ACCESSING THE CONFERENCE CALL LINE:

DIAL THE PHONE NUMBER
1-888-627-8019
WHEN PROMPTED, KEY IN THE PIN NUMBER
40994

[IF YOU HAVE A ROTARY DIAL PHONE, THIS WILL NOT WORK]

IF YOUR PHONE HAS A MUTE BUTTON, YOU MAY WANT TO MUTE YOUR CALL UNTIL YOU NEED TO SPEAK [I.E., FOR ROLL CALL]

FOR THOSE MEMBERS WISHING TO ATTEND IN PERSON, YOU WILL BE REQUIRED TO COMPLETE THE SCREENING UPON ENTERING THE BUILDING. WE WILL PRACTICE SOCIAL DISTANCING DURING THE MEETING. NO REFRESHMENTS WILL BE SERVED!

Please remember to sign the Section 222 [Page 27] and return it in the enclosed envelope. Also, if you wish to make your donation to the CMH PAC, you can write your check to "CMH PAC" and include that in the envelope as well.

Please notify Diane Hayka if you plan to conference in by calling 989-358-7749. Thanks!

Northeast Michigan Community Mental Health Authority
April 2020 Meetings

- Board Meeting – Thursday, April 9 at 3:00 pm {Organizational Meeting}
- Recipient Rights Committee* – Wednesday, April 15 at 3:15 pm

Both Meetings will be available as a Conference Call Meeting using:

1-888-627-8019 PIN # 40994

All meetings held at the main office located at 400 Johnson Street in Alpena unless otherwise noted

** Meeting held in the Administrative Conference Room/400 Johnson Street/Alpena*

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD
BOARD MEETING
April 9, 2020 at 3:00 p.m.
A G E N D A

I. Call to Order

II. Seating of Board Members

Bonnie Cornelius – Alcona County
No Appointment made yet – Alpena County
Roger Frye – Montmorency County
Gary Nowak – Presque Isle County

III. Roll Call & Determination of a Quorum

IV. Pledge of Allegiance

V. Acknowledgement of Conflict of Interest

VI. Appointment of Evaluator

VII. Report of the Nomination's Committee ..... (See page 1)

VIII. Election of Officers ..... (See page 2 – By-law excerpt)

IX. Information and/or Comments from the Public

X. Approval of Minutes..... (See pages 3-8)

XI. Budget Amendment #2 ..... (See pages 9-15)

XII. April Monitoring Reports

1. **Budgeting 01-004 ..... (See page 16)**
2. **Communication and Counsel 01-009 ..... (See pages 17-19)**

XIII. Board Policies Review and Self-Evaluation

1. **Financial Condition 01-005 ..... [Review Only] ..... (See pages 20-21)**
2. **Communication and Counsel 01-009 ..... [Review Only] ..... (See pages 22-23)**
3. **Governing Style 02-002 ..... [Review & Self Evaluate] ..... (See page 24)**
4. **Cost of Governance 02-013 ..... [Review & Self Evaluate] ..... (See page 25)**

XIV. Linkage Reports

1. **Northern Michigan Regional Entity**
   a. **Regional Board Meetings**
      i. **March 25, 2020..... (Cancelled)**
2. **Board Association**
   a. **Spring Conference June 9 & 10 – Grand Traverse Resort, Acme..... (Verbal)**

XV. Chair's Report

1. **CMH PAC Campaign Continues ..... (Verbal)**
2. **Section 222 & Conflict of Interest ..... (See pages 26-28)**
3. **Strategic Planning Discussion ..... (Verbal)**

XVI. Director's Report

1. **Directors Report..... (Verbal Update)**
2. **Annual Submission..... (See pages 29-40)**

XVII. Information and/or Comments from the Public

XVIII. Information and/or Comments for the Good of the Board

XIX. New Business

1. **Establishment of Regular Meeting Date**
2. **Appointment of Standing Committees ..... (See page 41)**

XX. Next Meeting – Thursday, May 14 at 3:00 p.m.

1. **Set May Agenda..... (See page 42)**
2. **Evaluation of meeting..... (All)**

XXI. Adjournment

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

Nominations Committee

February 13, 2020

Terry Larson called the meeting to order at 2:30 p.m. in the MI Conference Room.

Present: Terry Larson, Albert LaFleche, Gary Wnuk

Absent: Steve Dean (excused)

Staff & Guest: Lynne Fredlund

I. Slate of Officers Recommendation

The Committee reviewed the current officers of the Board.

Eric Lawson	--	Chair
Roger Frye	--	Vice Chair
Bonnie Cornelius	--	Secretary
Gary Nowak	--	Past Chair

Gary Wnuk noted Bonnie Cornelius has been reappointed to the Board for another three-year term and would recommend she continue in the role of Secretary. Albert LaFleche noted he had no concerns about the current officers remaining in their respective roles. Terry Larson noted there was support from the Nomination's Committee to recommend the current Slate of Officers continue in their position.

Adjournment by the call of the Chair. This meeting adjourned at 2:35 p.m.

_____

Terry Larson, Chair

Diane Hayka
Recorder

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 ….
- 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.

Northeast Michigan Community Mental Health Authority Board

Board Meeting

March 12, 2020

I. Call to Order

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

II. Roll Call and Determination of a Quorum

Present: Robert Adrian, Les Buza, Bonnie Cornelius, Roger Frye, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski, Gary Wnuk

Absent: Steve Dean (excused), Albert LaFleche (excused)

Staff & Guests: Lisa Anderson, Dennis Bannon, Carolyn Bruning, Lee Ann Bushey, Connie Cadarette, Renee Curry, Lynne Fredlund, Ruth Hewett, Chelsea Meeder, Mary Ann Pingot, Nena Sork, Jen Whyte

III. Pledge of Allegiance

Attendees recited the Pledge of Allegiance as a group.

IV. Appointment of Evaluator

Eric Lawson appointed Lester Buza as evaluator for this meeting.

V. Acknowledgement of Conflict of Interest

Board members had no conflicts to acknowledge.

VI. Information and/or Comments from the Public/ Board Member Communication

Diane Hayka informed Board members of the need to get an applicant for Alpena County for this board. Steve Dean's term will expire the end of this month and at this point we have been informed there were no applicants. Ideally, the applicant would be a primary consumer so we can assure we will be compliant with the Mental Health Code. The individual applying can have received services from other behavioral health providers.

Gary Wnuk informed the Board of a resolution about the restructuring of the mental health system. This will be discussed further in the Chair's Report.

VII. Approval of Minutes

Moved by Gary Nowak, supported by Roger Frye, to approve the minutes of the February 13, 2020 meeting as presented. Motion carried.

VIII. Audit Report – Financial/Compliance

Chelsea Meeder, accountant with Straley, Lamp & Kraenzlein, provided an overview of the financial audit report. She noted with changeover in management positions, risk increases. She noted the transition in management at this Agency went very smooth. She reported this audit was a clean audit. She notes there is stability in all reporting areas. Ms. Meeder reports there will be a new standard [Standard #84] related to fiduciary activities implemented this year, which will impact future audits. Their firm will assist in implementing the new standard. Gary Nowak questioned the amount of Accounts Receivable and Connie Cadarette noted this was high due to a receivable due from NMRE.

Mary Ann Pingot, auditor with Straley, Lamp & Kraenzlein, presented the Compliance audit to the Board. She noted the Michigan Department of Health and Human Services dictates what items must be reviewed in a compliance audit. She notes there was an immaterial noncompliance with the requirements outlined by MDHHS, which is noted in this report. She notes this was not a material weakness. Ms. Pingot reviewed the Examined Financial Status Report.

The Schedule of Findings and Questioned Costs was reviewed. Mary noted the finding this year was a repeat finding. Mary reviewed the two instances identified in the audit findings. Mary reviewed the Comment and Recommendation noting a contract amount was exceeded but had not been brought to the Board for approval prior to payment.

Gary Wnuk reported he had spoken with the Treasurer in Alcona County. He noted the discovery in our system addressed last month resulted in him discussing how to assure future financial statements are correctly reported. Nena Sork noted the accounting department is being reorganized. The automation of some of the account reporting will eliminate for potential human error and staff are being cross-trained as well. She reported a Contract Manager position has been posted and this will eliminate having several fingers in the processing of contracts.

Gary Wnuk suggested having a Board member be active in reviewing financial reports. The Director and Board Chair will determine what monitoring will be used for future.

Moved by Gary Nowak, supported by Pat Przeslawski, to accept and file the Financial and Compliance audit as presented. Motion carried.

IX. Board Member Recognition

Four Board members were recognized for reaching a milestone service year. Gary Nowak presented Chair Eric Lawson with a certificate for five-years of service. Chair Eric Lawson presented Bonnie Cornelius with a certificate for five-years of service. Les Buza received a certificate for 10 years as Board member and Pat Przeslawski received a 20-year certificate and token of appreciation. In total, Board members have 128 years of service combined. This meeting adjourned for a short recess in which cake was served.

Recess at 3:30 p.m.
Resume at 3:40 p.m.

X. Consent Agenda

1. **Blue Horizons Management Agreement**
2. **Presidio Ad Hoc Support Agreement**

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

XI. Presidio Emergency Equipment Purchase

Eric Lawson noted with the recent power surge, switching equipment was needed to replace equipment.

Moved by Pat Przeslawski, supported by Judy Jones, to approve the Emergency Purchase as presented. Roll call vote: Ayes: Robert Adrian, Les Buza, Bonnie Cornelius, Roger Frye, Judy Jones, Terry Larson, Eric Lawson, Gary Nowak, Pat Przeslawski, Gary Wnuk; Nays: None; Absent: Steve Dean, Albert LaFleche. Motion carried

XII. NMRE Contract Approval

The subcontract with NMRE and this Agency is the contract, which provides our Medicaid dollars to us. Bob Adrian questioned if an Attorney reviews the contracts prior to execution. Nena Sork noted the boilerplate is standard in this type of contract with only the rates changing.

Moved by Pat Przeslawski, supported by Bonnie Cornelius, to approve the contract with NMRE as presented. Motion carried.

XIII. March Monitoring Reports

1. Treatment of Individuals Served 01-002

The internal survey conducted in I/DD services is provided in the form of a brochure to Board members and also sent out to the individuals in the program. The surveys conducted in the various programs other programs presented in this monitoring report were conducted using a "Survey Monkey" on-line format through the NMRE. A sampling of questions in each program is depicted in the information provided to Board members. The full survey results are available if Board members would like to review the entire reports. The Clubhouse responses will be shared with Touchstone, manager of the Clubhouse program.

2. Treatment of Staff 01-003

Nena Sork reviewed the staff surveys completed when an employee leaves the Agency providing data of reasons for their exit. Lisa Anderson reported the "Other" includes retirements and many retirements occurred during the past year. She reports staff are also give the option to meet with the Director or management staff to provide input to programs, etc.

3. Budgeting 01-004

Connie Cadarette reports the adjustments have been made to address the budget issues identified last month. The Statement of Revenue and Expense for month ending January 31, 2020 was reviewed. She notes there is not a huge change in the bottom line. There is a close watch on General Funds to see if we can turn it around. The Community Relations/Education line item was a timing issue and this should be resolved as the year goes on. There will be a budget amendment to make some corrections to line items of various expenses at the April meeting.

4. Financial Condition 01-005

Connie Cadarette reviewed the Statement of Net Position for month ending January 31, 2020. She reports we are at 49 days of operating cash.

Bob Adrian questioned the under spending in the revenue streams as depicted on the Statement of Revenue and Expense report under "contract settlement items…" Connie noted Medicaid and Healthy Michigan are under spent; however, this can change monthly.

5. Asset Protection 01-007

The monitoring report addressing Asset Protection is the audit report provided by the auditing firm earlier in this meeting.

Moved by Lester Buza, supported by Gary Nowak, to accept the March monitoring reports as presented. Motion carried.

XIV. Board Policy Review and Self Evaluation

1. Budgeting 01-004

Board members reviewed the policy and no revisions were recommended.

2. Board Members Ethical Code of Conduct 02-008

Proposed revision of this policy includes changing Chief Executive to Executive Director. Board members were requested to sign the Code of Ethical Code of Conduct and submit the signed form to Diane Hayka.

Moved by Gary Nowak, supported by Gary Wnuk, to revise policy 02-008 Board Member Ethical Code of Conduct, as presented. Motion carried.

XV. Linkage Reports

1. Northern Michigan Regional Entity (NMRE)

a. Board Meeting February 26, 2020

Gary Nowak noted he had requested the SUD Board submit to each county how a county can access the PA2 Funds. Terry Larson noted he provided Board members with copies of the PA2 funds and a sample letter to be sent to each county on how to access the funds. Terry Larson noted only a licensed substance use provider can request the funds and the funds must be used within the county. The SUD Board is hoping to stimulate interest in providers to utilize these funds. Roger Frye and Terry Larson are members of the SUD Board. Carolyn Brummund is the SUD representative for Alcona County.

b. Board Meeting January 22, 2020

The printed minutes for this meeting was included in the materials mailed.

2. Community Mental Health Association of Michigan (CMHAM)

The Spring Board Conference is scheduled for June 9 and 10, 2020 at the Grand Traverse Resort in Acme. At this point, there is no printed schedule of the conference. Board members Eric Lawson, Roger Frye, Bonnie Cornelius, Gary Nowak, and Judy Jones all expressed interest in attending.

XVI. Operational Report

Eric Lawson noted a revised report was distributed tonight for month ending February 29, 2020. Nena Sork noted the revision was due to a person being discharged from a state inpatient facility. She noted Touchstone has increased attendance at the Clubhouse. Nena Sork also reported the Peer Support position was awarded to the person who participated in the Clubhouse presentation the Board had a few months ago.

XVII. Nomination's Committee

Terry Larson reported the Committee is recommending the officers remain the same for the next year's officers. Those officers are: Chair, Eric Lawson; Vice Chair, Roger Frye; Secretary, Bonnie Cornelius; and Past Chair, Gary Nowak.

XVIII. Chair's Report

1. County Resolution

Gary Wnuk reported the resolution discussed briefly under the Information and Comments section is on system reform and reported he modeled this resolution from the Centra Wellness Network's resolution and has adapted the resolution for Alcona County. Gary Wnuk offered to contact other counties.

Moved by Gary Wnuk, supported by Gary Nowak, to communicate the resolution to the other counties within our catchment area. Motion carried.

Bob Adrian suggested Nena Sork and Eric Lawson present this resolution to Alpena County. He will get it on the Alpena's agenda.

Motion amended to include the Director attending the Commissioner's meeting to present. Motion carried.

Nena Sork reported she will let Board members know when this has been scheduled in their respective counties.

Alpena County's next meeting is March 31. Eric Lawson might have a conflict with this date and will check his schedule.

2. CMH PAC Campaign

Eric Lawson noted the CMH PAC campaign is underway. Board members were encouraged to make a donation to this important campaign.

XIX. Director's Report

1. Director's Update

Nena Sork reported she attended NMRE Board meeting in February and Operations Committee. She notes the MDHHS system redesign is a hot topic. Nena Sork also noted she is working on trauma and ACE with a group and noted we are tracking trauma scores and will meet again April 17 with the team. She informed the Board of a Letter of Support for Alcona Health Center to provide physical health services in the schools.

She attended the Northern Michigan Opioid Response Consortium (NMORC) and this consortium is working on opioid crisis campaigns. She will be going to Houghton Lake tomorrow to meet with this group.

Several months ago, we discussed getting a second credit card. She notes we will be investigating options for our second credit card now that the position in accounting has been filled. Our current credit card was recently compromised which caused havoc.

Nena Sork reported there has been much discussion about the COVID-19 virus.

2. QI Council Update

The minutes were included in the mailed

XX. Information and/or Comments from the Public

There were no comments presented.

XXI. Information and/or Comments from the Board for the Good of the Organization

There were no comments presented.

XXII. Next Meeting

The next regularly scheduled meeting of Northeast Michigan Community Mental Health Authority Board will be held Thursday, April 9, 2020 at 3:00 p.m.

1. Set April Agenda

The April agenda items were reviewed.

XXIII. Evaluation of Meeting

Lester Buza reported the meeting started about three minutes late☺. The Board came away with good information about the audit report. The meeting went very well and participation was good.

XXIV. Adjournment

Moved by Gary Wnuk, supported by Bonnie Cornelius, to adjourn the meeting. Motion carried. This meeting adjourned at 4:38 p.m.

Bonnie Cornelius, Secretary

Eric Lawson, Chair

Diane Hayka
Recorder

Public Hearing Summarized
Budget Amendment #2

This amendment will see an increase in both revenues and expenses of $263,379.

	Revenue Adjustments [Page 11 of Packet]
1.	A $10,000 increase in the amount of interest income expected based on what was actually received last fiscal year and the current trend of receipt for this fiscal year.
2.	An increase of $40,091 in the Medicaid funds to be received from NMRE to equal the actual amount of the current contract. This amount was lowered in the original budget to balance out with the lower expenses needed.
3.	A decrease of $40,026 in General Funds to reflect the fact there was no carryforward of funds from the previous fiscal year.
4.	An increase of $253,314 in the Third Party Insurance and COFR funds received. This increase is based on the amounts received in the previous fiscal year and a change in how we are classifying those funds from the previous year. We are now reconciling with the cash receipts journal for a more accurate reporting of these funds.

	Expense Adjustments [Page 12 of Packed]
1.	Line #1 -- Salaries are increased to accommodate a 3% increase in staff salaries. The actual increase to salaries for the raise (and retro payment back to the first pay in the current fiscal year [October]) is $343,216. However, due to over budgeting of salaries in the previous budget, adjustments were made to the actual salaries needed. After adjustments, the net increase is $126,218.
2.	Line #4 – Health Insurance is being decreased by $158,451 as a better estimate to what will be needed for the remainder of the fiscal year.
3.	Line #5 – Prescription insurance is being decreased by $28,411 as a better estimate to what will be needed for the remainder of the fiscal year.
4.	Line #14 – Workers' Compensation is being decreased by $29,272 to correctly reflect the new policy that was negotiated in January.
5.	Line #18 – Public Relations was increased by $23,000 for the amount of the Partners in Prevention contract that was left out of this budget. [This contract had been transferred from a different line item last year to assure rates weren't skewed.]
6.	Line #19 – Employee Relations/Wellness was increased by $1,500 for the amount of the Employee of the Month checks issued during the fiscal year.
7.	Line #25 – Contracted inpatient is being increased by $400,000 to reflect an increase in spending in that area. Measures are being put in place to watch this budget line item and hopefully decrease spending, if possible.

Expense Adjustments (continued)	
8.	Line #28 – Contracted Employees/Services is being decreased by $83,029 due to several reasons. The contract for Rehmann group was added, the contracted employee in department 001 is being paid out of salaries so that amount was deducted here and our annual local drawdown amount we pay on a monthly basis was lowered by $50,000 this year and should be lowered each year for the next four years (currently around $200,000) until that amount is $0.00. There was a small adjustment to reconcile to actual spent in this account which also caused an addition decrease.
9.	Line #31 – Staff travel mileage was increased by $4,162 for a department missed in the original budget.
10.	Line #56 – Depreciation was lowered by $418 for Clubhouse depreciation that should have been taken out of the original budget as all assets were either removed or transferred to Touchstone.
11.	Line #57 – General Fund expenditures are the dollars we use as matching funds for the MRS Cash Match Agreement, which was missed in this year's budget.

Expenditures by Program [Page 13 of Packet]
This page shows how the changes affect each program – some areas were over budgeted more than others. Finance is showing a large increase due to the fact the entire incentive payment amount of approximately $228,500 has been placed in this line item until the Agency determines how best to utilize this incentive.

Capital Expenditures [Page 14 of Packet]
Changes to this budget area have items identified by "New" in the Line # column. The "New" items are requested by the Facilities Department except for the one item in the Information Systems which is the new switch/router which had the power surge last month in the main server room.

FTEs [Page 15 of Packet]
Only a couple of changes in FTEs. Line #1 – Board Administration was increased by moving the contract position into wages – where it is correctly being paid from. There was also changes in Line #s 19 and 23 to reflect a position switch between these two departments. One employee from Children's Home Based and Community Services was switched into the Applied Behavioral Analysis (Autism) Services department.

Respectively Submitted,

Connie S. Cadarette
Interim Finance Director

Northeast Michigan Community Mental Health Authority

2019-2020 Budget Amendment #2

Revenue Budget

Line #	Revenue Source	FY20 Budget Amendment #1	$$$ Incr./(Decr.)	**FY20 Budget Amendment #2**	**Totals**	% of Total Budget
1	**Rent Income**	$ 38,853	$ -	**$ 38,853**	**$ 38,853**	0.13%
2	**State Contracts**				**97,000**	0.31%
3	PASARR (Nursing Home Services)	97,000	-	**97,000**		
4	**Private Contracts**				**52,603**	0.17%
5	Blue Horizons Management Services	18,240	-	**18,240**		
6	MI Child Collaborative Care Grant	34,363	-	**34,363**		
7	**Local Funding**				**506,897**	1.64%
8	Alcona County Allocation	35,223	-	**35,223**		
9	Alpena County Allocation	150,216	-	**150,216**		
10	Montmorency County Allocation	31,435	-	**31,435**		
11	Presque Isle County Allocation	49,764	-	**49,764**		
12	Rebates/Incentives/Other local revenue	240,259	-	**240,259**		
13	**Interest Income**	10,000	10,000	**20,000**	**20,000**	0.06%
14	**Medicaid**	26,399,156	40,091	**26,439,247**	**26,439,247**	85.41%
15	**General Funds from MDCH**				**901,044**	2.91%
16	Operational (Community) Funding	941,070	(40,026)	**901,044**		
17	Carryforward from FY19 to FY20	-	-	**-**		
18	**Healthy Michigan Plan**	1,846,144	-	**1,846,144**	**1,846,144**	5.96%
19	**Third Party Insurance (incl. COFR & Child Waiver)**	246,000	253,314	**499,314**	**499,314**	1.61%
20	**Residential Clients - Room & Board**	516,351	-	**516,351**	**516,351**	1.67%
21	**Club House Food Sales**	-	-	**-**	**-**	0.00%
22	**Donations**	-	-	**-**	**-**	0.00%
23	**Other Revenue**				**36,485**	0.12%
24	Reimbursed Class Fees	6,000	-	**6,000**		
25	Telephone Usage Rebates	-	-	**-**		
26	Representative Payee Fees	17,544	-	**17,544**		
27	Record Copying Fees	8,000	-	**8,000**		
28	Michigan Rehabilitation Services	4,626	-	**4,626**		
29	Miscellaneous Other Income	315	-	**315**		
30	**Total Revenues**	$ 30,690,559	$ 263,379	**$ 30,953,938**	**$ 30,953,938**	100.00%

Northeast Michigan Community Mental Health Authority

2019-2020 Budget Amendment #2

Expenditure Budget (by account)

Line #	Expenditure Type	FY20 Budget Amendment #1	$$$ Incr./(Decr.)	**FY20 Budget Amendment #2**	% Incr./(Decr.)
1	Salaries	**$ 12,998,761**	$ 126,218	**$ 13,124,979**	1.0%
2	Social Security Tax	**622,521**	-	**622,521**	0.0%
3	Health Savings Accounts	**40,002**	-	**40,002**	0.0%
4	Health Insurance (self insured)	**1,986,356**	(158,451)	**1,827,905**	-8.0%
5	Prescription Insurance (self insured)	**430,509**	(28,411)	**402,098**	-6.6%
6	Dental Insurance (self insured)	**103,154**	-	**103,154**	0.0%
7	Vision Insurance (self insured)	**36,761**	-	**36,761**	0.0%
8	Life Insurance	**30,486**	-	**30,486**	0.0%
9	Long Term Disability Insurance	**28,829**	-	**28,829**	0.0%
10	Short Term Disability Insurance	**167,338**	-	**167,338**	0.0%
11	Pension	**708,797**	-	**708,797**	0.0%
12	Pension (Social Security Opt Out)	**319,313**	-	**319,313**	0.0%
13	Unemployment	**7,000**	-	**7,000**	0.0%
14	Workers Compensation	**226,439**	(29,272)	**197,167**	-12.9%
15	Office Supplies	**27,114**	-	**27,114**	0.0%
16	Postage	**19,615**	-	**19,615**	0.0%
17	Advertisement/Recruitment	**42,216**	-	**42,216**	0.0%
18	Public Relations/Community Education	**4,031**	23,000	**27,031**	570.6%
19	Employee Relations/Wellness	**44,373**	1,500	**45,873**	3.4%
20	Computer Maintenance/Supplies	**322,571**	-	**322,571**	0.0%
21	Activity/Program Supplies	**36,732**	-	**36,732**	0.0%
22	Medical Supplies & Services	**55,670**	-	**55,670**	0.0%
23	Household Supplies	**51,854**	-	**51,854**	0.0%
24	Clothing	**950**	-	**950**	0.0%
25	Contracted Inpatient	**1,178,228**	400,000	**1,578,228**	33.9%
26	Contracted Transportation	**119,668**	-	**119,668**	0.0%
27	Contracted Residential (incl. Self Determination)	**5,131,487**	-	**5,131,487**	0.0%
28	Contracted Employees/Services	**4,010,018**	(83,029)	**3,926,989**	-2.1%
29	Telephone / Internet (Communications)	**127,973**	-	**127,973**	0.0%
30	Staff Meals & Lodging	**34,262**	-	**34,262**	0.0%
31	Staff Travel Mileage	**236,198**	4,162	**240,360**	1.8%
32	Vehicle Gasoline	**136,372**	-	**136,372**	0.0%
33	Client Travel Mileage	**61,323**	-	**61,323**	0.0%
34	Board Travel and Expenses	**11,883**	-	**11,883**	0.0%
35	Staff Development-Conference Fees	**37,493**	-	**37,493**	0.0%
36	Staff Physicals/Immunizations	**16,988**	-	**16,988**	0.0%
37	Professional Fees (Audit, Legal, CARF)	**66,016**	-	**66,016**	0.0%
38	Professional Liability Insurance Drs.	**16,244**	-	**16,244**	0.0%
39	Property/Staff Liability Insurance (net)	**47,033**	-	**47,033**	0.0%
40	Heat	**31,205**	-	**31,205**	0.0%
41	Electricity	**99,578**	-	**99,578**	0.0%
42	Water/Sewage	**30,447**	-	**30,447**	0.0%
43	Sanitation	**11,009**	-	**11,009**	0.0%
44	Office Building/Equipment Maintenance	**75,961**	-	**75,961**	0.0%
45	Home Maintenance (incl. Envir. Modifications)	**79,624**	-	**79,624**	0.0%
46	Vehicle Maintenance	**54,864**	-	**54,864**	0.0%
47	Rent-Homes and Office Buildings	**259,620**	-	**259,620**	0.0%
48	Rent-Equipment	**5,290**	-	**5,290**	0.0%
49	Membership Dues	**16,450**	-	**16,450**	0.0%
50	Food	**147,854**	-	**147,854**	0.0%
51	Food Stamps	**(85,360)**	-	**(85,360)**	0.0%
52	Capital Equipment over $200	**230,746**	-	**230,746**	0.0%
53	Consumable Equipment under $200	**13,462**	-	**13,462**	0.0%
54	Computer Equipment over $200	**83,000**	-	**83,000**	0.0%
55	Client Adaptive Equipment	**30,000**	-	**30,000**	0.0%
56	Depreciation Expense Adjustment	**8,688**	(418)	**8,270**	-4.8%
57	General Fund Expenditures	**793**	8,080	**8,873**	1018.9%
58	Local Fund Expenditures (10% State Hospital)	**54,750**	-	**54,750**	0.0%
59	**Unidentified Budget Corrections (TBD)**	-	-	**-**	100.0%
60	**Total Expenditures**	$ 30,690,559	$ 263,379	**$ 30,953,938**	0.9%

Northeast Michigan Community Mental Health Authority

2019-2020 Budget Amendment #2

Expenditure Budget (by program)

