BARRY COUNTY COMMUNITY MENTAL HEALTH

STRATEGIC PLAN 2018

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Executive Summary

Barry County Community Mental Health Authority (BCCMHA) provides professional services to over 2,100 individuals annually. Those services may include: behavioral health services, co-occurring services for individuals with intellectual disabilities, children with severe emotional disturbances, and individuals with autism. In addition to what may be considered traditional community mental health services, BCCMHA provides an array of auxiliary services to support individuals such as; community living supports, respite, and employment services. We are also helping individuals on their road to recovery, as BCCMHA is engaging in emerging evidenced-based and/or researched-based practices.

To ensure we are meeting the expectations of individuals, stakeholders, and the State of Michigan; we will actively establish, measure, and review outcomes. A focus on current practices, as well as the future needs, is vital. It is important to continue to be vigilant in setting and achieving high benchmarks. We must measure the success of current services and programs and be willing to make adjustments as indicated by the data. We must also be willing to redefine how we provide health care, look at new service opportunities, and embrace community collaborations.

For FY 18, the proposed draft budget for the BCCMHA is approximately $11.4 million including the following business lines:

- Medicaid Program (Concurrent 1915 b/c waiver) - A benefit plan for persons with Severe Mental Impairment (SMI), Severe Emotional Development (SED), Intellectual/Developmental Disabilities (IDD) and/or Substance Use Disorder (SUD).
- General Fund Program (GF) - A state-funded program, mainly for Non-Medicaid persons with Mental Impairment (MI), Severe Emotional Development (SED) and/or Intellectual/Developmental Disabilities (IDD), with emphasis placed on the more serious forms of illness and disability.
- Autism Program - A Medicaid and MI-Child Autism Benefit (effective April 1, 2013), that provides Applied Behavior Analysis (ABA) services to those individuals ages 18 months through 21 years old, who have a medical diagnosis of Autism Spectrum Disorder (ASD).
- Public/Commercial Insurance - For persons not covered by another insurance plan noted above; who receive coverage through Medicare and/or private commercial insurance, or who qualify as having an ability to pay.

Based on recent legislative and regulatory activities, it is clear that budget planning and oversight is a vital factor for BCCMHA's Strategic Plan. It was with the above assumptions and expectations, that the BCCMHA Strategic Plan for FY 2017-18 was

created. This plan was established with contributions provided by individuals that were served, BCCMHA staff, our community, and BCCMHA management. It establishes the focus of the agency and sets overarching goals to include:

- Increase integration of physical and behavioral health for individuals that receive psychiatric services.
- Improve the quality of services and reduce costs via established metrics.
- Strengthen and foster community relationships and collaborations throughout Barry County.
- Promote and improve positive staff morale.
- Maintain and strengthen agency health.

Those that will actively enact the plan will be hope dispensers. Working with individuals and stakeholders, we will establish a path of recovery for Barry County residents; which shall in turn, create a healthier and stronger county for all residents. Achieving this outcome will take vision and courage from everyone; however, as Mr. Churchill stated, “Courage is the first of human qualities because it is the quality which guarantees all others”.

Introduction

Strategic planning is the systematic and organized process that organizations use to establish a road map to get from their current reality to the envisioned future. It starts with reviewing the mission, vision and values of the organization and leads to a strategic plan with goals and outcomes. The strategic plan establishes, operationally, how the organization will achieve their goals while maintaining the values of the organization.

Background Statement and History

Historically, the public mental health system put down roots shortly after Michigan became a State in 1837. In fact, in 1850 the Michigan constitution contained language for the care of the mentally ill and other disabilities. 1859 saw the opening and operation of the first mental health institution, the Kalamazoo Asylum for the Insane, within the State. In the years to come, additional State-operated intuitions would follow. At the time, the aforementioned State-operated institutions were viewed as providing best practice.

The Michigan legislature passed Public Act 54, the Community Mental Health Services Law, in 1963. The Michigan State constitution, in 1963, identified the State as the responsible party to care for persons with mental disabilities. Article VIII, section 8 states, "…institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise handicapped, shall always be fostered and supported".

These acts were followed by the passage of PA 258 of 1974, the Mental Health Code. This Public Act laid the foundation for the creation of the Community Mental Health Board. These acts also created the path for local government to partner with the State in providing services. In the second chapter of said code, the roles and responsibilities of the community mental health programs are defined. This led to the creation of specific systems of care for individuals with mental illness, individuals with developmental disabilities and children with serious emotional disturbances.

