BAY ARENAC BEHAVIORAL HEALTH

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, January 16, 2025 at 5:00 pm
Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

AGENDA

Page

1. CALL TO ORDER & ROLL CALL

2. PUBLIC INPUT (3 Minute Maximum Per Person)

3. REGULAR BOARD MEETING, 12/19/2024 – Distributed
   3.1 Motion on minutes as distributed

4. PERSONNEL & COMPENSATION COMMITTEE, 01/02/2025 – Distributed – Crete, Ch/Conley, V Ch
   There were no motions forwarded to the full Board
   4.1 Motion on minutes as distributed

5. RECIPIENT RIGHTS (RR) ADVISORY & APPEALS COMMITTEE, 01/06/2025 – Distributed – McFarland, Ch/ Mrozinski, V Ch
   There were no motions forwarded to the full Board
   5.1 Motion on minutes as distributed

6. FINANCE COMMITTEE, 01/08/2025 – Distributed – Banaszak, Ch/ Mrozinski, V Ch

4-5 6.1 Motion to accept investment earnings balances for period ending December 31, 2024 – *See pages 4-5*

3, 6 6.2 Res# 2501001: Approve the Finance January 2025 contract list – *See page 3 resolution sheet & page 6*

6.3 Motion on minutes as distributed

7. PROGRAM COMMITTEE, 01/09/2025 – Distributed – Girard, Ch/Mrozinski, V Ch

3 7.1 Res# 2501002: Approve the requests for clinical privileges – *See page 3 resolution sheet*

3, 7-11 7.2 Res# 2501003: Approve the policies to begin 30-day review – *See page 3 resolution sheet & pages 7-11*

7.3 Motion on minutes as distributed

BOARD OF DIRECTORS
REGULAR MEETING

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AGENDA

Page

8. AUDIT COMMITTEE, 01/13/2025 – Distributed – McFarland, Ch/ Pawlak, V Ch

3, 12-18 8.1 Res# 2501004: Accept financial statements – *See page 3 resolution sheet & pages 12-18*

3, 19-22 8.2 Res# 2501005: Accept electronic fund transfers – *See page 3 resolution sheet & pages 19-22*

3, 23 8.3 Res# 2501006: Approve disbursement & health care claims payments – *See page 3 resolution sheet & page 23*

8.4 Motion on minutes as distributed

9. BOARD MEETING CONTRACT LIST, 01/16/2025

24 9.1 Consideration of a motion to approve the Board meeting January 2025 contract list – *See page 24*

10. REPORT FROM ADMINISTRATION

25-40 10.1 Federal & State Health Policy Update – *See pages 25-40*

41-47 10.2 Bay & Arenac County Updates – *See pages 41-47*

11. UNFINISHED BUSINESS

11.1 None

12. NEW BUSINESS

12.1 Strategic Plan

48-53 Consideration of a motion to approve the 2025 Strategic Plan – *See pages 48-53 & plan attached to back of packet*

12.2 Holiday Hours

BABH Offices will be closed on Monday, January 20, 2025 in observation of Martin Luther King Jr. Day. BABH Offices will also be closed on Monday, February 17, 2025 in observation of President's Day

12.3 February Board Meeting

The February 20, 2025 regular Board meeting will be held at the Arenac Center, 1000 West Cedar Street, Standish, MI 48658

13. ADJOURNMENT

BAY ARENAC
BEHAVIORAL HEALTH

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, January 16, 2025 at 5:00 pm
Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

RESOLUTIONS

Finance Committee, January 8, 2025

Res# 2501001: Resolved by Bay Arenac Behavioral Health to approve the Finance January 2025 contract list.

Program Committee, January 9, 2025

Res# 2501002: Resolved by Bay Arenac Behavioral Health to approve the following requests for clinical privileges:

a) Nicholas Lazurka, PA-C – renewal privileges for a three-year term expiring January 31, 2028
b) Andrew Meyer, DO – renewal privileges for a three-year term expiring January 31, 2028
c) Melissa Wazny – PMHNP-BC renewal privileges for a three-year term expiring January 31, 2028
d) Maggie Ross – PA-C renewal for a three-year term expiring January 31, 2028

Res# 2501003: Resolved by Bay Arenac Behavioral Health to approve the following policies to begin 30-day review:

a) Prescriber Practice Guidelines for Co-Occurring Mental Health & Substance Use Disorders, 04-24-04 (deletion)
b) Welcoming, 04-24-01 (deletion)

Audit Committee, January 13, 2025

Res# 2501004: Resolved by Bay Arenac Behavioral Health to approve the Financial Statements for period ending December 31, 2025.

Res# 2501005: Resolved by Bay Arenac Behavioral Health to approve the electronic fund transfer (EFTs) for period ending December 31, 2025.

Res# 2501006: Resolved by Bay Arenac Behavioral Health to approve the disbursements and health care payments from December 20, 2024 through January 10, 2025.

Bay-Arenac Behavioral Health Authority
Estimated Cash and Investment Balances December 31, 2024

Balance December 1, 2024	9,065,837.45
Balance December 31, 2024	8,251,674.27
Average Daily Balance	7,441,043.71
Estimated Actual/Accrued Interest December 2024	21,800.01
Effective Rate of Interest Earning December 2024	3.52%
Estimated Actual/Accrued Interest Fiscal Year to Date	56,022.37
Effective Rate of Interest Earning Fiscal Year to Date	3.63%

Note: The Cash and Investment Balances exclude Payroll and AP related Cash Accounts.

Cash Available - Operating Fund

	Rate	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Beg. Balance Operating Funds - Cash, Cash equivalents, Investments		7,456,274	7,733,635	3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946
Cash in		11,480,507	4,835,627	19,658,739	13,131,069	13,733,115	3,521,802	21,031,319	18,649,095	11,484,363	12,579,941	20,255,107	13,201,840
Cash out		(11,203,146)	(9,401,946)	(16,716,214)	(13,094,320)	(14,391,408)	(7,959,163)	(17,914,080)	(16,135,454)	(12,277,820)	(13,159,621)	(16,962,838)	(14,017,688)
Ending Balance Operating Fund		7,733,635	3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099
Investments													
Money Markets		7,733,635	3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099
90.00													
180.00													
180.00													
270.00													
270.00													
Total Operating Cash, Cash equivalents, Invested		7,733,635	3,167,316	6,109,840	6,146,590	5,488,296	1,050,935	4,168,174	6,681,815	5,888,358	5,308,678	8,600,946	7,785,099
Average Rate of Return General Funds		4.04%	4.05%	4.08%	4.08%	4.08%	4.08%	4.08%	4.08%	4.05%	3.70%	3.61%	3.57%
		4.11%	4.10%	4.24%	4.08%	4.05%	4.08%	4.05%	4.08%	3.72%	3.70%	3.52%	3.48%
average		6,756,419	6,038,598	6,050,472	6,064,203	5,992,215	5,443,183	5,315,682	5,439,876	5,477,250	5,308,678	6,954,812	7,231,574

Cash Available - Other Restricted Funds

	Rate	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Beg. Balance-Other Restricted Funds - Cash, Cash equivalents, Investments		444,508	446,396	448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891
Cash in		1,888	1,773	1,903	1,850	1,919	1,865	1,935	1,943	1,828	1,803	1,675	1,684
Cash out													
Ending Balance Other Restricted Funds		446,396	448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575
Investments													
Money Market		446,396	448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575
91.00	0.70%												
91.00	1.10%												
91.00	1.15%												
91.00	1.35%												
90.00	1.70%												
91.00	2.05%												
90.00	2.15%	-	-	-	-	-	-	-	-	-	-	-	-
365.00	80.00%												
Total Other Restricted Funds		446,396	448,169	450,072	451,922	453,841	455,706	457,642	459,585	461,413	463,216	464,891	466,575
Average Rate of Return Other Restricted Funds		5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	4.99%	4.84%	4.84%	4.84%
		5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	4.84%	4.84%	4.84%	4.84%
average		443,587	444,504	445,432	446,359	447,294	448,229	449,170	450,117	451,058	463,216	464,054	464,894
Total - Bal excludes payroll related cash accounts		8,180,031	3,615,485	6,559,912	6,598,512	5,942,137	1,506,641	4,625,816	7,141,400	6,349,771	5,771,894	9,065,837	8,251,674
Total Average Rate of Return		4.21%	4.17%	4.20%	4.19%	4.19%	4.18%	4.19%	4.19%	4.17%	3.84%	3.71%	3.63%

Bay-Arenac Behavioral Health
Finance Council Board Meeting
Summary of Proposed Contracts
January 8, 2025

			Old Rate	New Rate	Term	Out Clause?	Performance Issues? (Y/N) Risk Assessment Rating (Poor/Fair/Good/Excellent)
SECTION I. SERVICES PROVIDED BY OUTSIDE AGENCIES							
Clinical Services							
1	ES	**New Dimensions, Inc.** 3 month contract extension	Cost settled contract	Cost settled contract	1/1/25 - 3/31/25	Y	N
2	S	**Superior Care of Michigan** Residential services to 1 BABHA consumer	$276.60/day	Same	1/25/25 - 1/24/26	Y	N
3*	M	**Flatrock Manor - Burton East** A second BABHA individual is being placed at this location	$542.39/day	Same	1/8/25 - 9/30/25	Y	N
SECTION II. SERVICES PROVIDED BY THE BOARD (REVENUE CONTRACTS)							
4	R	**McLaren Bay Region** Pre-Admission Screening Services - 5% increase for FY25 & FY26	$534.75/screen	FY25 Rate: $561/screen FY26 Rate: $590/screen	10/1/24 - 9/30/26	Y	N
SECTION III. STATE OF MICHIGAN GRANT CONTRACTS							
SECTION IV. MISC PURCHASES REQUIRING BOARD APPROVAL							
5	T	**United Way of Bay County** Termination of the Lease for Wirt	$2,125/month	$0	Terminated eff. 6/30/25	Y	N
6	N	**Talk Today** Booth for Mental Health Awareness Night at the Saginaw Spirit hockey game	$50	$50	2/22/25	N/A	N/A
7	R	**MMRMA** Excess crime coverage - annual premium renewal	$9,340	$9,714	1/19/25 - 1/19/26	Y	N/A

R = Renewal with rate increase since previous contract
D = Renewal with rate decrease since previous contract
S = Renewal with same rate as previous contract
ES = Extension
M = Modification
N = New Contract/Provider
NC = New Consumer
T = Termination

Footnotes:

3* HCBS provisional approval as been obtained for this location/move.

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment**		
Section: 24	**Co-Occurring Disorders**		
Topic: 4	**Prescriber Practice Guidelines for Co-Occurring Mental Health and Substance Use Disorders**		
Page: 1 of 6	**Supersedes Date:** **Pol:** **Proc:**	**Approval Date:** **Pol: 3-17-11** **Proc: 3-17-11**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 1/8/2025. For controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to publish prescriber practice guidelines for the treatment of persons with co-occurring mental health and substance abuse disorders.

Purpose

This policy and procedure was developed to educate psychiatric providers including psychiatrists, physician assistants, nurse practitioners and nurses about agency endorsed prescriber practice guidelines concerning the treatment of persons with co-occurring mental health and substance use disorders.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Psychiatrists and Agency Nurses - Clinical
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Psychiatrists, Physician Assistants, Nurse Practitioners, and Clinical Nurses
☐ Policy Only ☒ Policy and Procedure
☐ Other:

Chapter: 4	**Care and Treatment**		
Section: 24	**Co-Occurring Disorders**		
Topic: 4	**Prescriber Practice Guidelines for Co-Occurring Mental Health and Substance Use Disorders**		
Page: 2 of 6	**Supersedes Date:** **Pol:** **Proc:**	**Approval Date:** **Pol: 3-17-11** **Proc: 3-17-11**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
M. Swank	CLT	01/10/11	New	
K. Withrow	M. Swank	07/01/13	Revision	Triennial review: Updated with Person First Language and deleted obsolete information
J. Hahn	J. Hahn	10/1/18	No changes	Triennial Review
J. Hahn	J. Hahn	10/10/2021	No Change	Triennial review
J. Hahn	J. Hahn	12/26/24	Deletion	No longer needed as co-occurring treatment has been embedded into behavioral health treatment philosophy and education for the past several years.

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment**		
Section: 24	**Co-Occurring Disorders**		
Topic: 1	**Welcoming**		
Page: 1 of 2	**Supersedes Date:** **Pol: 2-15-07** **Proc: 10-12-10, 12-21-09, 10-20-09, 2-15-07**	**Approval Date:** **Pol: 10-17-13** **Proc: 8-15-13**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to coordinate comprehensive, competent, seamless, ongoing, and recovery-oriented care for individuals with co-occurring disorders.

Purpose

This policy and procedure was developed to guide the provision of care for mental health and substance use disorders (SUD) to the residents of Bay and Arenac Counties.

Education Applies to

☒ All BABHA Staff
☐ Selected BABHA Staff as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contract Providers, as follows:
☐ Policy Only ☐ Policy and Procedures
☐ Other

SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
M. Wolber	M. Swank	10/20/09	Revision	Updated to incorporate Kardex information on substance use, possession, selling, etc.
M. Wolber	CLT	12/21/09	Revision	Updated to include visitors
K. Withrow	CLT	10/12/10	Revision	Updated with People First language

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

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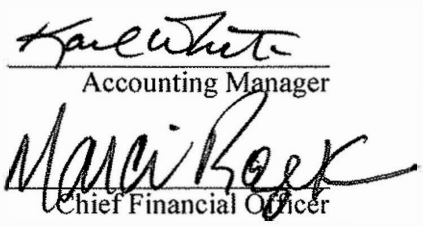
K. Withrow	PNLT	08/15/13	Revision	Triennial Review: Updated with Person First Language and language promoting recovery.
J. Hahn	J. Hahn	10/1/18	No changes	Triennial review
J. Hahn	J. Hahn	10/10/21	No Change	Triennial review
J. Hahn	J. Hahn	12/26/24	Deletion	Incorporated into C04-S05-T06 Recovery Oriented System of Care

Bay-Arenac Behavioral Health
Financial Statements
For Period Ending 12/31/2024

Certified for Accuracy



Bay-Arenac Behavioral Health Statement of Net Assets

Bay-Arenac Behavioral Health Consolidated Income Statement:

By Month to Date

By Year to Date

Bay-Arenac Behavioral Health Reconciliation of Fund Balance:

Bay-Arenac Behavioral Health Reconciliation of Unreserved Fund Balance:

Bay-Arenac Behavioral Health Fund Balance Summary:

Bay-Arenac Behavioral Health Cash Flow Statement

Bay-Arenac Behavioral Health Projected Cash Flows

Bay Arenac Behavioral Health
Statement of Net Assets

		Column identifiers A	B	C	
1	**ASSETS**		**Dec 31, 2024**	**Sept 30, 2024**	
2	**Current Assets**				
3	Cash and cash equivalents		$6,802,912.17	$4,894,930.68	
4	Consumer and insurance receivables		269,507.52	192,843.18	
5	Due from other governmental units		4,359,708.89	7,094,667.58	
6	Contract and other receivables		289,530.12	288,615.57	
7	Interest receivable		0.00	0.00	
8	Prepaid items		603,241.76	444,849.69	
9	**Total Current Assets**		**12,324,900.46**	**12,915,906.70**	(3+4+5+6+7+8)
10	**Noncurrent Assets**				
11	**Cash and cash Equivalents - restricted**				
12	Restricted for compensated absences		1,519,938.61	1,514,776.32	
13	Restricted temporarily - other		115,418.93	111,510.10	
14	**Cash and Cash Equivalents - restricted**		**1,635,357.54**	**1,626,286.42**	(12+13)
15	**Capital Assets**				
16	Capital assets - land		424,500.00	424,500.00	
17	Capital assets - depreciable, net		6,368,374.54	6,368,374.54	
18	Capital assets - construction in progress		-	-	
19	GASB 87 Right to Use Bldg		2,272,819.47	2,272,819.47	
20	GASB 87 Accum Depr, Lease Amortization		(613,824.99)	(613,824.99)	
21	Accumulated depreciation		(4,149,565.58)	(4,103,871.94)	
22	**Capital Asset, net**		**4,302,303.44**	**4,347,997.08**	(16+17+18+19+20+21)
23	**Total Noncurrent Assets**		**5,937,660.98**	**5,974,283.50**	(14+22)
24	**TOTAL ASSETS**		**18,262,561.44**	**18,890,190.20**	(9+23)
25	**LIABILITIES**				
26	**Current Liabilities**				
27	Accounts payable		0.00	3,852,625.64	
28	Accrued wages and payroll related liabilities		491,055.46	275,406.50	
29	Other accrued liabilities		4,753,200.01	1,360,069.00	
30	Due to other governmental units		256,379.00	243,583.00	
31	Deferred Revenue		2,553.73	2,903.73	
32	Current portion of long term debt		16,738.31	16,738.31	
33	Other current liabilities		-	-	
34	**Total Current Liabilities**		**5,519,926.51**	**5,751,326.18**	(27+28+29+30+31+32+33)
35	**Noncurrent Liabilities**				
36	Long term debt, net of current portion		226,000.32	230,134.98	
37	GASB 87 Noncurrent Lease Liability		1,502,277.10	1,502,277.10	
38	Compensated absences		1,244,839.08	1,359,019.52	
39	**Total Noncurrent Liabilities**		**2,973,116.50**	**3,091,431.60**	(36+37+38)
40	**TOTAL LIABILITIES**		**8,493,043.01**	**8,842,757.78**	(34+39)
41	**NET ASSETS**				
42	**Fund Balance**				
43	Restricted for capital purposes		3,966,653.00	3,966,653.00	
44	Unrestricted fund balance - PBIP		2,827,136.47	2,827,136.47	
45	Unrestricted fund balance		2,975,728.96	3,253,642.95	
46	**Total Net Assets**		**$9,769,518.43**	**$10,047,432.42**	(43+44+45) and (24-40)

Bay Arenac Behavioral Health
For the Month Ending December 31, 2024
Summary of All Units

	A	Column Identifiers B	C	D	E (C-D)	F (C / D)	G	
		December Actual	2025 YTD Actual	2025 YTD Budget	Variance	% to Budget	2025 Monthly Budget	
	Income Statement							
1	**REVENUE**		145					
2	**Risk Contract Revenue**							
3	Medicaid Specialty Supports & Services	4,210,743.77	13,979,014.05	15,740,340.50	(1,761,326.45)	89%	5,246,780.17	
4	Medicaid Autism	877,884.09	3,081,015.24	1,460,237.25	1,620,777.99	211%	486,745.75	
5	State Genl Fund Priority Population	135,505.00	406,514.00	406,513.25	0.75	100%	135,504.42	
6	GF Shared Savings Lapse	0.00	0.00	0.00	0.00	0%	0.00	
7	**Total Risk Contract Revenue**	**5,224,132.86**	**17,466,543.29**	**17,607,091.00**	**(140,547.71)**	**99%**	**5,869,030.33**	(3+4+5+6)
8	**Program Service Revenue**							
9	Medicaid, CWP FFS	0.00	0.00	0.00	0.00	0%	0.00	
10	Other Fee For Service	23,240.98	78,422.60	97,444.75	(19,022.15)	80%	32,481.58	
11	**Total Program Service Revenue**	**23,240.98**	**78,422.60**	**97,444.75**	**(19,022.15)**	**80%**	**32,481.58**	(9+10)
12	**Other Revenue**							
13	Grants and Earned Contracts	167,006.63	443,981.50	393,852.25	50,129.25	113%	131,284.08	
14	SSI Reimbursements, 1st/3rd Party	6,339.00	19,027.10	18,772.50	254.60	101%	6,257.50	
15	County Appropriation	65,587.83	196,763.49	196,763.62	(0.13)	100%	65,587.87	
16	Interest Income - Working Capital	22,186.52	56,958.64	79,144.37	(22,185.73)	72%	26,381.46	
17	Other Local Income	4,685.00	11,536.84	115,859.75	(104,322.91)	10%	38,619.92	
18	**Total Other Revenue**	**265,804.98**	**728,267.57**	**804,392.50**	**(76,124.93)**	**91%**	**268,130.83**	(13+14+15+16+17)
19	**TOTAL REVENUE**	**5,513,178.82**	**18,273,233.46**	**18,508,928.25**	**(235,694.78)**	**99%**	**6,169,642.75**	(7+11+18)
20	**EXPENSE**							
21	**SUPPORTS & SERVICES**							
22	**Provider Claims**							
23	State Facility - Local portion	7,063.00	32,894.28	43,839.75	10,945.47	75%	14,613.25	
24	Community Hospital	507,681.62	1,904,281.55	1,878,014.75	(26,266.80)	101%	626,004.92	
25	Residential Services	1,134,113.88	3,547,425.65	3,851,112.75	303,687.10	92%	1,283,704.25	
26	Community Supports	1,906,090.61	6,991,763.71	6,481,799.25	(509,964.46)	108%	2,160,599.75	
27	**Total Provider Claims**	**3,554,949.11**	**12,476,365.19**	**12,254,766.50**	**(221,598.69)**	**102%**	**4,084,922.17**	(23+24+25+26)
28	**Operating Expenses**							
29	Salaries	1,255,532.51	3,820,568.35	3,584,203.20	(236,365.15)	107%	1,194,734.40	
30	Fringe Benefits	422,171.75	1,173,762.65	1,194,970.27	21,207.62	98%	398,323.42	
31	Consumer Related	1,546.29	10,812.82	11,862.89	1,050.07	91%	3,954.30	
32	Program Operations	149,860.27	439,664.68	470,261.26	30,596.58	93%	156,753.75	
33	Facility Cost	49,824.08	151,143.53	175,255.00	24,111.47	86%	58,418.33	
34	Purchased Services	1,206.00	3,967.50	13,301.34	9,333.84	30%	4,433.78	
35	Other Operating Expense	160,673.77	373,489.87	531,470.78	157,980.91	70%	177,156.93	
36	Local Funds Contribution	17,906.00	53,718.00	53,718.00	0.00	100%	17,906.00	
37	Interest Expense	650.08	1,961.22	2,059.25	98.03	95%	686.42	
38	Depreciation	15,231.20	45,693.64	54,118.50	8,424.86	84%	18,039.50	
39	**Total Operating Expenses**	**2,074,601.95**	**6,074,782.26**	**6,091,220.50**	**16,438.24**	**100%**	**2,030,406.83**	(29+30+31+32+33+34+35+36+37+38)
40	**TOTAL EXPENSES**	**5,629,551.06**	**18,551,147.45**	**18,345,987.00**	**(205,160.46)**	**101%**	**6,115,329.00**	(27+39)
41	**NET SURPLUS/(DEFICIT)**	**(116,372.24)**	**(277,913.99)**	**162,941.25**	**(440,855.24)**	**-171%**	**54,313.75**	(19-40)

42 **Notes:**

43 Medicaid Revenue includes an accrual for additional funds if a (shortage) exists/reduction of funds if a surplus exists from/(to) Mid-State Health Network as follows:

BASED ON PEPM FUNDING:

44 Net Medicaid (shortage): ($2,320,198)

45 Medicaid (shortage): ($112,230)

46 Healthy Michigan (shortage): ($884,275)

47 Autism (shortage): ($1,323,693)

BASED ON APPROVED BUDGET:

48 Net Medicaid surplus: $266,350

49 Medicaid surplus: $703,108

50 Healthy Michigan (shortage): ($205,477)

51 Autism (shortage): ($231,281)

BAY-ARENAC BEHAVIORAL HEALTH
RECONCILIATION OF FUND BALANCE
AS OF DECEMBER 31, 2024

	TOTALS
Fund Balance 09/30/2024	10,047,432.42
Net (loss)/income December 2024	(277,913.99)
Net Increase/(Decrease) Funds Restricted for Capital Purposes	-
Calculated Fund Balance 12/31/2024	9,769,518.43
Statement of Net Assets Fund Balance 12/31/2024	9,769,518.43
Difference	-

BAY-ARENAC BEHAVIORAL HEALTH
RECONCILIATION OF UNRESTRICTED FUND BALANCE
AS OF DECEMBER 31, 2024

	TOTALS
Unrestricted Fund Balance 9/30/2024	6,080,779.42
Net (loss)/income December 2024	(277,913.99)
Increase/Decrease in net assets	-
Calculated Unrestricted Fund Balance 12/31/2024	5,802,865.43
Statement of Net Assets Unrestricted Fund Balance 12/31/2024	5,802,865.43
Difference	-

Bay-Arenac Behavioral Health
Fund Balance Summary

	Sept. 30, 2024 Unrestricted Fund Balance	Dec 31, 2024 Permanently Restricted	Dec 31, 2024 Temporarily Restricted	Dec 31, 2024 Unrestricted/ Reserved	Dec 31, 2024 Total Fund Balance
Unrestricted	3,253,643	-	-	2,975,729	2,975,729
Capital Purposes	844,325	-	-	844,325	844,325
Invested in Capital Assets	3,122,328	-	-	3,122,328	3,122,328
Performance Incentive Pool	2,827,136	-	-	2,827,136	2,827,136
Balances	10,047,432	-	-	9,769,518	9,769,518

BAY-ARENAC BEHAVIORAL HEALTH
Cash Flow

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Estimated Funds:												
Beginning Inv. Balance	-	-	-	-	-	-	-	-	-	-	-	-
Investment	-	-	-	-	-	-	-	-	-	-	-	-
Additions/(Subtractions)	-	-	-	-	-	-	-	-	-	-	-	-
Month End Inv. Balance	-	-	-	-	-	-	-	-	-	-	-	-
Beginning Cash Balance	7,784,968	6,118,366	5,348,047	4,747,586	4,030,985	3,260,665	2,660,205	1,943,604	223,284	(377,176)	(1,493,778)	(2,264,097)
Total Medicaid	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649	4,848,649
Total General Fund	135,505	135,505	135,505	135,505	135,506	135,505	135,505	135,506	135,505	135,505	135,506	135,505
Estimated Misc. Receipts	89,759	89,759	205,900	89,759	89,759	205,900	89,759	89,759	205,900	89,759	89,759	205,900
Client Receipts	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000
Interest	14,861	14,861	14,861	14,861	14,861	14,861	14,861	14,861	14,861	14,861	14,861	14,861
Total Estimated Cash	**12,928,741**	**11,262,139**	**10,607,961**	**9,891,360**	**9,174,757**	**8,520,580**	**7,803,979**	**7,087,376**	**5,483,199**	**4,766,597**	**3,649,995**	**2,995,817**
Total Estimated Available Funds	**12,928,741**	**11,262,139**	**10,607,961**	**9,891,360**	**9,174,757**	**8,520,580**	**7,803,979**	**7,087,376**	**5,483,199**	**4,766,597**	**3,649,995**	**2,995,817**
Estimated Expenditures:												
1st Payroll	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000
Special Pay												
ETO Buyouts												
2nd Payroll	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000
Board Per Diem	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343
3rd Payroll	550,000							550,000				
1st Friday Claims	825,000	825,000	825,000	825,000	825,000	825,000	825,000	825,000	825,000	825,000	825,000	825,000
Mortgage Pmt	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032
2nd Friday Claims	995,000	995,000	995,000	995,000	995,000	995,000	995,000	995,000	995,000	995,000	995,000	995,000
Board Week Bay Batch	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000	1,060,000
Board Week Claims	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000
Credit Card	-	-	-	-	-	-	-	-	-	-	-	-
4th Friday Claims	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000	900,000
5th Friday Claims	400,000							400,000		400,000		
Local FFP payment to MSHN		53,717			53,717			53,717			53,717	
Transfer to State of MI												
Transfer from/(to) Reserve Account												
Settlement with MSHN												
Funds from MSHN												
Transfer to (from) HRA												
Transfer to (from) Investment												
Transfer to (from) Capital Acct	-	-	-	-	-	-	-	-	-	-	-	-
Total Estimated Expenditures	**6,810,375**	**5,914,092**	**5,860,375**	**5,860,375**	**5,914,092**	**5,860,375**	**5,860,375**	**6,864,092**	**5,860,375**	**6,260,375**	**5,914,092**	**5,860,375**
Estimated Month End Cash Balance	**6,118,366**	**5,348,047**	**4,747,586**	**4,030,985**	**3,260,665**	**2,660,205**	**1,943,604**	**223,284**	**(377,176)**	**(1,493,778)**	**(2,264,097)**	**(2,864,557)**

Bay-Arenac Behavioral Health

Cash Flow Forecasting
For the Month of January

		Bank Balance	Investment Balance
Estimated Cash Balance January 1, 2025		**7,784,968**	-
Investment Purchased/Interest		-	
Investments coming due during month		-	-
Estimated Cash Balance January 31, 2025		**7,784,968**	-
Estimated Cash Inflow:			
Medicaid Funds:		4,848,649	
General Fund Dollars:		135,505	
Board Receipts:		89,759	
Client Receipts:		55,000	
Funds from Investment:		-	
Interest:		14,861	
Total Estimated Cash Inflow:		**5,143,774**	
Estimated Cash Outflow:			
Payroll Dated:	**01/03/25**	(550,000)	
Payroll Dated:	**01/17/25**	(550,000)	
Board Per Diem Payroll:	**01/17/25**	(3,343)	
Payroll Dated:	**01/31/25**	(550,000)	
Claims Disbursements:	**01/03/25**	(825,000)	
Claims Disbursements:	**01/10/25**	(995,000)	
Claims Disbursements:	**01/17/25**	(975,000)	
A/P Disbursements:	**01/17/25**	(1,060,000)	
Mortgage Payment:	**01/22/25**	(2,032)	
Claims Disbursements:	**01/24/25**	(900,000)	
Claims Disbursements:	**01/31/25**	(400,000)	
Local FFP Payment:		-	
Transfer to Reserve Acct:		-	
HRA transfer:		-	
Transfer to(from) MSHN:		-	
Transfer to State of MI		-	
Purchased Investment		-	
Total Estimated Cash Outflow:		**(6,810,375)**	
Estimated Cash Balance on January 31, 2025		6,118,366	-
		-	-

