



# Connections

— for communities that care

## Courage, Resilience, and the Quest for New Life

Marilyn Ashley and Michael Barkey, MSW, Director, Community Development Group, Summit Pointe CMH Authority



Marilyn Ashley

**F**ifty seven year old Marilyn Ashley has become what she never thought she would be: a quiet hero; a survivor of challenges which would have broken a lesser woman. Marilyn has wrestled with despair and crippling illness. Her life was broken, yet she has emerged stronger, more capable, and increasingly

more self-assured and happier. Like the quiet hero she is, Marilyn just goes on. This is the story of her struggle for a better quality of life, and a story of the people who joined her on that journey.

Marilyn is a life-long resident of Battle Creek. Born into a suburban working family, she was the fourth of five children. Marilyn's mother took in laundry and her father worked in the foundry and later started his own business.

Marilyn's life took a series of rough turns. She dropped out of high school, married young, and had children. She began to experience periodic depressions, unexpected angry outbursts, and continual anxiety and stress. In her 40s, the reasons for some of her difficulties became apparent. Marilyn was diagnosed as having a bipolar disorder. She twice sought treatment in inpatient settings to complement her ongoing therapy centered in medication and outpatient counseling. Although her emotional turmoil was great, Marilyn never gave up. Determined to succeed, she went back to school and got her high school diploma while in her 40s. She also took up a new hobby and became an accomplished scrapbooking artist.

In spite of her hard work and her successes, the challenges compounded as Marilyn was faced by a series of devastating and lingering illnesses: Fibromyalgia (which was painful and largely untreatable), migraines (more pain, and only poorly controllable), diabetes (which she struggled to control), hypertension, and irritable bowel syndrome (requiring aggressive self-management). Complicating these multiple problems was the cruel reality that

all of these chronic illnesses interacted with each other. An attempt to deal with her illnesses soon became like a version of the old "whack-a-mole" game where addressing one symptom would cause multiple other problems to emerge.

Marilyn's story continues. A series of life tragedies added to her medical and emotional challenges. Life seemed only to get harder and harder. Her son died. Dear friends and family members died or moved away. Her marriage ended. Marilyn was alone and in despair, seemingly without hope, and deeply confused. Sometimes she felt like "ending it all."

Marilyn persevered. She kept trying. She tried to find a way out and sought treatment at Summit Pointe, the Community Mental Health Services Program for Calhoun County. This time she began what she calls a "full court press." She participated in a variety of services: case management, psychiatric medication, and outpatient therapy. These helped, but Marilyn needed something more.

The leadership of Summit Pointe had recognized that many people who sought the agency's help were experiencing multiple medical problems, just like Marilyn. These coexisting medical conditions or disease processes that were additional to the mental health need, made recovery even more difficult. To address these situations of comorbidity, Summit Pointe had created its own primary care practice—the Summit Healthcare Group—which had a family practice physician, Dr. Curtis Simmons, MD, skilled in treating persons like Marilyn. Having also secured a grant from the Michigan Department of Community Health to strengthen its integrated care practices, Summit Pointe began deploying Certified Peer Support Specialists, who were certified to train consumers of services in self-management of chronic illnesses through an evidence-based program developed by Stanford University.

Marilyn began receiving a fully-integrated course of treatment and services. Her primary care physician, Dr. Simmons, and her psychiatric physician, Dr. Sven Zathelius—both Summit Pointe physicians—established a close partnership with Marilyn. They all worked together as a team in getting Marilyn's complicated treat-

*(continued page 11)*

# Facing the Challenges

Lynda Zeller, Deputy Director of the Behavioral Health and Developmental Disabilities Administration (BHDDA), Michigan Department of Community Health

I am very excited about the focus of this issue of *Connections*. When Clinton Galloway, our editor in chief, gave me a preview of the articles in this issue, I felt inspired by and proud of the responsiveness, creativity and solution building highlighted in these pages. CMHs are active partners and very often the drivers of some of the most forward thinking efforts around integration and increased access to healthcare for those we serve. This issue highlights some of the examples of the synthesis of local service systems promoted by CMHs partnered with public health departments, hospitals, law enforcement, jails and prisons, FQHCs, free and rural clinics, tribal health centers, physicians, and human service providers of all sorts. CMH service networks have a unique set of skills and experience that are invaluable in integrated care systems of the future. And, based on the stories in this issue (and many more not covered in this issue), we can be assured that localities are increasingly looking to CMHs as solution builders with unique skills and experiences. Of course, CMH and its provider networks must also pay attention to and proactively prepare for the rapidly evolving “managing entity” environment. In order to truly integrate physical health and behavioral health, we have to look critically at the often very separate systems that develop and manage networks, authorize, arrange and purchase services, and monitor quality of service provided. We need to take a careful look at processes involving Medicaid (through PIHPs), substance use disorder treatments beyond Medicaid (CAs), GF supported specialty services and supports (through CMHSPs) and Medicaid/Medicare funded physical health care (HMOs and health plans).

In order for our public MH/SUD/DD/SED system to continue to play a lead role in managed care, we must also synthesize administrative processes across our broad system. We need to streamline while holding fast to the unique and evidence-based services specific to individuals represented in the various population groups. This is not an easy task for the State or for managing entities (PIHPs/CAs/Medicaid and Medicare Health Plans). I am encouraged by the commitment to ensure we do not solely focus on the managing entity changes, but that we give first priority and energy to the local service structure synthesis that must work regardless of how the managing entity systems evolve in both public and private systems.

