BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, November 14, 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	X	Amanda Johnson, BABH ABA/Wraparound Team Leader	
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		Kathy Jonhson, Consumer Council Rep (J/A/J/O)	
Barb Goss, Saginaw Psychological COO		Lynn Blohm, BABH North Bay CLS Team Supervisor		Lynn Meads, BABH Medical Records Associate	X
Chelsea Hewitt, Saginaw Psychological Asst. Supervisor	X	Megan Smith, List Psychological Site Supervisor		Michele Perry, BABH Finance Manager	X
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	X	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	X	Sarah Van Paris, BABH Nursing Manager	
Heather Beson, BABH Integrated Care Director	X	Moregan LaMarr, Saginaw Psychological Clinical Director		Stephanie Gunsell, BABH Contracts Manager	
Heather Friebe, BABH Arenac Program Manager	X	Pam VanWormer, BABH Arenac Clinical Supervisor	X	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	Taylor Forwerck (SPSI)	X
Joelin Hahn (Chair), BABH Integrated Care Director	X	Stephani Rooker, BABH ID/DD Team Leader		Nicole Konwinski (BABH finance)	X
Joelle Sporman (Recorder), BABH BI Secretary III		Tracy Hagar, MPA Child OPT Supervisor	X	Craig Kanicki (BABH)	X

Topic	Key Discussion Points	Action Steps/Responsibility
1. **a. Review of, and Additions to Agenda** **b. Presentations:** **c. Approval of Meeting Notes: 10/10/2024** **d. Program/Provider Updates and Concerns**	a. There were no additions to the agenda. b. No Presentations. c. The October 10 meeting notes were approved as written. d. **Bay-Arenac Behavioral Health**: - ABA/Wraparound – No updates. - ACT/Adult MI – Just hired a bachelor's level specialist. Still have a master's level position open. There is a case manager on the adult side leaving next week so they will have that position posted soon. - Arenac Center – Still down one case manager, no other updates. - Children's Services – Still have opening to fill Therapist/Home based services. - CLS/North Bay – No updates.	

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	- Contracts – No updates. - Corporate Compliance – No updates. - EAS (Emergency Access Services)/Mobile Response – Hired a part-time MRT for second shift. Still hiring the rest of that team. - Finance – Karen states that there has been a change in authorizations, they say "before 12/01/24" and "after 12/01/24". Per finance, this is due to the rate changes that will be going into effect as of 12/01/2024. The system automatically knows to change rate. No new auth is needed. Karen is requesting that a communication be prepared to send out to staff and external providers as staff are noticing this change. A list of rates will be sent out with this communication. - ID/DD – We are continuing to be short staffed. Transfers were just approved to be put on hold. We have absorbed approximately 65 among our other case managers. Will still be taking new consumers on Intake. - IMH/HB – No updates - Madison Clinic – Dr. Exum is off and will not return until 1/21/25. Her caseload is being covered by nurses and other providers as needed. Tami Trea has left our system. Ashley Badour is our new NP and will be starting 12/16/24. Amy has sent out a message stating no prescriber swapping. If an individual is wanting a different prescriber, we are saying no, we are unable to honor those changes until mid to late January. Group therapy will be taking a break for the holidays and start up again	

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	01/08/2025. Amy states that she has been seeing a large uptick in lack of authorizations in charts for prescribers and nurses. This causes a bottleneck. If an individual misses a planning meeting an interim plan should be created and continue outreach, but an ABD should also go out because there is not going to be an active plan. - Medical Records – No updates. - Quality – IT, Corporate Compliance and Medical records will be moving out of the Wirt building. Quality and Karen A will be moving to Mulholland and IT and Medical Records will be moving to North Bay. These moves will begin in December. No other updates. - Recipient Rights/Customer Services – Moving to the Mulholland bldg., 2nd floor for easier access and more privacy. Complaints are beginning to go up again. Appeals have gone down slightly with the change in process. Training can be given for any Recipient Rights/Customer Service items. All has been changed to online training, where you get a link and take module and test online, like annual recipient rights training. Direct care still requires face-to-face trainings. - Self Determination – Nothing to report this month. **List Psychological**: No updates. **MPA:** No updates. May have a person leaving. **Saginaw Psychological:** We have some therapists that have left/leaving and onboarded a new therapist. No other updates.	

