BAY ARENAC

BEHAVIORAL HEALTH

COMMUNITY MENTAL HEALTH SERVICES PROGRAM

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2018

BOARD ADOPTION:
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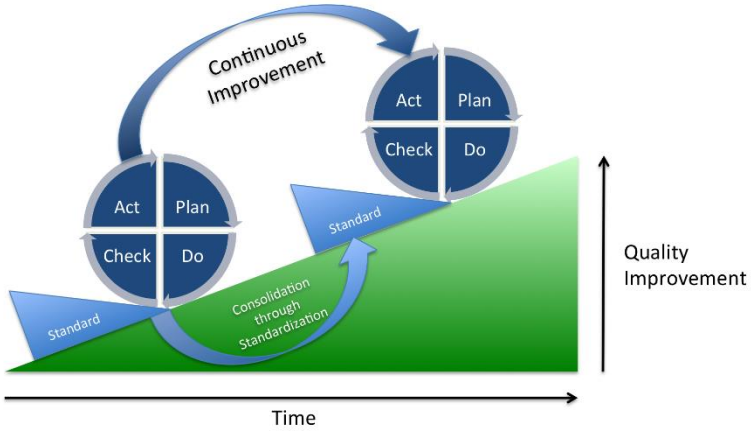
Section 1: Introduction

Bay-Arenac Behavioral Health (BABH) provides an array of behavioral health services and supports to individuals in the Michigan counties of Bay and Arenac through a network of direct operated programs and contracted service providers. BABH is a Michigan Department of Health and Human Services (MDHHS) certified Community Mental Health Services Program (CMHSP), a Children's Diagnostic and Treatment Service Program, and is licensed by MDHHS as a Substance Abuse Provider. BABH is also a CMHSP affiliate of the Mid-State Health Network (MSHN) Pre-Paid Inpatient Health Plan (PIHP) for Medicaid Specialty Services and Supports. In addition, BABH is accredited by the Council on Accreditation of Rehabilitation Facilities (CARF).

BABH is responsible for managing a local quality assessment and performance improvement program for its CMHSP provider operations, and ensuring its contracted network clinical service providers address quality improvement in their own operations through the BABH Quality Assessment and Performance Improvement Program (QAPIP). BABH's overall philosophy and mission governing its local quality management and performance improvement program can be summarized as follows: performance improvement is dynamic, system-wide and integrated; the input of a wide range of stakeholders, such as board members, consumers, providers, employees, community agencies, and other external entities, such as MDHHS, are critical to success; it is important and encouraged to have an organizational culture where staff are comfortable reporting errors, system failures, and possible solutions, and leaders see information as the means to improvement; improvements resulting from performance improvement must be communicated throughout the organization and sustained; and leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data. Continuous improvement is supported by the plan, do, check, act/adjust cycle (PDCA) drawn from the work of Deming and used in the application of lean methodology. Standard work statements are developed and utilized to implement and maintain improvements and are updated as the PDCA cycle is repeated to produce continuous improvement over time. The graphical representation of the continuous improvement methodology is below (http://en.wikipedia.org/wiki/File:PDCA_Process.png).



The BABH QAPIP "objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis" for "all demographic groups, care settings, and types of services" (MDHHS/CMHSP FY18

Contract, Attachment C 6.8.1.1, p. 2, 1). The program "achieves, through ongoing measurement and intervention, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction" (p. 1). This program "define[s] the system to collect data, set the organization's business and service delivery performance goals, and measure indicators for the purpose of review and analysis of results" (CARF, 2017 Standard 1.M.1, p. 93). The QAPIP provides a "written description of [the] performance measurement and management system that includes, at a minimum: a) Mission; b) Programs/services seeking accreditation; c) Objectives of the programs/services seeking accreditation; and d) Personnel responsibilities related to performance measurement and management (CARF, 2017 Standard 1.M.1, p. 93). The QAPIP, as described in this document, is evaluated annually for effectiveness and modifications are made as necessary.

The QAPIP applies to all BABH programs and services, including: Assertive Community Treatment (mental health – adults); Case Management/Supports Coordination (integrated DD/mental health – adults, children, and adolescents); Community Integration (psychosocial rehabilitation – adults); Crisis Intervention (integrated DD/mental health – children and adolescents, mental health – adults); Intensive Family-Based Services (family services – children and adolescents); and Outpatient Treatment (integrated DD/mental health – children and adolescents, mental health – adults). The objectives of these programs are reflected in the organization's mission statement, "to improve health outcomes to enhance quality of life and strengthen the community safety net for citizens of Arenac and Bay counties". In addition, "All who are associated with carrying out the mission of Bay-Arenac Behavioral Health are governed by the highest ethical standards and the following values: each person is unique, and will be treated with dignity and respect; we are committed to delivering services in a manner that is responsive to community needs, we seek to provide a recovery-focused and trauma-informed system of care; we believe that individual and community wellness is enhanced by the delivery of integrated healthcare services that are directed by and responsive to the person served; we are committed to promoting independence, choice control and meaningful engagement with peers, family friends, and community, we are committed to collaboration with our community partners to encourage wellness, to promote prevention, and to increase health literacy (www.babha.org/OurMissionStatement.aspx). A representative group of leadership and clinical staff participate in the Primary Network Operations and Quality Management Committee (PNOQMC), which includes the Performance Improvement staff. The PNOQMC is the entity responsible for initiating and monitoring performance improvement activities. In addition, staff have been designated responsible for performance measurement and management within their programs, which may include coordination and follow up with the PIC and/or the Quality Manager or designee.

