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MI Mind Memorandum

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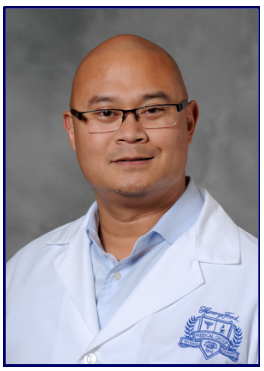
MULTI-PRONGED APPROACH PRIORITIZES COMMUNICATION, CORRECT CARE, AND TRUST



Emmanuel Dizon, M.D., Henry Ford Health Internal Medicine Specialist

Henry Ford Health physicians Emmanuel Dizon, M.D., Internal Medicine, and Doree Ann Espiritu, M.D., Psychiatry, teamed up with colleagues to spearhead two strategies aimed at making the most of limited resources and getting patients the right type of mental health care at the right time.

The first strategy is Behavioral Health Integration, a program created with Primary Care using the Collaborative Care Model (CoCM) developed by the University of Washington's AIMS Center. Henry Ford Health's model is unique because it is 100% virtual.

Doree Ann Espiritu, M.D., Henry Ford Health Psychiatrist

"Demand is greater than supply, and that led to collaboration between Behavioral Health and Primary Care," said Dr. Dizon. "We wanted to reduce access time for our patients needing short-term mental health care to get through a crisis like grief or job loss, or mild to moderate depression and anxiety."

The solution was online counseling, which created an avenue for primary care providers (PCPs) like Dr. Dizon to refer patients for therapy within Primary Care. Office staff make that first appointment for the patient before they leave, and patients go home with reassurance and a therapy session in place. In this model, mental health care stays in Primary Care. If patients need medications, the consulting psychiatrist gives a recommendation, and the PCP provides the prescription.

Patients appreciate the convenience and privacy of seeing a therapist from home. To head off technological frustration, a Behavioral Health team member calls the patient before the appointment with instructions.

"After short-term therapy, many patients gain skills, resources, and techniques to cope with emotions," says Dr. Dizon. Feedback from patients and providers has been positive, and the model is now used throughout Henry Ford Health Primary Care. Since it was initiated in 2017, more than 11,000 patients have been supported through the integrated care model.

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In this issue of 'The Mem'

MI Mind

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MULTI-PRONGED APPROACH PRIORITIZES COMMUNICATION, CORRECT CARE, AND TRUST

The second strategy is the creation of a triaging tool. It was launched in December 2024 after years of preparation. With mental health providers in short supply and 1,500 patients waiting to be seen, it has been difficult for Primary Care and Behavioral Health Services to prioritize more severe patients who need help urgently.

Now, says Dr. Espiritu, "Using Epic, when PCPs ask patients the questions on the PHQ-9 and discover risk for suicide, the Epic tool clarifies the urgency. Schedulers know which referrals to address immediately and make the referrals with greater accuracy."

There are also prompts for the PCP to mark if the patient has acute risk factor for suicide, including hallucinations or delusions, as well as a plan or intent for suicide. Dr. Espiritu points out that greater details enable schedulers to steer patients to mental health providers who are a good fit, increasing patient and provider satisfaction. They also keep a limited number of psychiatry crisis appointments available for patients with high PHQ-9 scores so they can be seen right away.

According to Dr. Espiritu, "I saw five crisis patients this week and it was the right care. Were it not for the triaging tool, they would have waited three months. It benefits the patient and the provider and decreases stress for our schedulers."

Another piece is giving patients resources while they wait for an appointment. Patients who have milder symptoms are connected with online behavioral health resources. "They can learn about their symptoms and use mindfulness and cognitive behavioral therapy apps," says Dr. Espiritu. "A digital navigator assists them, and patient liaisons check in to reassess and identify if stepped-up care is needed sooner."

According to Dr. Dizon and Dr. Espiritu, communication and collaboration between PCPs and Behavioral Health has grown. Precious time slots in Behavioral Health are used effectively and trusting relationships have been forged.

