AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
PROGRAM COMMITTEE MEETING

Thursday, March 13, 2025 at 5:00 pm

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

	Committee Members:	Present	Excused	Absent		Present	Excused	Absent	Others Present:
	Christopher Girard, Ch				Pam Schumacher				BABH: Chris Pinter, Joelin Hahn, Amanda Johnson, Sarah Holsinger, Karen Amon, and Sara McRae
	Sally Mrozinski, V Ch				Robert Pawlak, Ex Off				
	Jerome Crete				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
	Vacant								

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Clinical Program Review: Wrap Around Services, A. Johnson 4.2) Policies Ending 30-Day Review: a) Cultural Competence & Limited English Proficiency, 07-03-05 b) Targeted Case Management/Support Coordination, 04-05-03 (deletion) 4.3) Policies Beginning 30-Day Review: a) Medical Procedures & Treatment Completed by BABHA Staff at BABHA Sites, 04-09-23 (new)		4.1) No action necessary 4.2) Consideration of motion to refer the policies ending 30-day review to the full board for approval 4.3) Consideration of motion to refer the policy, Medical Procedures & Treatment Completed by BABHA Staff, 04-09-23, to begin 30-day review to the full board for approval

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	4.4) Primary Network Operations and Quality Management Committee Meeting Notes from January 9, 2025, S. Holsinger		4.4) No action necessary
	4.5) Quality Assessment & Prformance Improvement Plan (QAPIP) Quarterly Report, S. Holsinger		4.5) No action necessary
	4.6) Quality Survey Results, S. Holsinger		4.6) No action necessary
	4.7) Michigan Department of Health and Human Services (MDHHS) Competitive Procurement of Prepaid Inpatient Health Plans (PIHPs), C. Pinter		4.7) No action necessary
5.	Adjournment	M - S - pm MA	

Intensive Care Coordination with Wraparound

Amanda Johnson- Children's Supervisor

Emily Gerhardt- Children's Manager

What is Intensive Care Coordination with Wraparound?

- Wraparound is a team planning process
  - It's about taking action, developing a plan
- The process identifies
  - Strengths
  - Needs
  - Strategies to meet needs
  - Evaluating outcomes

Admission Criteria Checklist

- A resident of Bay or Arenac County.
- The identified youth's age is 0-17.
- Identified youth has an SED or I/DD diagnosis.
- Youth is at risk of an out-of-home placement or are currently in an out-of-home placement.
- Youth who have been served through other mental health services with minimal improvement in functioning.
- Numerous providers are serving multiple youth in a family and the identified outcomes are not being met.
- The risk factors exceed capacity for traditional community-based options.
- Children/youth on the SEDW are required to have Wraparound services or Case Management Services

ICCW Structure Change

Previous Wraparound structure:

- Wraparound Supervisor
- Wraparound facilitator
- Wraparound Team
- Community Team

ICCW structure:

- PIHP Administrator
- Service Planning Provider Administrator
- Care Coordination Supervisor
- Care Coordinator
- Wraparound Team
- Community Team

Main change for BABH is that the ICCW worker becomes the primary case holder, instead of being an add on service.

What is unique about Wraparound?

- Family voice and inclusion are the key elements in the process
  - Normally told what they HAVE to do
  - Sometimes people's support systems aren't included in the process
- Allows people with diverse beliefs, from differing systems and cultures to work together in a way that is meaningful and produces positive outcomes
- The family feels like they have more control over their lives
- Overall goal is to connect youth and their family with community resources, extended family, or friends to create a stable environment for the family
  - Family Determines the Child and Family Team members
    - DHHS, Court, family, friends, church members, service providers, ect

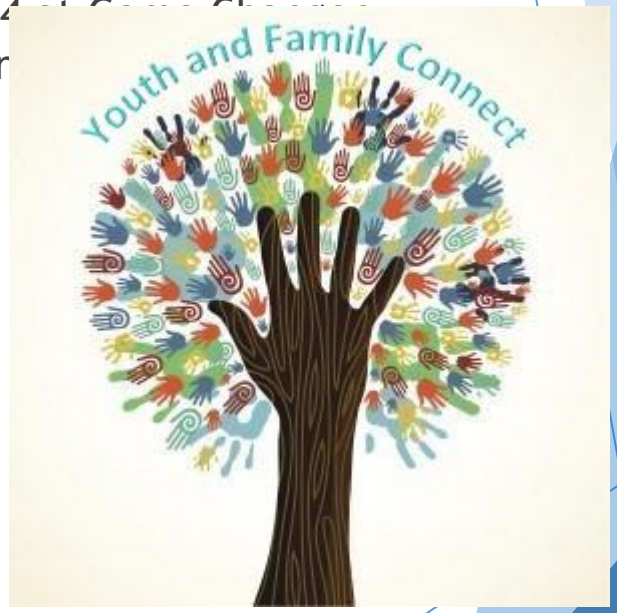
BABH WA Outcomes

- On average, six systems are involved with a family when wraparound begins. When the client graduates from wraparound, there are typically two systems still active, the therapist and the family. 10 systems is the most a family has been involved in at one time.
- The average amount of time in wraparound is 10.5 months, but the consumer can stay in wraparound up to two years.
- Wraparound teams have collaborated with 35 systems in the community including CMH, DHHS, Court system, families, lawyers, daycares, schools, CLS, and multiple residential facilities.
- On average, consumer's that received wraparound services had their CAFAS (Child and Adolescent Functional Assessment Scale) score decrease by 20 points.
- The greatest CAFAS change in a consumer during WA services was a decrease of 80 points from the beginning to end of wraparound.
- Wraparound has worked with children age 4-19 with DD and SED diagnoses. The average age is 13.

Youth and Family Connect

- Bay and Arenac's Wraparound Community Team
- Reviews ICCW plans to see where the community can help provide support
- Monthly Speaker from a community partner (BAWC, FCNC, GSRM, ect)
- Returning to community events that are free and show families resources in our community.
  - Previously did a state park day and family game night

- All Abilities Masquerade Ball
  - September 202[illegible] Therapy Center



BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 7	**Human Resources**		
Section: 3	**Education**		
Topic: 5	**Cultural Competence and Limited English Proficiency**		
Page: 1 of 2	**Supersedes Date:** **Pol: 5-15-03, 6-20-00, 3-16-00,** **Proc: 5-31-16, 5-14-15, 6-24-09, 3-20-08, 3-19-03, 6-20-02, 8-11-00** (previously C3-S9-T1)	**Approval Date:** **Pol: 3-20-08** **Proc: 10-21-19**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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DO NOT WRITE IN SHADED AREA ABOVE

Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) that behavioral health services be available and provided to all persons living in Bay and Arenac Counties by staff who demonstrate cultural competence and recognize the need for accommodations when providing services to individuals. As part of this commitment BABHA recognizes the importance of addressing the implicit biases of the organization and its personnel, in order to continue to move the organization forward with recognizing and respecting diversity. All direct operated and contracted programs will abide by LEP guidelines and will provide an augmentative communication specialist, voice interpreter, and translation services whenever needed, at no cost to individuals (see BABHA Policy and Procedure C04-S07-T35 – Accommodations for Communication Services).

Purpose

This policy and procedure is established to ensure that staff have the understanding and skills to work effectively in cross-cultural situations and with individuals who have Limited English Proficiency (LEP).

Education Applies to

☒ All BABHA Staff
☐ Selected BABHA Staff, as follows:
☒ All Contracted Providers: ☒ Policy Only ☐ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ BABHA's Affiliates: ☐ Policy Only ☐ Policy and Procedure
☐ Other:

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SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
M. Wolber	J. Pinter	02/06/08	Revision	Removal of PIHP language and change from Braille to audio for visually impaired persons served.
M. Wolber	C. Pinter	04/27/09	Revision	Policy and procedure needs updating in regards to cultural competence and LEP
M. Wolber	J. Pinter	06/24/09	Revision	Procedure updated to reflect current practices and appointments to Board of Directors
Rebecca Smith	Rebecca Smith	05/31/13	No Changes	Triennial review
Kim Cereske	Melissa Prusi	05/14/15		
Kim Cereske	Melissa Prusi	05/31/16	No Changes	Triennial review
Rebecca Smith		10/21/19	Revision	Triennial review
T. Dilley	J. Lasceski	4/11/22	Revison	Triennial review; added implicit bias and updated to current practice.
B. Beck/J. Lasceski	J. Lasceski	1/21/2025	Revision	Added Implicit bias and updated to current practice. This P&P in error did not get sent to board for approval of updates in 2022. Sending to Feb. 2024 board mtg for approval

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment Services**		
Section: 5	**Person Centered Planning**		
Topic: 3	**Targeted Case Management/Support Coordination**		
Page: 1 of 2	**Supersedes Date:** **Pol: 3-18-04** **Proc: 8-20-18, 8-29-13, 5-20-11, 3-21-11, 2-15-10, 11-11-09, 4-16-09, 7/28/98**	**Approval Date:** **Pol: 5-20-11** **Proc: 6-18-2021**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) that Client Service Specialists and Clinical Specialists assist recipients through the Person-Centered Planning process.

Purpose

This policy and procedure was developed to define Client Service Specialists (CSS) and Clinical Specialists (CS).

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: All Clinical and Clinical Provider Supervisors
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary Care/Outpatient
☐ Policy Only ☒ Policy and Procedure

☐ Other:

1.

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M. Swank	G. Lesley	11/11/09	Revision	Updated P&P to give emphasis to the importance of recovery and wellness
M. Swank	CLT	02/15/10	Revision	Updated P&P to add assessment of medication adherence and side effects by Client services specialists and supports coordinators during all service contacts.
M. Swank	CLT	03/21/11	Revision	Updated P&P to change requirement for assessment of medication adherence. Reassessments will be completed at least monthly.
M. Swank	M. Swank	05/20/11	Revision	Revised P&P statements renaming CSMs and SCs as Client Services Specialists.
M. Swank E. Albrecht	PNLT	08/29/13	Revision	Added person first language as well as multiple references to recovery, wellness, quality of life,
K. Amon	SLT	06/30/15	Revision	Change MDCH and typographical error
K. Amon	SLT	8/20/18	Revision	Triennial Review
K. Amon	SLT	11/27/19	No changes	Policy and Triennial Review-Early to begin a new Review cycle.
K. Amon	SLT/Leadership C. Pinter	5/12/21 6/18/21	Revisions	Update to comply with Medicaid Provider Manual. Add clarification on the oversight and training of the IPOS
H. Beson/J. Hahn	H. Beson/J. Hahn	12/11/24	Revision	Combined Support Coordination and Targeted Case Management per Medicaid Provider Manual. Referred to comprehensive program plan.Archiving and Merging with C04-S27-T01

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Section: 9	**Health Care Management**		
Topic: 23	**Medical Procedures and Treatment Completed by BABH Staff and at BABH Sites**		
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) etc. to ensure that individuals residing in our Specialized Residential AFC live in a safe environment and that all staff working with these individuals are trained to perform all care that a resident may require. Additionally, BABH ensures that Direct Care staff are not performing skilled nursing procedures or other procedures that are outside of their job description or scope of practice.

Purpose

The purpose of this procedure is to provide guidance to staff working in BABHA operated and contract licensed foster homes, community living supports (CLS) sites, day programs, and all other facilities in which BABHA staff or contractors are providing care regarding which medical procedures are allowed or not allowed at sites and/or can or cannot be performed by non-medical staff.

Education Applies to:

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Horizon Home DCW, North Bay CLS
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Specialized Residential Providers and CLS providers
☐ Policy Only ☐ Policy and Procedure
☐ Other:

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S. VanParis	HPC	6/15/2022	NEW	NEW

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, January 9, 2025

1:30 p.m. - 3:45 p.m.

