Northeast Michigan Community Mental Health Authority Board
July 2019 Meetings

- **Board Meeting -- Thursday, July 11, @ 3:00pm**
- **Recipient Rights Committee Meeting* -- Wednesday, July 17 @ 3:15pm**

All meetings are held in the Board Training Room at 400 Johnson Street in Alpena except those indicated with a "*" which are held in the Administrative Conference Room

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY BOARD
BOARD MEETING/ STRATEGIC PLANNING – PART III
July 11, 2019 at 3:00 p.m.
A G E N D A

I. Call to Order

II. Roll Call & Determination of a Quorum

III. Pledge of Allegiance

IV. Appointment of Evaluator

V. Acknowledgement of Conflict of Interest

VI. Information and/or Comments from the Public

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

VIII. Educational Session – Compliance Update ....Jen Whyte
Strategic Plan Review .... (PowerPoint)

IX. July Monitoring Reports
1. **Budgeting 01-004 ....(Available at meeting)**
2. **Asset Protection 01-007 .... (See pages 7-18)**
3. **Community Resources 01-010............. .... (See pages 19-20)**

X. Board Policies Review and Self-Evaluation
1. **Community Resources 01-010.......[Review]................................ (See page 21)**
2. **Public Hearing 02-010..................[Review & Self Evaluate] (See pages 22-23)**

XI. Linkage Reports
1. **Northern Michigan Regional Entity Update**
   a. **June 26, 2019 Meeting .... (Verbal Update)**
   b. **May 22, 2019 Meeting .... (See pages 24-29)**
2. **CMHAM**
   a. **CMH PAC Update.......................... ....(Available at meeting)**

XII. Operation's Report.. (See page 30)

XIII. Chair's Report
1. **Employee Recognition Luncheon/Lunch for a Cause Update.................(Verbal)**

XIV. Director's Report
1. **Director's Report................................ ....(Verbal)**
2. **CARF Update ....(Verbal)**
3. **QI Council Update.............................. ....(Available at meeting)**

XV. Information and/or Comments from the Public

XVI. Next Meeting – Thursday, August 8 at 3:00 p.m.
1. **Set August Agenda............................. .... (See page 31)**
2. **Meeting Evaluation ....(All)**

XVII. Adjournment

MISSION STATEMENT

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

Northeast Michigan Community Mental Health Authority Board

Board/Strategic Planning Meeting

June 13, 2019

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: Les Buza, Bonnie Cornelius, Steve Dean, Roger Frye, Mark Hunter, Terry Larson, Eric Lawson, Pat Przeslawski, Gary Wnuk

Absent: Judy Jones, Albert LaFleche, Gary Nowak (excused)

Staff & Guests: Carolyn Bruning, Cheryl Jaworowski, Mary Crittenden, Larry Patterson, LeeAnn Bushey, Cathy Meske, Peggy Yachasz, Renee Currie, Judy Hutchins, Lisa Anderson, Jen Whyte, Lauren Tallant, Roger Boston, Roger Engle, Nena Sork, Ruth Hewett, Laura Gray, Lynne Fredlund

III. **Pledge of Allegiance**
Attendees recited the Pledge of Allegiance as a group.

IV. **Acknowledgement of Conflict of Interest**
No conflicts were identified.

V. **Appointment of Evaluator**
Eric Lawson appointed Terry Larson as evaluator for this meeting.

VI. **Information and/or Comments from the Public**
There were no comments presented.

VII. **Approval of Minutes**
Moved by Roger Frye, supported by Steve Dean, to approve the minutes of the May 9, 2019 meeting as presented. Motion carried.

VIII. **Educational Session – Recipient Rights Overview**
Ruth Hewett provided an overview of the Recipient Rights training. She reported the Consumer Advisory Council previously had a brief session on this material. The new training packet was developed after a site visit last August and updates were provided. She notes the contract with the Michigan Department of Health and Human Services requires Board members to be trained in certain aspects of recipient rights.

Judy Jones arrived at 3:08 p.m.

Ruth Hewett noted having a rights system is a mandate of the Michigan Mental Health Code. She reviewed the classes of Abuse and Neglect, Confidentiality, Dignity and Respect and Rights of Family Members. Ruth Hewett noted she began at the Agency 30 years ago as a receptionist and there was no rights training provided at that time. She addressed the use of photos and social media and the mandates regarding that type of exposure.

Ms. Hewett addressed the reporting requirements for Abuse and Neglect. She reviewed the Investigating Rights Allegations process providing information on the role of the Office of Recipient Rights, the investigative process and the appeal process. There must be a preponderance of evidence to substantiate a complaint. She conducts a thorough investigation. She does not have the authority to issue disciplinary directives, that is up to the administration or if a contractor the owner.

Ms. Hewett reviewed the Appeals Committee role noting this Board has given the Recipient Rights Committee this delegated function. She reported a composition of the committee must be certified.

Ruth Hewett reported it is important to notify the individuals we serve with information about rights protection. Several methods are available.

The Family Rights section was added when the Mental Health Code was revised in 1975.

Pat Przeslawski requested what method is used to share information when the individual is not able to sign consent and sharing is needed. She noted she has worked with Ruth Hewett for several years and everything is brought to the group with integrity and accuracy.

Cathy Meske suggested the Board review Rights annually.

IX. June Monitoring Reports

1. Budgeting 01-004

Cheryl Jaworowski reviewed the Statement of Revenue and Expense for month ending April 30, 2019. She notes the change in net position at this point is positive in the amount of $120,809. She reviewed the contract settlement amount noting each revenue source (Medicaid/General Funds) are to the positive. She reported at this point there would be a General Fund payback to the Department of $87,727 if the contact was settled. She notes if there are other Boards in our partner group needing General Funds, this amount can be transferred between Boards. Northeast can keep $23,347 to carry forward into the next fiscal year.

Cheryl Jaworowski reviewed the variances identified on various line items noting the negative variances are mostly attributed to timing issues. She reported Line 35 – Rent Expense was not corrected when the budget amendment was approved. This variance will remain until another amendment is made to the budget. Cheryl Jaworowski introduced Larry Patterson as being the individual to present future budgeting reports to the Board as she will be retiring on July 9, 2019.

2. Ends 04-001

The Board reviewed the semi-annual report on the Ends established last fall for FY2019.

Cathy Meske reviewed the status on the CAFAS scores at midpoint. She noted only 63% have shown a 20+ point decrease in their CAFAS scores. Cathy reported she requested Lauren and Mary Crittenden to review this and it was discovered the method used in calculation needs to be clarified. This percentage will most likely need to be adjusted in the next year's sub-ends.

The sub-end related to development of additional contract residential providers has been focused on and this will be addressed further when the Strategic Plan discussion occurs.

The sub-end related to 75% of those persons with a diagnosed substance use disorder will have one objective in their plan of service addressing treatment options or services. Nena Sork noted this sub-end was developed when it was thought one provider in-house would become a prescriber of Suboxone. This did not occur. Our other providers did not indicate an interest to become a prescriber for this medication. Without prescriber coverage as back-up in our system, it is not recommended to move forward with this plan The difficulty in tracking the sub-end related to 75% of those person with a diagnosed substance use disorder will have one objective in their plan of service addressing treatment options or services" was relayed to the Board.

Cathy Meske reviewed the Financial Outcomes. Cheryl Jaworowski suggested this sub-end be revised to remove the words "in advance" as it is possible to forecast a shortage to get the approval in advance as there is no way to know until it actually occurs. Mark Hunter requested clarification as to the difficulty in predicting a shortage and Cheryl Jaworowski responded that because there are retroactive enrollments in Medicaid and unexpected losses of Medicaid, it is difficult to predict as notice is sometimes provided much later causing swings either way.

Cathy Meske reported the training presented to the community was rather robust during the first six months.

Moved by Pat Przeslawski, supported by Judy Jones, to accept the June monitoring reports as presented. Terry Larson inquired whether the sub-end should be revised at this point. The sub-ends established last fall will remain in place for this fiscal year with any revisions incorporated into new sub-ends for next fiscal year. Motion carried.
2

X. <u>Board Policy Review and Self Evaluation</u>

1. Disclosure of Ownership 02-016

Board members reviewed the policy. There were no recommended changes. The forms were completed last month.

XI. <u>Linkage Reports</u>

1. Northern Michigan Regional Entity (NMRE)

a. Board Meeting May 22, 2019

Nena Sork reported the meeting addressed the deficits among the partner boards, adjustments to salaries for staff, and liquor tax dollars. Eric Lawson requested input as to the discussion on the liquor tax. Roger Frye and Terry Larson noted there are dollars in the funds for each county and it is important to encourage the counties to begin using those funds.

2. Community Mental Health Association of Michigan (CMHAM)

a. Spring Conference Update

The Spring Board Conference was held on June 10 & June 11 in Novi, MI. Gary Nowak, Eric Lawson, Judy Jones, and Bonnie Cornelius attended.

Eric Lawson reported this conference was a very good conference. He attended a couple sessions regarding ACEs (Adverse Childhood Experiences) one entitled "Understanding Adverse Childhood Experiences (ACEs) and the Impact of Trauma. He noted this was provided by Jodi Spicer from MDHHS. He reported there were studies done to determine how DNA can be changed based on stress. He noted having a supportive environment can positively affect the outcome.

Bonnie Cornelius reported the last keynote speaker began during the lunch and this was a very powerful presentation. Her testimony of her life story was totally amazing. She really rose above her struggles.

b. CMHAM Membership Dues

The FY19 membership dues were recently received from CMHAM.

Moved by Pat Przeslawski, supported by Bonnie Cornelius, to approve the membership dues for the Community Mental Health Association of Michigan in the amount of $13,166.00 as presented. Roll call vote: Ayes: Les Buza, Bonnie Cornelius, Steve Dean, Roger Frye, Mark Hunter, Judy Jones, Terry Larson, Eric Lawson, Pat Przeslawski, Gary Wnuk; Nays: None; Absent: Albert LaFleche, Gary Nowak

XII. <u>Operation's Report</u>

Nena Sork reviewed the Operation's Report for month ending May 31, 2019. Nena reported prescreens spiked in May; however, overall the yearly average is lower than our previous years. She also noted the participation at Touchstone Clubhouse has increased.

The Board took a fifteen minute recess for cake to recognize this as the last official Board meeting for Cathy Meske who is retiring effective June 30, 2019.

XIII. Chair's Report

1. Strategic Plan Review

Eric Lawson reviewed the Mission Statement with Board members noting this was also reviewed with CARF earlier today. The Vision and Core Values were reviewed.

Eric Lawson reviewed the Forces in the Environment noting at the recent conference funding concerns were discussed related to 928 and 298 and the Governor's intent to fix the roads most likely with no approval of a new road tax. The largest budget in the state is the Michigan Department of Health and Human Services putting these dollars as a target.

The Mission statement was discussed further – addressing the "people" and whether it should be people in Northeast Michigan; however, there are individuals who receive services not living in our catchment area. Cathy Meske noted the Mission is meant to be broad and one person's independence is different than another person's independence.

Mark Hunter requested explanation related to the Medicaid proposed language with the removal of the work "prior" for sub-ends in the Financial Outcomes. Cheryl Jaworowski explained the Medicaid issues arise when individuals lose Medicaid and services have been provided and then services might be provided that hit General Funds and then the individual gets approved for Medicaid and funding is received from Medicaid retroactively.

Steve Dean addressed the current opportunity related to anger dyscontrol. Cathy Meske noted anger dyscontrol is the inability to manage themselves and calm themselves down.

Steve Dean noted a statement in the Plan, "Joint ventures will be established with community partners to provide seamless systems of care that eliminates duplication, lower costs, ensures quality care and achieve superior outcomes." Eric Lawson noted this is directed at encouraging collaboration with community partners.

Board members and Agency leadership reviewed the sub-ends semi-annual monitoring report in more depth.

The sub-end related to services to children "Children with serious emotional disturbances served by Northeast will realize significant improvement in their conditions." Last fall the goal was revised, increasing the percentage from 75% to 90% of all children who participate in services to show a 20 point or more decrease in CAFAS scores at completion of services. Lauren Tallant notes this, if drilled down, has some children who have left services due to relocation, detention center placement and those dropping out of services. These individual outcomes were beyond our control. Lauren noted the wording could be changed to state those completing treatment rather than ending treatment, which would eliminate the early departure stats. Lauren provided the CAFAS termination is conducted whether successful completion or unsuccessful completion. Staff will propose language to incorporate into a sub-end for next fiscal year.

The Mega Ends statement reads "All people in the region, through inclusion and the opportunity to live and work independently, will maximize their potential." Steve Dean requested whether the Ends statement needs to be revised as it states "All people in the region…" but the sub-ends are targeted to more specific population groups. Terry Larson reported the Ends statement is targeted at all people in the four county area regardless if they are receiving services from the Agency or not as this agency represents all the individuals living in our counties.

Sub-end #2 – Individuals needing independent living supports will live in the least restrictive environment by a) development of two additional contract residential providers within our catchment area to increase capacity for persons requiring residential placement and 2) development of additional supported independent services for two individuals currently living in licensed foster care. As depicted in the monitoring report, this sub-end is almost completed. One AFC has already been developed; the Agency actually provided consultation for another just

outside our catchment area. The second part of this sub-end was accomplished by the end of last calendar year. The Agency continues to focus on developing additional independent living opportunities for people currently living in specialized residential settings.

Sub-end #3 – Adults with co-occurring disorders will realize significant improvement in their condition. Nena Sork addressed part A of this sub-end noting the data needed to report on this goal is not easily obtained. To get the data would require an intensive search of each individual record. It is not something a report can be written to extract the information. This will need to be rewritten when developing the sub-end for next fiscal year.

Part B of Sub-end #3 was addressed. Nena Sork reported a prescriber can have 33 individuals initially when treating with Medication Assisted Treatment. The only method we have in tracking is BH-TEDS; however, this information is only as good as the reported data from the individual and there are cases where individuals never continued with services. The monitoring reports indicates when the report was run, only seven individual indicated they were receiving services through a medication assisted treatment program. Staff will propose a revision to sub-end #3.

Sub-end #4 and #5 related to the Financial Outcomes was discussed in detail previously and language will be proposed to eliminate the words "in advance" to the statement.

Sub-end #6 was discussed in the monitoring report earlier and the goals are well met.

XIV. Director's Report

1. **Director Report Summary**

Cathy Meske reported she and Nena Sork participated in the Children's Advocacy Center's Advisory Council meeting. She and Lisa Anderson worked with the OPEIU in negotiations. The Paraprofessionals approved their agreement. The Professionals voted and the results are not available until tomorrow. She reported the orientation with the two new Board members was conducted. She has attended the Alcona County and Presque Isle County Commission meetings. The meeting with the Alpena County Commissioners is scheduled for June 25.

a. Banking Resolutions

Cathy Meske reported new resolutions are needed to remove herself and Cheryl Jaworowski due to her retirement effective June 30, 2019 and Cheryl Jaworowski's retirement effective July 9, 2019. There are five different banks this agency has accounts with. Cheryl Jaworowski reported the Accounting Supervisor, Larry Patterson, cannot be on the main accounts due to his need to reconcile the accounts which would cause a conflict of interest. He can be added to the accounts used for the purchase of agency Certificate of Deposits, however. Three of the financial institutions are used for this purpose – Mbank, Chemical Bank and Northland Area Credit Union. It was proposed to have Nena Sork and Larry Patterson be the authorized signers on these three accounts.

Two accounts are used for the agency's routine business and payroll accounts. These two accounts – one with Huntington Bank and one with Alpena Alcona Area Credit Union are proposed to have Nena Sork and Connie Cadarette be the authorized signers.

There is also one additional account with Huntington Bank used for the accounts managed by the agency's representative payee. This account is proposed to have Nena Sork, Connie Cadarette and Joell Anthony be the authorized signers.

Moved by Pat Przeslawski, supported by Mark Hunter to authorize the execution of banking resolutions as proposed and authorize the individual signatures necessary to complete the banking resolutions. Motion carried.

b. Beneficiary Bequeath Approval
Cathy Meske reported we are in receipt of a request for signature on an Agreement for this Bequeath. The first installment is 95% of the balance in the amount of $13,988.00.

Moved by Pat Przeslawski, supported by Judy Jones, to authorize the Director to sign agreement. Motion carried.

c. Union Negotiations Update
This topic was discussed earlier in the Director's Report.

As this is the last Board meeting for Cathy Meske, she provided the Board with a farewell message.

XV. Information and/or Comments from the Public

There was no information or comments presented.

XVI. Next Meeting

The next regularly scheduled meeting of Northeast Michigan Community Mental Health Authority Board will be held Thursday, July 11, 2019 at 3:00 p.m.

1. Set July Agenda

The July agenda items were reviewed. Strategic Planning continues with Part III focusing on development of "Ends" for next fiscal year. Jen Whyte will provide the Board with a brief Compliance Update.

XVII. Evaluation of Meeting

Terry Larson noted the Board did everything right. He reminisced of his early days working with this Agency and Cathy Meske, probably from the very beginning.

XVIII. Adjournment

Moved by Pat Przeslawski, supported by Judy Jones, to adjourn the meeting. Motion carried.
This meeting adjourned at 5:00 p.m.

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Bonnie Cornelius, Secretary

____
Eric Lawson, Chair

Diane Hayka
Recorder

Northeast Michigan Community Mental Health Authority
Statement of Revenue and Expense and Change in Net Position (by line item)
For the Eight Months Ending May 31, 2019
66.7% of year elapsed

		Actual May Year to Date	Budget May Year to Date	Variance May Year to Date	Budget FY19	% of Budget Earned or Used
	Revenue					
1	State Grants	$ 63,667	$ 64,699	$ (1,032)	$ 97,000	65.6%
2	Private Contracts	31,185	38,240	(7,054)	57,331	54.4%
3	Grants from Local Units	418,385	338,767	79,617	507,897	82.4%
4	Interest Income	6,705	6,670	35	10,000	67.1%
5	Medicaid Revenue	16,853,475	16,643,406	210,069	24,952,633	67.5%
6	General Fund Revenue	452,029	533,911	(81,882)	800,467	56.5%
7	Healthy Michigan Revenue	818,363	1,043,057	(224,693)	1,563,803	52.3%
8	3rd Party Revenue	223,426	354,932	(131,506)	532,132	42.0%
9	SSI/SSA Revenue	334,154	336,744	(2,589)	504,863	66.2%
10	Other Revenue	58,430	58,090	340	87,092	67.1%
11	**Total Revenue**	**19,259,821**	**19,418,516**	**(158,695)**	**29,113,218**	**66.2%**
	Expense					
12	Salaries	8,295,366	8,344,426	49,060	12,510,384	66.3%
13	Social Security Tax	371,481	391,787	20,307	587,387	63.2%
14	Self Insured Benefits	1,393,075	1,447,866	54,791	2,170,713	64.2%
15	Life and Disability Insurances	144,752	154,990	10,237	232,368	62.3%
16	Pension	680,657	639,175	(41,482)	958,284	71.0%
17	Unemployment & Workers Comp.	124,514	127,343	2,829	190,919	65.2%
18	Office Supplies & Postage	26,761	30,065	3,304	45,076	59.4%
19	Staff Recruiting & Development	83,943	82,315	(1,628)	123,411	68.0%
20	Community Relations/Education	532	2,582	2,050	3,871	13.7%
21	Employee Relations/Wellness	32,925	34,732	1,807	52,072	63.2%
22	Program Supplies	295,823	307,515	11,692	461,042	64.2%
23	Contract Inpatient	681,876	724,035	42,158	1,085,509	62.8%
24	Contract Transportation	73,689	82,810	9,121	124,153	59.4%
25	Contract Residential	3,422,957	3,414,447	(8,510)	5,119,111	66.9%
26	Contract Employees & Services	2,285,214	2,372,183	86,969	3,556,496	64.3%
27	Telephone & Connectivity	74,548	74,866	318	112,242	66.4%
28	Staff Meals & Lodging	17,212	25,475	8,264	38,194	45.1%
29	Mileage and Gasoline	285,615	302,601	16,985	453,674	63.0%
30	Board Travel/Education	7,523	9,114	1,590	13,664	55.1%
31	Professional Fees	46,802	43,520	(3,281)	65,248	71.7%
32	Property & Liability Insurance	74,090	40,494	(33,596)	60,711	122.0%
33	Utilities	114,435	115,128	693	172,605	66.3%
34	Maintenance	110,409	127,475	17,066	191,117	57.8%
35	Rent	176,032	155,656	(20,376)	233,367	75.4%
36	Food (net of food stamps)	39,582	38,473	(1,108)	57,681	68.6%
37	Capital Equipment	18,307	79,637	61,329	119,395	15.3%
38	Client Equipment	8,361	18,989	10,627	28,469	29.4%
39	Miscellaneous Expense	33,279	58,916	25,637	88,330	37.7%
40	Depreciation Expense	167,649	171,902	4,253	257,723	65.0%
41	**Total Expense**	**19,087,410**	**19,418,516**	**331,107**	**29,113,218**	**65.6%**
42	**Change in Net Position**	**$ 172,411**	**$ -**	**$ 172,411**	**$ -**	**0.6%**
43	Contract settlement items included above:					
44	Medicaid Funds (Over) / Under Spent	$ (224,864)				
45	Healthy Michigan Funds (Over) / Under Spent	228,430				
46	**Total NMRE (Over) / Under Spent**	**$ 3,566**				
47	General Funds to Carry Forward to FY20	$ 26,682				
48	General Funds Lapsing to MDHHS	54,931				
49	**General Funds (Over) / Under Spent**	**$ 81,614**				

Northeast Michigan Community Mental Health Authority
Monitoring Report

POLICY CATEGORY: Executive Limitations
POLICY TITLE AND NUMBER: Asset Protection, 01-007
REPORT FREQUENCY & DUE DATE: Annual, July 2019
POLICY STATEMENT:
The CEO may not allow assets to be unprotected, inadequately maintained nor unnecessarily risked.

Accordingly, he or she may not:

1. Fail to insure against theft and casualty losses at:
   - Actual cash value less any reasonable deductible for vehicles
   - Replacement value less any reasonable deductible for personal and real property; and,
   - Against liability losses to board members, staff or the organization itself in an amount greater than the average for comparable organizations.
   - **Interpretation**
     A broad program of insurance or self-insurance is to be in place providing protection against these potential losses. Coverage is to be at replacement value. The level of liability coverage is to be "above average."

   - **Status**
     Northeast has been a member of Michigan Municipal Risk Management Authority (MMRMA) since 1982. The program provides coverage at or above the prescribed levels. Please see Attachment A - "Coverage Overview." Presently, personal and real property owned by the Board is insured at replacement value; however, vehicles are covered at actual cash value.

2. Allow unbonded personnel access to material amounts of funds.
   - **Interpretation**
     Any employee with access to agency funds is to be covered by fidelity bond.

   - **Status**
     MMRMA provides blanket employee fidelity bond for all employees at the level of $1,000,000. See attached "Coverage Overview (Attachment A, Page 3, Line 16)."

3. Unnecessarily expose the organization, its board or staff to claims of liability. The CEO's annual report shall include a risk analysis summary.
   - **Interpretation**
     The organization is to be managed and services are to be provided in ways that reduce exposure to liability.

   - **Status**
     The agency's Risk Management Plan is attached; it includes notes evaluating our status relative to each of the six major areas of risk covered by the plan.

4. Make any purchase wherein normally prudent protection has not been given against conflict of interest. Make any purchase of over $250 without having obtained comparative prices and quality. Make any purchase over $5,000 without a stringent method of assuring the balance of long term quality and cost; further, such purchases over $5,000 not included in the Board's capital equipment budget, shall require Board approval. Orders shall not be split to avoid these criteria.
   - **Interpretation**
     Management is to assure that purchasing decisions are made following a consistently applied procedure that meets these restrictions. The procedure should not be so onerous that savings that might accrue from it are lost to bureaucratic oversight.

   - **Status**
     The organization uses a policy that places much responsibility for purchasing at the staff level we hold responsible for budget performance—supervisors. When a proposed purchase exceeds the noted levels, additional approvals are required.

5. Fail to protect intellectual property, information and files from loss or significant damage.
   - **Interpretation**
     The organization will protect work products (primarily clinical records, management and financial records) from fire or other potential causes of loss.

   - **Status**
     The organization uses an electronic medical record (EMR). Case records are maintained in electronic format with controlled access. This matter has received considerable attention since the advent of HIPAA. Only designated personnel have access to maintenance of electronic records. Key to success is staff training and compliance with these procedures. Our policies 3810 and 5200 ("Confidentiality—Disclosure & Security of Information" and "Consumer Records") detail these procedures. Staff are trained at time of hire and periodically thereafter. These clinical records are backed up and stored off-site. Information stored on agency computer systems is backed up nightly. The same high standard of security and privacy is being upheld with the EMR system as it was with the past paper chart system.

6. Receive, process or disburse funds under controls which are insufficient to meet the board-appointed auditor's standards.
   - **Interpretation**
     Agency policies regarding internal controls and separation of duties will be followed; these policies will take into account the Auditor's advice.

   - **Status**
     Policies 4300, 4310, 4315, 4330 (among others) document these controls which are followed by employees. There has never been a significant loss of agency funds with the exception of very minor and infrequent shortages of petty cash accounts.

7. Invest or hold operating capital in insecure instruments, including uninsured checking accounts and bonds of less than AA rating, or in non-interest bearing accounts except where necessary to facilitate ease in operational transactions.
   - **Interpretation**
     Operating funds are to be managed only according to the organization's cash management policy.

   - **Status**
     All cash reserves are maintained according to our cash management policies. Since all cash is invested in either CD's or our interest-earning checking account as needed, there is a risk of loss due to maximum insurable FDIC rules. Four local banks are used to spread the FDIC risk.

8. Endanger the organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission, including changing the name of the organization or substantially altering its identity in the community.
   - **Interpretation**
     The mission of the organization, as established by the Board, must guide service provision and the interface with the community.

   - **Status**
     Over the past several years, we have worked hard to sharpen the focus of the organization to address the mandates of the mental health code and, due to general fund shortages, limit service to the "must serve" populations (versus "may serve"). Recognizing and observing this limitation has been somewhat painful—for consumers, Board members, staff and community partners. We must (and, I believe, do) excel in supporting people with the most severe disabilities in the community. We will have to continue to identify appropriate referral sources for people who do not meet our eligibility criteria. Since October 1, 2014 we have been responsible for Access Services locally. That has permitted us to make immediate referrals for individuals who are not eligible for our services.

9. Subject facilities and equipment to improper wear and tear or insufficient maintenance.
   - **Interpretation**
     The physical assets of the organization will not be abused and will be regularly maintained both for safety reasons and to extend their useful lives as much as possible.

   - **Status**
     The organization's policies require regular inspection and maintenance of all facilities and significant equipment.

     The organization uses a fleet of 64 vehicles. Fleet vehicles generally have a service life of 120,000 miles and/or five to six years of service. After June & July vehicle trade-ins are complete, all vehicles will have less than 120,000 miles. The Agency is committed to providing quality transportation in the four-county area.

Northeast Michigan Community Mental Health Authority
Monitoring Report

Board Review/Comments

Reasonableness Test: Is the interpretation by the CEO reasonable?

Data Test: Is the data provided by the CEO both relative 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?

MICHIGAN MUNICIPAL RISK MANAGEMENT AUTHORITY
COVERAGE OVERVIEW

Member: **Northeast Michigan C.M.H.S.** **Proposal No: Q000012060**

Date of Original Membership: **July 29, 1982**

Overview Dates: **July 1, 2019 To July 01, 2020**

Member Representative: **Cheryl Jaworowski** **Telephone #: (989) 358-7737**

Regional Risk Manager: **Michigan Municipal Risk Management Authority** **Telephone #: (734) 513-0300**

A. Introduction

The Michigan Municipal Risk Management Authority (hereinafter "MMRMA") is created by authority granted by the laws of the State of Michigan to provide risk financing and risk management services to eligible Michigan local governments. MMRMA is a separate legal and administrative entity as permitted by Michigan laws. **Northeast Michigan C.M.H.S.** (hereinafter "Member") is eligible to be a Member of MMRMA. **Northeast Michigan C.M.H.S.** agrees to be a Member of MMRMA and to avail itself of the benefits of membership.

Northeast Michigan C.M.H.S. is aware of and agrees that it will be bound by all of the provisions of the Joint Powers Agreement, Coverage Documents, MMRMA rules, regulations, and administrative procedures.

This Coverage Proposal summarizes certain obligations of MMRMA and the Member. Except for specific coverage limits, attached addenda, and the Member's Self Insured Retention (SIR) and deductibles contained in this Coverage Proposal, the provisions of the Joint Powers Agreement, Coverage Documents, reinsurance agreements, MMRMA rules, regulations, and administrative procedures shall prevail in any dispute. The Member agrees that any dispute between the Member and MMRMA will be resolved in the manner stated in the Joint Powers Agreement and MMRMA rules.

B. Member Obligations – Deductibles and Self Insured Retentions

Northeast Michigan C.M.H.S. is responsible to pay all costs, including damages, indemnification, and allocated loss adjustment expenses for each occurrence that is within the Member's Self Insured Retention (hereinafter the "SIR"). **Northeast Michigan C.M.H.S.**'s SIR and deductibles are as follows:

Table I

Member Deductibles and Self Insured Retention

COVERAGE	DEDUCTIBLE	SELF INSURED RETENTION
Liability	N/A	$75,000 Per Occurrence
Vehicle Physical Damage	$1,000 Per Vehicle	$15,000 Per Vehicle $30,000 Per Occurrence
Fire/EMS Replacement Cost	N/A	N/A
Property and Crime	$1,000 Per Occurrence	N/A
Sewage System Overflow	N/A	N/A

The member must satisfy all deductibles before any payments are made from the Member's SIR or by MMRMA.

Member's Motor Vehicle Physical Damage deductible applies, unless the amount of the loss exceeds the deductible. If the amount of loss exceed the deductible, the loss including deductible amount, will be paid by MMRMA, subject to the Member's SIR.

The **Northeast Michigan C.M.H.S.** is afforded all coverages provided by MMRMA, except as listed below:

1. Sewage System Overflow
2. Specialized Emergency Response Recovery Coverage
3.
4.

All costs including damages and allocated loss adjustment expenses are on an occurrence basis and must be paid first from the Member's SIR. The Member's SIR and deductibles must be satisfied fully before MMRMA will be responsible for any payments. The most MMRMA will pay is the difference between the Member's SIR and the Limits of Coverage stated in the Coverage Overview.

Northeast Michigan C.M.H.S. agrees to maintain the Required Minimum Balance as defined in the Member Financial Responsibilities section of the MMRMA Governance Manual. The Member agrees to abide by all MMRMA rules, regulations, and administrative procedures pertaining to the Member's SIR.

C. MMRMA Obligations – Payments and Limits of Coverage

After the Member's SIR and deductibles have been satisfied, MMRMA will be responsible for paying all remaining costs, including damages, indemnification, and allocated loss adjustment expenses to the Limits of Coverage stated in Table II. The Limits of Coverage include the Member's SIR payments.

The most MMRMA will pay, under any circumstances, which includes payments from the Member's SIR, per occurrence, is shown in the Limits of Coverage column in Table II. The Limits of Coverage includes allocated loss adjustment expenses.

