BAY ARENAC

BEHAVIORAL HEALTH

COMMUNITY MENTAL HEALTH SERVICES PROGRAM

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2021

BOARD ADOPTION:
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Section 1: Introduction and Overview

Bay-Arenac Behavioral Health Authority (BABHA) 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. BABHA 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. BABHA 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).

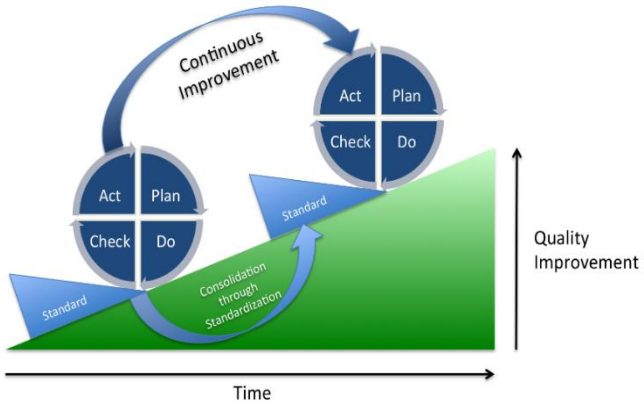
BABHA is responsible for managing a local quality assessment and performance improvement program for its CMHSP provider operations and ensuring its contracted network clinical service providers address quality improvement in their own operations through the BABHA Quality Assessment and Performance Improvement Program (QAPIP).

BABHA'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 shown here.

(http://en.wikipedia.org/wiki/File:PDCA Process.png)



The QAPIP, as described in this document, is evaluated annually for effectiveness and modifications are made, as necessary.

The QAPIP applies to all BABHA programs and services, including:

- Assertive Community Treatment (mental health – adults).
- Case Management/Supports Coordination (integrated IDD/mental health – adults, children, and adolescents).
- Community Integration (psychosocial rehabilitation – adults).
- Crisis Intervention (integrated IDD/mental health – children and adolescents, mental health – adults).
- Intensive Family-Based Services (family services – children and adolescents); and
- Outpatient Treatment (integrated IDD/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 Authority 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).

Section 2: Organizational Structure and Committees

The organizational structure and committees and their relation to the QAPIP, and performance improvement responsibilities in general, are detailed below.

Governance

The BABHA Board of Directors has established a committee specifically to address quality and compliance concerns. The Health Care Improvement and Compliance Committee (HCICC) monitors, evaluates, sets policies related to performance improvement and recommends approvals to the full Board of 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 Primary Network Operations and Quality Management Committee (PNOQMC) meeting notes 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. The Director of Healthcare Accountability is senior management liaison to the HCICC, and the Quality Manager attends on a regular basis to address quality program issues.

Chief Executive Officer

The BABHA 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 BABHA QAPIP. The CEO also sanctions the formation of QAPIP standing committees and is responsible for senior management and agency leadership meetings.

The BABHA Quality Manager, under the oversight of the Director of Healthcare Accountability, is the leader 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 by the Quality Manager to the senior leadership of BABHA and the Board of Directors.

Medical Director

The BABHA 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] leadership of the BABHA Healthcare Practices Committee and other standing committees as time permits, and through oversight of the organization's medical practices; serves as a liaison between BABHA'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 BABHA's CMHSP contracted service provider network. The BABHA Medical Director also provides oversight for the quality program by providing direct supervision for the Director of Healthcare Accountability and indirectly, the Quality Manager.

Leadership

The BABHA Strategic Leadership Team is comprised of senior management which meets regularly and has an Expanded Leadership meeting of which the Quality Manager is a member. The Quality Manager participates to coordinate day-to-day quality and process improvement related activities with senior management and to have direct access to senior management to address any quality related concerns such as barriers to improvement. Through performance measures, the progress of the organization is routinely evaluated, and reports are made by the Quality Manager to the senior leadership of BABHA.

The rest of BABHA managers and team leaders join senior management in a monthly Agency Leadership meeting, which develops and monitors staff competencies; collaborates on new processes, services and programs; 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 completes a Strategic Leadership Plan that establishes priorities in specific areas for risk reduction and service access for consumers.[2]

[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, Strategic Leadership Plan.