Even so, we do need to ask some tough questions about our existing carve-out for Medicaid and systems that manage our non-Medicaid services. There are vulnerabilities in our existing managing entity systems that will not serve Michigan well as we look to have our public system continue to play a leadership role in integrated care and integrated funding systems. Associations such as MACMHB, MASACA and others are busy with many such issues, yet there are other issues that require more active attention. Some of the most pressing work includes:

- Increase Medicaid Health Home readiness within CMH and provider systems for those with chronic conditions (such as SMI). MACMHB has provided some excellent learning opportunities on these topics, and the impressive work continues through various workgroups.
- Develop data analytics systems to provide population management information, using claims and encounter data inclusive of physical health, behavioral health, habilitation supports, substance use disorder and pharmaceutical systems to proactively address risk, cost and need. Through the models workgroup and TSG you will be hearing more information soon on potential opportunities in this area, which are very exciting, learning from the Missouri and North Carolina experience.
- Standardize assessment tools (from CMH to CMH, PIHP to PIHP) and processes to measure intensity of supports needed, particularly for habilitation. Most CMHs use tools to assess eligibility for supports and services for various populations, yet the lack of consistent tools weakens our common ability to function as a lead player amongst other managed care entities and creates perception issues with stakeholders such as family members and legislators.
- Align geographic boundaries across DCH funded service systems (physical health, habilitation, mental health, and substance use disorder services). Increase the ability of BHDDA managing entities to serve broader geographies that define both CMH/SUD networks as well as physical healthcare. Carefully consider how to address the single CMH “ownership” of a PIHP (acting on behalf of an affiliation) especially as managing entity regions grow and integration with physical health care managing systems evolves.
- Develop common standards for data exchange in order to minimize duplication at the service point forward, and prepare managing entity EHRs and data systems to broaden and change geographies quickly, or quickly add providers who may or may not have their own EHRs. TSG is tackling this very difficult work already, which is great.

By addressing the above challenges, we not only improve efficiency of administrative and managing systems, but we also strengthen the ability of local systems to continue to do the important and effective work we see evidence of in this issue.

In closing, I want to express my appreciation to the CMHs, providers and all managing entities for your commitment and energy. Local creativity, responsiveness and solution building is the strong foundation upon which we will continue Michigan’s legacy of being a local and national leader in services to persons with mental illness, substance use disorders, developmental disabilities and children with serious emotional disturbance. ■■

*Lynda Zeller, a contributor to the Fall 2011 edition of Connections, has more than 25 years of experience in the field of mental health—serving individuals with mental illness, developmental disabilities, substance use disorders, and children with emotional disturbances. She has served in executive positions with Lifeways PIHP, Hope Network, and Kent Health Plan. Most recently, she served as the Health Services Administrator for the Michigan Department of Corrections (MDOC), which included all health, behavioral health and dental services for the State’s correctional system.*

# WHEN THE INDIVIDUAL BECOMES THE HUB

## *The Evolution of Centra Wellness Network*

JOSEPH "CHIP" JOHNSTON, EXECUTIVE DIRECTOR, CENTRA WELLNESS NETWORK  
INGEMAR JOHANSSON, CHIEF OPERATING OFFICER, CENTRA WELLNESS NETWORK

### *Sandra's Story*

Sandra came in to the Honor Family Practice, a private primary care clinic, to address some of her physical health issues with her hands and arms. In the process she mentioned to Ellen Heit, her primary care provider at the clinic, that she had trauma issues with past sexual abuse as a child. Experiencing flashbacks, she had a recent anxiety attack resulting in a visit to the Emergency Room at Munson Hospital in Traverse City. She had addressed some of these issues in the past with counselors at another agency that had proven to be not such a good experience. Ellen suggested that she could easily see Bill Ramsey, the Counselor of Centra Wellness Network (CWN), who comes to the Honor clinic one day a week.

After an initial visit with Bill at the clinic followed by two more, she knew that it had been a good move. "He is the first person that has helped me with useful relaxation techniques," she says. "He showed me how to study my breathing and recognize the triggers for my anxiety."

After Bill had concluded these initial sessions at the clinic, he referred Sandra to the offices of Centra Wellness Network for extended therapy. "When I came to your offices the first time," she says, "it was very reassuring to see Bill's smiling face at the intake session. The hand-off to your other counselors at Centra Wellness was so smooth. It was so good to meet with Bill at the Honor clinic at first because I would probably not have sought your services at your offices when I needed them."

### *What makes this possible?*

CWN has an arrangement in Benzie County with the Honor Family Practice and two of the five Crystal Lake Clinics, all with private primary care, where psychiatric services and early mental health assessments are provided on their sites. It has proven to be a tremendous way to introduce people to mental health services on familiar turf without the stigma of going to a "mental health facility."

These arrangements have grown out of the relationships that CWN staff have built over the years with a concentrated effort to integrate many services and supports for people with behavioral health needs.

In order to combat the fact that people with mental illness die 25 years prematurely, we jumped on the opportunity to seek a block grant from the Michigan Department of Community Health to begin to address this stark statistic. As a result, three years later, three mental health therapists and our psychiatric services team provide services in local private primary care clinics, and we are in the midst of forming the Northern Michigan Health Coalition

with a number of provider organizations in our region. Plans are forming to construct a joint medical center in Manistee in accordance with the Patient Centered Medical Home model. Our paradigm as a service provider is turning upside down.

### *How did we get here?*

Integration has always been in the picture for our organization. The notion of great benefits to the consumers from integrating services with our community members is based on the premise that services and supports are inherently more effective when we go to the customer versus the customer coming to us. With customer convenience determining the date, time and location of sessions, our focus shifts. The customer is now at the center and flexibility in our response becomes pivotal.

Centra Wellness has lived this concept since the mid 1990s. In brief, it started with the provision of children's services in the schools that has since evolved to the point that every public school system in our two counties hosts a Centra Wellness Prevention Specialist for elementary level students with early interventions as flagged by teachers, principals and other school staff. During this same period, we also pursued the closure of all segregated facilities for people with disabilities. We closed two sheltered workshops and two day programs that we were operating in order to optimize community inclusion for all consumers. We developed attractive individual alternatives with the individual at the center. Since then, all community living support and supported employment services for people with developmental disabilities and mental illness have been provided in community integrated settings customized to the individual. Again, it has forced us to be flexible in our approach to services and supports.

As a result of the many successes that were achieved based on this community based support model, Centra Wellness staff has for some time provided services and supports in the jails, hospitals, senior centers, schools, and in a large number of community organizations and locations. With this approach, our consumers play an important role in contributing to a vibrant community life.

With our support, they work in a number of supported employment sites to make a living. They pursue their micro business projects. They volunteer at a variety of organizations, schools, meals-on-wheels, state parks, Habitat for the Humanity projects, nursing homes, food pantries, and wherever community members normally volunteer. People with disabilities have become a vital force in our community, and in the process, those with a psychiatric disorder have enhanced their recovery.

