

AGENDA

BAY ARENAC BEHAVIORAL HEALTH BOARD OF DIRECTORS PROGRAM COMMITTEE MEETING

Thursday, December 11, 2025 at 5:00 pm

Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

Committee Members:	Present	Excused	Absent		Present	Excused	Absent	Others Present:
Christopher Girard, Ch	_____	_____	_____	Sally Mrozinski	_____	_____	_____	BABH: Karen Amon, Nicole Sweet,
Pam Schumacher, V Ch	_____	_____	_____	Pat McFarland, Ex Off	_____	_____	_____	Joelin Hahn, and Sara McRae
Jerome Crete	_____	_____	_____	Robert Pawlak, Ex Off	_____	_____	_____	Legend: M-Motion; S-Support; MA-
Shelley King	_____	_____	_____					Motion Adopted; AB-Abstained

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Request for Clinical Privileges: a) Cynthia Mai, PMHNP-BC – Three-year renewal term expiring December 31, 2028 4.2) Policies Beginning 30-Day Review: a) Home and Community Based Rules, 04-05-08 4.3) Primary Network Operations and Quality Management Committee Meeting Notes from September 11, 2025		4.1) Consideration of a motion to refer the request for clinical privileges to the full Board for approval 4.2) Consideration of a motion to refer the policy, Home and Community Based Rules, 04-05-08, to begin 30-day review to the full Board for approval 4.3) No action necessary

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	4.4) Quality Assessment & Performance Improvement Quarterly Report, S. Holsinger 4.5) Strategic Plan Revisions, J. Hahn & N. Sweet		4.4) No action necessary 4.5) No action necessary
5.	Adjournment	M -	S - pm MA

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY POLICIES AND PROCEDURES MANUAL

Chapter: 04	Care and Treatment Services		
Section: 05	Person Centered Planning		
Topic: 08	Home and Community Based Services (HCBS) Compliance		
Page: 1 of 1	Supersedes Date: Pol: Proc:	Approval Date: Pol: Proc:	<div style="border-bottom: 1px solid black; padding-bottom: 5px; margin-bottom: 5px;"><i>Board Chairperson Signature</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;"><i>Chief Executive Officer Signature</i></div>
Note: Unless this document has an original signature, this copy is uncontrolled and valid on this date only: 12/2/2025. For controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to ensure compliance with Home and Community Based Services (HCBS) Program Rule federal and state regulations.

Purpose:

BABHA will ensure that internal services and contractual providers of HCBS, including residential and nonresidential home and community-based services are compliant with Federal HCBS Final Rule and Person Centered Planning.

Education Applies to:

- All BABHA Staff
- Selected BABHA Staff, as follows:
- All Contracted Providers: Policy Only Policy and Procedure
- Selected Contracted Providers, as follows:
 - Policy Only Policy and Procedure
- 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
K. Amon	SLT	9/23/25	New	To comply with HCBS Final Rule.



**BAY-ARENAC BEHAVIORAL HEALTH
PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING**

Thursday, September 11, 2025
1:30 p.m. - 3:30 p.m.
Lincoln Center - East Conference Room/Zoom

MEMBERS			AD-HOC MEMBERS		
Allison Gruehn, BABH Program Manager - Adult MI/CSM/ACT/Sr. O.	X	Kelli Wilkinson, BABH Supervisor - Children's IMH/HB	X	Amanda Johnson, BABH Supervisor - ABA/Wraparound	
Amy Folsom, BABH Program Manager - Psych/OPT Svcs.	X	Laura Sandy, MPA Clinical Director & CSM Supervisor	X	Barb Goss, SPSI COO	
Anne Sous, BABH Supervisor - EAS		Lynn Blohm, BABH North Bay Team Supervisor - CLS	X	Jacquelyn List, List Psychological COO	
Brad Parker, BABH Team Leader - Adult I-DD	X	Megan Smith, List Psychological Site Supervisor		Kathy Johnson, Consumer Council Rep (J/A/J/O)	
Chelsea Hewitt, SPSI Asst. Supervisor	X	Melanie Corrion, BABH Program Manager - Adult ID/DD		Lynn Meads, BABH Medical Records Associate	
Courtney Clark, SPSI Supervisor - CSM/OPT	X	Melissa Deuel, BABH Quality & Compliance Coordinator	X	Michele Perry, BABH Manager - Finance	
Emily Gerhardt, BABH Program Manager - Children		Melissa Prusi, BABH Director Health Care Accountability	X	Moregan LaMarr, SPSI Clinical Director	
Emily Simbeck, MPA Supervisor - Adult OPT	X	Nicole Sweet, BABH Director Integrated Care - Acute	X	Nathalie Menendes, SPSI COO	
Heather Friebe, BABH Director Integrated Care - Arenac	X	Pam VanWormer, BABH Program Manager - Arenac		Sarah Van Paris, BABH Manager - Nursing	
Jackie Kish, BABH Recipient Rights & Customer Services Manager	X	Sarah Holsinger (Chair), BABH Quality Manager	X	Stephanie Gunsell, BABH Manager - Contracts	
Jaclynn Nolan, SPSI Supervisor - OPT		Stacy Krasinski, BABH Program Manager - EAS	X	Taylor Keyes, BABH Team Leader - Adult MI	
Joelin Hahn (Chair), BABH Director Integrated Care - Child & Family	X	Stephani Rooker, BABH Program Manager - CLS/Horizon		GUESTS	
Joelle Sporman (Recorder), BABH BI Secretary III	X	Tracy Hagar, MPA Supervisor - Child OPT	X	Caitlin Youngs, List Psychological LMSW Intern	X
Karen Amon, BABH Director Integrated Care - Long-term	-			Stephanie Odell, SPSI Adult Case Manager and Counseling Intern	X

Topic	Key Discussion Points	Action Steps/Responsibility
1. <ul style="list-style-type: none"> a. Review of, and Additions to Agenda b. Presentation: None c. Approval of Meeting Notes: 08/14/25 d. Program/Provider Updates and Concerns 	<ul style="list-style-type: none"> a. There were no additions to the agenda. b. No presentations this month. c. The August meeting notes were approved as written. d. Program/Provider Updates and Concerns: <u>Bay-Arenac Behavioral Health:</u> <ul style="list-style-type: none"> - <u>ABA/Wraparound</u> – No updates to report this month. - <u>ACT/Adult MI</u> – Down an Intensive Case Manager. Referrals are limited. Down two ACT nurses and two case managers. Referrals are on hold. - <u>Children's Services</u> – Lots of referrals. Interviewing for a case manager and wraparound position. - <u>CLS/North Bay & Horizon</u> – No updates to report this month. - <u>Corporate Compliance</u> – No updates to report this month. - <u>Emergency Access Services (EAS)/Mobile Response Team (MRT)</u> – Not currently replacing the supervisor for MRT. Still need 2nd shift MRT position filled. - <u>ID/DD</u> – No updates to report this month. - <u>IMH/HB</u> – No updates to report this month. 	

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	<ul style="list-style-type: none"> - <u>Integrated Care</u>: <ul style="list-style-type: none"> • <u>Acute</u> – No updates to report this month. • <u>Arenac</u> – No updates to report this month. • <u>Child & Family</u> – No updates to report this month. • <u>Long-term</u> – No updates to report this month. - <u>Medical Records</u> – No updates to report this month. - <u>Physician/OPT Services</u> – We are in a crunch with adult prescriber time but are working out plans to alleviate the issue. - <u>Quality</u> – No updates to report this month. - <u>Recipient Rights/Customer Services</u> – Jackie Kish is fully transitioned into her new role. No updates to report this month. - <u>Self Determination</u> – No updates to report this month. <p><u>List Psychological</u>: List has two new therapists. Caitlin Youngs, a LMSW Intern, will be trained on Phoenix the end of September.</p> <p><u>MPA</u>:</p> <ul style="list-style-type: none"> - <u>CSM</u> – Lost a Child/Family Case Manager. They will not be replacing this position, because MPA cannot justify replacing the position due to inconsistent caseload sizes. Hoping to be back open to some cases in October. - <u>OPT-A</u> – No updates to report this month. - <u>OPT-C</u> – A couple groups are coming out. Parenting Group, Kids Mindfulness Group and DBT Skills Group. <p><u>Saginaw Psychological</u>:</p> <ul style="list-style-type: none"> - <u>CSM</u> – No updates to report this month. - <u>OPT</u> – No updates to report this month. 	
<p>2. Plans & System Assessments/Evaluations</p> <p>a. QAPIP Annual Plan (Sept)</p> <p>b. Organizational Trauma Assessment Update</p>	<p>a. QAPIP Annual Plan – The QAPIP Annual Plan has been redone and is much shorter than what it was. It will be taken to the board next month. The PNOQMC is the structure responsible for the QAPIP and performance improvement activities of BABHA’s operations. The PNOQMC is responsible for monitoring performance by: Receiving</p>	<p>a. Sarah will make changes to take to the board in October.</p>

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	<p>recommendations for improvement, identifying quality related indicators and measures, reviewing data reports to ensure validity, taking action to achieve improvement, and meeting regularly to review and assess performance. Sarah went through the QAPIP Annual Plan.</p> <p>b. <u>Organizational Trauma Assessment</u> – Nothing to report this month.</p>	
<p>3. Reports</p> <p>a. QAPIP Quarterly Report (Feb, May, Aug, Nov)</p> <p>b. <u>Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports</u></p> <p>i. MSHN Priority Measures Report (Jan, Apr, Jul, Oct)</p> <p>ii. Recipient Rights Report (Jan, Apr, Jul, Oct)</p> <p>iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec)</p> <p>iv. Consumer Satisfaction Report (MHSIP/YSS)</p> <p>v. Provider Satisfaction Survey (Oct)</p> <p>c. <u>Access to Care & Service Utilization Reports</u></p> <p>i. MMBPIS Report (Jan, Apr, Jul, Oct)</p> <p>ii. LOCUS (Mar, Jun, Sep, Dec) – Defer</p> <p>iii. Leadership Dashboard - UM Indicators (Jan, Apr, Jul, Oct)</p> <p>iv. Customer Service Report (Jan, Apr, Jul, Oct)</p> <p>v. Employment Data (Dec, Mar, Jun, Sep)</p> <p>d. <u>Regulatory and Contractual Compliance Reports</u></p> <p>i. Internal Performance Improvement Report (Feb, May, Aug, Nov)</p>	<p>a. <u>QAPIP Quarterly Report</u> – Nothing to report this month.</p> <p>b. <u>Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports</u></p> <p>i. <u>MSHN Priority Measures Report</u> – Nothing to report this month.</p> <p>ii. <u>Recipient Rights</u> – Nothing to report this month.</p> <p>iii. RAS – Defer till next month.</p> <p>iv. <u>MHSIP/YSS</u> – Nothing to report this month.</p> <p>v. Provider Satisfaction Survey – The Provider Network Survey obtains feedback from contracted clinical service providers who provide care to individuals within our service area. The survey was sent to all provider types, including the following organizations: residential, vocational, clubhouse, primary care, applied behavioral analysis, community living supports, and inpatient. Thirty-nine responses were received, which was less than previous years. A reminder email was not sent out this year so this may have contributed to this difference. The approximate breakdown of staff completing the survey is as follows: Residential/Community Living Supports/Vocational - 51%, Applied Behavior Analysis - 44%, and Primary Services - 1%.</p> <p>All statements exceeded the 85% standard. Seven statements showed a decrease in favorable responses in 2025 compared to 2024. The largest decrease was for the statement, “BABH’s provider site review process is fair”; however, over 8% of responses were marked as “N/A” because some providers do not receive a site review. In contrast, the statement “BABH operates as a partner with provider agencies” received 100% agreement in 2025, reflecting a 10% increase from 2024.</p>	<p>b. iii. RAS – Deferred till next month.</p>

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Lincoln Center - East Conference Room/Zoom

Topic	Key Discussion Points	Action Steps/ Responsibility
<ul style="list-style-type: none"> ii. Internal MEV Report iii. MSHN MEV Audit Report (Apr, Sep) iv. MSHN DMC Audit Report (Sept when applicable) v. MDHHS Waiver Audit Report (Oct when applicable) e. Ability to Pay Report f. <u>Program Capacity Status</u> <ul style="list-style-type: none"> i. Review of Referral Status Report 	<p>There were seven surveys out of 39 responses that accounted for the 22 ‘disagree/strongly disagree’ responses. Four of the surveys had three or more ‘disagree/strongly disagree’ responses. There were only a few comments received. The two trends received from these few comments were: 1) Changes occur without communication to providers ahead of time and 2) Primary case holders don’t respond in a timely manner.</p> <p>There were some positive comments received as well about the site review staff, Applied Behavioral Analysis staff, and finance and contract management staff. “BABH has been a great partner to work with and we look forward to our continued partnership.” “BABH is on point.” “We really enjoy working with BABH.” “I think the relationship between BABHA, its providers, and the office of Recipient Rights is one of the best I've encountered. Keep it up, it's appreciated!!!” A recommendation was received to have monthly emails that provide updates or any changes (just more regular communication; Applied Behavior Analysis provider).</p> <p>In addition to nine main survey questions, the survey included two additional questions regarding unmet community need. This information is used in strategic planning and is included by BABH in the State Annual Submission Needs Assessment Stakeholder Survey that is completed every two years.</p> <ul style="list-style-type: none"> - What do you see as being the most significant mental health needs that are not currently being adequately addressed in our community? <ul style="list-style-type: none"> • More resources for consumers and parents/caregivers, better collaboration between schools and ABA providers, housing, support for consumers in rural areas, knowledge of respite services, need for Occupational Therapy services. - What mental health trends have you identified that BABH should be aware of? <ul style="list-style-type: none"> • Drug use, suicide, need for understanding the importance of family guidance sessions in ABA, struggles to meet basic needs (x3), increased 	

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	<p align="center">need for Outpatient Therapy/Speech/Occupational Therapy, transportation (x3), staff burnout.</p> <p>All nine survey statements were above 85% standard. The survey results will be taken to provider meetings, leadership meetings, and Consumer Councils to discuss the results and any potential interventions and strategies for improvement. Reminder to staff to communicate timely with providers and encourage providers to reach out to supervisors if they are not receiving replies. BABH supervisors will re-educate staff on the policy related to expectations for response times. Explore the possibility of having at least semi-annual provider meetings with all provider types. Send reminder emails during the period the survey is open to encourage and remind staff to complete the survey. The information from the survey results will be incorporated into the annual BABH Strategic Plan and Annual Submission Needs Assessment.</p> <p>c. <u>Access to Care & Service Utilization Reports</u></p> <ul style="list-style-type: none"> i. <u>MMBPIS Report</u> – Nothing to report this month. ii. <u>LOCUS</u> – Nothing to report this month. iii. <u>Leadership Dashboard</u> – Nothing to report this month. iv. <u>Customer Service Report</u> – Nothing to report this month. v. Employment Data – Defer <p>d. <u>Regulatory and Contractual Compliance Reports</u></p> <ul style="list-style-type: none"> i. <u>PI Report</u> – Nothing to report this month. ii. <u>Internal MEV Report</u> – Nothing to report this month. iii. MSHN MEV Audit Report – Bay Arenac Behavioral Health Authority received 74.63% for the MSHN MEV review that took place in August 2025. There were a total of 319 claims reviewed. The findings relevant to this group were 20 claims were missing consumer/guardian signatures on an Addendum or Interim Plan. BABHA staff are going to challenge MSHN on the finding related to needing a signature on the interim plan. BABHA staff will share the outcome with this group 	

