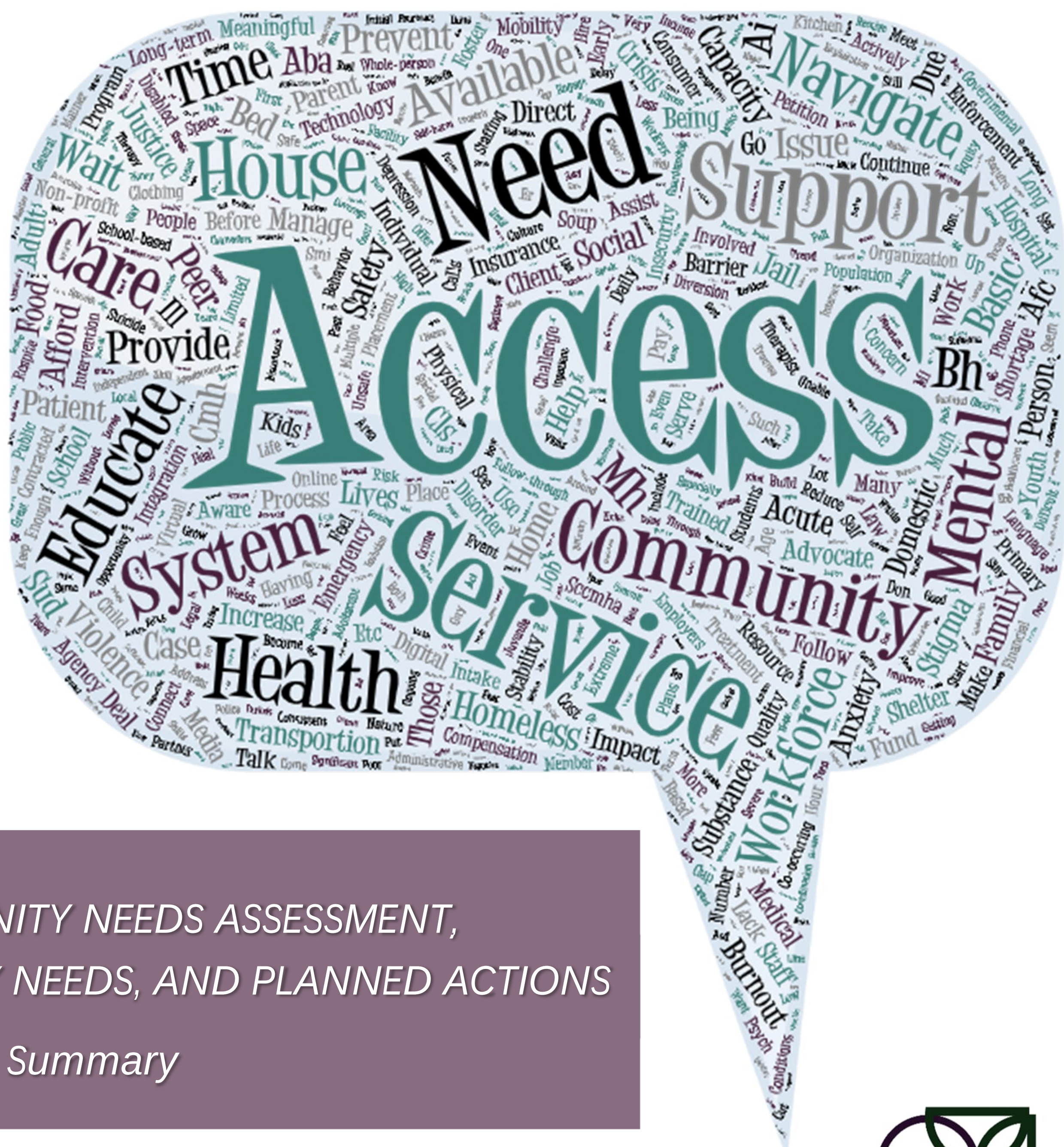
SCCMHA FY2025
MDHHS ANNUAL SUBMISSION



COMMUNITY NEEDS ASSESSMENT,
PRIORITY NEEDS, AND PLANNED ACTIONS

Executive Summary

Submitted by AmyLou Douglas, CIO / CQCO
March 2, 2026

Saginaw County
Community Mental
Health Authority

INTRODUCTION

The purpose of this overview is to provide the reader with a general understanding of the Annual Submission and its function in Michigan's Community Mental Health Service Program's public mental health program planning and policy implementation. An annual submission is required under the Michigan Mental Health Code and the CMHSP contract with the Michigan Department of Health and Human Services. The submission is required by the CMHSPs but not by the PIHPs.

The annual submission cover date is always the year before the submission date, because the CMHSPs are asked to provide data from the previous year. The submission includes specific forms. On alternating years, a community needs assessment is conducted; in the off years, the cycle requires an update of priority planned actions derived from the prior year's needs assessment.

The Annual Submission Reporting Requirements are found in Section 7.8 and Attachment C.6.5.1.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. The related reporting documents are found on the MDHHS Reporting Requirements website.

SUMMARY OF ANNUAL SUBMISSION CONTENT

There are four forms included in the annual submission this year, which are as follows:

ATTACHMENT A: Waiting List

The Mental Health Code, Section 330.1124, requires CMHSPs to establish and maintain waiting lists when all service needs cannot be met. The purpose of this form is to gather information on CMHSPs' use of waiting lists and the people waiting for various types of services.

ATTACHMENT B: Requests for Services and Disposition of Requests

MDHHS will use this report to gather data on service requests and their dispositions. The reporting categories in the CMHSP Assessment section are consistent with the waiting list standards established by The Standards Group (TSG). Additionally, a narrative submission is required to aid in the understanding of the information PROVIDED.

ATTACHMENT C: Community Data Sets Worksheet

The Community Data Sets Worksheet is an annual requirement. It is expected that data will be entered into, saved in the worksheet year-to-year, and used each time the CMHSP conducts a community needs assessment.

ATTACHMENT E: Needs Assessment - Priority Needs & Planned Actions

This form is a template for CMHSPs to use to identify at least five (5) priority needs following completion of the Stakeholder Survey. This is also completed every two (2) years. Based on stakeholder feedback and data collected through the stakeholder survey, the CMHSP must identify the five (5) priority needs. Of these, the CMHSP must identify the areas it intends to address and the actions planned for each.

2024 SCCMHA STAKEHOLDER SURVEY

STAKEHOLDERS

The 84 stakeholders whose feedback was received consisted of the following community partner types:

Type of Community Partner	Qty	Type of Community Partner	Qty
Law Enforcement/Justice System	11	Adult Foster Care	3
MH or BH Services	10	ABA Services	3
Consumers, Parents, & Advocates	10	Direct Care/CLS/Respite Provider	2
Non-Profit Organization	9	Homelessness Services/Soup Kitchen	2
Education System	8	SUD Services	1
CMH Contracted Provider	7	Pharmacy	1
Emergency Services	7	Primary Health Care	1
Social Service Agency	4	Public Health	1
Governmental Agency	4		

SURVEY QUESTIONS & ANALYSIS *(Top 5 responses)*

Question 1: What do you see as being the most significant mental health needs that are not currently being adequately addressed in our community?

Theme	Category	#
Access & Navigation	Service availability & wait times	14
Housing & Basic Needs	Affordable/supportive housing	8
Housing & Basic Needs	Homelessness & shelter access	8
Workforce & System Capacity	Workforce shortages & burnout	6
Crisis & Acute Needs	Emergency/acute stabilization & hospitalization	6

Question 2: From your perspective, what trends have you identified that SCCMHA should be aware of?

Theme	Category	#
Access & Navigation	Service availability & wait times	12
Prevention, Education & Community Support	Social connection, peer & meaningful activities	8
Workforce & System Capacity	Workforce shortages & burnout	5
Youth, Families & Schools	School-based mental health supports	4
Housing & Basic Needs	Homelessness & shelter access	4

Question 3: Based on what you have shared, please identify the top three concerns/priorities. *(three priorities combined)*

Theme	Category	#
Access & Navigation	Service availability & wait times	27
Housing & Basic Needs	Homelessness & shelter access	26
Workforce & System Capacity	Workforce shortages & burnout	23
Access & Navigation	Insurance & affordability	19
Crisis & Acute Needs	Beds, placement & long-term care	16

ANALYSIS: After analyzing all data from the community needs survey and annual assessment, the following top five priority needs were identified.

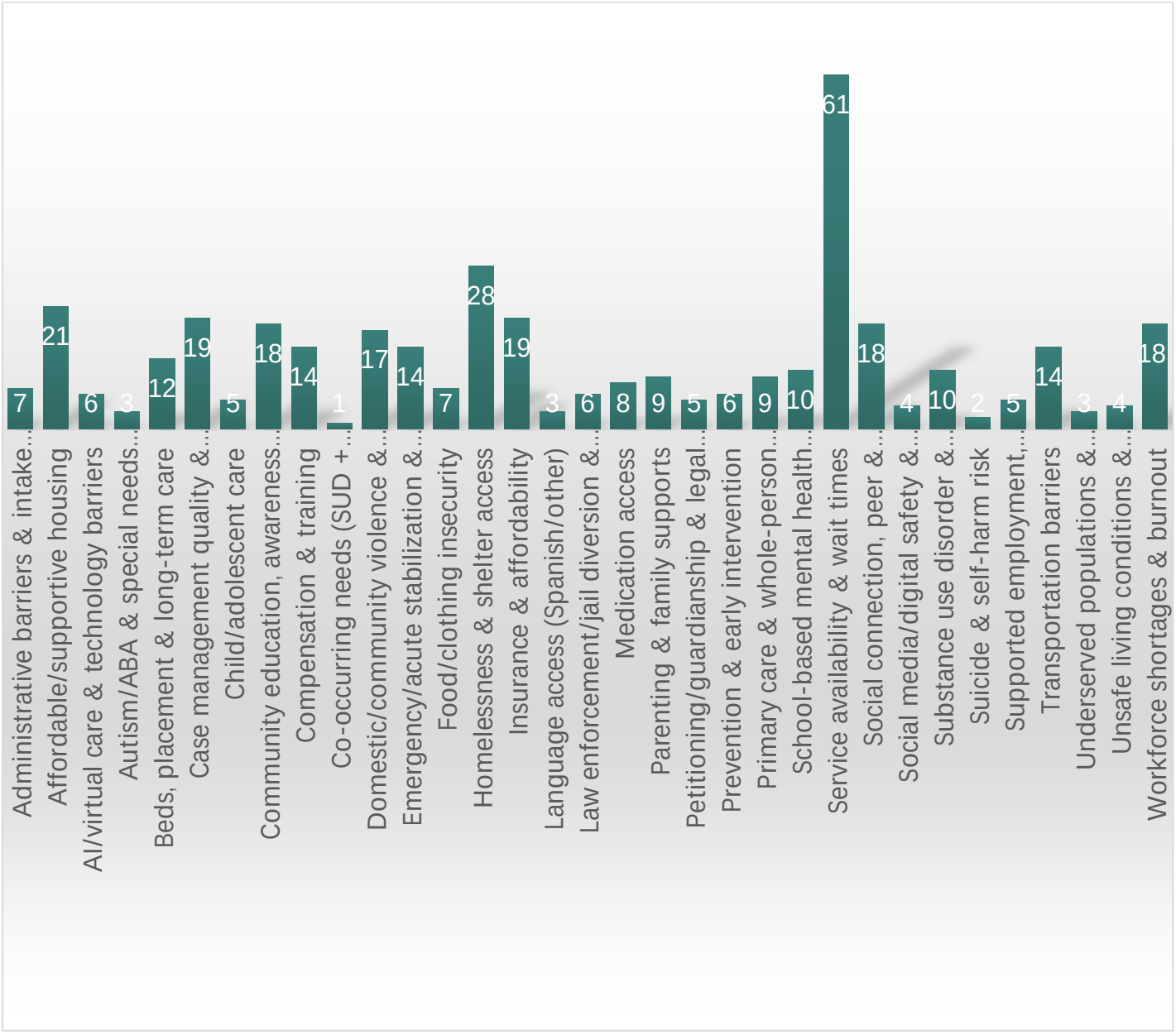
Theme	Category	#
Access & Navigation	Service availability & wait times	61
Housing & Basic Needs	Homelessness & shelter access	28
Housing & Basic Needs	Affordable/supportive housing	21
Workforce & System Capacity	Case management quality & follow-through	19
Access & Navigation	Insurance & affordability	19

