AGENDA

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

Monday, November 4, 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 notes from September 9, 2024		3.1) No action necessary 3.2) No action necessary
4.	Other Reports 4.1) Primary Network Operations and Quality Management Committee notes from August 8, 2024		4.1) No action necessary
5.	Unfinished Business 5.1) None		

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6.	New Business 6.1) 2025 Risk Management Plan 6.2) Quarterly Fraud Report to Midstate Health Network (MSHN) 6.3) Wirt Building Update		6.1) Consideration of a motion to refer the 2025 Risk Management Plan 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, September 9, 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	X
Amy Folsom, Clinic Practice Manager	X	Jennifer Lasceski, director of HR	E	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	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 August 12, 2024, meeting notes.** **c) Next Meeting: October 14, 2024**	a) No additions to the agenda. b) August 12, 2024, meeting approved as written. c) The next meeting is scheduled for October 14, 2024.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.) **Log No: 348** Restraint. 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. Are we enrolled as a provider? Our providers need to be enrolled by the end of August. Bulletin MMP 23-42: Heather B. states she was surprised about the extent of the Live-in exemption. We will need to write a protocol because it is very detailed about when they want what done including timeframes, etc. The Live-in Caregiver Attestation is an exemption from EVV. The individual's effected are in Melanie's and Heather's F's locations. Heather B. feels this needs to land with the Case Managers as they will identify whether they are a Live-in exemption and they would be completing the document. The document could then be forwarded to Ben. We do not have a specific EVV Policy. Exemption forms need to be filled out by 10/1/24 so they can be implemented. Communication was sent out to Program Managers regarding Live-in caregivers on Friday 9/6. There have been no MI situations identified where there is a Live-in staff. This may have to be included in CLS and Respite policies as it	

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		involves both services. No education needed for providers. Final Bulletin Policy and Procedure needs to address EVV both in CLS and Respite. Heather B. Will work on this. **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. **Log No: 403** EVV. PCE is ready for us to start to identify providers who are EVV eligible and they will start pushing through auths. We need to identify who will be reviewing response errors. **Log No: 409** CMS Fee Schedule changes. No updates. **Log No: 410** 42 CFR Part 2 Updates. No updates. **Log No: 412** HCBS - restrictions in the IPOS and BTRC. No updates. **Log No: 413** Medicaid Provider Manual updates. No updates **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. No updates. **Log No: 421** Proposed policy for Speech Language pathologists. Heather reviewed this Policy. She doesn't see how this will impact how we do business. Heather states Medicaid will no longer require licensed SLPs to be authorized by the American Speech-Language Hearing Association (ASHA) and to use the Certificate of Clinical Competence in Speech-Language Pathology credentials instead to reduce redundancy. **Log No: 422** Non-Emergency transportation. Final Letter released. **Log No: 423** Heath Care Items in lieu of services guide. Proposed policy Draft. Found in the MDHHS Lara Manuals Folder. This has to do with Health Care items in lieu of services policy guide. Drafted in July, not public yet. This was sent by Chris to be reviewed. Not open for discussion yet. It has to do with Medicaid State Plans and some of the services that can be included in the health plan which include Home Delivered Meals and Produce prescriptions. Karen feels that the 2 directors should review as there might be some services that can benefit individuals within Case Management group.	
	b) Review of CMHA Update on Legislative and Policy Changes c) Review of Compliance Updates/Regulatory Education Needed for Staff	b) Discussed above. c) Discussed above.	

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	d) Process for Ensuring Implementation of Policy Changes e) Updates from CMHAM ED Forum	d) Discussed above. e) Updates from CMHAM ED Forum: Summary **EVV**: There was an update on the EVV, that the payer level data should be available by 9/9/24, CLS staff training and preparations are expected to continue through September, there is a separate portal for "payer Only" and Pay and provider" agencies in the EVV system, it excludes congregate residential settings or any unlicensed provider and/or privately owned settings with 24/7 staff availability of 2 or more unrelated consumers per shift. We have one arrangement that will be affected directly by this that they will have to do EVV. It primarily applies to independent CLS and Self D settings. **Status of Waiver Renewals**: Current 1115 has been extended until 9 months after 10/1/24, SED, Habitation Supports and 1915(i) Waivers are still under review by CMS, we are tracking down state and federal dialogue on conflict free access & planning requirements and continue to advocate against designs, CFA&P delated until after 10/1/24. **PHIP and CMHSP Contract Negotiations**: CMHSP is advising MDHHS that the CMHs won't sign the general fund contract IF the state insists on including the Standard Cost Allocation for non-Medicaid. **PHIP Medicaid Deficits for FY24:** Six of the ten PHIP regions are reporting deficits up to $90M for the current year. MDHHS has unspent behavioral health funds and could be committed to some of these expenses. There are advocacy efforts regarding that. Chris sent out a letter to the Governor including several other individuals related to this topic. **Waskul Settlement:** More than 30 CMHSPs have joined in opposing this settlement in Federal Court. If this goes through it will only address a portion of CLS, the Self D arrangements. A huge amount of money would get pushed out towards those services. There is a federal hearing that has been pushed back until December.	
	f) Telehealth and In-Person Requirements email from CLC	f) Communication from CLC Group regarding Telehealth requirements and going back go having In-person meetings with a physician or practitioner. They were asking how this was going to impact the CMHs throughout our region. It will impact BABH negatively. Slated to be implemented 01/01/2025. Arenac will be exempt due to rural status. We only have one prescriber on site at Madison for 1600 consumers. Seeing a nurse would not qualify them as an in-person visit. This will be discussed at the next CLC meeting in September. Karen will respond to e-mail and find out if there is more advocacy to be done.	
3.	**Plans, Policies, Procedures, Assessments:** **a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).** **b) Appeals process to comply with releasing records.**	a) Nothing to report. Marci inquired if these can these be tied to performance evals? Karen will discuss with Jen. b) No update at this time.	

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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	a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of August. b) Jen reported no exclusions for staff and Board Members for September. Stephanie reported no exclusion/department for contractors. c) No unsecured PHI found. d) McLaren is back up to speed. Lab interfaces should be turned back on. Blumira Software (AI security system) Executive Summary: It collects data and alerts us if a human needs to look at it. To date it has collected 4.9TB of logs. We have had 2 findings, one of them to be threatening. Of the findings that it found, 100% of them were resolved. Both were found to be false positives. Our system is secure. Phishing test sent in August. Only 5 people clicked on this, only 2% of our user base. Also, 25% of our user base hit the Phishing alert button. e) For the Month of July received many complaints. There was only one complaint regarding confidentiality for July and one for August. Complaints that had the fraud/abuse component within the last quarter were around 5. In addition, Melissa feels that the agency needs to be aware that with the economic stuff going on people are having a very difficult time financially. Even people that were not paycheck to paycheck in the past, are now. She is finding a significant increase in complaints regarding either abuse of or exploitation of personal funds where people are gaining access to EBT cards and Debit cards and taking money from recipients. Asking to borrow money from recipients and recipients, who are usually our most vulnerable, are acquiescing to it and loaning them money and don't get paid back and now we have a Recipient Rights complaint, a police report, etc. f) Ben Reported that he checked 24 sets of progress notes for August. Education for two for improved detail in the notes. Spot checks completed on the consumer's staff on a corrective action plan. Two new Self D referrals.	

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	g) Corporate Compliance Activity Report: <u>August Reports</u> h) Service Grid Benefit Plan (September) **<u>September Reports:</u>** No September Reports	g) Karen is working on several investigations regarding potential fraud with CLS services. We are having some difficulty with PAO. We had a situation where there was a lot of copy and pasted notes including the signature of the staff person. This went back to October of 2022. When the overall cost of that was looked at, it was determined that it was over $22,000. Karen feels that it is impossible to determine whether the services were or were not provided and there is no other documentation to support either way. Karen submitted this to the OIG to make a determination. This was submitted last Thursday to Midstate then it will be sent to the OIG. Karen does need to communicate with Christine Quinn, the Executive Director of PAO regarding the fact that this was submitted to OIG because the last that was communicated there was no amount attached to it. There are also issues on the corrections to their last MEV. One example isthey submitted some progress notes that were missing but we believe that the staff person that signed on the notes is no longer working for them. This is being pursued to see how they were able to get the signature. Also, Karen just finalized a similar CLS potential fraud for Bay Human Services. Someone signed the guardian and consumer's name where services were not provided. This looks like there will be a couple thousand dollar take back on this and it won't be reported directly to the OIG, just through the regular process. h) Right now, in Phoenix, we do have our Medicaid Grid which lists all the Medicaid services. This has not been updated. Ellen has also downloaded this and made notes which can be reviewed as well. This all needs to be gone through and reviewed, for instance, is 1040 units a reasonable amount for ACT to have? Should it be less, should it be more for a PCP period. Heather B states, Joellen will probably be needed to help with review. Some questions, Heather would like to take back to her staff to gain their input. There are over 100 procedure codes that need reviewed. Elen is questioning the best way to accomplish this. Karen A inquires whether we should have a special meeting with the required individuals in attendance. Ellen agrees with this suggestion. Heather B would prefer that the grid be emailed out ahead of time so she is able to speak with her staff. Ellen will send out grid to review. Ellen with get with Michele and Marci and get some meetings set up.	
5.	**Outstanding Items/Other:** a) Implementation of EVV b) Statewide Credentialing Work Group Updates c) BABH Provider Tab	a) Discussed above. b) Stephanie received emails notification for upcoming training sessions slated for 10/7 – 10/17. She also received approximately 3 invites from MDHHS for those training sessions. There should be more information soon. c) Melissa sent out an email requesting anyone that has any information on the BABH website Provider tab such as resource materials, provider links, etc., to please review the information and make sure it is the most recent. Melissa has had calls from providers stating that a link is broken, or the information seems old. It is important as we have a few new providers and there is a lot of good information that can be helpful to	

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		them. Karen also forwarded this email to Jesse. Jesse says they would be more than happy to help getting sections updated, just let them know.	
6.	**Adjourn:**	**The next meeting is scheduled for Monday, October 14, 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, August 8, 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/CSM/Sr. Outreach Prog. Mgr.	X	Karen Amon, BABH Healthcare Accountability Director	-	Amanda Johnson, BABH ABA/Wraparound Team Leader	X
Amy Folsom, BABH Psych/OPT Svcs. Program Manager	X	Kelli Wilkinson, BABH Children's IMH/HB Supervisor		Jacquelyn List, List Psychological COO	
Anne Sous, BABH EAS Supervisor		Laura Sandy, MPA Clinical Director & CSM Supervisor	X	Kathy Jonhson, Consumer Council Rep (J/A/J/O)	
Barb Goss, Saginaw Psychological COO		Lynn Blohm, BABH North Bay CLS Team Supervisor	X	Lynn Meads, BABH Medical Records Associate	
Chelsea Hewitt, Saginaw Psychological Asst. Supervisor		Megan Smith, List Psychological Site Supervisor		Michele Perry, BABH Finance Manager	
Courtney Clark, Saginaw Psychological OPT Supervisor	X	Melanie Corrion, BABH Adult ID/DD Manager	X	Nathalie Menendes, Saginaw Psychological COO	
Emily Gerhardt, BABH Children Services Team Leader		Melissa Deuel, BABH Quality & Compliance Coordinator	X	Nicole Sweet, BABH Clinical Services Manager	-
Emily Simbeck, MPA Adult OPT Supervisor	X	Melissa Prusi, BABH RR/Customer Services Manager		Sarah Van Paris, BABH Nursing Manager	
Heather Beson, BABH Integrated Care Director	X	Moregan LaMarr, Saginaw Psychological Clinical Director	X	Stephanie Gunsell, BABH Contracts Manager	
Heather Friebe, BABH Arenac Program Manager		Pam VanWormer, BABH Arenac Clinical Supervisor		Taylor Keyes, Adult MI Team Leader	
Jaclynn Nolan, Saginaw Psychological OPT Supervisor		Sarah Holsinger (Chair), BABH Quality Manager	X	**GUESTS**	**Present**
James Spegel, BABH EAS Mobile Response Team Supervisor	X	Stacy Krasinski, BABH EAS Program Manager	X	Kathy DePrekel, Helen M. Nickless Volunteer Clinic	X
Joelin Hahn (Chair), BABH Integrated Care Director	-	Stephani Rooker, BABH ID/DD Team Leader			
Joelle Sporman (Recorder), BABH BI Secretary III	X	Tracy Hagar, MPA Child OPT Supervisor			