Lincoln Center - East Conference Room

MEMBERS	Present	MEMBERS	Present	AD-HOC MEMBERS	Present
Allison Gruehn, BABH ACT/CSM/Sr. Outreach Prog. Mgr.		Karen Amon, BABH Healthcare Accountability Director/CCC	X	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	X	Megan Smith, List Psychological Site Supervisor	X	Michele Perry, BABH Finance Manager	
Courtney Clark, Saginaw Psychological OPT Supervisor	X	Melanie Corrion, BABH Adult ID/DD Manager		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		Melissa Prusi, BABH RR/Customer Services Manager	X	Sarah Van Paris, BABH Nursing Manager	
xxx, BABH Integrated Care Director		Moregan LaMarr, Saginaw Psychological Clinical Director	X	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	Jill LeBourdais & Dan DeRow (sp?)., BCC Residential Unit	XX
Joelin Hahn (Chair), BABH Integrated Care Director		Stephani Rooker, BABH ID/DD Team Leader	X	Amber Wade, BABH Quality & Compliance Coordinator	X
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. Presentation: Jill LeBourdais, Bay City Crisis Residential Unit** **c. Approval of Meeting Notes: 11/14/2024** **d. Program/Provider Updates and Concerns** **e. IPOS Training Form Policy/Procedure** **f. OT/PT/SLP New Script**	a. There was an addition to the agenda; 4k. Psychiatric at Intake. b. Jill LeBourdais and Dan DeRow (sp?) presented on the Bay City Crisis Residential Unit which is located at 3282 East North Union Road in Bay City. A crisis residential unit is a short-term, community based, homelike setting to care for individuals in crisis. It is a step-down from psychiatric hospitalization. If an individual is presenting with suicidal thoughts and the desire to act on it or attempted suicide, psychotic and present safety issues to others, they are not a candidate for a CRU. The staff will do an intake and complete a health assessment and review medications and the needs the individual may have. The individual will see a Psychiatric Provider/Prescriber within 24 hours of admission to do a thorough evaluation of medications and diagnosis. We do not try to make major adjustments to medications or to completely change the diagnosis. Rather we try to fine tune the current plan or start fresh if the individual is new to mental health. Nursing staff will evaluate the patient. A therapist will see the consumer within 24 hours to complete an assessment and devise a short-term treatment plan and goals.	e. Sarah will address the discussion of the IPOS Training Form at the next provider meeting, so they know their roles.

Topic	Key Discussion Points	Action Steps/Responsibility
	The individual will be encouraged to participate in group therapy that is held during the day. There are opportunities to learn mindfulness/meditation/art therapy as well. Patients can smoke cigarettes in a designated outdoor area. The unit is not a locked setting. The staff will work with the individual 1-1 if necessary to help work toward his/her goals. The staff will work with the individual in crisis and the CMH and family if needed to secure a safe discharge. There is a discharge packet emailed over to BABH as to what took place during their stay at the unit. The unit does take Respite patients, but they do not receive nursing and medication services. Ages 18 and older, no children. c. The November meeting notes were approved as written with clarification on a few items. The December meeting was cancelled. d. **Program/Provider Updates and Concerns:** Bay-Arenac Behavioral Health: - ABA/Wraparound – No updates to report this month. - ACT/Adult MI – No updates to report this month. - Arenac Center – We are done one case manager. - Children's Services – Fully staffed and just hired an Intensive Case Manager and Wrap-Around Facilitator. - CLS/North Bay – Samaritas completely ended their contract with BABH, so they are no longer an option for CLS services. No updates to report this month for North Bay. - Contracts – No updates to report this month. - Corporate Compliance – No updates to report this month. - EAS (Emergency Access Services)/Mobile Response – MRT hired someone for 2nd shift who will work part-time on Tuesdays, Wednesdays, and Fridays from 8:30 pm - 12:00 am. Hired a Peer Support Specialist for the AOT Program. - Finance – No updates to report this month. - ID/DD – No updates to report this month. - IMH/HB – No updates to report this month.	

Topic	Key Discussion Points	Action Steps/Responsibility
	- Madison Clinic – Dr. Exum is set to return from her leave on January 21st. Dr. Bridget Smith is here till the end of June. Ashley Badour has replaced Tami Trea; she started December 16th. Nursing is in a good spot. - Medical Records – No updates to report this month. - Quality – No updates to report this month. - Recipient Rights/Customer Services – No updates to report this month. - Self Determination – No updates to report this month. List Psychological: - IDD – We are down two case managers for the IDD Program. We are still looking for applicants. MPA: - CSM – No updates to report this month for CSM. - OPT-A – We are losing a full-time therapist next week and just found out today we are losing a LL. We will try to keep referrals going but might put a hold on dual due to unlimited staff. Saginaw Psychological: - CSM – No updates to report this month. - OPT – No updates to report this month. e. IPOS Training Form Policy/Procedure – We have been discussing this and need to get it in a policy/procedure. Primary case holder initiates the training by contacting the provider. This should be completed within x business days of the IPOS being finalized. Training for the CLS providers, specialized residential providers, self-determination lead staff, and self-determination family/guardian /support person should be completed directly (in person or over the phone). Training for vocational providers, ABA providers, and respite camp providers can be completed via in person, over the phone, or	

Topic	Key Discussion Points	Action Steps/Responsibility
	via email if the plan only references the provider specific plans. For example, vocational providers and ABA providers have their own plans and the primary case holder plans typically only references the number of hours authorized. If the plan references any safety issues, it should be trained on via in person or over the phone. If the trainer does not have an account in PCE, a paper form of this document should be completed and uploaded in PCE under Plan Training Forms using the 'Add External Training Form' link. If the trainer (based on the form) DOES have a PCE account, the primary case holder will insert the name via the lookup option. When the form is completed by the primary case holder, the trainer will be notified that they have a document to sign. If the primary case holder trains a trainer and a back-up trainer from the provider agency, both staff should sign the form. (See form - Trainer signature line and Back-Up Trainer signature line). Providers are responsible for keeping documentation that they have trained each staff member working with the identified consumer. This documentation must contain the staff's printed name, staff's signature, and date as well as the trainer's signature, trainer's printed name, and date. This documentation should be kept at the provider agency. Do not send this form to BABH staff. BABH staff completing audits will request this documentation. The primary case holder should train the trainer within how many business days from the time the plan of service is finalized? This is not an easy target for staff that have a lot of staff they have to train. Providers cannot bill until their staff have been trained. An IPOS training form needs to be completed whenever there is a new plan or an addendum to the plan, including changes to the number of hours CLS, ABA, or Vocational being authorized. What is the actual timeframe to train staff? If a plan is signed and a service is provided prior to that plan date, we will get written up for that. You may need to have a pushed out start date in order to train in the allotted	

	Topic	Key Discussion Points	Action Steps/Responsibility
		timeframe. The plan of service needs to be completed within 3 business days, but the form needs to be completed before the plan of service is implemented. Prior to implementation or services being provided that would take away the 3 business days. No goals, objectives or interventions changed, including if there is an addendum, a plan of training form does not need to be completed but staff have to communicate if hours have changed. What is the expectation of the provider if the primary case holder does not reach out to them? If the provider sees someone did not reach out, we would ask the provider to contact a supervisor directly. f. OT/PT/SLP New Script – We had a finding for not having something in the physician's order script related to ongoing services. We have this form sent to physicians when needing referrals. Under the order section, we added Autism Assessment and ABA Treatment. This is a draft to meet the waiver requirements. Under the rational section, more wording was added. 'Conduct an assessment/evaluation to substantiate clinical need and medical necessity, *development of treatment planning, development of authorization requests to include the amount of services deemed medically necessary by the treating professional*, and monitoring of services. Services will be provided in-person, via Telehealth video conferencing, or Telehealth video conferencing and audio.' The physician is saying whatever is deemed medically necessary by the treating professional is what is being authorized. We will add the pathway to the footer.	
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 – Nothing to report this month. b. <u>Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports</u> i. MSHN Priority Measures Report: Nothing to report this month.	b.iv. MHSIP/YSS Report – Sarah will send out the MHSIP/YSS Report to the committee with

Topic	Key Discussion Points	Action Steps/Responsibility
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)** v. Employment Data (Dec, Mar, Jun, Sept) 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	ii. Recipient Rights: Deferred. RR Report is in the meeting folder and was sent out to the committee. iii. RAS: The RAS was sent out so you can review it, and if you have any questions you can get with Sarah. iv. **MHSIP/YSS**: For 2024, there was a 13% response rate (329/2486) for surveys distributed. The survey rate was significantly lower for 2024 (13%) compared to 2023 (39%). There was a 17% decline rate and 28% of consumers that were not seen for face-to-face contact during the four-week period. The MHSIP survey had a 16% response rate which resulted in a 93% confidence level. The YSS survey had a 7% response rate which resulted in a 53% confidence level which is a significant decrease from 2023 (81% confidence level). A drawing for a $50 gift card was also offered to consumers if they completed the survey and provided their name/phone number, and a LPS consumer was picked to win the gift card. Over the past several years, surveys have been distributed in a variety of different ways with varying degrees of success. Due to the significant decrease in the response rate for both the MHSIP and YSS surveys, it is recommended that, in the future, surveys be distributed during face-to-face contacts. The results of the MHSIP can be actioned due to falling just below the 95% confidence level, but the YSS results should not be actioned due to only producing an 53% confidence level. It is also recommended that there continues to be the option of being entered for a gift card. There were a total of 280 MHSIP surveys returned during 2024 out of 1797 surveys distributed, which resulted in a 93% confidence level and 16% response rate. This was a significant decrease from 2023 (41% response rate). In 2022, we were unable to determine a response rate due to an error with determining the number of surveys distributed, however, the method of survey distribution was hybrid (electronic, in person, via mail). In 2023, the method of survey distribution was primarily face to face and in 2024 surveys were	the additions made in the meeting. Sarah will talk with the Consumer Council as well and will note any additions to the report. d.i. PI Report – If the Help Desk sends out BI Reports, Karen can ask Theresa if she can add it to the BI Report to send to the Providers as well, not just BABH staff.

Topic	Key Discussion Points	Action Steps/Responsibility
e. Periodic Review Reports f. Ability to Pay Report g. Review of Referral Status Report	distributed by mail only. Overall, 83% of the respondents were from individuals/guardians with a Mental Illness (MI) diagnosis. It should be noted that in 2024, consumers with Intellectual Developmental Disability (IDD) were part of the survey distribution for the first time, therefore, making it difficult to compare previous surveys results. Two hundred and fifty one of the 329 surveys returned were individuals who best described their race as white and 147 of the individuals chose that their sex assigned as birth was female. 87% of the respondents had been in services more than 12 months. There are three domains that consistently score below the desired threshold of 80%: Outcomes, Functioning, and Social Connectedness, however, for 2024, the Social Connectedness domain scored 81.65% and Outcomes domain scored 80%; both an increase from 2023. All the other domains scored above the 80% standard but had a decrease from 2023 with Quality and Appropriateness having the biggest decrease of 8%. Analysis: Overall, for 2024, a majority of the questions had a lower percentage of agreeance compared to 2023. Three of the statements had more than a 10% decrease including, "Staff believed I could grow, change, and recover," "I was encouraged to use consumer run programs," and "I am better able to handle things when they go wrong." The statement that had the highest increase was "My housing situation has improved" (9%). All the questions, with the exception of one, in the Outcomes, Functioning, and Social Connectedness domains were below 80% which is typical of previous years. Action: Over the past several years, surveys have been distributed through a variety of methods. This year the surveys were distributed only through the mail. Consumers/guardians had the chance to win a $50 gift card. The PNOQMC committee determined action steps specifically related to the question, "Staff believed I could grow, change, and recover." The committee determined that staff turnover and burnout could be a cause for the decrease in agreeance.	

Topic	Key Discussion Points	Action Steps/Responsibility
	Staff suggested that teams/agencies continue to focus attention on staff self-care, a healthy work-life balance, and wellness. Internally, BABH staff have access to an Employee Assistance Program that can provide support to staff members to address any personal issues. Supervisors will encourage staff to share success stories during staff meetings as a way to provide encouragement to other staff. BABH is pursuing an opportunity for reflective supervision to support staff burnout and trauma so that they can better serve consumers as well. v. Provider Satisfaction Report: Nothing to report this month. c. <u>Access to Care & Service Utilization Reports</u> i. MMBPIS Report: Deferred. ii. LOCUS: Nothing to report this month. iii. Leadership Dashboard: Deferred. iv. Customer Service Report: Deferred. The CS Report is in the meeting folder and was sent out to the committee. d. <u>Regulatory and Contractual Compliance Reports</u> i. **PI Report**: Bay Direct, List, Saginaw Psychological and MPA had a significant number of plans of service that left the date blank in the 'Update Sent Link.' These blanks are not included in the overall percentage of compliance, but supervisors should be addressing this with staff and monitoring. The updated sent link needs to be updated when a plan is given, faxed, mailed, etc. If they are being left blank, we do not track if they are within the 15 days or out of the 15 days. It is recommended that providers indicate that the IPOS was sent under the Update Sent Link above the IPOS/IPOS Pre-Plan. The Quality and Compliance Coordinator will send out lists to supervisors for Bay Direct and Saginaw Psychological so they can determine any trends with specific staff and/or specific programs. The providers are not receiving the BI Report of what staff are not updating the send link so	

	Topic	Key Discussion Points	Action Steps/Responsibility
		Karen will get with the Help Desk to see if they can send that report to the providers as well. 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. 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	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: no updates to report this month. e. Clinical Capacity Issues Status i. **Referral Status Report**: Open for referrals. ii. **OPT Group Therapy**: Group Therapy started last night and 4 people showed up. there are different facilitators and open for new referrals. iii. Capacity Issue Discussion:	