We seek integration opportunities everywhere we go which demands that we stay flexible as to where and when services are provided. We have formed deep and lasting (continued on page 4)

relationships with our community members due to the fact that both staff and consumers live and breathe our neighborhoods.

### *A paradigm shift in health care*

This has helped us in our pursuit to stake out our future in the new paradigm of integrated health care. We received a MDCH Block Grant to integrate our medical services into primary care facilities in 2008. The establishment of our psychiatric services at a neighboring Crystal Lake Clinic made a lot of sense. It has set us on the path of becoming embedded in a Patient Centered Medical Home.

The whole concept of the Affordable Care Act (ACA) has brought a realization that we are indeed an integral part of an over arching healthcare system in which physical health care, mental health care, and substance abuse treatment are needed to serve the whole person. The community at large is beginning to recognize that the head is attached to the body and that our insurance coverage needs to reflect that. The component of the ACA of insurance parity between mental health and physical health has brought this realization to the national healthcare conversation.

We have had to embrace the fact that the healthcare industry—mental health care included—is going through major changes and embrace the notion that primary care is King. It is also clear that we serve the most vulnerable population and the most costly, to boot. It is therefore an attractive target for cost reduction in reforming our healthcare system. The current concerns expressed by individuals who are eligible for both Medicaid and Medicare are exhibit “A,” and therein lies both the challenge and the opportunity.

We see great opportunities in taking the lead in the reform effort—locally and regionally—thus avoiding becoming victims to circumstance by staking out our future. We believe in our ability to provide a unique service within the healthcare field and that we are well positioned to provide the leadership that it takes to make a local fragmented health care community whole. By embracing the notion that all health care is local and should be driven by local primary care entities, with our organization as the inevitably necessary mental health specialist, we can collaborate on equal terms with a unified goal in mind. It makes for a good game on a good playing field.

Since our medical staff—physicians, nurse practitioners, and nurses—moved into the Crystal Lake Clinic, we have not looked back. Our instincts told us that our name, then Manistee-Benzie CMH, and our public relations tools did not reflect the new paradigm that we want to design. We believed that people in the community had an aversion toward the term “mental health” and the stigma and “less than easy” access that came with it.

Therefore, as the Affordable Care Act (ACA) of 2010 began to unfold, we embarked on a project to re-brand our organization to reflect our position as an organization that for years has provided wellness oriented services and supports in our

community in an integrated network of locations. With a focus on health and wellness in the ACA, *Centra Wellness Network* was born with a whole new set of public relations tools. This also resulted in a renewed focus on customer service in all its aspects.

As is described in the ACA, it is important that people in need seek out services and supports in order to keep our community as a whole healthy and well. We project that our name change will have some impact on the accessibility to our mental health services.

### *Northern Michigan Health Coalition*

Our relationship with the team of physicians and nurses at Crystal Lake Clinic has blossomed. In discussing the principles of a Patient Centered Medical Home with their staff, it soon became clear that other friends needed to be invited to play in the sandbox. The decision was made to embark upon a coalition building process in which a full range of health care provider organizations would be invited. As a result, the following entities are members of the Northern Michigan Health Coalition at this time:

- *Centra Wellness Network* providing mental health related care within two counties
- *Crystal Lake Clinic* providing primary care within five private clinics in three counties
- *West Shore Medical Center* (hospital) providing acute and specialty physical health care in Manistee County
- *Northwest Michigan Health Services* (FQHC) providing primary care and dental care in seven counties
- *Benzie-Leelanau Health Department* providing services in two counties
- *Manistee Area Health Clinic* providing free primary care in one county
- *Catholic Human Services* providing substance abuse and mental health care in twenty-one counties
- *Paul Oliver Memorial Hospital*, providing acute and specialty physical health care, and the *District 10 Health Department*, serving ten counties, are involved in our conversations at the time of this writing.

Our Coalition embraces the vision that we, as a community of health care providers, will collaborate to provide a range of health care services to people of all ages in which we care for the whole patient and manage multiple, interrelated and chronic health problems. We will align our clinical and financial incentives to meet the triple aim of improved quality, patient experience and reduced costs. This would entail projects such as the development of a mutually accessible electronic health record.

At this point in time, our Coalition is pursuing planning for the implementation of a common electronic health registry as well as setting up formal governance and management structures.

“People come in to our clinic all the time with multiple problems,” says Geoff Turner, MD, of Crystal *(continued page 11)*



Geoff Turner, M.D.

# Journey Toward an Integrated Healthcare Partnership in Monroe County

Jane Terwilliger, Executive Director, Monroe CMH Authority

**T**his article describes the development of the partnership between Monroe Community Mental Health Authority (MCMHA) and The Family Medical Center (FMC) a Federally Qualified Health Center (FQHC); the steps taken to offer patients/consumers increased access and more seamless and coordinated care; lessons learned along the way and a description of our current status; and a look at future possibilities as we see them today.



Pictured above (from left) are MCMHA staff Lynne Spencer, Integrated Health Clinician; Dr. Nancy Hanke, Medical Director; and FMC staff Regina South, PA-C; and Dr. Cornelio Naguit.

**Background** Over the past decade there has been a growing awareness and concern about the health related needs of individuals served by behavioral health clinics and practitioners. The negative impact on longevity from untreated or under treated chronic health conditions for people with mental illness or developmental disabilities is well documented. Likewise, the correlation between chronic health conditions and mental illness has been well established (the co-occurrence of heart disease or diabetes and depression, for example). The growing awareness of the importance of care coordination and integration between primary care and behavioral healthcare has created opportunities for new partnerships and synergy for the accomplishment of shared visions for improved overall health and wellness.

Monroe County is located in the southeast corner of Michigan. The county population is 152,000 with 19,477 Medicaid covered lives. Although there are large health systems in surrounding areas such as Toledo, Wayne County, and Washtenaw County, health care is delivered by local providers. Mercy Memorial Hospital is a not-for-profit local hospital with an inpatient psychiatric unit in addition to the physical health inpatient and ambulatory care they provide. Health Plan of Michigan is the largest Medicaid HMO in Monroe County, and its provider panel includes both independent physician practices and the Family Medical Center.

