

BAY ARENAC

BEHAVIORAL HEALTH

Community Mental Health Services Program

*Quality Assessment and Performance Improvement Program
FY 2026*

Adopted by the Board: October 16, 2025

BOARD
ADOPTION:
10/16/25

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Section 1: Introduction and Overview

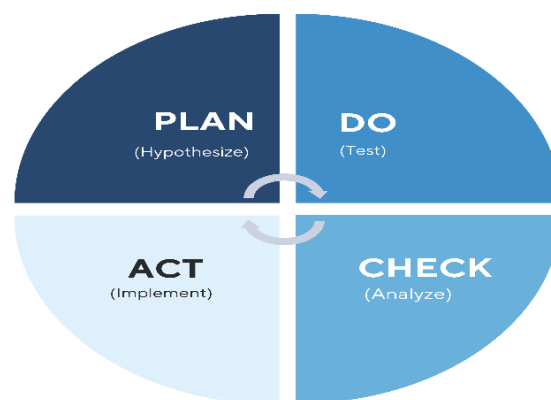
Bay-Arenac Behavioral Health Authority (BABHA) provides an array of behavioral health services and supports to individuals in the Michigan counties of Bay and Arenac through a network of direct operated programs and contracted service providers. BABHA is a Michigan Department of Health and Human Services (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, BABHA 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:

- 1 Performance Improvement is dynamic, system-wide and integrated.
- 2 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.
- 3 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.
- 4 Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- 5 Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

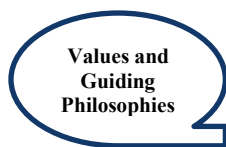
Continuous improvement is supported by the plan, do, check, act/adjust cycle (PDCA). Standard work statements are developed and utilized to implement and maintain improvements and are updated as the PDCA cycle is repeated to produce continuous improvement over time. The QAPIP, as described in this document, is evaluated annually for effectiveness and modifications are made, as necessary.





Mission

It is the mission of BABHA to improve health outcomes to enhance quality of life and strengthen the community safety net for citizens of Arenac and Bay counties.



Values and Guiding Philosophies

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.

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

Board of Directors

The Board of Directors is the governing body of BABHA and has ultimate responsibility for the quality of care and services delivered by the organization. The Board of Directors evaluates, sets policies related to performance improvement and sets priorities for performance improvement initiatives for the next year. Annually, the Board of Directors reviews and formally adopts the QAPIP.

Chief Executive Officer

The BABHA CEO 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, and designates the Director of Healthcare Accountability as Strategic Leadership Team (SLT) member responsible for the BABHA QAPIP.

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, and participation in relevant committees.

Leadership

The SLT is comprised of senior management which meets regularly and has an Expanded Leadership meeting of which the Quality Manager is a member. All managers and team leaders join the SLT in a monthly Agency Leadership meeting to collaborate on new processes and utilizes data effectively for informed decision making.

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 and identifying opportunities for improvement. They carry out the agency's mission and vision while providing direct care.

Quality Manager

The Quality Manager, under the oversight of the Director of Healthcare Accountability, is the leader responsible for the daily management of the QAPIP. The Quality Manager 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 the lead on the renewal of accreditation, assistance with preparation for various audits, and developing and implementing plans of corrections.

Quality and Compliance Coordinators

The Quality and Compliance Coordinators assist the Quality Manager with the coordination, initiation, guidance, and collaboration of local performance improvement projects. These individuals participate in regional performance measurement activities such as clinical record reviews for performance improvement projects, performing reviews of contracted service provider performance, Medicaid Event Verification, and are members on regional committees and work groups.

Stakeholders

BABHA sponsors regular meetings with key stakeholders to discuss system issues and process changes as well as 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.

QAPIP Committees

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 PNOQMC is responsible for monitoring performance by:

- Receiving recommendations for improvement,
- Identifying quality related indicators and measures,
- Reviewing data reports to ensure validity,
- Taking action to achieve improvement, and meeting regularly to review and assess performance.

Consumer Councils

BABHA sponsors two clinical consumer councils that report to the PNOQMC and provide input directly regarding program operations and performance. 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.

