



Quality Assessment and Performance Improvement Program

Annual Report

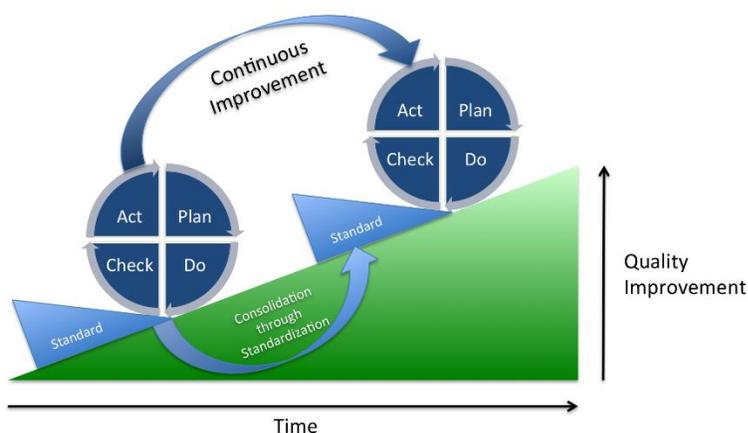
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I. Introduction

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.

1, 2). 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.

This annual report provides an analysis of the PI data reviewed during the past 6-12 months, and suggests any necessary data based adjustments to program priorities for the remainder of the fiscal year.

The data includes Performance Improvement Projects, Medicaid Event Verification, Michigan's Mission-Based Performance Indicator System, Health Conditions, and committee/work group reports Attachment 1 (Quality Dashboard) provides the performance on the identified measures at a glance. Additional data reviewed in this report includes Adverse Events, Jail Diversion, Recovery Assessment, and Oversight of Behavior Management.

II. Performance Improvement Projects

A. Medicaid Event Verification

Study Questions

1. Is the service provided in the Medicaid Manual?
2. Was the Medicaid service identified in the Person-Centered Plan (PCP)?
3. Do the units claimed (billed) equal the units documented?
4. The percentage of charts that have been audited that are in compliance with the previous three study questions.

Baseline

The data was initially gathered beginning in FY04Q3. The first question “Is the service provided in the Medicaid Manual” baseline data (FY04Q3-Q4) indicated that out of 1017 services provided, 1017 were services identified in the Medicaid Manual. Baseline data regarding the second question “Was the Medicaid service identified in the Person-Centered Plan” indicated that out of 1016 services provided, 986 (97%) of the services were identified in the Person-Centered Plan. Baseline data for the third question, “Do the units claimed equal the units documented”, indicated that out of 1015 services provided, 939 (93%) had evidence of the service being provided in the medical record.

Current Data (FY17) The results below include internal monitoring completed by Bay-Arenac Behavioral Health and external monitoring completed by the Pre-Paid Inpatient Health Plan (review dated 2-17), Mid-State Health Network. Attachment 1: Medicaid Event Verification provides the percentage of compliance for the combined results of questions 2 and 3.

1. Services Identified in the Medicaid Manual

There were no deficiencies during FY17 that required corrective action.

2. Services Identified in the Person-Centered Plan

BABH had achieved the desired performance level with an Internal - 99% external 100% during FY17Q4. This was consistent with the previous reporting period. No corrective action required during this year for internal reviews.

3. Did the Units Documented Match the Units Billed?

BABH had achieved the desired performance level with a 95% during FY17Q4. Three providers performance was below the desired performance level of internal - 95%, external 97% during this reporting year. A corrective action plan was completed to address system issues and the specific documentation issues.

Causal Factors/Ongoing Improvements

Clinical Service Providers that are below 95% are required to review their process and develop an improvement plan describing the systemic process to reducing deficits in the future and correcting any errors identified during the audit review process. The improvement plan is reported to BABH using the “Follow-up to Data Analysis Form”. BABH will monitor the progress of the plan through the data that is reported quarterly.

Each quarter, data is shared with department supervisors, who are given the responsibility of addressing the findings with corrective plans. Consumers were involved via each CMHSP's Consumer Advisory Council, where updates regarding MDHHS projects were provided and feedback was elicited.

Project findings are reviewed as a standing agenda item each quarter at the Corporate Compliance meetings. Typical turnaround in progress is expected within 12 months of putting the corrective plan into place.

In addition to the monitoring that is being done per each individual corrective action plan, it is recommended that a review of the project description and instructions be completed. Ongoing education and training of definitions and interpretations should be completed on a regular basis to ensure quality and reliability in the data collection process.

BABH has combined monitoring efforts with MSHN to expand oversight of the Medicaid Event Verification process. The sampling methodology has been reviewed and updated to ensure appropriate coverage and monitoring. Policies are being updated to ensure clarification for providers.

Conclusions

BABH – All which includes BABH - Direct clinical service providers and contracted provider's clinical service met the standard for each question regarding Medicaid Event Verification. Those that have been below during the previous quarters have improved which indicates that the corrective action plans that are currently in place have been effective. This will continue to be monitored on a quarterly basis through the Quality Management Committee.

B. Diabetes Screening for Individuals Diagnosed with Schizophrenia or Bipolar and Receiving Antipsychotic Medication

The Michigan Department of Health and Human Services(MDHHS) mandated the performance improvement project(PIP) topic based on a recommendation provided by the MDHHS's Quality Improvement Council (QIC). The QIC recommended the topic area. Each PIHP was to identify a specific area related to integration with physical health and mental health. After considering a number of possible topic areas, Mid-State Health Network chose the study topic "Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications." The goal of this PIP is to ensure that adult consumers with schizophrenia or bipolar disorder who are taking an antipsychotic medication are receiving necessary and relevant diabetes screenings (specifically glucose or HbA1c screenings) related to mental health medicines prescribed. This study topic aligns with the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications."

Study Question

Do targeted interventions increase the percentage of consumers diagnosed with bipolar or schizophrenia and prescribed an antipsychotic medication who also have an annual glucose or HbA1c diabetes screening?

Baseline

The data was re-pulled as a result of the original numbers including individuals that were not intended to be part of our eligible population for this study topic. During the baseline year of 2013-2014, Figure 1 indicates that BABH had 55% (383/696) consumers between the ages of 18-64 who were diagnosed with Bipolar or Schizophrenia, who were dispensed a second-generation antipsychotic medication and had a diabetes screening. This measurement excludes those who were diagnosed with diabetes or who had received a prescription for a diabetes medication.

Current Data

FY17Q4 demonstrated an increase greater than 1% improvement (77% screened) from the previous reporting period as indicated in Figure 1. The percentage screened is below the regional percentage of 84%, however still demonstrates improvement for BABH.