Line #	Program	FY20 Budget Amendment #2	$$$ Incr./(Decr.)	**FY20 Budget Amendment #2**	% Incr./(Decr.)
1	Board Administration	**$ 561,169**	$ 76,472	**$ 637,641**	13.6%
2	DD Administration	**105,298**	13,097	**118,395**	12.4%
3	Managed Information Systems (MIS)	**1,106,187**	2,150	**1,108,337**	0.2%
4	Staff Development	**34,281**	4,154	**38,435**	12.1%
5	Budget & Finance	**985,220**	240,711	**1,225,931**	24.4%
6	Clerical Support Services	**490,814**	(11,681)	**479,133**	-2.4%
7	Human Resources	**391,159**	12,164	**403,323**	3.1%
8	Facilities, Vehicles, Equip. Maintenance	**838,786**	1,524	**840,310**	0.2%
9	Quality Improvement	**210,933**	2,763	**213,696**	1.3%
10	MI Outpatient	**1,000,628**	(23,047)	**977,581**	-2.3%
11	MI Administration	**58,747**	862	**59,609**	1.5%
12	Physician Services	**1,730,718**	(10,844)	**1,719,874**	-0.6%
13	Housekeeping	**104,903**	(1,280)	**103,623**	-1.2%
14	Customer Service	**96,890**	(2,563)	**94,327**	-2.6%
15	Older Adult Services - PASARR	**111,843**	(1,101)	**110,742**	-1.0%
16	Older Adult Case Management	**577,491**	(8,543)	**568,948**	-1.5%
17	MI Case Management	**684,097**	(7,062)	**677,035**	-1.0%
18	Assertive Community Treatment (ACT)	**539,971**	(43,606)	**496,365**	-8.1%
19	Children's Home Based and Comm. Services	**753,112**	(60,072)	**693,040**	-8.0%
20	MI Child Collaborative Care Grant	**34,721**	(1,374)	**33,347**	-4.0%
21	Children's Wraparound	**119,847**	-	**119,847**	0.0%
22	DD Case Management	**834,186**	(2,371)	**831,815**	-0.3%
23	DD Clinical Support	**300,793**	(115)	**300,678**	0.0%
24	Applied Behavioral Analysis (Autism) Services	**1,669,519**	21,759	**1,691,278**	1.3%
25	Private Hospitalization (all populations)	**1,178,228**	400,000	**1,578,228**	33.9%
26	State Hospitalization (County 10% Share only)	**54,750**	-	**54,750**	0.0%
27	DD Community Employment	**1,195,442**	(13,495)	**1,181,947**	-1.1%
28	DD Community Support	**1,557,125**	(51,246)	**1,505,879**	-3.3%
29	MI Adult Clubhouse (Touchstone Inc. 1/1/2020)	**521,866**	(418)	**521,448**	-0.1%
30	Bay View Center	**100,713**	-	**100,713**	0.0%
31	Peer Directed Activities	**27,823**	2,602	**30,425**	9.4%
32	MI Peer Support Services	**126,148**	(42)	**126,106**	0.0%
33	MI Community Employment	**223,900**	(20,643)	**203,257**	-9.2%
34	Contracted Residential	**3,636,331**	(64,380)	**3,571,951**	-1.8%
35	Respite (DD & MI)	**149,443**	-	**149,443**	0.0%
36	DD SIP Monitoring	**521,033**	(13,934)	**507,099**	-2.7%
37	DD Supported Independent Living (SIP)	**1,583,083**	(79,058)	**1,504,025**	-5.0%
38	Self Determination (DD & MI)	**1,969,821**	(8,905)	**1,960,916**	-0.5%
39	Hospital Transportation	**23,676**	3,168	**26,844**	13.4%
40	Cambridge Residential DD	**501,864**	(6,584)	**495,280**	-1.3%
41	Princeton Residential DD	**575,837**	(16,177)	**559,660**	-2.8%
42	Walnut Residential DD	**591,294**	(3,653)	**587,641**	-0.6%
43	Thunder Bay Heights Residential DD	**589,540**	(6,358)	**583,182**	-1.1%
44	Pinepark Residential DD	**562,388**	(17,496)	**544,892**	-3.1%
45	Brege Residential DD	**567,781**	(17,779)	**550,002**	-3.1%
46	Harrisville Residential DD	**542,024**	(16,108)	**525,916**	-3.0%
47	Millcreek Residential DD	**549,136**	(8,112)	**541,024**	-1.5%
48	**Budget Corrections to be spread to programs**	-	-		100.0%
49	**Total Expenditures**	$ 30,690,559	$ 263,379	**$ 30,953,938**	0.9%

Northeast Michigan Community Mental Health Authority

2019-2020 Budget Amendment #2

Capital Purchases

Line #	Program	Description	$$$
	Equipment, Furniture, Building Improvements		
	Staff Development	First Aid Equipment	662
	Human Resources	Stand-up Desk for GD (per LA)	400
	Human Resources	New/Updated Camera	600
	Facilities	2 SUV's 4x4	56,000
	Facilities	3 Mini Vans	72,000
	Facilities	2 Sedans	38,000
	Facilities	2 HVAC Units - Alpena Office	18,000
	Facilities	1 Snowblower	1,500
	Facilities	2 Access Control Door Locks - Hillman Office	2,000
New	Facilities	Arjo Maxi Twin Patient Lift	5,000
New	Facilities	Alpena Office Heathing system Controler	4,000
New	Facilities	Conference Room Chairs for Hillman Office	2,640
New	Cambridge	Phoenix Reclining Shower Chair	4,000
	Cambridge	One Major Appliance	1,000
	Cambridge	Flooring for the Living Room and Hallway	8,000
	Princeton	One Major Appliance	1,000
	Princeton	Recliner	500
	Walnut	One Major Appliance	1,000
	Walnut	2 - Recliners	1,400
	Walnut	Gass Grill	400
	Thunder Bay	One Major Appliance	1,000
	Thunder Bay	3 Drawer Lateral File Cabinet	710
	Pine Park	One Major Appliance	1,000
New	Pine Park	Install New Flooring	11,000
	Brege	One Major Appliance	1,000
	Harrisville	One Major Appliance	1,000
	Harrisville	Counter Top for Kitchen	6,000
	Harrisville	OTC Microwave	500
	Millcreek	One Major Appliance	1,000
	Millcreek	Flooring	4,074
	Total Equipment, Furniture, Building Improvements		**$ 245,386**
	Computer Equipment		
	Information Systems	Notebooks/Laptops/Desktops	36,000
	Information Systems	Servers	30,000
	Information Systems	Copiers (Alpena, Rogers City, Hillman)	12,000
	Information Systems	Printers	2,000
	Information Systems	IP Phones	10,000
	Information Systems	Switch/Router	5,000
New	Information Systems	Switch/Router	8,000
	Total Computer Equipment		**$ 103,000**

Vehicle Replacement Policy:

Agency owned vehicles will be reviewed for replacement when:

a. they have reached a service life of five years and/or they have accumulated 120,000 miles,

b. excessive wear or costs dictates that the vehicle be removed from service, or

c. safety conditions require that they be removed from service.

Northeast Michigan Community Mental Health Authority

2019-2020 Budget Amendment #2

Staffing - Full Time Equivalents (FTE's)

Line #	Program	FY20 Budget Amendment #1	FTE Incr./(Decr.)	**FY20 Budget Amendment #2**	% Incr./(Decr.)
1	Board Administration	5.10	1.00	**6.10**	19.6%
2	DD Administration	2.20	(1.00)	**1.20**	-45.5%
3	Managed Information Systems (MIS)	6.10	(0.10)	**6.00**	-1.6%
4	Staff Development	0.37	-	**0.37**	0.0%
5	Budget & Finance	11.30	(0.80)	**10.50**	-7.1%
6	Clerical Support Services	9.45	(0.95)	**8.50**	-10.1%
7	Human Resources	4.15	-	**4.15**	0.0%
8	Facilities, Vehicles, Equip. Maintenance	3.01	(0.16)	**2.85**	-5.3%
9	Quality Improvement	2.00	-	**2.00**	0.0%
10	MI Outpatient	9.50	-	**9.50**	0.0%
11	MI Administration	0.50	-	**0.50**	0.0%
12	Physician Services	11.44	(0.29)	**11.15**	-2.5%
13	Housekeeping	2.68	(0.25)	**2.43**	-9.3%
14	Customer Service	1.96	0.17	**2.13**	8.7%
15	Geriatric Services - PASARR	1.13	0.25	**1.38**	22.1%
16	Geriatric Case Management	9.44	0.23	**9.67**	2.4%
17	MI Case Management (see DD Case Manage)	12.01	(0.88)	**11.13**	-7.3%
18	Assertive Community Treatment (ACT)	9.84	(2.00)	**7.84**	-20.3%
19	Children's Home Based and Comm. Services	10.56	(0.61)	**9.95**	-5.8%
20	MI Child Collaborative Care Grant	0.50	-	**0.50**	0.0%
21	DD Case Management (see MI Case Manage)	11.52	0.17	**11.69**	1.5%
22	DD Clinical Support	1.25	0.50	**1.75**	40.0%
23	Applied Behavioral Analysis (Autism) Services	12.00	1.80	**13.80**	15.0%
24	DD Community Employment	12.73	(0.13)	**12.60**	-1.0%
25	DD Community Living Supports	28.26	0.14	**28.40**	0.5%
26	MI Adult Clubhouse	1.05	(1.05)	**-**	-100.0%
27	Peer Directed Activities	0.89	(0.11)	**0.78**	-12.4%
28	MI Peer Support Services	2.33	0.30	**2.63**	12.9%
29	MI Community Employment	3.50	0.50	**4.00**	14.3%
30	SIP Monitoring	11.77	0.08	**11.85**	0.7%
31	DD Supported Independent Living (SIP)	36.82	1.88	**38.70**	5.1%
32	Self Determination (MI & DD)	2.41	1.22	**3.63**	50.6%
33	Hospital Transportation (new)	0.24	0.34	**0.58**	141.7%
34	Cambridge Residential DD	12.22	(0.08)	**12.14**	-0.7%
35	Princeton Residential DD	13.54	0.55	**14.09**	4.1%
36	Walnut Residential DD	14.03	(0.49)	**13.54**	-3.5%
37	Thunder Bay Residential DD	12.08	-	**12.08**	0.0%
38	Pinepark Residential DD	13.06	(0.39)	**12.67**	-3.0%
39	Brege Residential DD	12.45	1.01	**13.46**	8.1%
40	Harrisville Residential DD	12.60	0.02	**12.62**	0.2%
41	Millcreek Residential DD	12.30	0.13	**12.43**	1.1%
42	**Total FTE's**	340.29	1.00	**341.29**	0.3%

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Five Months Ending February 29, 2020
41.7% of year elapsed

		Actual February Year to Date	Budget February Year to Date	Variance February Year to Date	Budget FY20	% of Budget Earned or Used
	Revenue					
1	State Grants	48,492.48	**48,492.48**	$ -	$ 97,000	50.0%
2	Private Contracts	16,640.50	**16,640.50**	-	52,603	31.6%
3	Grants from Local Units	160,774.91	**138,554.99**	22,220	506,897	31.7%
4	Interest Income	7,158.40	**7,158.40**	-	10,005	71.5%
5	Medicaid Revenue	10,662,777.06	**10,201,428.22**	461,349	26,399,153	40.4%
6	General Fund Revenue	375,435.00	**427,328.37**	(51,893)	941,067	39.9%
7	Healthy Michigan Revenue	707,503.98	**608,949.68**	98,554	1,846,144	38.3%
8	3rd Party Revenue	186,968.54	**186,968.54**	-	245,999	76.0%
9	SSI/SSA Revenue	208,428.96	**208,428.96**	-	516,352	40.4%
10	Other Revenue	40,588.92	**40,588.92**	-	75,389	53.8%
11	**Total Revenue**	**12,414,769**	**11,884,539**	**530,230**	**30,690,610**	**40.5%**
	Expense					
12	Salaries	4,759,011	4,759,011	-	12,998,813	34.6%
13	Social Security Tax	215,606	215,606	-	622,521	34.6%
14	Self Insured Benefits	933,728	933,728	-	2,596,782	36.0%
15	Life and Disability Insurances	86,344	86,344	-	226,653	38.1%
16	Pension	380,315	380,315	-	1,028,110	37.0%
17	Unemployment & Workers Comp.	69,437	69,437	-	233,439	29.7%
18	Office Supplies & Postage	18,048	18,048	-	46,729	38.6%
19	Staff Recruiting & Development	39,851	39,851	-	96,698	41.2%
20	Community Relations/Education	6,514	6,514	-	4,031	161.6%
21	Employee Relations/Wellness	29,430	29,430	-	44,373	66.3%
22	Program Supplies	166,264	166,264	-	481,239	34.5%
23	Contract Inpatient	705,788	705,788	-	1,178,228	59.9%
24	Contract Transportation	44,291	44,291	-	119,668	37.0%
25	Contract Residential	2,289,325	2,289,325	-	5,131,487	44.6%
26	Contract Employees & Services	1,324,316	1,324,316	-	4,010,018	33.0%
27	Telephone & Connectivity	51,611	51,611	-	127,973	40.3%
28	Staff Meals & Lodging	10,375	10,375	-	34,262	30.3%
29	Mileage and Gasoline	157,903	157,903	-	433,893	36.4%
30	Board Travel/Education	3,330	3,330	-	11,883	28.0%
31	Professional Fees	25,979	25,979	-	66,016	39.4%
32	Property & Liability Insurance	49,838	49,838	-	63,277	78.8%
33	Utilities	66,225	66,225	-	172,239	38.4%
34	Maintenance	62,866	62,866	-	210,449	29.9%
35	Rent	107,551	107,551	-	264,910	40.6%
36	Food (net of food stamps)	31,661	31,661	-	62,494	50.7%
37	Capital Equipment	36,803	36,803	-	85,746	42.9%
38	Client Equipment	11,337	11,337	-	30,000	37.8%
39	Miscellaneous Expense	47,270	47,270	-	71,993	65.7%
40	Depreciation Expense	105,524	105,524	-	236,687	44.6%
41	**Total Expense**	**11,836,543**	**11,836,543**	**-**	**30,690,610**	**38.6%**
42	**Change in Net Position**	**$ 578,226**	**$ 47,996**	**$ 530,230**	**$ 0**	**1.9%**

43	Contract settlement items included above:	
44	Medicaid Funds (Over) / Under Spent	$ 461,349
45	Healthy Michigan Funds (Over) / Under Spent	98,554
46	**Total NMRE (Over) / Under Spent**	**$ 559,903**
47	General Funds to Carry Forward to FY20	$ -
48	General Funds Lapsing to MDHHS	(51,893)
49	**General Funds (Over) / Under Spent**	**$ (51,893)**

POLICY CATEGORY: Executive Limitations
POLICY TITLE AND NUMBER: Communication and Counsel to the Board, Policy # 01-009
REPORT FREQUENCY & DUE DATE: Annual: April 2020

POLICY STATEMENT:
With respect to providing information and counsel to the board, the Executive Director may not permit the board to be uninformed or unsupported in its work. Accordingly, he or she may not:

1. Neglect to submit monitoring data required by the board (see policy on Monitoring Executive Performance) in a timely, accurate and understandable fashion, directly addressing provisions of the board policies being monitored.
    - **Interpretation**

    The monitoring reports required by board policy and included in the monitoring schedule are to be prepared, delivered and presented clearly to the Board on a timely basis including any necessary data or evidence.
    - **Status**

    During the last 12 months, monitoring reports have been submitted on a timely basis in accordance with the monitoring schedule. This report will occur at our April meeting. Lead staff from various departments continue to be included in the development and presentation of various reports to more accurately relay information.

2. Let the board be unaware of relevant trends, anticipated adverse media coverage, material external and internal changes, and particularly changes in the assumptions upon which any board policy has previously been established.
    - **Interpretation**

    The Director will keep the Board apprised of any significant information or events that bear on the Board's responsibilities.
    - **Status**

    The Governor vetoed the 298 Pilots; however, MDHHS launched a "system redesign" plan that continues the Integration efforts of Behavioral and Physical Health Care and the Medicaid Health Plans. The 5 CMHSPs of the NMRE have develop a pilot program with MDHHS to continue our goal of integrating physical and behavioral health care in the Northern 21 counties. It is our goal to secure funding and begin this pilot program in FY 21. We continue to address the migration of those persons enrolled in DABs to the Healthy Michigan Plan, which negatively affects our Per Member Per Month funding formula. We have also discussed the impact of the Home and Community Based Services Rule on Community Living Supports, Residential placements, skill building and supported employment.

3. Fail to advise the board if, in the Executive Director's opinion, the board is not in compliance with its own policies on Governance Process and Board-Staff Relationship, particularly in the case of board behavior which is detrimental to the work relationship between the board and the Executive Director.
    - **Interpretation**

    The Director has the opportunity and responsibility to frankly raise concerns related to the Governance Process, Board Relationships and Board-Staff Relationships and the Board has the duty to consider those concerns.
    - **Status**

    The Board's commitment to adopt and implement Policy Governance appears to be very strong. Frank open conversation between the Board and Executive Director provides an environment which supports the governance model, allowing the sharing of critical information without placing Board Members in the role expected of the Director or other

employees. Board Members adhere to their policies and hold the Executive Director responsible for reporting and compliance with its annual planning goals, policies and expectations. Board members have managed concerns about individuals receiving services and citizens requests discretely and in a manner consistent with the laws of confidentiality and the Health Insurance Privacy and Portability Act.

4. Fail to marshal for the board as many staff and external points of view, issues and options as needed for fully informed board choices.
   - **Interpretation**

   Though the Director is the only employee that reports directly to the Board, he/she is expected to assure that the expertise of staff and valued input from other community resources are available for the Board.
   - **Status**

   Each month key staff participates in reporting to the Board in addition to the Executive Director. Routine reports from the Finance and Accounting Officers and Chief Operations Officer occur monthly along with Quality Improvement reports on at least a quarterly basis. Periodic reports from Human Resources and the Office of Recipient Rights are also made with regularity. Educational presentations from staff concerning programs and services occur throughout the year and occasional presentations from community partners, the NMRE Director, our Compliance Officer and staff of the Community Mental Health Association of Michigan Board is included in the Board's agenda.

5. Present information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation and other.
   - **Interpretation**

   Monitoring reports and other material prepared to assist the Board in its responsibilities should be concise and logical in presentation.
   - **Status**

   During the past year the Board heard reports on the NeMCMHA Audit, Compliance Plan, Staff Training Requirements, CARF Updates and a presentation by Touchstone our new contract provider for Clubhouse
   . The board also completed a thorough review of the By-laws of the Board. Monitoring Reports to the board occur using a perpetual calendar of review. While on occasion some of those presentations required lengthy detailed discussions, most presentations met the tests of this policy issue.

6. Fail to provide a mechanism for official board, officer or committee communications.
   - **Interpretation**

   The Director is to assist with and facilitate meetings of the Board and provide whatever support, including clerical, necessary to assure communication among board members and officers.
   - **Status**

   I believe this requirement continues to be met for all routine meetings, Recipient Rights Committee meetings and the Executive Committee and all other communications. Communication with Board members assigned to the Northern Michigan Regional Entity continues to be sufficient, in my opinion.

7. Fail to deal with the Board as a whole except when (a) fulfilling individual requests for information or (b) responding to officers or committees duly charged by the board.
   - **Interpretation**

   The Director is to respond to directives of the whole Board rather than to individual members except when such an individual member or committee is duly authorized by the Board for a specific purpose.

- **Status**

Over the last year the Board continues to act as an entire body and does not place individual demands on the Executive Director or leadership staff. Board members have handled citizen concerns professionally and confidentially.

8. Fail to report in a timely manner an actual or anticipated noncompliance with any policy of the Board.
   - **Interpretation**

   The Director is to inform the board when issues of noncompliance either actual or anticipated with any Board policy occurs either through communication at the next board meeting or via contacting the Chair directly to inform him/her of the noncompliance.

   - **Status**

   Over the last year, a matter of misinterpretation of the data regarding revenue was presented and corrected with detail provided to Board members.

9. Fail to supply for the consent agenda all items delegated to the Executive Director yet required by law or contract to be board approved, along with the monitoring assurance pertaining thereto.
   - **Interpretation**

     The Director is to report to the board all items required by law or contract to be distributed to the board in Agenda prior to the next board meeting. If there is an occasion where contracts or actions need to be addressed or signed prior to the next board meeting, the Director will contact the Chair for guidance and direction.

   - **Status**

     The Director has presented a thorough consent agenda for those contract obligations when received by the State or contract providers. The Director has also contacted the Chair when additions to the consent agenda needed to be included at the board meeting which were not originally sent out in the board packet. There was one instance involving a cost settlement with a contractor that exceeded contract amount. This was presented to the Board for approval when identified.

Board Review/Comments

Reasonableness Test: Is the interpretation by the Executive Director reasonable?

Data Test: Is the data provided by the Executive Director both relevant and compelling?

Fine-tuning the Policy: Does this report suggest further study and refinement of the policy?

Other Implications: Does this report suggest the other policies may be necessary?

EXECUTIVE LIMITATIONS
(Manual Section)

FINANCIAL CONDITION
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved	April ~~11~~09, ~~2019~~2020

●1 POLICY:

With respect to the actual, ongoing condition of the organization's financial health, the ~~CEO~~ Executive Director may not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from board priorities established in Ends policies.

Accordingly, he or she may not:

1. Expend more funds than have been received in the fiscal year to date unless the debt guideline (below) is met.

2. Borrow money in an amount greater than can be repaid by certain, otherwise unencumbered revenues within 60 days.

3. Use any designated reserves other than for established purposes.

4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of equal or greater to the original discrete fund balances by certain, otherwise unencumbered revenues within 30 days.

5. Fail to settle payroll and debts in a timely manner.

6. Allow tax payments or other government-ordered payments or filings to be overdue or inaccurately filed.

7. Acquire, encumber, or dispose of real property.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

•5 FORMS AND EXHIBITS:

EXECUTIVE LIMITATIONS
(Manual Section)

COMMUNICATION AND COUNSEL TO THE BOARD
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved	~~June 8, 2006~~April 9, 2020

●1 POLICY:

With respect to providing information and counsel to the board, the ~~CEO~~ Executive Director may not permit the board to be uninformed or unsupported in its work. Accordingly, he or she may not:

1. Neglect to submit monitoring data required by the board (see policy on Monitoring Executive Performance) in a timely, accurate and understandable fashion, directly addressing provisions of the board policies being monitored.

2. Let the board be unaware of relevant trends, anticipated adverse media coverage, material external and internal changes, particularly changes in the assumptions upon which any board policy has previously been established.

3. Fail to advise the board if, in the ~~CEO's~~ Executive Director's opinion, the board is not in compliance with its own policies on Governance Process and Board-Staff Relationship, particularly in the case of board behavior which is detrimental to the work relationship between the board and the ~~CEO~~Executive Director.

4. Fail to marshal for the board as many staff and external points of view, issues and options as needed for fully informed board choices.

5. Present information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation and other.

6. Fail to provide a mechanism for official board, officer or committee communications.

7. Fail to deal with the Board as a whole except when (a) fulfilling individual requests for information or (b) responding to officers or committees duly charged by the board.

8. Fail to report in a timely manner an actual or anticipated noncompliance with any policy of the Board.

9. Fail to supply for the consent agenda all items delegated to the ~~CEO~~ Executive Director yet required by law or contract to be board-approved, along with the monitoring assurance pertaining thereto.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

GOVERNING STYLE
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved by Board:	April ~~13~~9, ~~2006~~2020

●1 POLICY:

The board will govern with an emphasis on outward vision encouraging diversity of viewpoints, strategic leadership more than administrative detail, clear and concise roles of board and ~~CEO~~Executive Director, collectively and proactively focusing on the future.

The board will:

1. Function as a unit, be responsible for governing itself, and initiate its own practices. The board will use the expertise of individual members to enhance the ability of the board as a body.

2. Focus its primary efforts on the intended ~~long~~ long-term impact outside the operating organization, and will direct the organization through the development of written board policies.

3. Enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policymaking principles, respect of roles, and ensuring the continuity of governance capability. Continual board development will include orientation of new members in the board's governance process and periodic board discussion of process improvement.

4. Monitor and discuss the board's process and performance at each meeting. Self-monitoring will include comparison of board activity and discipline to policies in the Governance Process and Board-Staff Relationship categories.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

COST OF GOVERNANCE
(Subject)

Board Approval of Policy	November 7, 2002
Last Revision of Policy Approved	April ~~11~~09, ~~2019~~2020

●1 POLICY:

Because poor governance costs more than learning to govern well, the board will invest in its governance capacity.

Accordingly:

1. Board skills, methods and supports will be sufficient to assure governing with excellence.
   A. Training and retraining will be used liberally to orient new members and candidates for membership, as well as to maintain and increase existing member's skills and understandings.
   B. Outside monitoring assistance will be arranged so that the board can exercise confident control over organizational performance. This includes but is not limited to fiscal audits.
   C. Outreach mechanisms will be used as needed to ensure the board's ability to listen to owner viewpoints and values.
2. Costs will be prudently incurred, though not at the expense of endangering the development and maintenance of superior capability.
   A. Up to $~~13,664~~11,883 in fiscal year '~~19~~ 20 for training including attendance at conferences and workshops.
   B. Up to $~~28,192~~29,455 in fiscal year '~~19~~ '20 for audit and other third-party monitoring of organizational performance.
   C. Up to $~~5,039~~6,867 in fiscal year '~~19~~ 20 for surveys, focus groups, opinion analysis, and meeting costs.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

Northeast Michigan Community Mental Health Authority

M E M O R A N D U M

To: Northeast Board Members

From: Nena Sork

Date: March 30, 2020

Subject: Mental Health Code Section 222

Annually the Board ***must*** certify its compliance with Section 222 of the Mental Health Code. That section of the Code (a copy of which is attached) sets certain requirements and limitations for participation by individuals as board members. These requirements and limitations may be summarized as follows:

- At least four members must be primary consumers or family members of primary consumers
- At least two of the above four members must be primary consumers
- No more than four county commissioners
- No more than six public officials, including the above mentioned county commissioners (Please use the definitions on the survey form.)

It is important that Board members understand the use of this information. We are required to disclose to the Department (or essentially anyone who might ask) the composition of our Board and prove that we are in compliance with these provisions. It is the Department's interpretation that those Board members who we "count" as primary or family members be willing to have that information publicly disclosed. Therefore, please have this in mind as you complete this form.

Section 222 also addresses avoidance of conflict of interest. The attached form has been revised to address these items as well. Board members must not be:

- employed by the Department of Community Health or Community Mental Health;
- a party to a contract with Community Mental Health; or
- serve in a policy making position with an Agency under contract with Community Mental Health (except under certain circumstances)

Please complete this form and leave it or return it to Diane Hayka as soon as possible. Thank you.

Attachment: Sec. 222(1)(4)(5)

Northeast Michigan Community Mental Health Authority
Mental Health Code Section 222 Survey

_____	_____	_____
Printed Name	Signature	Date

Board Composition (please use the definitions immediately below in responding to these 4 questions.)

1. Are you, or have you ever been a "primary consumer" of mental health services?
   ☐ Yes ☐ No

2. Are you a family member of a primary consumer who is receiving, or has received, mental health services?
   ☐ Yes ☐ No

3. Are you a county commissioner?
   ☐ Yes ☐ No

4. Are you a public official?
   ☐ Yes ☐ No

Please use the following definitions in responding to this inquiry. These are the definitions used in the Mental Health Code.

Primary Consumer:
"Primary Consumer" means an individual who has received or is receiving services from the Department or a community mental health services program or services from the private sector equivalent to those offered by the Department or a community mental health services program.

Family Member:
"Family Member" means a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer is dependent for at least 50% of his or her financial support.

Public Official
"Public Officials" are individuals serving in an elected or appointed public office or employed more than 20 hours per week by an agency of federal, state, city, or local government.

Conflict of Interest

1. Are you employed by the Department or Community Mental Health?
   ☐ Yes ☐ No

2. Are you party to a contract with Northeast Michigan Community Mental Health?
   ☐ Yes ☐ No

3. Do you serve in a policy-making position with an agency under contract with CMH?
   ☐ Yes ☐ No

4. Do you serve in other than a policy-making position with an agency with which the Board holds a contract or is considering a contract? [If so, the procedure required by Sec. 222 (5) must be followed regarding disclosure and voting]
   ☐ Yes ☐ No

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

330.1222 Board; composition; residence of members; exclusions; approval of contract; exception; size of board in excess of § 330.1212; compliance.

Sec. 222. (1) The composition of a community mental health services board shall be representative of providers of mental health services, recipients or primary consumers of mental health services, agencies and occupations having a working involvement with mental health services, and the general public. At least 1/3 of the membership shall be primary consumers or family members, and of that 1/3 at least 1/2 of those members shall be primary consumers. All board members shall be 18 years of age or older.

(2) Not more than 4 members of a board may be county commissioners, except that if a board represents 5 or more counties, the number of county commissioners who may serve on the board may equal the number of counties represented on the board, and the total of 12 board memberships shall be increased by the number of county commissioners serving on the board that exceeds 4. In addition to an increase in board memberships related to the number of county commissioners serving on a board that represents 5 or more counties, board memberships may also be expanded to more than the total of 12 to ensure that each county is entitled to at least 2 board memberships, which may include county commissioners from that county who are members of the board if the board represents 5 or more counties. Not more than 1/2 of the total board members may be state, county, or local public officials. For purposes of this section, public officials are defined as individuals serving in an elected or appointed public office or employed more than 20 hours per week by an agency of federal, state, city, or local government.

(3) A board member shall have his or her primary place of residence in the county he or she represents.

(4) An individual shall not be appointed to and shall not serve on a board if he or she is 1 or more of the following:

(a) Employed by the department or the community mental health services program.

(b) A party to a contract with the community mental health services program or administering or benefiting financially from a contract with the community mental health services program, except for a party to a contract between a community mental health services program and a regional entity or a separate legal or an administrative entity created by 2 or more community mental health services programs under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512, or under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536.

(c) Serving in a policy-making position with an agency under contract with the community mental health services program, except for an individual serving in a policy-making position with a joint board or commission established under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536, or a regional entity to provide community mental health services.

(5) If a board member is an employee or independent contractor in other than a policy-making position with an agency with which the board is considering entering into a contract, the contract shall not be approved unless all of the following requirements are met:

(a) The board member shall promptly disclose his or her interest in the contract to the board.

(b) The contract shall be approved by a vote of not less than 2/3 of the membership of the board in an open meeting without the vote of the board member in question.

(c) The official minutes of the meeting at which the contract is approved contains the details of the contract including, but not limited to, names of all parties and the terms of the contract and the nature of the board member's interest in the contract.

(6) Subsection (5) does not apply to a board member who is an employee or independent contractor in other than a policy-making position with a joint board or commission established under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536, a separate legal or administrative entity established under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512, a combination of municipal corporations joined under 1951 PA 35, MCL 124.1 to 124.13, or a regional entity to provide community mental health services.

(7) In order to meet the requirement under subsection (1) related to the appointment of primary consumers and family members without terminating the appointment of a board member serving on March 28, 1996, the size of a board may exceed the size prescribed in section 212. A board that is different in size than that prescribed in section 212 shall be brought into compliance within 3 years after the appointment of the additional board members.