"Our approach is patient-centered and serving our patients and their families the right care at the right time with evidence-based treatments are priorities. It is truly comprehensive and makes everyone happier," concludes Dr. Espiritu.

Dr. Dizon and Dr. Espiritu are MI Mind Content Experts. Visit MI Mind to learn more about them and email MIMind@hfhs.org to connect.

MI MIND TEAM SUPPORTS SUICIDE PREVENTION AT 9TH ANNUAL KEVIN'S SONG EVENT

MI Mind team members Sarah Moore, LMSW, and Leslie Johnson, R.N., Clinical Quality Improvement, and Jason Robertson, Marketing, took part in the Kevin's song statewide three-day conference in January. Held at St. John's Resort in Plymouth, MI, the conference offered an opportunity to connect with suicide-prevention advocates.

According to Moore, "The conference inspired and moved us, and we learned more about the work people throughout Michigan and the country are doing to reduce, and hopefully one day eliminate, suicide. We made new connections and saw familiar faces, including MI Mind providers from Trinity Health IHA Medical Group."

The team attended a keynote presentation by Kevin Fischer, Executive Director, NAMI Michigan and CEO of EVERYBODY -VS- STIGMA. "His presentation was deeply inspirational and bolstered the importance of suicide prevention from someone with lived experience who is a survivor himself," said Moore. Fischer was the keynote speaker at MI Mind's October 2024 Collaborative-wide Meeting.

Learn more about Kevin's Song and upcoming events.

JAMA NETWORK OPEN STUDY SHOWS IMPACT OF ZERO SUICIDE MODEL ON SUICIDE PREVENTION

A recent multi-site study published in JAMA Network Open examines how health care systems can prevent suicide. The study—authored by MI Mind Co-Directors, Brian Ahmedani, Ph.D., LMSW and Cathrine Frank, M.D., as well as the Henry Ford Health Research team, and a research consortium from Kaiser Permanente— is titled "Zero Suicide Model Implementation and Suicide Attempt Rates in Outpatient Mental Health Care" and presents how the "Zero Suicide Model" impacted suicide attempt and death rates across six U.S. health systems from 2012 to 2019.

The Zero Suicide (ZS) Model, developed in 2001 by Henry Ford Health, is a structured care pathway that includes routine suicide risk screening, comprehensive assessment using validated tools, and timely delivery of interventions such as safety planning, caring contacts, and treatment. By embedding these steps into standard outpatient mental health visits, the model helps health systems consistently identify individuals at risk and connect them with evidence-based care. The model was effective at Henry Ford Health, which reported zero suicides in 2009.

When Kaiser Permanente and Henry Ford Health implemented the program at four new sites during the study period (2012-2019), suicide attempts dropped in three locations, with up to a 25% reduction overall, while the fourth system showed a sustained lower plateau. In addition, suicide deaths dropped at all four locations, with two of these locations observing significant reductions.

