AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
HEALTH CARE IMPROVEMENT & COMPLIANCE COMMITTEE MEETING

Monday, March 4, 2024 at 5:00 pm
William B. Cammin Clinic, Bay Room, 1010 N. Madison Avenue, Bay City, MI 48708

Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
Robert Pawlak, Ch				Patrick McFarland				BABH: Karen Amon and Sara McRae
Robert Luce, V Ch				Colleen Maillette, Ex Off				
Tim Banaszak				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
Ernie Krygier								

	Agenda Item	Discussion	Motion/Action
1.	Call to Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Corporate Compliance Report 3.1) Corporate Compliance Report 3.2) Corporate Compliance Committee meeting notes from January 22, 2024		3.1) No action necessary 3.2) No action necessary
4.	Other Reports 4.1) Primary Network Operations & Quality Management Committee meeting notes from January 11, 2024		4.1) No action necessary
5.	Unfinished Business 5.1) None		

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6.	New Business 6.1) Modification of Confidentiality of Substance Use Disorder (SUD) Patient Records Regulations 6.2) Quality Assessment and Performance Improvement Program (QAPIP) Quarterly Report 6.3) Fraud/Privacy Leadership Dashboard			6.1) No action necessary 6.2) No action necessary 6.3) No action necessary	
7.	Adjournment	M -	S -	pm	MA

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, January 22, 2024 (1:00 –1:53 pm)

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Karen Amon, Comp.& Privacy Officer, Chair	X	Heather Friebe, Clinical Program Manager	-	Melissa Prusi, Rec. Rights/Cust. Serv. Manager	-
Amy Folsom, Clinic Practice Manager	X	Jennifer Lasceski, director of HR	X	Sarah Holsinger, Quality Manager	X
Denise Groh, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Ellen Lesniak, Finance Manager, Vice Chair	-	Joelin Hahn, Director of Integrated Healthcare	-	Guests:	
Heather Beson, Director of Integrated Healthcare	-	Marci Rozek, CFO	X		

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of December 19, 2024, meeting notes.** **c) Next Meeting: February 12, 2024**	a) No additions to the agenda. b) December 19, 2024, meeting minutes – approved as written. c) The next meeting is scheduled for February 12, 2024. Members approved moving the meeting to Mondays.	
2.	**State-Federal Laws and Regulations** a) Review of Log and Subject Matter Expert Report Out	a) Karen has attended the Legislation and Policy Committee through the Community Mental Health Association. Karen and the committee reviewed the log: **CMHA Key Bills:** SB 27 and HB4707 regarding Mental Health & SUD Parity: **Log No. 349** - SB 0027 Modifies insurance Code has passed the House and now is in the Senate moved to committee. No updates. HB4707 Expands/strengthens medical necessity and out-of-network services is on the House floor but will most likely be a lame duck issue. No updates on the guardian items on the log. **Log No. 367** No updates for TCM for incarcerated individuals. **Log No. 380** Hab Supports Waiver – Melanie and Heather were to review those. 10-1 was the effective date for changes. **Log No 382**- MMP 23-76 Electronic Visit Verification Implementation: Jesse stated majority will be using the states solution. State probably not holding to March deadline. Some providers are already enrolled. **Log No 383** Staff education and forms updated – Marci double checked with Nicole, and everything has been completed. Forms have been updated in the EHR and training is being done at staff meetings. **Log No. 392** – HB4081 AFC Licensing changes – work group formed to modify this proposed Bill. **Log No. 394** - Memo regarding unusual incident reports – Rights is saying incident reports are subject to disclosure. We do not normally release incident reports. Sent to attorney for clarification on 1-18-24. Karen to meet with the attorney next week.	Log No. 380 – Melanie and Heather to review

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		Log No. 395 HB 4213 requiring Telemedicine coverage of SUD and behavioral health services HB 4579, 4580 & 4131 would require equitable coverage and reimbursement for telehealth services. This is currently in the Senate. Expecting it to pass. **Log No. 396**: HB 5184 & 5185 Social Worker Licensure Bills: Eliminate the test as part of licensure and Tie Michigan social worker licensure to the variables most directly tied to the quality of social work practice. – Most likely a Lame Duck issue. **Log No. 397:** SB 227 Amends the Childcare Licensing Act to allow for emergency physical management/therapeutic de-escalation (regarding certain levels of restraint & seclusion) in certain children's residential settings was recalled by the House due to conflict with an earlier Bill. Probably will pass once corrected. **Log No. 398**: SB 681 Death with Dignity – Assisted suicide – CMHs to engage in conversations but not take a stance on the issue. **Log No.399:** HB 5343-5347 MH Insurance Parity – passed in the House and is now in the Senate. **Log No. 400:** HB 5371-5372 CCBHC covered below. **Log No. 401**: SB625 Requiring Master Level Psychologist to have 3 years' experience to provide ABA services. Assign to psychologist and Heather Beason for review. **Log No.402**: Extreme Risk Order - Health care providers would be able to file a petition for an extreme risk protection order to disclose relevant info but must be compliant with disclosure laws. In layman's terms "The red flag law". Joelin attended a meeting regarding this. This is related to firearms. To petition someone who has a firearm and to have it removed. A public act is already in place to provide for issuance of restraining orders prohibiting certain individuals from possessing or purchasing firearms and ordering the surrender and seizure of those firearms. Both Heathers, Stacy, RR, Joelin to review. **Log No.403:** EVV update –Need to look at how to implement this with North Bay staff. Jesse, Nicole and Heather B. to go over this. **Log No. 404**: Final Policy Updates to HSW are ready for Heather B., and Melanie to review. **Log No. 405:** Behavior Treatment Review final policy updates Heather B., and psychologist to review. **Log No. 406**: MMP23-65 Children with Serious Emotional Disturbances Waiver final policy updates. Sarah, Joelin, Pam, Emily, Heather B., and Amanda Johnson to review. HB4693 – Open Meetings Act: Allows for remote participation for CMH & PIHP meetings. Hopefully be finalized by this summer. Chris felt this may not apply to our Board since they are compensated. Bulletin 2374 regarding Community Health Workers –Karen asked Amy, both Heathers and Joelin to look this over more closely. This will be carried over to the next meeting since only Amy was in attendance today. **CMHA FY25 Budget Issues** – Asking for real time adjustment to Medicaid rates – Caseloads have increased – asking for adjustment to include increases for staff and providers. Also, that people are slotted into the "correct" Medicaid category. The state is seeing unusual re-enrollment patterns. Plan First coverage is being selected by many since it is the easiest Medicaid benefit to apply for. This is causing issues. No Medicaid coverage for those individuals – trying to identify who these individuals are and change coverage back to regular Medicaid.	No. 401- psychologist and Heather Beason to review. No. 402 - Both Heathers, Stacy, RR, Joelin to review. No. 403 - Jesse, Nicole, and Heather B. to review. No. 404 – Heather B., and Melanie to review No. 405 – Heather B and psychologist to review. No. 406 - Sarah, Joelin, Pam, Emily, Heather B., and Amanda J. to review. B-2374 - Amy, both Heathers and Joelin to review

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3.	b) Review of CMHA Update on Legislative and Policy Changes c) Review of Compliance Updates/Regulatory Education Needed for Staff d) Process for Ensuring Implementation of Policy Changes	Continued phase out of local match draw down – State has taken CMH's local funds from each county. Trying to get the local dollars back to the CMH's where it belongs. Michigan has been selected as one of the additional participants in the Certified CBHC Demonstration. Wanting to continue expansion in demonstration sites. Karen stated there was some discussion on keeping them as demonstration projects giving the states more control about how they are implemented. Requesting a reduction in administrative burdens associated with reviews and audits for CMHs and provider organizations that have received full accreditation. Reverse the recent explosion in the number of procedure codes required for CLS. Change the CLS 15-minute codes back to having the option of a per day code which would be helpful. BH Accelerated Degree Program – requesting $10 million to support 300 social workers. Paid internship allows them to work while getting their master's degree. Grant in place to help 100 workers. Direct Care Wage Increase – requesting $20 per hour for DCW and an increase for managers, case managers, supervisors etc. Since $18 was declined last year, it is unlikely this will go through. Better Coordination with MH in school funding – More productive to collaborate rather than give money to the schools which takes staffing from public health system. Have our workers go into the schools rather than the school hiring workers. b) Discussed above. c) None d) Nothing to report.	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones April-May	a) Employee Attestation – Jennifer sent out the attestations by email yesterday. The e-sign feature is now usable.	
4.	**Data/Monitoring/Reports:** a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for	a) Monthly monitoring completed; no findings to report regarding Security Breaches in Phoenix and Gallery for December. b) Exclusion - No findings to report.	

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	Fraud/Abuse/Convictions during Staff Development Days) c) Monitoring of Group Drives for Unsecured PHI Files d) Security Officer Update e) Ethics/Recipient Rights/Customer Service Update f) Corporate Compliance Activity Report g) Review Updated Fraud Abuse Risk Assessment and Confirm Action Plan January Reports h) HIPPA Breach Log i) Review of OIG Work Plan j) Corporate Compliance Semi-Annual Progress Report	c) No findings of unsecured PHI Files. d) No security issues to report. e) Deferred until Melissa is in attendance. f) Deferred g) Updated Fraud Abuse Risk Assessment for 2023 is complete and has been approved by HCICC. h) HIPAA Breach Report – discussed under 5k. i) Karen reviewed OIG Work Plan key issues: Audit of Emergency Preparedness, infection prevention and control and life safety at nursing homes and ICFs for individuals with ID. Medicaid enrollees are at increased risk. Trying to determine whether certain States comply with Federal requirements. Suicide and self-harm are on the rise among youths. Highest risk following an attempt. Therefore, timely follow up MH treatment is essential. A study will be conducted to assess whether this follow-up care is done within an established timeframe. Experts will be interviewed to identify challenges and best practices that States encountered regarding follow-up care for youths enrolled in Medicaid and CHIP. Per Sarah, BABHA has been auditing this also. Study to determine what percentage of providers are treating Medicare and Medicaid patients with MOUD Medications for Opioid Use Disorder. Study to determine the extent to which people enrolled in Medicare Part D maintain Buprenorphine treatment for at least 6 months. Audit of Medicare Part C audits of documentation supporting specific diagnosis codes and health risk assessment diagnosis codes. A tool they use is a Health Risk Assessment. j) Deferred to February meeting.	

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	k) Dashboard Fraud-Abuse-Privacy-Security Enhanced Monitoring l) Intermittent Checks of Self Determination Service m) List Psychological – IPOS expired with services provided, several months of no documented progress notes, unsigned documents by staff/supervisor, stand-alone AUTH's, back dating of Interim Plans	k) On the Fraud Abuse Dashboard for FY24Q1, there was one substantiated documentation issue for Home based services. Billing for Home based and an IEP. One pending investigation from FY23 which was unsubstantiated. Fraud and Abuse for Providers - 2 substantiated fraud and one pending. In Q1 the pending was also substantiated. These were all on the same provider. FY24Q1 - two open cases which are in the process of being investigated. The graph shows a substantial increase in cases since FY23Q1. On the Privacy Dashboard FY23Q4 - we had 2 pending cases, one substantiated, and one unsubstantiated. Neither required reporting For FY23Q4 there were five pending cases which went through the RR process. All were unsubstantiated. Then five more cases came in which are being investigated. There is an increase in fraud and privacy complaints. One of the pending complaints is self-determination. Question of how we recoup. If we substantiate, we do not want to continue to pay anyone substantiated for fraud. Karen to reach out to Mid-State to see how to handle this. Marci did state in the past a case was turned over to the IOG. l) Chelli monthly report for December - Chelli reviewed five consumers notes for 1-6 weeks. Most were good. Two needed brief recommendations which were discussed at the PCP meeting. m) n) Remove from agenda.	Karen to reach out to Mid-State Remove 4m from the agenda
5.	**Outstanding Items/Other:** a) Statewide Credentialing Work Group Updates b) Ability to Pay Changes (PA 92 of 2022; eff. 6-6-22) We will have until 10/2023	a) No updates b) Take off agenda.	Remove 5b from the agenda
6.	Adjourn/Credentialing Committee Next Meeting	Credentialing meeting today. **The next meeting scheduled for Monday February 12, 2024, 1:00 – 3:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, January 11, 2024

1:30 p.m. - 3:30 p.m.