History: 1974, Act 258, Eff. Aug. 6, 1975;--Am. 1995, Act 290, Eff. Mar. 28, 1996;--Am. 2002, Act 596, Imd. Eff. Dec. 3, 2002;--Am. 2003, Act 278, Imd. Eff. Jan. 8, 2004

Waiting List Information

CMHSP: Mental Health Authority
Contact name and phone Nena Sork; 989-356-2161
As of (Date) 11-Feb-20
Time period covered for Added/Removed 02/13/19-02/11/20

	MI Adult	DD	SED	Total
Targeted CSM/Supports Coordination				
Specify HCPCS and CPT Codes included in this category				
Number on waiting list as of date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Intensive Interventions/Intensive Community Services				
Specify HCPCS and CPT Codes included in this category				
Number on waiting list as of date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Clinic Services				
Specify HCPCS and CPT Codes included in this category				
Number on waiting list as of date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Supports for Residential Living				
Specify HCPCS and CPT Codes included in this category				
Number on waiting list as of date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Supports for Community Living				
Specify HCPCS and CPT Codes included in this category				
Number on waiting list as of date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Narrative:				

How do you assure that service needs are met at an individual level as well as from a program capacity level?

NeMCMHA has a process which includes all persons placed on a waiting list be reviewed on a weekly basis to determine the need for services, the severity of symptoms, length of time places on waiting list, and change in Medicaid status. Priority is given to those based on highest need and severity. All on waiting list are encouraged to come into crisis walk-in if they are experiencing an increase in symptoms.

CMHSP: Northeast Michigan Community Mental

Period: October 1, 2018 to September 30, 2019 Contact person and e mail: Nena Sork; nsork@nemcmh.org

Report on the Requests for Services and Disposition of Requests

	CMHSP Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	Total # of people who telephoned or walked in	56	732	190	355	1333
2	Is Info on row 1 an unduplicated count? (yes/no)	Yes	Yes	Yes	Yes	
3	# referred out due to non MH needs (of row 1)	2	48	4	41	95
4	Total # who requested services the CMHSP provides (of row1)	37	509	147	308	1001
5	Of the # in Row 4 - How many people did not meet eligibility through phone or other screen	1	19	4	90	114
6	Of the # in Row 4 - How many people were scheduled for assessment	35	418	133	156	742
7	other--describe	17	175	39	6	237
	CMHSP ASSESSMENT					
8	Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.)	4	94	14	38	150
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	0	0	0	0	0
10	Of the # in Row 6 - how many were not served because they were MA HP enrolled and referred out to MA health plan	0	0	0	0	0
11	Of the # in Row 6 - how many otherwise did not meet cmhsp non-entitlement eligibility criteria	0	53	2	28	83
11a	Of the # in row 11 - How many were referred out to other mental health providers	0	43	1	18	62
11b	Of the # in row 11 - How many were not referred out to other mental health providers	0	10	1	10	21
12	Of the # in Row 6 - How many people met the cmhsp eligibility criteria	25	271	81	59	436
13	Of the # in Row 12 - How many met emergency/urgent conditions criteria	1	4	0	0	5
14	Of the # in Row 12 - How many met immediate admission criteria	24	265	81	58	428
15	Of the # in Row 12 - How many were put on a waiting list	0	2	0	1	3
15a	Of the # in row 15 - How many received some cmhsp services, but wait listed for other services	0	1	0	1	2
15b	Of the # in row 15 - How many were wait listed for all cmhsp services	0	1	0	0	1
16	Other - explain	0	0	0	0	0

	Commuity Needs Assessment															
	Community Data Sets															
	CMHSP name:															
	Contact person/e mail address:															
1	**Population (Census)-- As of September -- by county**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**			
County 1	**Alcona**	**11091**	**10942**	**10787**	**10635**	**10578**	**10454**	**10349**	**10461**	**10263**	**10413**	**10362**				
County 2	**Alpena**	**292289**	**29598**	**29352**	**29234**	**29091**	**28988**	**28803**	**28929**	**28076**	**28730**	**28360**				
County 3	**Montmorency**	**10094**	**9765**	**9590**	**9476**	**9350**	**9300**	**9259**	**9317**	**9157**	**9290**	**9265**				
County 4	**Presque Isle**	**13436**	**13376**	**13198**	**13129**	**13062**	**13004**	**12841**	**12955**	**12685**	**12854**	**12738**				
County 5																
County 6																
	Total CMHSP Population	326910	63681	62927	62474	62081	61746	61252	61662	60181	61287	60725	0			
	Change from Prior Year		-263229	-754	-453	-393	-335	-494	410	-1481	1106	-562	-60725			
	% change from Prior Year		-80.52%	-1.18%	-0.72%	-0.63%	-0.54%	-0.008001	0.0066937	-0.024018	0.0183779	-0.00917	-1			
	Cumulative Change since 2008		-263229	-263983	-264436	-264829	-265164	-265658	-265248	-266729	-2394	-2202	-62474			
	% cumulative change since 2008		-80.52%	-80.75%	-80.89%	-81.01%	-81.11%	-0.812633	-0.811379	-0.81591	-0.037594	-0.034993	-1			
	Source:	US Census Bureau from 2018 Estimates for 2019 information														
	This will provide you numbers for 2019	http://worldpopulationreview.com/us-counties/mi/														
	Use data from previous reports for years before 2019 or reference this website for previous years	https://datacenter.kidscount.org/data/tables/1698-total-population?loc=24&loct=5#detailed/5/3744-3826/false/37,871,870,573,869,36,868,867,133,38/any/3603														
2	**Medicaid Enrollment - Average Enrollment for September:**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
County 1	**Alcona**	1875	1947	1906	1892	1921	2307	1624	1715	1792	1863	1784				
County 2	Alpena	6787	6869	6786	6628	6778	7626	5323	5660	6075	5969	5555				
County 3	Montmorency	2364	2395	2331	2215	2148	2536	1625	1616	1787	1779	1824				
County 4	Presque Isle	2232	2285	2397	2353	2387	2829	2038	2122	2201	2215	2118				
County 5																
County 6																
	Total CMHSP Medicaid Enrollment	13258	13496	13420	13088	13234	15298	10610	11113	11855	11826	11281				
	Change from Prior Year		238	-76	-332	146	2064	-4688	503	742	-29	-545				
	% change from Prior Year		0.0179514	-0.005631	-0.024739	0.0111553	0.1559619	-0.306445	0.0474081	0.0667686	-0.002446	-0.046085				
	Cumulative Change since 2008		238	162	-170	-24	2040	-2648	-2145	-1403	-1432	-2215				
	% cumulative change since 2008		0.0179514	0.012219	-0.012822	-0.00181	0.1538694	-0.199728	-0.161789	-0.105823	-0.10801	-0.164123				
	Source:	MDCH to provide data to CMHSP														
3	**Number of Children in Foster Care**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
	Children Ages 0-17 in Out of Home Care-Abuse or Neglect (Number)	38	63	75	73	80	**93**	**102**	**75**	**68**	**103**					
	Children Ages 10-16 in Out of Home Care-Delinquency (DHS Placement)	14	12	9	15	n/a	**n/a**	**n/a**								
	Children Ages 0-5 in Foster Care (Number)	17	30	35	44	37	**n/a**	**63**	**42**	**41**	**56**					
	Source: http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI															
	****Some information may not be available for every year.**															
	Total CMHSP	69	105	119	132	117	93	165	117	109	159	0				
	Change from Prior Year		36	14	13	-15	-24	72	-48	-8	50	-159				
	% change from Prior Year		52.17%	13.33%	10.92%	-11.36%	-20.51%	0.7741935	-0.290909	-0.068376	0.4587156	-1				
	Cumulative Change since 2008		36	50	63	48	24	96	48	40	54	-119				
	% cumulative change since 2008		52.17%	72.46%	91.30%	69.57%	34.78%	1.3913043	0.6956522	0.5797101	0.5142857	-1				
4	**Number of Licensed Foster Care Beds in Catchment Area**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**							
	Adults - Enter the Total Number of Bed Capacity							**346**	**416**							
	http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717-82231--,00.html															
	Kids - Enter the Total Number of Licensed Facilities								68							
	http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27719-82293--,00.html															
	***This data is also provided by MDCH on the website under "Provided Information".**															
5	**Prevalence Proxy Data**															
		1990	**2008**	**Change**	***or most recent projection**					**2017**	**2018**	**2019**				
5-A	**Adults with Serious Mental Illness (Kessler Methodology)**															
	Trend - Kessler Prevalance Data															
	*Provided by MDCH in 2012															
		2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
5-B	**Children at risk for Serious Emotional Disturbance 100% below poverty**			2622					1299	1299	1284					
	https://data.census.gov/cedsci/?intcmp=aff_cedsci_banner															
		2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
5-C	**Persons with Developmental Disabilities -.005% of census**	319	318	314	312	310	307	306	308	301	306	304				

	Commuity Needs Assessment															
	Community Data Sets															
	CMHSP name:															
	Contact person/e mail address:															
6	**Community Homelessness- catchment area**	**2009**	**2011**	**2013**	**2015**	**2017**	**2019**									
6-A	**Local Continuum of Care Bi-ennial Homeless Count**															
	Change from Prior Time Period		0	0	0	0	0									
6-B	**# served from CMHSP data- of persons that are homeless**															
	Change from Prior Time Period		0	0	0	0	0									
6-C	**Community Employment**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
County 1	**Alcona**	**3376**	**3327**	**3424**	**3438**	**3436**	**3577**	**3659**	**3492**	**3683**	**3679**	**3637**				
County 2	**Alpena**	**12649**	**12234**	**12312**	**12299**	**12266**	**12373**	**13090**	**13149**	**12970**	**12858**	**12801**				
County 3	**Montmorency**	**3204**	**3129**	**3117**	**3046**	**3050**	**3165**	**2942**	**2701**	**2869**	**2831**	**2883**				
County 4	**Presque Isle**	**5025**	**4908**	**4949**	**5053**	**5132**	**5045**	**4966**	**4682**	**4984**	**4869**	**4903**				
County 5																
County 6																
	Total CMHSP	24254	23598	23802	23836	23884	24160	24657	24024	24506	24237	24224	0			
	Change from Prior Year		-656	204	34	48	276	497	-633	482	-269	-13	-24224			
	% change from Prior Year		-2.70%	0.86%	0.14%	0.20%	1.16%	0.0205712	-0.025672	0.0200633	-0.010977	-0.000536	-1			
	Cumulative Change since 2008		-656	-452	-418	-370	-94	403	-230	252	-17	626	-23802			
	% cumulative change since 2008		-2.70%	-1.86%	-1.72%	-1.53%	-0.39%	0.0166158	-0.009483	0.01039	-0.000701	0.0265277	-1			
	Source:	State of Michigan Labor Market Information														
		https://milmi.org/DataSearch/LAUS														
7	**Justice System**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
7-A	**Jail diversions**				**3**	**4**	**5**	**2**	**4**							
	(describe data source)															
		2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**							
7-B	**Prison discharges-number of people expected to meet SMI Criteria**	**3**	**4**	**5**	**3**	**8**										
	(describe data source)															
8	**Education System**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**					
8-A	**Number of students aging out or graduating special education**				**7**	**7**	**5**	**4**								
9	**Graduation and Dropout Rate**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**				
County 1	**Alcona**	**17**	**8**	**4**	**3**	**4**	**1**	**0**	**0**	**0**	**0**					
County 2	**Alpena**	**41**	**24**	**38**	**34**	**34**	**35**	**27**	**27**	**26**	**27**					
County 3	Montmorency	9	**4**	**11**	**6**	**5**	**7**	**4**	**6**	**7**	**2**					
County 4	Presque Isle	12	**6**	**17**	**16**	**12**	**17**	**10**	**15**	**6**	**5**					
County 5																
County 6																
	CMHSP Total:	79	42	70	59	55	**60**	**41**	**48**	**39**	**34**	**0**				
	Source - http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI															
9-A	% graduated	77	**72.85**	**82.725**	**76.025**	**78.25**	**84.125**	**89.1**	**92**	91.2	96.3	93				
9-B	% dropped out	12.85	12.55	4.925	8.575	9.53	15.875	10.9	8	8.8	3.7	7				
	Source - http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI															
		DATE														

	Commuity Needs Assessment															
	Community Data Sets															
	CMHSP name:															
	Contact person/e mail address:															
	For primary health items, identify point in time being reported		**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**						
10	**Primary Health**															
10-A	% of CMHSP consumers with an identified Primary Care Physican								39.46	46.67						
10-B	CMHSP Medicaid recipients with primary care service/encounter		198			540										
10-C	# with primary care plus emergency room		92			259										
10-D	# with emergency room no primary care		10			10										
	MDHHS does not have this data (10B, 10C, 10, D) availbale at this time.															
11	**Optional Information**	**2011**	**2012**	**2013**	**2014**	**2015**	**2017**	**2018**	**2019**							
	Private Providers and Public SA Providers															
11-A	Number of Existing Private Providers in Community															
11-B	Number of providers that utilize a sliding fee scale															
11-C	Number of providers that are accepting new clients															

Priority Needs and Planned Actions

CMHSP: Northeast Michigan Community Mental Health Authority

Based on feedback received from stakeholder groups and data collected from this process, the CMHSP must identify at least 5 priority needs. Of these, the CMHSP must identify the areas where it intends to address and what action is being planned in that area. The table below provides a format for identifying the top issues.

Priority Issue: Please give a brief explanation of the issue, in order of priority, with 1 being highest.

Reasons for Priority: Identify what makes this a priority issue. For example: the issue was identified by multiple stakeholder groups; or the size of the issue; or consistency with other community efforts, etc.

CMHSP Plan: Give a brief overview of what steps the CMHSP intends to take to address the identified issue. Please include basic time frames and milestones.

FY19 Update: Provide a narrative describing any progress or accomplishments made by the CMHSP on items identified in the Priority Needs and Planned Actions Assessment from FY18 or any changes made.

Priority Issue	Reasons for Priority	CMHSP Plan	FY 2019 Update
1. Trauma Informed Community	- Community concerns of domestic violence, sexual abuse, poverty, depression, self-harmful behaviors (cutting, substance use/opioids and alcohol abuse); Opioid abuse, prescription medication abuse; Mental Health concerns in middle and high school student population; violent outbursts in schools across all grade levels.	Promote a trauma-informed community through education, assessment and participation in community initiatives as evidenced by: Continue contracts with Partners in Prevention for community education specific to: - Caring for children who have experienced trauma - Mental Health First Aid and - Youth Mental Health First Aid - Coordination of efforts with the public schools specific to identifying and providing services/referral	1st Qtr Trauma Activities – conducted two 3-hour trainings on the topic "Trauma-Informed Practice for Providers in the Field of Intellectual and Developmental Disabilities reaching 45 participants. Held one 90-minute presentation on topic "Trauma-Informed Parenting" in the Power of Parenting series reaching 10 individuals. 2nd Qtr provided a 1-hour overview of how trauma affects children to 12 individuals in foster parent PRIDE training by DHHS and

		to those children and adults effected by trauma. Work collaboratively with the community partners in the region to address challenges related to the increasing opioid epidemic and increase in violence and anger dyscontrol.	Child & Family Services on 3/10/2019; Provided 90-minute Trauma Informed Strategies to 15 participants in a staff training at Alpena Childcare and Development Center 03/05/2019; Delivered a six-week, 12-hour course in Rogers City to 15 participants including Montessori School Director, Hope Shores Alliance staff, foster parents, grandparents and childcare providers 3rd Qtr – Worked to coordinate future community events. Information on trauma, Adverse Childhood Experiences (ACES) and mental health was presented and discussion was led at Circle of Parents meetings at Sunrise Centre (closed group) and First Congregational Church (open group. A total of 25 participants attended these sessions. A six-week "Caring for Children Who Have Experienced Trauma" course was held with 22 participants and 12 of those completing the course. 4th Qtr – 8/29/19 held a one-hour "The Effects of Trauma on Children" for Child and Family Services staff with 12 participants; 9/19/19 held a one hour

			"Seniors Dealing with the Effects of Childhood Trauma" course for the Alpena Senior Citizens Center with 32 participants; 9/25/19 first class of a six-week program "Caring for Children Who Have Experienced Trauma" with 25 participants.
2. Increase Suicide prevention across all populations	Increasing suicides in Northeast Michigan.	NeMCMHA has partnered with Presque Isle Suicide Prevention Task Force to increase suicide awareness and prevention. - Provide community trainings using 'safeTALK' from Living Works through our partnership with Partners in Prevention - Provide members of the community with myStrength App. - NeMCMHA staff are members of the Alpena Suicide Prevention Workgroup …and - the Board and staff of NeMCMHA are supporting efforts to establish a community NAMI group.	1st Qtr – 90-minute suicideTALK presentation for Power of Parenting with seven participants; 2nd Qtr – 3.5-hour safeTALK held in Onaway on 1/25/19 and Hillman on 2/05/19; 3rd Qtr – Worked to coordinate future community events. Received board approval to purchase the documentary "Suicide, the Ripple Effect." Made a presentation to the Alpena Noon Lions on current suicide prevention efforts. Made a similar presentation to the Rogers City Area Zonta Club about Mental Health First Aid and suicide prevention. 4th Qtr – 8/27 & 8/28 held a 15-hour Applied Suicide Intervention Skills Training (ASIST) for staff with 29 attending; 9/3/19 held a 3-hour safeTALK presentation for Rogers City Elementary School

			staff with 29 attending; 9/9/19 held a one-hour "Suicide Awareness Saves Lives" for Alpena Senior Citizens with 20 attending; 9/10/19 held a 30-minute presentation on "Suicide Awareness" for the First Methodist Church Men's Group with 10 attending; featured on three local television interviews during Suicide Prevention Week and Suicide Awareness Month.
3. Increased substance abuse services including prevention	Increasing opioid use disorders has strained community resources	Work collaboratively with the community partners in the region to address challenges related to the increasing opioid epidemic as evidenced by: - Participation in the Rural Communities Opioid Response Program Planning Grant to include participation in Board meetings and workgroups to attain the Consortium's Mission of, "An integrated consortium working to effectively treat, educate, train and reduce opioid use disorder in Northern Michigan through prevention, treatment and recovery" - NeMCMHA staff will continue as a member of the new Family Recovery Care Team (Catholic Human Services, Alpena/Montmorency County DHHS, Courts and Freedom Recovery Center) targeting families involved with DHHS Child	NMORC Board member NMORC Prevention committee member One Staff has completed their CADACC certification and another staff is in the process of completing their final hours towards this certification. Participated in the Montmorency County Substance Use Free Coalition NeMCMHA staff meet biweekly in Family Recovery Care Team Meetings with staff from DHHS, Catholic Human Services. These meetings review referrals for care coordination, provide support for recovery services for families who are addressing

		Welfare services and have a caregiver identified as having a substance use disorder or concern that substance abuse is present in the home. This project is a result of the Health Endowment Fund grant awarded to Catholic Human Services. - Northeast staff are members of the Substance Use Coalition and Northeast staff will continue training specific to substance use.	substance use disorders. 3 staff attended the annual SUD Conference in Detroit
4. Increasing need for consistent and accessible Behavioral Health Services in the schools for all populations.	'No wrong door', those without Medicaid are unable to access Mental Health Services, need a better process for communication and referral process Mental Health concerns in middle and high school	Two NeMCMHA staff have participated in the MDHHS-sponsored training by University of Michigan "TRAILS" (Transforming Research into Action to Improve the Lives of Students) model. "TRAILS" provides free training to school professionals in core concepts of cognitive behavioral therapy (CBT) and mindfulness – two evidence-based strategies shown to reduce anxiety and depression in youth. TRAILS is unique in that school partners receive not only classroom instruction, but also are provided a personal coach who helps implement a CBT- and mindfulness-based skills group to students in need, right at school. University of Michigan has identified Posen Consolidate Schools at the Pilot Site for TRAILS.	Two NeMCMHA staff were trained and certified by the University of Michigan "TRAILS" (Transforming Research into Action to Improve the Lives of Students) model. University of Michigan identified Posen Consolidate Schools as a Pilot Site for TRAILS. The 10 week program for junior high students focused on coping skills, mindfulness skill and self-care strategies for adolescents that were experiencing depression and anxiety. This program was completed during the 2018-2019 school year. In additional NeMCMHA staff trained school success staff member to continue to run the TRAILS program for future TRAILS programs to students in POSEN.

5. Increase awareness of Mental Health concerns	- Community concerns of depression, suicide, self-harm behaviors (cutting, substance use/opioids and alcohol abuse); Mental Health concerns in middle and high school student population – violent outbursts in schools across all grade levels - Community expressed need to establish Northern Michigan NAMI Chapter	NeMCMHA will continue to partner with Partners in Prevention to provide continued: - Caring for children who have experienced trauma - Mental Health First Aid and - Youth Mental Health First Aid …and - Coordination of efforts with the public schools specific to identifying and providing services/referral to those children and adults effected by trauma. - the Board and staff of NeMCMHA are supporting efforts to establish a community NAMI group.	1st Qtr – held an 8-hour Youth Mental Health First Aid with eight participants and five completing; held an 8-hour Adult Mental Health First Aid with 13 participants and 11 completing; 2nd Qtr – held an 8-hour Adult Mental Health First Aid with 16 participants and 15 completing; held an 8-hour Youth Mental Health First Aid with 9 participants and 8 completing; 3rd Qtr – held an 8-hour Adult Mental Health First Aid with 15 participants and 12 completing; held an 8-hour Youth Mental Health First Aid with 10 participants and all completing. 4th Qtr – held an 8-hour Youth Mental Health First Aid with 12 participants and 9 completing; held an 8-hour Adult Mental Health First Aid with 12 participants and 6 completing.

ESTIMATED FTE EQUIVALENTS

CMHSP: Northeast Michigan Community Mental Health
Contact name/e-mail: Nena Sork/nsork@nemcmh.org

TABLE 1 - Total Workforce in Specialized Residential Settings

	FTEs and Est DCW Cost	Actual Filled as of 9/30/19	Approved Vacancies	Total Actual and Approved
	Workforce in Specialized Residential Settings			
1	**Specialized Residential Settings**			
2	a. CMHSP Employees	93.4		93.4
3	b. Contract Agency Staff	81.4		81.4
4	Total	174.8	0	174.8

TABLE 2 - Total Workforce in Other Settings

	Total Workforce FTEs	Actual Filled as of 9/30/19	Approved Vacancies	Total Actual and Approved
5	CMHSP Employees	74.2		
6	Contract Agency Staff	46.4		46.4
7	Total	120.6	0	120.6

Expected FY 20 Workforce Changes

Provide a brief description (1-2 paragraphs) of expected FY 20 workforce changes

Also, please provide a brief description of the source of the FTE information (e.g. centrally maintained, surveyed providers, etc.)

The CMHSP FTE Information is centrally maintained. Contract Agency Staff estimate based upon pro rata projection of directly operated specialized residential sites FTE's onto contractual costs assuming the same staff to client ratios exist.

Our organization experienced turnover at a higher rate than the prior year due to several retiring employees however our overall turnover rate in comparison our industry of Health Care and Social Assistance is significantly below that rate but recruiting difficulties still remain. Continued enhanced direct support wages has helped increase the flow of applicants to our agency along with the use of web based recruiting tools. We have seen increased applicant flow for Master Level Social Workers which has been very helpful however our rural location hinders applicant's willingness to move to the area.

Northeast Michigan Community Mental Health Authority Board
COMMITTEE ROSTER

April 2020 [New]	**2019/2020 [Current]**
EXECUTIVE COMMITTEE	**EXECUTIVE COMMITTEE**
_____, Chair	Gary Nowak, Chair
_____, Vice Chair	Eric Lawson, Vice Chair
_____, Secretary	Bonnie Cornelius, Secretary
_____, Past Chair	Roger Frye, Past Chair
RECIPIENT RIGHTS COMMITTEE	**RECIPIENT RIGHTS COMMITTEE**
_____	Judy Jones (Board Rep.)
_____	Patricia Przeslawski (Board Rep.)
_____	Steve Dean (Board Rep. Alt.)
Tom Fredlund	Tom Fredlund
Renee Smart-Sheppler	Renee Smart-Sheppler
Lorell Whitscell	Lorell Whitscell
Barbara Murphy	Barbara Murphy
Ruth Hewett, Recipient Rights Officer	Ruth Hewett, Recipient Rights Officer

MAY AGENDA ITEMS

Policy Review

Policy Review & Self-Evaluation
Board Job Description 02-003
Board Core Values 02-014

Monitoring Reports
Treatment of Consumers 01-002 [Recipient Rights Log]
Budgeting 01-004
Financial Condition 01-005

Activity

Ownership Linkage

Educational Session
Environmental Scan – Eric Kurtz

WEEKLY UPDATE

March 27, 2020

Contents:

COVID-19 Resources: As the public mental health system copes with the COVID-19 pandemic, nearly every day brings additional information and announcements. To assist CMHA members in making sense of and locating this flurry of information, CMHA has developed a curated set of COVID-19-related resources and announcements from the state and national sources. That curated set of resources, which will be regularly updated, **is available by CLICKING HERE.**

Searching for past articles in Weekly Update: Weekly Update readers often remember seeing a past article or announcement that they would like to retrieve – but are unable to recall the date of the Weekly Update in which the article or announcement was published.

CMHA has now added a search feature to its website that allows the readers to search within past Weekly Update articles and announcements. This search feature can retrieve articles by key words in the title of the Weekly Update article/announcement. This feature also brings up any other resources, anywhere on the CMHA website, with that key word in their title – a useful feature given that sometimes the CMHA member or stakeholder is unclear as to the source of the information for which they are searching.

This Weekly Update search feature is accessed via the standard "search" box on the CMHA website: https://cmham.org/ at the top right side of the website.

We hope you find this new feature useful in making the most of the information captured by the Weekly Update.

Note: To aid Weekly Update readers in finding the newest resources, those Weekly Update articles that are new are noted as "**New!**" in the table of contents and in the body of the document.

CMH Association and Member Activities:

New! CMHA builds and continues to add content to COVID-19 webpage

As the public mental health system copes with the COVID-19 pandemic, nearly every day brings additional information and announcements. To assist CMHA members in making sense of and locating this flurry of information, CMHA has developed a curated set of COVID-19-related resources and announcements from the state and national sources. That curated set of resources, which will be regularly updated, is available by CLICKING HERE.

New! CMHA highlights its members' "Exceptional, Selfless Service Response To COVID-19"

As Weekly Update readers, you remember, CMHA has initiated an "Accurate Picture Campaign" as one of the core elements of our association's advocacy work. This campaign aims to highlight, in accessible formats and terms, the strengths of Michigan's public mental health system (one of the best in the country)

With the advent of the COVID-19 pandemic, the first phase of this campaign will highlight stories of excellence, innovation, selflessness, and heroic effort in response to the COVID-19 pandemic. We will use

these stories as part of a media relations effort, in partnership with the skilled PR firm of Lambert, aimed at media markets across the state.

These stories are coming to CMHA, from member organizations, across the state and are being highlighted on the Association's COVID-19 webpage under the heading "CMHA Members Exceptional, Selfless Service Response To COVID-19". The CMHA COVID-19 webpage can be found here.

New! Livingston County Community Mental Health: 'We are still open'

Below are excerpts from a recent news story of the safety net role being played by Livingston Community Mental Health as it serves the members of its community in the face of the COVID-19 pandemic. Livingston County Community Mental Health works with both children and adults with behavioral health and substance use disorder needs.

> The coronavirus outbreak won't change that, according to Connie Conklin, the organization's director.
> "We are the safety net mental health provider in the county, " she said. "We are still open."
>
> The agency's Howell offices will remain open to the public for psychiatric, injection and emergency appointments, she said. Stepping Stones Engagement Center, a substance abuse recovery support center will also remain open.
>
> "Part of what we continue to do is take calls and call people back. We try to be the dispatch, if we can't serve you we can at least direct people with the place to go," she said.
>
> The organization is limiting in-office staffing to prevent exposure, Conklin said, but has staff reaching out to consumers via phone and other telecommunications.
>
> A portion of their clients live independently but need contact and reassurance.
>
> "They need a touch stone, " she said.

The full article can be found here.

State and National Developments and Resources:

New! Six cases of coronavirus confirmed at Michigan-run psychiatric hospitals

Below are excerpts from a recent news story on the confirmation of COVID-19 cases in several Michigan state psychiatric hospitals.

> There are six confirmed cases of COVID-19 among psychiatric patients and staff in two Michigan state-run hospitals, the Department of Health and Human Services announced Tuesday, March 24.
>
> The cases include one patient from the 272-bed Center for Forensic Psychiatry in York near Ann Arbor, as well as two patients and three staff from Walter Reuther Psychiatric Hospital in Westland, MDHHS said.

> "Our primary focus is the health and safety of our staff and the patients at our state hospitals," MDHHS Director Robert Gordon said. "We treat the spread of COVID-19 with the greatest seriousness and are taking many steps to address it."
>
> "Several weeks ago," in preparation for the possible spread of the coronavirus, the state created isolation rooms in each of its five psychiatric hospitals, MDHHS said, and "additional cleaning measures have been undertaken at the facilities and staff and patients have been monitored closely for COVID-19 symptoms for the last two weeks."

The full article can be found here.

New! Health Affairs blog: Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During A Pandemic

Below is an excerpt from a recent Health Affairs blog post on COVID-19 and the social and health equity arguments around the need to protect vulnerable communities in the face of the pandemic.

> Federal, state and local governments are struggling to identify best practices for controlling the spread of COVID-19 while minimizing the negative effects of sweeping public health interventions, especially for poor and marginalized communities, which may be hardest hit. Social distancing and sheltering in place have emerged as a key strategies for flattening the curve of the epidemic and mitigating impacts on already-stressed health care systems. Measures to keep people at least six feet apart as much as possible—by closing schools, limiting the operations of nonessential businesses, and urging or requiring people to work from home and avoid gatherings—mean that many people will be sheltering in place for weeks or months. As authorities implement restrictions on personal liberty in some of the areas hit particularly hard by COVID-19, the potential for discriminatory enforcement and police escalation may endanger the safety and civil rights of at-risk and traditionally marginalized populations.

The full blog post can be found here.

