Uniqueness.

d) Qualifications (Academic & Credentials).

e) Opportunity to be hired, grow, and produce.

With this model, key decision makers are implored to base their decision to hire someone on other than their academic qualifications and credentials. There are some very talented applicants who are automatically dismissed as potential hires based on their names, dress attire, or because of their accent. Recruiters have access to this information via telephonic interviews, skype interviews, as well as other methods. The sad part about these biases is that they hinder the company's growth because they miss out on hiring these talented individuals. Some of these applicants could be difference makers. I am challenging key decision makers to reassess your hiring and recruiting agendas and protocols. Rather than basing the hiring decision on qualifications, you should ask what's missing at our agency that could help us with our delivery of care, increase our efficiency, increase our proficiency, and increase and improve our cultural competence. In addition, once a decision is made to hire these difference makers, there must be a mutual acculturation to retain these individuals. In other words, rather than expecting the new hire to adapt to the work culture, the culture must also adapt to the new hire culture.

One final thought, many of you are probably familiar with Motivational Interviewing (MI). With MI, come stages of change. Starting with Pre-Contemplation (unaware of the need to change), Contemplation (contemplating changes), Planning (strategy to change), Action (producing the change), and Maintenance (maintaining and improving on the change). I encourage you to assess your level of cultural competence by using the MI Stages of Change. I suspect that many of you are in the Pre-Contemplation Stage of Change and it could possibly be due to your social conditionings. As healthcare professionals, we challenge our clients to change some of their thinking and behaviors; however, we do not challenge ourselves. Whether it is conscious or unconscious, we tend to engage in clinical hypocrisy.

Conclusion

The purpose of writing this was to stimulate, challenge, inspire, and promote critical thinking among behavioral health professionals and key decision makers regarding your ability to deliver optimal care to our culturally diverse clients. I wanted to provide a catalyst for self-growth, self-improvement, self-care, and self-esteem. Finally, I am very receptive to engaging in healthy and stimulating dialogues with readers who are interested in furthering their knowledge in this important subject matter.

Visit Dr. Lumumba's website at: counselingenterprise.com

References

Hayes, P. A. (1996) Addressing the complexities of culture and gender in counseling. *Journal of Counseling and Development,* 74, 332–338.

Jun, H. (2010) *Social justice, multicultural counseling, and practice:Beyond a conventional approach*. Los Angeles, CA: Sage.

King, R.D. (2012) *Melanin: A key to freedom*. Createspace Independent Pub. Co.

Morell, V. (1995) *Ancestral Passions: The Leakey Family and the Quest for Humankind's Beginnings.*

Schumacher, J.A., & Madson, M.B. (2016) *Fundamental of Motivational Interviewing.* New York, NY: Oxford University Press.

Sue, D. W., & Sue, D. (2013) *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.

by Southwest Solutions. These transformations are an integral part of the health and wellness of the residents.

It is becoming apparent, like all great sagas, this story will have many chapters. Perceived from a historical and cultural perspective it is just beginning. Its central theme is about yet another incredible transformation that is reshaping our institutions that are essential for healthcare as we appreciate more fully what it means to be healthy. A more inclusive and therefore complete term may be "emotional well-being." When this becomes our focus, being healthy is not just about our bodies, as important as that is, it is also about the places where we live and work, having affordable housing in a safe and secure environment with access to essentials as well as a meaningful job and sufficient income. What needs to happen to diminish human suffering and enhance our emotional well-being must include the strategies that address the various dimensions of poverty in order to nurture a healing community. An understanding of this social dimension helps clarify and guide the transitioning of community mental health via the inclusion of a focus on the mental health of a community. If I live in a distressed neighborhood, my wellness requires more than treating the symptoms of a physical or psychological diagnosis. In fact, the former may well be a significant factor in the latter. Community development is equally essential for health. In this story, Southwest Detroit is ground zero but the mission, values, and strategies are applicable in any community.

Community Innovation

Before we venture further into the story of SWSOL, let me share some background John provided that has helped me understand community interventions thereby providing a framework for the transformation I witnessed. The winter 2004 issue of the *Stanford Social Innovation Review* (SSIR) included an article entitled, "Leading Boldly" that distinguished between technical and adaptive social problems. Technical problems are well defined and the solution is known in advance by a limited number of organizations. Applying their expertise, the resolution is described as isolated impact. An example of this is the development of a robust system of information technology that provides data to guide decision making. It could similarly apply to the construction or remodeling of a physical structure that houses these services. We can contract with competing organizations that have these skills to accomplish our tasks. In contrast to this, the answers to adaptive problems are unknown and no individual entity has the resources or authority to bring about the necessary changes. *Improving community health is an adaptive problem*. In order to reach an effective solution, it requires learning by all the stakeholders involved in the problem as well as changes in behavior to create a solution. We need to adapt! The results of this collaborative work are captured in the concept of collective impact. Southwest Solutions is aptly named as a response to an adaptive problem. The power of convening is recognition of the need for a collective impact. (To understand this more fully, see the companion article by James Madden, "On Community and Healing.")

The Evolution of Community Mental Health – the Need to Address the Mental Health of a Community

John provided some history, "In some ways you have to go back to the mid-sixties when President Kennedy started the conceptualization of community mental health." Within that frame you can understand the beginnings of Southwest Solutions that was founded in 1970 by Monsignor Clement Kern (1907-1983), the legendary pastor of Most Holy Trinity in southwest Detroit. Kern was known as the "conscience of Detroit" because of his passionate commitment to helping the poor and disenfranchised. The church was located near downtown Detroit and was attended by bankers, judges, elected officials, and business people. Kern made sure that those who were homeless or had a mental illness or drug addiction were also included. He not only developed a community within the church, he also worked in the larger community. Clem Kern's deep passion still animates the organization. The mission and values instilled at the start still compose who and why they are, it defines and assures their continued existence. What has changed is a growing appreciation for the complexities that *enhance the quality of life, success and self-sufficiency of individuals and families* and as this understanding has evolved, so has the shape and form of the solutions that pursue this vision.

SWSOL became a mental health agency in 1972. In the wake of deinstitutionalization, Southwest's mission was to help the mentally ill live in the community by providing psychiatric counseling and medication. John has been with Southwest Solutions since its beginning, when the agency had a staff of only ten people. He started as an administrative assistant and became head of the organization in 1981. To comprehend the evolution of SWSOL we need to appreciate that John was a pioneer in understanding the efficacy of community development when this critical dimension of mental health was only beginning to be recognized. As such, he advocated for expanding the vision. In addition to the traditional array of counseling solutions he believed that reintegrating the mentally ill and homeless into the community required providing decent, affordable housing and support services. It became imperative for the organization to actively participate in neighborhood revitalization and economic development. What began as a compassionate response to the needs of those with mental illness, utilizing the knowledge and understanding dominant in the 60s and 70s, soon grew into a multi-dimensional cluster of solutions designed to address the emergent knowledge of the various dimensions of emotional well-being. One way to frame this journey is the struggle to find a balance between people based strategies and place based strategies, a struggle that is enjoined by every community mental health agency that progresses. A head turner for

(Continued on Page 18)

those still immersed in a bio-medical model is how a response initially focused on placing individuals housed in mental hospitals into the community has now adopted the long-term evaluative measure of making a significant contribution to reducing poverty. However, this is exactly what has happened as SWSOL pursued their mission that embraced the wedded values of diversity, equity and inclusion. They discovered that people who participate in multiple services which constitute communities of shared interests improve their lives faster. As more people achieve these connections, momentum builds and contributes to population health. By maintaining a focus on what is essential for quality of life; community mental health has been evolving by addressing the mental health of a community. It is important to understand that many of the additional skills and activities that address the mental health of a community may be best acquired by partnering; this is an adaptive problem that requires the concerted efforts of multiple stakeholders.

A PEEK AT THE COMPLEXITY

Today, Southwest Solutions is a family of nonprofit and for-profit corporations that offers more than 50 vital and community-building programs and employs more than 350 staff. It is a foremost provider of human and housing services and real estate development. Its programs impact 12,000 people a year and are nationally known and recognized for achieving outstanding results in improving lives and strengthening communities. The extraordinary growth of Southwest Solutions and its national renown as an effective integrated-services and community-building organization stem from John's vision and knowledge linked to a style of leadership that enabled it to happen: *the power of convening*. In sorting out and addressing the various dimensions of emotional well-being, John has successfully convened, not only those in need of services, but also previously "siloed" experts, aligning their knowledge and resources. Their ongoing collective impact is impressive. As such, the corporate structures have mirrored the developing knowledge. Today there are three divisions: Southwest Counseling Solutions, Southwest Housing Solutions, and Southwest Economic Solutions.

A few moments of self-reflection may well be sufficient to appreciate the complexity of the organizational structures that have emerged to address quality of life and success of individuals and families in southwest Detroit. We are complex! One's emotional well-being has many dimensions or facets, each being dependent on innumerable relationships/connections.

SOUTHWEST COUNSELING SERVICES

Southwest Counseling Solutions has served the Southwest Detroit community since 1970. They help more than 7,500 individuals and families a year, improving their lives through four Centers of Excellence: Adult Counseling Services; Early Childhood and Family Literacy; Children, Youth and Families; and Supportive Housing.

Southwest Counseling Solutions is a 501(c)(3) that employs more than 250 staff persons. They represent the fields of psychiatry, psychology, social work, counseling and education. Focused on inclusiveness, they have more bilingual counseling professionals than any other organization in Michigan, one in three of their counselors are bilingual. Their adult counseling program for Spanish speaking consumers is highly effective, with 98% avoiding hospital psychiatric services. In partnership with Covenant Community Care, SWSOL has developed a model of integrated physical and mental health services.

It is also one of Detroit's largest providers of services to the homeless. In the last decade, they have placed into housing more than 1,900 homeless persons, and their housing retention rate after one year was at 94% which is one of the best in the nation. They are the lead agency to end homelessness in the city. The number of chronically homeless and homeless veterans has declined significantly in the past few years through the concerted and coordinated effort to address homelessness. Piquette Square is a 150-unit permanent supportive housing project that provides comprehensive support services, including access to healthcare, employment, benefits, and education. It is recognized as a national model in helping the veterans rebuild their lives and reintegrate into the community. Their Supportive Services for Veteran Families, (SSVF) has helped over 2,500 low-income veterans remain housed. In all its Centers of Excellence, Southwest Counseling Solutions is consistently recognized for its leadership, expertise and excellence. At the same time, they are known for their collaboration with numerous community partners to expand and enhance the services in all program areas.

SOUTHWEST HOUSING SOLUTIONS

Southwest Housing Solutions began in 1979 and is a leader in the planning, development and management of affordable housing and commercial property in Southwest Detroit. Their mission is to revitalize their community through collaborative, high-quality and innovative projects, and by promoting home ownership and resident-centered development initiatives. Their mixed-use projects stimulate commercial and cultural development.

They are the leading nonprofit multi-family developer of affordable housing in Wayne County, having developed or renovated nearly 1,400 units in multiple neighborhoods, including single-family homes and multi-family apartments. More than 2,000 people reside in their quality, affordable apartments and townhomes. They have renovated and sold more than 650 homes in the metro area that were vacant, helping to reduce blight and revitalize neighborhoods. They offer programs for home buyer counseling, foreclosure prevention, financial coaching, mortgage lending, and no interest home repair loans. More than 2,500 families are homeowners due to their programs. One of every ten homes purchased in Detroit with a mortgage in 2016

was assisted by their home buyer programs.

Southwest Housing Solutions is a trusted nonprofit partner with a deep-rooted commitment to community development and a proven track record–

- $150 million of real estate development completed or in progress
- 26 multistory buildings restored for residential and retail use
- 225,000 sq ft of commercial space created or managed for lease
- Neighborhood Preservation Team helps residents better the community
- Developer of Piquette Square, a 150-unit project for homeless vets
- Acquired, renovated and sold more than 400 REO homes that were vacant and are now owner-occupied

They manage more than 600 apartment units that they rent to low and moderate-income families and individuals –

- Safe, affordable and quality housing in beautifully renovated buildings
- Housing and support services for homeless or special needs persons
- Permanent supportive housing for formerly homeless veterans at Piquette Square
- A full range of services and opportunities for their residents
- Property management consulting services for other property owners

Southwest Lending Solutions is a community-based lender offering services to help prospective homeowners overcome home financing challenges, plus highly competitive rates and terms.

SOUTHWEST ECONOMIC SOLUTIONS

The mission of Southwest Economic Solutions is to provide opportunities for individuals and families to achieve greater economic success. They promote and preserve homeownership and advance financial literacy, and have become a leader in workforce development and adult literacy services. All their services are free for eligible individuals and families.

Their Adult Learning Lab helps adults improve their literacy, math and computer skills so they can be better qualified for employment.

ProsperUS Detroit is an entrepreneurial training and small business lending program for Detroit residents, particularly those who are African-American, Arab-American or Latino. By helping emerging entrepreneurs develop successful businesses, ProsperUS will help strengthen neighborhood economies, create jobs, serve residents with new goods and services, and cultivate community-based leadership. ProsperUS Detroit is the leading entrepreneurship program for aspiring minority business owners in the city. More than 850 ethnic and immigrant entrepreneurs have graduated from their program since it began in 2012, resulting in 150 new small businesses. ProsperUS has provided more than 1 million dollars in loans to 50 small businesses.