Figure 1

Reporting Period	BABH % Screened	MSHN % Screened
Baseline - October 2013-2014 through September 2014	55%	73.7%
First Review Period - October 2014 through September 2015	72%	77.5%
Second Review Period - October 2015 through September 2016	67%	80.03%
Third Review Period - October 2016 through September 2017	(Q4) 77%	84.19%

Interventions/Improvement Strategies

BABH will provide education to the beneficiaries during the person-centered planning process and during face to face interactions about the importance of ongoing monitoring by a primary care physician. Modifications are being made to the Individual Plan of Service to document such actions. BABH will coordinate, with the beneficiary and the primary care physician, the completion of a glucose test or HbA1c either by the CMHSP or through the Primary Care Physician (PCP). BABH has also begun the process of providing limited laboratory services in coordination with Quest Laboratory utilizing a locked drop box arrangement at the Madison Clinic for those who have difficulty obtaining laboratory work at other locations. BABH will utilize the “Care Alerts” data within the Zenith (ZTS) system to track consumers that meet the study population and have not had a completed diabetes screening to determine if said interventions have been effective.

Conclusions

The data for FY13/14 was used to determine a baseline goal for this project. MSHN identified FY14 as the baseline year for the date used. BABH demonstrated the required 1% improvement for FY14, FY15, and FY17. This project has been discontinued as a formal Performance Improvement Project.

C. Recovery Environment of the Clinical Service Providers

The study topic is the measurement of the recovery environment of the CMHSP, the consumer perception of individual recovery and the discernment of potential best practices within the region in addition to identifying effective strategies at both improving systems of recovery and identifying any additional needs for processes relating to recovery integration into agency practice.

Study Question

Did targeted interventions increase the region's recovery environment and the consumer's perception of the recovery?

Data Analysis-Regional level

Mid-State Health Network will collect, review and analyze data comparatively across CMHSPs, regional averages and where available against national benchmarks. This has been discontinued as a formal Performance Improving Project for MSHN.

CMHSP Management Level Data

CMHSPs will utilize individual survey responses to inform and guide individuals in their recovery journey. This is completed on an annual basis. This has been discontinued as a formal Performance Improvement Project for MSHN.

Clinical Service Provider Level Data

The consumer level data was gathered and analyzed for consumers who experience a mental illness and are 18 years of age and older. This has been discontinued as a formal Performance Improvement Project for MSHN. BABH will continue to monitor for outcomes related to the recovery environment and individual recovery score to be utilized during the treatment planning process.

BABH offered the Recovery Assessment Scale (RAS) to all Adults who experience a mental illness. The Likert scale was used with 1 being the lowest (disagree) and 5 being the highest (agree). Therefore, 3.5 would be considered the average. Anything above 3.5 would be considered in agreement. A score of a 2 or less would be considered in disagreement. The results were separated by those who were currently in treatment and may have already been impacted by the recovery systems of care and those that are new to the system and have not had an opportunity to have been affected by the recovery systems of care. It is expected that those who have received ongoing Recovery Assessment Scales will provide a higher rating. The results were reviewed and interventions put in place to increase the scores. Leadership, Quality Management Committee and the Recovery Committee will continue to review the results and to determine a plan of action to address the areas with a lower score which indicate a deficit in the recovery environment. A new more meaningful process for measuring change and exhibit progress or lack thereof is currently being developed.

- Personal Recovery
 - Questions: 1, 3, 4, 5, 7, 8, 9, 10, 11, 15, 17
 - Q1: I have a desire to succeed
 - Q3: I have goals in life that I want to reach.
 - Q4: I believe I can meet my current personal goals.
 - Q5: I have a purpose in life.
 - Q7: I can handle what happens in my life.
 - Q8: I like myself.
 - Q9: If people really knew me, they would like me.
 - Q10: Something good will eventually happen.
 - Q11: I'm hopeful about my future.
 - Q15: I know when to ask for help.
 - Q17: I ask for help, when I need it

- Clinical Recovery
 - Questions: 2, 13, 14
 - Q2: I have my own plan for how to stay or become well.
 - Q13: My symptoms interfere less and less with my life.
 - Q14: My symptoms seem to be a problem for shorter periods of time each time they occur.

- Social Recovery
 - Questions: 6, 18, 19, 20
 - Q6: Even when I don't care about myself, other people do.
 - Q18: I have people I can count on.
 - Q19: Even when I don't believe in myself, other people do.
 - Q20: It is important to have a variety of friends.

- Uncategorized Questions
 - Questions: 12, 16
 - Q12: Coping with my mental illness is no longer the main focus of my life.
 - Q16: I am willing to ask for help.

Improvement Strategies

The Recovery Committee convened to evaluate the use of the RAS within BABH. BABH will continue to train and educate staff regarding the purpose of the RAS, ensuring that a standardized process for administering the RAS is followed by all staff. Each domain below the acceptable threshold is reviewed and interventions implemented to ensure the threshold is met. The frequency of the RAS has been decreased to initially upon entering services, annually, and at discharge. The RAS will be used at Discharge for all population groups. A subset of the questions will be used for the Intellectually Developmentally Disabled on a trial basis at the close of services. Additionally, a training will be developed for clinicians on how to incorporate the RAS into treatment to ensure that the assessment is being utilized as research has determined to be most effective. It has been recommended that the progress of each individual RAS be incorporated into the consumers individual record for use during treatment.

D. Quality Reporting/Completeness – Record Reviews

1. Coordination with the Primary Care Physician

Michigan Department of Health and Human Services' (MDHHS) site review process assesses efforts at coordinating care with other healthcare providers. This stems from a need to coordinate efforts across healthcare delivery systems to ensure that an individual's healthcare needs and services are comprehensively identified, and delivered in an effective and efficient manner. The manner in which coordination of care occurs with healthcare providers, is being assessed for completeness. MDHHS site review process also reviews medical records to ensure that each individual receives or is offered the opportunity to receive a copy of their individual plan of service within 15 business days of completion of the planning process.

Study Question # 1: Did coordination of care occur between the consumer's primary healthcare provider, other physicians, and the CMHSP, for consumers receiving services?

Current Data

Attachment 1 indicates an improvement from FY15Q4 (69%) to FY17Q4 (97%). Coordination has continually increased throughout FY17. Interventions from FY16 have been effective as evidenced by the improved performance. Areas of focus will be on increasing integration and continued efforts of enhancing coordination through the use of technology and data through standard reports on Key Performance Measures, based on information that has been entered into the electronic health record (Phoenix), through Medicaid Claims data through Care Connect 360, and Integrated Care Delivery Platform (ICDP). A training plan is currently being developed to train key staff on the use of ICDP to obtain data for the use of coordination during the development of an individual plan of service. Corrective action includes ongoing reports to identify patterns and trends. This may include staff patterns or different processes throughout the organization that may contribute to barriers to integration. This may also include the location of documents and types of documents used to indicate that coordination has occurred.