New! College of Behavioral Health Leadership webinar: Sustaining Resilience During COVID-19 - From Leadership to the Front Line

Sustaining Resilience During COVID-19 - From Leadership to the Front Line

Wednesday, April 1, 2020
2:00pm PST / 3:00pm MST / 4:00pm CST / 5:00pm EST
60-minute panel discussion plus Q&A

What: COVID-19 has changed the world in which we live and work. Leaders and front-line healthcare professionals alike are facing new and more complex challenges as we adapt to a rapidly changing environment of care, while the level of uncertainty and ambiguity continues to grow. We are forced to make more difficult decisions, work in new ways and care for our own families, all while motivating our workforce to stay the course. So how do we collectively cultivate resiliency in order to remain strong and thrive while in stressful conditions, particularly when connection to others must be made from a distance? In this webinar, we will hear from three professionals to explore the dynamics of COVID-19 and how we can continue to support the development of our best selves as leaders through crisis. We will also learn about a model of peer

to peer support developed to support Chinese healthcare professionals, and an upcoming opportunity to virtually build resilience together

Who Should Attend? Healthcare leaders, community leaders, leaders of front-line workers, and others involved in the COVID-19 response
Our Panelists:

Cyra Perry Dougherty "Perry" is the founder and CEO of Rootwise Leadership, where she serves as the lead coach, consultant, facilitator, and teacher. With more than 15 years of experience working with global executive teams in the entrepreneurial, public, and social sectors, Perry enriches cutting-edge leadership and organizational development theory and practice with a deep understanding of the power of awareness, creativity, storytelling, and play. She pursues her work with transformation as both means and end.

Pu Cheng, M.D., FAPA is the Inpatient Director at Meridian Health Services and a volunteer Clinical Assistant Professor of Psychiatry at the Indiana University School of Medicine in Muncie Indiana. He received his medical degree from Shanghai Medical University and has been in practice for more than 10 years.

Shannon Mong, PsyD is passionate about making it easier for healthcare leaders to achieve their goals. An experienced consultant, she engages leaders and teams to solve complex problems in rapidly evolving environments. Shannon's career spans multiple industries and clients -- beginning in media and educational technology leadership before becoming a licensed psychologist. A former direct service provider and program administrator in the public behavioral health system and leader in a large provider organization, Shannon knows the challenge of managing day-to-day work while fostering innovation.

To Register click here.

State Legislative Update:

Legislature Passes Emergency Supplemental & Limits Session Days

Tuesday night the legislature unanimously approved another supplemental appropriations totaling $125 million to provide additional state funding to address COVID-19. This is in addition to $25 million in a separate supplemental bill approved last week that is currently on Governor Whitmer's desk.

The legislation contains $50 million for hospital services and medical supplies, $40 million for virus monitoring, infection control, among other things, and sets aside $35 million for additional spending to be made available via legislative transfer when necessary.

Both House and Senate leaders have effectively stopped all regularly schedule session days. It is the expectation that no business other than emergency business will be conducted **through April 20**. Specifically, "agenda items will be reduced to those already on the floor and those with true time constraints, as well as those deemed necessary to continue the essential functions of state government and address this public health emergency."

As this situation continues to evolve, we will continue to keep you apprised of developments regarding the legislature's schedule and other pertinent information.

Federal Update:

New! Latest COVID-19 Response Bill Supports Behavioral Health Providers

Early Thursday morning, the Senate unanimously passed Congress's third COVID-19 response package aimed largely at providing economic relief for businesses and workers. The bill features multiple direct supports for behavioral health providers, including direct relief to cover lost provider revenue, small business loans, more money for the Substance Abuse and Mental Health Services Administration (SAMHSA), and funds to improve the delivery of telemedicine and an extension and two-state expansion of the Certified Community Behavioral Health Clinic (CCBHC) program. As of this writing, the House is expected to vote on and pass the bill on Friday, and President Trump has signaled that he will sign it quickly into law. Stay tuned for further updates in *Capitol Connector* next week.

APPROPRIATIONS

The final Senate package includes new funding for health care providers to address the impact of COVID-19. These include:

- **SAMHSA**: **$425 Million Emergency Allocation:** This includes $250 million that the National Council requested be available for all community behavioral health organizations; $50 million for suicide prevention programs; $100 million for SAMHSA programs generally, and $15 million for tribes. Full details on how the funds will be distributed are not yet available.

- **Coronavirus Relief Fund**: **$150 billion** for states and local governments covering expenditures due to COVID-19. Each state will receive a minimum of $1.25 billion.

- **Public Health and Social Services Emergency Fund**: **$100 billion** in direct aid to health care institutions on the front line of the crisis – Per our reading of this line item, National Council members are eligible to receive funds from this allocation, at the discretion of the HHS Secretary.

- **Paycheck Protection Program: $350 billion** to provide eligible small businesses and nonprofits with a guarantee on a loan up to $10 million. This loan could then be forgiven for up to eight weeks of payroll, rent, utilities, and other essential operating expenses. Forgiveness would be reduced proportionally to any layoffs, as well as any reductions in salary above 25%. Eligible organizations include those with 500 or fewer employees. Language in an earlier draft would have excluded Medicaid providers, but the National Council advocated against this provision and in the final version it was removed, meaning **community behavioral health providers that receive Medicaid dollars are eligible to receive the loans**.

- **Small Business Administration Disaster Loans Program: $562 million** to support small businesses that need financial support. Businesses may request an emergency advance of up to $10,000, which does not have to be repaid, even if the loan application is later denied. Eligibility for these loans includes private nonprofits and businesses with 500 or fewer employees, among others.

- **Childcare Development Block Grant Childcare: $3.5 billion** to childcare assistance for essential workers which may include behavioral health providers. This is determined at the state level.

- **Distance Learning, Telemedicine, and Broadband Program**: **$25 million** to improve distance learning and telemedicine in rural America. Includes additional **$100 million** funds to increase broadband access.

- **Administration for Community Living: $955 million** to support nutrition programs, home and community-based services, and protections for people living with disabilities.

POLICY CHANGES

The package also includes many policy changes designed to support employers and expand access to care. The National Council continues to analyze these sections and will provide further updates.

Provisions for Employers:

- Emergency Unemployment Relief for Governmental Entities and Nonprofit Organizations provides payment to states to reimburse nonprofits, government agencies, and Native American tribes for half of the costs they incur through December 31, 2020 to pay unemployment benefits.

- Pandemic Emergency Unemployment Compensation provides an additional 13 weeks of unemployment benefits through December 31, 2020 to help those who remain unemployed after weeks of state unemployment benefits are no longer available.

- Allows employers and self-employed individuals to defer payment of the employer share of the Social Security tax they otherwise are responsible for paying to the federal government with respect to their employees. Employers generally are responsible for paying a 6.2-percent Social Security tax on employee wages. The provision requires that the deferred employment tax be paid over the following two years, with half of the amount required to be paid by December 31, 2021 and the other half by December 31, 2022.

- Employer shall not be required to pay more than $200 per day and $10,000 in the aggregate for each employee under FMLA

- Employer shall not be required to pay more than $511 per day and $5,110 in the aggregate for sick leave or more than $200 per day and $2,000 in the aggregate to care for a quarantined individual or child for each employee under paid sick leave provisions

- Allows employers to receive an advance tax credit from Treasury instead of having to be reimbursed on the back end

- Short-Time Compensation Programs provides funding to support existing "short-time compensation" programs, where employers reduce employee hours instead of laying off workers and the employees with reduced hours receive a pro-rated unemployment benefit. The federal government would pay 100 percent of the costs they incur in providing this short-time compensation through December 31, 2020. The legislation also provides $100 million in grants to states that enact "short-time compensation" programs to help them implement and administer these programs.

- **Modification of Limitations on Charitable Contributions During 2020:** Increases the limitations on deductions for charitable contributions by individuals who itemize, as well as corporations. For individuals, the 50-percent of adjusted gross income limitation is suspended for

2020. For corporations, the 10-percent limitation is increased to 25 percent of taxable income. This provision also increases the limitation on deductions for contributions of food inventory from 15 percent to 25 percent. Additionally, the legislation permits individuals to deduct up to $300 of charitable cash contributions, whether they itemize their deductions or not.

- **Clarification on COVID Coverage via Medicaid**: The final version includes language clarifying that individuals with Medicaid benefits that are not considered minimum essential coverage will still be eligible to get coverage for COVID-19-related expenses.

- **Flexibility for Members of National Health Service Corps During National Emergency:** Provides flexibility in the site of service locations for NHSC participants.

- **Confidentiality and Disclosure of SUD Records and Guidance on Protected Health Information:** Modifications have been made to 42 CFR Part 2 protecting SUD records. These records may now be shared with prior written consent; once consent is obtained, it is permissible for patient consent to be given once for all future uses for treatment, payment and health care operations.

Extension and 2-State Expansion of CCBHCs: The text includes:

- Extension of current demonstration through Nov. 30, 2020.

- Expansion of demonstration to two additional states within 6 months. The two states shall be selected based on the applications previously submitted to SAMHSA—essentially, allowing the two states that would have been next in line to participate without submission of any additional application materials. An enhanced federal match rate is available for the first 8 quarters of the demonstration for new states, and for the 8 quarters beginning 1/1/2020 for the eight current demonstration states.

WHAT'S NOT IN THE BILL:

"Distant Site" fix: Community behavioral health organizations were not included in the "distant site" fix that would allow FQHCs and rural health centers to serve as distant locations for Medicare telehealth. The National Council will continue working to advocate for this fix in future COVID response packages.

Click here for a section-by-section summary of the full bill, provided by Senate Majority Leader Mitch McConnell's office.

Education Opportunities:

What's Cancelled and What's Taking Place?????

With the rapidly changing situation, events and meetings are being cancelled, postponed, being held virtually or rescheduled. Please refer to www.cmham.org to see if your event /meetings taking place. The site is being updated several times a day.

Registration Opening Soon! CMHA 2020 Annual Spring Conference

New Location for Annual Spring Conference: Grand Traverse Resort, Traverse City, Michigan! The conference will be held on:

2020 Annual Spring Conference
June 8, 2020: Pre-conference Institutes
June 9 &10, 2020
Grand Traverse Resort, Traverse City

Conference Registration & Hotel Reservations are not available at this time.

COD Regional Trainings: Co-Occurring, Opioid Use, and Cannabis Use Disorder Treatment Planning

Course Description:
Treatment planning for adults with complex mental health, substance use, and physical health needs involves understanding stages of change and system navigation. Collaborating with these individuals on their wellness and recovery planning requires motivational approaches and often interventions that are more effective for early stage readiness. The prevalence of cannabis and opioid use makes these cases even more demanding to navigate.

Add to this, the opioid crisis in the U.S. Since 1999, sales of opioids in the U.S. have quadrupled. From 1999-2015, more than 180,000 people died from overdoses related to prescription opioids. In Michigan, in 2017, there were 1,600 opioid overdose deaths, an increase of 57% from 2016. It is now the #1 cause of accidental death for people under 50. The Centers for Disease Control (CDC) have issued recommendations that include a preference for non-pharmacological therapy. This presentation will provide an overview of a biopsychosocial model of pain, current best practices in pain management, and treatment planning and interventions. Finally, social justice issues for pain management will be addressed with constructs to improve organizationally and individually.

Who Should Attend?
This event is sponsored by the adult mental health block grant and is **only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the State of Michigan.** It contains content appropriate for CEOs, COOs, Clinical Directors, Supervisors, Case Managers, Support Coordinators, Therapists, Crisis Workers, Peer Support Specialists and any other practitioners at the beginning level of practice. This training is designed for persons providing COD services in Adult Mental Health and Substance Use services, including Integrated Dual Disorder Treatment teams.

Dates/Locations:
- ~~May 4, 2020 – Delta Hotels Kalamazoo Conference Center~~ | **CANCELLED**
- July 23, 2020 – Park Place Hotel & Conference Center, Traverse City | CLICK HERE for more information and to register now

Be sure to register as soon as possible, training space is limited and will fill up quickly!

Training Fee:
$65 per person. The fee includes training materials, continental breakfast and lunch.

FY20 Motivational Interviewing College regional trainings

Registration is now open for the FY20 Motivational Interviewing College regional trainings which includes Basic, Advanced, Supervisory, and the TNT course: Teaching Motivational Interviewing! For more information and to register now, click the links below.

This event is sponsored by the adult mental health block grant and is intended for persons who serve adults only through the mental health and substance abuse provider network in the state of Michigan. It contains content appropriate for CEOs, COOs, clinical directors, supervisors, case managers, support coordinators, therapists, crisis workers, peer support specialists and any other practitioners at the beginning, advanced and supervisory levels of practice.

Dates/Locations:
~~**April – DoubleTree Detroit – Dearborn**~~ **CANCELLED**

July – Hotel Indigo, Traverse City
Basic: Monday & Tuesday, July 20-21, 2020
Advanced: Monday & Tuesday, July 20-21, 2020
Supervisory: Tuesday, July 21, 2020

Times:
Registration starts at 8:30am & the training will run from 9:00am-4:15pm for all trainings.

Training Fees:
$125 per person for all 2-day trainings / $69 per person for the 1-day Supervisory training. The fee includes training materials, continental breakfast and lunch each day.

Be sure to register as soon as possible, training space is limited and will fill up quickly!

Please be sure you're clicking on the correct registration link in the brochure for the date/location you want; unfortunately, full refunds cannot be made when registering for the incorrect date.

FY20 DBT Trainings

2-Day Introduction to DBT Trainings

This 2-Day introduction to DBT training is intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan who are interested in learning the theoretical underpinnings of the treatment. It will explain what the key ingredients are in DBT that make up its empirical base. A basic overview of the original DBT skills will be covered along with how to structure and format skills training groups. This training is targeted toward those who are new to DBT with limited experience and who are looking to fulfill the pre-requisite to attend more comprehensive DBT training in the future.

Dates/Locations:
- ~~March 30-31, 2020 – Hilton Garden Inn Lansing West~~ | **CANCELLED**
- ~~April 14-15, 2020 – Great Wolf Lodge, Traverse City~~ | **CANCELLED**

Who Should Attend?
This event is sponsored by the adult mental health block grant and is *only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan*. This seminar contains content appropriate for medical directors, clinical directors, case workers, supports coordinators, and other practitioners at all beginning level of practice.

Training Fee:
$125 per person. The fee includes training materials, continental breakfast and lunch for both days.

5-Day Comprehensive DBT Trainings

- This training is designed for CMH, CMH service providers, PIHP, and PIHP service provider staff who are directly responsible for delivering DBT.
- Due to the fact DBT is a comprehensive treatment that treats high-risk individuals, one's core training ought to be comprehensive as well.
- IT IS EXPECTED THAT ALL PARTICIPANTS WILL MAKE A FULL COMMITMENT TO ATTEND ALL 5 DAYS mindfully and will participate fully in discussion, role-plays and complete daily homework assignments.
- Participants are asked to bring a copy of "Cognitive Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan, PhD, with them to the training.
- COMPLETION OF A 2-DAY INTRODUCTION TO DBT TRAINING OR EQUIVALENT IS A PRE-REQUISITE FOR ATTENDING THIS TRAINING.
- This is NOT a training that teaches DBT skills. There will be very little focus on DBT skills. The majority of the focus of this training will be to help clinicians on how to conduct individual DBT sessions. If your goal is to come to this training in order to learn DBT skills, do not attend. By attending, you understand and consent to knowing this ahead of time.

Dates/Locations:

- May 18-22, 2020 – Holiday Inn Grand Rapids Airport West | **SOLD OUT** – email Bethany Rademacher at brademacher@cmham.org to be placed on a waiting list
- June 8-12, 2020 – Park Place Hotel & Conference Center, Traverse City | CLICK HERE for more information and to register now

Who Should Attend?
This event is sponsored by the adult mental health block grant and is *only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan*. This seminar contains content appropriate for medical directors, clinical directors, case workers, supports coordinators, and other practitioners at all beginning level of practice.

Training Fee:
$250 per person. Fee includes training materials, continental breakfast and lunch for 5 days.

NEW DATE: Self-Determination Conference

This conference will broaden and deepen your understanding of the crucial elements of Self-Direction and the importance of Self-Determination in Behavioral Health. It will provide training and technical assistance on the topics of Effective Person-Centered Planning, Independent Facilitation, Supported Decision-Making, Fiscal Intermediaries, How to Structure Self-Directed Service Arrangements, Budget Development, and more. Dynamic presenters and speakers will reenergize your commitment to the principles and practice of Self-Determination!

Date & Time: Location:

Friday, September 11, 2020
8am – 5pm
Lansing, MI 48933

Lansing Center
333 E. Michigan Ave.

Who Should Attend?:
This conference contains content tracks appropriate for all individuals who receive services, family members, case managers, supports coordinators, clinicians, CMH administrative and clinical staff, providers, HCBS and waiver coordinators, fiscal intermediaries and independent facilitators.

Registration available soon, check CMHA website for more information and updates.

Ethics for Social Work & Substance Use Disorder Professionals & Psychologists Trainings

Community Mental Health Association of Michigan is pleased to offer Ethics for Social Work & Substance Use Disorder Professionals & Psychologists 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.
This training fulfills the MPA requirements for psychologists.

Trainings offered on the following dates:
April 15, 2020 – Kalamazoo **CANCELLED**
April 22, 2020 – Detroit **CANCELLED**

Additional dates to be scheduled soon!

Pain Management and Mindfulness Trainings

Community Mental Health Association of Michigan is pleased to offer Pain Management Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This course qualifies for 2 CEs and fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for pain management.

Trainings offered on the following dates:
April 23, 2020, 9:00am-11:00am – Detroit **CANCELLED**

Training Fees: (fee includes training material)
$39 CMHA Members
$47 Non-Members

Fetal Alcohol Spectrum Disorder Trainings - CANCELLED

The Fetal Alcohol Spectrum Disorder Training: Improving Outcomes for Youth, Families, and Agencies by Recognizing and Responding to Fetal Alcohol Spectrum Disorders (FASD) and Other Neurocognitive Impairments for Monday, March 16, 2020 – Gaylord and Monday, April 6, 2020 – Jackson are both cancelled. We will reschedule this popular training later in FY2020.

TREM and M-TREM Trainings

Michigan Department of Health and Human Services and Community Mental Health Association of Michigan present: TREM AND M-TREM TRAININGS Featuring: Community Connections, Washington, DC. Based on both clinical experience and research literature, TREM has become one of the major trauma recovery interventions for women and men. TREM and MTREM are fully manualized group interventions for trauma survivors served by behavioral health providers.

LOCATION, DATES AND AGENDA

- Holiday Inn Airport - Grand Rapids - April 28-30, 2020 **CANCELLED**
- Community Mental Health Association of Michigan (CMHAM), Lansing - June 2-4, 2020

Registration: 8:30a.m. - 9:00 a.m.; Training: 9:00 a.m. - 4:00 p.m.

Open to individuals working in the public Mental Health System. Note: The trauma policy is now an amendment to the CMHSP contract. PARTICIPANTS: Master's prepared clinicians (men and women), their clinical supervisor from CMHSPs. CMHSPs that currently DO NOT have trained TREM/M-TREM clinical staff will be prioritized for the training.

Cost is $150 per participant. Registration fees, hotel, travel and additional meals are at the agency's expense.

EXPECTATION: Clinicians and Clinical Supervisors registering for the training will be expected to:

1. Participate in 3-day TREM/M-TREM training
2. Participate in 12 monthly coaching calls (1-hour calls)

Clinicians will be expected to: Conduct 2 TREM or M-TREM groups in the year following the training

Teams are comprised of 1 limited licensed supervisor and, at a minimum, 2 limited licensed clinicians. All team members are expected to attend the three days of training. Participate in the monthly coaching calls; and implement 2 TREM/M-TREM groups in the next year.

Please email awilson@cmham.org for information. No continuing education credits available.

News from Our Preferred Corporate Partners:

Relias: Help Your Staff Understand Trauma-Informed Care

Implementing trauma-informed care involves everyone, including your administrative staff and assistants. Every interaction with a client can either:

- Contribute to a safe and trusting healing environment
- Detract from a safe and trusting healing environment

Research shows that interactions with non-clinical staff often set the tone of the practitioner-patient relationship, making it critical for administrative staff and assistants to understand trauma-informed care.

Read the Blog

Read this Q&A blog, You Asked, We Answered; 12 Questions About Trauma-Informed Care, to learn how supervisors and managers can help non-clinical staff leverage trauma-informed practices.

Abilita provides guidance to organizations working to employ E911 approaches

The workplace is quickly changing with the global COVID-19 crisis. As more organizations require employees to work from home, it's essential that they incorporate E911 into their remote communication strategies.

In addition, by the end of this year, all organizations in Michigan with greater than 20,000 square feet of workspace and/or multiple buildings or floors must comply. If someone from your organization called 911 now, would their location in the building get sent to the 911 center? Are you in compliance with the new Michigan E911 law?

Check out www.abilita.com/michigan-e911 to learn more about what you need to do to prepare!

myStrength: new digital behavioral health resources empower consumers to move beyond trauma

Click at left for a video overview of the new Moving Beyond Trauma program

Trauma is incredibly common. Approximately 90% of U.S. adults have experienced at least one traumatic event in their lives, which can adversely affect emotional well-being and interfere with relationships, work and overall quality of life. Expanding on our diverse whole-person resources, Livongo for Behavioral Health by myStrength is pleased to announce new, digital tools to help individuals Move Beyond Trauma. Leveraging gold-standard, evidence-based approaches including cognitive behavioral therapy (CBT) and mindfulness, these web and mobile resources:

- Address a wide range of trauma types from military deployment and assault, to natural disasters, accidents and other traumatic events.
- Empower individuals to manage discomfort and distress with actionable, in-the-moment coping skills to manage their daily symptoms
- Normalize thoughts, feelings and experiences to help consumers understand that there is a way forward that has been proven to work for so many others
- Complement Livongo's whole-person platform, which addresses chronic physical and behavioral health conditions including diabetes, stress, hypertension, and more.

Click here to request a demo.

CMH Association's Officers and Staff Contact Information:

CMHA 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: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Second Vice President: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Randy Kamps; randyk@4iam.com; (231)392-6670
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

CMHA Staff Contact Information:

CMH Association staff can be contacted at (517) 374-6848 and via the e-mail addresses below:

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
Audrey Daul, Administrative Assistant, adaul@cmham.org
Dana Ferguson, Senior Accounting Specialist, dferguson@cmham.org
Janessa Nichols, Accounting Clerk, jnichols@cmham.org
Anne Wilson, Training and Meeting Planner, awilson@mham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
Bethany Rademacher, Training and Meeting Planner, brademacher@cmham.org
Jodi Hammond, Training and Meeting Planner, jhammond@cmham.org
Alexandra Risher, Training and Meeting Planner, arisher@cmham.org
Madi Sholtz, Training and Meeting Planner, msholtz@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org

WEEKLY UPDATE

March 20, 2020

Contents:

COVID-19 Resources: As the public mental health system copes with the COVID-19 pandemic, nearly every day brings additional information and announcements. To assist CMHA members in making sense of and locating this flurry of information, CMHA has developed a curated set of COVID19-related resources and announcements from the state and national sources. That curated set of resources, which will be regularly updated, **is available by CLICKING HERE.**

Searching for past articles in Weekly Update: Weekly Update readers often remember seeing a past article or announcement that they would like to retrieve – but are unable to recall the date of the Weekly Update in which the article or announcement was published.

CMHA has now added a search feature to its website that allows the readers to search within past Weekly Update articles and announcements. This search feature can retrieve articles by key words in the title of the Weekly Update article/announcement. This feature also brings up any other resources, anywhere on the CMHA website, with that key word in their title – a useful feature given that sometimes the CMHA member or stakeholder is unclear as to the source of the information for which they are searching.

This Weekly Update search feature is accessed via the standard "search" box on the CMHA website: https://cmham.org/ at the top right side of the website.

We hope you find this new feature useful in making the most of the information captured by the Weekly Update.

Note: To aid Weekly Update readers in finding the newest resources, those Weekly Update articles that are new are noted as "**New!**" in the table of contents and in the body of the document.

CMH Association and Member Activities:

2020 Walk a Mile moved from May 14 to September 29

With the onslaught of COVID-19 (Coronavirus Disease 19), many functions, trainings, conferences and events are being cancelled locally, statewide, and nationally. In an effort to help prevent the spread of this virus, limit exposure, and to ensure the health of those we serve – some of the most vulnerable populations there are! – the Community Mental Health Association has decided to cancel the Walk A Mile Rally at the State Capitol on May 14, 2020.

WE KNOWN HOW IMPORTANT THIS EVENT IS FOR THOSE WE SERVE TO HAVE THEIR VOICES HEARD!!

A new date to rally and be heard by our State Legislators has been scheduled for September 29, 2020! More details will be sent out as they become available, and an updated Packet will be posted on the website as soon as it is developed.

Benjamin Franklin said that "An ounce of prevention is worth a pound of cure", and while there is no cure, yet, for COVID-19, the Association will do its best to provide an ounce of prevention in any way that we can to protect the Public Mental Health System.

Thank you for your understanding.

State and National Developments and Resources:

New! NACBHDD announces town hall meeting on best practices in response to the Coronavirus pandemic

On Mar 25, 2020 3:00 PM EDT, the National Association of County Behavioral Health and Developmental Disabilities Administration (NACBHDD) is holding a town hall on the best practices in response to the COVID19 pandemic. The coronavirus pandemic has changed life in America overnight. It also has changed how county behavioral health and I/DD programs operate. This Town Hall is intended to bring together our shared experiences in how best to respond to some of the challenges we are facing in our work and in our lives.

Register for this town hall here.

New! Resources available to help us deal with COVID19 and its related social distancing

Michiganders are asking for guidance in how to deal, and how to help others deal, with the stress of COVID19 and the stress that COVID19-related social distancing can cause. Links to some of the best resources on these subjects are found below:

- How to Care for Yourself While Practicing Physical Distancing
- How Do I Know Someone is Experiencing Anxiety or Depression?
- How to Help Someone with Anxiety or Depression During COVID-19
- How to Support a Loved One Going Through a Tough Time During COVID-19

New! Communities on the Coronavirus Disease 2019 (COVID-19) Response

Dr. Butler will share guidance with partners, public health practitioners, healthcare providers, and others working to protect the health of rural communities. He will describe what CDC knows at this point and what CDC is doing in response to this outbreak. We will also have time for questions and answers.

Please email eocevent337@cdc.gov to submit questions in advance and indicate that questions are for the 3/23 call.

This event will be recorded. Questions not answered during it may be sent to ruralhealth@cdc.gov.

REGISTER HERE.

New! Disability Groups Urge HHS to Take Steps to Prevent Discriminatory Rationing of Coronavirus Treatment

Below are excerpts from a recent letter from the CEO of the Bazelon Center, one of the nation's leading legal advocacy groups working on disability rights issues.

We are working hard to make sure that people with disabilities are not further discriminated against during the COVID-19 pandemic. During times like this, we are working very closely across our civil rights, disability rights, and mental health coalitions. Today the Consortium for Citizens with Disabilities (CCD), the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities, sent the following letter to the Department of Health and Human Services. Jennifer Mathis, our Policy Director & Deputy Director of Litigation & one of the co-chairs of the Rights Task Force, helped lead CCD's effort to urge Secretary Azar and Roger Severino, Director of the Office of Civil Rights, to ensure that if the current pandemic results in decisions to ration treatment, decisions about how medical treatment should be allocated are made without discriminating based on disability. You can read the letter HERE.

We will continue to keep you updated and we thank you for your ongoing support during this unprecedented time.

New! Health Affairs blog: Health care priorities for a COVID-19 stimulus bill: recommendations to the Administration, Congress, and other federal, state and local leaders from public health, medical, policy and legal experts

Below are excerpts from a recent Health Affairs blog on health care priorities that should be promoted as part of the federal COVID19 stimulus Bill.

With nationwide community-spread of the novel coronavirus COVID-19 and extreme volatility in the economic markets, Congressional action is necessary and appropriate to help keep the United States healthy and to avoid financial calamity. Doing so will require significant financial investment, legislative and executive action, and the full participation of all segments of American society — government, the private sector, and individual citizens.

As experts in public health, medicine, policy and law, and with prior expertise in developing federal health legislation and public health initiatives, we hereby present a framework designed to protect the health of all Americans in the face of this unprecedented epidemic. Because this framework is directed at Congress, we do not detail critical efforts that must be undertaken, and in some cases already are being undertaken at the state level. States have broad emergency powers to regulate insurance and health care access. If asked, the President should immediately invoke the Stafford Act to trigger an influx of federal funds and support state, tribal, and local government response efforts. An additional Presidential declaration via the National Emergencies Act would empower multiple federal agencies to waive or relax current legal restrictions.

Four basic principles guided the development of the framework offered here:

* Ensuring health security is the fundamental duty and responsibility of government at all levels — federal, state, and local.

* Protecting Americans' health in this time of crisis should be a unifying effort; it should not be and cannot be divisive.
* Immediate and targeted action is required to address the current coronavirus epidemic.
* Sustained investments in public health are needed to respond to this acute crisis and to prepare the nation for future epidemics.

The full blog can be found here.

New! SAMHSA Practitioner Training Center: a rich resource for mental health practitioners

At the recent NACBHDD conference, the participants learned of the SAMHSA Practitioner Training Center one of the best kept secrets as a source of information and resources for mental health practitioners. The Mental Health Technology Transfer Center (MHTTD) of the CMHA is the Michigan partner, is only one part of the Practitioner Training Center.

Information about the work of the Center can be found here.

New! MDHHS seeks comments on Psychiatric Collaborative Care Model policy

MDHHS has recently issued a policy that supports a practice that many CMHs, PIHPs, and providers and their primary care practice partners have been using for years, in integrated care practices across the state. Michigan's MC3 initiative, a nation-leading practice (that has been highlighted in the Weekly Update) that is in place at a large number of private practices across Michigan, in partnership with CMHs in their communities, is based on this model.

