AGENDA

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

Monday, October 7, 2024 at 5:00 pm

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

	Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
	Robert Pawlak, Ex Off, Ch				Patrick McFarland				BABH: Karen Amon, Chris Pinter, and Sara McRae
	Christopher Girard, V Ch				Pam Schumacher				
	Tim Banaszak				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
	Patrick Conley								

	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 Minutes from July 8, 2024 3.3) Corporate Compliance Committee Minutes from August 12, 2024		3.1) No action necessary 3.2) No action necessary 3.3) No action necessary
4.	Other Reports 4.1) Primary Network Operations and Quality Management Committee Minutes from July 11, 2024		4.1) No action necessary
5.	Unfinished Business 5.1) None		

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6.	New Business 6.1) Quality Assurance and Performance Improvement Plan (QAPIP) 6.2) Midstate Health Network Medicaid Event Verification Report 6.3) Strategic Initiatives Update		6.1) Consideration of a motion to refer the QAPIP to the full Board for approval 6.2) No action necessary 6.3) No action necessary
7.	Adjournment		

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, July 8, 2024 (1:00 –3:00 pm)

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

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of June 10, 2024, meeting notes.** **c) Next Meeting: August 12, 2024**	a) No additions to the agenda. b) June 10, 2024, meeting approved as written. c) The next meeting is scheduled for August 12, 2024.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Karen and committee reviewed the log: **Log No: 348** Restraint. Still in Committee – Monitoring Reviewers: Melissa, Heather. **Log No: 349** Insurance Parity. Marci Reviewed. Will not affect the agency. Signed into Law. Can be closed. **Log No: 356** Children's Guardianship and Payment for Guardianship. No Update **Log No: 357** Development of Drug overdose Review Team. State Level. Can be closed. **Log No: 358** Guardianship of IDD Individuals. Referred to Committee. **Log No: 359** Professional guardianship requirements. Some kickback from guardians on this saying if they enforce the caseloads that they are recommending that we will not have enough guardians to be able to provide the public guardianship functions. **Log No: 360** Children's protections in community camps/programs. Still in Committee. Will only pertain to use when sending kids to Respite Camp. Continue to monitor. **Log No: 367** Targeted Case Management for persons incarcerated. A lot of feedback from staff. This was supposed to be effective 07/01/2023. Nothing further has been put forward. **Log No: 376** Duplicate - Same as #348 **Log No: 379** Telemedicine extension for Controlled substances. Goes until 11/2024. No update. **Log No: 382** EVV Provider enrollment. Enrollments needed to begin August 1. Onboarding application due July 12. Heather B. is working on this. A memo was sent on 6/28 on claims submissions. Karen's understanding is that they are not going to have the providers submit their claims through the system but	

#	Topic	Key Discussion Points	Action Steps
		will submit claims just like always and claims will be paid like always and a post-payment verification of the claims to match up the claims against the EVV records. Jesse states that that tracks with one of their other sessions because of all the pushback with trying to tie the claim into the EVV system and they were considering separating it out. Ellen has concerns related to CLS and Respite Services provided outside of this scope using the location code 12 which would be anyone providing CLS in person's home either to or from person's home that Do-All, AOI, New Dimensions do not really provide in-home CLS and so they would not be part of the CLS that would need to implement the EVV. She was thinking that they may be Exempt. It was suggested that this question be asked at the in-person meeting on 7/18. Michele and Stephanie will be attending the in-person meeting. **Log No: 387** Psychiatric Residential Treatment Facility. Implemented and we have a role of requesting referral. Closed. **Log No: 390** Provider enrollment changes. Proposed effective date 9/1/24. Felony theft has been added as an exclusion. Ready to Close. **Log No: 392** AFC Licensing Changes. No update. A lot of revisions and updates. Revisions made taking out some of the requirements such as nursing and sw presence. May see a new bill in the fall on this. Still in committee. **Log No: 394** UIR Memo from RRO. Melissa and Karen are working on a policy regarding unusual IR not being considered Peer Review documents. They have gotten guidance from the attorney and are working on changing policies. **Log No: 395** Telehealth Bills. Signed into Law. **Log No: 396** SW Licensure Requirements. They want to eliminate exam as requirement. Propose reducing supervised hours down to 3000 vs 4000 currently. Supervision hours must be completed before taking an exam. If they are unable to get rid of the exam, they want to take this restriction away because they want people to take the exam sooner. Proposing that if they cannot eliminate exam completely, looking at replacing exam with one that would only pertain to laws regarding social work. Probably no movement with this until fall. **Log No: 397** Childcare Institutions to be able to use Physical Management. Signed into Law. Can be closed. **Log No: 398** Death with Dignity. To legalize assisted suicide. No Movement. National movement pushing this. **Log No: 399** Mental Health Insurance Parity. No update **Log No: 400** CCBHC. No movement **Log No: 401** Psychologists requirements for MA providing ABA services. No change. There are some bills coming through that would allow NPs to issue controlled substances without physician approval. Some MDs have problems and concerns with this (proposed SB 279). A similar bill (HB5114) to add NPs and PAs to the Mental Health code to allow them the ability to be first signer on the petition for commitment to the hospital. It is passed the house committee, on the house floor. Again, there is a lot of advocacies opposed to it. CMHA has not taken a stance on this. **Log No: 402** Extreme Risk order. No update **Log No: 403** EVV. Memo sent out regarding Claims submission. Michelle and Stephanie will be attending the next in-person meeting and will ask about the Place of Service questions that we have. Karen added all	

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		new memos that have come out under the MDHHS Lara Manuals Memos and Contracts and put them all under #403. **Log No: 407** Access Standards. No update. **Log No: 409** CMS Fee Schedule changes. Social Determinants of Health: Amy and Karen decided not to introduce these as our Biopsychosocial covers all these areas. HCPC G2211: Ellen needs to review this further. Psychotherapy for crisis 90839-40 currently Ellen needs to do more investigating with Atisha. **Log No: 410** 42 CFR Part 2 Updates. Karen will forward the summary to the group. **Log No: 411** Provider Manual Updates for January 2024. Closed **Log No: 412** HCBS - restrictions in the IPOS and BTRC. Still ongoing discussion. No update. Heather B is working on adding to policy. **Log No: 413** Medicaid Provider Manual updates. No updates **Log No: 414** Children's and Adolescents Durable equipment revisions. No updates **Log No: 415** CPT-HCPCS Code Update. Close **Log No: 416** Telemedicine Authorized Provider Policy Update. Close **Log No: 417** BHH Expansion and addition of Codes. **Log No: 418** MichiCANS. Joeline to verify that BABH is listed in the drop-down, then will send out to provider network. **Log No: 419** WHODAS Announcement. An e-mail went out announcing they identified the WHODAS 2.0 as the instrument that will replace the SIS for adults.	
	b) Review of CMHA Update on Legislative and Policy Changes (July Report) c) Review of Compliance Updates/Regulatory Education Needed for Staff d) Process for Ensuring Implementation of Policy Changes	b) Meeting held on 6/27/24. Notes can be found in the Corporate Compliance Regulation Log Folder. The budget was just passed, and a brief review was done regarding the Direct Care Wage increase of .20 per hour. There is still a reporting requirement for this. There was some money set aside for Peer Support and Peer Recovery Supports. There was some Medicaid Coverage for incarcerated individuals to get on Medicaid 90 days prior to their release. Would be a waiver but needs approval. c) Discussed above. d) May Policies updated C4-S4-T49 1915i SPA Policy	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones End of Summer/early fall. b) Updated Site Review and Use and Disclosure Policies and Procedures.	a) Time for new Attestations, end of summer, early fall. b) Need to review policy and procedure. Before Janis left, she was working on combining Policies "Uses and Disclosures of PHI under HIPAA, the Michigan Health Code and the Code of Fed Regulations" and Topic 17 which includes additional guidelines for supervisors and managers. Karen finalized, 14 and 17 will be deleted and the new policy is in the folder. Please review and give feedback. Nothing will strike bold because there are many changes to policy, many additions of definitions and categorizing of policy.	

#	Topic	Key Discussion Points	Action Steps
	c) Appeals process to comply with release records.	(Please see the new policy in the folder for all changes and additions). This committee needs to review this first, then it will go through the board process because it is brand new. c) Defer until Melissa can be here. Briefly, there is a new requirement that we must provide records to any appeals that come through. We are considering changing what we do for those people that drop out of service or we send them a notice closing them because they have not engaged in services and giving them a time frame when they can just call and get into services and not consider it an appeal. That seems to be what everyone else is doing in our region. Karen took this to Mid-State's Corporate Compliance Committee, and it seems like what we will propose is to do something different for those who drop out of service and then want to get in within 6 months if Melissa agrees with this process change.	
4.	**Data/Monitoring/Reports:** a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for 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) Report of spot checks for compliance for Self Determination g) Corporate Compliance Activity Report:	a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of June. b) Stephanie reported no findings for providers and Jennifer reported no findings for Officers and Employees for July. c) No unsecured PHI d) Nothing to report. e) Defer f) Karen feels that we have swayed away from the purpose of those. Initially when we implemented this based on our review of risk factors regarding Self Determination, we really wanted them to do spot checks on when staff should be working to make sure that the staff is actually working. Ben completed 15 spot checks in June to look at documentation. Provided education to one family on how to write effective notes. For June, Chelli completed 8 reviews of the consumers notes. Enrolled one person in Self D. Education on Fraud and Abuse was completed to that consumer. For May, Chelli reviewed progress notes for 5 different consumers. They Enrolled 2 new individuals in Self D providing education on fraud and abuse. Keeping track of this as Karen must start reporting on education to consumers in fraud and abuse. Karen, Ben and Chelli will check with other CMHs to see what they are doing as Self Determination is one of the riskier areas for fraud and abuse because it is a less supervised environment. g) Corporate Compliance Activity Report. See Semi Annual Report - 4 (i) h) Received. No findings of fraud or abuse. Good for fiscal year 2023 on Compliance Exam.	

#	Topic	Key Discussion Points	Action Steps
	July Reports h) Review of Compliance Audit Findings i) Corporate Compliance Semi-Annual Progress Report	i) This Progress report covers aspects of some of Karen's job responsibilities. Over the last FY24Q2 through FY24Q3 we have had no findings for any records security breach or sanctioned providers checks for employees and officers. Some site reviews have been completed and are continuing. On records review, we have had a slight decrease and the biggest area for decrease was a 24% decrease in not having evidence of outreach when a consumer misses an appt. There were 39 MEV audits completed and 7 required take backs. Karen has developed new one-on-one training for new supervisors regarding fraud and abuse. This will also be incorporated into the Relias system. Two factor authentication to access PHI has been implemented. Employees are not to use their personal equipment to access PHI. There has been discussion regarding installing outside cameras to identify visitors when they come into the building to sites that currently do not have them. More discussion is needed. Self D Education for new consumers has begun to be tracked and reported to MSHN as well as the 5% EOB's that are sent out annually. Karen completed "OIG General Compliance Program Guidance fore 2024". Karen completed CC Plan in June and board approved 6/20/24. Karen needs to schedule CC Training for Primary Providers in August.	
	j) Dashboard Fraud-Abuse-Privacy-Security	j) Defer to August.	
	k) Phishing Drills	k) New May 2024 phishing test report. 256 recipients, 45 clicked on it, 51 reported it. There was a significant increase in people reporting using phish alert button going from 5 reported in March to 51 in May. There has also been an increase in the number of clickers having 45 clicks on this test, which is way above our usual average and well above the industry average. We are enhancing phishing training, sending out the usual training for people that click once but people who are repeat clickers will be enrolled in some more intense training. The phish alert button should be used to report all suspected (real and Test) phishing emails.	
	l) Security Risk Assessment	l) Security Risk Assessment Findings and Remediation Plan 2024. We were compliant with most sections. In the remediation portion, Section 4 Question 23: How do you determine how ePHI is accessed? Jesse updated our remediation plan information from last year after conferring with Dimitri and our available options to limit device access to the cloud based EHR include IP filtering and/or a browser cookie. Due to our use of contracted providers, both options are problematic and present an unreasonable burden to both end users and IT staff. Section 5 Question 10: How do you validate a person's access to your facility? Remediation: Jesse will work with Facility Manager on ways to Improve monitoring unauthorized attempts to access our facilities. Access is adequately controlled with keypad and keycard entry in most of our facilities. Jen L. states that Mulholland 2nd floor does not have keypads and keycard is only used during nonbusiness hours. You can get in without a card reader by 7 am. More discussion is needed. Section 6 Question 7: How do you maintain awareness of business associate security practices? BABH will not be	