TABLE II
Limits of Coverage

Liability and Motor Vehicle Physical Damage	Limits of Coverage Per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
1. Liability	15,000,000	N/A	N/A	N/A
2. Judicial Tenure	N/A	N/A	N/A	N/A
3. Sewage Systems Overflows	0	N/A	0	N/A
4. Volunteer Medical Payments	25,000	N/A	N/A	N/A
5. First Aid	2,000	N/A	N/A	N/A
6. Vehicle Physical Damage	1,500,000	N/A	N/A	N/A
7. Uninsured/Underinsured Motorist Coverage (per person)	100,000	N/A	N/A	N/A
Uninsured/Underinsured Motorist Coverage (per occurrence)	250,000	N/A	N/A	N/A
8. Michigan No-Fault	Per Statute	N/A	N/A	N/A
9. Terrorism	5,000,000	N/A	N/A	5,000,000

Property and Crime	Limits of Coverage Per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
1. Buildings and Personal Property	9,112,642	350,000,000	N/A	N/A
2. Personal Property in Transit	2,000,000	N/A	N/A	N/A
3. Unreported Property	5,000,000	N/A	N/A	N/A
4. Member's Newly Acquired or Constructed Property	10,000,000	N/A	N/A	N/A
5. Fine Arts	2,000,000	N/A	N/A	N/A
6. Debris Removal (25% of insured direct loss plus)	25,000	N/A	N/A	N/A
7. Money and Securities	1,000,000	N/A	N/A	N/A
8. Accounts Receivable	2,000,000	N/A	N/A	N/A
9. Fire Protection Vehicles, Emergency Vehicles, and Mobile Equipment (Per Unit)	5,000,000	10,000,000	N/A	N/A
10. Fire and Emergency Vehicle Rental (12 week limit)	1,000 per week	N/A	N/A	N/A
11. Structures Other Than a Building	15,000,000	N/A	N/A	N/A
12. Storm or Sanitary Sewer Back-Up	1,000,000	N/A	N/A	N/A
13. Marine Property	1,000,000	N/A	N/A	N/A
14. Other Covered Property	10,000	N/A	N/A	N/A
15. Income and Extra Expense	5,000,000	N/A	N/A	N/A
16. Blanket Employee Fidelity	1,000,000	N/A	N/A	N/A
17. Faithful Performance	Per Statute	N/A	N/A	N/A
18. Earthquake	5,000,000	N/A	5,000,000	100,000,000
19. Flood	5,000,000	N/A	5,000,000	100,000,000
20. Terrorism	50,000,000	50,000,000	N/A	N/A

TABLE III

Network and Information Security Liability, Media Injury Liability, Network Security Loss, Breach Mitigation Expense, PCI Assessments, Social Engineering Loss, Reward Coverage, Telecommunications Fraud Reimbursement.			
	Limits of Coverage Per Occurrence/Claim	Deductible Per Occurrence/Claim	Retroactive Date
Coverage A Network and Information Security Liability: Regulatory Fines:	Each Claim Included in limit above Each Claim Included in limit above	$25,000 Each Claim	7/1/2013
Coverage B Media Injury Liability	Each Claim Included in limit above	$25,000 Each Claim	7/1/2013
Coverage C Network Security Loss Network Security Business Interruption Loss:	Each Unauthorized Access Included in limit above Each Business Interruption Loss Included in limit above	$25,000 Each Unauthorized Access Retention Period of 72 hours of Business Interruption Loss	Occurrence
Coverage D Breach Mitigation Expense:	Each Unintentional Data Compromise Included in limit above	$25,000 Each Unintentional Data Compromise	Occurrence
Coverage E PCI Assessments:	Each Payment Card Breach $1,000,000 Occ/$1,000,000 Agg. Included in limit above	$25,000 Each Payment Card Breach	Occurrence
Coverage F Social Engineering Loss:	Each Social Engineering Incident $100,000 Occ./$100,000 Agg Included in imit above	$25,000 Each Social Engineering Incident	Occurrence
Coverage G Reward Coverage	Maximum of 50% of the Covered Claim of Loss; up to $25,000 Included in Limit above	Not Applicable	Occurrence
Coverage H Telecommunications Fraud Reimbursement	$25,000 Included in limit above	Not Applicable	Occurrence

Annual Aggregate Limit of Liability

Member Aggregate	**All Members Aggregate**
$5,000,000	$25,000,000

The total liability of MMRMA shall not exceed $5,000,000 per Member Aggregate Limit of Liability for coverages A, B, C, D, E, F, G, and H, in any Coverage Period.

The total liability of MMRMA and MCCRMA shall not exceed $25,000,000 for All Members Combined Aggregate Limit of Liability for coverages A, B, C, D, E, F, G, and H, in any Coverage Period.

It is the intent of MMRMA that the coverage afforded under the Subjects of Coverage be mutually exclusive. If however, it is determined that more than one Subject of Coverage applies to one coverage event ensuing from a common nexus of fact, circumstance, situation, event, transaction, or cause, then the largest of the applicable Deductibles for the Subjects of Coverage will apply.

TABLE IV

Specialized Emergency Response Expense Recovery Coverage

Limits of Coverage

Specialized Emergency Response Expense Recovery	Limits of Coverage per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
	N/A	N/A	N/A	N/A

TABLE V

Specialized Emergency Response Recovery Coverage

Deductibles

Specialized Emergency Response Expense Recovery	Deductible per Occurrence
	Member
	N/A

NeMCMH Risk Management Plan
2018/2019

Northeast Michigan Community Mental Health Authority (NeMCMHA) is a member of a five Board PIHP called the Northern Michigan Regional Entity (NMRE). NeMCMHA provides services to consumers living in the Alcona, Alpena, Montmorency and Presque Isle Counties. Northeast is subject to surveys and audits from the State of Michigan, CARF and the NMRE.

Northeast Michigan CMHA Mission Statement:

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

Risk Reduction Efforts

NeMCMHA is committed to reducing risk in all areas of service. In order to provide the services promised in our Mission Statement, NeMCMHA expends time, finances and creativity in the prevention, reduction and monitoring of risk areas.

Financial Risk:

1. Annually a budget is developed for the upcoming year. This is completed every August prior to the beginning of a new fiscal year. Various supervisors of programs and the Finance Director complete this budget. The budget is shared and approved by the Board of Directors.
2. Supervisors receive monthly statements showing actual operational results as compared to their approved budgets. All operational results are reviewed monthly by finance staff and the Management Team.
3. As changes in the budget are needed, amendments are completed and reported to the Board of Directors for approval.
4. Annually a CPA Audit is completed. For the last 10 plus years, all audits completed have resulted in an unqualified audit. A representative of the CPA firm reports the results of this audit to the Board of Directors.
5. Monthly budget reporting to the Board.
6. Compliance hotline to report potential risks areas. Compliance forms are available on site for reporting compliance violations.

Environmental Safety Risk:

1. An external authority completes safety site reviews on every site. These reviews and recommendations of these reviews are addressed as identified.
2. NeMCMHA has a Safety Committee to review various areas of risk. This committee focuses on the reduction of staff injury risk. The Safety Committee looks at staff safety with regard to vehicle safety and physical environment. The Committee reviews all accident reports submitted by staff. Once reviewed, areas of potential risks to other staff are identified and recommendations for improvement are submitted.
3. This committee is responsible for ensuring the Environment of Care Manual and Emergency Flip charts are up to date. These flip charts allow staff easy access to what to do in the event of emergency. Emergency Flip Charts are located at all sites.
4. The Safety Committee is a Standing Committee to the Quality Improvement (QI) Council and all areas of improvement are filtered to and from the QI Council.
5. Emergency drills are conducted at all work sites on all shifts.
6. NeMCMHA has an assigned infection control nurse.

Technology Risk:

1. NeMCMHA has a network usage policy 3600, which is designed to protect employees, partners and the Agency from illegal or damaging actions by individuals, either knowingly or unknowingly.

2. NeMCMHA has installed a spam filter/virus protection server for all incoming email and has an internet firewall protection server for browsing the internet.
3. NeMCMHA uses an encryption email server for confidential emails to outside emails.

Insurance and Liability Risk:

1. Internal claims verification and documentation reviews.
2. Quarterly the NMRE's Compliance Director reviews claims of the previous quarter to ensure staff adhere to required documentation standards and individual plans of service are followed.
3. Adequate Insurance Coverage – NeMCMHA is a member of Michigan Municipal Risk Management Authority (MMRMA), which provides broad coverage for the organization and staff.
4. Independent contractors are required to have the appropriate insurances to complete the services requested.

Consumer Risk:

1. NeMCMHA has policies in place, which safeguard individuals' served funds.
2. NeMCMHA has a sentinel event policy, including protocols to follow in the event an individual served by the Agency has been involved in an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. These events are reported to the state, reviewed, analyzed and recommendations are identified and implemented.
3. Incident Reports are completed on individuals served involved in any unusual incident.
4. Death reports are completed on all deaths of an individual served by CMH when manner of death is indeterminate. The Recipient Rights Officer reviews every death report that is presented.
5. A CMH psychiatrist completes death reviews post mortem when death is by drug overdose.
6. Behavior Support Committee (BSC) meets monthly to review proposed behavior plans and approved behavior plans.

Record Review:

1. Record reviews are completed by supervisors on a monthly basis to ensure records contain the appropriate information and staff are documenting services as policy demands.
2. Quarterly, the Regional Entity's Compliance Coordinator, during the claims review, reviews the documentation to ensure compliance with documentation standards.

Potential Risk:

- Annually the Risk Management Committee selects from identified potential risks areas, at least one area to analyze and present recommendations for risk reduction in that area.

NeMCMHA through their ongoing processes; outside audits, surveys and self-assessments continue to demonstrate its commitment to protect its human, financial, and goodwill assets and resources through the practice of effective risk management. The Board, management and staff of NeMCMHA are committed to safeguarding the safety of individuals receiving services, staff, and anyone who has contact with the organization.

NeMCMHA continues to strive to improve its risk management program. Every year, new and innovative ways of reducing risk are identified and added to the list of efforts.

Annually the Risk Management Committee will review the Risk Management Plan.

POLICY CATEGORY: Executive Limitations
POLICY TITLE AND NUMBER: Community Resources, 01-010
REPORT FREQUENCY & DUE DATE: Annual: July 2019
POLICY STATEMENT:

With respect to the attainment of Northeast Michigan Community Mental Health Authority, the Executive Director may not fail to take advantage of collaboration, partnerships and innovative relationships with agencies and other community resources.

- **Interpretation**

The agency will develop and maintain collaborative and productive relationships within the community; we will be actively represented on Community Collaboratives (CCs). Further, agency staff will actively participate on appropriate community coordination/planning groups. Wherever possible, "wrap-around" approaches to serve families and children with complex needs should be pursued.

- **Status**

There are four CCs in the four-county area, one representing each county. Carolyn Bruning is a member of the Montmorency County Community Collaborative, Alcona County Community Collaborative, Alpena HSCC [including its Executive Committee] and the Presque Isle HSCC. In addition, we have staff actively representing the agency on the Homeless Coalition, ESD Transition Planning Council, CAN (Child Abuse & Neglect) Teams, EPSDT (Early & Periodic Screening, Diagnostic and Treatment), Children's Closet, Child Death Review Team, Wraparound Community Teams, Great Start Collaborative, Northeast MI Trauma-Informed Action collaborative, Alpena Public Schools Trauma initiative and Alpena, Montmorency DHHS trauma partnership with Children's Trauma Assessment Center (CBAT) and Catholic Human Services. Northeast staff are members of the Substance Use Coalition and Northeast staff is scheduled to participate in training specific to adolescent substance use. We are also members of Alpena County Prevention Council, Critical Incident Stress Management and debriefing team; bringing the total to five who are active in the CISM Team of Northeast Michigan, responding to community critical incidents. We have collaborated with District Health No. 2 and the Alpena County Community Emergency Response Departments to be included in the Community Emergency Response Plan.

We participate in several community partnerships, in addition to contracting with Partners in Prevention to provide education to the community, including the schools on the effects of trauma, suicide prevention and Adult and Youth Mental Health First Aid. During the First and Second Quarter of FY 19, 13 community members participated in Adult Mental Health First Aide and 22 community members participated in Youth Mental Health First Aid. In addition 70 individuals were trained on the effects of trauma. NeMCMHA staff has provided mental health training our local jail corrections staff (Alcona County, April 24th) and sheriff deputy (Alcona County, June 27th).

NeMCMHA had two staff trained by the University of Michigan "TRAILS" (Transforming Research into Action to Improve the Lives of Students) model sponsored by MDHHS. "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 (trained CMH staff) who helps implement a CBT- and mindfulness-based skills group to students in need, right at school.

One staff trained has since left the Agency. The remaining trained staff has worked with the Posen School District to implement this model. The staff continue to work with the school success workers to expand this program to other schools. In addition, we contract with Alcona Health Center (AHC) to provide additional outpatient counseling services in a school identified by Alpena Public Schools up to two days per week.

NeMCMHA, Partners in Prevention and other community partners are providing community-wide suicide awareness/prevention training during FY19. NeMCMHA has partnered with Presque Isle Suicide Prevention Task Force to increase suicide awareness and prevention using 'safeTALK' from Living Works.

NeMCMHA staff is 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 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.

Board Review/Comment

Reasonableness Test: Is the interpretation by the CEO reasonable?

Data Test: Is the data provided by the CEO both relative 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)

COMMUNITY RESOURCES
(Subject)

Board Approval of Policy	August 8, 2002
Last Revision of Policy Approved:	July ~~12~~11, ~~2007~~2019

●1 POLICY:

With respect to the attainment of Northeast Michigan Community Mental Health Authority "Ends," the ~~CEO~~ Executive Director may not fail to take advantage of collaboration, partnerships and innovative relationships with agencies and other community resources.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

GOVERNANCE PROCESS
(Manual Section)

PUBLIC HEARINGS
(Subject)

Board Approval of Policy August 8, 2002
Last Revision of Policy Approved July 14, 2016

●1 POLICY:

The Authority shall conduct public hearings of its response to the Michigan Department of Health and Human Services Annual Submission (a.k.a. – PPGs) prior to its submission, and for its adoption of its annual budget at or before the beginning of the fiscal year.

The Annual Submission public hearing may be conducted by the Director at a time and date necessary to accommodate a timely submission of required documents; Board members will be invited to participate in the hearing as well as members of the public.

The public hearing regarding the adoption of the budget shall be conducted by the Chair of the Authority at a meeting of the Board of the Authority.

The hearings shall adhere to these guidelines:

Annual Submission (PPGs) Hearing:
This hearing will be scheduled to be conducted as soon as possible after the release of the guidelines by the Department of Health and Human Services. The purpose of the hearing will be to explain to the public the requirements of those guidelines and the likely effect on local mental health programs; further, to receive public input from members of the public about ways to meet the intent of the guidelines and to offer opportunities for the public to suggest other priorities, as well.

Annual Budget Hearing:
This hearing will be conducted during either the September or October meetings of the Board of the Authority. The purpose of the meeting will be to adopt in public session a budget for the fiscal year that incorporates and supports the Ends adopted by the Board and reflects program adjustments that may have been included in the response the Department's Program Policy Guidelines.

Required Notice for Public Hearings:
Ten days advance notice of public hearings shall be required. The notice shall be placed in all area newspapers and shall include information about the purpose of

the hearing and the form of input members of the public may offer. Depending upon the type of hearing, specific invitations may be sent to interested parties such as county commissions, mental health service providers, the medical societies, boards of education, mental health advocacy organizations, etc.

Format of Hearings:
Hearings shall be conducted in such fashion as to assure that members of the public receive adequate information about the matter to be acted upon, and have sufficient opportunity to offer suggestions and alternative points of view.

The Hearing shall be documented, noting the names of participants, their affiliations, if any, and a summary of the input offered.

●2 APPLICATION:

The Northeast Michigan Community Mental Health Authority Board

●3 DEFINITIONS:

Annual Submission (PPGs): Guidelines released annually by the Michigan Department of Health and Human Services in which the Department introduces new directions it intends the public mental health system to move and gathers information from community mental health services programs regarding their level of readiness for such transitions. This annual submission also includes the annual needs assessment required by the Mental Health Code as well as statistical information about services offered and provided.

Fiscal Year: October 1 through September 30

●4 REFERENCES:

●5 FORMS AND EXHIBITS:

NORTHERN MICHIGAN REGIONAL ENTITY
BOARD OF DIRECTORS MEETING
10:00AM, MAY 22, 2019
NMRE BOARD ROOM, GAYLORD

BOARD MEMBERS IN ATTENDANCE:	**Roger Frye, Ed Ginop, Annie Hooghart, Randy Kamps, Gary Klacking, Terry Larson, Mary Marois, Gary Nowak, Jay O'Farrell, Richard Schmidt, Karla Sherman, Joe Stone, Don Tanner, Nina Zamora**
CEOs IN ATTENDANCE:	**Christine Gebhard, Chip Johnston, Karl Kovacs, Diane Pelts, Nena Sork**
NMRE STAFF IN ATTENDANCE:	**Eric Kurtz, Sara Sircely, Deanna Yockey, Carol Balousek**
PUBLIC IN ATTENDANCE:	**Chip Cieslinski, Ken Kauffman, Derek Miller, Sue Winter**

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

ROLL CALL
Let the record show that all NMRE Board Members were in attendance for the meeting on this date.

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

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

APPROVAL OF PAST MINUTES
The minutes of the April meeting of the NMRE Governing Board were included in the materials for the meeting on this date.
MOTION MADE BY JOE STONE TO APPROVE THE MINUTES OF THE APRIL 24, 2019 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SECOND BY ANNIE HOOGHART. MOTION CARRIED.

APPROVAL OF AGENDA
Mr. Kamps called for approval of the meeting agenda. Eric Kurtz requested that "NMRE Staff cola" be added under "New Business."
MOTION MADE BY JOE STONE TO APPROVE THE AGENDA FOR THE MAY 22, 2019 MEETING OF THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS AS AMENDED; SECOND BY KARLA SHRMAN. MOTION CARRIED.

CORRESPONDENCE
1. An email to Randy Kamps from Dennis Priess was distributed on this date serving as his resignation from the NMRE Board of Directors. Many Board Members spoke about the good work Mr. Priess has done on the Board and in his prior career at Northern Michigan Substance Abuse Services (NMSAS).

MOTION MADE BY ED GINOP TO ACCEPT THE RESIGNATION OF DENNIS PRIESS FROM THE NORTHERN MICHIGAN REGIONAL ENTITY BOARD OF DIRECTORS; SUPPORT BY KARLA SHERMAN. MOTION CARRIED.

2. Letter dated April 23rd from Eric Kurtz and the five CMHSP CEOs to Jon Villasurda is support of the Behavioral Health Home expansion to the NMRE's 21-counties.
3. The minutes from the April 4th PIHP CEO meeting.
4. Email correspondence from Bob Sheehan and Alan Bolter dated April 30th providing an update on advocacy efforts to omit Section 928 from the MDHHS budget.
5. Email correspondence from Bob Sheehan and Alan Bolter in support of the National Suicide Prevention Lifeline Network.
6. Email from Kathy Stiffler regarding Renewal Applications for Children's Waiver Program/Habilitation Supports Waiver/Waiver for Children with Serious Emotional Disturbances.
7. Email correspondence and diagram from Robert Sheehan and Alan Bolter detailing the transition from current Medicaid waivers to new waivers.
8. Proposed definition from waiver application of Overnight Health and Safety Support services.
9. Email correspondence from Robert Sheehan and Alan Bolter seeking representation on an MDHHS workgroup to amend the Mental Health Code to add mediation to the dispute resolution process.
10. Email correspondence from Robert Sheehan and Alan Bolter requesting voting delegates for the CMHAM Spring Conference.
11. Action Alert and informative documents from CMHAM advocating for support of adequate funding for Mental Health Services.
12. FY20 Michigan Senate and House Budget Proposals.
13. Office of the Auditor General Summary Report of Encounter Claim Integrity Performance Audit of Medicaid Health Plans.

Mr. Kurtz highlighted that efforts to eliminate Section 928 from the budget boilerplate are gaining momentum.

Mr. Kurtz drew attention to the waiver grid (#7 under "Correspondence"). Mr. Kurtz discussed CMS transparency rules for the 1115 Waivers which require an opportunity for a 30-day public comment period. After that, the State may submit its application to CMS. Within 15 days of receipt of the application, CMS will send the State written notice of receipt of the (completed) application and begin an additional 30-day public notice period. Current changes seem to be bypassing public comment by being issued as an Amendment to the current waiver issued by an MSA Bulletin. Mr. Johnston asserted that CMS needs to be aware that what is proposed is a "significant change." Don Tanner asked how quickly things can move forward. Mr. Kurtz responded, "as early as June." Mr. Johnston suggested creating a list of bullet points to share with stakeholders. Karl Kovacs suggested tapping into the Action Alert system. Randy Kamps requested an MDHHS organizational chart to know where to route communications. Mr. Kurtz responded that Director Gordon recently named Kate Massey as Michigan's Medicaid Director. Mr. Tanner emphasized that the failure of one region (Lakeshore) is being touted as a system failure. Christine Gebhard noted that Sen. Curt VanderWall is holding a town hall meeting about healthcare issues on May 24th at Kirkland College; she suggested this may be a possible venue to speak out about this issue.

Mr. Kurtz reported he found the OAG Report unsettling in a few ways: 1) the number of unsubstantiated claims (14%); 2) the number of unidentified improper or duplicated claims; and 3) the insufficient use of the Benefits Monitoring Program. He stressed the need to "be sure our house is clean" and suggested reviewing our region with the eyes of the Office of the Inspector General. Mr. Kamps asked whether NMRE has the resources to do so, to which Mr. Kurtz responded it does.

ANNOUNCEMENTS

Let the record show that Joe Stone commented on the need for voting delegates for the CMHAAM Spring

Conference (as noted in the Correspondence). The decision was made to name Eric Kurtz and Randy Kamps; this will be communicated to the Association.

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

REPORTS
Board Chair Report/Executive Committee
Let the record show that no meetings of the NMRE Executive Committee have occurred since the April NMRE Board Meeting.

CEO's Report
The NMRE CEO Monthly Report for May 2019 was included in the materials for the meeting on this date. Mr. Kurtz expressed that he enjoyed providing the Environmental Scan to the Northeast Michigan CMH Board on May 9th. Ms. Gebhard requested a copy of the PowerPoint presentation which Mr. Kurtz agreed to send.

SUD Board Report
Mr. Frye reported on the May 6, 2019 meeting of the Northern Michigan Regional Entity Substance Use Disorder Oversight Board. Discussed the PA2 distribution options. One topic discussed was the allocation of PA2 funds for region-wide initiatives. Three options were proposed: 1) allocation by county census, 2) allocation by 50% county census/50% state equalized value (SEV), and 3) allocation proportional to the amount of liquor tax generated. The SUD Board will revisit the discussion during the July meeting with breakdowns on the three methods provided by the NMRE. It was noted that liquor tax may not be used if another funding source is available. Mary Marois requested clear guidance on the use of PA2 dollars This will be the topic of a future Board presentation. Christine requested a list of PA2 funded projects.

Financial Report
The NMRE Monthly Financial Report for March 2019 was included in the meeting materials.

- Traditional Medicaid showed $78,687,875 in revenue, and $80,186,216 in expenses, resulting in a net deficit of $1,498,341 for five months ending March 31, 2019. Medicaid ISF was reported as $6,611,541. Medicaid Savings was reported as $1,428,126.
- Healthy Michigan Plan showed $9,092,850 in revenue, and $9,465,566 in expenses, resulting in a net deficit of $372,716. Healthy Michigan ISF was reported as $5,408,357. HMP carry forward $0.
- Behavioral Health Home showed $56,385 in revenue and $52,648 in expenses, resulting in a surplus of $3,737.
- SUD showed all funding source revenue of $6,957,904 and $7,318,454 in expenses, resulting in a net deficit of $360,550. Total PA2 funds were reported as $4,961,732.

Mary Marois asked about the Eligible Trending Graphs showing a migration of individuals from DAB to Healthy Michigan. Mr. Kurtz clarified that DAB is a disability-based benefit; HMP is income-based. Anyone who meets DAB could request to be eligible for HMP which has expanded coverage (dental). DAB revenue is much higher, so when those are lost to HMP it affects the budget.

Deanna Yockey noted the ISF is just shy of being fully funded. Medicaid savings and carry forward will be used to cover the deficit, some of which resulted from planned spending. New rates are expected in June. Mr. Kovacs commented that the current model still lacks the ability to build reserves from "actuarily sound" rates. Clarification was made that Liquor tax funds are collected three times per year.

DRAFT

MOTION BY ROGER FRYE TO RECEIVE AND FILE THE NORTHERN MICHIGAN REGIONAL ENTITY FINANCIAL REPORT FOR APRIL 2019; SUPPORT BY GARY NOWAK. MOTION CARRIED.

NEW BUSINESS

Liquor Tax Requests

1. Community Anti-Drug Coalitions of America (CADCA) Training – All 21 Counties - $9680.
2. Hidden in Plain Sight – Alcona, Alpena, Oscoda, Montmorency, Presque Isle Counties - $3350.
3. Hidden in Plain Sight – Benzie, Grand Traverse, Leelanau, Manistee, Wexford Counties – $10,485.
4. Medication Assisted Treatment – Benzie, Manistee Counties – $33,074.
5. Media Campaign – Antrim, Benzie, Grand Traverse, Kalkaska Leelanau Counties – $150,000.
6. Project ASSERT/SBIRT – Alpena, Charlevoix, Grand Traverse, Otsego, Wexford Counties – $250,000.
7. Recovery Residences – Charlevoix, Grand Traverse – $122,640.

MOTION MADE BY JOE STONE TO APPROVE THE LIQUOR TAX REQUESTS LISTED AS RECOMMENDED BY THE NORTHERN MICHIGAN REGIONAL ENTITY SUBSTANCE USE DISORDER OVERSIGHT BOARD ON MAY 6, 2019; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Mr. Kovacs noted that opioid services are the "favored child" currently, though alcohol use remains post prevalent with devastating consequences. Ken Kauffman, of the Substance Free Coalition of Northwest Michigan, voiced appreciation for the media campaign liquor tax approval noting that focus must be placed on substance use prevention, abstinence, and alternatives to pain management.

Plunkett Cooney Engagement Letter

An engagement letter from Plunkett Cooney dated May 7, 2019 was included in the materials for the meeting on this date. Mr. Kurtz explained that NMRE needed to seek a legal opinion on a human resources issue.
MOTION MADE BY JAY O'FARRELL TO APPROVE THE ENGAGEMENT LETTER FROM PLUNKETT COONEY FOR LEGAL SERVICES AT THE RATE OF TWO HUNDRED FORTY DOLLARS ($240.00) PER HOUR; SUPPORT BY GARY NOWAK. MOTION CARRIED.

Quality Assessment and Performance Improvement Program (QAPIP)

The NMRE's QAPIP was included in the materials for the meeting on this date in draft form. Mr. Kurtz tabled discussion of this item.

Planning Session During Upcoming Board Meeting (June, July, August)

Mr. Kurtz suggested that a Board Planning Session take place during an upcoming, scheduled Board meeting date, likely from 10:00am until 3:00-4:00pm. It was noted that the July meeting date of July 24th conflicts with the Directors Forum in Lansing. The decision was made to move the July Board meeting and the Planning Session to July 29, 2019.

NMRE COLA

Mr. Kurtz expressed that a 3% cost-of-living adjustment was built into the NMRE's FY19 budget. The Operations Committee discussed the topic on May 21st and voted to recommend up to a 3% COLA for NMRE staff. Mr. Stone asked what the CMHSPs have done in terms of a staff cola. Diane Pelts reported that AuSable Valley provided a 2% COLA to staff in October; Chip Johnston reported that Centra Wellness Network provided a 2.8% COLA to staff; Christine Gebhard reported North Country did not include a COLA increase in its FY19 budget; Nena Sork reported Northeast Michigan did not include a COLA increase in its FY19 budget; Karl Kovacs reported Northern Lakes is in its final year of a collective bargaining agreement that gave a 2% COLA to staff in each of the first two years and a one-time bonus of $1K to staff in the third year. Mr. Stone commented that he would be comfortable with offering NMRE staff a 2% increase, but not 3%.

MOTION MADE BY ROGER FRYE TO APPROVE UP TO A 3% COST OF LIVING ADJUSTMENT FOR NORTHERN MICHIGAN REGIONAL ENTITY STAFF; SUPPORT BY GARY NOWAK.

It was noted that a specific percentage amount needed to be attached to the motion. Mr. Frye withdrew his motion; Mr. Nowak withdrew his support.

MOTION MADE BY ROGER FRYE TO APPROVE A 2.5% COST OF LIVING ADJUSTMENT FOR NORTHERN MICHIGAN REGIONAL ENTITY STAFF; SUPPORT BY GARY NOWAK.

Roll call voting took place on Mr. Frye's Motion.

"Yea" Votes: **Roger Frye, Ed Ginop, Annie Hooghart, Gary Klacking, Terry Larson, Gary Nowak, Karla Sherman, Don Tanner, Randy Kamps**
"Nay" Votes: **Mary Marois, Jay O'Farrell, Richard Schmidt, Joe Stone, Nina Zamora**

WITH NINE "YEA" VOTES RECORDED AND FIVE "NAY" VOTES RECORDED, THE MOTION CARRIED.

OLD BUSINESS

Opioid Health Home Update

Mr. Kurtz reported 250 individuals are enrolled currently. The uptake for FQHCs has been slower than anticipated. Several (4-5) new Office-Based Opioid Treatment (OBOT) providers have been recently added to the pilot.

PRESENTATION

FY18 Financial Audit

Derek Miller, of Roslund Prestage & Company, was in attendance to report on the FY18 Financial Audit. At the conclusion of the presentation, Mr. Kamps asked how the NMRE "stacks up." Mr. Miller responded that he viewed NMRE to be in the upper tier of PIHP clients. On a scale of 1-10, Mr. Miller would rate the NMRE a solid 8. Because this was the first audit by Roslund Prestage & Company, Mr. Miller anticipates the NMRE rating even higher next year. Some verbal recommendations were passed on to Ms. Yockey and Mr. Kurtz.

MOTION MADE BY GARY NOWAK TO APPROVE THE NORTHERN MICHIGAN REGIONAL ENTITY FINANCIAL AUDIT BY ROSULND PRESTAGE & COMPANY FOR FISCAL YEAR 2018; SUPPORT BY ED GINOP. MOTION CARRIED.

COMMENTS

Board Members

- Karla Sherman suggested recognizing Dennis Priess with a Certificate of Appreciation; this will be pursued.
- Don Tanner thanked Ms. Yockey and Mr. Kurtz for the clean audit report.

Staff/CMHSP CEOs

- Christine Gebhard reported that four counties have passed resolutions to remove section 928 from the budget boilerplate; nine more are slated.
- Karl Kovacs suggested regional raffle items/gift items be collected for the Fall Conference/PAC.
- Karl Kovacs reported that the Grand Traverse Community Collaborative received confirmation that the State Chief Deputy Director for Opportunity will attend its annual meeting in October.
- Karl Kovacs reported that Mary Marois and Randy Kamps were reappointed to the Northern Lakes Board of Directors.

Public

Sue Winter thanked NMRE Staff for posting the Board Meeting Agenda to the website.

DRAFT

MEETING DATES

The next meeting of the NMRE Board of Directors is scheduled for 10:00AM on June 26, 2019 at 1999 Walden Drive in Gaylord.

ADJOURN

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

	Program	Consumers served June 2019 (6/1/19 - 6/31/19)	Consumers served in the Past Year (7/1/18 - 6/31/19)	Yearly Average (7/1/18 - 6/31/19)
1	**Access / Crisis / Prescreens**	42 - Routine 0 - Emergent 0 - Urgent 79 - Crisis 41 - Prescreens	740 - Routine 2 - Emergent 5 - Urgent 1019 - Crisis 580 - Prescreens	62 - Routine 0 - Emergent 0 - Urgent 85 - Crisis 47 -Prescreens
2	**Doctors' Services**	1114	1508	1123
3	**Case Management**			
	Older Adult (OBRA)	136	172	131
	MI Adult	197	336	224
	MI ACT	36	46	31
	Home Based Children	20	34	14
	MI Children's Services	124	221	130
	DD	327	368	334
4	**Outpatient Counseling**	212 (31/181)	474	201
5	**Hospital Prescreens**	41	580	47
6	**Private Hospital Admissions**	25	274	23
7	**State Hospital Admissions**	0	0	0
8	**Employment Services**			
	DD	76	87	76
	MI	40	85	48
	Touchstone Clubhouse	75	80	64
9	**Peer Support**	61	81	63
10	**Community Living Support Services**			
	DD	140	154	146
	MI	171	246	195
11	**CMH Operated Residential Services**			
	DD Only	58	61	59
12	**Other Contracted Resid. Services**			
	DD	31	36	32
	MI	29	36	28
13	**Total Unduplicated Served**	1129	2416	1138

County	Unduplicated Consumers Served Since July 2018
Alcona	269
Alpena	1524
Montmorency	255
Presque Isle	278
Other	71
No County Listed	19

Chair's Report
Employee Recognition Luncheon/Lunch for a Cause Update

CARF UPDATE
QI Council Update - Available at the meeting.

AUGUST AGENDA ITEMS

Policy Review

Policy Review & Self-Evaluation
Chairperson's Role 02-004
Board Member Per Diem 02-009
Board Self-Evaluation 02-012

Monitoring Reports
Treatment of Consumers 01-002 (Recipient Rights Complaint Log)
Staff Treatment 01-003 (Turnover Report/Exit)
Budgeting 01-004 (Finance Report)
Financial Condition 01-005 (Quarterly Balance Sheet)

Activity
Begin Self-Evaluation

Old Business

Ownership Linkage

Educational Session

CMHA
Community Mental Health Association of Michigan
SUMMER 2019
Connections
for communities that care

THE EVOLUTION OF SELF-DIRECTED CARE

Christopher Pinter, CEO, Bay-Arenac Behavioral Health

The traditional professional approach to mental health treatment has always been anchored in the illness-oriented model of care: 1) an individual reports or presents with a problem or symptom, 2) professional staff (physicians, nurses, psychologists, social workers) assess the problem or symptom to identify methods for remediation, and 3) a treatment plan is developed to eliminate the problem or symptom.

This model can work effectively for acute, short-term, and reversable problems such as dehydration, a biological infection, torn muscle or a fractured arm. These involve a rehabilitative medical response, whereas a skill or ability temporarily lost is repaired. However, the illness model has had a historically more tenuous relationship with alleviation of chronic mental health conditions such as mood disorders, psychotic disorders or addiction, and the rehabilitative nature of the model often has no applicability to persons with significant physical, intellectual or developmental disabilities.

The challenge to the professional mental health service system is that many individuals with longer term disabilities will more likely need habilitative services. These are services that assist people in adapting or accommodating skills or abilities that may never have been in place. Although the different types of mental health services and supports may be deployed in either a short or long-term manner, in many ways the traditional illness model emphasizes continued reliance upon a professional system of care instead of focusing on individual recovery. As a result, the utility of the illness model for persons with longer-term mental health and physical/intellectual disabilities is rather limited.

A self-directed care model attempts to move professional services from a problem-focused to a recovery-based approach. It does this by building on the person-centered planning process to expand service decisions to be based on the strengths and interests of the individual. The longer term arc of recovery from significant mental health, addictive, and physical/intellectual disabilities is recognized as a central component of service delivery. As a result, service objectives based on the full range of health, social/family relationships, employment, civic participation, and education are emphasized. Many of these are areas of recovery that can only be minimally impacted by the traditional illness based model. Self-directed models attempt to further the use of natural supports (i.e. family and friends), community resources, and professional health care services to enable persons to move beyond the challenges of mental illness or disability.