Policy Summary: The Psychiatric Collaborative Care Model (CoCM) is a model of integrated behavioral health services typically provided within the primary care setting. The goal is to increase access to behavioral health services for those with mild to moderate behavioral health disorders.

Purpose: To increase access to behavioral health services for those with mild-moderate behavioral health conditions within the primary care setting.

Comments should be sent to:

Janell Troutman
Bureau of Medicaid Policy, Operations, and Actuarial Services Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979
Telephone Number: 517-284-1248 Fax Number: 517-241-8969
E-mail Address: troutmanj1@michigan.gov

The full text of the proposed policy can be found at:
https://www.michigan.gov/documents/mdhhs/1945-CoCM-P_683568_7.pdf

State Legislative Update:

New! Legislature Passes Emergency Supplemental & Limits Session Days

Tuesday night the legislature unanimously approved another supplemental appropriations totaling $125 million to provide additional state funding to address COVID-19. This is in addition to $25 million in a separate supplemental bill approved last week that is currently on Governor Whitmer's desk.

The legislation contains $50 million for hospital services and medical supplies, $40 million for virus monitoring, infection control, among other things, and sets aside $35 million for additional spending to be made available via legislative transfer when necessary.

Both House and Senate leaders have effectively stopped all regularly schedule session days. It is the expectation that no business other than emergency business will be conducted **through April 20**. Specifically, "agenda items will be reduced to those already on the floor and those with true time constraints, as well as those deemed necessary to continue the essential functions of state government and address this public health emergency."

As this situation continues to evolve, we will continue to keep you apprised of developments regarding the legislature's schedule and other pertinent information.

Federal Update:

New! Federal Government Mobilizes Wide-Ranging Coronavirus Response Initiatives

As the novel coronavirus (COVID-19) pandemic continues impacting every corner of society, Congressional leadership and leaders in the Trump Administration are mobilizing wide-ranging supports that have direct impacts on the behavioral health field and the National Council's members. Congress passed its second response bill this week and is now turning its attention to a third legislative package, as various federal agencies provide clarity and increased flexibility to health care and other industries. The National Council has been hearing from our members about their biggest challenges and we are working hard to educate lawmakers and the Administration about the behavioral health field's needs.

The Families First Coronavirus Response Act (H.R. 6201) was passed by Congress on Wednesday and immediately signed into law by President Trump. Additionally, federal agencies including the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Drug Enforcement Administration (DEA), and others have been releasing guidance around a number of issues. See below for updates across these sources organized by issue area.

CONDUCTING TELEMEDICINE VISITS

CMS has clarified and provided more flexibility for states to respond to the coronavirus. The allowances outlined below will remain effective for the duration of the COVID-19 public health emergency.

Medicaid Telehealth:

CMS made clear to states that they already have **flexibility to utilize telehealth services, including audio-only services, in their Medicaid programs**. States can cover telehealth using various methods of

communication such as telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.

Note: **States themselves, not CMS, are responsible for making these options, including audio-only telephonic services, available to providers.**

Telehealth and Prescriptions of Controlled Substances: The DEA has announced that for the duration of the public health emergency, registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, providing the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.
- This temporary relief of the Ryan Haight Act has been a long-term advocacy goal of the National Council and its members. We thank all members who worked to build this case with DEA over the years to make this emergency declaration possible.

Medicare Telehealth

- Retroactive to March 6, Medicare will temporarily pay clinicians to provide telehealth services for beneficiaries across the country. Previously, Medicare only covered particular services in specific situations, such as if an enrollee lived in a rural area and was unable to receive in-person services within a reasonable distance. A range of providers, **including clinical psychologists and licensed clinical social workers**, will be able to offer Medicare-covered telehealth services to enrollees based in any health care facility, **including physicians' offices, nursing homes, as well as from enrollees' homes.**
- Additionally, the Families First Act corrects language included in Congress's first COVID-19 response package to clarify that, for the **purposes of establishing a relationship** with a provider to waive current prohibitions surrounding telehealth services in Medicare, any services allowable under Medicare will qualify as an existing relationship, even if Medicare was not the program paying for the service.

Telehealth Best Practices

- The National Council has compiled a reference document that includes details on these changes and more, titled "Best Practices for Telehealth During COVID-19 Public Health Emergency." This document is intended to provide mental health and substance use treatment providers with the background and resources necessary to help begin or expand the use of telehealth.

TELEHEALTH AND PRIVACY: HIPAA & 42 CFR PART 2

- **HIPAA:** The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) announced that it will exercise its enforcement discretion and will waive potential penalties for

HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 public health emergency. This applies to widely available communication apps such as FaceTime or Skype when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.

- **42 CFR Part 2:** SAMHSA issued guidance related to the sharing of substance use disorder health records throughout the public health emergency. SAMHSA makes clear in the guidance, information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed. SAMHSA notes that Part 2 requires programs to document certain information in their records after a disclosure is made pursuant to the medical emergency exception. **SAMHSA emphasizes that, under the medical emergency exception, providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.**

INCREASED HEALTH FUNDING

- **Federal Medicaid Funds:** The federal government's share of Medicaid payments, known as the Federal Medical Assistance Percentage (FMAP), has been increased by 6.2 percentage points. This increased assistance comes with the requirement that state Medicaid programs cover COVID-19-related treatment, vaccines, and therapeutics at no cost to enrollees as well as states not making eligibility standards more restrictive or increasing any cost sharing for enrollees.

- **More Funding for CDC & NIH:** The Trump Administration is updating its Fiscal Year 2021 Budget Request to include a request for an additional $45.8 billion and the necessary authorities for the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) to address ongoing preparedness and response efforts.

OTHER UPDATES

- **Paid Sick Leave:** The Families First Act requires employers to provide two weeks paid sick leave and up to three months of paid family leave for employees affected by the virus, the cost of which could then be claimed by the employer as a fully-refundable tax credit. The measure exempts health care and emergency responders, as well as companies with more than 500 employees. Companies with fewer than 50 employees may attain hardship waivers.

NEXT STEPS

Congress now turns its attention immediately to a third COVID-19 response package, which is rumored to focus on relief for small businesses, direct financial assistance to Americans, assistance for airlines, and a slew of health care updates such as extensions of important Medicaid programs like the Certified Community Behavioral Health Clinic (CCBHC) demonstration. The timeline for this third package is still unclear.

The National Council is hard at work advocating for its members amid these rapidly shifting federal responses. Our President and CEO, Chuck Ingoglia, focused his first monthly townhall with members yesterday on the National Council's COVID-19 efforts and focus. We have compiled a list of resources for the public and for our members that cover topics ranging from updates from the CDC and the World Health Organization all the way to tips and tricks on managing anxiety associated with the coronavirus. This site will be updated regularly, so continue checking back often for more resources. Additionally, check in with *Capitol Connector* each week for continuous updates as the situation evolves.

Education Opportunities:

New! What's Cancelled and What's Taking Place?????

With the rapidly changing situation, events and meetings are being cancelled, postponed, being held virtually or rescheduled. Please refer to www.cmham.org to see if your event /meetings taking place. The site is being updated several times a day.

Registration Opening Soon! CMHA 2020 Annual Spring Conference

New Location for Annual Spring Conference: Grand Traverse Resort, Traverse City, Michigan! The conference will be held on:

2020 Annual Spring Conference
June 8, 2020: Pre-conference Institutes
June 9 &10, 2020
Grand Traverse Resort, Traverse City

Conference Registration & Hotel Reservations are not available at this time.

COD Regional Trainings: Co-Occurring, Opioid Use, and Cannabis Use Disorder Treatment Planning

Course Description:
Treatment planning for adults with complex mental health, substance use, and physical health needs involves understanding stages of change and system navigation. Collaborating with these individuals on their wellness and recovery planning requires motivational approaches and often interventions that are more effective for early stage readiness. The prevalence of cannabis and opioid use makes these cases even more demanding to navigate.

Add to this, the opioid crisis in the U.S. Since 1999, sales of opioids in the U.S. have quadrupled. From 1999-2015, more than 180,000 people died from overdoses related to prescription opioids. In Michigan, in 2017, there were 1,600 opioid overdose deaths, an increase of 57% from 2016. It is now the #1 cause of accidental death for people under 50. The Centers for Disease Control (CDC) have issued recommendations that include a preference for non-pharmacological therapy. This presentation will provide an overview of a biopsychosocial model of pain, current best practices in pain management, and treatment planning and interventions. Finally, social justice issues for pain management will be addressed with constructs to improve organizationally and individually.

Who Should Attend?
This event is sponsored by the adult mental health block grant and is **only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the State of Michigan.** It contains content appropriate for CEOs, COOs, Clinical Directors, Supervisors, Case Managers, Support Coordinators, Therapists, Crisis Workers, Peer Support Specialists and any other practitioners at the beginning level of practice. This training is designed for persons providing COD services in Adult Mental Health and Substance Use services, including Integrated Dual Disorder Treatment teams.

Dates/Locations:

- ~~May 4, 2020 – Delta Hotels Kalamazoo Conference Center~~ | **CANCELLED**
- July 23, 2020 – Park Place Hotel & Conference Center, Traverse City | CLICK HERE for more information and to register now

Be sure to register as soon as possible, training space is limited and will fill up quickly!

Training Fee:
$65 per person. The fee includes training materials, continental breakfast and lunch.

FY20 Motivational Interviewing College regional trainings

Registration is now open for the FY20 Motivational Interviewing College regional trainings which includes Basic, Advanced, Supervisory, and the TNT course: Teaching Motivational Interviewing! For more information and to register now, click the links below.

This event is sponsored by the adult mental health block grant and is intended for persons who serve adults only through the mental health and substance abuse provider network in the state of Michigan. It contains content appropriate for CEOs, COOs, clinical directors, supervisors, case managers, support coordinators, therapists, crisis workers, peer support specialists and any other practitioners at the beginning, advanced and supervisory levels of practice.

Dates/Locations:
~~**April – DoubleTree Detroit – Dearborn**~~ **CANCELLED**

July – Hotel Indigo, Traverse City
Basic: Monday & Tuesday, July 20-21, 2020
Advanced: Monday & Tuesday, July 20-21, 2020
Supervisory: Tuesday, July 21, 2020

Times:
Registration starts at 8:30am & the training will run from 9:00am-4:15pm for all trainings.

Training Fees:
$125 per person for all 2-day trainings / $69 per person for the 1-day Supervisory training. The fee includes training materials, continental breakfast and lunch each day.

Be sure to register as soon as possible, training space is limited and will fill up quickly!

Please be sure you're clicking on the correct registration link in the brochure for the date/location you want; unfortunately, full refunds cannot be made when registering for the incorrect date.

FY20 DBT Trainings

2-Day Introduction to DBT Trainings

This 2-Day introduction to DBT training is intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan who are interested in learning the theoretical underpinnings of the treatment. It will explain what the key ingredients are in DBT that make up its empirical base. A basic overview of the original DBT skills will be covered along with how to

structure and format skills training groups. This training is targeted toward those who are new to DBT with limited experience and who are looking to fulfill the pre-requisite to attend more comprehensive DBT training in the future.

Dates/Locations:

- ~~March 30-31, 2020 – Hilton Garden Inn Lansing West~~ | **CANCELLED**
- ~~April 14-15, 2020 – Great Wolf Lodge, Traverse City~~ | **CANCELLED**

Who Should Attend?
This event is sponsored by the adult mental health block grant and is *only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan*. This seminar contains content appropriate for medical directors, clinical directors, case workers, supports coordinators, and other practitioners at all beginning level of practice.

Training Fee:
$125 per person. The fee includes training materials, continental breakfast and lunch for both days.

5-Day Comprehensive DBT Trainings

- This training is designed for CMH, CMH service providers, PIHP, and PIHP service provider staff who are directly responsible for delivering DBT.
- Due to the fact DBT is a comprehensive treatment that treats high-risk individuals, one's core training ought to be comprehensive as well.
- IT IS EXPECTED THAT ALL PARTICIPANTS WILL MAKE A FULL COMMITMENT TO ATTEND ALL 5 DAYS mindfully and will participate fully in discussion, role-plays and complete daily homework assignments.
- Participants are asked to bring a copy of "Cognitive Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan, PhD, with them to the training.
- COMPLETION OF A 2-DAY INTRODUCTION TO DBT TRAINING OR EQUIVALENT IS A PRE-REQUISITE FOR ATTENDING THIS TRAINING.
- This is NOT a training that teaches DBT skills. There will be very little focus on DBT skills. The majority of the focus of this training will be to help clinicians on how to conduct individual DBT sessions. If your goal is to come to this training in order to learn DBT skills, do not attend. By attending, you understand and consent to knowing this ahead of time.

Dates/Locations:

- May 18-22, 2020 – Holiday Inn Grand Rapids Airport West | **SOLD OUT** – email Bethany Rademacher at brademacher@cmham.org to be placed on a waiting list
- June 8-12, 2020 – Park Place Hotel & Conference Center, Traverse City | CLICK HERE for more information and to register now

Who Should Attend?
This event is sponsored by the adult mental health block grant and is *only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan*. This seminar contains content appropriate for medical directors, clinical directors, case workers, supports coordinators, and other practitioners at all beginning level of practice.

Training Fee:
$250 per person. Fee includes training materials, continental breakfast and lunch for 5 days.

Save the Date: Self-Determination Conference

This conference will broaden and deepen your understanding of the crucial elements of Self-Direction and the importance of Self-Determination in Behavioral Health. It will provide training and technical assistance on the topics of Effective Person-Centered Planning, Independent Facilitation, Supported Decision-Making, Fiscal Intermediaries, How to Structure Self-Directed Service Arrangements, Budget Development, and more. Dynamic presenters and speakers will reenergize your commitment to the principles and practice of Self-Determination!

Date & Time:
May 5, 2020
8am – 5pm
Lansing, MI 48933

Location:
Lansing Center
333 E. Michigan Ave.

Who Should Attend?:
This conference contains content tracks appropriate for all individuals who receive services, family members, case managers, supports coordinators, clinicians, CMH administrative and clinical staff, providers, HCBS and waiver coordinators, fiscal intermediaries and independent facilitators.

Registration available soon, check CMHA website for more information and updates.

Ethics for Social Work & Substance Use Disorder Professionals & Psychologists Trainings

Community Mental Health Association of Michigan is pleased to offer Ethics for Social Work & Substance Use Disorder Professionals & Psychologists 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.
This training fulfills the MPA requirements for psychologists.

Trainings offered on the following dates:

March 18, 2020 – Lansing | **Registration Full!**
April 15, 2020 – Kalamazoo | CLICK HERE for more information and to register now
April 22, 2020 – Detroit | CLICK HERE for more information and to register now

Training Fees: (fee includes training material, coffee, lunch and refreshments)

$115 CMHA Members
$138 Non-Members

Pain Management and Mindfulness Trainings

Community Mental Health Association of Michigan is pleased to offer Pain Management Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This course qualifies for 2 CEs and fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for pain management.

Mindfulness is recognized as a component of DBT, however it has now been expanded into Mindfulness Based Stress Response, Mindfulness Based Cognitive Therapy, and Mindfulness Based Relapse Prevention. Mindfulness proves an effective intervention with any type of impulse control issues. In addition, research proves Mindfulness as an important strategy with chronic pain. Participants attending this training should expect an overview of mindfulness applications in regard to pain management; realizing the relationship between nocioceptive, neuropathic, and affective pain; and understanding the benefits of Mindfulness regarding chronic pain management and being able to determine appropriate candidates for Mindfulness. This two-hour training WILL NOT provide a level of competency in Mindfulness interventions within clinical sessions.

Trainings offered on the following dates:

March 17, 2020, 2:00pm-4:00pm – Lansing | **Registration Full!**
April 23, 2020, 9:00am-11:00am – Detroit | CLICK HERE for more information & to register

Training Fees: (fee includes training material)

$39 CMHA Members
$47 Non-Members

Fetal Alcohol Spectrum Disorder Trainings - CANCELLED

The Fetal Alcohol Spectrum Disorder Training: Improving Outcomes for Youth, Families, and Agencies by Recognizing and Responding to Fetal Alcohol Spectrum Disorders (FASD) and Other Neurocognitive Impairments for Monday, March 16, 2020 – Gaylord and Monday, April 6, 2020 – Jackson are both cancelled. We will reschedule this popular training later in FY2020.

TREM and M-TREM Trainings

Michigan Department of Health and Human Services and Community Mental Health Association of Michigan present: TREM AND M-TREM TRAININGS Featuring: Community Connections, Washington, DC. Based on both clinical experience and research literature, TREM has become one of the major trauma recovery interventions for women and men. TREM and MTREM are fully manualized group interventions for trauma survivors served by behavioral health providers.

LOCATION, DATES AND AGENDA

- Holiday Inn Airport - Grand Rapids - April 28-30, 2020
- Community Mental Health Association of Michigan (CMHAM), Lansing - June 2-4, 2020

Registration: 8:30a.m. - 9:00 a.m.; Training: 9:00 a.m. - 4:00 p.m.

Open to individuals working in the public Mental Health System. Note: The trauma policy is now an amendment to the CMHSP contract. PARTICIPANTS: Master's prepared clinicians (men and women), their clinical supervisor from CMHSPs. CMHSPs that currently DO NOT have trained TREM/M-TREM clinical staff will be prioritized for the training.

Cost is $150 per participant. Registration fees, hotel, travel and additional meals are at the agency's expense.

EXPECTATION: Clinicians and Clinical Supervisors registering for the training will be expected to:

1. Participate in 3-day TREM/M-TREM training
2. Participate in 12 monthly coaching calls (1-hour calls)

Clinicians will be expected to: Conduct 2 TREM or M-TREM groups in the year following the training

Teams are comprised of 1 limited licensed supervisor and, at a minimum, 2 limited licensed clinicians. All team members are expected to attend the three days of training. Participate in the monthly coaching calls; and implement 2 TREM/M-TREM groups in the next year.

Please email awilson@cmham.org for information. No continuing education credits available.

New! Registration is open for the May 4, 2020 Michigan Health Policy Forum on Health Equity and Social Equity

The next Michigan Health Policy Forum (CMHA is a member of the Forum's Advisory Council) will be held on May 4, 2020. The Forum will begin at 1:00 PM at the Kellogg Center on the campus of Michigan State University. The topic will be "Health Equity and Social Equity".

It is easy to quantify the disparities in our health care outcomes and to attribute those disparities to the Social Determinants of Health. It is more difficult to discuss healthcare disparities through the lens of health equity because to do so requires us to acknowledge health inequities. Our panel of experts will address the topic of health equity, what it means to Michigan, and how we are moving to address this crucial issue.

I hope you will be able to join us for this forthright discussion of why health inequities exist and the steps that we are taking to eliminate them.

The agenda for the event can be found at: Agenda

Hope to see you on May 4! Please click here to register

Any individual or organization that would like to support the Michigan Health Policy Forum with a Sponsorship, please click here.

News from Our Preferred Corporate Partners:

Relias: Help Your Staff Understand Trauma-Informed Care

Implementing trauma-informed care involves everyone, including your administrative staff and assistants. Every interaction with a client can either:

- Contribute to a safe and trusting healing environment
- Detract from a safe and trusting healing environment

Research shows that interactions with non-clinical staff often set the tone of the practitioner-patient relationship, making it critical for administrative staff and assistants to understand trauma-informed care.

Read the Blog

Read this Q&A blog, You Asked, We Answered; 12 Questions About Trauma-Informed Care, to learn how supervisors and managers can help non-clinical staff leverage trauma-informed practices.

Abilita provides guidance to organizations working to employ E911 approaches

The workplace is quickly changing with the global COVID-19 crisis. As more organizations require employees to work from home, it's essential that they incorporate E911 into their remote communication strategies.

In addition, by the end of this year, all organizations in Michigan with greater than 20,000 square feet of workspace and/or multiple buildings or floors must comply. If someone from your organization called 911 now, would their location in the building get sent to the 911 center? Are you in compliance with the new Michigan E911 law?

Check out www.abilita.com/michigan-e911 to learn more about what you need to do to prepare!

myStrength: new digital behavioral health resources empower consumers to move beyond trauma

Click at left for a video overview of the new Moving Beyond Trauma program

Trauma is incredibly common. Approximately 90% of U.S. adults have experienced at least one traumatic event in their lives, which can adversely affect emotional well-being and interfere with relationships, work and overall quality of life. Expanding on our diverse whole-person resources, Livongo for Behavioral Health by myStrength is pleased to announce new, digital tools to help individuals Move Beyond Trauma. Leveraging gold-standard, evidence-based approaches including cognitive behavioral therapy (CBT) and mindfulness, these web and mobile resources:

- Address a wide range of trauma types from military deployment and assault, to natural disasters, accidents and other traumatic events.
- Empower individuals to manage discomfort and distress with actionable, in-the-moment coping skills to manage their daily symptoms
- Normalize thoughts, feelings and experiences to help consumers understand that there is a way forward that has been proven to work for so many others
- Complement Livongo's whole-person platform, which addresses chronic physical and behavioral health conditions including diabetes, stress, hypertension, and more.

Click here to request a demo.

CMH Association's Officers and Staff Contact Information:

CMHA 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: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Second Vice President: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Randy Kamps; randyk@4iam.com; (231)392-6670
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

CMHA Staff Contact Information:

CMH Association staff can be contacted at (517) 374-6848 and via the e-mail addresses below:

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
Audrey Daul, Administrative Assistant, adaul@cmham.org
Dana Ferguson, Senior Accounting Specialist, dferguson@cmham.org
Janessa Nichols, Accounting Clerk, jnichols@cmham.org
Anne Wilson, Training and Meeting Planner, awilson@mham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
Bethany Rademacher, Training and Meeting Planner, brademacher@cmham.org
Jodi Hammond, Training and Meeting Planner, jhammond@cmham.org
Alexandra Risher, Training and Meeting Planner, arisher@cmham.org
Madi Sholtz, Training and Meeting Planner, msholtz@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org

WEEKLY UPDATE

March 13, 2020

Contents:

Searching for past articles in Weekly Update: Weekly Update readers often remember seeing a past article or announcement that they would like to retrieve – but are unable to recall the date of the Weekly Update in which the article or announcement was published.

CMHA has now added a search feature to its website that allows the readers to search within past Weekly Update articles and announcements. This search feature can retrieve articles by key words in the title of the Weekly Update article/announcement. This feature also brings up any other resources, anywhere on the CMHA website, with that key word in their title – a useful feature given that sometimes the CMHA member or stakeholder is unclear as to the source of the information for which they are searching.

This Weekly Update search feature is accessed via the standard "search" box on the CMHA website: https://cmham.org/ at the top right side of the website.

We hope you find this new feature useful in making the most of the information captured by the Weekly Update.

Note: To aid Weekly Update readers in finding the newest resources, those Weekly Update articles that are new are noted as "**New!**" in the table of contents and in the body of the document.

CMH Association and Member Activities:

New! 2020 Walk a Mile moved from May 14 to September 29

With the onslaught of COVID-19 (Coronavirus Disease 19), many functions, trainings, conferences and events are being cancelled locally, statewide, and nationally. In an effort to help prevent the spread of this virus, limit exposure, and to ensure the health of those we serve – some of the most vulnerable populations there are! – the Community Mental Health Association has decided to cancel the Walk A Mile Rally at the State Capitol on May 14, 2020.

WE KNOW HOW IMPORTANT THIS EVENT IS FOR THOSE WE SERVE TO HAVE THEIR VOICES HEARD!!

A new date to rally and be heard by our State Legislators has been scheduled for September 29, 2020! More details will be sent out as they become available, and an updated Packet will be posted on the website as soon as it is developed.

Benjamin Franklin said that "An ounce of prevention is worth a pound of cure", and while there is no cure, yet, for COVID-19, the Association will do its best to provide an ounce of prevention in any way that we can to protect the Public Mental Health System.

Thank you for your understanding.

State and National Developments and Resources:

New! Michigan's Medicaid work requirement halted

Below is a recent notice from MDHHS regarding the halting of the work requirements being implemented for all of the Healthy Michigan Plan (HMP) enrollees.

> On March 4, 2020, a federal judge ruled that approval of the HMP work requirements was unlawful. It is MDHHS' responsibility to follow the federal judge's ruling. This ruling stopped MDHHS' implementation and enforcement of the work rules.
> This means HMP participants are no longer required to report work, school or other activities to maintain HMP health care coverage. This change is effective immediately.
>
> MDHHS is notifying individuals of the change online, by mail, and by phone. MDHHS will mail letters to active HMP beneficiaries throughout the month of March 2020. (A draft copy of the letter that will be sent to beneficiaries is attached.) It is possible work requirements could be restarted because of a future court decision. MDHHS will notify stakeholders if this happens.
>
> Health plans, providers, and other community partners who may be utilizing HMP work requirements-related materials that were previously issued by MDHHS should remove these documents from circulation.
>
> Beneficiaries with questions should contact the HMP Work Requirements and Exemption Reporting line at 1-833-895-4355 (TTY: 1-866-501-5656).
>
> Providers and community partners with questions can email HealthyMichiganPlan@michigan.gov.
>
> A copy of the letter sent to HMP enrollees notifying them of the halt to the work requirements can be found Here.

New! Behavioral Health Home policy: public comment period open

MDHHS is seeking comments on a recently issued a draft policy on the expansion of Michigan's Behavioral Health Home initiative.

Comments are due by April 4, 2020.
Mail Comments to: Lindsey Naeyaert
Behavioral Health and Developmental Disabilities Administration Lewis Cass Building
320 S. Walnut St. 5th Floor
Lansing, Michigan 48913
Telephone Number: 517-335-0076 Fax Number: 517-335-5376
E-mail Address: naeyaertl@michigan.gov

Below are key excerpts from the draft policy.

> Note: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS).
>
> Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of this policy is to provide for the

coverage and reimbursement of BHH services. This policy is effective for dates of service on and after October 1, 2020. The policy applies to fee-for-service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet BHH eligibility criteria. In addition, MDHHS will create a companion operation guide for providers called the Behavioral Health Home Handbook.

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from CMS to revise the current BHH SPA to optimize and expand the BHH in select Michigan counties. The BHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the BHH program: 1) improve care management of beneficiaries with SMI/SED; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's BHH model is comprised of a team of providers, including a Lead Entity (LE) and designated Health Home Partners (HHP). Providers must meet the specific qualifications set forth in the SPA, this policy, and provide the six federally required core health home services. Michigan's BHHs must coordinate with other community-based providers to manage the full breadth of beneficiary needs.

MDHHS will provide a monthly case rate to the LE based on the number of BHH beneficiaries with at least one BHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with an LE in order to be a designated HHP and to receive payment. The LE will reimburse the HHP for delivering health home services. Finally, MDHHS will employ a pay-for- performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

The full proposed policy can be found here.

New! MDHHS seeking comments on proposed Opioid Health Home policy

MDHHS is seeking comments on a recently issued a draft policy on the expansion of Michigan's Opioid Health Home initiative.

Comments are due by April 16, 2020
Mail Comments to: Kelsey Schell
Behavioral Health and Developmental Disabilities Administration Lewis Cass Building
320 S. Walnut St. 5th Floor
Lansing, Michigan 48909-7979
Telephone Number: 517-284-0202 Fax Number: 517-335-5376
E-mail Address: schellk1@michigan.gov

Below are excerpts from the proposed policy.

Purpose: Opioids were involved in 76.4% of drug overdose deaths (21.4 per 100,000 population) in 2017a 13.8% rate increase from 2016. The availability of treatment resources are limited and geographically disparate. MDHHS has identified PIHP Region 1, 2 and 9 in addition to Calhoun and Kalamazoo Counties in Region 4 as having the greatest need for these resources.

Note: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS).

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of this policy is to provide for the coverage and reimbursement of OHH services effective for dates of service on and after October 1, 2020. The policy applies to fee-for-service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet OHH eligibility criteria. In addition, the Michigan Department of Health and Human Services (MDHHS) will create a companion operations guide for providers called the OHH Handbook, which will be available on the MDHHS website at www.michigan.gov/ohh.

I. General Information

MDHHS is seeking approval from CMS to revise the current OHH SPA to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination of services to Medicaid beneficiaries with an opioid use disorder diagnosis. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's OHH model is comprised of a team of providers, including a Lead Entity (LE) and designated Health Home Partners (HHP). Providers must meet the specific qualifications set forth in the SPA, this policy, and provide the six federally required core health home services. Michigan's OHHs must coordinate with other community-based providers to manage the full breadth of beneficiary needs. MDHHS will provide a monthly case rate to the LE based on the number of OHH beneficiaries with at least one OHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with an LE in order to be a designated HHP and to receive payment. The LE will reimburse the HHP for delivering health home services. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

The full Opioid health home proposed policy can be found here.

New! CHRT releases report: The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy

The Center for Health and Research Transformation recently issued a report and related policy brief on the behavioral health workforce shortage. Excerpts from the report a provided below.

> Rural communities have some of the largest need for behavioral health care providers and yet the lowest availability. This is reflected in the fact that more than 60% of rural Americans live in a mental Health Professional Shortage Area, and more than 90% of psychologists and psychiatrists and 80% of social workers practice exclusively in metropolitan areas. By working with state rural health and health workforce offices, this study determined the current recruitment practices to both build the provider pipeline in a given state and incentivize practice in areas suffering from maldistribution of workers. This report describes state incentives for behavioral health provider recruitment, particularly in rural areas.

The full report can be found here.

The related policy brief can be found here.

New! CHCS webinar: What's Next? The Value of Evidence from the Camden Coalition and CareMore Health to Inform Complex Care Program Design

Date and Time: March 31, 2020, 1:00 – 2:30 pm ET (10:00 – 11:30 am PT)

Two notable randomized controlled trials (RCTs) of complex care management programs released earlier this year are spurring valuable discussions across the complex care field. The studies — based on interventions at the Camden Coalition of Healthcare Providers and CareMore Health — reported very different results. Whereas the Camden Coalition found no impact on readmission rates at 180 days, CareMore reported favorable reductions in expenditures and utilization. While both organizations serve people covered by Medicaid, their patient populations and study inclusion criteria are very different. Analyzed in tandem, these studies provide a valuable opportunity to reflect on what the evidence is telling us and can inform efforts to improve care for individuals with complex health and social needs.