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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 – Nothing to report this month.	
3.	**Reports** a. QAPIP Quarterly Report (Feb, May, Aug, Nov)	**a. QAPIP Quarterly Report:** Below is a summary of Report. (Full report is available in file). **Adverse Events:** There were three suicides which is the highest number for BABH since prior to FY20Q1. BABH completed root cause analyses on these to determine any potential process changes or action steps. Additionally, BABH discussed the trend in suicides in multiple different committees with various leadership, including the Medical Examiner of Bay County, as well as the Medical Director for BABH. Communication was sent to al BABH staff to make them aware of these trends and to provide information on actions and measures that can be taken to assess risk. **Behavior Treatment Events:** The number of emergency physical interventions increased for FY24Q4, however, the overall number of interventions continues on a downward trend. There were 12 consumers that led to the 76 emergency physical interventions with one individual accounting for 49. **Diabetes Screening, Diabetes Monitoring, and Cardiovascular Monitoring:** There was a decrease for each of these measures over FY24Q4. BABH will continue to action these alerts monthly to improve compliance. **Audited Services with Proper Documentation for Encounters Billed:** The overall total compliance for all tertiary services reviewed during FY24Q3 and FY24Q4 was above the 95% standard and increased from the previous two quarters. These reviews included applied behavioral analysis, specialized residential, dietary, and community living support providers. There were a total of 11,210 claims reviewed with only 94 errors resulting in 99% compliance rate. **Evidence of Primary Care Coordination:** BABH and two of the three contract providers had an increase in health care coordination for FY24Q4. One provider had a decrease due to a delay in providing documentation, however, the compliance is expected to	

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	increase next quarter. **Michigan Mission Based Performance Indicator System (MMBPIS) Indicators:** Across most indicators and populations, BABH is consistent with either MSHN or MDHHS. For indicator 3, the MI-Adult (mental illness) and IDD-Adult (intellectual developmental disability) populations were lower than MSHN and MDHHS. **Provider Survey:** All the statements on the provider survey received over the 85% standard. Eight of the questions scored higher in 2024 compared to 2023 which was significant improvement from 2023.	
b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports i. MSHN Priority Measures Report (Jan, Apr, Jul, Oct) ii. Recipient Rights Report (Jan, Apr, Jul, Oct) iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec) iv. Consumer Satisfaction Report (MHSIP/YSS) v. Provider Satisfaction Survey (Sept) c. Access to Care & Service Utilization Reports **i.** MMBPIS Report (Jan, Apr, Jul, Oct) ii. LOCUS (Mar, Jun, Sep, Dec) iii. Leadership Dashboard - UM Indicators (Jan, Apr, Jul, Oct) iv. Customer Service Report (Jan, Apr, Jul, Oct)	b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports i. MSHN Priority Measures Report: This report is in the folder for you to review. ii. Recipient Rights: Nothing to report this month. iii. RAS: Nothing to Report iv. MHSIP/YSS: Nothing to report this month. v. Provider Satisfaction Report: Nothing to report. c. Access to Care & Service Utilization Reports i. MMBPIS Report: Nothing to report. ii. LOCUS: Nothing to report this month. iii. Leadership Dashboard: Nothing to report. iv. Customer Service Report: Nothing to report. **d. Regulatory and Contractual Compliance Reports** i. **PI Report**: Nothing to report. ii. Internal MEV Report: Nothing to report this month.	