Topic	Key Discussion Points	Action Steps/Responsibility
1. **a. Review of, and Additions to Agenda** **b. Presentations: Helen M. Nickless Clinic** **c. Approval of Meeting Notes: 07/11/24** **d. Program/Provider Updates and Concerns**	a. There were no additions to the agenda. b. Kathy DePrekel at the Helen M. Nickless Volunteer Clinic gave an overview of what they do at the clinic. This is a free walk-in clinic open every Wednesday evening from 4:00 PM - 6:30 PM. You do not need an appointment and it will not cost you anything as all care provided by the clinic is free to those who meet the eligibility requirements that are listed. No referral is needed. They had 671 patient visits last year. They average about fifteen patients a night. Amy is the counselor there and her visits were up significantly. The patients that see Amy have scheduled appointments and she will refer them to her private practice or will refer out to one of our providers. In 20 years, they had 32,300 visits. 56% of their patients are employed with an annual income of ~$18,000. Staff consists of twenty-one practitioners: NP's, MD's, and DO's. There are twenty-four nurses, twenty-six support staff and several specialists. They do not have to fundraise because the Nickless family gave a bit of money which keeps them going. They will start providing food boxes to	

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	patients. Working on a social needs screening tool. The clinic is always looking for new patients. c. The July 11th meeting notes were approved as written. d. **Bay-Arenac Behavioral Health**: - ABA/Wraparound – There is a masquerade dance for people with disabilities and their friends and family on September 14th at Game Changers and it is up to age 26. Amanda sent fliers around. - ACT/Adult MI – One staff on leave of absence in CSM till September. ACT is down one bachelor level case manager and a master's therapist. - Arenac Center – Nothing to report this month. - Children's Services – Nothing to report this month. - CLS/North Bay – Fully staffed with DSP's. Rose home decided to stop providing services so that home will be staffed with people in the meantime. - Contracts – Nothing to report this month. - Corporate Compliance – Nothing to report this month. - EAS (Emergency Access Services)/Mobile Response – Hired a third shift person. There is still a second shift position open, and a second shift team lead is also open. Hired a second shift clinician for Mobile Response and will be looking for another clinician with a bachelor's degree. - Finance – Nothing to report this month. - ID/DD – A case management position remains open because that person took a promotion and is doing the Self Determination and Respite Coordinator position. We were down four staff but now down 2.5 since two are coming back half time. - IMH/HB – Hired a new homebased worker. - Madison Clinic – A new nurse was hired. Annette is on leave and will most likely retire after that. Tami Trea will be leaving in November. Dr. Exum will be going on maternity leave in October and November, but Dr. Bridget Smith will be working on Mondays to cover the maternity leave. Two more students will be starting up for the new school year.	

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		- Medical Records – Nothing to report this month. - Quality – Nothing to report this month. - Recipient Rights/Customer Services – Nothing to report this month. - Self Determination – Nothing to report this month. List Psychological: Nothing to report this month. MPA: Referrals are very low. Child and Family is still trying to hire another therapist. Not updates for OPT adult or Case Management. Saginaw Psychological: A new therapist started this week for the DBT Team. Will be interviewing for a new therapist tomorrow. Hired a new case manager who will start at the end of the month. Chelsee Baker is leaving. Moregan LaMarr is the Clinical Director and will be attending these meetings at times. Jaclynn and Courtney will be supervising the OPT case managers.	
2.	**Plans & System Assessments/Evaluations** a. QAPIP Annual Plan (Sept) b. **Organizational Trauma Assessment Update**	a. **QAPIP Annual Plan** – Nothing to report this month. b. **Organizational Trauma Assessment** - There were 164 staff from BABH, List Psychological, MPA, and Saginaw Psychological that completed the 2024 Organizational Trauma Assessment. There were 197 staff that completed the survey in 2021. This decrease came from the support staff role. There were two surveys completed that did not identify an agency and one that could not be identified. About 54% of the responses came from direct clinical staff, about 22% came from supervisors/managers/directors/other leadership positions, and approximately 24% came from support staff. These response rates are proportionate to the overall total number of staff for each category. There are 10 questions that scored below a 70% agreeance. These responses were the combined results from all staff categories. The top five questions with the lowest percentage of agreeance were the same questions that scored below 70% during the 2021 survey. All of these questions had a decrease in percentage of	

Topic	Key Discussion Points	Action Steps/Responsibility
	agreeance for the 2024 survey compared to the 2021 survey. There has been significant staff turnover since the last survey, so it is possible that newer staff are not aware of some of the steps and efforts that have taken place to involve consumers in policy reviews and the efforts staff are taking to ask consumers about defining physical safety. There was one question that scored below 70% agreeance across all staff categories (Outside consultants with expertise in trauma provide on-going education and consultation). Additionally, there were seven questions that scored below 70% agreeance across two staff categories. The question, 'The program involves consumers in its review of policies' scored 50% or less across two staff categories. There are questions that had a 15% or higher rate of disagree or strongly disagree. Seven of the questions were also those questions that scored less than 70%. Five of the top seven questions were related to staff receiving information and support related to trauma and stress. Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies). Topics related to trauma are addressed in team meetings. The agency helps staff members debrief after a crisis. Part of supervision time is used to help staff members understand their own stress reactions. Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers. Analysis: There were 16 questions that had 15% or more of the respondents' answer 'Do Not Know.' Of the questions that had the highest response rate of 'Do Not Know,' seven of the top nine questions were the same as those that fell below 70% of agreeance including: The program involves consumers in its review policies; The program recruits former consumers to serve in an advisory capacity; Outside consultants with expertise in trauma provide on-going education and consultation; Outside agencies with expertise in cultural competence provide on-going training and consultation; Previous head injury; Staff members ask consumers for their definitions of physical safety; Former consumers are	

	Topic	Key Discussion Points	Action Steps/Responsibility
		invited to share their thoughts, ideas, and experiences with the program. The questions that were identified in both those that scored below 70% agreeance and those that had the highest response rate of 'Do Not Know' should be considered as priority areas of focus. Final Action Steps: Complete ProQual with staff during May supervision; Review Clinical Supervision Policy; Explore Outside Consultant on Trauma and Burnout; Education on debriefing after CPI; Reconsider combining health and wellness and compassion; Explore reflective listening supervision training for supervisors. Recommendations: There was discussion during leadership to bring Carla in to give an overview of supporting staff through trauma. Reflecting about your own feelings on a case to help you work through it. Melanie's team came up with a strategy group where they do case consultations, reflect on peer supports, and vent about issues even related to their supervisor. There was discussion around a CISM team that we had in the past but did not have the need to continue this, so the team was dissolved. There is an internal need for a CISM team but not necessarily an external need. Nicole was able to help with this, but it is an urgent need and Nicole is not available all the time. Moregan suggested there is an outside consultant, R3, that is a crisis group that could come out and debrief with a team.	
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)	a. **QAPIP Quarterly Report** - Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH: There were seven types of adverse events reported during FY24Q3. There were nine deaths for FY24Q3, which was less than in previous quarters. There were two suicides which is the highest for BABH since prior to FY19Q1. BABH completed root cause analyses on these to determine any potential process changes or action steps. There was one emergency medical treatment due to harm from another, which is not a typical trend. There was an increase in adverse events for FY24Q3 compared to FY24Q2. This is the highest number of adverse events since FY20Q3 and was primarily due to emergency	

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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)** **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	medical treatment. There was one individual that had two emergency medical treatment incidences in FY24Q3, but there does not appear to be any other type of trend among these incidences, therefore, no specific actions are identified at this time. Reportable Behavior Treatment Events: The number of emergency physical interventions increased for FY24Q3; however, the overall number of interventions continues on a downward trend. There were 10 consumers that led to the 41 emergency physical interventions with one individual accounting for 18. The treatment team has been working together to explore changes to support improvement. There were five 911 calls made for behavioral assistance for FY24Q3 which is an increase from previous quarters, however, the overall trend continues downward. Risk Events: Risk events are identified as 'harm to self, harm to others, police calls for behavioral assistance, emergency physical interventions, and two or more hospitalizations.' The number of risk events increased during FY24Q3, and this appears to be associated with the increase in consumers with autism. Consumers Diagnosed with Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes: BABH had a slight increase in consumers receiving the appropriate labs for this measure during FY24Q3. BABH determined that actioning these alerts monthly was improving the compliance rate, so monthly actioning was reimplemented in March 2024. Consumers Diagnosed with Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes: BABH had a significant increase in consumers receiving the appropriate labs for this measure during FY24Q3. BABH determined that actioning these alerts monthly was improving the compliance rate, so monthly actioning was reimplemented in March 2024. Evidence of Primary Care Coordination: BABH and the contract providers had a significant increase in health care coordination for FY24Q3. This can be attributed to the continued efforts of staff as well as changes to the way the quality staff reviewed evidence based on a recent MDHHS waiver	

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	audit. More Than 40% of Children Served Will Have Meaningful Improvement in Their Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) Score: During FY24Q3, 37% of children showed meaningful improvement in their CAFAS/PECFAS scores, slightly below the goal BABH set. Quality of Care Record Reviews - Services are Written in the Plan of Service are Delivered at the Consistency Identified: 88% of the records reviewed during FY24Q3 received the level of services that were written in the plan which is below the 90% standard set by BABH. Of the records found to be out of compliance, staff received education and training on the standard of providing services as written in the plan of service. Quality of Care Record Reviews - All Services Authorized in the Plan of Service are Identified Within the Frequency, Intervention, and Methodology Section of the Plan of Service: 94% of the records reviewed during FY24Q3 had the services identified appropriately to match the services authorized which meets the 90% standard set by BABH. Copy of Plan of Service Offered Within 15 Days of Planning Meeting: Overall, the percentage of compliance for offering the plan of service within 15 days was consistent for FY24Q2 compared to FY24Q1. It was determined that staff are not always using the electronic health record completely so there is missing data and blanks. Quality Staff are working with providers to remind staff to complete all data elements related to the plan of service. One provider has not been using the data field correctly which resulted in a 100% compliance rate due to having only one record reviewed. Extra training and education have been provided. b. **Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports** i. MSHN Priority Measures Report: This report is in the folder for you to look at. We are close to the bottom in relation to compliance with others in the region because we are a month behind in data. ii. Recipient Rights: The BABHA ORR completed 190 ORR Complaints for FY23 with an average number of days to resolve the complaints being	

Topic	Key Discussion Points	Action Steps/Responsibility
	57.675 days. The BABHA ORR's goal is to complete RR complaint investigations within 30 days from receipt of the complaint. Moving forward the RRAC will be kept abreast of the average days to resolve complaints per quarter as we attempt to achieve our goal. The top three allegations for FY24Q1-3 are Neglect (28, with 21 being Neglect III), and Abuse (30, with 9 being Abuse III), and Disclosure of Confidential Information (20). iii. RAS: Nothing to report this month. iv. MHSIP/YSS: We have till August 30th to collect the MHSIP/YSS surveys, and we are not getting many surveys back. The information needs to be submitted by August 31st. v. Provider Satisfaction Report: Nothing to report this month. c. Access to Care & Service Utilization Reports i. MMBPIS Report: Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of Request: BABH performed above the 95% standard. BABH demonstrated 100% (56/56) compliance of the children who requested a pre-screen and received one within 3 hours. BABH demonstrated 100% (253/253) compliance of the adults who requested a pre-screen and received one within 3 hours. Indicator 2: Initial Assessment within 14 Days-Children/Adults: There were 173 consumers that were out of compliance for Indicator 2 during FY24Q2. There were 155 consumers out of compliance during FY24Q1. Below are the specific reasons identified: 78 consumer no-shows, 5 consumers chose not to pursue services, 1 consumer chose provider outside of network, 29 consumers refused an appointment within 14 days, 20 consumers rescheduled the appointment, 15 consumers unable to be reached (an increase over the past two quarters), 6 no appointments available, 2 eligible for services, but placed on a waitlist, 1 assessment completed and determined not eligible, 4 staff cancel/reschedule, 1 discharged out of the region or not CMH responsibility, 1 staff scheduled within 14 days	