In 2002, MCMHA had an ongoing “medication only” case load of 75 to 100 individuals assigned to an MCMHA Registered Nurse. Other consumers who were appropriate for this level of care as

part of discharge planning were on case management case loads, but could not be transitioned due to the size of the medication only case load. It was difficult to transition consumers to primary care physicians for ongoing management of the psychotropic medications needed to maintain recovery. Also, there was very little communication about the health needs of people with mental illnesses and developmental disabilities. Staff at MCMHA believed that the coordination of care letters sent to primary care physicians were rarely read and usually ended up shredded. Direct outreach to physicians occurred rarely and inconsistently.

**The Courting Relationship** Many consumers served by MCMHA received their primary care from the Family Medical Center. In 2002, FMC had two clinics—one in northern Monroe County and one in the southern part. FMC had limited psychiatric and behavioral healthcare capacity.

Initial conversations between MCMHA and FMC were related to our individual concerns. MCMHA wanted to transition consumers to primary care for follow up once their mental health conditions were stabilized. FMC recognized a need for increased availability for mental health services and was not knowledgeable about the community mental health system. FMC was providing brief outpatient therapy to individuals with Medicaid and billing the Medicaid HMO for those services. The first steps were to educate each other about our systems and begin to build trust that neither of us would abandon mutually served individuals. FMC physicians looked to MCMHA to assist them in managing patients with mental illness through phone consultations and assurances that people would be able to easily re-engage with MCMHA for services if needed. MCMHA wanted primary care doctors to accept consumers transitioning from CMH services. This stage could be categorized as reluctant dating without much mutual attraction or shared vision, but it opened opportunities for conversation.

In December 2007, MCMHA and FMC were invited to participate in an Integrated Care Learning Collaborative with six other counties in Michigan. This opened the way for discussions about developing a more collaborative relationship and possibilities for colocation. In the spring of 2008, FMC had an opportunity to apply for a HRSA grant and approached MCMHA to partner with them in the grant. This was a huge step forward. The purpose of the grant was “to increase the capacity for providing mental health and substance abuse services to low-income, uninsured and under-insured persons in Monroe County as well as increasing primary care and prevention services for identified mental health consumers of Monroe Community Mental Health Authority.” The grant application stated “a collaborative practice model will be utilized that fosters integration of behavioral health and primary care.” Although FMC was not awarded the HRSA grant, we proceeded to the next step in our dating relationship and began to plan to colocate, a little.

In September 2008, MCMHA completed renovation of its Raisinville Road site. This is the main CMH site and houses clinic-based services as well as all case management and administration. The renovation plan included creating space for (continued on page 6)

a FMC mid-level practitioner and medical assistant to provide primary care to MCMHA consumers. Based on FY 2007 consumer data, MCMHA served 1851 individuals; 65% were Medicaid beneficiaries and 35% were classified indigent. Of those without Medicaid, 232 (36%) did not have a primary care provider. In 2009, FMC placed a Physician Assistant at the MCMHA main site for half a day a month. Data collected since consumers began receiving primary care from FMC at MCMHA demonstrates increased access to primary care and consumer satisfaction.

- Increased the percentage of MCMHA consumers with primary care from 64% to 89%
- Increased the percentage of kept appointments with the FMC PA from 53% to 84%
- Consumer satisfaction with receiving primary care at MCMHA site was 100%

MCMHA began colocation within FMC by placing a psychiatrist one half day a week at the FMC Carleton clinic. Referrals from the FMC physicians to the MCMHA psychiatrist were screened and scheduled by the MCMHA Access Center. This ensured that individuals with emergent need were seen appropriately, those appropriate for CMH services were assessed and opened to MCMHA, and Medicaid beneficiaries with mild to moderate needs were referred to their Medicaid HMO for services. Individuals without health insurance who had mild to moderate needs were referred to the CMH psychiatrist at FMC for an initial evaluation and were transitioned back to their primary care physician for ongoing medication monitoring. The CMH psychiatrist remained available to the primary care doctor for consultation.

Beginning in FY 2010, MCMHA increased the number of staff collocated at FMC. A full-time Integrated Health Clinician, with a master's degree in behavioral health and two Certified Peer Support Specialists (CPSS) were hired as part of a two year block grant from the Michigan Department of Community Health. The role of the Integrated Health Clinician is to provide brief crisis intervention, screening and intake related services, referral, and care coordination to adults with (or at risk of) a mild to moderate mental health condition who are in need of a mental health consultation as identified by the staff at the Family Medical Center. The role of the CPSS staff is to provide advocacy support as an enhancement of services to individuals with (or at risk of) a serious mental illness; maintain rapport with consumers; and promote an environment for exercising responsible choices, effective problem solving, and maximum independence.

**Testimony** The Integrated Health Clinician, Lynne Spencer, shared the following thoughts:

"I think a big turning point for Dr. C. (an FMC physician) in accepting Integrated Health was the following situation. I was there on a Wednesday and Dr. C. was seeing someone who was experiencing some serious suicidal ideation with a plan. Dr. C. consulted with me and did a warm hand-off. I was able to screen the person right then and develop a safety plan. We were fortunate that Dr. H. (the MCMHA psychiatrist) had a cancellation the following day and was able to see the person then. I

have seen the gentleman since then, and he is still having occasional suicidal thoughts but without plan or intention. We continue to see him and he continues to improve. After that, Dr. C thanked me and told me I was a 'lifesaver.'

"There are some concerns among the primary care physicians about prescribing the same medications that Dr. H. prescribes when the consumers are transferred back to the PCP. They have had discussions about this and are starting to have case consults on an as-needed basis when people are transferred from Integrated Health back to the PCP. Also, the doctors and I are doing more consulting on the spot, and I have much more of a sense that I am part of the treatment team. The physicians are using screening tools for depression, anxiety, and bipolar disorder, and are more comfortable beginning treatment with medication prior to the individual seeing Dr. H."