Lincoln Center - East Conference Room

MEMBERS	Present	MEMBERS	Present	AD-HOC MEMBERS	Present
Allison Gruehn, BABH ACT/Adult MI Program Manager		Joelle Sporman (Recorder), BABH BI Secretary		Amanda Johnson, BABH ABA/FS Team Leader	
Amy Folsom, BABH Madison Clinic Manager		Karen Amon, BABH Healthcare Accountability Director		Denise Groh, BABH Medical Records Associate	
Anne Sous, BABH EAS Supervisor		Kelli Maciag, BABH Children's IMH/HB Supervisor		Ellen Lesniak, BABH Finance Manager	
Barb Goss, Saginaw Psychological COO		Laura Sandy, MPA Adult/Child CSM Supervisor		Jacquelyn List, List Psychological COO	
Chelsea Hewitt, Saginaw Psychological Asst. Supervisor		Lynn Blohm, BABH North Bay Team CLS Supervisor		Kathy Jonhson, Consumer Council Rep (J/A/J/O)	
Chelsee Baker, Saginaw Psychological Supervisor		Megan Smith, List Psychological Site Supervisor		Nathalie Menendes, Saginaw Psychological COO	
Courtney Clark, Saginaw Psychological OPT Supervisor		Melanie Corrion, BABH Adult ID/DD Manager		Nicole Sweet, BABH Clinical Services Manager	
Emily Gerhardt, BABH Children Services Team Leader		Melissa Deuel, BABH Quality & Compliance Coordinator		Sarah Van Paris, BABH Nursing Manager	
Emily Simbeck, MPA Adult OPT Supervisor		Melissa Prusi, BABH RR/Customer Services Manager		Stephanie Gunsell, BABH Contracts Manager	
Heather Beson, BABH Integrated Care Director		Pam VanWormer, BABH Arenac Clinical Supervisor		Taylor Keyes, Adult MI Team Leader	
Heather Friebe, BABH Arenac Program Manager		Sarah Holsinger (Chair), BABH Quality Manager		Tyra Blackmon, BABH Access/ES Clinical Specialist	
Jaclynn Nolan, Saginaw Psychological OPT Supervisor		Stacy Krasinski, BABH EAS Program Manager		**GUESTS**	**Present**
James Spegel, BABH EAS Mobile Response Team Supervisor		Stephani Rooker, BABH ID/DD Team Leader			
Joelin Hahn (Chair), BABH Integrated Care Director		Tracy Hagar, MPA Child OPT Supervisor			

	Topic	Key Discussion Points	Action Steps/Responsibility
1.	**a. Review of, and Additions to Agenda** **b. Approval of Meeting Notes: 12/14/23** **c. Program/Provider Updates and Concerns**	a. There was an addition to the agenda; 4m. Corporate Compliance Trends. b. The December 14th meeting notes were approved as written. c. **Bay-Arenac Behavioral Health**: - ABA/FS – Nothing to report this month. - ACT/Adult MI – ACT is down one nurse. We hired a Peer Support Specialist, and she started yesterday. Sarah Mulvaney from Case Management will be starting towards the master's level position in ACT. We will be down both Intensive Case Managers and 3 case managers for a total of 5 case managers. - Arenac Center – No updates to report this month. - Children's Services – Noreen has retired, and Emily G. took over for her. We are down a home-based worker. - CLS – Struggling to hire DSP's. Lynn is working on the wait list for CLS. - Contracts – Nothing to report this month. - Corporate Compliance – Nothing to report this month.	

BAY-ARENAC BEHAVIORAL HEALTH
PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING
Thursday, January 11, 2024
1:30 p.m. - 3:30 p.m.
Lincoln Center - East Conference Room

Topic	Key Discussion Points	Action Steps/Responsibility
	- EAS (Emergency Access Services)/Mobile Response – We filled all referrals for the contract agencies on Tuesday. We are looking for a team leader for 2nd shift and intake assessment staff. We hired a 2nd shift person but still need the MRT 2nd shift position filled. We are doing a CIT training for the 7 officers for the Bay City Police Department. - Finance – Nothing to report this month. - ID/DD – Nothing to report this month. - IMH/HB – Nothing to report this month. - Madison Clinic – Dr. Meyer is working. We replaced Jill Lebourdais with Melissa Wazny at the Arenac Center. - Medical Records – Nothing to report this month. - North Bay – Nothing to report this month. - Quality – Nothing to report this month. - Recipient Rights/Customer Services – There is an increase in options for an interpreter. If you are in need of EAS, there is an option for three-way calling. **List Psychological**: List is down several therapists. Megan Smith took over for Abbi Burns and will be working with BABH. List plans to open back up in February. **MPA:** Patricia Straney will be retiring in February. We will need to find someone to replace Patricia to do our hospital liaison and hospital discharges. A therapist is leaving and potentially another therapist may be leaving, and she is not taking any new referrals. A new therapist is coming on board, but she is replacing another therapist that left. **Saginaw Psychological:** Courtney Clark is new to the Saginaw Psychological Team as of January. She will be working with BABH and is hoping to open more referrals in the next month.	

BAY-ARENAC BEHAVIORAL HEALTH
PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING
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1:30 p.m. - 3:30 p.m.
Lincoln Center - East Conference Room

	Topic	Key Discussion Points	Action Steps/Responsibility
		We are all struggling with capacity. People seem to leave their job for easier hours and more pay. Emily S. said they come in with a limited license, they get their hours, pass their exam, and start looking for a new job because they are burnt out with Medicaid and Phoenix and want to work for private insurance. Things seem easier, less tedious, and there is not as much paperwork involved with private insurance. Melissa made a suggestion about having support coordination and case management assistants to relieve the administrative burden. Joelin stated that in Macomb County, they found so much success with having the supports coordinator/case management assistants that they have a whole department of just the assistants that do the case management/supports coordination functions under the supervision of a case management supervisor. We can put this on our agenda if there is intertest, and we can get someone who uses the assistants to do a presentation for us. We can consider having a meeting for an intern orientation. If this would be beneficial, we can add this to the agenda as well.	c. Add to agenda: Case Management/Supports Coordinator Assistants and Intern Orientation
2.	**Plans & System Assessments/Evaluations** a. QAPIP Annual Plan (Sept) **b. Organizational Trauma Assessment Update**	a. Nothing to report this month. b. The Organizational Trauma Assessment is done every three years. Sarah H. will be sending out a QR code and a link asking that you pass it along to all your staff including leadership. The survey has 106 questions.	
3.	**Reports** **a. QAPIP Quarterly Report (Feb, May, Aug, Nov)** b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports **i. MSHN Priority Measures Report (Jan, Apr, Jul, Oct)** **ii. Recipient Rights (Jan, Apr, Jul, Oct)** iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec) **iv. Consumer Satisfaction Report (MHSIP/YSS)**	a. 24 Hours of Children's Specific Training – Make sure you complete 24 calendar hours of children's specific training. There have been findings during audits and reviews. Plan of Service Training Forms – The Plan of Service Training forms are reviewed during site reviews and Melissa D. reviews them during the quarterly PI reviews. If you have consumers that have secondary services, those staff have to be trained in the plan of service. The last audit accounted for most of the errors due to not having a plan of service training form. We will start doing a monthly review of the forms. Reportable Behavior Treatment Events – Behavior treatment events have decreased in the last few quarters. Risk Events – Risk events (harm to self/other, 911 calls, CPI techniques) are trending upward but mainly from	c. i. Deferred c. ii. Deferred c. v. Remove Discharge Summary Disposition Report from the agenda.

Topic	Key Discussion Points	Action Steps/Responsibility
v. Provider Satisfaction Survey (Sept) c. Access to Care & Service Utilization Reports **i. MMBPIS Report (Jan, Apr, Jul, Oct)** **ii. LOCUS (Mar, Jun, Sep, Dec)** **iii. Leadership Dashboard - UM Indicators (Jan, Apr, Jul, Oct)** **iv. Service Requests Disposition Report (Feb, May, Aug, Nov)** **v. Discharge Summary Disposition Report (Feb, May, Aug, Nov)** **vi. Customer Service Report (Jan, Apr, Jul, Oct)** d. Regulatory and Contractual Compliance Reports **i. Internal Performance Improvement Report (Feb, May, Aug, Nov)** **ii. Internal MEV Report** iii. MSHN MEV Audit Report (Apr) iv. MSHN DMC Audit Report (Sept) v. MDHHS Waiver Audit Report (Oct when applicable) e. Periodic Review Reports f. Ability to Pay Report g. Review of the Referral Status Report	ABA services due to kids trying to harm themselves. Quality of Care Record Reviews – We look specifically to see that the services written in the plan are delivered at the consistency identified. We do 30 internal reviews a month and it shows we are at a 97% and doing well, but during the audits we are not doing well. We will be redoing that process to capture what is happening and making sure staff are looking at the information correctly. If you are authorizing therapy, it needs to say individual therapy and if you are authorizing medication reviews, it needs to say medication reviews. What is in the authorizations is in the frequency of the service being provided. You can look through the rest of the report when you have time, and if you have any questions, please get with Sarah. b. i. The MSHN Priority Measures Report was emailed so you can look through it when you have time, and if you have any questions, please get with Sarah. ii. In FY23, the ORR received 190 complaints. In FY22, the ORR received 133 complaints. In FY21, the ORR received 118 complaints. This is an increase of 57 complaints over last FY, and 72 complaints over FY21. Residential complaints are the highest number of substantiated complaints, which is to be expected. The allegations coming in shows abuse/neglect are tied, we are talking about abuse I/II and neglect I/II. Trends: There is an increase in complaints regarding Case Management services suited to condition. iii. Nothing to report this month. iv. Analysis: For 2023, there was a 39% response rate (1216/2200) for surveys distributed. A response rate could not be determined for 2022, but this was the highest return rate since 2018. There were 174 (8%) surveys that were mailed (not including those mailed to guardians), and two surveys that were completed by phone, however, these were not approved methods for distribution. Due to low response rates in the past, it was determined that surveys were only supposed to be distributed face to face. There is not a way to determine if the surveys	

Topic	Key Discussion Points	Action Steps/Responsibility
	that were returned were those that were distributed in person or by mail. There was a 17% decline rate and 28% of consumers that were not seen for face-to-face contact during the four-week period. The MHSIP survey had a 41% response rate which met the 95% confidence level. The YSS survey had a 34% response rate which did not meet the 95% confidence level; it was an 81% confidence level. A drawing for a $50 gift card was also offered to consumers if they completed the survey and provided their name/phone number. Action: Over the past several years, surveys have been distributed in a variety of different ways with varying degrees of success. Ninety-two percent of the surveys were distributed in person during 2023 and it appears that this produced a successful response rate. It is recommended that surveys continue to be hand delivered during face-to-face contacts. The results of the MHSIP can be actioned due to meeting the 95% confidence level, but the YSS results should not be actioned due to only producing an 81% confidence level. It is also recommended that there continues to be the option of being entered for a gift card. MHSIP Survey Findings: There was a total of 360 MHSIP surveys returned during 2023 out of 883 surveys distributed, which resulted in a 98% confidence level. It should be noted that Assertive Community Treatment (ACT), Bay Case Management (CSM), Bay Outpatient (OPT), Michigan Psychiatric Associates (MPA) CSM, and Saginaw Psychological Services (SPS) CSM had a significant decrease in the number of surveys completed for 2023 compared to 2022. List Psychological Services (LPS) OPT had a significant increase in the number of surveys completed for 2023 compared to 2022. These differences have the potential to impact the appearance of major increases or decreases in compliance.	