Behavior Treatment Review Committee

The Behavior Treatment Review Committee's (BTRC) primary function is to oversee the proposed use of intrusive and restrictive techniques that may be considered as a last resort for recipients of public mental health services. The committee is responsible for reviewing behavior treatment data, including information on approved intrusive or restrictive techniques, the number and duration of interventions per person, and instances where physical management or 911 calls to law enforcement were used during an emergency behavioral crisis. A quarterly analysis is conducted to identify trends or patterns of behavior that may indicate risk to an individual or group.

Healthcare Practices Committee

The Healthcare Practices Committee's 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 of BABHA 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. When trends or patterns in this data are recognized, the committee is responsible for making recommendations to management to resolve safety issues.

Corporate Compliance Committee

The Corporate Compliance Committee is responsible for all matters related to the legal and regulatory requirements of BABHA operations as it relates to contractual compliance, HIPAA privacy and security, and guarding against fraud and abuse of state and federal healthcare funds. The CCC performs fraud and abuse risk assessments and compliance program evaluations, identifies focus areas, conduct any necessary audits and self-review, and develop compliance program improvement priorities. The CCC assists with the review of internal and external monitoring and auditing activities to ensure that efforts are appropriate to provide assurance of compliance and ensures routine monitoring occurs as scheduled and findings are responded to.

Enrollee Rights and Responsibilities

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. Recipient Rights Office representatives report aggregated data on abuse, neglect and customer services findings and make recommendations to PNOQMC for system improvements when needed.

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 FY26 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 Behavioral Health Standards Manual, 1.M).

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

- ✓ Provider Qualification and Selection
- ✓ Harm Identification and Reduction
- ✓ Access to Care and Utilization
- ✓ Outcomes
- ✓ 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 to ensure they are qualified to perform services and have current, appropriate credentials and privileges. Orientation and training in regard to responsibilities, program policy, and operating procedures are required for new employees. Staff performance and competency are monitored on a regular basis. Training needs are identified through formal means, such as performance/competency reviews, as well as informally, through self-identified areas for improvement.

GOAL	FY2026 Performance Goal	Assigned Person	Frequency of Review	Review Committee
BABHA staff will review a sample of internal and provider staff to verify they have documentation to support the appropriate qualifications.	95%	Quality Manager	Annually	PNOQMC

Reviews will be completed of providers to verify that the staff have been trained in the Individual Plan of Service prior to providing services and it is accurately documented.	95%	Quality Manager	Quarterly	Provider Specific Committees as appropriate
BABHA will complete reviews to ensure that the staff responsible for implementing an Individual Plan of Service (IPOS) are receiving training from the author of the IPOS.	95%	Quality Manager	Monthly	PNOQMC

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 Rights (ORR). 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 help determine how BABHA can make improvements to reduce risk for consumers.

Processes are also in place for reporting on significant events, which include investigations, material litigation, catastrophes, sentinel events, and governmental sanctions, bans on admissions, fines, penalties, or loss of programs (CARF 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, the Habilitation Supports Waiver, and the 1915(i) State Plan Amendment (SPA) program.

Recipient Rights Office representatives report aggregated data on abuse, neglect and customer services findings and make recommendations to PNOQMC for system improvements when needed.

GOAL	FY2026 Performance Goal	Assigned Person	Frequency of Review	Review Committee
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.		Quality Manager	Quarterly	PNOQMC
Review the number of emergency physical interventions each year.	Decrease or remain consistent	Quality Manager	Quarterly	PNOQMC and BTRC
The number of days to complete the recipient rights investigation is lower than the Michigan Mental Health Code standard of 90 days.	100%	Recipient Rights Manager	Quarterly	PNOQMC

Abuse and neglect complaints substantiated have remedial action that includes disciplinary action and prevents recurrence.	100%	Recipient Rights Manager	Quarterly	PNOQMC
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Access to Care and Utilization Management

BABHA's utilization management plan is detailed in several sections of the Policies and Procedures Manual. 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. BABHA uses a dashboard to track data related to various performance measures and utilization.