Section 2: Organizational Elements and Activities

Organizational elements and activities and their relation to the QAPIP, and performance improvement activities in general, are detailed below.

<u>Governance</u>
The BABH Board of Directors: monitors, evaluates, sets policies related to performance improvement and approves the QAPIP Plan, including QAPIP priorities; receives an annual report on the effectiveness of the previous year's QAPIP and sets priorities for performance improvement initiatives for the next year; oversees the performance of the QAPIP through review of the Provider Network Operations and Quality Management Committee meeting notes (previously the Performance Improvement Committee), as well as a mid-year QAPIP performance report; monitors key organizational quality, safety, and

financial indicators through the review of a dashboard report; and advises the Chief Executive Officer to take action when appropriate and provides feedback regarding modifications and revisions to the QAPIP.

Chief Executive Officer

The BABH Chief Executive Officer: links the strategic planning and operational functions of the organization with the QAPIP functions; assures coordination occurs among organizational leaders to maintain quality and consumer safety; allocates adequate resources for the QAPIP; designates the Director of Healthcare Accountability as senior management team member responsible for the BABH QAPIP. The BABH Quality Manager is the person responsible for the daily management of the QAPIP which includes the implementation, monitoring, and revision of the QAPIP. Through performance measures, the progress of the organization is routinely evaluated and reports are made to the Board.

Medical Director

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

Leadership

The BABH Senior Leadership Team, in coordination with the BABH Leadership: develops and monitors staff competencies; collaborates on new processes, services and programs; identifies priorities for improvement based on stakeholder input, data review, the identification of vulnerable service populations and opportunities for improving oversight of their care and outcomes, best practices for service delivery, etc.; oversees the development of and data collection for performance measures or quality indicators for operational areas; utilizes data effectively for informed decision making; participates on and/or supports staff participation in committees and work groups; fosters a work environment where safety and error reporting is encouraged, and a systems perspective is utilized to resolve problems; addresses under performance through corrective action planning and seeking to replicate potential best practices; and establish priorities in their program areas for risk reduction for consumers.[2]

BABH Staff

Review the organization's QAPIP and expectations for their participation at employee orientation; participate in data collection activities related to performance measures and indicators at the department/program level; identify department/program and organization-wide opportunities for improvement; participate in organization-wide standing committees and work groups; report care errors, inform consumers of risks, and make suggestions to improve the safety of consumers; and provide input into QAPIP priorities through the BABH Employee Survey and Suggestion Box.

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

Quality Improvement Staff

Coordinate, initiate, guide, and collaborate on local performance improvement projects; sit on the BABH Primary Network Operations and Quality Management Committee and represent performance improvement on other agency council/committees; participate in regional performance measurement activities such as consumer satisfaction surveys and clinical record reviews for performance improvement projects and Medicaid event verification; and are members on regional committees and work groups.

Contract and Medical Providers

The BABH CMHSP sponsors regular meetings with key contracted service providers to discuss system issues and process changes. Site reviews of residential, outpatient and other providers produce information that flows into the Quality Management program through work groups and process improvement initiatives. Collaborative meetings are held with treating physicians at BABH clinical programs and contract sites to discuss medical practices.

Provider Qualification and Selection

Policies and procedures are in place to govern the selection and evaluation of directly employed staff and contract providers, including physicians and other health care professionals licensed by the state, to ensure they are qualified to perform services and have current, appropriate credentials and privileges.[3,4] Data reflective of the performance of practitioners is considered when privileges and credentials are renewed; this occurs via the Healthcare Practices Committee formerly the Medical Management and Peer Review Committee through Curriculum Vitae Organization (CVO) review. Additional policies and procedures exist to verify the qualifications of non-licensed care and support providers as well as the aforementioned licensed staff.[5] The policies and procedures referenced above also insure that staff possess appropriate qualifications per their job description as well as appropriate: educational background; relevant work experience; certification, registration, and licensure; and cultural competence.[6,7] Orientation and training in regard to responsibilities, program policy, and operating procedures are required for new employees.[8,9,10,11] Staff performance and competency are monitored on a regular basis.[12,13] Training needs are identified through formal means, such as performance/ competency reviews, as well as informally, through self-identified areas for improvement. It is BABH's policy to support employee educational pursuits and does so through in-service training, continuing education, and staff development activities.[14,15]

Recipient Rights

BABH is committed to treating members in a manner that acknowledges their rights and responsibilities. It is the policy of BABH to monitor and ensure that a recipient of mental health services has all of the

[3] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T01 Staff Credentials.
[4] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T13 Credentialing and Privileging of Licensed Independent Practitioners.
[5] Bay-Arenac Behavioral Health Employee Handbook
[6] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T05 Cultural Competence and Limited English Proficiency.
[7] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Cultural Competency and Diversity Plan.
[8] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T02 Orientation.
[9] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T01 Minimum Training Requirements.
[10] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Training Plan.
[11] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Operating Philosophy and Ethical Guidelines.
[12] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T05 Performance Management.
[13] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T02 Professional Staff Competency.
[14] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S02-T26 Continuing Education.
[15] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T03 Scheduling, Promoting, and Documentation of Staff Education.

rights guaranteed by state and federal law, in addition to those guaranteed by P.A. 258, 1974, Chapter 7 and 7A, which provide a system for determining whether, in fact, violations have occurred; and shall ensure that firm and fair disciplinary and appropriate remedial action is taken in the event of a violation. Procedures have been established to address the complaints, appeals, and mediation processes through the BABH Recipient Rights Office.[16] Appropriate remedial actions are taken in response to substantiated recipient rights complaints. The CEO ensures that BABH has written policies and procedures for the operations of the rights system on file with the Michigan Department of Health and Human Services (MDHHS) – Office of Recipient Rights. Education and training in Recipient Rights policies and procedures are provided to its Recipient Rights Advisory Committee and its Appeals Committee. MDHHS routinely conducts site reviews. Annual reports from the BABH Recipient Rights Office are submitted to MDHHS as required by Chapter 7 of the Michigan Mental Health Code.