PRIORITY ISSUES - SURVEY RESULTS

Based on feedback from stakeholder groups through the community needs assessment survey and on data collected, the CMHSP must identify at least 5 priority needs. Of these, the CMHSP must identify the areas it intends to address and the actions planned for each.

The following needs were identified as the most important to the community.

Priority Issue #1. Access & Navigation - Service availability & wait times
Priority Issue #2. Housing & Basic Needs - Homelessness & shelter access
Priority Issue #3. Housing & Basic Needs - Affordable/supportive housing
Priority Issue #4. Workforce & System Capacity - Case management quality & follow-through
Priority Issue #5. Access & Navigation - Insurance & affordability



PRIORITY ISSUE 1: Access & Navigation - Service availability & wait times

Responses:

1. *Access*
2. *Access to counselors.*
3. *Access to mental health promptly*
4. *Access to mental health resources.*
5. *Access to needed treatments and sufficient dosage of treatment*
6. *Access to social workers and counselors*
7. *Access to TIMELY Care*
8. *aging population*
9. *An increase in need for mental health supports.*
10. *Anxiety / Depression*
11. *Availability of the right resources in the right or best settings*
12. *Client transparency*
13. *Clients are overwhelmed by multiple life stressors, increasing depression and anxiety levels.*
14. *Consistent services are being provided to people served in the network.*
15. *Continued need to screen for anxiety.*
16. *Depression/isolation*
17. *Easily accessible*
18. *Easy access to mental health services for all. Many individuals disconnect if resources are readily available.*
19. *Extremely difficult to maintain continuity of care for those needing ongoing mental health treatment*
20. *From my perspective, SCCMHA is addressing important MH concerns in the community.*
21. *From our perspective as a healthcare provider working directly in the community, we are seeing a high volume of unmet behavioral health needs. Access to timely mental health care remains a significant challenge, with many patients experiencing long delays before they can follow up with a mental health provider or primary care physician, often waiting weeks after a critical mental health event. Earlier and more accessible mental health interventions could help prevent unnecessary emergency department visits and hospitalizations. We also identify a gap in consistent follow-up for patients after acute or crisis-level mental health encounters.*

Additionally, there appears to be a broader need for education related to mental health, emotional intelligence, and available resources. Many patients we serve experience high levels of anxiety, social isolation, and stigma related to healthcare systems. These factors significantly impact social determinants of health and create barriers to engagement in care. From a systems perspective, we have also observed challenges in collaboration among healthcare teams, where personal bias or interpersonal conflict can delay care coordination and negatively impact patient outcomes. Improved interdisciplinary communication and collaboration could meaningfully improve continuity and quality of care for individuals with mental health needs.

22. *Gaps in services*
23. *Healthy, Safe Communication*
24. *Higher needs despite increased access.*
25. *impacts of generational trauma*
26. *Increased funding for mental health to allow more staffing out in the community where the need is, instead of waiting for someone to attend an appointment*
27. *Individuals who need support and fall between gaps for (ALICE assistance populations) and those who struggle to navigate systems to access services.*
28. *Lack of treatment or focus on generational trauma and the impacts it has on the person in their daily lives*
29. *Limited resources.*
30. *Make sure evidence-based treatments for anxiety are readily available.*
31. *Making emergency appointments for medications is literally impossible! Clients wait weeks to get their meds*
32. *Mental health accessibility*
33. *Mental health patients lack continuous access to assistance and ultimately are left to access 911 for evaluation. From there, they aren't followed up on or have timely intervention in an outpatient environment.*
34. *more opportunities*
35. *More services for poor people*
36. *More services in general*
37. *Not enough providers or long waits for service.*
38. *Prioritizing access to all to maintain fairness, while not ensuring sufficient dosage needs based on individual needs*
39. *Programs helping the mentally ill*

40. *Proper handling of mentally ill people who need to be hospitalized for long periods of time.*
41. *Recidivism*
42. *Reduce wait times for those who need to be seen*
43. *Resource availability*
44. *Same as before. Overall, I feel that there are needed improvements in care.*
45. *SCCMHA has shifted its focus from serving the needs of its community to its bottom line.*
46. *SCCMHA is slashing intervention and service hours in an extremely unethical manner.*
47. *services*
48. *Slashing client hours*
49. *Solid counseling that emphasizes growth of the individual at all levels of cognitive development, despite chronological age.*
50. *stress. Need free counselling support to relieve stress.*
51. *The amount of time/meetings required by SCCMHA for an individual to go through before they get the opportunity to start working with a therapist on their mental health issues. It's just too overwhelming for most people who have a mental health disorder. I know this from personal experience with a family member who needed mental health services and just got overwhelmed by the processes required before even working on her mental health issues.*
52. *The increase in disabling anxiety among all ages.*
53. *The needs of people with Mental disabilities are not met when petitioned multiple times*
54. *The number of individuals struggling with anxiety seems to have increased greatly since COVID. With that has come an increase in anxiety-related health concerns (GERD, acid reflux, etc.). Also, the number of individuals reporting firearms in the home seems to have greatly increased.*
55. *To be able to speak like a synth. Heard.*
56. *Treatment*
57. *Treatment and support of those with SMI.*
58. *trend to remove local control*
59. *undiagnosed and untreated bipolar disorder*
60. *While a person is in hospitalization, an initial CMH appointment to start services needs to be done in person or via Zoom before discharge. Otherwise, the person doesn't follow through and disappears.*
61. *You guys are doing a great job.*

Reasons for Priority:

- Significant and growing unmet mental health needs across all ages, particularly anxiety, depression, serious mental illness (SMI), co-occurring substance use, and impacts of generational trauma, resulting in increased crisis events, hospitalizations, and criminal justice involvement.
- Insufficient provider capacity and workforce instability, including shortages of therapists, psychiatrists, case managers, and direct care workers, leading to long wait times, inconsistent services, reduced service hours, and difficulty maintaining continuity of care.
- Barriers to timely, affordable, and appropriate access to care, such as complex intake processes, delays in medication access, lack of Medicaid-accepting providers, transportation challenges, and financial hardship, causing individuals to disengage or rely on emergency services.
- Gaps in care coordination, follow-up, and system navigation, particularly after crisis or hospitalization, resulting in fragmented services, poor transitions to outpatient care, recidivism, and individuals falling through service gaps (including ALICE populations).
- Limited community integration, education, and stigma reduction, including lack of psychosocial and peer-support opportunities, inadequate public awareness of available resources, insufficient cross-system collaboration, and ongoing stigma that discourages individuals from seeking or continuing treatment.

CMHSP Plan Overview

SCCMHA will strengthen access to timely, appropriate mental health services by improving intake efficiency, expanding provider capacity, enhancing care coordination, and increasing community awareness of available resources. Initial efforts will focus on streamlining access points, prioritizing individuals with high-risk and acute needs, and reducing delays following a crisis or hospitalization.

Over the next 12–18 months, SCCMHA will continue our work to simplify and standardize intake and referral processes, including reviewing internal workflows, reducing duplicative requirements, and improving coordination between crisis, outpatient, and community-based services. SCCMHA will continue to assess wait times across service types and use data to guide service prioritization and resource allocation.

The QIP Accessibility Committee regularly monitors Time to Initial Evaluation, Time to Clinical Services, and Time to Crisis Services, so any rise in wait times can be addressed.

To help persons served begin and navigate their services, the QIP Accessibility Committee will develop a Roadmap to Starting Services to answer common questions, clarify processes, and outline what to expect. The goal is to create a more welcoming experience to help people achieve full engagement with services.

To address workforce and provider shortages, SCCMHA will continue to collaborate with network providers and community partners to support recruitment, retention, and service capacity, including exploring alternative service models (e.g., group services, peer support, telehealth where appropriate). Emphasis will be placed on improving continuity of care and ensuring timely follow-up after emergency department visits, hospitalizations, or crisis interventions.

The QIP Best Practices Committee created and monitors a Follow-Up to Hospitalization dashboard to identify individuals who require follow-up and communicate with existing and newly assigned case holders.

SCCMHA will also strengthen care coordination and system navigation, particularly for individuals with serious mental illness, co-occurring conditions, and those at risk of disengagement. This includes reinforcing expectations for timely follow-up, improving cross-system communication, and supporting coordination with primary care, hospitals, law enforcement, courts, and social service partners.

The QIP Outcomes Committee has created a dashboard to monitor faxes marked “unable to be sent” to improve care coordination for document requests and responses.

SCCMHA is exploring opportunities to strengthen and improve care coordination with hospitals and to ensure Adult Foster Care homes provide the necessary and accurate information to the medical profession for the person served during treatment.

SCCMHA works in conjunction with local law enforcement and monitors Court Order Cases to ensure services are delivered, and gaps or lapses are minimized for individuals on a court order. Tools are created to improve care coordination with law enforcement and the courts and to track follow-up.