Bay Arenac Behavioral Health
201 Mulholland, Bay City, MI 48708
Electronic Funds Transfers including Cash Transfers/Wires/ACHs
December 2024

Funds Paid from/ Transferred from:	Funds Paid to/ Transferred to:	Amount	Date of Payment	Description	Authorized By
Flagstar Bank	Flagstar Bank	600,000.00	12/4/2024	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Flagstar Bank	23,693.83	12/5/2024	Credit Card Payment	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	4,000.00	12/5/2024	Transfer from General Account to Flex Spending Account	Marci Rozek
Flagstar Bank	Flagstar Bank	120,000.00	12/5/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	590,000.00	12/5/2024	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	828,230.79	12/5/2024	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	515,000.00	12/9/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	30,000.00	12/9/2024	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Flagstar Bank	30,000.00	12/10/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	30,000.00	12/10/2024	Transfer from General Account to HRA Account	Marci Rozek
Flagstar Bank	Flagstar Bank	340,000.00	12/12/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	1,692,869.33	12/12/2024	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	880,000.00	12/13/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	15,000.00	12/18/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	750,000.00	12/18/2024	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	3,619.58	12/19/2024	Transfer from General Account to Flex Spending Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	748,041.84	12/19/2024	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	1,841,238.85	12/19/2024	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	145,000.00	12/20/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	2,031.96	12/24/2024	Transfer from General Acct for Mortgage payment	Marci Rozek
Flagstar Bank	Flagstar Bank	668,637.46	12/26/2024	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	3,530,000.00	12/27/2024	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	630,000.00	12/30/2024	Transfer from MMKT Account to General Account	Marci Rozek

Total Withdrawals: **14,017,363.64**

Submitted By: Marci Rozek or Christopher Pinter
Chief Financial Officer or Chief Executive Officer

Bay Arenac Behavioral Health
201 Mulholland, Bay City, MI 48708
Electronic Funds Transfers for Vendor ACH Payments
December 2024

Funds Paid from:	EFT #	Funds Paid to:	Amount	Date of Pmt	Authorized By
Flagstar Bank	E6910	MICHIGAN COMMUNITY SERVICES IN	144,020.56	12/6/2024	Marci Rozek
Flagstar Bank	E6911	LIBERTY LIVING, INC.	32,413.22	12/6/2024	Marci Rozek
Flagstar Bank	E6912	NORTH SHORES CENTER LLC	1,050.00	12/6/2024	Marci Rozek
Flagstar Bank	E6913	DISABILITY NETWORK	14,911.66	12/6/2024	Marci Rozek
Flagstar Bank	E6914	SAMARITAS	36,515.18	12/6/2024	Marci Rozek
Flagstar Bank	E6915	HEALTHSOURCE	16,200.00	12/6/2024	Marci Rozek
Flagstar Bank	E6916	PHC OF MICHIGAN - HARBOR OAKS	5,100.00	12/6/2024	Marci Rozek
Flagstar Bank	E6917	MPA GROUP NFP, Ltd.	23,204.01	12/6/2024	Marci Rozek
Flagstar Bank	E6918	LIST PSYCHOLOGICAL SERVICES	1,560.47	12/6/2024	Marci Rozek
Flagstar Bank	E6919	SAGINAW PSYCHOLOGICAL SERVICES	20,369.55	12/6/2024	Marci Rozek
Flagstar Bank	E6920	PARAMOUNT REHABILITATION	3,694.80	12/6/2024	Marci Rozek
Flagstar Bank	E6921	ARENAC OPPORTUNITIES, INC	31,337.80	12/6/2024	Marci Rozek
Flagstar Bank	E6922	DO-ALL, INC.	7,145.89	12/6/2024	Marci Rozek
Flagstar Bank	E6923	New Dimensions	21,652.00	12/6/2024	Marci Rozek
Flagstar Bank	E6924	TOUCHSTONE SERVICES, INC	8,723.52	12/6/2024	Marci Rozek
Flagstar Bank	E6925	Winningham, Linda Jo	474.00	12/6/2024	Marci Rozek
Flagstar Bank	E6926	WILSON, STUART T. CPA, P.C.	26,740.40	12/6/2024	Marci Rozek
Flagstar Bank	E6927	CAREBUILDERS AT HOME, LLC	6,893.14	12/6/2024	Marci Rozek
Flagstar Bank	E6928	CENTRIA HEALTHCARE LLC	35,505.05	12/6/2024	Marci Rozek
Flagstar Bank	E6929	Flourish Services, LLL	22,634.42	12/6/2024	Marci Rozek
Flagstar Bank	E6930	GAME CHANGER PEDIATRIC THERAPY	58,746.35	12/6/2024	Marci Rozek
Flagstar Bank	E6931	Spectrum Autism Center	15,868.72	12/6/2024	Marci Rozek
Flagstar Bank	E6932	ENCOMPASS THERAPY CENTER LLC	58,936.45	12/6/2024	Marci Rozek
Flagstar Bank	E6933	MERCY PLUS HEALTHCARE SERVICES LLC	9,448.05	12/6/2024	Marci Rozek
Flagstar Bank	E6934	HEALING WITH HEART	300.00	12/6/2024	Marci Rozek
Flagstar Bank	E6935	GoTo Technologies USA, Inc.	1,602.00	12/6/2024	Marci Rozek
Flagstar Bank	E6936	KING COMMUNICATIONS	149.35	12/6/2024	Marci Rozek
Flagstar Bank	E6937	AUGRES CARE CENTER, INC	3,718.20	12/13/2024	Marci Rozek
Flagstar Bank	E6938	HOPE NETWORK BEHAVIORAL HEALTH	71,377.90	12/13/2024	Marci Rozek
Flagstar Bank	E6939	Hope Network Southeast	124,867.53	12/13/2024	Marci Rozek
Flagstar Bank	E6940	BEACON SPECIALIZED LIVING SVS	13,271.00	12/13/2024	Marci Rozek
Flagstar Bank	E6941	Bay Human Services, Inc.	268,193.51	12/13/2024	Marci Rozek
Flagstar Bank	E6942	MICHIGAN COMMUNITY SERVICES IN	216,967.95	12/13/2024	Marci Rozek
Flagstar Bank	E6943	CENTRAL STATE COMM. SERVICES	33,863.80	12/13/2024	Marci Rozek
Flagstar Bank	E6944	VALLEY RESIDENTIAL SERVICES	87,262.37	12/13/2024	Marci Rozek
Flagstar Bank	E6945	LIBERTY LIVING, INC.	20,070.27	12/13/2024	Marci Rozek
Flagstar Bank	E6946	SUPERIOR CARE OF MICHIGAN LLC	8,298.00	12/13/2024	Marci Rozek
Flagstar Bank	E6947	Closer to Home, LLC	13,990.63	12/13/2024	Marci Rozek
Flagstar Bank	E6948	DISABILITY NETWORK	16,228.40	12/13/2024	Marci Rozek
Flagstar Bank	E6949	HEALTHSOURCE	27,552.00	12/13/2024	Marci Rozek
Flagstar Bank	E6950	CEDAR CREEK HOSPITAL	10,161.00	12/13/2024	Marci Rozek
Flagstar Bank	E6951	MPA GROUP NFP, Ltd.	46,201.44	12/13/2024	Marci Rozek
Flagstar Bank	E6952	LIST PSYCHOLOGICAL SERVICES	3,253.72	12/13/2024	Marci Rozek
Flagstar Bank	E6953	SAGINAW PSYCHOLOGICAL SERVICES	34,473.91	12/13/2024	Marci Rozek
Flagstar Bank	E6954	PARAMOUNT REHABILITATION	2,590.96	12/13/2024	Marci Rozek
Flagstar Bank	E6955	ARENAC OPPORTUNITIES, INC	8,671.27	12/13/2024	Marci Rozek
Flagstar Bank	E6956	DO-ALL, INC.	4,459.57	12/13/2024	Marci Rozek
Flagstar Bank	E6957	New Dimensions	6,703.96	12/13/2024	Marci Rozek
Flagstar Bank	E6958	TOUCHSTONE SERVICES, INC	6,115.20	12/13/2024	Marci Rozek
Flagstar Bank	E6959	Winningham, Linda Jo	535.00	12/13/2024	Marci Rozek
Flagstar Bank	E6960	WILSON, STUART T. CPA, P.C.	81,899.22	12/13/2024	Marci Rozek
Flagstar Bank	E6961	CENTRIA HEALTHCARE LLC	25,372.81	12/13/2024	Marci Rozek
Flagstar Bank	E6962	GAME CHANGER PEDIATRIC THERAPY	39,359.76	12/13/2024	Marci Rozek
Flagstar Bank	E6963	ENCOMPASS THERAPY CENTER LLC	47,824.04	12/13/2024	Marci Rozek
Flagstar Bank	E6964	Acorn Health of Michigan	648.68	12/13/2024	Marci Rozek
Flagstar Bank	E6965	MERCY PLUS HEALTHCARE SERVICES LLC	22,742.31	12/13/2024	Marci Rozek
Flagstar Bank	E6966	Positive Behavior Supports Corporation	2,381.68	12/13/2024	Marci Rozek
Flagstar Bank	E6967	HEALING WITH HEART	300.00	12/13/2024	Marci Rozek
Flagstar Bank	E6968	DO-ALL, INC.	145,117.00	12/13/2024	Marci Rozek
Flagstar Bank	E6969	Bromberg & Associates, LLC	890.00	12/13/2024	Marci Rozek
Flagstar Bank	E6970	Yeo & Yeo Technology	297.50	12/13/2024	Marci Rozek
Flagstar Bank	E6971	MICHIGAN COMMUNITY SERVICES IN	250.00	12/20/2024	Marci Rozek
Flagstar Bank	E6972	A2Z CLEANING & RESTORATION INC.	5,331.00	12/20/2024	Marci Rozek
Flagstar Bank	E6973	ERGOMED PRODUCTS, INC.	182.00	12/20/2024	Marci Rozek
Flagstar Bank	E6974	FLEX ADMINISTRATORS INC	1,054.20	12/20/2024	Marci Rozek
Flagstar Bank	E6975	HAMPTON AUTO REPAIR	1,287.07	12/20/2024	Marci Rozek

Flagstar Bank	E6976	HOSPITAL PSYCHIATRY PLLC	42,000.00	12/20/2024	Marci Rozek
Flagstar Bank	E6977	Iris Telehealth Medical Group, PA	38,850.00	12/20/2024	Marci Rozek
Flagstar Bank	E6978	J.E.JOHNSON CONTRACTING, INC.	465.36	12/20/2024	Marci Rozek
Flagstar Bank	E6979	McCoy Heating and Cooling	238.90	12/20/2024	Marci Rozek
Flagstar Bank	E6980	MOVVA, USHA	8,400.00	12/20/2024	Marci Rozek
Flagstar Bank	E6981	NETSOURCE ONE, INC.	38,446.96	12/20/2024	Marci Rozek
Flagstar Bank	E6982	SHRED EXPERTS LLC	438.50	12/20/2024	Marci Rozek
Flagstar Bank	E6983	Smith, Bridget M	4,200.00	12/20/2024	Marci Rozek
Flagstar Bank	E6984	UNITED WAY OF BAY COUNTY/RENT	2,125.00	12/20/2024	Marci Rozek
Flagstar Bank	E6985	V.O.I.C.E., INC.	835.56	12/20/2024	Marci Rozek
Flagstar Bank	E6986	Beson, Heather	136.97	12/20/2024	Marci Rozek
Flagstar Bank	E6987	BICKEL, MEREDITH	50.92	12/20/2024	Marci Rozek
Flagstar Bank	E6988	BINKLEY, CASEY	301.97	12/20/2024	Marci Rozek
Flagstar Bank	E6989	Brothers-Estrada, Abbie	144.72	12/20/2024	Marci Rozek
Flagstar Bank	E6990	BYRNE, RICHARD	257.95	12/20/2024	Marci Rozek
Flagstar Bank	E6991	Caddick, Michelle	231.89	12/20/2024	Marci Rozek
Flagstar Bank	E6992	Castillo, Mariah	354.43	12/20/2024	Marci Rozek
Flagstar Bank	E6993	CERESKE, KIM	57.17	12/20/2024	Marci Rozek
Flagstar Bank	E6994	Cook, Jordyn	196.98	12/20/2024	Marci Rozek
Flagstar Bank	E6995	Deshano, Jennifer	259.29	12/20/2024	Marci Rozek
Flagstar Bank	E6996	GUERTIN, SUSAN	606.28	12/20/2024	Marci Rozek
Flagstar Bank	E6997	Gunsell, Stephanie	195.18	12/20/2024	Marci Rozek
Flagstar Bank	E6998	HECHT, KERENSA	154.10	12/20/2024	Marci Rozek
Flagstar Bank	E6999	HEWTTY, MARIA	395.03	12/20/2024	Marci Rozek
Flagstar Bank	E7000	Kohn, Jessica	107.20	12/20/2024	Marci Rozek
Flagstar Bank	E7001	KOIN, STACEY E.	119.26	12/20/2024	Marci Rozek
Flagstar Bank	E7002	Konwinski, Nicole	236.41	12/20/2024	Marci Rozek
Flagstar Bank	E7003	Lagalo, Lori	278.55	12/20/2024	Marci Rozek
Flagstar Bank	E7004	Lemiesz, Rachel	442.87	12/20/2024	Marci Rozek
Flagstar Bank	E7005	LINDER, AMY	48.24	12/20/2024	Marci Rozek
Flagstar Bank	E7006	BEYER, NICOLE	368.50	12/20/2024	Marci Rozek
Flagstar Bank	E7007	Niemiec, Kathleen	120.60	12/20/2024	Marci Rozek
Flagstar Bank	E7008	NIX, HEATHER	20.77	12/20/2024	Marci Rozek
Flagstar Bank	E7009	Nixon, Heidi	138.96	12/20/2024	Marci Rozek
Flagstar Bank	E7010	O'BRIEN, CAROLE	84.42	12/20/2024	Marci Rozek
Flagstar Bank	E7011	RICKER, AMY	329.64	12/20/2024	Marci Rozek
Flagstar Bank	E7012	Rooker, Stephani	29.28	12/20/2024	Marci Rozek
Flagstar Bank	E7013	ROSE, KEVIN	81.07	12/20/2024	Marci Rozek
Flagstar Bank	E7014	Roznowski, Donna	90.58	12/20/2024	Marci Rozek
Flagstar Bank	E7015	Schneider, Maryssa	314.72	12/20/2024	Marci Rozek
Flagstar Bank	E7016	Schumacher, Pamela	49.31	12/20/2024	Marci Rozek
Flagstar Bank	E7017	Strode, Eric	48.43	12/20/2024	Marci Rozek
Flagstar Bank	E7018	Truhn, Emelia	296.57	12/20/2024	Marci Rozek
Flagstar Bank	E7019	VanWert, Laurie	50.36	12/20/2024	Marci Rozek
Flagstar Bank	E7020	VASCONCELOS, FLAVIA	260.46	12/20/2024	Marci Rozek
Flagstar Bank	E7021	Woodcock, Timothy	404.01	12/20/2024	Marci Rozek
Flagstar Bank	E7022	PETER CHANG ENTERPRISES, INC.	23,309.51	12/20/2024	Marci Rozek
Flagstar Bank	E7023	Staples	4,469.62	12/20/2024	Marci Rozek
Flagstar Bank	E7024	HAVENWYCK HOSPITAL	36,668.19	12/20/2024	Marci Rozek
Flagstar Bank	E7025	Bay Human Services, Inc.	105,801.44	12/20/2024	Marci Rozek
Flagstar Bank	E7026	LIBERTY LIVING, INC.	44,391.87	12/20/2024	Marci Rozek
Flagstar Bank	E7027	NORTH SHORES CENTER LLC	1,324.20	12/20/2024	Marci Rozek
Flagstar Bank	E7028	SAMARITAS	28,543.64	12/20/2024	Marci Rozek
Flagstar Bank	E7029	HEALTHSOURCE	55,080.00	12/20/2024	Marci Rozek
Flagstar Bank	E7030	CEDAR CREEK HOSPITAL	435.73	12/20/2024	Marci Rozek
Flagstar Bank	E7031	PHC OF MICHIGAN - HARBOR OAKS	8,500.00	12/20/2024	Marci Rozek
Flagstar Bank	E7032	MPA GROUP NFP, Ltd.	30,013.79	12/20/2024	Marci Rozek
Flagstar Bank	E7033	LIST PSYCHOLOGICAL SERVICES	2,487.79	12/20/2024	Marci Rozek
Flagstar Bank	E7034	SAGINAW PSYCHOLOGICAL SERVICES	25,508.62	12/20/2024	Marci Rozek
Flagstar Bank	E7035	PARAMOUNT REHABILITATION	35,929.68	12/20/2024	Marci Rozek
Flagstar Bank	E7036	DO-ALL, INC.	23,096.41	12/20/2024	Marci Rozek
Flagstar Bank	E7037	New Dimensions	21,312.03	12/20/2024	Marci Rozek
Flagstar Bank	E7038	TOUCHSTONE SERVICES, INC	6,801.60	12/20/2024	Marci Rozek
Flagstar Bank	E7039	Winningham, Linda Jo	1,808.00	12/20/2024	Marci Rozek
Flagstar Bank	E7040	WILSON, STUART T. CPA, P.C.	81,036.37	12/20/2024	Marci Rozek
Flagstar Bank	E7041	CAREBUILDERS AT HOME, LLC	20,545.53	12/20/2024	Marci Rozek
Flagstar Bank	E7042	AUTISM SYSTEMS LLC	6,795.47	12/20/2024	Marci Rozek
Flagstar Bank	E7043	CENTRIA HEALTHCARE LLC	49,298.81	12/20/2024	Marci Rozek
Flagstar Bank	E7044	PERSONAL ASSISTANCE OPTIONS INC	79,502.18	12/20/2024	Marci Rozek
Flagstar Bank	E7045	Flourish Services, LLL	32,680.21	12/20/2024	Marci Rozek
Flagstar Bank	E7046	GAME CHANGER PEDIATRIC THERAPY	57,687.91	12/20/2024	Marci Rozek
Flagstar Bank	E7047	Spectrum Autism Center	31,027.89	12/20/2024	Marci Rozek
Flagstar Bank	E7048	ENCOMPASS THERAPY CENTER LLC	77,999.45	12/20/2024	Marci Rozek
Flagstar Bank	E7049	Acorn Health of Michigan	81.72	12/20/2024	Marci Rozek
Flagstar Bank	E7050	MERCY PLUS HEALTHCARE SERVICES LLC	90.00	12/20/2024	Marci Rozek

Flagstar Bank	E7051	Badour, Ashley	541.00	12/20/2024	Marci Rozek
Flagstar Bank	E7052	GoTo Technologies USA, Inc.	112.31	12/20/2024	Marci Rozek
Flagstar Bank	E7053	HAMPTON AUTO REPAIR	100.92	12/20/2024	Marci Rozek
Flagstar Bank	E7054	PRO-SCAPE, INC.	374.00	12/20/2024	Marci Rozek
Flagstar Bank	E7055	V.O.I.C.E., INC.	170.10	12/20/2024	Marci Rozek
Flagstar Bank	E7056	HAVENWYCK HOSPITAL	1,937.00	12/27/2024	Marci Rozek
Flagstar Bank	E7057	HOPE NETWORK BEHAVIORAL HEALTH	299.01	12/27/2024	Marci Rozek
Flagstar Bank	E7058	Fitzhugh House, LLC	23,249.49	12/27/2024	Marci Rozek
Flagstar Bank	E7059	Bay Human Services, Inc.	64,847.84	12/27/2024	Marci Rozek
Flagstar Bank	E7060	MICHIGAN COMMUNITY SERVICES IN	880.67	12/27/2024	Marci Rozek
Flagstar Bank	E7061	CENTRAL STATE COMM. SERVICES	71.07	12/27/2024	Marci Rozek
Flagstar Bank	E7062	LIBERTY LIVING, INC.	32,665.77	12/27/2024	Marci Rozek
Flagstar Bank	E7063	DISABILITY NETWORK	14,352.67	12/27/2024	Marci Rozek
Flagstar Bank	E7064	HEALTHSOURCE	27,000.00	12/27/2024	Marci Rozek
Flagstar Bank	E7065	FOREST VIEW HOSPITAL	3,700.00	12/27/2024	Marci Rozek
Flagstar Bank	E7066	MPA GROUP NFP, Ltd.	43,016.72	12/27/2024	Marci Rozek
Flagstar Bank	E7067	LIST PSYCHOLOGICAL SERVICES	1,529.24	12/27/2024	Marci Rozek
Flagstar Bank	E7068	SAGINAW PSYCHOLOGICAL SERVICES	22,004.98	12/27/2024	Marci Rozek
Flagstar Bank	E7069	PARAMOUNT REHABILITATION	13,186.85	12/27/2024	Marci Rozek
Flagstar Bank	E7070	ARENAC OPPORTUNITIES, INC	14,886.28	12/27/2024	Marci Rozek
Flagstar Bank	E7071	DO-ALL, INC.	6,180.07	12/27/2024	Marci Rozek
Flagstar Bank	E7072	Winningham, Linda Jo	182.00	12/27/2024	Marci Rozek
Flagstar Bank	E7073	Nutrition for Wellness	978.50	12/27/2024	Marci Rozek
Flagstar Bank	E7074	WILSON, STUART T. CPA, P.C.	96,429.50	12/27/2024	Marci Rozek
Flagstar Bank	E7075	CAREBUILDERS AT HOME, LLC	730.13	12/27/2024	Marci Rozek
Flagstar Bank	E7076	CENTRIA HEALTHCARE LLC	31,772.40	12/27/2024	Marci Rozek
Flagstar Bank	E7077	PERSONAL ASSISTANCE OPTIONS INC	270.19	12/27/2024	Marci Rozek
Flagstar Bank	E7078	GAME CHANGER PEDIATRIC THERAPY	53,996.39	12/27/2024	Marci Rozek
Flagstar Bank	E7079	Spectrum Autism Center	33,123.37	12/27/2024	Marci Rozek
Flagstar Bank	E7080	ENCOMPASS THERAPY CENTER LLC	41,967.89	12/27/2024	Marci Rozek
Flagstar Bank	E7081	MERCY PLUS HEALTHCARE SERVICES LLC	57,896.51	12/27/2024	Marci Rozek
Flagstar Bank	E7082	Staples	809.45	12/27/2024	Marci Rozek
Flagstar Bank	E7083	Yeo & Yeo Technology	262.50	12/27/2024	Marci Rozek

Total Withdrawals: **3,633,977.30**

Submitted By: Marci Rozek or Christopher Pinter
Chief Financial Officer or Chief Executive Officer

BAY ARENAC
BEHAVIORAL HEALTH

INTEROFFICE CORRESPONDENCE

January 13, 2025

To: Sara McRae, Executive Assistant to the CEO

From: Karl White, Accounting Manager
Michele Perry, Finance Manager

Re: Disbursement Audit Information for Audit Committee

The following is a summary of disbursements as presented

Administration and Services for Behavioral Health

ITEMS FOR REVIEW:

EFT transfer - Credit Card 1/06/2025		**$ 7,224.68**
Weekly Special Checks:		
12/20/2024 Checks 100687-100702, E7051-E7055		$ 43,899.76
12/27/2024 Checks 100707-100719, E7082-E7083		$ 8,124.44
01/03/2025 Checks 100723-100732, E7099-E7100		$ 8,120.61
01/10/2025 Checks 100739-100746, E7130-E7132		$ 332,636.94
	SUBTOTAL - Special Checks	**$ 392,781.75**
Health Care payments		
12/20/2024	Checks 100683-100686, ACH Pmts E7024-E7050	$ 1,007,255.58
12/27/2024	Checks 100704-100706, ACH Pmts E7056-E7081	$ 661,337.44
01/03/2025	Checks 100720-100722, ACH Pmts E7084-E7098	$ 294,967.83
01/10/2025	Checks 100734-100738, ACH Pmts E7101-E7129	$ 1,005,077.36
	SUBTOTAL - Health Care Payments	**$ 2,968,638.21**
	TOTAL DISBURSEMENTS	**$ 3,368,644.64**

Prepared by: Karl White

Reviewed by: M B

Bay-Arenac Behavioral Health
Board of Directors Meeting
Summary of Proposed Contracts (Not Approved at Finance Committee Meeting)
1/16/2025

			Old Rate	New Rate	Term	Out Clause?	Performance Issues? (Y/N) Risk Assessment Rating (Low/Mod/High)
SECTION I. SERVICES PROVIDED BY OUTSIDE AGENCIES							
Admin/Other Services							
1	M	**Flatrock Manor, Inc.** Addition of targeted case management services to the CLS contract	$0	$77.25/unit	1/15/25 - 9/30/25	Y	N
2	N	**Hickory Hollow Specialized Residential, LLC** CLS Services for 1 BABHA individual	$0	$7.81/unit	1/17/25 - 9/30/25	Y	N
3	R	**MPA** **Contract Extension:** *OPT Assessment* *Brief Screen* *OPT Treatment Plan* *Treatment Plan Development & Monitoring* *Indiv therapy 16-37m* *Indiv therapy 38-52m* *Indiv therapy 53+m* *Psychotherapy for crisis - first 60m* *Psychotherapy for crisis - each addl. 30m* *Family therapy* *Group therapy* *DBT therapy 16-37m (adolescent)* *DBT therapy 38-52m (adolescent)* *DBT therapy 53+m (adolescent)* *DBT group therapy (adolescent)* *DBT therapy per 15m (adult)* *DBT group therapy per 15m (adult)* *Family Skills Training* *Targeted case management* *SED Childrens case management* *ABA Childrens case management* *I/DD Childrens case management* Stand-alone LOCUS Assessment	 $107.63/event 87.55/event $87.52/event $84.97/event $44.93/event $96.25/event $134.80/event $84.97/event $39.66/event $93.50/event $37.51/event $54.38/event $108.77/event $163.15/event 89.73/event $26.40/15m $13.20/15m $31/event $46.87/unit $49.34/unit $91/unit $53.05/unit $22/event	 Same rates except for the ones identified below. $52.50/unit $52.50/unit $55/unit	1/1/25 - 9/30/26	Y	N

R = Renewal with rate increase since previous contract
D = Renewal with rate decrease since previous contract
S = Renewal with same rate as previous contract
ES = Extension

M = Modification
N = New Contract/Provider
NC = New Consumer
T = Termination

Footnotes:

January 3, 2025

The Honorable John Thune
Majority Leader
United States Senate

The Honorable Chuck Schumer
Minority Leader
United States Senate

The Honorable Mike Johnson
Speaker
United States House of Representatives

The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives

Majority Leader Thune, Speaker Johnson, Minority Leader Schumer, and Minority Leader Jeffries:

Congratulations on your swearing-in as Members of the 119th U.S. Congress. As you well know, it is both a rare privilege and an extraordinary responsibility to represent and serve the American people.

Americans went to the polls last November to hold policymakers accountable to delivering better affordability for everyday needs like buying groceries, paying rent, and getting health care. To that end, we write today on behalf of over 300 organizations in one united voice to urge you to use your authority to protect, preserve, and strengthen Medicaid, a foundational source of health and economic security for 80 million Americans, and a key funding pillar for the hospitals, clinics, and health system on which we all rely.

The importance of Medicaid cannot be overstated. Medicaid provides insurance for 38 million children and covers more than 40 percent of all births in the country, allowing mothers to deliver safely and children to have a healthy start to life. It is the single most important source of financial support that keeps rural hospitals open to serve the health needs of their communities. It ensures people with disabilities can access critical home and community-based services and secure meaningful job opportunities. It is the largest payer of behavioral health services in the country, providing essential access to mental health and substance use disorder care. And it helps working people stay healthy so they can afford to feed their families and send their kids to school.

During the 2024 election cycle, cutting Medicaid was not a budget solution that American families asked for — and doing so now would betray your constituents of all political affiliations who are seeking more economic security, not less. Cutting Medicaid would shift costs and administrative burdens onto working class families, states and health systems. Proposals to cap funding, reduce the federal share of Medicaid spending, establish block

grants, institute work reporting and community engagement requirements, cut state revenue from provider taxes or otherwise undermine the fundamental structure of the Medicaid program all have the same effect. If instituted, Americans will lose access to lifesaving services, states will be strapped with massive budget holes, hospitals and clinics will lose revenues and be forced to cut staff and scale back services, and American families and workers will be unable to afford essential care and get sicker — leading to a loss in productivity and the economy suffering as a result.

If the 119th Congress is interested in lowering health costs, there are many well-vetted, commonsense and bipartisan proposals to address inefficiencies and inflated prices and eliminate waste from the health care system. We stand ready to work together on those solutions that will provide relief to those struggling with health costs, but there is no question that shredding the health care safety-net would have the opposite impact on American families.