In the past year, both FMC and MCMHA have had staffing challenges. The two CPSS staff MCMHA hired to work with FMC consumers each found different jobs—one left MCMHA for full-time employment, and the other moved to a different position in MCMHA. FMC experienced staffing changes also, and had to

move the Physician Assistant who was providing primary care at MCMHA to another site. Staff-

ing issues aside, MCMHA and FMC are planning to continue working together with collocated staff.

**Successes** Physicians are saying now that they are glad our integrated health clinician is there. They have found that having someone on site to refer to when individuals are in crisis has been helpful. We meet monthly with FMC to discuss any issues regarding the program. We designed a referral form to help physicians know why an individual was being referred to them. This assisted the physicians in providing the appropriate care and referrals in regards to behavioral healthcare.

**Barriers** Initially, the biggest barriers were the physicians adapting to behavioral healthcare individuals. Also, not surprisingly, some of the physicians had stigmas toward mental illness. Space at the FMC has been our other biggest barrier with expanding services. Having our peers trained for three months and moving to other positions has been a setback.

**Mistakes Made** The biggest mistake was in our hiring and training of our Peer Support Specialists. We learned that in order to make the grant work, a great deal of time has to be spent in training for this unique position. Cheat sheets were made by Access staff to assist CPSS staff. We also will do this differently in this next round by hiring and training first and then sending the individual to certification training. We would like to develop a written protocol now that we have a better idea what works in our county between FMC and MCMHA.

**Where we are going?** We are planning to expand, of course. MCMHA has a FY 2012 Block Grant to increase the number of CPSS staff from two to four individuals. After the grant funding ends, we expect to continue to support this initiative with general fund and funding (continued page 11)

# THE ART OF ENGAGEMENT— *A Connections Interview With Becky Flint*

**A**rguably the most important personal skill needed in a healthcare system dedicated to maintaining wellness in the population is the ability to engage individuals into making decisions that sustain their quality of life. Our investments in personnel that have this art of “engagement” may well yield the greatest return. Becky Flint, BSW, who works with individuals who have dementia and their families, was identified as one who excels in engagement. It becomes evident in this interview that this art is rooted in the faith that everyone possesses the wisdom essential to their own well-being. Engagement is the skill of evoking this innate wisdom. — Clint Galloway, Editor

*Connections:* I was given your name, Becky, because I was told you epitomized the gift of being able to engage people and build relationships, especially with those who are resistant to receiving services. Your style was characterized as being non-traditional.

**Becky:** [Laughs] That’s probably true but I’m not sure what is considered traditional.

*Is it that you don’t sit behind a desk?*

**Becky:** Yes that’s true.

*So how do you engage people?*

**Becky:** Well, I’m usually in the home of the people receiving services. Or I’m out in the community, from churches to even bars. I just go where people feel comfortable. One particular person owned a bar so I would just go and hang out there where I could talk with them.

*Do you have a cubicle here in the agency?*

**Becky:** Yes, but I would say probably 80% of my time is spent out in the community.

*So what do you do when you’re in the cubicle?*

**Becky:** Well, most of the time I’m probably chatting with co-workers [laughs and then says aside, “No, I like to joke around.”] It’s primarily phone calls and paperwork. This is a place where I can just take some time and think about people. It might be that I decide what needs to happen, like talk to the person’s family and see if they’re interested in doing this or that. I become more creative if I have a moment to think about stuff.

*Tell me more about this process you refer to as “creative.”*

**Becky:** I don’t know if I can really put it into words how I do that. [Hesitation] I get to know a person by their history. A situation that comes to mind is a couple who is ambivalent about receiving help inside their home. They have been married for 46 years. I re-

ally think they see their wedding vows as meaning they are completely responsible for caring for each other and they come from a generation that sees outside help as receiving “welfare.” I run into that a lot. So I went in to just chit chat. I don’t go in with my computer or papers. I always carry my cellphone, for safety reasons or in case something happens, but I just go in and talk. You just get to know them. I know the church the family attends; he’s an avid hunter and used to give guided hunting tours in Colorado. The home environment tells me a lot. I talked with their children, too. That’s how it all begins. As we get better acquainted I can start providing information about possible resources to address some of the problems elderly people inevitably face.



One woman was unable to be left alone, which made it impossible for her husband to engage in hobbies that took him outside. I found a woman who was able to come and stay with her while he was outside. It just kind of happens. [Becky gives several examples that have occurred recently and are fresh in her memory, and then breaks into another one of those infectious laughs.] Those are the easy ones. But it’s not always that easy.

*And the more difficult ones are?*

**Becky:** It’s really difficult when it’s a single adult or their children are out of state. There are no natural supports and it becomes such a burden on the ones you do find. They want to help but they might have someone else in their own family they are already helping.

*Could you talk about how you identify their needs when you’re doing an interview?*

**Becky:** Well, I just face the issues. Building communication is a key. When I enter a situation I never know what I’m going to say or do. Sometimes I’ll just stand and talk until we become comfortable enough to sit down. My appointments don’t last just a few minutes, they last a long time, sometimes an hour or two hours. It’s basically talking—talking about current events, talking about what they like to do—doesn’t have anything to do with dementia at first. [Pausing to collect her thoughts.] The way I was raised, my dad was very creative, and so if he saw something that was made for one use, he could find another use for the item. With that upbringing, I’ve learned to see things in different ways with different possibilities.

*I had a Sociology professor who called that the “noetic impulse,” you just approach everything with an insatiable curiosity. You’re interested!*

**Becky:** [Laughs] Yes! I love to learn about humans in general. “How do you do that?” “What do you think about that?” It doesn’t matter whether I agree or disagree. Just (continued on page 8)

tell me what you think. Humans are fascinating. That's all there is to it.

*It sounds to me like you're not just interested in what makes them tick, but that you really value them and have compassion.*

**Becky:** I strongly believe in "brotherhood." You should treat other people as you want to be treated. This is the United States of America, and we need to respect that and work together to make this a better place.

*Where did you learn that?*

**Becky:** From my childhood, my dad was in the Army and he served in World War II. I was raised with the American flag displayed every day on my house. In grade school we put the flag up every day and said the Pledge of Allegiance. I think that's where I learned that. I have some friends who were remarkable people; my husband is a remarkable man. I just got really lucky in my life that way.