To address transportation challenges, members of the QIP Accessibility Committee are launching an awareness campaign to help persons served learn how to schedule transportation via their Medicaid Health Plan and easily contact the transportation liaison for assistance.

SCCMHA will improve access to services by strengthening education and navigation support related to Medicaid transportation options. SCCMHA will offer ongoing monthly transportation training sessions to help persons served and case holders understand how to schedule rides through their Medicaid Health Plans, learn about available transportation options, and receive answers to common transportation-related questions. These sessions will be offered at a consistent location and time to promote accessibility and predictability. They will be supported by direct assistance from SCCMHA’s designated Transportation Liaison, who is available to help individuals navigate scheduling challenges, resolve barriers, and connect with appropriate transportation resources. This planned action is intended to reduce missed appointments, improve timely access to mental health and related services, and support individuals’ ability to independently manage transportation needs, particularly for those with limited resources or complex service schedules.

The QIP Accessibility Committee is also working to increase use of the CEHR portal to help reduce service gaps when IPOSs and other documents are awaiting signatures that can now be signed through the portal.

SCCMHA works diligently to remind persons served of their appointment times via phone calls and text messages.

SCCMHA is working to create an external provider orientation notification to assist with care coordination of initial appointments between persons served and case management.

SCCMHA is working with our EHR vendor to implement an external referrals and referral follow-up document and tracking system with primary care providers or specialists to improve care coordination.

In parallel, SCCMHA will expand community education, outreach, and stigma reduction efforts, including clearer communication about how to access services, what supports are available, and how to navigate the system. Efforts will include collaboration with community organizations to increase awareness of mental health resources and promote early engagement in care. Progress will be monitored through ongoing review of access metrics (e.g., wait times, follow-up completion, service engagement) and stakeholder feedback, with adjustments made as needed to improve responsiveness and outcomes.

SCCMHA continues to work within the parameters of the State grant for Veterans' and Military families. This grant allows a Veteran's Navigator to provide resources and education to individuals in the community regarding mental health services in locations and areas where veterans and their family members frequent.

SCCMHA also works with local law enforcement agencies to receive referrals and calls from law enforcement when on duty, so that individuals can be linked to mental health services. In contrast, law enforcement is present with the individual on a call. Mental Health staff provide stabilization and support as needed and requested, either by law enforcement or by the person served.

SCCMHA has hired a Spanish Bilingual Coordinator, whose primary job is to provide outreach and engagement to the Hispanic/Bilingual population in Saginaw County. This individual's job is to reduce the stigma and to assist individuals in navigating the complexities of the mental health system.

PRIORITY ISSUE 2: Housing & Basic Needs - Homelessness & shelter access

Responses:

1. *Building a relationship with the shelters to save beds for MH consumers*
2. *Consumers use the hospital when they lack housing*
3. *Co-occurring SUD and homelessness for mentally ill folks. Lots of shelters are uncooperative with taking in people from mental health treatment.*
4. *Homelessness*
5. *Homelessness*
6. *Homelessness*
7. *Homelessness*
8. *Homelessness*
9. *Homelessness*
10. *Homelessness*
11. *Homelessness*
12. *Homelessness*
13. *Homelessness*
14. *Homelessness*
15. *Homelessness and just because they are homeless does not mean they don't need assistance with their mental illness, or that they are only seeking help for a place to stay.*
16. *Homelessness, lack of safe shelters, and low-income housing for families.*
17. *Homelessness.*
18. *Housing for those individuals with mental health issues who are currently unhoused.*
19. *Housing- shelter*
20. *I know it's already on your radar, but homelessness is becoming a noticeably big issue.*
21. *Lack of shelter space.*
22. *Mental Health needs for those who are homeless or suffering in poverty. Access to mental health resources should be available to everybody in a community.*
23. *More available shelters*
24. *Need more help with placing homeless individuals*
25. *Not enough options for unhoused individuals.*

26. *not getting proper mental health treatment due to homelessness*
27. *Shelter, transportation, and stability*
28. *We can/should be mindful of the challenges mentioned above and intervene whenever possible to avoid the negative outcome of families being evicted and living in cars, shelters, and/or the uncertainty and anxiety of couch surfing.*

Reasons for Priority:

- Rising homelessness and housing instability, including individuals and families experiencing eviction, couch-surfing, living in vehicles, or relying on unsafe or overcrowded shelters, create ongoing uncertainty, stress, and trauma.
- Insufficient availability of safe and appropriate shelter options, particularly for families, low-income households, and individuals with mental health conditions, resulting in unmet basic needs and increased risk to personal safety.
- Barriers for individuals with mental illness and co-occurring substance use disorders, as many shelters are unable or unwilling to accommodate people engaged in mental health treatment, leaving high-need individuals without stable housing options.
- Homelessness significantly limits access to mental health care, with unstable housing contributing to missed appointments, disrupted treatment, and a lack of continuity in care for individuals already experiencing mental health challenges.
- Increased vulnerability of unhoused and high-risk populations amid funding constraints, heightening risks related to safety, health outcomes, and long-term stability when shelter, transportation, and supportive services are reduced or unavailable.

CMHSP Plan Overview

SCCMHA will continue to address homelessness and shelter access by strengthening coordination with housing, shelter, and community partners; improving linkage to supportive services; and prioritizing stability for individuals and families with mental health needs. Initial efforts will focus on mitigating immediate safety risks, supporting continuity of mental health care for unhoused individuals, and reducing reliance on emergency and crisis systems driven by housing instability.

Over the next 12–18 months, SCCMHA will enhance coordination with local shelters, housing providers, and community agencies to improve access to safe and appropriate shelter options, particularly for individuals with mental illness and co-occurring substance use disorders. This includes clarifying referral pathways, strengthening communication between mental health providers and shelter systems, and supporting reasonable accommodations that enable individuals engaged in treatment to access shelter services.

SCCMHA will prioritize outreach, engagement, and follow-up for unhoused and high-risk individuals, with emphasis on maintaining access to mental health services despite housing instability. Efforts will include reinforcing expectations for timely follow-up after crises, emergency department

visits, or hospitalizations, and improving coordination to reduce missed appointments, treatment disruptions, and recidivism. The agency is working to make the Social Drivers of Health Screening mandatory as part of the annual Psychosocial Assessment to ensure that the current needs of persons served are captured, and community coordination and education can occur.

Over 25 years ago, SCCMHA was a founding member of the Saginaw Consortium of Homeless Assistance Providers (SC-CHAP). SC-CHAP was organized as the local HUD continuum of care in accordance with HUD regulations and qualified members for competitive HUD grant opportunities. SC-CHAP is the local collaborative body addressing both homelessness and housing affordability. To support the work at SCCMHA in this space, a dedicated agency unit, the Housing Resource Center (HRC), was established. The HRC is the lead for SCCMHA in housing and homelessness collaboration in Saginaw County.

To address barriers related to transportation and basic needs, SCCMHA will support integration of housing-related supports with mental health services, including coordination around transportation, benefits navigation, and linkage to available community resources. Particular attention will be given to individuals and families experiencing repeated episodes of homelessness or instability.

In parallel, SCCMHA will participate in cross-system planning and advocacy efforts focused on homelessness prevention, shelter capacity, and service sustainability, particularly amid funding constraints. Progress will be monitored through review of service utilization patterns, crisis system involvement, and stakeholder feedback, with adjustments made to improve safety, stability, and continuity of care for unhoused populations.

SCCMHA will continue and formalize weekly, as needed, outreach visits to local homeless shelters to identify individuals in need of mental health services and facilitate timely access to care. SCCMHA's HRC staff conduct regular shelter visits to engage residents, assess needs, and assist with connection to Community Access Intake (CAI). When clinically appropriate, on-site eligibility screenings are completed by licensed staff, enabling immediate initiation of services and reducing barriers related to transportation and system navigation. For individuals requiring additional support, staff assist with referrals to CAI and linkage to other community resources to support stabilization and engagement in services.

This ongoing outreach strengthens early identification, reduces delays in access, and supports continuity of care for individuals experiencing homelessness, particularly those with serious mental illness or co-occurring conditions.

SCCMHA will continue to participate annually in the HUD-required Point-in-Time (PIT) Count, which identifies sheltered and unsheltered individuals experiencing homelessness during the last ten days of January. SCCMHA staff support both daytime and evening counts, including outreach to unsheltered locations such as parks, abandoned buildings, and other places not meant for human habitation.

Data from the PIT Count informs local and federal planning, funding decisions, and system-level strategies to address homelessness. SCCMHA uses this information to better understand trends, service gaps, and the scope of housing needs among individuals with mental health conditions in Saginaw County.

SCCMHA will continue community education and outreach efforts related to homelessness, permanent supportive housing, and access to mental health services. Housing Resource Center staff regularly provide presentations and trainings to internal teams, community partners, service providers, and community groups, including coordinated entry partners and advocacy organizations.

These efforts increase awareness of eligibility criteria, referral pathways, and available housing supports, while strengthening collaboration across systems and reducing stigma associated with homelessness and mental illness.

PRIORITY ISSUE 3: Housing & Basic Needs - Affordable/supportive housing

Responses:

1. *Access to Services/Transportation/Housing/Money Management=Payee Services*
2. *Access to Transportation/Housing Access to Services*
3. *Adequate planning for living situations for individuals who will need it as their families become unable to provide it.*
4. *AFC Homes, it's a money grab... and because it is, people are buying homes in low-income areas for cheap and trying to turn them into AFC homes.*
5. *Affordable housing*
6. *As a resident, I do feel like income-based housing is not adequate. Most subsidized housing has a minimum waiting list right now.*
7. *Consumers not being able to afford housing, even with SSI income*
8. *Housing*
9. *Housing*
10. *Housing*
11. *Housing*
12. *Housing*
13. *Housing*
14. *Housing and transportation*
15. *Individuals and families currently receiving mental health services are facing homelessness at a higher (and alarming) rate compared to previous years, and the availability of safe and affordable housing is also a concern. Application fees, past financial challenges, and family conflict(s) are a few of the barriers.*
16. *Lack of low-income housing.*
17. *Obviously, housing issues are the most significant need. Additionally, many AFCs are very problematic. Major issues are that some AFC homes have too many clients in the house, not enough staff, violent clients are not suitable for the home, and policies that prohibit staff from even following walkaway clients.*
18. *Resources for application fees, deposits, and the first month's rent.*
19. *Resources for low-income families*
20. *Supportive Housing*

21. While this is not a specific "mental health" need, the lack of supportive housing is an issue that is not helping the overall landscape of caring for those living with MI.