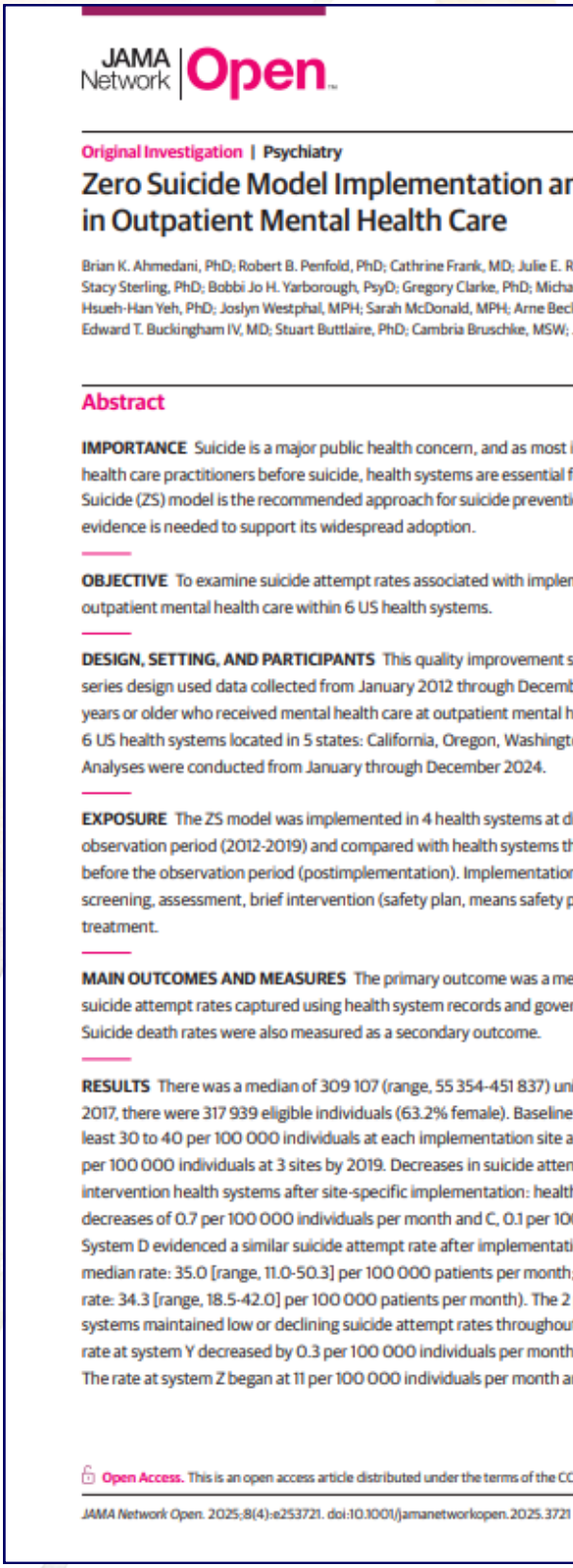
Two additional systems that adopted the ZS Model prior to the study maintained the lowest and most stable rates, including Henry Ford Health, which sustained a declining rate since its adoption in 2001.

In total, reductions across the six sites equated to 165–170 suicide attempts prevented annually, according to lead author Brian Ahmedani.

These results demonstrate the lasting benefits of fully integrating the ZS Model into routine care and underscore the importance of strong leadership, adequate resources, and a unified commitment to safety. The findings strongly support national efforts, such as the 2024 U.S. National Strategy for Suicide Prevention, which advocate for the widespread adoption of the ZS Model as a core approach to preventing suicide in health care settings.

Participants that are part of the MI Mind CQI have access to the ZS Model and the opportunity to achieve similar reductions in suicide attempt rates by implementing the model to fidelity.

Click here to read the full study.



JAMA Network Open

Original Investigation | Psychiatry

Zero Suicide Model Implementation ar
in Outpatient Mental Health Care

Brian K. Ahmedani, PhD; Robert B. Penfold, PhD; Cathrine Frank, MD; Julie E. R
Stacy Sterling, PhD; Bobbi Jo H. Yarborough, PsyD; Gregory Clarke, PhD; Micha
Hsueh-Han Yeh, PhD; Joslyn Westphal, MPH; Sarah McDonald, MPH; Arne Bec
Edward T. Buckingham IV, MD; Stuart Buttlaire, PhD; Cambria Bruschke, MSW;

Abstract

IMPORTANCE Suicide is a major public health concern, and as most
health care practitioners before suicide, health systems are essential f
Suicide (ZS) model is the recommended approach for suicide preventi
evidence is needed to support its widespread adoption.

OBJECTIVE To examine suicide attempt rates associated with implen
outpatient mental health care within 6 US health systems.

DESIGN, SETTING, AND PARTICIPANTS This quality improvement s
series design used data collected from January 2012 through Decemb
years or older who received mental health care at outpatient mental h
6 US health systems located in 5 states: California, Oregon, Washingt
Analyses were conducted from January through December 2024.

EXPOSURE The ZS model was implemented in 4 health systems at d
observation period (2012-2019) and compared with health systems th
before the observation period (postimplementation). Implementation
screening, assessment, brief intervention (safety plan, means safety p
treatment.