Topic	Key Discussion Points	Action Steps/Responsibility
e. <u>Clinical Capacity Issues Status</u> **i. Review of Referral Status Report** **ii. OPT Group Therapy** **iii. Capacity Issue Discussion** f. Medicaid/Medicare Updates i. Medicare Open Enrollment: Verify Insurance ii. Medicaid Reenrollment: Encourage /assist as needed with process g. General Fund for FY2025 h. Conflict Free Case Management **i. AOT Notification** **j. C04-S15-T21 Hospitalization for Adults Under Court Order** **k. Psychiatric at Intake**	f. Medicaid/Medicare Updates: Nothing to report this month. g. General Fund for FY2025: Nothing to report this month. h. Conflict Free Case Management: Nothing to report this month. i. **AOT Notification**: Adam Potter is the new AOT Coordinator. j. **C04-S15-T21 Hospitalization for Adults Under Court Order**: If an individual is on an assisted outpatient treatment (AOT) order, either combined with hospitalization or an AOT only order, the person per the Michigan Mental Health Code must have a goal in their individualized plan of services (IPOS) addressing the court order. The goal needs to address the criteria specified in the order and if the person is in a lesser restrictive level of care than ordered, the goal needs to explain the clinical justification. The IPOS needs to be completed, signed by consumer, and forwarded to AOTC within 21 days of the order being signed by the judge. The AOTC will submit signed IPOS to the court within 30 days of the judge signing the order. If the person is on deferment, they should have a goal in their IPOS as well. To be placed on an order or a deferment agreement, the person needs to have a substantial risk of harm due to impaired judgment. An individual is placed on an AOT combined order with hospitalization if they are petitioned into an inpatient unit and the order follows the hospitalization. Deferment agreements can also lead to AOT combined orders. An AOT only order is seen as a preventative measure before hospitalization is necessary. AOT combined or only orders should be viewed as an order that the treatment team follows, not the individual. Essentially the treatment provider, whether CMH or an alternative mental health provider, is on the order as the treatment team has to answer to the court if the person is not successful on the order. The treatment team is responsible for following up with the individual and making every attempt at engagement. If an individual on AOT does not attend appointments, the AOTC needs to be notified via the electronic health system or encrypted email as soon as possible, but no more than 5 days after a missed appointment. The case holder may need to fill out a Notification of Noncompliance and forward it to the AOTC for court submission if there is	

	Topic	Key Discussion Points	Action Steps/Responsibility
		noncompliance. The AOTC or EAS clinician may also complete this form as needed. Best practice has been found to be the following increased contact after a person is discharged from inpatient hospitalization to reduce recidivism and increase compliance with treatment: weekly for the first two months; twice monthly for the third month; at the fourth month the treatment needs to determine continued contact frequency based on success. Evidence of success is that the person attended all appointments, needed no medication changes, needed no contact with crisis services, etc. Continued contact frequency should be determined by the treatment team, including but not limited to the individual, primary case holder, therapist, psychiatrist, and AOTC. Michigan state court form PCM 230 Notification of Non-Compliance should be used to notify the applicable county court of noncompliance with treatment. Quick phrases will be sent to Karen and she will then forward to Theresa to add to the quick phrases. k. **Psychiatric at Intake**: We are all doing this differently and need to be on the same page.	
5.	**Announcements**	No announcements to report this month.	
6.	**Parking Lot** a. Periodic Reviews – Including Options for Blending with Plan of Services Addendums	a. NA	
7.	**Adjournment/Next Meeting**	The meeting adjourned at 3:45 pm. The next meeting is scheduled for February 13, 2025, 1:30-3:30, at the Lincoln Center in the East Conference Room.	

Executive Summary of QAPIP

- **Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH:** There were six types of adverse events reported during FY25Q1. There were 11 non-suicide deaths for FY25Q1 which was less than the previous quarter. There were two emergency medical treatments due to harm from another which is not a typical trend; one was reportable, and one was not reportable. These were for two separate individuals. There was a significant decrease in adverse events for FY25Q1 compared to previous quarters. 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 decreased significantly for FY25Q1, and the overall number of interventions continues on a downward trend. There were 12 consumers that led to the 30 emergency physical interventions with one individual accounting for 13. The treatment team has been working together to explore changes to support improvement for this individual. This was a significant decrease from last quarter when this individual had 49 interventions. There were six 911 calls made for behavioral assistance for FY25Q1 which is an increase from previous quarters, however, the overall trend continues to be flat.
- **Diabetes Screening, Diabetes Monitoring, and Cardiovascular Monitoring:** There was an increase for the diabetes measures for FY24Q4 compared toFY24Q3. 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 primary, secondary, and 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, primary providers, BABH direct services, and community living support providers. There was a total of 11,621 claims reviewed with only 99 errors resulting in a 99% compliance rate. The most common finding was that the documentation was not completed, or the number of units billed did not match the documentation.
- **Evidence of Primary Care Coordination:** All providers scored below 90% for primary care coordination. One provider had a significant improvement which was due to providing documentation in a timely manner. Reviews show that the coordination of care letter is either expired or was not completed. Corrective action plans have been completed to help improve compliance.
- **Michigan Mission Based Performance Indicator System (MMBPIS) Indicators:** Across most indicators and populations, BABH has higher compliance than MDHHS. For Indicator 3, BABH had lower compliance than MDHHS for all populations except IDD-Children.
- **Reduction of Inpatient Hospitalization Days (community inpatient and state facilities) for FY24:** BABH had 10,0031 inpatient hospitalization days during FY23 and 9,652 days in FY24. This was a decrease of 379 inpatient hospitalization days during FY24 which met the goal of an overall reduction. Further analysis determined that over the past couple of months consumers have been staying significantly longer than the 5-7 day average. The Emergency Access Service department is looking into specific individuals to determine other trends and factors.
- **Behavior Treatment Survey:** This survey report is completed annually at the end of each calendar year. The results from 2024 showed a 100% satisfaction rate for the seven surveys returned.

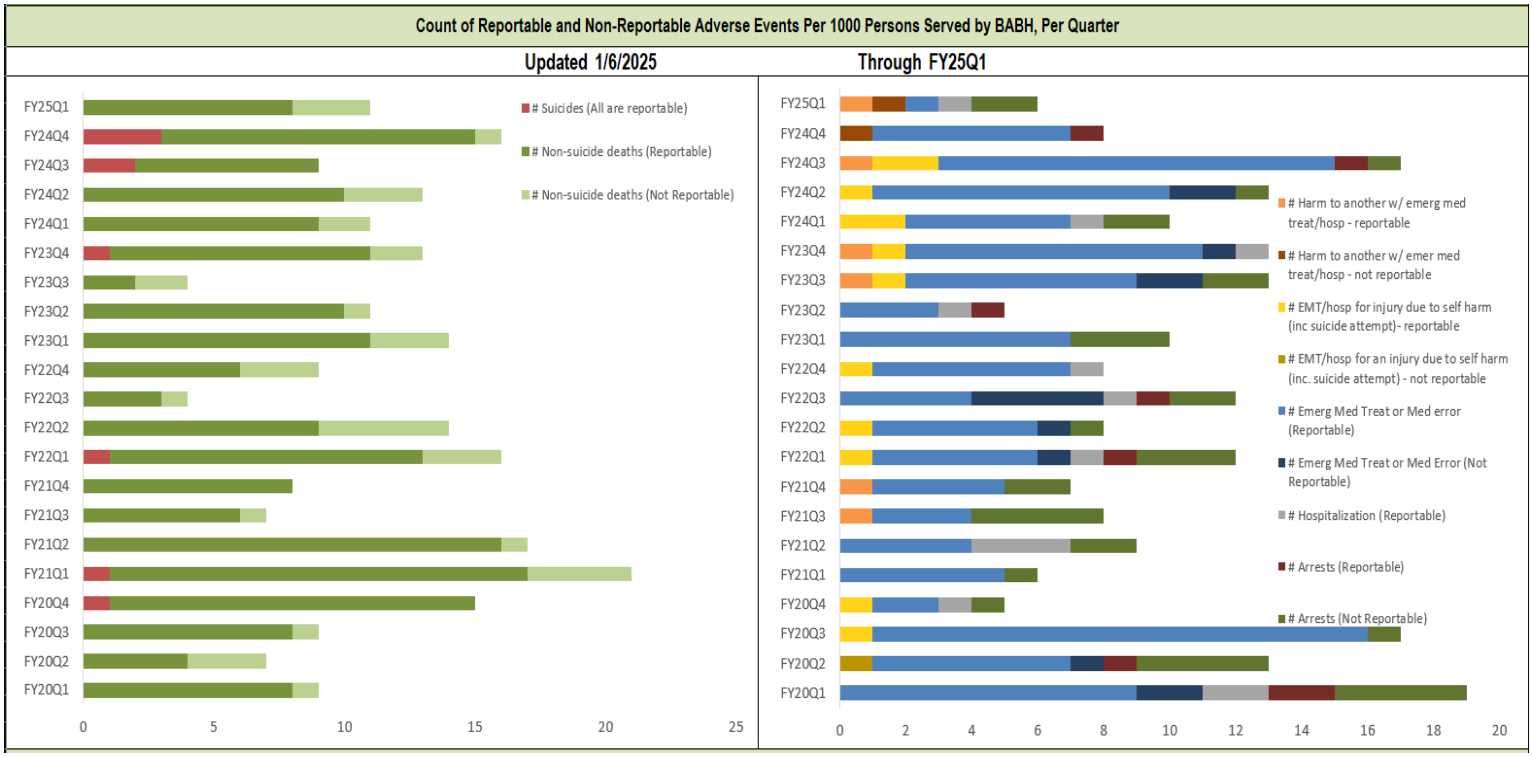
The following report provides a quarterly update to the goals identified in the QAPIP plan as well as an annual review.

PROVIDER QUALIFICATION AND SELECTION

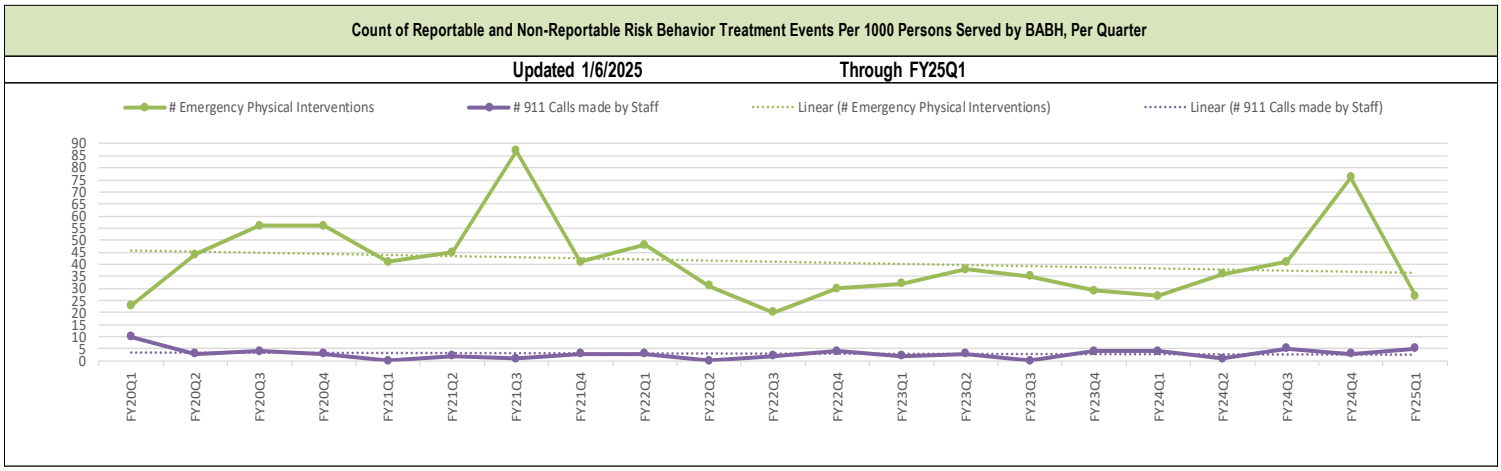
24 Hours of Children's Specific Training: Supervisors received training on how to access reports within Relias independently to track children's specific training. Additionally, the Staff Development department created a curriculum at the beginning of the year that children's staff can complete to ensure 24 hours of children's specific training is completed.

Plan of Service Training Forms: BABH quality staff are monitoring the use of the plan training form during scheduled site reviews, external audits, as well as monthly. The findings of these reviews are given to supervisors for follow-up with applicable staff.