BABHA Staff

Staff receive education and annual training of the organization's QAPIP and expectations for their participation, which includes participation in data collection activities related to performance measures and indicators at the department/program level; identifying department/program and organization-wide opportunities for improvement; participating in organization-wide committees and work groups; reporting care errors, informing consumers of risks related to healthy safety through Healthcare Effectiveness Data and Information Set (HEDIS) measures, and making suggestions to improve the health and safety of consumers; and providing input into QAPIP priorities through the BABHA employee survey and suggestion box.

Quality Manager and Quality/Compliance Staff

The BABHA Quality Manager, under the oversight of the Director of Healthcare Accountability, is the leader responsible for the daily management of the QAPIP which includes the design, implementation, evaluation, and revision of the QAPIP. The Quality Manager also identifies program priorities, sponsors work groups and committees, facilitates root cause analyses, supports data-based decision making, generates reports, analyzes data and many other QAPIP related activities. The Quality Manager is responsible for BABHA quality and performance related policies and procedures.

The Quality Manager supervises the Quality and Compliance Coordinator, who assists the Quality Manager with the coordination, initiation, guidance, and collaboration of local performance improvement projects. Both individuals sit on the BABHA PNOQMC 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. The Quality Manager chairs the quality portion of the PNOQMC and sets the agenda for that portion of the meeting.

The Quality Manager and Quality & Compliance Coordinator are responsible for performing reviews of contracted service provider performance, ensuring corrective actions are taken and technical assistance provided. These activities are coordinated with recipient rights, nursing, finance, clinical and contract management staff. The Quality Manager and staff coordinate reviews of BABHA performance by external payers and accrediting bodies, including readiness assessment, document submission, logistics and plans of correction.

Stakeholders

The BABHA CMHSP sponsors regular meetings with key stakeholders such as contracted service providers to discuss system issues and process changes, including prescriber/medical (psychiatrists, nurse practitioners, physician assistants), primary (outpatient therapy/case management), residential/community living supports, vocational and autism providers. Changes in rules, regulations, and requirements are discussed as well as system level concerns and improvements, training and credentialing, updates to processes and procedures, and other relevant topics.

Primary provider representatives and consumers participate in BABHA QAPIP committees. Site reviews of residential, outpatient and other providers produce information that flow into the Quality Management program through work groups and process improvement initiatives. Collaborative meetings are held with treating physicians at BABHA clinical programs and contract sites to discuss medical practices.

QAPIP Committees

Functions and duties of BABHA QAPIP Committees include the following:

1. Review of BABHA policies, procedures and plans related to their functions and duties, as assigned, and recommending new and revised policies and procedures to the BABHA Chief Executive Officer for approval.

2. Monitoring state and federal rule promulgation for changes in requirements relevant to their functions and duties, if any. Generating recommendations for changes to BABHA practices as indicated. Assisting with the education of staff regarding changes in requirements and implementation of action plans and/or making recommendations as necessary to bring the organization into compliance.

3. Reviewing data reports for which it is responsible for purposes of assisting with analysis of causal factors for desirable and undesirable change. Where feasible and appropriate, committees assist with setting desired performance thresholds and reliable external benchmarks/comparables when available. The committees take action and/or make recommendations for action, as appropriate, to address undesired levels of performance and/or excessive variability.

4. Committees report to their overseeing committee if any, or to the Senior Leadership Team as directed.

5. Meeting agendas and notes are recorded using standardized agency templates and stored on the BABHA group drive (unless containing protected health information) for access by other BABHA personnel.

Primary Network Operations and Quality Management Committee (PNOQMC)

The PNOQMC is the structure responsible for the QAPIP and performance improvement activities of BABHA's operations. The required membership is comprised of: BABHA Quality Management (QM) and Administrative Services staff; BABHA Strategic Leadership Team members; clinical supervisors and team members; QM representatives from contract provider agencies; consumer representative (quarterly) and ad hoc members including subject matter specialist from each department within the organization (Attachment 5).

The PNOQMC 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 PNOQMC is also responsible for identifying priorities for QM 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, 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 PNOQMC's activities, findings, recommendations, and actions are documented in meeting minutes. These minutes, as well as the associated meeting materials are available on the BABHA intranet site.

Population Committees

The BABHA QAPIP program has three clinical population ad-hoc committees that report to the PNOQMC. 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 BABHA, and also engages in advocacy and educational activities.