On the surface, self-directed care appears to be consistent with the comprehensive, person-centered planning approach mandated by the Michigan Mental Health Code at 330.1712. However, self-directed models take the planning and service delivery process further by implementing these key foundational elements: 1) Individual control, 2) Personal responsibility, 3) Individual choice, and 4) Avoidance of conflicts of interest (Cook, Shore et al., 2010). These elements ensure that the individual person is invested in care decisions that will be supportive of the most important aspects of their lives.

The first element of self-directed care is ***individual control***. This is evidenced by the development and implementation of a person-centered recovery plan inclusive of the future goals, professional services, natural supports, actions, and timelines as defined by the individual. This is essentially the person-centered mandate from 1996. The individual controls the planning process, the persons/family members present, and selects the location of the meeting themselves. This establishes the concept of the individual being in control and responsible for their own recovery.

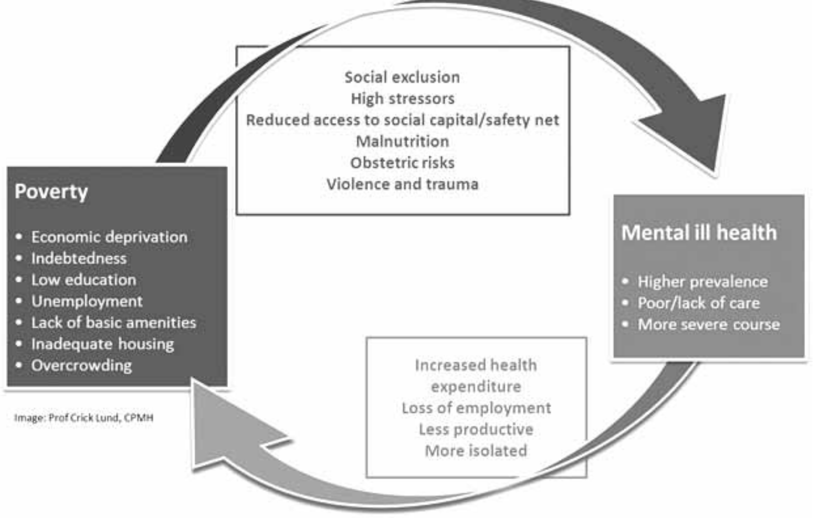
The second fundamental element is ***personal responsibility***. The individual works with professional staff to develop a budget to allocate resources for accomplishing the goals of their recovery plan. Although there *(Continued on page 19)*

Poverty and Mental Illness: *the relationship goes both ways*

Robert Sheehan, CEO, Community Mental Health Association of Michigan

Those of us with mental illness, who have friends or family members with mental illness, and those of us who serve, support, and treat persons with mental illness are often struck with the high rates of poverty among those with mental illness. What research is underscoring is that there is a two-way link between poverty and mental illness with each causing and exacerbating the others.

Researchers from across the country and the world, including Crick Lund, of the University of Capetown; the faculty and researchers at the McSilver Institute for Poverty Policy and Research at the NYU Silver School of Social Work; Chris Hudson, of the School of Social Work at Salem State University; the federal Substance Abuse and Mental Health Administration (SAMHSA); and the World Health Organization (WHO), have given us clearer insight into the bi-directional nature of the relationship between poverty and mental illness. The graphic, below, developed by Dr. Lund, provides a clear picture of the causative factors that link these two conditions.



Research Findings: While the findings, drawn from the work of the researchers and centers cited earlier in this article, are not surprising to those of us in the mental health field, a review of some of those findings, below, is eye-opening, sobering, and for many of us, a motivation for action:

- The rate of adults experiencing mental illness is highest among those with family income below the Federal poverty line
- Persons with the lowest socio-economic status are at eight times the risk for schizophrenia than persons with the highest socio-economic status
- Persons with schizophrenia are four times more likely to be unemployed or underemployed than persons without schizo phrenia
- Adults living in poverty are more likely to experience severe mental illness and have serious thoughts of suicide
- The odds of a household experiencing food insecurity in creased by 50 to 80 percent if a mother had moderate to severe depression
- Families living in poverty are rarely successfully connected with the mental health services they need
- Heightened exposure to violence and other traumas in low-income communities furthers the cyclical nature of poverty, trauma, and mental illness.
- Adults aged 26 or older living below the poverty line were nearly twice as likely to experience serious mental illness than those living at the poverty line and nearly three times as likely than those living above the poverty line
- Poverty has been shown to increase the likelihood of the onset of mental illness

Action needed: SAMHSA, WHO, and others thought leaders have outlined a number of actions designed to address both of these conditions and cut the link that exists between them:

- Implement a range of anti-poverty initiatives, with an eye to ensuring that persons with mental illness have access to these initiatives, including:
  - Increasing employment opportunities, with fair wages, to persons without higher education
  - Improve access to sound and affordable housing
  - Improve access to healthcare with an emphasis on maternal healthcare
- Improve access to mental health care, with an emphasis on early intervention for chidren, adolescents, and adults
- Implement efforts to reduce childhood trauma and violence including:
- parental support, education, and guidance
- substance use disorder and mental health treatment for parents
- community-based crime and violence prevention initia tives

These actions are not extraordinary. They represent the aims of many of us and the conditions that many of us believe are core to a civil healthy society.

Strengthening & Improving Transparency in Community Mental Health Agencies | Jeannie Goodrich, CEO, Summit Pointe

Jeannie Goodrich received her bachelor's degree with an emphasis in organizational management from Spring Arbor University and her MBA from Notre Dame University. In addition to being the CEO, she also is a member of the Regional Health Alliance Leadership Cabinet, The Coordinating Council Leadership Cabinet, and a Trustee for the Union City School Board.

Creating effective governance for a community mental health services program is primed with great challenges. CMH organizations are public governmental agencies that are formed to provide services to a patient population that has chronic mental and behavioral health conditions. The mechanisms to provide this care, the funding and the overall matrix of rules that govern the public entity are complex and governance that maintains an appropriate balance of efficiency and oversight can at times be difficult. The lack of balance in either direction can prove to be problematic for the organization.

Since 2015, as the new CEO of Summit Pointe/Calhoun County CMH, I was challenged to create an environment and culture that would create the right balance of efficiency and oversight with a newly minted *leadership team* and a newly appointed board. The board was clear in their direction to me as the new CEO, "Create a culture and environment that is transparent to the community, the staff, and the patients of Summit Pointe," and create this culture and environmental shift while sustaining the volume of high quality clinical services to the residents of Calhoun County. From that point in time, it would feel like we were starting a new agency while still operating an existing one!

On the staff organizational level I ensured that communication was available to our front line staff and that I was available as much as staff needed to answer questions, to ensure that staff felt secure with their positions and to provide proactive communication about the changes in our everyday procedures. On the leadership level, I created a team that had a mix of seasoned leadership members, some from within and outside of the CMH system, in addition to staff of Summit Pointe that have always been the informal leaders of the organization. This helped build the trust of the existing front line staff quickly as they saw some continuity of our organization.

On the board level, we were establishing a new organization. First, we established a five year strategic plan that received feedback from our patients, staff, providers and the community. The board established, with that feedback, a solid strategic plan that would encompass a blend of strategies including staff development, exploring stronger community collaborations, strengthening our provider network, and overall enhancing Summit Pointe presence in Calhoun County.

The board itself identified through the strategic planning process that they needed to examine and put into effect the proper governance. The governance style that evolved very quickly with the events in 2015 was an extraordinarily heavy dose of oversight that was necessary until the proper oversight by a functional Summit Pointe leadership was put in place. Once there was stability within the leadership team and key positions filled, the board could then begin rebuilding an effective governance style that would ensure the proper compliance and oversight.

Together with management, the board implemented board policies that they felt would sustain the organization long term, meet statutory guidelines, and provide the right balance of oversight and monitoring needed. In addition to the board policies, they also reviewed and approved bylaws that provide a subcommittee structure focused on human resources, finance/audit, corporate compliance and IT. Through this process, there are designated board members serving on the subcommittees who provide oversight to these functions and where appropriate make recommendations for action to the board.

Within the organization, I have built a leadership team structure that has evolved since 2015. While rebuilding the board level governance, the internal management oversight had just as much auditing and monitoring to be done. There have been foundational financial and compliance policies implemented that are required as a CMH organization. These are the two areas that have had the most structured change with both policies and process. I have now made it a personal goal to strike the right balance between efficiency and oversight for the organization– and in what I would still consider an *(Continued on page 19)*

Jeannie Goodrich

Using Adaptive Leadership to Address the Challenges and Opportunities of Section 298 – *One Leader's Approach*

Lisa A. Williams, Ph.D., Executive Director
West Michigan Community Mental Health

When I was first invited to attend a meeting on Section 298 in February of 2016, with then Lt. Governor Calley, I never thought I would spend the next several years trying to navigate, advocate against, understand, resist, and ultimately build a model for Healthcare Integration in Michigan. On that day in February, I could not envision a circumstance where West Michigan Community Mental Health (WMCMH) could support the concept of financially integrated managed care in Michigan, let alone apply to become one of four Community Mental Health Service Programs (CMHSPs) in the state to lead this effort. Although our organization had clearly crafted its mission, vision, and strategic plan with an understanding of the national healthcare drivers narrowing in on integrated care and funding, I must admit that the constructs we embraced around integration were clearly focused on care integration but theoretical and vague when it came to financial integration. We knew the care concepts would result in better outcomes for the people we serve, but we were skeptical about the necessity of financial integration to support this outcome.

The 298 Pilot and much of the work done within the context of the pilot have personally and professionally challenged my understanding of what it means to be a leader.

The 298 Pilot and much of the work done within the context of the Pilot have personally and professionally challenged my understanding of what it means to be a leader. WMCMH's internal work with Jeff Lawrence, a leadership consultant whose expertise is in *Adaptive Leadership*, has helped me to gain perspective on the challenges associated and leadership opportunities contained within the 298 Pilot, not only for myself but the entire leadership team at WMCMH. The competing perspectives I experienced and described above really epitomize most of my experience and leadership learning associated with being a part of the Pilot. That said, my internal tensions and continuum of experience are not unique to leading in the context of 298. These types of tensions become real in the work leaders in any system or business experience when they have come to the realization that the outcomes they are trying to achieve for their business are no longer attainable in their current operational, organizational, or systemic context.

The answers to three critical sets of questions helped WMCMH describe and gain insight into the tensions we felt when we came to understand that we were quite literally stuck in a constant cycle of problems and obstacles with limited solutions. Thinking through these questions was a pivotal point of discovery in our organization, not just specific to 298, but to other challenges we had been facing. I'm confident that other leaders who read these questions can infer many of the internal dialogues and questions that our organization faces. Perhaps they are even some of the same questions you asked yourself as your organization approached the many challenges and perceived threats associated with 298. As the Executive Director for WMCMH, our responses to these three questions changed my role in 298 from a leader who strongly advocated for maintaining the current system and advocated against 298, to actively pursuing relationships with the Medicaid Health Plans (MHPs) and applying to become a 298 Pilot Site.

Question 1: What is the role the leader plays? More specifically, where does my loyalty as a leader lie? Am I loyal to the current way of doing things or to the outcomes we've described for the organization as a whole?

I came to WMCMH almost 20 years ago in the midst of a family crisis. WMCMH was intended to be a brief stop along my way to a different job, back in line with my career aspirations. Literally, my plan was to be at WMCMH for six months and then to return to academia, research, and teaching. What happened in those six months changed my career trajectory forever. Everything I had been taught about community mental health as a clinical psychology graduate student went by the wayside as I got to walk in and experience the vision of community-based mental health services. The commitment within the organization to advance recovery and self-reliance for persons with chronic mental health, substance use, and intellectual and developmental disabilities grabbed me by the heart and planted me firmly on the ground exactly where I had never imagined being. As a leader in the organization 20 years later, my loyalty still

lies there, exactly at that place, dedicated and convinced of the importance of community-based services for the people we serve.

Question 2: What is the nature of the work we are trying to accomplish? Can we continue to tweak to try to attain the desired outcome or is it time to look for a better way to achieve the outcomes? When is the problem no longer "tweakable"? Are we continuing to perpetuate the problem by not looking outside our current understanding? Is there a more sustainable, different solution that will achieve the desired outcome?

My ability to serve the organization and achieve the vision that drew me into this work has been fundamentally challenged by funding, system structures that create barriers to access, and boundaries that make physical healthcare access to the people we serve insurmountable. Although my loyalty remains strong to achieving outcomes for people we serve, my beliefs about how to accomplish that have dramatically changed.

All of our organizational efforts to advocate for better funding, apply for grants, redesign internal and external administrative structures have bought us time but ultimately borne little fruit in terms of securing sustainability of services for our communities. We have co-located in primary care and have attempted primary care co-location in our service sites. We have shared staff resources with other organizations to maximize access and outreach. Our staff has spun themselves in knots attempting to improve outcomes while tweaking processes, revising policies, and addressing barriers that in the end result in little progress. This is not because our efforts are tempered or are misguided. It is not because our productivity is insufficient or our performance is poor. It's because the process tweaks and the policy changes are no longer sufficient to achieve the outcomes that we aspire to for our organization, our communities, and most importantly the people we serve.

Our fears and our perceived sense of loss of stepping outside of our comfort zone became less important that day than our desire to get a better outcome for the people we serve. It was both that unbelievably simple and that incredibly complex.

Our organizational decision to meet with the MHPs and explore different mechanisms for integration was not one we took lightly. I still remember the July Board meeting where my board chair courageously encouraged me to begin reaching out to MHPs to explore other ways to achieve the outcomes critical to the people and communities we serve. He, like me, could no longer see additional ways to exert pressure on our existing structure or demand more of our team. He could see no effort that could result in any outcome other than more of the same. Our fears and our perceived sense of loss of stepping outside of our comfort zone became less important that day than our desire to get a better outcome for the people we serve. It was both that unbelievably simple and that incredibly complex.

Question 3: How do we maintain perspective and focus when it becomes clear that a significant change in approach is necessary? When it's clear that the current approach isn't working, how do I hold true to the organization's values while asking the team to take an approach well outside their comfort zone and current understanding? And, most importantly, how do I make the purpose of the change clear and hold the banner high for the individuals who are scared of or threatened by the unknown?

WMCMH had been solidly in step for years with our Association and our CMH and PIHP colleagues in protecting a carve-out in Michigan. We had built our organization to be responsive and strong in managed care and had invested significant resources and time in helping form collaborations with other entities, two separate PIHPs, and strong relationships with local partners. But the resistance we feared was less important to us organizationally than the benefits/outcomes we could begin to see from considering a different way. Well in advance of the pilot RFI, we began by reaching out to individual MHPs and by vetting conversations with MDHHS, trusted colleagues, and experts. We started by sticking our toe in the water by having discussions with individual leaders in MHPs, forming relationships, asking questions, and researching other states' efforts and outcomes. We had hard conversations with other trusted colleagues within the system that we knew would be challenged by our decision to explore a 298 pilot but who we believed could give us balanced feedback. We found, not surprisingly, that we were not alone in our experience that all of our best efforts and skills at fixing problems in-house and in current context were not working. And, we also found understandable resistance.

As 298 has progressed, these three leadership questions are consistently a part of discussions within our organization. We ask these questions now specific to challenges and debates about what particular types of changes can be tolerated to advance integration and what types of changes are too risky or pose too great a threat. If the change cannot be reliably perceived or projected to result in a better outcome for the people we serve, then the cost is too great. Change for changes' sake is not okay. Change because it's easier is not okay. We consistently *(Continued on page 18)*

Hal Madden and Me | Robert S Lathers, LMSW

2019 Distinguished Alumnus of Grand Valley State University School of Social Work

The following is the acceptance speech delivered by Robert S Lathers in October, 2018 as the recipient of the Hal Madden Outstanding Service Award. This award is given to an individual annually by the Community Mental Health Association of Michigan in recognition and appreciation of their exceptional efforts as an advocate and ambassador for community mental health services and the people we exist to serve. The dedication and compassion of the awardee stand as benchmarks for all those who are committed to providing quality services in the community.

I first met Hal Madden when I was 15 years old and he scared me to death.

Hal was the Assistant Superintendent of Schools in my community, a four-year veteran of the Marine Corps, and a former defensive end and basketball player at Central Michigan University. He had an opportunity to tour the Mt. Pleasant Center while in college and claimed that it was a life changing event for him. "That's no way for people to live," he was known to exclaim when he told the story. That experience led him to be a life-long advocate for persons with mental health and developmental disabilities.

I, at 13 years old, through a highly traumatic event became an orphan and went to live with my six brothers and sisters with my aging grandparents. For the most part I was left to wander our Polish Catholic neighborhood and the city at large. But it seemed that everywhere I went I was always encountering teachers or school administrative staff who would never fail ask me, "What are you up to?" and was I "fifteen yet?" because at 15, I could get a work permit and get a job. I managed to land a *Detroit Free Press* paper route, but when I turned the magical 15 "Hal's people" contacted me and signed me up to work in the Federal CETA Youth Work Program for disadvantaged youth.

My first job paid $1.35 an hour and it was washing windows at the school administration building where Hal Madden's office was. It was a terrible job. Hal himself was constantly checking my work and mostly disapproving it, always with the admonishment from Hal, "You can do better!" I hated it. Through my charm I was able to convince the head of the maintenance department to reassign me. So, they put me to work scraping gum off the bottom of desks at the Jr. High. Do you know how much gum is stuck to the bottom of those things? It made me not like gum for a long time.

Then, the maintenance department (no doubt at the suggestion of Hal) decided that I would paint all the chain link fence in Ludington. To this day I swear that the city has more chain link fence per capita than any city in the country. The paint was a glossy rust resistant silver color. At the end of each day when I was walking home from that day's painting assignment, I looked like the Tin Man. People and kids in cars driving by would yell out from their rolled down windows things like, "Hey Tin Man" or "There's a tornado coming" or "Have a heart" and my personal favorite, "Dorothy is looking for you!" But nobody ever offered me a ride. It seemed that Hal would regularly check up on my work and have the maintenance supervisor deliver messages like, "You can do better" or "Don't be satisfied in just doing a job. Do it better!"

As a freshman in high school I tried out for the basketball team, and even though I had very little talent, I made the team. I didn't get to dress for every game, but I was on the team. I made the JV team the next year and dressed for every game even though I rarely played. It didn't really matter to me because I was part of that group of kids. As a junior I tried out for the varsity and at 6'3" I made the team. That is when I first started to suspect that Hal may have been influencing the coach's roster decisions. Then as a senior I lettered on one of Ludington's best-ever teams that lost our final game in the State Semi-Finals at Jenison Field House.

All the while I kept working for Hal and his maintenance department during summers and on weekends, snow days, etc. It gave me a steady income. During my senior year, while I continued to get paid, I fell behind and "owed Hal hours for work paid but not yet worked." Hal's maintenance supervisor would tell me that once basketball was over, they had a lot of work for me to do. But, the day after basketball ended, I decided I would go out for track. This did not sit well with my employer. I had never participated in track. I really was not all that interested in track but saw it as an opportunity to put off making up my hours.

On the very first day of track practice I was approached by a student teacher from CMU who introduced himself to me as Mr. Taylor and told me that he had been assigned as my personal track coach. "There must be some mistake," I protested, "Mr. Gomez is the track coach and I'll be fine with him. Thanks anyway." "Oh, there's no mistake," Mr. Taylor said with a grin, "I am YOUR personal track coach. I've been assigned by the school administrator's office." While I had been thinking about running the mile, I quickly changed it to the half-mile (less work). But Mr. Taylor worked me so hard, I hurt a lot and began to regret extending my athletic career. And then I made all-conference in track.

(Continued on back cover)

DEPRESSION: THE CHALLENGE AND PROMISE OF A BREAKTHROUGH THERAPY

Clint Galloway, Editor, *Connections*

As I write this, I'm filled with hope in spite of the grim statistics –16.2 million adults in the United States, equaling 6.7 percent, have experienced a major depressive episode in the past year. Nearly two thirds of these experienced an episode that resulted in severe impairment. To see a recent account of the statistics, go to: https://www.verywellmind.com/depression-statistics-everyone-should-know-4159056

Depression can be a grim reaper. My father took his own life at the age of 56. Another contributor to this issue, Tom Watkins, lost two brothers to suicide. Chances are that you know of someone who suffered a similar fate. Untreated depression, or what we label as "treatment-resistant" depression, greatly increases the risk of suicide – the 10th leading cause of death in the United States. It's the second leading cause of death among people ages 15-24. Approximately 44,000 Americans die by suicide each year. This is the tip of the depression iceberg.

Nevertheless I have hope; there is a lot of work being done to provide more effective treatment. Even before an individual seeks treatment, the National Alliance on Mental Illness (NAMI) is vigorously chiseling away at stigma which prevents people from taking that first step seeking help. (There is a wealth of stories there!) To capture a glimpse of new and promising treatments, the FDA provides a list of applications it reviews. I quote from their website designed for patients: "Speeding the availability of drugs that treat serious diseases are in everyone's interest, especially when the drugs are the first available treatment, or if the drug has advantages over existing treatments. The FDA has developed four approaches to making such drugs available as rapidly as possible: 1) priority review, 2) breakthrough therapy, 3) accelerated approval, and 4) fast track. Because each of these approaches implies speed, there can be confusion about the specific meaning of each, and the meanings and distinctions of each..." can be acquired here:

https://www.fda.gov/ForPatients/Approvals/Fast/default.htm

Of particular interest for those suffering from depression, is that on October 23, 2018, the FDA granted Compass Pathways a *Breakthrough Therapy* designation for a new therapeutic approach that addresses treatment-resistant depression. More information on how the FDA describes the *Breakthrough Therapy* designation is available at: https://www.accessdata.fda.gov/scripts/fdatrack/view/track.cfm?program=cber&id=CBER-All-Number-of-Breakthrough-Therapy-Requests-Received-and-Approvals.

As positive as this appears on the surface, there is a more salient feature about this therapeutic approach that warrants serious reflection. The dynamics involved in the *preliminary clinical evidence that demonstrates substantial improvement* are far more profound than simply tweaking the neurobiology of our brains. As such, it will require special training of those administering the treatment (elaborated on in the following article). This is indeed a breakthrough therapy, not simply the introduction of a new drug! As such, it will require much more preparation than simply making available a new pill your doctor can prescribe to be picked up at your local pharmacy, while another coin clinks in the coffers of a pharmaceutical company. As such, it will require the development of a new culture for addressing the symptoms that rob millions of quality life.

Since it involves the administering of a psychoactive substance that has been associated with the counter-culture – psilocybin – we will need to address the biases we may have developed regarding psychoactive drugs. We need to make the critical distinction between recreational and medical use; not letting the former contaminate the latter.

There is the additional requirement for a change of how it is classified by the FDA, however, this is definitely the lesser challenge in that their decision will be guided by the careful accumulation of clinical evidence. That is how this breakthrough therapy was selected. Unlike medications we can pick up at the drive-through window of our local pharmacy, this breakthrough therapeutic process includes the critical role of administration of the medication. This, as well, is discussed in the following article. Although we are aware of the push in some states for the legalization of psilocybin for recreational use, this is not discussed simply because we do not support such a move, in fact, such a movement may well threaten the progress of implementing this therapeutic breakthrough designed for medical use if it polarizes public opinion.

Following is an interview with Bill Richards who has been at the heart of this work for more than 50 years. The interview was conducted prior to the announcement by the FDA of this breakthrough therapy for treatment-resistant depression. As such, it does not reference by name this particular trial by Compass Pathways. There are many other research trials being conducted that utilize a similar therapeutic process to address other afflictions which are referenced in this article.

THE POTENTIAL PROMISE OF ENTHEOGENS

A *Connections* Interview with Bill Richards

Connections *is providing the following interview with Bill Richards to inform our readers of an emerging school of thought; one that holds both promise and controversy.*

It was exactly 60 years ago this fall that I met Bill Richards at Albion College where we were both freshmen pre-theological students. Our shared values quickly cemented our friendship. We ended up becoming roommates for the next three years and our friendship has endured. Bill spent three days visiting me this July, and having read his book, I decided to grab my recorder and capture some of our conversation to share.

Richards pursued a post-graduate degree at Yale University. As part of that study, he spent a year at the University of Gottingen in Germany. While there in 1963, Bill became interested in the Department of Psychiatry and subsequently experienced the administration of psilocybin (a hallucinogen obtained from the mushroom Psilocybe mexicana) that profoundly shaped the future direction of his work. In addition to reading about this in his book, Sacred Knowledge: Psychedelics and Religious Experience*, you can acquire an abbreviated story in,* "How to Change Your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression, and Transcendence," *(pp. 53 following) Michael Pollan, Penguin Press, 2018.*

Bill is a clinical psychologist at the Johns Hopkins Bayview Medical Center. In addition to institutions noted above, he attended Brandeis University, Catholic University and Andover-Newton Theological School. He has participated in the psychedelic research at the Spring Grove Hospital Center and the Maryland Psychiatric Research Center in Baltimore from 1967-1977 and at the Johns Hopkins School of Medicine during the past 18 years. Pollan considers Bill to be the bridge between the early research occurring before it was driven underground and the new emergent renaissance.

–Clint Galloway, Editor

Galloway: *Since reading your book, "Sacred Knowledge," in which you provide a comprehensive review of the use of psychedelics over the past six decades, I am discovering that there is a vibrant renaissance of the implications they have for our health and well-being. I must confess my ignorance, no doubt much of which can be attributed to cultural biases which we will get into later, but for now, let's explore the emergent activities that are essential for re-opening the pathways that can harvest its efficacy. It is difficult to avoid using superlatives when articulating the promise that the responsible use of psychedelics holds for addressing many of the symptoms we see every day in our mental health centers. [I will identify some resources during this interview for the benefit of you who desire to learn more.]*

Let's begin by providing definitions. As we well know, words can trigger powerful emotions, skewing our rational mind. At times we use them to persuade and influence our audience. One of those incendiary words – acquiring emotional impact in the 60s and 70s – is the word "psychedelic." You also use the word "entheogen." Please explain.

Richards: Personally, I use both words: psychedelics and entheogens. Psychedelic simply means mind-manifesting. The experiences they typically elicit within human consciousness are non-ordinary or alternate. There are many different kinds of experiences: childhood memories, conflicts, visionary religious states, transcendental or unitive consciousness. "Entheogen," coined in 1979 by Carl Ruck, a professor in Boston University's Classical Studies Department, has been growing in acceptance. Using entheogen connotes a religious or spiritual experience; it literally means "discovering God within." However, there are many forms of experience triggered by psychedelic substances that are not characterized by visionary or mystical content, which most of us would view as having relevance for religion or spirituality. There are many, many different experiences. So there's no such thing as a distinct psychedelic experience. You can access these non-ordinary experiences with psychedelic substances or with natural childbirth, sensory deprivation, sensory flooding, creative

performance, athletic performance, the "runner's high," meditation; there are many ways of triggering these profoundly meaningful states. The value of psychedelics is they provide potency and reliability. So it allows us to study these in a laboratory, a very nicely outfitted laboratory I might add, not quite what we think of with white coats & stethoscopes. It also paves the way for developing new treatments and accelerated psychotherapy for treating depressions, for treating addictions, and PTSD. If these applications for the medical use of psychedelics hold up, as the early pilots indicate, then we're going to see new mainstream treatments in the mental health world.

G: Tell me about the pilots you are referring to?

R: There are many studies that have appeared in prestigious peer reviewed journals. A recent one that we're building on, using psilocybin, which is the ingredient in so-called sacred mushrooms which college students call "shrooms," is in the treatment of depression and anxiety in cancer patients. There is a study at Johns Hopkins that essentially parallels one in New York University that finds dramatic improvement in both depression and anxiety after a single administration of psilocybin. This requires a maximum of maybe six hours in which the subject experiences different states of consciousness and then we find it's the memory of that experience in the follow up of over 6 months that decreases or eliminates the anxiety and depression. This involved a single administration of the substance. So it's not a drug like Prozac that you have to keep taking over and over. Rather, you receive the drug in the presence of someone that builds assurance through careful preparation, who knows what they're doing, who uses the pure substance and the right dose. And you have this profound experience, and then you integrate the memories and insights from that experience into your ongoing life. That's quite a new model in psychotherapy.

There is a study at Johns Hopkins that essentially parallels one in New York University that finds dramatic improvement in both depression and anxiety after a single administration of psilocybin.

G: So, what would be the kind of credentials or training that one might have to have in order to administer this?

R: Right now we require some kind of mental health certification; a psychiatrist, a psychologist, a social worker, a psychiatric nurse–someone who is qualified to provide what we consider good psychotherapy, eliciting the healing processes from within the person as opposed to imposing suggestions from without.

G: This does sound different. I'm assuming that there would have to be some differentiation between those who are graduating today with a master's degree in social work or clinical experience and what you'd be looking for in someone who was going to administer the psychedelic.

R: As of right now, there is a program at the California Institute of Integral Studies (CIIS) for acquiring a certificate in psychedelic-assisted therapy and research. To get into that program you have to be a licensed mental health practitioner. I would urge anyone interested to check them out.

[https://www.ciis.edu/research-centers/center-for-psychedelic-therapies-and-research/about-the-certificate-in-psychedelic-assisted-therapies-and-research]

G: Is there any indication that there is a growing acceptance or desire to acquire this kind of training or to receive this treatment? In other words, what do you see the future holding?

R: At CIIS, the current group includes 60 students. (An aside: I hesitate to use the word students because many of them are professors.) However, many really seasoned professionals are eager to become qualified to work with psychedelic substances, either in research or treatment, as soon as it becomes legally possible to do so.

G: In order for psychedelics to become legally integrated into mental health care, they would need to be rescheduled, that is moved off of Schedule I (or Class A in Europe), which assumes they have no medical use, have high abuse potential, and are dangerous even with medical supervision. How might that be accomplished?

R: Actually there are two different studies just beginning, one based in London, England, another designed by the Usona Institute in Madison, Wisconsin. [Usona Institute is a medical research organization focused on alleviating depression and anxiety in people for whom current medical treatments fall short. https://www.usonainstitute.org]

Both are designed to apply psilocybin in the treatment of depression. Those studies have been designed in consultation with *(Continued on page 10)*

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the FDA and EMA (European FDA). This research is designed to come up with the data that are required to establish safety and efficacy in order for psilocybin to come off of Schedule 1 and to become integrated into the culture by trained people, for example, to make it available in palliative and hospice care and probably in the treatment of addictions in the near future.

G: *Tell me more about those applications.*

R: People who receive psilocybin, and especially those who have deep visionary or mystical experiences, afterwards report decreased anxiety and depression--sometimes it's eliminated. They report more meaningful interpersonal relationships; they're "living until they're dying" instead of lying bed-ridden from their depression while approaching death with cancer. Many people report decreased preoccupation with pain and need less medication. But what's most interesting is that those who have these deep mystical types of experiences typically claim to have lost the fear of death. And instead of being anxious about death, they're kind of curious about it. They have no desire to speed it up, but the focus is on being thankful for every day they're given and to live each day as fully as they can, with the intention of spending their final days with the people they love, and maybe with a little music and laughter instead of feeling hopeless, depressed, trapped, and anxious.

G: *Two questions come to my mind…*

R: Only two? *[laughter!]*

G: *First question, how many palliative centers are actually using this now? And the other is, where could I find some studies or reports that would illuminate this practice?*

R: How many centers would use this? That's unknown. We haven't reached that point. I know there are oncologists who are very interested in being able to offer this as part of their treatment in their oncology centers, so this remains to be seen. But we do have published studies; one of the best places to go to is the website of The Heffter Research Institute.

[https://heffter.org/]

For those who want to look at the statistics and research design, you will also find them primarily in the *Journal of Psychopharmacology*.

In April (2018) *The Journal of Palliative Medicine* published an article, "Taking Psychedelics Seriously." *[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5867510/]*

G*: It appears that while the studies show great promise, the actual practice is in its infancy.*

R: Yes, but the promise is based on experience which actually extends over several decades, and it's a fairly substantial experience. There are numerous teams working in different areas we haven't mentioned and in a number of Universities. For example, there's a study at the University of Alabama in Birmingham using psilocybin in the treatment of cocaine addiction, work with alcoholism at New York University, and with nicotine addiction at Johns Hopkins University.

G: *Talk more about the work with addiction.*

R: What is there in the psychedelic experience that can impact a longstanding addiction? Bill Wilson, the co-founder of AA, was very supportive of LSD being used in the treatment of addictions. But the AA Organization has considered that embarrassing.

G*: Why was he supportive?*

R: It was based on his personal experience.

G: *What is there about the experience that addresses the addiction?*

B: It seems to be the change in how one views oneself, other people and the world. It's like discovering parts of your mind that you never knew were there. They're beautiful, strong, creative, loving and when you awaken to those realms within, why would you put anything in this wonderful body that would damage it, and why would you pretend to be a hopeless failure because you know better; you know by experience, to use the language of "a Higher Power," that there are resources available, that are really real. It's not just an abstract intellectual concept, it's not even a belief, it's a fact. You've related to it; you've experienced it, and it's an unforgettable experience.