HARM IDENTIFICATION AND REDUCTION

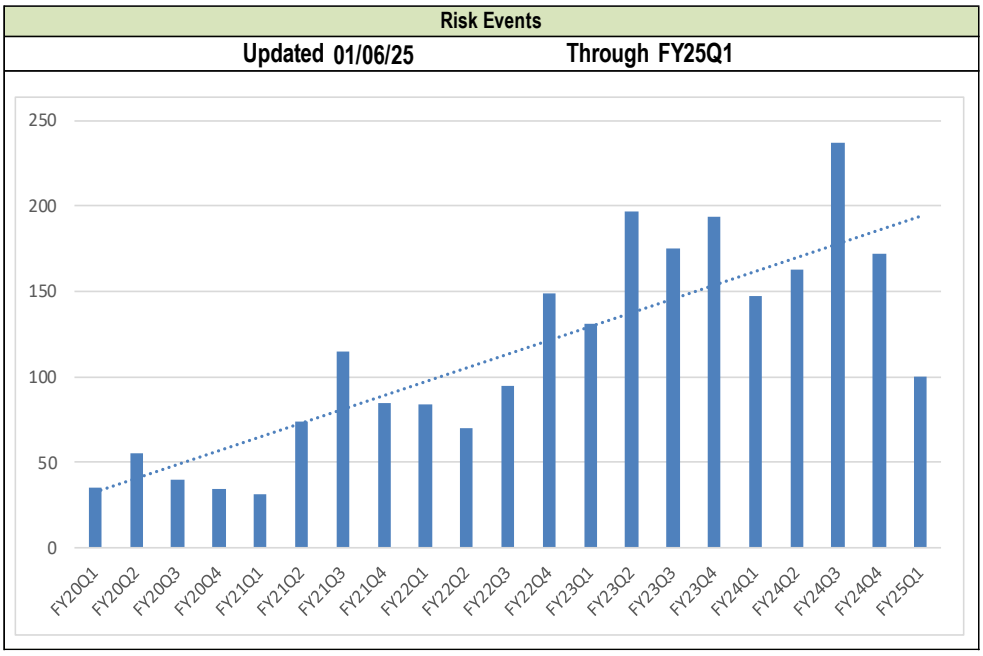


Count of Reportable and Non-Reportable Adverse Events Per 1,000 Persons Served by BABH: There were six types of adverse events reported during FY25Q1. There were 11 non-suicide deaths for FY25Q1 which was less than the previous quarter. There were two emergency medical treatments due to harm from another which is not a typical trend; one was reportable, and one was not reportable. These were for two separate individuals. There was a significant decrease in adverse events for FY25Q1 compared to previous quarters. There does not appear to be any other type of trend among these incidences, therefore, no specific actions are identified at this time.



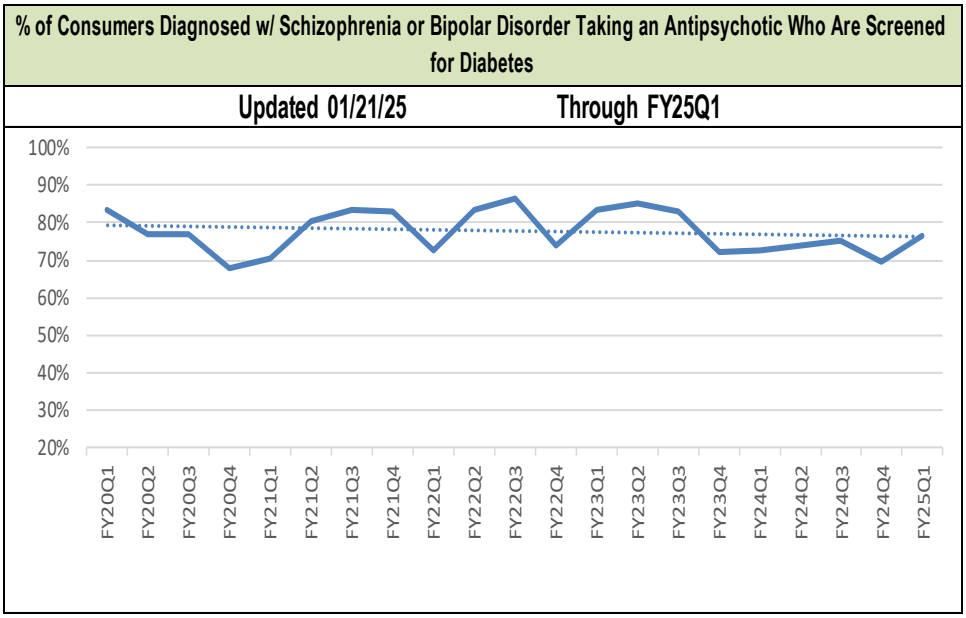
Reportable Behavior Treatment Events: The number of emergency physical interventions decreased significantly for FY25Q1, and the overall number of interventions continues on a downward trend. There were 12 consumers that led to the 30 emergency physical interventions with one individual accounting for 13. The treatment team has been working together to explore changes to support improvement for this individual. This was a significant decrease from last quarter when this individual had 49 interventions. There were six 911 calls made for behavioral assistance for FY25Q1 which is an increase from previous quarters, however, the overall trend continues to be flat.

Risk Events: Risk events are identified as 'harm to self, harm to others, police calls for behavioral assistance, emergency physical interventions, and two or more hospitalizations.' The number of risk events decreased during FY25Q1, but the trend continues to steadily increase.

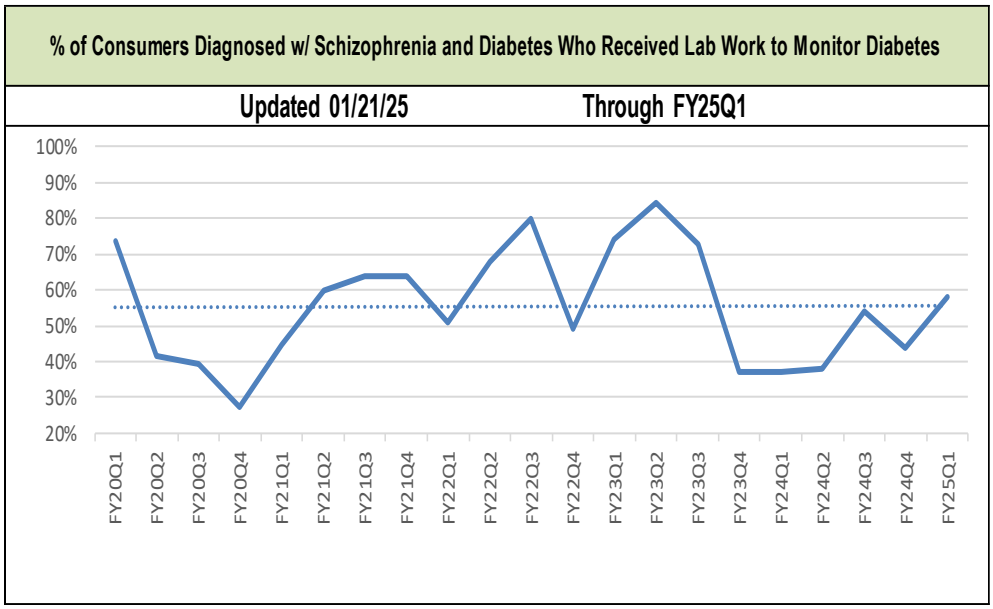


The Number of Days to Complete the Recipient Rights Investigation is Lower Than the Michigan Mental Health Code Standard of 90 Days: The Office of Recipient Rights has 90 days to complete an investigation. For FY24Q4, BABH averaged 15.3 days; well below the standard.

Abuse and Neglect Complaints Substantiated Have Remedial Action: Remedial action included written counseling, employee termination, training, suspension, contract action, and verbal counseling.

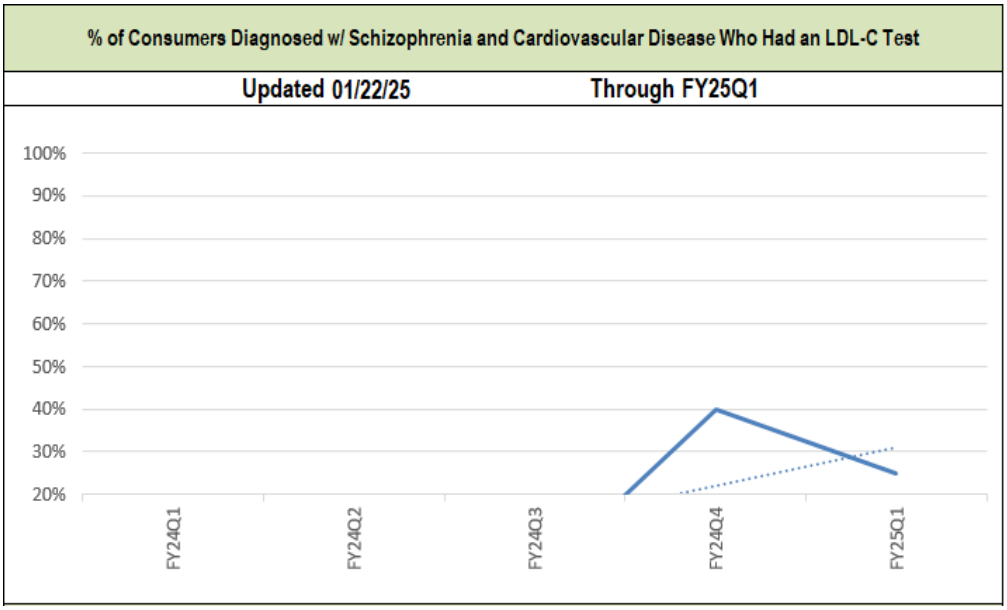


Consumers Diagnosed with Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes: BABH had an increase in consumers receiving the appropriate labs for this measure during FY25Q1. BABH will continue to action these alerts monthly to improve compliance. Staff recently made an adjustment to how these are being actioned, so compliance is expected to improve.

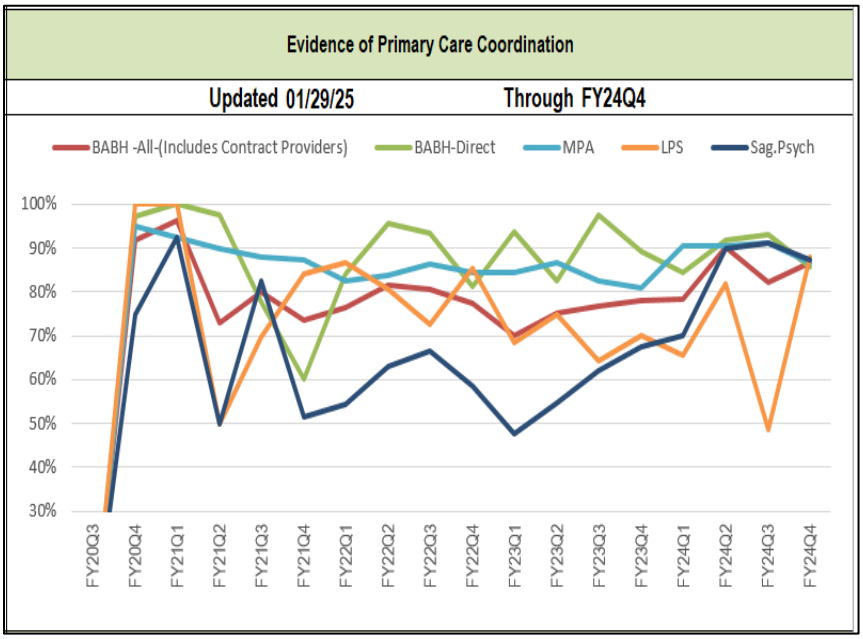


Consumers Diagnosed with Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes: BABH had an increase in consumers receiving the appropriate labs for this measure during FY25Q1. BABH will continue to action these alerts monthly to improve compliance. Staff recently made an adjustment to how these are being actioned, so compliance is expected to improve.

Consumers Diagnosed with Schizophrenia and Cardiovascular Disease Who Received an LDL-C Lab: There were recent changes to the specifications for this measure so there are only two quarters of data at the time of this report. BABH has now begun actioning this measure. It takes a few quarters for these efforts to take effect.



Evidence of Primary Care Coordination: All providers scored below 90% for primary care coordination. One provider had a significant improvement which was due to providing documentation in a timely manner. Reviews show that the coordination of care letter is either expired or was not completed. Corrective action plans have been completed to help improve compliance.