Consumer Councils

BABHA sponsors two clinical consumer councils that report to the PNOQMC and provide input directly to BABHA regarding program operations and performance through the population committees. A BABHA consumer council representative attends the PNOQMC on a quarterly basis to provide input and feedback. In addition, BABHA 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, plan of service planning, self-determination, self-advocacy, independent facilitation, community integration, anti-stigma activities, achievement of recovery, positive clinical outcomes and consumer satisfaction.

Work Groups

Quality improvement work groups are formed based upon improvement opportunities identified by individuals in the organization, committees, 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.

BABHA staff are invited to participate in local work groups by their supervisor or Quality Management 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 BABHA Quality Management 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.

Other Quality Related Committees

There are other standing BABHA Board and staff committees that are directly or indirectly part of the organization's quality management program but do not directly report to the PNOQMC. These committees include the: Behavior Treatment Plan Review Committee (BTPRC); Healthcare Practices Committee (HPC); Safety Committee;[27] Corporate Compliance Committee,[28] and Healthcare Integration Steering Committee (HISC). With limited exceptions, the Quality Manager and/or Quality and Compliance Coordinator are either seated on or work closely with the listed committees to collect and analyze data, and action the results to ensure service quality, optimal clinical outcomes and mitigate risk.

Behavioral Treatment Plan Review Committee

The BTPRC,[29]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.[30] 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 HPC 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. This is accomplished 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 (BABHA 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 BABHA.

Corporate Compliance Committee

It is the policy of the BABHA Board of Directors to have a Corporate Compliance Plan in effect, as stated in BABHA policy and procedure C13-S02-T18 Corporate Compliance Plan. The Corporate Compliance 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[31]. Furthermore,

the BABHA Corporate Compliance Plan ensures the integrity of the system in which BABHA 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.[32]

Health Care Integration Steering Committee
The purpose of the HCISC is to develop, recommend, support, promote and evaluate system-wide change as necessary to achieve BABHA goals for integration of mental, physical and substance use disorder-related health care. The committee is responsible for reviewing and actioning items to meet targets or benchmarks related to performance and providing recommendations and action steps to clinical providers. The HCISC and the PNOQMC will collaborate to improve the quality of services for the individuals we serve. Various technology and clinical resources will be utilized to access data and process information to assist with creating action steps and follow up plans.

Recipient Rights
BABHA is committed to providing quality services to consumers in a manner that acknowledges their rights and responsibilities, ensures they receive services suited to their condition, and protects them from abuse and neglect. The BABHA Recipient Rights Office monitors and ensures that recipients of mental health services have all of the rights guaranteed by state and federal law, and provides a system for determining whether, violations have occurred and that action is taken in the event of a violation. The CEO ensures that BABHA has written policies and procedures for the operations of the rights system. Education and training in Recipient Rights policies and procedures are provided to BABHA staff and contracted service providers are required to have recipient rights protections in place. The BABHA of Directors operates a Recipient Rights Advisory Committee and an Appeals Committee to oversee the program.

Section 3: Program Activities

The BABHA 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 FY21 Contract, Attachment C 6.8.1.1). 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). BABHA “demonstrates a culture of accountability by developing and implementing a performance measurement and management plan that produce information an organization can act on to improve results for the person served, other stakeholders, and the organization itself " (CARF, 2020 Standard M).

To ensure services provided are of high quality, effective and appropriate for all clinical populations, the QAPIP program addresses the:

- Competency of those who provide services.
- Harm identification and reduction.
- Access to care and utilization.
- Outcomes; and

- Stakeholder perceptions of care.

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.[3,4,5] Data reflective of the performance of practitioners is considered when privileges and credentials are renewed; this occurs via the Healthcare Practices 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 ensure 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.[6,8]

Orientation and training in regard to responsibilities, program policy, and operating procedures are required for new employees.[7,8,9,12] Staff performance and competency are monitored on a regular basis.[10,14] Training needs are identified through formal means, such as performance/ competency reviews, as well as informally, through self-identified areas for improvement. It is BABHA's policy to support employee educational pursuits and does so through in-service training, continuing education, and staff development activities.[11,16]

Harm Identification and Reduction

BABHA 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

[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 Policies and Procedures Manual, C08-S06-T06 Organizational Credentialing
[6] Bay-Arenac Behavioral Health Employee Handbook
Error! Bookmark not defined. Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T05 Cultural Competence and Limited English Proficiency.
[8] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Cultural Competency and Diversity Plan.
[9] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T02 Orientation.
[10] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T01 Minimum Training Requirements.
[11] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Training Plan.
[12] Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Operating Philosophy and Ethical Guidelines.
[13] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T05 Performance Management.
[14] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T02 Professional Staff Competency.
[15] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S02-T26 Continuing Education.
[16] Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T03 Scheduling, Promoting, and Documentation of Staff Education.
[17] Bay-Arenac Behavioral Health Policies and Procedures Manual, C03-S01-T01 Statutory Establishment.
[18] Bay-Arenac Behavioral Health Policies and Procedures Manual, C02-S01-T06 Reporting and Investigation of Adverse Events.