ProsperUS serves five neighborhoods:

- Cody Rouge
- Grandmont Rosedale
- Lower Eastside
- North End
- Southwest Detroit

The Center for Working Families (CWF) is based on a promising national concept and is designed to help low-income families reach financial stability, access income supports, develop educational and employment opportunities, build wealth, and move up the economic ladder. Participants are assisted by a financial coach, workforce development coach and benefits coach.

Financial coaching helps participants manage income, reduce debt, review credit, and plan for a more successful economic future. They offer one-on-one financial coaching and financial capability workshops.

They offer a variety of programs to help a family buy a home or keep their home. Their agency is HUD-approved, and their professional counselors are MSHDA certified and NeighborWorks trained and certified. They have English/Spanish bilingual counselors available.

The foreclosure intervention counseling provided by Southwest Economic Solutions serves homeowners throughout the metro Detroit and tri-county area.

They offer home buyer education classes, pre-purchase counseling and financial coaching through one-on-one sessions, group workshops, and community events. They offer special programs to help aspiring homeowners qualify for incentives such as down payment assistance and low-interest home loans. They also offer assistance for current Detroit homeowners to apply for the City's no-interest home repair loan program.

To address workforce development, they offer several programs to help eligible participants obtain the skills, resources and opportunities they need for gainful employment. *Earn+Learn* is an innovative and comprehensive model of workforce development that involves multiple partners working together to train, place and maintain participants in employment.

Homeless Veterans' Reintegration Program (HVRP) helps

(Continued on Back Cover)

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Leadership *(From Page 19)*

homeless vets find meaningful employment through a broad range of training, support and employment services.

PATH (Partnership Accountability Training Hope) assists welfare applicants and recipients to become self-sufficient and integrated into the labor force, based on the workforce needs of Michigan's current and emerging economy.

GAME CHANGERS

This incredible expansion of services has all been the result of a growth in understanding the components that constitute quality life, success and self-sufficiency of individuals and families. This burgeoning knowledge has enabled SWSOL to identify seven game changers. Retaining fidelity to the complexity we are as human beings, there is recognition that each game changer has a cascading effect, that is, each has an impact beyond its particular area of emphasis. This means that the various sectors and partners must align their strategies and objectives. Likewise, it means integrating services to address the interrelated needs of individuals and families, significantly increasing the likelihood of their well-being and success. We are more apt to retain effectiveness and relevancy if we focus on game changers rather than on the existing iteration of a program. In doing this, *why* has precedent over *what*. Instead of defending a program, we can ask, what are we doing to address this game changer? Are we making a difference? Where do we excel? What's missing?

The seven game changers are:

- Health
- Housing
- Income, Employment and Financial Empowerment
- Early Childhood and Education
- Transit
- Community Security and Stabilization
- Community Building and Engagement

A future article will focus more closely on these game changers and how they are indeed, having a significant impact on Southwest Detroit!

John VanCamp *retired in 2018 after a 45-year career with Southwest Solutions – the last 37 as Chief Executive Officer.* Connections *Editor, Clint Galloway, researched Southwest Solutions – and subsequently saw first hand the impact the organization has had on the renaissance taking place in Detroit – when VanCamp guided him on a tour a few weeks ago. This article is a result of that research, the visit to the organization, and conversations with VanCamp.*

CMHA Community Mental Health Association of Michigan

WEEKLY UPDATE

November 30, 2018

Contents:

CMH Association and Member Activities:

Northcare announces change in leadership

Below is a recent announcement from NorthCare Network, a member of the CMH Association of Michigan regarding change in leadership at NorthCare.

> NorthCare Network is pleased to announce that Dr. Timothy Kangas has been hired as our new CEO.
> Dr. Kangas is working with current CEO, William Slavin during this transition until Bill's retirement on December 14, 2018.
>
> Dr. Kangas will take over as NorthCare Network's CEO effective December 14, 2018. His email is tkangas@northcarenetwork.org

Best of luck to Bill Slavin, in his future endeavors, as he leaves his position as CEO at NorthCare, and to Timothy Kangas as he takes on the role of CEO at NorthCare.

CMHAM Committee Schedules, Membership, Minutes, And Information

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

News from Our Corporate Partners:

Abilita Highlights Recent Announcement of the Office of Civil Rights Giving Guidance for HIPAA and Addresses Ransomware

Below is an update, from Abilita, a longstanding corporate partner of the CMH Association of Michigan.

> OCR will periodically release guidance regarding certain HIPAA privacy and security rules. It is often difficult to properly navigate the rules and ensure compliance. To help with this, OCR releases more in-depth guidance that can help your organization determine what a rule requires.
>
> One of the more recent OCR guidance releases addresses ransomware. It provides information about how to protect against ransomware, what to do if you get ransomware, and how to determine if it's reportable. OCR also releases a monthly Cyber Awareness newsletter and can be accessed on the https://www.hhs.org/hipaa website.
>
> Abilita is the leader in telecommunications consulting and endorsed by CMHAM since 2011 to help members reduce risks, costs and prevent your staff from wasting their time. Abilita evaluates HIPAA technology risks and can insure you are in compliance without wasting your staffs' time. In addition, we reduce your telecom costs by 29% with no upfront costs or risk. Abilita is an independent consulting company with offices across Michigan and North America! As one of the largest independent Communications Technology consulting firms in America, Abilita has the experience needed to help members by not just identifying, but by managing the

implementation of recommendations you approve. For additional information, contact: Dan Aylward, Senior Consultant, Abilita at 888-910-2004 x 2303 or dan.aylward@abilita.com .

State and National Developments and Resources:

Leadership change in the MDHHS Division of Mental Health Services to Children and Families

Below is a recent announcement, from Jeff Wieferich, at BHDDA within MDHHS, regarding changes in leadership within Division of Mental Health Services to Children and Families.

> This is to announce that effective December 3, 2018, Kim Batsche-McKenzie has been appointed Acting Director of the Division of Mental Health Services to Children and Families. Kim has many years of experience with children's mental health services within the community mental health system and has, for the past 5 years, been the Manager of Programs for Children with Serious Emotional Disturbance within the Division. Please welcome Kim.

We wish Sheri Falvay, Kim Batsche-McKenzie's predecessor, the best in her future endeavors and wish Kim the best in this new role.

Michigan Partners in Crisis (PIC) Annual Winter Conference

Below is a recent announcement from the Mental Health Association in Michigan regarding the Michigan Partners in Crisis Annual Conference.
Dear Friends:

> You are cordially invited to attend a free event that is being hosted by the Mental Health Association in Michigan (MHAM) and Partners in Crisis (PIC) on Friday, December 14, 2018 from 9:15 am to Noon at the Community Mental Health Association located at 426 S. Walnut in Lansing.
>
> The winter conference will focus on issues/concerns such as mental health parity, the Michigan Legislative Corrections Ombudsman Program for inmates with mental health issues and PIC's initiatives for 2018. Partners in Crisis is comprised of a group of key individuals from the court system; the criminal justice system; and other citizens who are concerned about behavioral health public policy in Michigan as it relates to justice systems.
>
> If you would like to learn more about state parity issues and the federal parity law that was passed in 2008 as well as implications for Michigan, David Lloyd, Director of Policy and Programs, Kennedy Center, will be speaking about parity and will provide an update from across the United States.
>
> After closure during the Engler administration, the Michigan Legislative Corrections Ombudsman Program was reestablished, with a major
> push from PIC, in 2008. What has this office tackled and experienced in the past decade? What are the major problems for inmates & families encountered by the Ombudsman, and how have they been dealt with? Where does mental illness fit into the mix?
>
> December 14, 2018 | 8:30a-12 Noon | Community Mental Health Association
> 426 S. Walnut | Lansing

Registration: 8:30 to 9:15a | Program: 9:15a to 12Noon
I. State Parity Initiatives & News from across the Country
The federal parity law of 2008 is difficult to interpret, monitor and enforce. What are other states (e.g., Illinois, New Jersey) doing to improve behavioral health insurance parity for their residents? What is happening in the courts re alleged violations of the law? What can Michigan do to make parity more reachable?
Presenter: David Lloyd, Director of Policy & Programs, The Kennedy Forum

II. The Michigan Legislative Corrections Ombudsman Program, 2008-18
After closure during the Engler administration, this program was reestablished, with a major push from PIC, in 2008. What has this office tackled and experienced in the past decade? What are the major problems for inmates & families encountered by the Ombudsman, and how have they been dealt with? Where does mental illness fit into the mix? What systemic issues have been noted, and what are recommendations for improving them?

III. Progress on PIC's 2018 Initiatives
Presenter: Mark Reinstein, PIC Advisory Board Member

To register for this event (there is no charge), please fill out and return the form below. You may e-mail the form to Greg Boyd at ghb1@acd.net ; or you may fax it to 517.913.5941; or you can postal-mail the form to: MHAM, 2157 University Park Dr., Ste. 1, Okemos, MI 48864. (PIC is administered by the Mental Health Assn. in Mich.)
Please join us for this important and timely program.

- -

PIC December 14 Registration Form – please print
Name: ____
Organization: ____
Phone: _________________
Email: ____________________

CHCS offers webinar on addressing social determinants of health through 1115 Medicaid waivers

Below is the announcement, by the Center for Health Care Strategies (CHCS), of the upcoming webinar on approaches to addressing social determinants of health through Section 1115 Medicaid waivers.

Addressing Social Determinants of Health via Medicaid Managed Care Contracts and § 1115 Demonstrations
December 11, 2018 at 4:00 PM ET

Medicaid agencies and managed care organizations (MCOs) are increasingly recognizing the value of addressing beneficiaries' social determinants of health (SDOH). In this Association of Community Affiliated Plans (ACAP) webinar, the Center for Health Care Strategies (CHCS) will present findings from its nationwide review of Medicaid managed care contracts and § 1115 demonstrations.

Join this webinar to learn how states are using MCO contracts

and § 1115 demonstrations to require or incentivize SDOH-related activities through care coordination and management, quality assessment and performance improvement, MCO payment incentives, and value-based payment. CHCS will also present recommendations for federal policymakers to help plans and states design innovative strategies to address Medicaid beneficiaries' SDOH.

The webinar is based on a forthcoming ACAP report authored by CHCS, Addressing Social Determinants of Health via Medicaid Managed Care Contracts and § 1115 Demonstrations, that examines Medicaid managed care contracts or requests for proposals in 40 states in addition to 24 approved § 1115 demonstrations.

Health care policymakers, state officials, health plans, and other interested stakeholders are invited to join this 60-minute event.

Methods behind the dramatci Opioid Overdose death rate drop in Dayton Ohio

Below are excerpts from a recent New York Times article on the dramatic drop in opioid-related overdose deaths in Dayton, Ohio. The article outlines the components that led to this decrease.

This City's Overdose Deaths Have Plunged. Can Others Learn From It?

DAYTON, Ohio — Dr. Randy Marriott clicked open the daily report he gets on drug overdoses in the county. Only one in the last 24 hours — stunningly low compared to the long lists he used to scroll through last year in a grim morning routine.

"They just began to abruptly drop off," said Dr. Marriott, who oversees the handoff of patients from local rescue squads to Premier Health, the region's biggest hospital system.
Overdose deaths in Montgomery County, anchored by Dayton, have plunged this year, after a stretch so bad that the coroner's office kept running out of space and having to rent refrigerated trailers. The county had 548 overdose deaths by Nov. 30 last year; so far this year there have been 250, a 54 percent decline.

The full article can be found at:

https://www.nytimes.com/2018/11/25/health/opioid-overdose-deaths-dayton.html

The prospect of CMS paying for housing attracts attention, advice and questions

Below are excerpts from a recent article in Modern Healthcare triggered by the recent housing-related comments by the US Department of Health and Human Services (HHS) Director Azar.

The surprise announcement by HHS Secretary Alex Azar that the CMS was interested in paying for housing and other social services caught the industry's attention, prompting a slew of opinions on how that would work.

High on the list of suggestions among industry stakeholders is a warning for the CMS to keep in mind community organizations and other federal agencies as it considers any new payment

models in which housing and other social services are paid for.

Azar unveiled the possibility in a speech in which he remarked that the agency has a responsibility to address patients' social needs and that the Center for Medicare and Medicaid Innovation is working on a pilot model.

"In our very name and structure, we are set up to think about all the needs of vulnerable Americans, not just their healthcare needs," Azar said. "What if we went beyond connections and referrals? What if we provide solutions for the whole person, including addressing housing, nutrition and other social needs? What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing or make sure that a diabetic had access to, and could afford, nutritious food? If that sounds like an exciting idea … I want you to stay tuned to what CMMI is up to."

Healthcare organizations overwhelmingly welcomed the news as most recognize that being able to address patients' social needs is going to be critical as they are paid more for outcomes and less for direct medical services. There currently isn't a direct reimbursement mechanism to support such investments, so health systems largely use their own pocketbooks, which is unsustainable long-term.

"I think we have been very innovative in the way we have been addressing social determinants … but in order for it to be sustained and for us to expand our work in this space, a payment model is going to be critical," said Dr. Alisahah Cole, chief community impact officer at Charlotte, N.C.-based Atrium Health.

There is also now substantial literature to support that addressing patients' social determinants of health yields savings through lower utilization and readmission rates. That's likely why the CMS is ready to take on social needs as a reimbursable service, but health policy analysts caution that in order for such a venture to be successful, it needs to include—and support—all players that contribute to the social safety net. No one entity can tackle social services on its own, especially one like the CMS, which historically hasn't been involved in providing social services, they said.