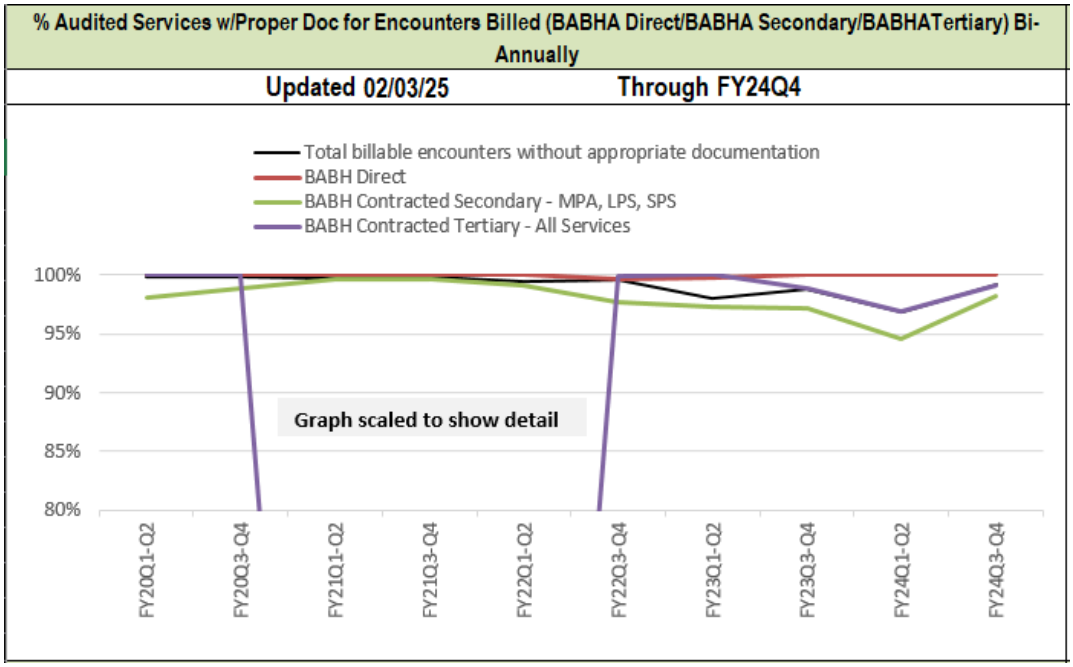


Quality of Care Record Reviews- Services Are Written in The Plan of Service Are Delivered at The Consistency Identified: 96% of the records reviewed during FY25Q1 received the level of services that were written in the plan which met the 90% standard set by BABH and demonstrated a 6% increase from the previous quarter. Staff of the records found to be out of compliance 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: 95% of the records reviewed during FY25Q1 had the services identified appropriately to match the services authorized which meets the 90% standard set by BABH. Staff of the records found to be out of compliance received education and training on the standard of providing services as written in the plan of service.

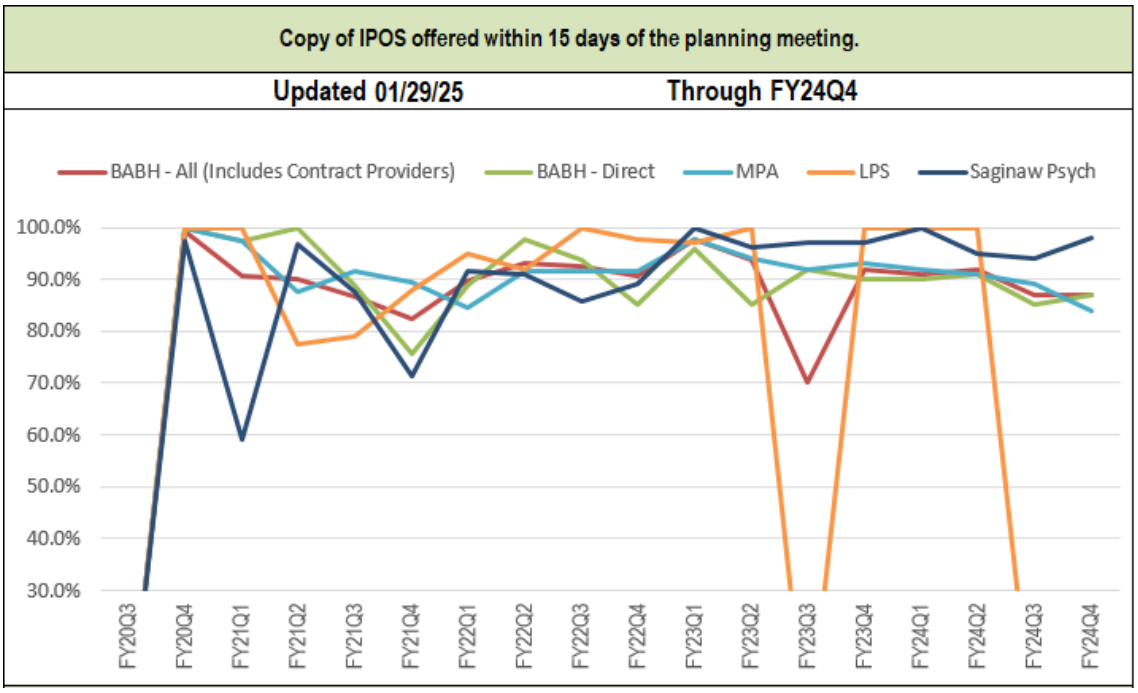
Develop Quarterly Reports to Increase the Quality Report and Outcomes Related to The Level of Care Utilization System (LOCUS): No update.

ACCESS TO CARE AND UTILIZATION MANAGEMENT



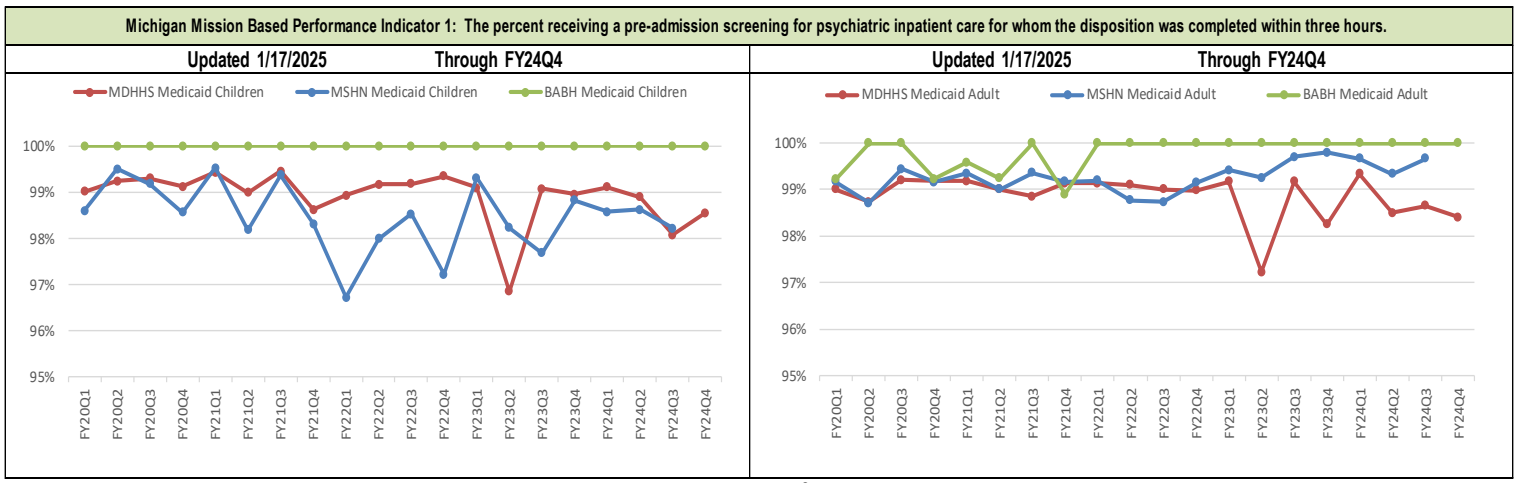
Audited Services with Proper Documentation for Encounters Billed: The overall total compliance for all primary, secondary, and tertiary services reviewed during FY24Q3 and FY24Q4 was above the 95% standard and increased from the previous two quarters. These reviews included applied behavioral analysis, specialized residential, dietary, primary providers, BABH direct services, and community living support providers. There was a total of 11,621 claims reviewed with only 99 errors resulting in a 99% compliance rate. The most common finding was that the documentation was not completed, or the number of units billed did not match the documentation.

Increase Medicaid Event Verification (MEV) Reviews: BABH continues to increase the services audited by completing reviews of all specialized residential, community living support, vocational, primary, autism providers, self-determination, dietary, occupational therapy, speech and language therapy, physical therapy, and specialized residential providers where we are the county of financial responsibility.

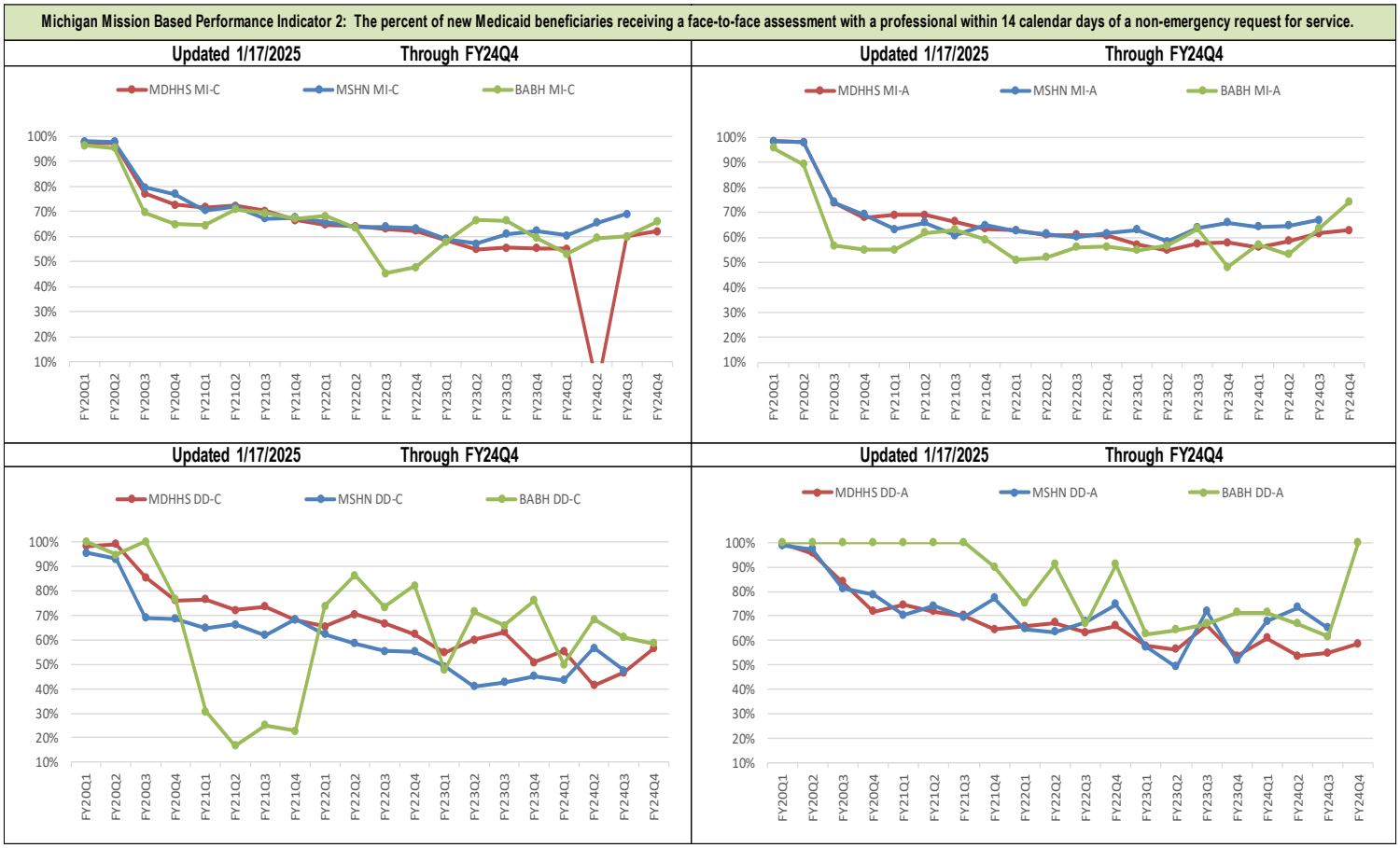


Copy of Plan of Service Offered Within 15 Days of Planning Meeting: Overall, the percentage of compliance for offering the plan of service within 15 days was consistent for FY24Q3 compared to FY24Q4. It was determined that staff are not always using the electronic health record completely so there is 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. Corrective action plans have been implemented.