Adverse Event Management

BABH has a reporting and investigating system in place to capture the occurrence of all adverse events which include critical events (including death), risk events, unusual events, near misses, and sentinel events that involve harm or injury or the risk of harm or injury are reported to the Office of Recipients Rights (ORR).[17] Processes are also in place for reporting on significant events, which includes: investigations; material litigation; catastrophes; sentinel events; and governmental sanctions, bans on admissions, fines, penalties, or loss of programs (CARF, 2017 Behavioral Health Standards Manual 1.H.9 p. 68). These processes address the review and follow up of sentinel, unusual, and critical events for all persons receiving services from BABH, including, but not limited to, those enrolled in the Children's Waiver, the Children with Serious Emotional Disturbance Waiver, the MI Child program, the Adult Benefit Waiver, and the Habilitation Supports Waiver. Data is gathered and reviewed by appropriately credentialed staff for causal analysis. As necessary, root cause analysis is completed and risk reduction strategies are recommended to reduce the likelihood of recurrence. As appropriate, BABH utilizes failure mode and effects analysis for review of potentially high risk or error prone processes. BABH submits event reports to the PIHP/MDHHS and CARF in accordance with each entity's reporting criteria and timelines.

Confidentiality and Conflict of Interest

All BABH staff are bound by federal, state, and the Michigan Department of Health and Human Services confidentiality regulations. To protect consumer confidentiality, consumer case numbers, not names, are used on forms, summary notes, or reports. To prevent a conflict of interest, individual members of a review committee do not solely review records in which s/he was a provider of care. At a committee chairperson's discretion, a member may be relieved from performing review activities on a temporary basis during the study of a member's case records.

Utilization Management

BABH's utilization management plan is detailed in several sections of the Policies and Procedures Manual.[18,1920,21,22] The utilization plan components address, "practices related to retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, and

[16] Bay-Arenac Behavioral Health Policies and Procedures Manual, C03-S01-T01 Statutory Establishment.
[17] Bay-Arenac Behavioral Health Policies and Procedures Manual, C02-S01-T06 Reporting and Investigation of Adverse Events.
[18] Bay-Arenac Behavioral Health Policies and Procedures Manual, C11-S08-T01 Utilization Management Plan.
[19] Bay-Arenac Behavioral Health Policies and Procedures Manual, C04-S04 Eligibility for Services.
[20] Bay-Arenac Behavioral Health Policies and Procedures Manual, C11-S08-T02 Clinical Criteria.
[21] Bay-Arenac Behavioral Health Policies and Procedures Manual, C04-S04-T43 Coordination of Care.
[22] Bay-Arenac Behavioral Health Policies and Procedures Manual, C04-S04-T36 Authorization Process.

other aspects of utilization management as deemed appropriate by administration." Additional information on the procedures to evaluate medical necessity, criteria used, information sources, and the process used to approve the provision of medical services is also found in the Policies and Procedures Manual. Specifically, the Policies and Procedures Manual includes mechanisms to identify and correct underutilization and overutilization, establishes prospective, concurrent, and retrospective access procedures, such that: 1) review decisions are supervised by qualified medical professionals; 2) efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate; 3) reasons for decisions are clearly documented and available to the member; 4) there are well-publicized and readily available appeals mechanisms for both providers and consumers; notification of a denial includes a description of how to file an appeal; decisions and appeals are made in a timely manner as required by the exigencies of the situation; and there are mechanisms to evaluate the effects of the program using data on member satisfactions, provider satisfaction, or other appropriate measures.[23,24]

Medicaid Service Verification

BABH has an established process to complete Medicaid service event verifications and follow-up restitution, as necessary.[25] The event verification process checks reimbursed Medicaid claims against chart documentation to verify: 1) if the service provided is an approved Medicaid or Health Michigan Plan code in the contract(including modifiers used following the HCPCS guidelines), 2) if the service is authorized within the consumer's person centered plan, 3) if the units claimed equal the units documented, and 4) if the individual has Medicaid at the time the service was provided, 5) if the services were provided by qualified individuals and falls within the scope of the code billed and paid, 6) if the amount billed/paid does not exceed the contract amount, 6) if this review will result in corrective action. Medicaid Event Verification projects are aggregated, analyzed, and reported to the Corporate Compliance Committee for monitoring and action.

Clinical Care Standards, Practice Guidelines, and Evidenced Based Practices

BABH looks to evidence based practices and clinical protocols for quality tested clinical pathways and has adopted the technical guidelines and evidence based practices mandated by MDHHS. Objectives include: maintaining the clinical care standards and guidelines through the oversight of initial implementation and ongoing use of evidence based practices across the CMHSP; promoting and overseeing the implementation of promising and emerging practices that strengthen clinical services and supports while also ensuring superior consumer outcomes; monitoring fidelity to proscribed models; and measurement of clinical and program outcomes.

Section 3: Quality Management Committee

The Quality Management Committee (QMC) is the structure responsible for the QAPIP and performance improvement activities of BABH's operations. The required membership is comprised of: BABH Quality Improvement (QI) and Administrative Services staff; BABH Senior Leadership Team members; clinical supervisors and team members; QI representatives from contract provider agencies; and ad hoc members including subject matter specialist from each department within the organization (Attachment 5).