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	<p>when BABHA knows more. BABHA staff submitted a corrective action plan to address the findings.</p> <ul style="list-style-type: none"> iv. <u>MSHN DMC Audit Report</u> – Nothing to report this month. v. <u>MDHHS Waiver Audit Report</u> – Nothing to report. <p>e. <u>Ability to Pay Report</u> – Nothing to report this month.</p> <p>f. <u>Referral Status Report</u> – For MPA, OPT for Medicare and Medicaid are on hold. There are no ABA referrals. For BABH Children’s Team, referrals are on hold. For BABH Adults, referrals are closed for ACT population due to MDHHS caps on number of consumers per staff.</p>	
<p>4. Discussions/Population Committees/Work Groups</p> <ul style="list-style-type: none"> a. <u>Harm Reduction, Clinical Outcomes and Stakeholder Perceptions</u> <ul style="list-style-type: none"> i. Consumer Council Recommendations (as warranted) b. Access to Care and Service Utilization c. <u>Regulatory Compliance & Electronic Health Record</u> <ul style="list-style-type: none"> i. Management of Diagnostics d. BABH Policy/Procedure Updates e. <u>Medicaid/Medicare Updates</u> <ul style="list-style-type: none"> i. Medicaid Monthly Algorithm - Effect on Medicaid Status f. General Fund <ul style="list-style-type: none"> i. Spenddown: Priority to Assist with Application for Redetermination 	<ul style="list-style-type: none"> a. <u>Harm Reduction, Clinical Outcomes and Stakeholder Perceptions</u> <ul style="list-style-type: none"> i. Consumer Council Recommendations – Nothing to report this month. b. <u>Access to Care and Service Utilization</u> – Nothing to report this month. c. <u>Regulatory Compliance & Electronic Health Record</u> <ul style="list-style-type: none"> i. Management of Diagnostics – Nothing to report this month. d. <u>BABH - Policy/Procedure Updates</u> – Nothing to report this month. e. <u>Medicaid/Medicare Updates</u> – Nothing to report this month. f. General Fund/OPT Referrals – Amy is receiving lots of message about referrals. We need to try our best to figure out an LMSW to send the referrals too. Christopher Fox is an internal LMSW. An exception is if the person should not transfer to a different therapist, but otherwise we do not have the extra GF or Medicaid funds to transfer them. The referrals at MPA need to stay with their LL’s, there is no room to transfer them out. BABH has an internal option but most of the female consumers do not want a male therapist. It’s based on clinical justification to send referrals to a fully licensed clinician and there are clinical exceptions. 	<ul style="list-style-type: none"> f. General Fund – Joelin will follow-up with the Help Desk to get a current listing of the diagnostic codes.

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<ul style="list-style-type: none"> ii. Inpatient Data Review/Analysis – Ad-hoc Work Group iii. OPT Referrals g. Conflict Free Case Management h. Re-opening Consumer Cases i. Referrals for Psychological Testing and Behavior Treatment j. Consent to Treat k. Coordination of Care l. Outreach Letter m. All Clinical Documentation to be Complete before leaving the agency (Assessments, Plans, Progress Notes...) n. HCBS Mandatory Trainings 	<p>Joelin went through the General Fund Benefit Plan for FY25. We now have to figure out what clinically makes sense for units of Case Management and how many group sessions should be given for therapy. Anyone coming in new starting 10/01/25 will be put on a wait list. If they get referred through, their first step for OPT will be group therapy. They will get individual therapy if the group therapist feels they have intense needs. That will be an exception and will need to be clinically justified as to why they need individual therapy. For individuals that have Medicare only and maybe could never qualify for Medicaid, they are partly a General Fund expense since they are seeing a therapist. Medicare will pay for therapy and psych services to an extent, but the copays fall to General Fund. Spenddown consumers are not included in the Medicaid Plan. Those with Medicare only, not Medicaid, will fall into the General Fund category. We would like to get a Medicare only consumer linked up to a therapist that is able to bill Medicare.</p> <p>We still start with one group therapy session and the clinician will make the determination if approved for the second group. We can put a range of up to 12 weeks of group, allowing two rounds of therapy. The assessment clinician or group clinician will make a determination to bypass group and go right to individual therapy. We do not need 12 med reviews. Two medication injections per month is adequate, some have one med injection. 48 units of CSM, 1 hour per month, will be adequate.</p> <p>Joelin went through the diagnostic codes, scores and ranges. Diagnostic categories that are moderate will not be supported by General Fund. Joelin will get a current list of diagnostic codes from the Help Desk.</p> <ul style="list-style-type: none"> g. <u>Conflict Free Case Management</u> – Nothing to report this month. h. Re-opening Consumer Cases – Reminder - when you have someone that comes in for services and then are reopened to services, sometimes the assessment doesn't need to be updated because it hasn't expired, however, a new IPOS is completed, potentially creating a large gap between the assessment and IPOS. It is recommended that the IPOS not be 	

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	<p>written for a full year, instead, have the IPOS end date be about 30-45 days after the assessment is due. This will help to eliminate this gap and make sure the alerts in PCE are accurate.</p> <p>i. Referrals for Psychological Testing and Behavior Treatment – Do we have parameters around asking for psychological testing? MDHHS is saying if someone needs a psychological, and it is related to their specialty mental health services, the PIHP is responsible to pay for it. Before, if someone needed a psychological, it was on the MHP’s. Joelin contacted MSHN to see if they have a list of individuals or agencies that provide psychological and neuropsychological evaluations. A list was sent but it’s not vetted. We need to get with providers that can do single case agreements with if someone comes up with a referral that needs a neuropsychological. We do not have those resources but are working on getting them.</p> <p>j. Consent to Treat – Case Managers are getting messages from the providers requesting MPA to complete a new consent to treat for everyone being served. They are not able to add providers to their consent to treat. If a case holder does a consent to treat, and a few months later therapy services are added on, then the therapy provider is trying to do a consent to treat for therapy services and that changes the due date for the consent to treat. There are now two consent to treat documents. The following year when the primary case holder does this, multiple services can be checked but the specific provider name cannot be added. What happens if a service is added on? When adding on a service, a new consent to treat can be done and the additional service can be added. The consent to treat is covered no matter where someone is sent because you cannot choose the provider, just the service. Whoever is doing the referral, the case manager should do their own new consent to treat to cover whatever services are needed. If you are a receiving provider for a secondary service, that provider cannot add a different provider’s name, but they can update the consent to treat. The primary case holder needs to be aware that this form should be updated at the time of the annual update.</p>	

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	<p>k. Coordination of Care – The minimum requirement is whoever the primary case holder is should be responsible for doing the coordination of care form because they are the primary case holder of the ancillary services as well.</p> <p>l. Outreach Letter – Allison made changes to the Outreach Letter. Included in the letter was a consumer’s primary service that can be chosen whether CSM or OPT. Allison is requesting that the first paragraph be editable; “We notice that you have either missed a recent appointment or that we have been unable to reach you to schedule your next appointment. Wording added was ‘In order to re-engage in all other treatment services, you will need to maintain your appointments with your primary treatment services’. Melissa Prusi suggests having the reading level checked. Amanda suggested having the ‘Please contact me...’ be highlighted.</p> <p>m. All Clinical Documentation to be Complete before leaving the agency (Assessments, Plans, Progress Notes...) – When staff have left the agency, there is documentation that hasn’t been completed. Please make sure any staff that leave the agency have completed all their documentation before leaving to avoid any recoupments. When you have new staff coming in, the supervisors should do a quick glance through their caseload so whatever documents are coming due, they are addressed right away.</p> <p>n. HCBS Mandatory Trainings – The state is mandating training for anyone who has consumers on the Home and Community Based Waiver. The trainings will take place twice a month. The trainings will go through HR and emails will come out from Jennifer Lasceski. More information to come.</p>	<p>i. Outreach Letter – Allison will look at the reading level before having the document finalized and make other changes addressed.</p>
5. Adjournment/Next Meeting	The meeting adjourned at 3:30 pm. The next meeting is scheduled for October 9, 2025, 1:30-3:30, at the Lincoln Center in the East Conference Room.	

Executive Summary of QAPIP

Plan of Service Training Forms: While progress continues, BABH achieved 87% compliance, below the 95% target during the monthly checks.

Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH: During FY25Q3, there were six types of adverse events reported. Key highlights include:

- **Non-Suicide Deaths (reportable):** 14 reported, marking an increase from the previous quarter, but consistent with other quarters.
- **Non-Suicide Deaths (non-reportable):** 3 reported, marking an increase from the previous quarter
- **Emergency Medical Treatment for Injury due to Self-Harm:** 5 incidents were recorded, an unusual uptick for the past two quarters.
- **Emergency Medical Treatment for Injury:** 1 incident was recorded.
- **Reportable Arrests:** 1 incident
- **Non-Reportable Arrests:** 3 incidents involving two separate consumers.

Trends for FY25 (to date): For the first three quarters of FY25 compared to previous years, there was an increase in Emergency Medical Treatment for Injury due to Self-Harm. Two of the five incidents were the result of one consumer. This consumer has a high acuity level, lives in specialized residential arrangements in other counties, and has behavior treatment plans. During FY25Q2, a new critical incident report was added; EMT and Hospitalization due to fall with injury. There were nine incidents during this quarter, but all the falls were the result of different individual concerns with the exception of one consumer having two falls within two months. A RN completed a fall risk assessment for this individual with added interventions.

Reportable Behavior Treatment Events:

- **Emergency Physical Interventions:**
 - BABH met the goal to decrease the number of emergency physical interventions for FY25 (142) compared to FY24 (180).

Quality of Care Record Reviews - Services Are Written in The Plan of Service Are Delivered at The Consistency Identified: Three of the four quarters met the 90% goal that BABH set for FY25.

Quality of Care Record Reviews - All Services Authorized in The Plan of Service Are Identified Within the Frequency, Intervention, and Methodology Section of the Plan of Service: All four quarters during FY25 met the goal that BABH set for 90% compliance.

Michigan Mission Based Performance Indicator System (MMBPIS): Indicator 1 (The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours.): For all quarters of FY25 with available data, both adult and child scores reached 100%, achieving the goal established by BABH.

MMBPIS: Indicator 2 (The percent of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergent request for services.): For FY25, BABH scored below the 75% goal for the

three quarters of available data; however, compliance was higher than the MSHN regional average for 8 of the 12 population/quarter data points.

MMBPIS: Indicator 3 (The percent of Medicaid beneficiaries starting any needed ongoing service within 14 days of a non-emergency assessment with a professional.): For FY25, BABH scored below the 75% goal for the three quarters of available data; however, compliance was higher than the MSHN regional average for 5 of the 12 population/quarter data points. The two primary reasons for non-compliance with this indicator is due to consumer no-shows and requesting appointments outside of the 14 days.

MMBPIS: Indicator 4 (The percent of discharges from a psychiatric inpatient unit who are seen for follow-up within seven days.): For FY25, BABH scored above the 95% goal for two of the three quarters of available data; however, compliance was higher than or consistent with the MSHN regional average for all of the population/quarter data points.

Reduction of Community Inpatient Days for FY25: BABH reported a total of 9,009 community inpatient hospitalization days during FY25 compared to 8,584 in FY24, reflecting an increase of 425 days. This outcome did not meet the goal of reducing inpatient days. Further analysis indicated that consumers have been remaining hospitalized longer than the typical 5–7 day average, primarily due to delays in state hospital admissions resulting from a lack of available beds. The Emergency Access Services department is reviewing individual cases to identify additional contributing trends and factors.

Adults and Children Indicating Satisfaction on Survey: During the FY25 satisfaction survey period, 94% of adults (an increase of 4% compared to FY24) and 90% (an increase of 1% compared to FY24) of children expressed a general satisfaction with services.

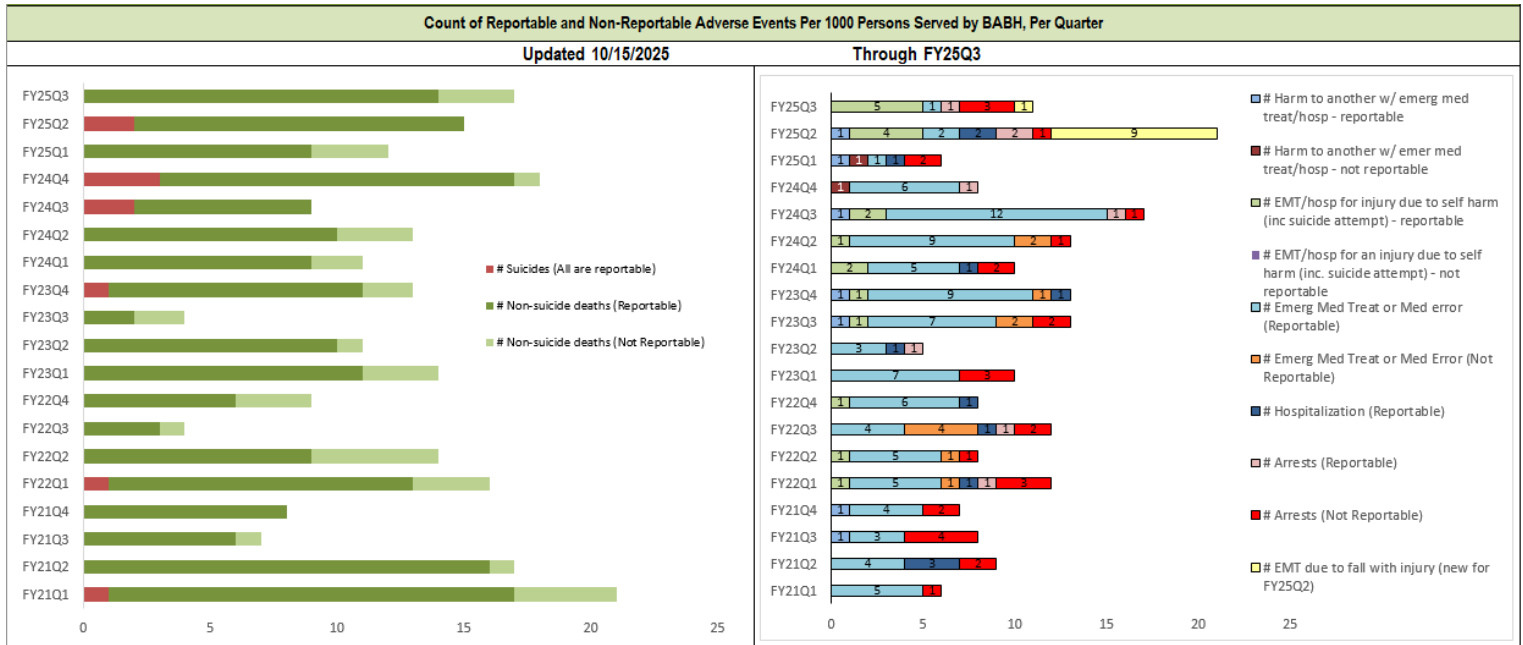
Provider Survey: All statements on the provider survey exceeded the 85% standard; however, seven of the nine statements showed a decrease in favorable responses in 2025 compared to 2024. BABH leadership has identified corrective actions to address these declines.