Topic	Key Discussion Points	Action Steps/Responsibility
	of access screen and not request for screen, 2 with unknown explanation, 9 were 'custom': Staff unable to provide documentation (3), Provider doesn't have record of referral (2), Requesting SUD services, ABD with delayed services and provider reached out 8 days after receiving authorization, Client transferred to a new therapist. Indicator 3: Start of Service within 14 Days Adult/Children: There were 87 consumers that were out of compliance for Indicator 3 compared to 265 last quarter. Below are the specific reasons identified: 34 consumer no shows, 3 consumers scheduled outside the 14 days because there were no available appointments, 18 consumers that refused an appointment within 14 days, 6 consumers that rescheduled their appointment, 2 consumers that could not be reached, 3 consumers that chose not to pursue services, 4 staff that canceled/rescheduled the appointment, 1 consumer where prior service was found, 16 'custom' reasons for being out of compliance: 9 were due to staff not getting assigned the case until 10 days or more into the 14 days, 2 were from staff no longer at the agency so no information was available, 1 was due to miscounting days, 1 was due to provider not receiving authorization, 1 was due to consumer being unwilling to schedule appointment, 1 was due to consumer being hospitalized before consumer could be seen, 1 was unknown. Indicator 4a: Follow-Up within 7 Days of Discharge from Inpatient Psychiatric Unit or Detox Unit: BABH demonstrated 100% (29/29) compliance for the child population and 94.74% (72/76) compliance for the adult population. Indicator 10: Re-admission to Psychiatric Unit within 30 Days: BABH met the standard of less than 15% readmission rate for the children and adult populations. The BABH Quality Manager will coordinate with specific agency supervisors regarding trends that are resulting in out of compliance and assist, as necessary, with determining what actions are necessary for	

Topic	Key Discussion Points	Action Steps/Responsibility
	correction. The Quality Manager did reach out to a specific team that was assigning cases 10 days or later into the 14 days. ii. LOCUS: Nothing to report this month. iii. Leadership Dashboard: Defer iv. Customer Service Report: Appeals have gone up since the start of FY24. The grievance issues for Q1-Q3 were Quality of Care (12), Service Concerns/Availability (5), Service Timeliness (3), Interaction with Provider or Plan (4), Plan or Provider Care Management/Case Management (3) Member's Rights (1), Provider Choice (1), Service Environment (1), Other (1) The total number of grievances which were resolved in favor of the beneficiary were 7 out of 31, which is about 22.6%. **d. Regulatory and Contractual Compliance Reports** i. PI Report: Bay Direct scored 100% for the MEV. MPA scored 97% which is a 1% decrease from FY23Q4. Saginaw Psychological scored 94%, which is a 4% decrease from FY23Q4. List scored 87% which is a 9% decrease from FY23Q4. There is a slight downward trend in compliance with the contract providers over the past 1.5 years. The most common finding were claims missing the 93 modifier when the service was Telemed Audio. Another common finding was the T1017 code being billed in conjunction with the 90791 code for the same service. It is recommended that staff double-check modifiers and to only bill the 90791 code when meeting with a consumer to complete the Assessment. Trends seen are: Person Centered Planning Tools check boxes being left blank. No explanation of why the Pre-Plan and Plan of Service were completed on the same day or if the Plan of Service was completed on a different date than what was requested. The "My objective will be completed through.." does not include the scope/frequency/duration. The Summary of Assessed Needs on pg. 11 of the Assessment is not being completed. It is either left blank or	

	Topic	Key Discussion Points	Action Steps/Responsibility
		marked, "N/A." Plan of Service Target Dates are missing. Pre-Plan Waiver Service Array checkboxes are blank. 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. e. **Periodic Review Reports** – Nothing to report this month. f. **Ability to Pay Report** – Nothing to report this month. g. **Referral Status Report** – Nothing to report this month.	
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** e. Clinical Capacity Issues Update i. OPT Group Therapy ii. OPT Individual iii. Referrals for Groups - Discussion f. Medicaid Re-Enrollment - Loss of Benefit Tracker g. Recommended Trainings	a. **Harm Reduction, Clinical Outcomes and Stakeholder Perceptions** i. Consumer Council Recommendations: Nothing to report this month. b. **Access to Care and Service Utilization** i. Services Provided during a Gap in IPOS: Nothing to report this month. ii. Repeated Use of Interim Plans: Nothing to report this month. c. **Regulatory Compliance & Electronic Health Record** i. 1915 iSPA Benefit Enrollment Form: Nothing to report this month. ii. Management of Diagnostics: Nothing to report this month. d. **BABH - Policy/Procedure Updates** – Nothing to report this month. e. **Clinical Capacity Issues Update** i. OPT Group Therapy: There is one skills group that meets on Wednesdays from 3:00-4:30 at Madison. It was agreed that if they have 2 notices, they can be referred to group. If they want to come to group, they can't be open to OPT and Group. ii. OPT Individual: We have Christopher seeing people virtual. Shalynda is limited license so she cannot take Medicare; she sees a mix of in-person and virtual. iii. Referrals for Groups: We will take more referrals. f. **Medicaid Re-Enrollment - Loss of Benefit Tracker** – Amy is going to train the students. If any primary case holders get messages that they need an ATP, a kiosk is at Madison so students can help consumers create MIBridges	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, August 8, 2024

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

Lincoln Center - East Conference Room

	Topic	Key Discussion Points	Action Steps/Responsibility
	h. **ABD Effected Service Drop-Down** i. Annual Checklists j. General Fund for FY25 k. Conflict Free Case Management l. **GF Request Process - Quick Phrases** m. **Meds Only**	accounts from Madison. Amy can be emailed until the students are trained to help with this. g. **Recommended Trainings** – Nothing to report this month. h. **ABD Effected Service Drop-Down** – If there is an advanced notice, you have to put the services in there and it would allow you to sign off without putting the services in there. A request was put in to have this addressed. i. **Annual Checklists** – Nothing to report this month. j. **General Fund for FY25** – Nothing to report this month. k. **Conflict Free Case Management**: Nothing to report this month. l. **GF Request Process - Quick Phrases** – Amy sent out an email about the GF exception requests and she did not want to create a new form so figured we could use our contact note and the discussion features. You can select this, and it prefills for you, so you pick what you need and delete the rest. See attachment that was sent to you and also saved in the meeting folder. m. **Meds Only** – Amy sent out an email about meds only and she did not want to create a new form so figured we could use our contact note and the discussion features.	
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 September 12, 2024, 1:30 - 3:30 in-person at the Lincoln Center in the East Conference Room.	

BAY ARENAC BEHAVIORAL HEALTH

Risk Management Plan 2024-2025
Executive Summary

Risk Management is defined as the ability to identify, assess, prevent, monitor, and remediate risk for the organization. The goal of the plan is to manage risk and reduce the severity of a loss if one were to occur, while accomplishing our mission and core objectives in providing quality behavioral health care to the people of Bay and Arenac Counties.
It is the policy of BABHA to ensure there are diligent actions to identify, assess, prevent, monitor, and remediate risk for the organization. BABHA will engage in a coordinated set of activities designed to control threats to its people, property, incomes, goodwill, and ability to accomplish goals.

Business Environment:

- Added the difficulty in retaining staff and the implementation of continued remote work environments.
- Deleted the references to the pandemic and infection control efforts to meet the orders related to the Public Health Emergency.
- Actions Steps:
    - Added re-evaluating the CCBHC model and making formal recommendation to Board by FY25Q1
    - Added implementation of tools to enhance Leaderships ability to monitor and evaluate staff activity in a remote environment and to evaluate physical plant and equipment needs.
    - Deleted/Completed the infection control strategies, testing, and other strategies to mitigate risks of the pandemic.

Medical and Clinical Practices:

- Deleted the Quality of Care Reviews from the Health Care Practices Committee. They are continuing to be completed.
- Added that Dr. Marrone, Addictionologist and Medical Examiner has regularly attended the Health Care Practices Committee and provided updates on trends related to substance use and deaths in Bay and Arenac Counties.
- Actions Steps:
    - Continue Root Cause Analysis of risk situations and take necessary system and process improvements.
    - Completed working with BI and PCE to get the death determination process and the Root Cause analysis process fully electronic.
    - Completed Narcan at all clinic sites and distribution to consumers, as well as Fentanyl test strips and Narcan dispensing machines in the community.
    - Completed the Coordination of Care letter in the electronic system and the universal consent form allows sharing of information to other health care providers without a consent.
    - Continuing Quarterly reports related to infection control, medication errors, morbidity and mortality, controlled substances, critical incidents that are reviewed by the Health Care Practices Committee.
    - Continue to have the Addictionologist participate in the Health Care Practices Committee meeting to provide input into Root Cause Analysis, Deaths and other Critical Incidents.
    - Continue quarterly Priority Performance Measures reports.
    - Continue quarterly reports on the Michigan Mission Based Performance Measures.

Service Needs:

- Added significant shortage of behavioral health workers and capacity to the provider network. Risk of capacity issues with Specialized Residential, Community Living Servies, Outpatient Therapy, and community inpatient hospitalization for children diagnosed with severe autism spectrum disorders.
- Added efforts to support the Specialized Residential and CLS included helping debrief with staff after a death, ongoing meetings with CLS providers, Northbay and Horizon Home staff assisting in emergent situations, Northbay moving to a community-based service.
- Added update on Outpatient Therapy which included the implementation of BABHA OPT groups, hiring two more therapists and two master's level clinicians to establish Same Day Access assessments for new referrals.

- Added update on Community inpatient for children and youth with severe ASD which included establishing single case agreements with ABA providers to provide enhanced CLS services to children and youth at risk of out of home placement.
- Added Ten 16 as an SUD agency working with the Arenac Center to expand SUD services in Arenac.
- Action Steps:
    - Continue to complete the Community Needs Assessment every two years.
    - Continue to participate in MDHHS and MSHN workgroups related to HCBS implementation, 1915i implementation, and CFA & P.
    - Continue working with Specialized Residential and CLS providers to strengthen the workforce and be able to handle individuals with higher needs.
    - Continue to increase the monitoring of Self Determination to address the higher risk for fraud and abuse.
    - Continue to monitor the capacity levels throughout the provider network.
    - Completed expansion of SUD services in Arenac County.
    - Added advocacy for additional inpatient and residential treatment capacity for children and youth diagnosed with ASD.

Environment and Safety:

- Added that all hazard assessments will be updated once the emergency declarations have been revoked.
- Action Steps:
    - Continue annual inspection process by the Facility Manager to assess for safety hazards and potential areas of risk.
    - Continue working with the Facility Manager and the Safety Committee and SLT to review and revise the BABHA EPP for the purpose of updating HVA every two years.
    - Continue to coordinate and conduct ALICE (Alert-Lockdown-Inform-Counter-Evacuate) safety training on security measures in the event of an active shooter.
    - Completed the implementation of Rave Smart 911 which provides 911 and first responders critical information in an emergency.
    - Continue to expand information available to 911 operators through Rave Smart.
    - Completed the distribution of PPE during the pandemic.

Legal and Regulatory:

- Added the increase of Medicaid Event Verification audits completed for each provider.
- Added the implementation of a Supervisors training to teach their role in compliance with program integrity.
- Action Steps:
    - Continue the verification process for providers
    - Completed modifying the event verification sampling to focus on atypical providers and self determination arrangements.
    - Continue monitoring of compliance with IPOS training requirements and continue to advocate for moderation of requirements at the state and regional enforcement levels.
    - Added increase education on Fraud, Abuse and Waste to Supervisors and consumers and in response to any substantiated Fraud and Abuse cases.

Ethical:

- Action Steps:
    - Continue to conduct two Ethics Committee meetings per year, provide annual Ethics training and solicit topics for discussion that the Ethics Committee meetings, and revise policies and procedures related to the outcome of the Ethics Committee meetings, as appropriate.

Financial:

- Action Steps:
    - Continue to complete the Risk Assessment Tool to monitor the performance of the direct operated and contracted service provider organizations.
    - Revised the Michigan Employment First Initiative for outcomes based contracts with the vocational providers to include the MDHHS Consultant recently engaged to provide feedback on this service model and whether the rates are competitive.