"To be effective, this can't just be another set of services. This really is about how to create an integrated system in a community," said Jeffrey Levi, professor of health policy and management at George Washington University.

In his speech, Azar didn't provide details regarding how the payment model might operate, but he did suggest providers would receive the payments. In a follow-up request, the CMS said it didn't have any additional information about the potential model.

The full article can be found at:

https://www.modernhealthcare.com/article/20181124/NEWS/181129980?utm_source=modernhealthcare&utm_campaign=am&utm_medium=email&utm_content=20181124-NEWS-181129980

MHEF announces recent awards

Below are excerpts from an announcement by the Michigan Health Endowment Fund (MHEF) regarding its most recent round of grant awards involving, among other issues, mental health and substance use disorder projects.

> We're pleased to announce $14 million in awards to dozens of Michigan organizations working to improve residents' health and wellness. 30 organizations will receive grants ranging from $100,000 to $500,000 as part of two programs: Healthy Aging and Special Projects & Emerging Ideas. As part of an ongoing partnership around caregiving, the Ralph C. Wilson Jr. Foundation is contributing $1 million to this grant round in support of caregiver-related projects.
>
> "Michigan's population is aging, and as a state we must adapt to support older adults and those who care for them," explained Health Fund Senior Program Officer Kari Sederburg. "In this grant cycle we're investing in potential game-changers, from projects that address social isolation to initiatives that could inspire a new generation of healthcare professionals focused on supporting seniors."
>
> Meanwhile, Michigan State University's "Building a Strong Caregiver Workforce" project focuses on formal career pipelines and professional development for caregivers. MSU will receive $407,000 to develop a training academy for family and professional caregivers. The academy will provide training for family caregivers, a master trainer certificate, a for-credit certification for high school students, and direct care professional online training.
>
> The Special Projects & Emerging Ideas grant awards support long-term, systemic change. These grants are by invitation only and have the potential for significant statewide impact on the health of Michigan residents. For example, the Michigan Public Health Institute will receive $499,412 to convene state and local stakeholders to collaboratively address the root causes of racial inequities in maternal and infant mortality.

The full notice and list of grant awards can be found at:

https://www.mihealthfund.org/health-fund-awards-14-million-in-healthy-aging-and-special-projects

Mental Health Care: Easier to Knock It Down than Build it Up?

Below are excerpts from a recent editorial, written by Tom Watkins, former CEO of Detroit-Wayne Mental Health Authority, in Dome Magazine on the state of Michigan's public mental health system.

> I pulled over to watch as the wrecking ball knocked the building apart. On a cold, blustery November pre-winter day, while riding down Seven Mile Road in Northville Township, out of the corner of my eye I saw the framed hulk of the former Northville Regional Psychiatric Hospital against a bold grey sky.
> As I watched, the crane slowly pulled the skin away from the crumbling, hulking edifice that had once warehoused up to 1,500 hundred people with a serious mental illness on any given day.

Back in the 80s's I had keys to that hospital and would often make unannounced visits at all hours of the day and night while serving as the Deputy, then Chief Deputy and, finally, Director of the former state of Michigan Mental Health Department from 1983-90.
Northville Regional Psychiatric Hospital – as it was called then – was a wicked place, full of challenges, often underfunded and short-staffed. Many good and decent staff there attempted to care for some of the most vulnerable people among us: Persons with serious and chronic mental illness.

Many psychiatric hospitals were shuttered; unceremoniously closed in the early days of then Michigan Governor Engler's first term in the 1990's. The policy of closing antiquated – and in many cases ineffective – state hospitals was not wrong. However, follow-through on promises to fill in behind their closings with community-based hospital care and alternative community programs were not kept during successive Engler (and others) administrations.

The promise of adequately funding community psychiatric beds in local hospitals for the truly needed never materialized. The ones that did develop psychiatric beds realized it was more profitable to serve the "walking worried" than underfunded Medicaid patients with serious mental illnesses. Providing 24 hour-a-day care to persons with serious brain disorders is expensive. However, community mental health system services were never fully funded or developed.

Today, we have more people with serious mental illnesses wandering our streets. Many are homeless and locked up in jails and prisons, rather than receiving the care they need and deserve in a civilized society. I wondered if the wrecking ball that was tearing down the old Northville Psychiatric Hospital was symbolic of a system of mental health care that has decayed in Michigan.

The full editorial can be found at:
http://domemagazine.com/mental-health-care-easier-to-knock-it-down-than-build-it-up/

Surgeon general pushes for community partnerships and collaborations to address opioid crisis

Below are excerpts from a recent editorial, in Behavioral Healthcare Executive on the need for a culture change to combat the nation's opioid crisis. The editorial was written by Ron Manderscheid, CEO of the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) – of which the CMH Association of Michigan is a long-time member.

On Monday, I had the honor to introduce the current surgeon general of the United States, Jerome M. Adams, MD, MPH, at the annual meeting of the American Public Health Association (APHA) in San Diego. Adams headlined our plenary session on "The Emerging Federal Response to the Opioid Crisis: What Organizations and Communities Can Do to Make an Impact."

In September, the surgeon general released Facing Addiction in America: The Surgeon General's Spotlight on Opioids, which calls for a cultural shift in the way Americans talk about the opioid crisis and recommends actions that can prevent and treat opioid misuse and promote recovery. The same day, he also released a digital postcard, highlighting tangible actions that all Americans can take to raise awareness, prevent opioid misuse and reduce overdose deaths. Both the full document and the digital postcard can be viewed on the surgeon general's website.

Read more at: https://www.behavioral.net/blogs/ron-manderscheid/prescription-drug-abuse/emerging-federal-and-community-response-opioid-crisis

CMS announces changes to prohibitions on use of Medicaid funds for inpatient care

Below are excerpts from a recent announcement, by the federal Centers for Medicare and Medicaid Services, on the expansion of innovative service delivery systems that will more likely obtain, as part of a 1115 waiver, approval by CMS, including the use of Medicaid dollars for institutions for mental disease (IMD).

CMS ANNOUNCEMENT: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance

Recently,, the Centers for Medicare & Medicaid Services (CMS) is sending a letter to State Medicaid Directors that outlines both existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The letter includes a new opportunity, under section 1115(a) of the Social Security Act, for states to receive authority to pay for treatment services provided to beneficiaries who are short-term residents of psychiatric hospitals or residential treatment settings that qualify as institutions for mental disease (IMDs) if those states are also committing to taking action to ensure good quality of care in those settings and to improve access to community-based services as well.

CMS currently offers states the opportunity to pursue similar demonstration projects focused on improving treatment for substance use disorders (SUDs), including opioid use disorder, under section 1115(a) of the Act. Through these SUD-focused demonstrations, CMS has been working with participating states to cover treatment in IMDs while also improving access for beneficiaries to a full continuum of care including community-based outpatient services and also ensuring the quality of SUD treatment provided to beneficiaries while residing in IMDs. To date, CMS has approved these SUD-focused demonstrations in 17 states, and there are already indications of improved outcomes for beneficiaries.

Similar to the SUD 1115(a) demonstration initiative, this SMI/SED demonstration opportunity outlines a number of milestones that states will be expected to achieve as part of these demonstrations aimed at making progress on a number of overarching goals. These milestones include specific activities to –

Ensure good quality of care in psychiatric hospitals and residential treatment settings; Improve care coordination and transitions to community-based care following stays in acute care settings;

Increase access to a continuum of care including crisis stabilization services and community-based services to address chronic, on-going mental health care needs; and

Identify individuals with SMI or SED earlier and engage them in treatment sooner.

States are encouraged to build on the evidence-based models discussed in the first part of the letter in order to achieve these milestones.

As a state's SMI/SED demonstration progresses, states will be expected to include, in their section 1115(a) demonstration monitoring reports, information detailing the state's progress toward meeting the milestones and timeframes for specific actions. These reports will also include information and data so that CMS can monitor the impact of these demonstrations and progress on the goals as well as ensure budget neutrality.

CMS will work closely with states on implementation and evaluation of these demonstrations and is hopeful that this policy guidance will create new opportunities to partner with states committed to implementing innovative service delivery reforms to improve care for beneficiaries with SMI or SED.

The State Medicaid Director Letter is available on Medicaid.gov here: https://www.medicaid.gov/federal-policy-Guidance/index.html

—sometimes providing inadequate care.

State Legislative Update:

Meekhof Introduces a Bill to Amend Prop 1

Senate Majority Leader Arlan Meekhof (R-West Olive) wanted the Legislature to adopt the marijuana legalization ballot proposal to make it easier to amend later. That didn't happen because House Republicans didn't want to go on record supporting legal marijuana and opponents thought they could beat it at the ballot box.

However, now that Proposal 1 passed it's going to take 29 senators and 83 House members, or a three-quarters super-majority, to make any changes, had the initiative been legislatively adopted, a simple majority could change the proposal.

This week, Sen. Meekhof introduced SB 1243, a bill designed to make the new recreational marijuana law look more like the regulation that governs medical marijuana so Michigan does not have two different sets of regulation. The 75-page legislation gets rid of legal marijuana "microbusinesses," which would let a person grow less than 150 plants as part of a "homebrew"-like arrangement.

"People don't get to make their own alcohol and serve it in their own bars to anybody they want to," Meekhof said. "So, you have the argument whether you think it should be criminalized or not criminalized, but at the end of the day it should be in some regulated form, so we have some consistency and safety. "

SB 1243 is a very long shot to get adopted by both chambers in the remaining days of session.

2018 Lame Duck Legislation

The first week of session is completed, three more weeks are scheduled. Below is a brief update regarding the legislative items of interest to the public mental health system:

HB 5625 – allows mediation to start immediately with a rights dispute and not waiting until after the investigation is closed. – **Passed out of House Law & Justice Committee Tuesday**

HB 5828 – Creates the school safety commission – **Passed out of Senate Education Committee on Wednesday**

HB 5806 – 5808 – Creates legislative framework on juvenile mental health court – **Passed out of House Judiciary Committee Tuesday.**

SB 745 - clarify when you need to license an adult foster care home… We want to make sure home that are currently unlicensed (if you own or rent your own home) remain unlicensed. – **Not going to move, HB 5505 is moving and has the same language to resolve the AFC licensing issue as SB 745 proposes by not requiring licensure for settings of up to 4 adults receiving benefits from a CMH services program, BUT HB 5506 is also moving and it 5506 includes transferring the cost of the FBI criminal history checks to AFC licensees beginning January 1, 2020. This cost transfer is proposed under HB 5506.**

SB 962 - The bill would allow certain facilities to be dually licensed as adult foster care facilities and substance use disorder programs so that an individual seeking treatment for a substance use disorder and mental health issues could be treated at a single facility, as long as the facility was approved as a co-occurring enhanced crisis residential program. **NO ACTION**

SB 641 – The bill would redefine limited licensed phycologists as a "psychological associate". **Passed out of the Senate Health Policy Committee.**

Raise the age package (HBs 4607, 4653, 4662, 4664, 4676, 4659, 4650 & 4685) – Michigan is one of only four remaining states in the United States where 17-year-olds are automatically considered adults for criminal offenses. To align with standard national practices, Michigan should raise the age of juvenile court jurisdiction to 18 – **Passed out of House Law & Justice Committee Wednesday.**

SB 1171 – Revised version of minimum wage bill passed in September – **Passed the Full Senate on Wednesday. Minimum wage will increase .23 cents every year until it reaches $12/hour.**

SB 1175 – Earned Sick time – **Passed the Full Senate on Wednesday. Changes the maximum amount of paid sick leave a person can earn to 36 hours a year, as opposed to the 72 hours in the original proposal.**

SB 1243 – Designed to make the new recreational marijuana law look more like the regulation that governs medical marijuana so Michigan does not have two different sets of regulation – **Introduced and Referred to Senate Govt Ops Committee**

FY19 Supplemental Budget – NO ACTION

HOUSE CARES TASK FORCE

HB 5085 – dedicates 4% of the unmarked money raised through Michigan's liquor sales and fees and earmark it specifically for substance use disorder treatment and prevention services. HB 5085 could provide more than $17 million a year to combat alcohol-related disorders, opiate addiction and other substance use disorders. **NO ACTION**

HB 5439 – requires the DHHS to establish and administer an electronic inpatient psychiatric bed registry, with beds categorized by patient gender, acuity, age, and diagnosis that is accessible through the DHHS website. **NO ACTION**

HB 5460 – require that programs and curricula for paramedics or medical first responders include training in treating drug overdose patients that is equivalent to training provided by the American Heart Association Basic Life Support (BLS) for Health Care Providers. **NO ACTION**

HB 5461 – Current law allows peace officers to possess and administer an opioid antagonist if they have been trained in its proper administration and have reason to believe that the recipient is experiencing an opioid-related overdose. The bill would stipulate that the training required before administration of an opioid antagonist must meet the requirements set out in HB 5460. **NO ACTION**

HB 5524 – requires that the Department of Education (MDE), in conjunction with the DHHS to develop or adopt a professional development course for teachers in mental health first aid. **NO ACTION**

HB 5487 – establishes a uniform credentialing requirement for individuals who provide medical services through a contract health plan. **NO ACTION**

HBs 5450-5452 – allows those once convicted of some minor felonies and misdemeanors would be allowed to work in some mental health care jobs (nursing homes, psychiatric facilities, & adult foster care homes). **NO ACTION**

HB 5810 – revising Kevin's Law, court-appointed outpatient and inpatient care, increasing accessibility. **NO ACTION**

HB 6202 – MI CARES hotline would create a statewide 24 hour/7 day a week referral system for individual who are seeking services. **NO ACTION**

Federal Update:

Trump Administration Approves Kentucky Work Requirements for Second Time

The Centers for Medicare and Medicaid Services (CMS) re-approved Kentucky's request to add work requirements to the state's Medicaid program last week, following a federal judge's ruling earlier this year that overturned the first iteration of these requirements. These changes would require the population covered by Kentucky's Medicaid expansion to report 80 hours of work or "work-related activities" each month, or face losing their coverage for a six-month lockout period. The approved 1115 waiver, which takes effect April 1, 2019, is almost identical to the state's previously overturned application, and has been projected to result in at least 95,000 Kentuckians losing Medicaid coverage over the next five years.