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	Analysis: There were six questions that had a 3% increase in agreement for 2023 compared to 2022, which was the biggest increase in agreement. These were found throughout four different domains. Question 17, "I, not staff, decided my treatment goals," Question 32, "I am better able to do things that I want to do," and Question 35, "I feel I belong in my community," were the three questions that had the biggest decrease in agreement for 2023 with 3%. All of the questions in the Outcomes, Functioning, and Social Connectedness domains were below 80% which is typical of previous years. Action: Over the past several years, surveys have been distributed through a variety of methods. This year the surveys were distributed primarily face to face and consumers/guardians had the chance to win a $50 gift card. There was a total of 360 MHSIP surveys returned resulting in a 98% confidence level. • We can present survey information to staff • We can go over the PCP policy • Remind staff of Independent Facilitation YSS Survey Findings: There were a total of 114 YSS surveys returned out of 333 surveys distributed for 2023 which resulted in an 81% confidence level. Four programs had an increase in surveys and four programs had a decrease in surveys. LPS had zero surveys returned in 2022 and 10 surveys returned in 2023. MPA CSM had 31 surveys returned in 2022 and 3 surveys returned in 2023. Analysis: Question 16, "My child is better at handling daily life" saw the biggest increase in agreement (9%) for 2023 compared to 2022 followed by Question 20, "My child is better able to cope when things go wrong" with a 7% increase in agreement. There were twelve questions that saw a decrease in agreement in 2023 compared to 2022. The two questions	

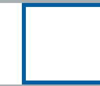
Topic	Key Discussion Points	Action Steps/Responsibility
	that saw the biggest decrease in agreement (4%) was Question 8, "The location of services was convenient for us" and Question 19, "My child is doing better in school and/or work." Action: For 2023, there were 114 YSS surveys returned from 333 distributed. This resulted in an 81% confidence level. Actions taken on results that are not statistically significant could change processes/procedures that could negatively impact consumers overall. Therefore, there is nothing specific to action with the results of the YSS for 2023. The response rate was 34% in 2023 compared to 14% in 2021. Staff will continue to provide education and encouragement on the value of completing these surveys and BABH, when possible, will continue to offer the chance to win a gift card. v. Nothing to report this month. c. i. The MMBPIS Report is for all the indicators. There are no shows primarily. There are gaps where a program was not accepting referrals, but we were not aware of that and there was a time issue getting them back. There is a standard for Indicators 2 and 3. ii. Deferred iii. Deferred iv. This is an older report, but it states EAS had a ton of referrals this year. It shows how no shows plays a big part in numbers. v. This is an older report, but people are dropping out of treatment which is why people are being discharged. Sarah is asking that we no longer report on the Discharge Summary Disposition Report at this meeting. vi. The BABH RR/CS Department processed 373 total CS cases (in addition to the 190 RR complaints) for FY23. The total number of grievances for Q4 was 5, inquiries were 53 and appeals was 58. We have some individuals who call frequently, so we start a case to make it easier for staff, otherwise, there would be more inquiries noted. Trends: There is an increase in grievances regarding quality of services for CSM and	

	Topic	Key Discussion Points	Action Steps/Responsibility
		Outpatient Therapy. There is an increase in appeals where recipients are reporting they are not getting outreach and their case is being closed. We are not saying this is happening, but it is being voiced by consumers. d. i. We continue to struggle with coordination of care. Looking at ways to include an attachment link to the coordination of care letter so things can be uploaded showing evidence of that. Frequency Scope Duration was another major issue. Make sure the summary section at the bottom of assessments are filled out; there are lots of blanks. Make sure you check the boxes of what criteria is met for the disability designation. ii. Nothing to report this month. iii. Nothing to report this month. iv. Nothing to report this month. v. Nothing to report this month. e. Nothing to report this month. f. Finance is supposed to be going around to meet with providers regarding the ATP Report. g. Nothing to report this month.	
4.	**Discussions/Population Committees/ Work Groups** a. Harm Reduction, Clinical Outcomes and Stakeholder Perceptions i. CAFAS Reports for Performance Improvement/LOC Utilization Mgmt. ii. PCP Treatment Team Input iii. Consumer Council Recommendations (as warranted) b. Access to Care and Service Utilization i. MMBPIS Work Group ii. Services Provided during a Gap in IPOS iii. Repeated Use of Interim Plans	a. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month. b. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month. c. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month. iv. Nothing to report this month. v. Nothing to report this month. vi. Nothing to report this month. d. We are in the process of revising the title of C04-S05-T10 to include the Advanced Crisis Planning. We did not realize we did not have a policy and	e. Deferred f. Defer Referrals till next meeting. g. Deferred h. Deferred j. Deferred k. Continue discussion next meeting. l. Deferred m. Providers need to email Karen Amon the name of their Corporate Compliance Officer.

Topic	Key Discussion Points	Action Steps/Responsibility
c. Regulatory Compliance & Electronic Health Record i. 1915 iSPA ii. Ability to Pay Assessments iii. Periodic Reviews - Including Options for Blending with Plan of Services Addendums iv. Management of Diagnostics v. MDHHS Standard Consent Module in Phoenix vi. PHE Ending Update and PCE Changes **d. BABH/Policy Procedure Updates** **i. C04-S05-T10 Advanced Crisis Planning, Advanced Directives, and Personal-Patient Advocate** **e. Coordination of Care - PCE** **f. Clinical Capacity Issues Update** **i. OPT Group Therapy** **ii. OPT Individual** **iii. Referrals - Not having enough staff to accommodate number of referrals (Emily S.)** **g. Education on Medicaid Renewal** **h. General Fund Budget Issues FY24** **i. Review of GE Exceptions P&P** **ii. Reimplementation of GF Plan - Update** **i. DBT Provider Network Team Expansion Opportunity** **j. RPOSN Referrals** **k. IPOS Ranges**	procedure on crisis planning. Crisis planning is not a requirement, but there are times there should be one. Advance Crisis Plan was added in the definition's section. Under the procedure's section, #5 and #6 were added: A crisis plan will be established with an individual in the following circumstances: The individual receives treatment services and supports with the Assertive Community Treatment (ACT) or Home-Based Services programs; As a part of discharge planning or upon discharge from an involuntary mental health inpatient admission; Participation with Mobile Response Team crisis intervention services. The crisis plan will be reviewed and revised as needed at the following intervals: ACT or Home-Based Services –at least every 6 months; As a part of discharge planning or upon discharge from an involuntary mental health inpatient admission; As requested by the individual served (and/or guardian). e. Deferred f. We identified a group of BABH staff that are willing to start the group process. We are hoping to start the end of January, beginning of February. We have one new outpatient therapist hired but we cannot let her start therapy until we get a case manager to replace her. We have interviews coming up for another therapist as well as a tele-therapist. Referrals is deferred till next meeting. g. Deferred h. Deferred i. BABH, MPA and Saginaw Psychological used to have a DBT Team. Throughout the years, there were fewer referrals, so BABH and MPA dismantled their teams, but Saginaw Psych still has their team. With the OPT capacity issues, Saginaw Psych has clinicians that resigned and now the DBT Team needs help. Saginaw Psych needs at least 2 clinicians to help out from other sites. Group takes place on Thursdays from 9:00-11:00 and then the team meets from 11:15-1:00. If staff do not have training but are interested, they need to fill out an application to be part of the team and then there would be an interviewing process and then training. They would have to do	

BAY-ARENAC BEHAVIORAL HEALTH
PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING
Thursday, January 11, 2024
1:30 p.m. - 3:30 p.m.
Lincoln Center - East Conference Room

	Topic	Key Discussion Points	Action Steps/Responsibility
	l. Recommended Training **m. Corporate Compliance Trends**	the 5-day training. Staff training would be covered by BABH. If anyone is interested in helping out, please get with Jaclynn Nolan. j. Deferred k. We had an issue with this on a site review. The state is not allowing us to use ranges. We are asking staff to use reasonable ranges at this time. l. Deferred m. There is a rise in complaints for potential fraud. The complaints are coming in from community-based services where people are reporting services they are not providing, and some are being substantiated. Please be aware of reporting services. Karen would like to meet with the Corporate Compliance Officers among the providers. Please send the name of the CCO to Karen and she will schedule a meeting to talk through issues and discuss how to prevent fraud from happening. There has also been an increase in privacy situations. This is not fraud, but it could fall under abuse with regard to Medicaid funding, where we are seeing trends with regards to plans of services expiring and then there being a gap and services are being provided without having a plan in place. BABH would review and take back money for services provided during that gap. Just a reminder for those billing for Case Management services, you cannot bill a unit until you have 15 minutes.	
5.	**Announcements** a. DHHS Outreach Worker i. MIBridges System b. Great Lakes Bay FAN – Recovery & Resource Fair, Delta College, Thursdays 5:00 - 7:00 PM	a. FYI b. FYI	
6.	**Parking Lot** a. Addendums (Primary Case Holder vs. Add-On Services)	a. Future discussion	
7.	**Adjournment/Next Meeting**	The meeting adjourned at 2:30 pm. The next meeting will be on February 8, 2024, 1:30 - 3:30 in-person at the Lincoln Center in the East Conference Room.	



Fact Sheet 42 CFR Part 2 Final Rule

Date: February 8, 2024

On February 8, 2024, the U.S. Department of Health & Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2 ("Part 2"). With this final rule, HHS is implementing the confidentiality provisions of section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act - PDF <https://www.congress.gov/116/bills/hr748/bills-116hr748enr.pdf> (enacted March 27, 2020), which require the Department to align certain aspects of Part 2 with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Background

The Part 2 statute (42 U.S.C. 290dd-2) protects "[r]ecords of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education,

prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States." Confidentiality protections help address concerns that discrimination and fear of prosecution deter people from entering treatment for SUD.

The modifications in this final rule reflect the proposals published in the December 2, 2022, Notice of Proposed Rulemaking (NPRM) <https://www.federalregister.gov/documents/2022/12/02/2022-25784/confidentiality-of-substance-use-disorder-sud-patient-records> and public comments <https://www.regulations.gov/docket/hhs-ocr-2022-0018> received from: substance use disorder and other advocacy groups; trade and professional associations; behavioral and other health providers; health information technology vendors and health information exchanges; state, local, tribal and territorial governments; health plans; academic institutions, including academic health centers; and unaffiliated or anonymous individuals. Following a 60-day comment period, HHS analyzed and carefully considered all comments submitted from the public on the NPRM and made appropriate modifications before finalizing.