Reasons for Priority:

- Increasing housing instability among individuals and families receiving mental health services, with homelessness occurring at higher and more alarming rates than in previous years due to the limited availability of safe and affordable housing.
- Severe shortages in affordable, income-based, and supportive housing, including long waitlists and insufficient low-income options, make it difficult for individuals with mental illness to secure and maintain stable living situations.
- Financial and administrative barriers to housing access, such as application fees, security deposits, first month's rent, past financial challenges, and family conflict, prevent otherwise eligible individuals from obtaining housing.
- Concerning the quality, safety, and oversight of Adult Foster Care (AFC) homes, including overcrowding, inadequate staffing, inappropriate client placement, and policies that limit staff ability to respond to safety or elopement risks.
- Lack of integrated housing supports linked to services, including transportation, payee services, and case management, resulting in increased hospital utilization, disrupted treatment, and poorer mental health outcomes when stable housing is unavailable.

CMHSP Plan Overview

SCCMHA will work to improve housing stability for individuals and families receiving mental health services by strengthening partnerships with housing providers, addressing barriers to affordable and supportive housing, and enhancing coordination between housing and mental health services. Initial efforts will focus on reducing housing instability that contributes to homelessness, hospital utilization, and disrupted treatment for individuals with mental illness.

Over the next 12–18 months, SCCMHA will collaborate with local housing authorities, developers, and community partners to support access to affordable, income-based, and supportive housing options for individuals with mental health needs. This includes participating in cross-system planning efforts, identifying gaps in housing availability, and supporting strategies that prioritize individuals with serious mental illness and those experiencing repeated housing instability.

SCCMHA will address financial and administrative barriers to housing access by strengthening coordination on application assistance, benefits navigation, and linkage to resources that cover application fees, security deposits, and initial housing costs.

Efforts will focus on reducing preventable barriers that delay or prevent housing placement for otherwise eligible individuals and families.

To improve safety and quality of care, SCCMHA will reinforce oversight, coordination, and expectations for Adult Foster Care (AFC) settings, including collaborating with licensing entities and providers to promote appropriate placement, adequate staffing, and responsiveness to safety and elopement risks. Emphasis will be placed on ensuring AFC settings align with individuals' clinical needs and support stability.

The QIP Safety Committee reviews provider trends each month to identify AFC homes that may need additional support or intervention.

In parallel, SCCMHA will strengthen the integration of housing supports with mental health services, including transportation coordination, payee services, and case management, to support sustained housing stability and continuity of care. Progress will be monitored through reviews of housing stability indicators, service utilization trends, and stakeholder feedback, with adjustments made to improve outcomes and reduce reliance on the system. Reviews of housing stability indicators, service utilization trends, and stakeholder feedback will be conducted, with adjustments made to improve outcomes and reduce reliance on the system driven by housing instability.

SCCMHA will maintain active participation in the Saginaw County Consortium of Homeless Assistance Providers (SC CHAP) and the countywide Coordinated Entry system to support equitable and efficient access to housing resources. Through monthly coordinated entry meetings, SCCMHA collaborates with HUD-funded providers to review the Homeless Management Information System (HMIS) priority list and determine appropriate placement based on acuity, chronicity, and program availability.

This coordinated approach ensures individuals experiencing homelessness—particularly those with serious mental illness—are prioritized appropriately for permanent supportive housing, rapid rehousing, or transitional housing, and reduces duplication, fragmentation, and delays in housing placement.

SCCMHA will continue to ensure safe, decent, and sanitary housing for individuals receiving rental subsidies through initial, quarterly, and annual housing inspections conducted by qualified housing inspection staff. Quarterly inspections are conducted in addition to annual inspections to proactively identify maintenance concerns, monitor housing conditions, and support early intervention when issues arise, rather than waiting for annual review.

SCCMHA currently utilizes HUD Housing Quality Standards (HQS) and is actively preparing for HUD's transition to NSPIRE inspection standards, scheduled for implementation on October 1, 2026. SCCMHA has invested in NSPIRE-compatible inspection software and is coordinating across departments to ensure compliance with updated federal requirements, continuity of housing assistance, and minimal disruption to persons served.

SCCMHA will prioritize eviction-prevention efforts for individuals receiving housing assistance by working directly with landlords and program participants to resolve issues before eviction proceedings begin. When housing stability is threatened, staff engage early to support communication, address compliance concerns, and pursue alternatives, such as notices to vacate when appropriate, to prevent formal evictions that would otherwise result in program termination.

When eviction cannot be avoided, SCCMHA ensures individuals have access to available community resources and referrals, with continued emphasis on minimizing housing disruptions and preventing repeat homelessness whenever possible.

SCCMHA has had a HUD-funded permanent supported housing grant for 25+ years. The grant provides tenant-based rental assistance for 70-80 households annually. SCCMHA is currently submitting our funding request to HUD for the second year of our current HUD grant award. The second year of funding for the competitive award will commence on July 1, 2026.

PRIORITY ISSUE 4: Workforce & System Capacity - Case management quality & follow-through

Responses:

1. *ACT for ATOs: lack of AFCs, care coordination for the SMI population, and psychosocial rehab facilities*
2. *Audit issues such as IPOS and other CMH responsibilities should not be counted against providers when case holders don't do their job. They are not our employees, and we shouldn't have to manage them.*
3. *Case Management*
4. *Communication- psych services*
5. *Consistent support from case management - getting IPOS timely & authorizations timely*
6. *Coordination with law enforcement and the courts*
7. *Destigmatization of treatment, availability of treatment providers, & training of service providers in the community to interact with those who are ill*
8. *Educate case managers on the need to connect persons with anxiety to evidence-based treatments beyond medications.*
9. *Failing to follow through promptly with guardianships.*
10. *Follow through by the client after initial engagement*
11. *From my perspective: We need good, qualified DCWs. DCWs should be licensed just like CNAs. There is a need to raise expectations for Direct Care Workers.*
12. *I think SCCMHA should be aware that case holders are not adequately trained. They seem to pass their duties to whoever will take them on, or they do the bare minimum. Therefore, the consumers are falling through the cracks.*
13. *Lack of Care coordination for the SMI population*
14. *Mental health is needed for psychology. We have a huge uptake of our CMH consumers wanting to commit suicide or talk, and case managers reporting back that they have extremely limited resources, and families reporting they feel loss and have no answers.*
15. *More case management involvement*
16. *Patients sent to Saginaw from other communities due to their lack of training*
17. *People served are being provided with services inconsistently due to a lack of retention of direct care workers, i.e., case managers, therapists, etc. Also, a lack of linking of people served to ancillary programs provided by the network.*
18. *Case managers do not properly follow services.*

19. Taking accountability for the actions of their staff

Reasons for Priority:

- Insufficient care coordination for individuals with serious mental illness (SMI), including gaps in ACT/ATO services, limited psychosocial rehabilitation options, lack of appropriate AFC placements, and inadequate coordination across service systems.
- Inconsistent and delayed follow-through by case management, including untimely IPOS development, authorizations, guardianship actions, and service implementation, resulting in individuals falling through system gaps.
- Concerns regarding case manager training, role clarity, and accountability, with reports of inadequate preparation, task shifting, minimal engagement, and failure to connect individuals to evidence-based treatments and appropriate supports.
- Limited system capacity to respond to acute and high-risk needs, including increased suicidal ideation among consumers, insufficient psychiatric resources, strained family supports, and lack of timely intervention pathways.
- Challenges in cross-system collaboration and continuity of care, including coordination with law enforcement, courts, providers, and families, as well as insufficient support for sustained client engagement after initial contact.

CMHSP Plan Overview

SCCMHA will strengthen workforce and system capacity by improving the quality, consistency, and accountability of case management services, with a focus on care coordination for individuals with serious mental illness (SMI). Initial efforts will prioritize reducing service gaps, improving follow-through on required actions, and ensuring individuals receive timely, appropriate, and coordinated supports across service systems.

SCCMHA is reviewing the training that AFC home staff receive to develop and enhance it, better supporting appropriate AFC placements.

Over the next 12–18 months, SCCMHA will reinforce expectations and standards for case management practice, including timely IPOS development, authorizations, guardianship actions, and service implementation. SCCMHA will review internal processes and monitoring practices to identify barriers to timely follow-through and support corrective actions that reduce individuals falling through system gaps.

The QIP Accessibility Committee has created a Case Management dashboard to highlight tasks and documents that are due or overdue, thereby improving follow-through and reducing service gaps.

SCCMHA will support enhanced training, role clarity, and accountability for case managers, with an emphasis on care coordination for SMI populations, evidence-based practices, and effective engagement with individuals and families. Efforts will focus on improving understanding of case

management responsibilities, strengthening linkage to appropriate services, and supporting consistent, person-centered engagement.

After fidelity reviews, the QIP Best Practices committee has teams report back on what they are doing to meet the recommendations, resulting in training for Case Managers on program philosophies, admission criteria, stage-wise interventions, proper documentation, and how to access and utilize data.

To address high-risk and acute needs, SCCMHA will strengthen system capacity to respond to individuals experiencing crisis, including improved coordination with psychiatric services, crisis providers, and families. Emphasis will be placed on timely intervention pathways, follow-up after crisis or hospitalization, and continuity of care to reduce risk, recidivism, and avoidable system involvement.

In parallel, SCCMHA will enhance cross-system collaboration and communication, including coordination with law enforcement, courts, providers, and community partners, to support continuity of care and shared accountability. Progress will be monitored through review of care coordination indicators, timeliness of required actions, service engagement, and stakeholder feedback, with adjustments made as needed to improve system performance and outcomes.

SCCMHA works with local and State Universities to provide an array of internship and learning opportunities for individuals seeking both bachelor's and master's level degrees. SCCMHA also offered state-funded internship stipends to attract applicants. This has encouraged and increased the number of Bachelor's and Master 's-level applicants applying for vacant positions to meet current workforce needs. SCCMHA offers student loan forgiveness through state and Federal funding to attract new applicants.

PRIORITY ISSUE 5: Access & Navigation - Insurance & affordability

Responses:

1. *Access to care for Medicaid patients/families*
2. *Accessing affordable healthcare*
3. *Affordability*
4. *Affordable Elder Care*
5. *Among my caseload, there is the challenge of financial shortages, social programs being discontinued that have previously assisted clients. These extreme physical health challenges have impeded Client's ability to work and provide for their families, resulting in insurance lapses.*
6. *Appropriate dosage of services based on needs and not financial costs*
7. *Barriers to cost*
8. *Cost of services for families, especially those who are uninsured.*
9. *Educating patients on how to access/utilize insurance benefits*
10. *Fears of losing health coverage*
11. *Fewer students are accessing support due to costs and lack of insurance. It is also harder to get parents to understand the need for support for their students.*
12. *Financial challenges hinder the Client's ability to continue receiving Mental Health services.*
13. *Funding*
14. *Increasing financial costs for supply with minimum or no income*
15. *Insurance coverage*
16. *Insurance Coverage, Bed availability, Resource sharing, Advocates*
17. *Lack of insurance*
18. *Support for under- or uninsured residents.*
19. *Therapy Coverage for NON-ASD clients*

Reasons for Priority:

- High numbers of underinsured and uninsured individuals and families, resulting in delayed or forgone mental health services due to lack of coverage, fear of losing benefits, or insurance lapses tied to income instability and health challenges.
- Cost-related barriers to accessing care, including unaffordable therapy services, limited coverage for non-ASD treatment, and out-of-pocket expenses that disproportionately impact low-income families, students, and those relying on SSI.