BACKGROUND In June of this year, District Court Judge James Boasberg blocked Kentucky's original waiver request on the grounds that CMS had not properly considered whether the initiative would violate Medicaid's central objective of providing medical assistance to the state's citizens, nor had the agency adequately addressed concerns about the expected total loss of coverage for thousands of Kentuckians. The decision did not outlaw Medicaid work requirements outright, but rather required CMS to carefully assess each Medicaid Section 1115 waiver for its impact on individuals' health care coverage. In response, CMS reopened a public comment period on the waiver, during which the National Council submitted comments strongly opposing work requirements and other harmful provisions included in the waiver.

In a letter to Kentucky's Medicaid Director re-approving the 1115 waiver, CMS Chief of Staff Paul Mango outlined the agency's assertion that work requirements and other measures included in the waiver "seek to improve beneficiary health and financial independence, improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries." He noted that CMS had considered public comments on the waiver, and that it had determined that the waiver was consistent with the goals of the Medicaid program. The letter also justifies experts' projections that 95,000 Kentuckians will lose coverage by contending that they account for a small percentage of total Medicaid enrollees, and their disenrollment will likely be due to a variety of factors beyond the institution of work requirements, such as transitioning to commercial coverage.

CONCERNS FROM THE FIELD CMS's reapproval of Kentucky's work requirements comes amid massive coverage losses for over 12,000 Arkansans operating under similar Medicaid restrictions as well as calls from many groups for CMS to halt approvals of new waivers that include work requirements. The Medicaid and CHIP Payment and Access Commission (MACPAC), a Congressionally-chartered body that advises Congress and CMS on Medicaid issues, submitted a formal request to Health and Human Services Secretary Alex Azar to cease approving these waivers.

Additionally, the National Council has joined many efforts to oppose work requirements, including submitting official comments on the Kentucky requirements, and sending a letter alongside other groups such as the Center on Budget and Policy Priorities, the Georgetown University Center on Children and Families and the March of Dimes, urging Secretary Azar to take immediate action to halt work requirements in the face of unnecessary coverage losses for Medicaid enrollees. Leonardo Cuello, Director of Health Policy at the National Health Law Program, one of the advocacy groups involved in

the lawsuit which resulted in the initial blockage of these requirements said, "We do not believe HHS's reapproval corrects the serious legal defects Judge Boasberg cited in his first opinion."

WHAT'S NEXT?

Before the waiver goes into effect on April 1, 2019, Judge Boasberg will consider CMS's reapproval of the Kentucky waiver, as well as the agency's approval of the similar waiver currently active in Arkansas. Stay tuned to *Capitol Connector* each week for continued updates on Medicaid work requirements and their impact on individuals living with mental illness and substance use disorders.

Education Opportunities:

CMHAM & Michigan Health Endowment Fund Present New Training Series: Managed Care Contracting from a Position of Strength!

Many behavioral health agencies mistakenly believe that they lack leverage with the MCOs to negotiate fair provisions in their participation agreements, overlooking legal protections available under state and federal law. In addition, many behavioral health agencies fail to position themselves to participate under value-based payment arrangements with MCOs, foregoing potential revenue streams. This full-day training will assist behavioral health agencies negotiate favorable participation agreements with MCOs. The training will address the following topics:

- Preparing for contract negotiations by identifying and assessing potential leverage points, such as regulatory leverage, market power, and competing on value;
- Evaluating managing care contracts using a team-based approach, considering an MCO's operational and financial stability;
- Negotiating strategies and tips to make the most persuasive case; and,
- Understanding common contract terms and what language is most advantageous.

FEATURING: ADAM J. FALCONE, JD, MPH, BA, PARTNER, FELDESMAN TUCKER LEIFER FIDELL, LLP
Based in Pittsburgh, PA, Mr. Falcone is a partner in FTLF's national health law practice group, where he counsels a diverse spectrum of community-based organizations that render primary and behavioral healthcare services. He counsels clients on a wide range of health law issues, with a focus on fraud and abuse, reimbursement and payment, and antitrust and competition matters.

WHO SHOULD ATTEND:

- Nonprofit mental health providers and those mental health providers serving within the public mental health network interested in negotiating contracts with managed care organizations
- Limited attendance: only 2 people per agency may attend

REGISTRATION: $100 per person. The fee includes training materials, continental breakfast and lunch.

ADDITIONAL INFO: https://macmhb.org/education, cward@cmham.org; or 517-374-6848.

TO REGISTER, CLICK ON YOUR DATE & LOCATION:

January 15, 2019 - Detroit Marriott, Livonia

January 16, 2019 - Holiday Inn & Suites, Mt. Pleasant

January 23, 2019 - Drury Inn & Suites, Grand Rapids

January 24, 2019 - West Bay Beach Holiday Inn

SAMHSA announces sequential intercept mapping workshops

Sequential Intercept Mapping Workshops Focusing on Improving and Expanding Diversion Opportunities at Intercepts 2 and 3

Sequential Intercept Mapping (SIM) Workshops are designed to allow local, multidisciplinary teams of people from jurisdictions to facilitate collaboration and to identify and discuss ways in which barriers between the criminal justice, mental health, and substance use systems can be reduced and to begin development of integrated local strategic action plans. This year's SIM Workshops will be focused on improving and expanding diversion opportunities at Intercept 2 and 3 of the Sequential Intercept Model, with particular emphasis on specialty/treatment courts (e.g., drug/recovery courts, DUI/DWI courts, mental health courts, veterans treatment drug courts, family treatment drug courts, tribal healing to wellness courts) and improving coordination and collaboration among judges, prosecutors, defense attorneys, treatment court coordinators and case managers, community corrections, behavioral health treatment provider agencies and organizations, and other community-based services and supports. The GAINS Center will offer the SIM Workshops free of charge to selected communities between March and August 2019.

To apply for a SIM workshop, please download the solicitation and submit a completed application form no later than December 21, 2018

Download the SIM Workshop Solicitation

SAMHSA GAINS Center offering criminal justice learning collaboratives

JOIN an upcoming INFORMATIONAL WEBINAR TO LEARN ABOUT participating in SAMHSA'S GAINS CENTER'S CRIMINAL JUSTICE LEARNING COLLABORATIVES

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc., and known nationally for its work regarding people with behavioral health needs involved in the criminal justice system, is convening five Learning Collaboratives to work intensively with select communities on the following topics:

- Risk-Need-Responsivity
- Family Drug Courts
- Equity and Inclusion
- Competency to Stand Trial/Competence Restoration
- SAMHSA's 8 Guiding Principles for Behavioral Health and Criminal Justice

For additional information related to how these topics will be addressed within each Learning Collaborative, register for one of the informational webinars by clicking the links below.

Criminal justice Learning Collaboratives

Each Learning Collaborative will bring together six local teams for an intensive learning, strategic planning, and implementation process to address local issues and needs within their topic area. Each Learning Collaborative will engage subject-matter experts and will facilitate peer-to-peer learning and information sharing. A unique blend of onsite and virtual methods will offer each team an intimate and familiar environment in which to learn and complete their work while providing a virtual forum to share with other communities and receive an array of technical assistance from subject matter experts across the country. The overarching objectives for this opportunity include:

- Enhancing collective knowledge of key issues and familiarity with the topic
- Understanding promising, best, and evidence-based practices to address the topic and related issues
- Developing strategic plans that focus on the issue, including defining assignments, deadlines, and measurable outcomes to be reported
- Increasing knowledge about the challenges and lessons learned in implementing strategies through peer-to-peer sharing

If you are interested in learning more about this exciting opportunity, register for one of the upcoming informational webinars:

Register for the webinar on Wednesday, December 5, 2-3:00 p.m. ET

Register for the webinar on Thursday, December 6, 3-4:00 p.m. ET

MDHHS Announces Training on Best Practice in Autism Evaluation for Medicaid Providers

WHO SHOULD ATTEND?

Psychologists, physicians, social workers, BCBAs, BCaBAs, supervisors, medical directors, and other medical and mental

ABOUT THE TRAINING

The Michigan Department of Health and Human Services (MDHHS) and Dr. Kara Brooklier have partnered to present Best Practice in Autism Evaluation, a course designed to provide mental health professionals and administrators with an understanding of the process for

ABOUT DR BROOKLIER:

Dr. Kara Brooklier has been a practicing pediatric neuropsychologist for over 15 years. Her specialization is in the area of neurodevelopmental disorders and specifically autism spectrum disorders. She is Director of

health professionals and administrators serving the Medicaid population who are interested in learning about the best practices in the evaluation of autism spectrum disorder.

The Department of Psychology at Wayne State University is approved by the American Psychological Association to sponsor continuing education for psychologists. The Department of Psychology at Wayne State University maintains responsibility for this program and its content.

accurate diagnosis of autism spectrum disorder in toddlers, children, and teens. The focus of this course will surround 1) understanding the core symptoms of autism, 2) common differential co-morbid conditions, and 3) best practices for evaluation from data gathering to clinical formulation and caregiver feedback. Aspects of assessment needed for differential and co-morbid diagnosis of autism spectrum disorders will be thoroughly reviewed.

LEARNING OBJECTIVES:

1. Participants will be aware of the core variables and symptoms associated with autism spectrum disorder

2. Participants will be able to identify common conditions in the differential diagnosis of autism spectrum disorders

3. Participants will demonstrate understanding of the best practice process for diagnosis of autism spectrum disorder in toddlers, children, and teens

REGISTRATION INFORMATION

DATE: December 7, 2018

TIME: 9:00 am- 12:00 pm

LOCATION: South Grand Building (Grand Conference Room) 333 S. Grand Avenue, Lansing MI 48933

CAPACITY: 100 attendees

REGISTER HERE: https://goo.gl/QUaXrq

Neuropsychological Services at the Children's Center of Wayne County and is clinical training faculty at Children's Hospital of Michigan and Wayne State University Department of Psychiatry & Behavioral Neurosciences. Dr. Brooklier works with her team of staff psychologists, doctoral interns, and postdoctoral fellow to conduct neuropsychological and differential diagnostic evaluations of autism spectrum disorders and associated neurodevelopmental conditions.

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

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

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

Trainings offered on the following dates.

- January 23 – Lansing Click Here to Register for January 23
- February 20 – Lansing Click Here to Register for February 20
- March 13 – Lansing Click Here to Register for March 13
- April 24 – Troy Click Here to Register for April 24

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

Miscellaneous News and Information:

Job Opportunity: Michigan Healthy Transitions (MHT) Project Director

Purpose: To coordinate a grant-funded initiative to provide the Transition to Independence Process (TIP) model in Kalamazoo and Kent counties by collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA), MDHHS, the Association for Children's Mental Health (ACMH), the Community Mental Health Services Providers (CMHSPs) in Kalamazoo and Kent counties, Stars Training Academy (TIP model purveyor), the MPHI Evaluation Team and the MHT Leadership Team and stakeholders.

Experience: Experience with supervision and oversight of an evidence-based practice. Familiarity with Transition to Independence Process Model preferred. Experience providing community-based mental health services to children and their families. Public mental health system experience preferred. Excellent written and oral communication skills. Demonstrated coordination and organizational skills.

For more information, Click Here!

Michigan Protection & Advocacy Service, Inc. (MPAS) is seeking an Executive Director

Michigan Protection & Advocacy Service, Inc. (MPAS) is seeking an Executive Director to lead this non-profit organization responsible for providing legally-based protection and advocacy services that advance the rights of individuals with disabilities in Michigan. The position is located in Lansing, MI. MPAS' next Executive Director will continue to advance the high-quality advocacy, legal representation, and connection with the disability rights and social justice communities in the state. Must have a commitment to the mission of MPAS and to the rights of people with disabilities.

Minimum Qualifications:

- Candidates with strong non-profit or legal services experience and a Bachelor's Degree from an accredited college in Business Management, Psychology, Social Work, Public Administration, or another human service related field with minimum of ten years of experience, or Master's Degree or JD and seven years' experience.
- A minimum of seven to ten years of leadership experience in a complex organization that includes engaging in strategic planning, management, development and supervision of personnel, financial planning, and monitoring internal controls for a multi-funded budget.

Application Process:

- Candidates should send a current resume and cover letter detailing the candidate's interest in the position, describing any experience with people with disabilities, and noting relevant leadership experience to mbrand@mpas.org
- Electronic submissions are preferred. Mailed submissions may be addressed to Michele Brand, Michigan Protection & Advocacy Service, Inc., 4095 Legacy Parkway, Suite 500, Lansing, MI 48911 or via fax at 517-487-0827.
- MPAS offers a competitive salary and benefits package. Position is open until filled.
- MPAS is an equal opportunity employer with a commitment to diversity. People with disabilities are encouraged to apply.