Major Changes in the New Part 2 Rule

The final rule includes the following modifications to Part 2 that were proposed in the NPRM:

- **Patient Consent**
  - Allows a single consent for all future uses and disclosures for treatment, payment, and health care operations.
  - Allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations.[1]
- **Other Uses and Disclosures**
  - Permits disclosure of records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule.
  - Restricts the use of records and testimony in civil, criminal, administrative, and legislative proceedings against patients, absent patient consent or a court order.

- **Penalties**: Aligns Part 2 penalties with HIPAA by replacing criminal penalties currently in Part 2 with civil and criminal enforcement authorities that also apply to HIPAA violations.[2]
- **Breach Notification**: Applies the same requirements of the HIPAA Breach Notification Rule[3] to breaches of records under Part 2.
- **Patient Notice**: Aligns Part 2 Patient Notice requirements with the requirements of the HIPAA Notice of Privacy Practices.
- **Safe Harbor**: Creates a limit on civil or criminal liability for investigative agencies that act with reasonable diligence to determine whether a provider is subject to Part 2 before making a demand for records in the course of an investigation. The safe harbor requires investigative agencies to take certain steps in the event they discover they received Part 2 records without having first obtained the requisite court order.

Substantive Changes Made Since the NPRM

In addition to finalizing modifications to Part 2 that were proposed in the NPRM, the Final Rule includes further modifications informed by public comments, notably the following:

- **Safe Harbor:** Clarifies and strengthens the reasonable diligence steps that investigative agencies must follow to be eligible for the safe harbor: before requesting records, an investigative agency must look for a provider in SAMHSA's online treatment facility locator and check a provider's Patient Notice or HIPAA Notice of Privacy Practices to determine whether the provider is subject to Part 2.
- **Segregation of Part 2 Data**: Adds an express statement that segregating or segmenting Part 2 records is not required.
- **Complaints**: Adds a right to file a complaint directly with the Secretary for an alleged violation of Part 2. Patients may also concurrently file a complaint with the Part 2 program.
- **SUD Counseling Notes**: Creates a new definition for an SUD clinician's notes analyzing the conversation in an SUD counseling session that the clinician voluntarily maintains separately from the rest of the patient's SUD treatment and medical record and that require specific consent from an individual and cannot be used or disclosed based on a broad TPO consent. This is analogous to protections in HIPAA for psychotherapy notes.[4]

- **Patient Consent:**
  - Prohibits combining patient consent for the use and disclosure of records for civil, criminal, administrative, or legislative proceedings with patient consent for any other use or disclosure.
  - Requires a separate patient consent for the use and disclosure of SUD counseling notes.
  - Requires that each disclosure made with patient consent include a copy of the consent or a clear explanation of the scope of the consent.
- **Fundraising**: Create a new right for patients to opt out of receiving fundraising communications.

What has not changed in Part 2?

As has always been the case under Part 2, patients' SUD treatment records cannot be used to investigate or prosecute the patient without written patient consent or a court order.

Records obtained in an audit or evaluation of a Part 2 program cannot be used to investigate or prosecute patients, absent written consent of the patients or a court order that meets Part 2 requirements.

What comes next?

The final rule may be downloaded at https://www.federalregister.gov/public-inspection/2024-02544/confidentiality-of-substance-use-disorder-patient-records <https://www.federalregister.gov/public-inspection/2024-02544/confidentiality-of-substance-use-disorder-patient-records>. HHS will support implementation and enforcement of this new rule, including through resources related to behavioral health developed by the SAMHSA-sponsored Center of Excellence for Protected Health Information <https://coephi.org/> </disclaimer.html>. Persons subject to this regulation must comply with the applicable requirements of this final rule two years after the date of its publication in the *Federal Register*. The Department will conduct outreach and develop guidance on how to comply with the new requirements, such as filing breach reports when required.

OCR plans to finalize changes to the HIPAA Notice of Privacy Practices (NPP) to address uses and disclosures of protected health information that is also protected by Part 2 along with other changes to the NPP requirements, in an upcoming final rule modifying the HIPAA Privacy Rule.

HHS planning to implement in separate rulemaking the CARES Act antidiscrimination provisions that prohibit the use of patients' Part 2 records against them.

Endnotes:

[1] However, these records cannot be used in legal proceedings against the patient without specific consent or a court order, which is more stringent than the HIPAA standard.

[2] *See* 42 U.S.C. 1320d–5 and 1320d-6.

[3] Section 13400 of the HITECH Act (codified at 42 U.S.C. 17921) defined the term "Breach". Section 13402 of the HITECH Act (codified at 42 U.S.C. 17932) enacted breach notification requirements, discussed in detail below.

[4] *See* https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html </hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html>.

Content created by Office for Civil Rights (OCR)
Content last reviewed February 8, 2024

Quality Assessment and Performance Improvement Program (QAPIP)
Quarterly Report

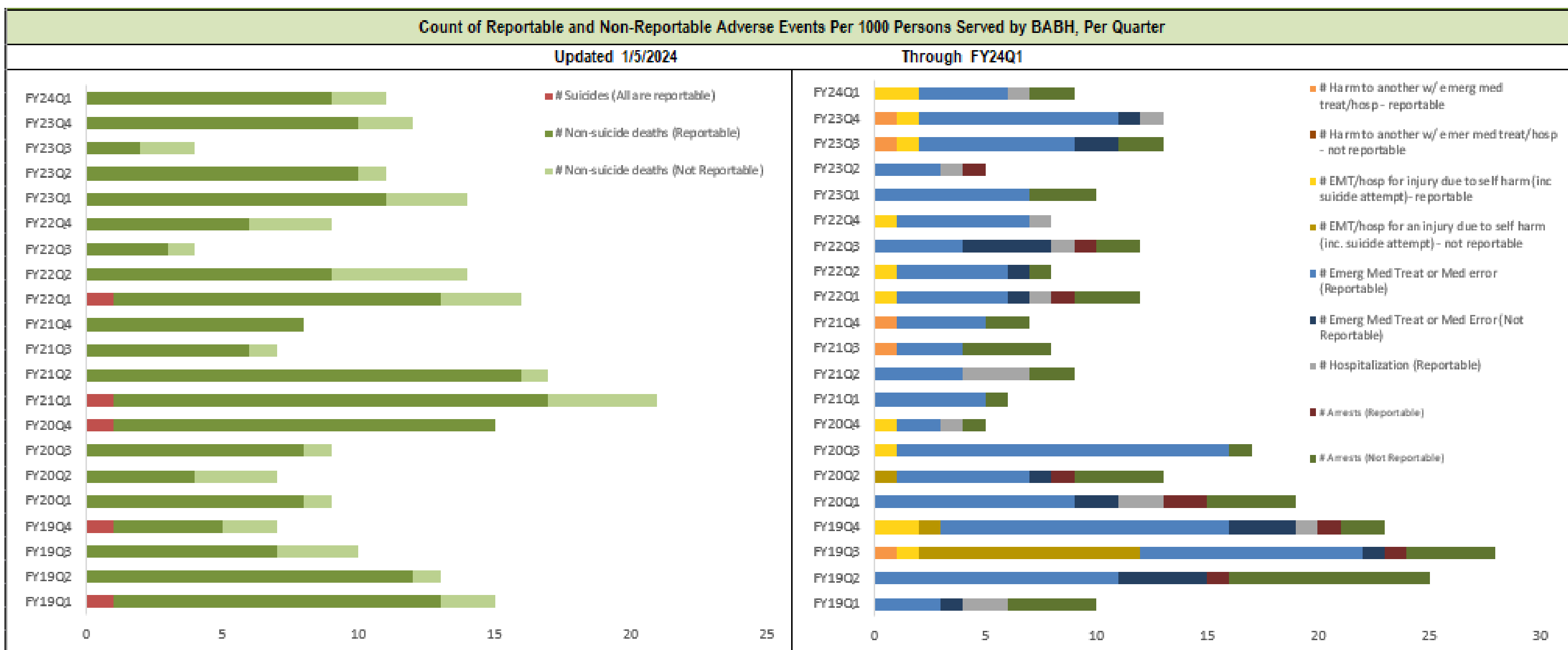
The following report provides a quarterly update to the goals identified in the QAPIP plan as well as an annual review.

PROVIDER QUALIFICATION AND SELECTION

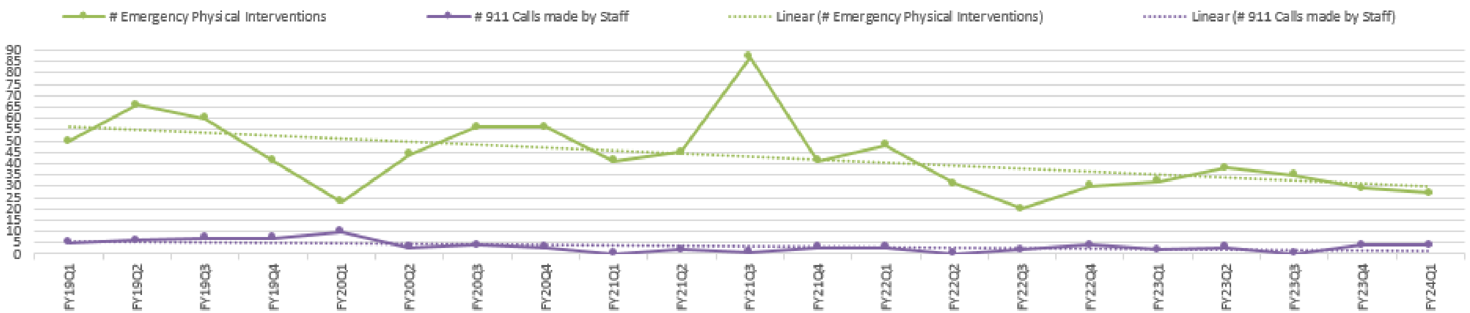
24 Hours of Children's Specific Training: The Staff Development department has been working on utilizing reports within Relias to provide to supervisors on a regular schedule to determine how staff are progressing with this requirement. Supervisors have received training on how to access this information independently within Relias. Additionally, the Staff Development department created a curriculum that each children's staff can complete to ensure 24 hours of children's specific training is completed.

Plan of Service Training Forms: BABH staff are reviewing the use of this form during scheduled site reviews, during the quarterly Performance Improvement review process, as well as monthly monitoring by the quality improvement staff. The findings of these reviews are given to supervisors for follow-up with applicable staff.

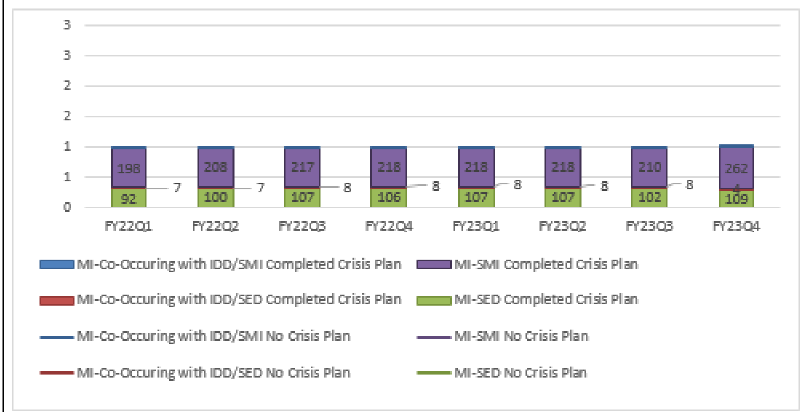
HARM IDENTIFICATION AND REDUCTION



Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH: There were six types of adverse events reported during FY24Q1; deaths (reportable and not reportable), emergency medical treatment due to self harm (reportable) and emergency medical treatment due to injury or med error (reportable), arrests (not reportable), and hospitalization (reportable). There were 11 deaths for FY24Q1 which was a slight decrease from the last quarter. There was a decrease in the number of reportable emergency medical treatments for FY24Q1 (4); compared to last quarter (9). The distribution of types of adverse events for FY24Q1 is comparable to previous quarters as well. There does not appear to be any type of trend among these incidences, therefore, no specific actions are identified at this time.