- Continue to assess positions as they become vacant to consolidate functions if at all feasible to reduce costs.
- Completed the assessment of the financial impact of the pandemic on the Network Providers and provide financial assistance as needed.

Personnel Qualifications and Training:

- Deleted the references to policy updates related to the pandemic.
- Action Step:
  - Continue to evaluate employees in accordance to the performance management system and identify areas of risk or deficiency and opportunity to address through training. Supervisors will continue to make use of reports available to them to monitor staff. Continue to monitor exclusions and debarment.

Media Relations and Social Media:

- Added the training that has been conducted on privacy breaches for employees at hire and annually.
- Added the IS Department has a process and are posting requests to the website and Facebook page.
- Added that there have been alerts added to let the IS Department know when three have been posts to the Facebook page so they can monitor.
- Action Steps:
  - Completed policy revisions made to address contact with the media.
  - Added to continue training on privacy with regard to social media and monitoring of postings.

Security and Technology:

- Added that multiple phishing tests have been implemented and training has been conducted for these that clicked on the phishing emails.
- Added that a phishing alert button has been installed so users can report to the Help Desk potential compromised emails.
- Added that the IS Manager conducted a Disaster Recovery Training for all Leadership staff.
- Action Steps:
  - Completed implementation of multifactor authentication
  - Completed implementation of multifactor authentication for providers that utilize the E.H.R.
  - Added Microsoft licensing upgrades for better remote management of devices to provide better security.
  - Added to continue end user education on security threats utilizing phishing campaigns and creating and implementing individual trainings for repeat clickers.
  - Added to monitor and make recommendations to SLT and the Board on systems that are becoming end of life. The phone system will be end of life 12/2025.

Infection Control:

- Added that in addition to providing education on infections, the community Nurses monitor and encourage individuals in Specialized Residential settings to obtain vaccinations.
- Action Steps:
  - Continue the Health Care Practices Committee will monitor infections on a quarterly basis.
  - Continue the Nursing Manager will review annual data and designate a goal for the upcoming year based on the data of the previous year.
  - Continue to have the Nursing Manager collaborating with the CDC and MDHHS on emerging health issues and communicates to BABHA staff.
  - Deleted monitoring of CDC and MDHHS information related to the pandemic.

Review of Insurance:

- Action Steps:
  - Continue to evaluate and renew the general liability coverage options through MMRMA, Workers Compensation coverage, Physician Malpractice coverage for the Medical Director and contractual Physician and Nurse Practitioner and crime bond coverage.

Management of Risk in the Contracted Service Provider Network:

- Action Steps:
  - Continue the Quality and Compliance Coordinator conducting quarterly performance improvement reviews of contract service providers as well as bi-annual MEV reviews.

- Added annual site reviews will be completed for designated contract service providers with an abbreviated review of the standards.

Mitigation, Remediation and Monitoring of Effectiveness of Risk Management Plan:

- No changes

Safety Committee Statement of Purpose:

- No changes

Status	Date Initiated	Source of Activity	Service/ Program	Provider Name	Brief description of issue/allegation	Codes Involved	# of Paid Claims	# of invalid Claims	# of Staff	# of Cons	Total Paid Amount Related to Complaint/ Activity	Overpay Identified?	Potential Fraud?	Date Referred to MIOHSIG	Total Over-payment	Disposition	Date Resolved
Closed	05/16/24	Tip or Grievance	Case Management	BABHA	An Assessment was not completed by the due date, supervisor instructed to complete a non-billable Assessment on a day that she visited the consumer.	T1017	0	0	2	1	$0.00	No	No	No report	$0.00	Investigation was complete last quarter. Plan of Correction received this quarter.	07/03/24
Closed	05/16/24	Tip or Grievance	CLS	PAO	A CLS staff was copy and pasting notes. Appears to be two separate versions. Beginning in 10/2022.	H2015	Multiple	0	1	1	$31,041.60	No	No	10/3/24 Meeting with OIG	$0.00	Referral to OIG was declined due to not having specific dates of services not rendered.	10/03/24
Closed	07/20/24	Tip or Grievance	CLS	BHS	CLS provider was documenting and billing for services she didn't provide.	H2015	9	9	1	4	$784.16	Yes	Yes	Under $5000	$784.16	Closed-funds recoverd. Employee resigned.	09/13/24
Closed	08/08/24	Beneficiary	OPT	MPA	Complaint that the parents of consumer didn't feel that the therapy sessions were not full amount of time. There were no dates identified	98032	0	0	1	1	$0.00	No	No	No report	$0.00	Closed-No findings	08/14/24
Closed	08/28/24	Audit-Random	FI	Stuart Wilson	Random Audit. Respite charges for periods of time when they should not have.	T2025	332	58	1	Mulitple	$151,003.59	Yes	No	No report	$1,721.19	Closed-Recovered	09/17/24
Open-pending Internal review	09/04/24	Audit-Scheduled	CLS	PAO	Scheduled audit resulted in findings of progress notes missing signatures. When the provider provided POC, updated notes had signature of an employee thought to not be employed.	H2015										Open-Pending finalization of Internal Review. Meeting with Provider is scheduled	
Closed	07/26/24	Audit-Scheduled	Specialized Residential	BHS-Jean Rd.	Scheduled audit.		302	2	Multiple	6	$30,737.83	Yes	No	No report	$189.81	Closed-Recovered	07/26/24
Closed	07/23/24	Audit-Scheduled	CLS	PAO	Scheduled audit.	H2015	34	9	Multiple	Multiple	$7,295.88	Yes	No	No report	$2,092.92	Closed-Recovered	09/27/24
Closed	04/18/24	Audit-Scheduled	Case Management/OPT	List	Scheduled audit. Review in FY24Q2 but funds didn't get recovered until this quarter	T1017/98032	45	6	Multiple	Multiple	$3,642.98	Yes	No	No report	$526.19	Closed-Recovered	07/02/24
							722	84			$224,506.04				$5,314.27		

BAY ARENAC

BEHAVIORAL HEALTH

Risk Management Plan 2024-2025

Approved by SLT~~Agency Leadership~~: 10/29/24
Reviewed by Healthcare Improvement and Compliance Committee: 11/4/24
Full Board Approval Date:

Contents

Overview

This document sets forth the Risk Management Plan for Bay-Arenac Behavioral Health Authority (BABHA). Risk Management is defined as the ability to identify, assess, prevent, monitor, and remediate risk for the organization. The goal of the plan is to manage risk and reduce the severity of a loss if one were to occur, while accomplishing our mission and core objectives in providing quality behavioral health care to the people of Bay and Arenac Counties.

It is the policy of BABHA to ensure there are diligent actions to identify, assess, prevent, monitor, and remediate risk for the organization. BABHA will engage in a coordinated set of activities designed to control threats to its people, property, incomes, goodwill, and ability to accomplish goals.

Risk Management Practices

BABHA's risk management practices include the following steps:

- Identification of loss exposures
- Evaluation and analysis of loss exposures
- Identification of how to rectify identified exposures
- Implementation of actions to reduce risk
- Monitoring of actions to reduce risk
- Reporting results of actions taken to reduce risks
- Inclusion of risk reduction in performance improvement activities
- Review of the organization's insurance package including:
    - Review for adequacy on an annual basis
    - Protection of assets
    - Review of property, liability, and other coverage, as appropriate

Identification of Risk

BABHA maintains various committees and councils in which risk is identified on an ongoing basis. These committees and councils are multidisciplinary groups of individuals who are continually assessing the activities within our organization and potential loss exposures. These committees and councils include, but are not limited to: Safety Committee, Performance Improvement Council, Strategic Leadership Team, Agency Leadership, Corporate Compliance Committee, Ethics Committee, and the Healthcare Practices Committee. In addition, BABHA complies with all applicable Federal, State, and regulatory agency laws, standards, rules, and regulations.

Areas of Risk Identified

- Business Environment
- Medical and Clinical Practices
- Service Needs
- Environmental and Safety
- Legal, Regulatory and Ethical
- Financial
- Personnel Qualifications and Training
- Security and Technology
- Infection Control

- Media Relations/Social Media
- Review of Insurance
- Management of Risk in the Contracted Service Provider Network

Analysis of Risk Areas (Potential Loss Exposures)[1]

Business Environment

~~[Chris]~~

The Agency Leadership engages in strategic planning on a regular basis and incorporates the assessment of risks, in the business environment through its core strategies and environmental scans. When conducting environmental scans, BABHA reviews both threats and weaknesses of the organization. This includes conditions internal and external to BABHA that may hinder achievement of core objectives if not decreased or eliminated. Strategies for responding are specific initiatives which may include policy and/or procedure changes, additional planning activities, staff training, program closure or development, emergency preparedness revisions, physical plant development, modernization or purchase of equipment, etc.

- See the BABHA Strategic Plan

Review of Past Year Actions to Mitigate Business Risk:

BABHA has implemented significant changes to service operations in since March of 2020 due to the international COVID-19 pandemic~~.~~ Staff shortages and ability to retain employees has become increasingly difficult. Implementation of continued remote work environments post-pandemic has been necessary to maximize efficiency and retainment of existing staff. Policies and procedures have been expanded from virtual work arrangements to a more widely implemented remote work environment. Tools have been created to assist managers in providing supervision and managing the work force. One example is a Leadership dashboard that assists the Managers in real time to evaluate the staff's activity. ~~This has included expansion of infection control, tracking, and screening measures, closing several work locations, redeploying staff to critical operations, training staff on pandemic procedures, expanding telehealth/telephonic service delivery options, more flexible sick leave/time off, environmental safety measures and expanded remote office practices. Many of these changes have been driven by CDC guidance, State Executive Orders, Local Health Department Emergency Orders and MIOSHA Emergency Rules. This has been particularly challenging for person with complex medical and mental health/disabilities living in the community that depend upon BABHA services. This includes the residential/community living network of over 300 persons in our area.~~

~~BABHA has coordinated our infection control and community distancing efforts with the Bay County health Department, the Michigan Department of Health and Human Services (MDHHS), Mid-State Health Network (MSHN) and our provider network to reduce the likelihood of community spread of the coronavirus. BABHA expanded its leadership team meetings to discuss pandemic planning efforts and ensure uniformity of action. BABHA has continued additional financial and resource support measures with our provider network to~~

[1] CARF: 1. Aspire to Excellence; G Risk Management; 1.a.

