Quality Assessment and Performance Improvement Program

Annual Report

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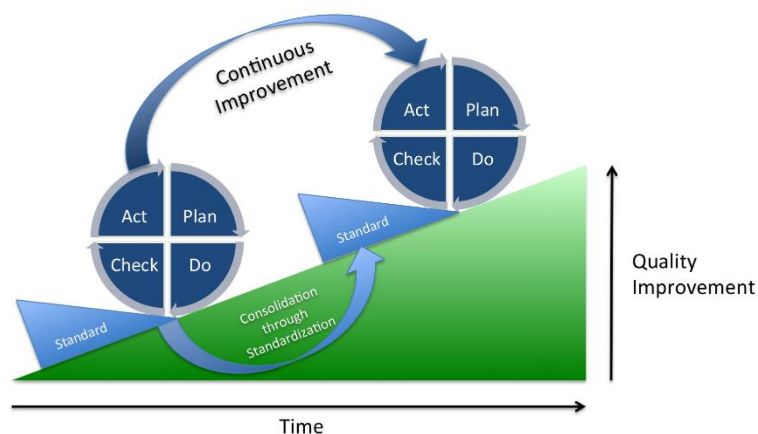
I. Introduction

Bay-Arenac Behavioral Health (BABH) provides an array of behavioral health services and supports to individuals in the Michigan counties of Bay and Arenac through a network of direct operated programs and contracted service providers. BABH is a Michigan Department of Health and Human Services (MDHHS) certified Community Mental Health Services Program (CMHSP), a Children's Diagnostic and Treatment Service Program, and is licensed by MDHHS as a Substance Abuse Provider. BABH is also a CMHSP affiliate of the Mid-State Health Network (MSHN) Pre-Paid Inpatient Health Plan (PIHP) for Medicaid Specialty Services and Supports. In addition, BABH is accredited by the Council on Accreditation of Rehabilitation Facilities (CARF).

BABH is responsible for managing a local quality assessment and performance improvement program for its CMHSP provider operations and ensuring its contracted network clinical service providers address quality improvement in their own operations through the BABH Quality Assessment and Performance Improvement Program (QAPIP). BABH's overall philosophy and mission governing its local quality management and performance improvement program can be summarized as follows: performance improvement is dynamic, system-wide and integrated; the input of a wide range of stakeholders, such as board members, consumers, providers, employees, community agencies, and other external entities, such as MDHHS, are critical to success; it is important and encouraged to have an organizational culture where staff are comfortable reporting errors, system failures, and possible solutions, and leaders see information as the means to improvement; improvements resulting from performance improvement must be communicated throughout the organization and sustained; and leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data. Continuous improvement is supported by the plan, do, check, act/adjust cycle (PDCA) drawn from the work of Deming and used in the application of lean methodology. Standard work statements are developed and utilized to implement and maintain improvements and are updated as the PDCA cycle is repeated to produce continuous improvement over time. The graphical representation of the continuous improvement methodology is below (http://en.wikipedia.org/wiki/File:PDCA_Process.png).



The BABH QAPIP "objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis" for "all demographic groups, care settings, and types of services" (MDHHS/CMHSP FY16 Contract, Attachment C6.8.1.1, p. 1, 2). The program "achieves, through ongoing measurement and intervention, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction" (p. 1). This program "define[s] the system to collect data, set the organization's business and service delivery performance goals, and measure indicators for the purpose of review and analysis of

results" (CARF, 2017 Standard 1.M.1, p. 93). The QAPIP provides a "written description of [the] performance measurement and management system that includes, at a minimum: a) Mission; b) Programs/services seeking accreditation; c) Objectives of the programs/services seeking accreditation; and d) Personnel responsibilities related to performance measurement and management" (CARF, 2017 Standard 1.M.1, p. 93). The QAPIP, as described in this document, is evaluated annually for effectiveness and modifications are made as necessary.

The QAPIP applies to all BABH programs and services, including: Assertive Community Treatment (mental health – adults); Case Management/Supports Coordination (integrated DD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Crisis Intervention (integrated DD/mental health – children and adolescents, mental health – adults); Intensive Family-Based Services (family services – children and adolescents); and Outpatient Treatment (integrated DD/mental health – children and adolescents, mental health – adults). The objectives of these programs are reflected in the organization's mission statement, "to improve health outcomes to enhance quality of life and strengthen the community safety net for citizens of Arenac and Bay counties". In addition, "All who are associated with carrying out the mission of Bay-Arenac Behavioral Health are governed by the highest ethical standards and the following values: each person is unique, and will be treated with dignity and respect; we are committed to delivering services in a manner that is responsive to community needs, we seek to provide a recovery-focused and trauma-informed system of care; we believe that individual and community wellness is enhanced by the delivery of integrated healthcare services that are directed by and responsive to the person served; we are committed to promoting independence, choice control and meaningful engagement with peers, family friends, and community, we are committed to collaboration with our community partners to encourage wellness, to promote prevention, and to increase health literacy (www.babha.org/OurMissionStatement.aspx). A representative group of leadership and clinical staff participate in the Primary Network Operations and Quality Management Committee (PNOQMC), which includes the Performance Improvement staff. The PNOQMC is the entity responsible for initiating and monitoring performance improvement activities. In addition, staff have been designated responsible for performance measurement and management within their programs, which may include coordination and follow up with the PIC and/or the Quality Manager or designee.

This annual report provides an analysis of the PI data reviewed during the past 6-12 months, and suggests any necessary data based adjustments to program priorities for the remainder of the fiscal year.

The data includes Performance Improvement Projects, Medicaid Event Verification, Michigan's Mission-Based Performance Indicator System, Health Conditions, and committee/work group reports Attachment 1 (Quality Dashboard) provides the performance on the identified measures at a glance. Additional data reviewed in this report includes Adverse Events, Jail Diversion, Recovery Assessment, and Oversight of Behavior Management.

II. Performance Improvement Projects

A. Medicaid Event Verification

<u>Study Questions</u>

1. Is the service provided in the Medicaid Manual?
2. Was the Medicaid service identified in the Person Centered Plan (PCP)?
3. Do the units claimed (billed) equal the units documented?
4. The percentage of charts that have been audited that are in compliance with the previous three study questions.

Baseline
The data was initially gathered beginning in FY04Q3. The first question "Is the service provided in the Medicaid Manual" baseline data (FY04Q3-Q4) indicated that out of 1017 services provided, 1017 were services identified in the Medicaid Manual. Baseline data regarding the second question "Was the Medicaid service identified in the Person Centered Plan" indicated that out of 1016 services provided, 986 (97%) of the services were identified in the Person Centered Plan. Baseline data for the third question "Do the units claimed equal the units documented" indicated that out of 1015 services provided, 939 (93%) had evidence of the service being provided in the medical record.

Current Data (FY16)

1. Services Identified in the Medicaid Manual

   BABH exhibited a 100% compliance with services identified in the Medicaid Manual for FY16Q4. There were no deficiencies during FY16 that required corrective action.

2. Services Identified in the Person Centered Plan

   BABH had achieved the desired performance level with a 99% during FY16Q4.

3. Did the Units Documented Match the Units Billed?

   BABH had achieved the desired performance level with a 99% during FY16Q4. Each provider demonstrated performance above the desired standard of 95%.

Causal Factors/Ongoing Improvements
Clinical Service Providers that are below 95% are required to review their process and develop an improvement plan describing the systemic process to reducing deficits in the future and correcting any errors identified during the audit review process. The improvement plan is reported to BABH using the "Follow-up to Data Analysis Form". BABH will monitor the progress of the plan through the data that is reported quarterly.

Each quarter, data is shared with department supervisors, who are given the responsibility of addressing the findings with corrective plans. Consumers were involved via each CMHSP's Consumer Advisory Council, where updates regarding DCH projects were provided and feedback was elicited.

Project findings are reviewed as a standing agenda item each quarter at the Corporate Compliance meetings. Typical turnaround in progress is expected within 12 months of putting the corrective plan into place.