G: *It's that experience that constitutes the healing?*

R: It's the memory of that experience; taking the memory of that experience into everyday life. It helps to have a supportive group in which to do that. This facilitates a process of integrating an internal experience into your outer life; it's not magic for most people. It still takes work, but there's something you know, if you want to use the word God, that "god" is real, or there's something incredibly meaningful and loving and constructive and intelligent within your consciousness. We recently had a very deeply dedicated atheist who said, "I'm still an atheist, that's my religion, but I saw God." *[laughter!]*

It's the experience people have in the depths or heights of their minds; they know it first-hand. It seems to be within us, a given within our consciousness and people of any culture, any religion, and any non-religion, seem capable of discovering this experience.

G: *This "change of mind" sounds different than what I usually think of when I imagine what the person on the street would say lies at the root of addiction and how to treat it. What seems to be the dominant perspective in the therapeutic community regarding addiction?*

R: There are many different languages and conceptual schemes used to try to understand it. But as a whole, people who fall prey to addictions are often feeling overwhelmed and under-supported in life and they feel the need to escape from the pressures of everyday living. They are out of touch with their inner resources to cope constructively with their stressors. Then depending on what the substance is, some physiological syndrome kicks in that seems to make the body crave that substance. One of the most dangerous addictions that kills the most people is actually nicotine. We've done pilot research at Hopkins where one to three psilocybin sessions were offered to people who had been addicted to nicotine for an average of 31 years. In a six month follow up, 80% were nicotine free.

People mean a lot of different things when they talk about depression. It's not just feeling sad. It's often feeling numb, having constricted awareness, a downward, repetitive spiral in thinking…

That's incredible, just in the terms of preventing death. The number of people who die from lung cancer and nicotine-related illnesses every year is immense, not only in the US but in China and throughout the world.

G: *And then you factor in the enormous cost to the health care system that is acquired during the stages of the disease.*

R: That's right, and if the research holds up, we now have this substance called psilocybin, that is administered once under ideal circumstances, is non-addictive, non-toxic, and has effects that may last for months if not years, in terms of helping people stay drug-free.

G: *Again, what comes to mind is the need for personnel who are going to be qualified to administer this. Talk more about its use in treating depression. That's one of the most common illnesses that afflict people.*

R: People mean a lot of different things when they talk about depression. It's not just feeling sad. It's often feeling numb, having constricted awareness, a downward, repetitive spiral in thinking, a narrowing of consciousness, if you will, and a feeling of hopelessness, feeling trapped, a lack of joy, lack of playfulness, lack of spontaneity. Robin Carhart-Harris in London at the Imperial College posits that psilocybin essentially resets the default mode network of the brain, the area that controls the life of the ego. It's sort of like throwing things up in the air and letting them land in a fresh, new way that opens up new pathways within the brain to sections that have been sealed off or forgotten.

["Psilocybin for treatment-resistant depression: fMRI-measured brain mechanisms" Robin Carhart-Harris *https://www.nature.com/articles/s41598-017-13282-7]*

It sounds very simplistic, and it is, but it's a helpful medical description of the kind of getting out of the ruts a depressed person is stuck in and kind of resetting the way you are in the world. There really is beauty in the world; there are people who care about me; I do have some talents I haven't developed yet; I've got some resilience to go for things; I want to learn; I want to set some goals. It's like a whole new world waking up that has always been there but the person has lost contact with it.

G: *Or never had contact?*

R: Yes. You can get into developmental issues, issues of being abused or deprived as a child. There's a lot of early suffering in life that often appears to lay the foundation for depression later in life.

G: *Bill, you have been a part of a vibrant, but generally unrecognized research trajectory for over 50 years. What do you see the future holding regarding the use of psychedelics for our mental well-being?*

R: I hope to live long enough to see them legally integrated into hospice, palliative care, addiction treatment, treatment of depression; I think that could happen within the decade, maybe closer to 5 years. We'll see. It might happen in Europe before it happens in the U.S. – or it may not.

G: *What are the biggest challenges?*

R: There is good research that

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needs to be completed, that's been designed, and is being implemented. It's in process. We need to wait for the results of the really big research studies before the FDA would feel comfortable in making psilocybin legal. But there's also a whole lot of misinformation, prejudice in the culture, and echoes of the craziness of the 1960's that need to be addressed. There are a lot of well educated people who, when they hear the word 'psychedelic', think of, if not deformed babies and people jumping off skyscrapers, it's the crazy kids in Golden Gate Park saying "make love and not war" and not going to work. The stereotypes need to be corrected. The drugs really are very safe when used responsibly.

G: Would you agree that they can be misused and perhaps lead to a lot of crazy behavior?

R: There's probably no drug out there that can't be abused, misused, etc. Marijuana used responsibly by those who choose to do so now and then can be abused by chronic smoking all day long and not working. It's not the marijuana; it's how you choose to use it. Alcohol: we can have a glass of wine with dinner or become an alcoholic who's not going to work and has liver damage. So it's not just the drug, but it's how the drug is used and the reason it is used. With psychedelics there's a huge difference between what's usually called recreational use, which is usually very low-dosage and often in a large group at music festivals, etc. and the serious medical use, which is one-on-one treatment of depression or addiction or whatever. With careful preparation, skillful guidance, wise use of music during the period of drug action, a safe confidential physical setting and help to apply the insights that occur, we facilitate outcomes that tend to be very different from just taking some mushrooms at a concert.

G: Is there anything else you would like to say?

R: We have in our midst a very fascinating frontier that could transform mental health care, or at least provide a viable alternative to what we're able to offer right now. I think there will always be people who just want a drug to make them feel better and who are not interested in the psychological work that psychedelics require. Some people don't want to go through their grief and their guilt in their bleakest hour; they just want to chase the anxiety away. I personally have seen hundreds of people, many hundreds, who have dramatically benefited, and they've been people from all different occupations, ages, races, degrees of physical health, cultural backgrounds, men and women.

G: What are the youngest?

R: We have always restricted the use to people 21 and over. That's controversial enough, but it doesn't mean that this form of treatment could not be helpful to younger people in certain ways.

G: That brings to mind autism, has there been any research there?

R: Yes there has been but I'm not qualified to address this area. You might contact Alicia Danforth who has some experience in this area at UCLA.

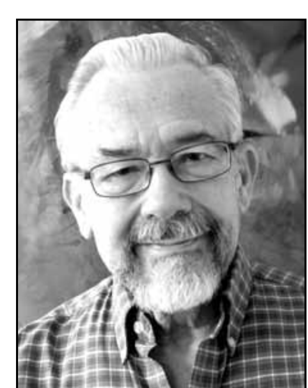
[https://www.aliciadanforth.com/faqs/]

G: That sounds like an area that is more in it's infancy than some other areas you've mentioned.

R: Yes. However in the big picture, besides being applied in medical treatment, psychedelics provide us with an incredibly valuable set of tools for understanding human consciousness, the mystery of what we are, and in that framework it has religious and educational implications, as well as medical implications.

G: Which is to look beyond its application to our deficits, where we are suffering, to that of exploring our human potential.

B: Yes. My friend Robert Jesse, is the Convener of the Council on Spiritual Practices (csp.org). CSP's interest in non-ordinary states focuses on "the betterment of well people," in contrast to the medical-model treatment of patients with psychiatric diagnoses. There's a lot of interest in facilitating creativity; there may be value for people who are considered high-functioning. If you want references for this kind of work, besides my own book, see "How to Change Your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression and Transcendence" by Michael Pollan. (2018). He provides a comprehensive history of the past, present and potential future.



Bill Richards

Creating a *Life* that Starves Addiction

Amanda Franklin, Certified Peer Recovery Coach, West Michigan Community Mental Health

I was born into a family where my 2 younger siblings and I went to church every Wednesday night, Sunday morning of course, and Sunday night. We were very involved in our church and the friends that I can remember coming over were of the church fellowship. I belonged to the youth group, and was *en fuego* for the life I had created for myself. My parents have always installed in us great morals, work ethics and standards to exceed our potential. I never witnessed my parents drink, and there was never a drop of alcohol or drugs in our home.

Since I have been able to talk, I've been in love with music and singing. I have recorded in the Barbara Mandrell recording studio, won the Jimmy Dean Country Showdown, opened for John Anderson, auditioned for American Idol, sung in countless weddings and Relay for Life, and wound up at a local community college, fresh out of high school, with a full scholarship singing with the Collegiates.

Even though I was still living at home with my parents when I went to community college and, I was introduced to a new and intriguing lifestyle. After growing up in a home and environment with no exposure to alcohol or drugs, I was suddenly exposed to both. My life changed dramatically. It was filled with nights of drinking and barely making it to class.

When I turned 18 years old, I met someone who I thought would change my life. I was right. He changed my life. There are a lot of things that I share that are personal to me; this is a part that I will just sum up in two words: self-hatred. That's what I felt from that point on.

I did everything in my power to numb whatever pain I was feeling. I quit school. I retreated into my room in the home I still shared with my parents. They had no idea what was going on with me. I refused to talk with my friends. I went to church because it was "required" of me to go. I no longer felt that I had any worth. I absolutely despised what I saw when I looked in the mirror.

I worked at a little bar in my hometown, and became the head bartender there, making more money than I knew what to do with. While working at this bar, I would run up tabs that exceeded my paychecks. One night while running up my own bar tab, I met a girl who was very well liked and popular in our community. "S" and I became the best of friends, so close a friend that she was in the delivery room when my son was born. We were like Thelma and Louise.

"S" introduced me to people that I thought were important, and to things that I thought mattered. She taught me how to make money. She was my partner in crime, in all the literal senses.

I found myself pregnant at 26 after a one-night stand following the closing of the bar. I remember thinking, "there's no way that I can take care of a baby, I can't even take care of myself!" I called my mother who told me the harsh reality that I needed to shape myself up and get my life back into order.

I quit the bar, started working for my parents at their store, as a DOT Drug and Alcohol Collector. Mason was born in February of 2005, in room 225, at 2:25 am, my little miracle baby. You would think that a newly single mother would have only one priority in mind. I had the best intentions of taking care of Mason and being the mom that he would be proud of, heck, that *I* would be proud of.

I found myself pregnant at 26 after a one-night stand…I remember thinking, "there's no way that I can take care of a baby, I can't even take care of myself!"

I was once told that my addiction wants me dead, but will settle for miserable. Addiction waits. It has all the time in the world to wait for a moment of weakness to come crawling back. Addiction will *always* take you back, in a heartbeat. That moment of weakness followed soon after having Mason. I began a self-maintenance program, and I felt that if I used after I put my child to bed, and shut the bedroom door of his room, that I was being a good mother.

"S" had a daughter who was six the first time I saw "S" hand her a joint. I remember thinking to myself, "I will never be that kind of mom." I watched her put a needle in that little girl's arm. I watched as she went to rehab at the ripe age of 12 after she stabbed her mother with a knife during a dispute over a pill.

I ignored every warning from my mother, thinking that my mom didn't know "S" like I knew her. And I told myself that I would *never* be that bad.

A house that I rented (conveniently, from S's parents) became party central. I began using cocaine, and of course

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crack followed right behind. I had found heaven and hell on earth. I loved and hated that drug more than everything in my life.

I also found that people wanted to be around me while I was using, because I was fun, happy, and social. I never took into account that I was also their dealer. Addicts love you when you're providing them with something.

In 2007, "S" introduced me to a gentleman that I married in 2008. He worked at the prison and we were extremely toxic for each other. There were so many fights, arguments, and physical altercations between us.

I was diagnosed with an illness that had me follow up with a doctor regularly. I found Dr. "Feelgood." He gave me literally anything that I asked for. I was learning things from "S" about what to ask for and how to ask for it without sounding like I was drug seeking. I began a routine. I knew what to take to make me feel better at *all* hours of every day. I had mastered self-medication.

In August of 2012, I put my seven year-old son, Mason, to bed. I was dyeing my hair, and took my nightly ritual of a handful of pills that night. I woke up several hours later in the bathtub with the water running. I watched my son with tears in his eyes and fear written all over his face as he shut the water off. Mason saved my life that night.

I put my seven year-old son to bed…and took my nightly ritual handful of pills. I woke up several hours later in the bathtub…I watched my son with tears in his eyes and fear written all over his face as he shut the water off. Mason saved my life that night.

In and out of consciousness, I told him, "Do not call the police," not for my benefit, but for his. Mason's biological father had not been involved in his life; there is no name on his birth certificate. He would have been placed in the care of the state immediately. I knew that much. Mason instead speed dialed my in-laws accidentally, and they got hold of my parents, threatening to call Child Protective Services if my parents didn't remove him immediately.

My parents came and took him from my home. I had fractured my femur during my fall in the bathtub and was in major pain and knew only one thing to help my pain. I was not in the right frame of mind when they took him. Still, I was okay with it. The night I took that handful of pills I remember thinking to myself, "If something were to ever happen to me, Mason would be loved so much better by my parents. I'm not worthy to be his mother."

My Dad called the next day and told my husband to pack up everything I was taking (all the substances I was using) and to bring me to him. He took me to the hospital in Cadillac, where we met Ed and Phyllis Gilbert. Ed Gilbert is an individual who woke up 40 years ago, on the streets of California ready to take his own life after being lost in his own addiction. He heard the voice of God telling him that He had more in store for his life. Ed has been sober ever since and is now a Pastor. It took us three and a half hours to make a 45 minute trip to Cadillac because I was so sick. I was in detox because my Dad had all my "stuff" on him in a brown paper bag. I was so angry with him. He could clearly see how sick I was and wouldn't listen to me about what I needed to do to *not* be sick. He just kept pulling over for me to be sick.

When we arrived, a male nurse took us into a room and he started taking pill bottles out of the brown paper bag. Each one, I claimed, "wasn't mine." I looked over at my Dad, who was sitting with his head down and hands held together. For the first time in 34 years, I watched my father sob. I looked at the nurse and said, "I think I have a problem." I'll never forget his next words, "Honey, you've taken the first step into your new life." He then gave me a shot of morphine, and sent us on our way to Traverse City, where they had arranged a detox facility for me there.

I spent six *awful* days there. Detox is not something you can put into words. To explain: it's pure agony. Knowing that I had done it to myself, made it worse. Following detox, I went to Munson Behavioral Health Center, for their 14 day rehab program.

I found out on my first day there that I had eight felony warrants out for my arrest. I contacted the sheriff back home, and they allowed me to finish my program with the intent of turning myself in when I completed rehab. My then husband asked for a divorce over the phone, which I quickly agreed to, knowing that we were so insanely toxic for each other.

I never did anything small. I never smoked half a joint. I never drank half a drink. I never snorted half a line. While I was in rehab, I decided that my recovery was going to be the same. I couldn't do it by half. I had to go big, or I was going home.

I completed rehab and returned to my hometown of Manistee, and turned myself in. I bonded out and awaited my sentencing. I was sentenced to a jail term.

I was cleaning one night in the cell with the other inmates when one of the guards who was supervising us, asked, "Why'd you go to rehab before you came here?" I did *not* hesitate with my reply, "Why do people come *here* before they go to rehab?" It was then that it clicked.

- I had a disease.
- had an addiction that wanted to take my life from me.
- I realized at that moment that I was worth something.
- That my life *did* matter, and I could stay sober.
- Not only could I, I *wanted* to.

After my release from jail, I had two years of probation, three meetings a week, an incredible amount of fines, and random drug tests at my probation officer's discretion. I started working a program, I went to meetings *five* days a week, I obtained a sponsor, and I started a Facebook recovery page that now has over 10,000 likes, and reaches over 212,000 people daily. That's a lot of recovery!

I paid back people who I owed money. I started paying on debts that I had racked up during my active addiction. I had a $50 co-pay for each ER visit (I had used the ER as a means to get my substances when the streets didn't work for me). Six years later, I am still paying monthly on a $17,000 bill of emergency room copayments.

When I was almost a year sober, I was sitting in an AA meeting at noon. In came walking this blue-eyed, cutest boy I'd ever seen in my entire life. I literally told the girl who was sitting next to me that I was going to marry him. She laughed it off; she obviously didn't know me very well! My sponsor was completely against the two of us being together until I had one year of sobriety under my belt. I was angry at this decision she decided to make *for* me! She wasn't the boss of me, in fact, I even told her that many times!

Whatever her reason, I listened to her. On my one year sober birthday, I received my anniversary coin and we went out on our first date. Soon after we started dating, he lost his brother to an overdose. I was there while I watched him agonize over this passing, and I was there when he relapsed because of not knowing how to "handle" his emotions, just like I once did. Not for one minute did I give up on him or our relationship. There have been many bumps and trials on our journey together, but I wouldn't trade them for anything.

Today this man is my best friend. He's the one that I cry out to when I am struggling. He's the one who holds me up when I cannot pick myself up from the day. He's the man who is adopting Mason as his own. He's the man who made a name in this community and turned it around and rose from the ashes. He's my recovery partner, and my husband of five years.

I started as a Peer Recovery Advocate at WMCMH on the Recovery Management Services team on February 1st, 2017. I am now one of the Certified Peer Recovery Coaches at WMCMH. I have the opportunity every day to walk with somebody in their recovery journey. Whether they're walking the straight and narrow path of recovery, or not even considering it at the time, I have the joy of being able to come up beside them and to walk with them. It's my role to believe in them until they begin to believe in themselves, to gain their trust by sharing my personal story, to let them know that they're not alone and that they have somebody in their corner to help them when they come in and say, "I want to get sober, but cannot imagine a life where I stay that way."

I'm grateful for a heart that today beats for a life that lives and breathes recovery. I'm grateful for a life beyond my wildest dreams.

My motto is this: I don't know how to do much, but I do know how to live life sober. I know what it takes when life throws curveballs at you and the only thing you know how to do is run back to the addiction that will take you back at any given second.

I absolutely love my job. I walk into the doors of WMCMH every day knowing that it's going to be a hard day, but completely worth it.

The Recovery Management team goes into jails to give a warm "hand off." We go to courthouses and sit and talk with prosecutors, lawyers, and judges. We go to doctors' appointments, funerals, and help people give blood because the thought of a needle going into their arm after sustaining recovery can be overwhelming for some.

I love the agency I work for. I love how we take care of our community. I am proud to come to work and to see the awesome people I work with who take such pride in their work and have a passion for their work.

For me, this has never been a job, it's been a lifestyle. And I'm grateful for a heart that today beats for a life that lives and breathes recovery. I'm grateful for a life beyond my wildest dreams. I'm grateful for a life that is exactly that.

A Life.

Pictured are: Amanda Franklin (right), Mason (middle) and (left), Amanda's husband, best friend, and the cutest boy she's ever seen!

China's Excellence in Addressing Poverty

Tom Watkins

China, like America, has human rights problems. I have touched on both our countries less-than-stellar human rights record in past columns so I'll not dwell on them again here.

One area where China is excelling and we are failing is in the area of poverty reduction or eradication. Poverty has devastating impact on the growth and development of individuals (especially children), families and society as a whole.

Clearly the Chinese Communist Party has taken many steps to address poverty since the founding of the People's Republic of China in 1949. What the Chinese Communist Party has done in this vein—to lift hundreds of millions of their own citizens from abject poverty to the equivalent of the middle class over the past 40 years—is remarkable and universally acknowledged.

Pres Xi Jinping talks eloquently about "a community of shared future for human beings." President Xi has vowed a "great rejuvenation" to restore China to its ancient prominence and glory. He is equally as clear that the Chinese "Communist Party is the solution to all China's problems and will drive change that will lead to continued progress for the Party and the Chinese people."

2018: 40th anniversary of China opening up

President Xi, in speaking to the Chinese Congress, emphasized that while past leader Mao made China independent, and leader Deng made it prosperous, he would make it strong again – propelling the country into its "new era." This new era is the Chinese equivalent of the policy to "lift all boats." The goal of eradicating poverty is certainly a lofty one.

What Would Confucius Say?

There is a renewed embrace of Confucian thinking in China: Where everyone fulfills their responsibilities and creates a harmonious situation for the whole country to prosper and reach for the "Chinese Dream."

Confucian ideas of agreed upon hierarchies and obedience to authority go back centuries. This philosophy clearly fits nicely with the Communist Party's ideas. Confucius believed that people should do what is right because it was the right thing to do. And, that the sheer act of people attempting to do the right thing would have a cascading, positive effect throughout society.

Chinese leadership—from Confucius to President Xi—are to be commended for seeking paths to eradicate poverty.

The Chinese, both its government and its people, are investing in education, infrastructure, and technology; fully embracing the future. They understand that knowledge, innovation, and creativity are the 21st century currency that will propel them forward as individuals, families and a nation, and are investing heavily in education as a poverty alleviation tool.

As the 1980's unfolded and China changed course, Premiere Deng Xiaoping—the preeminent leader following Mao—and now Chinese President Xi Jinping continue to change the course of the world.

Deng began the process and President Xi has placed it on steroids. They have established policies and practices that have lifted more people out of poverty than any other nation in the world. The number of Chinese that have escaped poverty is double that of America's entire population: over 750 million people.

Today, some argue the 20th century belonged to America and the 21st century will ultimately be led by China. I do not know if their arguments will withstand the test of time. However, I do know that our destinies are linked and we must find ways to live, work and solve problems together or we will surely fall together.

I have traveled throughout China numerous times since 1989, to cities many have heard of such as Beijing, Hong Kong, Shanghai, and Lasha, Tibet. Others less familiar include Lanzhou, Changsha, Beichuan, Bengbu, Changchun, Mianyang, Nanjing, Huizhou, Jurong, Shenzhen, Turpan, Urumqi, and Wuhan. During my travels I have seen the ultramodern as well as scenes that would take

you back centuries.

China, with all its progress, remains—in many parts of the country—a developing nation.

China Has Stood Up

However, there's no doubt that China has soared. Consider:

- 700 million people have moved from abject poverty to a Chinese middle class.
- China has become the world's fastest growing large economy.
- Many Chinese students significantly outperform U.S. students on international tests.
- China is the world's largest auto producer.
- China has become a banker to the U.S., owning more than 20 percent of our total foreign re serves (more than 3 trillion dollars).

There are three underlying facts that make China so vital in world affairs historically and, even more importantly, going forward:

1. One out of every five people on the planet are Chinese;
2. China is the oldest surviving civilization;
3. China was shaken from its historical pedestal as the "middle kingdom" and has spent decades attempting to regain its equilibrium, has clearly arrived or, as Mao said, "China has stood up."

I love the Chinese culture and people and have read and traveled in China enough to know more than the average westerner. Yet, I am careful to ensure that my comments are respectful and do not in any way interfere with the internal affairs of China. I see the country's strengths and weaknesses and have written about both.

China Dream

China will continue to build on its plan to lift the remaining citizens from abject poverty and propel China forward as they reestablish their "fuqiang" (i.e. "wealth and power").

I love America and want our nation and its values to prevail as the 21st century unfolds. Yet, I do not believe we are preordained to be number one— it is something we must earn. China is investing in improving its infrastructure, education (from the cradle to the grave), technology (especially "AI": Artificial Intelligence) and research and development. We, on the other hand, are disinvesting in these areas.

We need a National strategy to assure we remain number one. Whining about China's rise will not prevent our demise. Let me assure you, China is not sitting back waiting for us to get our act together. The individual, family, city, region, state/Provence or nation that chooses to invest in the future will rule it.

We need to stop whining and start investing in our collective future, before it is too late.

As Connections goes to press:

The above article on China's progress in addressing poverty is but one piece of the picture of Chinese culture. Watkins has been traveling and working for three decades in China – the first trip coincided with the Tiananmen Square incident in 1989. On that trip he led a delegation of over 30 CMH professionals.

He has continued visiting and writing about China, including an opinion piece for *The Detroit News* published June 3, 2019: **"30 years after Tiananmen Square, China has modernized, but government holds reins"** [scan code on right]. Taken together, these two articles present a remarkably clear picture of a critical component of our planet's humanity. The recent 30th anniversary of the student uprising in Tiananmen Square prompted Watkins to address their struggle to achieve the freedoms we take for granted. You can connect with Tom by email at: tdwatkins88@gmail.com

Tom Watkins has an eclectic career in both the public and private sectors. He served the citizens of Michigan as state superintendent of schools and director of the Department of Mental Health. He has held leadership positions in higher education, business and behavioral health. Watkins has a passion for in all things China and has written hundreds of articles on the value of this most important bilateral relationship in the world today.

This article first appeared in Dome, *December 21st, 2018 under the title,* "Whining is Not a Strategy or a Plan." Dome *is dedicated to "Covering the People, Issues & Events Shaping State, Politics & Policy." For additional information, see:*

https://domemagazine.com/whining-is-not-a-strategy-or-a-plan/

Adaptive Leadership *(From page 5)*

challenge the purpose of any proposed change to ensure that the outcome will be better than what we can currently produce. An outcome that is the same or worse is not worth the magnitude of change that either the MHP or the CMHSP systems can tolerate.

We've formed valuable relationships with our 298 Pilot partners where we continually ask and balance these questions among ourselves. The strength of the 298 Pilot CMHSPs comes from our collective efforts to balance the need for

In hindsight, we were overcommitted to our own stability and comfort, and under committed to our mission.

change, realistic outcomes of the type of change we're discussing, and the ultimate projected outcome of the change. By way of example, financial integration as the context for the Pilot is one of the major barriers we consistently confront with our MHP partners. 298 as a Pilot construct defines the outcome as financial integration. The CMHSPs and the MHPs see financial integration as the vehicle, not the outcome. Financial integration is a "fix" to an obstacle, not a design in and of itself.

The outcome we expect from the Pilot is more clearly and collectively defined in dialogues about care coordination, case management, and even utilization management. Research and experience tell us that the integration we need to support better outcomes for the people we serve lies close to the ground in our communities and within expanded systems of care. Concepts like case management, care coordination, single care plans, attribution models to support assignment of health home, real time data and information sharing are ideas that allow us to collectively expand beyond fixes for barriers to services to an architecture for improved outcomes for people in local delivery systems that support recovery and self-reliance for people we serve. They are also the structures that will result in more efficient delivery of care, lower healthcare costs overall, and decreased morbidity rates for the people we serve.

These are the outcomes that brought WMCMH to the 298 Pilot. These are the outcomes that found us wanting a seat at the table and having hard conversations about how to best improve the lives of people we serve. Collectively, we all want a system that directs more resources to and creates more leverage in achieving efficiency, reduced costs, and decreased morbidity. Few of us believe that the system is working optimally in its current form.

In our leadership work at WMCMH, Jeff Lawrence is working with us around the approach we take to address problems we identify. Our decision to engage is based on the premise that there are two camps ahead of us: *the architects of the future,* and *the obstacles that need to be overcome*. For WMCMH becoming a 298 Pilot is an effort to define a desired future state that is better than our current situation. In Jeff's language, we're becoming architects of our own future. All leaders in our system make this choice a thousand times a day in little ways. Sometimes navigating obstacles is important and a critical part of the work we do to help the people and communities we serve, but rarely is it sufficient to achieve our long-term desired outcomes.

For WMCMH, in focusing almost exclusively on the status quo of separate systems, we were inadvertently choosing to be committed to our own comfort. "Fixing things" allowed us to maintain a certain level of what we called "protection" for our staff and services. In hindsight, we were overcommitted to our own stability and comfort and under-committed to our mission. More specifically, our commitment to "fixing things" and to comfort and safety of our team actually made us *less* safe, *more* vulnerable, and *less* equipped to achieve our mission and vision and outcomes for the people we serve. Even now, we step out as architects in some ways (e.g., 298 and CCBHC) and work on fixing obstacles (process changes, program changes) in others.

I'm not sure if Jeff would agree with me or not, but I believe that there are many ways to be architects. Other leaders in our system have chosen to re-envision their organization's future based upon concepts like Opiate Health Homes (OHHs) or Certified Community Behavioral Health Centers (CCBHCs) or CMHSPs *and* Federally Qualified Health Centers (FQHCs). All are valuable and viable structures and systems to build on that can enhance the strength of the work we do locally to achieve outcomes for the people and communities we serve. The question for each of us as leaders becomes how do we stay vigilant to making sure that we're designing for the future and not just fixing things to stay comfortable?

...how do we stay vigilant to making sure that we're designing for the future and not just fixing things to stay comfortable?

WMCMH's work with Jeff Lawrence has me thinking about my role as a leader differently. Like many of my colleagues, I'm also greatly inspired by Brene´ Brown's work on leadership and vulnerability. A significant part of the work that Jeff Lawrence has done with our organization has called upon all of us to bravely envision/architect a future where we can't control the outcome but where we believe the outcomes we desire for the people we serve can be achieved. This is the essence of being an architect where the clients we design for are the people and communities we serve.

SELF-DIRECTED CARE *(From page 1)*

are different methods for developing a budget, a simple example would be to use the average annual cost of providing mental health services or supports to a person in similar circumstances. The budget will allocate resources to line items consistent with the services detailed in the recovery plan. The individual subsequently is expected to make purchases and monitor expenses on a regular basis, thus assuming personal responsibility for their own actions.

The third element of self-directed care arrangements is ***individual choice***. This is often supported using a "support broker " – someone trained to help individuals purchase mental health services, supports, and other material goods detailed in their recovery plan. A support broker may assist with monitoring the established budget, exploring available community resources, and making purchases. Support brokers may even assist with recruiting, hiring, and employing paid caregivers. In many cases, the support broker may also be someone with personal experiences in the recovery process.

The most common outcome associated with nearly all self-directed models has been high levels of customer satisfaction.

The fourth element of self-directed care involves protecting against a ***conflict of interest***. This typically involves the use of an independent fiscal agent or intermediary who is not a provider or otherwise benefitting from the budget allocation decisions. This fiscal intermediary acts as a third-party administrator by paying for provider claims/services authorized by the individual and processing vouchers for goods and services. The fiscal agent may also be the employer of record for paid caregivers and responsible for payroll, withholding taxes, unemployment insurance, etc. This creates a separation between the individual, service providers, and fiscal agent for management of public funds.

The initial self-directed care models in the late 1990s tended toward implementation with the elderly population and/or persons with physical/intellectual disabilities. These models have gradually been extended over time to projects designed to support persons with other significant mental health conditions. The most common outcome associated with nearly all self-directed models has been high levels of customer satisfaction. This should not be surprising given the amount of authority and control invested in the individual person to purchase non-traditional goods and services related to their overall health and well-being such as a gym membership and transportation. However, more current self-directed care projects are attempting to determine if such arrangements also contribute to sustained health and wellness, community participation, employment, and recovery. The significance of these future results will most likely determine the long-term viability and sustainability of self-directed care.

References

Cook, J.A., Shore, S., Burke-Miller, J., Jonikas, J., Ferrara, M., Colegrove, S., Norris, W., Ruckdeschel, B., Batteiger, A., Ohrtman, M., Grey, D., and Hicks, M. (2010). "Participatory Action Research to Establish Self-Directed Care for Mental Health Recovery in Texas." *Psychiatric Rehabilitation Journal*, 34 (2), 137-144.

Lifting the Roof *(From page 3)*

ever changing healthcare system.

In writing this article I was asked to focus on the high level strategies used to strengthen and improve transparency in the governance of Summit Pointe that may help guide other boards who are likely also challenged by these issues. To summarize the strategy, I think the best analogy would be that in doing this exercise with your organization, you will **lift the roof from your organization and view your processes and policies in action**. Audit against your policies to determine if they are followed and question all processes to ensure the right balance of oversight and monitoring is in place. The process review may uncover areas that are deficient or areas that can be streamlined and keep the board and all of the staff involved in the process. Discuss together what is learned and build effective long-term monitoring that will continue to build on processes and strengthen the organization where needed. In the end, the entire process can prove to build knowledge for everyone and indeed be worthwhile.

Discuss together what is learned and build effective long-term monitoring…

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Hal Madden and Me (*From page 6*)

When I graduated a few months later I learned that I had amazingly been accepted into GVSU despite a 2.3 GPA, and to top it off I got a substantial scholarship that I did not apply for. (Oh, Hal!) At my graduation party Hal Madden showed up to give me a congratulation card and a small financial gift.

I eventually finished working off the hours I owed and then I did not have any real contact with Hal over the next 20 years. When I did run into him on occasion he'd always say, "What's up Hot Shot?" and I always felt like I better say something good. When I took a job for MACMHB I had just turned 40. On the very first day of my employment there, Hal, who was the President of the board, told other board members that I was one of his student/athletes and that if I did anything good for the Association it was because I was a product of the Ludington School System.

Now today, here he is again. I am receiving an award named after one of the most influential people of my life.

In reflecting on my relationship with Hal Madden I realize that he consistently modeled three basic principles to me.

1) There are no throw-away people. Everyone is significant and has value whether they are in an institution or are a pimply faced 15 year-old little orphan kid whose long-term prospects are not very bright. There are no throw-away people.

2) Solutions to most of our problems are local, through relationships and interventions people make to help each other. (I may have been one of the original "wrap-around-kids.")

3) Finally, of course: Always strive to do better, because no matter how good we think we are doing, we can always do better.

I'd like to thank the Association for this award. And The Right Door Board of Directors for allowing me to partner with them for 17 years, and especially my life partner and spouse, Krista Hausermann, for all her support and for the sharing of mutual values, and of course, to you Hal Madden. I have tried to live up to these principles you taught me, and to practice them in all my affairs. Thank You, Hal!

Northern Michigan Regional Entity

Consumer Newsletter

Issue 20 **Spring 2019**

The *Consumer Newsletter* is written for consumers by consumers. If you have something you would like to contribute to the next issue, please contact Member Services at 1.800.834.3393.