For more information, please visit our website: https://www.mpas.org.

CMH Association's Officers and Staff Contact Information:

CMHAM Officers Contact information:

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

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

CMHAM Staff Contact information:

Alan Bolter, Associate Director, abolter@cmham.org
Christina Ward, Director of Education and Training, cward@cmham.org
Monique Francis, Executive Secretary/Committee Clerk, mfrancis@cmham.org
Jodi Johnson, Training and Meeting Planner, jjohnson@cmham.org
Nakia Payton, Data-Entry Clerk/Receptionist, npayton@cmham.org
Dana Owens, Accounting Clerk, dowens@cmham.org
Michelle Dee, Accounting Assistant, acctassistant@cmham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
Annette Pepper, Training and Meeting Planner, apepper@cmham.org
Bethany Rademacher, Training and Meeting Planner, brademacher@cmham.org
Anne Wilson, Training and Meeting Planner, awilson@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org

CMHA Community Mental Health Association of Michigan

WEEKLY UPDATE

November 16, 2018

Contents:

CMH Association and Member Activities:

CMHAM Committee Schedules, Membership, Minutes, And Information

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

State and National Developments and Resources:

CMS May Allow Hospitals to Pay for Housing Through Medicaid

Below is an excerpt from a recent edition of Modern Healthcare outlining the thinking of the US Department of Health and Human Services (DHHS) regarding the use of Medicaid dollars to cover housing costs.

> HHS Secretary Alex Azar on Wednesday said Medicaid may soon allow hospitals and health systems to directly pay for housing, healthy food or other solutions for the "whole person."
>
> In a speech to the Hatch Foundation for Civility and Solutions in Washington, Azar said Center for Medicare and Medicaid Innovation officials are looking to move beyond existing efforts to partner with social services groups and try to manage social determinants of health as they see appropriate.
>
> "What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food?" Azar said in his prepared remarks. "If that sounds like an exciting idea ... I want you to stay tuned to what CMMI is up to."
>
> The CMS has approved experiments in providing this care for Medicaid beneficiaries in California, Illinois, Minnesota and New York.

The full article is available at:
https://www.modernhealthcare.com/article/20181114/NEWS/181119981?utm_source=modernhealthcare&utm_campaign=mh-alert&utm_medium=email&utm_content=20181114-NEWS-181119981

MSU Offers Specialized Housing for Substance Use Recovery

Below is an excerpt from a recent news story on the opening of recovery housing on the campus of Michigan State University.

> Michigan State University is the first in Michigan to provide on-campus housing to students in recovery from substance use disorders, as it continues to expand student health and wellness services.
>
> Currently, 1,534 students, or 3.2 percent of those enrolled at MSU, identify themselves as being in recovery. On-campus housing provides an important resource because college stresses can threaten the recovery process, said Dennis Martell, director of MSU's Health Promotion department.

> "Students no longer have to choose between recovery and their education," he said. "Recovery housing through our Collegiate Recovery Community offers a safe, supportive environment where students can have a real college experience without alcohol or drugs. They form meaningful relationships based on sobriety, friendship and academic success

The full article can be found at:
https://msutoday.msu.edu/news/2018/msu-offers-specialized-housing-for-substance-use-recovery/?utm_campaign=standard-promo&utm_source=msufacebook-post&utm_medium=social

MDHHS Announces Conference Call to Understand Recent Agreement Between MRS and BHDDA

Below is a recent notice of an upcoming conference call being sponsored by the Behavioral Health and Developmental Disability Administration (BHDDA) regarding the recent Memorandum of Understanding (MOU) developed by BHDDA and the Michigan Rehabilitation Services (MRS)

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

DATE: November 5, 2018

TO: Executive Directors of Pre-Paid Inpatient Health Plans (PIHP's)
Executive Directors of Community Mental Health Service Programs (CMHSP's)

FROM: Brenda Stoneburner, M.A., LPC BKS
Manager
Community Practices and Innovation Section
Behavioral Health and Developmental Disabilities Administration

SUBJECT: November 30, 2018 Conference Call re Memo of Understanding between Michigan Rehabilitation Services (MRS) and Behavioral Health & Developmental Disabilities Administration (BHDDA) Follow-Up

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On December 14, 2017 a newly signed Memo of Understanding (MOU) for employment services between MRS and BHDDA was released. Interactive conference calls with both MRS and BHDDA were scheduled in January, 2018 to discuss the MOU and address questions or concerns. Subsequently, on March 21, 2018 a FAQ document was released addressing questions that were identified during these calls. For reference, both documents are attached to the email with this memo.

We are interested in hearing how implementation of this MOU has been going since its release, as well as any additional questions or concerns you may have. A follow-up conference call has been scheduled for any interested participants. It is anticipated colleagues from MRS will also be on this call.

DATE: Friday, November 30, 2018
TIME: 11:00 a.m.- 12:00 p.m.
Conference Line: 888-557-8511 Access Code: 582 7934

Please share this information with all relevant staff and contracted employment service providers.

Thank you for your continued dedication to help individuals achieve greater independence through employment. We look forward to the dialogue to further support individual competitive integrated employment.

Cc: Jeff Wieferich
Joe Longcor

State Legislative Update:

Conservative Hernandez To Chair Approps; Iden New 'Ways & Means' Panel

Rep. Shane Hernadez (R-Port Huron) was appointed this by incoming House Speaker Lee Chatfield (R-Levering) to chair the House Appropriations Committee for the 100th session of the Legislature. Hernandez is currently a House Appropriations Committee member who chairs the Michigan Department of Transportation (MDOT) budget and vice chairs the School Aid Fund budget.

The freshman House member ended 2017 with the chamber's most conservative voting record based on the calculation of key roll call votes. He also made a name for himself in 2017 when his first MDOT budget cut 191 positions with the idea that the $20 million saved could go to the roads.

"I am a conservative and I'm going to dig deep into some things so we can make progress as a state," he said. "But I've shown that I'm willing to compromise when necessary and just not be a 'no vote.'"

Chatfield's other big announcement this week was the creation of a House "Ways and Means" Committee. If like a congressional committee of the same name, it will deal more with revenue and government operations than divvying out money, which is what appropriations does.

Rep. Brandt Iden (R-Oshtemo Twp.), rumored to be a contender for the Appropriations Committee chair post, will chair Ways and Means, which is presumed to be Chatfield's go-to committee -- where he would send big, complex bill packages he needs passed.

Iden currently chairs the House Regulatory Reform Committee.

In other news, Chatfield appointed Rep. Jim Lilly (R-Park Twp.) to lead the temporary Committee on Committees, which is in charge of assigning House members their various committee assignments.

Could Whitmer's Old Senate Friends Be Part of Administration?

It may not be her "kitchen cabinet" per se, but as Gov.-Elect Gretchen Whitmer begins her journey, she will have close at hand four former Senate colleagues to whom she is very close. The exclusive list includes former Sens. Bob Emerson, Mike Prusi, Deb Cherry, and Dennis Olshove. All of them served with her in the state Senate and have been closely involved in her campaign.

Emerson, Gov. Jennifer Granholm's former budget director, has decided not to take a post in the new administration. Prusi from the Upper Peninsula is not looking for a job, but has not ruled one out. The drive back-and-forth isn't desirable, but sources say Prusi would consider doing it again for his close friend.

Prusi was at the victory celebration election night in Detroit and she's tapped him to be on her transition team, which will screen possible members of the new administration. He reported the group has not met, yet as some begin to wonder when it will since she needs key players in place by Jan. 1 when she sworn in.

By comparison, when Gov. Rick Snyder came into office, he was well on his way to having assembled his team and by Jan. 1 he had every major department head position filled with one exception -- the

Department of Corrections.

Prusi explained he is enjoying his retirement, but he did some surrogate speaking for the Governor-elect during the campaign and admitted to feeling good to have the "juices" flowing once more. When asked if he had a favorite job in mind, he confesses he does not adding, "I have not ruled anything out including coming to Lansing."

Running her Upper Peninsula office from his home is always a possibility.

One draw that would make the lengthy drive to Lansing palatable is that he does have five grandchildren, ages 5-11, in Kalamazoo and he enjoys having time with them.

He does report that once the word was out that he was on the transition team he has been fielding at least 50 phone calls from others looking for work.

As for Olshove, a Liquor Control Commissioner, and Cherry, the Genesee County treasurer, they have not spoken to their desires to do something, if anything, beyond being one of her closest friends.

As far as outgoing state legislators, a few possible suggestions for the Governor-elect include Rep. Pam Faris (D-Clio) or Rep. Fred Durhal III (D-Detroit) for their budgetary experience. Rep. Adam Zemke (D-Ann Arbor) is well studied on education policy. Rep. Tom Cochran (D-Mason), the former Lansing fire chief, or Rep. Henry Yanez (D-Sterling Heights) would be good fits for a Fire Marshal role. House Minority Leader Sam Singh (D-East Lansing) has years of experience in local government and the non-profit world that could fit well in a policy role.

Federal Update:

Health Care Emerges as Top Issue in Midterms

With historic levels of voter turnout, Tuesday's midterm election results saw Democrats regain control of the House of Representatives, while Republicans strengthened their majority in the Senate. Health care emerged as a clear priority for voters and Medicaid expansion proved to be a big winner on election night. With power now divided in Congress, the next two years could feature intense political gridlock or force bipartisan compromise. Right now, one thing is clear – the 2018 midterms will send one of the largest classes of freshmen Members to Washington in recent history – and with them come new advocacy opportunities for the National Council and its members.

HEALTH CARE A PRIORITY

According to a CNN exit poll, about four in 10 voters chose health care as the most important issue facing the country, ahead of issues like immigration and the economy. A closer look at the data showed health care to be a much bigger driver for Democratic voters than Republican voters. Although the issue may have driven a lot of Democratic voters to the polls, it did not appear that health care was a decisive factor in many of elections results on Tuesday.

LEGISLATIVE OUTLOOK

With Democrats controlling the House, Congress' health care agenda will change dramatically. Most importantly, Republican leaders are expected to abandon their efforts to repeal and replace the Affordable Care Act (ACA) and cut Medicaid by converting it to a block grant program. These efforts were strongly opposed by the National Council as they would have resulted in dramatic cuts in funding for behavioral health treatment services and harmed individuals living with mental illness and addiction.

So, what's next on Congress' health care agenda? At this point, little is known about the Democrats' next steps on health care beyond defending the ACA. Notably, Democrats have signaled interest in advancing another opioid-focused package in 2019, as many claimed the recently-signed opioid law does not go far enough for treatment-focused solutions. Each year, Congress has certain "must-pass" bills, including the appropriations bills, which fund the federal government each year. These bills may provide opportunities for bipartisan compromise on health care issues, including the opioid crisis, or we may see these bills fall into political gridlock between the two parties.

Regardless of the political environment, the National Council will work hard to maximize opportunities to advance access to mental health and addiction care for all Americans. We look forward to working with both chambers of Congress to advance key issues like expanding behavioral health treatment capacity through the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 1905/H.R. 3931), strengthening the behavioral health workforce, securing funding for federal mental health and addiction programs, and more.

MEDICAID EXPANSION GAINS

Medicaid expansion was a big winner at the ballot box this year, representing a great victory for individuals with low-incomes who lack health care coverage and the providers who serve them. Three Republican-led states, Utah, Nebraska, and Idaho passed ballot measures to begin Medicaid expansion. These measures are expected to extend Medicaid coverage to around 300,000 new recipients.

Beyond ballot measures, the outcomes of governors' races in Wisconsin and Kansas may also clear the way for Medicaid expansion in those states. Further, Maine, the first state to pass Medicaid expansion at the ballot box, may finally have the opportunity to implement its expansion with election of a Democratic governor and the departure of Governor Paul LePage (R), a vehement opponent of Medicaid expansion. This would bring the total number of Medicaid expansion states to 37 (with the potential addition of 2 states – Wisconsin and Kansas). These new Democratic governors may also have a big impact in the rollout of their more conservative predecessors' waiver requests, which included Medicaid work requirements and drug testing/screening.

ADVOCACY OPPORTUNITIES

With each new Congress comes opportunities for the National Council and its members to forge new relationships with Members of Congress, who can champion our issues on Capitol Hill. Do you have a relationship with any of the new or existing House or Senate members? Tell us about any key relationships you may have with Members of Congress or their staff. Successful advocacy often comes down to the strength of our relationships with legislators, so we'd love to hear from you!

Education Opportunities:

MDHHS Announces Training on Best Practice in Autism Evaluation for Medicaid Providers

ABOUT THE TRAINING

The Michigan Department of Health and Human Services (MDHHS) and Dr. Kara Brooklier have partnered to present Best Practice in Autism Evaluation, a course designed to provide mental health professionals and administrators with an understanding of the process for accurate diagnosis of autism spectrum disorder in toddlers, children, and teens. The focus of this course will surround 1) understanding the core symptoms of autism, 2) common differential co-morbid conditions, and 3) best practices for evaluation from data gathering to clinical formulation and caregiver feedback. Aspects of assessment needed for differential and co-morbid diagnosis of autism spectrum disorders will be thoroughly reviewed.