In addition to the monitoring that is being done per each individual corrective action plan, it is recommended that a review of the project description and instructions be completed. Ongoing education and training of definitions and interpretations should be completed on a regular basis to ensure quality and reliability in the data collection process.

Conclusions

BABH – All which included BABH-Direct clinical service providers and contracted provider's clinical service met the standard for each question regarding Medicaid Event Verification. Those that have been below during the previous quarters have improved which indicates that the corrective action plans that are currently in place have been effective. This will continue to be monitored on a quarterly basis through the Performance Improvement Council.

B. Diabetes Screening for Individuals Diagnosed with Schizophrenia or Bipolar and Receiving Antipsychotic Medication

The Michigan Department of Health and Human Services mandated the performance improvement project topic based on a recommendation provided by the MDHHS's Quality Improvement Council (QIC). The QIC recommended the topic area. Each PIHP was to identify a specific area related to integration with physical health and mental health. After considering a number of possible topic areas, Mid-State Health Network chose the study topic "Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications." The goal of this PIP is to ensure that adult consumers with schizophrenia or bipolar disorder who are taking an antipsychotic medication are receiving necessary and relevant diabetes screenings (specifically glucose or HbA1c screenings) related to mental health medicines prescribed. This study topic aligns with the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications."

Study Question

Do targeted interventions increase the percentage of consumers diagnosed with bipolar or schizophrenia and prescribed an antipsychotic medication who also have an annual glucose or HbA1c diabetes screening?

Baseline

The data was re-pulled as a result of the original numbers including individuals that were not intended to be part of our eligible population for this study topic. During the baseline year of 2013-2014, Figure 2 indicates that BABH had 55% (383/696) consumers between the ages of 18-64 who were diagnosed with Bipolar or Schizophrenia, who were dispensed a second generation antipsychotic medication and had a diabetes screening. This measurement excludes those who were diagnosed with diabetes or who had received a prescription for a diabetes medication.

Figure 2

Reporting Period	BABH % Screened	MSHN % Screened
Baseline - October 2013 through September 2014	55%	73.7%
First Review Period - October 2014 through September 2015	72%	77.5%
Second Review Period - October 2015 through September 2016	67%	Not Available

Interventions/Improvement Strategies

BABH will provide education to the beneficiaries during the person centered planning process and during face to face interactions about the importance of ongoing monitoring by a primary care physician. BABH will coordinate, with the beneficiary and the primary care physician, the completion of a glucose test or HbA1c either by the CMHSP or through the PCP (Primary Care Physician). BABH will utilize the "Care Alerts" data within the Zenith (ZTS) system to track consumers that meet the study population and have not had a completed diabetes screening.

Conclusions

The data for FY13/14 was used to determine a baseline goal for this project. MSHN identified FY14 as the baseline year for the date used. BABH demonstrated the required 1% improvement for FY14 and FY15. This was not demonstrated for FY16. It is expected that the interventions implemented will increase the percentage of those who receive a diabetes screen.

C. Recovery Environment of the Clinical Service Providers

The study topic is the measurement of the recovery environment of the CMHSP, the consumer perception of individual recovery and the discernment of potential best practices within the region in addition to identifying effective strategies at both improving systems of recovery and identifying any additional needs for processes relating to recovery integration into agency practice.

Study Question

Did targeted interventions increase the region's recovery environment and the consumer's perception of the recovery?

Data Analysis-Regional level

Mid-State Health Network will collect, review and analyze data comparatively across CMHSPs, regional averages and where available against national benchmarks.

CMHSP Management Level Data

CMHSPs will utilize individual survey responses to inform and guide individuals in their recovery journey. This is completed on an annual basis.

Clinical Service Provider Level Data

The consumer level data was gathered and analyzed for FY15Q3 and FY15Q4 active consumers. The results are indicated in Figure 3.

BABH completed the Recovery Assessment Scale (RAS) with the Adults who received a service from February 1 through April 30. The Likert scale was used with 1 being the lowest (disagree) and 5 being the highest (agree). Therefore, 3.5 would be considered the average. Anything above 3.5 would be considered in agreement. A score of a 2 or less would be considered in disagreement. The results were separated by those who were currently in treatment and may have already been impacted by the recovery systems of care and those that are new to the system and have not had an opportunity to have been affected by the recovery systems of care. It is expected that those who have received ongoing Recovery Assessment Scales will provide a higher rating. The results were reviewed and interventions put in place to increase the scores. Leadership, Performance Improvement Council and the Recovery Committee reviewed the results and determined a plan of action to address the areas with a lower score which indicate a deficit in the recovery environment.

- Personal Recovery
  - Questions: 1, 3, 4, 5, 7, 8, 9, 10, 11, 15, 17

    Q1: I have a desire to succeed

    Q3: I have goals in life that I want to reach.

    Q4: I believe I can meet my current personal goals.

    Q5: I have a purpose in life.

    Q7: I can handle what happens in my life.

    Q8: I like myself.

Q9: If people really knew me, they would like me.
Q10: Something good will eventually happen.
Q11: I'm hopeful about my future.
Q15: I know when to ask for help.
Q17: I ask for help, when I need it

- Clinical Recovery
  - Questions: 2, 13, 14
    Q2: I have my own plan for how to stay or become well.
    Q13: My symptoms interfere less and less with my life.
    Q14: My symptoms seem to be a problem for shorter periods of time each time they occur.
- Social Recovery
  - Questions: 6, 18, 19, 20
  - Q6: Even when I don't care about myself, other people do.
    Q18: I have people I can count on.
    Q19: Even when I don't believe in myself, other people do.
    Q20: It is important to have a variety of friends.
- Uncategorized Questions
  - Questions: 12, 16
    Q12: Coping with my mental illness is no longer the main focus of my life.
    Q16: I am willing to ask for help.

Figure 2 illustrates the average combined scores of "active" consumers for BABH programs and contract service providers for each domain. Two domains scored above the desired 3.50 threshold. The "Clinical Recovery" and "Uncategorized Questions" domains fell below the threshold. All domains exhibited a slight decrease from the previous reporting periods.

Figure 2

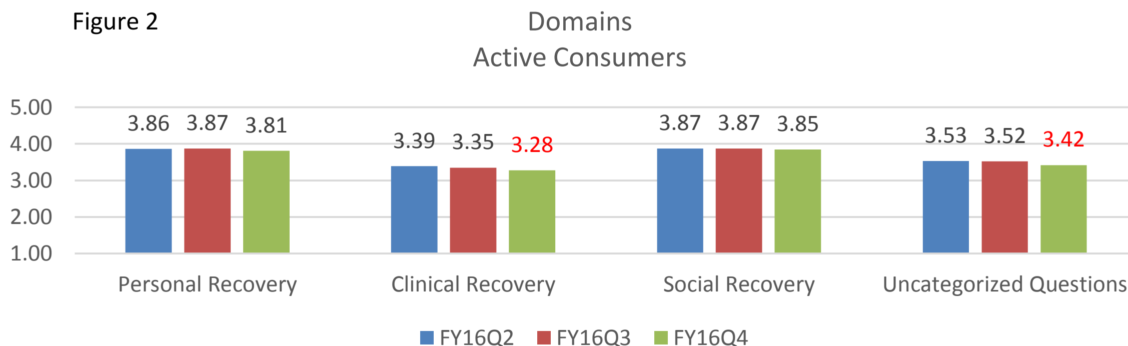
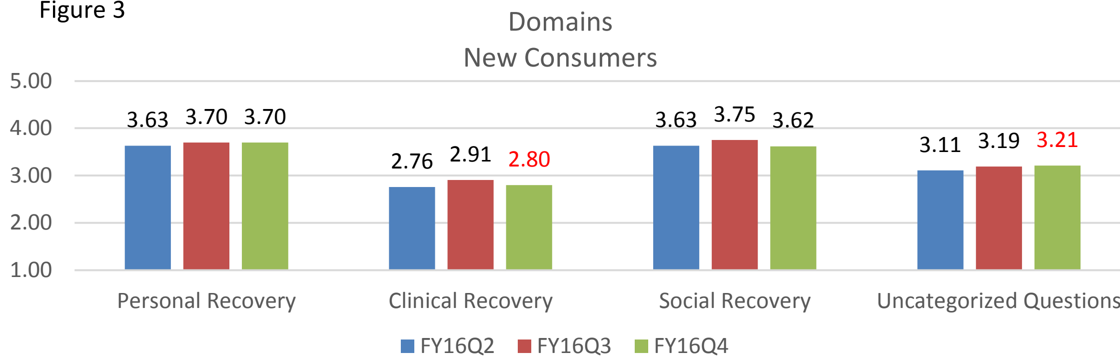


Figure 3 illustrates the average combined scores of "new" consumers. Two domains scored above the desired 3.50 threshold. The "Clinical Recovery" and "Uncategorized Questions" domains fell below the desired threshold. The average scores of new consumers are consistently lower than those that are active in treatment.