~~protect consumers and support preservation of these services through the pandemic. BABHA has also administered over 1600 Moderna COVID_19 initial vaccinations and subsequent boosters to consumers, employees, providers and the general public on a regular basis through our Madison clinic location. This has included mobile clinics to outlying Bay and Arenac service areas. BABHA will be continuing these efforts for the foreseeable future until our county and regional incidence and prevalence is under control.~~

An intense healthcare integration policy dialogue has continued at the state level since early 2016. Private and commercial health care interests continue to use the guise of "healthcare integration" to advocate for a transition from a state-county safety net mental health system in Michigan to a managed care insurance model. These efforts have continued despite ~~consistent public~~consistent public opposition to this approach, particularly from persons, families and advocates. These approaches are promised on the concept that private health care interests, far removed from any local constituent-based protections and only marginally overseen in Lansing, will produce cost savings and outcomes far better than existing safety net systems that have been in place for more than 50 years. In fact, several international studies including the Legatum Institute, the Commonwealth Fund and the Peterson-Kaiser Family Foundation consistently rank the commercial health care model in the United States as underperforming in patient outcomes as compared to other high-income nations despite having the highest per capita health care expense. As an alternative, both federal and state officials have been encouraging the implementation of integrated models such as Certified Community Behavioral Health Clinics and Person-centered Health Homes that integrate services at the point of contact. BABHA will continue to work with our stakeholders including consumers, families, community partners and county governments to advocate for system changes that build on the existing safety net and protect the important constituent-based democratic processes for our citizens.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
BABHA will continue to monitor health policy discussions at the federal and state levels and actively pursue opportunities to implement an integrated CCBHC model in Bay and Arenac Counties built on the constituent-based state and county community mental health system.	Chris Pinter	Revised	~~These policy discussion and post-pandemic proposals will be monitored on a regular basis throughout 2023. . It is anticipated that CCBHC opportunities will be available in the next 6 months.~~ The BABHA Board has asked Administration to evaluate the CCBHC model in other counties and make a formal recommendation to the Board by FY25Q1.
Implement tools to enhance Leadership to monitor and evaluate staff activity in a remote work environment. Evaluate long term staff equipment and physical plant needs.	Chris Pinter	New	BABHA will continue to monitor staff activity and productivity through the monthly Leadership Meeting. BABHA is evaluating long term space needs and will make a recommendiaton to the Board by June 2025.
Advocate for adequate funding to support the public Mental Health system.	Chris Pinter	New	BABHA will continue to monitor revenue and expense trends and communiate funding issues with the legislature, MDHHS and County Commissions throughout 2025.
~~BABHA will continue to implement~~	Chris Pinter	Completed~~Revised~~	~~BABHA will continue efforts to incrementally~~

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
~~infection control strategies, remote service options, vaccination clinics, testing protocols and other initiatives to protect our consumers, families, providers and employees as much as possible until COVID-19 moves to endemic status in North America.~~			~~return to routine operations consistent with MDHHS and Bay County Health Department guidance. These efforts will be monitored regularly in 2023 and coordinated with providers and employees based on the current risk levels in the Bay and Arenac County regions until the public health emergency has ended.~~

Medical and Clinical Practices

[Sarah H, Amy, Sarah VP]

The Healthcare Practices Committee (HPC) provides a comprehensive and coordinated approach to ensuring high quality of clinical services in an environment that is safe and conducive to the wellbeing of persons served, employees, and the community, and to meet or exceed established standards of care. Specific functions and duties of the committee focus on clinical and medical practices, including the following:

- ~~Quality of Care Reviews including reviews on:~~
  - ~~All deaths/suicides~~
  - ~~Unacceptable abbreviations, dose designations, acronyms, and symbols~~
  - ~~All medication occurrences, to include adverse reactions, toxicity, hospitalizations due to medications, etc.~~
  - ~~Emergency medical treatment or hospitalization due to an injury or medication error~~
  - ~~Injury or death because of emergency physical intervention~~
  - ~~Events that seriously disrupt or adversely affect the course of treatment/care of the person served and require further clinical or administrative attention.~~
  - ~~Persons served taking three (3) psychotropic medications in the same class~~

- Medical Record/Peer Review Processes conducted at each site providing services for individuals.
- Persons served taking 3 psychotropic medications in the same class are also reviewed by the Behavior Treatment Review Committee and is a component of the prescriber peer record review, the results of which are received by the Healthcare Practices Committee.
- Review of all data related to medication management, infection control and adverse events.
- Recommendations to the appropriate leadership team(s) that will ultimately improve the medication management process, infection control process, and/or clinical care.
- Along with the BABHA Medical Director, review all applications for clinical privileges, whether initial or a renewal.

- See the BABHA Medical Staff Plan
- See the BABHA Policy and Procedure Manual Chapter 6 Medication Management, Section 1 Operational

Review of Past Year Actions to Mitigate Medical Risk:

Monitoring of all adverse events through data collected through the incident reporting system. Data analyzed through sub reports of infection control, medication errors, morbidity & mortality reports, and controlled substances reports. Each report identified system improvements and actions taken to prevent recurrence. Each incident report was reviewed to ensure appropriate follow up and preventative actions on an individual basis. Root Cause Analyses were completed as deemed appropriate by the Quality Manager and Clinic Practice Manager to determine if any specific or casual factors impacted the outcomes of the incident being reviewed. Some of the action steps concluded were training and education to supervisors about ~~utilizing an Emergency Risk Management meeting when necessary,~~ increasinged coordination, accurate completion of incident reports, utilizing natural supports during treatment, and education regarding thorough documentation.

Incident rates for opiate and other forms of addiction have risen over the past few years in Arenac and Bay Counties. Opiate overdose remains a high risk for local populations served by BABHA. The BABHA Healthcare Practices Committee has added monitoring of controlled substances practices to its clinical practices oversight responsibilities to assist medical staff and leadership with monitoring use of medications with addictive qualities. In compliance with state regulatory requirements, prescribers are now checking the Michigan Automated Prescribing System (MAPS) for controlled substances before prescribing. Dr. Marrone, Addictionologist and Medical Examiner, has been attending the HCPC monthly and provided updates on trends related to substance use and deaths in Bay and Arenac Counties.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
Root Cause Analyses will be conducted of identified risk situations as deemed appropriate to determine necessary action steps for process and system improvements. ~~Work with BI and PCE to get the death determination process and the Root Cause Analysis process fully electronic.~~	Quality Manager~~Sarah Holsinger,~~and Clinic Program Manager ~~Amy Folsom~~	Continue	~~Throughout 2023~~ Ongoing as deemed necessary
~~Work with BI and PCE to get the death determination process and the Root Cause Analysis process fully electronic.~~	~~Quality Manager and Clinic Program Manager~~	Completed	
~~All clinic sites have a supply of Narcan Kits to distribute free of charge to consumers and community members at high risk of opiate overdose. BABHA can provide additional kits and training to local SUD providers and other community partners for distribution.~~	~~Amy Folsom, Sarah Van Paris~~	Completed~~Continue~~	~~Maintain supply of Narcan kits on an ongoing basis, assuming funding/supply remains available to BABHA~~.
~~The coordination of care letter can be sent to primary care physicians to address any potential issues identified during the MAPS review and reduce the risk of adverse clinical outcomes. This has been made electronic for primary program and remains electronic for clinic sites but no longer need consent to share of obtain.~~	~~Amy Folsom, Dr. Smith~~	C~~ontinue~~Cmpte	~~Throughout 2023~~

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
Quarterly sub reports related to infection control, medication errors, morbidity and mortality, controlled substances prescribed, and critical incidences will be reviewed by the Healthcare Practices Committee to analyze and determine any appropriate action steps for process and system improvements.	Quality MangerSarah Holsinger	Continue	Throughout 202543 on a quarterly basis
Local Addictionologist is invited to participatinge in monthly Healthcare Practices Committee meeting to provide valuable input into Root Cause Analysis, Deaths, and other Critical Incidents requiring review.	Clinic Program ManagerAmy Folsom	continueNew	Started 2020 and will continue throughout 2023

The BABHA Primary Network Operations/Quality Management Committee (PNOQMC) monitors events and reviews data that relates to areas of clinical risk for consumer populations and seeks to make system improvements to mitigate and remediate the risks identified. BABHA maintains a network-wide incident reporting system to identify opportunities for remediation and mitigation of risk.

Monitoring activities of the PNOQMC include:

- Quarterly review of Priority Performance Measures when the report is received from MSHN
- Quarterly review of Michigan Mission Based Performance Indicator System (MMBPIS)

- See the BABHA Quality Assessment and Performance Improvement Program Plan
- See the BABHA Policy and Procedure Manual Chapter 2 Continuous Quality Improvement, Section 1 Data Continuity and Section 3 Monitoring

Review of Past Year Actions to Mitigate Clinical Risk:

The Primary Network Operations and Quality Management Committee (PNOQMC) delegates the responsibility of reviewing and acting on data for adverse events related to risk events such as, but not limited to, emergency physical interventions and adverse clinical events to designated committees. Identification of system issues are discussed with appropriate committees and groups/programs to determine deficits and preventive measures. The Priority Performance Measures report is provided by MSHN and is distributed quarterly. The PNOQMC has reviewed the results and trends.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
Priority Performance Measures are reviewed at least quarterly when the report is received, paying close attention to identified performance improvement projects and any other specific measures that are targeted by the Healthcare Integration	Quality ManagerSarah Holsinger	Continue	Throughout 202543 at least quarterly

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
Steering Committee or other internal committees.			
Michigan Mission Based Performance Indicator System (MMBPIS) reports will be reviewed quarterly to discuss access to care and potential specific and/or casual barriers.	Quality Manager~~Sarah Holsinger~~	Continue	Throughout ~~2023~~ 20254~~at least~~ quarterly

Service Needs

[HeatherB, Heather F, ~~Karen,~~, Joelin]

BABHA conducts an annual Needs Assessment to monitor for unmet or partially met service needs within the community. This process is guided by MDHHS requirements. Community Focus Groups or surveys are held to gather perspectives from local providers and stakeholders. BABHA also obtains input from the Consumer Councils, Provider Network Operations/Quality Management Committee (PNOQMC), the Health Care Practices Committee, and the Leadership meeting on potential risk, needs, and areas of improvement for adults with mental illness, individuals with co-occurring substance use disorders, children with serious emotional disturbance and adults/children with developmental and/or intellectual disabilities. In addition, evidence-based practices are implemented throughout clinical treatment practices to reduce potential risk.

Due to a significant shortage of behavioral health workers in Michigan, there has been a shortage of adequate capacity within the BABH Provider Network for various programs. BABHA has worked with the provider network to increase the availability of funding (via MSHN) to support recruitment and retention efforts of the providers. Services identified as being at risk of capacity issues include: Specialized Residential services ~~and Community~~and Community Living Supports (CLS), Outpatient Therapy (OPT), and community inpatient hospitalization for children/youth diagnosed with severe autism spectrum disorder (ASD). Services for individuals in Arenac County with co-occurring mental illness and substance use disorder (SUD) that were previously at risk due to provider and behavioral health work force shortage have improved and will continue to be monitored.

Specialized Residential and Community Living Supports: Home and Community Based rule implementation, transition to 1915 (i), reduction in State Hospital beds, the pandemic and shortages of staff, and the difficulty getting people into the ~~hospital has~~hospital has created a crisis for the Specialized Residential and Community Living Supports (CLS) services. Local providers are unable to hire enough qualified staff to care for individuals, especially those who have behavioral issues. Over the last year, there have been three specialized residential homes where the provider has ended their contract due to not being able to provide adequate services with the funding that is provided. All of these factors have created a situation where appropriate level of care options are limited. Local providers are reluctant to care for ~~that~~ individuals with significant behavioral challenges, resulting in many out of county placements for high need individuals which often have long waiting lists. It is anticipated that t~~T~~he minimum wage increase for Direct Care Workers (DCW) slated for 2/21/25 will significantly impact providers ability to retain and hire staff. ~~All of these factors have created a situation where appropriate level of care options are limited. Over the last year, there have been three specialized residential homes where the provider has ended their contract due to not being able to provide adequate services with the funding that is provided.~~

The CLS Assessment tool has had revisions to better evaluate the CLS need for those individuals with behavioral or safety needs. Lack of adequate levels of CLS staffing has created some individuals to go without staffing for significant periods of time. ~~Finding~~ Utilizing North Bay staff for more emergent needs and when individuals go without staffing is being explored as an alternative to address that issue. -The complexity of filling vocational providers availability based on the needs of the consumer has proved challenging. For those individuals with low hours of CLS, finding and matching staff has proven difficult. Those with higher hours are easier to find adequate staff. Referrals to providers to maximize the ability to find staff is difficult. As a result, there has been a significant increase in self-determination cases. Self-Determination and self-directed CLS services are a high-risk service for fraud and abuse. MDHHS is developing an Electronic Visit Verification (EVV) system to better monitor the activity of workers and the provision of services. MDHHS has new Technical Requirements that include a change in how the budgets are determined providing the individual a maximum amount of money the individual can use for services.

~~Self-Determination and self-directed services are a high-risk service for fraud and abuse. MDHHS is developing an Electronic Visit Verification (EVV) system to better monitor the activity of workers and the provision of services. MDHHS has new Technical Requirements that include a change in how the budgets are determined providing the individual a maximum amount of money the individual can use for services.~~

~~Due to a significant shortage of behavioral health workers in Michigan, there has been a shortage of adequate capacity within the BABH Provider Network for various programs. BABHA has worked with the provider network to increase the availability of funding (via MSHN) to support recruitment and retention efforts of the providers. There have been slight improvements of capacity during the past few months and network capacity will continued to be monitored during FY23.Services for individuals with co-occurring mental illness and substance use disorder (SUD) are at risk in Arenac County due to provider and behavioral health work force shortage.~~

Outpatient Therapy (OPT) capacity: During the past year, BABH has experienced significant provider network shortages of capacity specific to outpatient therapy services. Many providers faced staffing turnover concurrently with onboarding new hires, at a time when referrals for OPT services were at an all-time high. This created an overall decrease in network capacity for OPT services.