In 1996 the State of Michigan formed the Michigan Department of Community Health (MDCH). This newly created office oversaw health-related functions that were previously in the departments of Mental Health and Public Health, as well as the Michigan Medicaid program.

The movement towards community-based and recovery-oriented services has greatly impacted how services in Michigan are delivered. This process has led us from a structure where the mental health delivery system was the State Hospitals and Institutions to a community-based system that partners with the state of Michigan. As the forty six (46) Community Mental Health

Boards were formed, they contracted directly with the State of Michigan. There was then the movement toward the creation of per paid insurance health plans with which the State would contract. In the late 1990's, there were eighteen (18) PIHPs and forty six (46) CMHSPs serving the Michigan's eighty three (83) counties, which were responsible for coordinating the diagnosis and treatment of consumers, supervising the activities of group and adult foster care homes, as well as offering an array of services and supports developed through individual plans of service and using a person/family-centered planning approach. In the early 2000's the regional PIHPs were reduced from 18 to 10. This is the current set up today; however the winds of change are blowing once again and with the Governor's purposed budgets of 2017 and 2018 the system could change once again.

Barry County Community Mental Health was established by the Barry County Board of Commissioners (BOC) in the years 1972-1973. During this time, the Barry BOCs appointed a twelve- member Mental Health Board to oversee mental health services as defined in Public Act 54. In early 1974, the BOC operations were opened in the Pennock Physician Center and the first Director was hired. Also in 1974, after PA 258, the focus on service delivery became more of the Community Mental Health Board's responsibility.

To meet these new regulatory demands, Barry County Community Mental Health embarked on an expansion of services and programs. The clinic space within Pennock Hospital was expanded. A skill building program was established in Freeport, MI for individuals with a developmental disability. During the 1980's many of the services that were provided only at State hospitals were now provided locally by Barry CMH. This included the ability to provide 24/hr., seven day a week crisis services to residents of Barry County. In the late 1980's the BOCs helped create a new skill building program facility at Algonquin Lake. By the mid 1990's, following revisions to the Mental Health Code, the Barry County Community Mental Health become a full management Board. This meant that Barry County Community Mental Health was responsible for all behavioral needs and costs for Barry County residents. Barry County CMH received its first Commission on Accreditation and Rehabilitation Facilities (CARF) at this time as well.

In 2002 Barry County Community Mental Health obtained Authority status. Thus, Barry County Community Mental Health became Barry County Community Mental Health Authority (BCCMHA). At this time BCCMHA partnered with Branch, Berrien, Calhoun, and Van Buren Counties to provide mental health services to all Medicaid clients within the region.