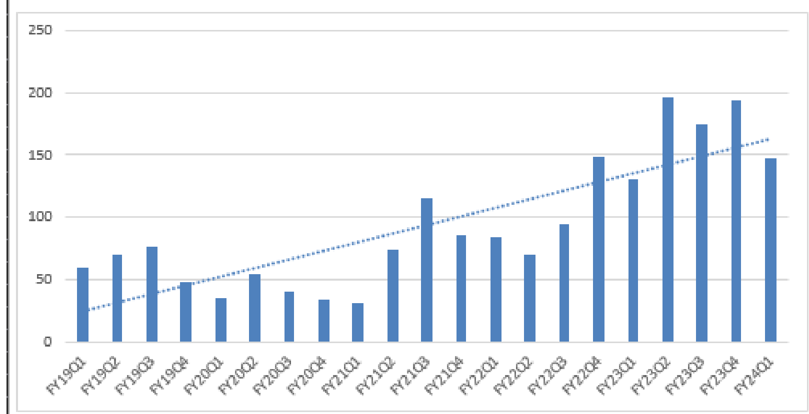


Reportable Behavior Treatment Events: The number of emergency physical interventions decreased for FY24Q1 and the overall number of interventions continues on a downward trend. There were 10 consumers that accounted for the 27 emergency physical interventions. There were four 911 calls made for behavioral assistance for FY24Q1; the overall trend continues downward.



Completion of Crisis Plan: There was a significant increase in the number of completed crisis plans for FY24Q1 compared to previous quarters for the MI-SMI and MI-SED populations.

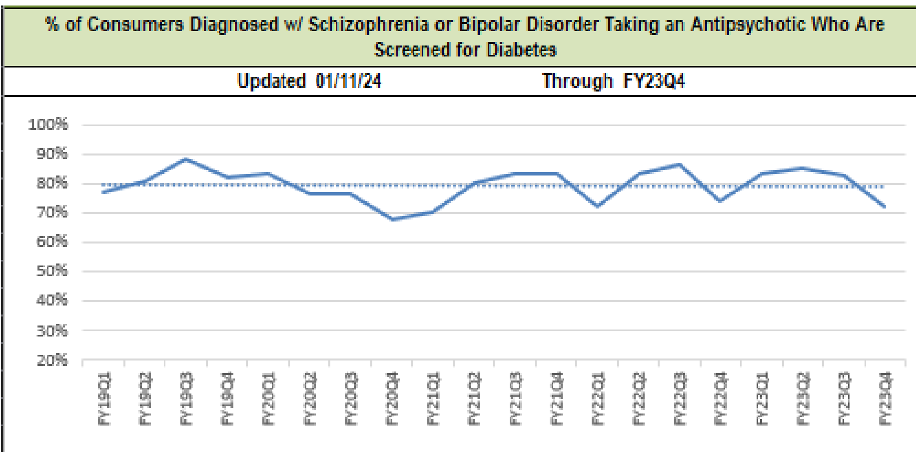
Risk Events: Risk events are identified as 'harm to self, harm to others, police calls for behavioral assistance, emergency physical interventions, and two or more hospitalizations.' The number of risk events decreased during FY24Q1.



The Number of Days to Complete the Recipient Rights Investigation is Lower Than the Michigan Mental Health Code Standard of 90 Days: This is a new goal for FY24 and data is not yet available.

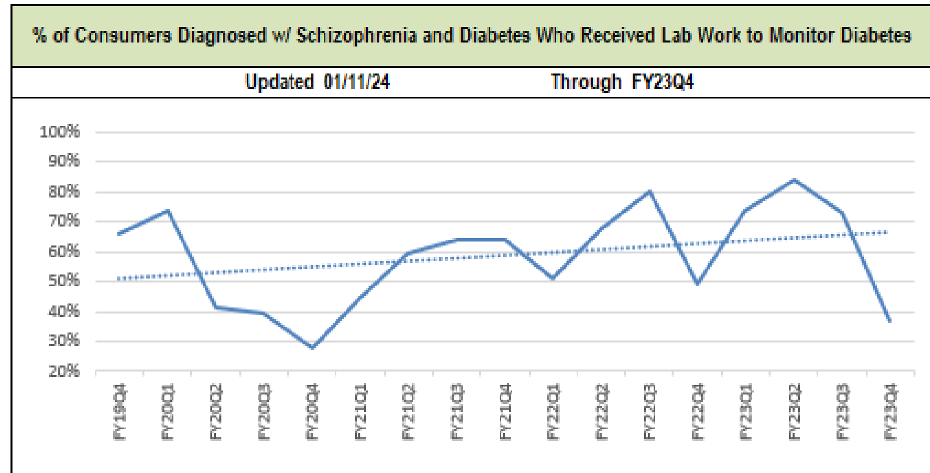
Abuse and Neglect Complaints Substantiated Have Remedial Action: This is a new goal for FY24 and data is not yet available.

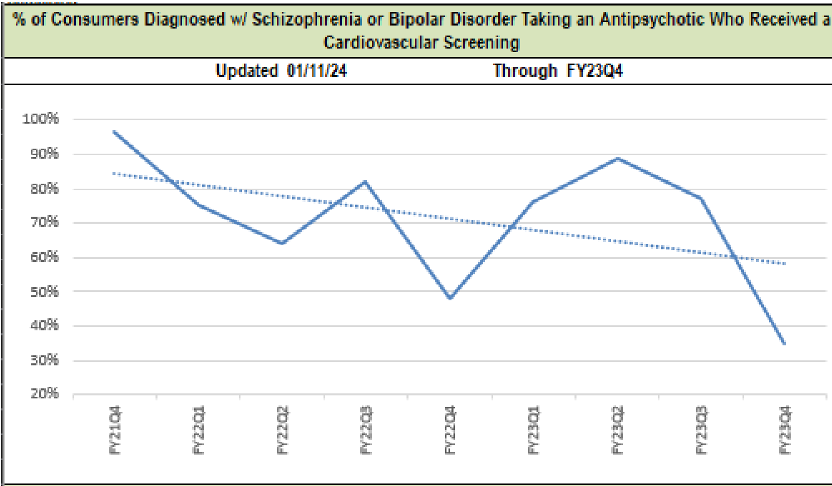
OUTCOMES



Consumers Diagnosed with Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes: BABH had a decrease in consumers receiving the appropriate labs for this measure during FY23Q4. It was identified that the compliance rate is determined solely by claims processed and not from our staff addressing these in the system. BABH will continue to monitor this to determine if looking at the Care Alerts monthly had improved compliance.

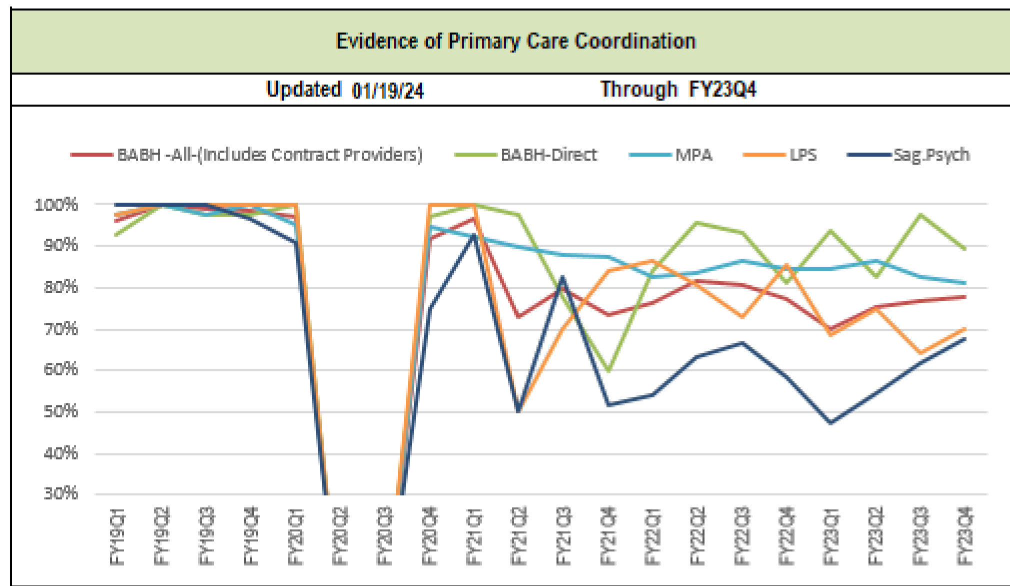
Consumers Diagnosed with Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes: BABH saw a significant decrease in consumers receiving the appropriate labs for this measure during FY23Q4 and there continues to be an upward trend. It was identified that the compliance rate is determined solely by claims processed and not from our staff addressing these in the system. BABH will continue to monitor this to determine if looking at the Care Alerts monthly had improved compliance.

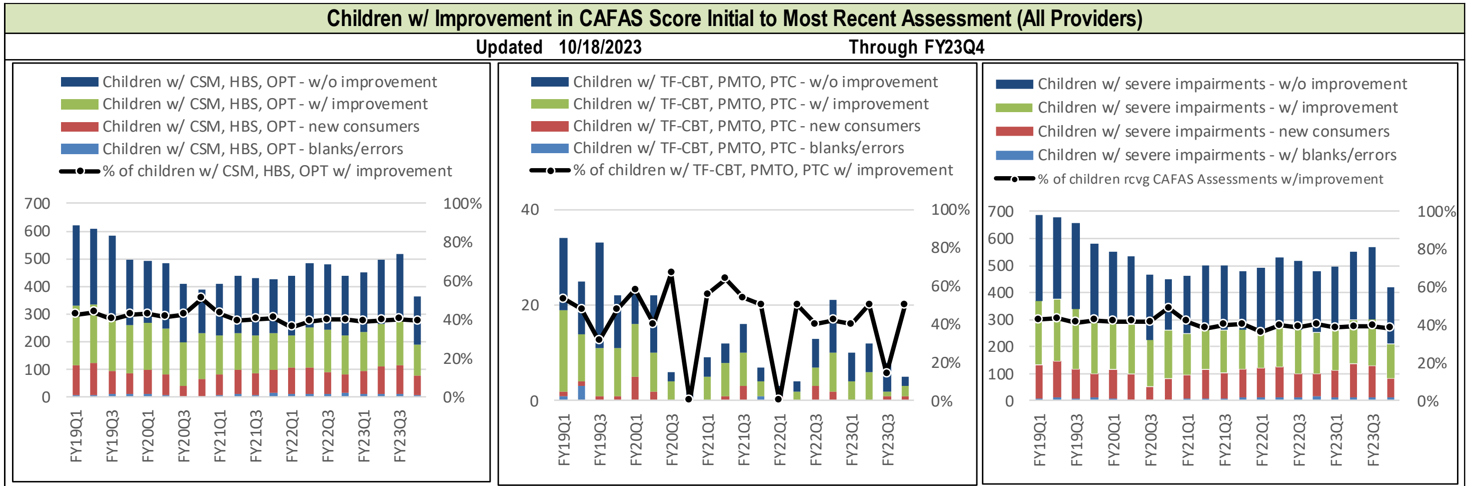




Consumers Diagnosed with Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Cardiovascular Disease: BABH saw a significant decrease in this measure for FY23Q4. It was identified that the compliance rate is determined solely by claims processed and not from our staff addressing these in the system. BABH will continue to monitor this to determine if looking at the Care Alerts monthly had improved compliance.