The following report provides a quarterly and annual update to the goals identified in the QAPIP plan based on available and current data.

PROVIDER QUALIFICATION AND SELECTION

Plan of Service Training Forms: BABH quality staff consistently monitor the use of the plan training form through site reviews, external audits, and monthly checks. Review findings are communicated to supervisors for appropriate staff follow-up. While progress continues, BABH achieved 87% compliance, below the 95% target during the monthly checks.

HARM IDENTIFICATION AND REDUCTION



Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH: During FY25Q3, there were six types of adverse events reported. Key highlights include:

- **Non-Suicide Deaths (reportable):** 14 reported, marking an increase from the previous quarter, but consistent with other quarters.
- **Non-Suicide Deaths (non-reportable):** 3 reported, marking an increase from the previous quarter
- **Emergency Medical Treatment/Hospitalizations for Injury due to Self-Harm:** 5 incidents were recorded, an unusual uptick for the past two quarters.
- **Emergency Medical Treatment for Injury:** 1 incident was recorded.
- **Reportable Arrests:** 1 incident
- **Non-Reportable Arrests:** 3 incidents involving two separate consumers.

Trends for FY25 (to date): For the first three quarters of FY25 compared to previous years, there was an increase in Emergency Medical Treatment for Injury due to Self-Harm. Two of the five incidents were the result of one consumer.

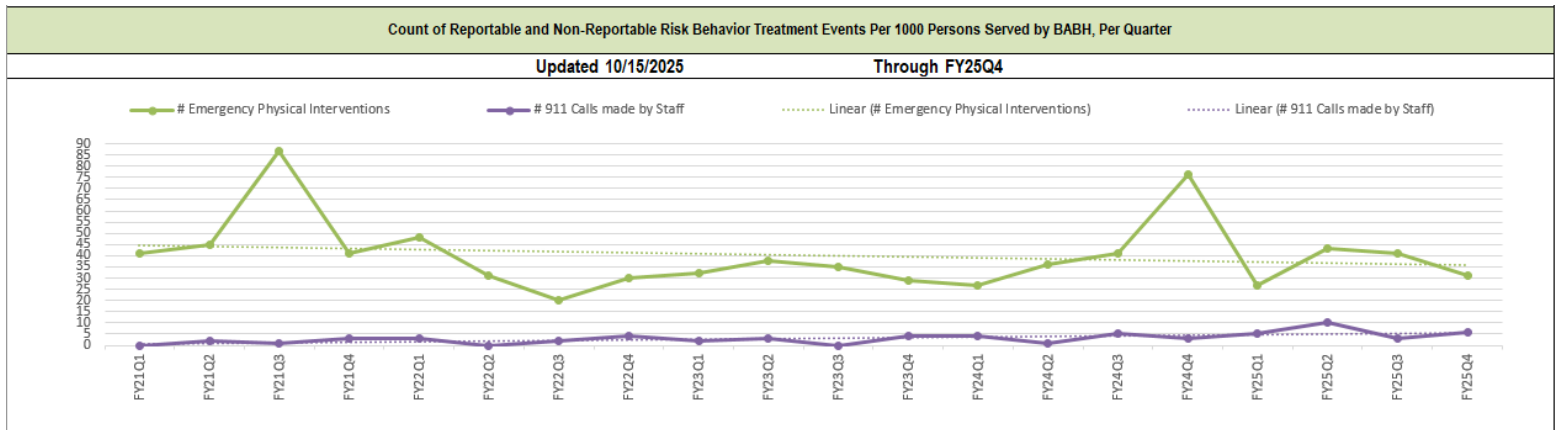
This consumer has a high acuity level, lives in a specialized residential arrangement in another county, and has a behavior treatment plan. During FY25Q2, a new critical incident report was added; EMT and Hospitalization due to fall with injury. There were nine incidents during this quarter, but all the falls were the result of different individual concerns with the exception of one consumer having two falls within two months. A RN completed a fall risk assessment for this individual with added interventions.

Areas needing improvement: For FY25 (to date), five root cause analyses were completed for the accidental and suicide deaths to determine if there were any areas needing improvement. During the root cause analyses, BABH determined there were no concerns related to equipment or staff training and there weren't any trends related to specific programs, locations, or consumers. There were no trends or areas of improvement identified through these analyses.

Action items: No action items determined for this quarter.

Implementation of action items: No actions to implement.

Results of action items: Not Applicable

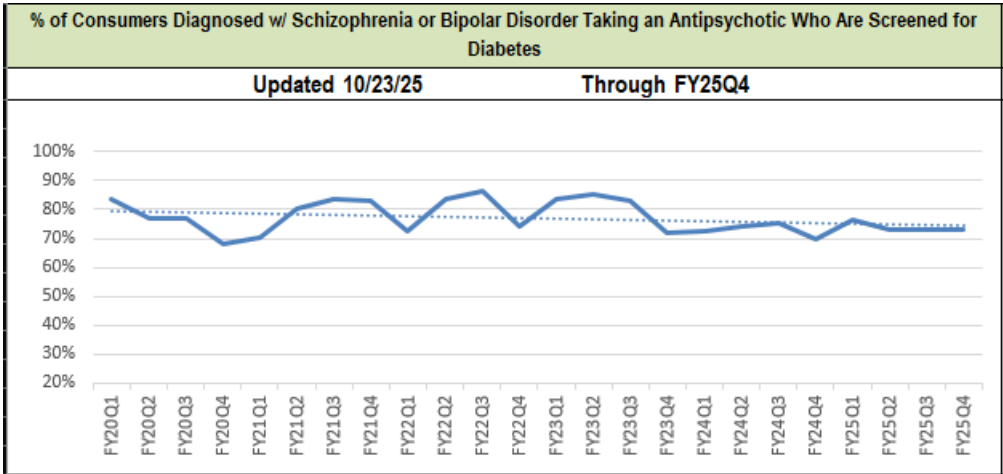


Reportable Behavior Treatment Events:

- **Emergency Physical Interventions:**
 - There were 31 emergency physical interventions during FY25Q4, involving 10 consumers. One individual accounted for 8 of these interventions.
 - This represents a decrease from the previous two quarters and continues a downward trend overall.
 - The treatment team holds regularly scheduled meetings to coordinate ongoing support strategies for the individual with the highest number of interventions.
 - BABH met the goal to decrease the number of emergency physical interventions for FY25 (142) compared to FY24 (180).
- **911 Calls for Behavioral Assistance:**
 - There were 6 calls made during FY25Q4, which marks an increase from the previous quarter. One individual recently changed living arrangements and accounted for 3 of the 6 calls.

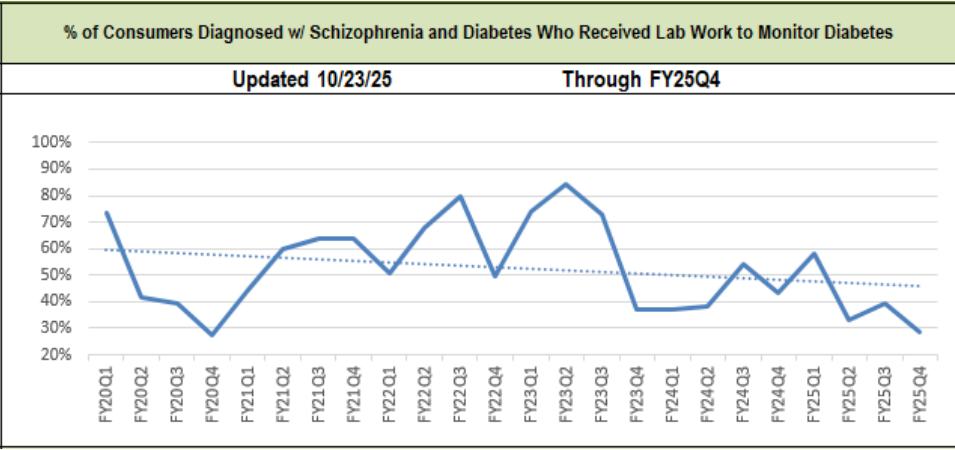
The Number of Days to Complete the Recipient Rights Investigation is Lower Than the Michigan Mental Health Code Standard of 90 Days: The Office of Recipient Rights has 90 days to complete an investigation. For FY25Q4, BABH averaged 69.5 days: well below the standard.

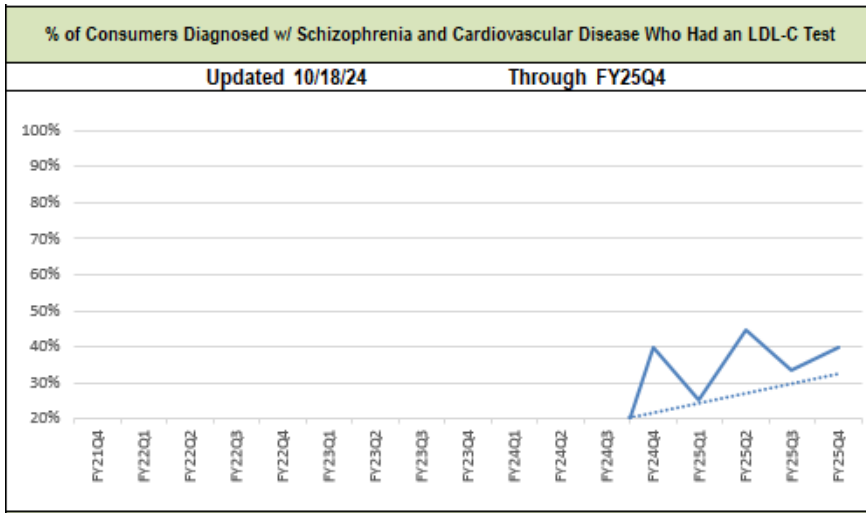
Abuse and Neglect Complaints Substantiated Have Remedial Action: All substantiated complaints were addressed with adequate remedial action to correct and prevent recurrence.



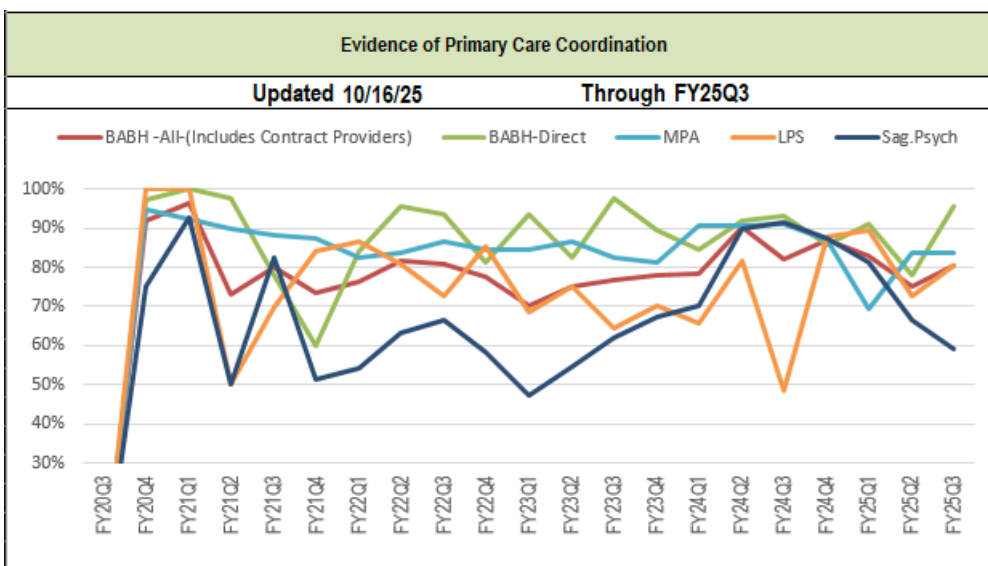
Consumers Diagnosed with Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes: Compliance remained consistent for FY25Q4 for consumers receiving the appropriate labs for this measure. BABH will continue to action these alerts monthly to improve compliance. BABH increased compliance by 1% for FY25 compared to FY24.

Consumers Diagnosed with Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes: BABH had a 9% decrease in consumers receiving the appropriate labs for this measure during FY25Q4 (28%). BABH will continue to action these alerts monthly to improve compliance. BABH decreased compliance by 4% for FY25 compared to FY24.





Consumers Diagnosed with Schizophrenia and Cardiovascular Disease Who Received an LDL-C Lab: Recent changes to the specifications for this measure resulted in only four quarters of data being available at the time of this report. In FY25Q4, there was a 7% increase, and the measure continues to trend upward. A full year of data for FY24 was not available for comparison to FY25.



Evidence of Primary Care Coordination: BABH scored above the 95% standard while the three external providers scored below the 95% compliance standard. Providers continue to face challenges in completing both the Universal Consent and the Coordination of Care form. Corrective action plans have been implemented to support improvement efforts. BABH staff continue to offer guidance on accurately documenting coordination with primary care providers. BABH did not meet the goal to consistently score 95% compliance in coordination with primary care providers.

Quality of Care Record Reviews - Services Are Written in The Plan of Service Are Delivered at The Consistency Identified:

85% of the records reviewed during FY25Q4 received the level of services that were written in the plan which fell below the 90% standard set by BABH. Staff received education and training on the standard of providing services as written in the plan of service. Three of the four quarters met the 90% goal that BABH set for FY25.

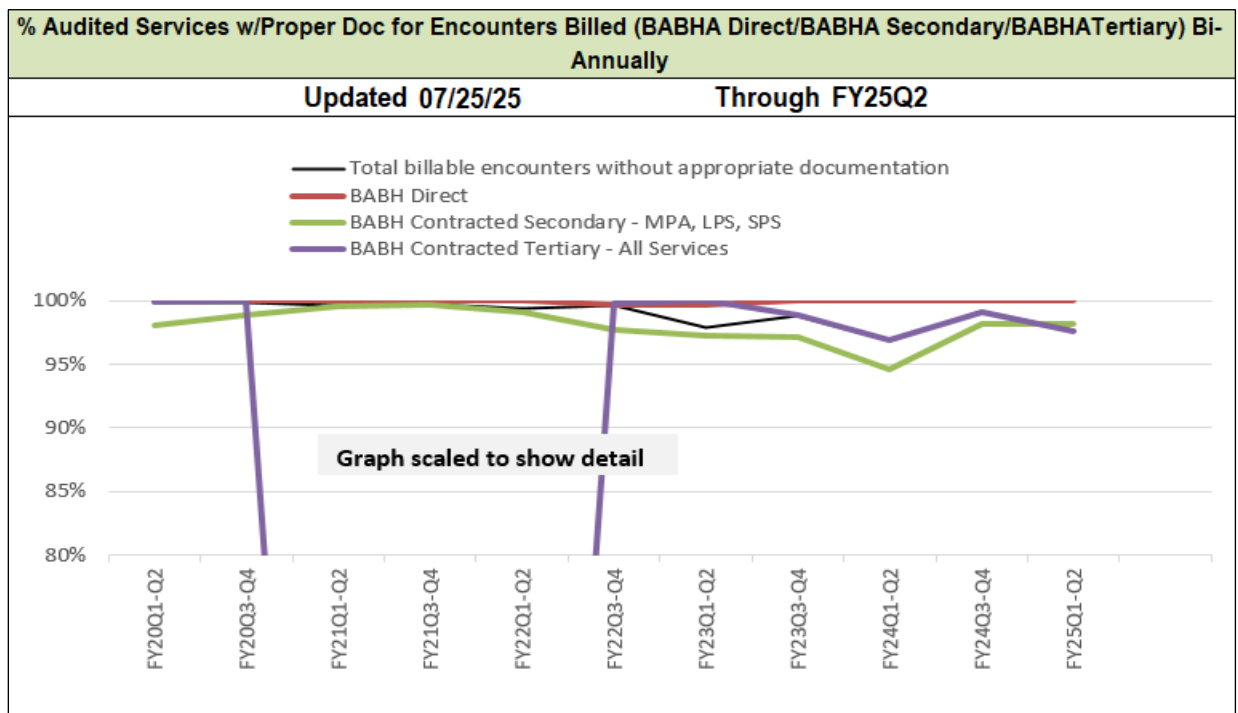
Quality of Care Record Reviews - All Services Authorized in The Plan of Service Are Identified Within the Frequency, Intervention, and Methodology Section of the Plan of Service:

96% of the records reviewed during FY25Q4 had the services identified appropriately to match the services authorized which meets the 90% standard set by BABH. All four quarters during FY25 met the goal that BABH set for 90% compliance.