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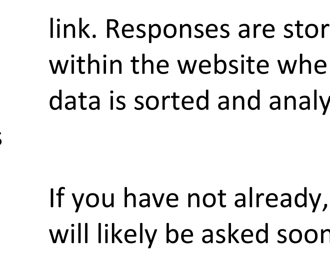
"At the end of the day, remind yourself that you did the best you could today, and that is good enough. You deserve to be happy. You deserve to live a life that lights you up. Don't ever forget that."

What is a Survey Monkey?



The NMRE's Contract with the Michigan Department of Health and Human Services (MDHHS) requires that satisfaction surveys are conducted annually to demonstrate individuals' level of satisfaction with Medicaid funded services. Beginning May 1st and continuing through September 30th, CMH Services recipients will be asked to participate in the survey. In the past, this has been achieved through a snapshot survey occurring during a two-week timeframe using color-coded paper surveys.

For fiscal year 2019, this process is changing to an online/electronic format through a web link to Survey Monkey. Survey Monkey is a tool that allows users to create their own surveys using question format templates. The surveys are then distributed through a web link. Responses are stored within the website where data is sorted and analyzed.

If you have not already, you will likely be asked soon to complete the online survey in Survey Monkey. In fact, you may be asked to complete more than one survey. The NMRE is measuring satisfaction for six Programs: Adult Case Management (May), Youth Case Management (May), Medical Services (June), Clubhouse (July), ACT (July), and Outpatient Services (September). Individuals involved in more than one program will be asked to complete the survey for each. How this is done depends on your CMH. Some may provide you with a laptop or tablet (ipad) to complete the survey, others may supply the web address for you to complete the survey on your phone, or they may offer both methods. No matter how you access the survey, your feedback is very important!

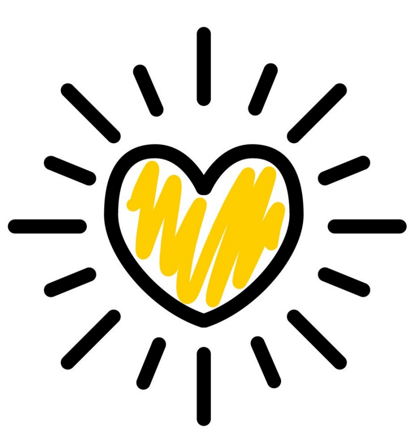
Questions will appear on the screen one at a time. Once you have answered the question you will select "Next" to take you to the following question. There are 20 questions rated on a 1-4 scale with 4 indicating the highest (strongly agree) level and 1 (strongly disagree) the lowest level of satisfaction. After the first 20 questions, you will be able to type in comments and give individual feedback. You will then select both the CMH you work with and your worker for each program (Case Manager, Doctor or Nurse, Club-house Director, etc.) It takes about 8 minutes to complete the survey. Your participation is appreciated and your answers remain private. Thank you for your participation!

My Kind of Different

Are you the type of person
Who marches to their own beat
Do you feel you're always watched
While walking down the street
Have your anxieties made you hide
When you've heard the doorbell ring
Are you the person in the crowd
Who always has to sing
Have you ever asked a question and got a puzzled look right back
Do you show the world you're confident
Though you feel it's all an act
Are you the type to love mankind
No matter what they may have done
Are you the type to give more than you get
Does your heart shine like the sun
If any of this sounds like you
These words put down in print
Then you are my type of person
You're my kind of different

Thank you Kelly

by: Robert Newsome



Devon's Story: the "Bread & Bagel Guy"

Studies show that working is good for our health and wellbeing. It contributes to our happiness, helps us to build confidence and self-esteem, and rewards us financially. Club Cadillac prides itself on assisting its Members with obtaining employment training through its Transitional Employment Program. This program provides job experience in an area business while earning the Member Colleague the prevailing minimum wage. Club Cadillac staff offer job coaching and assistance with reporting earnings to the appropriate agencies.

The Blue Heron of Cadillac has worked with Club Cadillac's Transitional Employment Program for the past two years. They highly value and appreciate the program and are very supportive of every Member Colleague that works for them.

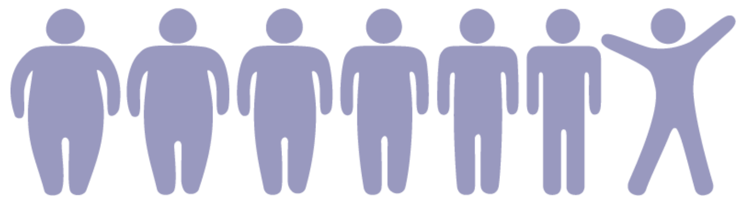
Although the kitchen atmosphere is upbeat and encouraging, the dishwashing position at the Blue Heron is a fast-paced and physically demanding job.

Devon R. obtained the position nine months ago (after being unemployed for two years) and has shown himself to be an exceptional worker and dedicated employee. As his time at the Blue Heron drew to an end, the manager offered him a permanent position at the restaurant!

Devon is being trained to be the "bread and bagel guy" and has impressed everyone with his ability to learn the different tasks. Devon, a man of few words, said of his achievement, "It's cool. I like it there."

Devon is just one of many Member Colleagues who have completed the Transitional Employment Program at Club Cadillac and gone on to obtain independent employment. Congratulations Devon! You are awesome!

Andrea's Story



Andrea S. has a photo of herself sitting in a wheelchair in 2007. As Andrea noted, "I look huge." She was 376 pounds. She used a wheelchair because it was difficult for her to get around carrying the weight. She tried through the years to lose weight and successfully lost some only to gain it back. In June 2018, she moved to a new Adult Foster Care home. With the help she received in her new home, and with the help of Club Cadillac monitoring what she ate, she lost 75 pounds. Along with some of the weight she previously lost and was able to keep off, she has gone from 376 pounds to 269—a difference of 107 pounds! More importantly, Andrea no longer uses her wheelchair. Recently someone told her that her shoelaces were untied; she went ahead and tied them. Seconds later she realized what she did. She hadn't been able to bend down and tie her own shoelaces in a long time.

When she called her brother and sister-in-law the to tell them, they thought she had bad news because she was crying. She had to explain that they were tears of happiness because she had bent over and tied her own shoes. They both cheered her on, congratulated her, and encouraged her to "Keep up the good work, Jill!" ("Jill" is the family's name for Andrea.) Her 7-year-old nephew came on the line with his own congratulations and told her "I love you, Aunt Jill."

Congratulations to Andrea and to everyone who is making better choices to lead healthier lives. Way to go! If you'd like to share your story contact the Customer Services Representative at your CMH.

Manistee Friendship Society

by: Cassandra Kamaloski

Diet and exercise play key roles in everyone's mental health. That is why at the Manistee Friendship Society we provide opportunities for our members to get exercise and to have healthy foods available to them.

Exercise offers incredible benefits that can improve nearly every aspect of your health from the inside out. Regular physical activity can increase the production of hormones that make you feel happier and help you sleep better. It can also improve your skin's appearance, help you lose weight and keep it off, and lessen the risk of chronic disease. Whether you practice a specific sport or follow the guideline of 150 minutes of activity per week, you will inevitably improve your health in many ways.

We offer free gym memberships at our local Health Connection. Members can go anytime during their business hours. They also offer free classes as part of the memberships (Step & Sculpt, Strength Training, Relax & Restore Yoga, Balance, Core Work, Kettle Bell, etc.). We also offer free monthly memberships at our community swimming pool! Our members seem to really enjoy these perks!

The food we put into our bodies also plays a huge role in our mental health. We teach that in our weekly healthy cooking classes! We have healthy breakfast, lunch, and snacks available for our members daily. On Fridays we play Fresh Food Bingo. At our bingo, everyone is a winner! Members can take home fresh fruits, vegetables, dairy products, and healthy snacks for the weekend. This is a big hit at our Center! We also have a food pantry for our members. A lot of our members are low income so this really comes in handy.

With that, remember, you are important. Take the time to exercise and nourish your body. Drink plenty of water. Take time to relax. Take care of yourself. Spend time with family & friends. Here at the Manistee Friendship Society you will always find and be a friend.

Walk-A-Mile Rally

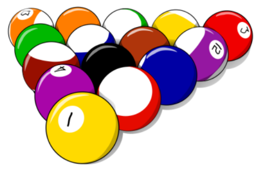
On May 9, 2019, nearly 2,000 participants joined together on the Capitol Lawn in Lansing! The weather forecast included thunderstorms, lightning, and heavy rain, but that did not deter individuals from showing up in droves! People in attendance wanted their voices heard. They made it clear to Legislators that until they "Walk a mile in my shoes!", they could not understand the needs of individuals living with a mental illness or intellectual/developmental disability.

Participants rallied to enhance public awareness and to put an end to the stigma related to mental health in Michigan. The 2,000 voices spoke the truth about living with mental illness. Together they are making a difference.

The event was covered by various news outlets. Local news media publications covered their local CMH organizations in addition to the state rally, demonstrating local and statewide reach. News coverage also addressed the overall underfunding of Michigan's public mental health system. If you would like to contact your State Senator or your State Representative about this issue, you can find his/her contact information by going to the following website: **https://www.michigan.gov/som/0,4669,7-192--86050--,00.html**,or by contacting your local Community Mental Health Provider or the Northern Michigan Regional Entity at **customerservices@nmre.org**.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Manistee Friendship Society **May 2019 Activity Calendar** **1475 South US 31, Manistee, MI, 49660** **(231) 398-0434** manisteefriendshipsociety.org **All services are free of charge.** **Breakfast, lunch, and snacks are served daily!**		1 Open 9:30-3:00 New! Grace Seekers: Bible Study: 11-12 Depression Support Group: 12:30-1:30 Ladies AA: 6:30-7:30	2 Open 9:30-3:00 Food Truck: 10:30-12:30 (Volunteers needed to help unload and put away food truck)	3 Open 9:30-3:00 Fresh Food Bingo: 1:00-2:00
6 Open 9:30-3:00 Anxiety Support Group: 11:00-12:00 Arts & Crafts: 1:00-2:00	7 Open 9:30-3:00 Healthy Cooking with Cassandra: 1:00-2:00	8 Open 9:30-3:00 New! Grace Seekers: Bible Study: 11:00-12:00 Depression Support Group: 12:30-1:30 Ladies AA: 6:30-7:30	9 Open 9:30-3:00 Walk-a-Mile-in-My-Shoes Rally: Sign up with Cassandra Bowling: 12:45-2:00	10 Open 9:30-3:00 Fresh Food Bingo: 1:00-2:00
13 Open 9:30-3:00 Anxiety Support Group: 11:00-12:00 Hearing Voices Support Group: 3:00-4:15	14 Open 9:30-3:00 Healthy Cooking with Cassandra: 11:00-12:00	15 Open 9:30-3:00 New! Grace Seekers: Bible Study: 11:00-12:00 Depression Support Group: 12:30-1:30 Ladies AA: 6:30-7:30	16 Open 9:30-3:00 Painting with Cassandra: 12:30-2:00 (Sign up)	17 Open 9:30-3:00 Green Ackers Volunteer Visit: Sign up with Cassandra) Fresh Food Bingo: 1:00-2:00
20 Open 9:30-3:00 Anxiety Support Group: 11:00-12:00 Arts & Crafts: 1:00-2:00	21 Open 9:30-3:00 Turkey Dinner: 12:00 Karaoke: 1:00-2:00	22 Open 9:30-3:00 New! Grace Seekers: Bible Study: 11:00-12:00 Depression Support Group: 12:30-1:30 Ladies AA: 6:30-7:30	23 Open 9:30-3:00 Bowling: 12:45-2:00	24 Open 9:30-3:00 Fresh Food Bingo: 1:00-2:00
27 Closed Memorial Day	28 Open 9:30-3:00 Healthy Cooking with Cassandra: 10:00-11:00 Board Meeting: 1:00-2:00	29 Open 9:30-3:00 **NMRE Day of Recovery:** All Day in Gaylord (Sign up with Cassandra) New! Grace Seekers: Bible Study: 11:00-12:00 Depression Support Group: 12:30-1:30 Ladies AA: 6:30-7:30	30 Open 9:30-3:00 Bowling 9:45-2:00	31 Green Ackers Volunteer Visit: (Sign up with Cassandra) Fresh Food Bingo: 1:00-2:00

Bay View Center



According to the Spring/Summer Bay View Bugler a lot of exciting things have been happening at the Bay View Center in Alpena.

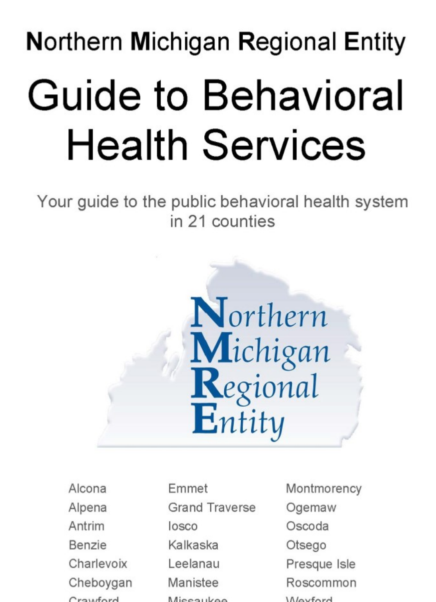
Johnny B. reported that several pool tournaments have taken place for sharp-shooters and non sharp-shooters alike! In Alpena, public pool tables are primarily located in bars and restaurants. Drinking and social awkwardness can be a problem for a lot of folks. The Bay View Center provides a safer atmosphere to be part of a pool tournament, improve pool skills, and practice trick shots.

The Center's Writers Group has been learning a lot about creative writing by doing several exercises from the book "The Writer's Little Helper," by James V. Smith. Working these has been informative, fun, and helpful.

Tuesdays have become "Smoothie Day" thanks to a gift of $500 from Alpena's MidMichigan Medical Center. Members choose their favorite frozen fruits from the stocked freezer, then staff whips them up into healthy and delicious drinks. Afterwards, everyone enjoys he or her smoothie while playing bingo. Replacing a full meal with a healthy smoothie just once a week will have positive health benefits.

The Bay View Center is open Monday-Friday 9:00-3:00. Visitors are welcome!

What is so Special about this Book?



Northern Michigan Regional Entity

Guide to Behavioral Health Services

Your guide to the public behavioral health system in 21 counties

Northern Michigan Regional Entity

Alcona	Emmet	Montmorency
Alpena	Grand Traverse	Ogemaw
Antrim	Iosco	Oscoda
Benzie	Kalkaska	Otsego
Charlevoix	Leelanau	Presque Isle
Cheboygan	Manistee	Roscommon
Crawford	Missaukee	Wexford

The NMRE Guide to Services is a book given to individuals when they enter into services and offered to them annually at the time of their Individual Plan of Services/Person-Centered Treatment Plan. The NMRE keeps the book up do date as rules and regulations change. Inside you will find:

→ Important phone numbers and contacts
→ Information about your rights
→ Information about available services
→ Information to help you understand benefits
→ Amazing resources

You can request a copy of the NMRE's Guide to Services from your CMH provider or on the NMRE website **nmre.org**.

Grievance & Appeal Process

A "grievance" is any expression of dissatisfaction about any matter regarding services that is not based on an "Action."

Examples of a grievance:

1. Condition of waiting room
2. Parking issues
3. Staff/client interactions
4. Wait time

An "appeal" is a request to review an "Action."

An "Action" is defined as:

1. Denial or limited authorization of a requested service, including the type or level of service.
2. Reduction, suspension, or termination of a previously authorized service.
3. Denial, in whole or in part, of payment for a service.
4. Failure of the NMRE to act within the timeframes required for disposition of grievances and appeals.
5. Failure to make an expedited authorization decision within three (3) working days from the date of receipt of a request for expedited service authorization.
6. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP/CMHSP.

You have the right to file a grievance or appeal. Contact your CMH customer services representative or the **customerservices@nmre.org** for more information.

June 28, 2019

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CMH Association and Member Activities:

Leadership Change at Northeast CMH

Northeast Michigan Community Mental Health recently announced the retirement of its Director, Cathy S. Meske, effective June 30, 2019. Nena Sork has been appointed to the Director position to succeed Cathy effective July 1, 2019. Nena has been with the Agency since December 2008. She has had a thirty-two year career in the mental health field. Nena has a Bachelors of Arts in Social Work from Anderson College in Anderson Indiana (1986) and a Masters of Social Work from Grand Valley State University in Allendale Michigan (1990).

We wish Cathy the best in the next phase of her life and welcome Nena to her new role.

Job Bank CMHA Member Benefit Now Available!

CMHA Members may log on to www.cmham.org under Services to access the Job Bank and upload any Job Postings within their organization. Experience the ease and accessibility of being able to post what you want – when you want – and reach the maximum number of people in the State of Michigan!

If you would like to POST a job, please use the following link (REMEMBER… You must be a member in order to enjoy this benefit!): https://cmham.org/services/job-bank/

If you would like to VIEW current job postings, please use the following link (you do NOT have to be a member to view postings!): https://cmham.org/job_postings/

Don't Forget About the 2019 PAC Campaign

Earlier this year we announced our 2019 CMH PAC campaign. We must increase our participation, last year we only had 15 boards participate in our PAC campaign. Please take some time over the next couple of board meetings to encourage your board and staff to participate in our 2019 PAC efforts. As you know, our CMH PAC is a key component to our overall advocacy efforts – the need to upgrade our PAC is greater today than ever before.

For those members who qualify for the drawing for the Tiger game suite (minimum 6 contributions per agency), this year's game is on Sunday, July 21 at 1:10pm vs. Toronto Blue Jays. Members should forward the results of their campaign and donations **to the CMHA office by June 28, 2019** in order to be in the drawing for the Tiger tickets if eligible.

Make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please). Thank you. Please feel free to contact Bob or Alan with any questions.

CMHA Committee Schedules, Membership, Minutes, and Information

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

News from Our Preferred Corporate Partners:

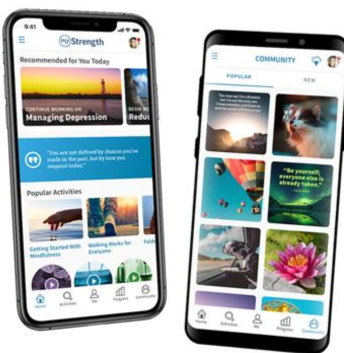
Lessons From the Field: Stories From Accreditation Surveyors and Consultants

Wouldn't you rather learn the potential pitfalls of preparing for an accreditation survey from others' mishaps, as opposed to experiencing them yourself?

Check out this webinar to learn how organizations have successfully (and not-so-successfully) prepared for national accreditation. Real-life examples from both the behavioral healthcare and child welfare fields are shared.

Get the Scoop

myStrength Offers In-the-Moment Support for Comorbid Medical-Behavioral Conditions



Behavioral health conditions are disabling on their own, but they also complicate clinical improvement for the large percentage of people experiencing chronic medical conditions alongside comorbid behavioral health symptoms. For example, it is very challenging to stabilize diabetes or hypertension until depression or anxiety symptoms are successfully managed.

myStrength's digital behavioral health platform is available whenever and wherever a consumer needs, with a consistent, personalized user experience across web and mobile devices.

myStrength's mobile app promotes more frequent engagement by consumers, and use of these evidence-based tools (grounded in mindfulness, cognitive behavioral therapy, and more) helps facilitate long-term health benefits.
In addition to various pathways to access myStrength, the platform also offers immediate access to diverse tools for depression, anxiety, stress, meditation and mindfulness, sleep, pregnancy and early parenting, balancing intense emotions, and chronic pain, as well as tools for drug, opioid or alcohol recovery.

myStrength's Mobile App Offers Real-Time Support:

- Instantly unwind with 3 short audio activities presented when app is opened
- Bookmark helpful resources for quick access when real-time support is critical
- Gain personalized, integrated support for multiple conditions
- Favorite or download inspirational images in the Community for instant access

State and National Developments and Resources:

MDHHS publishes report on BH capacity in EDs, part of Michigan Psychiatric Care Improvement Project

Below is a recent letter, to Advisory Group on this project, from MDHHS leadership on the latest steps in the state's Michigan Psychiatric Care Improvement Project:

> Dear workgroup members,
>
> The Michigan Department of Health and Human Services (MDHHS) is reaching out to you about the Michigan Psychiatric Care Improvement Project. Over the last two years, MDHHS has been working with stakeholders to address systemic barriers that individuals in psychiatric crisis experience in accessing inpatient care and other crisis services. Securing inpatient psychiatric services for individuals who present at emergency departments has become increasingly complex and time consuming over the last decade. This trend of "Emergency Department Boarding" has generated a national conversation which recognizes that psychiatric patients that are most in need of inpatient services are often made to wait the longest for a host of complicated reasons.
>
> To gain a better understanding of this problem, MDHHS commissioned TBD Solutions to survey and complete a thorough analysis of behavioral health service capacity within emergency departments across Michigan. MDHHS and TBD Solutions partnered with the Michigan Health & Hospital Association (MHA) to conduct the survey process of emergency departments. The Michigan Health Endowment Fund (MHEF) also supported this work through the provision of grant funding for the study.
>
> TBD Solutions submitted the final copy of its report and related recommendations to the department earlier this spring. MDHHS has posted the report to the department's website to support the ongoing statewide discussion on emergency department boarding. The report from TBD Solutions contains (1) the results of the survey process, (2) excerpts from subsequent interviews conducted with subject matter experts, (3) data on the use of community benefit dollars, (4) maps that depict

the availability of inpatient services and other crisis services across Michigan, and (5) recommendations from TBD Solutions on potential strategies to address emergency department boarding. The report can be accessed through the link below.

Webpage for the Michigan Psychiatric Care Improvement Project: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_85156---,00.html

MDHHS would like to express its gratitude to TBD Solutions, MHA, MHEF, and all of the survey participants who contributed to the development of this report. MDHHS will explore opportunities to address the recommendations within its programs, policies, and initiatives. The department will also continue to collaborate with stakeholders on addressing emergency department boarding, improving access to inpatient psychiatric services, and integrating access to services across a broad spectrum of healthcare resources. If you have any questions about the report or related recommendations, please reach out to me at estys@michigan.gov or Dr. Mellos at mellosg@michigan.gov.

Utah Waiver Proposal - A Bad Deal for Utah Taxpayers and Government

Below is an excerpt from a recent editorial, by Families USA, on the State of Utah's proposed 1115 Medicaid waiver. The concerns of Families USA and other observers is that this waiver moves Medicaid, in Utah, to a block-grant-like arrangement, capping both federal and state expenditures for Utah's Medicaid program.

> The Utah Department of Medicaid released its much-anticipated proposal for a Section 1115 Medicaid waiver seeking a "per capita cap" – or a limit on federal spending – on major portions of its Medicaid program. If approved by the Trump administration, it would set a new precedent that could have catastrophic effects for state budgets and Medicaid programs in the future. Capping the federal funding for Medicaid means that state taxpayers will face greater risks of rising health care costs, and will result in more pressure on state budgets.
>
> The state is taking public comments on the proposal before submitting a formal waiver submission to the Trump administration. The state's public comment period is open until June 30, 2019. Public comments can be submitted here. Once the waiver is submitted to federal officials another comment period will open before the waiver is reviewed by the Trump administration.
>
> The waiver proposal is the direct result of a controversial decision by Utah lawmakers to repeal and replace the voter-approved Medicaid expansion ballot initiative that passed in Utah with 54% of the vote in the November 2018 elections. Utah is the first in a small group of states pursuing proposals that would cap the federal funds they receive in the Medicaid program. Lawmakers in both Tennessee and Georgia have passed legislation directing the state agencies to pursue block grant proposals for the Medicaid program.
>
> Utah's proposal represents a new state-based approach to undermining the funding for Medicaid programs through per capita caps — an effort that was defeated in Congress in 2017. For months, the Trump Administration has been engaged in closed-door discussions with state lawmakers in several states to strike a "deal" to impose caps – or a funding ceiling – on the level of federal funding for state Medicaid programs. This kind of proposal involves major fiscal risk for states, with the supposed quid pro quo new flexibility to cut services or take away coverage if and when they hit their new federal funding cap. Per capita caps are a bad deal for state taxpayers and for state governments. But the Trump administration has a great deal of leverage to push states in this risky direction. A new precedent could be set if Utah's waiver is approved in its current form.

> Although Utah's proposal caps federal funding for low-income adults, the Trump administration has stated its intentions to apply caps to all Medicaid beneficiaries, including seniors, people with disabilities and the roughly 35 million children - nearly half of total Medicaid enrollment - who use Medicaid. Per capita caps for Medicaid's child population would be particularly concerning because the cap for children, given their relatively inexpensive coverage costs, would likely be far lower than for other Medicaid populations. With a low cap for children, states would have less "wiggle room" to adjust their spending and would be less likely to adopt new initiatives to improve access to care or delivery of services for kids.

The full article can be found at:
https://familiesusa.org/product/utah-waiver-proposal-bad-deal-utah-taxpayers-and-government

Making the promise of mental health parity a reality

Below is an excerpt from recent news story on the value of mental health insurance parity and the importance of parity efforts, such as the long-running effort in Michigan.

> A young woman said, "I thank my stars every day that I'm standing here before you." A mom said, "This disease has touched so many families, including mine." A father said, "Our son was killed by fentanyl-laced heroine. Addicts need help." And another mother said, "If drug addiction was treated like other physical diseases, my son might be alive today."
>
> These are direct quotes. They're from people in South Jersey, and they are things I've heard over and over again throughout the past few years. The last, painfully honest, quote really hits on something I've been focused on – getting others to understand that addiction is a disease and that we must combat the stigma surrounding addiction. As vice-chair of the Bipartisan Addiction Task Force, one of the largest bipartisan groups in Congress, I will keep shining a light on the fact that addiction is a medical condition – not a moral or criminal issue.
>
> Back in 2008, Congress rightly began requiring mental health parity – which means, under law, insurance plans must provide the same level of coverage for mental health and substance-use disorders that they provide for physical health conditions. However, we've hit a snag – the enforcement mechanism for the 2008 law is severely lacking. Insurance companies can get away with not following parity laws, even though lives are on the line. I recently proposed the Parity Enforcement Act to fix this. My bill would allow the Department of Labor to fully investigate and issue penalties against health insurers that knowingly break the law.

The full article can be found at: https://www.modernhealthcare.com/article/20180519/NEWS/180519900/as-families-struggle-to-get-behavioral-health-coverage-enforcement-of-parity-laws-lags

CMS offers integrated care technical assistance webinar

New Quality Measures Related to Medicaid Beneficiaries with Physical and Mental Health Integrated Care Needs and Adult Beneficiaries with Complex Care Needs (BCN)

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Innovation Accelerator Program is hosting a national learning webinar on **Wednesday, July 10, 2019, from 2:00 PM - 3:30 PM (ET)** to introduce three new Medicaid quality measures related to Medicaid beneficiaries with complex care needs and high costs

(BCNs) and beneficiaries with physical and mental health (PMH) care integration needs. The following measures will be discussed:

- All-Cause Emergency Department Utilization Rate for Medicaid BCNs
- All-Cause Inpatient Admission Rate for Medicaid BCNs
- Follow-Up Care for Adult Medicaid Beneficiaries who are Newly Prescribed an Antipsychotic Medication (NQF 3313)

In this webinar, Mathematica (the measure developer) will describe the purpose of the measures, walk through the steps for calculating each measure, and discuss issues states should consider when implementing the measures. The discussion will be followed by a question and answer session.
This effort is part of a larger CMS project that is intended to develop quality measures for certain groups of Medicaid beneficiaries who have the highest costs and greatest needs for health care and social support.

This webinar will include a question & answer session.

To Register for the webinar go to:
https://event.on24.com/eventRegistration/EventLobbyServlet?target=reg20.jsp&referrer=https%3A%2F%2Flinks.govdelivery.com%2F&eventid=1982089&sessionid=1&key=9FABC038D1BE5534F228DC50E72D1553®Tag=&sourcepage=register

The Farmer Mental Health Crisis: Understanding A Vulnerable Population

Join APA and Farm Aid for a special webinar on the mental health crisis among farmers and how psychologists can make a difference. This webinar is geared toward psychologists who are interested in working with this population. Panel experts will help you understand the realities that farmers face, their unique stressors, and the use of effective language to help farmers overcome some of the barriers to seeking mental health care.

The farm economy is in crisis and farmers are under intense stress. Calls to Farm Aid's farmer hotline increased by 109% between 2017 and 2018. And according to the Department of Health and Human Services, 111 million people live in areas with a shortage of mental health professionals.

If you have thought about working with farmers in your county and state, this is an opportunity to learn about the farming culture as well environmental and economic conditions affecting their mental health and well-being. The one-hour webinar will also highlight resources to help you connect with the farming community.

DATE	TIME
Wednesday, July 31, 2019	12 p.m.–1 p.m. EDT

Register at: https://register.gotowebinar.com/register/4633165377397709314

CHCS announces resources for treating trauma to address substance use disorder

Experiencing trauma strongly correlates to health-risk behaviors later in life, including substance use. With this understanding, many providers are seeking ways to acknowledge and address trauma as a hidden, underlying risk in patients' lives.

Integrating a Trauma-Informed Approach into Substance Use Disorder Treatment - This recent webinar, cosponsored by the Center for Health Care Strategies (CHCS) and ACEs Connection, highlighted how two providers operating in vastly different settings have incorporated trauma-informed care into substance use disorder treatment, and how doing so has shaped the experiences of their patients and staff. Learn more » https://www.chcs.org/resource/integrating-trauma-informed-approach-into-substance-use-disorder-treatment/?utm_source=CHCS+Email+Updates&utm_campaign=b6df762c9c-ATC+Round-up+CHCS+Main+6%2F25%2F19&utm_medium=email&utm_term=0_bbced451bf-b6df762c9c-152144421

At the Front Lines in Tennessee: Rural Clinic Offers Trauma-Informed Treatment for Substance Use Disorder - This blog post highlights a rural clinic in Tennessee that uses trauma-informed care to treat patients struggling with substance use disorder — many of whom have achieved significant results. Read more » https://www.chcs.org/at-the-front-lines-in-tennessee-rural-clinic-offers-trauma-informed-treatment-for-substance-use-disorder/?utm_source=CHCS+Email+Updates&utm_campaign=b6df762c9c-ATC+Round-up+CHCS+Main+6%2F25%2F19&utm_medium=email&utm_term=0_bbced451bf-b6df762c9c-152144421

CHCS announces. ¡Trauma-Informed Care Informational Videos Available in Spanish!

Two videos produced by the Center for Health Care Strategies (CHCS) on trauma-informed care are available in both English and with Spanish subtitles. The 3-4 minute videos are available for free online and can be used to introduce trauma-informed care in meetings, employee trainings, and presentations.

"What is Trauma-Informed Care?" - This animated video provides a clear and compelling message about the lifelong impact of trauma on health, and how trauma-informed care can create a more welcoming care environment for patients, providers, and staff. ENGLISH » | SPANISH »

"Trauma-Informed Care: From Treaters to Healers" - This video features providers and patients discussing the value of trauma-informed care and how trauma can be more effectively addressed in a health care setting.

ENGLISH: https://www.youtube.com/watch?v=8wxnzVib2p4&utm_source=CHCS+Email+Updates&utm_campaign=b6df762c9c-ATC+Round-up+CHCS+Main+6%2F25%2F19&utm_medium=email&utm_term=0_bbced451bf-b6df762c9c-152144421

SPANISH: https://www.youtube.com/watch?v=TKh2P4eakBk&utm_source=CHCS+Email+Updates&utm_campaign=b6df762c9c-ATC+Round-up+CHCS+Main+6%2F25%2F19&utm_medium=email&utm_term=0_bbced451bf-b6df762c9c-152144421

Report: Drug ODs, Suicides Soaring Among Millennials

Below is an excerpt from a news story on a recent report issued by the Well-Being Trust on the rising suicide rate among millennials and the causes behind that spike in suicides.

> So-called "deaths of despair" are skyrocketing among millennials, with thousands of 18- to 34-year-olds losing their lives to drugs, alcohol and suicide each year, a new report says.
>
> During the past decade, drug-related deaths among that age group increased by 108%, alcohol-induced deaths by 69%, and suicides by 35%, according to the report from the Trust for America's Health and Well Being Trust.
>
> Millennials are more heavily affected than older generations by each of these causes of death, the report states:
>
> - In 2017, there were nearly 31 drug overdose deaths for every 100,000 18- to 34-year-olds, but fewer than 23 drug deaths per 100,000 across all age groups.
> - Alcohol-induced death rates doubled for millennials between 1999 and 2007.
> - Young adults experienced a 35% increase in suicide rates between 2007 and 2017, compared with a 14% increase for 35- to 54-year-olds; a 24% increase for those 55 to 74; and 14% uptick for people older than 75.
>
> "We lost over 150,000 lives last year to drugs, alcohol and suicide. When we dive down deep into those data, the millennial generation just pops out," said Benjamin Miller, chief strategy officer of Well Being Trust, a national foundation focused on mental, social and spiritual health.
>
> "This is a call to action," Miller said of the new report. "It's unacceptable for us to continue to lose as many lives as we are losing to preventable causes. We have to do something different. What we are doing is simply not working."