[23] Bay-Arenac Behavioral Health Policies and Procedures Manual, C11-S08-T04 Provider Appeals of UM Decisions.
[24] Bay-Arenac Behavioral Health Policies and Procedures Manual, C03-S03-T12 Grievance and Appeal.
[25] Bay-Arenac Behavioral Health Policies and Procedures Manual, C13-S02-T20 Service Event Verification and Restitution.

The QMC is responsible for monitoring performance by:

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

The QMC is also responsible for identifying priorities for QI activities and addressing them by convening and overseeing cross-functional committees and work groups related to both the planning of new processes and improvement initiatives and receiving reports and taking action related to recommendations from such work groups. Action may include accepting recommendations, providing feedback to the committee or work group, seeking additional input with respect to implementation, or forwarding for approval. Records of the QMC's activities, findings, recommendations, and actions are documented in meeting minutes. These minutes, as well as the associated meeting materials are available on the BABH intranet site.

Quality Management Committee Standing Committees

Each BABH committee, including those affiliated with the QMC, has a chair and recorder; the chair is selected by the membership of the committee, unless appointed by the BABH CEO or designee. The chair or designee is also a member of the QMC. Each committee meets on an ongoing basis, with the exception of ad hoc committees. Standing committees and consumer councils report to the QMC on a routine basis and can request items be placed on the agenda as needed. Standing committees generally meet regularly, but may have some functions that are performed on an ad hoc basis. Each standing committee is responsible for reviewing assigned reports to ensure performance meets the standards as defined by the QMC and the appropriate population committee. On occasion, a standing committee may oversee a subcommittee or work group.

Population Committees

The BABH QAPIP program has three clinical population adhoc committees that report to the Quality Management Committee (QMC). The committees include: the Recovery Committee for Adults with Mental Health/Substance Use Issues, the Quality of Life Committee for Persons with Developmental Challenges, and the Child and Family Committee. Each committee utilizes the consumer councils to provide input into the design, implementation, and quality of service and supports provided by BABH, and also engages in advocacy and educational activities.

Consumer Councils

BABH sponsors two clinical consumer councils that report to the Quality Management Committee and provide input directly to BABH regarding program operations and performance through the population committees. In addition, BABH representatives participate in meetings as representatives from the

CMHSPs in the PIHP region who provide input regarding quality initiatives and service delivery related issues.

The consumer councils are responsible for supporting organizational efforts to ease service access, develop effective and efficient service provision, ensure active consumer participation, person centered planning, self-determination, self-advocacy, independent facilitation, community integration, anti-stigma activities, achievement of recovery, positive clinical outcomes and consumer satisfaction.

There are other standing BABH committees that are directly or indirectly part of the organization's quality management program but do not directly report to the QMC. These committees include the: Behavior Treatment Committee; Healthcare Practices Committee; Safety Committee;[26] and Corporate Compliance Committee.[27]

Behavioral Treatment Plan Review Committee

The Behavior Treatment Plan Review Committee,[28] whose primary function is to oversee the proposed use of any intrusive and restrictive techniques that might be considered for usage as a last resort with recipients of public mental health services, is responsible for review of behavior treatment data.[29] This includes data on approved intrusive or restrictive techniques, the number of interventions and length of time interventions were used per person, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. A quarterly analysis is performed to identify any trends or patterns of behavior that may demonstrate a risk to an individual or group. Recommendations are made to reduce the likelihood of any adverse event.

Healthcare Practices Committee

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

Safety Committee

The committee oversees the development and compliance level of the Environment of Care policies and procedures and emergency response plans to ensure that the environment in which we work is maintained adequately and that protections from potential hazards are in place. In addition, the committee monitors state and federal regulatory standards and accreditation standards to ensure that the agency meets the minimum requirements of applicable rules and regulations.

The committee also reviews and monitors performance on various safety related components of the environment. They include: Environmental concerns related to employee and consumer infections; Environmental concerns related to consumer incident reports; Completion of Environment of Care training; Employee Accidents, Incidents and Illnesses reported; Safety and Facility inspections (BABH

[26] Bay-Arenac Behavioral Health Policies and Procedures Manual, C05-S04-T02 Emergency Preparedness.
[27] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Corporate Compliance Plan.
[28] Bay-Arenac Behavioral Health Policies and Procedures Manual, C04-S26-T02 Behavior Treatment Plan Review Committee.
[29] Bay-Arenac Behavioral Health Policies and Procedures Manual, C04-S26-T02 Behavior Treatment Plans.

sites and group homes); Group Home evacuation difficulty scores; Emergency drills (fire, tornado, bomb). When trends or patterns in this data are recognized, the committee is responsible for making recommendations to management to resolve safety issues. The priority is to ensure a safe environment for all staff and customers of BABH.

Corporate Compliance Committee

It is the policy of the BABH Board of Directors to have a Corporate Compliance (CC) Plan in effect, as stated in BABH policy and procedure C13-S02-T18 Corporate Compliance Plan. The CC Plan is in place to guard against fraud and abuse, and to ensure that appropriate ethical and legal business standards and practices are maintained and enforced throughout BABHA[30].