- Limited access to providers who accept Medicaid or offer adequate coverage, restricting timely and appropriate care for Medicaid-eligible individuals and families and contributing to unmet mental health needs.
- Insufficient understanding and navigation of insurance benefits, with a need for education and advocacy to help individuals and family access, utilize, and maintain available coverage and resources.
- Broader financial instability affecting basic needs, including housing affordability, discontinued social support programs, and reduced service capacity, further compounding mental health challenges and limiting continuity of care.

CMHSP Plan Overview

SCCMHA will improve access to mental health services by addressing insurance-related and financial barriers that prevent individuals and families from obtaining timely, appropriate care. Initial efforts will focus on supporting individuals who are underinsured or uninsured, reducing cost-related obstacles to care, and improving navigation of available benefits and resources.

CCBHC services are available to any person in need, including but not limited to those with serious mental illness, serious emotional disturbances, long-term chronic addiction, mild or moderate mental illness, and substance use disorders. Any person with a behavioral health diagnosis is eligible for CCBHC services. All persons are entitled to walk into CCBHC clinics and be screened for service eligibility. CCBHC clinics must serve all individuals regardless of residency or ability to pay. For individuals residing out of state, CCBHC clinics are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services. They should have protocols in place to coordinate care across state lines. CCBHCs offer a sliding fee scale for uninsured or underinsured individuals.

The Ability to Pay/Sliding Fee Discount Program is a Federal program that allows Saginaw County Community Mental Health to discount our normal charges on services provided. The Federal Poverty Guidelines are used to determine eligibility for the Sliding Fee Discount Program. Eligibility is determined by household size and annual gross income. (Net income for self-employment) for the household, completed application, and proof of income.

Over the next 12–18 months, SCCMHA will strengthen coordination with network providers and community partners to support access to services for Medicaid-eligible, underinsured, and uninsured individuals. This includes promoting service options that reduce out-of-pocket costs, supporting continuity of care for individuals experiencing insurance lapses, and identifying strategies to improve provider participation where coverage limitations restrict access.

SCCMHA will enhance education, navigation, and advocacy related to insurance benefits, including clearer communication about available coverage, eligibility requirements, and how to access and maintain benefits. Efforts will focus on supporting individuals and families in understanding their options, reducing fear of benefit loss, and improving successful utilization of covered services.

The QIP Accessibility Committee reviews the Insurance Monitoring dashboard to track the number of individuals who are insured, underinsured, and uninsured, as well as those who are CCBHC, while ensuring they have active consents. The Accountability Committee assists by monitoring the Unsigned Documents dashboard to ensure timely billing to Medicaid and Third-Party Billing.

To address broader affordability challenges, SCCMHA will support the integration of financial and basic needs assistance with mental health services, including coordination on benefits navigation, housing affordability resources, and linkage to available social supports. Particular attention will be given to populations disproportionately impacted by cost barriers, including low-income families, students, and individuals relying on SSI.

In parallel, SCCMHA will monitor trends related to insurance coverage, service access, and affordability, using available data and stakeholder feedback to identify gaps and inform ongoing system improvement efforts. Progress will be reviewed through assessment of service engagement, continuity of care, and reported access barriers, with adjustments made as needed to improve equity, access, and outcomes.

The QIP Best Practices Committee is working on tip sheets for Supported Employment to help individuals prepare for the workforce and understand what is needed to enter it. These sheets will also help individuals navigate their benefits. Assisting individuals with gaining employment may help them acquire better insurance through their employers.

SCCMHA is working to improve the coordination of benefits so persons served who are insured can be appropriately matched to providers that accept their insurance.

Additional themes and categories

Theme	Category	#
Access & Navigation	Service availability & wait times	61
Housing & Basic Needs	Homelessness & shelter access	28
Housing & Basic Needs	Affordable/supportive housing	21
Workforce & System Capacity	Case management quality & follow-through	19
Access & Navigation	Insurance & affordability	19
Prevention, Education & Community Support	Community education, awareness & stigma	18
Prevention, Education & Community Support	Social connection, peer & meaningful activities	18
Workforce & System Capacity	Workforce shortages & burnout	18
Safety, Violence & Justice	Domestic/community violence & safety	17
Workforce & System Capacity	Compensation & training	14
Crisis & Acute Needs	Emergency/acute stabilization & hospitalization	14
Transportation & Mobility	Transportation barriers	14
Crisis & Acute Needs	Beds, placement & long-term care	12
Youth, Families & Schools	School-based mental health supports	10
Substance Use & Co-occurring	Substance use disorder & treatment access	10
Youth, Families & Schools	Parenting & family supports	9
Physical Health Integration	Primary care & whole-person integration	9
Access & Navigation	Medication access	8
Access & Navigation	Administrative barriers & intake process	7
Housing & Basic Needs	Food/clothing insecurity	7
Digital/Technology Impacts	AI/virtual care & technology barriers	6
Safety, Violence & Justice	Law enforcement/jail diversion & training	6
Prevention, Education & Community Support	Prevention & early intervention	6
Youth, Families & Schools	Child/adolescent care	5
Crisis & Acute Needs	Petitioning/guardianship & legal process	5
Employment & Daily Living Supports	Supported employment, programming & independent living	5
Digital/Technology Impacts	Social media/digital safety & online exploitation	4
Housing & Basic Needs	Unsafe living conditions & accessibility	4
Developmental Disabilities & Specialized Services	Autism/ABA & special needs services	3
Equity, Culture & Language Access	Language access (Spanish/other)	3
Equity, Culture & Language Access	Underserved populations & disparities	3
Crisis & Acute Needs	Suicide & self-harm risk	2
Substance Use & Co-occurring	Co-occurring needs (SUD + MH/SDOH)	1

Additional Responses:

1. *1. Lack of availability of services for ABA, Speech, and occupational therapies. 2. Kids being kicked out of school and schools not following IEPs.*
2. *1. Lack of availability of services for ABA, Speech, and occupational therapies. 2. Kids being kicked out of school and schools not following IEPs.*
3. *A person who wants help to address their mental health disorder has to have two lengthy meetings at SCCMHA (Screening & Assessment) before they even get to meet with a therapist to start their journey to healing. Then, when or IF they get referred for services, their first appointment with their therapist is a two-hour meeting spent documenting and addressing all of SCCMHA's requirements within the consumer's record. After all of that, it's not until the 4th appointment (2nd one with the therapist) that they can really begin working on their mental health issues.*
4. *A person who wants help to address their mental health disorder has to have two lengthy meetings at SCCMHA (Screening & Assessment) before they even get to meet with a therapist to start their journey to healing. Then, when or if they get referred for services, their first appointment with their therapist is a two-hour meeting spent documenting and addressing all of SCCMHA's requirements within the consumer's record. After all of that, it's not until the 4th appointment (2nd one with the therapist) that they can really begin working on their mental health issues.*
5. *A space for parents/family members of those with IDD/DD to gather together to build natural supports. people who know the educational/IEP system well enough to advocate in person with our families to ensure schools are following the laws.*
6. *A space for parents/family members of those with IDD/DD to gather together to build natural supports. people who know the educational/IEP system well enough to advocate in person with our families to ensure schools are following the laws.*
7. *Access to affordable medications and council.*
8. *Access to medical care/medications*
9. *Access to mental health and medications.*
10. *Access to online content and sending content*
11. *Access to Primary Care Physicians*
12. *Access to simple and accessible virtual mental health support for elderly patients who are mostly homebound. Trying to remove the technological barriers of a lack of devices or setup for easy access.*
13. *Acute Psychosis is becoming more prevalent with the epidemic of Methamphetamine use!*
14. *Adolescent care and jail diversion*

15. *Adult care for individuals with severe physical disabilities.*
16. *AFC Homes*
17. *Affordable medications.*
18. *AI takes over*
19. *AI, people are using it as a substitute for therapy.*
20. *Announcements about mental health are real, and there is help.*
21. *As a 1099 partner, CMH should pay for our liability insurance as their patients are the liability.*
22. *As stated, our CMH does a great job and is aware of what is going on in our community.*
23. *Assaultive behavior in general*
24. *Availability of treatment providers of all kinds*
25. *Bed Availability*
26. *Beds*
27. *Behavior Management and Support*
28. *Better pay for individuals providing the supports in homes and programming*
29. *bipolar is a much more prevalent diagnosis, and anxiety and depression are growing in our school population*
30. *Burnout, isolation, overload in caregivers and helpers*
31. *Clients in need of petitioning for mental health treatment.*
32. *CLS services for individuals living independently.*
33. *Community Program- To address mental health education, social determinants of health, and in-home barriers that impact getting care*
34. *Community resource sharing*
35. *Community Violence/Exposure to domestic violence, (1) Social media safety. (2) Self- Harm talk (3) Domestic violence.*
36. *Compromised individuals not connecting with community resources as needed in the optimal setting. "Connecting the dots" for those in need of services.*
37. *Continued support of the homes that care for residents living there.*
38. *Continuing consumer services & family support*
39. *Crime mentality*

40. *Crisis Home, stabilization. We had a guy break windows, cut himself, and was sent back home.*
41. *Crisis Mobile Team that can go into a person's home to do assessments/Mental Health Court*
42. *Depression and anxiety are very prevalent. We need more counselors and psychiatrists, as well as training for primary care providers.*
43. *Destigmatization of getting treatment*
44. *Destigmatizing mental health, having mandatory mental health days for employees/students, and offering more support groups for trauma victims*
45. *Disconnectedness*
46. *Disconnection between clinical care and community/faith-based support*
47. *Domestic violence*
48. *Domestic Violence; grandparents as guardians; extreme anger from kids; Community Violence, grief (loss to violence), Parenting Classes/Approaches, transportation issues, persistent neglect, homelessness. Domestic Violence, social media/digital safety (and the risk of those things). They need to have their phones on in school. Community Violence, unsafe neighborhoods, substance abuse, Domestic Violence, and aging grandparents who are guardians of their grandchildren. Secondary: effects of social media/ digital media with access to the world events every moment, and often in real time. Phones in school. Parent education (all aspects — teaching parents how to parent, screen time, school information, attendance & importance of being in school, involvement in child's education) Anxiety Navigating the mental health system - it's not friendly, and people need support making these connections Warning signs of teenage depression Access to counseling (waitlists are a barrier)*
49. *Drastically reducing medications sometimes without feedback from the people who observe the person served' s behaviors daily.*
50. *Drastically reducing medications, sometimes without feedback from the people who observe the person served's behaviors daily.*
51. *Drastically reducing medications, sometimes without feedback from the people who observe the person served's behaviors daily.*
52. *Drug use*
53. *Drug use and mental health connection*
54. *Early Intervention*
55. *Early intervention with normalizing mental wellness*