2. Copy of Person Centered Plan (PCP)/Individual Plan of Service (IPOS) within 15 Days

Study Question # 2: Did the consumers receive a copy of their person-centered plan (individual plan of service) within 15 business days of completion of the planning process?

Current Data

BABH's percentage of charts that provided evidence of the consumers receiving a copy of their IPOS within 15 days was (69%) below the expected performance level for FY15Q4. Attachment 1 indicates improvement, demonstrating an 94% for FY17Q4.

Causal Factors and Barriers

Issues that have interfered with the providers demonstrating desired performance is related to a variety of issues 1) the implementation of the new electronic medical record for one of the contracted providers. 2) the process for documenting the "Receipt of PCP within 15 Days" within the medical record.

Interventions/Improvement Strategies

Training has been completed on the correct way to provide documentation of the "Receipt of PCP within 15 Days". A report is pulled quarterly to identify the compliance rate of this measure. The "Copy of PCP within 15 Days" can only be completed during the PCP Process. It cannot be corrected until the next planning cycle. Internal audits of medical records will be phased out as the electronic report is implemented. The data is separated by BABH and BABH contract providers to determine which provider is in need of follow-up to ensure that the desired performance level is reached in future measurement periods. Follow-up to data analysis may include documentation of Best Practice if the provider performed above the desired level for more than three reporting periods, or a corrective action plan if the provider performed below the desired performance level for one reporting period. Each reporting period is defined as one quarter of the fiscal year. The desired

performance level is 95%. The standard Person-Centered Planning process is a maximum of one year. Therefore, it may take up to one year to see the results of the corrective action plan.

Conclusions

The standard was not met for the Healthcare Coordination for FY17Q1-Q3. The standard was not met for PCP/IPOS within 15 Days for FY17Q1, Q3, Q4. Corrective action have been put in place to increase performance.

3. Completion of Crisis Plan

Current Data

BABH's percentage of charts that provided evidence of the consumers completing a crisis plan was (99%) above the expected performance level for FY16Q4. Attachment 1 indicates a decline in performance demonstrating an 89% for FY17Q4.

Interventions/Improvement Strategies

Modifications are being made to the template for the Individual Plan of Service to modify the wording regarding the completion of the crisis plan. Staff are being educated on the use of the plan.

Conclusions

The standard was not met for the completion of the Crisis Plan for FY17Q4. Corrective action has been put in place to increase performance for those providers that demonstrated deficits in this area.

E. Michigan's Mission-Based Performance Indicator System

The data is fully valid and reliable. The data is obtained through the state reporting process. This measure allows for exclusions and exceptions. Exceptions are those that chose to have an appointment outside of the 14 days, or refuse an appointment that was offered within 14 days. The dates or offered appointments must be documented. Those excluded are those who are dual eligible (i.e. Medicaid/Medicare), and approved for services related to autism. Both BABH Direct and BABH Contracted Providers are included in the totals. There may be times when each contracted provider has only one who has not been in compliance, however, when combined; it results in a percentage that is less than the expected threshold. Each provider will document action taken to resolve such an issue in the future.

Current Data

FY17 data is exhibited in Attachment 1. BABH demonstrated performance above the standard in all areas except Indicator 3: Start of Service within 14 Days, Adult with a Developmental Disability and Indicator 10: Re-admission to Psychiatric Unit within 30 Days Child.

Causal Factors and Barriers

During FY17 the area that resulted in the most difficulty was Indicator 3: The percent of new Medicaid beneficiaries starting any needed ongoing service within 14 days of a non-emergent assessment with a professional. BABH began utilizing the electronic health record to collect the

data related to the Mission Based Performance Indicator System (MMBPIS). This required additional training beyond implementation. The Phoenix system has a report that is able to be obtained on demand to determine the status of each indicator, however documentation has to be completed in the appropriate required fields within the electronic health record to be included. A corrective action plan was developed to address the indicators in which BABH and the contract providers demonstrated performance below the desired standard.

Interventions/Improvement Strategies

An investigation of each occurrence to determine what the causal factors are and what program exhibited the largest issues occurs each time the performance is below the standard. When total population groups are separated, BABH did perform below the standard for the following areas: Indicator 2 - Assessment within 14 days of the Initial Request for Service (children with a mental illness). Indicator 3a, 3b, 3c - Ongoing Service within 14 days of the Assessment (children and adults with a Mental illness, children with a developmental disability). Indicator 4 – The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Adults). Indicator 10 – Readmissions to a Psychiatric Inpatient Hospital (children with a mental illness and developmental disability). As indicated, a corrective action plan was in place for FY17 to address the areas identified.

Conclusions

The identified population groups for Indicator 2, 3, 4, and 10 were below in FY17. The corrective action plan will be monitored through FY18 to ensure effectiveness. All funding sources will continue to be monitored and a full report will be provided at the end of the fiscal year.

III. Consumer Satisfaction Improvement Opportunities

A. Annual Consumer Perception of Care

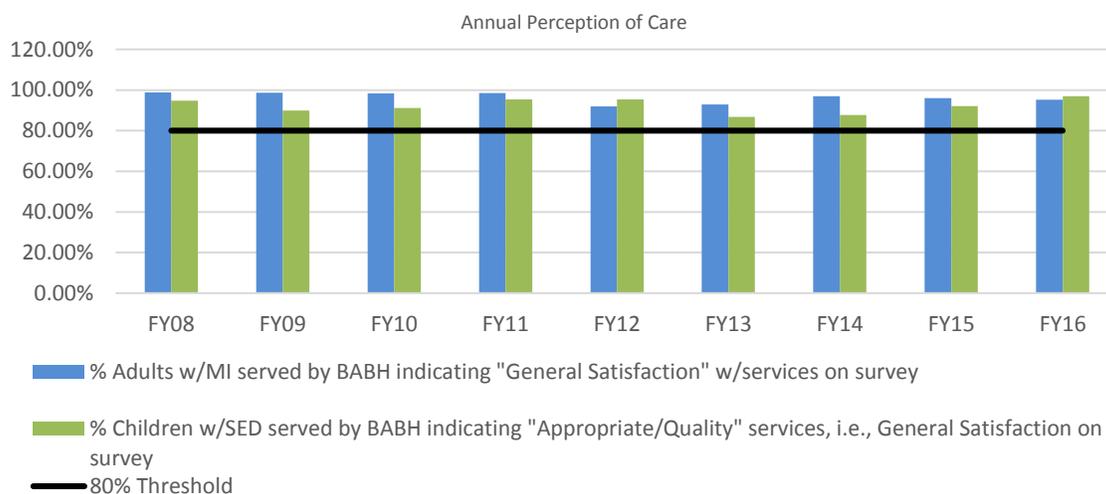
The Michigan Department of Health and Human Services (MDHHS) requires a survey be administered annually to programs identified by the Michigan Quality Improvement Council. All BABH programs and contract providers will have the opportunity to complete the Mental Health Statistics Improvement Program (MHSIP) and the Youth Satisfaction Survey for Families (YSS) over a two-week period of time. MDHHS provides implementation guidelines and instructions to each Prepaid Inpatient Health Plan (PIHP). Each BABH program and contract providers have utilized the MHSIP and the YSS to conduct a perception of care survey to all programs to determine any areas of deficit. The data obtained by the BABH programs and the contract providers was provided to BABH Quality Manager for analysis.