Furthermore, the BABH Corporate Compliance Plan ensures the integrity of the system in which BABH operates and the culture in which it is served is maintained at the highest standards of excellence, with a focus on business and professional standards of conduct compliant with federal, state and local laws, including confidentiality, compliance with reporting obligations to the federal and state government, and promotion of good corporate citizenship, prevention and early detection of misconduct.[31]

Committee Statement of Purpose

Functions and duties specific to BABH Committees are described in a Statement of Purpose and Membership. The following are standard responsibilities of each committee:

1. Policy, procedure and plan review
    a. On a bi-annual basis, or sooner if required, each committee reviews the BABH policies, procedures and plans related to their functions and duties, as assigned.
    b. Strategic Initiatives assigned to each committee are reviewed and feedback provided. The committee obtains feedback from the leadership of departments that will be affected as appropriate.
    c. Policies, procedures and plans approved by each committee are recommended to the BABH Chief Executive Officer and/or Board for approval.

2. Fidelity with external requirements
    a. Each committee monitors state and federal rule promulgation for changes in requirements relevant to their functions and duties, if any. Recommendation for changes to BABH practices are made as indicated.
    b. Each committee also monitors accrediting body publications and/or receives communications from the BABH Quality Department regarding changes in standards related to their functions and duties. Committees assist with the education of staff regarding changes in requirements and implement action plans and/or make recommendations as necessary to bring the organization into compliance.

3. Measurement
    a. Each committee establishes measures to collect data related to its functions and duties supporting the organizations Strategic Plan, including any subcommittees assigned, as relevant. Data is collected using standardized methods and defensible sampling techniques, in accord with the BABH QI program requirements.

[30] Managed Care Rules: 438.608 (a) Program Integrity Requirements
[31] CARF Standards: Section 1 Aspire to Excellence: E Legal Requirements: Standard 1

b. Each committee tracks and trends the data for which it is responsible for purposes of data analysis. Where feasible and appropriate, desired performance thresholds are determined and reliable external benchmarks/comparables are utilized when available.
c. The committees take action and/or make recommendations for action, as appropriate, to address undesired levels of performance and/or excessive variability.

4. Reporting
   a. Subcommittees report to their assigned standing committee. The standing committee incorporates the subcommittee's activities and data into its own reports.
   b. Standing committees report to their overseeing committee or council, or to the Senior Leadership Team as directed.
   c. Meeting agendas and notes are recorded.

Work Groups

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

BABH staff are invited to participate in local work groups by their supervisor or Quality staff. Proposals for formation of work groups include suggestions for work group representation. Work group membership typically includes disciplines appropriate to the subject matter at hand.

Work group meetings are facilitated by BABH Quality staff as necessary. During the first work group meeting the charge of the group is clarified through discussion, general meeting ground rules are reviewed, documentation and reporting expectations are discussed, and a chair and recorder are chosen from the participating qualified staff.

Consumers and Other Stakeholders

BABH's commitment to customer satisfaction and quality improvement is evaluated through quantitative and qualitative information obtained from a wide variety of stakeholders including consumers and/or their families, staff, and community members. Feedback on satisfaction and opportunities for improvement is provided through:

Consumer Satisfaction Survey

Consumers receiving services are surveyed by the PIHP or CMHSP annually, with the assistance of BABH CMHSP staff, using standardized survey tools measuring issues of quality, availability, and accessibility of care. Summary analyses are completed, regional benchmarks are used for comparison, and findings are presented in report form for distribution to practitioners, providers, service recipients and consumer councils, and the governing body. Survey results guide: specific action on individual cases as appropriate, identification and investigation of sources of dissatisfaction, and systematic action steps to follow up on findings. The effects of post-survey actions are evaluated for effectiveness, and maintenance or change of procedures are made as necessary. Consumers are also queried regarding their degree of satisfaction during periodic reviews and discharge planning for the cessation or transition of services. A post-service survey is sent to discharged consumers to evaluate their satisfaction with services and supports received. Information on consumer perception of care quality and individual outcomes is also gathered during dialogues between consumers and service

providers. BABH, in conjunction with MDHHS, is also participating in the National Core Indicators survey for individuals receiving services for developmental challenges.

Employee Survey
Employees of BABH have a regular opportunity to provide input into the following areas: clinical Service delivery and community need, as well as to provide feedback regarding organization wide support systems such as performance improvement, health and safety, community education, staff development and training, information systems, and managed care through the employee survey.

Suggestion Box Program
Staff, consumers, and other stakeholder of BABH may offer suggestions for process or program improvements at any time using readily available suggestion boxes at each site.[32] Suggestions are also received via email, US Mail, and verbally. Suggestions received go directly to BABH Leadership for response; responses are shared with relevant stakeholders.

MDHHS Annual Submission and Community Needs Assessment
BABH participates in the MDHHS Annual Submission and Community Needs Assessment. The Community needs assessment incorporates Community Data and a community survey that is completed every other year to utilizing the input of key areas that include the justice system, education, primary health, Michigan Department of Human Services, the private mental health and substance abuse providers and organizations, public health, and consumer and advocates. The input is then prioritized and incorporated into the strategies of the BABH Strategic Plan. The Annual Submission requirements are a MDHHS/CMHSP Contract requirement and can be found in Section 7.8 and Attachment 7.8.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract.