Figure 3



Summary:
Questions 12, 13 and 14 have consistently scored below the 3.50 threshold.

- Question 12 (coping with my mental illness is no longer the main focus of my life), 78% (7/9) of the programs/contract service providers fell below the threshold.
- Question 13 (my symptoms interfere less and less with my life), 78% (7/9) of the programs/contract service providers fell below the threshold.
- Question 14 (my symptoms seem to be a problem for shorter periods of time each time they occur), 67% (6/9) of the programs/contract service providers fell below the threshold.

Improvement Strategies

BABH will continue to train and educate staff regarding the purpose of the RAS, ensuring that a standardized process for administering the RAS is followed by all staff. Each domain below the acceptable threshold is reviewed and interventions implemented to ensure the threshold is met.

D. Quality Reporting/Completeness – Record Reviews

1. Coordination with the Primary Care Physician

Michigan Department of Health and Human Services' (MDHHS) site review process assesses efforts at coordinating care with other healthcare providers. This stems from a need to coordinate efforts across healthcare delivery systems to ensure that an individual's healthcare needs and services are comprehensively identified, and delivered in an effective and efficient manner. The manner in which coordination of care occurs with healthcare providers, is being assessed for completeness. MDHHS site review process also reviews medical records to ensure that each individuals receives or is offered the opportunity to receive a copy of their individual plan of service within 15 days of completion of the planning process.

Study Question # 1: Did coordination of care occur between the consumer's primary healthcare provider, other physicians, and the CMHSP, for consumers receiving services?

Current Data
Attachment A indicates an improvement from FY15Q4 (69%) to FY16Q4 (93%). Coordination has continually increased throughout FY16. Interventions that have occurred are the incorporation of the electronic release of information form that has begun to be utilized through Phoenix. Alerts have been added to the electronic health record for prescribers and clinicians to be aware of lab results or other health issues that may need attention. Standard reports on Key Performance Measures are utilized based on information that has been entered into the electronic health record (Phoenix) and through Medicaid Claims data through Connect 360, Michigan Department of

Health and Human Services System, and Integrated Care Delivery Platform (ICDP) which is a Mid-State Health Network Regional System. Corrective action includes ongoing reports to identify patterns and trends. This may include staff patterns or different processes throughout the organization. This may also include the location of documents and types of documents used to indicate that coordination has occurred. Copy of Person Centered Plan within 15 Days

2. Copy of Person Centered Plan (PCP)/Individual Plan of Service (IPOS) within 15 Days

Study Question # 2: Did the consumer's receive a copy of their person centered plan (individual plan of service) within 15 days (business) of completion of the planning process?

Current Data
BABH's percentage of charts that provided evidence of the consumers receiving a copy of their PCP within 15 days was (69%) below the expected performance level for FY15Q4. Attachment A indicates improvement, demonstrating an 86% for FY16Q4.

Causal Factors and Barriers
Issues that have interfered with the providers demonstrating desired performance is related to a variety of issues 1) the implementation of the new electronic medical record for one of the contracted providers. 2) the process for documenting the "Receipt of PCP within 15 Days" within the medical record 3) during the training phase this process was not fully developed within the system. Staff were completing the process in the system and outside of the system, which interfered with the ability to streamline the process. Training needs have been identified early in the year, however it takes a full year for the results of such trainings to be realized based on the planning cycle.

Interventions/Improvement Strategies
Training has been completed on the correct way to provide documentation of the "Receipt of PCP within 15 Days" A report is pulled quarterly to identify the compliance rate of this measure. The "Copy of PCP within 15 Days" can only be completed during the PCP Process. It cannot be corrected until the next planning cycle. Internal audits of medical records will be phased out as the electronic report is implemented. The data is separated by BABH and contract providers to determine which provider is in need of follow-up to ensure that the desired performance level is reached in future measurement periods. Follow-ups to data analysis may include documentation of a Best Practice if the provider performed above the desired level for more than three reporting periods, or a corrective action plan if the provider performed below the desired performance level for one reporting period. Each reporting period is defined as one quarter of the fiscal year. The desired performance level is 95%. The standard Person Centered Planning process is a maximum of one year. Therefore, it may take up to one year to see the results of the corrective action plan. Many of the interventions since the inception of this project have been part of the development of the internal process of communication for each provider.

Conclusions
The standard was not met for the Healthcare Coordination for FY16Q3 and Q4. The standard was not met for PCP within 15 Days for in FY16Q1-Q. Corrective action steps have been put in place to increase performance.

E. Michigan's Mission-Based Performance Indicator System

The data is fully valid and reliable. The data is obtained through the state reporting process. This measure allows for exclusions and exceptions. Exceptions are those that chose to have an appointment outside of the 14 days, refuse an appointment that was offered the dates or offered appointments must be documented. Those excluded are those who are dual eligible (i.e. Medicaid/Medicare). Both BABH Direct and BABH Contracted Providers are included in the totals below. At this time, BABH has three contract providers. There may be times when each provider has only one who has not been in compliance, however, when combined; it results in a percentage that is less than the expected threshold. Each provider will document action taken to resolve such an issue in the future. Figure 7 below exhibits the current status of performance within BABH. FY16Q4 data from MDHHS is not available at the time of this report. This is indicated with a **.

Figure 7

Michigan Mission Based Performance Indicator 1: The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS Medicaid children	95%	99.32%	99.28%	98.24%	**
MSHN Medicaid children	**95%**	99.80%	99.49%	99.02%	100%
BABH Medicaid children	**95%**	**100%**	**100%**	**100%**	**100%**
MDHHS Medicaid adult	**95%**	98.50%	99.18%	100%	**
MSHN Medicaid adult	**95%**	99.72%	98.65%	98.97%	99%
BABH Medicaid adult	**95%**	**100%**	**98.11%**	**99.10%**	**99%**
Michigan Mission Based Performance Indicator 2: The percent of new Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS-Total	**95%**	98.40%	98.52%	99%	**
MSHN-Total	**95%**	99.10%	98.40%	99.02%	99%
BABH-Total	**95%**	**98.13%**	**98.26%**	**95.74%**	**99%**
MDHHS MI-C	95%	98.39%	98.46%	98.14%	**
MSHN MI-C	**95%**	98.92%	98.79%	98.72%	99.41%
BABH MI-C	**95%**	93.18%	100%	100%	100%
MDHHS MI-A	**95%**	98.70%	99.22%	99.05%	**
MSHN MI-A	**95%**	99.72%	99.45%	99.20%	99.18%
BABH MI-A	**95%**	100%	97.62%	95.50%	99.01%
MDHHS DD-C	**95%**	98.84%	98.92%	99.32%	**
MSHN DD-C	**95%**	100%	98.44%	100%	97%
BABH DD-C	**95%**	100%	100%	100%	*
MDHHS DD-A	**95%**	99.25%	98.36%	97.77%	**
MSHN DD-A	**95%**	100%	100%	98.82%	98%
BABH DD-A	**95%**	*	100%	50.00%	*
Michigan Mission Based Performance Indicator 3: The percent of Medicaid beneficiaries' new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS-Total	**95%**	97.87%	97.85%	97.60%	**