Rights (ORR).[18] Adverse events are reviewed on a consumer specific level as well as overall trends that are reported. These adverse events have the potential to lead to the root cause analysis process if one is deemed appropriate. The trends identified through this analysis helps determine how BABHA can make improvements to reduce risk for consumers.

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, 2021 Behavioral Health Standards Manual 1.H). These processes address the review and follow up of sentinel, unusual, and critical events for all persons receiving services from BABHA, including, but not limited to, those enrolled in the Children's Waiver, the Children with Serious Emotional Disturbance Waiver, and the Habilitation Supports Waiver.

All deaths are reviewed and include:

a) Screens of individual deaths with standard information (e.g. coroner's report, death certificate)
b) Involvement of medical personnel in the mortality reviews
c) Documentation of the mortality review process, findings, and recommendations
d) Use of mortality information to address quality of care
e) Aggregation of mortality data over time to identify possible trends.

As part of the MDHHS Behavior Treatment Technical Requirements, BABHA collects data related to physical management that is used during emergency situations to prevent harm to self and/or harm to others. The information collected is reviewed monthly and quarterly to look at any trends or concerns.

Data is gathered and reviewed by appropriately credentialed staff for causal analysis. As necessary, root cause analyses are completed, and risk reduction strategies are recommended to reduce the likelihood of recurrence. At a minimum, identification of a sentinel event must occur within three business days in which the critical incident occurred, and the commencement of a root cause analysis must occur within two business days of the identification of the sentinel event. As appropriate, BABHA utilizes failure mode and effects analysis for review of potentially high risk or error prone processes. BABHA submits event reports to the PIHP/MDHHS and CARF in accordance with each entity's reporting criteria and timelines.

A crisis plan workgroup was developed in 2019 after it was determined there were improvements that could be made to the crisis plan document to more adequately assist consumers, families, friends, and staff with how to handle consumer-specific crisis situations. The crisis plan workgroup also identified a need to update the progress note to ask more specific risk-related questions to assess for safety. BABHA staff quarterly review a sample of records to determine if a crisis plan was offered and, if so, completed.

Appropriate remedial actions at the individual case level are taken in response to substantiated recipient rights complaints, including abuse and neglect. Recipient Rights Office representatives report aggregated data on abuse, neglect and customer services findings and make recommendations to PNOQMC for system improvements when needed. Recommendations for system improvements generated by the Consumer Councils are also reported to PNOQMC for actioning.

Goals:

1. Continue to review all adverse events to determine any follow-up actions. Analyze the data to assist with determining change in process, procedure, workflow, etc.
2. The number of emergency physical interventions per person served during the reporting period will demonstrate no change or decrease from the previous measurement period.
3. Meet or exceed 95% compliance of records with documented evidence that a crisis plan was offered and, if so, completed.
4. Reduce the number of substantiated recipient rights complaints from the previous quarter.

Access to Care and Utilization Management

BABHA's utilization management plan is detailed in several sections of the Policies and Procedures Manual.[12,13,14,15,23] The utilization plan components address, "practices related to retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, and 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; 5) decisions and appeals are made in a timely manner as required by the exigencies of the situation; and 6) there are mechanisms to evaluate the effects of the program using data on member satisfactions, provider satisfaction, or other appropriate measures.[16,25]

BABHA uses a dashboard to track data related to various performance measures and utilization, including, but not limited to HEDIS measures and MSHN Performance Improvement Projects (PIP), Autism metrics, and inpatient psychiatric hospitalization days. BABHA continues to add measures to the dashboard to track data for additional areas identified by BABHA leadership.

BABHA implemented MCG (Milliman Care Guidelines) in 2019 to monitor the utilization of inpatient psychiatric hospitalization with a consistent tool.