56. *Educate officers on how to interact during a mental health crisis*
57. *Educating the community on resources that exist - and using consistent messaging across ALL partner agencies*
58. *Educating the parents, family members*
59. *Education*
60. *Elderly/nursing home with behavioral issues and some mental health issues, along with significant medical issues*
61. *Emergency medical care for extreme mental health issues! Places to get medications prescribed immediately, rather than waiting weeks for an appointment.*
62. *Encourage employers and schools to offer mental health days*
63. *Enhanced collaboration with community providers*
64. *Extension of crisis services at MyMichigan Saginaw*
65. *Feelings of loneliness/disconnection from community; social media use likely to increase depression and anxiety in youth and adults*
66. *Follow up for patients who lack access to transportation and who have little access to primary or mental care.*
67. *Food*
68. *Food and clothing*
69. *Food insecurity*
70. *Food insecurity*
71. *Food insecurity, self-harm talk, parental absence (one or both parents are not involved in their life). Anxiety causes students not to come to school or causes them to want to go home early. Food insecurity, hyper sexualization at a young age (more kids know way too much or are doing too much), self-harm talk, cyber safety, parental absence, persistent neglect Students are experiencing food insecurity at home that the school is not able to alleviate, and often experience long periods of time without running water, electricity and are taught what happens at home stays in the home. "Don't talk about it." A high number of students are actively talking about suicide or suicide attempts. A high number of students with pervasive anxiety is making it difficult to get students into the building or to stay in class. Reactive nature of SCCMHA programming - need to partner with schools to be preventative. Increased aggression, anxiety, and anger (especially in younger children), limited coping skills*
72. *Funding*
73. *Guardianship*

74. *Having a space not in the ER to help those who are escalating but do not need inpatient care*
75. *Having activities and events for clients.*
76. *Having been in the field of working with individuals and families who are affected by MI and SUD, I will say that SCCMHA has done a wonderful job of responding to the trends, the ebb and flow of these issues over the years.*
77. *Health services*
78. *Hiring and keeping direct care workers*
79. *Hiring and keeping RN's*
80. *Homeless and juvenile mental health- some juveniles need to be placed in a secure facility to receive appropriate care and supervision.*
81. *Housing- we tend to have a difficult time finding placement for consumers*
82. *How to get people to engage before committing a crime.*
83. *I am not sure if there is a mental component or not, but we have far too much domestic violence and assaultive behavior in general.*
84. *I believe our CMH does an excellent job of addressing our community's mental health needs; however, it seems that there are far too many crimes committed by individuals who need services.*
85. *Inpatient adolescent care*
86. *An increase in depression and anxiety for students*
87. *Increased mental health needs to deal with national events and the lack of reliable basic needs being met*
88. *Increased presence of providers and supports/resources in partner facilities that provide education and employment services*
89. *Increasing numbers of individuals who need/could benefit from supported employment opportunities. Increase in individuals who are disconnected from education and/or employment due to mental health concerns that need to be addressed.*
90. *Increasing numbers of patients in the ED with mental health complaints due to them not having any resources or anywhere to go. They are looking for any placement, SUD, or MH to have shelter.*
91. *Indoor space for them to mingle that meets the needs for sensory issues*
92. *Inpatient treatment facilities*
93. *Intensive social work support and behavioral management/strategies for students*

94. *Intervention and assistance services are not available enough.*
95. *Jail diversion*
96. *Juvenile violence*
97. *Kids being kicked out of schools.*
98. *Lack of community education.*
99. *Lack of direct care or CLS for individuals living independently.*
100. *Lack of funds to provide services in schools*
101. *Lack of natural supports*
102. *Lack of planning for clients with severe physical disabilities, as families who care for them are aging and will be unable to provide care in the future. Also, the number of severely physically challenged individuals is increasing, and planning care for them is behind.*
103. *Lack of provider availability for service delivery*
104. *Lack of providers*
105. *Lack of providers*
106. *Lack of providers*
107. *Lack of psychosocial opportunities for the SMI population*
108. *Lack of quality therapists in the area who accept Medicaid*
109. *Lack of regard for the value of life*
110. *Lack of retention of good employees providing direct care services to people served.*
111. *Lack of social integration opportunities*
112. *Lack of training at jail, lack of understanding, or training at jail*
113. *Lacking sufficient space for crisis care and residential stabilization*
114. *Fewer opportunities, such as programming work/volunteer opportunities, have been offered since COVID. Physically disabled, especially being provided with fewer opportunities*
115. *Less bureaucracy in systems to get people where they need to be*
116. *Limited friendly relationship. low self-esteem*
117. *Long-term care and treatment*
118. *Long-term treatment, especially if addictions are also involved*
119. *Mental health amongst our youth is also extremely important. The teens in our community are its future, and the stigma for needing mental help must be improved upon.*
120. *Mental health issues leading to criminal system involvement*

121. *Mental health relationship with the police*
122. *Mental stress and fear*
123. *More difficult to hire and keep qualified workforce members*
124. *More disability-friendly parks/playgrounds*
125. *More help is needed for poor people and for those who speak another language, such as Spanish.*
126. *More opportunities are needed for residential stabilizing care*
127. *More Spanish-speaking staff*
128. *More things to do for people with mental health issues to interact with others/peers of the same mindsets/developments/abilities.*
129. *More violent people*
130. *Need more Mental Health Secure Facilities for both adults and juveniles*
131. *Needing transportation, needing case management services due to poverty, and the inability to pay bills*
132. *Needs from non-ASD consumers. Families who need support for kids with other diagnoses.*
133. *No place to put people with mental disabilities for longer than 48 hours*
134. *Not a lot of options for outside activities for those with disabilities*
135. *Not enough mental health therapists to provide therapy services to those in need, nor is it affordable*
136. *Not enough resources for co-occurring SUD*
137. *Number of beds and resources for those hospitalized.*
138. *Number of therapists available to provide services*
139. *Ongoing care for those diagnosed and treatment initiated. People are determined to drift away from prescribed care plans, and then an eventual crisis event ensues*
140. *Orientation of new case managers does not include visits to site-based ancillary programs to educate themselves on the array of services offered.*
141. *Our CMH does a great job; the issue I see is that people in need don't engage until they are required to, such as after committing a crime.*
142. *Our community benefits from a highly dedicated and resilient mental health workforce that continues to meet growing and increasingly complex needs despite staff shortages.*
143. *Overuse of technology / social media*
144. *Parental education and involvement*

145. *Partial hospitalization and psych ER*
146. *People are not kind to each other. Personal support is limited.*
147. *People don't have transportation*
148. *Persons served have access to basic needs, such as winter boots and coats, in freezing temperatures.*
149. *Petitioning*
150. *Phone spam*
151. *Physical Health challenges that are making life virtually unmanageable.*
152. *Police Brutality/Not knowledgeable to deal with person w/Mental Health conditions/Need more training*
153. *Positive trend: Continued efforts to reduce stigma around seeking help. Concerning: Difficulty finding support for patients with high needs and for patients without a support system.*
154. *Preventative support before a crisis.*
155. *Prevention methods (trainings, awareness, and stigma) and connecting the community to existing resources*
156. *Prevention training and awareness campaigns such as MHFA, Wellbeing, Developmental Assets, Confidence, etc.*
157. *Programming and work/volunteer opportunities for adults that will help individuals with self-esteem*
158. *Psych support for peds*
159. *Public conversations and reduced stigma. People are talking more openly about mental health than ever before. I believe this helps make it easier for people to admit they need help and take the first step.*
160. *Qualified staff will provide the services due to the continued staffing shortages.*
161. *Recidivism of hospitalizations*
162. *Reducing stigma/barriers to support/care and services*
163. *Reimbursement for OT pay*
164. *Resistance from PCP to schedule appointments promptly.*
165. *Resources*
166. *Safe communities for all, including immigrants, LGBTQ+, etc.*
167. *Safety of people in the community*

168. *Safety of Person Served*
169. *The safety of unhoused and high-risk populations is at risk as funding for services is cut/reduced.*
170. *Saginaw is a resilient community.*
171. *Scam calls are filling people's phones. People stop answering due to constant calls, voicemail boxes filling up, and medical teams being unable to reach patients in time with important updates.*
172. *SCCMHA is finding ways to assist providers with staffing shortages rather than making the situation worse by paying clinicians more than providers can afford.*
173. *SCCMHA has created administrative barriers that hinder community partners' ability to provide good mental health services.*
174. *SCCMHA has created administrative barriers to timely access to mental health services.*
175. *SCCMHA hiring provider staff is not helpful to the provider's ongoing staffing shortage. SCCMHA can pay more than the providers, which continually puts the providers at a disadvantage.*
176. *SCCMHA partners with the ISD to provide more access to schools, On-site workers/support/wrap-around services, and parent education/ involvement*
177. *SCCMHA requires too much training time for staff, which is unbillable time for clinicians. SC does not consider this because they do not have the same financial constraints as providers.*
178. *Secondary support systems for those without family/friend support*
179. *Set up more support groups, not just for recovery*
180. *Showing or sharing bad things. Sad and in pain. Because of their actions on social media.*
181. *Significant mental health needs include depression, anxiety, trauma, and grief. These are exacerbated by financial challenges, Physical Health needs, past traumatic experiences, and difficulties with managing the loss of close loved ones.*
182. *Skill-based programs, such as Clubhouse, help consumers struggling with their mental health get out of the house and work on goals to improve their lives and enrich the community as a whole.*
183. *So much depression, anxiety, bipolar, and SUD. It feels like there is more than we have counselors for, and primary care needs more education about caring for these diagnoses because we don't have enough psychiatrists for everyone, either.*
184. *Social media safety, Food insecurity, community violence (lots of kids have lost family members this way), homelessness*