Develop Quarterly Reports to Increase the Quality Report and Outcomes Related to The Level of Care Utilization System (LOCUS):

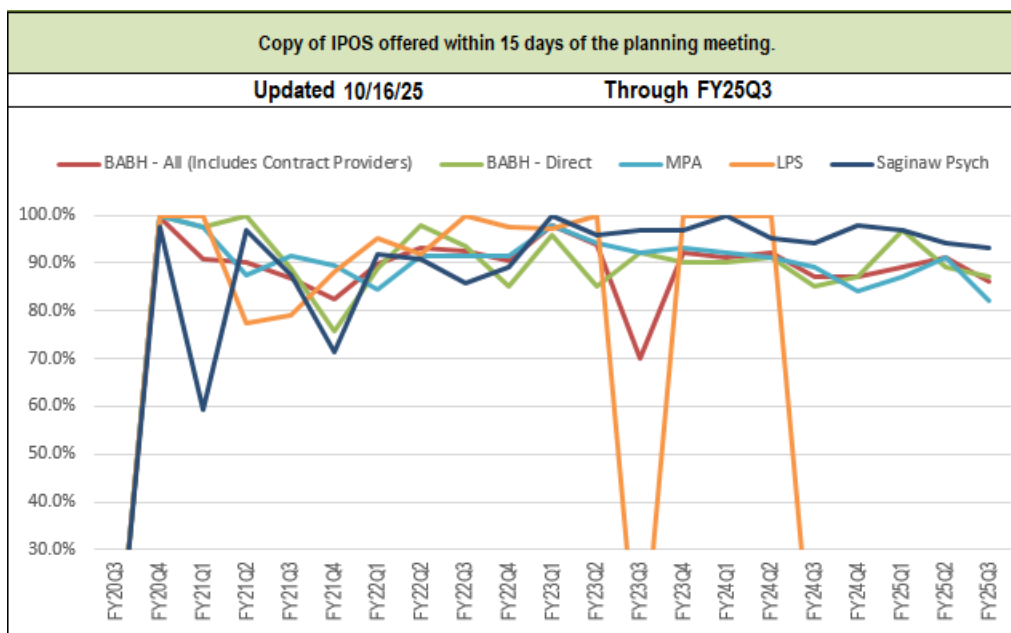
No update.

ACCESS TO CARE AND UTILIZATION MANAGEMENT



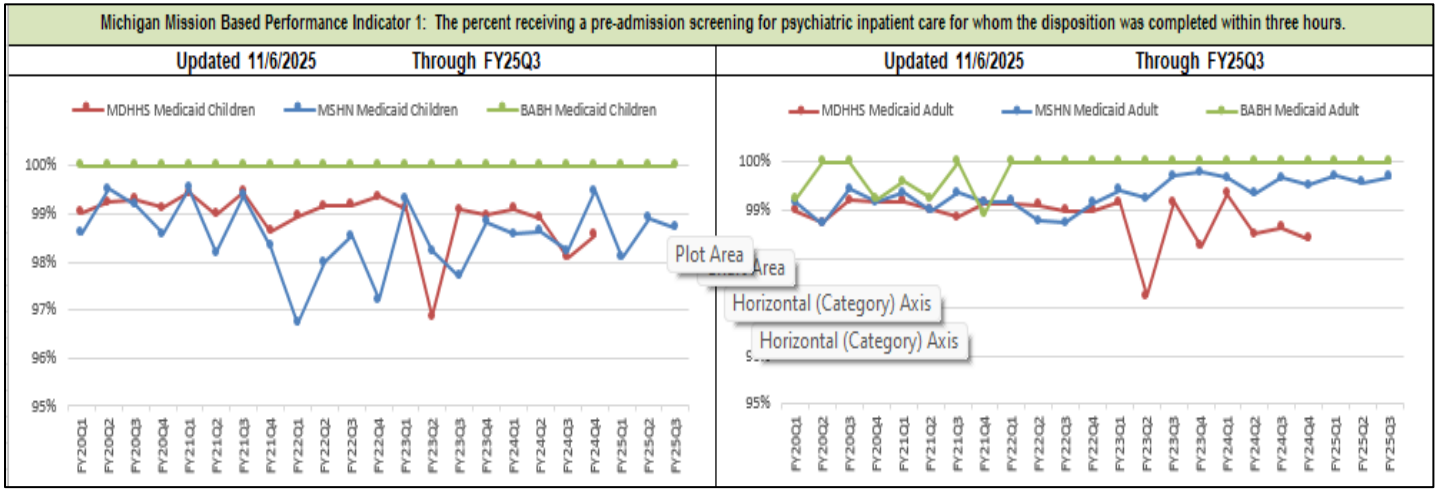
Audited Services with Proper Documentation for Encounters Billed: Overall compliance for all primary, secondary, and tertiary services reviewed during FY25Q1 and FY25Q2 exceeded the 95% standard. The reviews included psychosocial rehabilitation services, specialized residential services (for providers located outside of Bay and Arenac counties), dietary/nutrition services, occupational/physical/speech therapies, self-determination, direct services, and community living support providers. A total of 3,418 claims were reviewed, with 78 errors identified, resulting in a compliance rate of 97.6%. The most common findings were incomplete documentation or discrepancies between the number of units billed and the supporting documentation.

Increase Medicaid Event Verification (MEV) Reviews: BABH continues to increase the services audited by completing reviews of all specialized residential, community living support, vocational, primary, autism providers, self-determination, dietary, occupational therapy, speech and language therapy, physical therapy, psychosocial rehabilitation, and specialized residential providers where BABH is the county of financial responsibility.

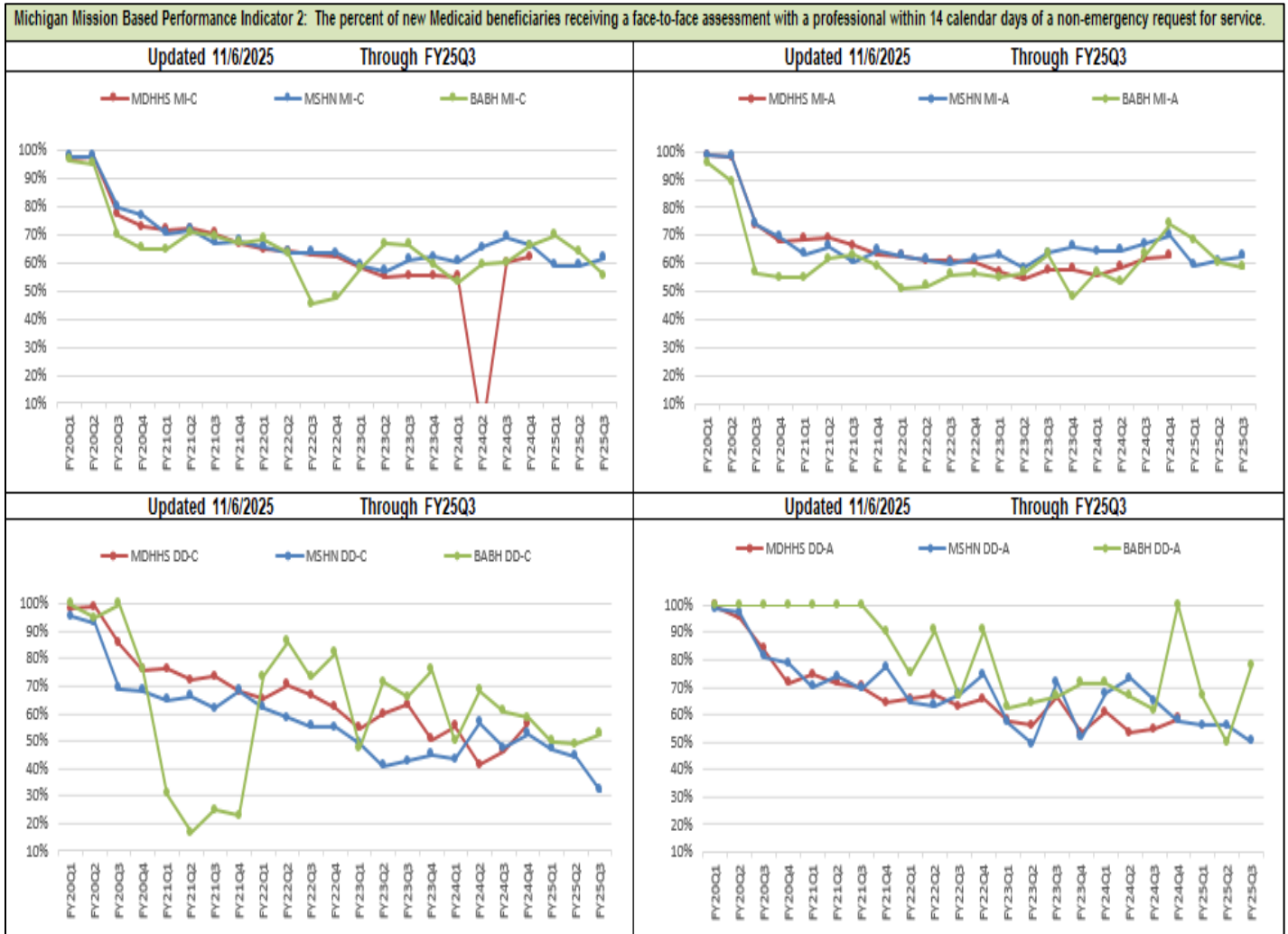


Copy of Plan of Service Offered Within 15 Days of Planning Meeting: Overall, compliance with offering the plan of service within 15 days decreased in FY25Q3 compared to FY25Q2. It has been identified that staff are not consistently utilizing the electronic health record (EHR) system fully, resulting in missing data and incomplete fields. Quality staff are actively working with providers to remind teams to complete all required data elements related to the plan of service. Corrective action plans have been implemented to address these issues.

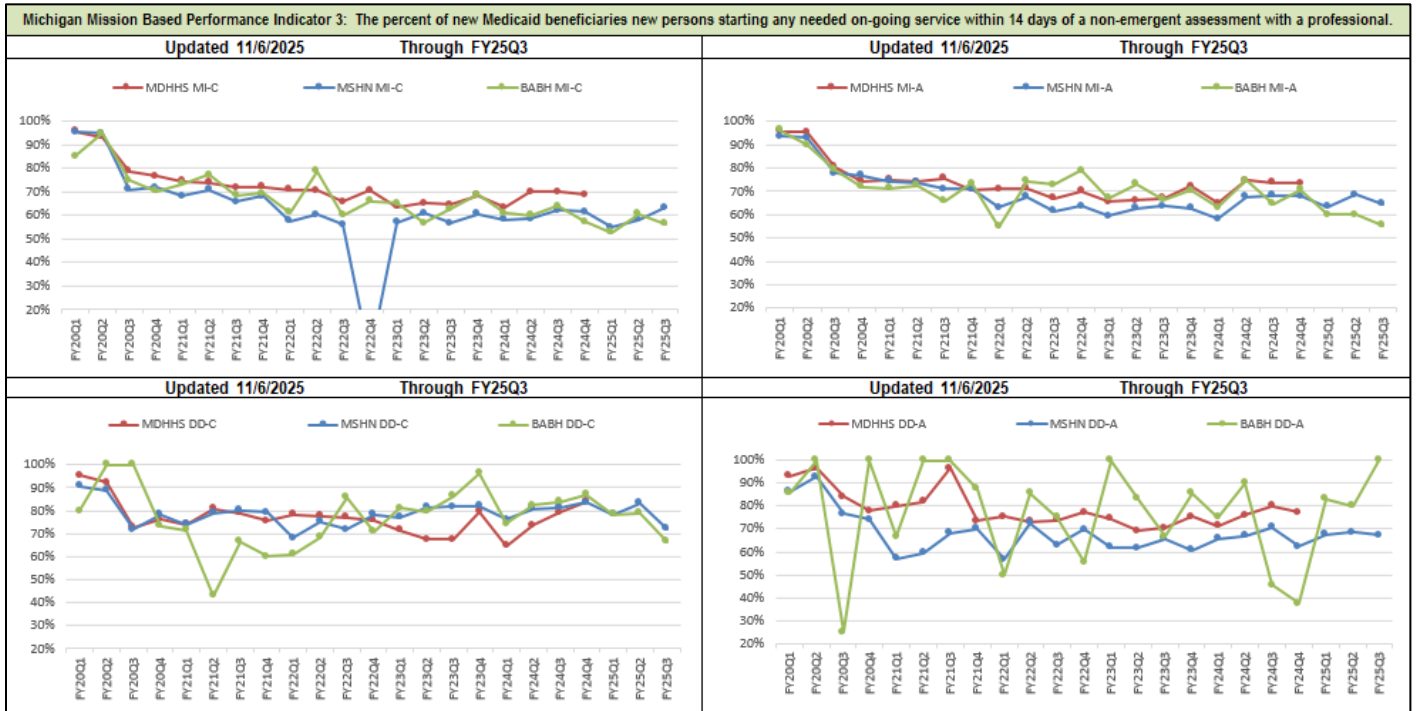
Michigan Mission Based Performance Indicator System (MMBPIS): Indicator 1 (The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours.): BABH demonstrated 100% compliance for Indicator 1 for both children and adult populations during FY25Q3. This was a higher rate of compliance than Mid-State Health Network (MSHN).