To monitor the service delivery process BABHA uses the Michigan’s Mission-Based Performance Indicator System (MMBPIS) established by MDHHS. There are five performance measures that address access to services and outcomes which are submitted by BABHA quarterly to MDHHS and

MSHN. Each of these measures are reported for adults with mental illness, children with serious emotional disturbances, and adults and children with intellectual/development disability.

BABHA reviews a sample of consumer records quarterly from each primary provider, including BABHA primary services, to determine that the POS was given to the consumer within 15 days.

Goals:

1. Achieve or exceed the 95 percent standard for adults and children receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
2. Achieve highest level of compliance for consumers who meet with a professional for an intake assessment within 14 days of request for service. `
3. Achieve highest level of compliance for consumers who have a first service within 14 days of intake assessment.
4. Achieve or exceed the 95 percent standard for consumers discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days.
5. Compliance equal to or less than 15 percent for consumers readmitted to an inpatient psychiatric unit within 30 days of discharge.
6. Meet or exceed 95% compliance that there is evidence that the individual served was given the Plan of Service within 15 days.

BABHA has an established process to complete Medicaid Event Verifications (MEV) and follow-up restitution, as necessary.[26] The event verification process checks reimbursed Medicaid claims against chart documentation to verify. BABHA completes internal reviews for contract services providers and internal services. Additionally, MSHN conducts two reviews annually of BABHA Medicaid claims. These reviews help to determine that the individuals that are served have access to a variety of services and that the services provided meet Medicaid guidelines.

Goals:

1. Meet or exceed 95% compliance for BABHA and all contract service providers that receive a MEV review. (Corrective action is required on anything less than 100%)
2. Meet or exceed 95% compliance for all external MEV reviews conducted by MSHN

<u>Outcomes</u>

BABHA continues to make strides in improving health outcomes for the individuals it serves. Healthcare improvement opportunities have been identified in the Strategic Plan and the HCISC continues to make targeted efforts to improve outcomes related to healthcare.

MDHHS tracks and monitors a variety of HEDIS measures that have been identified as activities used to improve healthcare for consumers. BABHA has been focusing on the Diabetes Screening and Diabetes Monitoring measures and actively working to improve healthcare outcomes for consumers related to diabetes. Through detailed reviews of death certificates in the Healthcare Practice Committees, BABHA has identified the need to focus on the Cardiovascular Screening HEDIS measure for 2021.

BABHA reviews a sample of consumer records quarterly from each primary provider, including BABHA primary services, to determine that coordination occurred with the primary healthcare physician.

Goals:

1. FY21 data will be compared to baseline data collected during FY20 with the goal to increase labs associated with the Diabetes Screening HEDIS measure.
2. FY21 data will be compared to baseline data collected during FY20 with the goal to increase labs associated with the Diabetes Monitoring HEDIS measure.
3. Review and begin to action/address the data related to the Cardiovascular Screening HEDIS measure.
4. Meet or exceed 95% compliance that there is evidence of health care coordination within the consumer record completed by the primary providers.

BABHA currently utilizes Evidenced Based Practices to support the achievement of the clinical outcomes and therefore, the organizational mission. BABHA 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. The Recovery Self-Assessment Scale (RSA) (Administrator and Provider Version) survey assesses the degree to which BABHA implements recovery-oriented practices for consumers with mental illness and/or co-occurring substance use disorders from the perspective of the administrators and providers. BABHA will submit survey data as requested by MSHN for analysis.

Goals:

1. Evaluate implementation and capacity of existing EBP. Evaluate existing system structures to determine if the agency has created a system that supports ongoing successful implementation of existing EBP.
2. Identify gaps in clinical services and determine the need and identify any EBP/Best Practice to address the identified need.
3. Determine the ability to implement and sustain the identified EBP/Best Practices. Develop a system that supports the implementation of EBP and incorporate a process of continuous quality improvement.
4. Assess and increase staff competence in Motivational Interviewing, Transtheoretical Model (Stages of Change) Dialectical Behavior Therapy (DBT) basic skills, co-occurring behavioral health/substance use treatment, and Integrated Care competencies.
5. Monitor fidelity to prescribed models.
6. BABHA will analyze the RSA (Provider and Administrator Versions) to identify areas for improvement within the agency.