Improvement/Intervention Strategies

It is recommended that this information be shared with department staff and the Consumer Council and review each domain and each question to identify areas of deficit. It is recommended to provide information regarding local process for follow up regarding consumer satisfaction scores and follow up of dissatisfaction. The QI Council recommended that an acceptable threshold be set at an 80% rate of agreement per domain. Each domain that is below 80% is subject to a corrective action/improvement plan. It was also recommended that those with a low number of returned responses review their process and determine if additional action may need to be taken. The low number of responses may result in an acceptable and/or unacceptable threshold based on

the standard set. The low numbers may not allow the results to be generalized throughout the population.

Figure 2



B. Post Service Survey

The Post Service survey, also called the End of Service survey, was implemented as a result of low outcome scores on the 2008 regional survey. The questions in the survey are not consistent with the outcome domain for each of the surveys that had been distributed to the consumer populations. There are a number of questions that are able to be compared. The other questions provide valuable information regarding discharge instructions.

Current Data

The total number of respondents for 2017 was (124). The standard of 80% was met for 100% (11/11) of the questions on the End of Service Survey. 82% (9/11) of the questions demonstrated an increase in favorable responses. 18% (2/11) of the questions demonstrated a decrease in favorable responses, however still maintaining above the 80% threshold.

Intervention/Improvement Strategies

Education should be provided to staff to ensure that each survey has the appropriate funding source and program marked appropriately when given to the consumer. Inclusion of the number of surveys distributed to determine the response rate may be available prior to finalization of this report. Discussion should take place to determine any other actions or situations that may improve the results or administration of the survey. This end of service survey will be discontinued after FY18Q1. The Recovery Assessment Scale will be used to assess the end of service status of the persons served.

Figure 3

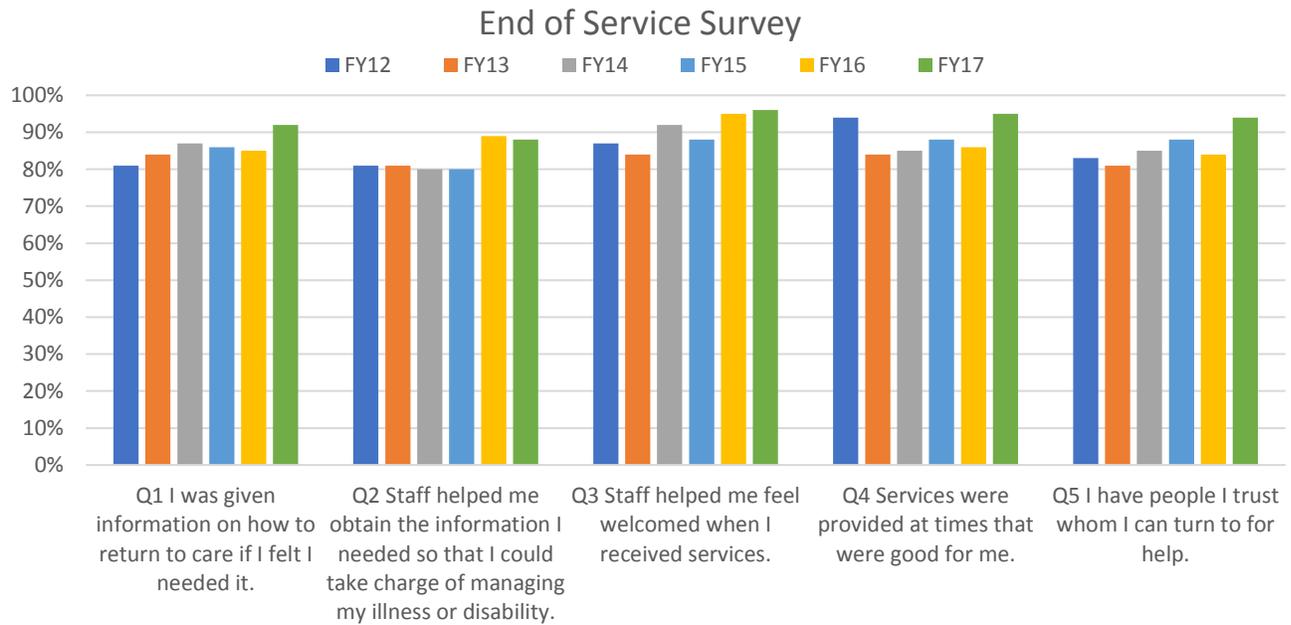
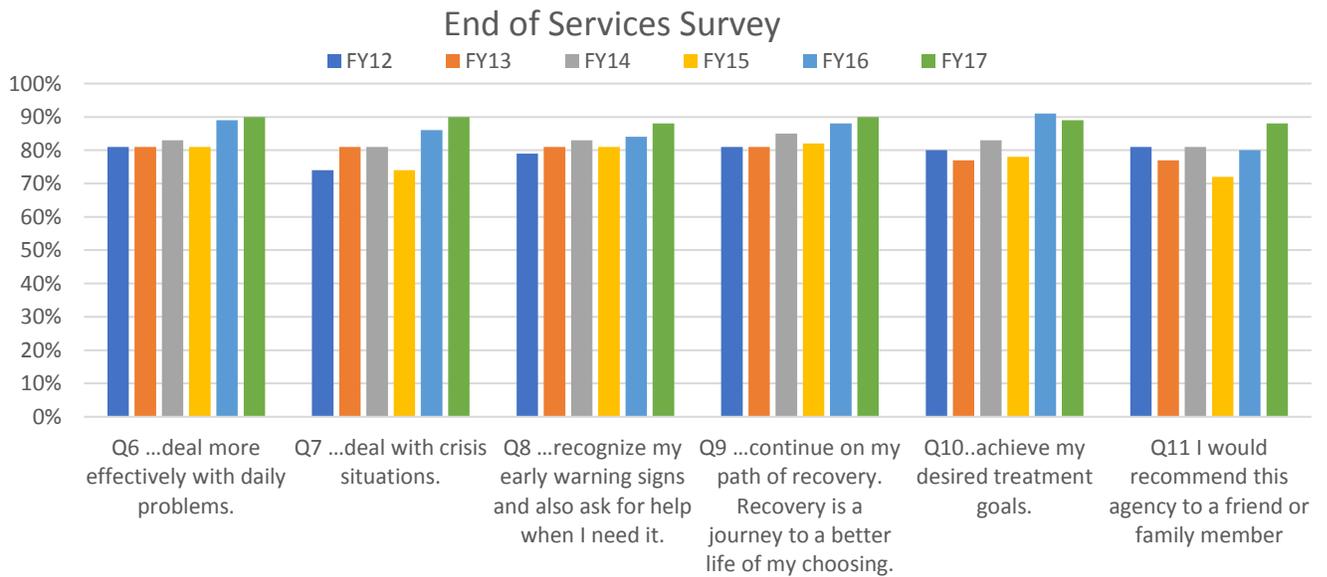
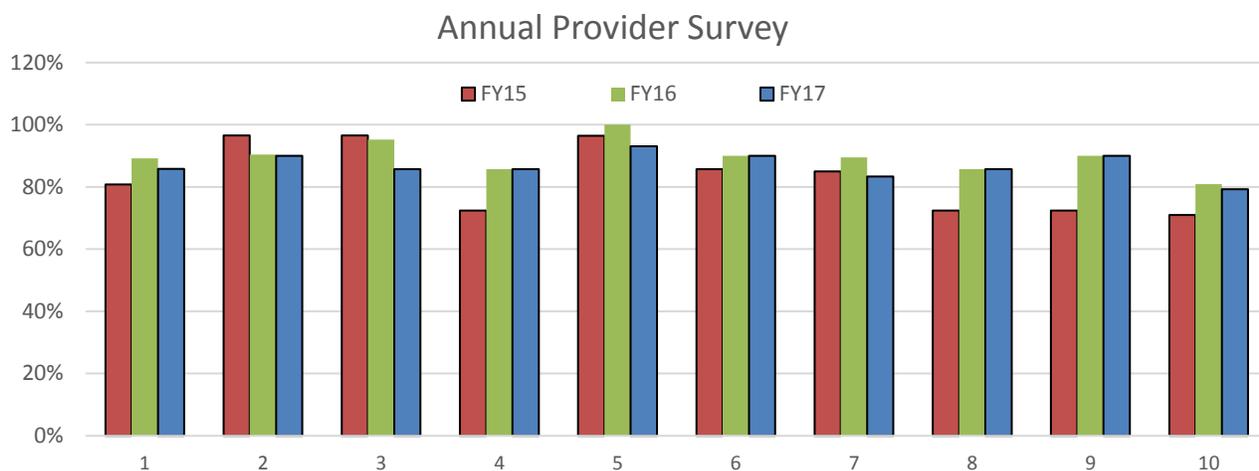