MAIN OUTCOMES AND MEASURES The primary outcome was a me
suicide attempt rates captured using health system records and gover
Suicide death rates were also measured as a secondary outcome.

RESULTS There was a median of 309 107 (range, 55 354-451 837) uni
2017, there were 317 939 eligible individuals (63.2% female). Baseline
least 30 to 40 per 100 000 individuals at each implementation site a
per 100 000 individuals at 3 sites by 2019. Decreases in suicide atten
intervention health systems after site-specific implementation: health
decreases of 0.7 per 100 000 individuals per month and C, 0.1 per 10
System D evidenced a similar suicide attempt rate after implementati
median rate: 35.0 [range, 11.0-50.3] per 100 000 patients per month;
rate: 34.3 [range, 18.5-42.0] per 100 000 patients per month). The 2
systems maintained low or declining suicide attempt rates throughou
rate at system Y decreased by 0.3 per 100 000 individuals per month
The rate at system Z began at 11 per 100 000 individuals per month a

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JAMA Network Open. 2025;8(4):e253721. doi:10.1001/jamanetworkopen.2025.3721

WOMEN'S HISTORY MONTH SPOTLIGHT NOMINATION

Congratulations to Dr. Cathrine Frank on her Women's History Month Spotlight Nomination. Each year to celebrate, Doximity.com invites community members to nominate women in medicine who have made a meaningful impact in their lives and work. Read all of the nominations here.

MICHIGAN MEDICINE PRACTICE INTRODUCES A TWO-PRONGED APPROACH TO SUICIDE PREVENTION

Jill Fenske, M.D.
Michigan Medicine

Jill Fenske, M.D., and her colleagues in ambulatory care at Michigan Medicine were in the process of developing a two-pronged approach to suicide prevention prior to joining MI Mind last fall.

"We reactivated a quality improvement initiative to strengthen depression management and suicide risk screening with two tactics," says Dr. Fenske. "An Epic workflow addresses a PHQ-9 score of nine or higher with tools and options for providers. We also hired a dedicated crisis social worker for ambulatory care patients who screen at risk for suicide."

High-risk patients with intent and plan are directed to the emergency department. Patients at moderate or low risk receive prompt intervention to ensure they are connected to the right level of care. These tactics were key to decreasing the anxiety providers expressed about screening for suicide.

"When patients screen moderate- or moderate-to-high risk for suicide, providers can call the social worker immediately. She connects with patients for same- or next-day safety planning," says Dr. Fenske. "With this system, PCPs can raise a a flag for their patients, and we offer PCPs a resource they can rely on."

The social worker coordinates continued access to mental health care, removing a barrier patients find especially challenging to navigate when they already feel emotional strain.

"Changing workflows and integrating a new process into the health record is challenging in a fast-paced ambulatory environment. We are cognizant of the many pressures occurring in a visit, and that suicide-risk intervention in the primary care setting is usually unanticipated," says Dr. Fenske.

The workflow was developed by a multidisciplinary team led by Dr. Fenske and Sr. Project Manager Laura Petersen, and launched in January 2025. Feedback from providers has been positive.

Implementing the workflow and introducing the social worker during the organization's first year with MI Mind was helpful. Increased funding to support the new position was secured when Michigan Medicine joined MI Mind. Provider training has presented evidence and dispelled myths.

"MI Mind assured our team that it doesn't raise risk to ask if a patient has thoughts of suicide or self-harm," says Dr. Fenske. "And now, we have resources in place when the answer is yes."

"AN ASPECT OF MI MIND TRAINING I APPRECIATED WAS TAKING A MOMENT TO PAUSE AND CHECK IN WITH MYSELF AND MY TEAMMATES. TALKING ABOUT SUICIDE AFFECTS US ALL, PERSONALLY AND/OR PROFESSIONALLY. PROVIDERS HAVE AN ELEVATED RISK FOR SUICIDE THEMSELVES."