MSHN-Total	**95%**	98.40%	97.44%	98.32%	99%
BABH-Total	**95%**	98.63%	94.78%	91.94%	93%
MDHHS MI-C	**95%**	97.22%	96.81%	96.68%	**
MSHN MI-C	**95%**	96.30%	96.68%	96.83%	97%
BABH MI-C	**95%**	100%	93.55%	95.00%	90%
MDHHS MI-A	**95%**	97.69%	97.94%	97.79%	**
MSHN MI-A	**95%**	97.69%	97.96%	97.55%	97.65%
BABH MI-A	**95%**	98.06%	97.47%	91.09%	93.41%
MDHHS DD-C	**95%**	96.48%	97.14%	97.45%	**
MSHN DD-C	**95%**	98.00%	95.74%	96.36%	100%
BABH DD-C	**95%**	100%	*	100.00%	*
MDHHS DD-A	**95%**	94.04%	95.97%	93.95%	*
MSHN DD-A	**95%**	98.08%	98.11%	96.36%	100%
BABH DD-A	**95%**	100%	75.00%	100%	100%
Michigan Mission Based Performance Indicator 4: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS Child	**95%**	98.89%	92.43%	97.51%	**
MSHN Child	**95%**	97.53%	100%	99.14%	100%
BABH Child	**95%**	100%	100%	100%	100%
MDHHS Adult	**95%**	96.70%	97.72%	94.31%	**
MSHN Adult	**95%**	98.14%	98.32%	97.03%	97%
BABH Adult	**95%**	97.18%	100%	100%	95%
Michigan Mission Based Performance Indicator 10: The percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days (Old Indicator #12)	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS MI and DD children	**15%**	10.60%	11.11%	10.15%	**
MSHN MI and DD children	**15%**	6.31%	11.90%	8.72%	9.43%
BABH MI and DD children	**15%**	4.35%	4.55%	10.71%	17.65%
MDHHS MI and DD adults	**15%**	13.05%	12.72%	11.79%	**
MSHN MI and DD adults	**15%**	9.18%	8.26%	10.58%	11.88%
BABH MI and DD adults	**15%**	1.00%	1.00%	1.00%	7.58%

Causal Factors and Barriers

During FY16 the total population for each indicator demonstrated performance above the standard for the Medicaid population. BABH began utilizing the electronic health record to collect the data related to the Mission Based Performance Indicator System (MMBPIS). This required additional training beyond implementation. The Phoenix system has a report that is able to be obtained on demand to determine the status of each indicator. A corrective action plan was developed to address the indicators in which BABH and the contract providers demonstrated performance below the desired standard.

Interventions/Improvement Strategies

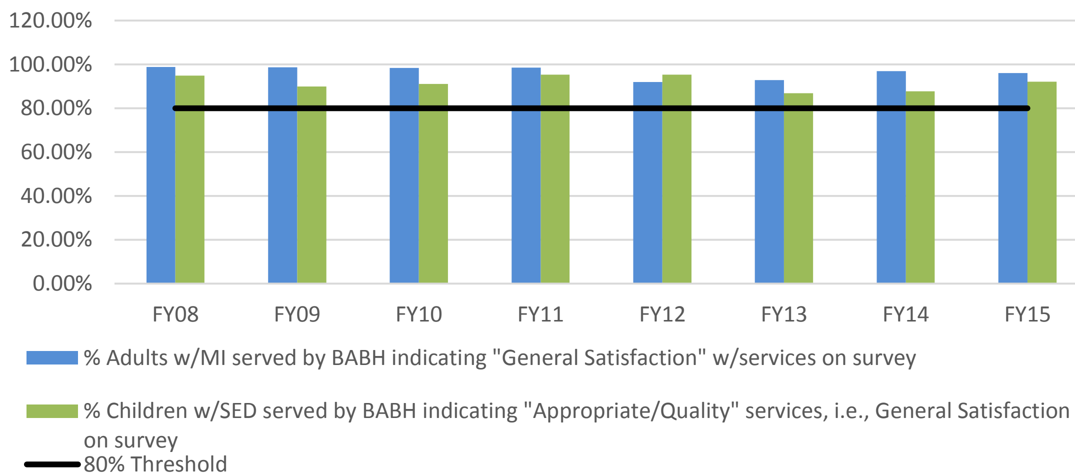
An investigation of each occurrence to determine what the causal factors are and what program exhibited the largest issues occurs each time the performance is below the standard. When total population groups are separated, BABH did perform below the standard for the following areas: Indicator 2 - Assessment within 14 days of the Initial Request for Service (children with a developmental disability, children with a mental illness). Indicator 3a, 3b, 3d - Ongoing Service within 14 days of the Assessment (children and adults with a Mental illness). Indicator 10 – Readmissions to a Psychiatric Inpatient Hospital (children with a mental illness and developmental disability). As indicated, a corrective action plan was in place for FY16 to address the areas identified.

Conclusions

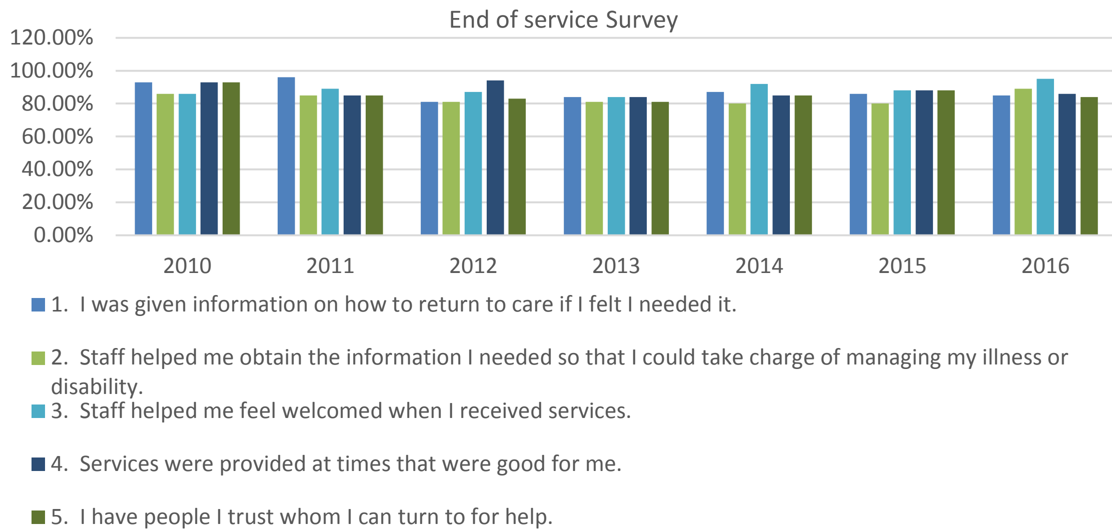
The identified population groups for Indicator 2 and 3 were below in FY16. The corrective action plan will be monitored through FY17 to ensure effectiveness. All funding sources will continue to be monitored and a full report will be provided at the end of the fiscal year.