Figure 4



C. Provider Survey

Figure 5



Provider Survey Questions

1. Overall Percentage
2. BABH establishes clear performance objectives/indicators with providers.
3. Overall, BABH staff (not specific to the Customer Service Department) provide quality customer service that is helpful and welcoming to providers.
4. BABH communicates effectively, the standards and requirements that providers are expected to meet.
5. BABH demonstrates knowledge of practice guidelines written within your area of care.
6. BABH's provider site review process is fair.
7. BABH operates as a partner with provider agencies.
8. BABH communicates clearly.
9. BABH communicates/responds in a timely manner.
10. BABH seeks provider agency input in decision making.

Current Data

Figure 5 indicates the areas in which a change from previous years was demonstrated. Three questions remained consistent with the previous survey. Five areas indicated a decrease in performance. These areas may exhibit performance above the expected performance level, however any decrease in performance will be reviewed to determine the causal factors.

The following areas demonstrated a decrease in performance:

Question 4. Overall, BABH staff (not specific to Customer Services Department) provide quality customer service that is helpful and welcoming to providers.

Question 5. BABH seeks provider agency input in decision making.

Question 6. When requested, BABH demonstrates knowledge of practice guidelines written within your areas of care.

Question 7. BABH responds in a timely manner.

Question 8. BABH operates as a partner with provider agencies.

Intervention/Improvement Strategies

BABH has implemented several changes as a result of the feedback received from the survey. The following interventions were identified by Leadership to address the areas that fell below the desired threshold.

BABH's provider site review process is fair.

BABH continually assesses the site review process. Internal meetings to address the contract expectations, site review tools to monitor the contract requirements and the corrective action planning. Meetings with providers regarding any issues with the site review have been occurring during the past several months.

BABH establishes clear performance objectives/indicators with providers.

BABH communicates clearly, the standards and requirements that providers are expected to meet.

BABH seeks provider agency input in decision making.

BABH operates as a partner with provider agencies.

BABH has reviewed the forums for communication between BABH and the provider organizations. As a result, several modifications have been made to address the areas above. BABH has added a meeting between the Directors/Leadership of the organizations who participate in the Residential Provider meeting. The purpose is to have a discussion regarding the requirements and issues that affect services provided by the said organizations. This allows for direct communication and planning at the Leadership level.

BABH has also began to meet with Vocational Provider CEO's on a quarterly basis and continue to meet monthly with the vocational provider Leadership. Increasing the meeting to include face to face contact with the CEO's is meant to ensure that communication and planning is occurring to support the vocational providers, and assure quality services to the individuals served by BABH and other Primary Providers.

BABH has streamlined the Performance Improvement Committee and the Primary Provider meeting in a combined effort to become the Primary Network Provider and Quality Management Committee. The purpose is to increase the consistency of information and have continued discussion and planning for those organizations providing core services.

When requested, BABH demonstrates knowledge of practice guidelines written within your area of care.

BABH responds in a timely manner.

Overall, BABH staff (not specific to the Customer Service Department) provide quality customer service that is helpful and welcoming to providers.

Additionally, BABH has reviewed the attendees for each forum to ensure that all BABH staff and network providers are invited to participate.

D. Other Stakeholder Feedback

1. Consumer Councils

The Arenac and Bay Advisory Councils have provided feedback on various topics within the QAPIP. The following projects have been reviewed and received input during the consumer council meeting during FY17: the BABH Strategic Plan, the Recovery Assessment Scale, the National Core Indicators, the End of Service Survey, and the Annual Consumer Satisfaction Surveys. The feedback has been incorporated into the project descriptions to the extent possible. Mandated projects may provide the methodology that does not allow for modifications. This is noted with the project descriptions. Other items that have been reviewed with the councils include Mid-State Health Network Site Review Results, the External Audit results, and the Supports Intensity Scale. The councils have made recommendations regarding support groups, educational classes, safety with law enforcement, and the reinstatement of the consumer newsletter.

IV. Agency-Level Clinical Improvement Opportunities

A. Behavioral and Primary Healthcare Improvement Opportunities

1. Adverse Events

An event that is inconsistent with, or contrary to the expected outcomes of the organization's functions that warrants review. Subsets of adverse events will qualify as a "reportable event" according to the MDHHS Event Reporting System. Adverse events reportable to, or subject to review by MSHN/MDHHS, include the MDHHS defined critical incidents, risk events and sentinel events.