A CONVERSATION WITH KEVIN FISCHER, EXECUTIVE DIRECTOR, NAMI MICHIGAN

You've been deeply involved in mental health advocacy for many years now, both personally and professionally, how has stigma shaped your experience along the way?

KF You know, stigma has taught me how hard it is to live with a mental illness and/or to experience suicidal ideation.

I learned directly from my late son Dominique how hard it is to recognize that something is not right emotionally or mentally and how much bravery it takes to ask for help, not just from random people in the community, but also from your family, your friends, and your loved ones. Why? Because once people learn about a mental illness diagnosis their view of that person instantly changes. It makes it so hard for a person to seek treatment or to remain compliant with their treatment because they're always looking over their shoulders and they're always trying to hide their diagnosis because of the stigma.

What is your experience with stigma in health care settings?

KF We're getting better, but physical health care and behavioral health care still exist in significant silos. You go to one building for your physical care, and if it's determined that you have a behavioral health care issue, you can't in most cases receive treatment in the same location. You have to go somewhere else and it's stigmatizing to many people to go to a building that literally says “mental health” on the signage. That is a challenge for many people because of the stigma associated with mental illness. Many won't seek treatment because they don't want to be seen walking through that door.

There is no stigma associated with someone going to their primary care doctor for an annual physical or for any other reason. Nobody looks at them any differently for doing that. But, if they say they have to go see their psychiatrist, their psychologist, or they have to go to community mental health, then people look at them very differently. That's stigmatizing.

If you could make a big meaningful change in the health care system to reduce stigma, where would you start? What would it be?

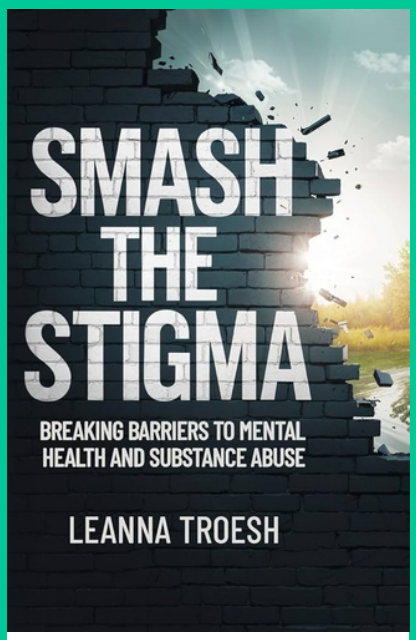
KF Honestly, I'd start with having the kind of conversation we're having right now, and I'd like to see us have this conversation at medical schools. I’d like to see us have this conversation at medical conferences. The first step to eradicating stigma is simply normalizing the conversation. Literally addressing that stigma does in fact impact us all. It doesn't matter how well educated you are, it doesn't matter how nice a house you live in. It doesn't matter if you're Democrat or Republican. None of that matters.

What are some of the biggest misconceptions or biases that you see as it relates to mental illness, whether it's amongst health care professionals or just anyone in general? What are you seeing out there?

KF You know the biggest bias is that most people think mental illness is a choice or they think that it is a weakness of character or faith. Most people don't recognize that mental illness is a medical condition and a medical diagnosis that requires medical treatment. Just like any physical illness. So that's one of the huge biases that I see. It's “your” fault. Like it’s a choice. No one chooses to have a mental illness.

To read the rest of the interview, visit our blog by clicking here.

RECOMMENDED READING



S*mash the Stigma: Breaking Barriers to Mental Health and Substance Abuse* is a powerful guide aimed at dismantling the stigmas surrounding mental health and substance abuse. Leanna Troesh, drawing from her personal recovery and over fifteen years in behavioral health, offers an authentic narrative blending lived experience, cutting-edge research, and practical strategies.

“The road to breaking the stigma around mental health and substance use is not an easy one. There will always be obstacles and believing we’re not making enough progress is tempting. But every small step counts. Every honest conversation, every moment we choose compassion over judgement, brings us closer to a world where no one has to struggle alone. Imagine a future where no one hesitates to ask for help, where communities rally together to support their most vulnerable members, and where mental health is treated with the same care and attention as physical well-being.”