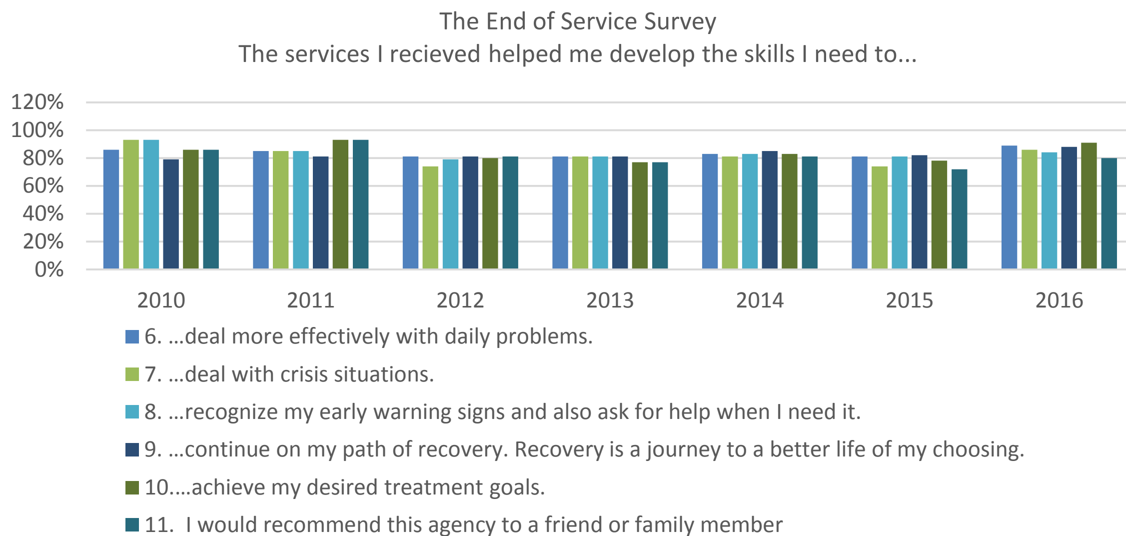
III. Consumer Satisfaction Improvement Opportunities

A. Annual Consumer Perception of Care

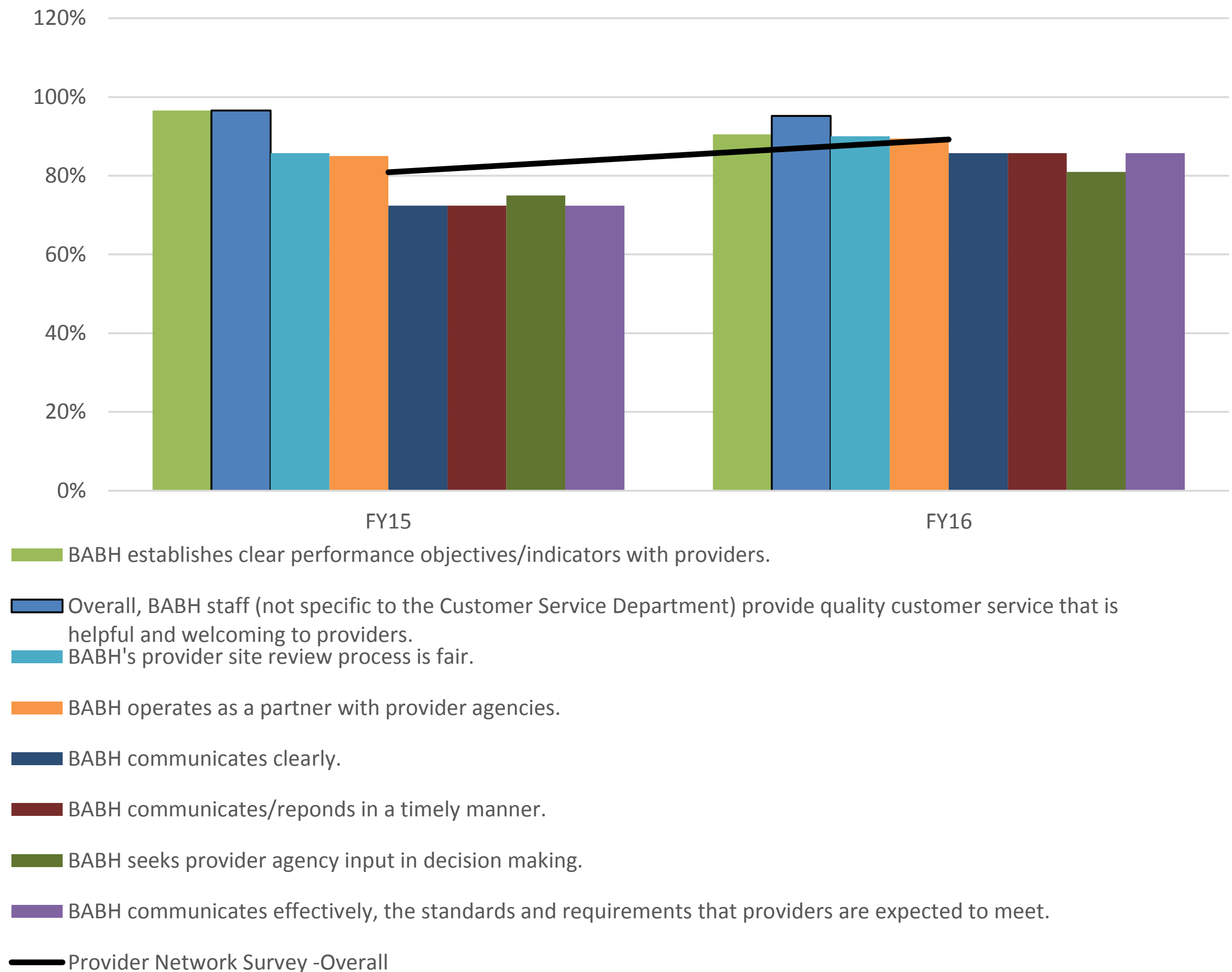


B. Post Service Survey





C. Provider Survey



D. Other Stakeholder Feedback

1. Consumer Councils

The Arenac and Bay Advisory Councils have provided feedback on various topics within the QAPIP. The following projects have been reviewed and received input during the consumer council meeting during FY16: the BABH Strategic Plan, the Recovery Assessment Scale, the National Core Indicators, the End of Service Survey, and the Annual Consumer Satisfaction Surveys. The feedback has been incorporated into the project descriptions to the extent possible. Mandated projects may provide the methodology that does not allow for modifications. This is noted with the project descriptions. Other items that have been reviewed with the councils include Mid-State Health Network Site Review Results, the External Audit results, and the Supports Intensity Scale. The councils have made recommendations regarding support groups, educational classes, safety with law enforcement, and the reinstitution of the consumer newsletter.

IV. Agency-Level Clinical Improvement Opportunities

A. Behavioral and Primary Healthcare Improvement Opportunities

1. Adverse Events

An event that is inconsistent with, or contrary to the expected outcomes of the organization's functions that warrants review. Subsets of adverse events will qualify as a "reportable event" according to the MDHHS Event Reporting System. Adverse events reportable to, or subject to review by MSHN/MDHHS, include the MDHHS defined critical incidents, risk events and sentinel events.

Study Question
Has the ability to identify events that are population specific led to an overall decrease of critical incidents/reportable events, increasing the safety of our consumers?

(1) Risk Events

A risk event is a critical event that puts individuals in one of the population categories at risk of harm. Michigan Department of Health and Human Services has identified five events that are classified under "risk" events.

- Action taken by individuals who receive services that cause harm to themselves.
- Action taken by individuals who receive services that cause harm to others.
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12 month period.
- Police calls by staff of specialized residential setting, or general (AFC) residential homes, or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan.
- Emergency use of physical management by staff in response to a behavioral crisis.

Baseline
2012 is considered to be the baseline year, however; currently we have compared quarter to quarter. There were a total of 2 incidents that were reported during FY12. Of the 2 incidents, 1 was a police call made by staff for police assistance with a behavioral crisis. The other incident was a staff person who received emergency medical treatment as a result of a self-injurious behavior.

Current Data (FY2016)
There were a total of 84 events reported for FY15 that met the criteria for risk as defined by MSHN/MDHHS. Of the 84, 55 were related to the use of emergency physical intervention. 24 were phone calls made by staff for police assistance with a behavioral crisis.

(2) Critical Events

MDHHS Critical Incident Reporting System: This system collects information on critical incidents that can be linked to specific service recipients and captures information on five specific reportable events:

- Suicide
- Non-suicide Death
- Emergency Medical Treatment due to Injury or Medication Error

- Hospitalization due to Injury or Medication Error
- Arrest of Consumer

Baseline (FY2012)

In fiscal year 2012, there were 40 events reported to MDHHS as an adverse event. Of the 40 events, 25 were non-suicide deaths. There were 2 suicide deaths during FY12. There were 7 events that involved emergency medical treatment due to injury or medication error. Three events were hospitalizations due to injury or medication error. None of the emergency medical treatments or hospitalizations was during emergency physical interventions. There were 3 arrests during FY12 that met criteria for reporting to MDHHS. There was 1 call made to the police by staff for behavioral assistance.