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	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	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. e. Periodic Review Reports – Nothing to report. f. Ability to Pay Report – Nothing to report. g. Referral Status Report – Nothing to report.	
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**	a. Harm Reduction, Clinical Outcomes and Stakeholder Perceptions i. Consumer Council Recommendations: Nothing to Report b. Access to Care and Service Utilization i. Services Provided during a Gap in IPOS: Nothing to report. ii. Repeated Use of Interim Plans: Nothing to report. c. Regulatory Compliance & Electronic Health Record i. 1915 iSPA Benefit Enrollment Form: Nothing to report. ii. Management of Diagnostics: Nothing to report. d. **BABH - Policy/Procedure Updates** – Please go to www.babha.org/Providers tab/New and Revised Policies and Procedures to view the actual Policies and Procedures. For **October**, it is recommended that you look at Access and Eligibility for Specialty Mental Health Services, Program Description, Reentry Project Offenders Special Needs, Intensive Crisis Stabilization, Enrollment Re-	

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	enrollment Screening and Referral, Community Living Supports and Organizational Credentialing Policies as there have been changes. For **November,** Trauma Informed System of Care, PCP Meeting Schedule, Validating Medicaid Eligibility Procedure, Psychiatric Evaluation and Coordination of Care. All are listed on the provide tab above. It was also added, to please make sure and pay attention to the policy that is for people who are court ordered for treatment. It talks about having to have a goal in the plan of service. Please add to agenda for next meeting for discussion.	
e. Clinical Capacity Issues Update **i. Review of Referral Status Report** **ii. OPT Group Therapy** **iii. Capacity issue discussion (as needed)**	e. Clinical Capacity Issues Update i. **Referral Status Report**: Stacy sent update last week. No changes since. The question was asked, "Are things stabilizing for you". It was stated it is looking better than it has. External providers state that things are still a little slow. ii. **OPT Group Therapy**: Group starting Jan 8 will be "A Life worth Living". Stephanie has asked to step down so possibly Andrea or one of the other clinicians would step up and do that. iii. **Capacity issue discussion**: No updates.	
f. Medicaid/Medicare Updates i. Medicare Open Enrollment: Verify Ins. ii. Medicaid Reenrollment: Encourage/assist as needed with process g. General Fund for FY2025 h. Conflict Free Case Management **i. Updated Staff List with Supervisor** **j. Ability to Pay Questions**	f. **Medicaid /Medicare Updates:** – No updates. g. General Fund FY2025: – No updates. h. Conflict Free Case Management: No updates **i. Updated Staff List with Supervisor:** Carried over from last meeting. There is a list available and typically gets sent out when there is a change.	

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	j. Ability to Pay Questions. What more can we do to document that we are trying our best to get these? Regarding ATPs, on occasion, we have consumers who are reluctant to fill them out or for whatever reason, don't. The most important thing is to have the form filled out and sign that it is correct to their knowledge and then try to get supporting documentation. The state says we must try. If we don't, we have to take their word for it, but we have shown that we have tried. Also, if you are trying to get the ATP and people are not bringing them back, we have had a case manager do a reminder call to let the consumer know they have an appt coming up and this is what they will be going over in that appt. She asks them to bring their information to that appt. and has had about 90% success rate by doing that. That is one suggestion. When it comes to documenting, we have started doing staff only contact notes. If you can document that you have tried multiple times in the 30-day window, then a 15-day letter can be sent that gets scanned into the chart. It gives the consumer 15 days from the date on the letter to turn in ATP information, if they don't, they will get billed for the cost of the service. Finance can look in chart to see if anything has been documented, and contact notes are what they are looking for. Finance will put the ATP form in, but request that you still try to get supporting documentation and document attempts. Amy Folsom stated that we don't want staff to have to create a separate contact note, that finance will need to look at progress note. Joelin says, no, we don't want anyone in the progress notes that are not clinical because there is not a need to know the details of a progress note. Emily Simbeck states her staff (MPA) have been documenting this in the Progress Notes. Per Joelin, if we do not have these documents, BABH gets dinged for not being in compliance with the Mental Health Code. The question was asked, how many attempts must be made to appease the site review committee. It is said that at least two attempts must be made within the 30-days. If after 30-days and two attempts have been made, finance asks that you reach out to them to send out that 15-day letter. They do not monitor every consumer's chart, so please reach out and then	