One lucky reader will win this book! *Winner will be selected via random drawing from The Mem subscriber list and will be notified by email the week of 5/5/25.*

COLLABORATION LEADS THE MI MIND QUALITY INITIATIVE

Sarah Moore, LMSW, Sr. Clinical Quality Improvement Lead

Not only is it the first word in "Collaborative Quality Initiative," collaboration is a key aspect of MI Mind that is driven by the providers themselves.

"Trainings and collaborative meetings, including regional meetings, are when our team sees collaboration among behavioral health and primary care providers the most," says Sarah Moore, LMSW, Sr. Clinical Quality Improvement Lead. "Trainings and meetings bring together MI Mind physicians, psychiatrists and psychologists, and we also see collaboration with social workers, nurses, and office managers when they can hear one another's perspectives."

Sometimes training sessions are a chance to put a face with a name. Participants can connect with a person from an agency or organization and share resources that can be helpful in the future. "Physicians and behavioral health providers in the same geographic area meet in these collaborative spaces, which can lead to referrals for counseling or primary care for the patients they serve," says Moore.

Similarly, Regional Meetings, held annually in the spring, are designed for collaboration within and among provider organizations. Before joining MI Mind, many providers were already engaged in suicide prevention. In Regional Meetings and training, they reveal their processes and help others consider how they can streamline, automate, or reinvent their protocols. In the future, collaboration can include data to reveal effective paths and processes based on numbers.

"It's exciting to meet people from multiple disciplines from across the state, talk about what we are doing separately and discover how we can come together," says Moore. "In every MI Mind training and Regional Meeting, we aim for an atmosphere where everyone feels united in working toward the goal of zero suicide."

REGISTER TODAY FOR A MI MIND REGIONAL MEETING

If you are a Practice Clinical Champion or Practice Liaison for your Provider Organization, be sure to register for one of these upcoming Regional Meetings:

Tuesday, May 20 from 11 a.m. to 2 p.m.
The H Hotel
111 W. Main Street, Midland

Tuesday, June 3 from 11 a.m. to 2 p.m.
Delamar Traverse City
615 E. Front Street, Traverse City

While attendance at one Regional Meeting by a Practice Clinical Champion or Practice Liaison fulfills the value-based reimbursement (VBR) requirement for your organization's scorecard, both are invited and welcome. Provider Organization leadership is encouraged to attend, but it is not required. Meetings include lunch, MI Mind "swag," and opportunities for collaboration and sharing of best practices. There is no cost to attend. Register today.

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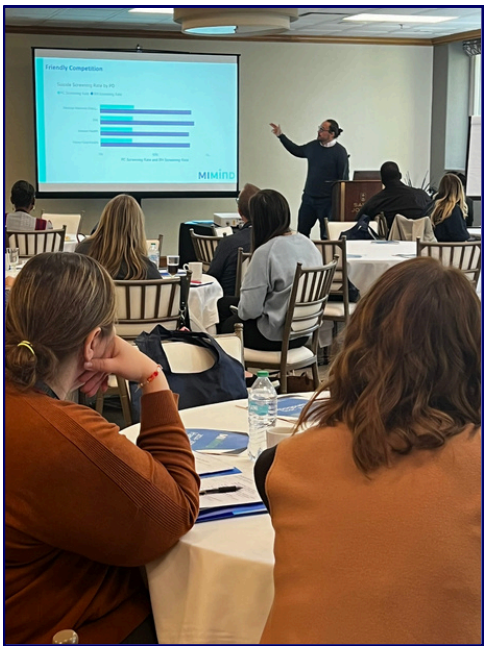
REGISTER TODAY FOR A MI MIND REGIONAL MEETING

Present at a Regional Meeting and Earn Additional Scorecard Points
Practice Clinical Champions and Physician Organization (PO) leads are invited to present at Regional Meetings. Presentations are 10- to 15-minutes long and can describe how you have strengthened your care pathway, partnered with other resources or organizations to prevent suicide, or another topic related to MI Mind protocols, processes, or suicide prevention. Presenters receive additional points on their PO Scorecard. For more information and to express your interest, email MIMind@hfhs.org.