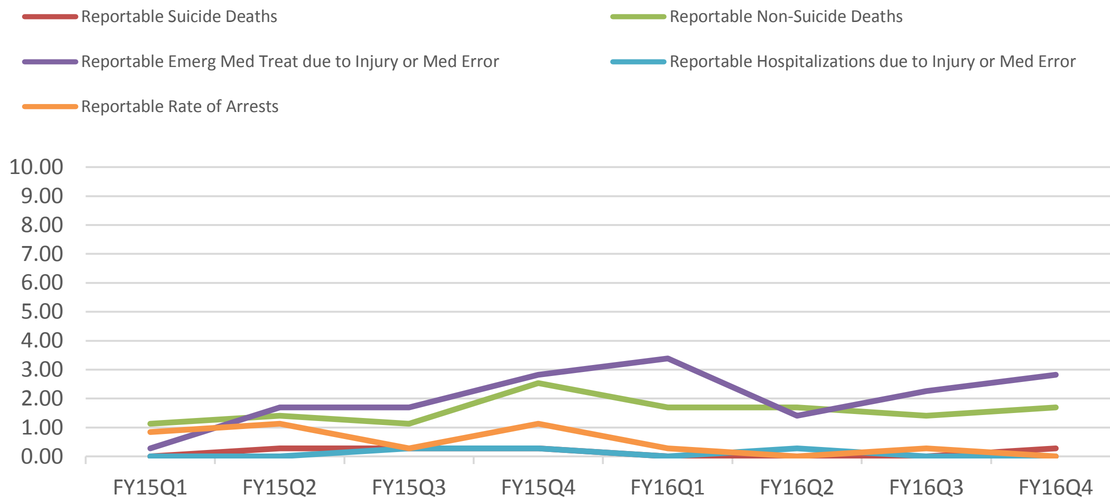
Current Data (FY2016)

One hundred and forty-four adverse events were identified during FY16. Seventy-four were risk events that are reviewed to ensure they do not become critical. The breakdown of event types is demonstrated in Figure 1. Of the 70 critical events 24 were deaths. Of the 24 deaths 1 was a suicide deaths. The reporting requirements of MDCH indicate the cause of death listed on the Death Certificate must be used when reporting deaths. 43 were emergency medical treatment for injury or medication error. Figure 8 provides a depiction of data by of each specific incident type from FY2015Q1 through FY2016Q4.

Figure 8

Risk Events	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**
Incidents in which a person receiving services receives emergency medical treatment or hospitalization for an injury due to self-harm. (this includes suicide attempts).**This is identified by the sub type of cause of injury, self-harm.**	0	2	1 (2)	2	0	0	0	0
Incidents in which a person (active in services) causes harm to another individual who then receives emergency medical treatment or hospitalization.	0	0	0	0	0	0	0	0
Police calls made by staff for assistance with a behavioral crisis.	5	4	6	9	0	10	5	3
(two or more) Unscheduled admissions to a medical hospital within a 12-month period.	*	*	*	*	*	*	*	*
Emergency Use of Physical Management by staff in response to a behavioral crisis	7	20	14	14	16	7	14	19
Critical Events	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**
Suicides	1	1	1	1	0	0	0	1
Non-suicide deaths	8	5	8	9	6	6	5	6
Hospitalizations due to injury or medication error	0	0	1	1	0	1	0	0
Emergency medical treatments due to injury or medication error.	1 (1)	6 (5)	6 (2)	10 (2)	12(4)	5(2)	8(1)	10(1)
Arrests	3	4	1	4	1(1)	0	1	0

Figure 9



Conclusions

Continue to monitor each risk/critical incident as reported. Subsets of the adverse events include medication errors, falls, and infections. The subset reports are monitored through the Healthcare Practices Committee in detail to identify trends in the agency. Actions are taken to address any issues to eliminate current safety issues and proactively address issues that may result in critical or risk events. The organization will continue to train and educate staff regarding the definitions as determined by Healthcare Practices Committee (HPC).

Ensure that a standardized process is followed by all staff regarding infection control reporting. Continue to train staff on infection control precautions.

(3) Sentinel Events

No reportable sentinel events occurred during FY16.

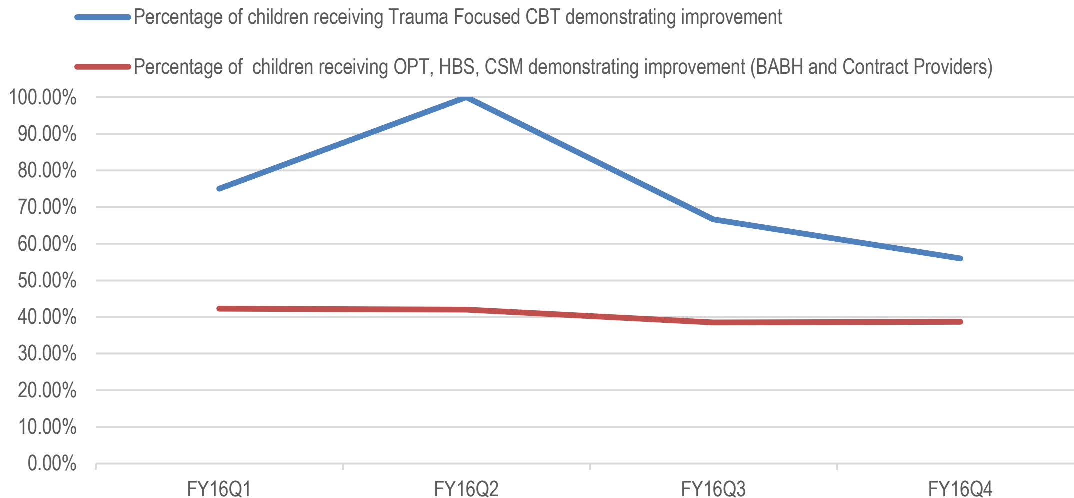
B. Child Systems of Care

Child Adolescent Functioning Assessment System (CAFAS)/Preschool and Early Childhood Functional Assessment System (PECFAS)

The CAFAS tool (approved by MDHHS to measure clinical effectiveness in children) has been used only by those certified as Reliable Raters. Clinical effectiveness is determined by comparing the Initial Assessment CAFAS score with the Most Recent assessment CAFAS score, on *closed* cases.

A decrease in the CAFAS score by 20 points or more reflects a meaningful and reliable improvement with the consumer. An increase of 20 points or more in the CAFAS score reflects a regression by the consumer. Figure 10 indicates the overall score for FY16Q1 to FY16Q4. Several individual programs show an average of 20 point difference in overall CAFAS scores from the initial CAFAS to the most recent CAFAS, but only one programs has met the 80% expectation in the “Meaningful and Reliable Improvements scores.

Figure 10 Children Served by BABH demonstrating "Meaningful and Reliable Improvement" on CAFAS Scores.



Severe Impairment Improvements shows the number and percent of youth who did not have any severe impairments at the most recent CAFAS assessment (improved) and those who still had at least 1 severe impairment (unchanged). "Unchanged" reflects children who still have moderate or severe (20 or 30) scores one or more domains. Excluded are CAFAS assessments that did not indicate severe impairment in the CAFAS scores.

Figure 11

		Severe Impairment Improvements (Excluded = No severe impairment at intake)		
		Improved	Unchanged	Excluded
All Providers Aggregate Total	2015	97 (57%)	72 (43%)	275
All Providers Aggregate Total	2016	103 (57%)	79 (43%)	313

The PECFAS is the CAFAS equivalent for children from ages 4-6. During 2013 it became a requirement of the state for all children in services to have PECFAS completed during the time they are seen. Of the 48 children either completed services during this quarter, or are still involved in services, 30 children were identified as having a severe impairment. Of those, 19 (63%) showed improvement and 11 (37%) were unchanged. 18 were excluded because there were no severe impairments, upon intake.