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		pursuing the DHHS Guidance within the DHHS SRA Tool because the hhs.gov website contradicts the guidance provided within the tool. Jesse spoke with Dimitri regarding the Ascension breach to assure us that our system is safe. Please see SRA Findings and Remediation Plan 2024 for more detailed information.	
	<u>August Reports Reminder for Next Meeting:</u> m) Quality Review of Medical Records (Deferred from June) n) MEV Quarter 2 Report/Plan within 15 days/Health Care Coord/Crisis Planning, etc. o) Ability to Pay Compliance p) Service Grid Benefit Plan	m) Report Due in August n) Report Due in August. o) Report Due in August. p) Report Due in August.	
	<u>Other:</u> q) ORR Background Checks	q) Melissa is unable to attend today's mgt. per e-mail from 7/3/24. She did state in her e-mail that she consulted with MDHHS (Cindy Shadeck) to ensure she wasn't missing anything after reviewing all MDHHS ORR Standards and not finding that noted anywhere. She states, "However, it is not a stretch to state they should be continued to be required based on MMHC Abuse/Neglect (The Michigan Mental Health Code 330.1722(1) states, "a recipient of mental health services shall not be subjected to abuse or neglect.") as background checks allow the ORR to notify potential employers that the employee has abuse/neglect in their work history (going back 10 years). This requirement is in all BABHA contracts, and I recommend it remain in the contract."	
5.	**Outstanding Items/Other:** a) Statewide Credentialing Work Group Updated	a) No updates.	

#	Topic	Key Discussion Points	Action Steps
6.	**Adjourn:**	**The next meeting is scheduled for Monday, August 12, 1:00 – 3:00 pm via MS Teams.**	
7.	**Credentialing Committee to follow**	No Credentialing Committee meeting.	

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, August 12, 2024 (1:00 –3:00 pm)

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

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of July 8, 2024, meeting notes.** **c) Next Meeting: September 9, 2024**	a) No additions to the agenda. b) July 8, 2024, meeting approved as written. c) The next meeting is scheduled for September 9, 2024.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Karen and committee reviewed the log: **Log No: 348** Restraint. Monitoring. **Log No: 356** Children's Guardianship and Payment for Guardianship. Monitoring. **Log No: 358** Guardianship of IDD Individuals. Monitoring. **Log No: 359** Professional guardianship requirements. Monitoring. **Log No: 360** Children's protections in community camps/programs. Monitoring. **Log No: 367** Targeted Case Management for persons incarcerated. Monitoring. **Log No: 379** Telemedicine extension for Controlled substances. Monitoring. **Log No: 382** EVV Provider enrollment. Monitoring. **Log No: 392** AFC Licensing Changes. Monitoring. **Log No: 394** UIR Memo from RRO. Working on. **Log No: 396** SW Licensure Requirements. Monitoring. **Log No: 398** Death with Dignity. Monitoring. **Log No: 399** Mental Health Insurance Parity. Monitoring. **Log No: 400** CCBHC. Monitoring. **Log No: 401** Psychologists requirements for MA providing ABA services. Monitoring. **Log No: 402** Extreme Risk order. Monitoring.	

#	Topic	Key Discussion Points	Action Steps
		Log No: 403 EVV. Needs Review. Ellen has completed the provider identification and provider information has been entered into PCE that will send authorization for CLS services and respite services to the HHA exchange. Meeting on Thursday, August 15 regarding EVV implementation. **Log No: 409** CMS Fee Schedule changes. Needs Review. Ellen to Review. **Log No: 410** 42 CFR Part 2 Updates. Working on. Karen will forward the summary to the group. Will not impact much, just coming more in line with the HIPAA guidelines and the mental health guidelines. **Log No: 412** HCBS - restrictions in the IPOS and BTRC. Working on. No update. Karen has a meeting this week with Psychologists to look at documents potentially going into the EHR. **Log No: 413** Medicaid Provider Manual updates. Amy reviewed. There may be a couple things that we need to make sure are written in the policy. No changes have been submitted at this time. Karen did receive Amy's information and placed in folder under The Medicaid Provider Manual tab. **Log No: 414** Children's and Adolescents Durable equipment revisions. Needs Review. **Log No: 417** BHH Expansion and addition of Codes. Needs Review **Log No: 418** MichiCANS. Needs Review. **Log No: 419** WHODAS Announcement. Needs Review. **Log No: 420** Telemedicine updates in the Medicaid Provider Manual. Amy and Joelin reviewed. Amy believes that our P&P may need to be updated. She is working on a Policy revision. **Log No: 421** Proposed policy for Speech Language pathologists. Heather B or Joelin to review. **Log No: 422** Non-Emergency transportation. Proposed policy. Needs Review. Open for public comment. Transportation needs to be paid for through the health plan. Even if it is behavioral health services they should include those appointments as being Non-emergency medical appts. for transportation. Heather B, Heather F. and Joelin to review.	
	b) Review of CMHA Update on Legislative and Policy Changes	b) Discussed above.	
	c) Review of Compliance Updates/Regulatory Education Needed for Staff	c) Discussed above.	
	d) Process for Ensuring Implementation of Policy Changes	d) Discussed above.	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).	a) Attestations: Still working on this. Options are given to staff to physically sign or e-sign. It is an ongoing process.	

#	Topic	Key Discussion Points	Action Steps
	b) Updated C13-S01-T16 Rights of person's Served regarding PHI. c) Appeals process to comply with release records.	b) We have a new form to be used by Medical Records associate for Access, Amendment, Restriction of Use or Accounting of disclosure of Health Record. Disclosures are also documented in EHR by Med records associate. Unless there are grounds to deny access to their own records, which is very rare, we will release information after sending out a courtesy email to their primary worker and supervisors letting them know these records will be released and when. Unless there can be severe harm to the individual, we will release records. The consequences of not releasing records to the consumer can be fines and legal issues. No response is necessary to Medical Records associate unless there is a problem with releasing records. Paragraph 2(b) states BABHA will not deny a parent access to records unless the parent is prohibited access by a protective court order. This form is also a request to amend records. We have only had one reported request to amend in the last several years. Process is the same. Forms are in the Corporate Compliance Folder to review. c) Melissa and Karen met regarding this. They discussed not considering every single person who drops out of services and gets an ABD as an appeal. They have come up with some processes based on feedback that was received from PNOQMC. Melissa will write that up and start implementing that. Our appeals should drastically go down.	
4.	**Data/Monitoring/Reports:** a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud/Abuse/Convictions during Staff Development Days) c) Monitoring of Group Drives for Unsecured PHI Files d) Security Officer Update	a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of July. b) Stephanie reported no exclusion/debarment for providers and officers. Jennifer reported no exclusions for employees or Board Members. c) No unsecured PHI found. d) Jesse states that McLaren was hit by cyber-attack. We have been monitoring the situation and they have not had any updates listed so far. The actions we have taken so far, besides making sure we are monitoring our own systems, were to disconnect sockets for lab connectors and PCE and are still disconnected. It has been difficult getting documents from McLaren as they are still using paper processing. Jesse will update when available. Jesse will be putting together a presentation outlining what we would need to know and our response if this were to happen to us. This will be presented at the Leadership meeting.	

#	Topic	Key Discussion Points	Action Steps
	e) Ethics/Recipient Rights/Customer Service Update	e) Defer	
	f) Report of spot checks for compliance for Self Determination	f) Ben reported that he reviewed 14 consumer's progress notes and provided appropriate training. He provided spot checks on the staff person requiring monitoring and the staff was present every time. He also provided a Noncompliant notice to a guardian who was exceeding their budget. Chelli completed 5 checks for July. Provided guidance on one person's notes. Karen would like to get with Ben or Heather B. to let them know that it is not just about looking at progress notes but looking at whether the person is working the days that they say they are working. It is more of a prevention of fraud vs. quality, although they both go together.	
	g) Corporate Compliance Activity Report:	g) Karen states there has been an increase in CLS fraud complaints that are valid. She has had 3 in the last 2 quarters and is working to wrap up 2 of them right now. Maybe the EVV will help this. There has been an Increase in privacy violations as well. Karen will be going to LIST Psychological to do a presentation on main documentation requirements related to assessments, IPOS, when to do an interim plan, when to do an addendum, what to put in progress notes, etc.	
	<u>August Reports</u> h) Quality Review of Medical Records	h) Per Sara H., this has the new questions so we were able to compare 2 quarters worth of data. We had 81% completion rate for the quality-of-care record reviews and 65% of the trainings that were required were completed. Sara asked the supervisors at the Leadership meeting to make sure and go in and take care of those things and clear them out once they have been addressed with staff. We are still struggling with the SMART goals and objectives at 89%, also with the plan occurring the same day with the Pre-plan and no explanation. The biggest struggle again is the POS being reviewed for effectiveness at the interval identified in the plan. We had 10 that were not completed so we were at 78%. We have had education and training on this. This will be listed on the new Supervisor Dashboard that will be rolled out so supervisors can go in and look that them. Action steps listed were remembering to use the COC form in PCE if possible, looking at possibly locking down the pre-plan and then completing the periodic review before or on the due date in the POS.	
	i) Verification of Medicaid Services	i) MEV section of report. We have seen a decrease with a couple of providers from previously. Overall, we have had a slight downward trend. Possibly connected to new modifiers. There is a new 93 modifier when using tele-med audio. We are getting findings for that in our Midstate audits. They are very particular about that modifier being accurate.	

#	Topic	Key Discussion Points	Action Steps
	j) Plan within 15 days; Health Care Coordination; Crisis Planning; medical Necessity	j) IPOS within 15 days: We are at 91% or higher for the plans that are showing that they are being given but some are left blank in "update sent date" which means they are not being captured positively or negatively in our system. COC, we have seen some drastic increases. Some of that is due to the staff, asking staff to focus on that. What we were looking for and what the state had accepted were different. When we realized this, we changed our way and should see some improvements.	
	k) Ability to Pay Compliance Rate	k) Per Michele, we had 179 ATPs not completed for the month of June. We are at 95.2% compliance.	
	l) Service Grid Benefit Plan	l) Defer	
5.	**Outstanding Items/Other:** a) Implementation of EVV b) Statewide Credentialing Work Group Updates	a) No additional updates. b) No updates at this time.	
6.	**Adjourn:**	**The next meeting is scheduled for Monday, September 9, 1:00 – 3:00 pm via MS Teams.**	
7.	**Credentialing Committee to follow**	Credentialing Committee meeting to follow.	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, July 11, 2024

1:30 p.m. - 3:15 p.m.