Michigan's Mission-Based Performance Indicator System (MMBPIS)

The Michigan Department of Health and Human Services (MDHHS), in compliance with federal mandates, establishes standards related to access, efficiency, and outcomes. Data is regularly collected, and quarterly reports are compiled and submitted to the PIHP for analysis, regional benchmarking. If BABHA's performance falls below the established goals, the Quality Manager, in collaboration with PNOQMC members, will complete a corrective action plan.

In October 2023, the Bureau of Specialty Behavioral Health Services began a comprehensive review of the existing quality assessment and performance improvement program with the goal of developing and implementing a new, more robust program. The revised program will feature a more comprehensive framework, clearer definitions, and a more rigorous methodology that aligns with national standards and practices from other states. This quality transformation has a 3-year rollout plan with new measures being added each year.

PIHP Performance Improvement Projects (PIP)

BABHA participates in at least two PIHP PIPs per year. 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.

GOAL	FY2026 Performance Goal	Assigned Person	Frequency of Review	Review Committee
Achieve or exceed the 95% standard for adults and children receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	95%	Quality Manager	Quarterly	PNOQMC

CARF Accredited Program and Standard – EFFICIENCY

ACT; CSM (integrated IDD/mental health - adults, children, and adolescents); Community Integration (psychosocial rehabilitation - adults); Intensive Family-Based Services (family services - children and adolescents); Outpatient Treatment (integrated IDD/mental health - children and adolescents, mental

health - adults); Crisis Intervention (integrated IDD/mental health - children and adolescents, mental health - adults)				
Achieve or exceed 63% compliance for consumers who meet with a professional for an intake assessment within 14 days of request for service with an increase from FY25.	63%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFICIENCY</u>				
ACT; CSM (integrated IDD/mental health - adults, children, and adolescents); Community Integration (psychosocial rehabilitation - adults); Intensive Family-Based Services (family services - children and adolescents); Outpatient Treatment (integrated IDD/mental health - children and adolescents, mental health - adults)				
Achieve or exceed 75% compliance for consumers who have a first service within 14 days of intake assessment with an increase from FY25	75%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFICIENCY</u>				
ACT; CSM (integrated IDD/mental health - adults, children, and adolescents); Community Integration (psychosocial rehabilitation - adults); Intensive Family-Based Services (family services - children and adolescents); Outpatient Treatment (integrated IDD/mental health - children and adolescents, mental health - adults)				
Achieve or exceed the 95% standard for consumers discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days	95%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFICIENCY</u>				
ACT; CSM (integrated IDD/mental health - adults, children, and adolescents); Community Integration (psychosocial rehabilitation - adults); Intensive Family-Based Services (family services - children and adolescents); Outpatient Treatment (integrated IDD/mental health - children and adolescents, mental health - adults)				
Compliance equal to or less than 15% for consumers readmitted to an inpatient psychiatric unit within 30 days of discharge with a decrease from FY25	Less Than 15%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFECTIVENESS</u>				
ACT; CSM (integrated IDD/mental health - adults, children, and adolescents); Community Integration (psychosocial rehabilitation - adults); Intensive Family-Based Services (family services - children and adolescents); Outpatient Treatment (integrated IDD/mental health - children and adolescents, mental health - adults)				
Meet or exceed 95% compliance that there is evidence that the individual served was given the Individual Plan of Service within 15 days	95%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>NA</u>				

A reduction in inpatient hospitalizations days will occur in FY26 for consumers with a severe, persistent mental illness	5% Reduction	Director of Integrated Care	Quarterly	PNOQMC
CARF Accredited Program and Standard - <u>EFFECTIVENESS</u>				
ACT; CSM (integrated IDD/mental health - adults, children, and adolescents); Community Integration (psychosocial rehabilitation - adults); Intensive Family-Based Services (family services - children and adolescents); Outpatient Treatment (integrated IDD/mental health - children and adolescents, mental health - adults); Crisis Intervention (integrated IDD/mental health - children and adolescents, mental health - adults)				
Reports will be created to determine if services authorized in the plan of service are being provided at the identified consistency.	New	Quality Manager	NA	Leadership
CARF Accredited Program and Standard - <u>NA</u>				

Medicaid Event Verification (MEV)

BABHA has an established process to complete Medicaid Event Verifications (MEV) and follow-up restitution, as necessary. The event verification process checks reimbursed Medicaid claims against chart documentation to verify accuracy and validity. BABHA completes internal reviews for contract services providers and direct services. Additionally, the PIHP 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.