BABHA has been working to streamline ways to collect and analyze data related to the children's population. BABHA currently uses Child and Adolescent Functional Assessment Score (CAFAS) data to determine improvement over time in conjunction with the type of treatment that the child is receiving. BABHA has also seen a significant increase in the number of consumers receiving Applied Behavior Analysis (ABA) services over the past few years. In 2019, BABHA started working towards identifying ways to collect valuable data. In 2020, BABHA began working with PCE to create some electronic forms to collect data that can be used to monitor outcomes. MDHHS has proposed some changes to the potential data points collected and this could impact the electronic forms that are being created.

BABHA started looking at the use of the LOCUS assessment in 2020 to determine ways that it can be used to monitor outcomes. A LOCUS fidelity review has been scheduled for 2021 and there will be a focus on looking at the various elements of the data to determine how to best measure outcomes.

Goals:

1. Increase the percentage of children with improvement in the CAFAS score from the initial assessment to the most recent assessment specific to the type of treatment provided.
2. Continue to work with PCE to finalize electronic forms for data collection with potential adjustments related to the proposed MDHHS changes.
3. Analyze the Autism data collected to determine outcomes and improvement.

Through the review of the QAPIP, BABHA has identified that there are gaps in outcomes for the IDD, Autism, and children's populations. BABHA has made it a priority for 2021 to identify ways to track and monitor outcomes related to these populations.

Stakeholder Perceptions

Customer satisfaction and service quality is evaluated through quantitative and qualitative information obtained from a wide variety of stakeholders including consumers and/or their families, providers, staff, and community members. Feedback on satisfaction and opportunities for improvement is provided through annual consumer and provider satisfaction surveys (provider survey, Mental Health Statistics Improvement Program (MHSIP), Youth Satisfaction Services (YSS), and a behavior treatment plan survey), an employee survey conducted every two years, a community needs assessment completed every two years, and suggestion boxes that are checked on a monthly basis.

Goals:

1. Meet or exceed 80% agreeance/favorable responses to the survey questions on the provider survey.
2. Meet or exceed 80% satisfaction during the annual survey for the MHSIP survey.
3. Meet or exceed 80% satisfaction during the annual survey for the YSS Survey.
4. Meet or exceed 80% satisfaction for the behavior treatment plan surveys.

Section 4: Performance Measurement Methodologies

The BABHA QM 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 the 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 performance improvement 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 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 BABHA 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 BABHA QAPIP priorities as stated earlier in this plan, and are developed using a standardized "Projection Description/Data Specifications" (Attachment 1). Measures in use by BABHA include treatment effectiveness and outcome, functional ability, fidelity, process, prevalence and incidence rates, quality of life indicators, and satisfaction.

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

Performance measures and dashboard data are reviewed at a variety of different committee meetings including, but not limited to, PNOQMC, Expanded SLT, and Board Meetings. Additionally, a formal semi-annual report and annual report are presented to the Board.

Data Collection

The "Project Description Data Specifications" 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. BABHA uses the leadership dashboard and various plans to monitor other non-clinical business operations.

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 are then used

as appropriate to analyze and display the aggregated data. BABHA data is analyzed over time to identify patterns and trends and compared to desired performance levels, including externally derived benchmarks when available. QM 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 ensure 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 Quality Manager.

Communicating Process and Outcome Improvements

The results of BABHA provider operations performance measurement and improvement activities are communicated through the periodic dissemination of materials to employees, providers, and stakeholders via the BABHA Website, BABHA Board of Directors, Strategic Leadership Team, agency Leadership Team, Consumer Councils, PNOQMC, population committees, staff meetings as well as the general distribution of applicable information through the leadership dashboard, BABHA intranet, and other outlets as deemed appropriate.

Section 5: Review/Evaluation of Plan Effectiveness

BABHA has led and been involved in many performance improvement activities during 2020. 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 2020 QAPIP plan has been determined to be effective and any updates, revisions, and new projects have been added to the 2021 plan as necessary to continue the pursuit of exceptional performance. During 2021, 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. There have been some gaps that have been identified during the review of the QAPIP and these will be addressed as priorities for 2021.

Section 6: Quality Assessment and Performance Improvement Priority Focus Areas for 2021

BABHA has identified access to care/utilization, harm identification and reduction, outcomes, and stakeholder feedback as key areas to focus on in 2021. Below are the activities that have been identified to assist with improving the quality of services and outcomes for the consumers served.