Older Americans and people with disabilities, people living in rural communities, pregnant women, people with chronic illness, small business owners, and children and families across the country are counting on you to stand by the promises you made to secure them better health and financial security. You can deliver on those promises right now by committing that you will protect and strengthen Medicaid.

In 2017, millions upon millions of Americans rose up against proposed cuts and caps and made clear how much they valued Medicaid as a critical health and economic lifeline for themselves, their families, and their communities. The American people are watching once again, and we urge you to take this opportunity to choose a different path: one that secures our country's health and economy.

Thank you for your consideration and ongoing engagement.

Respectfully,

National
Families USA
AAPD
ACA Consumer Advocacy
ADAP
AFL-CIO
Allergy & Asthma Network
American Association of Birth Centers
American Association on Health and Disability
American Association of Public Health Dentistry
American Dental Hygienists' Association (ADHA)
American Federation of State, County and Municipal Employees (AFSCME)
American Federation of Teachers

American Friends Service Committee
American Institute of Dental Public Health
American Medical Student Association
American Music Therapy Association
American Network of Community Options and Resources (ANCOR)
American Network of Oral Health Coalitions
American Public Health Association
Asian & Pacific Islander American Health Forum
Assistive Technology Law Center
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Maternal & Child Health Programs
Autistic Women & Nonbinary Network
CAEAR Coalition
Campaign for Tobacco-Free Kids
CareQuest Institute for Oral Health
Caring Across Generations
Center for Biological Diversity
Center for Health Law and Policy Innovation
Center for Public Representation
Child Welfare League of America
Children's Health Fund
Children's HealthWatch
Coalition on Human Needs
Community Catalyst
Congregation of Our Lady of Charity of the Good Shepherd, U.S. Provinces
Disability Rights Education and Defense Fund (DREDF)
Disability Victory
Doctors for America
First Focus on Children
FORCE: Facing Our Risk of Cancer Empowered
Friends Committee on National Legislation
Futures Without Violence
Gerontological Society of America
Health Care for America Now (HCAN)
Health Care Voices
Health Resources in Action
HealthHIV
HIV Dental Alliance
Hydrocephalus Association
Integrated Care for Kids/InCK Marks Initiative
Jewish Women International
Just Solutions
Justice in Aging
Lakeshore Foundation

Latino Commission on AIDS
LeadingAge
Legal Action Center
Little Lobbyists
Long Term Care Community Coalition
Lupus and Allied Diseases Association, Inc.
March for Moms
March of Dimes
MHP Salud
Millennium Campus Network
MomsRising
NAACP
NASTAD
National Adult Day Services Association (NADSA)
National Advocacy Center of the Sisters of the Good Shepherd
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
National Association of Pediatric Nurse Practitioners
National Center for Medical-Legal Partnership
National Center on Caregiving
National Community Action Partnership
National Consumers League
National Council of Urban Indian Health (NCUIH)
National Council on Severe Autism
National Diaper Bank Network
National Disability Rights Network (NDRN)
National Down Syndrome Congress
National Employment Law Project
National Health Law Program
National Immigration Law Center
National Kidney Foundation
National Latina Institute for Reproductive Justice
National League for Nursing
National Organization for Women
National Partnership for Women & Families
National Respite Coalition
NHMH - No Health without Mental Health
Overdose Prevention Initiative
Partners In Health
Pathways for Rare and Orphan Solutions
Planned Parenthood Federation of America
Policy Center for Maternal Mental Health

POWER OF 3
Prevention Institute
Primary Care Development Corporation
Public Advocacy for Kids (PAK)
Religious Community for Reproductive Choice
Reproductive Freedom for All (formerly NARAL Pro-Choice America)
School-Based Health Alliance
SIECUS: Sex Ed for Social Change
Service Employees International Union
Sisters of Mercy of the Americas Justice Team
Small Business Majority
Susan G. Komen For the Cure
Technical Assistance Collaborative, Inc.
The 6:52 Project Foundation, Inc.
The AIDS Institute
The Arc of the United States
The Health Alliance for Violence Intervention
The Leadership Conference on Civil and Human Rights
The National Alliance to Advance Adolescent Health
Third Way
Triage Cancer
UnidosUS
United Spinal Association
USAging
VOR - A Voice of Reason
Young Invincibles
YWCA USA
Zero to Three

Alabama
AIDS Alabama
Alabama Arise
Alabama State Nurses Association
Birmingham Friends Meeting
First Congregational Church, UCC Birmingham
Hispanic and Immigrant Center of Alabama
The Knights & Orchids Society
The Sisters Tuscaloosa
Equitable Neighborhoods Initiative
Five Horizons Health Services
VOICES for Alabama's Children

Arizona
Arizona Academy of Pediatric Dentistry

California
AJL Community Health
Alzheimer's Los Angeles
Archstone Foundation
Asian Resources, Inc.
California Association for Adult Day Services
California Association of Food Banks
California Coverage & Health Initiatives
California Foundation for Independent Living Centers
California Health Advocates
California Long-Term Care Ombudsman Association (CLTCOA)
California Pan-Ethnic Health Network
California State Association of Counties
Center For Independence of Individuals with Disabilities
Children Now
Citizens for Choice
Coalition for Compassionate Care of California
Coalition of California Welfare Rights Organizations
Community Access Center
County Welfare Directors Association of California
Courage California
CRLA Foundation
Equality California
Family Caregiver Alliance
Family Voices of California
FREED Center for Independent Living
Gray Panthers of San Francisco
Helping Hands ADP
Insure the Uninsured Project (ITUP)
LeadingAge California
Maternal and Child Health Access
Northeast Valley Health Corporation
On Lok
Senior and Disability Action
Sonrisas Dental Health
St Jude Neighborhood Health Centers
Stanford Settlement, Inc.
The Children's Partnership
The Public Interest Law Project
UDW/AFSCME Local 3930
Western Center on Law and Poverty
Westside Family Health Center

Colorado
Center for Health Progress
Colorado Academy of Pediatric Dentistry
Colorado Access
Colorado Behavioral Healthcare Council
Colorado Children's Campaign
Colorado Consumer Health Initiative
Colorado Cross-Disability Coalition
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Colorado Safety Net Collaborative
El Grupo Vida
Immunize Colorado
Meapta Inc.
One Colorado
Rocky Mountain Multiple Sclerosis Center
Show and Tell
Youth Healthcare Alliance

Connecticut
Connecticut Citizen Action Group (CCAG)
Connecticut Oral Health Initiative

Delaware
Christian Council of Delmarva

District of Columbia
A Higher Learning
Longevinet, Inc.
Rebuilding Independence My Style

Florida
Asian American Federation of Florida
Asian Caribbean Exchange
Florida Asian Services
Florida Asian Women Alliance
Florida Chapter of the American Academy of Pediatrics
Florida Health Justice Project
Florida Policy Institute
OCA South Florida Chapter

Georgia
Serving at-risk families everywhere, Inc.

Illinois
AgeOptions
AIDS Foundation Chicago
Citizen Action/Illinois
Erie Family Health Centers
Health & Medicine Policy Research Group
Illinois Association of Public Health Administrators
Illinois Public Health Association
The Arc of Illinois

Indiana
Covering Kids & Families of Indiana
Hoosier Action

Iowa
Disability Rights Iowa
Iowa Academy of Pediatric Dentistry
Iowa Citizen Action Network

Kansas
Alliance for a Healthy Kansas
El Centro, Inc.
Kansas Action for Children
Kansas Breastfeeding Coalition
Kansas Home Care & Hospice Association
Oral Health Kansas, Inc.

Kentucky
Kentucky Voices for Health

Louisiana
HOPE ICSS
Louisiana Democratic Party Disability Caucus

Maine
Children's Oral Health Network of Maine
Consumers for Affordable Health Care
Maine Equal Justice
Maine Primary Care Association

Maryland
AIDS Action Baltimore
High Note Consulting, LLC
Maryland Academy of Pediatric Dentistry

Maryland Dental Action Coalition
Maryland Health Care For All Coalition
Public Justice Center

Massachusetts
Disability Law Center (MA)
Disability Policy Consortium
Health Law Advocates
Massachusetts Academy of Pediatric Dentistry
Massachusetts Law Reform Institute
Personal Disability Consulting, Inc.
Project Bread

Michigan
Center for Civil Justice
Community Mental Health Association of Michigan
Michigan Council for Maternal and Child Health
Michigan Developmental Disabilities Institute
Michigan League for Public Policy
Self-Advocates of Michigan
The Arc Michigan
The Arc of Allegan County
UNIT
United Way for Southeastern Michigan

Minnesota
Reach for Resources

Missouri
Missouri Academy of Pediatric Dentistry

Montana
Smiles Across Montana

Nebraska
3Sisters
Nebraska Appleseed

Nevada
Minority Health Consultants
Silver State Equality

New Hampshire
New Hampshire Association of Pediatric Dentistry, PLLC

NH Legal Assistance

New Jersey
Disability Rights New Jersey
New Jersey Association of Mental Health and Addiction Agencies, Inc.
New Jersey Citizen Action
NewBridge Services
NJ Oral Health Coalition
LeadingAge New Jersey & Delaware

New Mexico
Casa de Salud
New Mexico Center on Law and Poverty

New York
Center for Elder Law & Justice
Center for Independence of the Disabled, New York (CIDNY)
Citizen Action of New York
Grand St Settlement
Medicaid Matters New York
Metro New York Health Care for All
New York Academy of Pediatric Dentistry
New York Legal Assistance Group (NYLAG)
NYS Alliance for Retired Americans
Public Health Solutions
Schuyler Center for Analysis and Advocacy

North Carolina
Disability Rights North Carolina
InReach, Inc.
Jaces Journey
NC Budget & Tax Center
North Carolina Justice Center
Pisgah Legal Services

North Dakota
North Dakota Protection & Advocacy Project

Ohio
Ohio Academy of Pediatric Dentistry
Ohio Poverty Law Center
SEM Food Pantry
UHCAN Ohio

Oklahoma
American Academy of Pediatric Dentistry
Oklahoma Policy Institute

Oregon
Oregon Academy of Pediatric Dentistry
Oregon Community Health Worker Association
SocialJustice Advocates

Pennsylvania
Center for Advocacy for the Rights and Interests of Elders (CARIE)
Disability Rights Pennsylvania
HIAS Pennsylvania
Pennsylvania Coalition for Oral Health
Pennsylvania Health Law Project
Pennsylvania Partnerships for Children
The Arc of Greater Pittsburgh

Rhode Island
Protect Our Healthcare Coalition RI
Rhode Island Junior Chamber of Commerce

South Carolina
South Carolina Appleseed Legal Justice Center

South Dakota
South Dakota Society of Pediatric Dentistry

Tennessee
Family Voices of Tennessee
Healthy and Free Tennessee
Tennessee Academy of Pediatric Dentistry
Tennessee Health Care Campaign
Tennessee Justice Center

Texas
Coalition of Texans with Disabilities
Disability Rights Texas
Every Body Texas
REV UP Texas
Texans Care for Children
Texas Academy of Pediatric Dentistry
UnitarianUniversalist Fellowship of Hidalgo County Texas

Utah
Children's Service Society of Utah
Disability Law Center of Utah
Utah Academy of Pediatric Dentistry
Utah Consumer Oral Healthcare Coalition
Voices for Utah Children

Virginia
Birth In Color
Legal Aid Justice Center
Virginia Coalition of Latino Organizations
Virginia Health Catalyst

Washington
Northwest Health Law Advocates

West Virginia
Rise Up WV
West Virginians for Affordable Healthcare
WV Citizen Action

Wisconsin
Disability Rights Wisconsin
Kids Forward
Wisconsin Aging Advocacy Network

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

M E M O R A N D U M

DATE: January 3, 2025

TO: Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Services Programs (CMHSP) Leadership

FROM: Patricia Neitman, MS LLP, Bureau Director PLN
Bureau of Children's Coordinated Health, Policy, and Supports

SUBJECT: Update on 1915(c) Waiver Programs for Children

The Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) is providing the following update on the renewal applications for the Waiver for Children with Serious Emotional Disturbances (SEDW) and Children's Waiver Program (CWP).

Waiver for Children with Serious Emotional Disturbances (SEDW):

The Michigan Department of Health and Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) for the renewal of the SEDW program on December 18, 2024. The waiver has been approved for a five-year period with an effective date of October 1, 2024. The renewal application included several programmatic changes, which are listed below. MDHHS will provide interim guidance to the PIHPs and CMHSPs in January 2025 that will address the following items, and MDHHS will also issue a policy bulletin in 2025 that will incorporate these items into the Medicaid Provider Manual.

- Revision to assessment tools including the addition of the Michigan Children and Adolescent Needs and Strengths (MichiCANS) tool
- Revision of Overnight Health and Safety Supports eligibility and coverage
- Removal of Wraparound from SEDW and Addition of Intensive Care Coordination with Wraparound (ICCW) to State Plan
- Removal of Family Support and Training from SEDW and 1915(i) and transition to the Parent Support Partner State Plan Amendment
- Addition of Equine Therapy as a new service type
- Change in name from "Children's Therapeutic Foster Care" to "Children's Therapeutic Family Care" and update to the best practice model
- Revision and addition of some performance measures for the Quality Improvement Strategy
- Update of Electronic Visit Verification language
- Update of Conflict Free Access and Planning requirements

- Language change from “Fiscal Intermediary” to “Financial Management Services”
- Change in frequency of provider qualification verifications from 2 years to 3 years
- Change in site review frequency from biennially to annually

Children’s Waiver Program (CWP)
MDHHS has not received approval from CMS for the renewal application for the CWP. MDHHS submitted and received approval for an extension request for the current waiver approval to allow for finalization of the updated waiver application.

Sara McRae

From: Chris Pinter
Sent: Tuesday, January 14, 2025 3:21 PM
To: Sara McRae
Subject: FW: Update on Waskul settlement

Importance: High

From: Chris Pinter
Sent: Wednesday, January 8, 2025 1:34 PM
To: Richard Byrne (redhorse2121@yahoo.com) <redhorse2121@yahoo.com>; Robert Pawlak (bopav@aol.com) <bopav@aol.com>; Patrick McFarland <pjmcfarland52@gmail.com>; Christopher Girard <cgirard1@msn.com>; Sally Mrozinski <smrozinski@arenaccountymi.gov>; Banaszakt@baycounty.net; Jerome Crete <jtcrete@yahoo.com>; niemieck@baycounty.net; conleypat@gmail.com; CAROLE OBRIEN <caroleo3@sbcglobal.net>; pschumacher82@gmail.com
Cc: Marci A. Rozek <mrozek@babha.org>; Sara McRae <smcrae@babha.org>; Jennifer Lasceski <jlasceski@babha.org>; Karen Amon <kamon@babha.org>
Subject: FW: Update on Waskul settlement
Importance: High

BABHA Board of Directors,

This is an update from the Community Mental Health Association of Michigan related to the Waskul settlement. As you may recall, this is the case in federal court involving guardians and family members of CMHSP consumers suing MDHHS and Washtenaw CMHSP to require hourly pay for direct care staff in certain arrangements be set at a minimum of **$30** per hour. Many of these current arrangements for CMHSPs are between $15-20 an hour at present.

Rather than acknowledging the MDHHS culpability in systematically underfunding CLS services in some areas prior to COVID, the State has opted to essentially “pay off” one group of plaintiffs rather than directly address the larger funding issues at hand. This will only exacerbate the problem over the long term.

Most of the CMHSP boards in Michigan filed briefs opposing this settlement as it would create a significant pay differential between existing staff as high as 40-50% for essentially the same service. This will mandate BABHA to direct more resources to self-determination arrangements at the expense of nearly ALL other mental health services (close to $1,000,000 annually just for BABHA). Not only does this interfere with our ability to obtain market rates by essentially setting a mandatory wage scale for some job descriptions (but not others), it completely disrupts our compensation scales for the entire agency and clearly picks winners and losers. Unfortunately, consumers needing other services will be the ultimate loser in this decision.

Additionally, we have absolutely no confidence that MDHHS will adequately increase the Medicaid rates for these services given that many PIHPs are already projecting deficits for FY2025 BEFORE adding millions in more expense.

As noted below, many additional steps will need to take place before this settlement can be implemented. These include federal approval for the related PIHP contract amendments, agreement from the 3 PIHP regions that have refused to sign the FY25 contract over this issue, and approval from the legislature for any rate increases

necessary to fund this settlement. The Appropriations boilerplate also includes requirements that the legislature be notified beforehand related to any MDHHS policy changes that will impact Medicaid rates for services so we should have an opening to oppose this settlement in the House. We will work with our Association to prepare talking points related to the Waskul settlement that we can share with our elected representatives in the House if the board decides to pursue such a course of action.

Chris

From: Monique Francis <MFrancis@cmham.org>
Sent: Tuesday, January 7, 2025 2:48 PM
To: Monique Francis <MFrancis@cmham.org>
Cc: Robert Sheehan <RSheehan@cmham.org>; Alan Bolter <ABolter@cmham.org>
Subject: Update on Waskul settlement

To: CEOs of CMHs, PIHPs, and Provider Alliance members
CC: CMHA Officers; Members of the CMHA Board of Directors and Steering Committee; CMH & PIHP Board Chairpersons
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: Update on Waskul settlement

An update on the *Waskul* case: In late December, 2024, the Court indicated that it was going to approve the *Waskul* settlement reached by MDHHS and Plaintiffs. The Court did not provide its reasoning yet and has not entered its order. While the judge has approved the settlement, this issue is far from settled. Once the settlement is formally approved by the court, MDHHS must satisfy the following conditions:

1. Minimum fee schedule provisions:
    1. For the minimum fee schedule provisions to take effect: CMS approval of any amendments to the HSW, any contract amendment to the MDHHS contract with the Community Mental Health Partnership of Southeast Michigan (CMHPSM), and any capitation rate increase for all PIHPs. CMHPSM must agree to the MDHHS contract amendment for the minimum fee schedule provisions to take effect.
    2. In the event the minimum fee schedule provisions do not take effect, MDHHS must amend the Medicaid Provider Manual to change the costing out rules.
2. MDHHS must change the Administrative Law Judge (ALJ) rules, applying to Medicaid Fair Hearings, to expand the ALJ's authority over HSW Self-Determination CLS participants' appeals. These rule changes include:
    1. ALJ authority to review authorized units for HSW SD CLS and HSW SD OHSS;
    2. ALJ authority to review HSW SD CLS budget attached to a recipient's IPOS;
    3. ALJ authority to order a specific budget or authorization for HSW SD CLS and HSW SD OHSS;
3. MDHHS must change the Medicaid Fair Hearings rules to give ALJs the authority to review a decision to terminate an Self Determination arrangement.
4. MDHHS must also make a number of other changes to the Medicaid Provider Manual and separately provide non-binding guidance on all of the new rules.

CMHA will keep you posted as this process moves forward.

Robert Sheehan
Chief Executive Officer
Community Mental Health Association of Michigan
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Bay-Arenac Behavioral Health Finance Committee
Certified Community Behavioral Health Clinic (CCBHC) Discussions
Updated, 1-8-25

Background
BABHA has been tasked with evaluating the regulatory, financial, legal and performance of the CCBHC model for consideration for the residents of Bay and Arenac Counties. The most salient questions relate to improved health care outcomes and long term sustainability of the model embedded in a community mental health service program (CMHSP).

BABHA has conducted interviews with executive, clinical and financial leadership of Ionia, Washtenaw, Clinton-Eaton-Ingham and Sanilac County CMHSPs to determine the impact of the CCBHC model on their existing service mission.

How have CCBHC services improved the care of your community
It has improved access and service penetration for all populations, particularly those with commercial insurance and non-specialty Medicaid. Also, they have noted significant increases in phone call volume and requests to support partner organizations in the community and increased public satisfaction with CMHSP services under the more defined core-CCBHC model

CMHSPs have developed more positive relationships with local Federal Qualified Health Centers (FQHC) to serve as an alternative provider for non-Medicaid cases; CMHSPs have embedded mental health outreach and psychiatric/prescriber services on site at the FQHC. There are additional improvement opportunities in the critical relationships with CCBHC-delegated Direct Care Organizations (DCOs) and substance use disorder providers. **For example, some CMHSPs have expanded their directly provided substance use services for outpatient and Medicaid assisted treatment to more effectively address co-occurring and primary care issues. Other CCBHCs have used DCO arrangements to expand their mild to moderate Medicaid population while remaining more cost competitive than traditional CMHSP services. Additionally, the indigent population faces less barriers to services through a CCBHC as compared to a CMHSP due to very limited general fund dollars and benefits.**

How well has your core CCBHC services aligned with your long term specialty services including community support and residential?
The core CCBHC services, 24/7 emergency response and stabilization, assessment and treatment, outpatient services, case management services, substance abuse services, peer support and veterans' services are easily built on existing CMHSP service arrays. **The adoption of "same day access" and "zero suicide" models have also enhanced traditional services.**

In general, the CCBHC population has more acute, primary care needs similar to the mild to moderate population rather than long term care service need associated with traditional specialty CMHSP services. **This has also permitted some CMHSPs to expand services to indigent/uninsured persons and more severe commercial cases that had eroded with non-**

Medicaid funding since 2014. In addition, the expanded mild to moderate population has encouraged re-evaluation of traditional emergency response options into new pathways for service access including a wider 24/7 service type availability, increased coordination and more group-based primary care. This requires a more robust CMHSP access array.

The MDHHS CCBHC team is competent but oftentimes implements state requirements that are even less flexible than the federal standards. MDHHS interacts with CCBHCs in the same recent experience as with PIHPs and CMHSPs but with more commitment to overall success of the demonstration.

Has the CCBHC structure and requirements permitted an expansion of CMHSP services to a broader population?
CCBHC has encouraged CMHSP emergency services and Mobile Response teams to expand their front line roles for community integration and leverage to expand certain services into rural areas **and offer a more inclusive continuum of care. In addition, the focus on recovery services (i.e. parent support, coaches and youth/peer support) and veterans mental health issues may be force multipliers for existing CMHSPs.** However, emergency services and MRT continue to be financial loss leaders in many rural areas.

The primary population expansion opportunities are for mild to moderate Medicaid, commercial insurance and uninsured individuals that historically have not needed acute CMHSP care but could benefit from components of the CCBHC model. **This has included expansion of basic outpatient care options to focus on as many active Medicaid beneficiaries as possible.**

Has your CCBHC expansion drawn consumers from outside your traditional catchment area?
Some cross boundary issues emerge with other CMHSPs but in general, the CCBHC has an obligation to meet the immediate needs of the consumer and then refer or coordinate a follow-up linkage with an alternative provider. **Some CCBHCs do report increased service boundary issues related to children and families moving/changing school districts. CCBHCs will divert individuals to their respective county for services such as ACT and home-based services in a manner similar to existing CMHSP practices.**

Has your health outcomes and primary care coordination improved under the CCBHC model?
The emphasis on health care screenings and co-located services encourages an integrated assessment of all health care outcomes. This inherently improves relationships and communication between primary and mental health care providers **and contributes to improved coordination by concentrating efforts on both the long term medical and mental health of shared populations.**

The CCBHC case management team uses a “group practice” approach focused on alleviating the immediate needs of consumers and transition planning to alternative provider arrangements such as the crisis stabilization team or outside providers. However, the CCBHC model has not yet outpatient services.

Has the CCBHC designation increased your CMHSP revenue stream, reduced expenses and/or made you less dependent upon Medicaid capitation funding?
The funding was plentiful the first years of the demonstration due to availability of block grants and redirected surpluses from other CCBHCs. **These factors have permitted several CMHSPs to build significant fund balances in a relatively short period of time.**

Other revenue increases have primarily been related to additional third party billing. This has required some return to traditional billing and accounting systems. This has also encouraged less dependence on PIHP Medicaid, assuming the CCBHC supplemental Medicaid prospect payment rate is based on a high and sustainable proportion of Medicaid v. non-Medicaid or indigent cases.

The challenge is to have sufficient general or local funds to cover any mild-moderate expenses not included in the supplemental rates. Some early adopter CMHSPs also have existing local millages for county-based mental health services to supplement local, grant and initial capital expenses.

It is anticipated that supplemental funding after years 3-4 will claw backward to actual utilization and may be insufficient to cover CCBHC expenses going forward. Unless a CMHSP develops a strong and sustainable source of unrestricted funds, the longer term prospect suggests that post-demonstration implementation in 2027 simply becomes cost shifting between the CCBHC prospective payments and the PIHP capitation payments, rather than additional Medicaid revenue. **Similarly, continued growth with the non-Medicaid population will result in increasing financial burdens on CCBHCs as more recent MDHHS rate adjustments have failed to adequately compensate for the cost of these services.**

How has your staff responded to CCBHC status and has it permitted more competitive compensation arrangements?
The overall organizational cultural change and commitment to the CCBHC has been positive and motivating for staff. The staff embrace of the model seems to be reflected in improved morale, customer service and community relationships. **It is important to incentivize both new and existing CMHSP staff in making the commitment to CCBHC. This is important as some staff have left CMHSP employment for private practice.**

The initial grant funding has permitted some CCBHCs to pay more competitively in order to attract professional staff, however this remains dependent upon the job market and has not necessarily resulted in fuller employment numbers. In addition, more recent CCBHC adopters have not reported the financial windfall of the original demonstration sites, nor did they not notice any advantages to staff recruitment.