The full article can be found at: https://www.usnews.com/news/health-news/articles/2019-06-13/drug-ods-suicides-soaring-among-millennials-report

CHCS issues resources to improve access to SBIRT in Primary Care for Adolescents

Adolescence is often a period for risky behavior and experimentation with alcohol and drugs. Misuse of alcohol and drugs can be major contributing factors to serious health problems, mental illness, and suicide. Primary care providers (PCPs) are well-positioned to identify and prevent problematic substance use in adolescents. However, PCPs often do not recognize the role they can play in mitigating adverse outcomes or feel they do not have the training to administer effective prevention practices.

Recognizing this opportunity, CHCS partnered with the Association of Community Affiliated Plans, through support from the Conrad N. Hilton Foundation, to coordinate Improving Access to Screening, Brief Intervention, and Referral to Treatment Services for Adolescents. Under this learning collaborative, seven Medicaid health plans -- serving more than 430,000 adolescents – designed and tested strategies to incorporate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into primary care practice for targeted at-risk teens.

This brief and companion resource center draw from the experiences of the health plans participating in the learning collaborative. These resources outline considerations, strategies, and practical tools for integrating SBIRT into primary care settings for adolescents around key topics, including: (1) provider engagement and support; (2) provider training; (3) coding and billing for SBIRT; and (4) measurement.

The report can be found at:
https://www.chcs.org/resource/improving-access-to-screening-brief-intervention-and-referral-to-treatment-in-primary-care-for-adolescents-implementation-considerations/?utm_source=CHCS+Email+Updates&utm_campaign=79d5de27f1-SBIRT+6%2F26%2F19&utm_medium=email&utm_term=0_bbced451bf-79d5de27f1-152144421

OMB proposes to redefine poverty

Recently the federal Office of Management Budget (OMB) proposed a change to the definition of poverty. . The OMB's proposal to change how the federal poverty level is calculated would cut the health benefits for millions, according to the Center on Budget and Policy Priorities. The change would use a lower inflation rate to determine economic poverty. As a result, fewer people would qualify for benefits as the poverty line rises more slowly than under today's calculation. The change would affect traditional beneficiaries of Medicare and Medicaid (including CHIP) as well as those enrolled under ACA Medicaid expansion and the marketplace subsidy program.

Federal anti-discrimination changes proposed

The HHS Office on Civil Rights (OCR) has issued draft regulations to roll back the Obama Administration's 2016 antidiscrimination regulations implementing Section 1557 of the ACA. The section prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. The proposed rule could adversely affect health care access not only for the LGBT community, but also for people with physical or behavioral disabilities and those with extensive health needs.

OCR says the rule is needed because the Obama-era regulation exceeded its authority, was confusing, and imposed unjustified burdens. Moreover, OCR contents the regulatory changes could save $3.6 billion over 5 years primarily by eliminating what are known as "language access" requirements that translate consumer print and electronic communications to meet the needs of our language-diverse population. Of greater concern, however, are other provisions related to healthcare civil rights. The proposed regulations are far narrower than those approved in 2016. Section 1557 protections would apply to people insured through plans purchased through Medicaid, CHIP, Medicare, or marketplace subsidies. Those insured through nonsubsidized individual or employer-sponsored plans would lose these protections.

Further, the entire definition section of the current rule would be deleted from the regulations, removing definitions of "covered entity" and "on the basis of sex." Nondiscrimination protections specific to sex and gender identity would be dropped. Appeals would be made more difficult because compliance coordinators and written grievance procedures would be eliminated. Curiously, the proposed OCR regulations would also make so-called "conforming amendments" to other HHS regulations unrelated to Section 1557, such as nondiscrimination standards for qualified health plans and ACA marketplaces. Comments on the highly controversial and potentially damaging proposed regulations are due by August 13, 2019.

Additional information on this proposed change and the site for submitting comments is:
https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities

NAMI Michigan announces NAMI Walks

NAMI Michigan (National Alliance on Mental Illness) invites you to the 2019 NAMI Walks Michigan Kick-Off Rally on July 10th at Emagine Theater - Royal Oak in Royal Oak, MI.

The Kick-Off Rally is a free, family-friendly event for everyone in the Metro-Detroit area to come together for a great afternoon of:

LIVE Entertainment: COCO the Comedian
Delicious apps & beverages provided by Emagine Theater - Royal Oak
Raffle Doorbuster Prizes (3 lucky names will be drawn!)
Icebreaker games & activities
Community fun & mental health awareness!

Attendees will also receive information on the many ways to become involved in the largest state-wide mental health awareness 5k, NAMIWalks Michigan, taking place on September 28, 2019 at Belle Isle Park Park.

RSVP Now: https://forms.gle/fQEX5EXUJLDwEzBW7

Come join NAMI for a wonderful kick-off celebration to the 2019 NAM Walks season! We'll see you on July 10th!

Veterans Administration - Urgent Care – Where and When You Need It

Below is information recently issued by the Veterans Administration regarding the MISSION Act, designed to improve access to primary and mental health care for America's veterans.

You've probably seen news about the MISSION Act, which expands same-day services in primary care and mental health, as well as expanded telehealth to Veterans in their homes. Under the MISSION Act, urgent care is now a supplemental benefit for eligible Veterans. Urgent care in VA or the community (i.e., non-VA) is for those minor injuries and illnesses that do not require emergency room care. This support for urgent care does not replace the important relationship that you have with your VA health care team.

If you need to use the new urgent care benefit, it is important that you go to an urgent care location in your community that is within the newly established VA contracted network. It is also important to know the following details about the prescription component of the benefit:

* If the urgent care provider gives you a prescription, you can fill a 14-day supply of that medication at the VA or in a pharmacy within the VA contracted network.
* If you choose to fill an urgent care prescription at a pharmacy outside of the VA network, you will be required to pay for the prescription at the time of pick up and then file a claim for reimbursement at your local VA medical facility.

This special publication about urgent care and the MISSION Act:https://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTkwNjE3LjcwNTgxMTEmbWVzc2FnZWlkPU1EQi1QUkQtQlVMLTIwMTkwNjE3LjcwNTgxMTEmZGF0YWJhc2VpZD0xMDAxJnNlcmlhbD0xNjc3ODk2MCZlbWFpbGlkPWJvYkBub3J0aGVybndpbmRzODE1MDYuY29tJnVzZXJpZD1ib2JAbm9ydGhlcm53aW5kczgxNTA2LmNvbSZ0YXJnZXRpZD0mZmw9Jm12aWQ9JmV4dHJhPSYmJg==&&&101&&&https://www.va.gov/communitycare/docs/pubfiles/factsheets/VA-FS_Vet-Urgent Care.pdf>

If you arrive at an urgent care network location and have any difficulty receiving care, you can call 866-620-2071 to receive assistance.

You can also call your local VA facility:
https://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIw

MTkwNjE3LjcwNTgxMTEmbWVzc2FnZWlkPU1EQi1QUkQtQlVMLTIwMTkwNjE3LjcwNTgxMTEmZGF0YWJhc2VpZD0xMDAxJnNlcmlhbD0xNjc3ODk2MCZlbWFpbGlkPWJvYkBub3J0aGVybndpbmRzODE1MDYuY29tJnVzZXJpZD1ib2JAbm9ydGhlcm53aW5kczgxNTA2LmNvbSZ0YXJnZXRpZD0mZmw9Jm12aWQ9JmV4dHJhPSYmJg==&&&102&&&https://www.va.gov/find-locations/ >

Login to My HealtheVet and send a Secure Message. (login required) to your health care team. Any Secure Message should get a response within 3 business days (usually fewer):
https://www.myhealth.va.gov/mhv-portal-web/home?p_p_state=maximized&p_p_mode=view&saveLastPath=false&_58_struts_action=%2Flogin%2Flogin&p_p_id=58&p_p_lifecycle=0&_58_redirect=%2Fmhv-portal-web%2Fsecure-messaging

Urgent Care:
https://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTkwNjE3LjcwNTgxMTEmbWVzc2FnZWlkPU1EQi1QUkQtQlVMLTIwMTkwNjE3LjcwNTgxMTEmZGF0YWJhc2VpZD0xMDAxJnNlcmlhbD0xNjc3ODk2MCZlbWFpbGlkPWJvYkBub3J0aGVybndpbmRzODE1MDYuY29tJnVzZXJpZD1ib2JAbm9ydGhlcm53aW5kczgxNTA2LmNvbSZ0YXJnZXRpZD0mZmw9Jm12aWQ9JmV4dHJhPSYmJg==&&&104&&&https://www.va.gov/COMMUNITYCARE/programs/veterans/Urgent_Care.asp

VA Launches New Health Care Options under MISSION Act:
https://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTkwNjE3LjcwNTgxMTEmbWVzc2FnZWlkPU1EQi1QUkQtQlVMLTIwMTkwNjE3LjcwNTgxMTEmZGF0YWJhc2VpZD0xMDAxJnNlcmlhbD0xNjc3ODk2MCZlbWFpbGlkPWJvYkBub3J0aGVybndpbmRzODE1MDYuY29tJnVzZXJpZD1ib2JAbm9ydGhlcm53aW5kczgxNTA2LmNvbSZ0YXJnZXRpZD0mZmw9Jm12aWQ9JmV4dHJhPSYmJg==&&&105&&&https://www.blogs.va.gov/VAntage/61286/va-launches-new-health-care-options-mission-act/

Veteran Community Care: Eligibility:
https://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTkwNjE3LjcwNTgxMTEmbWVzc2FnZWlkPU1EQi1QUkQtQlVMLTIwMTkwNjE3LjcwNTgxMTEmZGF0YWJhc2VpZD0xMDAxJnNlcmlhbD0xNjc3ODk2MCZlbWFpbGlkPWJvYkBub3J0aGVybndpbmRzODE1MDYuY29tJnVzZXJpZD1ib2JAbm9ydGhlcm53aW5kczgxNTA2LmNvbSZ0YXJnZXRpZD0mZmw9Jm12aWQ9JmV4dHJhPSYmJg==&&&106&&&https://youtu.be/z9ac0FqO8To

MISSION Act:
https://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTkwNjE3LjcwNTgxMTEmbWVzc2FnZWlkPU1EQi1QUkQtQlVMLTIwMTkwNjE3LjcwNTgxMTEmZGF0YWJhc2VpZD0xMDAxJnNlcmlhbD0xNjc3ODk2MCZlbWFpbGlkPWJvYkBub3J0aGVybndpbmRzODE1MDYuY29tJnVzZXJpZD1ib2JAbm9ydGhlcm53aW5kczgxNTA2LmNvbSZ0YXJnZXRpZD0mZmw9Jm12aWQ9JmV4dHJhPSYmJg==&&&107&&&https://www.missionact.va.gov/

State Legislative Update:

Senate Passes Bills to Update to Medicaid Work Requirements

This week the Senate unanimously passed legislation to prevent Medicaid recipients from losing coverage due to any bureaucratic red-tape tangles from the state's new Medicaid work requirement. Senate Bills 362 and 363 sponsored by Sen. Curtis Hertel (D-East Lansing) and Senate Majority Leader Mike Shirkey (R-Clarklake) make it clear that that when it comes to meeting the work requirements, recipients are eligible for Medicaid "unless proven otherwise."

Under the work requirement legislation passed in 2018, most beneficiaries under the Healthy Michigan part

of Medicaid alone will have to prove they are working at least 80 hours per month. They can also be in a post-secondary education, high school equivalency or job training program; conducting volunteer or community service; participating in an internship; or undergoing substance abuse treatment.

Exemptions were carved out for those over age 63 or disabled, pregnant women, parents of a dependent child younger than six, full-time students, recipients of unemployment benefits and anyone younger than age 21 who had been in a foster care program.

The bills will enter students or those who are already working into a database so they would not need to call in monthly to verify their eligibility. As more people re-verify their eligibility and are working, more people would migrate over to the database. Other recipients would have the whole month to check in and verify their status from the previous month rather than the 10-day window provided in the current law.

Governor Announces Michigan Opioid Partnership

On Monday Michigan Governor Gretchen Whitmer announced recipients of grant funding through a newly created Michigan Opioid Partnership in an effort to decrease opioid overdoses and deaths.

"Our goal is to implement medication-assisted treatment programs in hospitals, emergencies rooms and jails to get more people on track to recovery," Whitmer said at an afternoon press conference at Wayne State University.

The partnership will give a combined $1.3 million in grant funding to Munson Medical Center in northern and lower Michigan and Beaumont Hospital in southeastern Michigan to increase medication-assisted treatments.

Additionally, $1.5 million has been committed to expanding medication-assisted treatment and enhance identification of substance use disorders at jail intake. Wayne State University, Center for Behavioral Health and Justice will receive a grant to coordinate the effort. County jails will also be selected for funding, to work in partnership with the WSU team to serve inmates with addiction.

Dr. Joneigh Khaldun, chief deputy director for Health and chief medical executive for DHHS, said outpatient treatment for addiction should be no different than treatment for other diseases, such as diabetes. She said the usual treatment for overdoses in the emergency room does not provide sufficient outpatient care.

"We watch them for a few hours, and you know what we do? We send them home," Khaldun said. "We send them home with the usual stack of difficult to understand discharge instructions. No medication, no treatment, no appointment to see someone who can help them."

The Michigan Opioid Partnership includes:

Michigan Department of Health and Human Services
Michigan Health Endowment Fund
Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield of Michigan Foundation
Ethel and James Flinn Foundation
The Jewish Fund
Superior Health Foundation
The Community Foundation for Southeast Michigan

Federal Update:

Bipartisan Bill Introduced to Train More Doctors to Combat Opioid Epidemic

U.S. Representatives Brad Schneider (D-IL), Susan W. Brooks (R-IN), Annie Kuster (D-NH), and Elise Stefanik (R-NY) introduced bipartisan legislation to train more doctors equipped to combat the opioid epidemic.

H.R. 2439, the Opioid Workforce Act of 2019, would create 1,000 additional residency positions over five years to hospitals with addiction medicine, addiction psychiatry, or pain management programs.

This legislation to expand graduate medical education (GME) aims to alleviate the worsening physician shortage, which is anticipated to be as high as 121,000 physicians by 2032 according to a study by the Association of American of Medical Colleges. This shortage is particularly acute in the field of addiction medicine and substance use disorder (SUD) treatment. This shortfall of doctors threatens to harm our efforts to reverse the opioid epidemic.

"Turning the tide on the opioid crisis requires treating addiction like the disease that it is, and to do that, we need doctors," said Schneider. "Our medical professionals on the frontlines of this epidemic are already stretched too thin. Our bipartisan legislation aims to educate more physicians equipped with the latest training in addiction medicine and psychiatry to help the estimated 20 million Americans who need substance use treatment get much needed care."

"In order to combat the devastating opioid, heroin and fentanyl epidemic that continues to plague communities across our country, a critically important piece of the puzzle is to ensure we have more trained professionals, particularly physicians, who can prevent and treat addiction and substance abuse disorder," said Brooks. "This bipartisan bill will help provide more residency positions to hospitals that have programs focused on addiction medicine, addiction psychiatry or pain management. The opioid crisis will not stop taking innocent lives overnight, but without more trained doctors ready to help people who are struggling because of substance abuse, drug and opioid related overdose deaths will continue to claim more lives in Indiana and beyond."

"The opioid epidemic is impacting communities across New Hampshire and the country," said Kuster. "We know that to address this crisis we must bolster the capacity to treat individuals with substance use disorder and our bill will increase the number of physicians who can take on this challenge. The opioid epidemic requires an all-hands-on-deck response and our legislation will help to step up efforts on the frontlines to get individuals the help they need."

"Every single person knows of a family that has been devastated by the opioid crisis, and deaths related to overdoses have outpaced car accidents as the number one killer of young people," said Stefanik. "The number of health care professionals focused on the treatment and prevention of opioid abuse directly translates to the number of people who can be saved. In my district, so many families are suffering due to the wide-spread impact of this public health crisis, which is why I'm co-leading this bipartisan and life-saving bill."

The Opioid Workforce Act is endorsed by the Association of American Medical Colleges, the Greater New York Hospital Association, the American Hospital Association, American Society of Addiction Medicine, American College of Academic Addiction Medicine, and Indiana University.

The text of H.R. 2439 is available online.

Sen. Warren, Rep. Kennedy Reintroduce Bill to Strengthen Parity

Earlier this week, Senator Elizabeth Warren (D-MA) and Representative Joe Kennedy III (D-MA) reintroduced the Behavioral Health Coverage Transparency Act (H.R. 2874/S. 1576) with the aim of strengthening Americans' access to mental health and substance use disorder (SUD) treatment. Specifically, the bill would increase oversight and enforcement of the federal parity law, which requires that insurance coverage of mental health and SUD services be equal to the coverage of medical and surgical health services.

BACKGROUND

The Mental Health Parity and Addiction Equity Act of 2008 established parity between the coverage of behavioral health and medical/surgical benefits. While the law has led to gains in behavioral health coverage, many individuals and families continue to report being denied or charged more for necessary mental health and SUD treatments by their health care plan. A survey by the National Alliance on Mental Illness (NAMI) found that respondents experienced a rate of denials for mental health care that was nearly twice the rate of denials for general medical care. The bill's reintroduction also comes on the heels of a federal judge's ruling that found that the nation's largest insurer, UnitedHealth, unlawfully denied beneficiaries access to mental health and SUD treatment in an effort to cut costs.

BILL SUMMARY

The Behavioral Health Coverage Transparency Act (H.R. 2874/S. 1576) would require insurance providers to disclose the analysis they utilize in making parity determinations as well as the rates and reasons for mental health/SUD claims denials versus medical/surgical denials. It also would require the Department of Health & Human Services, the Department of Labor and the Department of Treasury to undertake a minimum of 12 random audits of health plans per year to discourage noncompliance with existing parity laws. The results of the audits would be made public. Finally, it would establish a Consumer Parity Unit, giving individuals a centralized online clearinghouse to get information about their rights and to submit complaints with assurance of timely responses.

"Patients with behavioral health concerns deserve the same access to care as patients with physical health conditions, but for far too long, insurance companies have unfairly denied behavioral health care services to cut costs," said Senator Warren in a statement. "Our bill would put a stop to these discriminatory practices and make sure patients get the treatment they need."

REACTION FROM THE FIELD

The bill has received widespread support from mental health and addiction advocacy organizations, including the National Council for Behavioral Health and Massachusetts behavioral health provider association, the Association for Behavioral Healthcare (ABH). Vic DiGravio, President and CEO of ABH explained why his organization supports the legislation saying, "As providers of behavioral health services, our members see first-hand the difficulty their clients face in accessing timely treatment because of insurance barriers. Our members frequently note that these barriers are in sharp contrast to when their clients are seeking physical health care. Senator Warren and Congressman Kennedy are right to fight to strengthen parity laws. Behavioral health care must be made as accessible as physical health care."

The National Council echoed support for the bill as part of the Mental Health Liaison Group (MHLG), a nonpartisan, nationwide coalition of mental health and addiction advocacy organizations, in this letter sent to bill sponsors.

Education Opportunities:

Required for Licensure Renewal: Ethics for Social Work & Substance Use Disorder Professionals & Psychologists Trainings

Community Mental Health Association of Michigan is pleased to offer 6 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.

Trainings offered on the following date.

July 17, 2019 – Lansing **Click Here to Register!**
August 21, 2019 – Lansing **Click Here to Register!**

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

$115 CMHA Members
$138 Non-Members

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

Join us for the Employment First Conference! Hear from national homegrown experts about how Michigan can ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Dates: July 31 & August 1, 2019
Location: Suburban Collection Showplace, Novi
Who Should Attend: Staff who are involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership
- CRO Leadership

Registration Fee: $50 (registration open soon)

Click here for more information and to register!

Sponsored by the Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

11th Annual Anti-Stigma Event Day – July 25, 2019 at LCC Downtown

The 11th Annual Anti-Stigma Event Day will be held Thursday, July 25, 2019 at the Lansing Community College - Downtown Lansing Campus in the Gannon Building. The event will be held from 9:00am to 4:00pm. Do you have anti-stigma initiatives at your CMHSP? Please contact Colleen Jasper jasperc@michigan.gov or 517-373-1255 to present your anti-stigma program. Or just come, and we will have time for CMHSPs initiative updates that very day. Registration is open online at https://cmham.org/events/?EventId=5302

Dialectical Behavior Therapy (DBT) Trainings for 2018/2019

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.

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

Dates/Locations:
August 12-16, 2019 | Great Wolf Lodge, Traverse City | REGISTER HERE

Co-Occurring College Registration Now Open!

Registration is now open for the 2019 Co-Occurring College! Click HERE for all the details, CE information and registration link.

The Michigan Department of Health and Human Services & the Community Mental Health Association of Michigan are pleased to host a statewide conference focusing on people who have substance use disorders as well as mental health disorders. These individuals are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis. This unique training opportunity will focus on program development, implementation, sustainability, and impact.

Date: Tuesday, July 30, 2019
Times: Registration check-in begins at 8:00am | Education will run from 9:00am-4:15pm
Location: DoubleTree by Hilton Hotel Bay City - Riverfront (1 Wenonah Park Place, Bay City, MI 48708)
Training Fee: $125 per person. The fee includes training materials, breakfast and lunch.

Hotel Reservations:
To make your overnight reservations at the discounted State rate, call 989-891-6000 and mention the Community Mental Health Association of Michigan to receive a $85/ + tax per night rate. Parking is complimentary. **Deadline for discounted hotel rate: July 8, 2019**.

Individualized Service Plans Using the ASAM Criteria and Motivational Interviewing Trainings

- July 16-17, 2019 – Best Western/Okemos Conference Center, Okemos
- August 13-14, 2019 – Hilton Garden Inn, Detroit
- August 27-28, 2019 – Radisson Plaza Hotel, Kalamazoo
- September 24-25, 2019 – Great Wolf Lodge, Traverse City

Visit www.cmham.org for more information.

20th Annual Substance Use Disorder and Co-Occurring Disorder Conference Save-the-Date!

"Innovative Strategies for Today's Challenges"
Pre-Conference Workshops: September 15, 2019
Full Conference: September 16-17, 2019
Cobo Center, Detroit, MI

More information including hotel reservations and registration links coming soon!

45th Annual National Association for Rural Mental Health Conference

August 26-29, 2019
45th Annual National Association for Rural Mental Health Conference
La Fonda on the Plaza Hotel
Santa Fe, New Mexico

The National Association for Rural Mental Health (NARMH) invites you to attend the 2019 NARMH Annual Conference. Registration is now open and you can register online at www.narmh.org.

About Our Conference: The National Association for Rural Mental Health (NARMH) Annual Conference is the premier interdisciplinary mental health event for rural families and peers, community members, clinicians, researchers, administrators and policy professionals. Now in its 45th year, the NARMH Annual Conference provides a collaborative environment for all participants across professions to learn and network on a myriad of vital issues concerning mental health practice, research, policy and advocacy in rural and remote populations.

Our Conference Theme: The 2019 NARMH Annual Conference theme is "From Surviving to Thriving: Embracing Connections". NARMH "rode the winds of change" in Santa Fe in 2002, and now we return in 2019 to see what we have learned, what has changed, and where we are headed. We want to learn from communities who have gone from surviving to thriving and how that impact is maintained and enhanced. We want to get to know each other and have fun together.

There are over 60 breakout sessions with topics focusing on the following areas: Surviving to Thriving, Workforce Issues, Innovations in Service Delivery, Dilemmas in Addressing Trauma, Rural and Frontier Workforce Development Strategies, Embracing the Reality of Behavioral Health in Rural Communities – Struggles, Responses and Successes, Co-Occurring Substance Use Disorders and Other Topics. The plenary sessions include: 1) The Path to Thriving: Strategic Doing and Rural Mental Health; 2) From Surviving to Thriving in American Indian Communities: Transcending Historical Trauma; 3) Introducing the MHTTC- A New Workforce Development Resource; and 4) The Very Large Array of Youth and Adult Peer Support. The conference also features a Reception with Flamenco Dancing as well as a NARMH Night at the Movies showing the film: The Providers.

There is no better place to do that than the City Different, Santa Fe, New Mexico. Bienvenidos! Visit the NARMH website at www.narmh.org to explore the details of the 2019 NARMH Annual Conference. We look forward to seeing you in Santa Fe!

Questions & General Information: If you need additional information after visiting the NARMH 2019 conference website at www.narmh.org, please contact Brenton Rice, NARMH Event Planner, by email at brenton@togevents.com or by phone at 651.242.6589.

CRA Announces 2nd Annual Crisis Residential Conference Registration

Registration is now open for the 2nd **Annual Crisis Residential Conference**, October 3rd & 4th in Grand Rapids, MI!

Hosted by the Crisis Residential Association, this conference is open to providers, payers, and advocates for residential alternatives to psychiatric hospitalization for youth and adults.

Plenary Speakers include:
Dr. Debra Pinals, MD,
Medical Director of Behavioral Health and Forensic Programs
Michigan Department of Health & Human Services

Marilyn Kresky-Wolff, MSW, MPH
Executive Director (Retired)
Open Arms Housing, Inc., Washington, D.C.

Dr. William Beecroft, MD
Medical Director of Behavioral Health
Blue Cross Blue Shield of Michigan

- Register at https://www.crisisresidentialnetwork.com/2019-cra-conference.html. Discounts available for CRA members.

- Our Call for Presentations has been extended! Interested presenters can submit their workshop proposals https://tinyurl.com/CrisisResConCFP.

- Sponsorship opportunities are also available! Visit the CRA website to learn more.

About CRA

The Crisis Residential Association exists to support the operational and clinical functions of Crisis Residential programs around the world. Founded in 2018 and rooted in the values of empathy, recovery, and continuous improvement, the association seeks to connect providers with the best ideas in behavioral health treatment to transform the way people receive mental health care. Learn more at www.crisisresidentialnetwork.com.

CMH Association of Michigan and the National Council Announce Michigan Practice Transformation Academy: Request for Applications

Background: While the term "value-based payment" is ubiquitous in today's health care industry, it leaves many of us wondering: What is it, and what does this mean for the public behavioral health system? Value-based payment (VBP) arrangements are those that move from fee-for-service arrangements to those that foster client/patient and population health outcomes. These VBP arrangements use a range of payment approaches, including pay-for-performance, case-rates, and capitated payments, with varying degrees of risk, from no-risk to up and downside risk. We know this is the wave of the future, and fragmented systems will soon become obsolete. Payers and providers need to know: What steps should we take - in our communities - to get ready?

The CMH Association and the National Council for Behavioral Health are proud to announce a **Michigan-specific Practice Transformation Academy (PTA) for interested CMHA members and Associate members.** This Academy runs from August 2019 through July 2020. All of the dates are listed later in this Request for Applications (RFA). ***Applications are due June 28, 2019****. Application instructions are provided later in this RFA.*

The Practice Transformation Academy will train and coach teams of payers and providers to develop the competencies needed to deliver value-based care and prepare for alternative payment arrangements. As the PTA progresses, **teams will be developing their own strategies for transitioning to value-based payment and will emerge from the Academy with a concrete, realistic plan for how to get there.**

With a faculty of national and local experts in health care finance and contracting, quality improvement, and both payer and provider value-based payment methodologies, the Practice Transformation Academy aims to provide organizations with the tools they need to bring population health management into their organization and prepare for payments and services more closely associated with health care outcomes. The curriculum provides simultaneous attention to quality and cost, allowing organizations to respond to system changes associated with value-based payment arrangements or quality-based contracts with managed care organizations.

The Michigan Practice Transformation Academy curriculum and delivery model is tailored to payer-provider teams. [Please note: For the purpose of this Academy, "providers" are public and private organizations that directly provide services within a PIHP/CMHSP network. "Payers" are defined as PIHPs and CMHSPs who contract with providers along any of segments of spectrum of service and support modalities.] Taking into consideration the unique needs of their communities, these teams will develop and work on goals together throughout the course of the Academy, developing a shared understanding of how to bring a value-based approach into their organizations.

The Michigan Practice Transformation Academy Request for Applications (RFA) and application can be found on the Community Mental health Association's website at:

Michigan Practice Transformation Academy Request for Applications (RFA): https://cmham.org/wp-content/uploads/2019/06/Michigan-Practice-Transformation-Academy-RFA-V4.pdf

Michigan Practice Transformation Academy Application: https://cmham.org/resources/important-information/ Go to the 2nd listed document entitled "Michigan Practice Transformation Academy Application" to open the application as a Word Document. Click on this document and select "Open" from the choices given. If required to "Allow" access to the document, select "Allow". This will allow you to complete the application as outlined in the Request for Applications.

Miscellaneous News and Information:

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

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
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June 21, 2019

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CMH Association and Member Activities:

Leadership Change at Northeast CMH

Northeast Michigan Community Mental Health recently announced the retirement of its Director, Cathy S. Meske, effective June 30, 2019. Nena Sork has been appointed to the Director position to succeed Cathy effective July 1, 2019. Nena has been with the Agency since December 2008. She has had a thirty-two year career in the mental health field. Nena has a Bachelors of Arts in Social Work from Anderson College in Anderson Indiana (1986) and a Masters of Social Work from Grand Valley State University in Allendale Michigan (1990).

We wish Cathy the best in the next phase of her life and welcome Nena to her new role.

Don't Forget About the 2019 PAC Campaign

Earlier this year we announced our 2019 CMH PAC campaign. We must increase our participation, last year we only had 15 boards participate in our PAC campaign. Please take some time over the next couple of board meetings to encourage your board and staff to participate in our 2019 PAC efforts. As you know, our CMH PAC is a key component to our overall advocacy efforts – the need to upgrade our PAC is greater today than ever before.

For those members who qualify for the drawing for the Tiger game suite (minimum 6 contributions per agency), this year's game is on Sunday, July 21 at 1:10pm vs. Toronto Blue Jays. Members should forward the results of their campaign and donations **to the CMHA office by June 28, 2019** in order to be in the drawing for the Tiger tickets if eligible.

Make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please). Thank you. Please feel free to contact Bob or Alan with any questions.

CMHA Committee Schedules, Membership, Minutes, and Information

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

News from Our Preferred Corporate Partners:

Relias: Our Training Platform Manages and Tracks Regulatory Compliance so You Don't Have To

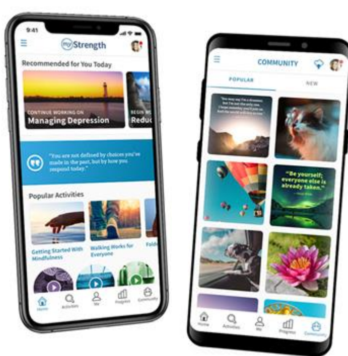
When new mandates come down around staff training and licensure, do you break into a sweat thinking about maintaining compliance?

With more contracts than ever to manage and a high-need population to serve, the last thing you need is to find and implement training to keep your staff compliant with new mandates. Delivering and reporting on necessary training often interferes with time that could be spent with clients or on other tasks, adding yet another layer of complexity.

Relias helps you serve your population by ensuring that our courses are aligned to current regulations – and automating the reporting process so that you can focus on what matters

Learn More

myStrength Offers In-the-Moment Support for Comorbid Medical-Behavioral Conditions



Behavioral health conditions are disabling on their own, but they also complicate clinical improvement for the large percentage of people experiencing chronic medical conditions alongside comorbid behavioral health symptoms. For example, it is very challenging to stabilize diabetes or hypertension until depression or anxiety symptoms are successfully managed.

myStrength's digital behavioral health platform is available whenever and wherever a consumer needs, with a consistent, personalized user experience across web and mobile devices.

myStrength's mobile app promotes more frequent engagement by consumers, and use of these evidence-based tools (grounded in mindfulness, cognitive behavioral therapy, and more) helps facilitate long-term health benefits.
In addition to various pathways to access myStrength, the platform also offers immediate access to diverse tools for depression, anxiety, stress, meditation and mindfulness, sleep, pregnancy and early parenting, balancing intense emotions, and chronic pain, as well as tools for drug, opioid or alcohol recovery.

myStrength's Mobile App Offers Real-Time Support:

- Instantly unwind with 3 short audio activities presented when app is opened
- Bookmark helpful resources for quick access when real-time support is critical
- Gain personalized, integrated support for multiple conditions
- Favorite or download inspirational images in the Community for instant access

REQUEST A DEMO

State and National Developments and Resources:

MDHHS Announces Delay of Section 298 Pilot Implementation

Below are excerpts from a recent press release regarding changes in the implementation date for the Section 298 pilots.