Access to Care/Utilization

BABHA has made significant progress in using a standardized tool and creating a process to help review the utilization related to CLS services. A CLS committee meets monthly to discuss the utilization of services and determine an appropriate number of hours of CLS authorized for each consumer. BABHA continues to look at the MMBPIS data quarterly to determine overall performance related to access of care and utilization and has struggled with meeting the standards set by MDHHS. In April 2020, MDHHS made changes to Indicators 2 and 3. The changes made to Indicator 2 now uses the data a screen was requested versus the date the screen was started and this impacts the timeliness for consumers access to care. BABHA has also identified an ongoing trend with consumer no-shows for the intake appointment and first service appointment. The PNOQMC expressed a desire to look into the utilization of telehealth services and the number of service units provided.

Goals:

1. Explore ways to continue to measure the use of CLS services to determine how to monitor outcomes.
2. Look at specific and casual factors that are resulting in consumers having a delay to accessing services and readmissions to inpatient hospitals.
3. Collect and analyze data related to the date the access screen was requested and the date the access screen was completed to determine any areas identified for improvement.
4. Review data related to the use of telehealth services and units of service provided.

Outcomes

BABHA has identified a need to increase healthcare integration for 2021. Steps have been taken to provide BABHA with the information needed to identify specific focus areas. There will be a focus on increasing the percentage of individuals that have received the appropriate labs to improve the Diabetes Screening, Diabetes Monitoring, and Cardiovascular Screening HEDIS measures for 2021.

Additionally, BABHA has identified gaps in outcome measurement for the IDD, Autism, and children's populations. Some outcome measures have been used for the MI Adult population, but BABHA will also be focusing on additional tools that can be used. As a part of the Strategic Plan, BABHA intends to look at our current system and the use of EBP and the impact it has on outcomes.

Goals:

1. Explore ways to look at each population group to determine how to best measure outcomes.
2. Explore the LOCUS assessment to determine how the data can be used to measure the intended outcomes.
3. Provide refresher trainings in EBP to account for loss of knowledge and staff turnover

Attachment 1

Quality Assessment and
Performance Improvement Program

PROJECT DESCRIPTION/DATA SPECIFICATIONS

REQUESTOR	PROJECT/REPORT NAME
STAFF COMPLETING THIS FORM	DATE
PROJECT SUMMARY	
OPTIONAL OR REQUIRED? IF REQUIRED, BY WHOM?	
STUDY QUESTION(S)	

INDICATORS (WHICH ANSWER THE QUESTION)	
Indicator #1	
Numerator:	
Denominator:	
Baseline Measurement:	
Benchmark:	
Baseline Goal:	
Indicator #2	
Numerator:	
Denominator:	
Baseline Measurement:	
Benchmark:	
Baseline Goal:	
Indicator #3	
Numerator:	
Denominator:	
Baseline Measurement:	
Benchmark:	
Baseline Goal:	

DATA VALIDATION METHODS TO BE USED
(face validity checks, primary source verification, known logic errors)

FREQUENCY OF DATA PULL AND/OR REPORT GENERATION

☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY ☐ OTHER (DESCRIBE)

STATISTICAL ANALYSIS/TESTING METHODS, IF ANY

STUDY POPULATION/DATA PARAMETERS

Data Universe

Fund Source	All	
Fund Source	Autism Waiver (Medicaid, MI Child)	
Fund Source	General Fund	
Fund Source	Medicaid (EPSDT, B3, HSW, State Plan)	
Fund Source	Medicaid Fee for Service (Child Waiver, SED Waiver)	
Fund Source	Medicaid Healthy Michigan Plan	
Fund Source	Other State (ABW, MI Child)	
Fund Source	Medicare	
Fund Source	Other Insurance	
Fund Source	Fund Source Not Specified	

Sampling Frame

Record Source	Encounter data (sent or unsent)	
Record Source	Fully adjudicated claims	
Record Source	Service activity logs (SAL's)	
Document	Phoenix document data field tables	
Other Source(s)		

Sampling Unit

	Encounters	
	Claim lines	
	Service activity events	
	Consumers	
	Clinical Document(s)	
	Clinical Service(s) (HCPCS Code or Modifier)	
	Clinical Program(s) or Provider(s)	

Detail/Filters

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)	
Phoenix Views (diagnosis)	Diagnosis Source (Claims-Phoenix Diagnostic Module)	