PO Leadership: Register Today for the Fall Collaborative-wide Meeting
It's never too soon for PO Leadership to put the MI Mind Collaborative-wide Meeting on their schedules. This year's event takes place Friday, Oct. 24 from 9 a.m. to 1 p.m. at Weber's Boutique Hotel, 3050 Jackson Ave., Ann Arbor. One member of each PO Leadership team must attend to receive credit toward their PO Performance Index Scorecard. Clinical Practice Champions and Clinical Liaisons are invited and encouraged to attend, but it is not required. Register today.

WEBINAR SUCCESS LEADS TO NEW FALL SERIES

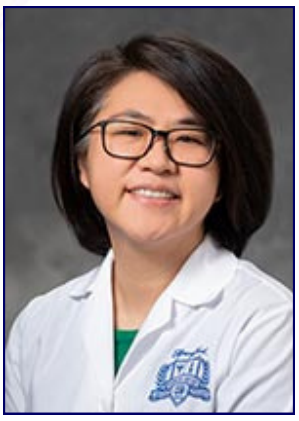
MI Mind launched its inaugural webinar series last fall, with attendance averaging 200 people per webinar. Attendees heard from Lisa MacLean, M.D., on the healing properties of being a provider; Cathrine Frank, M.D., presented a two-part series on the use of psychotropic medications for depression and anxiety; and Jordan Bracizsewski, Ph.D., described how to use motivational interviewing in suicide prevention. The most recent webinar was March 27, with Paul Pfeiffer, M.D., M.S., who delved into collaborative care and suicide prevention.

Upcoming Webinars
With provider attendance a clear indication that topics and speakers are compelling, a new webinar series will launch in September. You can already register for the first scheduled webinar, Tuesday, Sept. 30. Debbra Snyder, MS, LLP, CAADC, CCS, Michigan Medicine Psychiatry Department, will discuss problem-solving therapy in primary care settings, a brief, evidence-based, cognitive-behavioral intervention for treating depression and anxiety.

MI Mind will email providers as webinars are scheduled, but you can also visit our website to see upcoming webinars and register. Webinars are typically scheduled from noon to 12:45 p.m. There is no cost to attend, and attendees do not need to be part of MI Mind. If you are interested in hosting a webinar, email Jason Robertson, Sr. Marketing Specialist at jrober40@hfhs.org.

MI MIND BIOSTATISTICIAN FOCUSES ON COMMUNICATION AND UNDERSTANDING

When Hsueh-Han Yeh, Ph.D., joined Henry Ford Health in 2017, her first project focused on suicide prevention within health systems and was led by Brian Ahmedani, Ph.D. The opportunity to be involved with the project and rich, evidence-based data provided a strong foundation for her ongoing interest in suicide prevention.



Hsueh-Han Yeh, Ph.D.
Sr. Biostatistician / Assistant Scientist

According to Yeh, "As I worked on that first project, I recognized how prevalent suicide is and how many people are affected. I also realized that among people who die by suicide, about half have no mental health diagnosis a year before they die. If we only focus on people with mental health diagnoses, we miss half of those at risk."

Senior Biostatistician for MI Mind and Assistant Scientist for Henry Ford Health's Center for Health Policy & Health Services Research, Yeh specializes in analyzing complex longitudinal data. "We use statistical modeling to dive into complex data and then turn the findings into clear, understandable insights that help guide actionable strategies," she says.

Currently, she is working with the MI Mind data team and programmers to collect data. They ensure it is relevant and reflects clinical practice before analysis begins. She explains, "We work with clinicians to understand what they see on the front line and get their feedback. Communication and insight into clinicians' perspectives enables our team to interpret the data accurately. Through close collaboration, we ensure our analyses are grounded in real-world clinical insights."