GOAL	FY2026 Performance Goal	Assigned Person	Frequency of Review	Review Committee
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%)	95%	Quality Manager	Quarterly	PNOQMC/ CCC
Meet or exceed 95% compliance for all external MEV reviews conducted by the PIHP.	95%	Quality Manager	Bi-Annually	PNOQMC/ CCC
Continue completing internal MEV reviews to reduce risk related to billable services.		Quality Manager	Various	PNOQMC/ CCC

Outcomes

BABHA continues to make strides in improving outcomes for the individuals it serves. Improvement opportunities have been identified in the Strategic Plan. 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, Diabetes Monitoring, and Cardiovascular Monitoring in an effort to improve health outcomes for the individuals that BABHA serves.

Additionally, 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. MDHHS monitors this standard during annual Waiver Audit.

GOAL	FY2026 Performance Goal	Assigned Person	Frequency of Review	Review Committee
The Diabetes Screening HEDIS measure will increase in compliance from FY26.	Increase by 5%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFECTIVENESS</u>				
ACT; CSM (adults only); Community Integration (adults only); Outpatient Therapy (adults only)				
The Diabetes Monitoring HEDIS measure will increase in compliance from FY26.	Increase by 5%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFECTIVENESS</u>				
ACT; CSM (adults only); Community Integration (adults only); Outpatient Therapy (adults only)				
The Cardiovascular Monitoring HEDIS measure will increase in compliance from FY26.	Increase by 5%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>EFFECTIVENESS</u>				
ACT; CSM (adults only); Community Integration (adults only); Outpatient Therapy (adults only)				
Meet or exceed 95% compliance that there is evidence of health care coordination within the consumer record completed by the primary providers.	95%	Quality Manager	Quarterly	PNOQMC
CARF Accredited Program and Standard – <u>NA</u>				
Review Peer Review documents for the prescribers to determine any trends.		Madison Clinic Program Manager	Quarterly	HPC
CARF Accredited Program and Standard - <u>NA</u>				

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 are provided through:

- Suggestion Boxes- monthly
- Behavior Treatment Plan Survey- annually
- Mental Health Statistics Improvement Program (MHSIP) and Youth Satisfaction Services (YSS) Survey- annually
- National Core Indicators (NCI) Survey- annually
- Provider Survey- annually
- Community Needs Assessment- every two years
- Employee Survey- every two years

GOAL	FY2026 Performance Goal	Assigned Person	Frequency of Review	Review Committee
Meet or exceed 80% agreeance/favorable responses to the survey questions on the provider survey.	80%	Quality Manager	Annually	Expanded SLT and All Provider Specific Committees
Meet or exceed 80% satisfaction during the annual survey for the MHSIP survey specific to the General Satisfaction domain.	80%	Quality Manager	Annually	PNOQMC
Meet or exceed 80% satisfaction during the annual survey for the YSS Survey specific to the Appropriateness (General Satisfaction) domain.	80%	Quality Manager	Annually	PNOQMC
Meet or exceed 80% satisfaction for the Behavior Treatment Surveys.	80%	Quality Manager	Annually	BTRC
Meet or exceed 80% agreeance/favorable responses to the survey questions on the provider survey.	80%	Quality Manager	Annually	Expanded SLT and All Provider Specific Committees

Section 4: Performance Measurement Methodologies

The BABHA QM program uses a variety of methods to establish measures, collect data, analyze and report findings, and implement and monitor corrective actions as necessary.