Recommendations

1. **BABHA pursues implementation of a reverse integration model such as CCBHC or Behavioral Health Homes for FY2026. This is based on the positive experiences reported by the CMHSPs including:**

- **Improved access and service penetration for all populations such as the mild to moderate and underinsured/indigent**
- **More positive relationships with local Federal Qualified Health Centers (FQHC)**
- **Encouraged expansion of CMHSP emergency services and Mobile Response teams for front line community integration and a more inclusive continuum of care.**
- **Improved communication and coordination between primary and specialty care providers for concentration on both the long term medical and mental health of shared populations including expansion of SUD services to address co-occurring disorders.**

2. **BABHA coordinates its choice of a reverse integration model in the context of both state and federal policy discussions over the next four months (February-April) including:**
    - **Legislative response to release of the Governor's Executive Budget proposal for FY2026 and inherent integration projects**
    - **Legislative response to MDHHS state-wide CCBHC effectiveness study required by FY2025 Appropriations Act.**
    - **Congressional Budget Reconciliation instructions to oversight committees related to Health and Human Services, Centers for Medicare/Medicaid Services and the Substance Abuse & Mental Health Services Administration concerning FY2026 entitlement and discretionary expenses.**

3. **BABHA implements its reverse integration model once a sustainable financial pathway forward has been confirmed.**

Community Mental Health Association of Michigan - Comparison of Actuarial Projected Funding versus Actual Funding Advances FY25

As of: 1/8/25

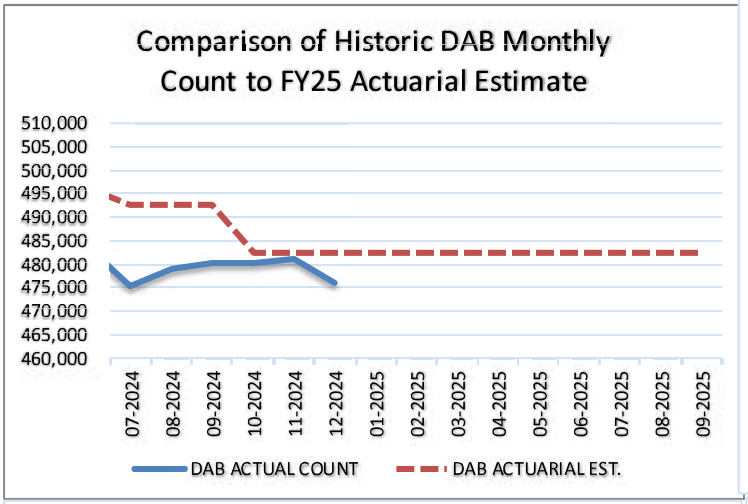
Funding per Date Comparison *	Actual Advanced on A YTD Basis	Actual Advanced on A YTD Basis	Number of Months of Advances	Year to Date Over+ & (Under -)	Percentage Advanced
DAB Capitation Behavioral Health	$ 535,900,000	$ 514,586,343	3	($21,313,657)	96.0%
DAB Capitation Substance Use Disorder	$ 10,775,000	$ 10,580,777	3	($194,223)	98.2%
TANF Capitation Behavioral Health	$ 98,050,000	$ 96,578,250	3	($1,471,750)	98.5%
TANF Capitation Substance Use Disorder	$ 11,600,000	$ 11,211,741	3	($388,259)	96.7%
HSW,CWP, & SED Payments	$ 171,750,000	$ 167,469,398	3	($4,280,602)	97.5%
HMP Capitation Behavioral Health	$ 78,750,000	$ 77,432,024	3	($1,317,976)	98.3%
HMP Capitation Substance Use Disorder	$ 37,325,000	$ 36,270,233	3	($1,054,767)	97.2%
Autism all Populations	$ 98,875,000	$ 98,206,750	3	($668,250)	99.3%
Total:	**$ 1,043,025,000**	**$ 1,012,335,516**	3	**($30,689,484)**	**97.1%**

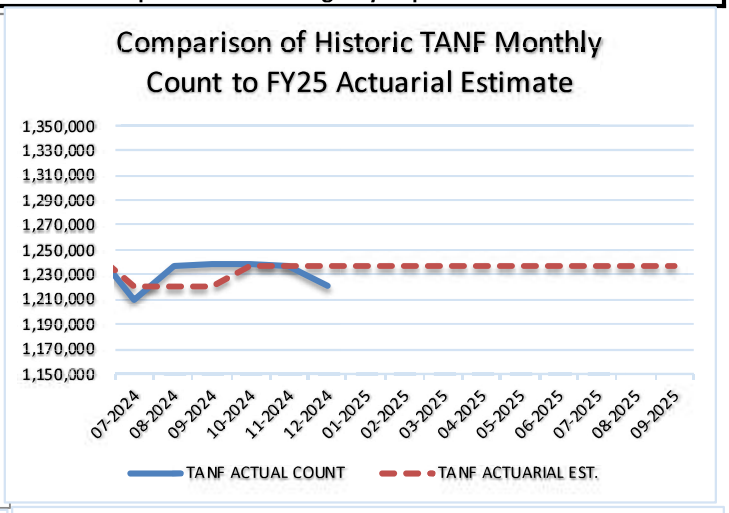
Capitation Populations	*Projected Per Certification Document	Actual Paid Census	Difference	As a Percentage	Aproximate Difference due to Population Counts
DAB Average Population per month	482,397	466,339	(16,058)	96.7%	($18,197,304)
TANF Average Population per month	1,237,340	1,232,198	(5,142)	99.6%	($455,701)
HMP Average Population per month	710,394	701,119	(9,275)	98.7%	($1,515,545)
HSW Average paid per month	7,322	7,205	(117)	98.4%	($2,744,435)

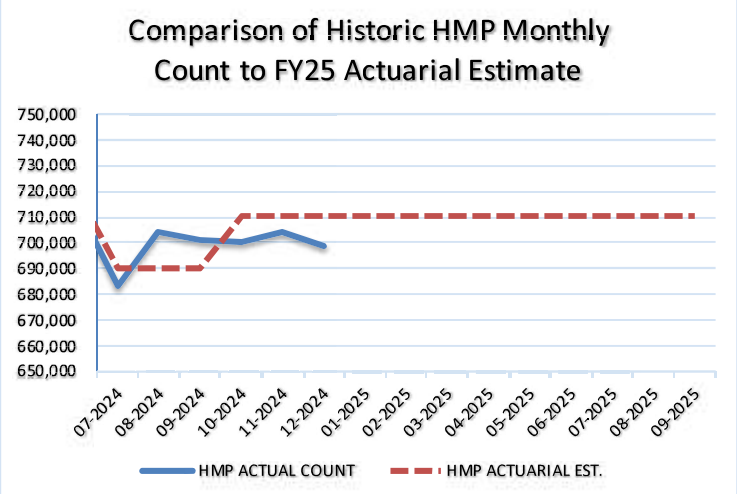
** Population projection is from appendix 5 of Capitation Rate Certfication Document*

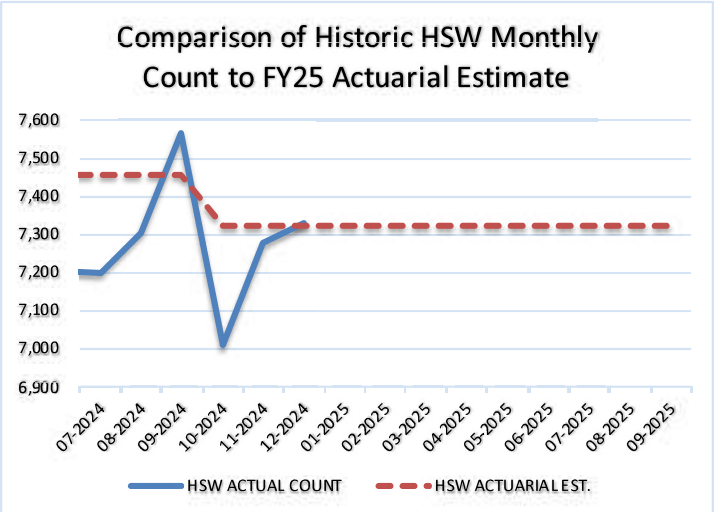
Capitation Population Average Rate per Month	Average Certification PM/PM Rate:	Average Rate Paid Per Member Month	Difference in Expected versus Actual	Percentage Paid rate is to Certification Rate:	Aproximate Funding Difference due to Rates
DAB Population:	$ 377.75	$ 375.38	($2.37)	99.4%	($3,310,576)
TANF Population:	$ 29.54	$ 29.16	($0.38)	98.7%	($1,404,308)
HMP Population:	$ 54.47	$ 54.06	($0.41)	99.3%	($857,198)
HSW Population:	$ 7,818.90	$ 7,747.83	($71.07)	99.1%	($1,536,167)

Charts begin with July 2024 which is the first month with no public health emergency impact



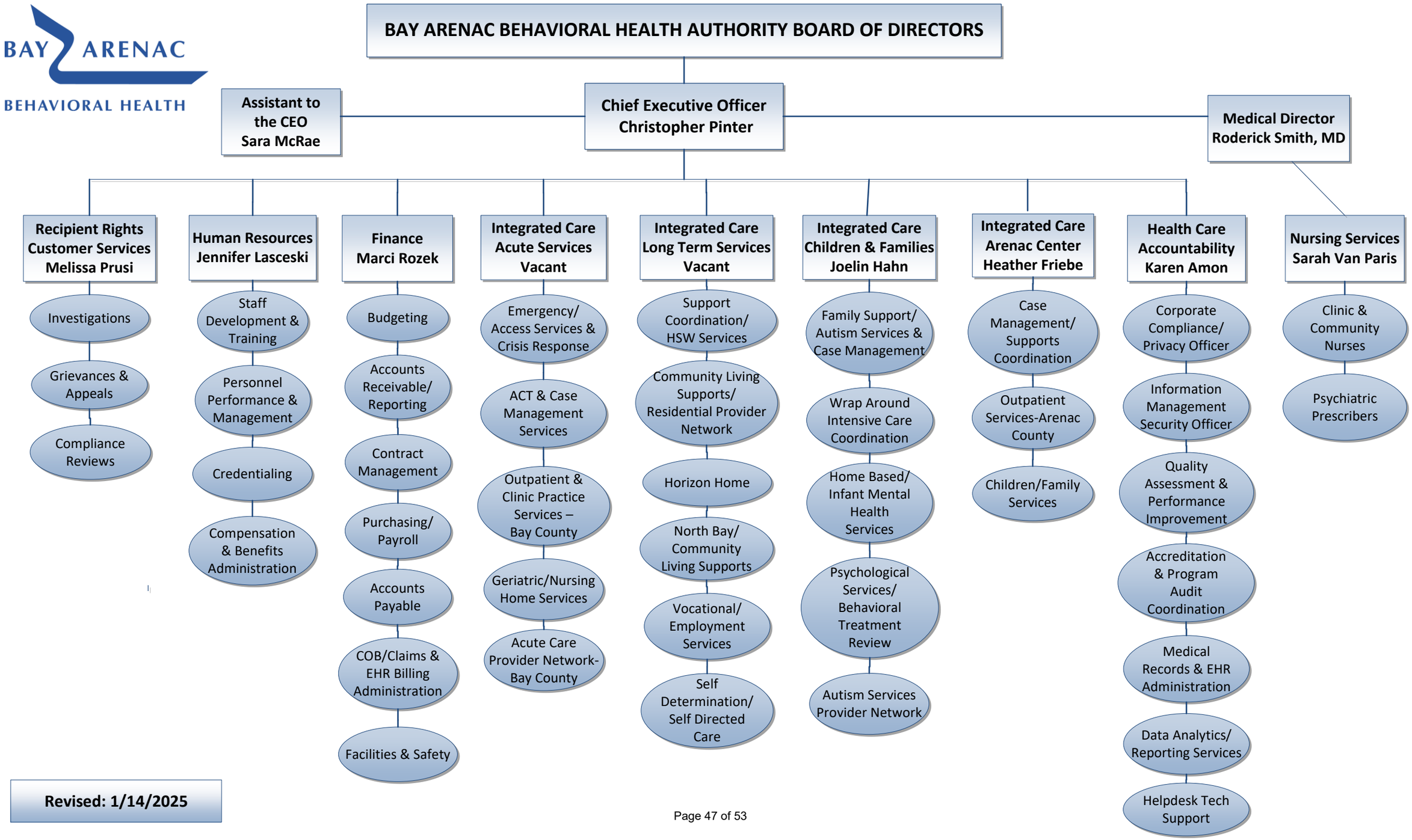






Community Mental Health Association of Michigan - Capitation Information for DAB Funding since July

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
DAB Capitation Behavioral Health Funding	$ 179,670,000	$ 179,670,000	$ 179,670,000	$ 178,633,333	$ 178,633,333	$ 178,633,333
DAB Capitation Substance Use Disorder Funding:	$ 3,460,000	$ 3,460,000	$ 3,460,000	$ 3,591,667	$ 3,591,667	$ 3,591,667
Number of cover lives expected:	492,400	492,400	492,400	482,397	482,397	482,397
Average expected amount paid per DAB Life:	$ 371.91	$ 371.91	$ 371.91	$ 377.75	$ 377.75	$ 377.75
DAB Capitation Behavioral Health Paid:	$ 167,703,001	$ 169,312,890	$ 177,654,049	$ 161,334,871	$ 177,623,047	$ 175,628,425
DAB Capitation Substance Use Disorder Paid:	$ 3,266,152	$ 3,272,298	$ 3,735,200	$ 3,456,136	$ 3,572,982	$ 3,551,659
Number of cover members Paid:	475,350	478,992	**518,372**	**441,953**	481,033	476,032
Average amount paid per member:	$ 359.67	$ 360.31	**$ 349.92**	**$ 372.87**	$ 376.68	$ 376.40
Funding Difference Due to member counts:	($6,341,118)	($4,986,611)	$9,659,326	($15,277,682)	($515,250)	($2,404,373)
Funding Difference Due to Rates being Different	($5,819,729)	($5,558,201)	($11,400,077)	($2,156,311)	($513,721)	($640,544)
Total Difference:	($12,160,847)	($10,544,812)	($1,740,751)	($17,433,992)	($1,028,971)	($3,044,916)
% Shortfall or Overage due to Membership Difference:	-3.5%	-2.7%	5.3%	-8.4%	-0.3%	-1.3%
% Shortfall or Overage due to Rate Differences	-3.2%	-3.0%	-6.2%	-1.2%	-0.3%	-0.4%
Total Shortfall or Overage as a Percentage:	-6.6%	-5.8%	-1.0%	-9.6%	-0.6%	-1.7%



Revised: 1/14/2025

Bay-Arenac Behavioral Health Strategic Planning
2025 Summary

Organizational Concept Statement

Bay-Arenac Behavioral Health is in existence to ensure the delivery of a comprehensive array of health-related supports and services for people with developmental disabilities, mental illness, and/or substance use disorders that are inherently accountable to the persons and families in our community.

- **No Changes**

Mission Statement

It is the mission of Bay-Arenac Behavioral Health to improve health outcomes to enhance quality of life and strengthen the community safety net for citizens of Arenac and Bay counties.

- **No Changes**

Values/Guiding Philosophies

All who are associated with carrying out the mission of Bay-Arenac Behavioral Health are governed by the highest ethical standards and the following values…

- Each person is unique and will be treated with dignity and will be respected regardless of ethnicity, religious preference, age, race, sex, sexual preference, gender identity and respected for their lived experience.
- We are committed to delivering services in a manner that is responsive to urgent, emergent, and long term community needs of our stakeholders.
- We seek to provide a recovery-focused and trauma-informed system of care.
- We believe that individual and community wellness is enhanced by the delivery of integrated healthcare services that are directed by and responsive to the person served.
- We are committed to promoting independence, choice, control and meaningful engagement with peers, family, friends, and community.
- We are committed to collaboration with our community partners to encourage wellness, to promote prevention, and to increase health literacy.

- **No changes**

Core Strategies

1. Effectively manage behavioral health care services for persons with developmental disabilities, mental illness, severe emotional disturbance, and substance use disorders.
2. Delivery of integrated behavioral health care through a coordinated network of services.
3. Coordinate service delivery and collaborate in decision making with stakeholders to maximize responsiveness to community needs.
4. Operate in compliance with local, state and federal regulatory and/or contractual requirements.
5. Maximize administrative and clinical efficiency, including coordination of benefits, to minimize the cost of service and optimize revenues.
6. Ensure individual safety, service quality, and management accountability through use of evidence-based practices, measurement of outcomes and effective use of information.
7. Seek to maintain an organizational environment that promotes excellence and workforce competence and utilizes recruitment and retention strategies to remain competitive in the behavioral healthcare marketplace.
8. Apply principles of good customer service to all clinical, business and service relationships.

- **No Changes**

History:

- Added that the pandemic forced BABH to consider longer term remote work opportunities which provides greater access in some cases for consumers and allows us to be able to recruit and retain employees better.

Statistics:

- There was a slight increase in the number of employees. BABH has increased positions to cover the outpatient service gaps, the expanding children's service needs, and the Mobile Response Teams. The Horizon Home staffing increased due to the ongoing situations arising that require support and assistance to providers in crisis.
- Contracted providers were added to address the ongoing need for ABA services and out of county residential placements.
- The number of unique individuals served has increased to numbers before the pandemic.
- Program numbers continue to indicate that the need for Outpatient Therapy, Case Management and Children's services continue to grow.
- Revenue and Expenses continue to increase. The increase in ABA and outpatient

service provision has been the primary factors in the revenue and expense increases.

Strategic Areas:

Integrated Health and Coordination of Care (Mental Health, Physical Health, and Substance Use Disorders)

- The Breakthrough Initiatives under this Committee were moved to the **Program Committee** due to the restructuring of the Board of Directors.
- Added for Opportunities, the Bay City Crisis Residential Unit has opened for Bay and Arenac County individuals.
- Added the initiative and objectives to "Investigate CCBHC for implementation".
- Added the initiative and objectives to "Implement CCBHC or alternative reverse integration model at BABHA".
- Eliminated initiative and objectives to "Define Policy and Procedure for external information exchange".
- Eliminated initiative and objectives for "Exploring integrated behavioral health home models for ACT".

Management of Internal Operations and Provider Network within BABHA Annual Budget

- Added "Michigan's earned sick time act and minimum wage changes will affect the Provider Network".
- Added "MDHHS actuarial rate calculations have negatively impacted funding in the behavioral health and SUD system".
- Added "Medicaid redeterminations are affecting benefits and as a result funding the system".
- No change in the Breakthrough Initiatives.

Availability of Community Living Support Services (CLS) for Adults & Children

- Added under threats, "EVV implementation increases administrative burdens, loss of one CLS provider and providers are reluctant to provide both Home Help and CLS. Paid medical leave will also impact providers".
- Added under strengths, "Addition of CLS providers for children both in Bay and Arenac Counties and the existing providers have accepted some additional referrals".
- Added under threats, "CLS services are difficult to monitor and stay compliant with documentation standards and there has been an increase in fraud substations".
- Continued the Initiative and objectives to expand options for CLS services.

- Continued the Initiative to assist providers and families with maintaining CLS staffing. Added objective to continue to ensure that the CLS staff are trained on the Individual Plan of Service. Added objective to provide additional training for Self Determination arrangements in the areas of managing employees, EVV system and Fraud and Abuse.

Stabilization and Long-Term Viability of Residential System

- Added opportunity item to include the addition of the Crisis Residential Home.
- Added threats the financial status is less stable than in previous years, paid medical leave and increase in minimum wage will impact providers.
- Added strengths are that there are alternative training opportunities for DCW, ancillary services are available to residents, North bay and Horizon Home staff have been available to step in and support crisis situations.
- Added weaknesses include the closure of three specialized residential homes and one provider ended a contract for another home.
- Continue the Breakthrough Initiative to "continue to advocate, prioritize and support appropriate financial adjustments to stabilize the residential services and advocates at all levels for improving the Direct Care workforce. Added objectives to explore more individualized living arrangements to meet the needs of individuals with higher behavioral needs and to collaborate with the Crisis Residential home to provide services to individuals in crisis.
- Continue Breakthrough Initiative to Support staff's ability to perform effectively and to ensure resident's needs are met.
- Eliminate the objective to increase the development of crisis plans in residential settings.

Integration with Substance Use Disorder Treatment and Prevention

- Continue to expand referral and treatment options/supports for SUD services
- Continue to expand medication assisted treatment and related recovery supports in Arenac County
- Continue to increase coordination of care between Mental Health and SUD treatment providers.
- Continue to increase Co-occurring capability within the provider network.

Evidence-Based and Best Practices in Clinical Service Delivery

- Added weaknesses of lack of knowledge on benefit counseling for employment, current IPS referrals are low compared to the number of individuals that are served, and lack of IPS referrals in Arenac.
- Continue theTrauma Informed Services initiatives.

- Continue the Clinical Effectiveness and Expanding Evidenced Based Practices initiative and objectives.
- Included objectives under Clinical Effectiveness and Expanding EBP: Monitoring activities for the Alternative Outpatient Treatment and Mobile Response Team grant programs and determine sustainability post grant.
- Included objectives under Clinical Effectiveness and Expanding EBP: expanding Individual Placement Support services and improve fidelity to the model and to improve education on Benefits to Work coaching and dispel myths associated with working while receiving benefits.

Community Engagement

- Added under Opportunities that BABHA has School Liaison in two schools, MRT is available M-F daytime and some evening hours, participating in Homeless Taskforce, the Leadership meeting has included a communication to staff agenda item to assure that information is getting to all staff.
- Added under Strengths there has been an improved relationship with law enforcement, jail and courts.
- Added to Weaknesses the need to track community events and opportunities that BABHA attend, the need to improve social media presence.
- Continue the Initiative to continue to work with Community partners to increase understanding, reduce stigma and promote trauma informed communities.
- Continue the Initiative to assure that behavioral health literature is in community partner lobbies and available to public.
- Continue the Initiative to maintain efforts to include service providers in prompt communication and collaboration.
- Continue the Initiative to expand Stepping Up.
- Eliminate the Initiative to establish an agency wide team meeting .

Recruitment and Retention

- Continue the Initiative to attract and retain LBSW and LMSW candidates.
- Added the Objective to consider other qualified Bachelor level degrees for Case Management positions.
- Continue the Initiative to attract and retain qualified DCW candidates.
- Continue the Initiative to monitor the financial impacts of potential compensation adjustments.

Development of Workforce

- Continue the Initiative to increase cross departmental understanding.
- Continue the Initiative to increase consistency by supervisory staff.
- Continue the Initiative to increase SUD competency.

- Continue the Initiative to develop and promote staff training in MH diagnoses.
- Continue the Initiative to outline the role of case management in integrated health care environment.
- Continue the Initiative to supporting residential staffing of our direct operated homes.
- Continue the Initiative to support recovery based, trauma informed and co-occurring services and foster a culture of gentleness.
- Continue the Initiative to investigate CEU process for other disciplines.
- Continue the Initiative to Provide leadership training.
- Continue the Initiative to develop succession planning, health care competencies and supervisory competencies into the performance management process.

Review of Remote Work and Physical Plan Needs

- Continue the Initiative to Implement a Leadership Dashboard and other reports to allow supervisors to have real time monitoring and evaluate staff's activity.
- Continue the Initiative to evaluate long-term staff equipment and space needs post remote work implementation.
- Continue the Initiative to revise the 2025 replacement schedule and make recommendations to the Board for consideration.
- Continue the Initiative to prepare long term physical plan recommendations for Board consideration.

Organizational Chart updated.

Organizational Relationships updated.

Leadership Dashboard and Report Indicators by Committee of the Board of Directors updated.

20245

Strategic Plan

Agency Leadership Team Approval Date: 1/7/25
Strategic Leadership Team Approval Date: 1/14/25
Full Board Approval Date:

2025 Strategic Plan

Table of Contents

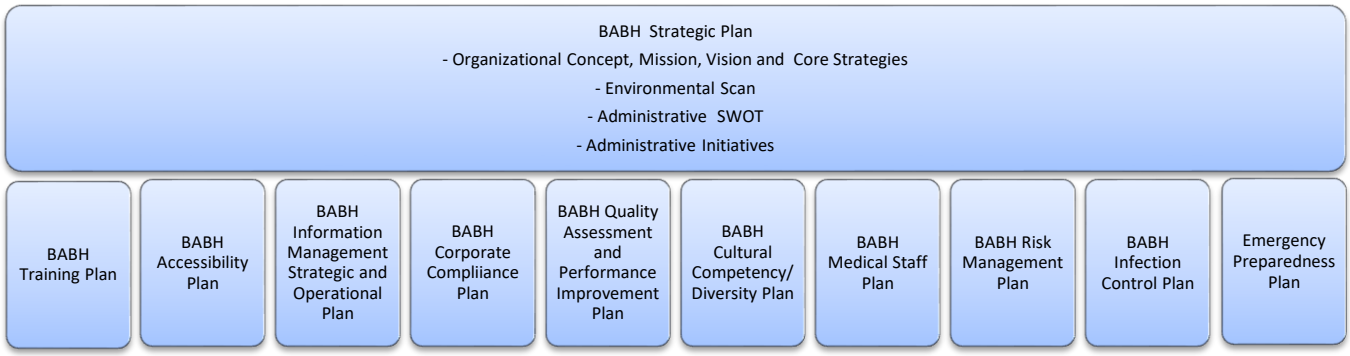
Purpose

The purpose of this document is to fulfill Bay-Arenac Behavioral Health Authority's (BABHA's) need for an organizational plan, which describes the history of the organization and depicts its operational structure and community relationships, as well as a strategic document outlining the mission, vision, values and core strategies of the organization, and current strategic initiatives. The BABHA Strategic Plan describes the purpose and goals of the organization, as well as strategies to ensure the organization can continue accomplishing its mission. It documents Leadership's current assessment of any forces in the environment with the potential to impact the organization and defines strategies for responding.

The BABHA Strategic Plan is the master plan for the organization. The BABHA Strategic Plan is focused on functions which impact all areas of the organization, such as its legal structure, personnel management, financial management, quality management, recipient rights, information technologies, corporate compliance and so on. It outlines strategic initiatives for the operation of the provider network of BABHA, which delivers behavioral health services in Bay and Arenac counties. It also addresses BABHA's delegated responsibilities for behavioral health managed care functions for specialty mental health and substance use disorder services for Arenac and Bay Counties.

Subsidiary Operational Plans

BABHA generates a number of operational plans which are companions to this document, in that they address sub-elements of the organization's overall mission and functions (see graphic below). In addition, BABHA develops annual revenue and expense budgets which are approved by the Board of



Directors and compiled based upon financial planning activities with organizational departments and their leadership. A mid-year amendment is completed to adjust this financial plan to accommodate intra- and inter-organizational revenue and expense fluctuations throughout the year.

Scope and Methodology

Strategic Planning Methodology

Strategic planning for the organization is performed by the BABHA Chief Executive Officer (CEO), members of the BABHA Strategic Leadership Team (SLT), and the entirety of agency Leadership, to foster leadership skill development among future senior managers of the organization. Agency Leadership encompasses leadership positions in the organization including Directors, Managers, Supervisors and Team Leaders. Once a first draft is prepared, additional stakeholder input is obtained, from the Board of Directors, Medical Staff and Consumer Councils.

The components of the planning process include establishing the organizational concept statement, the mission statement, the vision statement, organizational values and core strategies which will guide the

organization to achieving the mission while staying true to its stated values.

An environmental scan is performed to identify threats and opportunities in the environment in which BABHA operates. From the most important of these scans, strengths and weaknesses of the organization relative to pursuing opportunities and blocking threats are identified, and strategic or breakthrough initiatives established for the year.

Findings and recommendations from BABHA planning and evaluative processes which are systemic and strategic in nature are considered by agency Leadership as warranted in the development of the strategic plan, including[1]:

- BABHA Quality Assessment and Performance Improvement Plan and associated performance reports, which encompass organizational performance data and adverse/sentinel events
- Corporate Compliance Plan and associated reports
- Emergency Preparedness Plan
- Risk and Accessibility Plans
- Information Management Plan
- BABHA Annual (Community) Needs Assessment Summary and Attachments, and the BABHA Annual Submission
- Recommendations from Consumer Advisory Councils
- Results of surveys of provider networks, employees and consumers
- Suggestion Box submissions
- Employee Exit Interview findings
- Employee Survey findings
- Provider site review findings
- Financial Audits and reports
- Findings of external audits and reviews, such as Michigan Department of Health and Human Services (MDHHS) and Mid-State Health Network (MSHN) site reviews, finance compliance audits and CARF accreditation reviews

Education

The BABHA Board of Directors reviews and approves the BABHA Strategic Plan each year.

BABHA staff are educated on the BABHA Strategic Plan via the BABHA electronic staff education system, Relias, and/or during CEO All Staff Meeting(s), including review of the plan and the status of strategic initiatives.[2]

The BABHA Strategic Plan is shared with persons served[3] for feedback through review on an annual basis with the BABHA consumer population councils. The BABHA Strategic Plan is shared with other stakeholders[4] via the BABHA website and strategic initiatives are reviewed with key contracted clinical service provider groups via network meetings as appropriate.

[1] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standards 1and 2
[2] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standard 3b
[3] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standard 3a
[4] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standard 3c

Monitoring and Reporting

Target Dates

The timeframe for completion of strategic initiatives is assumed to be one year, unless otherwise specified in this plan. Strategic changes are worked on throughout the year and the order in which the initiatives are listed suggests necessary contingencies or sequencing.

Reporting

Members of agency Leadership report as needed on progress in accomplishing breakthrough initiatives during monthly agency Leadership Meetings. Initiatives are deleted, revised, or added mid-year as needed based upon shifts in the environment, changes in the needs or capacities of the organization, or as new information is gathered about optimal strategies.

The CEO and other members of agency Leadership engage in ongoing monitoring of the environment for opportunities and threats and report such information to other stakeholders and the Board of Directors as warranted.

Staff provide input to leadership decision making, including strategic planning, through an ongoing suggestion program, program/team level staff meetings and a periodic employee survey process.

In addition to agency Leadership reporting on strategic initiatives, significant reporting occurs through BABHA's internal staff teams and committees/ councils. Charters for the various committees are included in BABHA operational plans.

Leadership Dashboard Indicators

Key indicators are identified by the organization as a means of monitoring variables that may impact the organization's ability to continue to fulfill its purpose, operate within its value system, and accomplish its core strategies. The indicators are used by the Board of Directors, CEO and agency Leadership to adjust priorities, make strategic decisions and identify areas of emerging risk for the organization. Key indicator data is presented in a Leadership Dashboard Report and through Power Business Intelligence reports. The monitoring of key indicators is a companion process to the environmental scan, strengths, weaknesses, opportunities, and threats (SWOT) analysis and breakthrough initiatives.

Indicators are chosen based upon the organization's mission, purpose, values, core strategies and results of the environmental scan. Depending on the nature of the indicator, source data is generated by subject matter experts within BABHA and analyzed by either a member of agency Leadership or BABHA staff committees, councils, or teams. The resulting information then flows up to Leadership, for review at Strategic Leadership Team meetings with the CEO.

Reporting to leadership and the Committees of the Board of Directors occurs on a monthly, quarterly, semi-annual, or annual basis, depending upon the indicator. Board Committees receive and file the reports. The CEO or designee presents the reports and participates in discussion at the discretion of the Committee Chair.

The data for each indicator is presented in a graph. If performance targets, benchmarks or control limits have been established, they are included. Data trend-lines are shown where value-added for purposes of analysis and action planning. The current list of indicators is included as an Attachment to this Plan.

Organizational Description

History

On October 31, 1963, Congress passed, and President John F. Kennedy signed into law, the Community Mental Health (CMH) Centers Act. This legislation recognized society's growing awareness that people with mental illness are constitutionally entitled to receive voluntary treatment in the least restrictive environment. It authorized federal grants for construction of public, nonprofit, CMH centers and ended the prolonged institutional confinement of thousands of citizens with mental illnesses, making it possible for them to receive community-based care and allowing them to remain a part of their homes and communities.

In February1963, the Michigan Senate and House of Representatives had introduced identical bills that were later signed into law by then Governor George W. Romney as Act 54 of the Public Acts of 1963. This legislation was Michigan's own CMH Center Act and gave counties the option to create a CMH program if they so desired. Counties could develop a local CMH program through the appointment of a 12- member board, who would select a chief executive officer and other professional staff while contributing 25% of local funds to the overall budget. The State would fund the remaining 75%.

On September 10, 1963, the Bay County Board of Supervisors adopted Act 54 and authorized the Chair to appoint a CMH Board. The Bay County Community Mental Health Board (BCCMHB) was formed under Public Act 54 as a single county board and the first BACMHB board members were appointed on September 23, 1963. State recognition of the local CMH program was ensured once the local county Board of Commissioners passed a resolution establishing the Board as a CMH.

Effective July 23, 1965, the Department of Public Health was created under Section 16.503 of Act 380 of the Public Acts of 1965. This legislation reorganized Michigan governmental departments.

In 1967, the Michigan Association of Community Mental Health Boards (MACMHB) was organized in response to the growing number of counties in the state creating CMH programs under Act 54.