Lincoln Center - East Conference Room

MEMBERS	Present	MEMBERS	Present	AD-HOC MEMBERS	Present
Allison Gruehn, BABH ACT/Adult MI Program Manager	X	Joelle Sporman (Recorder), BABH BI Secretary	X	Amanda Johnson, BABH ABA/FS Team Leader	
Amy Folsom, BABH Madison Clinic Manager	-	Karen Amon, BABH Healthcare Accountability Director	X	Ellen Lesniak, BABH Finance Manager	
Anne Sous, BABH EAS Supervisor		Kelli Wilkinson, BABH Children's IMH/HB Supervisor	X	Jacquelyn List, List Psychological COO	
Barb Goss, Saginaw Psychological COO		Laura Sandy, MPA Adult/Child CSM Supervisor		Kathy Jonhson, Consumer Council Rep (J/A/J/O)	
Chelsea Hewitt, Saginaw Psychological Asst. Supervisor	X	Lynn Blohm, BABH North Bay Team CLS Supervisor		Lynn Meads, BABH Medical Records Associate	
Chelsee Baker, Saginaw Psychological Supervisor		Megan Smith, List Psychological Site Supervisor	X	Nathalie Menendes, Saginaw Psychological COO	
Courtney Clark, Saginaw Psychological OPT Supervisor	X	Melanie Corrion, BABH Adult ID/DD Manager		Nicole Sweet, BABH Clinical Services Manager	X
Emily Gerhardt, BABH Children Services Team Leader		Melissa Deuel, BABH Quality & Compliance Coordinator	X	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	X	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	X	Stacy Krasinski, BABH EAS Program Manager	X	**GUESTS**	**Present**
James Spegel, BABH EAS Mobile Response Team Supervisor	X	Stephani Rooker, BABH ID/DD Team Leader		Do-All: Amelia - President/CEO, Julie - VP, Scott - Job Developer	XXX
Joelin Hahn (Chair), BABH Integrated Care Director	X	Tracy Hagar, MPA Child OPT Supervisor			

Topic	Key Discussion Points	Action Steps/Responsibility
1. **a. Review of, and Additions to Agenda** **b. Presentations: Do-All, Vocational Services** **c. Approval of Meeting Notes: 06/13/24** **d. Program/Provider Updates and Concerns**	a. There were additions to the agenda; 4h. Military Cultural Competency Training and LOCUS Online Training, and L. Annual Checklists b. There is a PowerPoint presentation in the meeting folder. Do-All has been serving people with disabilities for over 50 years. Seven years ago, Do-All shifted their focus to having all individuals in our community placed in community, integrated, and employment opportunities. Employment helps to reduce crisis people go through. When someone has a diagnosed mental illness, and employed, they are less likely to be hospitalized and less likely to use crisis services and report overall better quality of life. Do-All is a zero-exclusion program, there are no readiness models. You can be homeless, actively using, refusing to take medications, there are no conditions where we will not provide services to you. Individualized Placement and Supports (IPS) is an evidence-based model to help people rapidly get employment if they have a mental illness. Consumers will need to be disengaged from their case management/therapy services, and as a result they are looking at closure to those programs but they are still in communication with their	

Topic	Key Discussion Points	Action Steps/Responsibility
	vocational services team so they can keep their job or get a job. It is vital to keep in communication and get reengaged to get the services going again. Do-All staff do go through Motivational Interview training. There are a lot of individuals that are not employed but are able to work and are interested in working. There is a huge gap of people with a mental illness who are in services currently but are not being referred to any provider for IPS services and we need to figure out why. There are only 143 consumers among all providers that have active authorizations for IPS. If a consumer is not eligible for BABH services, they may be eligible for Michigan Rehab Services (MRS). It is important to let your clinicians know about the employment programs. There are grants through United Way that provide funding to purchase bikes, vehicle repair, tire repair, etc., to help consumers look for a job. Do-All has had luck with employers removing having a high school diploma as a requirement for those that dropped out, have a certification of completion or a GED. A reference card has been handed out and can be put in the lobbies at all sites. <u>Barriers to Job Employment</u>: - EAS/Mobile Response Team – There is a lot of guilt and shame where the consumers feel they should be able to get a job on their own as they have done it before, so client hesitation. - IMH Program – Childcare and transportation were issues in getting a job. - Plan of Service training has been a barrier. Look at expanding the questions in the employment area to figure out why someone is not working or why they are not happy with their job. Having more conversations about employment may help with the referring process. People are worried about losing their benefits if they get a job. Tracy Howard from the state does a monthly training discussing the dispelling benefit to work myths (handout in the meeting folder). She will also come to your office or any location and discuss this as well. We can put	

Topic	Key Discussion Points	Action Steps/Responsibility
	this information on the BABH website and have staff take the 2-hour training. c. The June 13th meeting notes were approved as written. d. **Bay-Arenac Behavioral Health**: - ABA/FS – Nothing to report this month. - ACT/Adult MI – A case manager, Princess Hardy, is on maternity leave but other staff are covering for her. If you have mutual cases with her, her cases have all been reassigned. We are down a bachelor's level case manager and soon to be master's level. Sarah Mulvaney will be leaving BABH and going to Saginaw Psych. - Arenac Center – We are down a case manager but are fully staffed on the therapy side. - Children's Services – Nothing to report this month. - CLS/North Bay – North Bay is fully staffed; Tonia, the secretary, is back. We have another CLS provider with the Arnold Center which is taking referrals. There is another provider, Aidaly, which is not taking referrals yet till they get their staff trained but they will be taking children as well. They will be good for behavioral consumers. There are trends in corporate compliance with CLS. Karen asked for primary case holders to be reminded to look at documentation in regard to CLS services to make sure they are being provided like they are in plan, and that the documentation is reflecting what they should be doing for CLS. When the case managers are meeting with individuals to do their renewal of their plan of service, they still need to coordinate services with the CLS provider or both providers. They do not need to attend the meeting, but you still need to coordinate to be trained on the plan of service. - Contracts – Nothing to report this month. - Corporate Compliance – Nothing to report this month. - EAS (Emergency Access Services)/Mobile Response – There was an interview, so we have half a team for 2nd shift, bachelor's level hire. The	

Topic	Key Discussion Points	Action Steps/Responsibility
	State will be changing on October 1st to two Bachelor level positions. There are difficulties with the Rite Aids closing. Everyone is being sent to Walgreens for scripts. The Standish Rite Aid is sending everything to the Walgreens in West Branch so if consumers do not want to travel to West Branch, they need to let their Rite Aid know to send their scripts to the Family Fair Pharmacy in Standish. - Finance – Nothing to report this month. - ID/DD – Nothing to report this month. - IMH/HB – We have shifted a position to be a SED Case Manager. This was a home-based position that was vacant for over a year and was not able to be filled. The other home-based workers were covering caseloads, and there was no one to transition, so the SED Case Management position was created. This position freed up the caseload capacity for the master's level home-based positions. It is a new position but is not adding a new position to BABH, just a shift in work. - Madison Clinic – Nothing to report this month. - Medical Records – Nothing to report this month. - Quality – Melissa D. is working on the MSHN MEV and will be scheduling the primary provider on-site reviews. - Recipient Rights/Customer Services – Nothing to report this month. - Self Determination – Nothing to report this month. **List Psychological**: There are 3 new hires from June who are being trained in LOCUS next week along with 2 interns. Hoping to take on referrals in August. We are fully staffed. **MPA:** Nothing to report this month. **Saginaw Psychological:** There are no updates for CSM. We are fully staffed. A child therapist started the end of May. We will have 2-3 more therapists	

	Topic	Key Discussion Points	Action Steps/Responsibility
		starting in August, at least one is for children's therapy, and they will be a mixed caseload. We have a MSW intern that started in July and as of July 1st, the intake department took over with BABH referrals. - Nicole Sweet addressed an issue she is having with medical records. When she sends referrals from Saginaw Psych, the records request is not sending any contact information to MRS, the demographics is missing. The intakes are being sent, but there are no demographics on the consumer. Nicole can go through Morgan for medical records. Chelsea Hewitt will check in to this.	
	Plans & System Assessments/Evaluations a. QAPIP Annual Plan (Sept) b. Organizational Trauma Assessment Update	a. Nothing to report this month. b. Nothing to report this month.	
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 Report (Jan, Apr, Jul, Oct)** iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec) **iv. Consumer Satisfaction Report (MHSIP/YSS)** 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)**	a. QAPIP: Nothing to report this month. b. i. MSHN Priority Measures Report: Defer ii. Recipient Rights: Defer iii. RAS: Nothing to report this month. iv. MHSIP/YSS: Please ask your consumers to return the MHSIP/YSS surveys that were mailed to them as we have a very low return rate as of today. Look into a QR code being used to take the surveys for future mailings. v. Provider Satisfaction Report: Nothing to report this month. c. i. MMBPIS Report: Defer ii. LOCUS: Nothing to report this month. iii. Leadership Dashboard: We are working to update the dashboard indicators looking at whether the data is relevant to what we want to look at as a committee. iv. Customer Service Report: Defer d. i. PI Report: Nothing to report this month. ii. Internal MEV Report: Nothing to report this month. iii. MSHN MEV Audit Report: Nothing to report this month. iv. MSHN DMC Audit Report: Nothing to report this month. v. MDHHS Waiver Audit Report: Nothing to report this month.	b.i. MSHN Priority Measures Report: Deferred b.ii. RR Report: Deferred c.i. MMBPIS: Deferred c.iii. Dashboard: Deferred c.iv. Customer Service Report: Deferred

	Topic	Key Discussion Points	Action Steps/Responsibility
	iv. 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 Referral Status Report**	e. Periodic Review Reports: Nothing to report this month. f. Ability to Pay Report: Nothing to report this month. g. Review of Referral Status Report: Stacy sends out the Referral Status report monthly based on the input everyone gives her. Please send an update to Stacy on a weekly basis, then BABH staff will know where the referrals need to go. BABH does have a tele-therapist, but we would rather get capacity from the providers than use another tele-therapist.	
4.	**Discussions/Population Committees/ Work Groups** a. Harm Reduction, Clinical Outcomes and Stakeholder Perceptions i. Consumer Council Recommendations (as warranted) b. Access to Care and Service Utilization i. Services Provided during a Gap in IPOS ii. Repeated Use of Interim Plans c. Regulatory Compliance & Electronic Health Record i. 1915 iSPA Benefit Enrollment Form ii. Management of Diagnostics **d. BABH/Policy Procedure Updates** - **iSPA Policy Update** e. Clinical Capacity Issues Update	a. i. Nothing to report this month. b. i. Nothing to report this month. ii. Nothing to report this month. c. i. Nothing to report this month. ii. Nothing to report this month. d. iSPA Policy Update: BABH's policies and procedures are on the BABH website under the provider tab. When new policies are ready to be reviewed, you will be informed and will need to review them there. The 1915 iSPA policy is new and is ready for review. You need an assessment in place. If the assessment was not done in the 365 days, you need to put in an explanation in the narrative section of the referral form, as to why it was not done. e. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month. f. Medicaid Re-Enrollment - Loss of Benefit Tracker: Joelin received reports and sent out to the providers on those that had Medicaid and now they do not. Make sure the case managers are aware of those individuals that do not	f. Medicaid Re-Enrollment - Loss of Benefit Tracker: Joelin will put in a request with IT to run a report on Medicaid consumers to make sure they are flagged for the correct county.