Community Inpatient ~~and Autism services~~for children/youth with ASD: With the decrease in State Hospital bed availability, it is evident that there is a lack of qualified inpatient providers to support the treatment and support needs of children and youth diagnosed with severe autism. Even with the offered authorization of 1:1 or 2:1 staffing, many inpatient mental health units decline the admission of said youth. This has resulted in children/youth, who meet criteria for community inpatient services, experiencing extended stays in the local Emergency Department (ED) of the local hospital, which increased the risk to the child/youth, the parent/care giver, and the ED staff.

- See the BABHA Community Needs Assessment

Review of Past Year Actions to Mitigate Service Risk:

Specialized Residential/CLS: BABHA representatives participate in MDHHS and MSHN meetings addressing HCBS rules and BTRC, 1915 (i) implementation and requirements. BABHA and the Network Providers have

been addressing the DCW shortages by ~~providing provider stabilization funding, allocating funding to support wage increases,~~ advocating at a state level for increase in wages, providing crisis intervention when needed, debriefing after a death, and providing a Quality-of-Life Mentor and other additional supports for the staff and consumers. ~~BABHA has provided COVID testing, vaccinations, Personal Protective Equipment and nursing support to the providers. Providers and BABHA staff have been meeting monthly to address ongoing concerns related to the pandemic and staffing shortages.~~ Meetings with all CLS providers have occurred to encourage continued recruitment of staff and to address barriers that they are experiencing. Development of BABHA Transition and Crisis Team Policy was completed and approved and has been put in place several times this year for emergent case consultation and North Bay and Horizon Home staff have filled in for emergent situations. Community Living Support Services are being evaluated to assure that the services are being authorized based on medical necessity. The BABHA CLS Committee continues to review, approve, authorize and monitors the CLS requests. Northbay has moved to a community based CLS provider and ~~have~~has been providing services to individuals in their homes as well as provide community integration opportunities. The vocational providers have increased their primarily community based CLS services. BABHA Self Determination Coordinator and Supports Broker implemented spot checks comparing billing and progress notes to assure the CLS services meet the Medicaid requirements.

Outpatient Therapy (OPT): During FY24, BABH increased monitoring OPT capacity from monthly to weekly, which substantiated the capacity issues. BABH implemented the use of OPT groups, facilitated by BABH clinical staff willing to work beyond their normal 40-hour work week. Simultaneously, BABH hired 2 internal therapists, which increased capacity for new referrals and gave the network OPT providers a chance to onboard new therapist to assume established caseloads without being overwhelmed with new referrals. BABH also hired 2 master's level clinicians and established Same Day Access assessments for new referrals. This process included providing initial assessments for a portion of the new referrals going to the provider network, which allowed providers additional time to adequately onboard the new therapist. The steps implemented by BABH have resulted in stabilization of the Outpatient Therapy services. BABH will continue to monitor referrals and the status of the provider network capacity monthly, with additional capacity discussions at the monthly Provider Network Operations and Quality Management Committee (PNOQMC).

Community inpatient for children/youth with severe ASD: During the past year, BABH has established single case agreements with a well-established ABA provider to provide enhanced CLS services to children/youth who are at risk of needed out-of-home placement (i.e.: inpatient hospitalization, treatment residential placement) due to significant symptoms and behavioral issues associated with severe autism. The enhanced CLS services include CLS staff who have knowledge and experience working with children diagnosed with autism, and who have been trained in crisis intervention and escalation skills. The enhanced CLS services may be provided in the home or as an additional support for extended stays in the ED. BABH has and will continue to advocate for additional inpatient and residential treatment capacity for child/youth diagnosed with ASD with MDHHS and Mid-State Health Network (MSHN).

Arenac County SUD Services: BABHA has expressed concerns regarding the lack of SUD services in Arenac County to Mid-State Health Network (MSHN), who manages the SUD provider network. Collaboration with Recovery Pathways and Peer 360 to enhance the SUD service availability in Arenac County has been successful in providing Medication Assisted Treatment and Peer Recovery services at the Arenac Center. Ten 16 is another SUD agency that is working with the Arenac Center to expand SUD services to that area. Four of the therapists at the Arenac Center are in the process of obtaining an Addiction Credential and continue to attend trainings to assure competency in this area.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
The community needs assessment will be completed every two years~~on an annual basis~~ to ensure that progress is made, and areas of need are identified. All areas have been incorporated into the Strategic plan for action and are monitored through updates to the board and addressed through committees and workgroups as appropriate.	Quality Manager~~Sarah Holsinger~~	Continue	The Community Needs Assessment is completed every two years~~each year~~ at the end of the calendar year and due to Michigan Department of Health and Human Services at the end of March~~February~~. The information gathered from the assessment are incorporated into the Strategic plan.
BABHA will continue to participate in MDHHS and MSHN workgroups related to HCBS Rule implementation, 1915 (i) implementation, Conflict Free Planning and Access workgroups to stay informed of initiatives that will impact service provision and develop processes to assure compliance.	Clinical Program Manager-IDD Services; Director of Integrated Services-Specialty Services	~~New~~Continue	Ongoing through Sept 30,2025~~-3.~~
BABHA will work collaboratively with Specialized Residential and CLS providers to strengthen the workforce. Strategic Plan Initiatives will include potential expansion of specialized residential settings that handle individuals with behavioral challenges. Work will be done with CLS providers to continue to encourage adequate hiring of staff.	Director of Integrated Services	Continue	~~Residential and CLS stabilization will be included in the FY 2023 Strategic Plan to be completed by Sept 30, 2023~~ Ongoing
BABHA will continue to implement the current Action Plan to address the potential for fraud and abuse risks for Self-Determination arrangements. ~~Continue to stay informed on the progress of an EVV system.~~ Electronic Event Verification system selected with plans to begin transitioning providers early 2024.~~,~~	Self Determination Coordinator; Director of Integrated Services	Continue	~~Policy has been updated on 10/18/22 and will be approved by 1/1/2023. Ongoing through Sept 30, 2023~~. Implementation of the EVV began 10/1/24. Monitoring of the system to continue through 9/30/25
BABHA will monitor program capacity levels throughout the provider network. BABHA will also continue to notify the provider network of regional and state opportunities that support staff recruitment and retention.	Directors of Integrated Services, Arenac Program Manager, Chief Financial Officer~~Joelin Hahn; Marci Rozek; Karen Amon~~	~~New~~ Continue	~~It is projected that behavioral health workforce stability will continue to stabilize during FY23.~~ Ongoing
~~BABHA will continue to work with the local SUD provider network and MSHN to secure expansion of SUD services in~~	~~Heather Friebe; Joelin Hahn~~	~~Continue~~ Completed	~~It is projected that SUD service expansion efforts will continue in Arenac County through 2023.~~

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
~~Arenac County.~~			
BABH will continue to advocate for additional inpatient and residential treatment capacity for child/youth diagnosed with ASD with MDHHS and Mid-State Health Network (MSHN).	Directors of Integrated Services, Chief Executive Officer	New	It is projected that advocacy efforts will result in change during FY25.

Environment and Safety

~~[Marci]~~

The Safety Committee serves as a part of an integrated patient safety program at BABHA. Its purpose is to reduce or eliminate potential or actual risk and improve care through the identification, analysis, evaluation, and remediation of risks to persons served, visitors, volunteers, and employees. Specific functions and duties of the committee include, but are not limited to:

- Ensuring compliance with regulatory and accrediting body requirements related to environment of care, infection control, emergency preparedness, and risk management
- Supporting the safe delivery of care within reasonable limits
- Ensure proper disinfecting of office space and vehicles for staff, those served and visitors
- Receiving/reviewing reports on safety and environmental concerns and making recommendations for changes in practice as appropriate
- Facilitating the timely identification of and making objective recommendations regarding risks to reduce or prevent the potential(s) for injuries
- Exercising internal controls to reduce risks associated with injury
- Overseeing the development and ongoing assessment of the Environment of Care policies and procedures, including completing required reviews and making recommendations for revisions, as deemed necessary
- Conducting an annual community-based "all hazards" vulnerability analysis (HVA) to identify risk areas for inclusion in the BABHA Emergency Preparedness Plan

- See the BABHA Policy and Procedure Manual Chapter 5, Environment of Care
- See the BABHA Emergency Preparedness Plan

Review of Past Year Actions to Mitigate Environmental Risk:

Typically, the annual property inspection report from liability insurance carrier, MMRMA, is reviewed to ensure all leased and owned property/buildings met safety guidelines and standards as well as the Facility Manager's annual Site Safety Inspection Report for compliance. The inspections conducted by the BABHA Facility Manager were completed on all properties/building during 2024~~2~~. A property valuation was last conducted by CBIZ Valuation Group, LLC in May 2021 and those valuations incorporated into our policy renewal.

The Safety Committee quarterly reviewed consumer incident reports and building issues as they related to environmental concerns and the safety program performance measures. An HVA is now required every two years and was ~~due to be~~ conducted in the third~~second~~ quarter of FY242~~2~~. ~~Due to the ongoing pandemic this was put on hold. An HVA will be completed once the public health emergency declarations have been revoked.~~ Completion of the HVA occurs in consultation with the Bay County Emergency Management Coordinator and the Central Michigan District Health Department contact for Arenac County. This activity will subsequently be completed by Site Safety Representatives and Supervisors at each building.

The agency-wide Emergency Preparedness Plan (EPP) based on federal regulations regarding HVA, emergency policies/procedures, communication plans and training/testing requirements was revised in March 20233~~2~~. This report includes information that BABHA activated the agency EPP at the beginning of the pandemic which has remained active for the last 36 months, the BABHA all hazard assessments will be updated once the emergency declarations have been revoked and Mutual Aid Agreements are being updated.~~and redirected much of our operations into remote and telephonic service means. Due to the pandemic, there were limited opportunities for staff to attend any ongoing staff education regarding preparedness of safety risks in the workplace.~~

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
Outside of the required annual inspection process, Facility Manager assesses sites for safety hazards or potential areas of risk and addresses as needed.	Facility Manager~~Eric Strode~~	Continue	Ongoing
The Facility Manager will work with the Safety Committee and SLT to review and revise the BABHA EPP for purpose of an updated HVA every two years.	~~Eric~~ Facility Manager~~Strode~~	Continue	~~Revisions to the BABHA EPP will be completed in February or March 2023.~~ Due March 2025
The BABHA EPP will include agency participation in both a full-scale community exercise and facility-based table exercises for key service locations to continue ongoing training for all staff.	Facility Manager~~Eric Strode~~	Continue	Participation in full-scale community and facility-based table exercises will occur in 2026~~the year after the public health emergencies are revoked.~~
Coordinate and conduct an ~~active~~ ALICE (Alert-Lockdown-Inform-Counter-Evacuate) safety training on security measures that can be taken in the event of an ~~shooter training which continues to be delayed due to the pandemic. The BABHA Facility Manager will become an~~ active shooter. The BABHA Facility Manager has become and active shooter trainer for purposes of conducting these staff trainings tailored to each facility.	Facility Manager~~Eric Strode~~	Continue	~~During fiscal year 2023~~ During FY25.
~~Implement Rave Smart 911 providing 911 operators and first responders critical information needed in any type of emergency.~~	~~Eric Strode~~	~~Completed~~	~~During fiscal year 2021~~
Continue to expand information available to 911 operators through Rave Smart 911 to include maps of	Facility Manager~~Eric~~	Continue	~~During fiscal year 2023~~ During FY25

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
each BABHA facility and emergency contact personnel at each of those locations.	~~Strode~~		
~~The Facility Manager will coordinate with the Nursing Manager to ensure proper amount of PPE on-site and available for staff and Contracted Network Providers~~.	~~Eric Strode/ Sarah VanParis~~	~~Continue~~ Completed	~~During fiscal year 2023~~

Legal and Regulatory

~~[Janis~~ Karen~~]~~

The Corporate Compliance Committee conducts risk assessments to identify and mitigate the risk of Medicaid, Medicare and other state and federal healthcare program related fraud and/or abuse. The Committee closely tracks federal and state legislation, as well as federal Medicare/Medicaid and state Medicaid policy, to ensure BABHA is responsive to changes in the regulatory environment. Members of the Committee perform routine monitoring of key risk areas related to participation in federal and state health care programs, which are outlined in the BABHA Corporate Compliance Plan.