This Better Care Playbook webinar, made possible through support from the Six Foundation Collaborative, will feature leaders from both organizations who will highlight key takeaways from the recent studies to help guide future program and measurement approaches for complex care management interventions.

Register here.

New! HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data

Below are excerpts from a recent HHS rule announcement related to the sharing of health information.

Final rules require access to health information, spur innovation and aim to end information blocking.

The U.S. Department of Health and Human Services (HHS) today finalized two transformative rules that will give patients unprecedented safe, secure access to their health data. Interoperability has been pursued by multiple administrations and numerous laws, and today, these rules finally deliver on giving patients true access to their healthcare data to make informed healthcare decisions and better manage their care. Putting patients in charge of their health records is a key piece of giving patients more control

in healthcare, and patient control is at the center of the Trump administration's work toward a value-based healthcare system.

The two rules, issued by the HHS Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS), implement interoperability and patient access provisions of the bipartisan 21st Century Cures Act (Cures Act) and support President Trump's MyHealthEData initiative. MyHealthEData is designed to empower patients around a common aim - giving every American access to their medical information so they can make better healthcare decisions. Together, these final rules mark the most extensive healthcare data sharing policies the federal government has implemented, requiring both public and private entities to share health information between patients and other parties while keeping that information private and secure, a top priority for the Administration.

For more information on the ONC final rule, please visit: https://healthit.gov/curesrule.

For more information on the CMS final rule, please visit: https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet

State Legislative Update:

New! Legislature and Governor Agree on Another FY20 Supplemental Budget

A combined $25 million in Coronavirus response money found its way into $321.3 million ($180.6 million General Fund) in supplemental spending bills, SB 151 & 373, that the House voted overwhelmingly to support.

The long-awaited deal with the Senate and Governor's Office also includes $16 million for the Pure Michigan marketing program, $35 million for Gov. Gretchen Whitmer's Michigan Reconnect job training program for non-traditional students, and $15 million for the Going Pro program started under the previous administration.

The bipartisan deal gives $1 million to the Attorney General to investigate clergy abuse of children, a 7% increase in Medicaid outpatient hospital reimbursement rates ($47.5 million), and $11.3 million to start replacing the beleaguered MiSACWIS computer system within the Department of Health and Human Services.

On the Coronavirus response money, $10 million is being set aside for immediate preparedness and response activities, including monitoring, laboratory testing, contact tracing, and infection control. The other $15 million is going to a Coronavirus Response Fund that will be set aside in case more money is needed later. The combined $25 million came at Whitmer's special request.

Other notable behavioral health additions include:

- $3.2 million Gross ($1.9 million GF/GP) – Behavioral Health System Redesign Includes and authorizes 16.0 FTE positions for policy development and projects for integrating behavioral health services and supports with physical health services.

- $4.0 million GF/GP – Hospital Behavioral Health Pilot Program Includes on a one-time basis for a behavioral health pilot project through McLaren Greenlawn Campus in Lansing.

- $100,000 GF/GP – SAFE Substance Abuse Coalition Includes on a one-time basis for the SAFE Substance Abuse Coalition in Wayne County.

Federal Update:

New! Supreme Court Will Hear Challenge to Affordable Care Act

The U.S. Supreme Court decided to review *Texas v. United States*, the court case challenging the constitutionality of the Affordable Care Act (ACA). A ruling in favor of the plaintiffs would invalidate the entire law, leaving an estimated 20 million people uninsured. It is unclear how the timing will align with the November elections.

Background

A coalition of Republican attorneys general challenged the constitutionality of the ACA in 2018. The U.S. Court of Appeals for the 5th Circuit found the individual mandate portion of the ACA unconstitutional but instead of ruling on the entire law, the Court sent the challenge back to a federal judge in Texas who previously invalidated the entirety of the ACA.

Democratic attorneys general and the Democratic-led House of Representatives, who are leading the legal defense, asked the Supreme Court to expedite a review of the case. The plaintiffs and the Trump Administration argued that this would have been premature. In January the Supreme Court announced it would not complete an expedited review of the case but on Monday, decided to take the case on a regular schedule.

What comes next?

The decision by the Supreme Court to take on the case came as a surprise to many legal experts as it is rare for them to do so when a case has not received full consideration in lower courts. The Court will begin reviewing this case in the fall when the term starts and oral arguments may come just weeks before the November general elections, but a ruling may not come until spring of 2021. Polls show that health care remains a top issue among voters and this case will become a talking point on the campaign trail.

According to an estimate by The Urban Institute, a ruling to invalidate the ACA would lead to an increase of 20 million uninsured people, a 65 percent increase in the number of nonelderly people without insurance coverage. In addition to the loss of insurance coverage, many other facets of the law would be subject to elimination affecting millions living with mental illnesses and addictions and the providers who serve them.

Education Opportunities:

Call for Presentations: CMHA 2020 Annual Spring Conference

New Location for Annual Spring Conference: Grand Traverse Resort, Traverse City, Michigan! The conference will be held on:

2020 Annual Spring Conference
June 8, 2020: Pre-conference Institutes
June 9 &10, 2020
Grand Traverse Resort, Traverse City

Click Here to Download the Workshop Submission Form

Deadline to Respond to Call for Presentations: Friday, March 13, 2020

Conference Registration & Hotel Reservations are not available at this time.

COD Regional Trainings: Co-Occurring, Opioid Use, and Cannabis Use Disorder Treatment Planning

Course Description:
Treatment planning for adults with complex mental health, substance use, and physical health needs involves understanding stages of change and system navigation. Collaborating with these individuals on their wellness and recovery planning requires motivational approaches and often interventions that are more effective for early stage readiness. The prevalence of cannabis and opioid use makes these cases even more demanding to navigate.

Add to this, the opioid crisis in the U.S. Since 1999, sales of opioids in the U.S. have quadrupled. From 1999-2015, more than 180,000 people died from overdoses related to prescription opioids. In Michigan, in 2017, there were 1,600 opioid overdose deaths, an increase of 57% from 2016. It is now the #1 cause of accidental death for people under 50. The Centers for Disease Control (CDC) have issued recommendations that include a preference for non-pharmacological therapy. This presentation will provide an overview of a biopsychosocial model of pain, current best practices in pain management, and treatment planning and interventions. Finally, social justice issues for pain management will be addressed with constructs to improve organizationally and individually.

Who Should Attend?
This event is sponsored by the adult mental health block grant and is **only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the State of Michigan.** It contains content appropriate for CEOs, COOs, Clinical Directors, Supervisors, Case Managers, Support Coordinators, Therapists, Crisis Workers, Peer Support Specialists and any other practitioners at the beginning level of practice. This training is designed for persons providing COD services in Adult Mental Health and Substance Use services, including Integrated Dual Disorder Treatment teams.

Dates/Locations:
- May 4, 2020 – Delta Hotels Kalamazoo Conference Center | CLICK HERE for more information and to register now
- July 23, 2020 – Park Place Hotel & Conference Center, Traverse City | CLICK HERE for more information and to register now

Be sure to register as soon as possible, training space is limited and will fill up quickly!

Training Fee:
$65 per person. The fee includes training materials, continental breakfast and lunch.

FY20 Motivational Interviewing College regional trainings

Registration is now open for the FY20 Motivational Interviewing College regional trainings which includes Basic, Advanced, Supervisory, and the TNT course: Teaching Motivational Interviewing! For more information and to register now, click the links below.

This event is sponsored by the adult mental health block grant and is intended for persons who serve adults only through the mental health and substance abuse provider network in the state of Michigan. It contains content appropriate for CEOs, COOs, clinical directors, supervisors, case managers, support coordinators, therapists, crisis workers, peer support specialists and any other practitioners at the beginning, advanced and supervisory levels of practice.

Dates/Locations:
April – DoubleTree Detroit – Dearborn
Basic: Monday & Tuesday, April 20-21, 2020
Advanced: Monday & Tuesday, April 20-21, 2020
Supervisory: Tuesday, April 21, 2020
Teaching MI: Wednesday & Thursday, April 22-23, 2020

July – Hotel Indigo, Traverse City
Basic: Monday & Tuesday, July 20-21, 2020
Advanced: Monday & Tuesday, July 20-21, 2020
Supervisory: Tuesday, July 21, 2020

Times:
Registration starts at 8:30am & the training will run from 9:00am-4:15pm for all trainings.

Training Fees:
$125 per person for all 2-day trainings / $69 per person for the 1-day Supervisory training. The fee includes training materials, continental breakfast and lunch each day.

Be sure to register as soon as possible, training space is limited and will fill up quickly!

Please be sure you're clicking on the correct registration link in the brochure for the date/location you want; unfortunately, full refunds cannot be made when registering for the incorrect date.

FY20 DBT Trainings

2-Day Introduction to DBT Trainings

This 2-Day introduction to DBT training is intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan who are interested in learning the theoretical underpinnings of the treatment. It will explain what the key ingredients are in DBT that make up its empirical base. A basic overview of the original DBT skills will be covered along with how to structure and format skills training groups. This training is targeted toward those who are new to DBT

with limited experience and who are looking to fulfill the pre-requisite to attend more comprehensive DBT training in the future.

Dates/Locations:

- March 30-31, 2020 – Hilton Garden Inn Lansing West | **SOLD OUT** – email Bethany Rademacher at brademacher@cmham.org to be placed on a waiting list
- April 14-15, 2020 – Great Wolf Lodge, Traverse City | **SOLD OUT** – email Bethany Rademacher at brademacher@cmham.org to be placed on a waiting list

Who Should Attend?
This event is sponsored by the adult mental health block grant and is *only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan*. This seminar contains content appropriate for medical directors, clinical directors, case workers, supports coordinators, and other practitioners at all beginning level of practice.

Training Fee:
$125 per person. The fee includes training materials, continental breakfast and lunch for both days.

5-Day Comprehensive DBT Trainings

- This training is designed for CMH, CMH service providers, PIHP, and PIHP service provider staff who are directly responsible for delivering DBT.
- Due to the fact DBT is a comprehensive treatment that treats high-risk individuals, one's core training ought to be comprehensive as well.
- IT IS EXPECTED THAT ALL PARTICIPANTS WILL MAKE A FULL COMMITMENT TO ATTEND ALL 5 DAYS mindfully and will participate fully in discussion, role-plays and complete daily homework assignments.
- Participants are asked to bring a copy of "Cognitive Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan, PhD, with them to the training.
- COMPLETION OF A 2-DAY INTRODUCTION TO DBT TRAINING OR EQUIVALENT IS A PRE-REQUISITE FOR ATTENDING THIS TRAINING.
- This is NOT a training that teaches DBT skills. There will be very little focus on DBT skills. The majority of the focus of this training will be to help clinicians on how to conduct individual DBT sessions. If your goal is to come to this training in order to learn DBT skills, do not attend. By attending, you understand and consent to knowing this ahead of time.

Dates/Locations:

- May 18-22, 2020 – Holiday Inn Grand Rapids Airport West | **SOLD OUT** – email Bethany Rademacher at brademacher@cmham.org to be placed on a waiting list
- June 8-12, 2020 – Park Place Hotel & Conference Center, Traverse City | CLICK HERE for more information and to register now

Who Should Attend?
This event is sponsored by the adult mental health block grant and is *only intended for persons who serve adults through CMH, CMH Service Providers, PIHP, and PIHP providers in the state of Michigan*. This seminar contains content appropriate for medical directors, clinical directors, case workers, supports coordinators, and other practitioners at all beginning level of practice.

Training Fee:
$250 per person. Fee includes training materials, continental breakfast and lunch for 5 days.

Save the Date: Self-Determination Conference

This conference will broaden and deepen your understanding of the crucial elements of Self-Direction and the importance of Self-Determination in Behavioral Health. It will provide training and technical assistance on the topics of Effective Person-Centered Planning, Independent Facilitation, Supported Decision-Making, Fiscal Intermediaries, How to Structure Self-Directed Service Arrangements, Budget Development, and more. Dynamic presenters and speakers will reenergize your commitment to the principles and practice of Self-Determination!

Date & Time:
May 5, 2020
8am – 5pm
Lansing, MI 48933

Location:
Lansing Center
333 E. Michigan Ave.

Who Should Attend?:
This conference contains content tracks appropriate for all individuals who receive services, family members, case managers, supports coordinators, clinicians, CMH administrative and clinical staff, providers, HCBS and waiver coordinators, fiscal intermediaries and independent facilitators.

Registration available soon, check CMHA website for more information and updates.

Ethics for Social Work & Substance Use Disorder Professionals & Psychologists Trainings

Community Mental Health Association of Michigan is pleased to offer Ethics for Social Work & Substance Use Disorder Professionals & Psychologists 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.
This training fulfills the MPA requirements for psychologists.

Trainings offered on the following dates:

March 18, 2020 – Lansing | **Registration Full!**
April 15, 2020 – Kalamazoo | CLICK HERE for more information and to register now
April 22, 2020 – Detroit | CLICK HERE for more information and to register now

Training Fees: (fee includes training material, coffee, lunch and refreshments)

$115 CMHA Members
$138 Non-Members

Pain Management and Mindfulness Trainings

Community Mental Health Association of Michigan is pleased to offer Pain Management Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This course qualifies for 2 CEs and fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for pain management.

Mindfulness is recognized as a component of DBT, however it has now been expanded into Mindfulness Based Stress Response, Mindfulness Based Cognitive Therapy, and Mindfulness Based Relapse Prevention. Mindfulness proves an effective intervention with any type of impulse control issues. In addition, research proves Mindfulness as an important strategy with chronic pain. Participants attending this training should expect an overview of mindfulness applications in regard to pain management; realizing the relationship between nocioceptive, neuropathic, and affective pain; and understanding the benefits of Mindfulness regarding chronic pain management and being able to determine appropriate candidates for Mindfulness. This two-hour training WILL NOT provide a level of competency in Mindfulness interventions within clinical sessions.

Trainings offered on the following dates:

March 17, 2020, 2:00pm-4:00pm – Lansing | **Registration Full!**
April 23, 2020, 9:00am-11:00am – Detroit | CLICK HERE for more information & to register

Training Fees: (fee includes training material)

$39 CMHA Members
$47 Non-Members

Fetal Alcohol Spectrum Disorder Trainings - CANCELLED

The Fetal Alcohol Spectrum Disorder Training: Improving Outcomes for Youth, Families, and Agencies by Recognizing and Responding to Fetal Alcohol Spectrum Disorders (FASD) and Other Neurocognitive Impairments for Monday, March 16, 2020 – Gaylord and Monday, April 6, 2020 – Jackson are both cancelled. We will reschedule this popular training later in FY2020.

TREM and M-TREM Trainings

Michigan Department of Health and Human Services and Community Mental Health Association of Michigan present: TREM AND M-TREM TRAININGS Featuring: Community Connections, Washington, DC. Based on both clinical experience and research literature, TREM has become one of the major trauma recovery interventions for women and men. TREM and MTREM are fully manualized group interventions for trauma survivors served by behavioral health providers.

LOCATION, DATES AND AGENDA

- Holiday Inn Airport - Grand Rapids - April 28-30, 2020
- Community Mental Health Association of Michigan (CMHAM), Lansing - June 2-4, 2020

Registration: 8:30a.m. - 9:00 a.m.; Training: 9:00 a.m. - 4:00 p.m.

Open to individuals working in the public Mental Health System. Note: The trauma policy is now an amendment to the CMHSP contract. PARTICIPANTS: Master's prepared clinicians (men and women), their clinical supervisor from CMHSPs. CMHSPs that currently DO NOT have trained TREM/M-TREM clinical staff will be prioritized for the training.

Cost is $150 per participant. Registration fees, hotel, travel and additional meals are at the agency's expense.

EXPECTATION: Clinicians and Clinical Supervisors registering for the training will be expected to:

1. Participate in 3-day TREM/M-TREM training
2. Participate in 12 monthly coaching calls (1-hour calls)

Clinicians will be expected to: Conduct 2 TREM or M-TREM groups in the year following the training

Teams are comprised of 1 limited licensed supervisor and, at a minimum, 2 limited licensed clinicians. All team members are expected to attend the three days of training. Participate in the monthly coaching calls; and implement 2 TREM/M-TREM groups in the next year.

Please email awilson@cmham.org for information. No continuing education credits available.

New! Registration is open for the May 4, 2020 Michigan Health Policy Forum on Health Equity and Social Equity

The next Michigan Health Policy Forum (CMHA is a member of the Forum's Advisory Council) will be held on May 4, 2020. The Forum will begin at 1:00 PM at the Kellogg Center on the campus of Michigan State University. The topic will be "Health Equity and Social Equity".

It is easy to quantify the disparities in our health care outcomes and to attribute those disparities to the Social Determinants of Health. It is more difficult to discuss healthcare disparities through the lens of health equity because to do so requires us to acknowledge health inequities. Our panel of experts will address the topic of health equity, what it means to Michigan, and how we are moving to address this crucial issue.

I hope you will be able to join us for this forthright discussion of why health inequities exist and the steps that we are taking to eliminate them.

The agenda for the event can be found at: Agenda

Hope to see you on May 4! Please click here to register

Any individual or organization that would like to support the Michigan Health Policy Forum with a Sponsorship, please click here.

News from Our Preferred Corporate Partners:

Relias: Help Your Staff Understand Trauma-Informed Care

Implementing trauma-informed care involves everyone, including your administrative staff and assistants. Every interaction with a client can either:

- Contribute to a safe and trusting healing environment
- Detract from a safe and trusting healing environment

Research shows that interactions with non-clinical staff often set the tone of the practitioner-patient relationship, making it critical for administrative staff and assistants to understand trauma-informed care.

Read the Blog

Read this Q&A blog, You Asked, We Answered; 12 Questions About Trauma-Informed Care, to learn how supervisors and managers can help non-clinical staff leverage trauma-informed practices.

Abilita provides telecommunication guidance

There are many secrets we have learned and refined over the years as communications technology consultants. Here are our top 6 cost reduction secrets:

1. Start with the easy stuff
Sometimes there's SO MUCH to do, you don't know where to start. Start with the no brainer, slam dunk, home-run tasks: telecom bills that are largest. These have the most potential for savings and will make the biggest impact.

2. Look at the bills….and don't just assume if the bill is the same as last month, all is good!
We at Abilita normally find ourselves working in between finance and IT. Finance looks at the bills, but doesn't know what the services are for. IT doesn't look at the bills, but generally knows what the bills are for. Document what each telecom bill is for and the services received.

3. Keep contract copies
A LOT of our clients simply don't keep track of their contractual documents with their telecom providers. Having a countersigned copy of the contract is particularly rare, but necessary. Some contracts have an auto-renew clause. Make sure you keep track of contract end dates so you can negotiate better rates upon contract renewal.

4. Make sure everything is under contract
Contract rates will be lower than off-the-shelf pricing. All of your circuits and services should be included in your contract to receive the lower rates.

5. If you don't know what it is, cut it
We consistently find savings on unused and unnecessary services. We suggest you request a CSR (customer service record) to help determine the location and description and eliminate those no longer needed.

6. BUT….be careful what you cut
I realize this contradicts #5, however you will want to identify all of your circuits and Monthly Recurring Costs (MRC). One technique we use is to either unplug or have the LEC "busy out" a circuit. Then if still needed we can turn it back up in a matter of minutes.

All this can be complicated and time-consuming. That's where Abilita can help you and your staff! As leaders in the communications technology consulting industry, we average 28% savings for our clients, and there is great satisfaction in knowing your inventory is up-to-date and your pricing is as low as possible. For help on this or any other communications technology project, contact your Abilita consultant today.

You can also schedule a 10 minute phone call to explore how we can help to reduce costs at your organization. Please forward and share this email with any other interested staff.

Dan Aylward, Managing Consultant

517-853-8130 daylward@abilita.com

myStrength: new digital behavioral health resources empower consumers to move beyond trauma

Click at left for a video overview of the new Moving Beyond Trauma program

Trauma is incredibly common. Approximately 90% of U.S. adults have experienced at least one traumatic event in their lives, which can adversely affect emotional well-being and interfere with relationships, work and overall quality of life. Expanding on our diverse whole-person resources, Livongo for Behavioral Health by myStrength is pleased to announce new, digital tools to help individuals Move Beyond Trauma. Leveraging gold-standard, evidence-based approaches including cognitive behavioral therapy (CBT) and mindfulness, these web and mobile resources:

- Address a wide range of trauma types from military deployment and assault, to natural disasters, accidents and other traumatic events.
- Empower individuals to manage discomfort and distress with actionable, in-the-moment coping skills to manage their daily symptoms
- Normalize thoughts, feelings and experiences to help consumers understand that there is a way forward that has been proven to work for so many others
- Complement Livongo's whole-person platform, which addresses chronic physical and behavioral health conditions including diabetes, stress, hypertension, and more.

Click here to request a demo.

Relias announces CCBHC webinar

Below is an announcement of an upcoming webinar, sponsored by Relias, a Preferred Corporate Partner of CMHA, on the certification criteria for organization's wishing to become Certified Community Behavioral Health Center (CCBHC).

CCBHC Certification Criteria: Hiring, Training, and Reporting
Wednesday, March 18th, 2020
2:00 pm - 3:00 pm EST

In the webinar, you'll learn:

- How to implement and manage the CCBHC model of delivery using Relias as a total performance solution
- How to collect and report on clinical and patient data in accordance with SAMHSA guidelines
- Board member and staff training plans that align with CCBHC required services and certification criteria
- How to advance staff training, implement a culture of learning, and support your team throughout the CCBHC transition

Register for this webinar here.

CMH Association's Officers and Staff Contact Information:

CMHA 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: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Second Vice President: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Randy Kamps; randyk@4iam.com; (231)392-6670
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

CMHA Staff Contact Information:

CMH Association staff can be contacted at (517) 374-6848 and via the e-mail addresses below:

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
Audrey Daul, Administrative Assistant, adaul@cmham.org
Dana Ferguson, Senior Accounting Specialist, dferguson@cmham.org
Janessa Nichols, Accounting Clerk, jnichols@cmham.org
Anne Wilson, Training and Meeting Planner, awilson@mham.org
Chris Lincoln, Training and Meeting Planner, clincoln@cmham.org
Carly Sanford, Training and Meeting Planner, csanford@cmham.org
Bethany Rademacher, Training and Meeting Planner, brademacher@cmham.org
Jodi Hammond, Training and Meeting Planner, jhammond@cmham.org
Alexandra Risher, Training and Meeting Planner, arisher@cmham.org
Madi Sholtz, Training and Meeting Planner, msholtz@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org

CMHA Community Mental Health Association of Michigan

WINTER 2020

Connections

for communities that care

INTEGRAL HEALTH CARE BEGINS WITH CONSCIOUSNESS

Clinton Galloway, Editor

Although I have a body, I am not that body.
I am a conscious being, not a thing.
The only way you will know me is to listen.

The World Health Organization defines health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Integral is defined as that which is essential to make a whole complete. With this understanding, health care is best understood as integral care and begs an understanding of what constitutes being human.

Arguably the most important subject that needs more open discussion, especially in healthcare, is about the fundamental nature of a human being. Simply put, "What am I?" What is it that we are trying to heal? The relative absence of discussion may be attributed in part to the fact that academia and large for-profit corporations have influenced our world view to their advantage, assuming the conclusions have been determined and align with what they are providing. There is no need for debate. Ultimately, they have decided, we are *physical/biological organisms*, albeit enormously complex ones. That's it. Consequently the most vigorous research is occurring in the neurosciences, centering on the complexities of the brain. As such, only the most sophisticated intelligentsia has the ability to comprehend what we are. What was once the territory explored by philosophers and religions, stories meticulously catalogued by mythologists like Joseph Campbell, wisdom exchanged by common folk and passed from generation to generation, is now the prerogative of an elite group of scientists including, but certainly not limited to, biologists, chemists, neuroscientists, and physicians who work in laboratories where the "real stuff" can be measured and verified. The consequences of this shift have produced many modern "miracles." But it also has impacted how we address our well-being; some of the consequences are devastating. In a recent study, the health status of people living in the United States ranked 35th in the World and was declining. Populations within Cuba, Croatia, Estonia, Chile and Costa Rica fared better.* It's not for lack of money; we have by far the most expensive healthcare system in the world.** It doesn't have to be this way. (To read more on the performance of our healthcare system, there is free access to the Peterson Center on Healthcare and KFF (Kaiser Family Foundation) which has partnered to monitor how well the U.S. healthcare system is performing in terms of quality and cost.) *https://www.healthsystemtracker.org/about-us/.*

We have come to identify our *self* with our body—how we look and especially what we do. A historical marker was the 1898 publication by Albert Marquis of *Who's Who*, which soon became a common colloquialism. Albert Marquis has been forgotten, but everyone recognizes the phrase "who's who." The shift towards thinking of our *self* as being fundamentally a physical body has been a gradual one, spanning centuries during which the physical sciences have overshadowed traditional wisdom as the mediators of truth and what is really real. Relevant to our focus on healthcare, it is noteworthy to recall that Marilyn Ferguson published and edited the well-regarded science newsletter, *Brain/Mind Bulletin*, from 1975 to 1996. I think of her as the sage that recorded the events taking place after academia had adopted the physical organ of the brain as the defining characteristic of *Homo sapiens*. But Ferguson didn't make that mistake; although fascinated with the brain, she was more excited about the potential of our mind that was unfolding. She became a founding member of the Association of Humanistic Psychology. While academia had adopted materialism and physicalism as its reigning philosophical position, she was chronicling a significant cultural change taking place in the widely popular book, *The Aquarian Conspiracy*, published in 1980. The sub-title best captures the contents, "Personal and Social Transformation in the 1980s." As the title suggests, she was focusing on what was happening in our minds and

(Continued on page 16)

About This Issue

Clinton Galloway, Retiring Editor

This being the last issue for which I am responsible as Editor, I am very pleased and excited to announce that Lois Shulman has consented to take on those responsibilities for the future. I firmly believe Lois has the skills, knowledge, values, connections and passion that are essential for the continual evolution of *Connections*! In conversations with Lois, I've become confident that the potential of this communication venue will be taken to a new level. For those who don't already know Lois, you will catch a glimpse of what Lois brings in an article she has written for this issue. To acquire a much richer appreciation, you need to meet her in person.

One of the first requests Lois made was that I write down my vision for *Connections*, thus you are being subjected to an atypical dose of my thinking in this issue. I apologize. Fortunately, you won't be dumped on like this in the future! However, it would be disingenuous to deny that I have appreciated the opportunity to share with you a peek into my world. (I've enjoyed the dump!) My closest companions are frequently the authors of the thousands of books that have helped me find direction and meaning during my lifetime. I am constantly amazed by the knowledge of countless people. I find myself living in exciting times!

It is difficult to find words that convey my feelings when I reflect on my involvement with the evolution of *Connections* over the past 13 years. Make no mistake, they are very positive feelings! Having pursued an education that would hopefully equip me to serve people as an ordained clergyman, I believe my work within the public community-based mental health system has provided me incredible opportunities to do just that. For me, a sense of meaning and fullness was never about having the right beliefs; it was about doing the right thing amongst those of us who have the least. "God"was never a concept I carried around in my head; it is more like a sense of a presence deeply felt in acts of compassion. That was what I learned when I attended graduate school at Boston University School of Theology, sitting at the feet of the same teachers Martin Luther King, Jr. had sat a few years earlier. Part of my education there was pastoral clinical training in a Massachusetts State Asylum, a challenging experience! The text was *Client Centered Therapy,* by Carl Rogers. All in all, I was initiated into the work of social justice coupled to a realization that we are all equal and interconnected. Is it any wonder that the title for this publication became *Connections for Communities that Care*?

There have been many who have played a very important role in *Connections* over the years; perhaps the best way to acknowledge them is to invite you to peruse the contents of the back issues on our website. [https://cmham.org/resources/connections/]

However, I must call attention to one. This issue contains a piece written by my closest ally throughout this adventure, Cindy Chadwick. I first became acquainted with Cindy's husband, Bob, when he became the CEO of our local CMH in Ionia. Some years later, Bob was working part time at the Association where he learned of my desire to initiate what became *Connections*. He knew I needed to meet Cindy and arranged it. Cindy and I came bearing an armful of stuff accompanied by a head full of possibilities. They fit like hand and glove and the rest is history. One thing about our connection is the realization that what we each brought was essential to the future success—whereas I was responsible for acquiring the material, Cindy fashioned it into a form that caught our attention. Presentation is imperative for success. *Connections* would not have survived beyond a few issues had Cindy not worked her magic! Of that I am certain.

Finally, an individual who has played an increasingly important role in the evolution of *Connections* is our CEO, Bob Sheehan! I have undoubtedly been inspired in watching Bob's tireless efforts in providing leadership for what seems, at times, like the impossible job of salvaging decades of work spent building the complex community-based networks that are increasingly being proven as the most effective and efficient systems for population health. The efficacy of these systems is directly attributed to the principles that have been creating them; he articulates them in this issue. They are the self-same principles that you see at work in Bob. I regard him as my brother.

Of course, integral to *Connections* are the stories, and this issue is no exception. With Lois at the helm, you are assured of a continuing stream from the heart of our work.

Integral Health Care Begins with Consciousness:
Response by David Neal, in Conversation with Clinton Galloway

David Neal has had a distinguished career in the Department of Psychiatry at the University of Michigan Medical Center as an Assistant Professor of Social Work. His accomplishments and awards are numerous. And while Neal's work has been recognized by numerous professional organizations, those honors do not capture the complete picture of why he is so effective.