Evidence of Primary Care Coordination: BABH and the contract providers did not meet the 95% standard for having evidence of health care coordination during FY23Q4. Two contract providers did see an increase in compliance. There have been some barriers to using the Coordination of Care form in PCE, but these were addressed during FY24Q1 so we expect to see compliance increase.





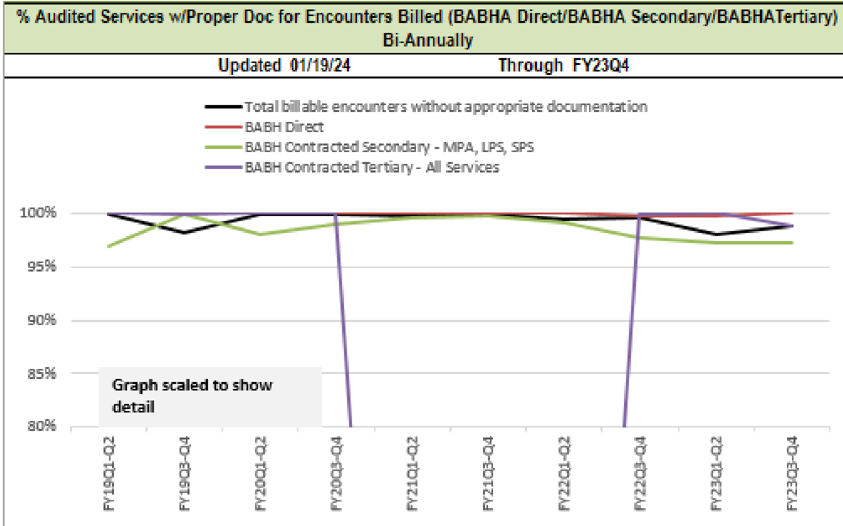
More Than 40% of Children Served Will Have Meaningful Improvement In Their Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) Score: During FY23Q4, 39% of children showed meaningful improvement in their CAFAS/PECFAS scores, slightly below the goal BABH set.

Quality of Care Record Reviews- Services Are Written In The Plan of Service Are Delivered At The Consistency Identified: 100% of the records reviewed during FY24Q1 received the level of services that were written in the plan which meets the 90% standard set by BABH. However, there were findings from the MSHN Delegated Managed Care audit that did not demonstrate this high of compliance. Quality Staff are planning to provide more guidance and detail about this question to staff in the Quality of Care Record Review process to get a more accurate compliance rate.

Quality of Care Record Reviews- All Services Authorized In The Plan of Service Are Identified Within the Goals/Objectives of the Plan of Service: 96% of the records reviewed during FY24Q1 had the services identified appropriately to match the services authorized which meets the 90% standard set by BABH.

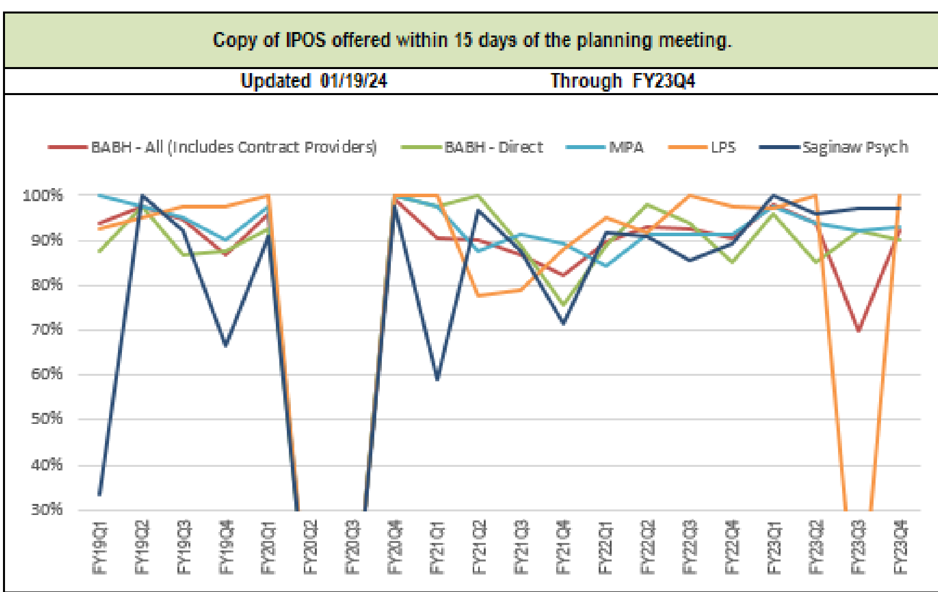
Develop Quarterly Reports to Increase the Quality Report and Outcomes Related To The Level of Care Utilization System (LOCUS): No update.

ACCESS TO CARE AND UTILIZATION MANAGEMENT



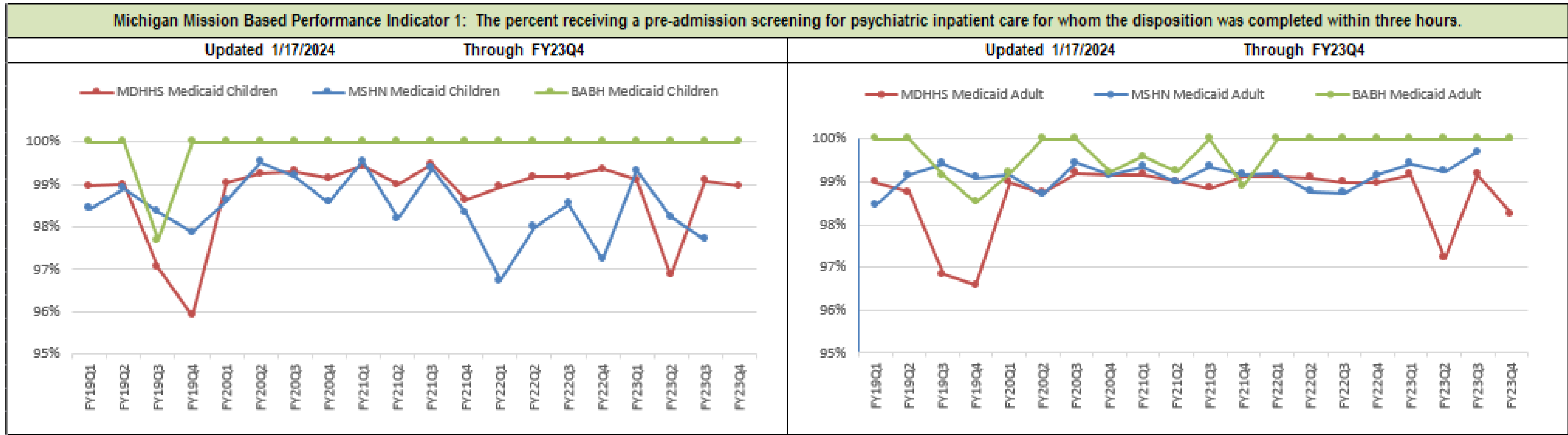
Audited Services with Proper Documentation for Encounters Billed: All ancillary services reviewed during FY23Q3 and FY23Q4 scored above the 95% standard. These reviews included specialized primary and community living support providers. There was a total of 9,883 claims reviewed with only 114 errors resulting in a 98.8% compliance rate. The most common finding was that the documentation did not contain enough detail to meet the Medicaid standard for the service billed.

Increase Medicaid Event Verification (MEV) Reviews: BABH continues to increase the services audited by completing reviews of all specialized residential, community living support, vocational, primary, and autism providers. BABH also updated the MEV policy and procedure to include more frequent reviews of services determined to be higher risk such as community living supports (CLS).

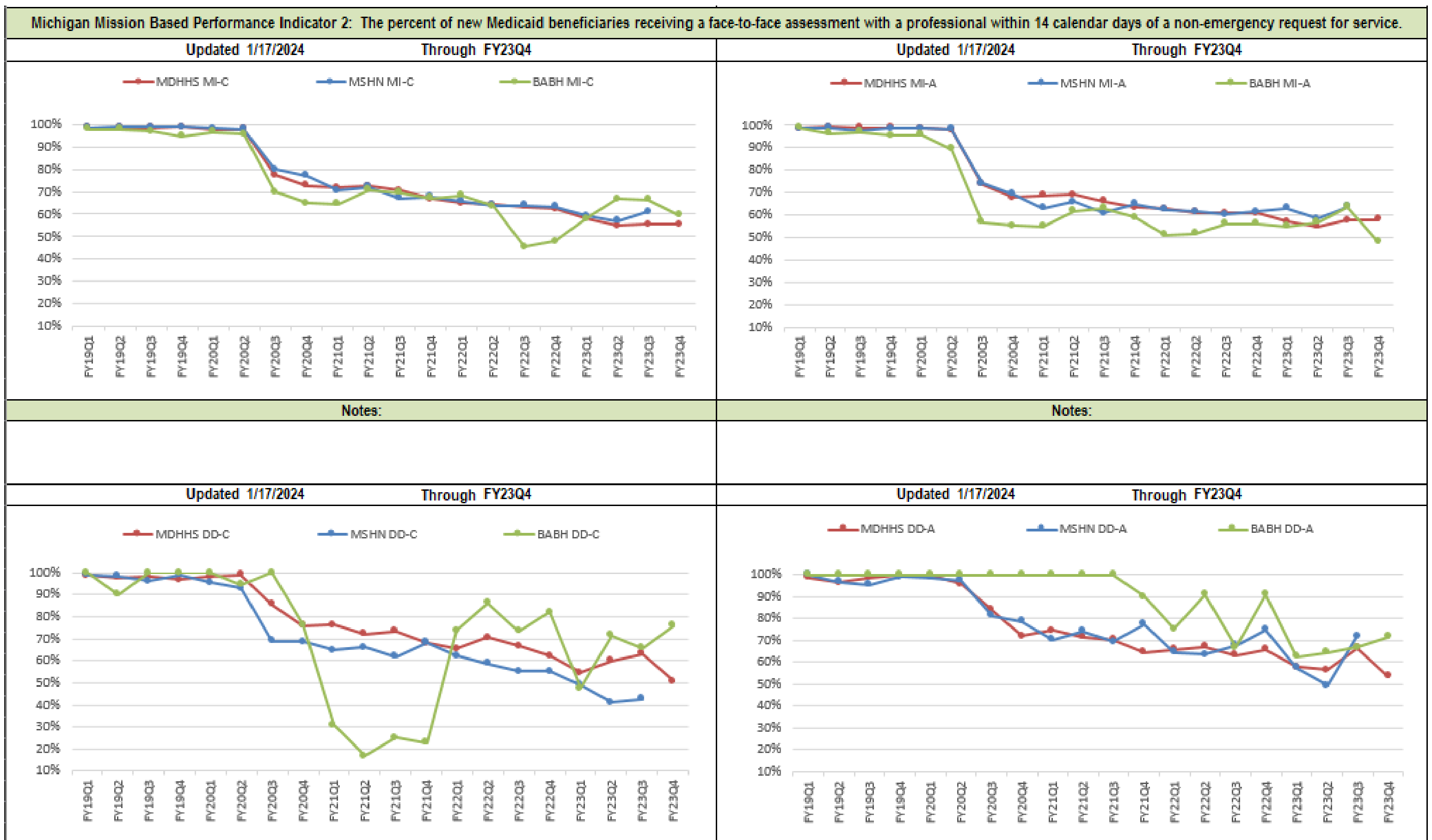


Copy of Plan of Service Offered Within 15 Days of Planning Meeting: BABH had a 2% decrease in providing a copy of the IPOS within 15 days while the other contract providers all had an increase. It was determined that staff are not always using the electronic health record completely so there is missing data and blanks. Quality Staff are working with providers to remind staff to complete all data elements related to the plan of service. One provider has not been using the data field correctly that resulted in a 100% compliance rate due to having only one record reviewed. Extra training and education has been provided.