Study Question

Has the ability to identify events that are population specific led to an overall decrease of critical incidents/reportable events, increasing the safety of our consumers?

(1) Risk Events

A risk event is a critical event that puts individuals in one of the population categories at risk of harm. Michigan Department of Health and Human Services has identified five events that are classified under "risk" events.

- Action taken by individuals who receive services that cause harm to themselves.
- Action taken by individuals who receive services that cause harm to others.
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

- Police calls by staff of specialized residential setting, or general (AFC) residential homes, or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan.
- Emergency use of physical management by staff in response to a behavioral crisis.

Baseline

2012 is considered to be the baseline year, however; currently we have compared quarter to quarter. Two incidents were reported during FY12. Of the 2 incidents, 1 was a police call made by staff for police assistance with a behavioral crisis. The other incident was a staff person who received emergency medical treatment as a result of a self-injurious behavior.

Current Data (FY2017)

Attachment 1 indicates a total of 161 events reported for FY17 that met the criteria for risk as defined by MSHN/MDHHS. Of the 161, 128 were related to the use of emergency physical intervention. 30 were phone calls made by staff for police assistance with a behavioral crisis.

(2) Critical Events

MDHHS Critical Incident Reporting System: This system collects information on critical incidents that can be linked to specific service recipients and captures information on five specific reportable events:

- Suicide
- Non-suicide Death
- Emergency Medical Treatment due to Injury or Medication Error
- Hospitalization due to Injury or Medication Error
- Arrest of Consumer

Baseline (FY2012)

In fiscal year 2012, there were 40 events reported to MDHHS as an adverse event. Of the 40 events, 25 were non-suicide deaths. There were 2 suicide deaths during FY12. There were 7 events that involved emergency medical treatment due to injury or medication error. Three events were hospitalizations due to injury or medication error. None of the emergency medical treatments or hospitalizations was during emergency physical interventions. There were 3 arrests during FY12 that met criteria for reporting to MDHHS. There was 1 call made to the police by staff for behavioral assistance.

Current Data (FY2017)

Attachment 1 indicates two hundred and fifty-two adverse events were identified during FY17. Ninety-one were critical events. The breakdown of event types is demonstrated in Figure 5. Of the 91 critical events 30 were deaths. Of the 30 deaths 1 was a suicide death. The reporting requirements of MDCH indicate the cause of death listed on the Death Certificate must be used when reporting deaths. 40 were emergency medical treatment for injury or medication error. Figure 8 provides a depiction of data by of each specific incident type from FY2015 through FY2017.

Conclusions

Continue to monitor each risk/critical incident as reported. Subsets of the adverse events include medication errors, falls, and infections. An additional subset report will be added to include emergency medical treatment to more clearly identify the injuries that do not include falls. The subset reports are monitored through the Healthcare Practices Committee in detail to identify trends in the agency. Actions are taken to address any issues to eliminate current safety issues and proactively address issues that may result in critical or risk events. The organization will continue to train and educate staff regarding the definitions as determined by Healthcare Practices Committee (HPC).

Ensure that a standardized process is followed by all staff regarding infection control reporting. Continue to train staff on infection control precautions.

(3) Sentinel Events

No reportable sentinel events occurred during FY17.

B. Child Systems of Care

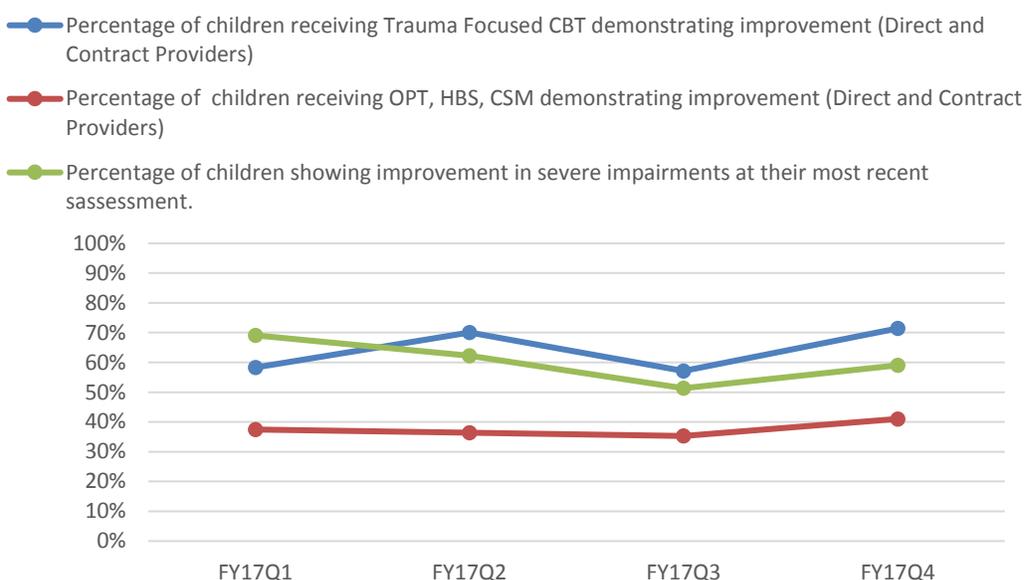
Child Adolescent Functioning Assessment System (CAFAS)/Preschool and Early Childhood Functional Assessment System (PECFAS).

The CAFAS tool (approved by MDHHS to measure clinical effectiveness in children) has been used only by those certified as Reliable Raters. Clinical effectiveness is determined by comparing the Initial Assessment CAFAS score with the Most Recent assessment CAFAS score, on *closed* cases.

A decrease in the CAFAS score by 20 points or more reflects a meaningful and reliable improvement with the consumer. An increase of 20 points or more in the CAFAS score reflects a regression by the consumer. Figure 7 indicates the overall score for FY17Q1 to FY17Q4. Several individual programs show an average of 20-point difference in overall CAFAS scores from the initial CAFAS to the most recent CAFAS, but only one programs has met the 80% expectation in the “Meaningful and Reliable Improvements scores.

Figure 6

Children Served by BABH demonstrating improvement - “Meaningful and Reliable Improvement and “In Severe Impairment” on CAFAS Scores



Severe Impairment Improvements shows the number and percent of youth who did not have any severe impairments at the most recent CAFAS assessment (improved) and those who still had at least 1 severe impairment (unchanged). “Unchanged” reflects children who still have moderate or severe (20 or 30) scores one or more domains. Excluded are CAFAS assessments that did not indicate severe impairment in the CAFAS scores.

The PECFAS is the CAFAS equivalent for children from ages 4-6. During 2013 it became a requirement of the state for all children in services to have PECFAS completed during the time they are seen. Of the 48 children either completed services during this quarter, or are still involved in services, 30 children were identified as having a severe impairment. Of those, 19 (63%) showed improvement and 11 (37%) were unchanged. 18 were excluded because there were no severe impairments, upon intake.