Figure 12

PECFAS Data					**Severe Impairment Improvements**			**Pervasive Behavioral Impairment** (Excluded = No PBI at intake)		
	Total	Initial	Most recent	Point difference	Improved	Unchanged	Excluded	Improved	Unchanged	Excluded
2015 Q4 All Providers Aggregate Total	50	87	70	17	19 (58%)	14 (42%)	17	12 (33%)	24 (67%)	14
2016 Q4 All Providers Aggregate Total	48	87	69	18	19 (63%)	11 (37%)	18	18 (51%)	17 (49%)	13

Conclusions

The desired level of performance for "Meaningful and Reliable Improvement" (80% expectation) was not achieved. Overall 39% of our consumers achieved a Meaningful and Reliable improvement, which is a decrease from the level of improvement in the previous quarter. There are no identified causal factors at this time. Further analysis and research are warranted to determine a) if the set expectation of 80% of consumers served is appropriate for the SED population eligible for specialty mental health services; b) to determine the potential causal factors that impede improvement; c) to determine if corrective action is needed.

The desired level of performance for "Severe Impairment Improvements" (80% expectation) was not achieved. Overall 57% of our consumers achieved improvement in Severe Impairments. There are no identified causal factors at this time. Further analysis and research are warranted to determine a) if the set expectation of 80% of consumers served to have no "Severe Impairments" is appropriate for the SED population eligible for specialty mental health services; b) to determine the potential causal factors that impede improvement; c) to determine if corrective action is needed.

"Severe Impairment Improvement" is evidenced by the absence of a "30" on any CAFAS subscale score from initial CAFAS to the most recent CAFAS. Overall 57% of our consumers achieved improvement in Severe Impairments, which is a 7% increase from last quarter.

Autism

Implementation of Autism Benefit/ABA Services-Center Based Service at Madison Clinic. The Autism Medicaid Benefit began April 1, 2013. This was for children ages 18 months to 21 years and uses the evidence based practice of Applied Behavioral Analysis (ABA). BABH staff have been trained with an increased focus on Autism. In addition, BABH contracts with 3 external organizations to provide assessment services and ABA for Autism. BABH also provides internal ABA services for individuals with autism. In addition to opening the autism clinic, and expanding the network specific to autism services, administration is concentrating on recruiting an additional psychologist. Since In FY16Q4, BABH has provided ABA services to 70 individuals.

Wraparound

Implementation of Wrap-Around Services to increase community organization coordination. Wraparound services were expected to be available from BABH starting April 1, 2013. This has been challenging due to transitions of trained staff. This service was implemented again in February of 2015. "Wraparound is an established vehicle for delivery of services and supports to children and families with severe and multiple needs and risks being served by multiple agencies. Wraparound refers to an individually designed set of services and supports provided to children with serious emotional disturbance or serious mental illness and their families that includes treatment services, personal support services or any other supports necessary to maintain the child in the family home." (MDHHS) Currently one individual is in receiving wraparound services. Two individuals dropped out of the wraparound program.

C. Jail Diversion/Juvenile Diversion

BABH Jail Diversion program from October 1, 2015 through September, 2016, has recorded 7 referrals and all were diverted. Since October 1, 2015, Thirty-three adolescents were screened for the jail diversion program. Twenty of the adolescents were accepted/qualified for the BABH jail diversion program and placed into services.

D. Trauma Informed Care

Implement Trauma Informed Services. BABH has implemented Trauma Informed Practices across our agency and across the Contracted Provider Agencies. Training in the EBP model Trauma Focused CBT will. BABH and its contracted clinical service providers have 13 certified Trauma Focused (TF)-Cognitive Behavioral Therapy (CBT) Clinicians and 2 are trained as supervisory staff. BABH will reassess Trauma Informed Care utilizing PIHP tool. BABH has utilized the PIHP tool and has evaluated the system for current status of knowledge of Trauma Informed Care.

E. Recovery Based Method

Implementing recovery oriented services. The Recovery Assessment Scale was implemented and is analyzed on a quarterly basis. The next step is to incorporate it into the individual consumer electronic health record and is currently in the testing phase. The Recovery System Assessment Scale-Managers Version has been utilized for a baseline measurement and one re-measurement. Policies and Procedures have been developed that incorporates recovery into training, treatment and the entire system. Recovery training has been implemented at new employee training and annually. Recovery principles have been incorporated into the core competencies for employees and included in policy throughout the agency.

F. Healthcare Integration Coordination

Co-Occurring and Integrated Services. As a result of the QI Data being discontinued and the Behavior Health TEDS reporting beginning, the method of collecting such data is currently being modified to accurately determine the current penetration rate of consumers who receive integrated co-occurring treatment and increase the consumers who are receiving Co Occurring treatment. Improve and increase the Coordination of care between mental health and substance use disorder service providers for shared individuals.

V. Data Based Recommendations

BABH celebrates its successes in continuous quality improvement to better meet the needs of providers and consumers alike. BABH will aspire to continue in maintaining these successes in 2017 as well as identifying new areas for improvement. The following initiatives have been recognized as priorities for 2017.

1. Performance Improvement Opportunities
   a) Medicaid Event Verification
   b) Diabetes Screening (MSHN)
   c) Recovery Assessment Scale (Recovery Based Services) (MSHN)
   d) Quality Reporting/Completeness-Record Reviews
      - Copy of PCP within 15 Days
      - Offering Crisis Plan
      - Evidence of Primary Care Physician/Consent
      - Person Centered Plan
      - Discharge/Transition Summary/Aftercare Plan

e) MDHHS data reporting: Michigan Mission Based Performance Indicator System (MMBPIS) (Access)
f) Behavioral TEDS Reporting
g) Other performance improvement opportunities as applicable

2. Stakeholder Satisfaction Improvement Opportunities
   a) Annual consumer satisfaction and post-service satisfaction surveys
   b) National Core Indicators Survey
   c) Provider Survey
   d) Behavior Treatment Effectiveness
   e) Consumer Councils
   f) Other stakeholder feedback as provided/requested via surveys, suggestion boxes, etc.

3. Behavioral and Primary Healthcare improvement opportunities, continued development and outcome measurement of
   a) Jail/Juvenile diversion
   b) Services for children with autism - Autism Clinic (VBMAP, ADOS)
   c) Supports Intensity Scale (SIS)
   d) Evidenced Based and Best Practices in Clinical Service Delivery - Trauma Informed Services (TF-CAFAS)(Co-Occurring Services) (Person Centered Planning)
   e) Sore-Hi
   f) CAFAS/PECFAS
   g) DECA
   h) Adverse event reporting and investigation (sentinel, critical, risk, near miss)
   i) Healthcare Integration
   j) Infection control in residential facilities
   k) Co-occurring Treatment

4. Agency-Level Improvement Opportunities
   a) Leadership dashboard measures related to the QAPIP through Strategic Plan development (Identified needs based on the MDHHS Annual Submission incorporated into the Strategic Plan)
   b) Quality Reporting – Providing technical support and assistance for data collection and analysis from the EHR and identifying opportunities for verifying and improving data integrity.
   c) Access to Data - Data Model
   d) Continued development of the utilization management program
   e) External Review Improvement Plans (CARF, MSHN, MDHHS)