Topic	Key Discussion Points	Action Steps/Responsibility
i. OPT Group Therapy ii. OPT Individual iii. Referrals for Groups - Discussion **f. Medicaid Re-Enrollment - Loss of Benefit Tracker** **g. IPOS Ranges: Site Review Follow-Up** **h. Recommended Training** - **Military Cultural Competency 08/20/24** - **LOCUS Online Training** **i. ABD Effected Service Drop-Down – Follow-Up from June Meeting** **j. Preplanning Process – Site Review Follow-Up: Invite Guardians** **k. Periodic Reviews – Site Review Follow-Up: Input from Guardians** **l. Annual Checklists** **m. General Fund for FY25** n. Conflict Free Case Management	have Medicaid so they can assist them with reapplying for Medicaid or appealing the denial. For outpatient therapy, encourage consumers to go to MiBridges and reapply. Stacy said to make sure people have Medicaid in Bay and Arenac counties. Joelin will put in a request for a report to be run so the insurance can be cleaned up. g. IPOS Ranges - Site Review Follow-Up: BABH had a site review specific to the waiver programs. BABH is still advocating with the state that we believe a certain amount of using ranges is necessary for the work we do. It is not person centered planned to not allow for a range because we do not know what a consumer needs throughout the year. We need to use as much clinical justification and common sense when determining authorizations and ranges. h. Military Cultural Competency Training: There is a Military Cultural Competency training on August 20th. The suicide rate for veterans is very high. BABH feels we need to be competent in military and is recommending the training so everyone is aware of the basic understanding of military culture. MSHN is offering a training as well. LOCUS Online Training: There has been an issue with accessing the online LOCUS training. A new company took over and they thought it was set up to move to the new site, but the link was broken and has now been fixed. i. ABD: Clinicians are doing the ABDs, and they are putting the reason for closure in the narrative, but it needs to be selected from the drop-down list. Follow-up next month. j. Preplanning Process – Site Review Follow-Up - Invite Guardians: We need to make sure we are extending the invitation to the guardians when there is an IPOS. We also need the public guardians' input as well as we are doing the planning. Continue to document the efforts of including the guardians. k. Periodic Reviews – Site Review Follow-Up - Input from Guardians: When clinicians are doing the periodic review, there is no evidence that the clinician is talking to the guardian or getting any input from the guardian on how they think the consumer is doing. This is happening more with public	

	Topic	Key Discussion Points	Action Steps/Responsibility
		guardians. You need to include the guardians in the process, and if you have not talked to them, it needs to be addressed in a contact note that you tried calling them. l. Annual Checklists: BABH has an annual intake checklist form which we do not mandate everyone to use but it is strongly suggested and recommended that it is used. m. General Fund for FY25: BABH will be making a change to the exceptions form. Amy is getting it embedded into the Phoenix system. In the contact note, there is a lightning bolt with quick phrases. Amy is working at getting the GF exceptions request in that contact note. Working on a transition who those exception requests go to. More details to follow. n. Conflict Free Case Management: Nothing to report this month.	
5.	**Announcements**	No announcements to report.	
6.	**Parking Lot** a. Periodic Reviews – Including Options for Blending with Plan of Services Addendums	a. Nothing to report.	
7.	**Adjournment/Next Meeting**	The meeting adjourned at 3:20 pm. The next meeting will be on August 8, 2024, 1:30 - 3:30 in-person at the Lincoln Center in the East Conference Room.	

Quality Assessment and Performance Improvement Program (QAPIP) Plan Executive Summary for 2025

- Continued focus on training staff in the individual plan of service for each consumer they provide services to
- Reviewing the elements of the new MichiCans assessment to determine what areas can be used to track outcomes
- Explore data points needed for new performances measures to be implemented next year
- Continue to complete Medicaid Event Verification (MEV) reviews to reduce risk related to billing
- Monitor outcomes related to Cardiovascular Monitoring, Diabetes Screening, and Diabetes Monitoring
- Review records for Healthcare Coordination
- Receive 80% in surveys related to consumer satisfaction
- Explore data collection for LOCUS
- Review all adverse events to determine any trends or areas for process improvement
- Continue to work on meeting the standards for the Michigan's Mission-Based Performance Indicator System (MMBPIS) focusing on:
    - Receiving clinical assessment within 14 days from requesting services
    - Receiving an ongoing service within 14 days of the clinical assessment

BAY ARENAC BEHAVIORAL HEALTH

COMMUNITY MENTAL HEALTH SERVICES PROGRAM

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM FY 2025~~4~~

BOARD ADOPTION:
OCTOBER 7~~2~~, 2024~~3~~

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Section 1: Introduction and Overview

Bay-Arenac Behavioral Health Authority (BABHA) 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. BABHA 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. BABHA 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).

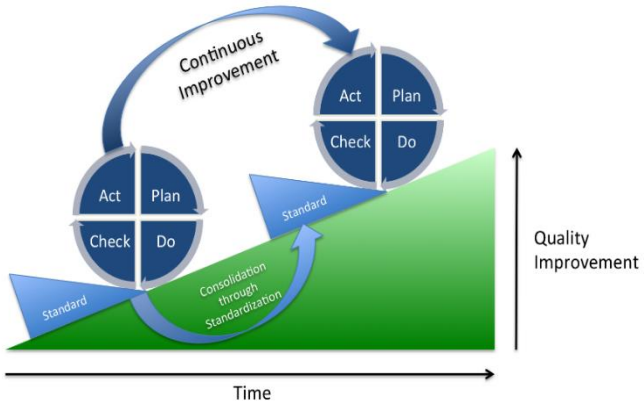
BABHA is responsible for managing a local quality assessment and performance improvement program for its CMHSP provider operations and ensuring its contracted network clinical service providers address quality improvement in their own operations through the BABHA Quality Assessment and Performance Improvement Program (QAPIP).

BABHA'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 shown here.

(http://en.wikipedia.org/wiki/File:PDCA Process.png)



The QAPIP, as described in this document, is evaluated annually for effectiveness and modifications are made, as necessary.

The QAPIP applies to all BABHA programs and services, including:

- Assertive Community Treatment (mental health – adults).
- Case Management/Supports Coordination (integrated IDD/mental health – adults, children, and adolescents).
- Community Integration (psychosocial rehabilitation – adults).
- Crisis Intervention (integrated IDD/mental health – children and adolescents, mental health – adults).
- Intensive Family-Based Services (family services – children and adolescents); and
- Outpatient Treatment (integrated IDD/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 Authority 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).

Section 2: Organizational Structure and Committees

The organizational structure and committees and their relation to the QAPIP, and performance improvement responsibilities in general, are detailed below.

Governance

The BABHA Board of Directors has established a committee specifically to address quality and compliance concerns. The Health Care Improvement and Compliance Committee (HCICC) monitors, evaluates, sets policies related to performance improvement and recommends approvals to the full Board of the QAPIP Plan, including QAPIP priorities; receives an annual report on the effectiveness of the previous year's QAPIP and sets priorities for performance improvement initiatives for the next year; oversees the performance of the QAPIP through review of the Primary Network Operations and Quality Management Committee (PNOQMC) meeting notes as well as quarterly QAPIP performance reports; monitors key organizational quality, safety, and financial indicators through the review of a dashboard report; and advises the Chief Executive Officer (CEO) to take action when appropriate and provides feedback regarding modifications and revisions to the QAPIP. The Director of Healthcare Accountability is senior management liaison to the HCICC~~,~~ and the Quality Manager attends on a regular basis to address quality program issues.

Chief Executive Officer

The BABHA CEO: links the strategic planning and operational functions of the organization with the QAPIP functions; assures coordination occurs among organizational leaders to maintain quality and consumer safety; allocates adequate resources for the QAPIP; designates the Director of Healthcare Accountability as senior management team member responsible for the BABHA QAPIP. The CEO also sanctions the formation of QAPIP standing committees and is responsible for senior management and agency leadership meetings.

Medical Director

The BABHA Medical Director provides clinical oversight related to quality and utilization of services both directly, through case supervision, participation in root cause analyses and review of critical incidents, chairing the meetings of the Medical Staff,[1] leadership of the BABHA Healthcare Practices Committee and other standing committees as time permits, and through oversight of the organization's medical practices; serves as a liaison between BABHA's clinical operations and community physicians, hospital staff and other professionals and agencies regarding psychiatric services; leads physician peer review activities; and recommends licensed independent practitioners for initial and renewal of clinical privileges for BABHA's CMHSP contracted service provider network.

Leadership

The BABHA Strategic Leadership Team is comprised of senior management which meets regularly and has an Expanded Leadership meeting of which the Quality Manager is a member. The Quality Manager participates to coordinate day-to-day quality and process improvement related activities with senior management and to have direct access to senior management to address any quality related concerns such as barriers to improvement. Through performance measures, the progress of the organization is routinely evaluated, and reports are made by the Quality Manager to the senior leadership of BABHA.

The rest of BABHA managers and team leaders join senior management in a monthly Agency Leadership meeting, which develops and monitors staff competencies; collaborates on new processes, services and programs; utilizes data effectively for informed decision making; participates on and/or supports staff participation in committees and work groups; fosters a work environment where safety and error reporting is encouraged, and a systems perspective is utilized to resolve problems; addresses under performance through corrective action planning and seeking to replicate potential best practices; and completes a Strategic Leadership Plan that establishes priorities in specific areas for risk reduction and service access for consumers.[2]

BABHA Staff

Staff receive education and annual training of the organization's QAPIP and expectations for their participation, which includes participation in data collection activities related to performance measures and indicators at the department/program level; identifying department/program and organization-wide opportunities for improvement; participating in organization-wide committees and work groups; reporting care errors, informing consumers of risks related to healthy safety through Healthcare Effectiveness Data and Information Set (HEDIS) measures, and making suggestions to improve the health and safety of consumers; and providing input into QAPIP priorities through the BABHA employee survey and suggestion box.

[1] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Medical Staff Plan.
[2] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Strategic Leadership Plan.

Quality Manager and Quality/Compliance Staff

The BABHA Quality Manager, under the oversight of the Director of Healthcare Accountability, is the leader responsible for the daily management of the QAPIP which includes the design, implementation, evaluation, and revision of the QAPIP. The Quality Manager also identifies program priorities, sponsors work groups and committees, facilitates root cause analyses, supports data-based decision making, generates reports, analyzes data and many other QAPIP related activities. The Quality Manager is responsible for BABHA quality and performance related policies and procedures.

The Quality Manager supervises the Quality and Compliance Coordinators, who assists the Quality Manager with the coordination, initiation, guidance, and collaboration of local performance improvement projects. These individuals sit on the BABHA PNOQMC and represent performance improvement on other agency council/committees; participate in regional performance measurement activities such as consumer satisfaction surveys and clinical record reviews for performance improvement projects and Medicaid event verification; and are members on regional committees and work groups. The Quality Manager chairs the quality portion of the PNOQMC and sets the agenda for that portion of the meeting.

The Quality Manager and Quality and~~&~~ Compliance Coordinators are responsible for performing reviews of contracted service provider performance, ensuring corrective actions are taken and technical assistance provided. These activities are coordinated with other departments within BABHA. The Quality Manager and staff coordinate reviews of BABHA performance by external payers and accrediting bodies, including readiness assessment, document submission, logistics and plans of correction.

Stakeholders

The BABHA CMHSP sponsors regular meetings with key stakeholders such as contracted service providers to discuss system issues and process changes, including prescriber/medical (psychiatrists, nurse practitioners, physician assistants), primary (outpatient therapy/case management), residential/community living supports, vocational and autism providers. Changes in rules, regulations, and requirements are discussed as well as system level concerns and improvements, training and credentialing, updates to processes and procedures, and other relevant topics.

Primary provider representatives and consumers participate in BABHA QAPIP committees. Site reviews of residential, outpatient and other providers produce information that flow into the Quality Management program through work groups and process improvement initiatives. Collaborative meetings are held with treating physicians at BABHA clinical programs and contract sites to discuss medical practices.

QAPIP Committees

Functions and duties of BABHA QAPIP Committees include the following:

1. Review of BABHA policies, procedures and plans related to their functions and duties, as assigned, and recommending new and revised policies and procedures to the BABHA Chief Executive Officer for approval.

2. Monitoring state and federal rule promulgation for changes in requirements relevant to their functions and duties, if any. Generating recommendations for changes to BABHA practices as indicated. Assisting with the education of staff regarding changes in requirements and implementation of action plans and/or making recommendations as necessary to bring the organization into compliance.