During the mid-1960s, BCCMHB recruited a psychiatrist as its director. The original outpatient clinic was located at Mercy Hospital in 1964. It included an adult clinic for psychiatric and outpatient services for persons recently discharged from state facilities. It also received referrals from Mercy Hospital. There were no separate administrative offices for the board since it was a function of county government. Concurrently, BCCMHB contracted with the Bay Area Child Guidance Center to provide children's services.

Paul Dingman, a clinical psychologist, was hired as the BCCMHB Executive Director and the board expanded to include Arenac County in 1968. An outpatient clinic was opened on the grounds of Standish Community Hospital to serve the residents of Arenac County.

Some of the clinical operations were moved to 1600 Center Avenue in 1970. This is the building currently occupied by the CPA firm of Weinlander- Fitzhugh. A separate Board Administrative office was also located in this site to manage the increasing number of services offered to the community. This site was eventually converted entirely to clinical operations and the Board administrative offices were moved to Garfield Avenue

In 1971, Arenac County joined with Bay County to form the Bay-Arenac Community Mental Health Board (BACMHB). BACMHB approved the Arenac County By-Laws on August 9, 1974 and the Arenac County Board of Commissioners approved the BACMHB By-Laws on September 24, 1974.

Throughout the years, measures had been taken by the State of Michigan to address the changing needs of those affected by mental illness, among them is the enactment of the Michigan Mental Health Code (MMHC) in 1974 as Public Act (P.A.) 258 and expansion of services, including treatment for children and those who suffered from drug and/or alcohol addiction. With the Arenac County partnership, BACMHB aggressively began to develop services for persons with substance use disorders and for persons with developmental disabilities.

William B. Cammin, Clinical Psychologist, was promoted to Executive Director in 1972 upon Mr. Dingman's departure. On August 8, 1975, Bay County elected to come under P.A. 258 of 1974. The required rules for complying with the MMHC were approved by Bay County on July 15, 1975, and by Arenac County on August 4, 1975.

In the mid-1970s, BACMHB applied for a federal CMH center construction grant. The Mental Health Center federal grant was approved on May 24, 1976, enabling construction of a comprehensive CMH center. A lease between BACMHB and the Bay Medical Center was signed January 17, 1977, after which BACMHB leased the Mental Health Center building located at 201 Mulholland. In accordance with the requirements associated with the construction grant, BACMHB followed federal guidelines for providing the minimal five essential services: inpatient, outpatient, children's services, adult services, and consultation and education.

Most administrative and clinical operations were ultimately consolidated at Bay Medical Center upon completion of the Behavioral Health Center in 1978. This has remained the central location of most operations and the location of the Board Office for more than 43 years.

On July 1, 1987, the Bay Area Guidance Center employees transferred to BACMHB, as children's services were now being delivered in-house rather than through contract as was previously done.

With the arrival of the 1980s, Michigan recognized the need for public mental health services in local communities. At that time, a significant amount of responsibility and resources went into the state psychiatric hospital system and local CMH boards had few resources to provide a complete range of services, particularly for people with serious and long-term impairments. By the mid-1980s, CMH boards were given the opportunity to assume primary responsibility for all public mental health services in their respective counties. Over the course of the next decade, the state hospital system shrank dramatically and individuals with mental illness and developmental disabilities were returned to their counties of residence to receive services.

In the mid-1980s, BACMHB applied to the Michigan Department of Community Health (MDCH) (formerly known as the Michigan Department of Mental Health) to be recognized and sanctioned as a Full Management Board. This permitted the Board to move forward with the development of a full array of community-based services and pursue moving area residents from state hospital care to community care. During this period, the Board developed a significant network of residential homes for individuals with mental illness and developmental disabilities, along with appropriate specialty support services and a case management component to ensure the appropriate coordination and monitoring of community-based services.

Throughout the later 1980's and into the first half of the 1990's, BACMHB grew its service array and participated in several statewide funding and community-inclusive service delivery initiatives which focused on the provision of ever more intensive treatment in non-clinic settings. This included the

establishment of Medicaid Habilitation and Support Waiver funding for services to persons with developmental disabilities and the adoption of specialized models such as; supported employment, Assertive Community Treatment (ACT) for adults experiencing mental illness, and Home Based care for children and families. An additional focus during this time was the formation of collaborative community efforts. BACMHB took the lead in applying to MDCH for funds to support personnel, including administrative support for a coordinator to staff a multi-purpose collaborative body. The Board, to this day, continues to support this position and provides leadership in promoting this effort which brings together a variety of human service agencies in a common effort to maximize collaboration, reduce duplication, and evaluate community needs for financial and other support.

The MMHC was revised and enacted into P. A. 290, effective March 27, 1996. This resulted in a massive reorganization of health-related functions at the state level. One of the significant provisions of this Act was the requirement to recruit and include people receiving services to serve on the Board of Directors for CMH Centers.

In 1995-1996, MDCH announced its intention to seek a Health Care Financing Authority (HCFA) waiver to implement a public mental health managed care program. In 1995, BACMHB, along with nine other CMHs, discussed potential collaboration for purposes of efficiency and managed care service delivery, forming the Mid-Michigan Community Mental Health Partnership (MMCMHP). The partnership included CMH Boards from Central Michigan, Gratiot, Midland-Gladwin, Montcalm, Newaygo, Saginaw, and Western Michigan.

In 1997, MDCH went further and stated its goal of contracting with fewer entities to manage specialty services. The potential for a competitive bid process for the selection of providers of public mental health services increased and provoked far reaching debate locally and statewide. MDCH issued a Request for Information (RFI) to the CMH system to trigger shifts in CMH operational strategies toward managed care and market driven principles. At this time, the MMCMHP engaged a consulting firm to develop a plan and possible structure to meet managed care guidelines and prepare for a possible competitive bid process. Concurrently, Western Michigan CMH decided to join a region on a west side of the state.

The new direction entered by MDCH included a focus on quality and customer service. This required CMH boards to follow the principles of Person-Centered Planning and Self-Determination, both of which are designed to give an individual greater control of the service delivery process. A shift toward “consumerism” encompassed ideas of choice of provider and the opportunity to appeal service delivery decisions. The term “mental health” transitioned to the more widely used term in health care systems, “behavioral health”, and “clients” became “consumers” of services.

This was accompanied by the development of continuous quality improvement (CQI) programs and performance improvement initiatives, both within BACMHB and the State. Accreditation of CMH centers became part of the dialogue as a means of assuring standards of quality, and in 1998, BACMHB received its first accreditation from the Joint Commission on Accreditation of Healthcare Organizations.

In June of 1998, MDCH obtained HCFA approval of a managed specialty care waiver. In October of 1998, MDCH implemented the specialty care waiver as a carve-out of the Medicaid Health Plan for physical health care services and began to fund the bulk of the service delivery system using a capitated payment model.

BACMHB continued to prepare for operation in a competitive managed care world. In conjunction with its regional collaborators, BACMHB developed a managed care division to provide access, authorization, and claims management, called the Access Alliance of Michigan (AAM). Midland-Gladwin CMH decided

to leave the regional partnership, so AAM was designed and implemented with the participating CMHs of Bay-Arenac, Gratiot, Montcalm, and Saginaw Counties. An Information Systems Alliance (ISA) was also developed now, aimed at providing state-of-the-art and leading-edge information systems capacity.

In September of 1999, MDCH issued a concept paper "Competition for Management of Publicly Funded Specialty Services" which identified an optimal size of 20,000 covered Medicaid lives.

In addition, HCFA mandated a shift from sole source to competitive procurement for public behavioral health care in Michigan. Through extensive negotiations with MACMHB and HCFA, the MDCH maintained the carve out but incorporated into the system a selection process that would foster competitive procurement in the provider network and provide incentives for single mental health boards to merge or affiliate to enhance efficiencies, reduce duplication, etc.

On June 12, 2001, the Arenac County Board of Commissioners adopted a resolution creating a Community Mental Health Authority. On June 19, 2001, the Bay County Board of Commissioners followed suit and adopted a resolution creating the Bay-Arenac Community Mental Health Authority. Shortly thereafter, on July 19, 2001, BACMHB approved changing the name of the organization to Bay-Arenac Behavioral Health Authority (BABHA), subject to adoption by the Bay and Arenac County Boards of Commissioners as an amendment to the original resolution.

From 1998 to 2002, AAM functioned as an administrative service organization for the affiliated CMH centers. Further shifts in the AAM membership occurred as Community Mental Health Services Programs (CMHSPs) throughout the state responded to MDCH's call for at least 20,000 covered lives for each entity hoping to secure contracts to provide public behavioral health services. Changes were driven by regional affiliation models, capitation rates, and operating philosophies. The AAM was joined by Tuscola County in the summer of 1999. During 2000-2001, Huron and Shiawassee Counties joined while Gratiot and Saginaw departed, and the AAM eventually formed its own region.

By May of 2000, the Michigan legislature had issued a plan for Medicaid and indigent specialty services. In August of 2000, MDCH issued a revised plan to HCFA. The MDCH now required local CMH boards to submit an Application for Participation (AFP). The purpose of the AFP was to determine whether the CMH program met the state requirements for selection as a pre-paid health plan.

BABHA, along with its affiliate boards, Tuscola Behavioral Health Systems (TBHS), Huron Behavioral Health (HBH), Shiawassee County Community Mental Health (SCCMH), and Montcalm Center for Behavioral Health (MCBH), was successful in being awarded a contract in 2002 to be the Pre-Paid Inpatient Health Plan (PIHP) for Specialty Behavioral Health Services for Medicaid recipients in Arenac, Bay, Huron, Montcalm, Shiawassee, and Tuscola counties.

Another very significant development in 2002 was the formation of a regional substance abuse coordinating agency. The State's reorganization of substance abuse services was initiated to complement the pre-paid health plan specialty services and to include the treatment and prevention of substance use disorders in the affiliate counties.

Among the five (5) AAM partners there were also five (5) regional Substance Abuse Coordinating Agencies through which to coordinate services. Following a detailed analysis, BABHA and its affiliation partners developed a plan to realign CMH and Substance Abuse Coordinating Agency responsibilities. In 2001, BABHA began working closely with MDCH to become designated as a Coordinating Agency. In August of 2002, MDCH designated BABHA as the single Coordinating Agency for the six (6) county region and on October 1, 2002, BABHA Coordinating Agency operations became fully operational.

While BABHA organized and administered the AAM, the affiliated CMHSPs assisted through functional and contractual arrangements with a network of specialty supports and administrative planning. From 2002 through 2006, the AAM and its affiliate CMHSPs worked on developing uniform, and where possible, integrated operational systems to facilitate performance of managed care functions but also to achieve the desired efficiencies wherever possible. In addition, BABHA further evolved mechanisms to address its responsibilities as a health plan for specialty mental health, developmental disability, and substance use disorder services.

Robert Blackford, previously the AAM Director, was promoted to Chief Executive Officer in 2007 upon Dr. Cammin's retirement. In April of 2008, BABHA purchased a residential home and its adjacent lot to operate an Intensive Residential Services Program. This was initiated by the need to provide a safe home for persons who were receiving services from BABHA after MDCH's decision to close the Mt. Pleasant Center. Named the "Horizon Home", it officially opened in September of that same year with two people moving in for an ultimate census of six people.

In the fall of 2009, BABHA leadership decided to actively pursue changing its accrediting body from the Joint Commission (JCAHO) to the Commission on Accreditation and Rehabilitation Facilities, otherwise known as CARF. This decision was made primarily because CARF's standards specifically targeted BABHA's needs as a community mental health organization and supported the Agency's ongoing commitment to offer programs and services focused on the needs of individuals served and based on the highest standards of quality and accountability. Subsequently in January of 2010, BABHA was awarded a three year accreditation by CARF for the following programs: Assertive Community Treatment: Mental Health - Adults; Case Management/Services Coordination: Developmental Disability (DD)/Mental Health - Adults; Case Management/Services Coordination; Integrated DD/Mental Health - Children and Adolescents; Community Integration: Psychosocial Rehabilitation - Adults; Crisis Intervention: Mental Health - Adults; Crisis Intervention: Integrated DD/Mental Health - Children and Adolescents; Intensive Family-Based Services: Family Services - Children and Adolescents; Outpatient Treatment: Mental Health - Adults; and Outpatient Treatment: Integrated DD/Mental Health - Children and Adolescents

In February of 2010, plans were put in place for all clinical staff currently residing on the third floor of Mulholland (except for Emergency Services staff) to move to the Davidson Building in downtown Bay City. It was also decided that the AAM would close their Saginaw location and move their staff into the offices vacated by the clinical staff. These moves were accomplished by mid-June, 2010.

Due to deep general fund cuts by the State in fiscal years 2010 and 2011, all operations were reviewed for efficiency and quality, which led to the exploration of alternative sources of revenue. BABH joined with other CMHSP's in the AAM affiliation forming an association which would organize two different service organizations and a charitable entity to assist with generating funding for critically needed services for indigent populations; one of the service organizations, Crossroads was developed but ultimately closed in 2014. Tele-psychiatry services were added as a component of existing treatment programs after other means of providing timely and cost-efficient psychiatric services were explored. The Riverhaven Coordinating Agency (RCA) and the AAM aligned and integrated their managed care functions for increased efficiency including access, prevention, utilization and quality management, and contract management.

As the second decade of the new century began, a national and statewide focus on integration of physical and behavioral health emerged, in addition to emphasis on recovery and wellness. Of interest were individuals with chronic health conditions who also experience serious mental illness(es), as studies identified such populations were dying decades earlier than those without such co-morbid

health conditions. BABHA instituted the Health Integration Project at the Arenac Center site in Arenac County. Numerous wellness and health education classes were offered to consumers such as smoking cessation, nutrition, exercise classes, computer training to access health information, etc. In addition, wellness goal setting and support at Person Centered Planning meetings and home and telephone support from a Peer Support Specialist were also available through the Project.

Mr. Blackford departed BABHA in 2012 and was replaced by Christopher Pinter, Clinical Social Worker, who was promoted from the AAM Director role. BABHA remained a Community Mental Health Services Program and a Substance Abuse Coordinating Agency (d.b.a., Riverhaven Coordinating Agency) employing over 250 personnel. BABHA's designation as a Pre-Paid Inpatient Health Plan (d.b.a., Access Alliance of Michigan) ended 12/31/13. In 2014, BABHA became a CMHSP operating under a collaborative agreement within the Mid-State Health Network (MSHN), a 21-county region designated by the Michigan Department of Community Health as one of ten Pre-Paid Inpatient Health Plans for Medicaid specialty behavioral health services. Since that time BABHA has continued to perform numerous managed care functions on behalf of MSHN on a contractual basis, based upon its previous experience operating as the AAM.

In 2014 further transitions occurred in the region, as effective October 1, 2014 the Coordinating Agency network in Michigan was folded into the PIHP system by the MDCH. Thus, MSHN assumed responsibility for substance use disorder prevention and treatment services for all its 21 counties. To facilitate a seamless and expedited transition, MSHN issued a request for proposals to the CMHSP's in the region for selection of sub-regional entities to manage these services and BABHA was awarded a contract for 12 of the 21 counties, specifically Arenac, Bay, Clare, Gladwin, Huron, Isabella, Mecosta, Midland, Montcalm, Osceola, Shiawassee and Tuscola.

This sub regional arrangement for substance use disorder services lasted for approximately one year until all related administrative functions were consolidated at the MSHN central office in Lansing on October 1, 2015. BABHA retained some local prevention responsibilities for Arenac and Bay Counties and provided similar administrative supports to Huron and Tuscola CMHSPs via contract arrangement.

The Michigan Department of Human Services merged with MDCH into a consolidated structure in February 2015 to create the Michigan Department of Health and Human Services ("MDHHS"). In addition, the new MDHHS continued to initiate affirmative efforts to reduce historical funding inequality for mental health and substance use services, restored some CMHSP general funds and encouraged further integration of care between regional PIHPs and the Medicaid Health Plans. These actions served to strengthen the ability of BABHA to continue to effectively serve the most vulnerable persons in the community for the foreseeable future.

MDHHS presented final proposals for physical and behavioral health integration for Specialty Mental Health Services and Supports in 2017 based on extensive public stakeholder feedback. These recommendations and other legislative priorities have led to continued dialogue regarding the future roles of private Medicaid health plans and public CMHSPs in the management and delivery of public mental health services.

BABHA ended the last of its administrative service agreements with MSHN to provide selected PIHP managed care functions as of December 31, 2017, BABHA now performs only those managed care functions which are delegated to all CMHSP's in the region.

In 2020, BABHA faced significant challenges to service delivery when the COVID-19 virus spread throughout the world, infecting millions. Michigan was particularly hard hit, including Bay County. BABHA worked closely with local public health officials and by the end of March 2020 had transitioned

all but direct support staff and selected psychiatric clinic staff to virtual offices. On-site services at BABHA locations were reduced to only those services that could not be performed remotely. Audio and video telehealth options were expanded markedly by Medicaid and Medicare. Obtaining and rationing needed personal protective equipment (PPE) became critical to BABHA's ability to continue to operate. Staffing capacity de-stabilized as the virus spread through congregate settings such as specialized residential homes. BABHA sought and obtained a grant to establish an emergency shelter at its North Bay location should a congregate setting no longer have the ability to operate or a isolative non-inpatient care space be needed. As of the end of 2020, BABHA remained in a state of partial shutdown.

The BABHA Board authorized Strategic Leadership to initiate several actions between 2021 and 2023 to respond to the pandemic and protect the safety of our communities. These actions included extensive COVID screening and monitoring at service locations, enhanced infection control and PPE requirements, installation of improved air filtration mechanisms, establishment of emergency shelter protocols, use of remote/virtual technology for public meetings, financial stabilization payments and revised contract amendments to support vulnerable network providers, and enhanced compensation/retention payments to direct care staff. In addition, BABHA in partnership with Bay County Public Health was designated as a COVID-19 vaccination clinic by MDHHS and began providing the Moderna initial and booster vaccines to Bay and Arenac County residents in January 2021. BABHA prioritized persons in residential and individual housing arrangements that might be more vulnerable to community spread and/or have less access to primary care and included mobile clinics throughout both Bay and Arenac Counties. BABHA continued ~~offering vaccination~~offering vaccination services to all consumers, employees, retirees, board members and members of the public through the end of the public health emergency in May 2023.

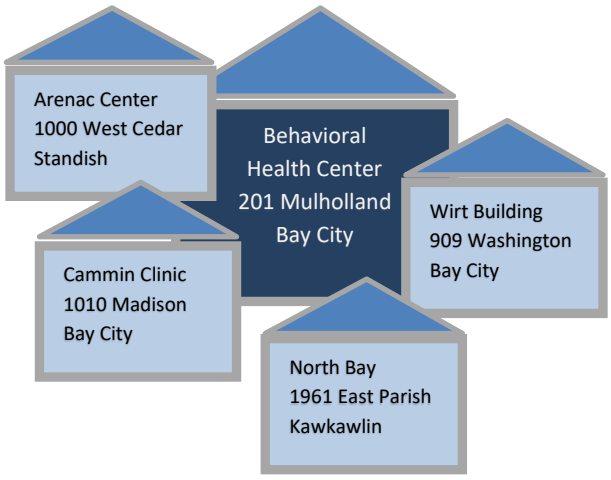
The pandemic created an environment that forced BABH to consider more remote work opportunities for certain services and departments. Not only to provide greater access to individuals served but to recruit and retain employees. Throughout 2024, BABH has continued to update policies, procedures and practices to address the move towards a more remote workforce and provision of services via telehealth. The decreased need for office space and the expanded equipment needs due to the remote work environment continues to be evaluated and addressed. .

Statistics

BABHA operates out of five office locations (see Figure 1: BABHA Office Locations~~Figure 1: BABHA Office Locations~~), with its main offices located in the Behavioral Health Center at 201 Mulholland in Bay City and additional administrative offices housed at the Wirt (United Way) building.

Clinics are operated at the Arenac Center in Standish and at the Madison and Mulholland locations. Community Living services are provided out of the North Bay location, as well as additional clinical services, such as case management and support coordination services. BABHA directly operates a licensed adult foster care home, which is certified as a specialized residential setting, and some related supported independent living arrangements.

Figure 1: BABHA Office Locations



BABHA employs psychiatrists, nurses/practitioners, licensed social workers, professional counselors, psychologists, and other licensed professionals, as well as certified direct care staff, administrative support staff, human resource professionals, accountants, and other administrative professionals (See Figure 2: # of Employees~~Figure 2: # of Employees~~).

BABH has had an increase in the number of employees in 2024. New positions have been added to cover the outpatient service gaps, the expanding children's service needs and the development of the Mobile Response Team. The Horizon Home staffing increased to adequately address the ongoing crises occurring in the Specialized Residential system.

~~. Post pandemic hiring for most positions has been difficult due to lack of applicants. It has been especially difficult to hire and maintain Licensed Social Workers, Nurses and Direct Care Workers. In 2023, there has been a slight increase in the number of employees to be able to meet the increase in the numbers of individuals served.~~

Figure 2: # of Employees

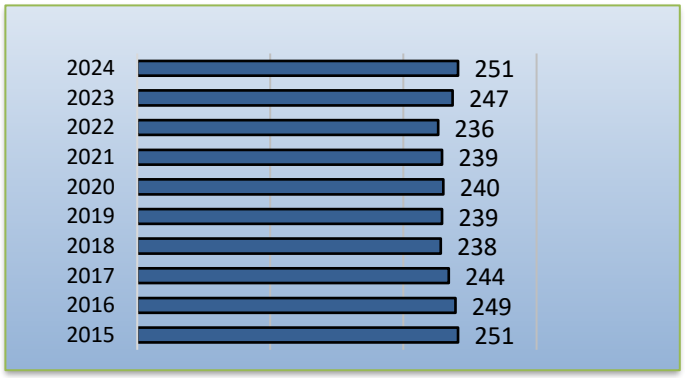
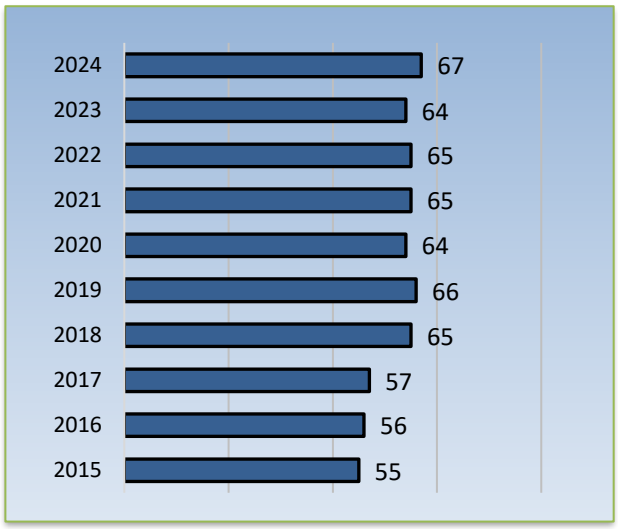


Figure 3: # of Contracted Clinical Service Providers



BABHA contracts with several licensed independent practitioners, organizational service providers, Applied Behavioral Analysis providers, adult foster care homes and psychiatric inpatient hospitals (See Figure 3: # of Contracted Clinical Service Providers~~Figure 3: # of Contracted Clinical Service Providers~~). The number of providers increased around 2018 due to expansion of demand for Autism related services.

Clinical service populations include:

- Adults with mental illness
- Children with serious emotional disturbance
- Adults and children with intellectual and developmental disabilities.
- Individuals with co-occurring substance use disorders

BABHA expanded our provider network in FY24 due to an ongoing need for ABA services and due to factors resulting in out-of-county residential placements.

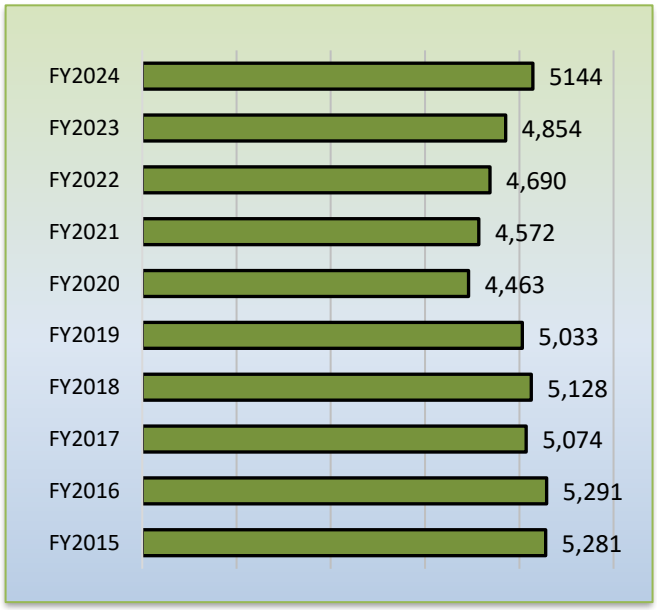
Typically, over 5,000 residents of Arenac and Bay Counties are served each fiscal year (FY) by BABHA direct operated programs and contracted service providers (See Figure 4: Total # of Individuals Served~~Figure 4: Total # of Individuals Served~~).

The number of people served was significantly impacted by the international pandemic which began in the Spring of 2020 and continued through the Fall of 2021. Emergency public health related orders, the inability to deliver some types of services via tele-health, the illness of people served and/or BABHA personnel and contracted service providers, among other challenges reduced the number of people able to access services. Every year since the pandemic, the numbers of individuals served has steadily increased.

The numbers of individuals served in 202~~3~~ have exceeded the numbers of people served pre-pandemic years.~~are much closer to the 5,000 that have been served annually prior to the pandemic.~~

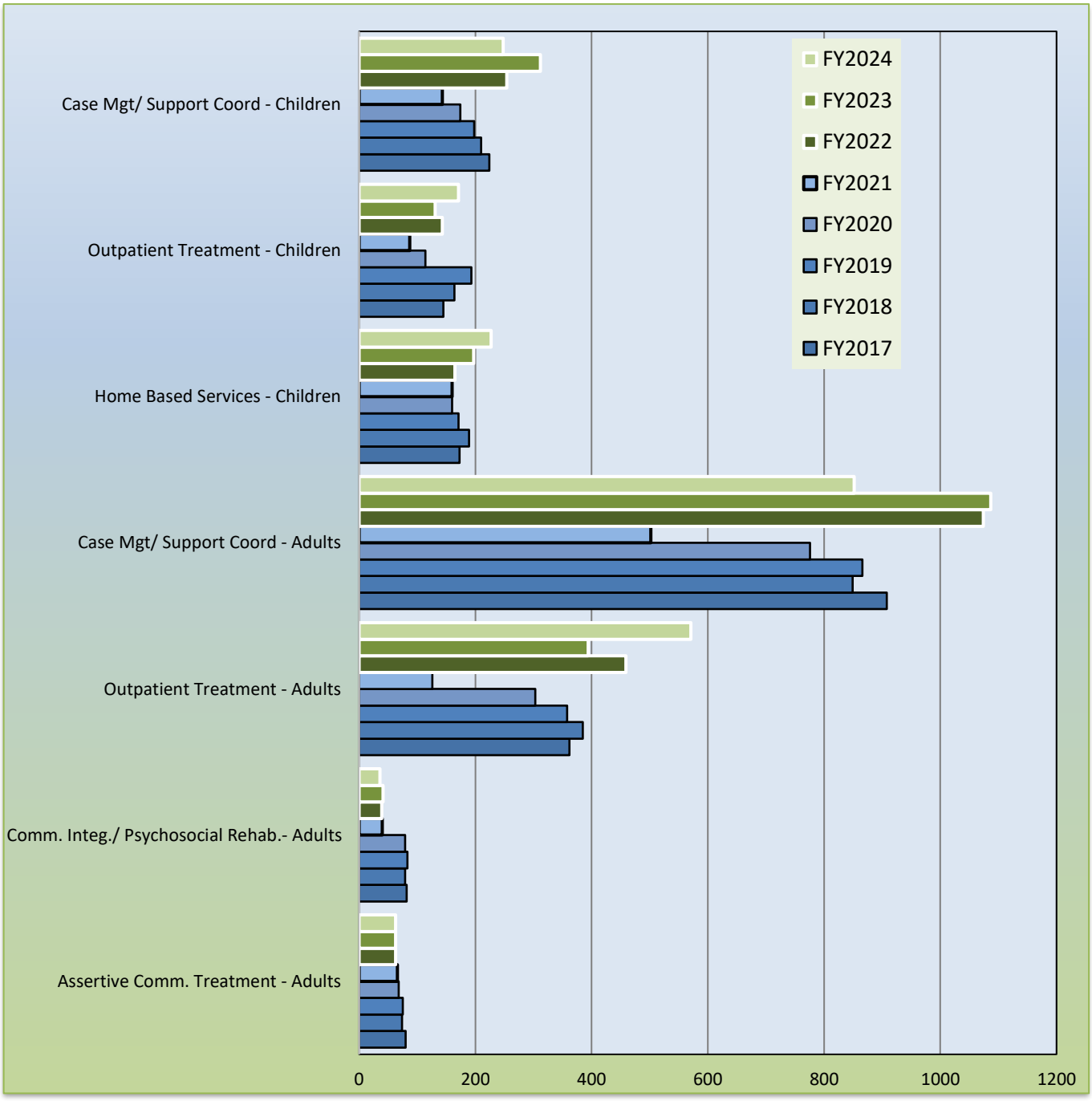
Services provided through the BABHA service provider network include clinical assessment, psychological testing, psychiatric evaluation, medication management, outpatient therapy, behavioral treatment, case management, support coordination, nursing, occupational therapy, speech/ language therapy, independent living support, residential living, vocational services, skill building services and psychiatric inpatient care, among others.