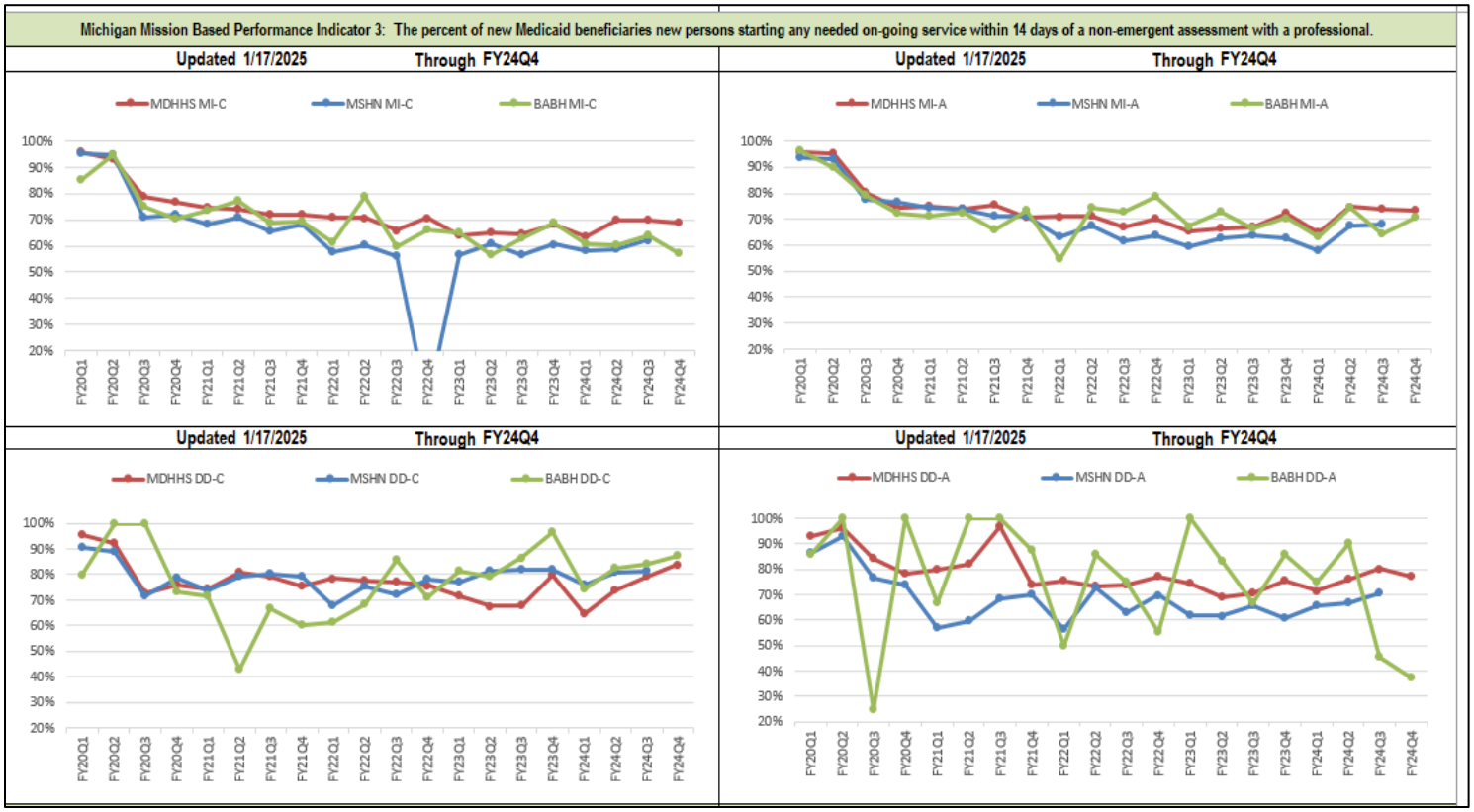
Michigan Mission Based Performance Indicator System (MMBPIS): Indicator 1 (The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours.): BABH demonstrated 100% compliance for Indicator 1 for both children and adult populations during FY24Q4. This was a higher rate of compliance than MDHHS and MSHN.



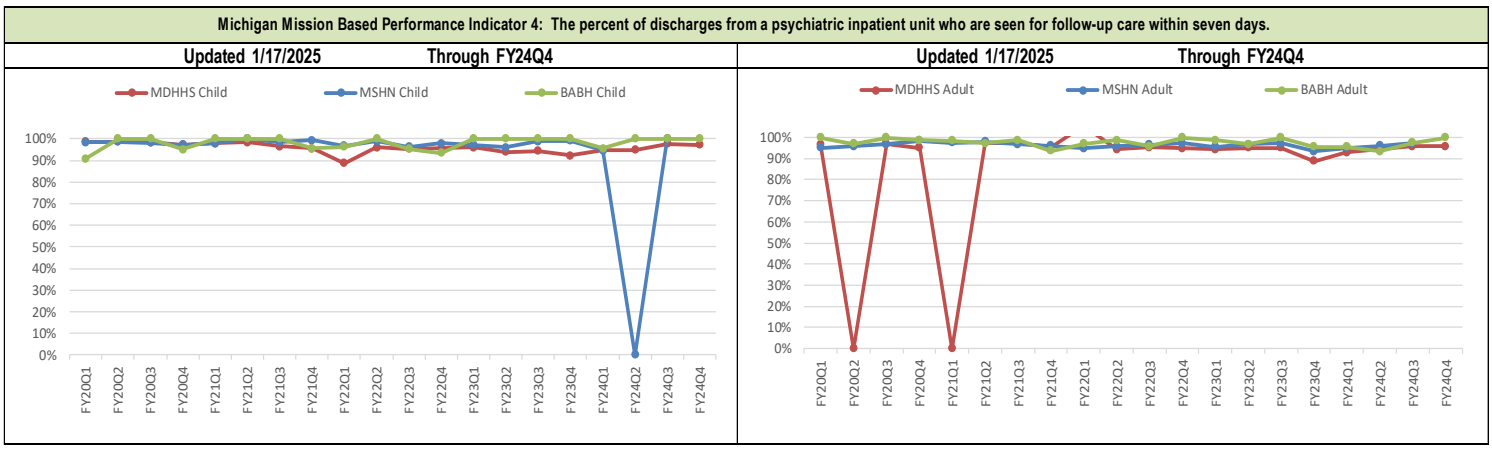
MMBPIS: Indicator 2 (The percent of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergent request for services.): BABH has higher compliance rates for all populations compared to Michigan Department of Health and Human Services (MDHHS). MSHN data has not been received. BABH saw an increase in all populations except IDD-Children.



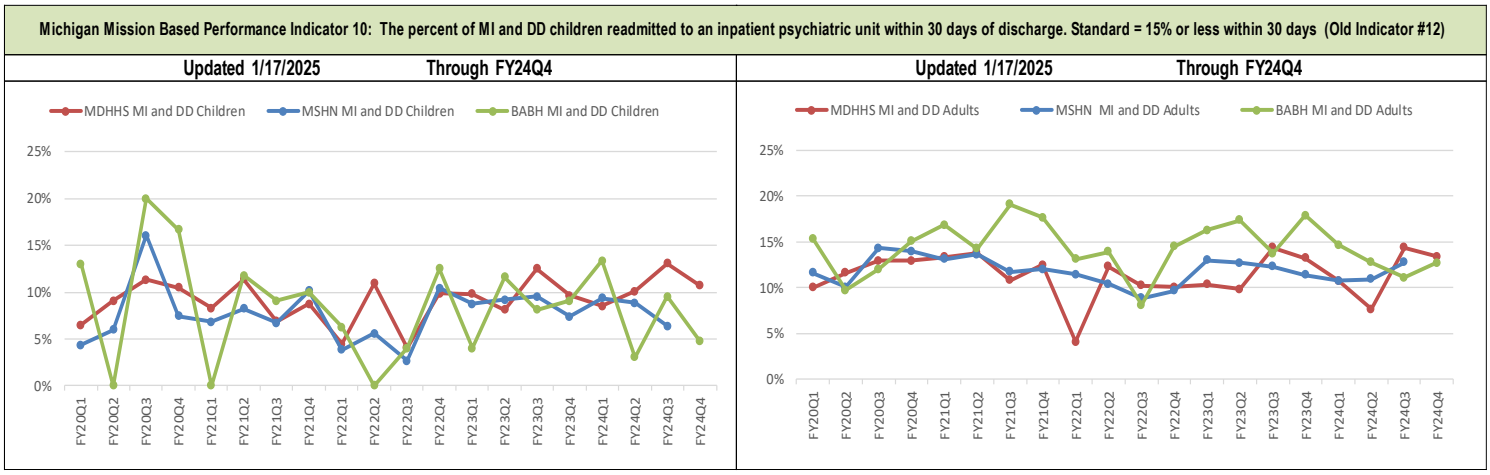
MMBPIS: Indicator 3 (The percent of Medicaid beneficiaries starting any needed ongoing service within 14 days of a non-emergency assessment with a professional.): For FY4Q4, BABH had lower compliance rates when compared with MDHHS for all populations except IDD-Children, which has had a steady increase for the past several quarters. MSHN data was not available. The highest contributing factor to lower compliance rates are no-show appointments.



MMBPIS: Indicator 4 (The percent of discharges from a psychiatric inpatient unit who are seen for follow-up within seven days.): The BABH child and adult populations met the 95% compliance standard for FY24Q4. This is above or consistent with MDHHS. MSHN data was not available.



MMBPIS: Indicator 10 (The percent of beneficiaries readmitted to an inpatient psychiatric unit within 30 days of discharge.): BABH met the compliance rate for the child and adult populations for FY24Q4 (both populations below 15%).



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STAKEHOLDER PERCEPTIONS

Adults and Children Indicating Satisfaction on Survey: During the FY24 satisfaction survey period, 88% of adults and 89% of children expressed a general satisfaction with services. This was a decrease from last year but surpassed the goal of 80% satisfaction.

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 a significant improvement from 2023. BABH leadership identified corrective action steps to implement.

Behavior Treatment Survey: This survey report is completed annually at the end of each calendar year. The results from 2024 showed a 100% satisfaction rate for the seven surveys returned.

Prepared by: Sarah Holsinger, LMSW, CAADC – Quality Manager Date: February 7, 2025

Introduction

The Michigan Department of Health and Human Services (MDHHS) requires a survey to be administered annually. All BABH programs and contract providers serving individuals with a mental illness will have the opportunity to complete the Mental Health Statistics Improvement Program (MHSIP) and the Youth Satisfaction Survey for Families (YSS).

Survey Response Rates

Since 2019, the surveys have been distributed through a variety of different methods including face to face, regular mail, electronic, and hybrid versions. For 2024, there were additional elements that were required to be tracked, making survey distribution more complicated and prone to error with the data collection process. As a result, it was determined that surveys would be distributed via mail. The response rates are calculated by dividing the number of surveys that were returned by the number of surveys that were distributed. Figure 1 below shows the breakdown in the surveys distributed and received separated by population groups.

Figure 1

Population Groups	# Distributed	# Received	# Served during reporting period	Response Rate
MHSIP Adults - MI	1454	197	1859	14%
MHSIP Adults - IDD	343	83	446	24%
Total	**1797**	**280**	**2305**	**16%**
YSS Children/Family - SED	454	34	617	7%
YSS Children/Family - IDD	225	15	261	7%
Total	**679**	**49**	**878**	**7%**

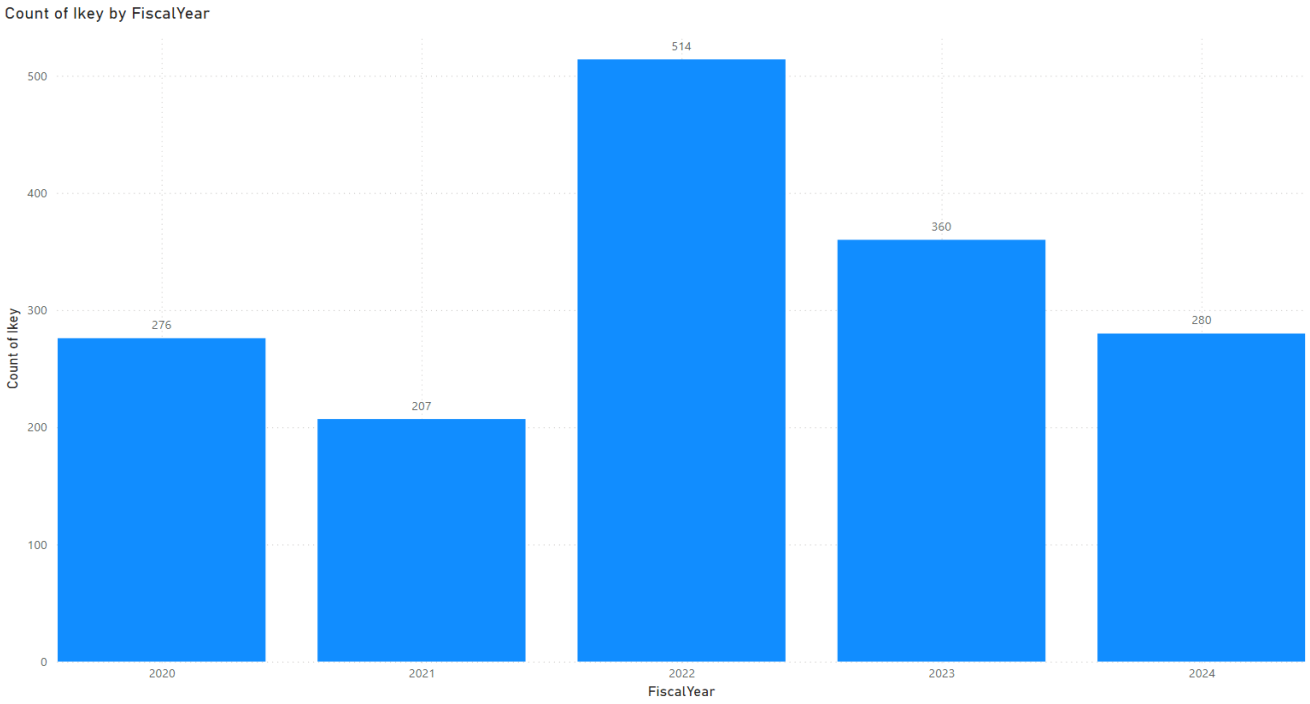
Analysis: For 2024, there was a 13% response rate (329/2486) for surveys distributed. The survey rate was significantly lower for 2024 (13%) compared to 2023 (39%). There was a 17% decline rate and 28% of consumers that were not seen for face-to-face contact during the four-week period. The MHSIP survey had a 16% response rate which resulted in a 93% confidence level. The YSS survey had a 7% response rate which resulted in a 53% confidence level which is a significant decrease from 2023 (81% confidence level). A drawing for a $50 gift card was also offered to consumers if they completed the survey and provided their name/phone number. The only staff able to view this information was the Quality Improvement staff.