*This is very refreshing. I find a number of people who are very patriotic, who believe very much in their country, but they also believe that the government shouldn't be providing as much social welfare. This kind of patriotism of which you are speaking seems to be more about that "safety network."*

**Becky:** Yes, I understand the concern about people "using" the system. That bothers me too. But there are lots of people who simply can't get off the system, whether it's a serious mental illness or disability. Those are the people I'm talking about, not the ones who are "riding." Anyway, I rarely see those, especially in the field of dementia in which I'm working. The problem I see is that the people who need the services are not receiving them.

*What would you say is one of the most important desires people express?*

**Becky:** I would not describe the people that I see as desperate, but embarrassed and worried. The children worry that they will "get it." The couples worry that they will not be able to maintain their lifestyle. Then there is the embarrassment of asking for help. It is difficult to be willing to have someone else come into your house, giving that trust to them. So, I believe the most important desire would be to live life to the fullest.

*How did you come to be in this work?*

**Becky:** I've always wanted to help people. I was raised on a centennial farm in the U.P. My father used to have people with disabilities work on the farm. We would take in hurt animals, take care of them, then let them go; not just little animals but full-grown animals: coyotes, foxes and bears. That's the way my work is with most of the people. I spend just a little time with each individual and then they go on their way.

*So you were raised in a culture of caring?*

**Becky:** Yes, I remember the first time I ever met a person with a disability. I was two years old. "Gabby" used to talk all the time so we called him Gabby. He was just so much fun to be around because he would just not stop talking. [Laughs] I just found that fascinating, I would just sit there and look at him. He would talk about anything and everything.

*Sounds like you were observing the soul of the person and not just the*

*external behaviors.*

**Becky:** Right, and wondering why their brain is telling them to do that. I think that way often. It's not that their behavior annoys me, I just find it interesting. The brain is a fascinating, sneaky little organ.

*You have a very rich interior life, Becky. Tell me, what's the hardest thing you have to do?*

**Becky:** Attend funerals, and it's not the individual with dementia, it's the caregiver if they die first. That's really difficult. You mourn a lot with the family. There have been times when I just couldn't go.

*[By this point in the interview, I felt as though I was chatting with an old friend. Her ease and manner of speaking were triggering thoughts in my own mind about subjects in which I was interested. Becky was turning the table and I was doing the talking.]*

**Becky:** So let me put this back on you. You've shared some thoughts about what's going on within you, that's what happens when I go to see people. I really and truly enjoy what you just taught me. You have to put this in the article.

*But this interview is about you, not me.*

**Becky:** I'm saying this illustrates what happens. I'll go into a gas station, and ask the clerk just one question and he or she will tell me something about their life just like that. It's the connection there that happens. Now I've learned about you, you love the sciences; science is your cup of tea.

*Becky hooks me again! I start to talk. She not only nails my interests, the tables are turned. I have become the interviewee. Finally, after one of a series of questions I ask, "Who's doing this interview anyway?" Becky laughs once again. Later on she talks about how important humor is to her. She often engages in laughter with the people with whom she is working and reminds me that humor is one of the last things we lose. "Does that mean if we joke a lot we're near the end?" I asked.*

**Becky:** I hope not! [Laughing] Because that means I should have a tag on my toe already. ❖❖

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**MACMHB SPRING CONFERENCE**  
May 22 & 23, 2012  
May 21: Pre Conference Institutes  
Hyatt Regency Hotel  
Dearborn, Michigan



# My Friend Kevin

Tina Tilley, Home Manager, McBride Quality Care Services

**C**ommunity Mental Health for Central Michigan has embraced the philosophy of creating a culture of gentleness within the agency as well as the individuals they support. In the six counties that CMHCM provides services, McBride Quality Care Services has taken a lead on training caregivers in Gentle Teaching. Tina Tilley is a Home Manager who has made it her mission to build a relationship with everyone who lives at this home and is an example and teacher for her staff. Tina treats everyone with the dignity and respect they deserve, and more importantly, provides hope. She has complete confidence that they will be able to achieve their dreams, when others may have given up on them. It is this leading by example that makes Tina the excellent gentle teacher that she is. — Joani E. Hogan, Case Manager, Community Mental Health for Central Michigan—Midland



Kevin and Tina Tilley

I would like to tell you about my friend Kevin.

Kevin was born in the late 1950s with a condition we now refer to as autism. Since autism wasn't widely known until decades later, Kevin was more than likely simply labeled as "retarded." He came from a fairly large family and went to school until he was around ten years old.

After this, Kevin's history is spotty at best because he was mostly hidden from the outside world. His extended family described him as the "wild boy," left to his own devices much of the time and roaming the wooded area behind his run-down family home. When he would return home at the end of the day, many times he was locked in a bedroom, sometimes for days at a time, by a mother who was undiagnosed and untreated for schizophrenia. Surrounded by his own feces and urine, it is believed that he was given little, if any, food or water during these times. On the nights that he wasn't locked in his bedroom, he slept in a lawn chair on an enclosed patio.

He lived this way until his situation was brought to the attention of the state when he was over 50 years old. That's when Kevin was introduced to the woman who would prove to be his own personal guardian angel. Appointed by the state and well-practiced in Gentle Teaching, Jan Lampman became Kevin's guardian. When she first entered his family home, she found all three family members covered from head to toe in black soot, as they had been using coal to heat the home without proper ventilation. They were hoarders, so there was only a very narrow path to walk through the rooms. The refrigerator was packed tightly with old, rotting plastic containers of food. (It is believed that one person was receiving Meals on Wheels and they would share the one meal amongst themselves.) Kevin was taken out of the home after he witnessed a near-fatal, self-inflicted shooting by one of his family members.

While his home life was a horror to those of us on the outside, it was all Kevin had ever known, so his transition to the outside world was a bumpy one. He refused to sleep in a bed or to use the

bathroom properly. He would urinate and defecate in his bedroom, as he had done at home. He began hoarding out of both habit and fear. He hoarded clothing (wearing up to 17 long sleeve shirts at a time), water (keeping up to 20 cups and bottles in his room every night, filled to the brim with water), and magazines that he enjoyed looking at. He refused to step his foot into a shower, only allowing his staff to sponge bathe him once or twice a week. Additionally, the transition from living out in the middle of nowhere to a larger city brought its own set of obstacles for Kevin, who wasn't familiar with situations such as traffic, property boundaries, and dealing with the general public.