Section 4: Performance Measurement

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

Identification of Quality Concerns and Opportunities for Improvement
Quality improvement opportunities are brought to the attention of quality team in a variety of ways. Routine data collection, such as: service encounter information; activity/caseload reports; chart reviews, including Medicaid event verification and PI projects; MDHHS clinical process related indicators, including quality improvement, performance, and demographic data; and the MDHHS annual local needs assessment may illustrate areas for improvement. Regional, and where available, statewide, performance comparisons are also made to better gauge local performance. Stakeholders, including consumers, staff, committees and community agencies may also suggest improvement opportunities. Incident reporting of safety and risk events, complaints, appeals and grievances, safety drills and inspections, clinical record reviews, utilization review activities, special studies or projects, and other information, such as financial and human resources reports may also provide insight into opportunities for improvement. Routine performance of environmental scans and assessments of organizational strengths, weaknesses, opportunities and threats as a component of leadership strategic planning

[32] Bay-Arenac Behavioral Health Policies and Procedures Manual, C02-S01-T03 Consumer/Stakeholder Suggestion Box Process.

activities are also used to bring about positive change. Root cause analyses of systems in response to the occurrence of critical clinical and administrative incidents also provide information on improvement opportunities. The evaluation of risk points in new systems using tools such as failure mode and effects analysis to review system weaknesses prior to implementation is also used as a means to ensure effective implementation and outcomes.

Establishing Measures

Measures are chosen based upon their relevancy to stakeholders due to the prevalence of a condition, the need for a service, demographics, health risks, the interests of stakeholders as determined through qualitative and quantitative assessment, or other aspects of care and service as identified by BABH and/or MDHHS. Measures may be clinical or non-clinical. Indicators are objective, measurable, actionable, based on current knowledge and clinical experience, are likely to yield credible and reliable data over time, are selected consistent with established BABH QAPIP priorities as stated earlier in this plan, and are developed using a standardized "Description of Project/Study/Data Specifications (Attachment 1). Measures in use by BABH include: treatment effectiveness and outcome, functional ability, fidelity, process, prevalence and incidence rates, quality of life indicators, and satisfaction.

BABH participates in at least two PIHP PI projects per year and a regional program to verify the delivery of services billed to Medicaid. The PI projects and Medicaid service event verification are completed on a regional basis. PI project topics are either mandated by MDHHS or selected by the PIHP and its partner CMHSPs. Data collected through the PI projects are aggregated, analyzed, and reported by BABH Quality Improvement staff for review at regional Quality Council and local Quality Management Committee meetings and opportunities for improvements are identified.

Data Collection

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

Data Analysis and Reporting

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

Data is aggregated at a frequency appropriate to the process or activity being studied. Data aggregation timeframes and methods are defined in project descriptions. Statistical testing and analysis is then used as appropriate to analyze and display the aggregated data. BABH data is analyzed over time to identify patterns and trends and compared to desired performance levels, including externally derived benchmarks when available. QI staff utilize a dashboard or a Summary Report (Attachment 2) for data

results including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.
Undesirable patterns, trends, and variations in performance are identified. In some instances, further data collection and analysis is necessary to isolate the causes of poor performance or excessive variability and remedial/corrective actions may be required. The department responsible for a pattern of desirable performance may also be asked to document their strategy for maintaining positive performance.

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

Corrective Actions
Remedial and/or corrective actions are taken when benchmarks are not met as determined by performance measurement. We utilize a corrective action process that outlines how quantitative measures are evaluated by reporting period and historical performance. Patterns and variations are considered in context, and corrective action response requirements are outlined in the process document. Corrective action interventions, implementation dates, and expected impact dates are documented on the Follow-up to Data Analysis (Attachment 3) form. Actions taken are implemented systematically to insure any improvements achieved are associated with the corrective action. Corrective actions are monitored and evaluated to assure that appropriate changes have been implemented and maintained. Adhering to the following steps promotes process integrity: develop a step-by-step action plan; limit the number of variables impacted; implement the action plan, preferably on a small or pilot scale initially; collect data to check for expected results; and modify the plan as necessary based on post-implementation findings. Specifics on the review and response process are available by request from the Performance Improvement Specialist.

Communicating Process and Outcome Improvements
The results of BABH provider operations performance measurement and improvement activities are communicated through the periodic dissemination of materials to employees, providers, and stakeholders via the BABH Website, the BABH Board of Directors, the Senior Leadership Team, the Leadership Team, the Consumer Councils, the Primary Network Operations and Quality Management Committee, the population committees, staff meetings as well as the general distribution of applicable information through the leadership dashboard, BABH intranet, and other outlets as deemed appropriate.

Section 5: Review/Evaluation of Plan Effectiveness (the majority of this section will be on the actual report as indicated below)

BABH has led and been involved in many performance improvement activities during FY17. The QAPIP Semi-Annual and Annual Report provide the data used to make the determination of the effectiveness of the QAPIP. Given the nature and scope of the accomplishments, the 2017 QAPIP plan has been determined to be effective and any updates, revisions, and new projects have been added to the 2018 plan as necessary to continue the pursuit of exceptional performance. During FY2018 continued evaluation of the QAPIP will take place. Continued evaluation will occur to develop, define, collect, and validate data within current systems; and to communicate/collaborate with primary providers such areas that need improvement.

Section 6: QAPIP Priorities for 2018

BABH celebrates its successes in continuous quality improvement to better meet the needs of providers and consumers alike. BABH will aspire to continue in maintaining these successes in 2018 as well as identifying new areas for improvement. The following initiatives have been recognized as priorities for 2018.

1. Performance Improvement Opportunities
   a) Medicaid Event Verification
   b) MDHHS Required Topic Performance Improvement Project TBD (MSHN)
   c) Required Choice Performance Improvement Project TBD (MSHN)
   d) Quality Reporting/Completeness-Record Reviews
      - Copy of PCP within 15 Days
      - Offering Crisis Plan
      - Evidence of Primary Care Physician/Consent
      - Developmentally Disabled Proxy Assessment
      - Quality of Care Record Reviews
   e) MDHHS data reporting: Michigan Mission Based Performance Indicator System (MMBPIS) (Access)
   f) Behavioral TEDS Reporting
   g) Other performance improvement opportunities as applicable

2. Stakeholder Satisfaction Improvement Opportunities
   a) Annual consumer satisfaction and post-service satisfaction surveys
   b) National Core Indicators Survey
   c) Provider Survey
   d) Behavior Treatment Effectiveness
   e) Consumer Councils
   f) Other stakeholder feedback as provided/requested via surveys, suggestion boxes, etc.