Action: Over the past several years, surveys have been distributed in a variety of different ways with varying degrees of success. Due to the significant decrease in the response rate for both the MHSIP and YSS surveys, it is recommended that, in the future, surveys be distributed during face-to-face contacts. The results of the MHSIP can be actioned due to falling just below the 95% confidence level, but the YSS results should not be actioned due to only producing an 53% confidence level. It is also recommended that there continues to be the option of being entered for a gift card.

Survey Findings

The Adult Perception of Care Survey (MHSIP) - There were a total of 280 MHSIP surveys returned during 2024 out of 1797 surveys distributed, which resulted in a 93% confidence level and 16% response rate. This was a significant decrease from 2023 (41% response rate). Figure 2 below shows the total number of surveys returned this year compared to previous years. In 2022, we were unable to determine a response rate due to an error with determining the number of surveys distributed, however, the method of survey distribution was hybrid (electronic, in person, via mail). In 2023, the method of survey distribution was primarily face to face and in 2024 surveys were distributed by mail only.

Figure 2



Summary: Figure 3 below shows the demographics of the surveys that were returned. Overall, 83% of the respondents were from individuals/guardians with a Mental Illness (MI) diagnosis. It should be noted that in 2024, consumers with Intellectual Developmental Disability (IDD) were part of the survey distribution for the first time, therefore, making it difficult to compare previous surveys results. Two hundred and fifty one of the 329 surveys returned were individuals who best described their race as white and 147 of the individuals chose that their sex assigned as birth was female. 87% of the respondents had been in services more than 12 months.

Figure 3

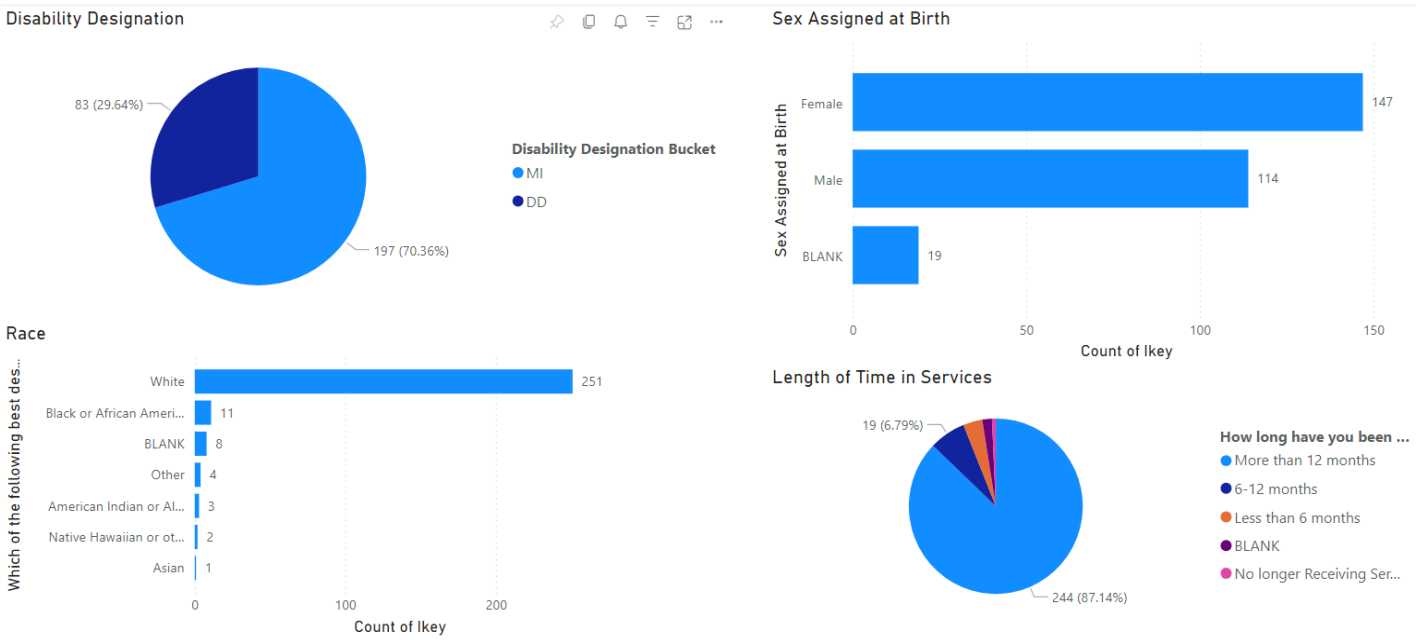
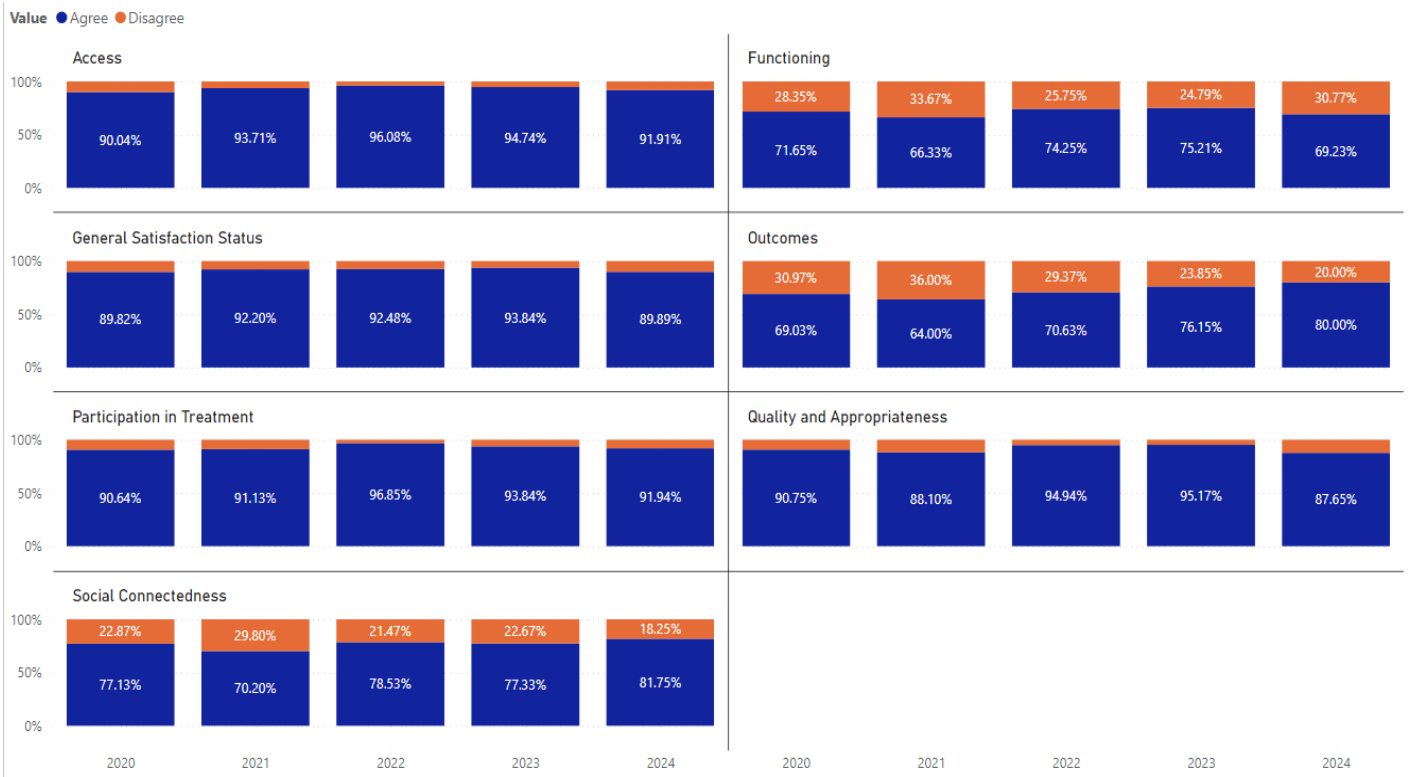


Figure 4



Analysis: Figure 4 demonstrates the percentage of agreement for each domain for the MHSIP survey from 2020-2024. There are three domains that consistently score below the desired threshold of 80%: Outcomes, Functioning, and Social Connectedness, however, for 2024, the Social Connectedness domain scored 81.65% and Outcomes domain scored 80%; both an increase from 2023. All the other domains scored above the 80% standard but had a decrease from 2023 with Quality and Appropriateness having the biggest decrease of 8%.

Figure 5 below demonstrates the percentage of agreement for each question in the domain for all BABH programs and contract service providers and those highlighted in red were less than 80%.

Figure 5

Domain	2020	2021	2022	2023	2024	Difference
General Satisfaction						
1. I like the services that I received.	90%	92%	94%	95.3%	90.7%	-4.6%
2. If I had other choices, I would still choose to get services from this mental healthcare agency.	84%	88%	90%	90.2%	89.3%	-0.9%
3. I would recommend this agency to a friend or family member.	90%	89%	91%	92.2%	89.9%	-2.3%
Access						
4. The location of services was convenient.	89%	91%	91%	91.2%	87.3%	-4.0%
5. Staff were willing to see me as often as I felt it was necessary.	86%	89%	94%	92.5%	87.5%	-5.0%
6. Staff returned my calls within 24 hours.	81%	86%	89%	89.7%	86.5%	-3.2%
7. Services were available at times that were good for me.	92%	91%	97%	94.4%	92.4%	-2.0%
8. I was able to get all the services I thought I needed.	87%	88%	92%	92.2%	86.4%	-5.8%
9. I was able to see a psychiatrist when I wanted to.	80%	79%	85%	87.5%	83.7%	-3.8%
Quality and Appropriateness						
10. Staff believed that I could grow, change and recover	84%	85%	92%	91.2%	80.7%	-10.5%
12. I felt free to complain.	80%	83%	89%	87.6%	82.1%	-5.5%
13. I was given information about my rights.	92%	91%	93%	96.0%	92.7%	-3.3%
14. Staff encouraged me to take responsibility for how I live my life	84%	85%	93%	91.2%	83.8%	-7.4%
15. Staff told me what side effects to watch for.	78%	76%	81%	83.6%	81.3%	-2.4%
16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	90%	94%	95%	94.6%	91.7%	-2.9%
18. Staff were sensitive to my cultural/ethnic background (e.g.,race, religion, language, etc.).	86%	84%	92%	92.3%	88.7%	-3.6%
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	87%	89%	94%	93.2%	83.5%	-9.8%
20. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line,	76%	81%	85%	84.1%	72.6%	-11.5%
Participation in Treatment						
11. I felt comfortable asking questions about my treatment, services and medication.	89%	90%	93%	93.1%	86.7%	-6.3%
17. I, not staff, decided my treatment goals.	84%	84%	93%	89.1%	86.8%	-2.3%
Outcomes						
21. I deal more effectively with daily problems.	70%	69%	74%	76.5%	71.5%	-5.1%
22. I am better able to control my life.	69%	68%	72%	75.3%	67.2%	-8.1%
23. I am better able to deal with crisis.	65%	62%	68%	68.8%	53.7%	-15.1%
24. I am getting along better with my family.	66%	64%	69%	67.3%	77.6%	10.3%
25. I do better in social situations.	54%	56%	62%	61.6%	64.8%	3.2%
26. I do better in school and/or work.	52%	51%	60%	61.4%	63.1%	1.7%
27. My housing situation has improved.	63%	60%	65%	68.6%	77.7%	9.2%
28. My symptoms are not bothering me as much.	54%	54%	60%	58.2%	54.5%	-3.7%
Functioning						
29. I do things that are more meaningful to me.	64%	65%	68%	69.2%	72.5%	3.3%
30. I am better able to take care of my needs.	73%	65%	73%	71.6%	69.4%	-2.2%
31. I am better able to handle things when they go wrong.	59%	55%	64%	66.3%	51.9%	-14.4%
32. I am better able to do things that I want to do.	64%	62%	70%	67.7%	65.7%	-2.0%
Social Connectedness						
33. I am happy with the friendships I have.	72%	69%	73%	75.9%	78.6%	2.8%
34. I have people with who I can do enjoyable things.	74%	71%	78%	78.2%	80.7%	2.5%
35. I feel I belong in my community.	56%	55%	60%	56.7%	64.8%	8.2%
36. In a crisis, I would have the support I need from family or friends.	79%	73%	77%	74.9%	79.8%	4.9%

Analysis: Overall, for 2024, a majority of the questions had a lower percentage of agreeance compared to 2023. Three of the statements had more than a 10% decrease including, "Staff believed I could grow, change, and recover," "I was encouraged to use consumer run programs," and "I am better able to handle things when they go wrong." The statement that had the highest increase was "My housing situation has improved" (9%). All the questions, with the exception of one, in the Outcomes, Functioning, and Social Connectedness domains were below 80% which is typical of previous years.