Figure 7

	PECFAS DATA				Severe Impairment Improvements			Pervasive Behavioral Impairment (Excluded = No PBI at Intake)		
	Total	Initial	Most recent	Point difference	Improved	Unchanged	Excluded	Improved	Unchanged	Excluded
2015 - Q4 All Providers Aggregate Total	50	87	70	17	19 (58%)	14 (42%)	17	12 (33%)	24 (67%)	14
2016 - Q4 All Providers Aggregate Total	48	87	69	18	19 (63%)	11 (37%)	18	18 (51%)	17 (49%)	13

2017 - Q4 All Providers Aggregate Total	57	80	69	11	16 (62%)	10 (38%)	31	11 (41%)	16 (59%)	30
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Conclusions

The desired level of performance for “Meaningful and Reliable Improvement” (80% expectation) was not achieved. Overall 39% of our consumers achieved a Meaningful and Reliable improvement, which is a decrease from the level of improvement in the previous quarter. There are no identified causal factors at this time. Further analysis and research are warranted to determine, a) if the set expectation of 80% of consumers served is appropriate for the SED population eligible for specialty mental health services; b) to determine the potential causal factors that impede improvement; c) to determine if corrective action is needed.

The desired level of performance for “Severe Impairment Improvements” (80% expectation) was not achieved. Overall 57% of our consumers achieved improvement in Severe Impairments. There are no identified causal factors at this time. Further analysis and research are warranted to determine a) if the set expectation of 80% of consumers served to have no “Severe Impairments” is appropriate for the SED population eligible for specialty mental health services; b) to determine the potential causal factors that impede improvement; c) to determine if corrective action is needed.

“Severe Impairment Improvement” is evidenced by the absence of a “30” on any CAFAS subscale score from initial CAFAS to the most recent CAFAS. Overall, 57% of our consumers achieved improvement in Severe Impairments, which is a 7% increase from last quarter.

Autism

Implementation of Autism Benefit/ABA Services - Center Based Service at Madison Clinic. The Autism Medicaid Benefit began April 1, 2013. This was for children ages 18 months to 21 years, and uses the evidence based practice of Applied Behavioral Analysis (ABA). BABH staff have been trained with an increased focus on Autism. In addition, BABH contracts with external organizations to provide assessment services, and ABA for Autism. BABH also provides internal ABA services for individuals with autism. In addition to opening the autism clinic, and expanding the network specific to autism services, a psychologist has been hired to assist in providing services. At the end of FY17Q4, BABH has provided ABA services, including assessments to 101 individuals.

Wraparound

Implementation of Wrap-Around Services to increase community organization coordination. Wraparound services were expected to be available from BABH starting April 1, 2013. This has been challenging due to transitions of trained staff. This service was implemented again in February of 2015. “Wraparound is an established vehicle for delivery of services and supports to children and families with severe and multiple needs and risks being served by multiple agencies. Wraparound refers to an individually designed set of services and supports provided to children with serious emotional disturbance or serious mental illness and their families that includes treatment services, personal support services or any other supports necessary to maintain the child in the family home.”

C. Jail Diversion/Juvenile Diversion

BABH Jail Diversion program from October 1, 2016 through September 2017, has recorded 0 diversions. Since October 1, 2016, twenty-seven adolescents were screened for the jail diversion program. Twenty-two of the adolescents were accepted/qualified for the BABH jail diversion program and placed into services.

D. Trauma Informed Care

Implement Trauma Informed Services. BABH has implemented Trauma Informed Practices across our agency and across the Contracted Provider Agencies. BABH and its contracted clinical service providers have 13 certified Trauma Focused (TF)-Cognitive Behavioral Therapy (CBT) Clinicians and 2 are trained as supervisory staff. BABH will reassess Trauma Informed Care utilizing PIHP tool. BABH has the Trauma Informed Organizational Assessment. Results are currently unavailable. This will be analyzed and action taken based on the results. The report will be included in the FY18 Semi Annual Report.

E. Recovery Based Method

Implementing recovery oriented services. The Recovery Assessment Scale was implemented and is analyzed on a quarterly basis. The next step is to incorporate it into the individual consumer electronic health record and is currently in the testing phase. The Recovery System Assessment Scale-Managers Version has been utilized for a baseline measurement and one re-measurement. Policies and Procedures have been developed that incorporates recovery into training, treatment and the entire system. Recovery training has been implemented at new employee training and annually. Recovery principles have been incorporated into the core competencies for employees and included in policy throughout the agency.

F. Healthcare Integration Coordination

Co-Occurring and Integrated Services. As a result of the QI Data being discontinued and the Behavior Health TEDS reporting beginning, the method of collecting such data is currently being modified to accurately determine the current penetration rate of consumers who receive integrated co-occurring treatment and increase the consumers who are receiving Co Occurring treatment. Improve and increase the Coordination of care between mental health and substance use disorder service providers for shared individuals.

V. Data Based Recommendations

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 - To Be Decided (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)

VI. Attachment 1: BABH Performance Improvement Quality Dashboard

Performance Improvement Opportunities	Green = Met the standard Tan = Did not meet the standard				
Medicaid Event Verification	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
% Audited Services w/Proper Documentation for Encounters Billed for all Service Providers	95%	100%	97%	100%	98%
% Audited Services w/Proper Documentation for Encounters Billed (BABH Direct) per quarter	95%	96%	98%	97%	98%
The percentage of consumers diagnosed with schizophrenia or Bipolar Disorder and taking an antipsychotic who have received a screen for diabetes.	Increase .1%	FY17Q1	FY17Q2	FY17Q3	FY17Q4 (10/2017)
Goal			79.00%	79.00%	79.00%
MSHN			80.00%	80.00%	84.19%
BABH		67%	72%	74%	77%
Consumers Recovery Assessment Scale-Active, Ongoing	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
Personal Recovery (MSHN Domains)		3.85	3.86	3.9	3.86
Clinical Recovery (MSHN Domains)		3.41	3.36	3.38	3.37
Social Recovery (MSHN Domains)		3.91	3.93	3.98	3.92
Uncategorized Questions (MSHN Domains)		3.48	3.47	3.54	3.53
Total # of total respondents of the Recovery Assessment Scale (BABH)		337	329	380	361
Copy of IPOS offered within 15 days of the planning meeting.	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH -All (Includes Contract Providers)	95%	89%	95%	94%	94%
BABH-Direct	95%	91%	96%	95%	97%
Completion of Crisis Plan	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH -All- (Includes Contract Providers)	95%	96%	98%	96%	89%
BABH-Direct	95%	94%	98%	97%	95%
Evidence of Primary Care Coordination	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH -All- (Includes Contract Providers)	95%	89%	84%	90%	97%
BABH-Direct	95%	95%	86%	86%	95%
Completeness Reporting-Accumulative	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
% of BH TEDS completed	95%	96.42%	96.46%		94.76%
Data Completeness-DD Proxy	95%	99%	99%	99%	100%
Michigan Mission Based Performance Indicator 1: The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MDHHS Medicaid children	95%	98.97%	98.11%	98.03%	98.76%
MSHN Medicaid children	95%	99.10%	99.17%	99.42%	99.59%
BABH Medicaid children	95%	100.00%	100.00%	100.00%	100.00%