3. Behavioral and Primary Healthcare improvement opportunities, continued development and outcome measurement of
   a) Jail/Juvenile diversion
   b) Services for children with autism - Autism Clinic (VBMAP, ADOS)
   c) Supports Intensity Scale (SIS)
   d) Evidenced Based and Best Practices in Clinical Service Delivery - Trauma Informed Services (TF-CAFAS) (Co-Occurring Services) (Person Centered Planning)
   e) Sore-Hi
   f) CAFAS/PECFAS
   g) DECA
   h) Adverse event reporting and investigation (sentinel, critical, risk, near miss)
   i) Healthcare Integration
   j) Infection control in residential facilities
   k) Co-occurring Treatment

4. Agency-Level Improvement Opportunities
   a) Leadership dashboard measures related to the QAPIP through Strategic Plan development (Identified needs based on the MDHHS Annual Submission incorporated into the Strategic Plan)

b) Quality Reporting – Providing technical support and assistance for data collection and analysis from the EHR and identifying opportunities for verifying and improving data integrity.
c) Access to Data - Data Model
d) Continued development of the utilization management program
e) Organizational Trauma Assessment (Every three years)
f) External Review Improvement Plans (CARF, MSHN, MDHHS)

Attachment 1

Quality Assessment and Performance Improvement Program

DATA SPECIFICATIONS

REQUESTOR PROJECT NAME

BI STAFF COMPLETING THIS FORM DATE

PROJECT SUMMARY/QUESTION BEING ANSWERED

OPTIONAL OR REQUIRED? IF REQUIRED, BY WHOM?

PRIMARY DATA SOURCES

What data sources (including Zenith ICDP, PCE standard reports, and BABH routine reports or data cubes) have you been using to try and answer this question before now?

INDICATORS WHICH ANSWER THE QUESTION

1.

REQUIRED OR EXPECTED PERFORMANCE LEVEL

IDENTIFY VALIDATION METHODS TO BE USED (FACE VALIDITY CHECKS, PRIMARY SOURCE VERIFICATION, KNOWN LOGIC ERRORS)

STATISTICAL ANALYSIS/TESTING METHODS DESIRED, IF ANY

Frequency of data pull: ☐ annual ☐ biannual ☐ quarterly ☐ monthly ☐ other
Other statistical analysis requested

STUDY POPULATION/DATA PARAMETERS

Identify the desired data dimensions and inclusion/exclusions on the attached spreadsheet.
Describe any other requests/considerations below.

Dimension	Field Name	All fields and data will be included unless otherwise specified here	Check any fields to be shown in data model or report	Data source defaults to Phoenix unless otherwise specified here
Age at Service Date	Adult or Child			
Age at Service Date	Age			
Age at Service Date	Age Grouping - Census			
Age at Service Date	Age Groupings			
Consumer	Consumer Status (Closed, Not Yet Open, Open, Deleted)			
Consumer	County Name By Zip Code			
Consumer	Address Plus Zip			
Consumer	Zip Code			
Consumer	Disability Designations (SPMI, SED, IDD, MI/IDD)			
Consumer	Substance Use Problem (from BH-TEDS field)			
	Diagnosis Source (Claims or Phoenix Diagnostic Module)			
	Diagnosis Code (DSM/ICD)	[see worksheet below if more space needed]		
	Service Eligibility Status			
Consumer	Primary Program			
Consumer	Primary Site			
Consumer	Primary Staff			
Consumer	Primary Type (Contract, Direct Operated, Unassigned)			
Consumer	Integrated SUD & MH Treatment			
Consumer	Education Level			
Consumer	Employment Status			
Consumer	Gender			
Consumer	Race/Hispanic			
Consumer	Corrections Related Status			
Consumer	Living Arrangements			
Consumer	School Attendance Status			
Consumer	Case Number			
Consumer	Consumer Name			
Fund Source	Autism Waiver (Medicaid, MIChild)			
Fund Source	General Fund			
Fund Source	Medicaid (EPSDT, B3, H SW, State Plan)			
Fund Source	Medicaid Fee for Service (Child Waiver, SED Waiver)			
Fund Source	Medicaid Healthy Michigan Plan			
Fund Source	Other State (ABW, MIChild)			

Dimension	Field Name	All fields and data will be included unless otherwise specified here	Check any fields to be shown in data model or report	Data source defaults to Phoenix unless otherwise specified here
Fund Source	Medicare			
Fund Source	Other Insurance			
Fund Source	Fund Source Not Specified			
Provider	Address			
Provider	Org Type (Contracted, Direct or Hospital)			
Provider	Primary Office Site			
Provider	Provider Name			
(Zenith)	Provider Classification			
(Zenith)	Provider Type			
Staff	Primary Program			
Staff	Staff Name			
Staff	Staff Status (Active or Inactive)			
Staff	Supervisor Name			
Record Source	Record Source (Claims, SALS or Unknown)			
Service Category	Procedure Code Type (CPT or Revenue Code)			
Service Category	Procedure Type (code groups)			
Service Category	Procedure Code (specific codes)	[see worksheet below if more space needed]		
CPT Mod1	CPT Modifiers	(see worksheet below if more space needed]		
Encounter Status	Encounter Status (Sent, Not Sent, Unreportable)			
Client Attendance	Client Attendance (cons cancelled, cons present, staff cancelled, no show)			
Place of Contact	Place Of Contact			
Place of Contact	Unit of Time			
Document	Document Name			
	Medication Name			
	Medication Therapeutic Class			
	Other (specify):			