3. Reviewing data reports for which it is responsible for purposes of assisting with analysis of causal factors for desirable and undesirable change. Where feasible and appropriate, committees assist with setting desired performance thresholds and reliable external benchmarks/comparable when available. The committees take action and/or make recommendations for action, as appropriate, to address undesired levels of performance and/or excessive variability.

4. Committees report to their overseeing committee if any, or to the Senior Leadership Team as directed.

5. Meeting agendas and notes are recorded using standardized agency templates and stored on the BABHA group drive (unless containing protected health information) for access by other BABHA personnel.

Primary Network Operations and Quality Management Committee (PNOQMC)

The PNOQMC is the structure responsible for the QAPIP and performance improvement activities of BABHA's operations. The required membership is comprised of: BABHA Quality Management (QM) and Administrative Services staff; BABHA Strategic Leadership Team members; clinical supervisors and team members; QM representatives from contract provider agencies; consumer representative (quarterly) and ad hoc members including subject matter specialist from each department within the organization (Attachment 5).

The PNOQMC is responsible for monitoring performance by:

- Receiving recommendations for improvement from the PIHP; consumer councils; population committees; stakeholders, including, but not limited to, primary and secondary consumers and staff; Office of Recipient Rights; Customer Service department; staff meetings; and suggestion boxes.
- Identifying quality related indicators and measures and ensuring that:
  - Measures meet the requirements defined in the QAPIP; and
  - Sampling and data collection methodologies meet reasonable standards for statistical control.
- Reviewing data reports to ensure validity.
- Taking action to achieve improvement.
- Assigning ongoing review of data reports to appropriate committees for information dissemination
- Monitoring performance and the effectiveness of improvement efforts to ensure change is real and sustained; and
- Meeting regularly to review and assess performance and develop/evaluate intervention plans, as necessary.

The PNOQMC is also responsible for identifying priorities for QM activities and addressing them by convening and overseeing cross-functional committees and work groups related to both the planning of new processes and improvement initiatives, receiving reports, and taking action related to

recommendations from such work groups. Action may include accepting recommendations, providing feedback to the committee or work group, seeking additional input with respect to implementation, or forwarding for approval. Records of the PNOQMC's activities, findings, recommendations, and actions are documented in meeting minutes. These minutes, as well as the associated meeting materials are available on the BABHA intranet site.

Consumer Councils

BABHA sponsors two clinical consumer councils that report to the PNOQMC and provide input directly to BABHA regarding program operations and performance through the population committees. A BABHA consumer council representative attends the PNOQMC on a quarterly basis to provide input and feedback. In addition, BABHA representatives participate in meetings as representatives from the CMHSPs in the PIHP region who provide input regarding quality initiatives and service delivery related issues. The consumer councils are responsible for supporting organizational efforts to ease service access, develop effective and efficient service provision, ensure active consumer participation, plan of service planning, self-determination, self-advocacy, independent facilitation, community integration, anti-stigma activities, achievement of recovery, positive clinical outcomes, and consumer satisfaction.

Work Groups

Quality improvement work groups are formed based upon improvement opportunities identified by individuals in the organization, committees, or through the input of consumers and community stakeholders. Work groups may also be convened for specific planning/implementation activities related to new processes, services, or programs. They are also convened to address specific performance improvement initiatives.

BABHA staff are invited to participate in local work groups by their supervisor or Quality Management staff. Proposals for formation of work groups include suggestions for work group representation. Work group membership typically includes disciplines appropriate to the subject matter at hand. Work group meetings are facilitated by BABHA Quality Management staff, as necessary. During the first work group meeting, the charge of the group is clarified through discussion, general meeting ground rules are reviewed, documentation and reporting expectations are discussed, and a chair and recorder are chosen from the participating qualified staff.

Other Quality Related Committees

There are other standing BABHA Board and staff committees that are directly or indirectly part of the organization's quality management program but do not directly report to the PNOQMC. These committees include the: Behavior Treatment Review Committee (BTRC); Healthcare Practices Committee (HPC); Safety Committee;[27] Corporate Compliance Committee (CCC),[28] and Healthcare Integration Steering Committee (HCISC). With limited exceptions, the Quality Manager and/or Quality and Compliance Coordinators are either seated on or work closely with the listed committees to collect and analyze data, and action the results to ensure service quality, optimal clinical outcomes and mitigate risk.

Behavior Treatment Review Committee

The BTRC,[29]whose primary function is to oversee the proposed use of any intrusive and restrictive techniques that might be considered for usage as a last resort with recipients of public mental health services, is responsible for review of behavior treatment data.[30] This includes data on approved intrusive or restrictive techniques, the number of interventions and length of time interventions were used per

person, and when physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. A quarterly analysis is performed to identify any trends or patterns of behavior that may demonstrate a risk to an individual or group. Recommendations are made to reduce the likelihood of any adverse event.

Healthcare Practices Committee

The HPC whose primary function is to provide a comprehensive and coordinated approach to ensuring the delivery of clinically effective series in an environment that is safe and conducive to the wellbeing of consumers, employees and the community and to thus meet or exceed the established standards of care. This is accomplished through review, remediation and mitigation of clinical incidents/events that meet risk, critical, sentinel criteria but not limited to such events; medical record/peer review process; credentialing/privileging review; developing standards of care; and ongoing monitoring of reports.

Safety Committee

The committee oversees the development and compliance level of the Environment of Care policies and procedures and emergency response plans to ensure that the environment in which we work is maintained adequately and that protections from potential hazards are in place. In addition, the committee monitors state and federal regulatory standards and accreditation standards to ensure that the agency meets the minimum requirements of applicable rules and regulations. The committee also reviews and monitors performance on various safety related components of the environment. They include Environmental concerns related to employee and consumer infections; Environmental concerns related to consumer incident reports; Completion of Environment of Care training; Employee Accidents, Incidents and Illnesses reported; Safety and Facility inspections (BABHA sites and group homes); Group Home evacuation difficulty scores; Emergency drills (fire, tornado, bomb). When trends or patterns in this data are recognized, the committee is responsible for making recommendations to management to resolve safety issues. The priority is to ensure a safe environment for all staff and customers of BABHA.

Corporate Compliance Committee

It is the policy of the BABHA Board of Directors to have a Corporate Compliance Plan in effect, as stated in BABHA policy and procedure C13-S02-T18 Corporate Compliance Plan. The Corporate Compliance Plan is in place to guard against fraud and abuse, and to ensure that appropriate ethical and legal business standards and practices are maintained and enforced throughout BABHA[31]. Furthermore, the BABHA Corporate Compliance Plan ensures the integrity of the system in which BABHA operates and the culture in which it is served is maintained at the highest standards of excellence, with a focus on business and professional standards of conduct compliant with federal, state and local laws, including confidentiality, compliance with reporting obligations to the federal and state government, and promotion of good corporate citizenship, prevention and early detection of misconduct.[32]

Healthcare Integration Steering Committee

The purpose of the HCISC is to develop, recommend, support, promote and evaluate system-wide change as necessary to achieve BABHA goals for integration of mental, physical and substance use disorder-related health care. The committee is responsible for reviewing and actioning items to meet targets or benchmarks related to performance and providing recommendations and action steps to clinical providers. The HCISC and the PNOQMC will collaborate to improve the quality of services for

the individuals we serve. Various technology and clinical resources will be utilized to access data and process information to assist with creating action steps and follow up plans.

Recipient Rights
BABHA is committed to providing quality services to consumers in a manner that acknowledges their rights and responsibilities, ensures they receive services suited to their condition, and protects them from abuse and neglect. The BABHA Recipient Rights Office monitors and ensures that recipients of mental health services have all of the rights guaranteed by state and federal law, and provides a system for determining whether, violations have occurred, and that action is taken in the event of a violation. The CEO ensures that BABHA has written policies and procedures for the operations of the rights system. Education and training in Recipient Rights policies and procedures are provided to BABHA staff and contracted service providers are required to have recipient rights protections in place. The BABHA Board of Directors operates a Recipient Rights Advisory Committee and an Appeals Committee to oversee the program.

Section 3: Program Activities

The BABHA 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 FY241 Contract, Attachment C 6.8.1.1). 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). BABHA “demonstrates a culture of accountability by developing and implementing a performance measurement and management plan that produce information an organization can act on to improve results for the person served, other stakeholders, and the organization itself " (CARF, 20243 Standard M).

To ensure services provided are of high quality, effective and appropriate for all clinical populations, the QAPIP program addresses the:

- Competency of those who provide services.
- Harm identification and reduction.
- Access to care and utilization.
- Outcomes; and
- Stakeholder perceptions of care.

Provider Qualification and Selection
Policies and procedures are in place to govern the selection and evaluation of directly employed staff and contract providers, including physicians and other health care professionals licensed by the state, to ensure they are qualified to perform services and have current, appropriate credentials and privileges.[3,4,5] Data reflective of the performance of practitioners is considered when privileges and credentials are

[3] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T01 Staff Credentials.
[4] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T13 Credentialing and Privileging of Licensed Independent Practitioners.
[5] Bay-Arenac Behavioral Health Policies and Procedures Manual, C08-S06-T06 Organizational Credentialing

renewed; this occurs via the Healthcare Practices Committee through Curriculum Vitae Organization (CVO) review.

Additional policies and procedures exist to verify the qualifications of non-licensed care and support providers as well as the aforementioned licensed staff.[5] The policies and procedures referenced above also ensure that staff possess appropriate qualifications per their job description as well as appropriate: educational background; relevant work experience; certification, registration, and licensure; and cultural competence.[6,8]

Orientation and training in regard to responsibilities, program policy, and operating procedures are required for new employees.[7,8,9,12] Staff performance and competency are monitored on a regular basis.[10,14] Training needs are identified through formal means, such as performance/competency reviews, as well as informally, through self-identified areas for improvement. It is BABHA's policy to support employee educational pursuits and does so through in-service training, continuing education, and staff development activities.[11,16]

~~During previous external audits, it was identified that BABHA could improve the tracking method for determining that children's staff received the required 24 hours of children's specific training each year. BABHA is currently in the process of implementing corrective action plans that were developed to monitor this standard and additional internal reviews will help determine if the corrective action measures are effective. BABHA is working to develop reports for supervisors to have easy access for ongoing tracking and monitoring.~~
During external audits, there have been repeat citations for a lack of documentation showing evidence that staff have been trained in the individual's plan of service. BABHA has implemented a process for the Quality and Compliance Coordinators to review a sample of consumer records each month to determine if the necessary documentation is present to show evidence that this training has occurred by the author of the plan of service. Additionally, the Quality and Compliance Coordinators review the training on the individual plan of service during annual site reviews for the contracted providers.

[6] Bay-Arenac Behavioral Health Employee Handbook
~~Error! Bookmark not defined.~~[6] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T05 Cultural Competence and Limited English Proficiency.
[8] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Cultural Competency and Diversity Plan.
[9] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T02 Orientation.
[10] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T01 Minimum Training Requirements.
[11] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Training Plan.
[12] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Operating Philosophy and Ethical Guidelines.
[13] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T05 Performance Management.
[14] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T02 Professional Staff Competency.
[15] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S02-T26 Continuing Education.
[16] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T03 Scheduling, Promoting, and Documentation of Staff Education.
[17] Bay-Arenac Behavioral Health Policies and Procedures Manual, C03-S01-T01 Statutory Establishment.
[18] Bay-Arenac Behavioral Health Policies and Procedures Manual, C02-S01-T06 Reporting and Investigation of Adverse Events.