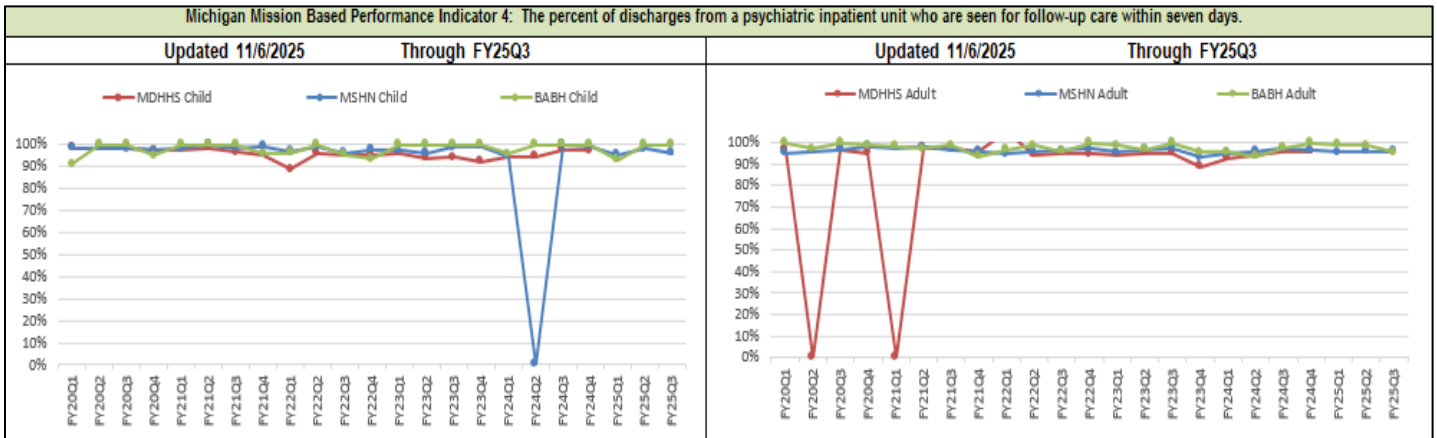
MMBPIS: Indicator 2 (The percent of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergent request for services.): In FY25Q3, BABH reported higher compliance rates for the IDD-Child and IDD-Adults populations compared to MSHN. Compliance for the MI-Adult and MI-Child populations were below MSHN.



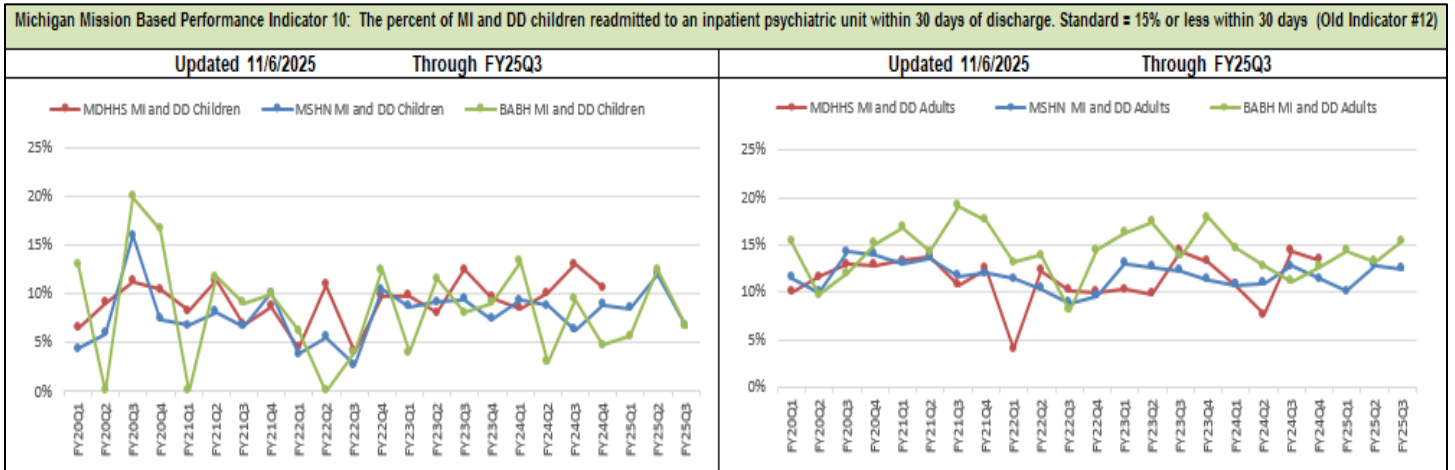
MMBPIS: Indicator 3 (The percent of Medicaid beneficiaries starting any needed ongoing service within 14 days of a non-emergency assessment with a professional.): In FY25Q3, BABH reported lower compliance rates than MSHN for the MI-Adult, MI-Child, and IDD-Child populations. Compliance was higher for the IDD-Adult population. The primary contributing factor to lower compliance rates was a high volume of no-show appointments.



MMBPIS: Indicator 4 (The percent of discharges from a psychiatric inpatient unit who are seen for follow-up within seven days.): Both the Adult and Child populations met the 95% compliance standard for FY25Q3. This is above or consistent with MSHN.



MMBPIS: Indicator 10 (The percent of beneficiaries readmitted to an inpatient psychiatric unit within 30 days of discharge.): BABH met the compliance rate for the child adult population for FY25Q3, but was out of compliance by less than 1% for the adult population and higher than MSHN.



Reduction of Community Inpatient Days for FY25: BABH reported a total of 9,009 community inpatient hospitalization days during FY25 compared to 8,584 in FY24, reflecting an increase of 425 days. This outcome did not meet the goal of reducing inpatient days. Further analysis indicated that consumers have been remaining hospitalized longer than the typical 5–7 day average, primarily due to delays in state hospital admissions resulting from a lack of available beds. The Emergency Access Services department is reviewing individual cases to identify additional contributing trends and factors.

STAKEHOLDER PERCEPTIONS

Adults and Children Indicating Satisfaction on Survey: During the FY25 satisfaction survey period, 94% of adults (an increase of 4% compared to FY24) and 90% (an increase of 1% compared to FY24) of children expressed a general satisfaction with services.

Provider Survey: All statements on the provider survey exceeded the 85% standard; however, seven of the nine statements showed a decrease in favorable responses in 2025 compared to 2024. BABH leadership has identified corrective actions to address these declines.

Behavior Treatment Survey: This survey report is completed annually at the end of each calendar year. The results from 2024 showed a 100% satisfaction rate for the seven surveys returned.



2026~~5~~

Strategic Plan

Agency Leadership Team Approval Date: ~~1/7/25~~
Strategic Leadership Team Approval Date: ~~1/14/25~~
Full Board Approval Date: ~~1/16/25~~

2026 Strategic Plan

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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, including¹:

- 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 served³ for feedback through review on an annual basis with the BABHA consumer population councils. The BABHA Strategic Plan is shared with other stakeholders⁴ 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 February 1963, 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 ~~December 31, 2013.12/31/13~~. 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 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.

On August 4, 2025, MDHHS released a Request for Proposals (RFP) for replacing the 10 CMHSP Regional PIHPs. The RFP as originally released permitted the new PIHP contractor to be a private nonprofit organization and mandated that it operate as a "payor-only" entity and forbade the delegation of core managed care functions such as utilization management, network development, and claims processing to its contracted network providers such as CMHSPs. The RFP dictated a specific, private-style corporate governance structure for the PIHP contractor and mandated a board of no more than 15 members that must be entirely separate from any provider entity. In addition, the RFP contractually required the contractor to establish and manage its own internal grievance and appeals process for beneficiaries which may interfere with the Michigan Mental Health Code Chapter 7 (MCL 330.1700) which establishes a comprehensive and independent Recipient Rights system. The existing CMHSP and MDHHS systems have statutory power to investigate and remedy rights violations separate from the entities making payment decisions. As a result of the RFP, PIHP and CMHSPs throughout the state have engaged in legal objections based on the potential violations imbedded in the RFP requirements. On October 9, 2025, the Court of Claims held an evidentiary hearing regarding the MSHN lawsuit against MDHHS's PIHP Procurement Process and on October 14, 2025, the Court of Claims issued its initial determinations. The Court determined that (1) MDHHS has the unilateral authority to shift to a competitive procurement model for Medicaid behavioral health services; and (2) MDHHS can reduce the number of regions.

The Court also said that it could not issue a final decision in the case because the PIHP procurement as written may violate Michigan law in assigning functions to the new PIHPs that belong to county CMHSPs Community Mental Health Services Programs by statute. BABHA will continue to respond to future actions of MDHHS and/or the Court's decisions.

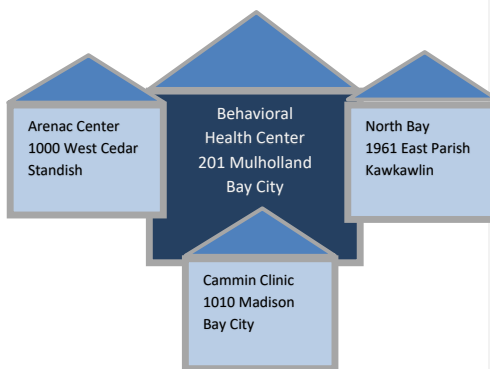
As a result of the federal government shutdown in 2025, the Supplemental Nutrition Assistance Program (SNAP) was also paused which caused the loss of food assistance for a vast majority of individuals served through BABHA. SLT members met to discuss planning for assisting individuals supported by BABHA and its contracted provider network in finding resources to assist those individuals. Thankfully the federal shutdown ended in November permitting SANP and Medicaid benefits to continue to be available to eligible parties. As BABHA enters 2026, we are preparing for further legal and legislative actions to protect the public mental health system under the RFP and respond to significant federal changes in Medicaid expected in 2027. However, despite the federal shutdown, Michigan's budget including MDHHS's budget was passed in October 2025. This resulted —

Statistics

BABHA operates out of five-four office locations (see Figure 1: BABHA Office LocationsFigure 1: BABHA Office LocationsFigure 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.

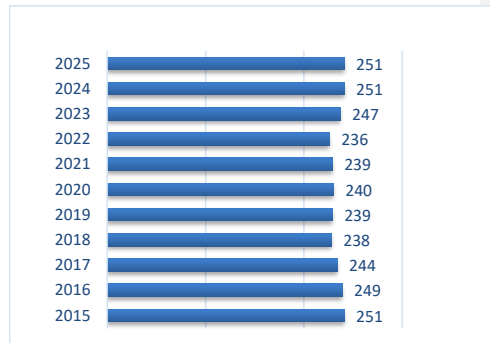
Figure 1: BABHA Office Locations



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](#)).

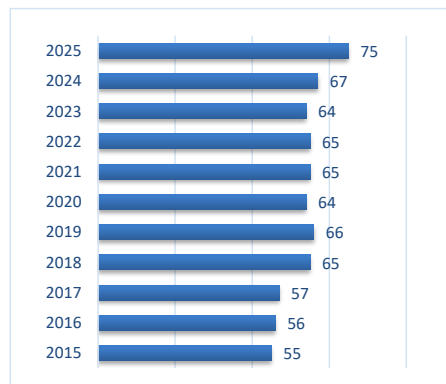
BABH has had an increase in the number of employees in 2024. New positions have been added to cover the outpatient service gaps, the expanding children’s service needs and the development of the Mobile Response Team. The Horizon Home staffing increased to adequately address the ongoing crises occurring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

Figure 2: # of Employees



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](#)). The number of providers increased around 2018 due to expansion of demand for Autism related services.

Figure 3: # of Contracted Clinical Service Providers



Clinical service populations include:

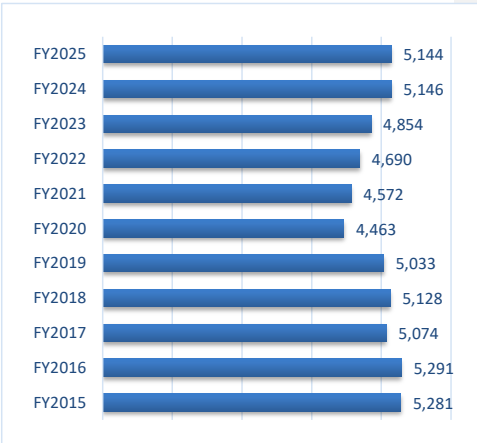
- Adults with mental illness
- Children with serious emotional disturbance
- Adults and children with intellectual and developmental disabilities.
- Individuals with co-occurring substance use disorders

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.

Figure 4: Total # of Individuals Served

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](#)).

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.