Figure 4: Total # of Individuals Served



BABHA is CARF accredited for specific clinical programs, as shown in Figure 5: Unduplicated Consumers Served per Accredited Program~~Figure 5: Unduplicated Consumers Served per Accredited Program~~. The number of people needing outpatient therapy continue to increase at the same time there is a shortage of qualified clinicians to support the need. BABH has increased internal capacity to help address the gap in services. BABH hired one full time therapist and one telehealth therapist and provided group therapy to address the increase need for outpatient therapy. Emergency Services/Access Services have added Intake workers to quickly get people into services to reduce the dropout rate and gap of time between contact and actual service provision. ~~The number of people served during the latter part of Fiscal Year 2020 and all of Fiscal Year 2021 was greatly impacted by the COVID-19 world-wide pandemic. Case mManagement Services haves had significant increases in 2022 and 2023. Outpatient therapy services are slightly down due to the difficulty in hiring Licensed Social Workers. It is anticipated that January of 2024 will provide some relief when Licensed Professional Counselors will be able to bill Medicare.~~

Figure 5: Unduplicated Consumers Served per Accredited Program



Please note: there were several changes to the formula for identifying "sent" encounters between 2021 and 2022 in order to more accurately account for many service locations that had been excluded prior to COVID-19. The changes were designed to reflect the significant increase in telehealth services during public health emergencies and primarily impacted outpatient and case management services.

BABHA revenue and expense for community mental health services are shown in Figure 6. Expenses are closely managed to remain within regional Medicaid revenue levels in order for BABHA to operate within the resources provided local counties and regional and state payers.

An Organizational Chart is included as Attachment One, which depicts the functions of BABHA at a summative level.

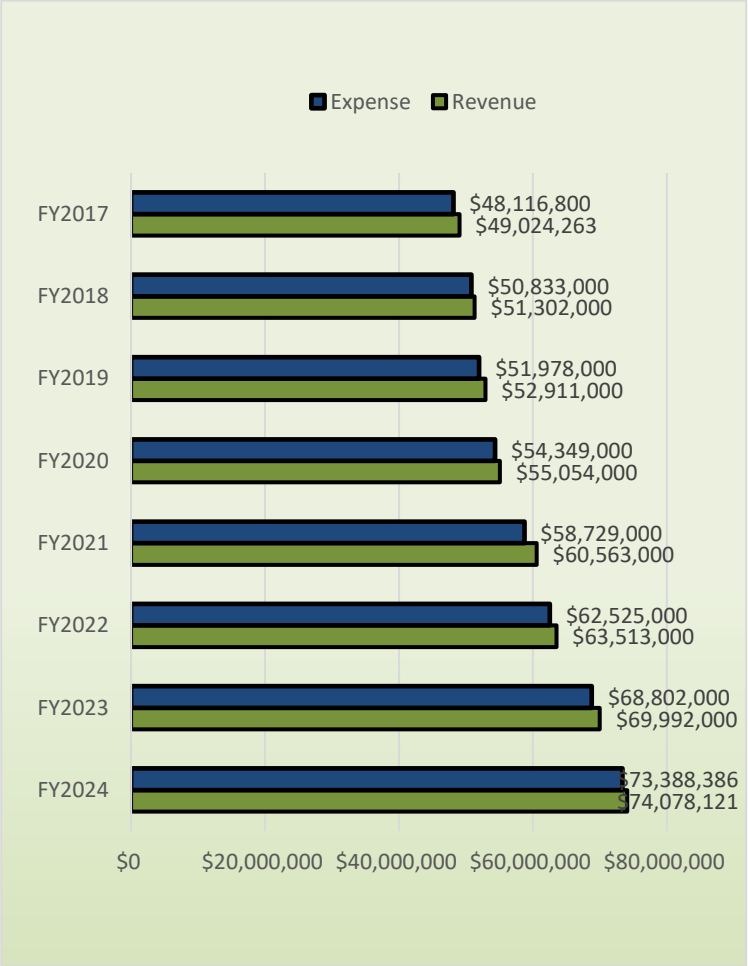


Figure 6: Revenue and Expenses

Strategic and Operational Relationships[5]

Bay-Arenac Behavioral Health operates within the context of its role as a component of the federally mandated and state certified public safety net and government funded health care delivery systems, as well a regional participant and collaborator, a county authority with a Board of Directors appointed by Arenac and Bay Counties, and a community partner for local human service agencies and health care providers. Functioning effectively in this rich mixture of often competing expectations necessitates close attention to communication and collaboration.

As a result, BABHA personnel are seated on numerous external groups, including work groups, councils and committees of the Michigan Department of Health and Human Services, Michigan Community Mental Health Association, Mid-State Health Network and regional and community collaboratives.

In addition, BABHA's internal operations require frequent gatherings of staff, contracted service providers and other stakeholders directly related to BABHA daily activities to transmit information, manage networks, improve operations and coordinate workflows.

Attachment Two of this document is a list of such Organizational Relationships for BABHA.

[5] CARF Standard Section I: Aspire to Excellence; C Strategic Planning; Standard 1i: Strategic planning considers the organizations relationships with external stakeholders

Organizational Concept Statement

Bay-Arenac Behavioral Health is in existence to ensure the delivery of a comprehensive array of health-related supports and services for people with developmental disabilities, mental illness, and/or substance use disorders that are inherently accountable to the persons and families in our community.

Mission Statement

It is the mission of Bay-Arenac Behavioral Health to improve health outcomes, to enhance quality of life and strengthen the community safety net for citizens of Arenac and Bay counties.

Values/Guiding Philosophies

All who are associated with carrying out the mission of Bay-Arenac Behavioral Health are governed by the highest ethical standards and the following values…

- Each person is unique and will be treated with **dignity** and will be respected regardless of ethnicity, religious preference, age, race, sex, sexual preference, gender identity and respected for their lived experience.
- We are committed to delivering services in a manner that is **responsive to urgent, emergent, and long term community** needs of our stakeholders.
- We seek to provide a **recovery**-focused and **trauma**-informed system of care.
- We believe that individual and community wellness is enhanced by the delivery of **integrated healthcare** services that are directed by and responsive to the person served.
- We are committed to promoting **independence, choice, control** and meaningful engagement with peers, family, friends, and community.
- We are committed to collaborating with our community partners to encourage **wellness**, to promote **prevention**, and to increase health literacy.

Core Strategies

1. Effectively manage behavioral health care services for persons with developmental disabilities, mental illness, severe emotional disturbance, and substance use disorders.
2. Delivery of integrated behavioral health care through a coordinated network of services.
3. Coordinate service delivery and collaborate in decision making with stakeholders to maximize responsiveness to community needs.
4. Operate in compliance with local, state and federal regulatory and/or contractual requirements.
5. Maximize administrative and clinical efficiency, including coordination of benefits, to minimize the cost of service and optimize revenues.
6. Ensure individual safety, service quality, and management accountability through use of evidence-based practices, measurement of outcomes and effective use of information.
7. Seek to maintain an organizational environment that promotes excellence and workforce competence and utilizes recruitment and retention strategies to remain competitive in the behavioral healthcare marketplace**.**
8. Apply principles of good customer service to all clinical, business and service relationships.

Environmental Scan and Breakthrough Initiatives

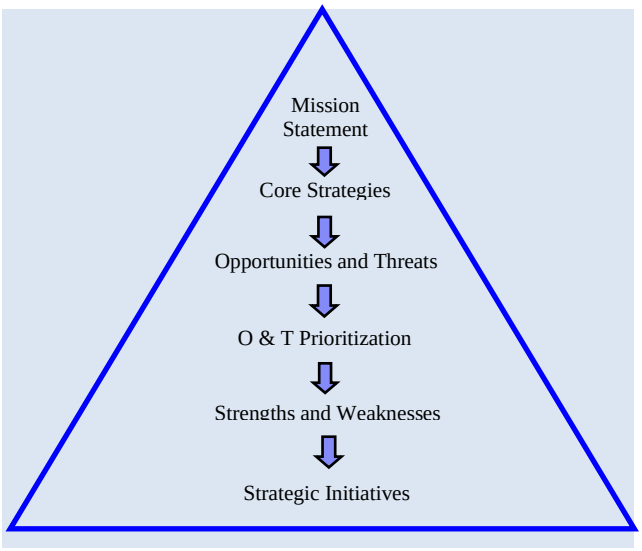
BABHA reviews what is occurring in the environment external to the organization and engages in an analysis and action planning process to ensure the organization continues to remain viable to achieve its mission. An ENVIRONMENTAL SCAN identifies OPPORTUNITIES AND THREATS in the environment that may impact the organization's ability to achieve its core strategies in the present or near future (1-2 years). The organization defines opportunities and threats as follows:

Opportunities:	Conditions external to the organization that the organization may want to take advantage of to facilitate achievement of core objectives
Threats:	Conditions external to the organization that may hinder achievement of core objectives if not decreased or eliminated

Organizational STRENGTHS AND WEAKNESSES are then assessed for the highest priority opportunities and threats. The organization defines these terms as follows:

Strengths:	Attributes of the organization that are expected to be helpful to the organization in taking advantage of an opportunity or fending off a threat
Weaknesses:	Attributes of the organization that may hinder the organization's ability to take advantage of an opportunity or fend off a threat

BREAKTHROUGH INITIATIVES, present short-term strategies (12-24 months) to address the highest priority environmental opportunities and threats, taking into consideration the organization's strengths and weaknesses. The strategies are specific with responsible parties, sub-tasks and due dates defined.



STRATEGIC INITIATIVES by their nature do not include operational activities and are transformative in nature. The focus is on opportunities and threats with the potential to impact achievement of core strategies. Top priority is given to mission critical strategic opportunities and threats, with secondary priority given to systems transformation. Not every opportunity or threat warrants action.

Most of the organization's activity will be operational, so it is important when reviewing this plan to not consider the resulting breakthrough initiatives as representative of the organization's total outputs. The following graphic illustrates this point.

Highest Priority	Mission Critical
⇩	Systems Transformation
Lowest Priority	Operational

A STRATEGIC INITIATIVE TIMELINE is defined to portray when the strategic initiatives will be targeted for completion and to represent potential sequential relationships or contingencies between initiatives. The timeline may also be used by the CEO to hold lead team members accountable for strategic action.

Environmental Scans, SWOT and Breakthrough Initiatives for 2024

Program ~~Health Care Improvement and Compliance~~ Committee

Environmental Scan:	**Integrated Health and Coordination of Care (Mental Health, Physical Health and Substance Use Disorders)**		
Lead Team Member(s):	Karen Amon, Joelin Hahn, Heather Friebe, Amy Folsom, Sarah Van Paris, Jesse Bellinger	**Status:**	Revised for 2025~~4~~

Impact on Ability to Accomplish Mission:

- Must be able to evolve with changing health care industry or may lose opportunity to continue mission
- Improved health status of consumers and reduced co-morbidities through stronger coordination with community partners and reverse integrated practice models
- Improved Health Status of consumers and effective management of co-morbidities through expansion of Advanced Health Serviced Nursing.

Opportunities/Threats:

Threats

- Accountable care initiatives based upon health performance indicators
  - PIHP Medicaid contract to include performance incentives
- PIHP/CMHSP and Health Plan contract requirements
  - Coordination of Care with primary care physician
  - Coordination of care with SUD providers
  - Incorporating results into the Individual Plan of Service
  - Basic health screening including vitals and blood glucose levels if not seen by primary care physician for more than 12 mos.
  - Basic annual health screening including percentage of members 18-64yo w/schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.
  - MDHHS likely to add requiring sending of ACRS (i.e., consumer identifying information) files to Michigan

Strength/Weaknesses:

Strengths

- Implemented the MDHHS Universal Consent Form 2023.
- Current access to nursing and psychiatrist support:
  - Psychiatric clinic – Outpatient services
  - Residential services include access to nursing as medically necessary)
  - ACT model includes access to nursing and psychiatry
  - Advanced Health Nursing Services
  - Triage by Medical Assistants (Madison Clinic and Arenac Center)
- Availability to BABHA of Medicaid claims data for non-behavioral health services, including the Mi Gateway access for medical staff and other selected staff MDHHS Care Connect 360 and Zenith Integrated Care Delivery Platform (ICDP) provided by MSHN, including Key Performance Indicators
- Consumer health literacy materials developed by BABHA
- EHR that supports integrated health care:
  - DIRECT messaging (secure communication between healthcare provider EHR's)
  - Inbound and outbound Admission-Discharge-Transfer records (ADT's)
  - E-consent module compliant with MDHHS standardized behavioral health consent
  - Patient portal for document sharing and e-signature capabilities implemented 2023Lab ordering and interfaced test results (BABHA is active with Quest Labs, McLaren and Ascension-Standish labs)
- Psychiatric Clinic – currently fully staffed and meeting demand of referrals and follow ups. Wait times are less of a problem
- Automated patient appointment reminder system largely functional. Updated 2023 to rolling reminders and improved language to clarify destination site of virtual appointments
- Federal and state information resources to support integrated health care initiatives

Health Information Network Services (MiHIN)
- Poly-pharmacology– to include individuals who get psychotropic medication from external prescribers and CMH network prescribers and/or individuals on multiple medications and their needs cannot be met in community care once stabilized
- On going epidemic of opiate and other addictions in the community
- CMHSP's still lack billing codes to support integrated health care, such as consultation codes
- Difficulty in maintaining fully staffed nursing services
- Community prescriber staffing shortages in the physical health care environment
- ~~Bay City Crisis Residential Unit has opened in Bay City for Bay and Arenac county individuals.~~

Opportunities
- Behavioral Health Home Models emerging in Michigan
- Preventative or early intervention with youth before health conditions become chronic – including but not limited to obesity
- Community health care potential partners
  - Bay County Public Health - possible co-located health and wellness facility
  - Great Lakes Bay Health Centers (FQHC)Sterling Area Health Center
  - Recovery Pathways
  - Echo Project
- Potential to become a learning center for student nurses, nurse practitioners and physicians through partnership with local university medical schools as well as local high school co-op placements
- Educate medical staff to the introduction of nursing case management role(s)
- Availability of the option to utilize certified peer specialists to support integrated health efforts
- State health care initiatives
  - Beh. Health Home initiative
- Improved coordination of care letter now electronic in 2023 allows BABH to receive more information from PHCP and other medical providers
- Using certified electronic health record with capability to transmit continuity of care documents, receive admission/ discharge/ transfer documents and direct message
- Already entered into an agreement with a health information exchange (GLHC, now part of MiHIN) for lab results interface
- BABH Clinic Staff routine use of MiGateway with MiHIN for ADTs in addition to VIPR. Being used by nursing staff at all states of treatment.
- ~~MSHN Key Performance Indicators (and Zenith Care Alert Reports – CMHSP's will be monitoring for progress in management of population health~~
- ~~Implementation of Medical Assistants in Bay and Arenac Counties to assist with triaging and rooming patients~~
- Helen Nickless Free Medical Clinic relationship – Helen Nickless staff provide screening for mental health symptoms/distress, Great Lakes Bay Health Center provides a psychiatric provider and mental health professional (therapist) from BABHA who then assesses for CMH level of care and referral if eligible. Helen Nickless staff assist individuals in applying for Medicaid.
- Emergency and Access Services Department has hired two Intake Assessment Specialists. However, they are often at capacity and do not have room for Same Day Intake. Another EAS Intake Assessment Specialist would need to be hired to enable same day intake.

Weaknesses
- Inpatient and outpatient demand post-COVID exceeds current provider capacities.
- BABHA performance on MMBPIS access indicators has declined
- Loss of staff competencies in motivational interviewing (including assessing stage of change), mindfulness and recovery- oriented systems of care; nurses not yet at desired level of competence
- Discomfort among some non-medical staff in addressing whole health issues
- Consumers not currently utilizing BABHA nursing and psychiatric support services, including some:
  - Children and families experiencing developmental disabilities or serious emotional disturbances (SED)
  - Consumers with MI and DD case management not living in residential settings nor receiving psychiatric services
  - Consumers using contracted primary service providers who do not have nursing staff
- Integrated health related competencies of staff are variable
- Integrated health not adequately addressed or implemented with internal staff or with contracted service provider contracts and scope of work
- Lack of understanding among community primary healthcare providers regarding behavioral health, including hospital emergency room staff
- Openness to collaboration often limited to primary healthcare providers on Medicaid Health Plan provider network panels
- Management of chronic health conditions is difficult, especially for people not in recovery or with unstable housing
- Multi-generational families with poor health management skills
- Lack of certified peer specialists
- Lack of transportation for healthcare
- Existing Coordination of Care system with general practitioners is not as effective as it could be but improvement has been made with clinic-only

○ Certified Community Behavioral Health Clinics (CCBHCs) Duals Projects (MI-Health Link) • Bay City Crisis Residential Unit has opened in Bay City for Bay and Arenac County individuals. ~~○~~	letter and electronic coordination of care document for primary case holders • Coordination of care with SUD providers is lacking • Recent federal regulatory changes did not lessen the burden of protecting substance abuse treatment information • Lack of awareness/understanding/use among other health care providers for DIRECT messaging, Admission-Discharge-Transfer records (ADT's), Continuity of Care Document (CCD's), etc.
Breakthrough Initiatives:	**Resources:**
1. Investigate CCBHC option for implementation in Bay and Arenac Counties a. Review CCBHC experience and financial results with existing CMHSPs for Ionia, Washtenaw, Sanilac and Clinton-Eaton-Ingham counties b. Discuss strengths and weaknesses of CCBHC model with SLT and Agency Leadership c. Present final recommendation to BABHA board for consideration ~~1. Prepare for Behavioral Health Home (BHH) integrated health readiness.~~ ~~a. Identify next steps specific to health care improvement and create a work plan that incorporates every department so that health integration becomes a natural part of clinical flow.~~ ~~b. Continue to expand Advanced Health Services through the addition of an RN whose primary role is to adopt a caseload of individuals with multiple chronic health conditions, high E.R. utilizers.~~ ~~c.~~ ~~d.~~a. ~~Explore Behavioral Health Home service provision.~~	Extended SLT, Agency Leadership, Health Care Integration Steering Committee (HCISC)
~~2. Define Policy and procedures for external information exchange and/or messaging processes with other (i.e., non-BABH provider network) health care providers:~~ ~~a. Determine how expectations for how BABHA clinicians will interact with ADT feed and activate alerts specific to such expectations.~~ ~~b. Define expectation for routine use of MiGateway and VIPR. Nurses are using. Expand for other clinical staff~~ ~~c. Continue to offer to exchange data with local health providers who are able to exchange DIRECT messages. If yes, determine what BABH would like to send/receive and what entities would like to send/receive. Target entities that do not contribute to MiGateway.~~ ~~d.~~b. ~~Continue to use CC360 for care management, increase utilization to routine clinical workflow.~~	~~HCISC, Denise Groh- Amy Folsom, Sarah Van Paris~~
~~i.~~	
2. Implement CCBHC or alternative reverse integration model at BABHA a. Baseline evaluation of readiness against selected integration standards b. Explore federal and state grant opportunities for related infrastructure c. Identify necessary improvements in BABHA operations to comply with related standards d. Create a work plan that incorporates every department so that health integration becomes a natural part of clinical flow. ~~3. Expand BABHA same-day access, outpatient, and crisis residential service options.~~	Extended SLT, Agency Leadership, Health Care Integration Steering Committee (HCISC)~~Joelin Hahn, Stacy Krasinski, Amy Folsom~~
~~4. Explore integrated behavioral health home models for ACT~~	

~~5.~~ Implementation of health literacy training guidelines for staff and individuals served ~~(Jen- do we assign health literacy Relias modules for new hires?)~~	Joelin Hahn, Karen Heinrich, Sarah VanParis
~~New employee performance review health care integration competency assessment (Jen- we haven't don't this in a couple of years)~~	Sarah VanParis, Jennifer Lasceski

Finance Committee

Environmental Scan: **Management of Internal Operations and Provider Network within BABHA Annual Budget and Available Revenue**

Lead Team Member: Marci Rozek; Christopher Pinter

Status: **Additional** Revision for 2025~~4~~

Impact on Ability to Accomplish Mission:

- It is important to make strategic decisions while maintaining competitive business operations and a strong Provider Network in a manner that is consistent with organizational values
- As resources are impacted, service arrays, provider networks, staffing, and supporting infrastructure are also changed
- Shared risk nature of contract financing requires similar commitment from MDHHS,MSHN and BABHA to meet population service needs

Opportunities/Threats:

- Annual Performance Improvement Bonus Incentive Payment
- An increasing fund balance
- State and federal grant opportunities for integration and staff retention
- Funding of mandated direct care wage increase through capitated rates
- ~~MSHN Network Provider Stabilization Plan developed to assist Providers with lost revenue and unusual expenditures during the pandemic has ended.~~
- Michigan's earned sick time act and minimum wages changes will affect Provider Network
- Threat to public services posed by financial integration strategies
- Inpatient utilization/expense has increased 40% in two years
- Autism funding not sufficient to meet volume of services provided
- Demand for ~~outpatient and~~ autism services greater than internal and external capacity
- Community Living Support expenses have increased 16% in last two years
- Medicaid expansion has outpaced available mental health providers for all service populations
- Maintaining a stable Provider Network crucial. Staff recruitment and retention still a concern even after the pandemic.
- Long term financial viability of residential contracts
- Evaluation/monitoring of outcomes based vocational contracts
- Expansion of Mobile Response Team to second shift with financial assistance from grant funds and MSHN
- Pervasiveness of need in some areas, such as SUD services in Arenac County
- MDHHS Home and Community Based Services changes and potential Waskul settlement will dramatically increase CMHSP costs without offsetting revenue enhancements
- Post COVID labor market increasing all provider expenses.
- Lower cost crisis residential unit to divert higher cost inpatient hospitalizations

Strengths/Weaknesses:

- Board aware of budget status and supportive of investments in provider systems
- Zero-based budgeting not performed periodically
- Scale of MSHN region allows opportunity to fund additional budget requests annually when MSHN's Medicaid savings and ISF allows
- Use of non-representational service utilization trends affects the MDHHS rate setting process
- MSHN supportive of Provider Stabilization efforts within each CMHSP budget
- Efficient use of EHR.
- Regional capitation basis not reflective of the specific needs of individual geographic areas, particularly with autism and healthy MI
- MDHHS actuarial rate calculations have negatively impacted funding the behavioral health and SUD system.
- Medicaid redeterminations are affecting benefits and as a result funding the system

- Expansion of CCBHC site in the MSHN region consuming excess Medicaid funding/savings

- Lack of consistent information to community – i.e., services available before a crisis arises
- High turn-over rate and over-time costs with Network Providers of direct care services
- MDHHS eligibility specialist and staff critical to monitoring Medicaid benefits
- MDHHS phasing out CMHSP local match drawdown commitments

Breakthrough Initiatives:	**Resources:**
1. Monitor Long Term (3-5 year) Financial Plan based on revenue trends	Extended SLT; Finance Department; IT Department~~Chris Pinter;; Joelin Hahn; Heather Beson~~
2. Monitor Medicaid and General Fund expenses in every programmatic, personnel and financial consideration; continually monitor fiscal year revenue projections	"
3. Monitor financial stability of Network Providers; Monitor staff retention and impact of recent CLS and provider rate adjustments related to the DCW mandate	"
4. Monitor financial impact of Individual Placement and Support (IPS) Evidence Based Model, related vocational service, Outcome-Based Contracts and community living support services in response to home and community-based waiver.	"
5. Implement local crisis residential facility and pursue expansion of inpatient psychiatric beds in Bay and/or Saginaw counties as alternative service options	"
6. Expand use of telehealth and mobile technology to increase productivity and compliance at individual service and staff level	"
7. Investigate options to revise eligibility/authorization criteria for inpatient care, outpatient services and autism services to reduce the increasing expense curve in 2025.. 8. Evaluate the financial impact of MDHHS ABA reimbursement rates against the actual cost of related services	"
9. Identify other options to reduce autism, Healthy Mi and General Fund expenses consistent with contract requirements 10. Partner with CMHAM, MSHN and county officials to advocate with State for sustainable public mental health funding levels .	

Program Committee

Environmental Scan: **Availability of Community Living Support Services (CLS) for Adults & Children**

Lead Team Member: ~~Heather Beson~~, Director of Integrated ~~Melanie~~Services, Melanie Corrion, Nicole Sweet, ~~Noreen Kulhanek~~ Emily Gerhardt

Status: Revised for 2025~~4~~

Impact on Ability to Accomplish Mission:
Community Living Service staffing is less available than is needed and therefore the demand for services across multiple clinical populations and service settings is not being met.

Opportunities/Threats:

Opportunities:

- Partnering with MALA and other Advocacy organizations to advocate for increase in wages for CLS positions.
- Possibility to look at existing and new provider network/programs to fulfill this gap in services.
- North Bay has moved to community based services.
- HCBS rules may require more community-based service provision increasing the need for more CLS;
- North Bay CLS services have been able to assist in supporting other CLS arrangements.
- Potential to increase Self Directed Arrangements utilizing Peer Support Brokers
- MDHHS requirement and implementation of Electronic Visit Verification systems for Personal Care and CLS

~~North Bay has moved to community based CLS services~~

Threats:

- Negative impact on availability of staff during and after pandemic ; increased staffing crisis in CLS including specialized residential settings
- Wages are a barrier to hiring and retaining qualified staff.
- Needed hours of services are generally less than a typical 8-hour shift and reduces the likelihood of being able to hire and retain staff.
- ABA Technicians, Assisted Living Workers, and other similar workers etc. currently make more than the CLS workers.
- Other entry level jobs generally pay more than CLS positions; heightened awareness during pandemic of vulnerability and wage disparities
- As Self Determined arrangements increase, the demand increases for CLS staffing and there is a potential that services will not meet the needs of individuals as identified in their Individual Plan of Service.
- Individuals with high support needs have waited for services which contributes to increased family stress and increased risk of crises.
- HCBS rule implementation may create a situation that will require more use of CLS and there is already a wait list for these services.
- Changes that add administrative burdens to implement the 1915(i) process.
- Conflict Free Access and Planning Work at MDHHS is a threat and could affect our Horizon Home and Case Management services.
- EVV implementation has placed administrative burdens on current CLS providers.
- Lost~~s~~ of one of our CLS providers.
- Providers reluctant to provide both adult home help and CLS as wages are less for adult home help.
- Paid medical leave act will force providers to provide paid time off

Strengths/Weaknesses:

Strengths:

- Currently have multiple providers who provide CLS services.
- Provider system is in place with potential individuals who can provide CLS services.
- Direct Care Workers have received permanent post COVID and minimum wage rate increases.
- Implementation of Self-Directed services for people with SPMI.
- Have been able to pay a differential rate for Arenac County CLS.
- Have included the CLS Leadership Providers at Residential Meetings with BABHA staff.
- North Bay is providing CLS services and has successfully met HCBS rule requirements
- North Bay and Horizon Home staff have successfully supported a variety of emergent situations and has stabilized those situations. Transitions to new providers have been smooth as a result of the Crisis Team interventions.
- Have expanded CLS Services with the Vocational providers to include new consumers.
- BABHA has vehicles for each of the internal programs and Client Services Specialist assist with transportation when possible.
- Hired a Peer Support Broker and expanding the self-directed services for individuals with SPMI
- Development of the CLS Assessment tool and implementation of the CLS Approval Committee to achieve more consistency in the approval of CLS services.
- Have added a new CLS provider in Arenac County for children
- Have added a new CLS provider for Bay County and the provider serves children
- Existing providers accepted additional referrals.
- AOI accepted more children in Arenac County.

Weaknesses:

- The individualized nature of CLS services creates a situation that makes it difficult to hire adequate staffing, i.e. small numbers of hours needed per person per day.
- Uncertainty of the financial environment.
- Lack of resources in Arenac County for CLS staffing.
- There continues to be a lack of available CLS workers in Arenac County despite providers efforts to provide this service.
- ~~CLS services provided by the vocational providers has created additional concerns related to potential issues related to medical necessity, duplication of services and the identified goals of CLS provided by the voc. Providers.~~??
- Vocational CLS providers not doing in home CLS due to EVV implemen~~an~~tation process and extra administrative burden this creates.
- Self Determination and provision of self-directed services are inherently higher risk for abuse and fraud.
- Reimbursement rate doesn't cover provider transportation costs to send a staff from Bay County to Arenac. ~~?~~ Clarification on rate differential for Arenac.
- Long wait lists due to providers not having staff to do the work.