Phoenix Views (diagnosis)	Diagnosis Code (DSM/ICD)	
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	
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	
Service Category	Procedure Code Type (CPT or Revenue Code)	
Service Category	Procedure Type (code groups)	
Service Category	Procedure Code (specific codes)	
CPT Mod1	CPT Modifiers	
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	
Medications	Medication Name	
Medications	Medication Therapeutic Class	
	Other (specify):	

DETAIL OF DIAGNOSTIC OR PROCEDURE CODES TO BE INCLUDED (IF NECESSARY)

Service or Diagnosis Name	Code(s)	Modifiers/Specifiers

NOTES

Attachment 2

Quality Assessment and
Performance Improvement Program

Summary Report

Title of Measure:

Committee/Dept:

Reporting Period:

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

Data Interpretation: (performance against targets and benchmark data)

Baseline Data

Current Data

Interventions/Improvement Strategies

Conclusions:

Attachment 3

Quality Assessment and
Performance Improvement Program

Follow-Up to Data Analysis

Title of Measure:

Provider/Program Reporting:

Reporting Period:

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.

If the variation is undesirable, what causes do you see for the variation in performance?

Causal Factors	Common Cause (Y/N/NA)	Special or Assignable Cause (Y/N/NA)

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

Intervention(s)	Implementation Date	Date Full Benefit/ Impact Anticipated

Comments:

Submitted by: Date:

Approved by: Date:

Attachment 4

Bay-Arenac Behavioral Health Authority		
Board of Directors		
April 1, 2020 through March 31, 2023		
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	04/01/19 to 03/31/22	Bay
James Anderson Vice Chair	04/01/20 to 03/31/23	Bay
Robert Pawlak Treasurer/Parliamentarian	04/01/19 to 03/31/22	Bay
Colleen Maillette Secretary	04/01/20 to 03/31/23	Bay
John Andrus	04/01/18 to 03/31/21	Bay
Ernie Krygier	04/01/18 to 03/31/21	Bay
Robert Luce	04/01/18 to 03/31/21	Arenac
Sally Mrozinski	04/01/19 to 03/31/22	Arenac
Patrick McFarland	04/01/18 to 03/31/21	Bay
Justin Peters	04/01/19 to 03/31/22	Bay
Thomas Ryder	04/01/20 to 03/31/23	Bay

Revised 01/27/2021

Attachment 5

Primary Network Operations and Quality Management Committee Membership		
Positions/Committee Representative	Attendance	Member
Business Intelligence Recorder	Required	Joelle Sporman
Recipient Rights/Customer Services Manager	Required	Melissa Prusi
SLT - Director of Healthcare Accountability Corporate Compliance Committee	Required	Janis Pinter
SLT - Primary Care (Co-Chair)	Required	Joelin Hahn
SLT - Integrated Care Behavior Treatment Committee	Required	Karen Amon
Arenac Center	Required	Heather Friebe
BI - Medical Records/Electronic Health Records	Required	Brenda Beck
BI - Quality Manager (Co-Chair)	Required	Sarah Holsinger
BI - Quality and Compliance Coordinator	Required	Chris Tomczak
BI - SIS Assessor	Required	Mary Gilbert
Emergency Service/Access	Required	Kristy Moore/Margaret Dixon/Stacy Krasinski
Medical Services - Prescribers Healthcare Practices Committee	Required	Amy Folsom
Adults with MI	Required	Kathy Palmer
Adults with IDD	Required	Melanie Corrion
North Bay	Required	Lynn Blohm
Children with SED	Required	Kelli Maciag
Children with ID	Required	Noreen Kulhanek/Emily Young
BABHBABHA Contracts	Adhoc	Stephanie Gunsell
Medical Director	Adhoc	Dr. Roderick Smith
Finance Rep	Adhoc	Ellen Lesniak
Medical Services - Nursing	Adhoc	Sarah Van Paris
Consumer Rep	Adhoc - Quarterly	
Contract Provider Reps	Attendance	Member
LPS	Required	Jackie List/Rachel Keyes
MPA	Required	Emily Simbeck/Lloysa Gallery/Matt Lance/ Tracy Hagar
Saginaw Psych	Required	Ashley Luplow/Barb Goss/Megan Crippin/K athy Coleman/Kristen Kolberg/Nathalie Menendes
Other Subject Matter Experts as needed	Adhoc	

Revised 01/27/2021

Attachment 6

Bay-Arenac Behavioral Health
Quality Assessment and Performance Improvement Program
Reporting Structure
2021