Establishing Measures

Performance measures, developed in alignment with BABHA’s strategic priorities, address clinical and non-clinical areas. The QAPIP is used but is not limited to the following means for identification of issues and opportunities for improvement:

- Growth areas identified based on performance
- Stakeholder feedback
- Oversight and monitoring reviews

Data Collection

Methods of Data Collection:

- Surveys and Questionnaires: Collect feedback from patients, staff, and stakeholders.
- Electronic Health Record (EHR): Use data from EHR to track patient outcomes and service utilization.
- Record Reviews
- Frequency of Data Collection:
 - Continuous Monitoring: Implement real-time data collection for ongoing assessment.
 - Periodic Reviews: Conduct monthly or quarterly reviews to identify trends and areas for improvement.
 - Annual Evaluations: Perform comprehensive annual evaluations to assess overall program effectiveness.

Data Analysis and Reporting

Data is aggregated at intervals appropriate to the process or activity under review, with specific timeframes and methods defined in project descriptions. Statistical testing and analysis are applied as needed to interpret and display the aggregated data. BABHA data is examined over time to identify patterns and trends and is compared against desired performance levels, including external benchmarks when available. Quality Management staff use dashboards or summary reports to present data results, along with recommendations for further investigation, data collection improvements to address validity concerns, and/or system-level improvements.

Undesirable patterns, trends, or performance variations are flagged for action. In some cases, additional data collection and analysis may be required to identify root causes, leading to remedial or corrective measures. Conversely, departments demonstrating consistently positive performance may be asked to document the strategies used to sustain those outcomes.

Quarterly and annual reports are formally reviewed by the Board. These reports summarize studies conducted, results obtained, follow-up actions, and aggregated data on utilization and service quality. This review ensures the QAPIP’s continuity, effectiveness, and ongoing relevance.

Corrective Action Plans

A corrective action plan (CAP) is a step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to:

- Identify the most cost-effective actions that can be implemented to correct error causes.
- Develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient.
- Achieve measurable improvement in the highest priority areas.
- Eliminate repeated deficient practices

BABHA utilizes the CAP process throughout the agency to improve compliance and quality.

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, 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 2025. Given the nature and scope of the accomplishments, the 2025 QAPIP plan has been determined to be effective and any updates, revisions, and new projects have been added to the 2026 plan as necessary to continue the pursuit of exceptional performance. During 2026, 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 providers and internal programs for such areas that need improvement. There have been some gaps and improvements that have been identified during the review of the QAPIP and these will be addressed as priorities for 2026.