- Increase in minimum wage happening 2/1/25 (increased cost to BABHA)
- CLS services are difficult to monitor regarding compliance to standards and there has been an increase in substantiated fraud as well as non-compliant documentation.
- DNMM has ended their Independent Facilitation and now the only provider in Bay and Arenac County is the Arc of Bay County.
-

Breakthrough Initiatives:	**Resources:**
1. Expand options for CLS services. a. Continue to expand Northbay/Horizon Home CLS services to take on new referrals that contracted providers are not able to provide the services due to capacity issues, crisis situations, and to help provide immediate CLS supports until providers can secure staffing. b. Continue to explore options to expand hiring for individuals in Self Determined arrangements. ~~Look for opportunities for individuals to participate in Agency of Choice.~~ c. Explore options to increase existing and new providers of children's and adult CLS services. d. Encourage external providers to participate in Advocacy ~~Statewide~~ efforts to ~~to~~ explore options to address staffing crisis and maintain accountability to meet service needs and contractual requirements~~.~~	Self Determination Coordinator, Certified Peer Supports Broker, MI Adult Team, IDD Adult team, CLS Program Manager, Financial Department, Northbay Leadership, Children's Leadership
2. Assist providers and families with maintaining CLS staffing. a. Increase the network's ability to handle workforce challenges, ~~crises,~~ crises, and people with challenging behaviors, ~~crises,~~ etc. by providing additional supports such as psychological services, Quality of Life Mentor services, Mobile Crisis Response Team, and other necessary support services. ~~a.~~b. Continue to ensure that all CLS staff are trained in the Individual Plan of Service initially and ongoing. ~~b. Explore starting team treatment meetings for CLS staff to participate in to learn more about how to support the individuals they serve.~~ c. Advocate for Statewide efforts for Direct Care Worker wage increases and professional certification. d. Develop and implement additional training for individuals in Self Determination arrangements including topics of Fraud/Waste and Abuse, the EVV system, and other trainings to assist them in the role of employer.~~Explore offering a training for Self-Determined families to help support them in being an employer.~~	Self Determination Coordinator, Certified Peer Supports Broker, MI Adult Team, IDD Adult team, CLS Program Manager, Financial Department, Northbay Leadership, Horizon Home Leadership, Emergency Services, MI Adult Case Management Leadership Team, IDD Leadership Team, Fiscal Intermediaries, Corporate Compliance Officer

Environmental Scan: **Stabilization and Long-Term Viability of Residential System**

Lead Team Member: ~~Heather Beson~~, Melanie Corrion, Sarah Van Paris **Status:** Revise for 2025~~4~~

Impact on Ability to Accomplish Mission:

- Services with long "episodes of care" are highly sensitive to changes in the economy, and there is a tendency for staff turnover warranting close monitoring to ensure continuing effectiveness

Opportunities/Threats:

Opportunities

- Home and Community Based Services (HCBS) revised rules may promote the development of more individualized and integrated living situations

Strengths/Weaknesses:

Strengths

- Multiple providers. Numerous homes in both counties which gives us options
- Longevity of providers both with BABHA and experience overall~~.~~

- ~~BABHA financial picture more stable than previous years.~~
- MDHHS has maintained ~~approved~~ increases that have helped retain staff. There are several advocacy groups working to increase the wages of DCW and competencies of that workforce.
- ~~North Bay has moved to community based CLS services.~~
- Higher wages may increase quality
-
-

- More individuals living arrangements may be developed
- Addition of crisis residential home

Threats

- Licensing consultants – not on same page, suggesting guardianship, recommending provider gives emergency notice for behavioral challenges
- BABHA financial picture less stable than in previous years
- Population aging so seeing increase in dementia/Alzheimer's
- Paid medical leave act will force providers to provide paid time off
- Increase in minimum wage happening 2/1/25 (increased cost to BABHA)
- HCBS revised rules and identification of 'Heightened Scrutiny' status for some providers.
- Providers may not be able to meet HCBS rules or may choose not to meet HCBS rules and opt out of providing services for people with Medicaid.
- ABA Benefit expansion – brings increased financial costs and wages are higher than Residential DCW's causing a problem with retention of Staff
- Competition for low wage jobs
- Losing long term direct care staff with experience and passion
- Seeing people w/higher support needs (autism, aggression, personal care)
- Affordable Care Act requirements – effecting some providers
- ~~Planned minimum wage increases (increased cost to BABHA)~~
- Providers saying they cannot meet needs with current reimbursement
- Providers having difficulty w/challenging behaviors~~.~~
- High staff turnover rate in homes (direct care workers and managers) and difficulty recruiting
- Home staff have multiple personal/social issues (low income, single parents…)
- Lack transition options
- Provider commitment/buy in for Gentle Teaching
- Provider have made progress with the Quality of Life Initiative
- BABHA Group Home Training. Web based training has been positive for some. COVID has forced us to look at accepting alternative and other CMHSP trainings for the direct care workers. Alternative training platforms available for direct care workers.
- Several Specialized Residential providers have begun using an electronic Medication Administration Record with built in safeguards and time saving features.
- Providers open to other financial arrangements
- Most providers haven't refused to provide service – always willing to help even with financial concerns
- Many truly care about the people we support
- Several successful crisis interventions utilizing a Crisis Team to assist in transitions.
- Ancillary care providers such as Occupational Therapy, Dietician, and Nursing are providing care
- Ongoing Collaboration related to working through the HCBS rules and implementation, developing Plans of Correction and to address Heightened Scrutiny status.
- Pass through on DCW wage increase to providers and increase in the minimum wage
- Quality of Life Mentor is ~~hired, trained and~~ providing services in the Specialized Residential Homes and other CLS arrangements
- North Bay has moved to community based CLS services.
- Increase the development of individual crisis plans to direct residential staff on appropriate responses to crisis situations.

Weaknesses

- Not enough supported independent living options
- Center for Positive Living Supports no longer does mobile crisis team.
- Funds for Self Determination limited
- Low direct care wages – state assistance level wages – many on Medicaid/Healthy Michigan Plan (HMP)
- Closed ~~two~~three specialized residential homes for a total of 19~~3~~ beds. One provider ended a contract for another specialized residential home. Providers are struggling and making decisions to close homes.
- Home managers not getting support they need from their corporations
- Vacant bed expenses
- Overtime/long hours. Large number are working multiple jobs.
- Providers look to us for the answers in a crisis – have limited solutions of their own (some providers better than others)
- Lease rates of some facilities may be above market
- Need more barrier free homes
- Pressure and cost related to constant training
- Support for high need people (behavioral challenges, dementia)
-
- Gentle Teaching training is stand-alone – costs providers so they don't send staff

- Other counties direct staff wages are higher – they have provided increases, bonuses, annual percentage increases to contracts
- Lack of safe, affordable housing in Arenac County.

Breakthrough Initiatives:	**Resources:**
1. Continue to advocate, prioritize and support appropriate financial adjustments to stabilize the residential services and advocate at all levels for improving the Direct Care workforce. ~~a. Consolidate traditional specialized residential bed capacity to reduce system vacancies.~~ a.~~b~~. Explore development of more direct and provider operated~~direct operated~~ living arrangements that are capable of~~o be able to~~ providinge~~~~ adequate services for individuals with higher behavioral needs. b. Explore more individualized and potentially unlicensed arrangements to be able to meet the needs of individuals with higher behavioral needs in more appropriate settings. c. Continue to collaborate with the Crisis Residential home to provide services to individuals with higher behavioral needs in crisis.	SLT, Financial Department, Board of Directors, , Horizon Home Leadership, North Bay Leadership, IDD Team Leadership, Residential Liaison
2. Support staff's ability to perform effectively and to ensure residents' needs are met. a. Increase the residential provider network's ability to handle workforce challenges, crises, and people with challenging behaviors, ~~crises~~, etc. by providing additional supports such as psychological services, Quality of Life Mentor services, debrief counseling and other necessary support services.	Staff Development, Quality of Life Mentor, Specialized Residential and CLS Providers, Clinical Leadership, IDD Team/MI Adult Team, Horizon Home Leadership, North Bay Leadership, Behavior Treatment Committee, Residential Nursing Staff, BI Department and Quality Assurance Team
b. ~~Increase the development of individual crisis plans to direct residential staff on appropriate responses to crisis situations.~~	~~Clinical Leadership Team~~

Environmental Scan: **Integration with Substance Use Disorder Treatment and Prevention**

Lead Team Member: Joelin Hahn, Heather Friebe **Status:** Revise for 2025~~42024~~

Impact on Ability to Accomplish Mission:

- BABHA must be responsive to changes in the prevalence of health conditions in the environment in which it operates
- BABHA must address necessary shifts in resources and respond in a timely manner in response to shifting community needs.

Opportunities/Threats:	**Strengths/Weaknesses:**
• Minimal availability of SUD providers in Arenac Co. • Increased Substance Use during the COVID-19 pandemic • Availability of Opioid Settlement funds.	• BABHA Access and ES staff continue to provide SUD screening, referring and coordination to Arenac, Bay, Huron and Tuscola Counties • Standish The Well Outreach, Recovery Pathways, Ten16, and Peer 360 interested in collaboration to develop SUD continuum in Arenac County • Collaboration and partnership with court system and law enforcement in Bay County.

- Working with medical community
- Increasing training and collaboration with community partners
- Limited financial resources for substance use disorders
- More dangerous substances in communities
- Increased access to drugs
- Expansion of Medicaid/SUD Behavioral Health benefit
- Increase in availability of potential grant funding
- Continuation of problems with underage alcohol use

- Participation in Project ECHO, Bay County Prevention Network (BCPN), Arenac County Prevention Coalition~~Arenac Drug and Alcohol Containment Task Force~~ (ACPC~~DACT~~), and the Heroin Task Force
- Participation with Great Lakes Bay Families Against Narcotics (FAN).
- Expanded community education and distribution of Narcan kits
- Obtaining Narcan and harm reduction vending machines in both Arenac and Bay Counties.
- Program/Provider development to increase co-occurring enhanced services.
- Bay and Arenac Counties both have local coalitions to address SUD public health issues
- Lack of access to detox and residential services in Bay and Arenac Counties
- Limited available programs/services in Arenac County to meet needs of expanded benefit packages
- Limited transportation to out-county SUD facilities
- Lack of recovery housing in Arenac and Bay Counties
- BABHA's Bay Consumer Advisory Council is supportive
- Breadth of staff competencies in SUD treatment and prevention is improving, but is not as broad as needed
- MCBAP requiring supervisors to have specific supervision credential which takes two years
- MSHN system and funding design continues to encourage segregated mental health and SUD service systems

Breakthrough Initiatives:	**Resources:**
1. Increase treatment and/or referral activities, including consultation with BABH Addictionologist, for adolescents and adults identified with co-occurring SUD conditions.	Joelin Hahn, Stacy Krasinski, Emergency & Access Services (EAS), Child/Family programs, Dr. Morrone .
2. ~~Assist~~ Support Arenac County efforts related to ~~in establishment of a~~ Recovery court ~~-~~and continued ~~expansion of~~expansion of SUD service in the area.	Joelin Hahn, , Heather Friebe, Arenac County Commission, Chief Judge, Sheriff, Prosecutor , Recovery Pathways, , Arenac County Prevention Coalition (ACPC)~~Drug and Alcohol Containment Task Force (ADAC~~), The Well Outreach, Sterling Area FQHC and MSHN.
3. Increase coordination of care and increase the ability to navigate smoothly between mental health and substance use disorder treatment providers.	Joelin Hahn, PNOQMC, BCPN, ~~ADACT,~~ACPC, local MSHN SUD provider network.
4. Increase co-occurring capability within provider network.	Joelin Hahn, Heather Friebe, PNOQMC, Staff Development ~~Training~~ Department.

Environmental Scan: **Evidence-Based and Best Practices in Clinical Service Delivery**

Lead Team Member: Joelin Hahn, Heather Friebe, ~~Allison Gruehn~~, Nicole Sweet **Status:** Revise for ~~2024~~2025

Impact on Ability to Accomplish Mission:

- Use of validated practices supports achievement of clinical outcomes and therefore the organizational mission

Opportunities/Threats:

Opportunities:

- Continued operationalization of culture of gentleness (Region 5-AFP 2013, 5.1.7)

Strengths/Weaknesses:

Strengths:

- Already have multiple Best Practices and EBP's implemented.

- Internal quality oversight equivalent to oversight of contracted provider network and measurement of clinical outcomes/ evidence-based practices
- Continued operationalization of recovery oriented and trauma informed system(s) of care – with a link to integration of care efforts and including attention to co-occurring capacity within the organization in light of recent personnel changes (Region 5-AFP 2013, 5.5 Recovery), see MH Commission Wellness Plan - #5 societal impact, data/outcome, anti-stigma
- Utilization of effective services will improve the lives of consumers and reduce costs.
- Development of outcome measures will assist in thoughtful implementation of clinical practices.
- Partnering with local colleges who educate criminal justice students

Threats:

- Limited finances can prohibit some of the more expensive EBP's.
- Focus on more pressing threats, including COVID-19, has created less attention on implementing EBP.
- With the focus on efficiency and with staff adding on more individuals to their caseloads, it leaves less time to focus on the more time consuming EBP.
- With a greater focus on reduction in revenue, focus on EBP's may become less in the forefront.

- Agency commitment to providing quality services.
- Agency has already developed and implemented pilot projects that have increased the quality of life and reduced costs of services.
- Systems are in place to support ongoing implementation of these practices.
- Successful Mi-FAST (fidelity) Reviews have been conducted and improvement continues in the existing EBP's.
- BABHA's Bay Consumer Advisory Council is supportive
- BABHA financial status has stabilized and it's likely that more resources may be able to be invested in EBP's.
- Arenac Center therapists have been trained in SUD and Trauma Group Curriculum and began to implement groups prior to the pandemic.
- Currently have Individual Placement Supports and Outcome Based Supported Employment models for vocational services.

Weaknesses:

- Lack of Peer and Parent Support options in both counties
- Loss of champions for these practices and reduction in trained staff/loss of workforce.
- Multiple directions and many changes for the agency.
- Lack of specific Trauma Treatment methods for adults.
- Lack of knowledge between ABA providers and the Specialized Residential staff on the different philosophies and methods of treatment.
- Turnover of staff
- Reduction of the EBP's that have been utilized in the past
- Lack of knowledge on benefit counseling and employment services
- Current IPS referrals are low given the number of individuals served by BABH.
- Lack of IPS referrals in Arenac County

Breakthrough Initiatives:	**Resources:**
Trauma Informed Services: 1. Continuation of~~Implement~~ the three-year organizational Assessment for Trauma and develop the Improvement Plan based on the results of the Assessment. 2. Incorporate recommendations from the Wellness/Compassion Satisfaction Initiative (CSI) team to reduce vicarious trauma/secondary traumatic stress. - continue 3. Evaluate capacity and need for EBP to treat trauma in all populations. - continue 4. Identify and Implement Trauma Treatment Groups (Seeking Safety, TREM, Helping Women Recover, etc.) ~~– have made some progress; continue~~	J. Hahn, Staff Development, ~~,;;~~ PNOQMC, Contract Provider Agencies; ~~Compassion Satisfaction Initiative (CSI)/Kathy Palmer;~~ Wellness/Compassion Satisfaction Initiative (CSI) Committee, TF-CBT Initiative/ Emily ~~Young~~Gerhardt, MDHHS Trauma Initiative to address Secondary Traumatic Stress, Quality Assurance/Sarah Holsinger, Arenac Center Outpatient Therapists/Pam VanWormer
Clinical Effectiveness and Expanding Evidenced Based Practices	
1. Monitor~~Implement a~~ LOCUS training plan that includes~~to include~~ ongoing activities to strengthen model fidelity throughout the provider network serving adults with a Serious Mental illness (SMI).	J. Hahn, Kaytie Brooks, Staff Development, BABA internal LOCUS trainers.

	Evaluate implementation and capacity of existing Evidence Based Practices. Evaluate existing system structures to determine if the agency has created a system that supports ongoing successful implementation of existing EBP	
2.	Focus on co-occurring SED/IDD training for the Children's Department.	Emily ~~Young~~Gerhardt, Kelli Wilkinson ~~Maciag~~, Kaytie Brooks, Joelin Hahn
3.	Develop and implement Peer Support Services programs to include Peer Support Specialist, Parent Support Partners, and Youth Peer Support.	J. Hahn, ~~A. Folsom~~Clinical Leadership, SLT
4.	Assess and increase staff competence in the following areas: Motivational Interviewing, Transtheoretical Model (Stages of Change), Dialectical behavior therapy (DBT) basic skills, Co-occurring BH/SUD treatment, Child Parent Interaction, Fetal Alcohol Syndrome Disorder (FASD), Child Parent Psychotherapy (CPP), and Integrated Care competencies.	SLT, Clinical Leadership, Staff Development, Health Care Practices Committee, Provider Network Operations Quality Improvement Committee, MDHHS resources such as www.improvingMIpractices website and MiFAST teams.
5.	Develop outcomes monitoring processes to assure and measure fidelity to EBP', including participating in the MiFAST reviews for existing EBP's; completing the MiFAST for the LOCUS. MiFAST for LOCUS will be conducted in FY24.	MDHHS Practice Improvement Committee, MDHHS MiFAST Review Teams, SLT, Clinical Leadership, Population Committees, Provider Network Operations Quality Improvement Committee, Vocational Providers
6.	Monitor activity~~Implement~~ for the~~MDHHS approval for an~~ Infant and Early Childhood Mental Health Consultation grant.	Pam VanWormer, Kelli Maciag
7.	Monitor activities for the Alternative Outpatient Treatment (AOT) and the Mobile Response Team (MRT) grant programs. Determine program sustainability post grant. ~~Improve, ensure and monitor that the amount, scope and duration outlined in the Individual Plan of Service is met.~~	Stacy Krasinski, James Spegel, Finance Department, Joelin Hahn~~Clinical Leadership, Primary Providers, Population Committees, Provider Network Operations Quality Improvement Committee, BI Department.~~
8.	Expand IPS services and improve fidelity amongst current providers. Increase referrals and expand on education around the impact of IPS services.	Nicole Sweet, MDHHS and MIFAST Team, Clinical leadership, Vocational Providers
9.	Improve education on Benefits to Work coaching and dispelling myths associated with working while receiving benefits.	Nicole Sweet, MDHHS and MIFAST Team, Clinical Leadership, Vocational Providers.

Environmental Scan: **Community and Employee Engagement**

Lead Team Members: Chris Pinter, Amy Folsom, Melissa Prusi, Stacy Krasinski, Jennifer Lasceski **Status:** Revise for 2025~~4~~

Impact on Ability to Accomplish Mission:

- A lack of awareness of BABH mission and services and how the public may access them
- Lack of understanding of behavioral health conditions and the impact on special populations in the community is negatively impacting access to care and coordination of services
- Lack of understanding for employees concerning strategic and resource decisions

Opportunities/Threats:

Opportunities:

- Information is welcomed when it is made available.

Strengths/Weaknesses:

Strengths:

- Establishment of dedicated school liaison position
- Mental Health First Aid Training program

- Availability of several media outlets to get information out (Facebook, agency website, paper educational materials, social media venues, program to program sharing of information, Linked In, ~~Twitter~~ X).
- Community Events (Saginaw Spirit has MH night, Bay County Prevention Network, Great Start Collaborative-Winter Family Fun Fest, A Night Out, Yellow Ribbon events, Recovery Community events).
- People we serve have support systems with resources
- NPR Delta College advertising or Behavioral Health awareness
- Local library systems offer community education series keeping BABH leaflets there or provide education to their staff
- Area Colleges & Social work department organizations (speaking engagements)
- Local association or Groups in our community including PFLAG, Great Lakes Bay Mental Health Consortium
- Improve relationships with local colleges and area high schools for recruiting and training for real-world experiences. Offer and advertise BABH as a learning-based site for social work, nursing, medical assistants, physicians, and high school students who are interested in this field.
- BABH has a dedicated school liaison to two schools
- BABH to be a presence at area job fairs for recruitment as well as exposure to services.
- Improved communication with employees
- Community engagement with youth services.
- MRT is available Monday through Friday daytime and some evening hours.
- Participate in the Bay City Housing (Homeless) Task Force Coalition.
- Establish collaboration with new community partners.
- Leadership meeting synopsis disseminated to agency staff via internet and leadership to review at staff meetings.

Threats:

- Lack of understanding and stigma fosters failure to access needed care, potentially leading to avoidable negative clinical outcomes
- Community Partners practice in their own vacuum; not realizing the resources available to people who meet criteria for CMH level of care
- Lack of knowledge about what kinds of information community partners need—what is helpful and what is not
- Missed opportunities to impact those who need services
- Failure to engage employees in crucial agency decisions
- Motivational Interviewing Training program
- QPR Question Persuade Refer Suicide Prevention Training Program
- Two CIT Crisis Intervention Team trainers on staff
- BHEP Behavioral Health Emergency Partnership trainings partnership with law enforcement.
- BABH Staff who participate in community meetings/events
- Established relationships exist
- BABH Staff are willing to participate at community events even on weekends when supported by agency.
- BABH does have an existing FB page and website.
- BABH has a large, contracted provider network that is and can be used to disseminate information.
- Establishment of mobile response team with Bay Couty First responders.
- Improved relationship with the police, jail, Bay and Arenac County court systems.~~-~~
- Network providers report improved timeliness and input/collaboration of BABH decision-making processes
- Established agency leadership processes
- Comprehensive employee survey process

Weaknesses:

- Schools do not fully understand BABH services
- General community lacks understanding of mental illness, substance use disorders and developmental challenges
- Community Partners do not understand mild to moderate vs SMI.
- Employees of BABH are not fully aware of what others are doing or involved in.
- Lack of public relations staff to oversee efforts or create sustainability.
- Many BABH staff participate in community meetings but~~and~~ BABH does not track who participates or where resources are shared. Consider Sharepoint site to log all community events/opportunities.
- Lack of community support to our partners with their initiatives. Consider piggybacking community events with community partners.
- Inconsistent Team Meeting agendas or communication requirements
- Little to no social media presence. Staff are not aware of our Facebook. [Each department responsible for posting once a month? Employee spotlight? Postings must be related to BABHA/Mission/Values/Services. Must have approval by SLT? May benefit employee recruitment.]

Breakthrough Initiatives:	**Resources:**
1. Continue to work with Community partners (law enforcement, courts, MDHHS, schools, medical	Extended SLT, Agency Leadership, ~~C. Pinter, J. Hahn, H. Friebe, S. Krasinski, M. Prusi, A. Folsom,~~ Bay County Prevention Network, Arenac Drug and Alcohol

	facilities, etc.) to increase understanding, reduce stigma and promote trauma informed communities	Containment task Force, Arenac and Bay County Sheriffs, McLaren MHU and Emergency Department, ~~Ascension Health~~MyMichigan Standish Hospital, MyMichigan Bay City ED, Recovery Pathways, Sacred Heart, Great Lakes Bay Southside and Westside FQHC, Sterling Area Health Center, Bay County Public Health Department
2.	Re-instate a process for keeping behavioral health literature in community partner lobbies and available to the public. (Possibility to have secretaries be responsible for distribution and two way communication for community events.)	Extended SLT, ~~C. Pinter, A. Folsom, M. Prusi, BABHA~~ Agency Leadership. Helen Nickless Free Medical Clinic, Good Samaritan Rescue Mission, Opportunity Center, Arenac Community Center, Bay Area Women's Center, Bay Arenac ISD, CAN Council, MI Works in Standish and Bay City, Great Lakes Bay, McLaren, Recovery Pathways, Sacred Heart, DOT Caring Center, 1016 House, Catholic Family Services, MyMichigan Standish, MyMichigan Bay City ED
3.	Maintain efforts to actively include service providers in prompt communication and opportunities for collaboration	Extended SLT, Agency Leadership, Provider Network Operations and Quality Committee~~Heather Beson Joelin Hahn, Sarah Holsinger, Amy Folsom~~
4.	Create a shared site for informative educational series to share on social media. (Sharepoint, Facts for Families, Phoenix library for meds and diagnoses)	Agency Leadership, ~~C. Pinter, J. Lasceski, J. Bellinger,~~ Staff Development, Information Technology and Help Desk
5.	Expand Stepping Up Initiative to address safety net and treatment issues for youth and juveniles into Arenac County. ~~Coordinator of the initiative died and replacement hasn't scheduled any meetings.~~	J. Hahn, H. Friebe, P. Van Wormer, Arenac County Probate Judge, Arenac County Prosecutor's Office, Arenac County DHHS, Arenac County Sheriff, Arenac County ISD, Arenac County Commission
6.	~~Establishment of agency-wide team meeting expectations, agendas, and Leadership reporting (Unsure if this has happened.) Remind department managers/supervisors to provide trickle-down information from Leadership meetings.~~	~~C. Pinter, S.McRae, Leadership~~

Personnel and Compensation Committee

Environmental Scan: **Recruitment and Retention**

Lead Team Member: Jennifer Lasceski **Status:** Continue for 2025~~4~~

Impact on Ability to Accomplish Mission:

- Inability to recruit qualified staff – Masters and bachelors level clinician shortage across the state; shortage of direct care staff across the state
- Staff dissatisfaction with compensation
- Staff turnover negatively impacts service delivery
- Scheduled increases in minimum wage
- Uncertain state/federal funding to sustain increases
- Shortage of qualified candidates in this geographic area and statewide impacts efforts to fill long term vacancies

Opportunities/Threats:

- Increased staff morale
- Improved competitive edge in recruitment
- Improve quality of job applicants
- Positive effect on employee retention
- Financial impact may affect sustainability

Strengths/Weaknesses:

- Market-based compensation structure in place
- Total compensation is competitive for a number of positions as adjusted in 2018, 2020, 2021, 2022 and 202~~4~~2
- Agency ~~benefits and~~ training opportunities exceed many area employers

- Perceived inequality of implementation (not all positions may be positively impacted)
- Use of non-traditional incentives (signing and referral bonuses)
- Agency continues to be guarded due to the uncertainty of adequate funding
- Ability to maintain competitive compensation levels and benefits is impacted by current economic environment
- Competing priorities for limited budget
- Competing industries offering -higher pay and bonuses with reduced risk and responsibility

Breakthrough Initiatives:	**Resources:**
1. Strategies to attract and retain qualified LBSW and MSW candidates. ~~1.~~2. Explore the option to consider other qualified candidates that meet QIDP and QMHP criteria for Case Management positions. ~~continue~~	~~Heather Beson,~~ Joelin Hahn, Director of Integrated Care
~~2.~~3. Strategy to attract and retain qualified and invested direct care staff – maintain continuous posting practices	Justeen Blair, ~~Heather Beson~~Director of Integrated Care
~~3.~~4. Financial impact of additional potential compensation adjustments (salary and/or benefits) for the organization – consider adding compensation review on an annual basis to the Board By-Laws	M. Rozek; SLT

Environmental Scan: **Development of Workforce**

Lead Team Member: Jennifer Lasceski **Status:** Continue for 2025~~4~~

Impact on Ability to Accomplish Mission:

- Time involved in replacing key staff
- Loss of institutional knowledge, history & experience
- Continued need for ongoing leadership training & documented succession plans
- Advance staff skills to ensure continuing organizational viability
- Increase internal educational opportunities to reduce budget impact
- Improve competencies and health literacy of BABH staff
- Continue to reduce stigma

Opportunities/Threats:

- Lack of provisions for back-up/coverage (i.e., cross-training)
- Need department buy-in and commitment to succession planning process
- Planned departures provide lead time to groom successors
- Need to expand staff training on SUD, recovery, trauma and cultural competence
- Continued training support for non-clinical staff related to mental health conditions, customer service, CPI, etc.
- Need for leadership orientation and continued learning
- Increased turnover may lead to gaps in service
- Increase opportunities to engage stakeholders and relay organizational messaging
- Competing training opportunities
- Limited financial resources

Strengths/Weaknesses:

- Training capacity is stretched, if unexpected absence we lack back-up
- Increased communication (SLT): All staff meetings; all-Leadership meetings; regular SLT updates on intranet site
- More robust succession planning policy and procedure implemented
- Continue to identify potential internal talent
- Staff development plan (w/in annual performance evaluations) to identify leadership potential & development activities
- Encourage team building and other employee engagement activities
- Increased demands on staff
- Knowledgeable staff as subject matter experts
- Dedicated training facilities
- Many training opportunities made available via Zoom and other technology
- Short notice of training affects ability of Staff Development Center to obtain CEUs
- Breadth of staff competencies in SUD treatment and prevention is not as broad as needed
- Staff turnover has decreased since 2018 and a more competitive wage structure.

Breakthrough Initiatives:	**Resources:**

1.	Increase cross-departmental understanding through increased exposure during orientation/training, all-staff events, etc., including job shadowing and document – continue to utilize alternate methods to present training; look at use of alternative training programs for direct care post pandemic	Agency Leadership
2.	Increase consistency in the application of standards by supervisory staff	Agency Leadership
3.	Continue to increase SUD competency of BABHA clinical programs through training and expanding the number of certified/licensed staff; modify job descriptions as warranted	Clinical Directors~~Heather Beson; Joelin Hahn~~; Agency Leadership
4.	Develop/promote staff training on common MH diagnosis in order to increase staff competency in providing education to persons served. Suggestions from the Employee Survey regarding specific training topics will be forwarded to Staff Development for consideration.	Agency Leadership
5.	Formally outline the role for case management in an integrated healthcare environment and educate staff~~ continue~~	Sara VanParis; ~~Karen Amon~~
6.	Continue to support residential staffing for BABHA's direct operated home and apartment settings through training and redeployment during the pandemic and beyond	Justeen Blair; Nicole Sweet; Melissa Spellerberg
7.	Continue initiatives that support agency efforts relative to recovery-based care, trauma informed services, co-occurring services and fostering a culture of gentleness.	~~Heather Beson,~~ Directors of Integrated Care Nicole Sweet
8.	Investigate CEU process for other disciplines such as nurses, psychologists, etc.	Kaytie Brooks
9.	Provide leadership training related to employment practices at monthly all-leadership meetings. Provide leadership and/or management training to Agency management staff.	HR Director
10.	Continue to fully develop succession planning, health care competencies, and supervisory competencies into the performance management process	Agency Leadership

Facilities

Environmental Scan: **Review of Remote Work and Physical Plant needs**

Lead Team Members:
Karen, Marci and Jennifer

Status: ~~New 3/28/24~~ Continue 2025

Impact on Ability to Accomplish Mission:

The remote work environment has a direct affect on the need for office space, equipment needs and accommodation at work sites for those staff working remotely when they need work space in office.