185. *Some behavioral issues are misunderstood by others in the community*
186. *Some do not have the funds to participate in activities they would like to do, and some cannot always fund activities*
187. *space/programs for people to build natural supports*
188. *Staffing for inpatient psych*
189. *Staffing Shortage*
190. *Stigma*
191. *Students have access to supportive, trained adults*
192. *Substance use*
193. *Substance use disorder*
194. *Substance Use Disorder accessibility*
195. *Substance use disorder paired with mental health*
196. *Substance use in teens, access to therapy if parents deny, technology, and use of exploitation /sexting, ADHD, and parent divorce*
197. *SUD is still a concern*
198. *Suicidal ideation when law enforcement is involved, having trained officers*
199. *Support for multiple visits across multiple modalities (in-person, virtual, hybrid, etc.).*
200. *Support for students by mental health practitioners, not school counselors.*
201. *Supporting students with depression and anxiety*
202. *Technology*
203. *Teen/Tween social media influence. There is a need for support in schools, especially elementary and middle schools. Funding for after-school programs to keep kids out of trouble and engaged in positive activities.*
204. *When the police are called, note that they have not been trained to deal with a person with Mental Health conditions.*
205. *The county jail is being used as a mental health facility*
206. *The start of mental health services is while in a mental health hospital.*
207. *There are not enough places for Spanish-speaking people.*
208. *There could be more activities outside of the home that are set up for this population, such as parties and picnics, where all involved are aware of and knowledgeable about those with mental disabilities*

209. *There is an emphasis on early intervention supported by technology to improve timely access to care.*
210. *There is a shortage of licensed therapists in the Saginaw area. Waiting lists are weeks out.*
211. *There is inadequate long-term care available for people with extreme mental health disorders*
212. *Those who need increased treatments, but do not need inpatient care*
213. *Those with mental health issues getting transportation*
214. *Those with mental health issues suffering from SUD*
215. *To speak without being judged*
216. *Too much hate and how to deal with hate coming from national officials.*
217. *Training and resources for first responders*
218. *Training at local hospitals*
219. *Training service providers in the community to interact with those who are ill*
220. *Transportation*
221. *Transportation*
222. *Transportation*
223. *Transportation*
224. *Transportation*
225. *Transportation*
226. *Transportation*
227. *Transportation access to services*
228. *Transportation for individuals who are non-drivers.*
229. *Transportation services*
230. *Trust*
231. *Uptake in suicide concerns with limited support or direction for providers to help support parents and guardians.*
232. *We are seeing several gaps that significantly impact patient care and mental health in our community. One major issue involves communication and technology barriers. Many patients receive an overwhelming number of phone calls from Medicare Advantage plans, care coordinators, loan services, and other agencies. As a result, voicemail boxes often become full, and patients grow accustomed to ignoring phone calls altogether. This makes it difficult for healthcare providers to reach patients for follow-up and care coordination,*

and it is largely unaddressed. We are also seeing ongoing concerns with Adult Foster Care (AFC) homes. Inconsistent oversight has led to unsafe living conditions, including utility shutoffs, limited transparency in financial control by AFC homeowners, and unmet basic health and safety needs. These situations directly affect patient health and well-being. Access to wound care supplies remains a challenge, often delaying healing and increasing the risk of complications. Housing conditions are another concern. We frequently encounter apartment complexes that do not provide reliable heating in the winter or air conditioning in the summer, which negatively impacts both physical and mental health for vulnerable individuals. Lastly, there are no consistent community resources available to assist with home accessibility, such as wheelchair ramps. As a result, some patients, including those living in Amigo's housing, have been unable to leave their homes for extended periods of time, contributing to isolation, delayed medical care, and declining mental health.

233. *What is LE supposed to do after we petition someone multiple times and they still get released, and we have to deal with them*
234. *When you petition someone multiple times, they still get out within 48 hours, and you keep having to deal with them.*
235. *Widespread crisis management and support within the community. The stigma and mistreatment of folks with mental health issues as they navigate the emergency care system.*
236. *Workforce capacity*
237. *Workforce shortage and burnout in MH providers, shifts from "silence" to "storytelling," tech-driven support, and increased focus on early prevention, especially in youth*
238. *Youth violence*

Attachment A: Waiting List Report

SCCMHA uses the wait list when insufficient mental health General Fund (GF) revenues are available to serve non-Medicaid consumers. The SCCMHA Intake Department balances each individual's needs with program capacity using a severity scale. The person's need for services is ranked on a severity scale of 1-5, with one being the least severe and five being the most severe. Any non-Medicaid-eligible client with a severity scale of 5 is presented to our Entitlements Supervisor for approval/exception to begin services based on need. Additionally, when a person served asks to be removed from the waitlist, they are given a list of alternative providers in our community to utilize. As a Certified Community Behavioral Health Clinic (CCBHC), SCCMHA has expanded our service delivery to accommodate persons meeting criteria for services in the mild-to-moderate population and with private and/or dual insurance. The Ability To Pay (ATP)/ Sliding Fee Scale was implemented once SCCMHA became a CCBHC, and this form is completed for each person seeking services to ensure that any charges that persons seeking services would incur would be based on their income, household size, and type of service they received. If approved for the Sliding Fee discount program, persons are notified via letter stating the details of their financial responsibility for services received.

Reporting Period: October 1, 2024, to September 30, 2025

Program Type	MI Adult	DD	SED	Total
Targeted CSM/Supports Coordination				
Specify all HCPCS and CPT Codes included in this category here:				
Number on waiting list as of the date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during the time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Intensive Interventions/Intensive Community Services				
Specify all HCPCS and CPT Codes included in this category here:				
Number on waiting list as of the date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during the time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0

Clinic Services				
Specify all HCPCS and CPT Codes included in this category here:				
Number on waiting list as of the date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during the time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Supports for Residential Living				
Specify all HCPCS and CPT Codes included in this category here:				
Number on waiting list as of the date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during the time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0
Supports for Community Living				
Specify all HCPCS and CPT Codes included in this category here:				
Number on waiting list as of date above	0	0	0	0
Added during the time period covered	0	0	0	0
Removed during the time period covered- service provided	0	0	0	0
Removed during time period covered - all other reasons	0	0	0	0
Number left at the end of the time period covered	0	0	0	0

Attachment B: Report on the Requests for Services and Disposition of Requests

NARRATIVE 1:

Provide a brief description of how the CMHSP collects and maintains the data reported on this form.

SCCMHA uses several data warehouse reports (Screening Calls, Claims Cube, Eligibility Screens, Not Eligible for Service, Wait List) developed by our I.T. Team to assist in calculating the data reported on the form.

NARRATIVE 2:

Briefly describe the process by which the CMHSP determines eligibility [e.g., per use of assessment instrument (ID name), per telephone screen, or face-to-face assessment or combination, etc.].

SCCMHA Central Access & Intake Worker and Hospital Diversion Specialist and/or Family Guide Representative will conduct eligibility screens either over the telephone or "face-to-face" with the person seeking services, obtaining pertinent information regarding the person's current challenges and situations. The eligibility screen is a tool used to identify persons' needs, and this is documented within the Sentri electronic health record. The Intake Worker and Hospital Diversion Specialist will complete the initial orientation form with the person served and/or guardian and will also identify the person's needs through the initial psychosocial assessment. Intake Worker and Hospital Diversion Specialist will obtain needed documentation and signatures. Intake Worker and Hospital Diversion Specialist will conduct necessary assessments: LOCUS/CAFAS/PECFAS/DECA/SCQ/M-Chat/PHQ-9/Trauma Screen/MichiCANS, as applicable, with the person seeking services to assist in determining eligibility. These assessments are completed according to services requested and specific population types.

NARRATIVE 3:

Provide a brief, clear, and easily understood narrative that describes noticeable trends and the CMHSP's response to them. If trends indicate an increased demand for services, explain how the CMHSP plans to manage this demand moving forward. If changes in eligibility rules result in termination of services to current enrollees, include this information.

With the implementation of CCBHC, SCCMHA has experienced increased community demand for services. SCCMHA has noticed this occurs for both adult and child populations. In an effort to meet these needs, SCCMHA is working to stabilize our workforce and increase the level of staffing to ensure all persons eligible for services are able to be treated according to timely compliance standards. SCCMHA is working to improve efficiency with the eligibility process to ensure persons are being connected to services in a timely and accommodating manner.

Report on the Requests for Services and Disposition of Requests

Period: October 1, 2024, to September 30, 2025

Row	CMHSP Point of Entry-Screening	DD	MI Adult	SED	Unknown / All Others	Total
1	Total # of all people who telephoned or walked in with any request	465	1815	779	0	3059
2	Of the # in Row 1 (all people who telephoned or walked in), total # of people referred out due to non-mental health needs	3	63	91	0	157
3	Of the # in Row 1 (all people who telephoned or walked in) total # of people who requested services the CMHSP provides, irrespective of eligibility	462	1752	688	0	2902
4	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who did not meet eligibility through phone or other screening	6	36	27	0	69
5	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who were scheduled for assessment	456	1716	661	0	2833
6	Of the # in Row 3 (People requested services the CMHSP provides), total # of people with other circumstance - Describe below on-line 32	0	0	0	0	0
7	Is Row 1 (all people who telephoned or walked in) an unduplicated count in each category? Answer Yes or No for each category	Yes	Yes	Yes	N/A	N/A

Row	CMHSP ASSESSMENT	DD	MI Adult	SED	Unknown / All Others	Total
8	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who did not receive intake/biopsychosocial assessment (dropped out, no show, etc.)	95	725	206	0	1026
9	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	1	3	0	0	4
10	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA HP enrolled and referred out to MA health plan	1	2	3	0	6
11	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who otherwise did not meet CMHSP non-entitlement intake/assessment criteria.	0	1	1	0	2
11a	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were referred out to other mental health providers	0	1	1	0	2

Row	CMHSP ASSESSMENT	DD	MI Adult	SED	Unknown / All Others	Total
11b	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were not referred out to other mental health providers	0	0	0	0	0
12	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who met the CMHSP intake criteria	359	985	451	0	1795
13	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met emergency/urgent/priority conditions criteria	0	0	0	0	0
14	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met regular/routine/usual admission criteria	359	985	451	0	1795
15	Of the # in Row 12 (Met CMHSP eligibility criteria) - total # of people who were put on a waiting list	0	0	0	0	0
15a	Of the # in Row 15 (Put on a waiting list) - total # of people who received some CMHSP services, but wait listed for other CMHSP services	0	0	0	0	0
15b	Of the # in Row 15 (Put on a waiting list) - total # of people who were waitlisted for all CMHSP services	0	0	0	0	0
16	Other Requests for Service and Disposition of Requests - Report total # of people in each category and describe on Line 32.	0	0	0	0	0
Row	CMHSP Point of Entry-Screening	DD	MI Adult	SED	Unknown / All Others	Total
1	Total # of all people who telephoned or walked in with any request	309	1332	717	0	2358
2	Of the # in Row 1 (all people who telephoned or walked in), total # of people referred out due to non-mental health needs	6	201	81	0	288
3	Of the # in Row 1 (all people who telephoned or walked in) total # of people who requested services the CMHSP provides, irrespective of eligibility	303	1131	636	0	2070
4	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who did not meet CMHSP eligibility through phone or other screening	1	17	7	0	25
5	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who met eligibility and were scheduled for intake/biopsychosocial assessment	302	1114	628	1	2045