LEARNING OBJECTIVES:

1. Participants will be aware of the core variables and symptoms associated with autism spectrum disorder

2. Participants will be able to identify common conditions in the differential diagnosis of autism spectrum disorders

3. Participants will demonstrate understanding of the best practice process for diagnosis of autism spectrum disorder in toddlers, children, and teens

REGISTRATION INFORMATION

DATE: November 27,2018

TIME: 9:00 am- 12:00 pm

LOCATION: The Children's Center (Training Rooms A&B) 79 W. Alexandrine, Detroit MI 48201

WHO SHOULD ATTEND?

Psychologists, physicians, social workers, BCBAs, BCaBAs, supervisors, medical directors, and other medical and mental health professionals and administrators serving the Medicaid population who are interested in learning about the best practices in the evaluation of autism spectrum disorder.

The Department of Psychology at Wayne State University is approved by the American Psychological Association to sponsor continuing education for psychologists. The Department of Psychology at Wayne State University maintains responsibility for this program and its content.

ABOUT DR BROOKLIER:

Dr. Kara Brooklier has been a practicing pediatric neuropsychologist for over 15 years. Her specialization is in the area of neurodevelopmental disorders and specifically autism spectrum disorders. She is Director of Neuropsychological Services at the Children's Center of Wayne County and is clinical training faculty at Children's Hospital of Michigan and Wayne State University Department of Psychiatry & Behavioral Neurosciences. Dr. Brooklier works with her team of staff psychologists, doctoral interns, and postdoctoral fellow to conduct neuropsychological and differential diagnostic evaluations of autism spectrum disorders and associated neurodevelopmental conditions.

CAPACITY: 70 attendees

REGISTER HERE: https://goo.gl/ifn1Eu

DATE: December 7, 2018

TIME: 9:00 am- 12:00 pm

LOCATION: South Grand Building (Grand Conference Room) 333 S. Grand Avenue, Lansing MI 48933

CAPACITY: 100 attendees

REGISTER HERE: https://goo.gl/QUaXrq

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

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

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

Trainings offered on the following dates.

- January 23 – Lansing Click Here to Register for January 23
- February 20 – Lansing Click Here to Register for February 20
- March 13 – Lansing Click Here to Register for March 13
- April 24 – Troy Click Here to Register for April 24

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

Michigan Developmental Disabilities Council – Upcoming Events

The Michigan Developmental Disabilities Council is hosting learning opportunities and a train-the-trainer session November 26-28, 2018, at the Kellogg Hotel & Conference Center in East Lansing, MI.

Monday, November 26th Charting the Course to Employment Summit:
Join us to learn about Charting the LifeCourse and the roles we hold in our day-to-day lives to support individuals with Intellectual and Developmental Disabilities (IDD). You will learn about key principles for supporting individuals and engaging families to enhance a person-centered approach for planning and supporting life experiences that will provide preparation for employment.

Tuesday, November 27th Train-the-Trainer: Family Engagement around Employment and Partnering with Families around employment:
The Michigan Employment First Initiative has sponsored the creation of two training resources to build the capacity of educators, employment professionals and advocates in Michigan to better engage families around employment. This event will provide curriculums and presenter notes for each.

Wednesday, November 28th Charting the LifeCourse Community Wide Event:
Join us for this interactive, hands-on workshop to learn about tools that can be used at every life stage to enhance a person-centered approach for planning and supporting life experiences that support a person to reach their vision of the life they choose.
The cost to attend each day is $20. There are scholarships available for self-advocates and family members. Please call the DD Council office at 517-335-3158 to request a scholarship. Registration deadline is November 16th. Space is limited so please register ASAP!

Please contact Yasmina Bouraoui at bouraouiy@michigan.gov, with questions related the Employment Summit and Family Engagement Train-the Trainer, or Tracy Vincent at vincentt1@michigan.gov with questions about the Charting the LifeCourse Community wide Event.

Miscellaneous News and Information:

Job Opportunity: Michigan Healthy Transitions (MHT) Project Director

Purpose: To coordinate a grant-funded initiative to provide the Transition to Independence Process (TIP) model in Kalamazoo and Kent counties by collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA), MDHHS, the Association for Children's Mental Health (ACMH), the Community Mental Health Services Providers (CMHSPs) in Kalamazoo and Kent counties, Stars Training Academy (TIP model purveyor), the MPHI Evaluation Team and the MHT Leadership Team and stakeholders.

Experience: Experience with supervision and oversight of an evidence-based practice. Familiarity with Transition to Independence Process Model preferred. Experience providing community-based mental health services to children and their families. Public mental health system experience preferred. Excellent written and oral communication skills. Demonstrated coordination and organizational skills.

For more information, Click Here!

Michigan Protection & Advocacy Service, Inc. (MPAS) is seeking an Executive Director

Michigan Protection & Advocacy Service, Inc. (MPAS) is seeking an Executive Director to lead this non-profit organization responsible for providing legally-based protection and advocacy services that advance the rights of individuals with disabilities in Michigan. The position is located in Lansing, MI. MPAS' next Executive Director will continue to advance the high-quality advocacy, legal representation, and connection with the disability rights and social justice communities in the state. Must have a commitment to the mission of MPAS and to the rights of people with disabilities.

Minimum Qualifications:
- Candidates with strong non-profit or legal services experience and a Bachelor's Degree from an accredited college in Business Management, Psychology, Social Work, Public Administration, or another

human service related field with minimum of ten years of experience, or Master's Degree or JD and seven years' experience.

• A minimum of seven to ten years of leadership experience in a complex organization that includes engaging in strategic planning, management, development and supervision of personnel, financial planning, and monitoring internal controls for a multi-funded budget.

Application Process:

- Candidates should send a current resume and cover letter detailing the candidate's interest in the position, describing any experience with people with disabilities, and noting relevant leadership experience to mbrand@mpas.org
- Electronic submissions are preferred. Mailed submissions may be addressed to Michele Brand, Michigan Protection & Advocacy Service, Inc., 4095 Legacy Parkway, Suite 500, Lansing, MI 48911 or via fax at 517-487-0827.
- MPAS offers a competitive salary and benefits package. Position is open until filled.
- MPAS is an equal opportunity employer with a commitment to diversity. People with disabilities are encouraged to apply.

For more information, please visit our website: https://www.mpas.org.

CMH Association's Officers and Staff Contact Information:

CMHAM Officers Contact information:

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

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

CMHAM Staff Contact information:

Alan Bolter, Associate Director, abolter@cmham.org
Christina Ward, Director of Education and Training, cward@cmham.org
Monique Francis, Executive Secretary/Committee Clerk, mfrancis@cmham.org
Jodi Johnson, Training and Meeting Planner, jjohnson@cmham.org
Nakia Payton, Data-Entry Clerk/Receptionist, npayton@cmham.org
Dana Owens, Accounting Clerk, dowens@cmham.org

Michelle Dee, Accounting Assistant, acctassistant@cmham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
Annette Pepper, Training and Meeting Planner, apepper@cmham.org
Bethany Rademacher, Training and Meeting Planner, brademacher@cmham.org
Anne Wilson, Training and Meeting Planner, awilson@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org

CMHA Community Mental Health Association of Michigan

WEEKLY UPDATE

November 9, 2018

Contents:

CMH Association and Member Activities:

Spectrum Community Services receives full CARF accreditation

Spectrum Community Services, a longstanding member of the Community Mental Health Association of Michigan, has received another three-year accreditation through CARF for the services we provide in community housing, supported living, services to children and adolescents and service coordination. Spectrum has been accredited since 1997.

In awarding that accreditation, CARF said, "Together the board, leadership, and personnel foster a culture of integrity, accountability, transparency, mutual trust, and continuous quality improvement. this culture has served the organization well in building an exceptional consumer-first approach to service delivery. The organization approaches change with an innovative spirit and efficiently and effectively resolves challenges."

Congratulations to Spectrum.

CMHAM Committee Schedules, Membership, Minutes, And Information

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

State and National Developments and Resources:

MDHHS Announces Changes to HCBS Heightened Scrutiny Process

Below is a recent announcement from the Home and Community Based Services (HCBS) Transition team within MDHHS.

> The HCBS Transition team at MDHHS BHDDA would like to share the following information with you.
>
> After analyzing our data and information shared by the field, we have developed a process to review and validate our Heightened Scrutiny (HS) provider list.
>
> As a result of this review we have determined that there are several questions that caused confusion on the part of the providers completing the required HCBS surveys.
>
> Those providers who, after further validation, are found not to be institutional or isolating in nature based upon the evidence reviewed, will be removed from the HS list and will be forwarded to the PIHP lead for out of compliance work.
>
> When BHDDA has completed the evidence review for these providers the PIHP leads will be notified of provider status relative to their regions.
>
> When evidence is present to verify that a provider responded inaccurately to these questions, they will be referred to their PIHP lead for out of compliance work.

The questions and the remedies the BHDDA team has instituted are below.

Residential Settings HSW Question Number	Question	MDHHS Action
163.	Does the setting offer a continuum of care?	MDHHS has contacted the providers who responded yes to this question and for who this question alone resulted in placement on the HS list. Those providers were given our definition of continuum of care and asked whether they agreed that they do provide a continuum of care. Those providers who said they do not offer a continuum of care will be removed from the HS list and will work with the PIHP leads to address out of compliance issues.
9.	Is the residence separate from or outside of the building and off the grounds of a hospital, nursing, Intermediate Care Facility for Individuals with Intellectual Disabilities? (ICF/IDD) or Institute for Mental Disease (IMD)?	MDHHS BHDDA has utilized mapping software and internet stes to isolate each address to determine if in fact it is connected to or on the grounds of any other building. These are providers who answered tier 3 questions in accordance with the rule and would not be on the HS list except for this question.
12.	Is the residence located outside of a building and off the campus of an education program, school or child caring institution?	MDHHS BHDDA has utilized mapping software and internet stes to isolate each address to determine if in fact it is connected to or on the grounds of any other building.

Michigan Mental Health Children's Services Director Retiring

Below is a recent letter from Dr. George Mellos, the Director of the Behavioral Health and Developmental Disability Administration, regarding the announcement, by Sheri Falvay, or her retirement from MDHHS, and the invitation to her farewell celebration. We wish Sheri the best in her future endeavors.

> All,
>
> Please join me in wishing Sheri Falvay a very happy and relaxing retirement. After 39 years with State Government, Sheri's last day with the Michigan Department of Health and Human Services will be November 30, 2018.
>
> Since its inception in 1993, Sheri has been the Director of the Division of Mental Health Services to Children and Families. Sheri's leadership in this role has resulted in the development and implementation of innovative service initiatives and improvements: wraparound, Waiver for Children with Serious Emotional Disturbance, evidence-based practices, prevention services/child care mental health consultation, family driven and youth-guided policy, parent leadership training, and partnership with other child serving system and agencies to improve services for children and families.
>
> Sheri is a past recipient of the Betty Tableman Award in recognition of the outstanding services she has promoted for the welfare of infants and toddlers and their families. She was also the first recipient of the Association for Children's Mental Health "Partnerships Award" for her work with families of children with emotional and behavioral disorders. Sheri is also the past Chair of the Children, Youth and Families Division of the National Association of State Mental Health Program Directors (NASMHPD).
>
> To celebrate Sheri's retirement, there will be a retirement/farewell celebration on Wednesday, November 28, 2018, from 4:30 p.m. to 7:30 p.m. at the Crown Plaza Lansing, 925 South Creyts Road, Lansing, Michigan.
>
> Please see instructions to RVSP below.
> https://www.evite.com/event/003DQUTRKIYEI4ECSEPI3U4H4THSKQ/rsvp?utm_source=NA&utm_medium=sharable_invite&utm_campaign=send_sharable_link

Beaumont's Psychiatric Facility in Dearborn Helps Fill 'Serious Shortage'

Below are excerpts from a recent Detroit News article on the plans, by Beaumont Health, to expand inpatient psychiatric bed capacity.

> Mental health advocates lauded plans announced Monday for a new psychiatric hospital in Dearborn, saying it will bring needed relief to the region's strained mental health system.
>
> Beaumont health announced it will begin construction on the new 150-bed, free-standing psychiatric hospital in early 2019. The comprehensive facility will also expand capacity for outpatient mental health treatment and clinical psychiatric training.

> The facility will be constructed on eight acres of vacant land across the street from Beaumont Hospital-Dearborn, near the Southfield Freeway. It will be built in partnership with Universal Health Services, one of the nation's largest mental health providers with more than 200 mental health hospitals serving more than 600,000 patients annually across the country.

The full article can be found at:
https://www.detroitnews.com/story/news/local/wayne-county/2018/11/05/beaumont-build-new-psych-hospital-expand-mental-health-services/1861075002/

MDHHS's Opioid Website – A Rich Source of Information

The state's website provides opioid-related information and resources for addicts and their families, as well as prescribers and pharmacists.

Along with opioid facts and Michigan-specific statistics, the site includes maps that show treatment centers and medication take-back centers. A number of state programs are also linked to the site, such as information on the Department of State Police's Angel Program, which allows those addicted to drugs to seek help at any post without fear of prosecution.

https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_79584---,00.html

MDHHS Submits Section 298 Initiative Progress Report to Legislature

Below is a recent press release on the submission of the Section 298 report to the state legislature.