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee
~~BABHA will create a way for supervisors to easily track and monitor their staff's progress toward reaching the required 24 hours of children's specific training.~~	~~100%~~	~~Quality Manager~~	~~Bi-Annually~~	~~PNOQMC/CCC~~
BABHA will complete reviews to ensure that the staff responsible for implementing a Individual Plan of Service (IPOS) are receiving training from the author of the IPOS.	95%	Quality Manager	Monthly~~Quarterly~~	PNOQMC

Harm Identification and Reduction

BABHA has a reporting and investigating system in place to capture the occurrence of all adverse events which include critical events (including death), risk events, unusual events, near misses, and sentinel events that involve harm or injury or the risk of harm or injury are reported to the Office of Recipients Rights (ORR).[18] Adverse events are reviewed on a consumer specific level as well as overall trends that are reported. These adverse events have the potential to lead to the root cause analysis process if one is deemed appropriate. The trends identified through this analysis help determine how BABHA can make improvements to reduce risk for consumers.

Processes are also in place for reporting on significant events, which includes investigations; material litigation; catastrophes; sentinel events; and governmental sanctions, bans on admissions, fines, penalties, or loss of programs (CARF, 20243 Behavioral Health Standards Manual 1.H). These processes address the review and follow up of sentinel, unusual, and critical events for all persons receiving services from BABHA, including, but not limited to, those enrolled in the Children's Waiver, the Children with Serious Emotional Disturbance Waiver, and the Habilitation Supports Waiver.

All deaths are reviewed and include:

a) Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
b) Involvement of medical personnel in the mortality reviews
c) Documentation of the mortality review process, findings, and recommendations
d) Use of mortality information to address quality of care

e) Aggregation of mortality data over time to identify possible trends.

As part of the MDHHS Behavior Treatment Technical Requirements, BABHA collects data related to physical management that is used during emergency situations to prevent harm to self and/or harm to others. The information collected is reviewed monthly and quarterly to look at any trends or concerns.

Data is gathered and reviewed by appropriately credentialed staff for causal analysis. As necessary, root cause analyses are completed, and risk reduction strategies are recommended to reduce the likelihood of recurrence. At a minimum, identification of a sentinel event must occur within three business days in which the critical incident occurred, and the commencement of a root cause analysis must occur within two business days of the identification of the sentinel event. As appropriate, BABHA utilizes failure mode and effects analysis for review of potentially high risk or error prone processes. BABHA submits event reports to the PIHP/MDHHS and CARF in accordance with each entity's reporting criteria and timelines.

Appropriate remedial actions at the individual case level are taken in response to substantiated recipient rights complaints, including abuse and neglect. Recipient Rights Office representatives report aggregated data on abuse, neglect and customer services findings and make recommendations to PNOQMC for system improvements when needed. Recommendations for system improvements generated by the Consumer Councils are also reported to PNOQMC for actioning.

Goals:

Goal	20254 Performance Goals	Assigned Person	Frequency of Review	Review Committee
Continue to review all adverse events to determine any follow-up actions. Analyze the data to assist with determining change in process, procedure, workflow, etc.		Quality Manager	Quarterly	PNOQMC
Review the number of emergency physical interventions each year	Decrease ~~of 5%~~or remain consistent	Quality Manager	Quarterly	PNOQMC and BTRC
~~BABHA will gather data to determine a baseline for the number of crisis plans completed across all populations.~~	~~Increase of 5%~~	~~Quality Manager~~	~~Quarterly~~	~~PNOQMC~~

The number of days to complete the recipient rights investigation is lower than the Michigan Mental Health Code standard of 90 days.	100%	Recipient Rights Manager	Quarterly	PNOQMC
Abuse and neglect complaints substantiated have remedial action that includes disciplinary action (or prevents recurrence).	100%	Recipient Rights Manager	Quarterly	PNOQMC

Access to Care and Utilization Management

BABHA's utilization management plan is detailed in several sections of the Policies and Procedures Manual.[12,13,14,15,23] The utilization plan components address, "practices related to retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, and other aspects of utilization management as deemed appropriate by administration." Additional information on the procedures to evaluate medical necessity, criteria used, information sources, and the process used to approve the provision of medical services is also found in the Policies and Procedures Manual.

Specifically, the Policies and Procedures Manual includes mechanisms to identify and correct underutilization and overutilization, establishes prospective, concurrent, and retrospective access procedures, such that: 1) review decisions are supervised by qualified medical professionals; 2) efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate; 3) reasons for decisions are clearly documented and available to the member; 4) there are well-publicized and readily available appeals mechanisms for both providers and consumers; notification of a denial includes a description of how to file an appeal; 5) decisions and appeals are made in a timely manner as required by the exigencies of the situation; and 6) there are mechanisms to evaluate the effects of the program using data on member satisfactions, provider satisfaction, or other appropriate measures.[16,25]

BABHA uses a dashboard to track data related to various performance measures and utilization, including, but not limited to HEDIS measures and MSHN Performance Improvement Projects (PIP), and inpatient psychiatric hospitalization days. BABHA continues to add measures to the dashboard to track data for additional areas identified by BABHA leadership.

To monitor the service delivery process, BABHA uses the Michigan's Mission-Based Performance Indicator System (MMBPIS) established by MDHHS. There are five performance measures that

address access to services and outcomes which are submitted by BABHA quarterly to MDHHS and MSHN. Each of these measures are reported for adults with mental illness, children with serious emotional disturbances, and adults and children with intellectual/development disability. MDHHS set a standard for Indicator 2 and Indicator 3. ~~for FY24.~~ PIHPs that are below the 50th percentile of the benchmark are expected to reach or exceed the 50th percentile. PIHPs that fall in the 50th-75th percentile of the benchmark will be expected to reach or exceed the 75th percentile. For the MSHN region, the performance rate was 62% so the standard for FY254 is to reach or exceed the 75th percentile.

BABHA reviews a sample of consumer records quarterly from each primary provider, including BABHA primary services, to determine that the IPOS was given to the consumer within 15 days. MSHN monitors this standard during the Delegated Managed Care audit. ~~MSHN monitors this standard during the Delegated Managed Care audit that occurs every two years and BABHA recently had some findings around this standard.~~

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee	CARF Accredited Program and Standard
Achieve or exceed the 95% standard for adults and children receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	95%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults); Crisis Intervention (integrated IDD/mental health – children and adolescents, mental health – adults). **EFFICIENCY**

Achieve or exceed 75% compliance for consumers who meet with a professional for an intake assessment within 14 days of request for service with an increase from FY24~~3~~	75%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFICIENCY**
Achieve or exceed 75% compliance for consumers who have a first service within 14 days of intake assessment with an increase from FY24~~3~~	75%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFICIENCY**
Achieve or exceed the 95% standard for consumers discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days	95%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFICIENCY**

Compliance equal to or less than 15% for consumers readmitted to an inpatient psychiatric unit within 30 days of discharge with a decrease from FY24~~3~~	Less Than 15%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFECTIVENESS**
Meet or exceed 95% compliance that there is evidence that the individual served was given the Plan of Service within 15 days	95%	Quality Manager	Quarterly	PNOQMC	NA
A reduction in inpatient hospitalizations days will occur in FY25~~4~~ for consumers with a severe, persistent mental illness	5% Reduction	Director of Integrated Care	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults); Crisis Intervention (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFECTIVENESS**
Performance Improvement Project #1: Reducing or	Determine data points in the Electronic Health Record	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration

eliminating the racial or ethnic disparities between the rate of new persons who are black/African American and the rate of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.	that can be used for analysis				(psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults); Crisis Intervention (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFICIENCY**
Performance Improvement Project #2: Penetration rates by race: Reducing or eliminating the racial or ethnic disparities in penetration rates between Medicaid recipients who are black/African American and Medicaid recipients who are white.	Determine data points in the Electronic Health Record that can be used for analysis	Quality Manager	Quarterly	PNOQMC	ACT; CSM (integrated IDD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (integrated IDD/mental health – children and adolescents, mental health – adults); Crisis Intervention (integrated IDD/mental health – children and adolescents, mental health – adults) **EFFICIENCY**

BABHA has an established process to complete Medicaid Event Verifications (MEV) and follow-up restitution, as necessary.[26] The event verification process checks reimbursed Medicaid claims against chart documentation to verify. BABHA completes internal reviews for contract services providers and direct~~internal~~ services. Additionally, MSHN conducts two reviews annually of BABHA Medicaid claims. These reviews help to determine that the individuals that are served have access to a variety of services and that the services provided meet Medicaid guidelines.

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee
Meet or exceed 95% compliance for BABHA and all contract service providers that receive a MEV review. (Corrective action is required on anything less than 100%)	95%	Quality Manager	Quarterly	PNOQMC/CCC
Meet or exceed 95% compliance for all external MEV reviews conducted by MSHN.	95%	Quality Manager	Bi-Annually	PNOQMC/CCC
~~Increase the number of~~Continue completing internal MEV reviews ~~that are completed~~ to reduce risk related to billable services.	~~Increase by 10%~~	Quality Manager	Annually	PNOQMC/CCC

Outcomes

BABHA continues to make strides in improving health outcomes for the individuals it serves. Healthcare improvement opportunities have been identified in the Strategic Plan and the HCISC continues to make targeted efforts to improve outcomes related to healthcare. MDHHS tracks and monitors a variety of HEDIS measures that have been identified as activities used to improve healthcare for consumers. BABHA has been focusing on the Diabetes Screening, Diabetes Monitoring, and Cardiovascular Monitoring~~Screening~~ in an effort to improve health outcomes for the individuals that BABHA serves.

BABHA reviews a sample of consumer records quarterly from each primary provider, including BABHA primary services, to determine that coordination occurred with the primary healthcare physician. MSHN monitors this standard during the Delegated Managed Care audit and MDHHS reviews this during the Waiver Audit.~~that occurs every two years and BABHA recently had some findings around this standard.~~

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee	CARF Accredited Program

The Diabetes Screening HEDIS measure will increase in compliance from FY4~~2~~3.	Increase by 5%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (adults only); Community Integration (adults only); Outpatient Therapy (adults only) EFFECTIVENESS
The Diabetes Monitoring HEDIS measure will increase in compliance from FY2~~3~~4.	Increase by 5%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (adults only); Community Integration (adults only); Outpatient Therapy (adults only) EFFECTIVENESS
The Cardiovascular Monitoring ~~Screening~~ HEDIS measure will increase in compliance from FY23~~.~~4	Increase by 5%	Quality Manager	Quarterly	PNOQMC	ACT; CSM (adults only); Community Integration (adults only); Outpatient Therapy (adults only) EFFECTIVENESS
Meet or exceed 95% compliance that there is evidence of health care coordination within the consumer record completed by the primary providers	95%	Quality Manager	Quarterly	PNOQMC	NA

~~BABHA currently utilizes Evidenced Based Practices to support the achievement of the clinical outcomes and therefore, the organizational mission. BABHA looks to evidence-based practices and clinical protocols for quality tested clinical pathways and has adopted the technical guidelines and evidence-based practices mandated by MDHHS. The BABHA Strategic Plan has a specific initiative and goals designated toward evaluating implementation, identifying gaps, assessing the need, and increasing availability of staff trained in evidence-based practices.~~

BABHA has been working to streamline ways to collect and analyze data related to the children's population. BABHA plans to review the elements of the MichiCans assessment and begin collecting baseline data to use in the future to determine outcomes and areas for improvement. ~~currently uses Child and Adolescent Functional Assessment Score (CAFAS) data to determine improvement over time in conjunction with the type of treatment that the child is receiving. BABHA has also seen a significant increase in the number of consumers receiving Applied Behavior Analysis (ABA) services over the past few years.~~

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee	CARF Accredited Program
Collect baseline data from the MichiCans Assessment to use for future outcomes measures~~More than 40 percent of children served will have meaningful improvement in their CAFAS/PECFAS score~~	~~40%~~	Director of Integrated Care	Quarterly	PNOQMC	Case Management/Supports Coordination (mental health – children and adolescents); Intensive Family-Based Services (family services – children and adolescents); Outpatient Treatment (mental health – children and adolescents) **EFFECTIVENESS**

Stakeholder Perceptions

Customer satisfaction and service quality is evaluated through quantitative and qualitative information obtained from a wide variety of stakeholders including consumers and/or their families, providers, staff, and community members. Feedback on satisfaction and opportunities for improvement is provided through annual consumer and provider satisfaction surveys (provider survey, Mental Health Statistics Improvement Program (MHSIP), Youth Satisfaction Services (YSS), and a behavior treatment plan survey), an employee survey conducted every two years, a community needs assessment completed every two years, and suggestion boxes that are checked on a monthly basis.