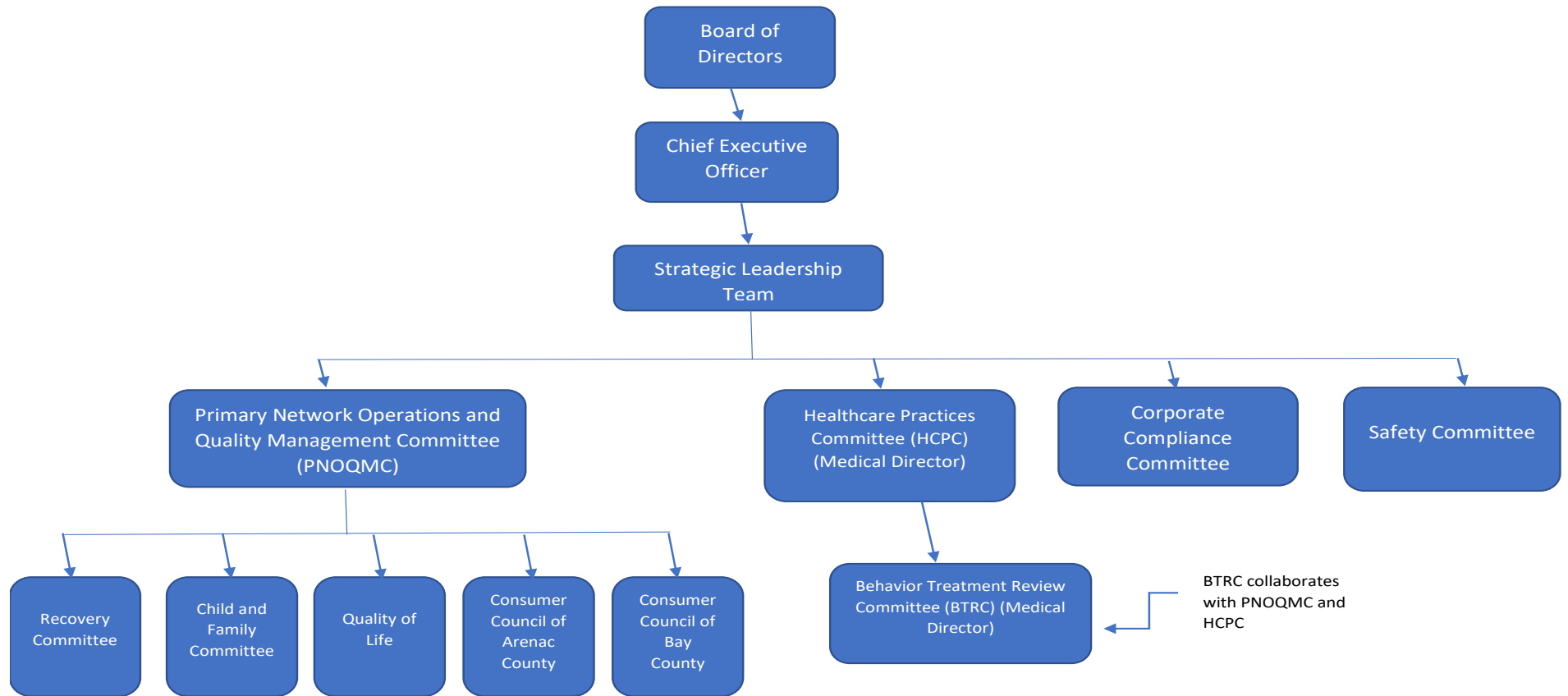
References

- Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Medical Staff Plan
- Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Strategic Leadership Plan
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T01 Staff Credentials
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T13 Credentialing and Privileging of Licensed Independent Practitioners
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C08-S06-T06 Organizational Credentialing
- Bay-Arenac Behavioral Health Employee Handbook
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T05 Cultural Competence and Limited English Proficiency.
- Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Cultural Competency and Diversity Plan.
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T02 Orientation
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T01 Minimum Training Requirements
- Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Training Plan
- Bay-Arenac Behavioral Health Policies and Procedures Manual, Agency Action Plans, Operating Philosophy and Ethical Guidelines
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T05 Performance Management
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S01-T02 Professional Staff Competency
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S02-T26 Continuing Education
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C07-S03-T03 Scheduling, Promoting, and Documentation of Staff Education
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C03-S01-T01 Statutory Establishment
- Bay-Arenac Behavioral Health Policies and Procedures Manual, C02-S01-T06 Reporting and Investigation of Adverse Events

Bay-Arenac Behavioral Health Authority		
Board of Directors		
April 1, 2025 through March 31, 2026		
Original Board Appointed 09/23/63		
County Elected to Come Under PA 258, effective 08/08/75		
MH Code revision PA 290, 1995, effective 03/27/96: All board member terms were extended 3 months to end on 03/31, and thereafter be 3-year terms		
Name	Term	County Represented
Robert Pawlak Chair	04/01/25 to 03/31/28	Bay
Patrick McFarland Vice Chair	04/01/24 to 03/31/27	Bay
Chris Girard Treasurer	04/01/25 to 03/31/26	Bay
Sally Mrozinski Secretary	04/01/25 to 03/31/28	Arenac
Tim Banaszak	04/01/23 to 03/31/26	Bay
Richard Byrne Parliamentarian	04/01/25 to 03/31/28	Bay
Patrick Conley	04/01/24 to 03/31/27	Bay
Jerome Crete	04/01/23 to 03/31/26	Bay
Shelley King	04/01/25 to 03/31/28	Bay
Kathy Niemiec	04/01/23 to 03/31/26	Bay
Carole O'Brien	04/23/24 to 03/31/27	Arenac
Pamela Schumacher	04/01/24 to 03/31/27	Bay

Revised 05/01/2025

Bay-Arenac Behavioral Health Quality Assessment and Performance Improvement Program Reporting Structure 2026



Monitors routine reports, receives assignments from and reports progress and activities directly to PNOQMC.

Monitors routine reports. Collaborates with PNOQMC when performance is not meeting standard, outcome measurement is needed and/or improvement is desired.