MDHHS Medicaid adult	95%	98.28%	98.05%	97.64%	98.19%
MSHN Medicaid adult	95%	98.72%	98.89%	99.31%	99.47%
BABH Medicaid adult	95%	100.00%	99.49%	100.00%	100.00%
Michigan Mission Based Performance Indicator 2: The percent of new Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MDHHS -Total	95%	98.01%	97.23%	97.49%	97.74%
MSHN -Total	95%	98.76%	98.78%	98.82%	99.16%
BABH -Total	95%	95.55%	97.50%	96.70%	99.54%
MDHHS MI-C	95%	98.01%	97.15%	96.23%	96.98%
MSHN MI-C	95%	98.19%	98.90%	98.51%	98.48%
BABH MI-C	95%	94.12%	100.00%	96.43%	98.33%
MDHHS MI-A	95%	98.22%	98.56%	99.00%	98.68%
MSHN MI-A	95%	98.81%	98.78%	99.26%	99.65%
BABH MI-A	95%	96.13%	96.19%	96.61%	100.00%
MDHHS DD-C	95%	99.23%	95.81%	97.73%	98.31%
MSHN DD-C	95%	98.67%	100.00%	97.30%	98.68%
BABH DD-C	95%	100.00%	100.00%	100.00%	100.00%
MDHHS DD-A	95%	99.00%	96.14%	99.07%	98.07%
MSHN DD-A	95%	100.00%	100.00%	100.00%	98.86%
BABH DD-A	95%	100.00%	100.00%	100.00%	100.00%
Michigan Mission Based Performance Indicator 3: The percent of new Medicaid beneficiaries new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MDHHS -Total	95%	97.25%	97.49%	97.05%	97.02%
MSHN -Total	95%	98.46%	98.18%	98.61%	98.16%
BABH -Total	95%	96.00%	96.31%	97.81%	95.16%
MDHHS MI-C	95%	97.15%	96.91%	95.70%	96.04%
MSHN MI-C	95%	97.87%	97.23%	96.98%	96.72%
BABH MI-C	95%	96.47%	95.70%	94.87%	96.00%
MDHHS MI-A	95%	97.41%	97.42%	97.00%	97.27%
MSHN MI-A	95%	97.50%	97.31%	98.25%	97.46%
BABH MI-A	95%	95.49%	97.01%	99.29%	96.12%
MDHHS DD-C	95%	95.39%	97.81%	96.85%	95.46%
MSHN DD-C	95%	100.00%	96.97%	100.00%	94.74%
BABH DD-C	95%	100.00%	83.33%	100.00%	33.00%
MDHHS DD-A	95%	95.14%	96.64%	96.90%	94.13%
MSHN DD-A	95%	93.94%	97.37%	98.48%	98.55%
BABH DD-A	95%	100.00%	100.00%	100.00%	100.00%

Michigan Mission Based Performance Indicator 4: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MDHHS Child	95%	97.42%	92.69%	96.76%	97.24%
MSHN Child	95%	98.13%	98.52%	99.22%	100.00%
BABH Child	95%	100.00%	100.00%	96.43%	100.00%
MDHHS Adult	95%	95.90%	94.38%	96.10%	96.19%
MSHN Adult	95%	97.11%	98.26%	96.79%	96.55%
BABH Adult	95%	98.11%	96.15%	92.42%	97.18%
MDHHS Indicator 5: Percentage of Area Medicaid Recipients Having received Managed Services		6.90%	7.54%	9.85%	9.43%
MSHN Indicator 5: Percentage of Area Medicaid Recipients Having received Managed Services		7.59%	8.34%	11.10%	10.62%
BABH Indicator 5: Percentage of Area Medicaid Recipients Having received Managed Services		10.77%	11.06%	10.08%	10.28%
Michigan Mission Based Performance Indicator 10: The percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days (Old Indicator #12)	Standard	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MDHHS MI and DD children	15%	13.04%	9.30%	9.03%	11.40%
MSHN MI and DD children	15%	8.11%	8.97%	11.88%	12.20%
BABH MI and DD children	15%	11.54%	13.79%	8.11%	15.78%
MDHHS MI and DD adults	15%	13.29%	9.78%	12.16%	12.65%
MSHN MI and DD adults	15%	9.85%	7.61%	11.10%	10.34%
BABH MI and DD adults	15%	9.88%	9.78%	12.37%	6.73%
FUH-Follow up to Hospitalization Hedis Measure Children (ages 6-20)	70%	Feb-17	Jun-17	Aug-17	Sep-17
MSHN	70%	81%	81%	76%	72%
BABH	70%	88%	95%	91%	79%
FUH-Follow up to Hospitalization Hedis Measure Adults (ages 21+)	58%	Feb-17	Jun-17	Jul-17	Sep-17
MSHN	58%	76%	62%	74%	67%
BABH	58%	77%	79%	75%	65%
Jail/Juvenile Diversion		FY17Q1	FY17Q2	FY17Q3	FY17Q4
% of juvenile individuals diverted from jail into treatment	track and trend	88%	60%	88%	83%
# of individuals receiving treatment for Autism		92	90	93	101
# of individuals completing the Supports Intensity Scale		31	32	53	44

Children Served by BABH and Contract Providers demonstrating "Meaningful and Reliable Improvement" on CAFAS Scores Initial to Most Recent Assessment by Quarter		FY17Q1	FY17Q2	FY17Q3	FY17Q4
Percentage of children receiving Trauma Focused CBT demonstrating improvement (Direct and Contract Providers)		58%	70%	57%	71%
Percentage of children receiving OPT, HBS, CSM demonstrating improvement (Direct and Contract Providers)		37%	36%	35%	41%
Adverse Event Reporting (percent per 100)		FY17Q1	FY17Q2	FY17Q3	FY17Q4
Reportable Adverse Events (risk, critical, sentinel) per 1000 persons served by BABH	track and trend	4.39	6.84	5.21	3.86
Reportable Suicide Deaths		0.27	0.00	0.00	0.00
Reportable Non-Suicide Deaths		1.65	2.85	2.47	1.10
Reportable Emerg Med Treat due to Injury or Med Error		2.19	3.70	2.47	2.76
Reportable Hospitalizations due to Injury or Med Error		0.27	0.28	0.00	0.00
Reportable Rate of Arrests		0.00	0.00	0.27	0.00

VII. Attachment 2: Bay-Arenac Behavioral Health Authority Board of Directors

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