> The Michigan Department of Health and Human Services (MDHHS) announced today that it has submitted a progress report on the implementation of the Section 298 Initiative to the Michigan Legislature. The initiative is a statewide effort to improve the coordination of physical and behavioral health services in Michigan.
>
> Under Section 298, MDHHS was directed to implement up to three pilots and a demonstration project to test the integration of Medicaid-funded physical health and behavioral health services. MDHHS is also required to submit a progress report on the implementation of the pilots, demonstration project and any related policy changes.
>
> Since the last report was submitted to the legislature, previously announced progress on the initiative includes the selection of the pilot sites, preliminary agreements on the financing model framework and progress on the identifying a financing model for services for the unenrolled population.
>
> The three pilot sites are:
>
> HealthWest and West Michigan Community Mental Health
> Genesee Health System
> Saginaw County Community Mental Health Authority
>
> The demonstration project site is Kent County.

The progress report includes an overview of the structure of the pilots and demonstration project and describes the progress that has been made to date on implementation. The report also provides an update on the implementation of 76 recommendations from the 298 Facilitation Workgroup. Finally, MDHHS provided a related set of detailed action plans for implementing the policy recommendations.
MDHHS is continuing to work with the participants in the pilot and demonstration project sites to implement the models by Oct. 1, 2019.

To view the progress report and related action plans, visit Michigan.gov/stakeholder298.

Rural Healthcare Funding Availability Announced

A funding opportunity of possible interest to those in, or with capacity to reach, rural communities. Although this was shared via the ECHO group (note scope of resources below), the FOA is relevant for other approaches to improving care. It's limited funding but could be enough for a pilot focused on improving access to specialty care for PWE including mental health care, by more systematically linking affiliates, epilepsy centers, and PCP practices.

Due Date for Applications: November 30, 2018

Anticipated Total Annual Available FY 2019 Funding: $2,200,000
Estimated Number and Type of Awards: Up to 22 grants
Estimated Award Amount: Up to $100,000
Cost Sharing/Match Required: No
Period of Performance: July 1, 2019 through June 30, 2020 (1 year)

Eligible Applicants: To be eligible to receive a grant under this subsection, an entity - (A) shall be a rural public or rural nonprofit private entity; (B) shall represent a network composed of participants - (i) that include 3 or more health care providers; and (ii) that may be nonprofit or for-profit entities; and (C) shall not previously have received a grant under this subsection (other than a grant for planning activities) for the same or a similar project. See Section III-1 of this notice of funding opportunity (NOFO) for complete eligibility information.

This notice announces the opportunity to apply for funding under the Rural Health Network Development Planning Program ("Network Planning"). The purpose of the Network Planning program is to assist in the development of an integrated health care network, specifically network participants who do not have a history of formal collaborative efforts in order to: (i) achieve efficiencies; (ii) expand access to, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system as a whole. A rural health network is defined as an organizational arrangement among at least three separately owned regional or local health care providers that come together to develop strategies for improving health services delivery systems in a community. Health care networks can be an effective strategy to help smaller rural health care providers and health care service organizations align resources and strategies, achieve economies of scale and efficiencies, and address challenges more effectively as a group than as single providers. For example, a critical access hospital, a community health center, and a public health department may collaborate to form a network around a shared purpose. Other examples of health care providers could be: hospitals, public health agencies, home health providers, mental health centers, substance abuse service providers, rural health clinics, primary care providers, oral health providers, social service agencies, health profession schools, local

school districts, emergency services providers, community and migrant health centers, federally-qualified health centers, tribal health programs, churches, faith-based organizations, and civic organizations that are/will be providing health care. The goals of the Network Planning program are centered around approaches that will aid providers in better serving their communities given the changes taking place in health care, as providers transition from focusing on the volume of services to focusing on the value of services. The intent is that rural health networks will expand access to care, increase the use of health information technology, explore alternative health care delivery models, and continue to achieve quality health care across the continuum of care from prevention and wellness to acute and long-term care.

The full RFP can be found at:
https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx?id=820ff0a2-594f-4944-81b4-54365531cab1

Opioid Deaths May Be Starting to Plateau, HHS Chief Says

Below are excerpts from a recent National Public Radio story on the views of the Secretary of the United State Department of Health and Human Services on the trending of the nation's opioid crisis.

> The American opioid crisis is far from over, but early data indicate the number of deaths are beginning to level off, according to Alex Azar, secretary of the U.S. Department of Health and Human Services, citing "encouraging" results in overdose trends.
>
> In a speech on Tuesday at a Milken Institute health summit, Azar walked through statistics suggesting deaths were plateauing and he highlighted efforts he says may be turning the tide in the drug epidemic. In 2017, the number of Americans dying from opioid overdoses rose to 72,000 from 64,000 the previous year.
>
> However, according to new provisional data from the Centers for Disease Control, the numbers stopped rising toward the end of 2017, a trend that has continued into the beginning of this year.
>
> It is "finally bending in the right direction," Azar said. He added that the death toll flattening out is "hardly a victory," especially at such high levels. Current government statistics show that opioids kill over 115 Americans each day.

The full article can be found at:
https://www.npr.org/2018/10/24/660089369/opioid-deaths-are-starting-to-plateau-u-s-health-chief-says

Resources SAMHSA First National Older Adult Mental Health Awareness Day 2018

The materials from a webinar in celebration to attend the First National Older Adult Mental Health Awareness Day 2018 recently sponsored by the Substance Abuse and Mental Health Services Administration, the Administration for Community Living, and the National Coalition on Mental Health and Aging, can be accessed at:
https://resnet-garm.webex.com/resnet-garm/lsr.php?RCID=c813160849d392242db05d1a0e2adc70

Trauma-Related Resources Announced

A recent UCLA study points out a relationship between mental health problems and parents who have experienced trauma:

"Previous research has looked at childhood trauma as a risk factor for later physical and mental health problems in adulthood, but this is the first research to show that the long-term behavioral health harms of childhood adversity extend across generations from parent to child," said the study's lead author, Dr. Adam Schickedanz. He is a pediatrician and health services researcher and assistant professor in the department of pediatrics at the David Geffen School of Medicine at UCLA.

See the summary link:
https://medicalxpress.com/news/2018-07-parents-severe-trauma-stresses-childhood.html

NPR reports on another recently published study out of Harvard -- the largest study to date -- about the broad prevalence of ACEs and their disproportionate impact on minorities:

This new study suggests a need to target prevention resources where they can help most, says Jack Shonkoff, a professor of child health and development at the Harvard T.H. Chan School of Public Health. This also requires identifying what makes some people more susceptible than others to the effects of adversity.

"Nobody is immune to adverse experiences in childhood but for some population groups, they're a larger burden of childhood adversity than others," he says. "We need to focus on targeting limited resources to the people at greatest risk and making sure those resources go into programs that reduce or mitigate adversity."

See the link:
https://www.npr.org/sections/health-shots/2018/09/17/648710859/childhood-trauma-and-its-lifelong-health-effects-more-prevalent-among-minorities

Very interesting recent study release from the University of Wisconsin-Madison..."Childhood trauma leaves scars that are genetic, not just emotional."

"Neglect, abuse, violence and trauma endured early in life can ripple directly into a child's molecular structure and distort their DNA, according to a new study from the University of Wisconsin-Madison."

The summary is here:
https://www.jsonline.com/story/news/2018/07/19/uw-madison-study-affirms-trauma-creates-genetic-change-endures/797668002/

The brief quotes here from persons impacted by trauma -- "25 Things People Don't Realize You're Doing Because of Childhood Trauma" -- are very enlightening, and perhaps most of us can relate in some way! Check them out...
https://themighty.com/2018/07/things-people-do-because-of-childhood-trauma-habits/

State Legislative Update:

2018 Election Results

In the link below, please find a detailed summary of Tuesday's statewide races (including ballot proposals). They highlighted newly-elected office holders and, where applicable, seats which were "flipped" yesterday. Republicans will maintain their majorities in the state Senate and state House but by slimmer margins (22 – 16 and 58 – 52, respectively) over the current session.

https://rwcadvocacy.box.com/v/ElectionResults11-6-2018

Here are some top-line results:

- Governor – Gretchen Whitmer (D)
- Lt. Governor – Garlin Gilchrist (D)
- Secretary of State – Jocelyn Benson (D)
- Attorney General – Dana Nessel (D)

- Republicans have retained their majority in the State House of Representatives by a margin of 58 – 52 (currently the margin is 67 – 43).

- Republicans have retained their majority in the State Senate by a margin of 22 – 16 (currently the margin is 27 – 11).

- All three ballot proposals were approved by voters.

- U.S. Senator Debbie Stabenow won re-election.

- Democrats Elissa Slotkin (D-8th) and Haley Stevens (D-11th) won their congressional races flipping two seats previously held by Republicans.

- Democrats have won majorities on all statewide elected education boards, including the State Board of Education.

On Thursday, the 2019-2020 incoming legislators held their caucus leadership elections. Below is a list of the incoming leadership teams.

2019-2020 Caucus Leadership Teams Selected

Senate Republicans
Majority Leader: Senator Mike Shirkey
Majority Floor Leader: Senator Peter MacGregor
Appropriations Chairman: Senator Jim Stamas
Majority Whip: Senator-elect Pete Lucido (R-Shelby Township)
Majority Caucus Chairman: Senator-elect Curt VanderWall (R-Ludington)
Assistant Majority Leader: Senator Wayne Schmidt (R-Traverse City)
Assistant Majority Floor Leader: Senator-elect Dan Lauwers (R-Brockway Township)

Assistant Majority Whip: Senator-elect Dr. John Bizon (R-Battle Creek)
Assistant Majority Caucus Chairman: Senator-elect Jim Runestad (R-White Lake)
President Pro Tempore: Senator-elect Aric Nesbitt (R-Lawton)
Assistant President Pro Tempore: Senator-elect Lana Theis (R-Brighton)
Caucus Dean: Senator-elect Ed McBroom (R-Vulcan)

House Republicans
Speaker of the House: Rep. Lee Chatfield (R-Levering)
Majority Floor Leader: Rep. Triston Cole (R-Mancelona)
Speaker Pro-Tempore: Rep. Jason Wentworth (R-Farwell)
Associate Speaker Pro-Tempore: Rep. Pamela Hornberger (R-Chesterfield Twp.)
Associate Speaker Pro-Tempore: Rep. Jim Lilly (R-Holland)
Assistant Majority Floor Leader: Rep. Mary Whiteford (R-Allegan)
Assistant Majority Floor Leader: Rep. Michael Webber (R-Rochester Hills)
Majority Whip: Rep. Jason Sheppard (R-Lambertville)
Deputy Whip: Rep. Diana Farrington (R-Utica)
Caucus Chair: Rep. Eric Leutheuser (R-Hillsdale)
Caucus Vice Chair: Rep.-elect Graham Filler

Senate Democrats
Senate Minority Leader: Jim Ananich
Senate Minority Floor Leader: Stephanie Chang
Minority Vice Chair, Appropriations Committee: Curtis Hertel

House Democrats
House Minority Leader: Christine Greig
House Minority Floor Leader: Yousef Rabhi

Whitmer Announces Transition Team

Governor-elect Gretchen Whitmer today announced key members of her transition team, including a diverse group of policy, business and philanthropic leaders serving as honorary co-chairs for the transition. The website michigantransition.org is now live and will serve as the portal for all news and announcements from the transition.

"I am proud to have this esteemed group of leaders from across Michigan helping set the foundation needed to get to work for the people of this state on day one of my administration," said Governor-elect Whitmer. "These individuals bring the know-how and can-do experience that will be critical to expanding access to affordable healthcare, improving education and skills training, cleaning up Michigan's drinking water and, of course fixing our roads."

Honorary Transition Committee members are as follows:

Dr. Mona Hanna-Attisha MD, MPH, FAAP – An associate professor of pediatrics and human development at Michigan State University's College of Human Medicine and a nationally-recognized child advocate, Dr. Mona is founder and director of the MSU and Hurley Children's Hospital Pediatric Public Health Initiative, a model program mitigating the impact of the Flint water crisis.

Barbara McQuade – A professor at University of Michigan School of Law, Professor McQuade served as the U.S attorney for the Eastern District of Michigan from 2010-2017. Appointed by President Barack Obama, she was the first woman to serve in her position.

Dennis Archer – Mayor of Detroit from 1994-2001, Mr. Archer has also served as Chair of the Board of Directors of the Detroit Regional Chamber and as President of the American Bar Association, National Bar Association and the State Bar of Michigan.

Kate Pew Wolters – Chair of the Steelcase Foundation and a Grand Valley State University Trustee, Ms. Wolters is also president of the Kate and Richard Wolters Foundation and is involved with the Progressive Women's Alliance of West Michigan, Michigan Protection and Advocacy Service and is co-chair of the Kent County Children's Commission.

Mike Prusi – Former Michigan Senate Minority Leader, Mr. Prusi represented Michigan's 38th District in the Michigan Senate, serving three terms in the House of Representatives prior to that. He is a native of Negaunee, working more than two decades in the iron ore mines and serving as president of USW Local 4950 in the Upper Peninsula.

Joe Schwarz, M.D. – Former U.S. Congressman for Michigan's 7th District and a practicing physician, Dr. Schwarz is a lecturer at University of Michigan's Gerald R. Ford School of Public Policy and serves on the board of directors of "Voters Not Politicians."

Allan Gilmour – Retired Vice Chairman of Ford Motor Company, Mr. Gilmour held a number of key senior management positions at Ford as well as serving as president of Wayne State University from 2010-2013. Mr. Gilmour currently serves as president of The Gilmour-Jirgens Fund and co-chair of the HOPE Fund Committee.

Dug Song – Co-Founder of Ann Arbor-based internet security provider Duo Security, Mr. Song is a leading voice in the information security industry and has a history of building successful products and companies to solve pressing security problems.