Opportunities/Threats:

Opportunities:

- Flexibility in staffing schedules to recruit more employees.
- Reduce costs for buildings and work spaces.
- Advance the use of technology to be more efficient.
- Leases for the Wirt Building and the Mulholland office space are soon going to be expired.

Threats:

Strengths/Weaknesses:

Strengths:

- Have had three years during the Pandemic to work through remote work issues.
- Prior to the Pandemic, had a successful virtual office arrangement in place for several years.
- IS staff are very familiar with technology that is needed for more remote work.
- BABHA owns North bay and the Madison Clinic.
- BABHA has been able to adapt well during the Pandemic.
- There are many reports that have been developed to be able to monitor quality, effectiveness and efficiency of staff and services.

- Perceived lack of supervision for remote staff.
- Potential distancing and lack of cohesiveness among teams and within the Organization
- Potential reduction in effective communication between staff and within departments.

Weaknesses:

- Past satisfaction surveys have identified a lack of communication from BABHA, which could worsen if remote work lessens responsiveness.
- Costs for equipment may increase if there are additional needs to accommodate remote work.

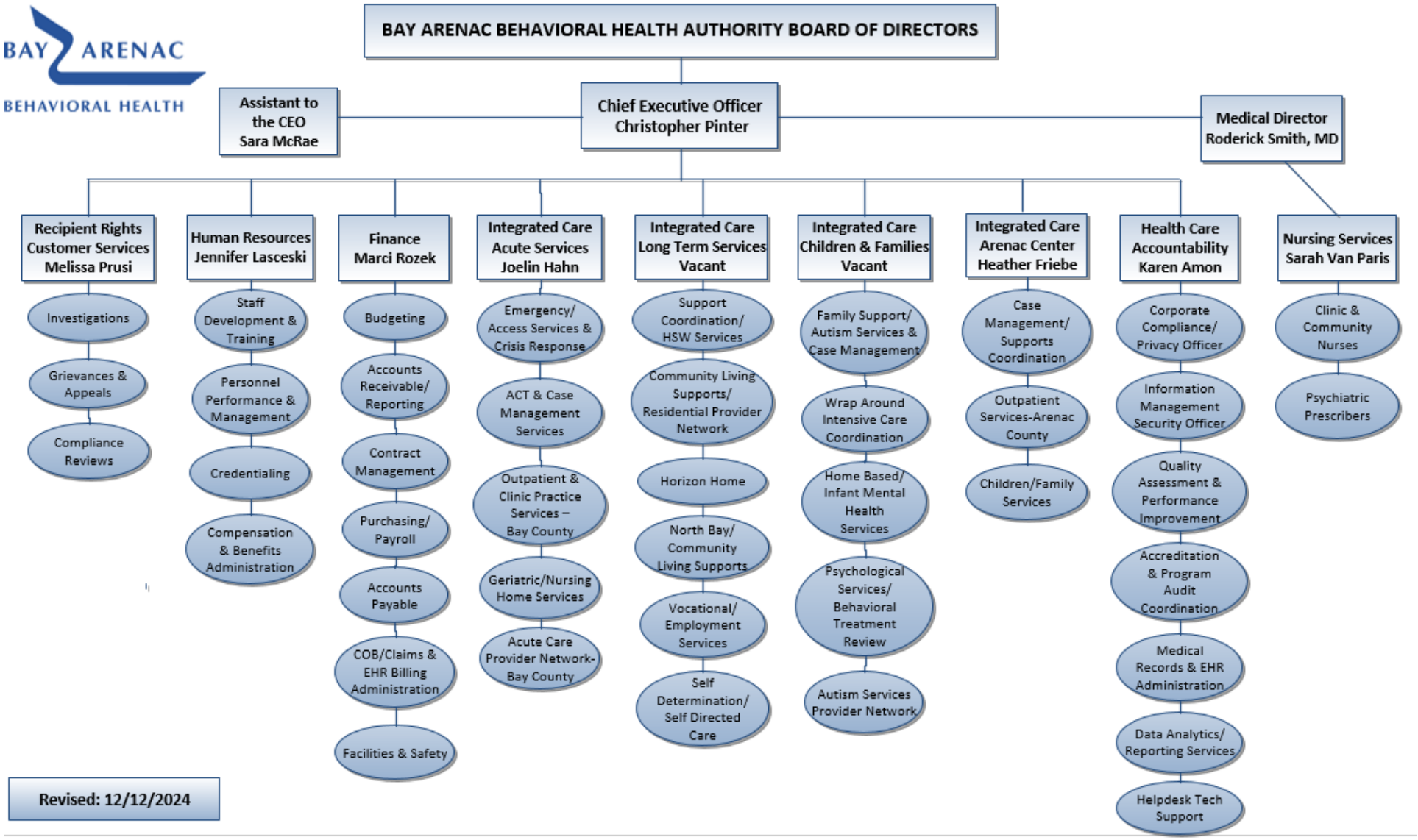
Breakthrough Initiatives:	**Resources:**
1. Implement Leadership Dashboard and other reports to allow Supervisors and Managers for real time monitoring and evaluate staff's activity.	BI Department, Leadership
2. Evaluate long term staff equipment and space needs post remote work implementation.	IS Department, Facility Manager, Leadership
3. Prepare/Revise ~~2024~~ 2025Replacement schedule for Board consideration.	IS Manager, Finance Manager
4. Prepare long term physical plant recommendations for Board consideration.	Leadership, Finance Manager, Facilities Manager

Bay-Arenac Behavioral Health

20254 Strategic Plan

Attachments

Attachment One: Organizational Chart



Organizational Relationships

External

MDHHS

- MDHHS National Core Indicators Work Group – Sarah Holsinger
- Parent Management Training Oregon Model MDHHS Steering Committee – ~~Amy Anderson~~
- MDHHS Children's Administration Meeting –, Kelli Maciag
- Michigan Motivational Interviewing Team – Karen Amon
- MDHHS Peer Liaison Meeting –
- MDHHS Recharging Supported Employment – Nicole Sweet
- MDHHS Medical Clearance Work Group – Stacy Krasinski
- Fair Hearings Officers – Kim Cereske
- MDHHS ORR Directors Group – Melissa Prusi
- Practice Improvement Steering Committee – J. Hahn
- MDHHS Transition to Community – Melanie Corrion
- MDHHS Medical Directors Advisory Committee – Dr. Smith
- MDHHS Public Relations Committee – ~~Heather Beson~~
- MDHHS Contract and Finance Issue Committee – Marci Rozek
- ~~MDHHS Conflict Free Access and Planning Karen Amon, Heather Beson~~

State Association

- MDHHS/CMHA Capitation/Cost Allocation Work Group – Chris Pinter
- CMHA Legislative and Policy Committee-Chris Pinter, Karen Amon
- Chief Information Officer (CIO) Forum – Jesse Bellinger
- CMHA Customer Services Work Group-Melissa Prusi; Kim Cereske

Regional (Mid-State Health Network – MSHN)

- Councils/ Committees
  - MSHN Operations Council – Chris Pinter
  - MSHN Finance Council – Marci Rozek
  - MSHN Quality Improvement Council-Sarah Holsinger; Karen Amon
  - MSHN Corporate Compliance – Karen Amon;
  - MSHN IT Council – Jesse Bellinger
  - MSHN Customer Service Committee – Kim Cereske
  - MSHN Utilization Management Committee – Joelin Hahn
  - MSHN Provider Network Committee – Marci Rozek, Stephanie Gunsell
  - MSHN Clinical Leadership – Joelin Hahn; ~~Heather Beson,~~ Karen Amon
  - MSHN Medical Directors – Dr. Smith
- Work Groups/Teams
  - MSHN Regional Autism Monitoring – Sarah Holsinger, Melissa Deuel
  - MSHN HSW Coordinators-Melanie Corrion; Jackie Kish
  - MSHN HCBS Coordinators –Melanie Corrion; Jackie Kish
  - MSHN 1915(i) Lead Staff- Melanie Corrion; Jackie Kish

- MSHN Autism Work Group – Amanda Johnson; Emily Young
- MSHN Data Analytics –Lisa Nagel; Sarah Holsinger
- MSHN Care Management Ad Hoc Committee – Amy Folsom
- MSHN Inpatient Reciprocity – Melissa Prusi; Sarah Holsinger
- MSHN Behavioral Treatment (data) Review Committee – ~~Heather Beson,~~ Karen Amon (temporarily), Flavia Vasconcelos, Casey Binkley
- MSHN Recipient Rights – Melissa Prusi
- MSHN Training Coordinators Work Group – Jennifer Lasceski; Kaytee Brooks
- MSHN East Recovery Oriented System of Care (ROSC) – Joelin Hahn

Regional/State CMHSP Professionals:

- Occupational Therapy Area Quarterly Group Meeting - Meredith Bickel
- Michigan Nursing Forum Meetings – ., Sara Van Paris, Amy Folsom, Nicole Konwinski

Community/County

General

- Bay County Services Partners for Homelessness – Allison Gruehn
- Bay Human Services Collaborative Council - Joelin Hahn
- Arenac Multi-Purpose Collaborative Body – Heather Friebe
- Human Trafficking Multi-Disciplinary Team (Arenac County) – Heather Friebe
- Vulnerable Adult Committee (Arenac) – Monica Baniel
- Project Echo – No one assigned
- Enhanced Mental Health Provider Access: ~~Heather Beson~~

Child and Family

- Bay-Arenac Great Start Collaborative – Amanda Johnson (when resumes)Bay Community Collaborative Service Partners –Sue Guertin
- Arenac County Child Protection Council – Pam VanWormer,Kaitlyn Kokaly
- Preschool Partnership Advisory Council – Kelli Maciag
- Child Death Review Team (Bay County) – Kelli Maciag
- Child Death Review Team (Arenac County) – Heather Friebe
- ACE's & Trauma Informed Care Committee – Emily Young, Brad Parker
- Youth and Family Connect (Systems of Care for Children) - Stacy Krasinski, ~~,~~Amanda Johnson, Ashley Aho, Shannon Leyton
- DHHS Partnership (Bay) – Noreen Kulhanek; Stacy Krasinski
- DHHS Trauma –Pam VanWormer
- ISD Mental Health Meeting – Pam VanWormer; Emily Gerhardt and Brad Parker.
- Great Lakes Bay PFLAG-J. Schultz
-

Crisis Response and Prevention

- Bay Arenac Suicide Prevention Coalition – Stacy Krasinski, Jill Schultz, Heather Friebe

Educational/Vocational

- Seamless Transitions Committee (w ISD)–; Melanie Corrion~~; Monica Baniel~~
- Bay Arenac ISD Youth and Vocational Committee: Nicole Sweet, Melanie Corrion

Law Enforcement and the Courts

- Community Corrections Board (511 Board- Bay County) – Joelin Hahn
- Stepping Up (Bay County) – Joelin Hahn; Stacy Krasinski; Amy Folsom
- Bay County Adult SUD Treatment Court – vacant
- Adolescent Treatment Court – Jane Bollinger; Kelli Maciag

- Family Treatment Court – Jill Schultz

Service to Senior Adults

- Adult Services Collaborative – Melanie Corrion; Melissa Prusi

Substance Use Disorders/Co-Occurring Disorders

- Arenac County Prevention Coalition (ACPC)~~Alcohol and Drug Containment Taskforce (ADACT~~) – Heather Friebe~~; Nicholas Berkobien~~
- Bay County Prevention Network – Joelin Hahn
- Families Against Narcotics – Joelin Hahn
- Northern Michigan Opioid Response Consortium– Heather Friebe

Internal

Councils/Committees (and facilitator/chair)

- SLT and All Leadership – Chris Pinter; Rotation Schedule
- Arenac Consumer Council – Kim Cereske
- Bay Consumer Council – Kim Cereske
- Medical Staff Meeting – Dr. Roderick Smith; Sara Van Paris; Amy Folsom
- Healthcare Practices Committee – Dr. Roderick Smith; Sarah Van Paris; Amy Folsom
- Health Care Integration Steering Committee – Amy Folsom; Joelin Hahn ?
- Behavior Treatment Plan Review Committee – ~~Heather Beson~~ Karen Amon(temporarily)
- Safety Committee – Eric Strode
- Corporate Compliance Committee – Karen Amon
- Ethics Committee – Melissa Prusi
- Autism Provider Meeting – Amanda Johnson
- Residential/CLS Provider Meeting – ~~Heather Beson;~~ Melanie Corrion
- Vocational Provider Meeting – ~~Heather Beson;~~ Nicole Sweet
- Primary Network Operations and Quality Management Committee (PNOQMC) – Joelin Hahn; Sarah Holsinger
- Residential/CLS Crisis Response Team (Ad Hoc) –; Nicole Sweet; Melanie Corrion
- CLS Committee- Nicole Sweet
- Residential Referral Committee- Rachel Lemiesz; Melanie Corrion
- ~~Staff Population Ad Hoc Work Groups (meetings called as determined at PNOQMC)~~
  - ~~Quality of Life Ad Hoc Work Group – Melanie Corrion~~
  - ~~Children's Ad Hoc Work Group – Noreen Kulhanek~~
  - ~~Recovery Ad Hoc Work Group- Allison Gruehn~~
- EHR Management Team – Karen Amon
- Data Governance Committee – Jesse Bellinger

Attachment Three: Leadership Dashboard and Power BI Report Indicators by Committee of the Board of Directors

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
~~Health Care Improvement &~~ Corporate Compliance Committee	Status and Nature of Fraud and Abuse Investigations by Quarter – Direct Operated Programs	# of investigations: not-substantiated; substantiated regarding documentation issues, credentialing issues or potential fraud/abuse; or in-process (for direct operated programs)	Open and closed fraud/abuse investigations as of the last date of the quarter
~~Health Care Improvement &~~ Corporate Compliance Committee	Status & Nature of Fraud/Abuse Investigations by Quarter - Contracted Service Providers	# of investigations: not-substantiated; substantiated regarding documentation issues, credentialing issues or potential fraud/abuse; or in-process (for contracted service providers)	Open and closed fraud/abuse investigations as of the last date of the quarter
~~Health Care Improvement &~~Corporate Compliance Committee	Status & Nature of Privacy/Security Investigations by Quarter - Direct Operated Programs	# of investigations: not-substantiated; substantiated with and without breach notice required; or in process (for direct operated programs)	Open and closed privacy/security investigations as of the last date of the quarter
~~Health Care Improvement &~~Corporate Compliance Committee	Status & Nature of Privacy/Security Investigations by Quarter - Contracted Service Providers	# of investigations: not-substantiated; substantiated with and without breach notice required; or in process (for contracted service providers)	Open and closed privacy/security investigations as of the last date of the quarter
~~Health Care Improvement &~~ Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (BABHA Direct, Contracted Secondary & Tertiary) Per Quarter	Total billable encounters without appropriate documentation	Total billable encounters
~~Health Care Improvement &~~Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (BABHA Direct) Per Quarter	Direct # of services billed without appropriate documentation	BABHA Direct # of encounters billed that were reviewed
~~Health Care Improvement &~~Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (Secondary - MPA, LPS, SPS) Per Quarter	Secondary (MPA, LPS, SPS) # of services billed without appropriate documentation	Secondary (MPA, LPS, SPS) # of encounters billed that were reviewed
~~Health Care Improvement &~~Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (Tertiary - Specialized Residential, Vocational, etc.) Per Quarter	Tertiary (Specialized Residential, Vocational) # of services billed without appropriate documentation	Tertiary (Specialized Residential, Vocational) #of encounters billed that were reviewed
~~Health Care Improvement & Compliance Committee~~Program Committee	% Of Consumers Diagnosed w/ Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes	# Of those that have had a diabetes screening (glucose or A1c(HbA1c)) in the measurement period	# Of Adult (18-64) Medicaid consumers with a diagnosis of Schizophrenia or Bipolar actively receiving services who are prescribed at least one atypical antipsychotic medication.

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
Program Committee~~Health Care Improvement & Compliance Committee~~	% Of Consumers Diagnosed w/ Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes	# Of those that have had an HbA1c and LDL-C test in the measurement period	# Of Adult (18-64) Medicaid consumers with a diagnosis of Schizophrenia who have been diagnosed with diabetes
Program Committee	% of Consumers Diagnosed w/ Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Received a Cardiovascular Screening	# of those that have had one or more LDL-C screenings performed during the measurement year	# of Adults (25-64) consumers with a diagnosis of Schizophrenia or Bipolar Disorder who were prescribed an antipsychotic medication
~~Health Care Improvement & Compliance Committee~~Program Committee	~~Reported Medication Related Occurrences for BABHA Per Quarter~~	~~# Of medication errors; # of omissions (Not LOA); # of other occurrences; # of LOA Omissions~~	~~Total # of medication occurrences~~
~~Health Care Improvement & Compliance Committee~~Program Committee	~~Reported Infections (Spec. Resid. & Day Program Staff) Per Quarter~~	~~# Of reported infection in Residential/DP (frequency count)~~	
~~Health Care Improvement & Compliance Committee~~Program Committee	Count of Reportable and Non-Reportable Adverse Events Per Quarter.	# of sentinel events (as defined by CARF/MDHHS); # of critical events (injuries-harm to self or others, med errors, suicide, non-suicide death, arrests)	
Program Committee~~Health Care Improvement & Compliance Committee~~	Count of Reportable Risk Behavior Treatment Events Per Quarter	# of 911 Calls made by staff; # of Emergency Physical Interventions	
~~Health Care Improvement & Compliance Committee~~Program Committee	% Adults w/MI Served by BABHA Indicating "General Satisfaction" w/Services on Survey	# of MI Adults CSM/ACT/OPT whose average response was less than or equal to 2.5 for domain	# of MI Adults CSM/ACT/OPT who had valid responses to this domain
Program Committee~~Health Care Improvement & Compliance Committee~~	% Children w/ SED Served by BABHA Indicating "Appropriate/Quality" Services, i.e., General Satisfaction on Survey	# of MI Children CSM/HBS/OPT whose average response was greater than or equal to 3.5 the for domain. Excludes contract providers	# of MI Children CSM/HBS/OPT who had valid responses to this domain. Excludes contract providers
~~Program Committee~~Health Care Improvement & Compliance Committee	~~Average Annual Provider Site Review Performance Scores~~		

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
~~Health Care Improvement & Compliance Committee~~ Corporate Compliance Committee	~~Critical Information Systems Outages per month (network, desktop, and phone issues)~~ % of user phishing preparedness compared to industry standard	~~VDI-Frequency count in minutes Phoenix-Frequency Count in Minutes Phone System Outages in Minutes~~ Number of users who report simulated phishing emails and number of users who click on simulated phishing emails compared to industry standard.	
~~Health Care Improvement & Compliance Committee~~ Corporate Compliance Committee	~~Critical Information Systems Outages per month (network, desktop, and phone issues)~~ # of security incidents per month	~~Wide Area Network(WAN)Outages in Minutes: Identify if affects phone specific to building~~ Number of security findings, false positives, and resolved issues	~~AT&T, Charter, Tel-Net .~~
~~Health Care Improvement & Compliance Committee~~ Corporate Compliance Committee	~~Critical Information Systems Outages per month (network, desktop, and phone issues)~~ Critical system outages per month	~~Local Area Network (LAN) Outages in Minutes: Identify if affects phone specific to building~~ Number and duration of outages including network, communications, and critical software	~~Arenac, Madison, Mulholland, North Bay, Wirt~~
~~Health Care Improvement & Compliance Committee~~	~~Percent of Storage Space Used~~	~~Amount of GB used each quarter.(G Drive, P Drive, Email, SQL 1, SQL 2)~~	~~Total amount of GB available.(G Drive, P Drive, Email, SQL 1, SQL 2)~~
~~Program Committee~~	~~Children receiving Trauma Focused CBT or Parent Management Training demonstrating improvement~~	~~# Children in TF-CBT, PMTO or PTC Showing >20 Point Improvement on CAFAS Score AND % of children in TF-CBT, PMTO or PTC Showing >20 Point Improvement on CAFAS Score~~	~~Total # of Children in TF-CBT, PMTO or PTC with an Initial Assessment and a Discharge Assessment in the CAFAS System~~
~~Program Committee~~	~~Children receiving OPT, HBS, CSM demonstrating improvement~~	~~# Children in OPT, HBS and CSM Showing >20 Point Improvement on CAFAS Score AND % of Children in OPT, HBS and CSM Showing >20 Point Improvement on CAFAS Score~~	~~Total # of Children in OPT, HBS and CSM with an Initial Assessment and additional Assessment in the CAFAS System~~
~~Program Committee~~	~~Children showing improvement in severe impairments at their most recent assessment.~~	~~# Children who did not have any severe impairments at the most recent CAFAS assessment. AND % of Children who did not have any severe impairments at the most recent CAFAS assessment.~~	~~Total # of Children assessed~~
~~Program Committee~~	~~Average score for adults with mental illness on Recovery Assessment Scale: Personal Recovery, Clinical Recovery, Social Recovery; Uncategorized Questions~~	~~Average score (across domain questions) in the domain; excludes blanks/refused~~	~~Total # of total respondents of the Recovery Assessment Scale; excludes blanks/refused~~
~~Program Committee~~	~~Percentage of People w/ Behavior Treatment Plans Utilizing Restrictive/Intrusive Techniques~~	~~# Of consumers who have a Behavior Treatment Plan with Restrictive and Intrusive Interventions, per quarter~~	~~# Of consumers served, per quarter~~
~~Program Committee~~	~~Incident Reports by category for Residential Homes, CLS - Deaths-Suicide/Non-Suicide, Emergency Medical Treatment, Hospitalization, Law Enforcement, Health & Safety.~~	~~# Of Incident Reports by Category Suicide Non-Suicide Emergency Medical Treatment Hospitalization Law Enforcement~~	~~Total incident reports submitted by the residential homes.~~

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
	~~Medication Incident, Challenging Behavior~~		
Program Committee	Penetration Rate for Medicaid, Healthy Michigan		
Program Committee	Service Penetration Rate Proxy Measures	Frequency count of persons served (i.e., unduplicated # of people with sent encounters) per month	MSHN Eligibles Paid file (includes Total of DAB, HMP and TANF for Arenac and Bay Counties)
Program Committee	State Facility Days Per Month	Frequency Count	
Program Committee	Community Inpatient Days Per Fund Source (Power BI Report)	# of community inpatient days per month for adults per fund source: General Fund; Medicaid State Plan; Healthy Michigan Plan; # of community inpatient days per month for children per fund source: General Fund; Medicaid State Plan; Healthy Michigan Plan	
Program Committee	People Served, By Population and Age (Power BI Report)	Frequency count per disability designation per quarter: # of Adults w SMI; # of Children w SED; # Adults w IDD/SMI; # of Children w IDD/SMI; # of Adults w IDD; # of Children w IDD; # Not Evaluated/Reported; # w SUD Diagnosis	
Program Committee	% of Pre-Admission Screening Dispositions By Type for Adults/Children (Power BI report)	# of mental health diversions, substance use diversions, partial hospitalizations, intensive crisis stabilization service referrals, inpatient admissions, crisis residential placements, withdrew/declined to finish, and other	Total pre-admission screenings completed
Program Committee	Adults/Children Who Received Emergency Services (Power BI report)	# of adults and children who received a crisis intervention that was billable (i.e., 'sent'), per quarter; # of adults and children who received a crisis intervention that was non-billable (i.e., not 'sent'), per quarter; # of adults who received partial hospitalizations, in total and per provider, per quarter; # of adults and children who received crisis residential stays, in total and per provider, per quarter; # of children who received crisis stabilization/mobile crisis response services, in total and per provider, per quarter; # of adults and children who received psychotherapy for crisis, in total and per provider, per quarter	
Program Committee	Adults Who Received Core Services (Power BI Report)	# of Adults who received ACT per quarter # of Adults who received CSM/SC, in total and per provider, per quarter # of Adults who received Outpatient Therapy, in total and per provider, per quarter	
Program Committee	Adults Who Received CLS Day Activity Services (Power BI Report)	Total # of Adults who received CLS services through North Bay, per quarter	

Board Committee	**Indicator (including unit of measure)**	**Numerator**	**Denominator**
Program Committee	Adults Attending Clubhouse (Power BI Report)	Total # of Adults who received Psychosocial Rehabilitation Services through Touchstone Services, per quarter	
Program Committee	Adults Who Received Services in Vocational Settings (Power BI Report)	# of Adults who received CLS 15 Minute (H2015; place of service code 99) through a vocational provider, in total and per provider, per quarter; # of Adults who received Skill Building services, in total and per provider, per qtr; # of Adults who received Supported Employment services, in total and per provider, per quarter # of Adults who received IPS (Individual Placement Services), in total and per provider, per quarter	
Program Committee	Adults and Children Who Received Community Living Supports (Power BI Report)	# of Adults who received CLS Per Diems (H2016) in a specialized residential setting, in total and per provider, per quarter; # of Adults who received CLS Per Diems (H0043; place of service code 12) in unlicensed independent living or their own home, in total and per provider, per qtr; # of Adults who received CLS 15 Minute (H2015; place of service code 12) in-home supports, in total and per provider, per quarter; # of Children who received CLS Per Diems (H2016) in a foster care home or a CCI, in total and per provider, per quarter; # of Children who received CLS Per Diems (H0043; place of service code 12) in their own home, per quarter; # of Children who received CLS 15 Minute (H2015; place of service code 12) in-home supports, per quarter	
Program Committee	Children Who Received Core Services (Power BI Report)	# of Children who received Homebased services, per quarter; # of Children who received CSM/SC, in total and per provider, per quarter; # of Children who received Outpatient Therapy, in total and per provider, per qtr; # of Children who received Autism Services, in total and per provider, per quarter	
Recipient Rights Advisory Committee	Substantiated BABH Abuse & Neglect Complaints Per Quarter	# of Substantiated Complaints	# of complaints
Recipient Rights Advisory Committee	Recipient Rights Appeals	# of Investigations upheld	# of Appeals (those that meet the criteria to be appealed)
Recipient Rights Advisory Committee	Medicaid Grievance Decisions in Favor of CMHSP vs. Beneficiary Per Quarter	# of Decisions if Favor of CMHSP # of Decisions in Favor the Beneficiary	# of Medicaid Grievances filed
Recipient Rights Advisory Committee	Medicaid/GF Appeal Decisions in Favor of CMHSP vs Beneficiary Per Quarter	# of Decisions in Favor of CMHSP # of Decisions in Favor of Beneficiary # Resolved, not wholly in favor of Beneficiary or CMHSP	# Medicaid/GF Appeals
Recipient Rights Advisory Committee	Medicaid Fair Hearing Decisions in Favor of CMHSP vs Beneficiary Per Quarter	# of Decisions if Favor of CMHSP # of Decisions in Favor the Beneficiary	# of Medicaid Hearing Decisions
Personnel & Compensation Committee	New Positions Added Per Quarter		

Board Committee	**Indicator (including unit of measure)**	**Numerator**	**Denominator**
Personnel & Compensation Committee	New Hires Per Quarter		
Personnel & Compensation Committee	Voluntary Terminations Per Quarter		
Personnel & Compensation Committee	Percent of employees attending training sessions on site (at SDC outside of NEO, RR Fair and Fall/Spring on-line training cycles)	# of employees who have attended trainings on site that are not part of the mandatory identified training for employees	# of employees employed on the last day of the reporting period
Personnel & Compensation Committee	Non BABHA Staff attending BABHA sponsored trainings	Non BABHA Staff attending BABHA sponsored trainings	
Facilities & Safety Committee	Employee Accidents/ Illnesses/Injuries Per 100 Employees; By Reporting Status; Per Quarter	# of reportable incidents (employee accidents/ employee; illness/ employee injuries) per MIOSHA standards; # of non-reportable incidents (employee accidents/ employee illness/employee injuries) that are not reportable to MIOSHA; # of employees at the end of the reporting period	
Facilities & Safety Committee	Facility Site Review Compliance	# of Sites Compliant (that do not need corrective action)	# of Sites Reviewed
Finance~~/By-Laws & Policies~~	Revenue Versus Funds Expended by Fund Source Per Quarter in Thousands (fund sources include GF, Medicaid, Healthy MI, and MI Child, Children's Waiver) Reported for each quarter formulas must calculate accumulative	GF Revenue Medicaid Revenue Healthy Michigan Revenue ~~MI Child Revenue (d/c)FY16~~ ~~Children's Waiver Revenue(d/c)FY16~~	GF Expense Medicaid Expense Healthy Michigan Expense ~~MI Child Expense(d/c)FY16~~ ~~Children's Waiver Expense(d/c)FY16~~
Finance~~/By-Laws & Policies~~	Number of days of operations ratio (unrestricted fund balance/total daily expenditures) (Determine target days/threshold)	Unrestricted fund balance	Total daily expenditures