His life revolves around many centers that comprise his social networks, understanding that every life has multiple facets and we will not be successful in our work until we help the individuals we serve make numerous connections. Neal has a family, a church community, six years in the armed services, an avid interest in sports, and is now a certified tree farmer.

The following dialogue between Clint Galloway and David Neal was in response to the essay [see front page] Galloway penned, entitled "Integral Health Care Begins with Consciousness."

Galloway: The purpose of writing "Integral Health Care Begins with Consciousness" was to advocate for giving primacy to our subjective experiences, believing that healthcare has become skewed by a limited focus on our physical bodies. This orientation has produced some remarkable successes which serve to reinforce the underlying bias—the ontological primitive of our humanity is physical.The current healthcare system has definitely been tilted by the accumulating weight of this bias. We now refer to physical care as *primary* care. Attention to our subjective experience of care has been relegated to second class status—*mental health*. Add to this the recognition of dismal progress in population health compared to other developed countries; there is a growing realization that something is desperately wrong in our current system of healthcare.

***Neal**: I wish that we had more time to talk about your paper. You are always challenging us to consider different approaches to health. From my experience of working in health care, I do not think the system is capable of moving as far as you are suggesting. I think that the system has made significant progress understanding the importance of integrating behavioral health services and respecting the person receiving services.*

When I joined the Department of Psychiatry at the University of Michigan Health System in 1966, psychiatry was not respected by the medical community. The Department of Psychiatry received a direct appropriation from the State of Michigan which the medical school could not touch. This was the major factor which allowed the Department to become a leading program in the country. Today the medical school understands that psychiatry has an important role in developing integrated healthcare services. This shows how far physical health providers have come in accepting/integrating behavioral health services.

Galloway: This reveals the powerful impact of policy and funding. Comment further on the development of integrating primary and mental health.

***Neal**: In 2000 when we started the WCHO (Washtenaw County Health Organization) and the University of Michigan joint partnership to integrate physical and behavioral health services, there was little interest from the physical health care providers in the University. Other CMHs questioned why we were doing this. It was only after the research showed that mental health consumers died 25 years younger because of poor physical health care that interest increased.*

Galloway: So in this case, research was an important factor; what happened next?

***Neal**: The WCHO had to be dissolved because of the county's financial situation. The University and Saint Joseph Mercy Health System wanted to continue a relationship with CMH to integrate physical health services and obtained seats on the Board. There was an understanding that it was necessary to treat the whole person and not function in separate silos. I understand that now all primary care clinics and most specialty clinics in the University system have a social worker to address behavioral health needs and social determinants. The younger doctors see the value of these services. Look what progress has been made in developing integrated care in twenty years! Everyone is on board, the question is what should policies be and how should it be funded. It has only been twenty years and now all CMHs and most health systems have some form of integrated services.*

Galloway: You were an Assistant Professor of Social Work at the University of Michigan Medical Center. Share with us some insight into the history of the role of the social worker.

***Neal**: In the 70s social workers were not seen as competent to provide mental health and substance use services, and were never reimbursed. By the turn of the century, social workers were providing more behavioral health services than any other discipline and became licensed to diagnose and do therapy. Counselors just received this recognition in the legislature this past year. Funding is now available to these disciplines although it can still be a challenge in some settings. I share this because I have seen significant progress in the acceptance of the importance of meeting the need for behavioral health services.*

Galloway: What does social work education contribute to the healthcare team?

***Neal**: Social work education includes a focus on the individual,*

(Continued on page 4)

Neal Response *(continued from Page 3)*

their relationships, and social determinants affecting their lives. Master degree programs for nurses have developed programs that are very similar. I think that this is moving more towards your concept of consciousness. Time and financial pressures do not allow providers to fully understand someone's consciousness. The system of care has moved to include the consideration of multiple factors that affect one's health.

Galloway: This is helpful in understanding the attempt to treat the whole person. What other positive trends have you seen?

***Neal**: I have seen a major change in how individuals are treated. Fifty years ago, everything centered around the doctor's schedule and recommendations. Persons receiving services either accepted or rejected what they were told. Now they are involved in the decision-making progress. Appointments are coordinatated, individuals are told the diagnosis and given the pros and cons of treatment recommendations, and the final plans are made by the person served. This is a bit idealist, but it is the goal for progressive health systems. As an individual receiving service, I find it refreshing when this occurs and very frustrating when it idoesn't.*

Galloway: This seems like a step in moving toward the first of the Triple Aims Don Berwick, et.al. identified in 2008—"the experience of care." As this gains momentum, I believe we will see progress on the other two aims: population health and the cost per capita. This is part of the reason I believe we should begin with consciousness. I would think that the core principles of self-determination and being person-centered that have emerged in behavioral health would also have efficacy in primary care.

***Neal**: I appreciate that in talking about consciousness you are expanding the concept beyond mental health and substance abuse services. I do not disagree with your paper, but I do not see docs, or people being served, as really being supportive of moving in that direction. I just saw my primary care doc and he shared the pressure they are under to do more with less. I do not see funders moving to have health care professionals spend time dealing with consciousness. Also, I do not think most health care professionals are trained to do so. Individuals receiving services are equally a challenge. When you are sick, most folks just want someone to take care of them which often means getting some pill or medical procedure.*

Galloway: I agree; when it comes to *next steps* we need to be both realists and pragmatists. The system we have is not equipped. Being somewhat of a dreamer, I have always sought orienting generalizations that can help me understand where we need to go. "Integral Care Begins with Consciousness" was written to fulfill that function. However, your experience and wisdom keeps me grounded. What are some of the things you see taking place in the immediate environment?

***Neal**: I am part of an e-mail exchange with faculty in psychiatry. A concern has been raised nationally that training and research is more focused on the biology of individuals and illness, rather than the unconscious and relationships. Gradually life events and social determinants have been included in the discussion. Only a few years ago they would not have been. There has been acknowledgement that behavioral health research has not integrated key factors that must be included in delivering behavioral care. Suicide is an example where no progress has been made. On the other hand, there has been lots of progress in cancer, cardiology, etc. Financial support will naturally go where the most progress is being made.*

There is no question that biological research has made some very significant gains in treating medical conditions. I believe that this has been achieved because of the technology available to them to identify and evaluate different biological aspects of individuals. This type of research is held in high esteem and it has drawn behavioral health researchers to start focusing on the biology of illness while other factors have received less attention. We do not have the tools to easily assess the severity of depression, anxiety, and other conditions. As you note in your paper, consciousness is subjective. Most believe that there are unconscious factors affecting who we are but we have not done well learning how that may occur.

I just talked with a state senator who said that mental health is a big focus for legislators. They know that they need to do something but they are not sure what to do. The 298 pilots are a good example about how some progress has been made but there is no agreement on what the policies should be nor how integrated care should be organized and funded with CMH agencies.

I also have seen articles by physicians delivering physical health services discussing what their role should be in the future. They recognize that health care has become very specialized and complex. It has become necessary to involve providers from several disciplines including behavioral health. It has already changed significantly from the doctor working alone or in a small group practice. How will health care in the future be organized and funded? Will it address your concern about how health care providers can really get to know their consumers as you suggest in your paper?

Galloway: These are indeed significant concerns that are stirring the waters! However, this conversation illuminates one important fact that has promise—dialogue speeds up the process of understanding and consequential change. And as the feedback loops expand, the pace of change accelerates. The technological innovations of modern media, especially the ubiquitous cell phone, have enabled our networks to circumscribe the entire planet. This factor is impacting every dimension of society; we see it pronounced in the transformation of political structures which represent the geographical coalescence of the power of people.

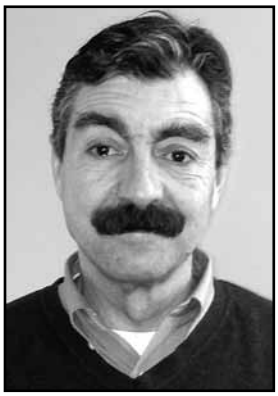
***Neal**: I agree. Our new communication networks have shrunk the world. I believe that it is positive in that fewer people in the world*

(Continued on Page 19)

CMHA's System Integrity and Design Principles

Robert Sheehan, CEO, Community Mental Health Association of Michigan

Michigan's public mental health system, the envy of the nation, is a system for which creating and nimbly responding to change along all of its dimensions-–clinical, fiscal, structural, statutory, regulatory, governance, and partnering dimensions-–are part of the system's DNA.



Recently, in addition to the large number of innovation-related changes that Michigan's public mental health system is leading and to which the system is responding, the State's CMHs, PIHPs, and providers are now responding to proposals from State policy makers to redesign the state's public mental health system.

As has been the long tradition of our system, the changes that we have sought and our responses to externally driven changes have been grounded in a solid value set. The system's response to the current system redesign proposal is no different. The set of values that are driving our system's advocacy work around this most recent system design effort were recently captured in a set of system integrity and design principles passed unanimously by the Executive Board of this Association in December of 2019. These CMHA principles and design elements are summarized below:

System design should:

1. Always start with what is best for those served by the system.
2. Be built on a set of core values that are so fundamental to Michigan's public mental health system, that they do not need explanation beyond their listing: an individual's right to self-determination, person-centered planning, full community inclusion, a recovery orientation, cultural competence in the services, and supports provided them.
3. Recognize and build on the current system's strengths, building on the nationally recognized strengths and accomplishments of the State's leading edge public mental health system.
4. Foster real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports), and build structural and financial supports from there.
5. Ensure strong local county government-based public governance in 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.
6. Ensure that the persons served are mandated members of the local governance bodies and the governing bodies (not only advisory bodies) of the public-private partnership that may be formed to manage the behavioral health care benefit.
7. Protect and strengthen the full set of roles played by Michigan's public mental health system—driven by a commitment to the common good, public interest, population health, social determinants, and community collaboration:
   - Organizers of care – Providers, purchasers, and managers of a well organized comprehensive array of services and supports across a network of proven and experienced providers.
   - Community conveners and collaborators – initiating and participating—often in key roles—collaborative efforts designed to address a broad range of social determinant-related 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.
8. Ensure adequate and sustainable 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.
9. Ensure that the State of Michigan retain its long-standing statutory (i.e., Michigan Mental Health Code) and constitutional risk sharing role in the State's public mental health system.
10. Use competition as a design element only when it benefits the persons served and the communities in which they live.
11. Provide for foundational and standard risk management tools, including:

(Continued on page 18)

THE *MISSION* OF *CONNECTIONS*

Clint Galloway

Connections, like the "Weekly Update" (formerly the Friday Facts) is a communication publication of CMHA, however, their primary missions differ. Over the past decade-plus (the duration of the *Connections* publication) the mission of each has remained somewhat constant while the substance has significantly increased, especially in the Weekly Update. I think it is time to reflect on the unique mission of *Connections* a little more closely, enabling us to effectively move forward. There is no doubt that there is growing need for the production of the Weekly Update, given its mission and the increasing complexity of the system the CMHA represents. What is less obvious is what I perceive as an equally demanding need to expand the scope and content of *Connections*, enabling it to better address the complementary role it plays in the CMHA communities. What is that complementary role? In a nutshell, it is to explore the interiority of our system, the subjective experiences of those providing and receiving services and thereby strengthen the underlying force that creates an integral system of healthcare.

From my perspective as Editor of *Connections* since its inception in 2007, the Weekly Update is an essential, pragmatic source of information assisting members in performing their tasks. It focuses on the effectiveness of the system of care and provides resources to that end. If you want to know what is happening "on the ground" or "under the hood," you can do so by keeping abreast of Weekly Update. As such, it provides an exterior view of our public community-based systems of care. *Connections* is more focused on the subjective experiences of both those providing and those receiving services; it provides an interior perspective, primarily utilizing first person stories which communicate the values and motives that are the heart and soul of our work. Instead of focusing on system structures, the subjective experiences that constitute the moment-by-moment consciousness of the people served as well as those providing services become the subject matter. As such, they are two quite distinct sources of information. Whereas the increasing complexifications of the structures of our community-based delivery system are obvious, the incredible, accumulative force, and consequent impact of the band of sisters and brothers who show up every day in acts of compassion along and beside those who are seeking care is somewhat hidden; yet, it is this force that ultimately creates an authentic system of caring. To see it requires an introspective orientation; the stories come from within and are accessible only by interpersonal sharing. The mission of *Connections* is to illuminate and strengthen these threads that bind us together as we strive for wellness. Any individual who is cultivating and expanding their self-awareness realizes, there is a tremendous proliferation of material that addresses both this personal and social transformation. It is a resource-rich territory! Tapping into it nourishes us all.

One way to frame the daunting task that the Weekly Update addresses is: How do we provide structures that keep the doors open for, and expand this band of sisters and brothers in fulfilling this mission of compassion? That is a challenging task in a culture that has nurtured an appetite for material goods. If we are to have integrity we cannot ignore this battle; it is present inside every one of us. *Connections* illuminates this struggle by addressing the question of **why**. This is a very personal question. It becomes increasingly poignant if we attempt to be person-centered, or advocate for self-determination and self-directed care. Furthermore, it becomes sheer hypocrisy to invite those seeking services to reveal their interior selves if we do not do likewise. Why have we chosen this field of work?

Most of the stories in *Connections* are stories that are navigating this interiority of consciousness, revealing experiences on the journey to wellness. Focusing on personal experiences provides more room to take a deep breath, enabling us to grasp a clearer vision of who we are and why we are involved in this system of care. It provides a crack in the door to grasp a wider perspective, to catch a glimpse of the "big picture" in which we are operating, to take note of cultural shifts, expanding opportunities for personal and social transformation, the burgeoning field of the neurosciences, and the proliferation of philosophical treatises that focus on the nature of mind. (A review of current influential philosophers found that 60% identified their work as a philosophy of the mind.) How well do we understand not only our **self**, but the nature of that which we profess to heal? Perhaps the greatest benefit of pausing to reflect is to take stock of the myriad of mixed motives that are pushing for change— what are the benefits and who are the beneficiaries in the systems for which we work? How do the cultural changes in which our systems are embedded impact the individuals we serve, and the communities in which we live? *(Continued on Page 18)*

Our Dreams Empower Us

Lois Shulman, Incoming Editor

Much of what follows was delivered at the CMHAM Member Assembly on June 11, 2019. What I shared at that time is relevant as I excitedly follow my chosen path. My journey has brought me to this joyous moment, being selected as the new Editor of Connections for Communities that Care.

Martin Luther King had a dream. You and I have dreams. I dream of a humanity where all people are seen as valuable, where all people feel hopeful and empowered to seek their joy, and where listening with kindness and working together uplifts and encourages us all.

In 2008, the door to Oakland Community Health Network (OCHN) opened to me. I proudly found a home on the organization's board. I immediately became aware that I had entered a beautiful magical garden where people come first; where the mission is to inspire hope, empower people, and strengthen community. The OCHN staff, providers, and the individuals served were joined in spirit to protect and promote the public mental health programs for people.

Along my wonderful journey with these courageous people, I have sought to understand the dynamic, complex CMH network with all its twists and turns, I have strived to identify my strengths to nurture and share with the people I've served, and I have experienced happiness upon each discovery of how OCHN's staff, its providers, and the board positively impact the lives of the valued people we serve every day and night.

Through my position as an OCHN board member I had the honor of attending the Community Mental Health Association of Michigan conferences. I met lovely people from around the State, including fellow board members, executive directors, persons served, vendors, and CMH staff. Their trust to share their stories; their voices— full of struggle and laughter—of lived experiences, of challenges within their agencies, and their thoughts, were humbling. I came to understand that to work together with one voice, we must advocate for the CMH network safety net with legislators and state leadership.

Their words changed me for the better forever. My dream was shaped by a deep desire to participate to my fullest to make their voices as strong as possible. Seeing miracles all around me, I am reminded of my commitment to myself and to the people served by the public mental health system, to fulfill my choice to show up, speak up, and provide support to people wherever and whenever I can. That is how dreams are realized.

Clint Galloway, *Connections*' creator and Editor since 2007, shared with me his story and his dreams. His words, full of wisdom and hope, shined a light on my path and on my dream. When asked, I chose to serve as the Editor of *Connections*. In this position, I will seek, see, listen, and hear all valuable voices together, one person at a time, one community at a time, to experience the connections I feel listening to their stories. I am humbled by the honor, ready to work to fulfill my commitment to lead, advocate and write with respect, compassion and kindness. Through the words shared in *Connections* I will advocate for the right of all people to lead self-directed lives. As I continue to listen to people, seek to be aware of the miracles all around me, I am strong in my purpose as I take this position as Editor.

My journey has brought me to this joyous moment, being selected as the new Editor of *Connections* for Communities that Care.

Regardless of the uncertainty and chaos around each of us, like you, I am strong in my purpose to put people first; to inspire hope, empower people and strengthen community. We may not be able to clearly see the immediate path before us nor even the next step, but we can feel the power that will enable us to find a path.

My cup runneth over with abundance for this opportunity. My feelings for those I have served and worked with here at CMHA and at OCHN will light my path. My dream, forever and always, will fill my heart and direct my actions.

I express my appreciation and gratitude to the amazing individuals at the Association and OCHN. I commit to you that I will be present with passion, kindness and grace; to always see, hear and strive to understand. And now, once again, a door has opened! I have been selected as your Editor of "*Connections* for Communities that Care." ■

Editorial Staff note: *In addition to the new responsibilities of Connections Editor, Lois has remained involved at OCHN as a member at large on the OCHN Recipient Rights Committee, Chair of the OCHN Citizens Advisory Committee, volunteer driver for Freedom Road Transportation, and member of the OCHN Advocacy Workgroup.*

My Life With Cerebral Palsy

Renee Uitto

I was born with cerebral palsy, a condition that affects most of my body. People have a difficult time understanding my speech sometimes, and I cannot walk. It is also hard to move my arms. I was diagnosed at nine months old. Life has been a challenge for me, but I always try to have a positive attitude about everything. I am not afraid to try anything.

My parents enrolled me in school before I was three years old so I could have physical, occupational, and speech therapy. If I was born twenty years earlier, I would have been in an institution most of my life, if not all. My mom wanted me in classes with the regular kids, but my special education teacher said no. She didn't think I could handle it. I started going to regular classes when I was in fourth grade.

If I was born twenty years earlier, I would have been in an institution most of my life, if not all.

My mom advocated for me when I was in school. A lot of teachers didn't want me in their classroom because they didn't think I would do well or I'd be too much of a burden to them. But my mother talked to them and convinced them otherwise. I ended up getting good grades in their classes.

I started going to community college in 1989. I only started going part-time, just to see how well I'd do at first. I had two professors that did not want me in their classroom because they didn't want to hear me talk. *Really?* I was sick of dealing with this. Both of them were old and were strict. One of the professors asked my mother, "Does she have it up here?" and pointed to his brain. That was the worst comment I've ever heard! My speech may be hard to understand sometimes, but I am a smart person. I got my Associate's Degree in 1993 and then transferred to Oakland University. I wanted my Bachelor's in Journalism. I got through my classes pretty well. I only had one problem with a professor. He was an older guy and didn't want me in his classroom. The class was Law of the Press and it was so hard! I had to read all these cases and understand them. I left the class after I failed the mid-term exam. I took it later with another professor.

I lived on campus for my last three semesters of college. I had learned to be more independent. I was patient and taught myself how to get dressed, put on shoes, and had easy-to-put-on shirts and pants. I learned to get in and out of my wheelchair by myself, take myself to the bathroom, and get myself into bed. I made more friends. I loved being on campus. It was a new freedom for me.

Four weeks after I graduated in 1997, my father passed away. It was a hard time for me because I had just graduated from college and I didn't know what I was going to do. I had sent out a lot of resumes but no one was calling me for interviews. I was just sitting at home with not a lot to do. I sent 100 resumes and got two interviews. My first real job experience came about ten years later when I started working at a mental health agency and participated in different meetings. I prepared a PowerPoint presentation that explained self-determination and how it related to my life. I felt like I was contributing to something and I was good at it. I was even the chairperson of one committee. I went to meetings where we discussed recipient rights, state and local issues, and advocacy; I learned how to contact my federal, state, and local officials to advocate about a transportation issue. Some of the legislators even wrote me back and sided with me. When I started at the mental health agency and Community Living Services of Oakland County, I wrote articles for their newsletter. I wrote from my personal experiences about using public transportation, going out into the community, and how self-determination worked in my life.

I had two professors that did not want me in their classroom because they didn't want to hear me talk...

When I first moved out on my own, I lived with my partner, Mike, who also had cerebral palsy. He was also my caregiver. We were best friends and had a lot in common. We loved to travel, go out to concerts, and have long talks. However, our relationship had a lot of ups and downs. I wanted to get married, but he didn't. He didn't accept his disability. I tried to encourage him, but that didn't always work. I also felt like

(Continued on page 15)

RIDE OF A LIFETIME

William S. Slavin, MA, LLP, LMSW

Boarding the CMH train in 1976, I rode to my final station climbing off in December of 2018, having experienced the ride of a lifetime. At my graduation time, CMH in Michigan was still relatively young, and fittingly, the director of the Department of Mental Health was a pediatrician. I knew I wanted to work at CMH and I knew I wanted to work in rural northern Michigan. I had also interviewed at a State facility, but when I got the call from North Central in Cadillac I knew where I was headed. I called the State Hospital to let them know of my decision and the medical director there was supportive but warned me he didn't think CMH was going to be around for long. This was only the start of the many surprises to the system, and change became the norm rather than the exception.

Working in rural settings requires some degree of flexibility and adaptability and in the early days we were all generalists to some extent although my initial classification was as a child and family outpatient therapist. Even then I knew that it was all about relationships—in therapeutic settings, with coworkers, community providers and administrators, commissioners and board members. Based primarily in Cadillac, I shared a lot of responsibilities with other therapists and each of us was assigned a half day per week to conduct two intake assessments and simultaneously cover crisis duties for that office. Intakes were dictated and service plans and case notes were hand written. I soon learned the value of editing transcripts, finding reference to "*old factory* hallucinations" in one of my documents.

Clinical staff all participated in the after hours crisis program as well, covering four counties at that time. This meant four jails, four probate courts (each run differently) and two hospital emergency rooms in our region. One was assigned coverage on weeknights from five PM until eight AM, and weekends from eight AM Saturday until eight AM Monday. Maps and key phone number contacts were provided and two agency vehicles were available for travel to remote locations. Cell phones were still well in the future as were pagers, so on call meant sitting home by your land line waiting for the answering service to call. Calls were common, most requiring only phone intervention, but inevitably a call would require an on-scene response. Crisis intervention in rural settings is ninety percent showing up, quickly. We logged many dashboard hours at night.

Voluntary hospitalizations were fairly common and when families were unable to transport, on call staff were expected to accommodate. There were some rules: You never transported anyone who was an imminent risk of harm to themselves or others, and you never transported anyone alone. This often meant calling a co-worker, rousing them from slumber and appealing to their sense of duty to join you on a midnight ride. We often drove significant distances to get to an inpatient unit and coworkers were not reimbursed. No one ever refused. If a male staff person was transporting a female consumer, a female staff had to be called upon.

The call came in late one night in the fall. The weather had been drizzly all day and a dense fog had set in. A resident of a foster care home in a remote corner of a neighboring county had broken some windows and the police were on scene. The client, well known to us and invariably cooperative, was willing to go voluntarily to the State Facility in Traverse City (voluntary admissions were not uncommon in those days), and my supervisor was willing to ride along. Neither of us had ever visited this home before and GPS was still science fiction in those days. We followed the directions the home operator had provided us and found ourselves on a desolate gravel road on the edge of nowhere. A rusty mailbox provided a clue but the only driveway nearby was a two track wandering into the fog along a pasture. No house could be seen from the road. Courageous CMH workers that we were, we ventured onto the two track and after crawling along in the dense fog for what seemed like miles (in reality fifty yards) we came face-to-backside with the first of a series of Holsteins who had knocked the fence down in order to graze on the greener grass in the yard of our destination. We met with our fare, found him to be most amiable and interested in a nice ride to Traverse City and proceeded with our mission.

Upon arrival at the hospital we had the attending physician paged so that he might conduct the admissions interview before we headed home. The doctor arrived in sartorial splendor, bedecked in T-shirt, cut offs jeans and cowboy boots. Admission was approved.

Many things have changed since those days. Arnell Engstrom opened and closed. Deinstitutionalization changed the entire public mental health landscape. AIS homes were developed (sometimes with considerable and totally unwarranted community resistance). Medicaid became a primary funder of services and supports, bringing with it piles of regulations, requirements and red tape. ACT was launched in Michigan, EBPs, AFPs, PHPs and PIHPs became part of the alphabet soup. Accreditation became essential along with person-centered planning, full community participation, and other long overdue improvements. With all the changes however, it was and is still *(Continued on page 15)*

‘I know what they’re going through’:

From Muskegon’s woods, Cowboy builds bridges between the city’s homeless and housed

Thomas Hardy, also known as Cowboy, was homeless his entire life until 2013, when he was 54 years old. Cowboy was a drifter from birth, his father moving the family of five children around the United States to find work or escape the law. The family would occasionally come back to Muskegon County, where Cowboy’s maternal and paternal grandmothers lived, to visit. As Cowboy came of age, he continued to live the life he was brought up in, working odd jobs, collecting scrap metal and sleeping in the woods, until his health finally gave in and he had to seek stable housing.

Today, Cowboy puts his life experience and his passion for the homeless and vulnerably housed to use in Muskegon County. Cowboy’s on call around the clock working to connect homeless and vulnerably housed individuals to community and much-needed resources. Cowboy first came back to Muskegon to be close to his family in 2013; he joined Sacred Suds as a volunteer and soon after found permanent housing in the city. Cowboy has lived in Muskegon since 2013, the longest he has ever lived in any one place.

“I will continue working what I do, to help someone out that is in the same position that I grew up in, homelessness,” he says.

Cowboy sees the obvious solution to easing homelessness as affordable quality housing, and local steady jobs that pay a livable wage. He dreams of a day when his experience will no longer be needed, but, until then, he will continue to help those in Muskegon County who are living the life he once had. ▼

Cowboy shows a picture of himself at around six months being held by his mother. Cowboy thinks that by the time this picture had been taken, he had already traveled through most of the southern United States, and some of Mexico, before heading to Muskegon County, where his parents’ families were based.

Cowboy poses in his bedroom for a portrait, “The last thing I have of my father, except for my height, is my looks.” Cowboy’s father believed that God had come to him in a vision and had commanded him to physically and emotionally abuse his children. Cowboy has finally been able to accept the abuse that he suffered at the hands of his father, even being able to forgive him, but he will never be able to forget. His experiences as a child have deeply shaped who he has become and the work he now does.

Cowboy drives a scooter donated by a member of the Muskegon chapter of Rolling Thunder, a local veterans biker group. The Scooter is Cowboys main form of transportation until the snow gets too heavy, then he relies on the help of friends and family to get around.

Cowboy suffers from arthritis, emphysema, and epilepsy. The three health conditions combined finally pushed Cowboy to accept help in finding housing. If he hadn't sought out housing, Cowboy thinks he would have died on the side of the road from a mixture of the three conditions.

Cowboy comforts a friend seeking housing resources at a weekly community breakfast offered by United Church of Christ (UCC) in Nelson, Muskegon County.

Within the homeless community, there is a lack of trust of anyone housed; most homeless people have experienced physical and verbal abuse from housed people based on their current life situations. That lack of trust leads people to further isolate themselves and not go looking for available help. To add to this, the bureaucracy that surrounds housing people is so complex and slow-moving that it often leaves homeless people feeling even more ignored. Cowboy often finds himself acting as cheerleader, urging people mired in the system to stick with it.

Cowboy jokes with a volunteer at the UCC community breakfast during the winter of 2017. He has become a small celebrity among the homeless community due to his openness and humor.

The average story Cowboy comes across within the homeless community is that people lose their jobs due to the economic climate: businesses close, move or downsize; or people lose their job due to ill health, leaving them unable to pay their rent, leading to eviction. With an eviction on one's record, it is very hard to find another place: many landlords now enforce policies that renters must be eviction free for a number of years. This leaves many people facing homelessness, with very little help in finding housing. ▼

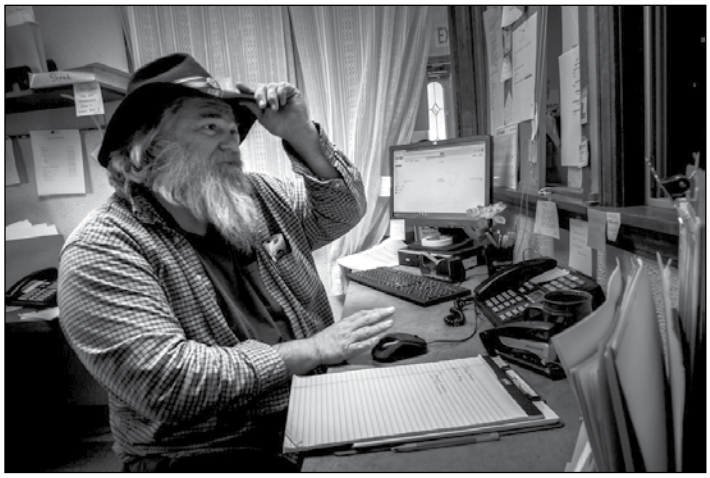
An old friend from Sacred Suds and the UCC community breakfast embraces Cowboy.

"The Good Lord allowed me to go through what I went through; which is 54 years of homelessness, a recovering alcoholic, and cross-addicted drug addict, and being physically abused growing up to work with and minister to the street homeless. I know what they're going through; I've been there; I know where to go looking for them," Cowboy says.

(Continued on Page 12)

Cowboy stands next to the north branch of the Muskegon River. Cowboy's last camp site before finding housing was next to the Muskgon River in 2013. Every morning, he would wash in the river before heading into town to volunteer at Sacred Suds, a local community center offering laundry and shower facilities—as well as internet access and community space to socialize. Cowboy loves the outdoors. When he was homeless, Cowboy would set up camp in wooded areas, to keep away from housed people but also to enjoy the peace and quiet nature provides. Cowboy misses the freedom of being a drifter, being his own boss, and being free to live the way he wanted.