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	finance takes over the process from there and case managers are asked to let the consumer know that they are now full cost for service. Joelin asks Karen A and Melissa P., "If it stays in the Progress Note and finance is not looking in note for evidence but just taking the clinician's word at face value and saying that it is in there, do you think that is ok". Melissa states she doesn't see where it is a problem that it is in the progress note. Amy Folsom states that when documenting in the finance section of the chart, there is no way to put anything in unless you are uploading a document, so she suggests that if an item could be put in without having to upload a document, contact notes could be put right in the finance section. You could click on Other Admin/Finance Document and if there could be a drop-down for ATP attempts. Then we could pull reports to see who has had two attempts and who hasn't, and we wouldn't have to upload a document. It is also suggested that one contact note be added to PCE, documenting the dates in which there were attempts made. Finance needs to know these dates when sending out the 15-day letter. It is agreed that a contact note with dates be completed and then sent to finance by way of "send to staff" in PCE. This seems to be the best solution to address everyone's concerns and the least amount of additional work for staff. Michele Perry also requests that staff send a contact note to her when Medicaid is being re-applied for as it is very helpful to know this. Also, when signing the consent to treat, the consumer is signing that they are aware that there could be charge if they don't comply. The finance dept has talked about drafting a letter, as well, about the ATP and what to bring to the first appt. for Intake. Finance states that they will gladly calculate cost for them before they start services if they request it.	
k. General Fund Exceptions	**k. General Fund Exceptions.** Finance will take questions back and have internal talks on how to go forward on General Fund Exceptions. A new policy will be drafted and sent out. Every 6 months it is the case holder's responsibility to re-submit for General Fund Exceptions if needed. It is stated that last year,	

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	FY24, we were $600,000 over budget on our general fund so that is why we are trying to get tighter on how those general fund dollars are used. Many of the general fund exceptions are due to credentialling new providers and whether to change consumer's provider if they were to get a different insurance.	
l. Interim Plans/ ABD Process **m. Advance Benefits Determination**	l. **Interim Plans/ABD Process:** Emily S. is requesting information regarding Interim Plans, consumers missing planning appts and ABDs. Amy states that if the consumer is not engaging and outreach has been attempted, they should not be seeing a Prescriber, and an ABD should be sent. Per Karen A., once there is no Plan of Service, including interim plans, no services should be rendered. There should only be one interim plan for 45 days. This should be the exception, not the normal. What we are tending to see, though, it's not the exception, it's more the norm for individuals to have two or three interim plans and part of it is they are not engaged. What is happening is there are multiple interim plans being completed, instead of provider services being cancelled and ABD being sent. Amy suggests what when the first interim plan gets created, an ABD should be created as well. It is also suggested to start the process very early in case a consumer misses the planning appt. The plan should still be dated when the current IPOS expires even if completed early. Per Amy, a call should be made to the office of the prescriber, not emailed to her, when a second planning appt. is missed, and the prescriber appt. can be cancelled until the consumer is engaging in services. If they are not engaged, and they are getting meds, they are not really getting "treatment". The messages get sent out from Amy when prescribers contact her not being able to sign a note due to no auths available. A suggestion is to have the PCP meeting, roughly 4 weeks before the current plan expires, put auths in effective when they need to be and then you are meeting all the timeline requirements. That way, if there is a no-show, cancellation, hospitalization, etc., there is time to get it re-scheduled before the current plan expires but keep the effective date where	l. Interim Plans – Karen A to send out education about authorizing two assessments to account for the assessment the following year.