Current focal areas include ensuring rendering service providers meet the qualifications set by the state for delivery of Medicaid funded behavioral health services, and complying with increasingly complex Medicaid waivers (used by the state to fund behavioral health services).

Medicaid waiver program requirements are increasingly aligned with traditional utilization management principles, versus the person centered and recovery philosophies which have driven behavioral health services for many years. This evolution is increasing BABHA's risk of audit findings (and therefore potential recoupment of overpayment) due to non-compliance with increasingly inflexible mandatory service delivery parameters.

BABHA performs exclusion and debarment checks monthly to mitigate the risk of an excluded individual being involved in whole or in part, either directly or indirectly in the delivery of federal and state funded health care services. Contracted clinical service providers are also asked to complete such checks. Emerging risk areas related to provider qualifications are ensuring compliance with population specific designations which are required of rendering providers for certain Medicaid service ~~codes and~~codes and maintaining evidence of direct care staff training in each individual's plans of service. Higher staff turnover due to the current job market is making compliance challenging for BABHA and contracted providers.

BABHA continues to perform its own verification of service claims, in addition to those required of the PIHP by Federal regulations, to reduce the risk of invalid claims causing an overpayment of Medicaid or Medicare funds. Priority in sampling claims is given to service encounters rendered by atypical providers (i.e., not licensed medical personnel) and those service areas where the nature of the Medicaid service delivery format limits BABHA's locus of control, such as self-determination arrangements (where the person served acts as the employer of some of their service providers) and Community Living Support services being provided by a Provider agency in individuals homes.

The State of Michigan implemented a provider enrollment system for typical health care providers, to increase its controls over provider qualifications. A system is also planned for atypical health care providers, but

implementation by MDHHS has been delayed. However, under a Federal mandate, the State has begun to implement ~~is preparing to implement~~ an electronic event verification system statewide which will require direct service professionals and similar personnel to log-in and track service delivery information.

- See the BABHA Corporate Compliance Plan
- See the BABHA Policy and Procedure Manual Chapter 13 Corporate Compliance; Section 2 Administrative and Operational Practices

Review of Past Year Actions to Mitigate Regulatory Risk:

BABHA expanded staff capacity to perform service event verification. The Policy and procedures for Medicaid Event Verification has been revised to reflect the increase in audits for providers. BABHA continues to provide ~~increased its~~ oversight of provider qualifications through expanded credentialing processes for higher risk providers, such as Autism service providers. BABHA continues to ~~expanded its~~ review ~~of~~ personnel records during site reviews of contracted service providers. Routine training of providers in documentation requirements has been added. A Supervisors training was developed to teach their role in program integrity and corporate compliance. Individual training was conducted with two new Program Managers.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
Increase verification of rendering provider population designations	~~Janis Pinter; Sarah Holsinger~~ Director of Heath Care Accountability, Quality Manager	Continue~~New~~	Ongoing~~03/01/23~~
~~Modify event verification sampling to focus atypical providers and self-determination arrangements.~~	~~Janis Pinter; Sarah Holsinger~~	~~Completed~~New	~~03/01/23~~
Increase monitoring of compliance with plan of service training requirements; continue to advocate for moderation of requirements at state and regional enforcement levels	~~Janis Pinter; Sarah Holsinger; Karen Amon~~ Director of Health care Accountability, Quality Manager	Continue~~New~~	Ongoing~~09/30/23~~
Increase education on Fraud, Abuse and Waste to Supervisors and consumers and in response to any substantiated Fraud and Abuse cases.	DHCA	New	Beginning 10/1/24 and Ongoing

Ethical

~~**[Jennifer]**~~

BABHA operates an Ethics Committee, which is a sub-group of the Corporate Compliance Committee. The Ethics Committee offers critical analysis and recommendations for courses of action in response to ethical risks/ challenges faced by employees in their day-to-day work. The Committee is available to all staff for consultation. BABHA maintains a manual for staff that provides guidance for dealing with ethical concerns including conflicts of interest, called the BABHA Operating Philosophy and Ethical Guidelines.

- See the BABHA Operating Philosophy and Ethical Guidelines

Review of Past Year Actions to Mitigate Ethics Risk:

The Ethics Committee reviewed ethical dilemmas brought to the committee by BABHA staff. Several concerns were addressed, including the COVID-19 and the vaccine, and continued discussion regarding expectations related to professional boundaries, family members with medical licensure writing prescriptions for minor children residing in licensed settings, and informing consumers of medical diagnosis. Professional boundaries is an ongoing ethical issues and will remain on the Ethics Committee agenda for continued discussion.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
The Ethics Committee will continue to meet as scheduled 2 x per year and as ethical concerns arise. In addition, BABHA will continue to provide annual ethics training during Staff Development Days and in response to ethical dilemmas. The Ethics Committee will proactively solicit topics for discussion prior to each scheduled meeting. Policies and procedures will be developed and/or revised based on the outcome of Ethics Committee meetings, as appropriate	~~Jennifer Lasceski~~ Human Resources Director	Continue	Training will occur each year and on an as-needed basis. Requests for ethical topics for discussion will be made in May and November each year.

Financial

~~[Marci]~~

The Finance Department provides the Agency's budget on a regular basis with monthly budget reports to managers responsible for the agency's various programs and departments. External compliance audits are conducted on an annual basis. BABHA is part of routine actuarial assessments through its affiliation with a capitated Medicaid Pre-Paid Health Plan covering a 21-county region. The assessments are performed to ensure long term financial obligations can be met. BABHA financial statements are reviewed monthly by the Board of Directors.

- See the BABHA Annual Operating Budget
- See BABHA monthly Financial Statements
- See the BABHA Policy and Procedure Manual Chapter 8 Fiscal Management

Review of Past Year Actions to Mitigate Financial Risk:

BABHA submitted an Original Budget to the Board of Directors in September 2023~~1~~, prior to the start of the fiscal year. Subsequently a final amendment was submitted for approval. The agency's FY 23~~1~~ Financial Audit was conducted, and the final report presented to the Board for adoption on March ~~28,~~ 2024~~2~~. The Annual Compliance Audit was completed with preliminary results presented to the Board on March ~~28, 2022~~2024.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
BABHA continues to complete the Risk Assessment tool that was developed in FY17 which is a means to formally monitor the performance of the agency's network of specialty behavioral health direct operated and contracted service provider organizations through the review of performance data and site reviews. This Risk Assessment tool returns a risk score for each provider and for BABHA of high, moderate, or low and is associated with four outcomes related to ongoing monitoring activities. Scoring of the Risk Assessment was updated during FY22 by adding an additional outcome to more accurately represent performance. When contracts are proposed for renewal to the Board of Directors, the most recent risk assessment is presented.	~~Stephanie Gunsell~~Contracts Manager	Continue	Ongoing
The agency continually assesses contracts as they come up for renewal to determine current need and any potential to restructure the contract for costing savings. In response to the Michigan Employment First Initiative assistance was sought and provided by MDHHS to restructure rates in vocational contracts to be outcomes based. A significant amount of progress has been made through this assistance which has resulted in revised contracts. BABHA has begun working with an MDHHS consultant to review these outcome based services and payment model. The consultant will provide feedback on this service model and whether the rates are competitive.~~This payment structure will continue to be monitored during the current year since data was skewed as a result of lower than anticipated utilization as a result of the ongoing pandemic.~~	~~Marci Rozek~~Chief Financial Officer	Continue	Ongoing
The agency assesses positions as they become vacant to determine whether consolidation of functions is possible or feasible.	~~Marci Rozek~~Chief Financial Officer	Continue	Ongoing
~~BABHA will assess the financial impact the pandemic has had on our Network Providers' business operations. Financial assistance may be provided under the parameters of the MSHN Provider Network Stabilization Plan and/or the MSHN Network Staffing Crisis Stabilization Plan.~~	~~Marci Rozek~~ Chief Financial Officer	Completed~~Continue~~	~~Ongoing~~

Personnel Qualifications and Training

~~**[Jennifer]**~~

Personnel participate in the BABHA performance management system, which evaluates job performance and competency. This process also identifies areas for growth and areas where additional training/education is needed, to reduce the risk of error due to incompetency. The Employee Handbook, along with the BABHA's Operating Philosophy and Ethical Guidelines, describes employee performance expectations to ensure at least

minimum quality standards are met. Annual and new employee training requirements to mitigate risk are defined in the Agency Training Plan and policies governing minimum training requirements.

- See the BABHA Agency Training Plan
- See the BABHA Policy and Procedure Manual Chapter 7 Human Resources, Section 1 Administration of Personnel Management and Section 3 Education

Review of Past Year Actions to Mitigate Personnel Risk:

The Employee Handbook is reviewed on an annual basis and updated as needed to address areas that may place BABHA at risk such as conflict of interest, use of agency equipment/technology, workplace safety, standards of conduct, etc. All staff acknowledge training related to updates to the Handbook.

Performance evaluations were conducted on BABHA staff during 20233 and at 3 and 6-month intervals for new hires. Performance Improvement Plans (PIPs) were developed as warranted, to address areas of deficiency.

~~HR related policies and procedures (including training) have been under review in 2022. Due to the continuation of the COVID19 pandemic, BABHA has continued the policy to provide BABHA staff with necessary paid leave to protect the health and wellbeing of staff and their eligible family members, and to ensure adequate staffing levels are maintained. This review also resulted in several updates including those related to staff credentialing and credentialing and privileging of Individual Practitioners.~~

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
BABHA will continue to evaluate employees in accordance with the performance management system and identify areas of risk or deficiency and the opportunity to address through internal or external training. Supervisors will make use of reports available to them through Phoenix and will document supervision using supervision logs. HR staff will continue to monitor exclusion databases monthly to ensure that staff are not excluded from providing services to people supported by BABHA.	~~Jennifer Lasceski~~Human Resources Director	Continue	All actions noted above are ongoing. Evaluations and training will be completed within designated timeframes as identified. Completion after required due dates will be addressed on an individual level.

Media Relations and Social Media[2]

[Chris/Jennifer/Karen~~Janis~~]

Contact with the media by BABHA personnel requires prior approval of management to ensure that any communication with local or national media is consistent with the agency's mission, values, core strategies

[2] CARF; 1. Aspire to Excellence; G. Risk Management; 3.

and reduces the likelihood of any -potential adverse effect on BABHA business operations, the Board of Directors or the Bay and Arenac Communities

BABHA personnel are not discouraged from using social media in their personal lives, but a business-related social medial presence must be pre-approved by the appropriate SLT member. Employees are prohibited from posting information attributable to BABHA without permission and must include a disclaimer dis-associating BABHA from their communications if a political opinion is expressed.

BABHA privacy policies are restrictive regarding any release of protected health information without the authorization of the person served, although social media is not always specifically addressed. Information regarding persons served must be protected consistent with regulatory requirements and BABHA policies and procedures regarding disclosure of protected health information, including in situations involving any form of social or other media.

BABHA has a limited social media presence as a business and centralized management of these venues in the IT Department in collaboration with clinical leadership. This included revisions to BABHA social media profiles to reduce the likelihood of negative, non-constructive messaging to be linked to the organization.

- See the BABHA Operating Philosophy and Ethical Guidelines
- See the BABHA Employee Handbook; Social Media

Review of Past Year Actions to Mitigate Media Relations and Social Media Risk:

Training on the risks of privacy breaches related to social media has been conducted with employees at hire and annually. The IS Department has received requests to post various informational materials on the website and the Facebook page. There have been alerts set up to notify BABHA when there are posts being displayed so that better monitoring can be done. ~~None.~~

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
~~Ensure direct references to social media and contact with the media are addressed in BABHA policies~~.	Director of Health Care Accountability, IT Manager, Directors of Integrated Services~~Janis Pinter; Jesse Bellinger; Karen Amon; Joelin Hahn~~	~~Completed~~	~~12/31/22~~
Continue with Training on Privacy with regard to social media and monitoring of postings.	Director of Health Care Accountability, IS Manager.	New	Ongoing

Security and Technology

[Jesse]

BABHA developed a disaster recovery plan and system configuration that provides core computing functions in the event of a disaster. Security provisions, including Unified Threat Management Systems (UTMS), firewalls, and anti-virus software, are in place, which actively monitor for security/privacy lapses and breach attempts. An annual security risk assessment is completed, and remediation performed to address areas of weakness identified in the organization's technology. Multi-factor authentication is used when accessing our private cloud computing resources, public cloud computing resources, and our Electronic Health Record.