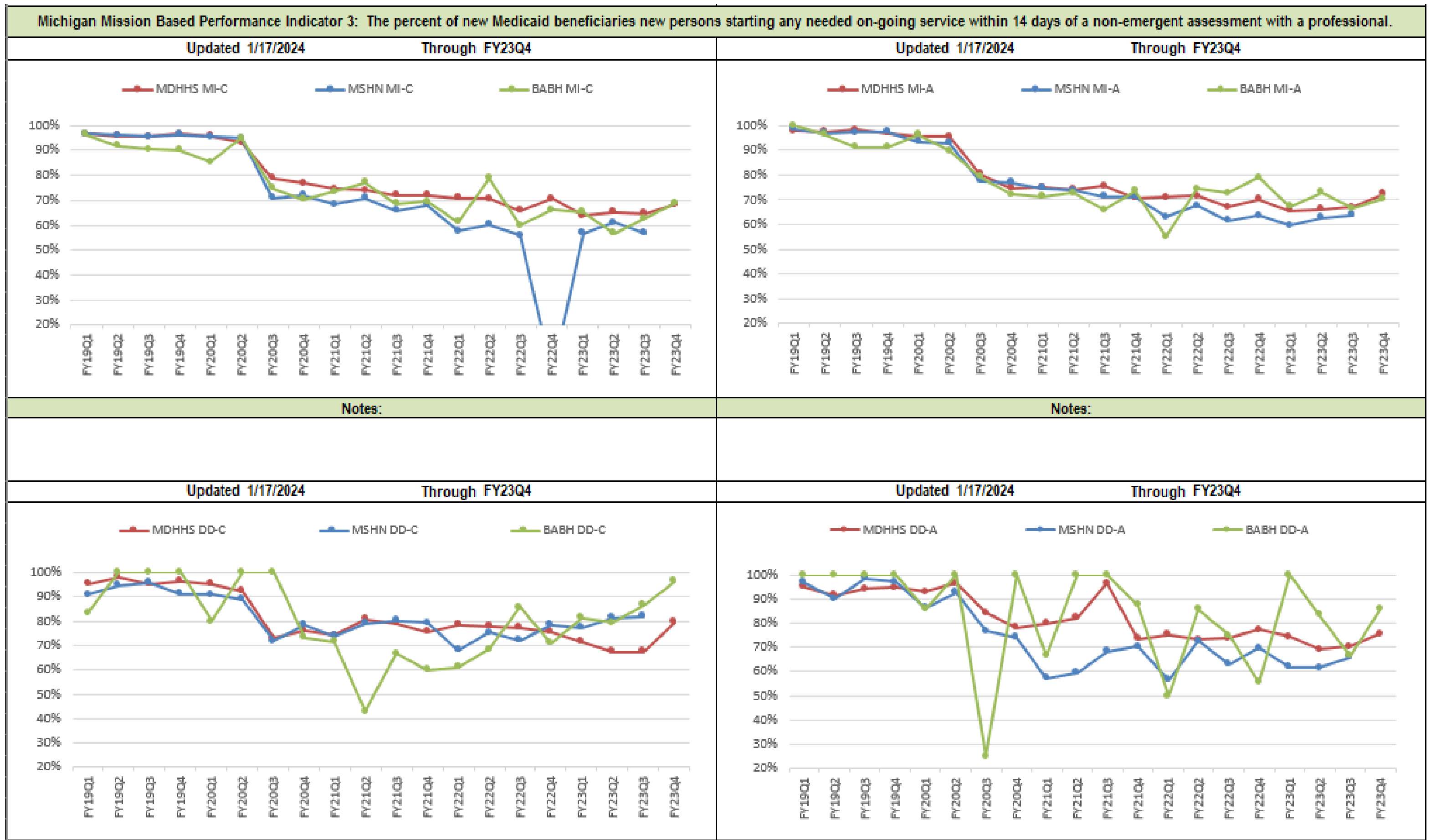
Michigan Mission Based Performance Indicator System (MMBPIS): Indicator 1 (The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours.): BABH demonstrated 100% compliance for Indicator 1 for both children and adult populations during FY23Q4. This was a higher rate of compliance than MSHN and MDHHS.



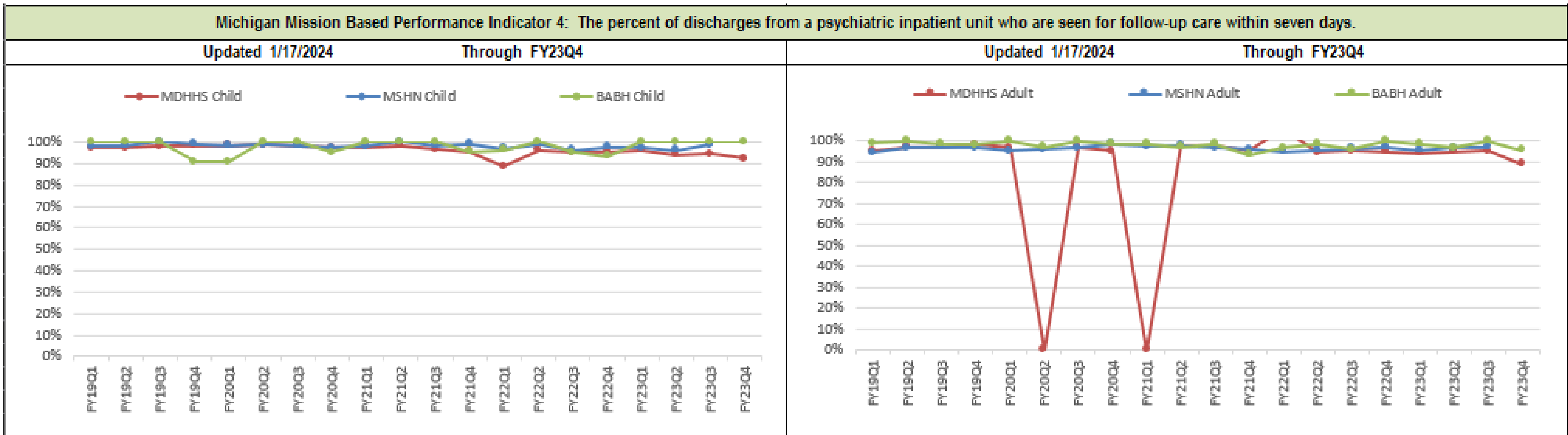
MMBPIS: Indicator 2 (The percent of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergent request for services.): BABH has consistent or higher compliance rates for all four populations when compared to the MSHN region and the Michigan Department of Health and Human Services (MDHHS). BABH continues to make concerted efforts to improve engaging consumers in services such as working toward starting a consumer engagement group, expanding Clinical Assessment Specialist positions internally, and exploring Same Day Access.



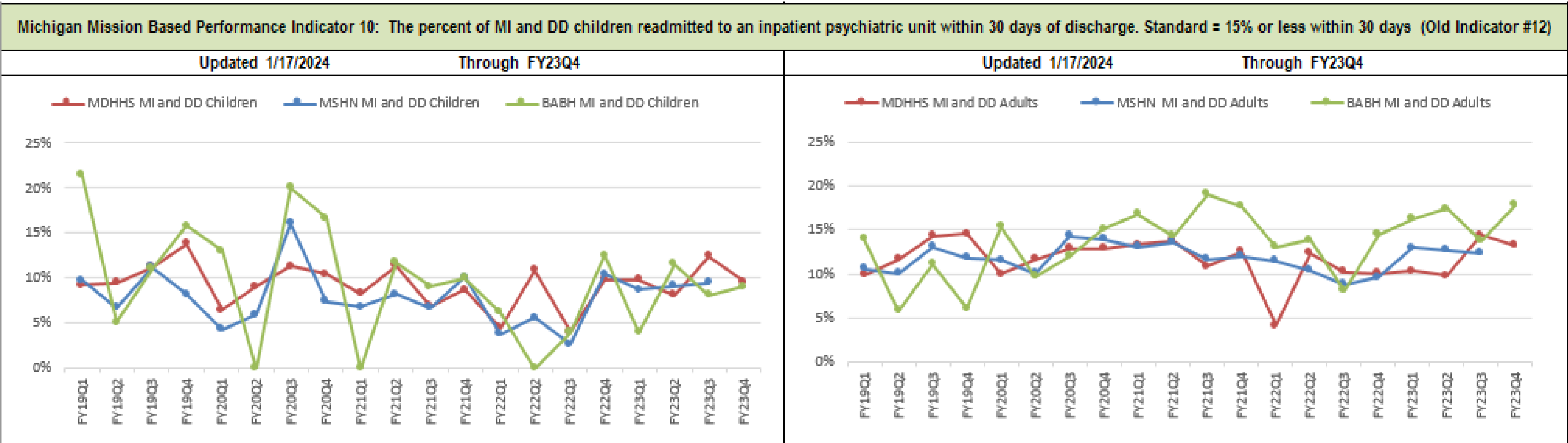
MMBPIS: Indicator 3 (The percent of Medicaid beneficiaries starting any needed ongoing service within 14 days of a non-emergency assessment with a professional.): BABH has consistent or higher compliance levels compared to MSHN and MDHHS. Most of those out of compliance were the result of consumer action.



MMBPIS: Indicator 4 (The percent of discharges from a psychiatric inpatient unit who are seen for follow-up within seven days.): The BABH Child population had 100% compliance for FY23Q4 and 95.5% for the BABH Adult population. Both populations were above the 95% standard as well as the regional and state compliance rates for FY23Q4. This is above the MSHN region and MDHHS.



MMBPIS: Indicator 10 (The percent of beneficiaries readmitted to an inpatient psychiatric unit within 30 days of discharge.): BABH met the compliance rate for the child population for FY23Q4, but did not meet compliance for the adult population. It was determined that the level of care for adults has been increasing as well as other external factors such as homelessness, substance use, involuntary petitions, and consumers new to BABH.



Reduction of Inpatient Hospitalization Days for FY23: BABH had 6,115 inpatient hospitalization days during FY22 and 8,385 FY23. This was an increase of 2,270 inpatient hospitalization days during FY23 which did not meet the goal of an overall reduction. Further analysis determined that over the past couple of months consumers have been staying significantly longer than the 5-7 day average. The Emergency Access Service department is looking into specific individuals to determine other trends and factors.