When his guardian felt that the staffing agency she had originally used had done all they could for Kevin, she decided to go with the agency I work for, McBride Quality Care Services, which specializes in Gentle Teaching. This is where I first had the pleasure of meeting Kevin.

I had been transferred to Kevin's city to be the home manager of a new AFC home my agency was opening. Since Kevin would be the first to move into the new home, I had the opportunity to work with him for three weeks prior to move-in.

At just over six feet tall and over 250 pounds, Kevin was a bit intimidating at first. He used barely any words, instead using hand gestures and the inflection of his grunts to communicate his needs. He shied away from any touching, and his interaction with staff was minimal and only on a "have to" basis. When Kevin moved into his new home, he refused to sleep for three straight days. He became erratic and irritable because of his lack of sleep, requiring two staff at all times.

But after a short amount of time, Kevin began bonding with his new staff who were highly trained in the Gentle Teaching approach. Since his words were extremely minimal, we relied on body language and his tone to provide cues as to how he was feeling. When we could see that he was beginning to feel irritated, we would hold out a hand and speak to him in a calm voice. When he was calm and in an amiable mood, my staff and I would spend time with him doing the things he enjoyed. (Mostly taking walks in the backyard, watching traffic go

*(continued on page 10)*

# Thoughts on Evolution, Transcendence, and a New Order – Clint Galloway, Editor

I have been fascinated with evolution since doing independent study my senior year in college with a biology professor. Over the year, she fed me books on evolution, beginning with Darwin's *Origin of Species*. I would meet with her to discuss the books.

Since then, I have discovered Ken Wilber (*A Brief History of Everything*) who has integrated the research of physical, social, psychological and cultural systems. He refers to these as the four quadrants of knowledge. Two quadrants study the exteriors of reality: the physical sciences study the individual entities (quarks, atoms, neurons, cells, etc.), and the social sciences study the behaviors of groups. The other two quadrants study the interiors: psychology explores what goes on in the mind of an individual while cultural studies explore groups cemented together by common beliefs and values. Wilber has done a magnificent job in integrating these sciences, pointing out the fallacies attributed to trying to explain everything from the perspective of a single quadrant.

But to the point here, when he uses the maps each of the systems has produced of evolutionary development within their quadrant, they all correlate and reveal the same dynamics surrounding each evolutionary step. With every successful advance in evolutionary development, several processes must occur: the current system of organization is disturbed as relationships with new entities are developed, and the emergent order transcends but includes the previous system. For example, when oxygen bonds with hydrogen to create water, a new phenomenon appears but the oxygen atom still remains oxygen and the two hydrogen atoms still remain hydrogen. The process is simple but elegant. In water, the atoms of oxygen and hydrogen are no longer “free,” but they still retain their integrity as atoms of oxygen and hydrogen. In order to evolve into water, they surrender their independence and freedom while maintaining their identity. They have been transcended and included in a new order.

This simple but elegant process has been creating and unfolding our universe from the beginning. Our current public behavioral health system in Michigan borders on being infinitely more complex than the atomic structure of water, but the principles that govern a successful evolution are identical. Our isolated individualities are being challenged by the prospect of becoming integrated into relationships with other entities. We will have to sacrifice this notion of “freedom.” We not only can do this, but will do it wholeheartedly if we realize the transcending order includes and preserves our integrity—an integrity built on supports and services for individuals with complex needs in our local communities.

Nature is replete with unsuccessful attempts to evolve into increasingly complex orders. And that is worthy of great caution! What we need to assure is that the new order is one that not only transcends—building new critical relationships—but also includes our current integrity. The unsuccessful attempts are those that fail to accommodate the full value of any of the original components. If the motive for integration is self serving, at the expense of any partner, it will create more suffering than healing and eventually join the trash heap of history. ■■

## Kevin (from page 9)

by, listening and dancing to polka music, and cooking.) The focus was not on making Kevin behave, but in building a relationship with him. In the very beginning, when he did have episodes of physical violence, instead of scolding or otherwise punishing him, we continued to express love to him and let him know that he was safe with us. Whenever we introduced something new to him that might cause anxiety or stress, we made sure to have two trusted staff with him at all times so that he would feel safe.

At first, the triumphs were seemingly small. A sponge bath three to four times per week rather than once or twice. He began allowing several staff to shave him on a regular basis, sometimes even trimming his eyebrows. One day he allowed us to cut his hair! New words kept coming, including saying “please” and “thank you.”

All this time, we were working on the larger goals of showering and more inclusion into the public. While he wouldn't step foot into the shower, he would play with the shower head and enjoyed spraying it into the shower while standing on the outside. We would take him for rides and sit in the Wal-Mart parking lot, watching the people go inside.

Then one weekend I received a call after 9 PM. I never like to receive those calls, because it usually means something is wrong. Quite to the contrary, it was my assistant manager telling me that Kevin had taken a shower...an honest to goodness, inside the shower stall, head to toe, shower!

Then the next night I received another call about the same time. Kevin had taken another shower, then jumped in the van with my assistant and went to Wal-Mart, went inside for about twenty minutes without incident, then came home!

Tears of joy were definitely in order at that point.

It has been just over nine months since I first met Kevin, and it seems like every day he is learning something new. He is able to clearly tell us “yes,” “no,” “I don't like that,” “I like it,” or “I don't want to.” Every morning he greets me with a hug and a big smile on his face. He helps us do household chores like making his bed, sweeping, taking out the garbage, laundry, and washing dishes. He is learning to make wise choices about clothing, and he is taking a shower nearly every day. He no longer feels the need to hoard water or clothing, and his magazine collection consists of about 10 rather than the hundred or so he had when we first met him.

But most of all, Kevin is HAPPY. He is surrounded by people who make him feel safe and loved, and in turn, he trusts us enough to reveal more of himself every day.