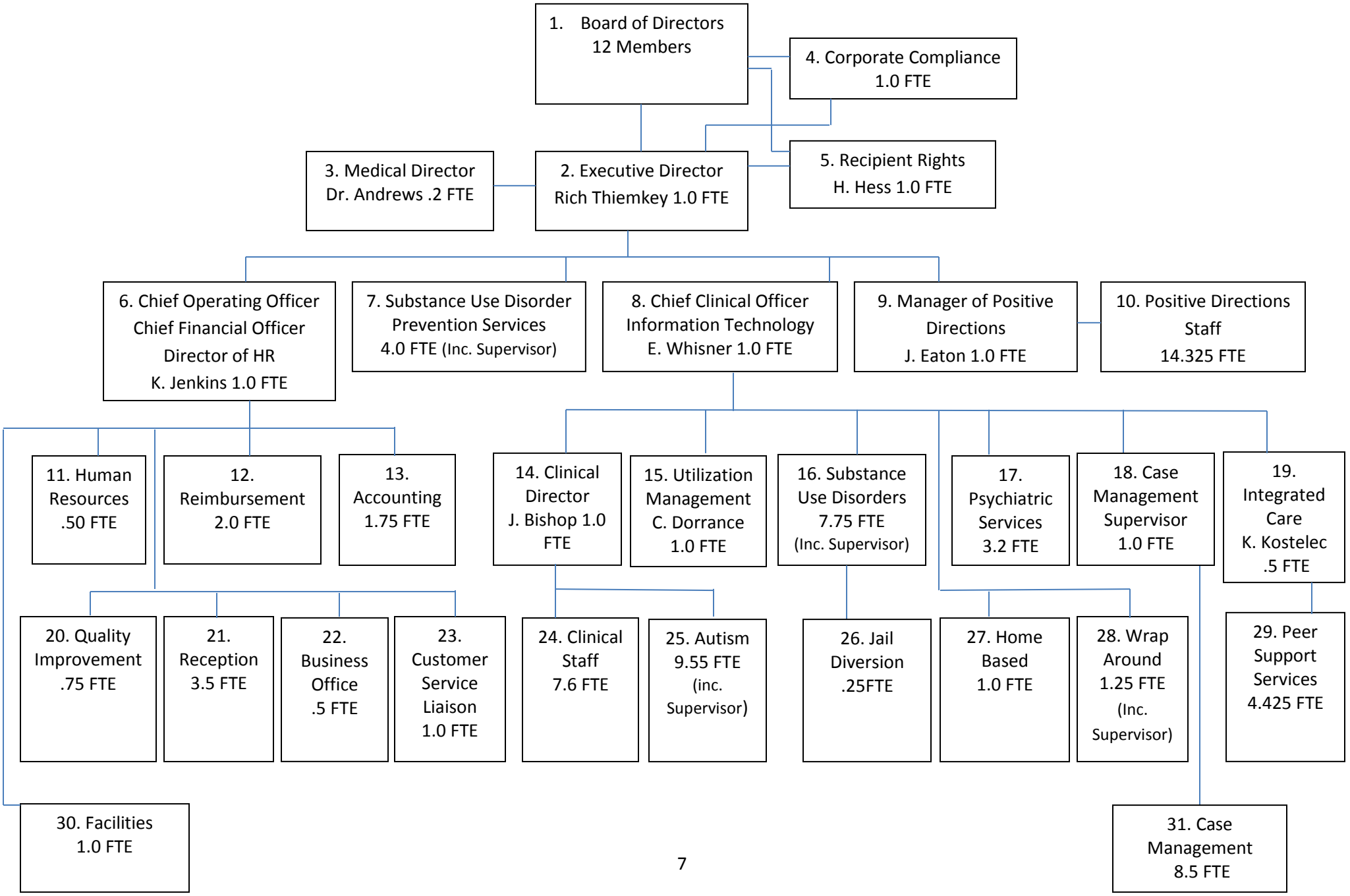
In 2008, Barry County Substance Abuse Services and BCCMHA merged to become a fully integrated program; this improved services to all residents of Barry County by creating "no wrong door" for those seeking services. Under the BCCMHA umbrella, Substance Use Disorder (SUD) services have significantly expanded, from three co-occurring clinicians to eighteen, from

one jail group to four, and from participation in one specialty court to participation in four. Services continue to evolve; embracing evidenced-based practices and clinical techniques, establishing community partnerships to facilitate the implementation of medication-assisted treatment, and working with community partners to imbed clinical staff.

In 2014, BCCMHA collaborated with Berrien, Brach, Calhoun, Van Buren, Kalamazoo, St. Joseph and Cass to form a regional entity. The regional entity was called South West Michigan Behavioral Health (SWMBH). This regional entity receives Medicaid and Healthy Michigan (Michigan Medicaid expansion) funding and administers the funding on behalf of the aforementioned eight community mental health organizations.

Management and Board and Staff

BARRY COUNTY COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES ORGANIZATIONAL CHART



Mission and Vision Statement

Mission Statement

Barry County Community Mental Health Authority will provide accessible and affordable mental health and substance abuse services focused on prevention, treatment and rehabilitation to county residents who can benefit from our endeavors and assistance. Our mission will be supported by efficient and prudent use of our finances and appropriate diversification.

Vision statement

Believing in Recovery
Connecting with community
Combating stigma
Making a difference
Helping those in need
Aspiring to be the best

BCCMHA Values:

Holistic Person Centered

Honesty

Transparency

Ethical

Integrity

Excellence

Accountability

Evidence based

Promote innovation

Community partnerships and Collaborations

Strategic Goals for Fiscal Year 2017-2018

Goal #1: Maintain/strengthen agencies Health.

Objectives	Data	Met or Not Met
BCCMHA team shall develop a full strategic plan 1. Introduction and history 2. Executive summary 3. Succession planning 4. SWOT analysis 5. Agency values. 6. Mission statement		
BCCMHA shall have an Administrative Loss Ratio at or below 7.5%		
BCCMHA shall reduce its Medical Loss Ratio by 10%		

Goal #2: Strengthen/Foster community relationships and collaborations throughout Barry County.

Objectives	Data	Met or Not Met
BCCMHA Director shall actively participate in at least 4 community meetings to foster community collaboration.		
BCCMHA Director shall meet at least once per quarter with local community leaders and or state representatives to enhance working relationships and promote BCCMHA's mission.		