- See the BABHA Information Management Strategic and Operational Plan
- See the BABHA Policy and Procedure Manual Chapter 9 Information Management

Review of Past Year Actions to Mitigate Security Risk:

Unified Threat Management firewalls were implemented at all 5 of our locations. These firewalls monitor internal network traffic between sites for malicious activity while also providing protection for our local cable internet connections. The firewalls also provide redundant network connections between all our locations via SD-WAN technology that allows for multiple networks to be used simultaneously. Multi-factor authentication is used when accessing our private cloud computing resources, public cloud computing resources, and our Electronic Health Record. Multiple phishing tests have been implemented and training conducted for those that click on the phishing email. Both individual and group trainings have occurred because of these phishing tests. A phishing alert button has been installed so that staff can quickly alert the Help Desk if they suspect an email is compromised. The IS Manager conducted a Disaster Recovery Training for all Leadership staff.

~~P~~Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
~~BABHA will implement multi-factor authentication access to our critical systems~~	~~Jesse Bellinger, Greg Wedge, Theresa Adler~~	~~Completed~~	~~September 30, 2021~~
~~BABHA will implement multi-factor authentication access with providers that utilize BABHA's EHR~~	~~Jesse Bellinger, Greg Wedge, Theresa Adler, Justin Louks~~	~~Completed~~	~~September 30, 2022~~
Microsoft licensing upgrades for better remote management of devices to provided better security.	IS Manager	New	2/2025
Continue end user education on security threats utilizing phishing campaigns and creating and implementing individual training for repeat clickers.	IS Manager	New	Ongoing
Monitor and make recommendations to SLT and the Board on systems that are becoming end of life. The phone system will be end of life 12/2025.	IS Manager	New	12/2025

Infection Control

[Sarah VP]

The Infection Control and Prevention program incorporates the accepted principles of surveillance, prevention, identification, and control through an agency wide interdisciplinary collaborative initiative that utilizes a standardized approach for the identification of adverse events, tracking outcomes, and implementing evidence-based interventions. Subsequently, episodic and epidemic/pandemic patterns of nosocomial and community acquired infections will be proactively minimized and prevented, and the organization will respond to an influx, or the risk of an influx, of infectious individuals as part of its emergency management activities.

- See the BABHA Infection Control Plan
- See the BABHA Policy and Procedure Manual Chapter 14 Infection Control
- See BABHA Risk Management Plan

Review of Past Year Actions to Mitigate Infection Risk:

BABHA monitors infections in the specialized residential group home settings through infection control reports monthly. The data is compiled on a quarterly basis and is reviewed by the Healthcare Practices Committee. BABHA community-based nurses serve as a resource to give recommendations and education to group home staff to help decrease the incidence of infection. The Community Based Nurses provided each Specialized Residential Home educational information regarding early identification of the warning signs of sepsis in 2020. The information in this binder is updated and reviewed annually. The Community Based Nurses also monitor and encourage individuals residing in Specialized AFC homes to obtain recommended vaccinations to prevent infection.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
The Healthcare Practices Committee will monitor infections on a quarterly basis through data collected from Specialized Residential Homes through the infection control reporting process.	~~Sarah Van Paris~~Nursing Manager	Continue	Ongoing
The Nursing Manager will review annual data and designate a goal for the upcoming year based on the previous years' data.	~~Sarah Van Paris~~Nursing Manager	Continue	Ongoing
The Nursing Manager receives Health Advisories from the CDC and MDHHS regarding emerging health issues and provides necessary communication to BABHA staff in a timely manner.	~~Sarah Van Paris~~Nursing Manager	Continue	Ongoing
~~The Nursing Manager monitors the CDC and MDHHS websites and any advisory related to the pandemic for changes to any guidelines for employers and reports to the appropriate SLT member~~	~~Sarah Van Paris~~	~~Ongoing~~	~~Undetermined/ through pandemic~~

Review of Insurance[3]

[Marci/Jennifer]

BABHA retains comprehensive insurance coverage available to local governments as a member of the MI Municipal Risk Management Authority (MMRMA). This includes specific coverage for general liability, motor vehicle physical damage, property protection and crime. There are also ancillary coverages included per occurrence related to network/information security, media injury, data breach mitigation (including certain

[3] CARF: 1. Aspire to Excellence; G. Risk Management: 2.a-c.

types of ransomwares), business interruption loss, PCI assessments, social engineering loss, reward coverage and telecommunications fraud. BABHA reviews these coverages on an annual basis with the assistance of the Lighthouse Group as our insurance broker. Most of the coverage limits range up to $15 million.

BABHA has Worker's Compensation coverage through the Accident Fund with limits established at $1 million for each accident, employee and/or disease. BABHA also secures specific physician malpractice insurance for our Medical Director, Roderick Smith through Admiral (medical director responsibilities) up to $1 million per event/$3 million in aggregate and through The Doctors Company (medical malpractice) up to $1 million per event/$4 million in aggregate. The coverages for Worker's Compensation and the medical director are also reviewed on an annual basis.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
BABHA will evaluate and renew the general liability coverage options available through MMRMA	Marci Rozek, Karl White	Continue	This review will be completed for a July, 2025~~3~~ renewal date.
BABHA will evaluate and renew Worker's Compensation coverage	Jennifer Lasceski	Continue	This review will be completed by December, 2024~~2~~.
BABHA will evaluate and renew Physician Malpractice coverage for the Medical Director and Malpractice cover age for the agency's contractual Physician and Nurse Practitioner	Jennifer Lasceski	Continue	These reviews will be completed in ~~February~~ March February and August, 2025~~3~~.
BABHA will evaluate and renew crime bond coverage available to protect BABHA assets.	Marci Rozek, Karl White	Continue	This review will be completed for a February 2025 ~~February 2023~~ renewal date.

Management of Risk in the Contracted Service Provider Network[4]

[Sarah H]

BABHA seeks CARF accreditation for direct operated programs only. BABHA contracts with outpatient treatment and case management/service coordination providers, however, they seek their own accreditation. BABHA does have a formal process for completing annual site reviews of these contract service providers. These annual site reviews assess performance in relation to the scope and requirements of their contracts, ensure the providers follow applicable policies and procedures, review qualifications of personnel including training, background checks, and exclusion/debarment checks, evaluate primary source verification to complete Medicaid Event Verifications.

In addition to the annual site review process, BABHA conducts quarterly reviews of the contracted service providers for performance activities and bi-annual reviews of documentation/billing. These reviews consist of MEV and quality type activities including, but not limited to, evidence of healthcare coordination, the Individual Plan of Service being given to the consumer within 15 business days, and the completion of a crisis

[4] CARF: 1. Aspire to Excellence; G. Risk Management: 4. a-d.

plan. The results are communicated to the provider who then completes a corrective action plan for the findings identified.

BABHA also completes Organizational Credentialing for contracted clinical service providers which assigns a risk rating for each organization based upon the past two years of performance in a variety of risk domains, including financial, fraud/abuse, recipient rights protections, quality and prevention of adverse clinical events, among others. These ratings are used by the Board of Directors when determining whether to renew contractual agreements.

Review of Past Year Actions to Mitigate Security Risk:

Due to the COVID-19 pandemic, the annual site reviews for the contracted services providers were placed on hold, but were resumed in May 2022 with an abbreviated review of the standards. BABHA will continue to explore how to move forward with a review process for providers in a way that does not impose disruption to services and administrative burdens. For FY22, quarterly reviews (MEV and performance improvement activities) were completed for the contracted service providers.

Planned Action(s) to Mitigate Risk	Assigned To	Status (New; Continuation; Completed)	Planned Completion Date
The Quality and Compliance Coordinator will conduct quarterly ~~MEV and~~ performance improvement reviews of contract service providers as well as bi-annual MEV reviews.	~~Sarah~~ Quality Manager and Quality and Compliance Coordinators~~Holsinger, Amber Wade, Melissa Deuel~~	Continuation	Ongoing
Annual site reviews will be completed for designated contract service providers with an abbreviated review of the standards.	~~Sarah Holsinger, Amber Wade~~Quality Manager and Quality and Compliance Coordinators	New	Ongoing

Mitigation, Remediation and Monitoring of Effectiveness of Risk Management Plan[5]

The risk management activities of BABHA are supported by the BABHA Strategic Plan, Emergency Preparedness Plan, Training Plan, Corporate Compliance Plan, Infection Control Plan, Medical Staff Plan, Quality Assessment and Performance Improvement Plan (QAPIP), Information Management Strategic and Operational Plan, Annual Needs Assessment and other strategic documents such as security and fraud/abuse risk assessments. Each plan identifies priority areas, action steps or recommendations which serve to mitigate and remediate organizational risk and improve the agency's performance.

[5] CARF: 1. Aspire to Excellence: G. Risk Management: 1.b., 1-2.

When the plans and assessments are updated, progress toward actioning these recommendations is assessed. The Corporate Compliance Plan, Strategic Plan, QAPIP and the Infection Control Plan also include regular reporting of data and other status information to relevant organizational committees.

Senior Leadership Team incorporates risk management action items into its standing agenda for monitoring over the course of the year. BABHA generates a Leadership Dashboard and Power BI reports through which key risk and performance indicators are monitored by agency leadership.

The Risk Management Plan is updated annually by senior leadership and key staff and more frequently if needed. The Plan is reviewed and approved by the BABHA Board of Directors.

Attachments

References

1. BABHA Agency Action Plans
    - Strategic Plan
    - Medical Staff Plan
    - Quality Assessment and Performance Improvement Program Plan
    - Corporate Compliance Plan
    - Emergency Preparedness Plan
    - Agency Training Plan
    - Information Management Strategic and Operational Plan
    - Infection Control Plan
2. BABHA Financial Statements
3. BABHA Needs Assessment
4. BABHA Employee Handbook
5. BABHA Operating Philosophy and Ethical Guidelines
6. BABHA Policy and Procedure Manual

Safety Committee Statement of Purpose

[Marci]

The Safety Committee (formerly Risk Management) was established in July 1998 in response to federal, state and accreditation requirements. The purpose of the committee is to reduce or eliminate potential or actual risk and improve the quality of care through the identification, analysis, evaluation and remediation of risks to persons served, visitors, volunteers and employees.

The committee oversees the development and compliance level of the Environment of Care policies and procedures and emergency preparedness and 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)
- Oversight of the community based HVA

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.

The membership consists of a multidisciplinary group and includes representation from Strategic Leadership (ad hoc), Clinical Leadership, Specialized Residential Program (ad hoc), Finance Department, Medical Practices, Environment of Care, Infection Control, Program Coordinators, Clinical staff and Site Safety Representatives.

The current members of the Safety Committee are:

- Facility Manager (also Safety Coordinator and Committee Chair)
- Nursing Manager
- Clinic Service Program Manager – Arenac Center
- Arenac Center Safety Rep.
- Madison Safety Reps (2).
- Washington (First Level) Site Safety Rep.
- North Bay Safety Rep.
- Washington (Lower Level) Site Safety Rep.
- Mulholland 2nd Floor Safety Rep.
- Mulholland 3rd Floor Safety Rep.
- Madison Secretary
- (ad hoc) Manager Residential Program and Safety Rep.
- (ad hoc) Human Resources Director
- (ad hoc) Supervisor, North Bay
- (ad hoc) Accounting Manager
- Clinic Practice Manager

The Safety Committee meets quarterly in the months of February, May, August and November on the 1st Wednesday from 8:30 - 10:00 a.m. Any staff member who has a safety concern can contact a committee member and request evaluation and consideration by the Safety Committee. We welcome ideas, suggestions and participation from all stakeholders.