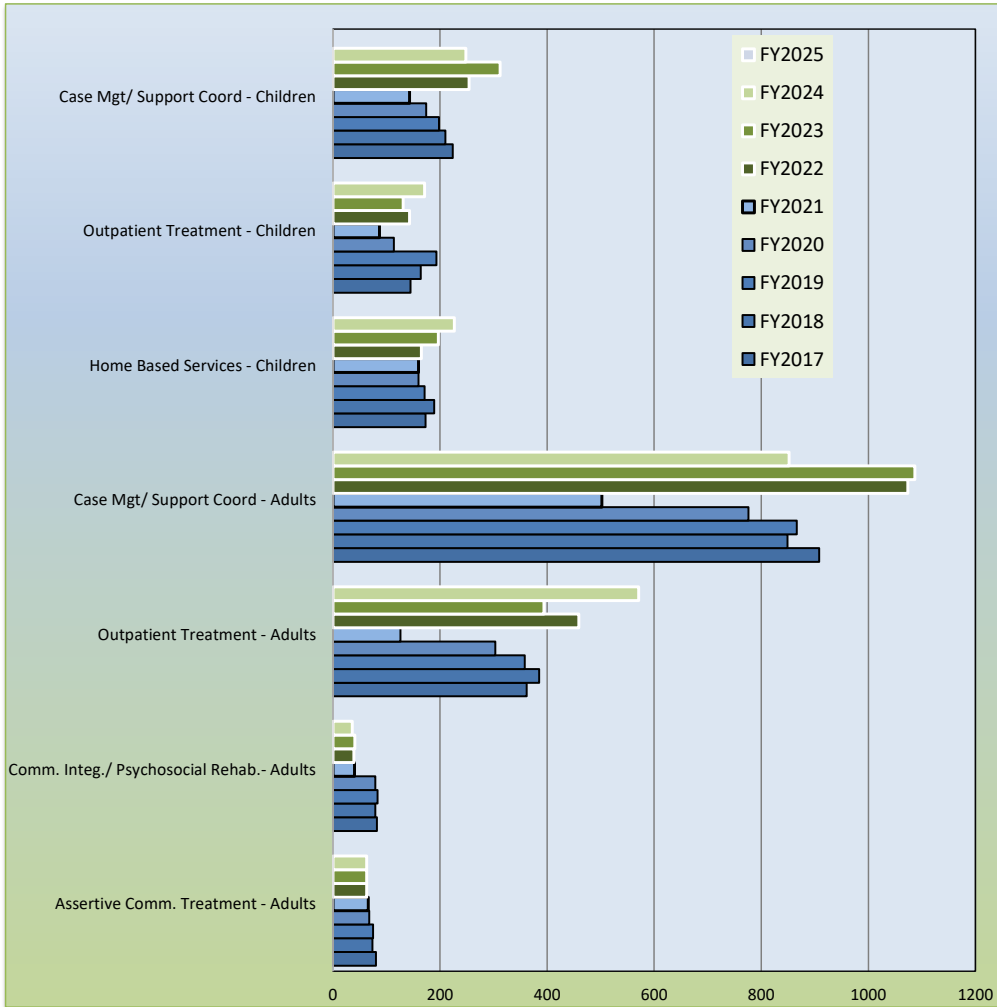


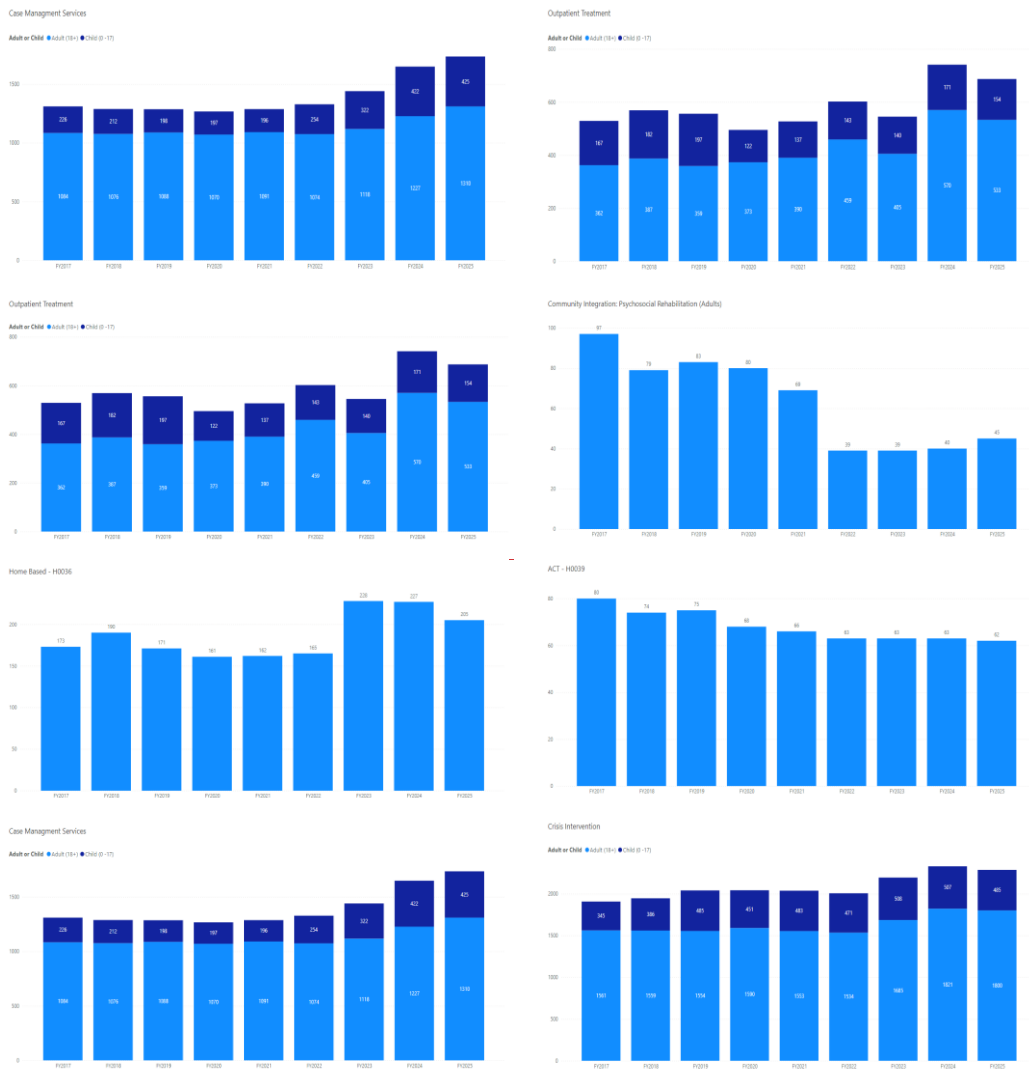
The numbers of individuals served in ~~2024-FY24 and FY25 have exceeded~~continue to exceed the numbers of people served pre-pandemic years-

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.

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~~Figure 5: Unduplicated Consumers Served per Accredited Program. The number of people needing outpatient therapy continues 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 increased 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.

Figure 5: Unduplicated Consumers Served per Accredited Program FY17 to FY25





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. [In addition, BABHA migrated information from previous sources to PowerBI as a means to compile data for the dashboard reports noted in the Strategic Plan to ensure accuracy moving forward.](#)

[One area BABH is addressing is the increasing use of Applied Behavioral Analysis \(ABA\), which has increased from 100 consumers served in FY2017 to 368 consumers served in 2025 as noted in Figure 6.](#)

Figure 6: Unduplicated Consumers Served in ABA FY17 to FY25

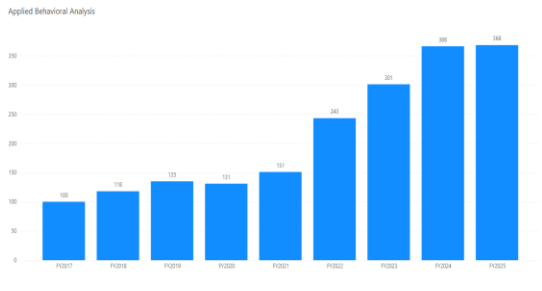


Figure 7: Revenue and Expenses

BABHA revenue and expense for community mental health services are shown in Figure 7. Expenses are closely managed to remain within regional Medicaid revenue levels for BABHA to operate within the resources provided by local counties and regional and state payers.

During the pandemic years 2020 & 2021 when service utilization declined due to restrictions on face-to-face services, BABH implemented strategies with Network Providers to ensure their longevity and financial viability. BABH Per Member Per Month Funding (PMPM) during these years permitted the agency to stabilize Providers. Beginning in 2022 as restrictions were lifted in regards to face-to-face services, BABH experienced an increase in service utilization. This coupled with the MDHHS rate setting process and BABH’s higher penetration rate as compared to the MSHN region CMHSPs, BABH service expenditures exceeded revenue by approximately 15%. Due to the financial stability of the MSHN Region, BABH PMPM Medicaid Funds were supplemented by MSHN over the last 4 years in following amounts:

- FY 2022 \$3.2M
- FY 2023 \$8.4M
- FY 2024 \$10.1M
- FY 2025 \$10.9M

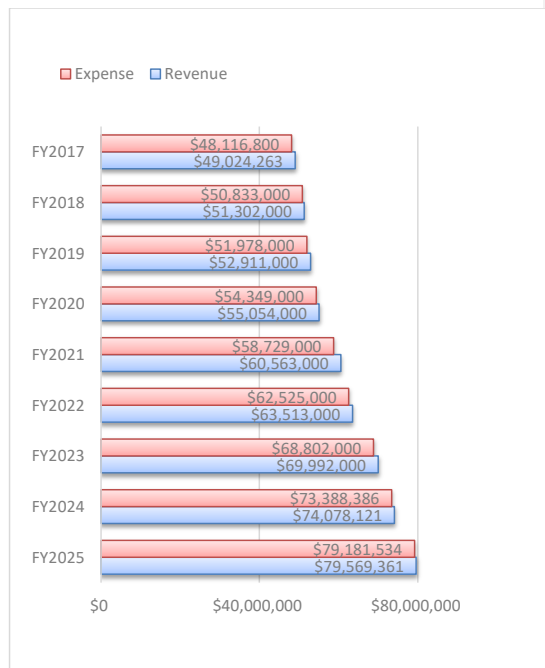


Figure 6: Revenue and Expenses

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

Strategic and Operational Relationships⁵

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 ~~an~~ 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
	Operational
Lowest Priority	

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 2026⁴

Program 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

Commented [MP1]: Consider putting on hold/remove?

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 2023 Lab 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

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
 - Certified Community Behavioral Health Clinics

- 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.
- 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 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

- (CCBHCs) Duals Projects (MI Health Link)
- Bay City Crisis Residential Unit has opened in Bay City for Bay and Arenac County individuals.
- 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:
<ol style="list-style-type: none"> 1. Investigate CCBHC option for implementation in Bay and Arenac Counties <ol style="list-style-type: none"> 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 	Extended SLT, Agency Leadership, Health Care Integration Steering Committee (HCISC)
<ol style="list-style-type: none"> 2. Implement CCBHC or alternative reverse integration model at BABHA <ol style="list-style-type: none"> 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. 	Extended SLT, Agency Leadership, Health Care Integration Steering Committee (HCISC)
<ol style="list-style-type: none"> 3. Implementation of health literacy training guidelines for staff and individuals served 	Sarah VanParis, Jennifer Laseeski

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 CFO, CEO **Status:** Revision for 2026

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:	Strengths/Weaknesses:
<ul style="list-style-type: none"> • 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 • Michigan's earned sick time act and minimum wages changes will affect Provider Network 	<ul style="list-style-type: none"> • Board aware of budget status and supportive of investments in provider systems • Zero-based budgeting not performed periodically

- 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 autism services greater than internal and external capacity
- MDHHS mandate to pay a minimum hourly rate for behavioral tech services
- Waskul Settlement creating wage disparities for CLS workers
- 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
- Expansion of CCBHC site in the MSHN region consuming excess Medicaid funding/savings
- MDHHS procurement of the PIHPs jeopardizes financial viability of CMHSPs
- 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.
- BABH PMPM funding has not kept up with service utilization/expenditure trends
- Medicaid redeterminations are affecting benefits and as a result funding the system
- 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

<u>Breakthrough Initiatives:</u>	<u>Resources:</u>
1. Monitor Long Term (3-5 year) Financial Plan based on revenue trends	Extended SLT; Finance Department; IT Department
2. Monitor Medicaid, <u>Healthy Michigan, ABA</u> and General Fund expenses in every programmatic, personnel and financial consideration; continually monitor fiscal year revenue projections	"
3. <u>Monitor financial stability of Network Providers; Monitor staff retention and impact of recent CLS and provider rate adjustments related to the DCW mandate</u>	"
4. <u>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.</u>	"

- | | |
|--|---|
| 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 <u>including formal procurement and discount pricing arrangements</u> | |
| 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 Cost Containment Strategies and Availability of~~ **Community Living Support Services (CLS) for Adults & Children**

Lead Team Member: ~~Director of Integrated Services, Melanie Corrion~~ **Karen Amen, Nicole Sweet, Emily Gerhardt** **Director of Integrated Services-Long Term.** **Status:** ~~Revised~~ **Revised** for 2025

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. The significant increase in the costs of CLS services has negatively impacted our budget and cost containment strategies must be implemented to assure that BABHA will be able to continue to provide adequate services to those in most need.

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

Threats:

- ~~Lack of 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.

Strengths/Weaknesses:

Strengths:

- Currently have multiple providers who provide CLS services. Have added three new CLS providers over the last two years.
- 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.

- 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. Northbay CLS and Case Management services.
 - EVV implementation has placed administrative burdens on current CLS providers. New compliance standards for EVV may threaten funding for CLS services.
 - Lost of ~~two~~ one of our CLS providers.
 - Providers reluctant to provide both adult home help and CLS as wages are less for adult home help.
 - Implementation of ESTAPaid medical leave act will force providers to provide paid time off
 - 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.
 - BABHA doesn't have the financial revenue to support continued practices and increases in CLS services similar to the increases from 2024 to 2025 (\$3.3 million).
 - Waskul Settlement raising wages for only a select group of CLS providers, may cause losses of workers who do not fall under that provider category.
 - 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. CLS services have increased from 2024 to 2025 by \$1.7 million and an increase of \$1.6 million CLS-Autism.
 - 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.
 - Vocational CLS providers not doing in home CLS due to EVV implementation process and extra administrative burden this creates.
 - Vocational providers have been on a cost settlement contract and this has inflated the CLS rates. Conversion back to a Fee for Services has resulted in a reduction in the rates for those providers for CLS services.
 - 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.
 - DNMM has ended their Independent Facilitation and now the only provider in Bay and Arenac County is the Arc of Bay County.
 - The CLS Assessment Tool is not always completed consistently, and the Committee isn't as cohesive in determining approvals as it should be.
 - CSM's need more training on the Assessment Tool and Managers and Supervisors need to be more diligent on reviewing and signing before they are submitted to the Committee.
 - Duplicate CLS providers to the same consumer has significantly increased the costs of CLS services.
 - Northbay CLS has periods of time when the staff are not providing CLS Services.
 - Northbay CLS is only available during regular business day hours, not on weekends nor holidays.

Breakthrough Initiatives:

Resources:

<p>1. <u>Review current CLS approval process and make necessary changes to implement a more comprehensive and consistent CLS Assessment and Committee approval process: Expand options for CLS services.</u></p> <p><u>a. Review the existing CLS Committee structure and consider revisions that will enhance consistency with approvals.</u></p> <p><u>b. Provide training on the Assessment Tool to all internal and external Case Management providers.</u></p> <p><u>c. Assure that CLS is the last resort for consumers and that all other avenues have been pursued prior to approval of CLS.</u></p> <p><u>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.</u></p> <p><u>b. Continue to explore options to expand hiring for individuals in Self Determined arrangements.</u></p> <p><u>c. Explore options to increase existing and new providers of children's and adult CLS services.</u></p> <p><u>d. Encourage external providers to participate in Advocacy efforts to explore options to address staffing crisis and maintain accountability to meet service needs and contractual requirements</u></p>	<p><u>CLS Program Manager, All Director's of Integrated Services, CLS Committee members. All Program Managers. Financial Department, Self Determination Coordinator, Certified Peer Supports Broker, MI Adult Team, IDD Adult team, CLS Program Manager, Financial Department, Northbay Leadership, Children's Leadership</u></p>
<p>2. <u>Implement Procurement Strategy for highest cost community living supports (CLS) and Northbay arrangements and transition to new providers. Assist providers and families with maintaining CLS staffing.</u></p> <p><u>a. Identify/solicit network of available CLS providers to transition approximately 50% of the existing NB consumers over time.</u></p> <p><u>b. Identify CLS arrangements that may need a transition period utilizing Northbay CLS filling the gap between referrals to a provider and/or in times of crisis.</u></p> <p><u>c. Identify internal BABHA options to utilize Northbay staff to provide limited CLS and explore other services that the Northbay staff might be able to provide (i.e. Supports Coordinator Assistants, limited CLS for barrier free access, individuals with high behavioral needs).</u></p> <p><u>d. Continue to expand the CLS provider network, including for children.</u></p> <p><u>e. Transition vocational providers on a cost settlement contract back to a fee for service contract with CLS rates being more in line with other CLS providers.</u></p> <p><u>a. Increase the network's ability to handle workforce challenges, crises, and people with challenging behaviors, etc. by providing additional supports such as psychological services, Quality of Life Mentor services, Mobile Crisis Response Team, and other necessary support services.</u></p> <p><u>b. Continue to ensure that all CLS staff are trained in the Individual Plan of Service initially and ongoing.</u></p> <p><u>c. Advocate for Statewide efforts for Direct Care Worker wage increases and professional certification.</u></p> <p><u>d.f. Develop and implement additional training for individuals in Self Determination arrangements including topics of Fraud/Waste and Abuse, the EVV system, and other training to assist them in the role of employer.</u></p>	<p><u>Director of Integrated Services-Long term, CLS Program Manager, IDD Program Manager, Northbay Supervisor, Children's Program Manager, Contracts Manager, Finance Department CLS Committee members, 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</u></p>
<p>3. <u>Identify and transition any duplicative CLS arrangements.</u></p> <p><u>a. End CLS social/recreational services at vocational programs for consumers who already receive CLS services in AFC settings.</u></p> <p><u>b. Establish consistent and stricter, time limited parameters for CLS social recreation services for consumers living in non-licensed settings.</u></p>	<p><u>Clinical Program Managers, Directors of Integrated Services, Self Determination Coordinator, Finance and Contracts Managers, CLS Committee members.</u></p>

c. Review and assure that Self Determination arrangements are covering all CLS services and not getting CLS services outside of the Self Determination arrangement.