Detail of Diagnostic or Procedure Codes to Be Included (if necessary):

Service Or Diagnosis Name	Code(s)	Modifiers/Specifiers

Attachment 2

Quality Assessment and Performance Improvement Program

Summary Report

Title of Measure:

Committee/Department: Performance Improvement/Business Intelligence (BI)

Reporting Period (month/year):

Data Analysis:

Data Interpretation:

Baseline Data

Current Data

Causal Factors and Barriers

Interventions/Improvement Strategies

Accomplishments (best practices) - Adaptations if applicable

Conclusions

Attachment 3

Quality Assessment and Performance Improvement Program

Follow-Up to Data Analysis

Title of Measure:

Reporting Period (month/year):

Purpose of Follow-Up:

List causes of variation (if unable to identify causal factors, indicate "unknown")

Common cause variations are system related and require long-term system wide improvements to resolve; there are many small reasons for the variations and they occur relatively constantly. Sources of common cause variation are manpower, material, method, measurement, machine and environment. Per Deming, 97% of variation is common cause.

Special or assignable cause variations result from an identifiable cause which can be addressed; they often appear as individual data points that vary greatly from the rest; if the result is a desired variation in performance, the cause should be replicated; if undesired, then identified and eliminated.

Causal Factors	Common Cause (Y/N/NA)	Special or Assignable Cause (Y/N/NA)
1. 2. 3.		

List interventions that have been/will be implemented to address common cause variation:

Intervention(s)	Implementation Date	Date Full Benefit/ Impact Anticipated
1. 2. 3.		

Comments:

Submitted by: **Date:**

Attachment 4

Bay-Arenac Behavioral Health Authority		
Board of Directors		
April 1, 2017 through March 31, 2018		
Original Board Appointed 9/23/63		
County Elected to Come Under PA 258, effective 8/8/75		
MH Code revision PA 290, 1995, effective 3/27/96: All board member terms were extended 3 months to end on 3/31, and thereafter be 3 year terms		
Name	**Term**	**County Represented**
Richard Byrne Chair	4/1/16 to 3/31/19	Bay
James Anderson Vice Chair	4/1/17 to 3/31/20	Bay
Robert Pawlak Treasurer Parliamentarian	4/1/16 to 3/31/19	Bay
Thomas Ryder Secretary	4/1/17 to 3/31/20	Bay
John Andrus	12/13/16 to 3/31/18	Bay
Ernie Krygier	4/1/15 to 3/31/18	Bay
Richard Gromaski	4/1/17 to 3/31/20	Bay
Robert Luce	4/1/15 to 3/31/18	Arenac
Colleen Maillette	4/1/17 to 3/31/20	Bay
Teresa (Terri) Marta	4/1/16 to 3/31/19	Arenac
Patrick McFarland	4/1/15 to 3/31/18	Bay
Thomas Starkweather	4/1/16 to 3/31/19	Bay

Revised 05/05/17

Attachment 5

Provider Network Operations and Quality Management Committee Membership		
Positions/Committee Representative	**Attendance**	
Recorder	Required	Joelle Sporman
Medical Director	Adhoc	Dr. Roderick Smith
Recipient Rights Manager	Adhoc	Melissa Prusi
SLT-Director of Healthcare Accountability		Janis Pinter
Recipient Rights & Customer Services Rep	Required	Jeff Wells/ Janelle Steckley
Finance Rep	Adhoc	Ellen Lesniak
SLT -Primary Care	Co-Chair	Joelin Hahn
SLT-Integrated Care	Required	Karen Amon
Arenac Center	Required	Heather Friebe
BI-Medical Records/Electronic Health Records	Adhoc	Brenda Beck
BI-Quality Manager	Co-Chair	Sandra Gettel
BI-Quality and Compliance Coordinator		Sarah Holsinger
Emergency Service/Access	Required	Kristy Moore/ Margaret Dixon/Stacy Krasinski
Medical Services-Prescribers	Required	
Medical Services-Nursing	Required	Sarah Van Paris/ Heather Seagraves
Vocational Services	Required	Brenda Rutkowski
Adults with MI	Required	Kathy Palmer
Adults with ID	Required	Melanie Corrion
Children with SED	Required	Kelli Maciag
Children with ID	Required	Noreen Kulhanek
Healthcare Practices Committee	Required	Amy Folsom
Behavior Treatment Committee	Adhoc	Karen Amon
Safety Committee	Adhoc	
Corporate Compliance Committee	Adhoc	Janis Pinter
Training	Adhoc	Tina Dilley
BABH Contracts	Adhoc	Erin Lewis
At Large Member	Adhoc	
Contract Provider Reps	**Attendance**	
MPA	Required	Katy Dean/ Michelle Richards/Matt Lance
MBPA	Required	Cindy Soto/Kathy Coleman/Sandra Garcia
LPS	Required	Jackie Thompson/Kim Kern/
Saginaw Psych	Required	Barb Goss/Nathalie Menendes

Other Subject Matter Experts as needed	Adhoc	

Revised 01-2016

Attachment 6

Bay-Arenac Behavioral Health
Quality Assessment and Performance Improvement Program
Reporting Structure
2017