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	it is. There has also been some discussion regarding authorizing more than one assessment during the year so that you can do the assessment ahead of time because there is already an auth in place. Per Karen A., there will be some communication sent out regarding this. m. **Advance Benefits Determination:** See above.	
n. Staff Credentialing	**n. Staff Credentialing:** This was added to the agenda because during the waiver audit that we had from MDHHS, we did not end up with a finding for this, but we had to do a lot of scrambling, last minute, to try to get the documentation that MDHHS was looking for. We had to make some internal changes to our form, having to change some of our process and probably having to change the policy and procedure related to this. Sarah wanted to share the form with changes to accommodate what MDHHS is looking for. They want to know whether someone is a QMHP, QIDP, CMHP and so on but what they are looking for is something that is documenting the experience that is needed, either the 1-year or 3-year, depending on what the qualification is for. We were using resumes to gain this information, however, a lot of times on the resume it will not say what population the individual has been working with. MDHHS was not accepting this resume because it didn't specify the population, so we had to go back and have staff update resumes to include this information. With this new verification process, when new staff comes in, we are having them also include the years of experience and what population they were working with. There is an area to describe related experience and what populations were served and any special training which qualifies them. Sarah will be sending this form out.	n. Staff Credentialing – Sarah H to send out form to providers.
o. MichiCans Update	**o. MichiCans Update:** There is a Mid-State meeting once a month for discussion to solve issues that come up. Per Joelin, she understands, through this meeting, that the CANS is actually a treatment planning tool. It has nothing to do with level of care or eligibility. The state took the CANS and	

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	created the MichiCANS where they are trying to weave in eligibility and it doesn't fit from what Joelin is hearing everyone say. With that, encourage your team to really use the MichiCANS for what it was intended for, as a planning tool to help with the planning process. We still need staff to use their clinical judgement because we do not have that CAFAS number to fall back on. From what Joelin is hearing, a huge majority of these MichiCANS are resulting in a recommendation for the SED waiver. According to the Medicaid Provider Manual, one of the main criteria for the SED Waiver is the child must meet criteria for state hospitalization. If that child does not need to be in Hawthorn, we are not justified in doing the SED waiver so they would need to select the box labeled "does not meet Medicaid eligibility. It is also her understanding that CLS and Respite are coming up for most. For those, have staff document that this service is not available at this time. In some counties, there is also starting to be some friction between CMH and the local DHS because of the MichiCANS. Please make sure that staff knows, if there is any issue with the local DHS due to the MichiCANS, it needs to be brought to the supervisor's attention and then they need to reach out to Joselin as we do not want this to happen in our counties.	
p. ISPA Eligibility in Assessment	**p. iSPA Eligibility in Assessment:** This is for individual's who are being authorized or are eligible for CLS, environmental modifications, enhanced pharmacy, if they are on a Self D with the fiscal intermediary, if they have family support and training, housing assistance, Respite, Skill building, supported/integrated employment, special medical equipment or vehicle modifications. These are all services that fall under the 1915iSPA waiver, so if they do that, they must fill out the benefit referral form that is either in the assessment, or there is a stand alone form that is in PCE. This needs to be filled out, once filled out, they need to put "incomplete", and it goes into a queue, and it goes to Nicole P. over at the MI Adult team and she process that with the WSA. When it is approved, she will document that and get you	p. iSPA Eligibility in Assessment: Karen to send out training on how to complete the form.

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	q. Consent to Exchange	some kind of proof that they have been approved. Karen will screen shot the document and send out instructions on how to complete this form. **q. Consent to Exchange:** Amy states we are sending out the new Consent to Exchange information and we typically have a lot of virtual patients, so we mail those out. We highlight where we want the person to sign but they are coming back signed in both places, consenting, and then revoking. Karen A. states that this is a non-changeable form. One solution is to not send the third page, revoking signature. It will be scanned in and available if requested.	
5.	**Announcements**	No announcements to report.	
6.	**Parking Lot** a. Periodic Reviews – Including Options for Blending with Plan of Services Addendums	a. See discussion under Waiver Audit Review.	
7.	**Adjournment/Next Meeting**	The meeting adjourned at 3:15 pm. The next meeting will be on December 12, 2024, 1:30 - 3:30 in-person at the Lincoln Center in the East Conference Room.	