4. Explore additional areas for cost containment:

- a. Continuously review all HMP consumers to determine if eligible for Medicaid.
- b. Implement discharge proceedings for enrollees that lose Medicaid/fail to meet spend down requirements in CLS arrangements.
- c. Establish more robust UM parameters for medical necessity for CLS in vocational services.
- d. Explore consolidation of vocational services to two primary vendors.

Clinical Program Managers, Directors of Integrated Services, Finance Department.

5. Implement quality review process to ensure EVV compliance standards are met.

- a. Identify key members to participate in this review process
- b. Continue to review EVV bulletins for updates and train CLS providers and staff on correct use of EVV.

Clinical Program Manager CLS, Horizon Home Supervisors, Directors of Integrated Care, Finance Department, Quality Improvement Manager

Commented [NS2]: Not sure the official title of Sarah Holsingers team

Environmental Scan: ~~Stabilization and Long Term Viability of~~ **Stabilization and Cost Containment Strategies for Residential System**

Lead Team Member: ~~Director of Integrated Services Long Term, Melanie Corrion, Sarah Van Paris, Karen Amen~~ Director of Integrated Services-Long Term **Status:** Revise for 2026

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
- MDHHS has maintained increases that have helped retain staff. There are several advocacy groups working to increase the wages of DCW and competencies of that workforce.
- 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

Strengths/Weaknesses:

Strengths

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

- 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
 - 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](#)
 - [Increase in out of county placements due to lack of local providers willing/able to provide higher level of 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 providing services in the Specialized Residential Homes and other CLS arrangements
 - North Bay has moved ~~to community~~ [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 three specialized residential homes for a total of 19 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.](#)
 - [Increase of vacant beds for long periods of time.](#)

Breakthrough Initiatives:

1. Continue to advocate, prioritize and support [efforts appropriate financial adjustments](#) to stabilize the residential services and advocate at all levels for improving the Direct Care workforce.
 - a. Explore development of more direct and provider operated living arrangements that are capable of providing 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.

Resources:

SLT, Financial Department, Board of Directors, Horizon Home Leadership, North Bay Leadership, IDD Team Leadership, Residential Liaison

<p>2. Support staff's ability to perform effectively and to ensure residents' needs are met.</p> <p>a. Increase the residential provider network's ability to handle workforce challenges, crises, and people with challenging behaviors, , etc. by providing additional supports such as psychological services, Quality of Life Mentor services, debrief resourcescounseling and other necessary support services.</p>	<p>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</p>
<p>3. <u>Address high cost out of county placements and vacancies in the Specialized Residential provider network.</u></p> <p>a. <u>Eliminate payments for vacant bed days to encourage providers to increase current occupancy rates.</u></p> <p>b. <u>Explore consolidation of vacant specialized residential beds to either direct operate or contract out to a provider who will provide services to higher need individuals.</u></p> <p>c. <u>Explore the possibility of adding another crisis residential home</u></p> <p>d. <u>Transition Northbay CLS staff to residential technicians if assume another direct operated home.</u></p> <p>e. <u>If vacancies can't be filled in the existing provider network, consider closing a current residential facility.</u></p>	<p><u>Directors of Integrated Services, Program Managers, Residential Liaison, Residential Referral Committee, Specialized Residential providers, Finance Department.</u></p>

Environmental Scan: [Applied Behavior Analysis \(ABA\) Services Stabilization and Cost Containment Strategies](#)

Lead Team Member: [Directors of Integrated Care – Children](#) **Status:** [New for 2026](#)

Impact on Ability to Accomplish Mission:

Applied Behavior Analysis (ABA) Service referrals have consistently expanded each year since the implementation of the program in FY16. The volume of referrals continues to exceed both the available program capacity and the program budget. The significant increase in referrals for ABA services has had a negative impact on our budget and cost containment strategies must be implemented to assure that BABHA will be able to continue to provide adequate services to those in most need.

Opportunities/Threats:

Opportunities:

- Utilization of effective ABA services will improve language and communication, social skills, daily living and adaptive skills, and a reduction in challenging behaviors for children.
- Outcomes Monitoring: Internal quality oversight equivalent to oversight of contracted provider network and measurement of clinical outcomes/ evidence-based practices
- Development of outcome measures will assist in thoughtful implementation of cost containment strategies.

Strengths/Weaknesses:

Strengths:

- BABH staff knowledge and expertise related to ABA service regulations.
- Longevity of BABH ABA services program. ABA services were implemented in FY16.
- Expertise of the current BABH ABA provider network.
- Agency commitment to providing quality services.
- Early and consistent ABA intervention has been linked to better educational outcomes and greater social integration later in life.

Threats:

- [BABHA does not have the financial revenue to support the volume of referrals for ABA services.](#)
- [State mandated rates for ABA services provided by Behavioral Technician. The State has not increased the budget to adequately fund the mandated rates.](#)

Weaknesses:

- [Inadequate State funding for the volume of children in Bay and Arenac Counties who have been diagnosed with Autism Spectrum Disorder \(ASD\) and who meet medical necessity criteria for ABA services.](#)
- [Low direct care wages – state assistance level wages](#)

Breakthrough Initiatives:

1. [Develop a value-based care model for services.](#)
 - a. [BABH will work with a consultant to develop this significant shift from the traditional model.](#)
 - b. [Form a time limited work group to develop key standards.](#)
 - c. [Incorporate the use of data analytics to support an outcomes-based approach to ABA treatment.](#)
2. [Improve operational efficiencies within the ABA provider network.](#)
 - a. [Develop a procurement process/ Request for Proposal \(RFP\).](#)
 - b. [Educate current provider network on new model and expectations.](#)
 - c. [Selection of ABA providers](#)

Resources:

[Director Integrated Care – Children, Financial Department, Children’s Leadership team, BI](#)

Breakthrough Initiatives: Environmental Scan:

Resources: Integration with Substance Use Disorder Treatment and Prevention

[Increase treatment and/or referral activities, including consultation with BABH Addictionologist, for adolescents and adults identified with co-occurring SUD conditions.](#)

[Joelin Hahn, Heather Friebe, Stacy Krasinski, Emergency & Access Services \(EAS\), Child/Family programs, Dr. Morrone, Joelin Hahn, Heather Friebe](#)

Status: [Revise for 2025](#)

Lead Team Member:

[Support Arenac County efforts related to Recovery the Recovery court and continued expansion of SUD service in the area. **Impact on Ability to Accomplish Mission:**](#)

[Joelin Hahn, Heather Friebe, Arenac County Commission, Chief Judge, Sheriff, Prosecutor, Recovery Pathways, Arenac County Prevention Coalition \(ACPC\), The Well Outreach, Sterling Area FQHC and MSHN.](#)

- [Increase coordination of care and increase the ability to navigate smoothly between mental health and substance use disorder treatment providers. 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.](#)

[Joelin Hahn, PNOQMC, BCPN, ACPC, local MSHN SUD provider network.](#)

[Increase co-occurring capability within provider network. **Opportunities/Threats:**](#)

[Joelin Hahn, Heather Friebe, PNOQMC, Staff Development Department. **Strengths/Weaknesses:**](#)

Commented [MP3]: Move to training initiatives

- Minimal availability of SUD providers in Arenac Co.
- Increased Substance Use during the COVID-19 pandemic
- Availability of Opioid Settlement funds.
- 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
- 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.
- Participation in Project ECHO, Bay County Prevention Network (BCPN), Arenac County Prevention Coalition (ACPC), and the Heroin Task Force
- Participation with Great Lakes Bay Families Against Narcotics (FAN).
- Expanded community education and distribution of Narecan kits
- Obtaining Norecan 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

<u>Breakthrough Initiatives:</u>	<u>Resources:</u>
1. Increase treatment and/or referral activities, including consultation with BABH Addictionologist, for adolescents and adults identified with co-occurring SUD conditions.	Joelin Hahn, Heather Friebe, Stacy Krasinski, Emergency & Access Services (EAS), Child/Family programs, Dr. Morrone
1.	
2. Support Arenac County efforts related to Recovery the Recovery court and continued 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), 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, ACPC, local MSHN SUD provider network.
4. Increase co-occurring capability within provider network.	Joelin Hahn, Heather Friebe, PNOQMC, Staff Development Department.

Commented [MP4]: Move to training initiatives

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

Lead Team Member: Joelin Hahn, Heather Friebe, , Nicole Sweet
Directors of Integrated Care

Status: Revise for 20265

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)
- 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.

Strengths/Weaknesses:

Strengths:

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

- Trauma Informed Services:
1. Continuation of 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.)

Resources:

[J. Hahn Directors Integrated Care, Clinical Leadership](#), Staff Development, PNOQMC, Contract Provider Agencies; Wellness/Compassion Satisfaction Initiative (CSI) Committee, [TF-CBT Initiative/ Emily 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 LOCUS training plan that includes ongoing activities to strengthen model fidelity throughout the provider network serving adults with a Serious Mental illness (SMI). 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	Director Integrated Care- Acute Care/Arenac, J. Hahn, Kaytie Brooks , Staff Development, BABA internal LOCUS trainers.
2. Focus on co-occurring SED/IDD training for the Children’s Department.	Emily Gerhardt, Kelli Wilkinson, Kaytie Brooks, Joelin Hahn Director Integrated Care- Children, Children’s Leadership, Staff Development.
3. Develop and implement Peer Support Services programs to include Peer Support Specialist, Parent Support Partners, and Youth Peer Support.	J. Hahn , 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 Directors of Integrated Care , Clinical Leadership, Population Committees , Provider Network Operations Quality Improvement Committee, Vocational Providers
6. Monitor activity for the Infant and Early Childhood Mental Health Consultation grant.	Pam VanWormer, Kelli Maciag Children Clinical Supervisor – Arenac and Bay
7. Monitor activities for the Alternative Outpatient Treatment (AOT) and the Mobile Response Team (MRT) grant programs. Determine program sustainability post grant. Apply for new grant opportunities for additional grant funding as they arise.	EAS Clinical Program Manager, Stacy Krasinski, James Spegel , Finance Department, Joelin Hahn Director of Integrated Care
8. Expand IPS services and improve fidelity amongst current providers. Increase referrals and expand on education around the impact of IPS services.	Nicole Sweet, Clinical Program Manager , 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, Clinical Program Manager , 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 CEO, Strategic Leadership Team, Agency Leadership, Wellness Committee
	Status: Revise for 2026

- 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 CMHSP disaster behavioral health responsibilities and obligations to conditions and the impact on special populations in the larger community is negatively impacting access to care and coordination of services
- Lack of understanding for employees concerning strategic and resource decisions and detrimental effects on morale

Opportunities/Threats:

Opportunities:

- Information is welcomed when it is made available.
- 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, 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

Strengths/Weaknesses:

Strengths:

- ~~Establishment of dedicated school liaison position~~
- Mental Health First Aid Training program
- 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.
- Expanding use of intranet and social medial platforms for community engagement~~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 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~~

- Missed opportunities to impact those who need services
- Failure to engage employees in crucial agency decisions

[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 facilities, etc.) to increase understanding, reduce stigma and promote trauma informed communities	Extended SLT, Agency Leadership, Bay County Prevention Network, Arenac Drug and Alcohol Containment task Force, Arenac and Bay County Sheriffs, McLaren MHU and Emergency Department, 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, 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
4. Implement Staff recognition process for milestone years of service developed by Wellness CreateCommittee -a shared site for informative educational series to share on social media. (Sharepoint, Facts for Families, Phoenix library for meds and diagnoses)	Agency Leadership, Human Resources Department Staff Development, Information Technology and Help Desk
5. —Add a Critical Incident Response Team SCHISM-team to expand BABHA capacity to respond to disaster behavioral health and other community emergencies Expand Stepping Up Initiative to address safety net and treatment issues for youth and juveniles into Arenac County.	Strategic Leadership Team, Human Resources Director, Director of Integrated Services-Acute Care 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
5. 6.	

Personnel and Compensation Committee

Environmental Scan:

Recruitment and Retention

Lead Team Member:

[Jennifer Lasceski](#) HR Director

Status:

Continue for 2026

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
- Perceived inequality of implementation (not all positions may be positively impacted)
- Use of non-traditional incentives (signing and referral bonuses)

Strengths/Weaknesses:

- Market-based compensation structure in place
- Total compensation ~~was~~ competitive for a number of positions as adjusted in 2018, 2020, 2021, 2022 and 2024, however a lack of wage adjustment in 2025 has put BABH behind area competitors
- Agency training opportunities exceed many area employers
- 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:

1. Strategies to attract and retain qualified LBSW and MSW candidates.
2. Explore the option to consider ~~other qualified candidates that meet QIDP and QMHP criteria for~~ Case Management Assistant positions.
3. Strategy to attract and retain qualified and invested direct care staff – ~~maintain~~ continuous posting practices ~~post~~ positions as needed
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

Resources:

- ~~Joelin Hahn~~, Director of Integrated Care
- ~~Justeen Blair~~, Residential Supervisor - Horizon, Director of Integrated Care
- ~~M. Rozek~~ CFO; SLT

Environmental Scan:

Development of Workforce

Lead Team Member:

Director of Human Resources ↓

Status:

Continue for 2026~~5~~

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

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

- Increase opportunities to engage stakeholders and relay organizational messaging
- Competing training opportunities
- Limited financial resources
- Breadth of staff competencies in SUD treatment and prevention is not as broad as needed
- Staff turnover has decreased since 2018, however, a ~~more~~ lack of consistent wage increases has affected a competitive wage structure.

<u>Breakthrough Initiatives:</u>	<u>Resources:</u>
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; 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	Sara VanParis ; Nursing Manager
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 Residential Supervisor - Horizon; Nicole Sweet Clinical Team Leader; Melissa Spellerberg Human Resources Generalist
7. Continue initiatives that support agency efforts relative to recovery-based care, trauma informed services, co-occurring services and fostering a culture of gentleness.	Directors of Integrated Care; Nicole Sweet Clinical Team Leader
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: CFO, CEO ~~Karen, Marci and Jennifer~~ Status: Continue 202~~65~~⁶⁵

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.

Strengths/Weaknesses:

- Strengths:
- Have had three years during the Pandemic to work through remote work issues.

- Reduce costs for buildings and work spaces.
- Advance the use of technology to be more efficient.
- Leases renewal options for the Wirt Building and the Mulholland office space extends through February 2033 are soon going to be expired.
- Option to expand the Madison Building to accommodate other departments

Threats:

- 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.
- Legacy costs associated with older North Bay property
- Lack of equity value in 201 Mulholland location

- 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 Arenac Center, 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.
- Remote work experience has modeled opportunities for further consolidation of physical space including vacating the United Way building in 2025.