This is what Gentle Teaching is all about. It is about helping those entrusted to our care to feel safe and loved. One of the positive end results is that there will be fewer negative behaviors, but this is not the ultimate goal of Gentle Teaching. The goal is to treat everyone with the dignity and respect that every one of us deserves.

Gone are the days of physical restraints, punishments, and even the threats of such things. We have entered into an era where a culture of gentleness in our homes and facilities is an absolute necessity. Whenever someone tells me that Gentle Teaching doesn't work, I will always look to Kevin. He is the perfect example that a little unconditional love can go a very long way. ■■

## **Courage** (from page 1)

ments “right.” Together they reviewed all the medications Marilyn received for all her conditions and began a process of streamlining them. They stopped unnecessary medications, prescribed different medications when side effects and contraindications suggested this, and closely managed the dosages Marilyn was taking.

At the same time, Marilyn started classes in the Summit Pointe *Personal Action Toward Health* [PATH] program to learn how to manage her medical illnesses. She also enrolled in *Wellness and Recovery Action Planning* [WRAP] classes to learn to manage her own psychiatric distress. Marilyn worked with a team of physicians, social workers (particularly Kim Spencer), Peer Support Specialists, and an outpatient therapist. She was truly committed to her own well-being and success.

The improvements began to mount. Her depression lifted for the most part and her memory improved. Marilyn’s lethargy decreased and was replaced by greater activity. She got out into the community more regularly. Her self-care improved. She managed her schedule to attend all her medical and psychiatric appointments.

Marilyn now cooks for herself. Her diabetes has come under control. Her hypertension is now manageable. Marilyn values her relationships and friendships with her peer support specialists. She has moved into a senior apartment complex and participates in many lifestyle enrichment activities there.

Marilyn has reconnected with her children. She is a loving presence in the lives of her seven grandchildren and her two great grandchildren. Marilyn says her life “has become a life to be cherished.”

The problems are not all gone, but fighter that she is, Marilyn keeps walking toward the future while enjoying the richness of today. She is a hero. She has more than her fair share of medical and emotional challenges, but Marilyn struggles on in her own journey, in a quiet and often hidden way. The problems are not all gone, but Marilyn has some secret weapons to help her: courage and resilience. And, of course, there’s the happy need to spend more time with her grandchildren and great-grandchildren. Life is good. ■■

## **Integrated Healthcare** (from page 6)

received through the Meaningful Use certification of our affiliation electronic medical record, E.II. We plan to double the psychiatric hours from four to eight hours a week and are adding a second master level Integrated Health Clinician (IHC). The Family Medical Center has given us a small suite of offices at its Carleton location, and one IHC with two CPSS will be located there. The other IHC and two CPSS staff will be at the FMC Temperance clinic in southern Monroe County. With the four peers assisting, more individuals will be linked and coordinated with benefits, housing, and employment. FMC has committed to returning a mid-level primary care provider to the MCMHA Raisinville Road site when they are again fully staffed. ■■

## **INDIVIDUAL BECOMES THE HUB** (from page 4)

Lake Clinic in Benzonia, “and they have lots of stress in their lives due to housing, income and mental health issues. This greatly affects their health. It is great to have the easy referral to Maripat (the Centra Wellness therapist in their office) for my patients to handle their issues. The easy access to her clinical notes is of great value. She is part of the treatment team.

“I recently had this couple in their mid-30s that were fairly functional,” continues Dr. Turner, “until he had a work related accident severely injuring his leg leading to multiple surgeries and loss of his job and income, and great marital problems. She was in school, they had several foster children, and their lives began to unravel and got extremely stressful. It was a given to refer them to Maripat next door. It is great. We should have had this ten years ago.”

This type of issue can be substantiated by a recent Robert Wood Johnson Foundation survey report released in December of 2011 (American Medical News: <http://www.ama-assn.org/amed-news/2012/01/02/hlsa0102.htm>), in which the claim is made that 85% of primary care physicians and pediatricians say that unmet social needs are directly leading to worse health for all Americans. Yet only 20% of doctors feel confident in their ability to address those needs. Many physicians say they want to prescribe nutritional food, offer housing assistance and help with utility bills in an effort to improve their patients’ health. The physicians state that health concerns are frequently caused by unmet social needs that are beyond their control as physicians and that these unmet needs often prevent them from providing quality medical care. This applies to patients of all income levels.

This reflects an unmet need and a potential market share for our community mental health system in general, and supports coordination/case management in particular. This part we do well. Opportunity knocks. Building relationships that enable a friendly hand-off to a mental health specialist and/or a substance abuse counselor in one visit, with a scheduled follow up session by a Care Manager, perhaps in the person’s home; it only makes sense.

There has never been a better time to form new partnerships between provider entities. All human service entities need to work together in new and creative ways. This goes for mental health agencies, law enforcement, state operated human services, private and public physical health, private and public hospitals, substance abuse, federally qualified health centers, foundations and other funding entities, and any other entities that would add value to the system.

There is a great opportunity knocking on the door of our industry at this moment. It is a shorter leap for the community mental health system to adjust its business model to that of the primary care than the other way around. And why wouldn’t it be? We have learned that we can offer the local primary care facility a great service by embedding ourselves into their practice. We become part of their solution. ■■



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## Healthcare or Health Care?

In the last two issues you've no doubt noticed that sometimes we use the word "health-care" (one word) and at other times the phrase "health care" (two words). There is considerable difference between the two usages. Unfortunately some of the tension in the current environment arises over confusion between these two, or more sadly, because of conflicting agendas.

Health care refers to what happens to a person receiving services. These are the "high touch" relationships that occur between provider and individual. That is why we say, "All health care is local." *Connections* has primarily focused on these stories, believing this is the heart of our work. However, there is another critical element that makes this all possible and that is the healthcare system. When we receive services, this element is largely invisible. It is that "high tech" virtual activity in the background, electronically processing encounter data and channeling the funding. We need a healthcare system in order to have health care. We need both. In this issue, Lynda Zeller has cited the challenges we must address in designing a new generation of healthcare here in Michigan. No doubt, with billions of dollars at stake, there are people knocking on her door. The challenge is to assure that our healthcare system is driven by the desire to enhance the quality of our health care.