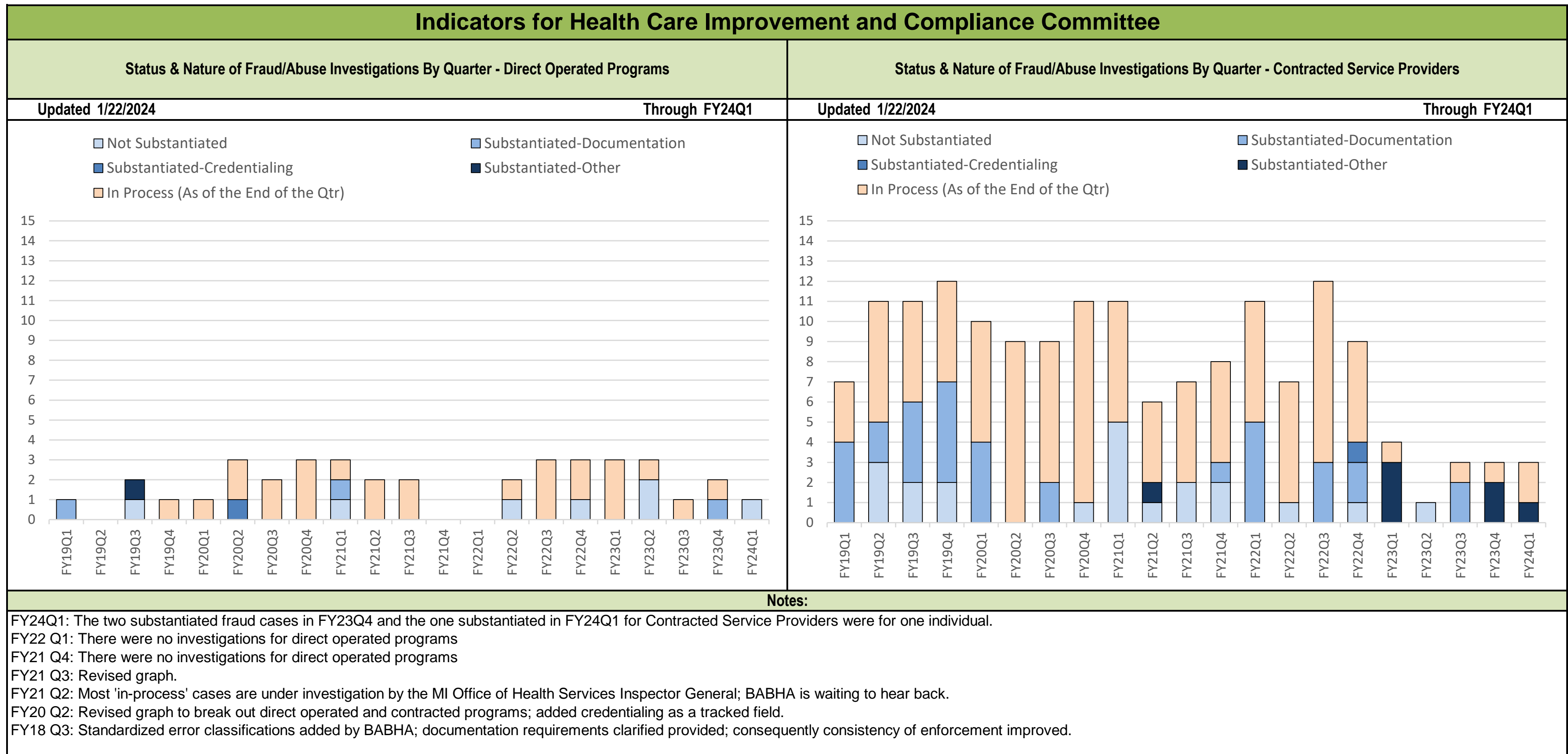
STAKEHOLDER PERCEPTIONS

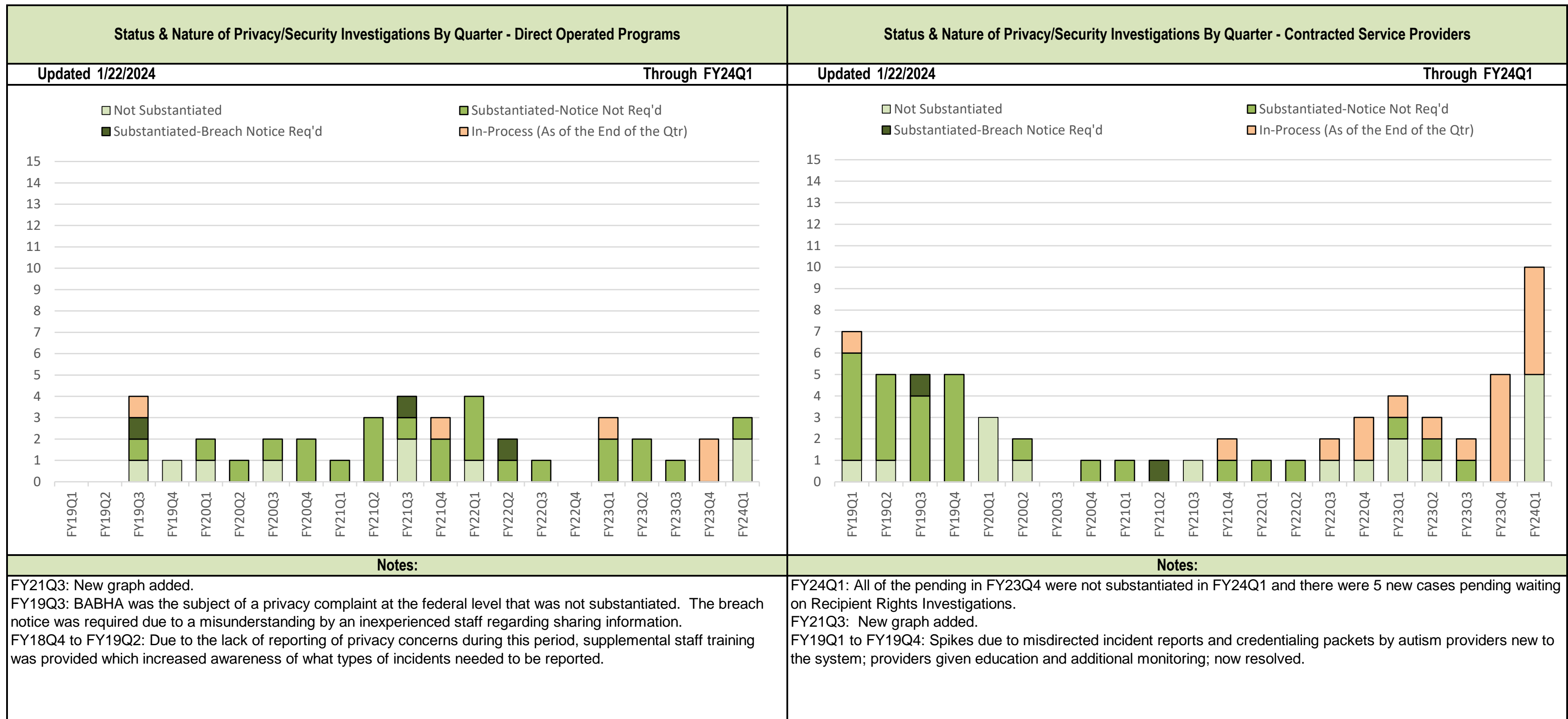
Adults and Children Indicating Satisfaction on Survey: During the FY23 satisfaction survey period, 94% of adults and 95% of children expressed a general satisfaction with services. BABH had a goal of 80% satisfaction so this greatly surpassed the FY23 goal. Additionally, both the adult and child population increased in satisfaction for FY23 compared to FY22.

Provider Survey: All the statements except one on the provider survey received over the 85% standard. Overall, scores have been decreasing since 2020. Eight of the questions scored lower in 2023 compared to 2022. BABH leadership identified corrective action steps to implement.

Behavior Treatment Survey: This survey report is completed annually at the end of each calendar year. The results from 2022 showed a 100% satisfaction rate for the seven surveys returned. There was a process issue identified which resulted in surveys not being sent out consistently. The Quality Manager will be sending out reminders and monitoring this during 2023.

Prepared by: Sarah Holsinger, LMSW, CAADC – Quality Manager Date: January 31, 2024


Indicators for Health Care Improvement and Compliance Committee
Status & Nature of Fraud/Abuse Investigations By Quarter - Direct Operated Programs
Updated 1/22/2024
Through FY24Q1
Not Substantiated
Substantiated-Documentation
Substantiated-Credentialing
Substantiated-Other
In Process (As of the End of the Qtr)
Status & Nature of Fraud/Abuse Investigations By Quarter - Contracted Service Providers
Updated 1/22/2024
Through FY24Q1
Not Substantiated
Substantiated-Documentation
Substantiated-Credentialing
Substantiated-Other
In Process (As of the End of the Qtr)
Notes:
FY24Q1: The two substantiated fraud cases in FY23Q4 and the one substantiated in FY24Q1 for Contracted Service Providers were for one individual.
FY22 Q1: There were no investigations for direct operated programs
FY21 Q4: There were no investigations for direct operated programs
FY21 Q3: Revised graph.
FY21 Q2: Most 'in-process' cases are under investigation by the MI Office of Health Services Inspector General; BABHA is waiting to hear back.
FY20 Q2: Revised graph to break out direct operated and contracted programs; added credentialing as a tracked field.
FY18 Q3: Standardized error classifications added by BABHA; documentation requirements clarified provided; consequently consistency of enforcement improved.


Status & Nature of Privacy/Security Investigations By Quarter - Direct Operated Programs
Updated 1/22/2024
Through FY24Q1
Not Substantiated
Substantiated-Notice Not Req'd
Substantiated-Breach Notice Req'd
In-Process (As of the End of the Qtr)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
FY19Q1 FY19Q2 FY19Q3 FY19Q4 FY20Q1 FY20Q2 FY20Q3 FY20Q4 FY21Q1 FY21Q2 FY21Q3 FY21Q4 FY22Q1 FY22Q2 FY22Q3 FY22Q4 FY23Q1 FY23Q2 FY23Q3 FY23Q4 FY24Q1
Notes:
FY21Q3: New graph added.
FY19Q3: BABHA was the subject of a privacy complaint at the federal level that was not substantiated. The breach notice was required due to a misunderstanding by an inexperienced staff regarding sharing information.
FY18Q4 to FY19Q2: Due to the lack of reporting of privacy concerns during this period, supplemental staff training was provided which increased awareness of what types of incidents needed to be reported.
Status & Nature of Privacy/Security Investigations By Quarter - Contracted Service Providers
Updated 1/22/2024
Through FY24Q1
Not Substantiated
Substantiated-Notice Not Req'd
Substantiated-Breach Notice Req'd
In-Process (As of the End of the Qtr)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
FY19Q1 FY19Q2 FY19Q3 FY19Q4 FY20Q1 FY20Q2 FY20Q3 FY20Q4 FY21Q1 FY21Q2 FY21Q3 FY21Q4 FY22Q1 FY22Q2 FY22Q3 FY22Q4 FY23Q1 FY23Q2 FY23Q3 FY23Q4 FY24Q1
Notes:
FY24Q1: All of the pending in FY23Q4 were not substantiated in FY24Q1 and there were 5 new cases pending waiting on Recipient Rights Investigations.
FY21Q3: New graph added.
FY19Q1 to FY19Q4: Spikes due to misdirected incident reports and credentialing packets by autism providers new to the system; providers given education and additional monitoring; now resolved.