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee
Meet or exceed 80% agreeance/favorable responses to the survey questions on the provider survey.	80%	Quality Manager	Annually	Expanded SLT and All Provider Specific Committees
Meet or exceed 80% satisfaction during the annual survey for the MHSIP survey specific to the General Satisfaction domain.	80%	Quality Manager	Annually	PNOQMC

Meet or exceed 80% satisfaction during the annual survey for the YSS Survey specific to the Appropriateness (General Satisfaction) domain.	80%	Quality Manager	Annually	PNOQMC
Meet or exceed 80% satisfaction for the Behavior Treatment Surveys.	80%	Quality Manager	Annually	BTRC
~~Meet or exceed 80% response rate for the statement, 'Overall I/they are satisfied with the services they receive for the IDD/Guardian survey.~~	~~80%~~	~~Quality Manager~~	~~Annually~~	~~Expanded SLT and PNOQMC~~

Section 4: Performance Measurement Methodologies

The BABHA QM program uses a variety of methods to identify quality concerns and opportunities for improvement, establish measures, collect data, analyze, and report findings, and implement and monitor corrective actions as necessary.

Identification of Quality Concerns and Opportunities for Improvement

Quality improvement opportunities are brought to the attention of the quality team in a variety of ways. Routine data collection, such as: service encounter information; activity/caseload reports; chart reviews, including Medicaid event verification and performance improvement projects; MDHHS clinical process related indicators, including quality improvement, performance, and demographic data; and the MDHHS annual local needs assessment may illustrate areas for improvement. Regional, and where available, statewide, performance comparisons are also made to better gauge local performance. Stakeholders, including consumers, staff, committees, and community agencies may also suggest improvement opportunities. Incident reporting of safety and risk events, complaints, appeals and grievances, safety drills and inspections, clinical record reviews, utilization review activities, special studies or projects, and other information, such as financial and human resources reports may also provide insight into opportunities for improvement. Routine performance of environmental scans and assessments of organizational strengths, weaknesses, opportunities, and threats as a component of leadership strategic planning activities are also used to bring about positive change. Root cause analyses of systems in response to the occurrence of critical clinical and administrative incidents also provide information on improvement opportunities. The evaluation of risk points in new systems using tools such as failure mode and effects analysis to review system weaknesses prior to implementation is also used as a means to ensure effective implementation and outcomes.

Establishing Measures

Measures are chosen based upon their relevancy to stakeholders due to the prevalence of a condition, the need for a service, demographics, health risks, the interests of stakeholders as determined through qualitative and quantitative assessment, or other aspects of care and service as identified by BABHA

and/or MDHHS. Measures may be clinical or non-clinical. Indicators are objective, measurable, actionable, based on current knowledge and clinical experience, are likely to yield credible and reliable data over time, are selected consistent with established BABHA QAPIP priorities as stated earlier in this plan, and are developed using a standardized "Projection Description/Data Specifications" (Attachment 1). Measures in use by BABHA include treatment effectiveness and outcome, functional ability, fidelity, process, prevalence and incidence rates, quality of life indicators, and satisfaction.

BABHA participates in at least two PIHP Performance Improvement Projects (PIP) per year and a regional program to verify the delivery of services billed to Medicaid. The PIP and ~~Medicaid service event verification~~MEV reviews are completed on a regional level~~basis~~. PIP topics are either mandated by MDHHS or selected by the PIHP and its partner CMHSPs. Data collected through the PIP are aggregated, analyzed, and reported by BABHA Quality Management staff for review at the regional Quality Improvement Council and local PNOQMC meetings and opportunities for improvements are identified.

Performance measures and dashboard data are reviewed at a variety of different committee meetings including, but not limited to, PNOQMC, Expanded SLT, and Board Meetings. Additionally, a quarterly report and annual report are presented to the Board.

Data Collection

The "Project Description Data Specifications" document template (Attachment 1), defines the sample population and data sources, sampling method, standardized data collection methodology and frequency, and when known, desired performance ranges and/or external benchmarks. If sampling is to be used, appropriate sampling techniques are employed to achieve a stated confidence level. Data collection methodology and frequency, as detailed in the project description, are appropriate and sufficient to detect the need for program change. Each data collection description delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Provisions for primary source verification of data completeness and accuracy as well as maintenance of documentation are also addressed in the project description. BABHA uses the leadership dashboard and various plans to monitor other non-clinical business operations.

Data Analysis and Reporting

Analysis is the dynamic process by which data becomes information; data must be systematically aggregated and analyzed to become actionable information. Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making, performance improvement, and priorities for risk reduction.

Data is aggregated at a frequency appropriate to the process or activity being studied. Data aggregation timeframes and methods are defined in project descriptions. Statistical testing and analysis are then used as appropriate to analyze and display the aggregated data. BABHA data is analyzed over time to identify patterns and trends and compared to desired performance levels, including externally derived benchmarks when available. Quality Management staff utilize a dashboard or a summary report for data results including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Undesirable patterns, trends, and variations in performance are identified. In some instances, further data collection and analysis is necessary to isolate the causes of poor performance or excessive variability

and remedial/corrective actions may be required. The department responsible for a pattern of desirable performance may also be asked to document their strategy for maintaining positive performance.

The quarterly and annual reports are formally reviewed by the Board and includes details on studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QAPIP's continuity, effectiveness, and current acceptability.

Corrective Actions
Remedial and/or corrective actions are taken when benchmarks are not met as determined by performance measurement. We utilize a corrective action process that outlines how quantitative measures are evaluated by reporting period and historical performance. Patterns and variations are considered in context, and corrective action response requirements are outlined in the process document. Actions taken are implemented systematically to ensure any improvements achieved are associated with the corrective action. Corrective actions are monitored and evaluated to assure that appropriate changes have been implemented and maintained. Adhering to the following steps promotes process integrity: develop a step-by-step action plan; limit the number of variables impacted; implement the action plan, preferably on a small or pilot scale initially; collect data to check for expected results; and modify the plan as necessary based on post-implementation findings. Specifics on the review and response process are available by request from the Quality Manager.

Communicating Process and Outcome Improvements
The results of BABHA provider operations performance measurement and improvement activities are communicated through the periodic dissemination of materials to employees, providers, and stakeholders via the BABHA Website, BABHA Board of Directors, Strategic Leadership Team, agency Leadership Team, Consumer Councils, PNOQMC, staff meetings as well as the general distribution of applicable information through the leadership dashboard, BABHA intranet, and other outlets as deemed appropriate.

Section 5: Review/Evaluation of Plan Effectiveness

BABHA has led and been involved in many performance improvement activities during 20243. Given the nature and scope of the accomplishments, the 2024 QAPIP plan has been determined to be effective and any updates, revisions, and new projects have been added to the 2025 plan as necessary to continue the pursuit of exceptional performance. During 2025, continued evaluation of the QAPIP will take place. Continued evaluation will occur to develop, define, collect, and validate data within current systems; and to communicate/collaborate with providers and internal programs for such areas that need improvement. There have been some gaps and improvements that have been identified during the review of the QAPIP and these will be addressed as priorities for 2025. At the request of the Consumer Council, BABHA will make an outline of the goals determined for this year and make those available as handouts to consumers who may want to know more about the priority areas for FY25.

Section 6: Quality Assessment and Performance Improvement Priority Focus Areas for 2025

BABHA has identified access to care/utilization and outcomes as key areas to focus on in 2025. Below are the activities that have been identified to assist with improving the quality of services and outcomes for the consumers served.

Access to Care/Utilization

BABHA continues to look at the MMBPIS data quarterly to determine overall performance related to access of care and utilization and has struggled with meeting the standards set by MDHHS. BABHA has identified an ongoing trend with consumer no-shows for the intake appointment and first service appointment ~~that will continue to be explored during 2024~~and embedded clinical assessment specialists into the Emergency and Access Service department to improve same day access to services. During recent MDHHS Waiver reviews, BABHA has noticed a higher level of scrutiny surrounding amount, scope, and duration of the IPOS as well as training from the author of the IPOS. The MSHN region has had repeated findings with these standards so BABHA has identified these standards as a priority to review and monitor for 20254.

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee
Improve compliance for the question, "Services written in the IPOS are delivered at the consistency identified" in the Quality-of-Care Record Reviews.	90%	Quality Manager	Quarterly	PNOQMC/CCC
Improve compliance for the question, "All services authorized in the IPOS are identified within the goals/objectives of the POS" in the Quality-of-Care Record Reviews.	90%	Quality Manager	Quarterly	PNOQMC/CCC
BABHA will complete reviews to ensure that the staff responsible for implementing the IPOS~~a Plan of Service (POS)~~ are receiving training from the author of the IPOS.	95%	Quality Manager	Quarterly	PNOQMC

Outcomes

In 20254, BABHA will make concerted efforts to focus on outcome measures and quality reporting. A LOCUS fidelity review was completed in March 2020 and there were gaps identified in the area of outcome measures. Changes in upcoming regulations have placed a focus on the LOCUS data as a tool to determine level of care.

Goals:

Goal	20254 Performance Goal	Assigned Person	Frequency of Review	Review Committee
Develop and finalize quarterly reports to primary providers to increase the quality of reporting for LOCUS and outcome measures.		Quality Manager	Quarterly	PNOQMC
Track baseline data from the LOCUS assessment to determine specific areas to focus on for improvement.		Quality Manager	Quarterly	PNOQMC
Continue completing ~~Increase the~~ MEV reviews for internal services to reduce risk.	~~Increase by 10%~~	Quality Manager	Annual	PNOQMC/CCC

Attachment 1

BAY ARENAC BEHAVIORAL HEALTH

Quality Assessment and
Performance Improvement Program

PROJECT DESCRIPTION/DATA SPECIFICATIONS

REQUESTOR	PROJECT/REPORT NAME
STAFF COMPLETING THIS FORM	DATE
PROJECT SUMMARY	
OPTIONAL OR REQUIRED? IF REQUIRED, BY WHOM?	