> The Michigan Department of Health and Human Services (MDHHS) and Section 298 pilot participants are delaying implementation of the Section 298 Initiative until Oct. 1, 2020 in order to complete design of the financial integration pilot model.
>
> The initiative is a statewide effort to improve the integration of physical health services and specialty behavioral health services in Michigan. It is based upon Section 298 in Public Act 268 of 2016. The Michigan legislature approved a revised version of Section 298 as part of Public Act 207 of 2018.
>
> As part of the initiative, the Michigan legislature directed MDHHS to implement up to three pilots to test the financial integration of Medicaid-funded physical health and specialty behavioral health services.
>
> Progress has been made on the initiative, including developing a proposed care management workflow; identifying an approach to key public policy needs; and defining key data sharing requirements critical to whole-person care. However, further work is still needed to reach agreements on risk-management and ownership of the specialty behavioral health provider network; utilization management, claims processing and other managed care responsibilities; and rates and payment structures.
>
> Following resolution of these items, time will be needed to secure federal Centers for Medicare & Medicaid Services waiver approval, establish new contracts, finalize technology and reporting changes, establish new payment flows and potentially create new legal structures and undergo accreditation reviews. An Oct. 1, 2019 agreement on outstanding elements and design of the integrated model is being targeted to allow time for these implementation activities.
>
> Due to this decision, the proposed renewal applications for Children's Waiver Program, Habilitation Supports Waiver and Waiver for Children with Serious Emotional Disturbances have been revised to reflect that waiver changes regarding the 298 site implementation initiative will not be submitted to CMS at this time. The revised waivers will be posted on June 14 and public comments will be accepted until July 15.
>
> For more information about the initiative, visit https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_76181---,00.html

MAC news story: Pressure is on Mental Health System; Counties are in Best Position to Lead Reforms

Below are excerpts from a recent edition of Michigan Counties, the Michigan Association of Counties newsletter, regarding MAC's view of some of the issues facing Michigan's county-based public mental health system

> LEGISLATIVEUPDATE: Increasing strains on Michigan's treatment systems for mental illness have led leaders in the Legislature and executive branch to elevate mental health treatment to a priority for state attention. However, reform efforts have collided with Michigan's recent history, in which the entire mental health system was badly underfunded and previous reform efforts have prompted unintended, unwanted and unresolved consequences.
>
> With so many items in need of additional general funds — especially state priorities like roads and schools — it's difficult to see how legislators will pursue any major mental health reforms that rely on state dollars. The question for county leaders at this moment is: Are there opportunities to improve our system and use Medicaid managed care to local advantage?
>
> Counties are best suited to preserve local roles of the community mental health infrastructure, while exploring opportunities where different types of providers may benefit the system and ultimately create a better mental health funding model that ensures the best services for our residents.

The full article can be found at: https://micounties.org/wp-content/uploads/June-2019-Michigan-Counties-2.pdf

California Tests a Digital 'Fire Alarm' for Mental Distress

Below are excerpts from a recent media story on the promise and concerns raised by a "digital mental health fire alarm" system being piloted in several California communities.

> The state is teaming up with Silicon Valley to make mental health services more available. Promises abound, and so do potential problems.
>
> Last winter, several dozen people who were struggling with suicidal urges and bouts of intense emotion opened their lives to a company called Mindstrong, in what has become a closely watched experiment in Silicon Valley.
>
> Mindstrong, a venture co-founded by a former director of the National Institute of Mental Health, promised something that no drug or talk therapy can provide: an early-warning system that would flag the user when an emotional crisis seemed imminent — a personal, digital "fire alarm."
>
> For the past year, California state and county mental health officials, along with patient representatives, have met regularly with Mindstrong and another company, 7 Cups, to test smartphone apps for people receiving care through the state's public mental health system. Officials from 13 counties and two cities are involved, and the apps are already available to the public.
>
> The new users, most of whom have a diagnosis of borderline personality disorder, receive treatment through the Los Angeles County mental health network, and were among the first test
>
> The potential for digital technology to transform mental health care is enormous, and some 10,000 apps now crowd the market, each promising to soothe one psychological symptom or another. Smartphones allow near continuous monitoring of people with diagnoses such as depression, anxiety and schizophrenia, disorders for which few new treatments are available. But there has been little research to demonstrate whether such digital supports are effective.
>
> California's collaboration with Silicon Valley is an attempt to change that: in effect, enlisting some of the state's most privileged residents to help some of its least. California has set aside taxpayer money to pull it off, more than $100 million over five years, which is a portion of Proposition 30, a

tax increase on millionaires approved in 2012. If Big Data can help manage persistent mental distress, the path forward is likely to run through the Golden State.

But if early signs are any indication, the road will be slow and winding, pitted with questions about effectiveness, privacy and user appeal. At least for now, California's effort to jump-start medicine's digital future is running into some of the same issues that have dogged old-fashioned drug trials: recruiting problems, questions about informed consent, and the reality that, no matter the treatment, some people won't "tolerate" it well, and quit.

The full article can be found at: https://www.nytimes.com/2019/06/17/health/mindstrong-mental-health-app.html?smid=nytcore-ios-share

National Association for Rural Mental Health Announces Conference and Range of Resources

Below are excerpts of a recent announcement from David Weden, the President-Elect of the National Association for Rural Mental Health (NARMH)

I wanted to be sure that you were aware that registration for the 45th Annual NARMH Conference will be held in Santa Fe, New Mexico, August 26 through 29 is open and that the reduced rate for conference registration is good through July 29. Additional details regarding the conference may be found at http://www.togpartners.com/narmh/2019/default.aspx Hope to see you in Santa Fe. You are a vital link in our success in promoting the voice of rural mental health.

In addition, following is an update of some of the NARMH activities and efforts.

NARMH is a membership organization focused on raising awareness of and responding to a variety of rural mental health and social service concerns. Through your NARMH membership, your voice is linked with others to promote rural mental health issues at the federal, state and county levels. For more information on membership levels, please visit http://narmh.org/membership.html

ADVOCACY: Within the past year, NARMH has participated in and helped sponsor Congressional Briefings on topics such as:

- Is Treating Depression the Answer to Solving the Opioid Crisis?
- Preventing Suicide in Older Adults

Medicaid, the Affordable Care Act and Impact of Repeal Efforts on Individuals with Intellectual and Developmental Disabilities

In addition, NARMH is a member of the Mental Health Liaison Group- a coalition of more than 60 national organizations representing consumers, family members, mental health and addiction providers, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and addiction care.

PUBLICATIONS: The *Journal of Rural Mental Health* is the official journal of NARMH. It publishes peer-reviewed articles on rural mental health research, practice, and policy within the United States and internationally. Focused on issues of special interest to those living and working in rural areas, the journal welcomes research on such topics as barriers to improving or accessing care in rural environments, issues faced by underserved populations, and disparities in mental health care. Discussion of policy implications, community-level issues, and multidisciplinary considerations is encouraged as is exploration of evidence-based practices, cultural factors, and ethical and regulatory considerations. Paid members of NARMH receive free access to the online version of the *Journal of Rural Mental Health* which is published by the Journals

Program of the American Psychological Association. If you are interested in submitting an article for the journal, please visit the General Call for Papers at https://www.apa.org/pubs/journals/rmh/call-for-papers-general

In addition, members also receive the monthly newsletter from NARMH and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) as well as a monthly *Under the Microscope*, which provides a policy analysis of a current issue, and *Headline DC*, which provides updates on major developments in the Nation's Capital.

ANNUAL CONFERENCE: One of the highlights for NARMH each year is the National Conference. The 45th Annual NARMH Conference, *From Surviving to Thriving: Embracing Connections*, will be held from August 26 to 29 in Santa Fe, New Mexico at the La Fonda on the Plaza. The conference includes over 60 break-out sessions and four plenary sessions. Registration is now open at http://www.togpartners.com/narmh/2019/2019registration.aspx.

In addition to other benefits, individuals with a current membership receive a discount on conference registration Make plans now to come and make connections with others interested in rural mental health, and embrace the connections to help advance our system from surviving to thriving.

Let your voice be linked with others in promoting rural mental health. Renew your NARMH membership and make plans to attend the annual conference. Joining together we brighten the spotlight on the importance of rural mental health and the resources that are needed.

State Legislative Update:

Senate Passes Bills to Update to Medicaid Work Requirements

This week the Senate unanimously passed legislation to prevent Medicaid recipients from losing coverage due to any bureaucratic red-tape tangles from the state's new Medicaid work requirement. Senate Bills 362 and 363 sponsored by Sen. Curtis Hertel (D-East Lansing) and Senate Majority Leader Mike Shirkey (R-Clarklake) make it clear that that when it comes to meeting the work requirements, recipients are eligible for Medicaid "unless proven otherwise."

Under the work requirement legislation passed in 2018, most beneficiaries under the Healthy Michigan part of Medicaid alone will have to prove they are working at least 80 hours per month. They can also be in a post-secondary education, high school equivalency or job training program; conducting volunteer or community service; participating in an internship; or undergoing substance abuse treatment.

Exemptions were carved out for those over age 63 or disabled, pregnant women, parents of a dependent child younger than six, full-time students, recipients of unemployment benefits and anyone younger than age 21 who had been in a foster care program.

The bills will enter students or those who are already working into a database so they would not need to call in monthly to verify their eligibility. As more people re-verify their eligibility and are working, more people would migrate over to the database. Other recipients would have the whole month to check in and verify their status from the previous month rather than the 10-day window provided in the current law.

Governor Announces Michigan Opioid Partnership

On Monday Michigan Governor Gretchen Whitmer announced recipients of grant funding through a newly created Michigan Opioid Partnership in an effort to decrease opioid overdoses and deaths.

"Our goal is to implement medication-assisted treatment programs in hospitals, emergencies rooms and jails to get more people on track to recovery," Whitmer said at an afternoon press conference at Wayne State University.

The partnership will give a combined $1.3 million in grant funding to Munson Medical Center in northern and lower Michigan and Beaumont Hospital in southeastern Michigan to increase medication-assisted treatments.

Additionally, $1.5 million has been committed to expanding medication-assisted treatment and enhance identification of substance use disorders at jail intake. Wayne State University, Center for Behavioral Health and Justice will receive a grant to coordinate the effort. County jails will also be selected for funding, to work in partnership with the WSU team to serve inmates with addiction.

Dr. Joneigh Khaldun, chief deputy director for Health and chief medical executive for DHHS, said outpatient treatment for addiction should be no different than treatment for other diseases, such as diabetes. She said the usual treatment for overdoses in the emergency room does not provide sufficient outpatient care.

"We watch them for a few hours, and you know what we do? We send them home," Khaldun said. "We send them home with the usual stack of difficult to understand discharge instructions. No medication, no treatment, no appointment to see someone who can help them."

The Michigan Opioid Partnership includes:

Michigan Department of Health and Human Services
Michigan Health Endowment Fund
Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield of Michigan Foundation
Ethel and James Flinn Foundation
The Jewish Fund
Superior Health Foundation
The Community Foundation for Southeast Michigan

Federal Update:

Bipartisan Bill Introduced to Train More Doctors to Combat Opioid Epidemic

U.S. Representatives Brad Schneider (D-IL), Susan W. Brooks (R-IN), Annie Kuster (D-NH), and Elise Stefanik (R-NY) introduced bipartisan legislation to train more doctors equipped to combat the opioid epidemic.

H.R. 2439, the Opioid Workforce Act of 2019, would create 1,000 additional residency positions over five years to hospitals with addiction medicine, addiction psychiatry, or pain management programs.

This legislation to expand graduate medical education (GME) aims to alleviate the worsening physician shortage, which is anticipated to be as high as 121,000 physicians by 2032 according to a study by the

Association of American of Medical Colleges. This shortage is particularly acute in the field of addiction medicine and substance use disorder (SUD) treatment. This shortfall of doctors threatens to harm our efforts to reverse the opioid epidemic.

“Turning the tide on the opioid crisis requires treating addiction like the disease that it is, and to do that, we need doctors,” said Schneider. “Our medical professionals on the frontlines of this epidemic are already stretched too thin. Our bipartisan legislation aims to educate more physicians equipped with the latest training in addiction medicine and psychiatry to help the estimated 20 million Americans who need substance use treatment get much needed care.”

“In order to combat the devastating opioid, heroin and fentanyl epidemic that continues to plague communities across our country, a critically important piece of the puzzle is to ensure we have more trained professionals, particularly physicians, who can prevent and treat addiction and substance abuse disorder,” said Brooks. “This bipartisan bill will help provide more residency positions to hospitals that have programs focused on addiction medicine, addiction psychiatry or pain management. The opioid crisis will not stop taking innocent lives overnight, but without more trained doctors ready to help people who are struggling because of substance abuse, drug and opioid related overdose deaths will continue to claim more lives in Indiana and beyond.”

“The opioid epidemic is impacting communities across New Hampshire and the country**,”** said Kuster. “We know that to address this crisis we must bolster the capacity to treat individuals with substance use disorder and our bill will increase the number of physicians who can take on this challenge. The opioid epidemic requires an all-hands-on-deck response and our legislation will help to step up efforts on the frontlines to get individuals the help they need.”

“Every single person knows of a family that has been devastated by the opioid crisis, and deaths related to overdoses have outpaced car accidents as the number one killer of young people,” said Stefanik. “The number of health care professionals focused on the treatment and prevention of opioid abuse directly translates to the number of people who can be saved. In my district, so many families are suffering due to the wide-spread impact of this public health crisis, which is why I’m co-leading this bipartisan and life-saving bill.”

The Opioid Workforce Act is endorsed by the Association of American Medical Colleges, the Greater New York Hospital Association, the American Hospital Association, American Society of Addiction Medicine, American College of Academic Addiction Medicine, and Indiana University.

The text of H.R. 2439 is available online.

Sen. Warren, Rep. Kennedy Reintroduce Bill to Strengthen Parity

Earlier this week, Senator Elizabeth Warren (D-MA) and Representative Joe Kennedy III (D-MA) reintroduced the Behavioral Health Coverage Transparency Act (H.R. 2874/S. 1576) with the aim of strengthening Americans’ access to mental health and substance use disorder (SUD) treatment. Specifically, the bill would increase oversight and enforcement of the federal parity law, which requires that insurance coverage of mental health and SUD services be equal to the coverage of medical and surgical health services.

BACKGROUND

The Mental Health Parity and Addiction Equity Act of 2008 established parity between the coverage of behavioral health and medical/surgical benefits. While the law has led to gains in behavioral health coverage, many individuals and families continue to report being denied or charged more for necessary mental health

and SUD treatments by their health care plan. A survey by the National Alliance on Mental Illness (NAMI) found that respondents experienced a rate of denials for mental health care that was nearly twice the rate of denials for general medical care. The bill's reintroduction also comes on the heels of a federal judge's ruling that found that the nation's largest insurer, UnitedHealth, unlawfully denied beneficiaries access to mental health and SUD treatment in an effort to cut costs.

BILL SUMMARY

The Behavioral Health Coverage Transparency Act (H.R. 2874/S. 1576) would require insurance providers to disclose the analysis they utilize in making parity determinations as well as the rates and reasons for mental health/SUD claims denials versus medical/surgical denials. It also would require the Department of Health & Human Services, the Department of Labor and the Department of Treasury to undertake a minimum of 12 random audits of health plans per year to discourage noncompliance with existing parity laws. The results of the audits would be made public. Finally, it would establish a Consumer Parity Unit, giving individuals a centralized online clearinghouse to get information about their rights and to submit complaints with assurance of timely responses.

"Patients with behavioral health concerns deserve the same access to care as patients with physical health conditions, but for far too long, insurance companies have unfairly denied behavioral health care services to cut costs," said Senator Warren in a statement. "Our bill would put a stop to these discriminatory practices and make sure patients get the treatment they need."

REACTION FROM THE FIELD

The bill has received widespread support from mental health and addiction advocacy organizations, including the National Council for Behavioral Health and Massachusetts behavioral health provider association, the Association for Behavioral Healthcare (ABH). Vic DiGravio, President and CEO of ABH explained why his organization supports the legislation saying, "As providers of behavioral health services, our members see first-hand the difficulty their clients face in accessing timely treatment because of insurance barriers. Our members frequently note that these barriers are in sharp contrast to when their clients are seeking physical health care. Senator Warren and Congressman Kennedy are right to fight to strengthen parity laws. Behavioral health care must be made as accessible as physical health care."

The National Council echoed support for the bill as part of the Mental Health Liaison Group (MHLG), a nonpartisan, nationwide coalition of mental health and addiction advocacy organizations, in this letter sent to bill sponsors.

Education Opportunities:

Required for Licensure Renewal: Ethics for Social Work & Substance Use Disorder Professionals & Psychologists Trainings

Community Mental Health Association of Michigan is pleased to offer 6 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.

Trainings offered on the following date.

July 17, 2019 – Lansing **Click Here to Register!**
August 21, 2019 – Lansing **Click Here to Register!**

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

$115 CMHA Members
$138 Non-Members

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Dates: July 31 & August 1, 2019
Location: Suburban Collection Showplace, Novi
Who Should Attend: Staff who's involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership
- CRO Leadership

Registration Fee: $50 (registration open soon)

Watch www.cmham.org for conference details and registration! Sponsored by the Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Free Webinar: Tobacco Free Policies and Interventions in Behavioral Health Care Settings

The Smoking Cessation Leadership Center (SCLC) invites you to join us for this webinar, "***Tobacco Free Policies and Interventions in Behavioral Health Care Settings***" on **Tuesday, June 18, 2019, at 2:00 pm EDT** (90 minutes). We are honored to have the following speakers presenting on this important and timely topic:

- **Chad D Morris, PhD,** Professor of Psychiatry, University of Colorado
- **Timothy Stacey, LPC-S,** Integrated Care Systems Program Manager, Integral Care

Webinar Objectives:

- Identify proven steps toward bringing your agency tobacco free
- Discuss how to effectively enforce a tobacco free grounds policy
- Describe how to implement tobacco cessation interventions into clinical practice.
- Identify and overcome common barriers experienced during tobacco free policy implementation

REGISTER HERE: **https://cc.readytalk.com/r/aahucxsi8hjk&eom**

11th Annual Anti-Stigma Event Day – July 25, 2019 at LCC Downtown

The 11th Annual Anti-Stigma Event Day will be held Thursday, July 25, 2019 at the Lansing Community College - Downtown Lansing Campus in the Gannon Building. The event will be held from 9:00am to 4:00pm. Do you have anti-stigma initiatives at your CMHSP? Please contact Colleen Jasper jasperc@michigan.gov or 517-373-1255 to present your anti-stigma program. Or just come, and we will have time for CMHSPs initiative updates that very day. Registration is open online at https://cmham.org/events/?EventId=5302

Dialectical Behavior Therapy (DBT) Trainings for 2018/2019

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.

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

Dates/Locations:
August 12-16, 2019 | Great Wolf Lodge, Traverse City | REGISTER HERE

Co-Occurring College Registration Now Open!

Registration is now open for the 2019 Co-Occurring College! Click HERE for all the details, CE information and registration link.

The Michigan Department of Health and Human Services & the Community Mental Health Association of Michigan are pleased to host a statewide conference focusing on people who have substance use disorders as well as mental health disorders. These individuals are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis. This unique training opportunity will focus on program development, implementation, sustainability, and impact.

Date: Tuesday, July 30, 2019
Times: Registration check-in begins at 8:00am | Education will run from 9:00am-4:15pm
Location: DoubleTree by Hilton Hotel Bay City - Riverfront (1 Wenonah Park Place, Bay City, MI 48708)
Training Fee: $125 per person. The fee includes training materials, breakfast and lunch.

Hotel Reservations:
To make your overnight reservations at the discounted State rate, call 989-891-6000 and mention the Community Mental Health Association of Michigan to receive a $85/ + tax per night rate. Parking is complimentary. **Deadline for discounted hotel rate: July 8, 2019**.

Individualized Service Plans Using the ASAM Criteria and Motivational Interviewing Trainings

- June 18-19, 2019 – Holiday Inn, Marquette
- July 16-17, 2019 – Best Western/Okemos Conference Center, Okemos
- August 13-14, 2019 – Hilton Garden Inn, Detroit
- August 27-28, 2019 – Radisson Plaza Hotel, Kalamazoo
- September 24-25, 2019 – Great Wolf Lodge, Traverse City

Visit www.cmham.org for more information.

20th Annual Substance Use Disorder and Co-Occurring Disorder Conference Save-the-Date!

"Innovative Strategies for Today's Challenges"
Pre-Conference Workshops: September 15, 2019
Full Conference: September 16-17, 2019
Cobo Center, Detroit, MI

More information including hotel reservations and registration links coming soon!

45th Annual National Association for Rural Mental Health Conference

August 26-29, 2019
45th Annual National Association for Rural Mental Health Conference
La Fonda on the Plaza Hotel
Santa Fe, New Mexico

The National Association for Rural Mental Health (NARMH) invites you to attend the 2019 NARMH Annual Conference. Registration is now open and you can register online at www.narmh.org.

About Our Conference: The National Association for Rural Mental Health (NARMH) Annual Conference is the premier interdisciplinary mental health event for rural families and peers, community members, clinicians, researchers, administrators and policy professionals. Now in its 45th year, the NARMH Annual Conference provides a collaborative environment for all participants across professions to learn and network on a myriad of vital issues concerning mental health practice, research, policy and advocacy in rural and remote populations.

Our Conference Theme: The 2019 NARMH Annual Conference theme is "From Surviving to Thriving: Embracing Connections". NARMH "rode the winds of change" in Santa Fe in 2002, and now we return in 2019 to see what we have learned, what has changed, and where we are headed. We want to learn from communities who have gone from surviving to thriving and how that impact is maintained and enhanced. We want to get to know each other and have fun together.

There are over 60 breakout sessions with topics focusing on the following areas: Surviving to Thriving, Workforce Issues, Innovations in Service Delivery, Dilemmas in Addressing Trauma, Rural and Frontier Workforce Development Strategies, Embracing the Reality of Behavioral Health in Rural Communities – Struggles, Responses and Successes, Co-Occurring Substance Use Disorders and Other Topics. The plenary sessions include: 1) The Path to Thriving: Strategic Doing and Rural Mental Health; 2) From Surviving to Thriving in American Indian Communities: Transcending Historical Trauma; 3) Introducing the MHTTC- A New Workforce Development Resource; and 4) The Very Large Array of Youth and Adult Peer Support. The

conference also features a Reception with Flamenco Dancing as well as a NARMH Night at the Movies showing the film: The Providers.

There is no better place to do that than the City Different, Santa Fe, New Mexico. Bienvenidos! Visit the NARMH website at www.narmh.org to explore the details of the 2019 NARMH Annual Conference. We look forward to seeing you in Santa Fe!

Questions & General Information: If you need additional information after visiting the NARMH 2019 conference website at www.narmh.org, please contact Brenton Rice, NARMH Event Planner, by email at brenton@togevents.com or by phone at 651.242.6589.

CRA Announces 2nd Annual Crisis Residential Conference Registration

CRISIS RESIDENTIAL CONFERENCE

October 3rd & 4th
Grand Rapids, MI

Registration is now open for the 2nd **Annual Crisis Residential Conference**, October 3rd & 4th in Grand Rapids, MI!

Hosted by the Crisis Residential Association, this conference is open to providers, payers, and advocates for residential alternatives to psychiatric hospitalization for youth and adults.

Plenary Speakers include:
Dr. Debra Pinals, MD,
Medical Director of Behavioral Health and Forensic Programs
Michigan Department of Health & Human Services

Marilyn Kresky-Wolff, MSW, MPH
Executive Director (Retired)
Open Arms Housing, Inc., Washington, D.C.

Dr. William Beecroft, MD
Medical Director of Behavioral Health
Blue Cross Blue Shield of Michigan

- Register at https://www.crisisresidentialnetwork.com/2019-cra-conference.html. Discounts available for CRA members.
- Our Call for Presentations has been extended! Interested presenters can submit their workshop proposals https://tinyurl.com/CrisisResConCFP.
- Sponsorship opportunities are also available! Visit the CRA website to learn more.

About CRA
The Crisis Residential Association exists to support the operational and clinical functions of Crisis Residential programs around the world. Founded in 2018 and rooted in the values of empathy, recovery, and continuous improvement, the association seeks to connect providers with the best ideas in behavioral health treatment to transform the way people receive mental health care. Learn more at www.crisisresidentialnetwork.com.

Arc Michigan Announces Disability Policy Seminar

Sponsored by Arc Michigan
June 28 9:00 am – 3:30 pm
Heritage Room - University Club of MSU
3435 Forest Road, Lansing, MI. 48910

Speakers: Sherri Boyd, Executive Director, The Arc Michigan; Betsy Weihl, Partner, RWC Advocacy; Sarah Esty, Senior Deputy Director for Policy and Planning – Michigan Department of Health and Human Services; Hillary Hatch, Area Work Incentive Coordinator, Social Security Administration; Brian Calley, President, Small Business Association of Michigan; Nicole Jorwic, Director, Rights Policy, The Arc of the United States

Register at: https://arcmi.org/event/dps/

CMH Association of Michigan and the National Council Announce Michigan Practice Transformation Academy: Request for Applications

Background: While the term “value-based payment” is ubiquitous in today’s health care industry, it leaves many of us wondering: What is it, and what does this mean for the public behavioral health system? Value-based payment (VBP) arrangements are those that move from fee-for-service arrangements to those that foster client/patient and population health outcomes. These VBP arrangements use a range of payment approaches, including pay-for-performance, case-rates, and capitated payments, with varying degrees of risk, from no-risk to up and downside risk. We know this is the wave of the future, and fragmented systems will soon become obsolete. Payers and providers need to know: What steps should we take - in our communities - to get ready?

The CMH Association and the National Council for Behavioral Health are proud to announce a **Michigan-specific Practice Transformation Academy (PTA) for interested CMHA members and Associate members.** This Academy runs from August 2019 through July 2020. All of the dates are listed later in this Request for Applications (RFA). ***Applications are due June 28, 2019****. Application instructions are provided later in this RFA.*

The Practice Transformation Academy will train and coach teams of payers and providers to develop the competencies needed to deliver value-based care and prepare for alternative payment arrangements. As the PTA progresses, **teams will be developing their own strategies for transitioning to value-based payment and will emerge from the Academy with a concrete, realistic plan for how to get there.**

With a faculty of national and local experts in health care finance and contracting, quality improvement, and both payer and provider value-based payment methodologies, the Practice Transformation Academy aims to provide organizations with the tools they need to bring population health management into their

organization and prepare for payments and services more closely associated with health care outcomes. The curriculum provides simultaneous attention to quality and cost, allowing organizations to respond to system changes associated with value-based payment arrangements or quality-based contracts with managed care organizations.

The Michigan Practice Transformation Academy curriculum and delivery model is tailored to payer-provider teams. [Please note: For the purpose of this Academy, "providers" are public and private organizations that directly provide services within a PIHP/CMHSP network. "Payers" are defined as PIHPs and CMHSPs who contract with providers along any of segments of spectrum of service and support modalities.] Taking into consideration the unique needs of their communities, these teams will develop and work on goals together throughout the course of the Academy, developing a shared understanding of how to bring a value-based approach into their organizations.

The Michigan Practice Transformation Academy Request for Applications (RFA) and application can be found on the Community Mental health Association's website at:

Michigan Practice Transformation Academy Request for Applications (RFA): https://cmham.org/wp-content/uploads/2019/06/Michigan-Practice-Transformation-Academy-RFA-V4.pdf

Michigan Practice Transformation Academy Application: https://cmham.org/resources/important-information/ Go to the 2nd listed document entitled "Michigan Practice Transformation Academy Application" to open the application as a Word Document. Click on this document and select "Open" from the choices given. If required to "Allow" access to the document, select "Allow". This will allow you to complete the application as outlined in the Request for Applications.

National Council offers webinar: Building an Analytic Data Infrastructure Using Integrated Social and Health Service Data

Below is a recent announcement of an upcoming webinar on the value of integrated health and social services data to inform policy and service delivery decisions.

> Join us on Monday, June 24, from 1-2:30 p.m. ET, for the webinar Building an Analytic Data Infrastructure Using Integrated Social and Health Service Data. Dr. David Mancuso, director of the Washington State Department of Social and Health Services' Research and Data Analysis Division, will explain his experience with interagency data linking, including Medicaid claims and state behavioral health data, and discuss how developing integrated analytic data systems can be used as a highly strategic asset to help inform policy and improve service delivery.
>
> Key topics:
> The business case for developing integrated analytic data systems
> A legal framework for integration: research data repositories and limited data sets
> Highlighted analytic use cases:
> Medical cost offsets
> "Social determinants"
> Adverse childhood experiences
> Resource for free software for linking records from multiple data system
> Lessons learned in Washington State
>
> REGISTER TODAY at:
> https://register.gotowebinar.com/register/8585784334728783362?mkt_tok=eyJpIjoiT1RRd056ZGxNamN4WVdZMCIsInQiOiJyZ0FRSzRBTkpYWk15WGc2N0QraGQzTVN0NUVYZG5TUGw5RGFkS1dCU3VF

amw2S1dNQ3hwOXZHbEIzbFZXNUNNN2QxaThwU1B0SEphVkpwd0d6cEtTOEh0NWE0M3ZXRVpXXC92c0JXWmlwRlNOYW53YklYUHhJUUVmanBnNFRsMVgifQ%3D%3D

Miscellaneous News and Information:

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

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
Nakia Payton, Data-Entry Clerk/Receptionist, npayton@cmham.org
Dana Ferguson, Accounting Clerk, dferguson@cmham.org
Michelle Dee, Accounting Assistant, acctassistant@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 Johnson, Training and Meeting Planner, jjohnson@cmham.org
Alexandra Risher, Training and Meeting Planner, arisher@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org

June 14, 2019

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CMH Association and Member Activities:

Huron County Suicide Coalition to Host Walk for Awareness

The Huron County Suicide Prevention Walk for Awareness
will be held on Saturday, September 14, 2019 at the Huron County Nature Center and Wilderness Arboretum, 3336 Loosemore Rd Port Austin, Michigan 48467.
Registration and breakfast 9 am to 9:30 am.
Walk begins on nature trail following speaker presentation from 10:30 to 11:15 am; followed by closing ceremony and door prize giveaway.

Registration fee is $20; walkers will receive an event T-shirt, refreshments and the opportunity to win door prizes. Shirts and size availability may be limited on the day of the event. Please register by August 31, 2019 to insure yours will be available.

The community is invited to join us rain or shine as we support our survivors and remember those we've lost to suicide.

9:30 am Presentation by guest speaker Eric Hipple. A suicide survivor himself, former Detroit Lions quarterback and author of "REAL MEN Do Cry", Eric Hipple shares his heartwarming and very inspiring story; this personal journey will inspire and give hope that life can go on when you have severe depression. Eric's book "Real Men Do Cry" will be available for purchase before and after the presentation.

Please contact Shelly at 269-3333 for more information. WALK-INS WELCOMED

Don't Forget About the 2019 PAC Campaign

Earlier this year we announced our 2019 CMH PAC campaign. We must increase our participation, last year we only had 15 boards participate in our PAC campaign. Please take some time over the next couple of board meetings to encourage your board and staff to participate in our 2019 PAC efforts. As you know, our CMH PAC is a key component to our overall advocacy efforts – the need to upgrade our PAC is greater today than ever before.

For those members who qualify for the drawing for the Tiger game suite (minimum 6 contributions per agency), this year's game is on Sunday, July 21 at 1:10pm vs. Toronto Blue Jays. Members should forward the results of their campaign and donations **to the CMHA office by June 28, 2019** in order to be in the drawing for the Tiger tickets if eligible.

Make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please). Thank you. Please feel free to contact Bob or Alan with any questions.

CMHA Committee Schedules, Membership, Minutes, and Information

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

News from Our Preferred Corporate Partners:

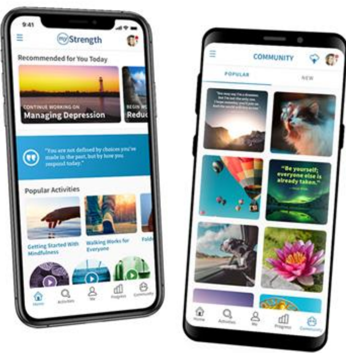
Relias: Our Training Platform Manages and Tracks Regulatory Compliance so You Don't Have To

When new mandates come down around staff training and licensure, do you break into a sweat thinking about maintaining compliance?

With more contracts than ever to manage and a high-need population to serve, the last thing you need is to find and implement training to keep your staff compliant with new mandates. Delivering and reporting on necessary training often interferes with time that could be spent with clients or on other tasks, adding yet another layer of complexity.

Relias helps you serve your population by ensuring that our courses are aligned to current regulations – and automating the reporting process so that you can focus on what matters

myStrength Offers In-the-Moment Support for Comorbid Medical-Behavioral Conditions



Behavioral health conditions are disabling on their own, but they also complicate clinical improvement for the large percentage of people experiencing chronic medical conditions alongside comorbid behavioral health symptoms. For example, it is very challenging to stabilize diabetes or hypertension until depression or anxiety symptoms are successfully managed.

myStrength's digital behavioral health platform is available whenever and wherever a consumer needs, with a consistent, personalized user experience across web and mobile devices.

myStrength's mobile app promotes more frequent engagement by consumers, and use of these evidence-based tools (grounded in mindfulness, cognitive behavioral therapy, and more) helps facilitate long-term health benefits.
In addition to various pathways to access myStrength, the platform also offers immediate access to diverse tools for depression, anxiety, stress, meditation and mindfulness, sleep, pregnancy and early parenting, balancing intense emotions, and chronic pain, as well as tools for drug, opioid or alcohol recovery.

myStrength's Mobile App Offers Real-Time Support:

- Instantly unwind with 3 short audio activities presented when app is opened

- Bookmark helpful resources for quick access when real-time support is critical
- Gain personalized, integrated support for multiple conditions
- Favorite or download inspirational images in the Community for instant access

REQUEST A DEMO

State and National Developments and Resources:

MDHHS Seeks Comments on Proposed SUD Crisis Residential Licensing

Below is a recent announcement from MDHHS regarding the proposed issuance of new licensing requirements for substance use disorder crisis residential services. Comments, on these proposed requirements, are sought by MDHHS by July 17, 2019.