Gary Torgow – Chairman of Chemical Financial Corporation, the holding company of the largest bank headquartered in Michigan, Mr. Torgow is also the founder of the Sterling Group. He is a member of the Executive Board of Business Leaders for Michigan and the Jewish Federation of Metropolitan Detroit and is a member of the Board of the Detroit Downtown Partnership.

Portia Roberson – CEO of Focus: HOPE, Ms. Roberson spent four years as Group Executive of the City of Detroit's Civil Rights, Inclusion and Opportunity Department leading the charge on how Michigan and Detroit-based businesses can work together to enhance local employment. Prior to this position, she served as Corporation Counsel for the Law Department as Detroit lead for the White House Domestic Policy Council for "Strong Cities, Strong Communities."

Daniel J. Loepp – President and Chief Executive Officer of Blue Cross Blue Shield of Michigan, Mr. Loepp also serves on the board of the National Institute for Health Care Management, is the Executive Committee Chairman of the Downtown Detroit Partnership board and serves on the Mackinac Island State Park Commission.

"The election of Gretchen Whitmer is a beacon of hope for Michigan. From strengthening education and healthcare to protecting our environment and public health, I'm fired-up to work with Governor-elect Whitmer's team to ensure that all Michigan kids succeed," said Dr. Mona Hanna-Attisha.

"Governor-elect Whitmer is already bringing a diverse and committed group of stakeholders to the table during this transition to solve the very real problems we are facing in Michigan, and I am proud to be part of that effort," said Dr. Joe Schwarz.

In addition to the honorary chairs, **Whitmer has named Mark Bernstein as Director of her Transition Office. Bernstein**, who is president and managing partner of The Sam Bernstein Law Firm, PLLC and serves on the University of Michigan Board of Regents, will lead day-to-day operations of Whitmer's transition. **Also serving on the transition are Awenate Cobbina as deputy director, JoAnne Huls as COO, Mark Burton as chief strategist and Steve Liedel as general counsel**.

The michigantransition.org transition website, which went live earlier today, will serve as a clearinghouse for news from the transition, applications of those looking to apply for positions within the administration, inaugural engagement opportunities and all other activities related to both the transition and inaugural festivities.

https://michigantransition.org/governor-elect-gretchen-whitmer-announces-honorary-co-chairs-website-for-transition/

For more information, visit www.michigantransition.org.

Federal Update:

Health Care Emerges as Top Issue in Midterms

With historic levels of voter turnout, Tuesday's midterm election results saw Democrats regain control of the House of Representatives, while Republicans strengthened their majority in the Senate. Health care emerged as a clear priority for voters and Medicaid expansion proved to be a big winner on election night. With power now divided in Congress, the next two years could feature intense political gridlock or force bipartisan compromise. Right now, one thing is clear – the 2018 midterms will send one of the largest classes of freshmen Members to Washington in recent history – and with them come new advocacy opportunities for the National Council and its members.

HEALTH CARE A PRIORITY

According to a CNN exit poll, about four in 10 voters chose health care as the most important issue facing the country, ahead of issues like immigration and the economy. A closer look at the data showed health care to be a much bigger driver for Democratic voters than Republican voters. Although the issue may have driven a lot of Democratic voters to the polls, it did not appear that health care was a decisive factor in many of elections results on Tuesday.

LEGISLATIVE OUTLOOK

With Democrats controlling the House, Congress' health care agenda will change dramatically. Most importantly, Republican leaders are expected to abandon their efforts to repeal and replace the

Affordable Care Act (ACA) and cut Medicaid by converting it to a block grant program. These efforts were strongly opposed by the National Council as they would have resulted in dramatic cuts in funding for behavioral health treatment services and harmed individuals living with mental illness and addiction.

So, what's next on Congress' health care agenda? At this point, little is known about the Democrats' next steps on health care beyond defending the ACA. Notably, Democrats have signaled interest in advancing another opioid-focused package in 2019, as many claimed the recently-signed opioid law does not go far enough for treatment-focused solutions. Each year, Congress has certain "must-pass" bills, including the appropriations bills, which fund the federal government each year. These bills may provide opportunities for bipartisan compromise on health care issues, including the opioid crisis, or we may see these bills fall into political gridlock between the two parties.

Regardless of the political environment, the National Council will work hard to maximize opportunities to advance access to mental health and addiction care for all Americans. We look forward to working with both chambers of Congress to advance key issues like expanding behavioral health treatment capacity through the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 1905/H.R. 3931), strengthening the behavioral health workforce, securing funding for federal mental health and addiction programs, and more.

MEDICAID EXPANSION GAINS

Medicaid expansion was a big winner at the ballot box this year, representing a great victory for individuals with low-incomes who lack health care coverage and the providers who serve them. Three Republican-led states, Utah, Nebraska, and Idaho passed ballot measures to begin Medicaid expansion. These measures are expected to extend Medicaid coverage to around 300,000 new recipients.

Beyond ballot measures, the outcomes of governors' races in Wisconsin and Kansas may also clear the way for Medicaid expansion in those states. Further, Maine, the first state to pass Medicaid expansion at the ballot box, may finally have the opportunity to implement its expansion with election of a Democratic governor and the departure of Governor Paul LePage (R), a vehement opponent of Medicaid expansion. This would bring the total number of Medicaid expansion states to 37 (with the potential addition of 2 states – Wisconsin and Kansas). These new Democratic governors may also have a big impact in the rollout of their more conservative predecessors' waiver requests, which included Medicaid work requirements and drug testing/screening.

ADVOCACY OPPORTUNITIES

With each new Congress comes opportunities for the National Council and its members to forge new relationships with Members of Congress, who can champion our issues on Capitol Hill. Do you have a relationship with any of the new or existing House or Senate members? Tell us about any key relationships you may have with Members of Congress or their staff. Successful advocacy often comes down to the strength of our relationships with legislators, so we'd love to hear from you!

Education Opportunities:

MDHHS Announces Training on Best Practice in Autism Evaluation for Medicaid Providers

WHO SHOULD ATTEND?

Psychologists, physicians, social workers, BCBAs, BCaBAs, supervisors, medical directors, and other medical and mental health professionals and administrators serving the Medicaid population who are interested in learning about the best practices in the evaluation of autism spectrum disorder.

The Department of Psychology at Wayne State University is approved by the American Psychological Association to sponsor continuing education for psychologists. The Department of Psychology at Wayne State University maintains responsibility for this program and its content.

ABOUT THE TRAINING

The Michigan Department of Health and Human Services (MDHHS) and Dr. Kara Brooklier have partnered to present Best Practice in Autism Evaluation, a course designed to provide mental health professionals and administrators with an understanding of the process for accurate diagnosis of autism spectrum disorder in toddlers, children, and teens. The focus of this course will surround 1) understanding the core symptoms of autism, 2) common differential co-morbid conditions, and 3) best practices for evaluation from data gathering to clinical formulation and caregiver feedback. Aspects of assessment needed for differential and co-morbid diagnosis of autism spectrum disorders will be thoroughly reviewed.

LEARNING OBJECTIVES:

1. Participants will be aware of the core variables and symptoms associated with autism spectrum disorder

2. Participants will be able to identify common conditions in the differential diagnosis of autism spectrum disorders

3. Participants will demonstrate understanding of the best practice process for diagnosis of autism spectrum disorder in toddlers, children, and teens

REGISTRATION INFORMATION

DATE: November 27,2018

TIME: 9:00 am- 12:00 pm

LOCATION: The Children's Center (Training Rooms A&B) 79 W. Alexandrine, Detroit MI 48201

ABOUT DR BROOKLIER:

Dr. Kara Brooklier has been a practicing pediatric neuropsychologist for over 15 years. Her specialization is in the area of neurodevelopmental disorders and specifically autism spectrum disorders. She is Director of Neuropsychological Services at the Children's Center of Wayne County and is clinical training faculty at Children's Hospital of Michigan and Wayne State University Department of Psychiatry & Behavioral Neurosciences. Dr. Brooklier works with her team of staff psychologists, doctoral interns, and postdoctoral fellow to conduct neuropsychological and differential diagnostic evaluations of autism spectrum disorders and associated neurodevelopmental conditions.

CAPACITY: 70 attendees

REGISTER HERE: https://goo.gl/ifn1Eu

DATE: December 7, 2018

TIME: 9:00 am- 12:00 pm

LOCATION: South Grand Building (Grand Conference Room) 333 S. Grand Avenue, Lansing MI 48933

CAPACITY: 100 attendees

REGISTER HERE: https://goo.gl/QUaXrq

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

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

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

Trainings offered on the following dates.

- January 23 – Lansing Click Here to Register for January 23
- February 20 – Lansing Click Here to Register for February 20
- March 13 – Lansing Click Here to Register for March 13
- April 24 – Troy Click Here to Register for April 24

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

Michigan Developmental Disabilities Council – Upcoming Events

The Michigan Developmental Disabilities Council is hosting learning opportunities and a train-the-trainer session November 26-28, 2018, at the Kellogg Hotel & Conference Center in East Lansing, MI.

Monday, November 26th Charting the Course to Employment Summit:
Join us to learn about Charting the LifeCourse and the roles we hold in our day-to-day lives to support individuals with Intellectual and Developmental Disabilities (IDD). You will learn about key principles for supporting individuals and engaging families to enhance a person-centered approach for planning and supporting life experiences that will provide preparation for employment.

Tuesday, November 27th Train-the-Trainer: Family Engagement around Employment and Partnering with Families around employment:
The Michigan Employment First Initiative has sponsored the creation of two training resources to build the capacity of educators, employment professionals and advocates in Michigan to better engage families around employment. This event will provide curriculums and presenter notes for each.

Wednesday, November 28th Charting the LifeCourse Community Wide Event:
Join us for this interactive, hands-on workshop to learn about tools that can be used at every life stage to enhance a person-centered approach for planning and supporting life experiences that support a person to reach their vision of the life they choose.
The cost to attend each day is $20. There are scholarships available for self-advocates and family members. Please call the DD Council office at 517-335-3158 to request a scholarship. Registration deadline is November 16th. Space is limited so please register ASAP!

Please contact Yasmina Bouraoui at bouraouiy@michigan.gov, with questions related the Employment Summit and Family Engagement Train-the Trainer, or Tracy Vincent at vincentt1@michigan.gov with questions about the Charting the LifeCourse Community wide Event.

Miscellaneous News and Information:

Job Opportunity: Michigan Healthy Transitions (MHT) Project Director

Purpose: To coordinate a grant-funded initiative to provide the Transition to Independence Process (TIP) model in Kalamazoo and Kent counties by collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA), MDHHS, the Association for Children's Mental Health (ACMH), the Community Mental Health Services Providers (CMHSPs) in Kalamazoo and Kent counties, Stars Training Academy (TIP model purveyor), the MPHI Evaluation Team and the MHT Leadership Team and stakeholders.

Experience: Experience with supervision and oversight of an evidence-based practice. Familiarity with Transition to Independence Process Model preferred. Experience providing community-based mental health services to children and their families. Public mental health system experience preferred. Excellent written and oral communication skills. Demonstrated coordination and organizational skills.

For more information, Click Here!

Michigan Protection & Advocacy Service, Inc. (MPAS) is seeking an Executive Director

Michigan Protection & Advocacy Service, Inc. (MPAS) is seeking an Executive Director to lead this non-profit organization responsible for providing legally-based protection and advocacy services that advance the rights of individuals with disabilities in Michigan. The position is located in Lansing, MI. MPAS' next Executive Director will continue to advance the high-quality advocacy, legal representation, and connection with the disability rights and social justice communities in the state. Must have a commitment to the mission of MPAS and to the rights of people with disabilities.

Minimum Qualifications:
- Candidates with strong non-profit or legal services experience and a Bachelor's Degree from an accredited college in Business Management, Psychology, Social Work, Public Administration, or another

human service related field with minimum of ten years of experience, or Master's Degree or JD and seven years' experience.

• A minimum of seven to ten years of leadership experience in a complex organization that includes engaging in strategic planning, management, development and supervision of personnel, financial planning, and monitoring internal controls for a multi-funded budget.

Application Process:

- Candidates should send a current resume and cover letter detailing the candidate's interest in the position, describing any experience with people with disabilities, and noting relevant leadership experience to mbrand@mpas.org
- Electronic submissions are preferred. Mailed submissions may be addressed to Michele Brand, Michigan Protection & Advocacy Service, Inc., 4095 Legacy Parkway, Suite 500, Lansing, MI 48911 or via fax at 517-487-0827.
- MPAS offers a competitive salary and benefits package. Position is open until filled.
- MPAS is an equal opportunity employer with a commitment to diversity. People with disabilities are encouraged to apply.

For more information, please visit our website: https://www.mpas.org.

CMH Association's Officers and Staff Contact Information:

CMHAM Officers Contact information:

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

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

CMHAM Staff Contact information:

Alan Bolter, Associate Director, abolter@cmham.org
Christina Ward, Director of Education and Training, cward@cmham.org
Monique Francis, Executive Secretary/Committee Clerk, mfrancis@cmham.org
Jodi Johnson, Training and Meeting Planner, jjohnson@cmham.org
Nakia Payton, Data-Entry Clerk/Receptionist, npayton@cmham.org
Dana Owens, Accounting Clerk, dowens@cmham.org

Michelle Dee, Accounting Assistant, acctassistant@cmham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
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Anne Wilson, Training and Meeting Planner, awilson@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org