STUDY QUESTION(S)

INDICATORS (WHICH ANSWER THE QUESTION)

Indicator #1	
Numerator:	
Denominator:	
Baseline Measurement:	
Benchmark:	
Baseline Goal:	
Indicator #2	
Numerator:	
Denominator:	
Baseline Measurement:	
Benchmark:	
Baseline Goal:	
Indicator #3	
Numerator:	
Denominator:	
Baseline Measurement:	
Benchmark:	
Baseline Goal:	

DATA VALIDATION METHODS TO BE USED
(face validity checks, primary source verification, known logic errors)

FREQUENCY OF DATA PULL AND/OR REPORT GENERATION

☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY ☐ OTHER (DESCRIBE)

STATISTICAL ANALYSIS/TESTING METHODS, IF ANY

STUDY POPULATION/DATA PARAMETERS

Data Universe

Fund Source	All	
Fund Source	Autism Waiver (Medicaid, MI Child)	
Fund Source	General Fund	
Fund Source	Medicaid (EPSDT, B3, HSW, State Plan)	
Fund Source	Medicaid Fee for Service (Child Waiver, SED Waiver)	
Fund Source	Medicaid Healthy Michigan Plan	
Fund Source	Other State (ABW, MI Child)	
Fund Source	Medicare	
Fund Source	Other Insurance	

Fund Source	Fund Source Not Specified	
Sampling Frame		
Record Source	Encounter data (sent or unsent)	
Record Source	Fully adjudicated claims	
Record Source	Service activity logs (SAL's)	
Document	Phoenix document data field tables	
Other Source(s)		
Sampling Unit		
	Encounters	
	Claim lines	
	Service activity events	
	Consumers	
	Clinical Document(s)	
	Clinical Service(s) (HCPCS Code or Modifier)	
	Clinical Program(s) or Provider(s)	
Detail/Filters		
Age at Service Date	Adult or Child	
Age at Service Date	Age	
Age at Service Date	Age Grouping - Census	
Age at Service Date	Age Groupings	
Consumer	Consumer Status (Closed-Not Yet Open-Open-Deleted)	
Consumer	County Name by Zip Code	
Consumer	Address Plus Zip	
Consumer	Zip Code	
Consumer	Disability Designations (SPMI, SED, IDD, MI/IDD)	
Consumer	Substance Use Problem (from BH-TEDS field)	
Phoenix Views (diagnosis)	Diagnosis Source (Claims-Phoenix Diagnostic Module)	
Phoenix Views (diagnosis)	Diagnosis Code (DSM/ICD)	
Consumer	Primary Program	
Consumer	Primary Site	
Consumer	Primary Staff	
Consumer	Primary Type (Contract, Direct Operated, Unassigned)	
Consumer	Integrated SUD & MH Treatment	
Consumer	Education Level	
Consumer	Employment Status	
Consumer	Gender	
Consumer	Race/Hispanic	
Consumer	Corrections Related Status	
Consumer	Living Arrangements	
Consumer	School Attendance Status	
Consumer	Case Number	
Consumer	Consumer Name	
Provider	Address	
Provider	Org Type (Contracted, Direct or Hospital)	
Provider	Primary Office Site	
Provider	Provider Name	

(Zenith)	Provider Classification	
(Zenith)	Provider Type	
Staff	Primary Program	
Staff	Staff Name	
Staff	Staff Status (Active or Inactive)	
Staff	Supervisor Name	
Service Category	Procedure Code Type (CPT or Revenue Code)	
Service Category	Procedure Type (code groups)	
Service Category	Procedure Code (specific codes)	
CPT Mod1	CPT Modifiers	
Encounter Status	Encounter Status (Sent, Not Sent, Unreportable)	
Client Attendance	Client Attendance (cons cancelled, cons present, staff cancelled, no show)	
Place of Contact	Place of Contact	
Place of Contact	Unit of Time	
Medications	Medication Name	
Medications	Medication Therapeutic Class	
	Other (specify):	

DETAIL OF DIAGNOSTIC OR PROCEDURE CODES TO BE INCLUDED (IF NECESSARY)		
Service or Diagnosis Name	Code(s)	Modifiers/Specifiers

Attachment 2

Bay-Arenac Behavioral Health Authority		
Board of Directors		
April 1, 20243 through March 31, 20254		
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
Richard Byrne Chair	04/01/22 to 03/31/25	Bay
~~Colleen Maillette~~ ~~Vice Chair~~	~~04/01/23 to 03/31/24~~	~~Bay~~
Robert Pawlak ~~Treasurer~~Vice Chair/Parliamentarian	04/01/22 to 03/31/25	Bay

Patrick McFarland Treasurer	04/01/24 to 03/31/27	Bay
Chris Girard Secretary	04/01/22 to 03/31/25	Bay
Tim Banaszak	04/01/23 to 03/31/26	Bay
Patrick Conley	04/01/24 to 03/31/27	Bay
Jerome Crete	04/01/23 to 03/31/26	Bay
~~Ernie Krygier~~	~~04/01/21 to 03/31/24~~	~~Bay~~
Sally Mrozinski	04/01/22 to 03/31/25	Arenac
Kathy Niemiec	04/01/23 to 03/31/26	Bay
~~Robert Luce~~	~~04/01/21 to 03/31/24~~	~~Arenac~~
~~Sally Mrozinski~~	~~04/01/22 to 03/31/25~~	~~Arenac~~
~~Patrick McFarland~~	~~04/01/21 to 03/31/24~~	~~Bay~~
Carole O'Brien	04/23/24 to 03/31/27	Arenac
Marie (Toni) Reese	04/01/23 to 03/31/26	Bay
Pamela Schumacher	04/01/24 to 03/31/27	Bay

Revised 054/0721/20243

Attachment 3

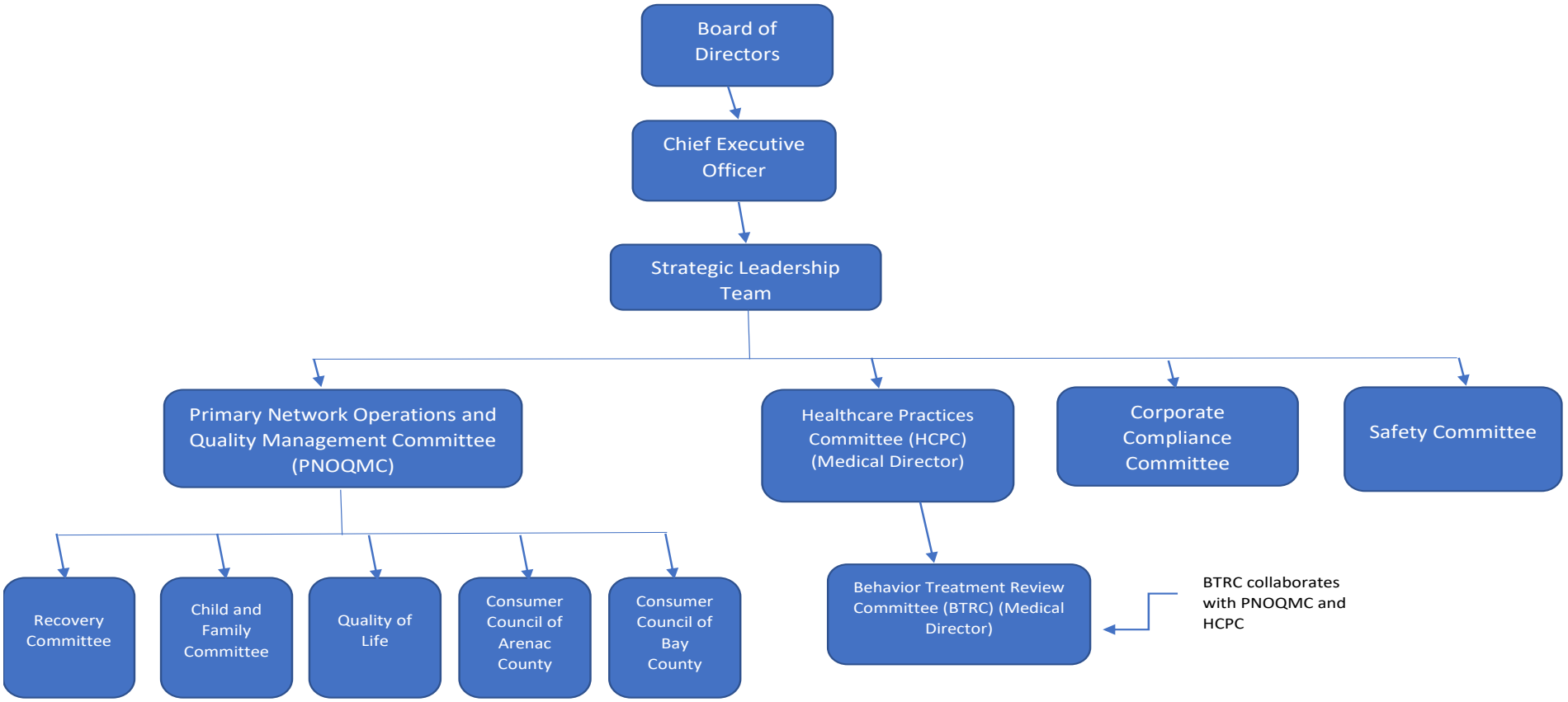
Primary Network Operations and Quality Management Committee Membership

Positions/Committee Representative	Attendance	Member
Business Intelligence Recorder	Required	Joelle Sporman
Recipient Rights/Customer Services Manager	Required	Melissa Prusi
SLT - Director of Healthcare Accountability Corporate Compliance Committee	Required	Karen Amon
SLT - Primary Care (Co-Chair)	Required	Joelin Hahn
SLT - Integrated Care Behavior Treatment Committee	Required	Heather Beson
Arenac Center	Required	Heather Friebe/Pam VanWormer
BI - Quality Manager (Co-Chair)	Required	Sarah Holsinger
BI - Quality and Compliance Coordinator	Required	Melissa Deuel
~~BI - Quality and Compliance Coordinator~~	~~Required~~	~~Amber Wade~~
Emergency Service/Access	Required	Stacy Krasinski/James Spegel/Anne Sous
Medical Services - Prescribers Healthcare Practices Committee	Required	Amy Folsom
Adults with MI	Required Ad-hoc	Allison Gruehn Taylor Keyes
Adults with IDD	Required	Melanie Corrion/Stephani Rooker
BI - Medical Records/Electronic Health Records	Ad-hoc	~~Denise Groh~~Lynn Meads~~/Brenda Beck~~
BABH Clinical Services Manager	Ad-hoc	Nicole Sweet
North Bay	Required	Lynn Blohm
Children with SED	Required	Kelli ~~Maciag~~Wilkinson
Children with ID	Required Ad-hoc	~~Noreen Kulhanek~~Emily Gerhardt~~/Emily Young~~ ~~/~~Amanda Johnson
BABHA Contracts	Adhoc	Stephanie Gunsell
~~Medical Director~~	~~Adhoc~~	~~Dr. Roderick Smith~~
Finance Rep	Adhoc	~~Ellen Lesniak~~Michele Perry
Medical Services - Nursing	Adhoc	Sarah Van Paris
Consumer Rep	Adhoc - Quarterly	Kathy Johnson
Contract Provider Reps	Attendance	Member
LPS	Required Ad-hoc	~~Jackie List/Abigail Burns~~Megan Smith Jackie List
MPA	Required	Emily Simbeck/Laura Sandy/~~/~~ Tracy Hagar
Saginaw Psych	Required Ad-hoc	~~Megan Crippin/Kristen Kolberg~~Jacklyn Nolan/Courtney Clark/Chelsea Hewitt/Barb Goss/Moregan LaMarr Nathalie Menendes
Other Subject Matter Experts as needed	Adhoc	

Revised 01/27/2021

Attachment 4

Bay-Arenac Behavioral Health
Quality Assessment and Performance Improvement Program
Reporting Structure
2022



Monitors routine reports, receives assignments from and reports progress and activities directly to PNOQMC.

Monitors routine reports. Collaborates with PNOQMC when performance is not meeting standard, outcome measurement is needed and/or improvement is desired.

August 2024 Mid-State Health Network (MSHN) Medicaid Event Verification (MEV) Results

Bay Arenac Behavioral Health Authority received **87.71%** for the MSHN MEV review that took place in August 2024. There were a total of 286 claims reviewed.

Findings:

- There were 19 claims that did not have IPOS Training documentation.
- There were 2 claims where the IPOS Training was signed after the date of service.
- One claim had the incorrect staff listed on the billing.
- There were 2 claims where the correct number of units were billed, but the progress note start/stop times did not match the tracking sheet start/stop times.
- There were 6 claims where the claim was missing the HS modifier.
- There were 13 claims where the unit rate billed/paid ($14.35) for the 97153 code exceeded the contract rate ($14.03).
- One claim had the incorrect amount of units billed for the UQ modifier. There were 13 units billed, but should have been 12 as one of the 13 units should have been billed with the UP modifier.

BABHA staff submitted a corrective action plan to address the findings.