Goal #3: Increase integration of physical and behavioral health for individuals that receive psychiatric services.

Objectives	Data	Met or Not Met
BCCMHA will develop a systematic process, including best practices, for the collection of blood pressure and blood sugar (glucose) levels.		
BCCMHA will provide blood pressure and blood sugar (glucose) educational information to 80% of clients, who receive psychiatric services, whose blood pressure or glucose fall outside the established parameters.		
BCCMHA will provide health educational information to 80% of clients, who receive psychiatric services, with a Body Mass Index of 30 or more.		
BCCMHA will utilize the Care Management Technologies System to identify at least 10 clients who have accessed services through the Emergency Department more than 4 times in a six-month period and facilitate coordination with the primary care provider / help client establish contact with primary care provider.		

Goal #4: Promoting/improving positive staff morale

Objectives	Data	Met or Not Met
BCCMHA will hold at least two (2) organizational-wide staff meetings to facilitate open communication and provide an opportunity for collaboration and feedback.		
BCCMHA will decrease staff turnover by 10%.		
BCCMHA will implement at least two (2) suggestions from staff on methods of increasing communication/retention and support for staff.		

Goal #5: Establish agency metrics in quality, efficiency and improved outcomes.

Objectives	Data	Met or Not Met
BCCMHA shall establish measurable outcomes for each department.		
BCCMHA shall create an Agency Dashboard to monitor progress towards established metrics.		
BCCMHA shall establish a process for utilization reviews of services and develop a schedule for utilization reviews of each department.		

Board Approved 12/14/17 – cjh 1/10/18

Executive Leadership Succession Planning

Policy: Succession planning for executive leadership ensures continuity of leadership due to planned or unplanned departures.

Purpose: The objective of succession planning is to ensure that the organization continues to operate effectively when individuals occupying critical positions depart. A succession plan may not include all existing managerial positions and may include positions that are not supervisory or managerial, but instead utilize unique, hard-to-replace competencies.

Position	**Skills Needed**	**Interim Replacement**	**Possible Replacement**
Executive Director	Understanding financial, operational, political, state funding; extensive management experience. Education: Masters or higher in social services, business, public administration or human services	Chief Operations Officer, Chief Clinical Director, or Contract with retired CMH Director Some areas of joint/delegated responsibility until replacement is found could be provided by: Chief Clinical Director, Chief Operations Officer, Clinical Director DD Program Coordinator Clinical program managers	Chief Operations Officer Chief Clinical Director Clinical Specialist DD Program Coordinator Statewide search
Chief Operations Officer (also HR Director and CFO)	Financial operations including software, office operations, business functions; HR knowledge, extensive management experience. Education: Masters in business or public administration	Executive Director to perform some of the duties and oversee delegation of parts of the position Contract with retired CMH CFO SWMBH finance department	Likely to look outside of organization – most likely statewide search
Chief Clinical Officer (also IT director)	Agency planning in conjunction with the Chief Operating Officer and the Executive Director, funding regulations, extensive management experience, extensive EHR, and software	Clinical: Clinical Director or clinical supervisors IT: contract with appropriate vender.	Likely look outside for appropriately credential IT Director.

	knowledge, ability to pull and analyze data. Education: Master's in psychology or related area, 10 years' experience clinical management, IT knowledge and or certification.		
Clinical Director	Funding regulations, program planning and scheduling, diagnostic knowledge, excellent clinical skills and experience; management experience. Education: Masters in psychology or related area, 10 years experience;	Joint responsibility: Clinical Specialist and Clinical Supervisor	Internal staff if possible depending on experience – more likely to look outside of organization (statewide).
DD Program Coordinator/ Case Management Supervisor	Funding regulations, program planning and scheduling, diagnostic knowledge, service coordination with outside groups Education: Masters in psychology or related area	Clinical Director until replacement is found. Some areas of joint/delegated responsibility until replacement is found by the appropriate supervisor and or program managers. Contract with retired DD Manager from CMH System, support from SWMBH.	Internal staff with experience in allied services (i.e., case management, CLS, etc.)
Substance Abuse Services Coordinator	Funding regulations, program planning and scheduling, diagnostic knowledge, excellent clinical skills and experience providing services to the SUD population. Education: Master's in psychology or related experience, CAADC credentialed.	Chief Clinical officer and or Clinical Director until replacement is found.	Internal staff if properly credentialed and experienced. External statewide search.

Board Approved 2/8/2018.