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.
- Mulholland and North Bay locations are aging, i.e. 50 and 70 years respectively, and may not be conducive to significant renovation or remodeling.
- Constant changes in McLaren Bay Region leadership renders long term lease arrangements difficult to predict

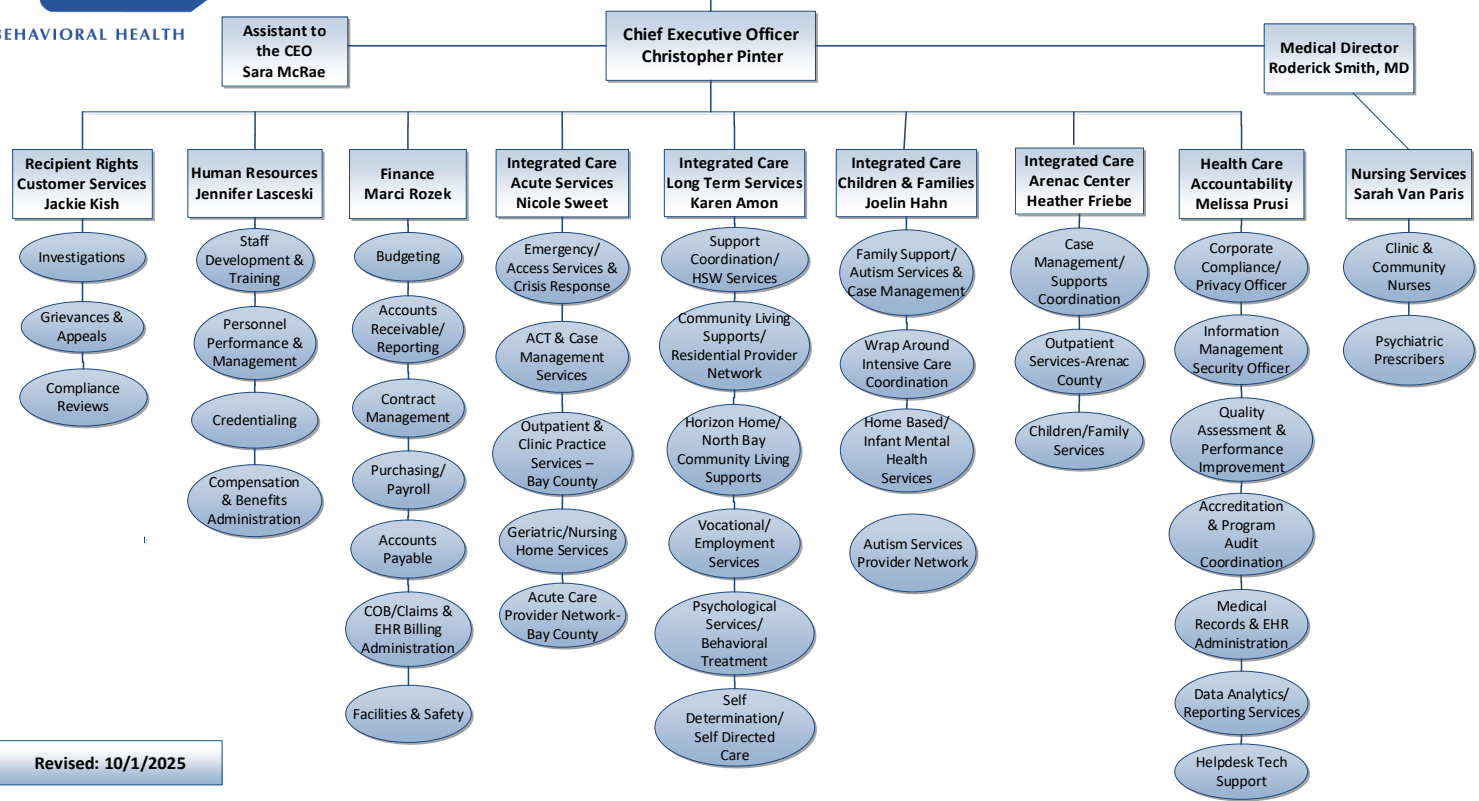
Breakthrough Initiatives:	Resources:
1. Implement Leadership Dashboard and other reports to allow Supervisors and Managers for real time monitoring and evaluate staff's activity.	BI Department, Leadership
2. Evaluate long term staff equipment and space needs post remote work implementation.	IS Department, Facility Manager, Leadership
3. <u>Prepare/Revise-Maintain an inventory of equipment for deployment; hold on 2026 Replacement schedule for Board consideration.</u>	IS Manager, CFO Finance Manager
4. Prepare long term physical plant recommendations <u>related to Bay County locations</u> for Board consideration.	Leadership, CFO Finance Manager, Facilities Manager

Bay-Arenac Behavioral Health
202~~6~~5 Strategic Plan

Attachments

Attachment One: Organizational Chart

BAY ARENAC BEHAVIORAL HEALTH AUTHORITY BOARD OF DIRECTORS



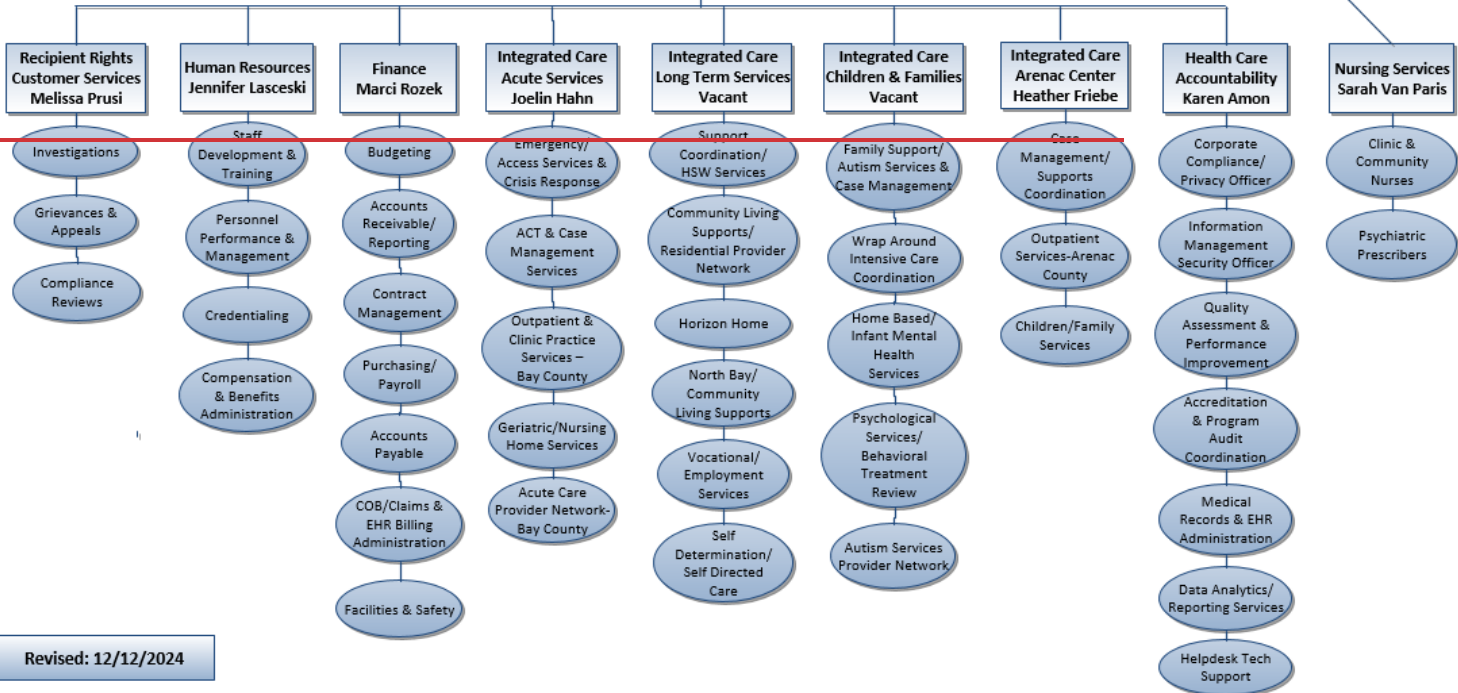
Revised: 10/1/2025

BAY ARENAC BEHAVIORAL HEALTH AUTHORITY BOARD OF DIRECTORS

Assistant to the CEO
Sara McRae

Chief Executive Officer
Christopher Pinter

Medical Director
Roderick Smith, MD



Revised: 12/12/2024

Attachment Two: Organizational Relationships



Organizational Relationships

External

MDHHS

- MDHHS National Core Indicators Work Group – Sarah Holsinger
- Parent Management Training Oregon Model MDHHS Steering Committee – [Andrea Rayl](#)
- MDHHS Children’s Administration Meeting – ~~J. Kelli Macias~~ [Wilkinson](#)
- Michigan Motivational Interviewing Team – Karen Amon
- MDHHS Peer Liaison Meeting – [?](#)
- MDHHS Recharging Supported Employment – ~~Nicole Sweet~~ [Stephani Rooker](#)
- MDHHS Medical Clearance Work Group – Stacy Krasinski
- Fair Hearings Officers – ~~Kim Cereske~~ [Kim Cereske](#), [NEED BACK UP](#)
- MDHHS ORR Directors [Quarterly](#) Group – ~~Melissa Prusi~~ [Jackie Kish](#)
- Practice Improvement Steering Committee – ~~J. Hahn~~ [Karen Amon](#)
- MDHHS Transition to Community – Melanie Corrion
- MDHHS Medical Directors Advisory Committee – Dr. Smith
- MDHHS Public Relations Committee – [Lynn Blohm](#)
- MDHHS Contract and Finance Issue Committee – Marci Rozek

State Association

- MDHHS/CMHA Capitation/Cost Allocation Work Group – Chris Pinter
- CMHA Legislative and Policy Committee-Chris Pinter, ~~Karen Amon~~ [Melissa Prusi](#)
- Chief Information Officer (CIO) Forum – Jesse Bellinger, [Greg Lietzow](#)
- CMHA Customer Services Work Group – ~~Jackie Kish~~ [Melissa Prusi](#); Kim Cereske
- [Walk-A-Mile Planning Committee](#) – [Lynn Blohm](#)

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~~ [Melissa Prusi](#)
 - MSHN Corporate Compliance – ~~Karen Amon~~; [Melissa Prusi](#)
 - MSHN IT Council – Jesse Bellinger
 - MSHN Customer Service Committee – [Jackie Kish](#), Kim Cereske
 - MSHN Utilization Management Committee – Joelin Hahn, [Heather Friebe](#), [Nicole Sweet](#), [Karen Amon](#)
 - MSHN Provider Network Committee – Marci Rozek, Stephanie Gunsell
 - MSHN Clinical Leadership – Joelin Hahn; ~~Karen Amon~~, [Heather Friebe](#), [Nicole Sweet](#)
 - MSHN Medical Directors – Dr. Smith
- Work Groups/Teams
 - MSHN Regional Autism Monitoring – Sarah Holsinger, Melissa Deuel
 - MSHN HSW Coordinators-Melanie Corrion; ~~Jackie Kish~~ [Craig Kanicki](#)/[Brad Parker](#)
 - MSHN HCBS Coordinators –Melanie Corrion; ~~Jackie Kish~~ [Craig Kanicki](#)/[Brad Parker](#)

- MSHN 1915(i) Lead Staff- Melanie Corrion; ~~Jackie Kish~~[Craig Kanicki/Brad Parker](#)
- MSHN Autism Work Group – Amanda Johnson; ~~Emily Young~~[Gerhardt](#)
- 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 – Karen Amon (~~temporarily~~); Flavia Vasconcelos, Casey Binkley
- MSHN Recipient Rights – ~~Melissa Prusi~~[Jackie Kish](#)
- MSHN Training Coordinators Work Group – Jennifer Lasceski; Kayt~~ie~~[ie](#) Brooks
- ~~MSHN East Recovery Oriented System of Care (ROSC) – Joelin Hahn~~

Regional/State CMHSP Professionals:

- Occupational Therapy Area Quarterly Group Meeting - Meredith Bickel
- Statewide Contract Network – Stephani Rooker.
- Michigan Nursing Forum Meetings – ~~→~~ Sara Van Paris, Amy Folsom, Nicole Konwinski

Community/County

General

- ~~Bay County Services Partners for Homelessness~~Mid-Michigan Local Planning Body – Allison ~~Gruehn~~[Taylor Keyes](#)
- 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 = Jackie Kish:
- Great Lakes Bay – lookup – Jackie Kish

Child and Family

- Bay-Arenac Great Start Collaborative – Amanda Johnson (when resumes)Bay Community Collaborative Service Partners –Sue ~~Guertin~~[Vian](#)
- 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~~[Gerhardt](#), Brad Parker
- Youth and Family Connect (Systems of Care for Children) - ~~Stacy Krasinski~~, Amanda Johnson, Ashley Aho, ~~Shannon Leyton~~
- DHHS Partnership (Bay) – ~~Noreen Kulhanek~~; ~~Emily Gerhardt~~; Stacy Krasinski
- DHHS Trauma –Pam VanWormer
- ISD Mental Health Meeting – Pam VanWormer; Emily Gerhardt and Brad Parker.
- Great Lakes Bay PFLAG- ~~Jill~~; Schultz
-

Crisis Response and Prevention

- Bay Arenac Suicide Prevention Coalition – Stacy Krasinski, Jill Schultz, Heather Friebe
- Regional Suicide Prevention Coalition (Bay, Saginaw, Midland) – Stacy Krasinski

Educational/Vocational

- Seamless Transitions Committee (w ISD)–~~;~~ Melanie Corrion
- 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~~ Jackie Kish; Stacy Krasinski

Substance Use Disorders/Co-Occurring Disorders

- Arenac County Prevention Coalition (ACPC) – Heather Friebe
- 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 –Karen Amon(~~temporarily~~)
- Safety Committee – Eric Strobe
- Corporate Compliance Committee – ~~Karen Amon~~ Melissa Prusi
- Ethics Committee – ~~Melissa Prusi~~ Jackie Kish
- Autism Provider Meeting – Amanda Johnson
- Residential/CLS Provider Meeting – Melanie Corrion
- Vocational Provider Meeting – ~~Nicole Sweet~~ Stephani Rooker
- Primary Network Operations and Quality Management Committee (PNOQMC) – Joelin Hahn; Sarah Holsinger
- Residential/CLS Crisis Response Team (Ad Hoc) –; ~~Nicole Sweet~~ Stephani Rooker; Melanie Corrion
- CLS Committee- ~~Nicole Sweet~~ Karen Amon; Stephani Rooker
- Residential Referral Committee- Rachel Lemiesz; Melanie Corrion
- EHR Management Team – ~~Karen Amon~~ Melissa Prusi
- ~~Data Governance Committee~~ – Jesse Bellinger
- Internal Provider Management - Melissa Prusi

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
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
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
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
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
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
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
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
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
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.
Program 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	<u>% of Consumers Diagnosed w/ Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Received a Cardiovascular Screening</u> % of Consumers Diagnosed w/	# 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

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
	Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Received a Cardiovascular Screening		
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	Count of Reportable Risk Behavior Treatment Events Per Quarter	# of 911 Calls made by staff; # of Emergency Physical Interventions	
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	% 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
Corporate Compliance Committee	% of user phishing preparedness compared to industry standard	Number of users who report simulated phishing emails and number of users who click on simulated phishing emails compared to industry standard.	
Corporate Compliance Committee	# of security incidents per month	Number of security findings, false positives, and resolved issues	
Corporate Compliance Committee	Critical system outages per month	Number and duration of outages including network, communications, and critical software	
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	

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
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	
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	

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
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		
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

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
Finance	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	GF Expense Medicaid Expense Healthy Michigan Expense
Finance	Number of days of operations ratio (unrestricted fund balance/total daily expenditures) (Determine target days/threshold)	Unrestricted fund balance	Total daily expenditures