Project number: 1915-BHDDA
Comments Due: July 17, 2019
Proposed Effective Date: September 1, 2019

Mail Comments to:
Jeff Wieferich
Bureau of Community-Based Services
Behavioral Health and Developmental Disabilities Administration
Lewis Cass Bldg., 5th Floor
320 S. Walnut Street
Lansing, Michigan 48913

Telephone Number: 517-335-0499 Fax Number: 517-335-5376
E-mail Address: wieferichj@michigan.gov

Policy Subject: New Criteria for Substance Use Disorder Crisis Residential Services
Affected Programs: Healthy Michigan Plan
Distribution: Prepaid Inpatient Health Plans, Community Mental Health Services Programs
Policy Summary: This policy describes the approval needed from the Michigan Department of Health and Human Services (MDHHS) for a program to provide substance use disorder crisis residential setting to comply with a new Adult Foster Care licensing standard.

Purpose: The behavioral health benefit in the Healthy Michigan Plan allows for crisis residential services to be provided for someone with only a substance use disorder (SUD). The intent was to allow a provider of mental health crisis residential services to be able to provide the SUD service in the same location. Due to Adult Foster Care licensing rules, the programs providing mental health crisis residential services were not able to provide SUD treatment due to this service being prohibited as part of licensure. PA 388 of 2018 removed that prohibition in situations where MDHHS designated the program as a "co-occurring enhanced crisis residential program."

Distribution: Prepaid Inpatient Health Plans, Community Mental Health Services Programs
Issued: August 1, 2019 (Proposed)
Subject: New Criteria for Substance Use Disorder Crisis Residential Services
Effective: September 1, 2019 (Proposed)

Programs Affected: Healthy Michigan Plan

As a result of the passage of PA 388 of 2018, crisis residential programs that provide mental health services under the behavioral health benefit of the Healthy Michigan Plan will now be able to provide this service to individuals with substance use disorders when the crisis residential program is:

- Licensed as a substance use disorder program; and
- Approved as a Co-occurring Enhanced Crisis Residential Program which means a program approved by the Michigan Department of Health and Human Services (MDHHS) for providing short-term intensive mental health and substance use disorder services. Approved programs can address the mental health needs, substance use disorder needs, or both, of an individual through enhanced programming and staffing patterns that are reviewed and approved by MDHHS.

These programs will continue to require prior approval as currently outlined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual. The Medicaid Provider Manual is available on the MDHHS website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-87572--,00.html

New Report Shows Employment Rate Increased for Individuals with Serious Mental Illness in 2018

Below are excerpts from a recent news release underscoring the progress, in the labor market, that Michiganders with mental illness have made over the past several years.

The Michigan Department of Health and Human Services (MDHHS) 2018 Individual Placement & Support (IPS) report shows a 30 percent competitive, integrated employment rate was achieved by individuals with serious mental illness who were supported by evidence-based IPS services, an increase from 26 percent in 2017.
This is more than double the 10.4 percent employment rate reported in 2016, when only general supported employment services were provided. In 2018, 1,465 individuals received IPS supports in 18 Michigan counties. This is an increase of 148 individuals from 2017.

IPS is a model of supported employment for people with serious mental illness. IPS-supported employment helps people living with behavioral health conditions work at individual, competitive and integrated jobs of their choosing. Employment specialists help clients obtain part- and full-time competitive jobs that pay at least minimum wage in community settings alongside others without disabilities. Mainstream education and technical training are included as ways to advance career paths.

"Through the years, IPS has had a profound impact on many individuals across Michigan, making a significant difference in not only their lives but the lives of their families," said Robert Gordon. MDHHS director. "This program has helped these individuals by increasing their confidence, self-worth, pride and perhaps most importantly, hope."

Michigan began implementing the Evidence-Based Practice Supported Employment – IPS model in 2004. Twenty-one IPS programs currently serve Michigan residents through local Community Mental Health Services Programs (CMHSPs) or contracted providers. Employment services are closely integrated with mental health treatment and benefits counseling.

Participants averaged 26.89 hours a week and earned an average of $10.40 per hour as people gained greater financial independence.

CMHSPs or providers interested in being an IPS site or seeking to register should visit :https://www.improvingmipractices.org/ and select the Practice Areas tab, then the Individual Placement & Support tab (https://www.improvingmipractices.org/practice-areas/individual-placement-and-support)

Suicide, Depression on Rise in Rural Michigan, but Psychiatrists are Scarce

Below is an excerpt from a recent news story on the lack of psychiatric providers in rural Michigan.

> For Upper Peninsula mother Katie Sinclair, the memories are still painful.
>
> Her then 10-year-old son, Jacob, had struggled for years with mental health issues that stretched back to kindergarten. Diagnosed with depression, he suffered panic attacks. He had outbursts at school. He would stab himself with knives, and when they were removed from the house, with pencils or paperclips.
>
> In late 2017, he told a psychologist he wanted to cut his throat. He referred Jacob to UP Health System-Marquette, where doctors ordered inpatient psychiatric care. But there's no in-patient psychiatric beds for children anywhere in the U.P. So Katie and her husband, Jacob, drove him nearly 250 miles from their home north of Escanaba to a hospital in Milwaukee, Wisc.
>
> He was discharged after five days, with instructions for follow-up care. But it would be nearly two weeks before the Sinclairs could get an appointment with a psychologist for Jacob.
>
> "We struggled mightily finding follow-up care in our area," Katie Sinclair said. "I was frustrated. I was worried. I was crazy."

The full article can be found at: https://www.bridgemi.com/michigan-health-watch/suicide-depression-rise-rural-michigan-psychiatrists-are-scarce

Flint Water Prosecution Team Expands Investigation Based on New Evidence, Dismisses Cases Brought by Former Special Counsel

Below is a recent press release on the work of the Flint Water Crisis prosecution team.

> The Department of Attorney General (AG) through the Flint Water Crisis prosecution team has dismissed without prejudice all pending criminal cases brought by the former Office of Special Counsel (OSC) in order to conduct a full and complete investigation. The OSC was appointed by former Attorney General Bill Schuette. The affected cases are listed below.
>
> There will be no response to any media inquiries until after Solicitor General Fadwa Hammoud and Wayne County Prosecutor Kym L. Worthy have had an opportunity to speak directly to the people of Flint. A community conversation in Flint has been scheduled for Friday, June 28. Further details will be announced in the coming days.
> Solicitor General Fadwa Hammoud and Wayne County Prosecutor Kym L. Worthy issued the following statement:
>
> "Legitimate criminal prosecutions require complete investigations. Upon assuming responsibility of this case, our team of career prosecutors and investigators had immediate and grave concerns about the investigative approach and legal theories embraced by the OSC, particularly regarding the

pursuit of evidence. After a complete evaluation, our concerns were validated. Contrary to accepted standards of criminal investigation and prosecution, all available evidence was not pursued. Instead, the OSC entered into agreements that gave private law firms—representing Michigan Department of Health and Human Services, Michigan Department of Environmental Quality, the Department of Treasury, and the Executive Office of former Governor Rick Snyder—a role in deciding what information would be turned over to law enforcement.

"From the outset, our team seriously considered dismissal of all pending cases initiated by the OSC. However, we believed the people of Flint deserved expeditious action, despite the shortcomings of the OSC, and we worked to salvage whatever progress had been made. We were also mindful of the massive expenditure of public resources up to that point and sought to use taxpayer money as efficiently as possible. Nonetheless, we cannot provide the citizens of Flint the investigation they rightly deserve by continuing to build on a flawed foundation. Dismissing these cases allows us to move forward according to the non-negotiable requirements of a thorough, methodical and ethical investigation.

"Our career prosecutors and investigators have worked around the clock to conduct the kind of criminal investigation to which all citizens are entitled, regardless of their zip code. That begins with a commitment to obtain and review all evidence. By executing a series of search warrants, our investigators aggressively pursued an extraordinary amount of potential evidence not previously examined by law enforcement. This week, we completed the transfer into our possession millions of documents and hundreds of new electronic devices, significantly expanding the scope of our investigation. Our team's efforts have produced the most comprehensive body of evidence to date related to the Flint Water Crisis. We are now in the best possible position to find the answers the citizens of Flint deserve and hold all responsible parties accountable.

"Our team has already identified additional individuals of interest and new information relevant to the Flint Water Crisis. These investigative leads will be aggressively pursued. Additionally, we will evaluate criminal culpability for all Legionnaires deaths that occurred after the switch to the Flint River, which was never done by the OSC.

"It is important to note that this voluntary dismissal by our team is not a determination of any defendant's criminal responsibility. We are not precluded from refiling charges against the defendants listed below or adding new charges and additional defendants.

"We understand this decision will not bring immediate remedy or relief to the citizens of Flint, who remain victims of one of the worst man-made environmental disasters in United States history. However, we recognize the only acceptable remedy is the vigorous pursuit of justice, which demands an uncompromising investigation of the Flint Water Crisis and professional prosecution of all those criminally culpable.
Accordingly, our team will move forward unrestrained by political motivations, prior tactics, or opportunities for financial gain."
--
People v. Gerald Ambrose, 18-042559-FH
People v. Patrick Cook, 16TC1685
People v. Howard Croft, 16TC2850
People v. Darnell Earley, 16TB2850
People v. Nicolas Lyon, 18-043836-FH
People v. Nancy Peeler, 16TD1685
People v. Robert Scott, 16TE1685
People v. Eden Wells, 18-044241-FH

Anthem to Buy Beacon Health Options

Below is an excerpt from a recent news story on the recent/upcoming purchase of Beacon Health Options (a specialty behavioral health managed care firm that operates in a number of states, including Michigan) by Anthem/Blue Cross/Amerigroup (a national health plan/health insurance company).

> Anthem said it will buy Beacon Health Options, adding a national network of behavioral health services as the health insurer looks to manage care of the "whole person."
>
> Anthem didn't disclose a price it is paying Bain Capital Private Equity and Diamond Castle Holdings for Beacon Health, which is privately held. The acquisition is expected to close in the fourth quarter of this year.
> Beacon manages mental health, substance abuse and other behavioral health services to more than 36 million people across the U.S., "including nearly 3 million individuals under comprehensive risk-based behavioral programs." Anthem, which owns Blue Cross and Blue Shield plans in 14 states, already has more than 40 million members in its health plans.
>
> The deal is significant because it's further acknowledgement by health insurers that managing medical care isn't enough to make sure patients are getting the right care, in the right place and at the right time. Insurers increasingly are working to address social determinants of their customers outside of traditional medical care and an estimated one in five American adults suffers from mental illness, according to the National Institute of Mental Health.
>
> "As Anthem works to improve lives, simplify healthcare and serve as an innovative and valuable partner, we're focused on providing solutions that address the needs of the whole person," Anthem president and chief executive Gail Boudreaux said.
>
> "With an extensive track record in behavioral health, Beacon fits well with our strategy to better manage the needs of populations with chronic and complex conditions, and deliver integrated whole health solutions," Boudreaux said. "Together with Beacon, we will enhance our capabilities to serve state partners, health plans and employer groups as they seek to address consumer behavioral health needs."

My Stutter Made Me a Better Writer

Below is an excerpt from the most recent installment, written by Darcey Steinke, in the New York Times' series featuring the voices of persons with disabilities.

> At times it caused suffering, but it also gave me a passion for words and language.
>
> The J in "juice" was the first letter-sound, according to my mother, that I repeated in staccato, going off like a skipping record. This was when I was 3, before my stutter was stigmatized as shameful. In those earliest years my relationship to language was uncomplicated: I assumed my voice was more like a bird's or a squirrel's than my playmates'. This seemed exciting. I imagined, unlike fluent children, I might be able to converse with wild creatures, I'd learn their secrets, tell them mine and forge friendships based on interspecies intimacy.
>
> School put an end to this fantasy. Throughout elementary school I stuttered every time a teacher called on me and whenever I was asked to read out loud. In the third grade the humiliation of being

forced to read a few paragraphs about stewardesses in the Weekly Reader still burns. The ST is hard for stutterers. What would have taken a fluent child five minutes took me an excruciating 25.

https://www.nytimes.com/2019/06/06/opinion/reading-writing-stuttering.html

National Association for Rural Mental Health Announces Conference and Range of Resources

Below are excerpts of a recent announcement from David Weden, the President-Elect of the National Association for Rural Mental Health (NARMH)

I wanted to be sure that you were aware that registration for the 45th Annual NARMH Conference will be held in Santa Fe, New Mexico, August 26 through 29 is open and that the reduced rate for conference registration is good through July 29. Additional details regarding the conference may be found at http://www.togpartners.com/narmh/2019/default.aspx Hope to see you in Santa Fe. You are a vital link in our success in promoting the voice of rural mental health.

In addition, following is an update of some of the NARMH activities and efforts.

NARMH is a membership organization focused on raising awareness of and responding to a variety of rural mental health and social service concerns. Through your NARMH membership, your voice is linked with others to promote rural mental health issues at the federal, state and county levels. For more information on membership levels, please visit http://narmh.org/membership.html

ADVOCACY: Within the past year, NARMH has participated in and helped sponsor Congressional Briefings on topics such as:

- Is Treating Depression the Answer to Solving the Opioid Crisis?
- Preventing Suicide in Older Adults

Medicaid, the Affordable Care Act and Impact of Repeal Efforts on Individuals with Intellectual and Developmental Disabilities

In addition, NARMH is a member of the Mental Health Liaison Group- a coalition of more than 60 national organizations representing consumers, family members, mental health and addiction providers, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and addiction care.

PUBLICATIONS: The *Journal of Rural Mental Health* is the official journal of NARMH. It publishes peer-reviewed articles on rural mental health research, practice, and policy within the United States and internationally. Focused on issues of special interest to those living and working in rural areas, the journal welcomes research on such topics as barriers to improving or accessing care in rural environments, issues faced by underserved populations, and disparities in mental health care. Discussion of policy implications, community-level issues, and multidisciplinary considerations is encouraged as is exploration of evidence-based practices, cultural factors, and ethical and regulatory considerations. Paid members of NARMH receive free access to the online version of the *Journal of Rural Mental Health* which is published by the Journals Program of the American Psychological Association. If you are interested in submitting an article for the journal, please visit the General Call for Papers at https://www.apa.org/pubs/journals/rmh/call-for-papers-general

In addition, members also receive the monthly newsletter from NARMH and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) as well as a monthly *Under the*

Microscope, which provides a policy analysis of a current issue, and *Headline DC*, which provides updates on major developments in the Nation's Capital.

ANNUAL CONFERENCE: One of the highlights for NARMH each year is the National Conference. The 45th Annual NARMH Conference, *From Surviving to Thriving: Embracing Connections*, will be held from August 26 to 29 in Santa Fe, New Mexico at the La Fonda on the Plaza. The conference includes over 60 break-out sessions and four plenary sessions. Registration is now open at http://www.togpartners.com/narmh/2019/2019registration.aspx.

In addition to other benefits, individuals with a current membership receive a discount on conference registration Make plans now to come and make connections with others interested in rural mental health, and embrace the connections to help advance our system from surviving to thriving.

Let your voice be linked with others in promoting rural mental health. Renew your NARMH membership and make plans to attend the annual conference. Joining together we brighten the spotlight on the importance of rural mental health and the resources that are needed.

State Legislative Update:

Updates to Medicaid Work Requirements Introduced

Updates to the state's Medicaid work requirements passed last year were introduced on Wednesday in the Senate. Senator Curtis Hertel, Jr. (D-East Lansing) and Senate Majority Leader Mike Shirkey (R-Clarklake) sponsored Senate Bills 362 and 363 respectively, outlining increased flexibility for those reporting their compliance and those processing benefits.

Under the updates, students or those who are already working would be automatically entered into a database, so a monthly verification call would not be necessary. The idea is to make the process for migration to the database smoother as more people re-verify their eligibility or employment status. Other Medicaid recipients would have the full month to check in and verify their status from the previous month, rather than the current 10-day window.

The proposed changes were determined as legislators and other officials continued to monitor other states implementing work requirements. Commenting on the importance of the updates, Senator Hertel stated, "If there is going to be a state policy, we don't want there to be unintended consequences."

Mr. Hertel also noted the changes provide flexibility for individuals unable to report within the original time frame and will prevent recipients from "falling through the cracks" despite compliance with the program. Deputy Chief of Staff for Majority Leader Shirkey Alisha Cottrell echoed that sentiment.

The bills were referred to the Senate Health Policy and Human Services Committee, where they are expected to move quickly, as the work requirements go into effect in 2020.

Federal Update:

Bipartisan Bill Introduced to Train More Doctors to Combat Opioid Epidemic

U.S. Representatives Brad Schneider (D-IL), Susan W. Brooks (R-IN), Annie Kuster (D-NH), and Elise Stefanik (R-NY) introduced bipartisan legislation to train more doctors equipped to combat the opioid epidemic.

H.R. 2439, the Opioid Workforce Act of 2019, would create 1,000 additional residency positions over five years to hospitals with addiction medicine, addiction psychiatry, or pain management programs.

This legislation to expand graduate medical education (GME) aims to alleviate the worsening physician shortage, which is anticipated to be as high as 121,000 physicians by 2032 according to a study by the Association of American of Medical Colleges. This shortage is particularly acute in the field of addiction medicine and substance use disorder (SUD) treatment. This shortfall of doctors threatens to harm our efforts to reverse the opioid epidemic.

"Turning the tide on the opioid crisis requires treating addiction like the disease that it is, and to do that, we need doctors," said Schneider. "Our medical professionals on the frontlines of this epidemic are already stretched too thin. Our bipartisan legislation aims to educate more physicians equipped with the latest training in addiction medicine and psychiatry to help the estimated 20 million Americans who need substance use treatment get much needed care."

"In order to combat the devastating opioid, heroin and fentanyl epidemic that continues to plague communities across our country, a critically important piece of the puzzle is to ensure we have more trained professionals, particularly physicians, who can prevent and treat addiction and substance abuse disorder," said Brooks. "This bipartisan bill will help provide more residency positions to hospitals that have programs focused on addiction medicine, addiction psychiatry or pain management. The opioid crisis will not stop taking innocent lives overnight, but without more trained doctors ready to help people who are struggling because of substance abuse, drug and opioid related overdose deaths will continue to claim more lives in Indiana and beyond."

"The opioid epidemic is impacting communities across New Hampshire and the country**,"** said Kuster. "We know that to address this crisis we must bolster the capacity to treat individuals with substance use disorder and our bill will increase the number of physicians who can take on this challenge. The opioid epidemic requires an all-hands-on-deck response and our legislation will help to step up efforts on the frontlines to get individuals the help they need."

"Every single person knows of a family that has been devastated by the opioid crisis, and deaths related to overdoses have outpaced car accidents as the number one killer of young people," said Stefanik. "The number of health care professionals focused on the treatment and prevention of opioid abuse directly translates to the number of people who can be saved. In my district, so many families are suffering due to the wide-spread impact of this public health crisis, which is why I'm co-leading this bipartisan and life-saving bill."

The Opioid Workforce Act is endorsed by the Association of American Medical Colleges, the Greater New York Hospital Association, the American Hospital Association, American Society of Addiction Medicine, American College of Academic Addiction Medicine, and Indiana University.

The text of H.R. 2439 is available online.

Sen. Warren, Rep. Kennedy Reintroduce Bill to Strengthen Parity

Earlier this week, Senator Elizabeth Warren (D-MA) and Representative Joe Kennedy III (D-MA) reintroduced the Behavioral Health Coverage Transparency Act (H.R. 2874/S. 1576) with the aim of strengthening Americans' access to mental health and substance use disorder (SUD) treatment. Specifically, the bill would

increase oversight and enforcement of the federal parity law, which requires that insurance coverage of mental health and SUD services be equal to the coverage of medical and surgical health services.

BACKGROUND

The Mental Health Parity and Addiction Equity Act of 2008 established parity between the coverage of behavioral health and medical/surgical benefits. While the law has led to gains in behavioral health coverage, many individuals and families continue to report being denied or charged more for necessary mental health and SUD treatments by their health care plan. A survey by the National Alliance on Mental Illness (NAMI) found that respondents experienced a rate of denials for mental health care that was nearly twice the rate of denials for general medical care. The bill's reintroduction also comes on the heels of a federal judge's ruling that found that the nation's largest insurer, UnitedHealth, unlawfully denied beneficiaries access to mental health and SUD treatment in an effort to cut costs.

BILL SUMMARY

The Behavioral Health Coverage Transparency Act (H.R. 2874/S. 1576) would require insurance providers to disclose the analysis they utilize in making parity determinations as well as the rates and reasons for mental health/SUD claims denials versus medical/surgical denials. It also would require the Department of Health & Human Services, the Department of Labor and the Department of Treasury to undertake a minimum of 12 random audits of health plans per year to discourage noncompliance with existing parity laws. The results of the audits would be made public. Finally, it would establish a Consumer Parity Unit, giving individuals a centralized online clearinghouse to get information about their rights and to submit complaints with assurance of timely responses.

"Patients with behavioral health concerns deserve the same access to care as patients with physical health conditions, but for far too long, insurance companies have unfairly denied behavioral health care services to cut costs," said Senator Warren in a statement. "Our bill would put a stop to these discriminatory practices and make sure patients get the treatment they need."

REACTION FROM THE FIELD

The bill has received widespread support from mental health and addiction advocacy organizations, including the National Council for Behavioral Health and Massachusetts behavioral health provider association, the Association for Behavioral Healthcare (ABH). Vic DiGravio, President and CEO of ABH explained why his organization supports the legislation saying, "As providers of behavioral health services, our members see first-hand the difficulty their clients face in accessing timely treatment because of insurance barriers. Our members frequently note that these barriers are in sharp contrast to when their clients are seeking physical health care. Senator Warren and Congressman Kennedy are right to fight to strengthen parity laws. Behavioral health care must be made as accessible as physical health care."

The National Council echoed support for the bill as part of the Mental Health Liaison Group (MHLG), a nonpartisan, nationwide coalition of mental health and addiction advocacy organizations, in this letter sent to bill sponsors.

Education Opportunities:

Required for Licensure Renewal: Ethics for Social Work & Substance Use Disorder Professionals & Psychologists Trainings

Community Mental Health Association of Michigan is pleased to offer 6 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.

Trainings offered on the following date.

July 17, 2019 – Lansing **Click Here to Register!**
August 21, 2019 – Lansing **Click Here to Register!**

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

$115 CMHA Members
$138 Non-Members

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Dates:	July 31 & August 1, 2019
Location:	Suburban Collection Showplace, Novi
Who Should Attend:	Staff who's involved in helping someone with an employment goal: – Employment Practitioners – Supports Coordinators/Case Managers – CMHSP Leadership – CRO Leadership
Registration Fee:	$50 (registration open soon)

Watch www.cmham.org for conference details and registration! Sponsored by the Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Free Webinar: Tobacco Free Policies and Interventions in Behavioral Health Care Settings

The Smoking Cessation Leadership Center (SCLC) invites you to join us for this webinar, "***Tobacco Free Policies and Interventions in Behavioral Health Care Settings***" on **Tuesday, June 18, 2019, at 2:00 pm EDT** (90 minutes). We are honored to have the following speakers presenting on this important and timely topic:

- **Chad D Morris, PhD,** Professor of Psychiatry, University of Colorado
- **Timothy Stacey, LPC-S,** Integrated Care Systems Program Manager, Integral Care

Webinar Objectives:

- Identify proven steps toward bringing your agency tobacco free
- Discuss how to effectively enforce a tobacco free grounds policy
- Describe how to implement tobacco cessation interventions into clinical practice.
- Identify and overcome common barriers experienced during tobacco free policy implementation

REGISTER HERE: **https://cc.readytalk.com/r/aahucxsi8hjk&eom**

11th Annual Anti-Stigma Event Day – July 25, 2019 at LCC Downtown

The 11th Annual Anti-Stigma Event Day will be held Thursday, July 25, 2019 at the Lansing Community College - Downtown Lansing Campus in the Gannon Building. The event will be held from 9:00am to 4:00pm. Do you have anti-stigma initiatives at your CMHSP? Please contact Colleen Jasper jasperc@michigan.gov or 517-373-1255 to present your anti-stigma program. Or just come, and we will have time for CMHSPs initiative updates that very day. Registration is open online at https://cmham.org/events/?EventId=5302

Dialectical Behavior Therapy (DBT) Trainings for 2018/2019

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.

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

Dates/Locations:
August 12-16, 2019 | Great Wolf Lodge, Traverse City | REGISTER HERE

Co-Occurring College Save-the-Date & Hotel Information!

The 2019 Co-Occurring College will be held Tuesday, July 30th at the DoubleTree by Hilton Hotel Bay City – Riverfront (1 Wenonah Park Place, Bay City, MI 48708). To make your hotel overnight reservations call 989-891-6000 and mention the Community Mental Health Association of Michigan to receive the discounted room rate of $85 per night by the deadline of July 8th. More information including conference agenda & registration links coming soon!

Individualized Service Plans Using the ASAM Criteria and Motivational Interviewing Trainings

- June 18-19, 2019 – Holiday Inn, Marquette
- July 16-17, 2019 – Best Western/Okemos Conference Center, Okemos
- August 13-14, 2019 – Hilton Garden Inn, Detroit
- August 27-28, 2019 – Radisson Plaza Hotel, Kalamazoo
- September 24-25, 2019 – Great Wolf Lodge, Traverse City

Visit www.cmham.org for more information.

20th Annual Substance Use Disorder and Co-Occurring Disorder Conference Save-the-Date!

"Innovative Strategies for Today's Challenges"
Pre-Conference Workshops: September 15, 2019
Full Conference: September 16-17, 2019
Cobo Center, Detroit, MI

More information including hotel reservations and registration links coming soon!

45th Annual National Association for Rural Mental Health Conference

August 26-29, 2019
45th Annual National Association for Rural Mental Health Conference
La Fonda on the Plaza Hotel
Santa Fe, New Mexico

The National Association for Rural Mental Health (NARMH) invites you to attend the 2019 NARMH Annual Conference. Registration is now open and you can register online at www.narmh.org.

About Our Conference: The National Association for Rural Mental Health (NARMH) Annual Conference is the premier interdisciplinary mental health event for rural families and peers, community members, clinicians, researchers, administrators and policy professionals. Now in its 45th year, the NARMH Annual Conference provides a collaborative environment for all participants across professions to learn and network on a myriad of vital issues concerning mental health practice, research, policy and advocacy in rural and remote populations.

Our Conference Theme: The 2019 NARMH Annual Conference theme is "From Surviving to Thriving: Embracing Connections". NARMH "rode the winds of change" in Santa Fe in 2002, and now we return in 2019 to see what we have learned, what has changed, and where we are headed. We want to learn from communities who have gone from surviving to thriving and how that impact is maintained and enhanced. We want to get to know each other and have fun together.

There are over 60 breakout sessions with topics focusing on the following areas: Surviving to Thriving, Workforce Issues, Innovations in Service Delivery, Dilemmas in Addressing Trauma, Rural and Frontier Workforce Development Strategies, Embracing the Reality of Behavioral Health in Rural Communities – Struggles, Responses and Successes, Co-Occurring Substance Use Disorders and Other Topics. The plenary sessions include: 1) The Path to Thriving: Strategic Doing and Rural Mental Health; 2) From Surviving to Thriving in American Indian Communities: Transcending Historical Trauma; 3) Introducing the MHTTC- A New Workforce Development Resource; and 4) The Very Large Array of Youth and Adult Peer Support. The conference also features a Reception with Flamenco Dancing as well as a NARMH Night at the Movies showing the film: The Providers.

There is no better place to do that than the City Different, Santa Fe, New Mexico. Bienvenidos! Visit the NARMH website at www.narmh.org to explore the details of the 2019 NARMH Annual Conference. We look forward to seeing you in Santa Fe!

Questions & General Information: If you need additional information after visiting the NARMH 2019 conference website at www.narmh.org, please contact Brenton Rice, NARMH Event Planner, by email at brenton@togevents.com or by phone at 651.242.6589.

CRA Announces 2nd Annual Crisis Residential Conference Registration

CRISIS RESIDENTIAL CONFERENCE

October 3rd & 4th
Grand Rapids, MI

Registration is now open for the 2nd **Annual Crisis Residential Conference**, October 3rd & 4th in Grand Rapids, MI!

Hosted by the Crisis Residential Association, this conference is open to providers, payers, and advocates for residential alternatives to psychiatric hospitalization for youth and adults.

Plenary Speakers include:
Dr. Debra Pinals, MD,
Medical Director of Behavioral Health and Forensic Programs
Michigan Department of Health & Human Services

Marilyn Kresky-Wolff, MSW, MPH
Executive Director (Retired)
Open Arms Housing, Inc., Washington, D.C.

Dr. William Beecroft, MD
Medical Director of Behavioral Health
Blue Cross Blue Shield of Michigan

- Register at https://www.crisisresidentialnetwork.com/2019-cra-conference.html. Discounts available for CRA members.

- Our Call for Presentations has been extended! Interested presenters can submit their workshop proposals https://tinyurl.com/CrisisResConCFP.

- Sponsorship opportunities are also available! Visit the CRA website to learn more.

About CRA
The Crisis Residential Association exists to support the operational and clinical functions of Crisis Residential programs around the world. Founded in 2018 and rooted in the values of empathy, recovery, and continuous improvement, the association seeks to connect providers with the best ideas in behavioral health treatment to transform the way people receive mental health care. Learn more at www.crisisresidentialnetwork.com.

Arc Michigan announces Disability Policy Seminar

Sponsored by Arc Michigan
June 28 9:00 am – 3:30 pm
Heritage Room
University Club of MSU
3435 Forest Road
Lansing, MI. 48910

Speakers: Sherri Boyd, Executive Director, The Arc Michigan; Betsy Weihl, Partner, RWC Advocacy; Sarah Esty, Senior Deputy Director for Policy and Planning – Michigan Department of Health and Human Services; Hillary Hatch, Area Work Incentive Coordinator, Social Security Administration;
Brian Calley, President, Small Business Association of Michigan; Nicole Jorwic, Director, Rights Policy, The Arc of the United States

Register at: https://arcmi.org/event/dps/

CMH Association of Michigan and the National Council Announce Michigan Practice Transformation Academy: Request for Applications

Background: While the term "value-based payment" is ubiquitous in today's health care industry, it leaves many of us wondering: What is it, and what does this mean for the public behavioral health system? Value-based payment (VBP) arrangements are those that move from fee-for-service arrangements to those that foster client/patient and population health outcomes. These VBP arrangements use a range of payment approaches, including pay-for-performance, case-rates, and capitated payments, with varying degrees of risk, from no-risk to up and downside risk. We know this is the wave of the future, and fragmented systems will soon become obsolete. Payers and providers need to know: What steps should we take - in our communities - to get ready?

The CMH Association and the National Council for Behavioral Health are proud to announce a **Michigan-specific Practice Transformation Academy (PTA) for interested CMHA members and Associate members.** This Academy runs from August 2019 through July 2020. All of the dates are listed later in this Request for Applications (RFA). ***Applications are due June 28, 2019****. Application instructions are provided later in this RFA.*

The Practice Transformation Academy will train and coach teams of payers and providers to develop the competencies needed to deliver value-based care and prepare for alternative payment arrangements. As the PTA progresses, **teams will be developing their own strategies for transitioning to value-based payment and will emerge from the Academy with a concrete, realistic plan for how to get there.**

With a faculty of national and local experts in health care finance and contracting, quality improvement, and both payer and provider value-based payment methodologies, the Practice Transformation Academy aims to provide organizations with the tools they need to bring population health management into their organization and prepare for payments and services more closely associated with health care outcomes. The curriculum provides simultaneous attention to quality and cost, allowing organizations to respond to system

changes associated with value-based payment arrangements or quality-based contracts with managed care organizations.

The Michigan Practice Transformation Academy curriculum and delivery model is tailored to payer-provider teams. [Please note: For the purpose of this Academy, "providers" are public and private organizations that directly provide services within a PIHP/CMHSP network. "Payers" are defined as PIHPs and CMHSPs who contract with providers along any of segments of spectrum of service and support modalities.] Taking into consideration the unique needs of their communities, these teams will develop and work on goals together throughout the course of the Academy, developing a shared understanding of how to bring a value-based approach into their organizations.

The Michigan Practice Transformation Academy Request for Applications (RFA) and application can be found on the Community Mental health Association's website at:

Michigan Practice Transformation Academy Request for Applications (RFA): https://cmham.org/wp-content/uploads/2019/06/Michigan-Practice-Transformation-Academy-RFA-V4.pdf

Michigan Practice Transformation Academy Application: https://cmham.org/resources/important-information/ Go to the 2nd listed document entitled "Michigan Practice Transformation Academy Application" to open the application as a Word Document. Click on this document and select "Open" from the choices given. If required to "Allow" access to the document, select "Allow". This will allow you to complete the application as outlined in the Request for Applications.

Miscellaneous News and Information:

Job Opportunity: Healthy Transitions Youth/Young Adult Peer Coordinator at ACMH

Association for Children's Mental Health (ACMH) is currently accepting applications for a Healthy Transitions Youth/Young Adult Peer Coordinator. To apply, mail or email a cover letter and resume to: Jane Shank, Executive Director | 6017 W. St. Joe Hwy, Suite 200, Lansing, MI 48917 acmhjane@sbcglobal.net
To learn more see the complete job posting below or download it here: Healthy Transitions Posting final

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
Second Vice President: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451

Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

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
Nakia Payton, Data-Entry Clerk/Receptionist, npayton@cmham.org
Dana Ferguson, Accounting Clerk, dferguson@cmham.org
Michelle Dee, Accounting Assistant, acctassistant@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 Johnson, Training and Meeting Planner, jjohnson@cmham.org
Alexandra Risher, Training and Meeting Planner, arisher@cmham.org
Robert Sheehan, CEO, rsheehan@cmham.org