Due to the mistrust and fear many homeless people feel towards the housed, numerous individuals will often camp out in the woods to be left alone, just like Cowboy once did. Due to this, Cowboy tries to make contact with people camping in the woods so he can build trust with them and connect them to services they may need.



Cowboy works with local agencies to get people into the housing system and connect them to needed resources. In his work he sees major issues that need to be addressed if homelessness is going to be tackled in a meaningful and systemic way. There needs to be more locally situated jobs that pay a livable wage, decent opportunities to make a career, and more affordable quality housing.

Cowboy visits with a friend at the Patriot House, a homeless veterans housing unit he once supervised. Between 1977 and 2013, Cowboy worked odd jobs to support himself. In that time he became a recovering alcoholic and cross-addicted drug addict, lived on the highway, rode boxcars, and hitchhiked. ▼

Connections would like to thank ***The Muskegon Times***, the original publisher, and **Pat ApPaul** the author and photographer, for permission to reprint the "Cowboy" story here.

A documentary photographer from South Wales, UK, Pat ApPaul is now based in Muskegon, Michigan. He is interested in exploring and sharing the stories of people on the edges of society in western Michigan. ApPaul's work can be found at www.PatApPaul.com, and he can be contacted by e-mailing Pat.ApPaul@gmail.com.

Additional photographs can be found at www.patappaul.com/cowboy. Also a videographer, Mr. ApPaul has made a video about Cowboy, which can be found at:

https://youtu.be/K6fLEpr3uC0.

To view this article as it originally appeared in the Muskegon Times (with larger color photographs), scan the QR code below. We also extend our thanks to Mr. ApPaul for trusting us to edit the sizes, and convert his photographs to black and white for printing.

COMMUNITY CORNER PUBLIC BROADCAST TV SHOW

Community Mental Health Association of Michigan

2019 Jim Neubacher Media Award Winners

David DeWitt Taylor • Ryan Nicholas Gray • Aaron Castle

The **Community Corner TV** show is hosted by David DeWitt Taylor, Ryan Nicholas Gray, and Aaron Castle. The show first aired in October of 2007, after these three young men (students at the time) enrolled in a video production class at Community Media Network (CMN) in Troy, MI.

Community Media Network offers classes for individuals interested in the taping, directing, filming, and editing of cable broadcasting. These classes are open to anyone in the community. David, Ryan, and Aaron were the first people with intellectual and developmental disabilities to enroll in the class.

They were pleased to learn that the CMN class instructors were very welcoming of people with all ability levels in their classes. Being a part of such an inclusive experience is positive for all involved, not just the students with disabilities and their families who witness this exceptional community-based learning environment, but also for other enrollees in the classes, fellow CMN staff, and those who volunteer time to help along the way. The Video Production classes meet the needs of all their diverse community attendees and serve as a role model of the benefits of community inclusion.

The **Community Corner** production moved from CMN TV in Troy to ONTV in Lake Orion with episode 65 in February of 2013. Joe Johnson, the guys' original class instructor from 2007, transitioned from CMH TV to ONTV in Lake Orion to continue as the Studio Director of the Community Corner TV show.

Each month, David, Ryan, and Aaron invite guests on the show for personal interviews to discuss community resources and issues that affect the lives of people with disabilities. Hosting this show has allowed David, Ryan, and Aaron to use their talents and passion to increase awareness, reduce stigma, and make a difference in our community.

They have recorded 128 episodes and have had a range of guests that contribute significantly to improving the lives of individuals with disabilities. Their guests have included Jane Porter, of Leader Dogs for the Blind; Roger McCarville, the creator and producer of the PBS show "Disabilities Today"; plus many more guests from advocacy organizations; hospitals and service provider organizations; Oakland County Community Mental Health; and even Karen Drew, Investigative Reporter and Anchor from the Channel 4 WDIV News.

The three gentlemen have wonderful on-air personalities and are engaging hosts. The Community Corner Show is impressive and successful. It is an asset to our community, and the commitment of these three young men is highly commendable. I know receiving an honor such as the ***Jim Neubacher Media Award*** from the Community Mental Health Association of Michigan was a tremendous honor for them and their families.

To watch the YouTube presentation, enter this URL of the Special 100th episode special into your browser window:

https://www.youtube.com/watch?v=yOalmBmCw4I

CHAD'S STORY

Catherine Kellerman, Newaygo County Mental Health Center, CMHAM Secretary

Chad and Catherine

This is the story of a boy/man named Chad. It is also the story of a broken family—mom, dad, brother—and their journey through the world of divorce and mental health. Mental health disorders can affect anyone at any time. Mental health disorders can tear down, and also build up; can separate and bring together. You will experience failures and triumphs. The binding factor is love and perseverance. The journey through the field of mental health can achieve great outcomes if we hold on, embrace hope, and never give up.

Chad was adopted by a young couple at the age of three months. He was a wonderful, remarkable infant, toddler, child, and young man. I am/was his mother. Unfortunately I had married a man who could not hold a family together; a self-centered, self-serving man who only cared about seeking his own pleasure. As Chad grew through his teen years, his adoptive dad looked more toward outside pleasures and chose not to be involved in the needs and desires of a child, especially when he approached puberty. It is a time when a son should be able to look to his dad as an example of manhood, fatherhood, and marital accord. This did not happen and Chad suffered as a result.

As this family fell apart, Chad was affected in ways that brought a latent mental disorder to the forefront. A young teen's feelings are very tentative as he traverses through the world of growing into a young man; hopefully he has a father who can show him the way. This was not the case for Chad.

When Chad was 10 years old I brought another child into this world, thinking we would be a wonderful, loving family. Little did I know that the dad in this scenario was finding pleasure elsewhere to the detriment of his family's well-being. Chad was an extremely intelligent and intuitive boy and recognized what was happening before his mom did. He could not handle the deception he saw everyday and finally brought it to his mom's attention. Chad began to rebel—breaking rules, and causing problems as the family disintegrated. Mom attempted to seek help through a bevy of counselors, doctors, and rehabilitation programs that hopefully would keep Chad, mom and baby brother together as a family unit. Eventually Chad was diagnosed with juvenile diabetes, and bi-polar and anxiety disorders

Once the root of the problem was diagnosed, and the proper help secured, Chad began to make many strides to recovery as did his mom, brother, and new stepdad through counseling and outpatient services. This did not happen all at once, but took many years of counseling and working through issues. Eventually his adoptive father recognized the needs of working with mom, Chad and brother along with mental health experts. The best help came through a local CMH in the city in which Chad lived. For the first time we saw improvements in Chad's frame of mind and he began a road to recovery.

In some respects, this story did not ultimately have a happy ending. Over the years, Chad's juvenile diabetes took a toll on his system, especially during his rebellious period when he did not take care of his physical health as prescribed. At the age of 46, after the ravages of diabetes, rebellious behaviors, three years of dialysis for kidney failure, two heart stents, serious retinopathy, and a leg amputation took their toll. Chad succumbed to death on August 3, 2018 while in hospice care. However, Chad did end up with a passable, love/hate relationship with his dad, and a warm and connected relationship with his mom, stepdad and brother. I have Genesee County CMH to thank for the last several years of a wonderful, close relationship with my wonderful son. Chad recognized, and often commented on the fact that I never gave up on him, even during his most trying behaviors. Love is the most important emotion during times of trials and troubles; mine was strengthened by the knowledge that my son was a wonderful person underneath all the emotional turmoil.

I will always remember the love that shone from Chad's eyes the day my husband and I went to the doctor with him, offering to give him a kidney if we matched. We learned that we were too old to donate, but the fact that we offered meant the world to him. I know he left this life feeling thoroughly loved. It was his decision to call hospice. I told him I knew he had been fighting to hold on just for me, so I told him I would certainly honor his decision. This is what I said to him when he asked me to call hospice, "I have loved you from the first moment I saw you; I have loved you all your life. When God calls me home my soul will find yours and I

(Continued on back cover)

RIDE OF A LIFETIME *(Continued from Page 9)*

all about relationships.

I remember fondly the interoffice softball games and bowling tournaments. The men's league softball team (we won a championship), our basketball win over the staff at the Regional office (played at the gym at Arnell Engstrom), the agency Christmas parties, and the friendship and cohesion of staff. Dedication to a common mission. I found this everywhere I went. Relationships.

Looking back (and I often do) I realize how generous these years have been to me. I am amazed at the number of extraordinary people I have met. Courageous clients, dedicated case workers, doctors, law enforcement officers, EMTs, commissioners, judges, community providers, family members and board members on both sides of the bridge I crossed so many times. All about people, never profits. Committed to communities and full community participation for all. I made the right choice years ago and am a wealthy man. Wealthy in experiences and relationships and a trove of wonderful memories I will always cherish.

Bill Slavin pursuing one of his favorite activities.

I would not trade this for anything.

More about the author: *Born and raised in Howell, Michigan, William Slavin earned a BS from Michigan State University, and an MA in clinical psychology from Western Michigan University.*

He began his career in public mental health as a children's outpatient therapist for North Central CMH. Over time his clinical and administrative responsibilities were expanded and he served in a variety of clinical supervisory roles, and as CEO of NorthCare Network until his retirement in 2018.

Slavin is the President of the Critical Incident Response Team of Northern Michigan, and former Vice President of the Michigan Consortium for Healthcare Excellence. He has served on numerous committees at the PIHP and MDHHS. He also served on the Executive Board of the Community Mental Health Association of Michigan.

He is spending his retirement years enjoying time with family, friends, and pets and in the relentless pursuit of trout fishing (catch and release, of course).

My Life *(From Page 8)*

he put me down a lot because he didn't like what I was doing. He went out with other people and one day I asked him to leave. I had to get caregivers to help me a few hours a day. I needed help with preparing meals, grocery shopping, laundry, and personal care.

I have been fortunate to live in an area near a mall, a lot of shopping centers, a movie theater, and restaurants. One of my favorite things to do is to go to Panera Bread, Tim Horton's, or Starbuck's, and get a snack and read a book. That is so relaxing for me!

In the summer of 2017, I had my left hip replaced. It had a lot of arthritis and I crawled all the time to get around the house. I had the surgery on a Tuesday and went to a rehab center on Friday. It was more like a nursing center than anything else because people were living there for a long time. I was there for three months. I got physical and occupational therapy so I could get stronger. It changed my life since I no longer had to crawl. Instead of needing about 12 hours of help a day, because I had needed help with transferring, I now only needed a few hours a day.

There's a lot of stigma around nursing homes. People told me I wouldn't be happy in one.

I moved into a nursing home a couple years later. I was having problems with caregivers. They were leaving me alone too long and I stayed in bed because my morning caregiver fell asleep and didn't hear me when I wanted to get up.

There's a lot of stigma around nursing homes. People told me I wouldn't be happy in one and all my rights would be taken away. That simply isn't true. I get to be showered, something that I wasn't getting at home, and I get to go places, out to Wal-Mart, and to Panera Bread. They encourage me to speak up when things aren't going right. They remind me that this is my home and I have rights.

I feel very blessed with the life I have. I feel fortunate I have the support of my family and friends. I am thankful for every day I have.

A note by Lois Shulman: *Renee moved from Detroit (where she lived in her own apartment and hired her own staff), to a nursing home. Her lived experience of this transition is invaluable to leaders, decision makers, and her peers. She has gained the insight and understanding of how these two living situations function to serve those in need of the services provided, her concerns, and her vision. She enjoys writing and wishes to share her lived experiences, and wisdom gained.*

Integral Health Care *(Continued from Page 1)*

the consequences for our relationships. By that time, Ferguson already knew who and what was dominating the way we think about ourselves; contrasting it with what was really important in our lives. For us to journey inside and develop our potential as human beings, it would require a conspiracy at the ground level. Chapter 8, "Healing Ourselves," (pp. 241-277), is even more poignant today than when it was written. What follows are quotes from the first and last pages of that chapter: "The autonomy so evident in social movements is hitting the old assumptions of medicine hard," (p.241) and "Surely historians will marvel at the heresy we fell into, the recent decades in which we disregarded the spirit in our efforts to cure the body. **Now, in finding health, we find ourselves**." (p. 277)

The question that arises is; what is this "self" that I'm trying to find?

Rene Descartes, widely regarded as the father of modern philosophy, in his *Discourse on Method* (1637), stated that there is one incontrovertible fact that still stands today, "I think, therefore I am." A moment of introspection verifies this truth; I have consciousness; more accurately, "I am consciousness." *It is this first person phenomenon of awareness that constitutes my fundamental existence.* **This subjective, interior *experience*** is more fundamental than my physical body, including the most complex organ, my brain. To repeat, consciousness is the only incontrovertible experience common to every human being! It is a first person phenomenon. Being an interior, subjective, unique experience, we simply do not have the ability to directly know what another person is experiencing. The dominant world view of materialism, without any means of proof, has reduced our first person experience to a physical, material process; an epiphenomenon of the brain. Our consciousness is undoubtedly enabled and correlated by and with the brain but there remains a categorical, qualitative difference between the object (my brain) and my subjective experience. The implications are profound!

In healing the whole person, we must begin with the subjective experience of consciousness.

In healing the whole person, we must begin with the subjective experience of consciousness. Let me provide a personal story that may help clarify the issue. Having been deaf in my right ear since birth, I became aware of one of those miracles produced by this dominant scientific worldview, artificial cochlear implants which restore the pathway for sound waves to be received by the auditory nerve and transmitted to the brain, enabling me to experience sounds on my right side for the first time in my life. Before attempting this procedure, the surgeon ordered an MRI, an image created by a machine using a magnetic field of resonance. This is a physical process that is capable of producing an image of my physical brain. The experienced technician that looked at these pictures provided an interpretation to the surgeon. His experienced opinion was that the biological mechanism I had between my ears (brain) had the capacity to process sound waves. I was a viable candidate for implanting an artificial cochlea. (And importantly, I was qualified by the standards established by the FDA to be eligible for coverage by Medicare.) However, neither the MRI interpreter nor the surgeon had any idea of what my conscious experience was when I was inside that noisy contraption! What they were perceiving and interpreting was an *extrinsic* picture of a physical brain that correlated with an *intrinsic* experience of my consciousness. They were looking at a physical structure but they had no direct access to my mind. We need to distinguish between the ontological primitive of reality that is consciousness and the correlating activity of a physical entity, be it quantum, biological, chemical or neurological. As we learn to do this perhaps we will see the wisdom of giving a lot more credence to the first person *experience of care* which is an attribute of consciousness.

Let's expand on the implication of granting primacy to the experience in consciousness with another personal story. Self-directed care is already a reality for some of us who have the resources. Some years back, having entered my sixth decade, a physically active lifestyle, coupled to a genetic predisposition, had exacted a toll on my left hip, requiring daily dosages of extra strength Tylenol to manage the pain. I sought out an orthopedic surgeon who had a stellar reputation for hip replacement. Sure enough, after viewing the x-rays, he assured me I was a candidate for a titanium hip which hopefully would resolve that conscious experience of pain. I signed up!

Then came the stack of literature that has become common place with such interventions, the list of "what ifs," limitations and waivers that will hopefully provide some cover for the surgeon should my *experience* not be what I was led to believe it would be. Fair enough. However, it was the limitations that snared my consciousness. Upon reading what I should not do, ever again, I reasoned my quality of life (ongoing conscious experiences) would be worse than it was with my daily regimen of Tylenol. I went back and cancelled the surgery. The surgeon was gracious and understood, "Come back when you are ready." Several years later I decided it was time. I needed more than Tylenol to keep the experience of pain at bay that was intruding into my consciousness. I believe I made the right decision both times; both were driven by my interior experience that correlated with an exterior condition of my physical body. It was that

subjective experience that directed the surgeon to step back at first, and years later to step in and apply his skills. Self-directed care is a critical dynamic if we value the experience of satisfaction as a criterion of quality. Granted, it requires knowledge of available resources, informed decision making and assistance in navigating the possibilities, but it remains as ultimately being an activity of consciousness.

Another implication of acknowledging the priority of the individual subjective experience (consciousness) is the realization of the critical role social determinants play in our well-being; quality of life is not limited to the condition of our body. A moment's reflection on what is essential to our quality of life—and by inference, to our wellness—quickly identifies numerous factors not addressed in the doctor's office. Do I have a place to live, do I feel safe, do I have friends, do I have adequate income, transportation, education, availability of healthy food, and embedded in a healthy environment? We know that the stressors of poverty greatly diminish our well-being. Needing to address all of these social factors is a cornerstone of the foundation of integral care; again, integral means including everything that is essential to my quality of life. When we start making a list of all the essential factors for being a whole (healthy) person, a couple categories emerge that seldom are addressed by our primary care physician unless we are about to completely fall apart: relationships, and the quality of my interior/subjective experience. The multiple array of services, coupled with case management available in community based services, comes closest to providing access to the essentials of wellness. Can this be called "integral care"? Well, not quite, but it is a huge step in the right direction.

With healthcare being dominated by the bias for conflating our identity with our physical bodies, physical health has become regarded as primary. In spite of some amazing benefits this has developed; as we saw earlier, it has acquired very disappointing results in the outcomes of the triple aim: population health, experience of care, and the per capita cost. Why?! Many reasons are presented, but one that is seldom acknowledged is our cultural bias that puts misplaced value on material/physical realities. One place we can make a significant difference is by challenging the bias in healthcare that focuses primarily on physical interventions such as drugs to alleviate our conscious maladies. A recent issue of the *British Medical Journal* cited a review of 148 studies that concluded "the influence of social relationships on the risk of death are comparable with well-established risk factors for mortality such as smoking and alcohol consumption, and exceed the influence of other risk factors such as physical inactivity and obesity," and that "physicians, health professionals, educators, and the media should take social relationships as seriously as other risk factors that affect mortality." We all know this intuitively; yet we shy away from a deeper discussion of why this is so. Let's be honest; it is difficult to monetize social solutions within the current structures of primary healthcare. [https://www.mentalhealth.org.uk/publications/relationships-21st-century-forgotten-foundation-mental-health-and-wellbeing]

Social determinants and relationships are but a couple of the myriad of factors that surface when we shift our primary focus from our biological bodies, balancing it with first person accounts. It is time to seriously challenge the efficacy of the culture that has invaded the offices of our primary care physicians—leaving minimal time for first person stories—primarily because they are not billable units. There is hope. The importance of telling our stories is the basic theme in the emerging practice of Narrative Medicine. [https://www.narrativemedicine.org/about-narrative-medicine/]

The dominant system of healthcare which is responsible for generating the alarming statistics of quality and efficiency is suffering the affliction of misplaced concreteness. The primacy of individual experience-—our consciousness—which should be the concrete fact that is being addressed, has been relegated to second class status of behavioral health with the failures hopefully being gathered up in a public safety net which has become increasingly strained by lack of funding. The scope of resources needed to address all of the essential components of integral care is not expedient for existing primary care providers to pursue. The time frames in which they are operating are often dictated by the demand for *timely* reports by their shareholders. The drive for integral care must arise from the people being served— the public. It will not arise from the desire to gain monetary profit by a privileged few. Coupled with the worldview that we are fundamentally physical beings, the desire to accumulate material goods has acquired considerable power. A materialistic worldview nurtures greed. The primary motivation of integral care is compassion, focused on the well-being of the individual being served, guided by their subjective experience. Integral care treats the whole person, beginning with an assessment of their experience. To paraphrase Descartes, "my interior experience is who I am"; when I enter your presence, see me. Care of the *heart* and *soul* is what we all desire at both the beginning and end of the day. Somewhere along the way our healthcare culture seems to have become confused; identifying with material compensation, the physical body, and discounting the primacy of our interiority. Who do they think they are?

---

*https://www.bloomberg.com/news/articles/2019-02-24/spain-tops-italy-as-world-s-healthiest-nation-while-u-s-slips

** https://specials-images.forbesimg.com/imageserve/5d4be2265040990008805ab0/960x0.jpg?fit=scale

CMHA's System Integrity *(Continued from page 5)*

- State financing of risk reserves
- Sub-capitation payments to the CMHs and the ability to retain savings; with incentive and shared saving structures.
- Sharing of savings across the physical-mental health care line.

12. Retain and expand the groups served by the public mental health system to include:

Current groups served by the 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

Groups to be added to responsibility of the public mental health system:

- children, adolescents, and adults with mild to moderate mental health needs

Guided by this set of system integrity and system design principles, CMHA, in partnership with its members, persons served, advocates, and community partners, will continue its work with policy makers to refine and redesign Michigan's public mental health system.

MISSION *(Continued from Page 6)*

What and who all are involved in our well-being? Evidence shows that the circle of care encompasses a far greater expanse than we are accustomed to thinking. A question that needs exploring by all healthcare providers is: Do we have the means to address these multiple relationships that are essential for our wellness in today's society? Has our specialization blinded us to the complexity of the individuals we are serving? *Connections* explores the impact of a multiplicity of relationships from the inside through personal stories.

After the first couple years or so, as Editor of *Connections*, someone remarked to me that they never thought it would last that long. Now, a dozen years later, my deepest concern is keeping abreast of what I truly believe is the burgeoning potential. It has become apparent that a key part to its success lies in plain sight, the healing function of storytelling; stories that resonate within the heart and soul of countless people which constitute our communities that care. Isak Dinesin said, "To be a person is to have a story to tell."* The diversification over the past few decades in the field of psychology is a reminder that our stories have countless chapters with many dimensions. We are far more complex than the systems that treat us, and everyone is unique!**

I firmly believe that the primary factor that will shape the efficacy of healthcare in the future is an appreciation for this complexity. A positive trend is the recognition of the importance of the experience of care which requires an entirely different set of skills than those of the neuroscientist studying the brain. A quick glance at their respective pay scales reveals what's driving our current system. Nevertheless, the cumulative impact of the experience of care will ultimately shape the efficacy of our systems; the question is how much needless suffering will occur as we tinker with our current structures with their competing motives? Meanwhile, the mission of *Connections* is to tap into and share the fathomless depth of compassion that lies at the heart of the subjective experiences within both those providing and receiving the care that impacts our well-being. These are the stories you will read. This is the force that will endure.

> **"To be a person is to have a story to tell."**
>
> **— Isak Dinesin**

*Isak Dinesin, a Danish author, is considered one of the greatest story tellers to have lived. *Out of Africa* is one of them.

** https://www.medicalnewstoday.com/articles/154874.php The above article is but one that addresses the bewildering proliferation of various fields dedicated to a study of the mind/consciousness. Perhaps the most revealing statement was made by Sonu Shamdusani, widely regarded as the leading Jung historian at work today, "I think one has to look first at how psychological concepts are actually used and were developed in a task to complete the scientific revolution. The notion was that psychology was to be the master science that would underpin all other sciences. Well, this clearly didn't work. We've got as many psychologists almost as there are people. And one thing that I think all psychologists have in common is that they don't agree about anything, apart from that they use the word 'psychology.' So you have to ask is this a science?" *Lament of the Dead: Psychology after Jung's Red Book* pp. 11-12.

Neal Response *(Continued from Page 4)*

are isolated and we are more knowledgeable about different cultures. This can be threatening to some people and promote conflict and divisiveness. Unfortunately, the political debates and many talk shows are people yelling at each other. I always wonder what examples they are for our children and our future. We need to learn to listen.

Galloway: Yes! I firmly believe the underlying drive on our planet today is the quest for autonomy, and to have a voice. Facilitated by the wireless technology of communication, memes develop networks overnight! Our world has not only shrunk, it is rapidly changing. The collective force of the innate push for recognition is powerful; as a result, hierarchical structures have been eroding fast. We live in virtual chaos. I believe that the systems that endure will be those that are rooted in and guided by these grassroots' networks.

***Neal**: Agree again. The individual desire of many people to be free, to be themselves, and do better is the hope for the future. There are always some individuals who are willing to join groups. Most people like to feel a part of a group. Some are fringe groups that create more conflict in the world.*

Galloway: This brings me to a deep concern that arises from recognizing the complexity of our consciousness. There is an assumption that we are being person-centered when we offer individual choice. That seems, at best to be a half-truth that can become a screen for the vested interests of those making the offers. Let's consider choosing your health plan. The choice is only a true and valid choice if (1) the individual is being offered what represents the best care available for their affliction, and (2) they understand how their choice will impact them. Those are two big "ifs." We know the power of persuasion employed by vested interests. Individual choice must be protected by eliminating the interference of vested interests. What is your experience in enabling people to make good choices?

***Neal**: It seems that you are raising two issues. I agree that giving choice to the patient and attempting to make their treatment a positive experience is far from understanding their consciousness. For me it is a start at beginning to involve the patient and respect that all individuals are not the same.*

The question of what is the "best care available" and how it should be organized are major issues for providers and the individuals served to determine. Your example of first declining the hip replacement is an example of how you were not ready for the surgery even though it was available. Think of the number of people who do not have a funding source and access to it. Should every individual have access to "best care"? If so, how should it be funded? I am not sure that the "Medicare for All" that is being proposed would provide funding for everyone to have access to the best care available.

Galloway: There is one issue we haven't discussed that arises as we focus more on our subjective experiences—how do we, as a system, handle that information? I recently asked a psychiatrist what change would help him the most for improving the integration of care. His response was immediate and simple; "Open access to all the patient's records." He made the point that you could have both physical and mental health services in the same building and it wouldn't help if those attending the care did not have access to what others were providing.

***Neal**: This one hits my career. When I started at the U of M, Psychiatry had its own record room. No one outside of the Department could have access to the records. Records are now fully integrated with access to any provider who needs to know. It is possible to track who accesses an electronic record so it is very difficult for it to be abused. Before electronic systems, records were sent around in grocery carts; there was no way to monitor who read them. However, if an individual goes to providers in different systems, they are dependent on the providers sharing their information. This often does not happen. It takes time to send info or to make a call. In the past, persons served were never told their diagnosis or even what the professional thought their problem was. Now most of that information is available to them via a personal portal.*

On a related note, I did a lot of group therapy. I had each member write a note from their last session; I also wrote one for each member. We would then begin the next session with each member reading their note and then I read mine. The goal was to help each individual, including the therapist, to be open and not keep secrets. They were encouraged to share their inner thoughts and feelings which allowed members to develop supportive relationships. Even in this setting it was often difficult for members to reveal their consciousness.

Galloway: Interesting! We've made a lot of progress in record keeping but perhaps we need more of the work you did in group therapy.

***Neal**: I really respect the challenge your paper on consciousness raises for the health care system. Providers are not close to achieving what you are suggesting. I do believe that significant progress has been made by mainstream health care providers— and that they are moving in a positive direction—but there remain many obstacles both internally, in the system, and externally that challenge progress.*

To read more of Neal's thinking, see "A Peek at the Future of Healthcare" at https://cmham.org/wp-content/uploads/2018/06/Fall-2017-Connections-web.pdf

Community Mental Health Association of Michigan
426 S WALNUT
LANSING MI 48933
Telephone: 517-374-6848
www.cmham.org

Non-Profit Org.
U.S. Postage
PAID
Lansing, MI
Permit No. 975

Online editions of *Connections* can be found at: www.cmham.org: select "RESOURCES" on the home page, and choose "*Connections*" from the pull-down menu. Committed to diversity and inclusion, *Connections* is pleased to include authors of a variety of beliefs, opinions, and interpretations of facts and events. We do not make the determination of print-worthiness based solely on agreement with the *Connections* Editorial Board or the publisher, CMHAM. Individuals interested in contributing to *Connections* are invited to contact the editor at: loisshulman@comcast.net.

CHAD'S STORY *(From Page 14)*

will love you through eternity." At that point he gave me the greatest smile which I hold in my heart and mind to this day.

Mental disorder should never succumb to stigma as a reason for not seeking help. Mental disorders are no different than someone who has cancer, heart disease, or any other ailment of body or soul. As a parent, relative, or friend, you just need to continue to search for the treatment that will work. Yes, it does take perseverance, vigilance and hard work to combat mental illness, but it is totally worth it—no matter how long it takes—when you see your loved one totally invested in the road to recovery.

I miss my son every day, but I know that he revels in the fact that we never gave up on him. His life is a testimony to the positive results of good mental health programs. Please do not be ashamed to recognize and work toward mental health recovery. We all have gifts to leave to this world and those working through mental illness are no different. A little support can bring out talents and hidden accomplishments that we would not know about if we did not engage with these recipients and help to highlight their talents. So please take an interest in your local mental health programs or club houses to learn where you can be of service and uplift the lives of others.

Who Took My Fine Tooth Comb?

Cindy Chadwick, Connections Designer

In 1971 and fresh out of MSU, I was somehow hired and working in an Adult Activity Program. I loved it and believed I'd found my forever career. Well, I'd found the *first* one. Other jobs followed, and in the years after 1986, I held some wonderful positions in human service organizations, but I still missed my CMH days.

By the time I met Clint Galloway in 2007, I'd had my own consulting and design firm for several years. Clint was looking for a "graphic design/print layout specialist, with a knowledge of mental health, kind of person" who could help him put together a MACMHB newsletter. And just like 1971, I was offered a job not quite knowing what I was getting into but very happy to be back "home."

The past thirteen years of working on *Connections* have been exciting, rewarding, and sometimes—well, sometimes just teeth-grindingly difficult. But I've been blessed to be a part of it, and just like leaving CMH in 1986, I'm going to miss all of you once again. I will especially miss working with Clint, one of the most generous and supportive individuals I have ever known. Fortunately, my contract states that he must remain my friend after retirement.

New people with passion, fresh thoughts, and big ideas will now guide *Connections* as it continues to grow. And to each of you who have ideas to share and stories to tell—*Connections* is your vehicle; get in and take a drive! *(Just be careful not to run over any excess comas, dashes, and semi-colons on the way. I haven't finished picking them up yet.)*