Row	CMHSP ASSESSMENT	DD	MI Adult	SED	Unknown / All Others	Total
6	Of the # in Row 3 (People requested services the CMHSP provides), total # of people with other circumstance - Describe below on-line 32	0	0	0	0	0
7	Is Row 1 (all people who telephoned or walked in) an unduplicated count in each category? Answer Yes or No for each category	Yes	Yes	Yes	Yes	N/A

Row	CMHSP ASSESSMENT	DD	MI Adult	SED	Unknown / All Others	Total
8	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who did not receive intake/biopsychosocial assessment (dropped out, no show, etc.)	65	107	19	0	191
9	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	0	1	0	0	1
10	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA HP enrolled and referred out to MA health plan	2	4	7	1	14
11	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who otherwise did not meet CMHSP non-entitlement intake/assessment criteria.	0	1	0	0	1
11a	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were referred out to other mental health providers	0	0	0	0	0
11b	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were not referred out to other mental health providers	0	1	0	0	1

12	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who met the CMHSP intake criteria	300	1109	621	0	2030
13	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met emergency/urgent/priority conditions criteria	0	0	0	0	0
14	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met regular/routine/usual admission criteria	300	1109	621	0	2030
15	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who were put on a waiting list	0	0	0	0	0
15a	Of the # in Row 15 (Put on a waiting list) - total # of people who received some CMHSP services, but wait listed for other CMHSP services	0	0	0	0	0
15b	Of the # in Row 15 (Put on a waiting list) - total # of people who were waitlisted for all CMHSP services	0	0	0	0	0
16	Other Requests for Service and Disposition of Requests - Report total # of people in each category and describe on Line 32.	0	0	0	0	0

ATTACHMENT C: COMMUNITY DATA SETS WORKSHEET

Commuity Needs Assessment																	
Community Data Sets																	
CMHSP name:		Saginaw CMH															
Contact person and e-mail address:		Kim Hall, kim.hall@sccmha.org															
ROW 1	**Population (Census)-- As of September -- by county**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
County 1	**Saginaw**		**198899**	**198363**	**196794**	**195248**	**193305**	**192507**	**191965**	**190791**	**190539**	**190124**	**189120**	**188116**	**185810**	**187191**	**187604**
County 2																	
County 3																	
County 4																	
County 5																	
County 6																	
	Total CMHSP Population		198899	198363	196794	195248	193305	192507	191965	190791	190539	190124	189120	188116	185810	187191	187604
	Change from Prior Year		198899	-536	-1569	-1546	-1943	-798	-542	-1174	-252	-415	-1004	-1004	-2306	1381	413
	% change from Prior Year		#DIV/0!	-0.27%	-0.79%	-0.79%	-1.00%	-0.004	-0.003	-0.006	-0.001	-0.002	-0.005	-0.005	-0.012	0.0074	0.0022
	Cumulative Change since 2009		198899	198363	196794	195248	193305	192507	191965	190791	-8360	-8239	-7674	-7132	-7495	-5316	-4361
	% cumulative change since 2009		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	-0.042	-0.042	-0.039	-0.037	-0.039	-0.028	-0.023
	Source:	World Population Review or US Census Bureau from 2019 Estimates for 2020 information															
ROW 3	**Number of Children in Out of Home Care**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
	Children Ages Birth-17 in Out of Home Care-Abuse or Neglect (Number)	245	189	133	117	126	**117**	**121**	**123**	**160**	**184**	**162**	**142**	**169**	**181**	**162**	**NA**
	Children ages Birth-8 in out of home care - abuse or neglect (Number)	141	106	81	76	72	**81**	**73**	**69**	**95**	**NA**	**NA**	**92**	**111**	**130**	**112**	**NA**
	Children Ages Birth-5 in out of home care - abuse or neglect (Number)	108	72	59	61	54	**66**	**58**	**53**	**71**	**NA**	**NA**	**61**	**82**	**110**	**95**	**NA**
Source:	http://datacenter.kidscount.org/data/bystate/Default.aspx?state=MI																
	****Some information may not be available for every year.**																
	Total CMHSP	494	367	273	254	252	264	252	245	326	184	162	295	362	421	369	0
	Change from Prior Year		-127	-94	-19	-2	12	-12	-7	81	-142	-22	133	67	59	-52	-369
	% change from Prior Year		-25.71%	-25.61%	-6.96%	-0.79%	4.76%	-0.045	-0.028	0.3306	-0.436	-0.12	0.821	0.2271	0.163	-0.124	-1
	Cumulative Change since 2009		-127	-221	-240	-242	-230	-242	-249	-168	-183	-111	41	110	157	117	-245
	% cumulative change since 2009		-25.71%	-44.74%	-48.58%	-48.99%	-46.56%	-0.49	-0.504	-0.34	-0.499	-0.407	0.1614	0.4365	0.5947	0.4643	-1
ROW 2	**Medicaid Enrollment - Average Enrollment for September:**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
County 1	**Saginaw**	47550	47305	46157	45759	43139	43124	42831	42610	42674	42248	44630	47084	49264	49848	46295	45345
County 2																	
County 3																	
County 4																	
County 5																	
County 6																	
	Total CMHSP Medicaid Enrollment	47550	47305	46157	45759	43139	43124	42831	42610	42674	42248	44630	47084	49264	49848	46295	45345
	Change from Prior Year		-245	-1148	-398	-2620	-15	-293	-221	64	-426	2382	2454	2180	584	-3553	-950
	% change from Prior Year		-0.005152	-0.0243	-0.0086	-0.0573	-0.0003	-0.007	-0.005	0.0015	-0.01	0.0564	0.055	0.0463	0.0119	-0.071	-0.021
	Cumulative Change since 2009		-245	-1393	-1791	-4411	-4426	-4719	-4940	-4876	-5302	-2675	927	3505	6709	3171	2514
	% cumulative change since 2009		-0.005152	-0.0293	-0.0377	-0.0928	-0.0931	-0.099	-0.104	-0.103	-0.112	-0.057	0.0201	0.0766	0.1555	0.0735	0.0587

ROW 4	Number of Licensed Foster Care Beds in Catchment Area			2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	Adults - Eneter the Total Number of Bed Capacity			1248	1289	1387	1472	1594	1865	2041	2754	2885	3098	3075	2961	2951	2931
Source	http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717-82231--,00.html																
	Kids - Enter the Total Number of Licensed Facilities			329	329	329	321	321	321	321	265	211	211	155	155	155	155
Source	http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27719-82293--,00.html																
	*This data is also provided by MDHHS on the website under "Provided Information".																
ROW 5B	Children at risk for Serious Emotional Disturbance 100% below poverty	12223	13988	12414	12630	10543	11376	10026	9726	8984	12664	NA	13520	10058	8340	9735	NA
Source	Census Bureau Search																
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
ROW 5C	Persons with Developmental Disabilities: Formula Populated	0	994.495	991.815	983.97	976.24	966.525	962.54	959.83	953.96	952.7	950.62	945.6	940.58	929.05	935.96	938.02
ROW 6	Community Homelessness- catchment area	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
ROW 6A	Local Continuum of Care Bi-ennial Homeless Count	305	390	402	350	325	308	343	388	357	364	431	331	313	324	383	365
	Change from Prior Time Period		85	12	-52	-25	-17	35	45	-31	7	67	-100	-18	11	59	-18
ROW 6B	# served from CMHSP data- of persons that are homeless		113		71		219	227	261	254	272	336	306	344	351	376	435
	Change from Prior Time Period		113	-113	71	-71	219	8	34	-7	18	64	-30	38	7	25	59
ROW 6C	Community Employment	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
County 1	Saginaw	79177	80920	80697	81049	82867	83973	84819	83412	82908	82965	78071	76155	78761	80762	81012	80153
County 2																	
County 3																	
County 4																	
County 5																	
County 6																	
	Total CMHSP	79177	80920	80697	81049	82867	83973	84819	83412	82908	82965	78071	76155	78761	80762	81012	80153
	Change from Prior Year		1743	-223	352	1818	1106	846	-1407	-504	57	-4894	-1916	2606	2001	250	-859
	% change from Prior Year		2.20%	-0.28%	0.44%	2.24%	1.33%	0.0101	-0.017	-0.006	0.0007	-0.059	-0.025	0.0342	0.0254	0.0031	-0.011
	Cumulative Change since 2008		1743	1520	1872	3690	4796	5642	4235	3731	3788	-2849	-4542	-2288	-2105	-2961	-4666
	% cumulative change since 2008		2.20%	1.92%	2.36%	4.66%	6.06%	0.0713	0.0535	0.0471	0.0478	-0.035	-0.056	-0.028	-0.025	-0.035	-0.055
	Source: State of Michigan Labor Market Information																
ROW 7	Justice System	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
ROW 7A	Jail diversions							16	19	22	34	25	24	13	17	22	17
	Source: BH TEDS records for the FY being reported																
					2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
ROW 7B	Prison discharges-number of people expected to meet SMI Criteria				26	21	31	27	22	11	14	14	15	11	17	15	18
	Source: Betsy Hardwick																
ROW 8	Education System	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
ROW 8A	Number of students aging out or graduating special education	NA	NA	NA	NA	NA	NA	NA	NA	184	162	201	174	169	154	160	NA
	Source: www.mischooldata.org/selected-indicator-reports/																
ROW 9	Graduation and Dropout Rate	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
County 1	Saginaw																
County 2																	
County 3																	
County 4																	
County 5																	
County 6																	
	CMHSP Total:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

		DATE	1/15/2026
	For primary health items, identify point in time being reported		
ROW 10	**Primary Health**		
ROW 10A	% of CMHSP consumers with an identified Primary Care Physican	94.4	
10B	CMHSP Medicaid recipients with primary care service/encounter		
10C	# with primary care plus emergency room		
10D	# with emergency room no primary care		
	MDHHS does not have this data (10B, 10C, 10D) available at this time.		
ROW 11	**Optional Information**		
	Private Providers and Public SUD Providers		
ROW 11A	Number of Existing Private Providers in Community		
ROW 11B	Number of providers that utilize a sliding fee scale		
ROW 11C	Number of providers that are accepting new clients		