With her experience analyzing data, Yeh anticipates MI Mind data will generate a wealth of information. "We hope to provide evidence-based recommendations using information from our findings. Ultimately, that data could help guide clinical practice and lead to better outcomes," she says.

Yeh has a master's degree in statistics and a doctorate in epidemiology from Michigan State University. She earned her bachelor's degree in mathematics in Taiwan.

"My educational journey has shaped my approach to data. Having a background in mathematics, statistics, and epidemiology, I've gained a solid foundation in both the technical aspects of data analysis and the real-world applications of statistical models in public health. This combination allows me to approach data not just with a focus on robust analysis, but for its broader implications—especially when it comes to improving health outcomes."

Yeh is optimistic her role at MI Mind will lead to meaningful change. "We have an opportunity to work with health systems and providers throughout the state and impact everyone in Michigan. By ensuring our data is comprehensive and reliable, we can have a stronger voice and potentially lead to policy change. Suicide is preventable, and we have the opportunity to help save lives. It's wonderful to be part of that."

Learn more about Hsueh-Han Yeh and the entire MI Mind team.

FOLLOW US ON LINKEDIN AS WE RECOGNIZE MENTAL HEALTH AWARENESS MONTH

May is Mental Health Awareness Month, and in recognition, MI Mind will offer frequent posts on our LinkedIn page. Follow us as we lift up mental health awareness throughout the month and continue to follow us for MI Mind news and mental health resources.

“FRANKLY SPEAKING” WITH DR. FRANK

By: Cathrine Frank, M.D.
Co-Director, MI Mind

More than half the people with mental illness do not receive help for their disorders. A major reason for this tragic statistic is stigma, prejudice, and discrimination. Stigma can be subtle or obvious, but no matter the magnitude it can lead to harm. Stigma not only affects the individual with mental illness, but also their loved ones and family that support them. It can rob individuals with mental health disorders from job opportunities, housing, healthcare, and relationships with others.

Everyone holds unconscious beliefs about various identity groups, including those with mental illness. All of us can take affirmative steps to acknowledge these beliefs and mitigate our responses. We need to commit to change for all unconscious and conscious biases so we can provide support and treatment for people with mental health disorders.

I appreciate this quote from President Bill Clinton (1999): *“Mental illness is nothing to be ashamed of, but stigma and bias shame us all.”*

THE “PETS OF MI MIND” - PIPPIN, SHADOW, AND RAVEN

MI Mind Quality Improvement Lead Leslie Johnson, RN, has a trio of pets who benefit her well-being. Her dog Pippin was found in an abandoned house in Detroit with his littermates. Since being adopted by Leslie in May 2013, he lives the life of luxury with plenty of treats, belly rubs and playing his favorite game—fetch. Pippin can also catch treats in mid-air, a skill he figured out all on his own.

A mixed breed, Leslie thinks he most resembles a German shorthair pointer. He’s a big guy, weighing in at 68 pounds. While his actual birthdate is unknown, Leslie chose Feb. 14, Valentine’s Day, as his official birthday. An older gentleman at 12, Pippin doesn’t go on long hikes anymore, but he and Leslie still get outside often to enjoy shorter walks and the outdoors.

Last summer, Leslie adopted twin black cats, Shadow and Raven. She says the only way to tell them apart is a tiny patch of white on Shadow’s back toes. Born to a feral mother cat, they were rescued at two days old and later adopted by Leslie from Tails, a Grosse Ile rescue organization.

“I decided on these two kittens because black animals are historically harder to adopt, and I wanted to give these two a forever home,” says Leslie. Shadow and Raven keep Leslie entertained and laughing with their kitten antics.

“My pets are always there for me,” says Leslie. “If I am discouraged or down, caring for them takes my mind off my own problems and allows me to focus on them. A great thing about pets is that they are always in the present moment, and they help me forget about my stresses and problems.”

CONTACT US

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If you have questions or suggestions for *The Mem,* please contact Program Manager Heather Omdal, homdal1@hfhs.org.