Action: Over the past several years, surveys have been distributed through a variety of methods. This year the surveys were distributed only through the mail. Consumers/guardians had the chance to win a $50 gift card. The PNOQMC committee determined action steps specifically related to the question, "Staff believed I could grow, change, and recover." The committee determined that staff turnover and burnout could be a cause for the decrease in agreeance. Staff suggested that teams/agencies continue to focus attention on staff self-care, a healthy work-life balance, and wellness. Internally, BABH staff have access to an Employee Assistance Program that can provide support to staff members to address any personal issues. Supervisors will encourage staff to share success stories during staff meetings as a way to provide encouragement to other staff. BABH is pursuing an opportunity for reflective supervision to support staff burnout and trauma so that they can better serve consumers as well.

Survey Findings

The Youth Perception of Care Survey (YSS) - Figure 6 shows that there were a total of 49 YSS surveys returned out of 679 surveys distributed for 2024 which resulted in a 53% confidence level. This was a significant decrease from 2023 (81% response rate). Figure 5 below shows the total number of surveys returned this year compared to previous years. In 2022, we were unable to determine a response rate due to an error with determining the number of surveys distributed, however, the method of survey distribution was hybrid (electronic, in person, via mail). In 2023, the method of survey distribution was primarily face to face and in 2024 surveys were distributed by mail only.

Figure 6

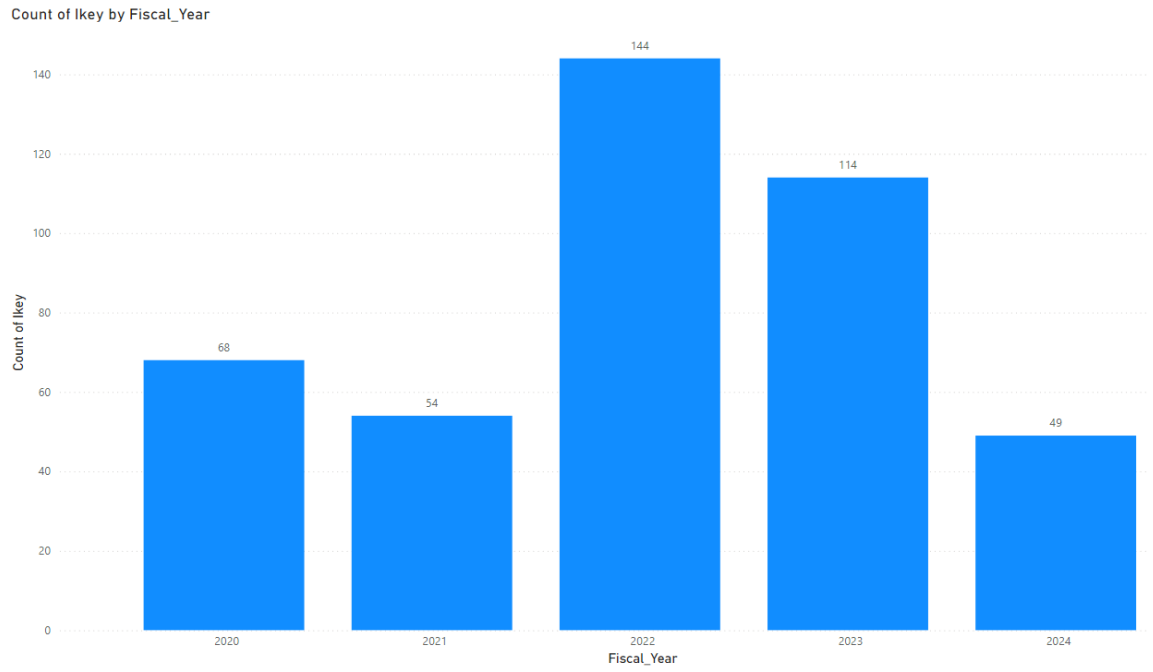


Figure 7

Analysis: Figure 7 demonstrates the percentage of agreement for each domain. Five of the seven domains consistently score above the desired threshold of 80%. For 2024, BABH and the contract service providers met the desired threshold in all the domains except the Outcomes and Functioning domains. It should be noted that the Functioning and Outcomes domains contain six out of seven of the same questions. Three of the seven domains had an increase for 2024 compared to 2023. The Participation in Treatment domain saw the biggest decrease for 2024 (7%).

Figure 8 demonstrates the percentage of agreement for each question in the domain for all BABH programs and contract service providers for the YSS.

Figure 8

Domain	2020	2021	2022	2023	2024	Difference
Access						
8. The location of services was convenient for us.	90%	96%	99%	94.6%	95.9%	1.3%
9. Services were available at times that were convenient for us.	91%	89%	94%	92.1%	87.5%	-4.6%
Appropriateness						
1. Overall, I am satisfied with the services my child received.	79%	89%	96%	93.0%	87.8%	-5.2%
4. The people helping my child stuck with us no matter what.	88%	85%	92%	93.0%	89.8%	-3.2%
5. I felt my child had someone to talk to when he/she was troubled.	81%	83%	91%	94.7%	89.4%	-5.3%
7. The services my child and/or family received were right for us.	78%	89%	90%	89.5%	81.6%	-7.8%
10. My family got the help we wanted for my child.	72%	80%	86%	87.6%	79.2%	-8.4%
11. My family got as much help as we needed for my child.	68%	81%	81%	83.9%	80.4%	-3.5%
Cultural Sensitivity						
12. Staff treated me with respect.	96%	96%	99%	98.2%	100.0%	1.8%
13. Staff respected my family's religious/spiritual beliefs.	90%	89%	95%	92.9%	95.3%	2.4%
14. Staff spoke with me in a way that I understood.	93%	98%	98%	98.2%	100.0%	1.8%
15. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language).	93%	87%	94%	92.1%	95.0%	2.9%
Outcomes						
16. My child is better at handling daily life.	53%	60%	58%	67.5%	73.5%	5.9%
17. My child gets along better with family members.	60%	61%	66%	64.9%	69.4%	4.5%
18. My child gets along better with friends and other people.	59%	65%	65%	69.0%	73.5%	4.4%
19. My child is doing better in school and/or work.	48%	51%	57%	53.1%	66.7%	13.6%
20. My child is better able to cope when things go wrong.	52%	52%	53%	60.5%	46.9%	-13.6%
21. I am satisfied with our family life right now.	59%	69%	67%	64.9%	60.4%	-4.5%
22. My child is better able to do things he or she wants to do.	59%	61%	75%	75.4%	65.3%	-10.1%
Participation in Treatment						
2. I helped to choose my child's services.	87%	91%	92%	91.2%	91.5%	0.3%
3. I helped to choose the goals in my child's service plan.	91%	96%	95%	96.5%	93.9%	-2.6%
6. I participated in my child's treatment/services.	94%	93%	94%	92.1%	89.8%	-2.3%
Social Connectedness						
23. I know people who will listen and understand me when need to talk.	83%	92%	92%	93.9%	89.8%	-4.1%
24. I have people that I am comfortable talking with about child's problems.	91%	92%	92%	91.2%	93.9%	2.6%
25. In a crisis, I would have the support I need from family friends.	80%	92%	88%	86.8%	87.8%	0.9%
26. I have people with whom I can do enjoyable things.	80%	83%	90%	93.7%	95.9%	2.2%

Analysis: 50% of the questions scored higher for 2024 than 2023. “My child is better at handling daily life” had the biggest increase for 2024 (almost 6%). “My child is better able to cope when things go wrong” and “My child is better able to do things he or she wants to do” saw a 10% or more decrease for 2024 compared to 2023.

Action: For 2024, there were only 49 YSS surveys returned from 679 distributed which resulted in a 53% confidence level. Actions taken on results that are not statistically significant could change processes/procedures that could negatively impact consumers overall. Therefore, there is nothing specific to action with the results of the YSS for 2024. It should be noted that 20 YSS were returned several months after the deadline. Staff will continue to provide education and encouragement on the value of completing these surveys and BABH, when possible, will continue to offer the chance to win a gift card.

General Feedback from the Consumer Council:

- Change the gift card options to five, $10 gift cards.
- Hand deliver the surveys instead of mailing them.
- Include an option for consumers to complete the survey with staff if they need assistance.
- Reduce the number of questions.
- Email or send text reminders to complete the survey to those that have opted in.
- Have a contest for consumers to share their success stories. Determine how it could be shared; via the intranet, website, Facebook.
- Update the graphs on the report to be easier to read.
- Change the timeframe of when surveys are distributed to avoid summer vacations.
- Update the Recovery Training video link for staff so that the training is more meaningful.

Submitted by: Sarah Holsinger, LMSW, Quality Manager Date: 12/27/2024

MDHHS launches initiative to strengthen behavioral health care access, quality and choice for Michigan families

Online survey offered to identify opportunities and improvements to Medicaid behavioral health services prior to selecting Pre-Paid Inpatient Health Plans

LANSING, Mich. – The Michigan Department of Health and Human Services (MDHHS) is launching an initiative designed to improve access to quality behavioral health care. As part of this effort, MDHHS is seeking public input through an online survey as the department moves to a competitive procurement process for the state's Pre-Paid Inpatient Health Plan (PIHP) contracts.

This initiative will help to increase consumer choice and access to services while preserving the Community Mental Health Services Programs (CMHSPs) many Medicaid beneficiaries go to for behavioral health care services today.

"Michigan Medicaid beneficiaries deserve access to behavioral health care services when and where they need them," said Elizabeth Hertel, MDHHS director. "This effort brings together the investment, creativity and commitment of the department and its partners – including community mental health, health care providers, individuals served and communities – to create a more accessible and person-centered system of care dedicated to ensuring Michigan residents a healthier future."

Michigan's specialty behavioral health system provides health care coverage to approximately 300,000 Michiganders, including adults with serious mental illness, children with serious emotional disturbance, individuals with substance use disorder, and individuals with intellectual and developmental disabilities. MDHHS contracts with PIHPs as the regional Medicaid managed care entity. PIHPs are charged with providing adequate supports and services to those in need of the specialty behavioral health benefit and are key to achieving the department's mission to improve the health, safety and prosperity of residents. PIHPs manage provider networks including CMHSPs and behavioral health providers.

"The specialty behavioral health system needs to be more accountable and responsive to the needs of people served. It's time for a change," said Sherri Boyd, executive director, The Arc Michigan.

Through an online survey, MDHHS seeks input from people currently enrolled in Medicaid and their families, advocacy groups, community-based organizations, federally recognized tribal governments, providers of health care, behavioral health and other interested parties to identify opportunities for innovation and improvement in the services and supports provided through the PIHP system.

Survey questions seek feedback on priorities to help determine where the state should focus its efforts. Examples include strengthening person-centered care, conflict-free access and planning, increasing access to providers, beneficiary behavioral health plan choice, beneficiary provider choice, enhancing quality, strengthening outcomes and using data to drive quality.

Feedback received will help guide planning and decision-making in preparation for the implementation of new PIHP behavioral health plan contracts, as well as other MDHHS efforts to improve the health of residents served by the programs.

Survey responses must be submitted through the online survey no later than 5 p.m., Monday, March 31. The Arc Michigan, The Mental Health Association in Michigan and other advocacy organizations are working with MDHHS to include the voices of individuals served and their families who may not have internet access, have alternative communication needs or would prefer to work through an advocacy organization.

For more information, visit Michigan.gov/BehavioralHealth. Procurement-related questions can be sent to MDHHS-BHSurvey@michigan.gov.