VI. Attachment 1: BABH Performance Improvement Quality Dashboard

Performance Improvement Opportunities					
Medicaid Event Verification	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
% Audited Services w/Proper Documentation for Encounters Billed for all Service Providers	**95%**	99%	100%	99%	100%
	Standard	**FY15Q4**	**FY16Q2**	**FY16Q4**	
The percentage of consumers diagnosed with schizophrenia or Bipolar Disorder and taking an antipsychotic who have received a screen for diabetes. (Hedis measure: "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications."	**1% increase**	55%	68%	67%	
Consumers Recovery Assessment Scale-Active, Ongoing	**Improvement**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
Goal and Success Orientation Average (Old Domains)		3.93	3.97	3.96	3.86
Reliance on Others Average (Old Domains)		3.91	3.87	3.87	3.85
Personal Confidence and Hope Average (Old Domains)		3.79	3.74	3.78	3.72
Willingness to ask for Help (Old Domains)		3.95	3.95	3.88	3.89
No Domination by Symptoms (Old Domains)		3.07	3.19	3.15	3.04
Total # of total respondents of the Recovery Assessment Scale		286	307	338	322
Copy of IPOS offered within 15 days of the planning meeting.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
BABH -All (Includes Contract Providers)	**95%**	75%	80%	84%	93%
BABH-Direct	**95%**	75%	81%	83%	86%
Completion of Crisis Plan	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
BABH -All-(Includes Contract Providers)	**95%**	99%	99%	99%	99%
BABH-Direct	**95%**	99%	99%	98%	99%
Evidence of Primary Care Coordination	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
BABH -All-(Includes Contract Providers)	**95%**	96%	99%	90%	94%
BABH-Direct	**95%**	95%	99%	89%	100%
Michigan Mission Based Performance Indicator 1: The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS Medicaid children	95%	99.32%	99.28%	98.24%	**
MSHN Medicaid children	**95%**	99.80%	99.49%	99.02%	100%
BABH Medicaid children	**95%**	**100%**	**100%**	**100%**	**100%**
MDHHS Medicaid adult	**95%**	98.50%	99.18%	100%	**
MSHN Medicaid adult	**95%**	99.72%	98.65%	98.97%	99%
BABH Medicaid adult	**95%**	**100%**	**98.11%**	**99.10%**	**99%**

Michigan Mission Based Performance Indicator 2: The percent of new Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS-Total	**95%**	98.40%	98.52%	99%	**
MSHN-Total	**95%**	99.10%	98.40%	99.02%	99%
BABH-Total	**95%**	**98.13%**	**98.26%**	**95.74%**	**99%**
MDHHS MI-C	95%	98.39%	98.46%	98.14%	**
MSHN MI-C	**95%**	98.92%	98.79%	98.72%	99.41%
BABH MI-C	**95%**	93.18%	100%	100%	100%
MDHHS MI-A	**95%**	98.70%	99.22%	99.05%	**
MSHN MI-A	**95%**	99.72%	99.45%	99.20%	99.18%
BABH MI-A	**95%**	100%	97.62%	95.50%	99.01%
MDHHS DD-C	**95%**	98.84%	98.92%	99.32%	**
MSHN DD-C	**95%**	100%	98.44%	100%	97%
BABH DD-C	**95%**	100%	100%	100%	*
MDHHS DD-A	**95%**	99.25%	98.36%	97.77%	**
MSHN DD-A	**95%**	100%	100%	98.82%	98%
BABH DD-A	**95%**	*	100%	50.00%	*
Michigan Mission Based Performance Indicator 3: The percent of new Medicaid beneficiaries new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS-Total	**95%**	97.87%	97.85%	97.60%	**
MSHN-Total	**95%**	98.40%	97.44%	98.32%	99%
BABH-Total	**95%**	98.63%	94.78%	91.94%	93%
MDHHS MI-C	**95%**	97.22%	96.81%	96.68%	**
MSHN MI-C	**95%**	96.30%	96.68%	96.83%	97%
BABH MI-C	**95%**	100%	93.55%	95.00%	90%
MDHHS MI-A	**95%**	97.69%	97.94%	97.79%	**
MSHN MI-A	**95%**	97.69%	97.96%	97.55%	97.65%
BABH MI-A	**95%**	98.06%	97.47%	91.09%	93.41%
MDHHS DD-C	**95%**	96.48%	97.14%	97.45%	**
MSHN DD-C	**95%**	98.00%	95.74%	96.36%	100%
BABH DD-C	**95%**	100%	*	100.00%	*
MDHHS DD-A	**95%**	94.04%	95.97%	93.95%	*
MSHN DD-A	**95%**	98.08%	98.11%	96.36%	100%
BABH DD-A	**95%**	100%	75.00%	100%	100%
Michigan Mission Based Performance Indicator 4: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS Child	**95%**	98.89%	92.43%	97.51%	**
MSHN Child	**95%**	97.53%	100%	99.14%	100%
BABH Child	**95%**	100%	100%	100%	100%
MDHHS Adult	**95%**	96.70%	97.72%	94.31%	**

MSHN Adult	95%	98.14%	98.32%	97.03%	97%
BABH Adult	**95%**	97.18%	100%	100%	95%
Michigan Mission Based Performance Indicator 10: The percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days (Old Indicator #12)	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
MDHHS MI and DD children	**15%**	10.60%	11.11%	10.15%	**
MSHN MI and DD children	**15%**	6.31%	11.90%	8.72%	9.43%
BABH MI and DD children	**15%**	4.35%	4.55%	10.71%	17.65%
MDHHS MI and DD adults	**15%**	13.05%	12.72%	11.79%	**
MSHN MI and DD adults	**15%**	9.18%	8.26%	10.58%	11.88%
BABH MI and DD adults	**15%**	1.00%	1.00%	1.00%	7.58%
Behavioral TEDS Reporting	**Standard**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
% of BH TEDS completed	**75%**	80.15	84.27	87.47	91.46
Behavioral and Primary Healtcare Improvement Opportunities					
Jail/Juvenile Diversion		**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
% of juvenile individuals diverted from jail into treatment	**increase**	67%	67%	60%	25%
# Diverted		8	8	3	1
# Referred		12	12	5	4
% of Adult individuals diverted from jail into treatment	**increase**	100%	100%	100%	100%
# Diverted		1	1	4	1
# Referred		1	1	4	1
# of individuals receiving treatment for Autism		23	41	66	70
# of individuals completing the Supports Intensity Scale		36	31	32	30
Children Served by BABH and Contract Providers demonstrating "Meaningful and Reliable Improvement" on CAFAS Scores Initial to Most Recent Assessment by Quarter		**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
Percentage of children receiving Trauma Focused CBT demonstrating improvement		75%	100%	67%	56%
Percentage of children receiving OPT, HBS, CSM demonstrating improvement (BABH and Contract Providers)		42%	42%	39%	39%
Adverse Event Reporting (percent per 100)		**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
Reportable Adverse Events (risk, critical, sentinel) per 1000 persons served by BABH		5.36	3.39	3.95	4.80
Reportable Suicide Deaths		0.00	0.00	0.00	0.28
Reportable Non-Suicide Deaths		1.69	1.69	1.41	1.69
Reportable Emerg Med Treat due to Injury or Med Error		3.39	1.41	2.26	2.82
Reportable Hospitalizations due to Injury or Med Error		0.00	0.28	0.00	0.00
Reportable Rate of Arrests		0.28	0.00	0.28	0.00

VII. Attachment 2: Bay-Arenac Behavioral Health Authority Board of Directors

Bay-Arenac Behavioral Health Authority		
Board of Directors		
April 1, 2015 through March 31, 2016		
Original Board Appointed 9/23/63		
County Elected to Come Under PA 258, effective 8/8/75		
MH Code revision PA 290, 1995, effective 3/27/96: All board member terms were extended 3 months to end on 3/31, and thereafter be 3 year terms		
Name	**Term**	**County Represented**
William Powell Chair	4/1/15 to 3/31/18	Bay
Richard Byrne Vice-Chair/Parliamentarian	4/1/13 to 3/31/16	Bay
James Anderson Secretary	4/1/14 to 3/31/17	Bay
Robert Pawlak Treasurer	4/1/13 to 3/31/16	Bay
Richard Gromaski	4/1/14 to 3/31/17	Bay
Ernie Krygier	4/1/15 to 3/31/18	Bay
Robert Luce	4/1/15 to 3/31/18	Arenac
Colleen Maillette	4/1/14 to 3/31/17	Bay
Teresa (Terri) Marta	Term expires 3/31/16 Appointed 6/4/2013 to fill unexpired term	Arenac
Patrick McFarland	4/1/15 to 3/31/18	Bay
Thomas Ryder	4/1/14 to 3/31/17	Bay
Thomas Starkweather	4/1/13 to 3/31/16	Bay